

# North Tees and Hartlepool



## NHS Foundation Trust

Operational Plan Document for 2014-16

North Tees and Hartlepool NHS Foundation Trust

**FINAL**

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## 1.1 Operational Plan for y/e 31 March 2015 and 2016

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

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

In signing below, the Trust is confirming that:

The Operational Plan is an accurate reflection of the current shared vision of the Trust Board having had regard to the views of the Council of Governors and is underpinned by the strategic plan;

The Operational Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;

The Operational Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans; and

All plans discussed and any numbers quoted in the Operational Plan directly relate to the Trust's financial template submission.

Approved on behalf of the Board of Directors by:

Name (Chair)	Paul Garvin
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Signature

Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Alan Foster
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Signature

Approved on behalf of the Board of Directors by:

Name (Finance Director)	Lynne Hodgson
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Signature

## 1.2 Executive Summary

North Tees and Hartlepool NHS Foundation Trust is a successful, highly performing, efficient provider of integrated acute and community based healthcare. As a Foundation Trust now for over six years the Trust Board of Directors has a proven track record of effectively planning, driving quality and safety, improving patient experience and delivering operational and financial standards. The Trust has ambitious plans for the future to work with healthcare partners to transform health and healthcare services under the *Momentum; Pathways to Healthcare Programme*. The *Momentum; Pathways to Healthcare Programme* aims to improve access for patients but not everything can be delivered locally and that is a challenge with regard to on-going public engagement.

The Board of Directors has used 2013 as a chance to pause and reflect on the strategic direction that the Trust is following and with a sound history of strong quality, service and financial performance, has refreshed the strategy (published in October 2013) in line with the challenges and opportunities within the national and local landscape. This Operational Plan sets out a number of short term challenges and objectives, not least delivering 7 day services to improve access and the quality of care for patients. In addition, the plan details a number of priority quality objectives such as the drive to ensure demonstrable progress to reduce avoidable deaths in and influencing progress, out of, hospital. This includes delivery within the expected national mean for HSMR and SHMI.

The Trust values its staff and will capitalise on the success of the staff engagement exercise in 2013 and embark upon a further programme of staff engagement in 2014, inclusive of the Friends and Family Test for staff and formal and informal surveys and events.

The Service Line Management approach will continue to be the focus of operational delivery in the Trust, within which there are three key strands of work, including, strengthening clinical leadership in management, developing service line reporting through Patient Level Information and Costing and improving and streamlining the performance improvement and management approach.

The Trust has met all of its statutory financial duties in every financial year since becoming a Foundation Trust in 2007. The financial strategy over the next two years is about future performance building on the historic success of the past. Strong financial performance is fundamental to the Trust's service aspirations and plans which need to be substantiated within a strong business model. The size of the efficiency target presents another challenge in the year ahead; by planning in advance, however, a number of initiatives are already progressing, improving the likelihood of delivering the efficiencies required. The Trust's medium term financial strategy, linked to the development of the new single site hospital, continues to drive clinical and operational efficiency, utilising lean management principles and service line management.

In summary, transformational change is required to enable the Trust to continue to deliver high quality, safe and affordable services. A significant programme of change will be delivered in 2014/15 streamlining services and pathways of care across both sites with the emphasis on delivering clinical pathway improvements across acute and community, enabling patients to be treated closer to home. Balancing delivery of high quality services whilst also delivering a challenging cost improvement programme continues

to be a high priority for the Board of Directors and this is addressed within the robust planning and the overarching governance and performance improvement and delivery framework.

With sound quality governance, risk management and financial control, the Trust is well placed to continue to deliver incremental improvements in the quality of services delivered to patients and to deliver the financial and service performance targets, despite significant challenges.

## 1.3 Operational Plan – Short Term Challenge

### 1.3.1 Background

North Tees and Hartlepool NHS Foundation Trust is a successful, high performing, efficient provider of integrated hospital and community-based healthcare to around 365,000 people living in East Durham, Hartlepool, Stockton on Tees and surrounding areas including Sedgefield, Easington and Peterlee. As a centre for breast and bowel screening, services do extend further, taking in a population of around 400,000.

The Trust has ambitious plans for the future to work with healthcare partners to transform health and healthcare services under the *Momentum: Pathways to Healthcare Programme*. This programme will help to keep people healthy, intervene early and provide transformational care both ‘in hospital’ and ‘out of hospital’, in or closer to people’s homes, by an infrastructure of integrated services, to provide excellent tailored healthcare, culminating in a new single site hospital build.

The *Momentum: Pathways to Healthcare Programme*, established in 2007 with key stakeholders, has since provided a foundation for NHS policy implementation and as such has encompassed the principles and ambitions of the Better Care Fund, providing a focus for key partners.

As the new NHS structures mature, the Trust’s partner organisations continue to be involved in development and delivery, with commitment strengthened via partnership arrangements to support implementation and direct links to the Hartlepool and Stockton on Tees Clinical Commissioning Group (CCG) and Durham, Darlington, Easington and Sedgefield CCG Clear and Credible Plans and the Joint Strategic Needs Assessments of Hartlepool, Stockton and Durham Health and Wellbeing Boards.

The Programme vision (Table 1) provides a frame of reference to guide planning; with implementation influenced by three major projects:

- Service Transformation
- Primary and Community Care Capital Planning Project; and
- Hospital Capital Planning Project.

These are supported by three work streams:

- Workforce Strategy;
- Financial Assessment, Compliance and Affordability; and
- Communication and Engagement.

**Table 1: Momentum Vision**

Delivery of the Momentum vision will result in:	
Better services	Better facilities

<ul style="list-style-type: none"> <li>• Continued focus on prevention and appropriate self-care</li> <li>• Proactive management of long term conditions</li> <li>• Better integration of primary, secondary, community and social care</li> <li>• Better access to diagnostics in the community</li> <li>• Sustainable high quality emergency care services</li> </ul>	<ul style="list-style-type: none"> <li>• A new state of the art hospital with near 100% single rooms</li> <li>• Better community facilities that are accessible closer to home</li> <li>• Spaces that are innovative, flexible and sustainable</li> <li>• Low carbon facilities that are efficient and cost effective</li> <li>• Great places to get better, work and visit</li> </ul>
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The *Momentum: Pathways to Healthcare Programme* Capacity Plan was refreshed during 2013 to support the health and social care deliverables including:

- Reduced General and Acute care bed stock.
- Accident and Emergency (A&E) attendances to be seen at the community integrated care centres, relieving pressure on the major A&E department of the new single site hospital.
- Negligible increase in emergency admissions and a reduction in emergency lengths of stay by up to one third, ensuring that trust performance for emergency length of stay is at, or close to top decile nationally.
- Increased outpatient appointments in the community, including 90,000 physiotherapy and occupational therapy contacts
- Shift of treatments that currently take place in day case or inpatient facilities to procedure rooms, possibly in a community setting.
- Shift of appropriate inpatient treatments into day case setting to achieve an overall day case rate of 78%. (see operational efficiency table).

As planning progresses, the assumptions underpinning these deliverables will be continuously reviewed and refreshed to ensure that the service configurations will meet the evolving needs of the local population.

Service Transformation under-pins the operational delivery outlined within the *Momentum: Pathways to Healthcare Programme*; to wrap care around the patient and to execute change across care pathways to deliver the bed reductions required in the capacity plan, provide care closer to home and increase quality, accessibility, integration and responsiveness and value for money. This philosophy is now fully integrated into the Trust's mainstream business and following full engagement with Better Care Fund planning, alignment with health and social care plans is overseen by the 'unit of planning' - the North of Tees Partnership Board.

In 2013/14 the Trust successfully delivered Phase 1 of Service Transformation, bringing together critical care, acute medical and complex surgical services onto the North Tees hospital site and establishing the Holdforth Unit on the Hartlepool hospital site, to provide step down care for Hartlepool and Durham residents following a period of acute care. The model of care delivered in the Holdforth Unit will continue to be developed with partners, with a phased approach towards a truly integrated service for patients.

The Trust continues to be committed to developing and improving service quality and efficiency. The track record of delivery has seen substantial efficiency gains and given the historical efficiency record, evidenced in the Reference Cost Index (94 – including market force factors) position, the Trust recognises the challenge and specifically the need to speed up the pace of change and therefore will continue to explore and deliver new and better ways of providing patient care. As a provider of innovative and high quality community services, the Trust is in a prime position to further develop patient pathways, evident in the Clinical Services Strategy and to promote integration of care to enable and capitalise on improved efficiency across the system, in line with the principles of the Better Care Fund.

Whilst the Trust continues to engage with partner organisations across Teesside to deliver the Momentum Programme and recognises the requirement to deliver all financial duties, there is also an embedded acknowledgement of the enormity of the challenge, having successfully delivered required savings over recent years. The Trust has a proposed methodology, linked to the Momentum Programme and capitalising on the success in service provision and delivery of quality, operational and financial standards, to generate, identify and monitor efficiency savings.

In addition, the Trust understands the risks in balancing priorities within quality and safety, operational and financial performance, as outlined in this plan, and has sufficiently advanced governance and assurance structures, supported by detailed milestones in service transformation, to address service sustainability. Quality objectives have been developed to reflect national recommendations, including the outcomes of the Professor Keogh and Frances reviews, with one of the key priorities being the reduction of mortality rates (see section 1.4.1).

2014/15 onwards will see the early implementation of Phase 2 of Service Transformation, as outlined in this 2 year operational plan.

## 1.4 Quality Plans

### 1.4.1 Key Priorities

The Board of Directors and staff have pledged continued commitment to improving the quality of care, patient safety and experience, supported by the Trust's corporate strategy and Service Line Management operating model. This priority is prevalent at every level of the organisation and is generating excellent performance results.

The Board of Directors and Council of Governors, receive and discuss quality, performance and finance at every meeting and with a strong governance culture inherent in the organisation, the Board sub committees; Patient Safety and Quality Standards (PS&QS) and Audit and Finance, assess and review systems of internal control, to provide the challenge and assurance in relation to patient safety, effectiveness of service, quality of patient experience and financial viability, to ensure not only delivery from Board to Ward but to assure compliance with legal duties and requirements.

The Board of Directors requires and derives assurance on the Trust's performance at all times and recognises that there is no better way to do this than by talking to patients and staff, and testing the reality of delivery in practice. During 2013/14, members of the Board of Directors and Nursing and Patient Safety team undertook night time reviews of services and patient experience. These scheduled and unannounced visits enabled members of the Board to witness care delivery first hand and to test patient and staff experience. This approach has served to strengthen quality governance and will continue during 2014-2016, supported by a regular schedule of Patient Experience and Quality Standards (PEQS) visits. PEQS visits are undertaken with members of the Council of Governors and provide an objective oversight of quality and safety within care delivery and service provision.

The Trust's key priorities for the delivery of quality and safety, operational and financial performance are outlined below, evident in the Corporate Strategy and endorsed by the Council of Governors;

**Table 2: Key Priorities for delivery in 2014 -16**

Key Priorities & Timescales	How this Priority underpins the strategy	Key milestones (2014-2016) & External assurance
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Quality and Safety of Services	Putting Patients First, Service Development, Maintain Compliance and Performance	<ul style="list-style-type: none"> <li>• Positive feedback from Care Quality Commission 2014/15 – 2015/16: achieve Intelligent Monitoring Report score of 6 in 2015-16</li> <li>• Maintain annual successful self-assessment and registration with CQC</li> <li>• Tackle the mortality position (HSMR and SHMI); to ensure a robust governance structure supports a continuous reduction in mortality including: <ul style="list-style-type: none"> <li>○ demonstrable progress to reducing avoidable deaths in and (where possible influencing progress) out of hospital</li> <li>○ (HSMR/SHMI), to achieve parity with the expected national mean of 100</li> </ul> </li> </ul>
<p>Patient Satisfaction (Improve year on year, would you recommend family or friend?) February Position Ward Score = 67 A&amp;E Score = 64 Maternity (Birth) Score = 65</p> <p>Implement Friends and Family across Outpatients, Day Case and Staff during 2014/15 in line with CQUIN requirements (see section 1.3.3.4)</p>	Putting Patients First, Integrated Care Pathways, Service Development, Manage our Relationships, Maintain Compliance and Performance	<ul style="list-style-type: none"> <li>• Improve Friends and Family return rates and scores</li> </ul> <p><b>Return Rates</b></p> <p>30% - 40% 2014/15 40% - 50% 2015/16</p> <p><b>Scores</b></p> <p>75 - 80 2014/15 80 - 85 2015/16</p> <ul style="list-style-type: none"> <li>• Improve positive comments on NHS Choices website and achieve a higher star rated position.</li> <li>• Monitor and manage credible implementation plan to Outpatients and Day Case services and staff</li> </ul>
<p>Staff Satisfaction</p> <p>Awarded Bronze accreditation for Investors in People</p> <p>Maintain (IIP)</p>	Putting Patients First, Manage our Relationships, Maintain Compliance and Performance	<ul style="list-style-type: none"> <li>• Year on year accreditation (IIP)</li> <li>• Staff survey to be undertaken with all staff in the Trust (2014)</li> </ul> <p>Staff engagement and involvement plan to be reviewed and rolled out in 2014/2015.</p>
<p>Maintain and improve core services and become the Provider of Choice for new tendered services across community settings (maintain / increase % of market share)</p>	Integrated Care Pathways, Service Development	<ul style="list-style-type: none"> <li>• In addition to providing the Community Podiatry services already commissioned by Durham, Darlington, Easington and Sedgefield (DDES) CCG, the Trust has submitted the following bids: <ul style="list-style-type: none"> <li>○ Stop Smoking Services: South Tees Acute Trust – successful bid</li> <li>○ Diabetes services: DDES CCG – awaiting outcome</li> <li>○ Speech and Language Therapy Services: DDES CCG – awaiting outcome</li> </ul> </li> <li>• The Trust is also working with the Local Authorities, Hartlepool and Stockton on Tees CCG and Tees, Esk and Wear Valley NHS FT in the development of plans for the Better Care Fund, and will exploit any opportunities to bid for additional services that will contribute to the objectives of supporting patients in the community and so preventing avoidable admissions.</li> </ul>
<p>Governance - maintain and deliver new governance indicators and national standards within service performance and continue to develop clinical services in line</p>	Putting Patients First, Maintain Compliance and Performance, Service Development	<ul style="list-style-type: none"> <li>• Monitor Risk Assessment Framework – quarterly submissions in line with Terms of Licence</li> <li>• Achieve and maintain <b>Green</b> Risk Rating assigned to Governance.</li> </ul>

with research and technology Continue to deliver against Monitor regulatory requirements across Continuity of Services and Governance		<ul style="list-style-type: none"> <li>Achieve Risk Rating of 3 or above for Continuity of Services</li> </ul>
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In driving the key priorities and in maintaining the required emphasis on quality and safety the following clinical and quality priorities are evident in the Quality Accounts and endorsed by the Council of Governors and key stakeholders.

## 1.4.2 Clinical and Quality priorities and milestones over the next two years

This section of the Annual Plan describes the Trust's main clinical and quality priorities for the next 2 years, key actions required to deliver on these, the risk of delivery and how progress will be measured and reported to the Board of Directors to gain appropriate assurance.

Staff have been engaged in defining the priorities and understanding the emphasis on key measures of success; this is apparent in quality performance measures adopted and monitored at team and service line level.

The priorities, which are consistent with those laid out in the Trust's Quality Accounts, and published within the Trust's Annual Quality Report, reflect the strategic focus, to deliver the care expected by commissioners, patients and service users and are consistent with the Trust's philosophy of 'Putting Patients First'. Table 4 provides the detail behind each of the priorities and the associated measures, in aligning to commissioning intentions.

### 1.4.2.1 Risks to Quality

Risks to quality are an inherent element of Trust-wide governance including the philosophy of openness, prompt action and learning. Information from across all Trust services, reported directly into the Trusts risk register, is used in the preparation of the Trust Assurance Framework. The framework is in accordance with Monitor's guidance, regulations and Terms of Licence. Strategic, financial and governance risks are addressed by the Board sub Committee (Patient Safety and Quality Standards) and using a quarterly self-assessment process the Board of Directors considers the framework in the self-certification process. Each of the individual risk areas identified within the framework is assigned to a relevant Executive Director with an appropriate governance mechanism in place for identifying and reviewing new risks.

The Assurance Framework is categorised into three key areas, governance, quality and patient safety and continuity of services. Examples of the risks identified by the Board are outlined in Table 3.

**Table 3: Assurance Framework**

Category	Examples of Risk
Quality and Patient Safety	<ul style="list-style-type: none"> <li>Hospital Acquired Infection – risks of non-delivery against targets</li> <li>Lack of staff competence to use medical devices when providing patient care.</li> <li>Risk of clinical harm to patients through incorrect use of medications.</li> </ul>
Governance	<ul style="list-style-type: none"> <li>Risk that Board assurance could be given without supporting evidence or objective processes in place to provide validation.</li> <li>Compliance is declared, without a detailed evidence framework.</li> </ul>

	<ul style="list-style-type: none"> <li>Risk to non-compliance with key performance indicators i.e. RTT, Cancer, A&amp;E waits, Mixed Sex Accommodation</li> </ul>
Continuity of Services	<p>Momentum pathways to healthcare:</p> <ul style="list-style-type: none"> <li>Programme will deliver new healthcare pathways and new ways of working alongside the hospital and community capital developments (capitalising on opportunities presented in the Better Care Fund planning).</li> <li>An unplanned and incoherent approach to Service Transformation will mean the non-delivery of key aspects of business and service change.</li> </ul> <p>Finance:</p> <ul style="list-style-type: none"> <li>Failure to meet financial target surplus as per FT Annual Plan</li> <li>Potential tendering of services by Clinical Commissioning Groups and Local Authorities;</li> <li>Non delivery of aspects of CQUIN.</li> <li>Financial impact of locum cover</li> </ul> <p>Human Resource, workforce and employment requirements:</p> <ul style="list-style-type: none"> <li>Non- compliance with key statutory and legal requirements in relation to pre-employment checking.</li> <li>Without appropriate terms and conditions there is a risk of an unsafe workforce during periods of industrial unrest.</li> </ul>

These risks are related directly to key priorities, are supported by mitigation plans, control mechanisms and independent audit and assurance to support the Trust-wide governance framework, enabling due consideration by the Board of Directors in planning and appropriate declarations, with regard to the regulatory framework.

#### **1.4.2.2 Internal and External Assurance**

Independent review is of significant value within the Trust, in managing the risk framework. Over the last year, the Trust has been subject to a number of formal and informal visits across a wide range of services. These include unannounced Care Quality Commission inspections, Clinical Commissioning Group assurance visits and various quality assurance visits covering laboratory and diagnostics services.

The Trust has also been involved in various peer review programmes over the last year; these reviews look at services and the care provided to assist the Trust in identifying areas of potential improvement against national benchmarks or other required standards.

To supplement the controls framework, the Trust has a robust internal audit programme to assess individual key standards and to support self-regulation in line with the Risk Assessment Framework. This is further enhanced using an external audit assurance programme.

In line with the requirements of the annual certification of the Trust's Quality Accounts an external audit is carried out against two of the mandatory quality indicators plus one chosen by the Governors. In April 2014 Price Waterhouse Cooper will carry out the annual audit against 'Clostridium Difficile' (C-Diff) and 'Cancer 62 day referral to treatment standard'. A third locally agreed indicator will also be audited (to be agreed).

Further external audits will be carried out during 2014/15 to supplement 'internal control' and the Board of Directors ability to declare compliance to Terms of Licence.

The Trust utilises the Healthcare Evaluation Data (HED) analysis tool to support internal reporting and intelligent decision making. This is enhanced at service line level, with the inception of Patient Level Information Costing System (PLICS) and the Qlikview investigating and reporting tool, to enable intelligent decision making.

#### **1.4.2.3 Development of the Clinical Strategy and Goals**

The Board of Directors receive regular reports with regard to a number of quality goals in order to assess and challenge performance and risks going forward.

Highlights include a measurable year on year reduction in hospital acquired infection rates, improved referral to treatment times and cancer pathway delivery, Bronze accreditation of Investors in People status, good performance in stroke care delivery, improved performance in protecting the deteriorating patient and delivery of more services from non-acute settings.

Quality measures feature on specialty level performance dashboards whereby a balanced scorecard approach is taken to drive the ownership and delivery of quality and safety, service and financial performance.

Priorities for improvement are discussed and agreed each year with all stakeholder groups, as required by the Quality Account's recommendations; these are outlined in Table 4.

The Trust recommended to the stakeholders that a continuity of priorities would be beneficial in reporting for 2014/15, this proposal was welcomed by all stakeholders. Therefore the priorities that were included in the 2013/2014 Quality Accounts will be carried forward this year, with progress measurable in stretch targets.

**Table 4: Stakeholder Priorities (Quality Accounts 2014/15 – 2015/16)**

Patient safety	Effectiveness of care	Patient experience
<b>Mortality</b>		
<p><b>The Trust, while using national mortality measures as a warning sign, is investigating more broadly and deeply the quality of care and treatment provided.</b></p> <p><b>As a priority objective the emphasis is on demonstrable progress to reducing avoidable deaths in and (where possible influencing progress out of hospital) See section 1.4.3.1</b></p>		

<b>Dementia care</b>  Key measure of improvement (CQUIN)  Find, Assess, Investigate and Refer – 6% of CQUIN Clinical Leadership - 1% of CQUIN Supporting Carers of People with Dementia. -3% of CQUIN	<b>Discharge processes – information</b>  All patients discharged to a nursing or care home requiring district nurse review, will receive a written summary of care provided and of ongoing care required 100%. A copy will be provided to the home or district nurse.  <b>Discharge processes – medication</b> All patients will receive information about medication side-effects to watch out for at home 100% stretch target.	<b>End of life Pathways &amp; Family's voice</b>  <b>2013/14</b> Family Voice completed = 165  Continue to embed use of the Family's Voice in hospital and continue to rollout into the community.
<b>Safeguarding adults (Learning disabilities (LD) and sensory loss)</b>  All patients with LD will be referred on admission to the LD specialist nurse. The LD Specialist nurse will act as the named advocate and will ensure that an individualised plan of care is in place and reasonable adjustments documented. A new Safeguarding Database will be set up to record all incidents of Adult Safeguarding	<b>Discharge processes – Safe and Warm</b>  Through collaborative working, deliver a 'Safe and Warm' campaign, review the pathways and protocols for transferring and discharging patients to ensure that blankets are always provided and are adequate to maintain warmth throughout the patient journey. Liaise with the ambulance services and staff to ensure patients are kept warm until they arrive at their destination.	<b>Is our care good (patient surveys)</b>  Ask the question to every patient interviewed in the Patient Experience and Quality Standards (PEQS) reviews. Ask the question in all Trust patient experience surveys.  Monitor patient feedback from national surveys.  Review baseline and set stretch targets.
<b>Infection control – Clostridium Difficile</b>  2012/13 target 44 (actual cases 61) 2013/14 target of 40 (actual 30) 2014/15 target 40; rate 20.2 per 100,000 bed days  90% of all staff will receive infection control training  The number of e-coli bacteraemia's will be reported and reduced. Every hospital acquired e-coli infection will be investigated to establish cause and potential actions to take  Every hospital acquired C Difficile infection will continue to undergo a multi-professional Route Cause Analysis (RCA) within 3 days. Antimicrobial stewardship will be championed and monitored by consultant medical staff	<b>Nursing dashboard</b>  Ward matrons will present their analysis in a public area of the ward for patients and staff to see. Monthly dashboard analysis to the Director of Nursing Monitored at Senior Nurse Management meeting and remedial action.	<b>Friends and Family recommendation</b>  CQUIN target – increased return rate from benchmark position of 15%  30% - 40% 2014/15 40% - 50% 2015/16  Internal target improvement in score  <b>January baseline position</b> Ward Score = 71 A&E Score = 70 Maternity (Birth) Score = 77  Target 75 - 80 2014/15 80 - 85 2015/16

### 1.4.3 Monitoring Delivery of Quality

#### 1.4.3.1 Mortality

The Board is sufficiently aware of and has an understanding of the higher than expected values of both Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) and as a priority objective the emphasis is on demonstrable progress to reduce avoidable deaths in and (where possible influencing progress) out of hospital (see Table 2, section 1.4.1).

In reflecting on the progress within mortality performance and governance and the renewed national emphasis, the Trust has established a Keogh Task and Finish Group to address a root and branch review of Professor Keogh's eight recommendations / indicators, which in turn impact on mortality levels.

The Trust, while using national mortality measures as a warning sign, is investigating more broadly and deeply the quality of care and treatment provided. Further progress this year will be supported by:

- Strengthening leadership, governance and assurance at specialty level, reinforced by an appropriate resource infrastructure,
- Regional and national networking and peer review to enable a continuous learning and sharing cycle, specifically in understanding and tackling regional anomalies,
- Targeted trigger alerts to mortality positioning in sub categories, enabling proactive deep dives,
- Clinical audit to support the demonstrable reduction in avoidable deaths,
- Examining data and information relating to clinical quality and outcomes to develop key lines of enquiry and integrate appropriate indicators of safe care into practice,
- Correlation of pertinent data and information to further understand the quality and safety perspectives of care, including:
  - Patient experience information, including PEQS, FFT (section 1.4.1), NHS Choices and feedback from Matron intentional rounding,
  - Staff feedback, including staff forums, director clinics, supervision and mentoring,
  - Safety of care delivery, utilising objective data sources and clinical observation,
  - Workforce positioning, including talent management, staff to patient ratios, transparency in sharing workforce and staffing information, succession planning,
  - Clinical and operational effectiveness, utilising benchmarking comparators.

The Trust will be involved in the Community Acquired Pneumonia Project, which has been set-up by North East Quality Observatory System (NEQOS), with IT support from Clarity Informatics.

The Trust will continue to work with GPs and the CCGs to examine patient pathways into and out of hospital to tackle improvements in end of life pathway delivery and safe discharge processes.

#### **1.4.3.2 Delivering Compassionate Care (6 Cs)**

In March 2014, the Trust recruited a team of senior nurses with an aim to lead and drive excellent professional standards and leading improvements to deliver true 'compassion and dignity' in care.

The Trust is focused upon full implementation of the six measures of compassionate patient care within all wards, departments and the community. A project plan and Key Performance Indicators will be developed to support and monitor progress throughout the year. The team will have a focus on ensuring they fully demonstrate a culture within nursing which reflects the 6cs; care, compassion, competence, communication, courage and commitment.

#### **1.4.3.3 Effectiveness Matters Indicators**

The Trust has implemented a Nursing and Midwifery Dashboard which incorporates the following indicators; patient falls, pressure ulcers, compliments, formal complaints, infections, hand hygiene and the Friends and Family Test data and returns.

The Trust utilises the dashboard to monitor the Indicators for trends and performance issues, the dashboards are displayed on all in-patient areas for the public, patients and staff to see how individual areas are performing.

#### **1.4.3.4 CQUIN 2014/2015**

The Commissioning for Quality and Innovation (CQUIN) targets for 2014/2015 include indicators covering;

- Friends and Family Test: covering A&E, Inpatients, Maternity, Outpatients, Day Cases and Staff.
- Dementia support
- Making Every Health Contact Count Phase 2: covering Alcohol and smoking services
- Pulmonary Rehabilitation: increasing the benefits for people new diagnosed or with low level Chronic Obstructive Pulmonary Disease
- Assessment of Frail Elderly
- 7 day a week Standard 2:consultant assessment within 14 hours/ ICU consultant to consultant referrals
- Discharge Planning
- NEWS: Implementation of the national early warning score tool.
- Ambulance Handovers: 15 minute handover to assessment

The Trust has already begun the measuring and implementation requirements to support progress with delivery. This is linked to contract/commissioning negotiations in 2014/15 and the outcomes as detailed in section 1.8.

#### **1.4.3.5 Care Quality Commission Inspections**

Like all NHS Trusts, North Tees and Hartlepool NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions for all services provided.

During May 2013 the Trust received an unannounced visit to the Minor Injuries Unit. The report, which provided details of compliance against all of the inspected standards was published on the CQC website. The report was very positive regarding the care provided to patients in the Unit and complimentary of the staff. There were two minor comments regarding the signage and environment that the Trust has passed onto the owners of the building for action.

A further unannounced inspection relating to the Child Safeguarding pathways was undertaken, mid-January 2014. The informal feedback has been positive with some areas of good practice noted; there were some suggested areas for action that will be defined in the draft report which at the time of writing this plan is yet to be received.

Quarterly meetings with the local CQC Compliance Team are taking place to foster relationships and share information. Leading on from this relationship and following the transformation of services in 2013, the Trust arranged for the CQC Compliance Officer to undertake an informal visit of all areas affected by these changes. This provided an improved understanding of the different ward structures, in addition to the improvements to patient environment and the enhanced care pathways delivered post transformation.

In October 2013 the CQC published a new form of monitoring tool – the Intelligent Monitoring Report (IMR). In the most recent published report, March 2014, the Trust was rated as level 5, with 3 areas rated as ‘elevated risk’; HSMR, SHMI, PROMS – Groin Hernia.

Analysis of the details within this report has been commenced in order to identify where improvements can be made, to allow replication and forward projection for future reports. Improving the IMR rating to a level of 6 is one of the measures within the Trust's key priorities (see Table 2, section 1.4.1)

#### **1.4.3.6 Quality Governance Framework**

The draft Quality Governance Framework (QGF) was originally considered by the Board of Directors in September 2012 in readiness for submission of the 2013/14 Annual Plan. With the publication of the final QGF guidance in April 2013, the Board further reviewed the Trust's position against each of the questions within the November 2013 Board seminar. An assessment matrix was developed to support the Board's review of the organisation's ability to deliver consistent, quality services across each of the key domains. This included supporting evidence for each element, which gave the Board the assurance that appropriate processes and procedures are in place to ensure;

- An open and honest culture
- Engagement with staff, public and stakeholders
- A quality culture throughout all levels of the organisation
- Effectiveness in the delivery of the Trust's services
- Quality impact is assessed across all new service changes/development
- Valid/accurate quality information is available and utilised to monitor and measure service delivery
- Assurance processes are in place to support delivery of services
- Risks to quality are monitored and managed appropriately

The Board will continue to assess the Trust's position against the QGF on an annual basis to gain on-going assurance. Staff, patient and stakeholder forums will be utilised to attain open and honest feedback on the delivery of quality services across the organisation.

#### **1.4.3.7 Quality Summary**

The Trust has developed and implemented a robust clinical strategy to support the delivery of the vision over a number of years. This is inextricably linked to the quality priorities, mission and values of the Trust. Assurance is provided through the use of both internal and external monitoring processes, including audits, peer reviews, CQC inspections, Healthwatch reviews of services and clinical benchmarking analysis.

### **1.5 Overview of Corporate Strategy and Key Challenges**

#### **1.5.1 Corporate Strategy and Relationship Management**

The Board considers the Corporate Strategy each year in preparation for the submission of the Annual Plan, this year taking particular account of the considerable changes to national policy and the local landscape.

The engagement and support of local political stakeholders remains crucial in transforming services to provide enhanced quality, clinical effectiveness and improved patient experience to the people of Easington, Hartlepool, Sedgefield and Stockton whilst refining clinical outcomes.

One area of policy direction strengthened since the advent of the Government White Paper is the new freedoms to make a major impact on improving people's health and tackling health inequalities. Public Health is now the responsibility of Local Authorities, and to this end the Trust continues to develop its contribution to the Public Health (Health and Wellbeing) Strategy to complement those of the Local Authority areas served by the Trust. The Trust is also a full member on each of the Local Authority Health

and Wellbeing Boards which it serves, ensuring influence with regard to impact of strategy and implementation upon the health agenda.

It is also important to note that under governance, the Trust continues to engage with and involve the local Health Scrutiny function of Local Authority Committees and Local Healthwatch organisations.

## 1.5.2 Service Delivery – Operational Plan (2014-16)

The specific deliverables over the next two to three year period are as follows:

- Refinement and understanding of the Single Operating Model to inform identification of subsequent Service Transformation initiatives, for delivery as appropriate throughout the next three to five years which mirrors national drivers such as 7 day working remains a focus.
- Service Transformation Phase 2 – refresh, further development and implementation of the Clinical Services Strategy, in line with quality and safety initiatives, the required workforce strategy, the affordability model and information and technological advancements to inform key milestones' identification and hence delivery to single site provision.

### 1.5.2.1 Operational Delivery – Historical Trend

The Trust has, historically, consistently achieved significant improvements in the delivery of patient care. This has included;

- reducing inpatient stays by converting inpatient elective procedures to day cases, improving pre-assessment systems and processes and delivering an enhanced recovery programme
- the transfer of short stay emergency inpatients to ambulatory care
- direct to ward admissions for appropriate emergency pathways i.e. Stroke and respiratory conditions, reducing unnecessary pressure on the Accident and Emergency department and
- improved discharge processes across acute and social care, resulting in significant reduction in delayed transfers of care.

As shown in table 5, this has resulted in a significant shift in activity over the previous 5 years (2009/10 – 2013/14). Day case admissions have increased by 24% (n=6982), reducing inpatient elective stays by 22.4% (n=1772), whilst accommodating an overall 14.1% (n=5210) increase in elective activity. A 21.4% (4639) reduction in elective occupied bed days has also been delivered, resulting in a year on year delivery of bed reductions (see table 9, section 1.6.1)

Over the 5 year period the overall general and acute (G&A) emergency admissions has increased by 4.64% (n=1824), however a significant decrease in admitted inpatient activity is evident, reporting 15.9% (n=6246) lower. This has been achieved with the introduction of ambulatory care pathways, with approximately 20% (n=8070) of emergency activity now being seen, diagnosed and treated through an ambulatory care setting. This has enabled a reduction in avoidable admissions and the associated bed days, supporting the delivery of the year on year bed reductions.

The improved discharge processes across acute and social care have delivered a significant reduction in the number of beds utilised by patients who are ready for discharge, however required additional support in the community. As Table 5 indicates, from the baseline position of over 4000 bed days in 2011/12, a reduction of 30.1% (n=1278) has been achieved. This has resulted in reducing unnecessary extended lengths of stay in hospital and improved patient care pathways.

**Table 5: 5 Year Historical Change in Activity (2009/10 – 2013/14)**

Point of Delivery	2009/10 Baseline	2013/14 forecast based on month 10 position	5 year variance estimated based on 2013/14 forecast against 2009/10 actual	5 year % variance estimated based on 2013/14 forecast against 2009/10 actual
			2013/14 forecast based on month 10 position	5 year variance estimated based on 2013/14 forecast against 2009/10 actual
Day Case Admissions*	29,003	35,985	6982	24.07
Inpatient Planned Admissions	7,906	6,134	-1772	-22.41
<b>All Planned Admissions</b>	<b>36,909</b>	<b>42,119</b>	<b>5210</b>	<b>14.12</b>
Elective Bed Days	21,614	16,975	-4639	-21.46
Inpatient Emergency Admissions (G&A)**	39,276	33,030	-6246	-15.90
Ambulatory Care Admissions***	N/A	8,070	8070	19.64
<b>All Emergency Admissions</b>	<b>39,276</b>	<b>41,100</b>	<b>1824</b>	<b>4.64</b>
Emergency Occupied Bed Days	175,547	162,365	-13182	-7.51
A&E Attendances	96,426	88,149	-8277	-8.58

\* Excludes day case to outpatient procedure conversions

\*\* Excludes maternity episodes

\*\*\* Ambulatory care shown as a percentage of all emergency activity

**Table 6: Reduction in Delayed Bed Days**

	2011/12 Actual	2012/13 Actual	% Variance based on month 10 position	2013/14 forecast	% Variance	3 year variance estimated based on 2013/14 forecast against 2011/12 actual	3 year % variance estimated based on 2013/14 forecast against 2011/12 actual
				based on month 10 position	2013/14 forecast against 2012/13		
Delayed Discharges (bed Days)	4237	3552	-16.17%	2959	-16.7%	-1278	-30.16

### 1.5.3 The Better Care Fund (BCF)

Preparation for the implementation of the Better Care Fund in 2015/16 is underway, led by Hartlepool and Stockton-on-Tees CCG. The total local impact (for Hartlepool and Stockton-on-Tees CCG) is £19.5m for 2015/16, and the CCG will be seeking to source the necessary resources over and above those elements already in place, through reductions in its acute healthcare spend.

The Trust is fully involved in the ‘unit of planning’ work, to achieve identified health outcomes for the population, reducing the demand on acute health and social care services. Agreed plans must be in place to meet specified national conditions, including admission avoidance and reduction in delayed discharges by April 2015; arrangements for risk sharing are currently being finalised.

The key objective of the Better Care Fund is to reduce avoidable admissions by 15% and as such presents both opportunities and risks for the Trust. To affect these changes, the CCG is leading a discussion on risk sharing arrangements at the North of Tees Partnership Board (NoTPB).

The opportunity that the Better Care Fund direction of travel affords is the alignment to the Momentum; Pathways to Healthcare philosophy and vision and the manifestation of that in the Trust’s Clinical Services Strategy. It should be noted that the Trust has already made significant improvements to the delivery of care closer to home though this initiative will provide opportunity for further enhancements and opportunities for integrated delivery in care pathways. However this also presents risks to the Trust; of particular note are the impacts of admission avoidance and delayed discharges. As admissions are avoided and delays to

discharges reduced this will present challenges around bed capacity and associated resource requirements and the management of income to ensure financial and clinical sustainability, particularly during the transitional phases.

In the short term, this will require flexibility in resource management, including reallocation and reviews of skill mix to deliver services effectively, however this will also need to be managed against the need for staff ratios to meet safe standards and therefore will require appropriate planning and flexibility to take this forward effectively.

Appendix 1 (within section 1.11 Commercial and Confidential) demonstrates a sliding scale of the risk/opportunity through estimated numbers that could potentially shift into community/primary care, with regard to BCF planning and delivery. The Trust has calculated maximum risk by assessing potential reductions across all emergency inpatient activity, however in reality the key shift in activity would be attached to the reduction in admissions associated with long term conditions and rehabilitation pathways.

It is anticipated that the infrastructure to support these changes in pathway management will require investment in community services, in addition to seven day working in social care services.

In understanding the opportunities and risks associated with Better Care Fund planning, the Trust is continuing to plan for pathway delivery to support the BCF and hence the validation of risk impact. These plans will be triangulated with Stockton and Hartlepool council plans with alignment of metrics to ensure a correlation between growth in community and reductions in acute. This work will be further progressed as plans for the BCF are refined in 2014/15.

#### **1.5.3.1 Delivery of Community Led Step-down Facilities**

A key planning element of future service delivery, in order to provide care closer to home, is the provision of community based step-down facilities. As part of the capacity planning to support the development of the Outline Business Case for the new hospital, a detailed review of the existing bed base, the utilisation of beds and the appropriateness of current pathways were challenged. A range of scenarios were modelled, based on historical data, assuming different proportions of patients and associated lengths of stay, resulting in the identification of the option of a reduction of 60 acute beds as viable.

The proposed step down facilities will support the delivery of care pathways for between 2,000 and 2,750 patients from the General Medicine, General Surgery and Orthopaedics specialties being transferred from the acute setting to step-down care at an appropriate point in the patient's hospital stay, based upon their assessed needs and reduce the Trust's acute bed base by approximately 60 beds. These patients will be recuperating from a range of medical conditions such as stroke, respiratory conditions, urinary tract infections, cardiac problems, abdominal and intestinal disorders and hip and femur fractures.

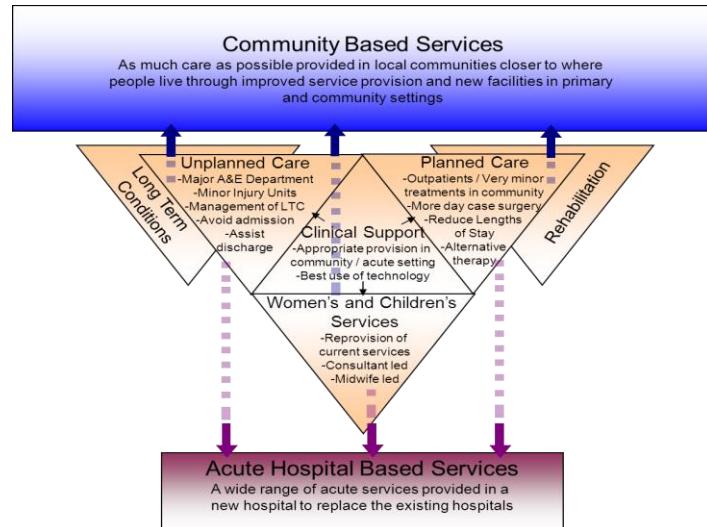
As outlined in section 1.3.1, the first stage in the development of this model, as part of Service Transformation Phase 1, was the establishment of the Holdforth Unit at the University Hospital of Hartlepool which provides 30 step-down beds. The model and the associated staff skill mix will be developed in phases to enable this provision to be transferred to a community setting in due course. It is planned to provide a second, smaller unit at the University Hospital of North Tees as the next stage of the development.

#### **1.5.4 Clinical Service Strategy - 2014/16**

As outlined in section 1.3.1, the Trust's *Momentum: Pathways to Healthcare Programme* is the means by which the organisation will reconfigure services and as such, the Clinical Service Strategy is built around the key principles of the *Programme*, supporting the development of integrated services across acute and community care and primary and social care. The model has been refreshed and refocused during 2013/14

to drive clinical service innovation to 2016/17. This programme is the driver towards the Trust's long term objective of a new single site, hospital build. Graphic 1 below outlines the principles underlying the Momentum Clinical Services Strategy.

### Graphic 1: Momentum Clinical Services Strategy Model



The graphic represents the move toward care closer to home and the investment required to improve the infrastructure of support in the Community, to ensure acute care contacts are appropriate, providing the level of specialist and acute services expected in a new hospital/care facility.

A vision and a set of overall objectives have been developed to support the delivery of these key elements of clinical services strategy. The vision for each key element is outlined in graphic 2;

### Graphic 2: Clinical Services Strategy Vision

Vision	
Long Term Conditions	<i>Vision: To provide better outcomes for patients with long term health conditions through an integrated approach.</i>
Unplanned Care - Major A&E Department - Minor Injury Units - Management of LTC - Avoid admission and readmission - Assist discharge	<i>Vision: To ensure the provision of emergency services in the right place, at the right time, by the right healthcare professional(s) services</i>
Planned Care - Outpatients / Very minor treatments in community - More day case surgery - Reduce Lengths of Stay - Alternative therapy	<i>Vision: To provide access to timely, streamlined, safe and effective elective care</i>
Women's and Children's Services - Reprovision of current services - Consultant led - Midwife led	<i>Vision: To provide an optimised model of care which maximises choice for patients and referrers (GPs and midwives) within a range of safe and effective services provided in the right environment</i>
Rehabilitation	<i>Vision: To provide a distinct service as part of the integrated care pathway that will maximise the patients' level of independence and facilitate their timely discharge from the acute service</i>
Clinical Support - Appropriate provision in community / acute setting - Best use of technology	<i>Vision: To develop and provide efficient services, in appropriate settings in hospital or the community, that utilise state of the art technology, are safe, effective, timely and offer excellent value for money</i>

These objectives are the cornerstones of all future planning, with the aim to transform Trust clinical service delivery around these key principles. Details of the planned service developments for 2014 – 16, in line with the key elements of the Clinical Services Strategy, are outlined below.

## 1.5.5 Future Service Development Plans

### 1.5.5.1 Profile for 2014/15 to 2015/16

The key priorities for the delivery of service change over the next two years embrace the development and delivery of integrated care pathways across long term conditions, including frail elderly, respiratory, stroke, end of life, diabetes, rheumatology and cardiology, linked to the implementation of the Better Care Fund, as outlined in section 1.5.3.

The Trust will also continue to work closely with social care to get truly integrated models of pathway delivery, to enable care closer to home.

The emergency care infrastructure will be strengthened, as recommended in the Professor Keogh review, with 7 day working further developed, supported by a robust Emergency Planning Preparedness and Resilience (EPPR) framework for the delivery of unplanned care during periods of pressure *in* and *out* of hours.

Delivery of service improvements across planned care include the centralisation of revision surgery, further development of Bariatric surgery, in collaboration with South Tees and Durham and Darlington Foundation Trusts and the introduction of minimal intervention Urology services.

Diagnostic services will be further developed to provide timely and efficient access and value for money, an example being the implementation of a collaborative approach to the provision of Pathology testing with South Tees Foundation Trust, linking cost improvement to operational delivery.

Maternity services will be further strengthened to fully integrate new and innovative standards. Neonatal and Paediatric pathways will continue to be developed to ensure robust care pathways are delivered in line with national standards and the local quality improvement work, known as Securing Quality in Hospital Services (SeQIHS).

Details of a number of planned service developments / changes for the next 2 years, to support the Momentum Programme are outlined below.

### Development and Integration of Community Services and Long Term Conditions

- Further develop the integrated approach to the delivery of services across *in hospital* and *out of hospital* care in line with the BCF planning. (2014 onwards)
- Further develop Telehealth enabling patient monitoring at home preventing admission/readmission to hospital. (Ongoing)
- To continue to develop the Single Point of Access (SPA) model, providing a single point of access into Community Integrated Assessment Team (CIAT), Teams Around the Practice Service (TAPS) and Specialist Nursing and a point of contact and care navigation for patients. This will also include a pilot with Hartlepool Council on an integrated SPA. (Ongoing)
- Pilot a CIAT Discharge Team (CIAT and the acute therapy teams) to support the reduction in acute hospital length of stay and delayed discharges. (2014)

- To develop and establish local services for patients with Long Term Neurological Conditions to enable the provision of care closer to home, including spasticity/botox service and community based respiratory care for people with neuromuscular disorders. (March 2015)
- Development of a community enhanced respiratory service as part of the integrated care pathway scoping, which will facilitate care closer to home whilst reducing hospital admissions. (2014/15)

The intense development and scoping work for Integrated Care Pathways for patients with long term conditions commenced in 2013. Many of these developments will be linked to the implementation of the joint health and social care plans produced as part of the implementation of the Better Care Fund planning. Key to this will be the successful integration of secondary, primary, GP, community health, and social care services. Detailed Project Initiation Documents (PIDs) to guide this work will be finalised during the first part of 2014/15. The following summarises the key milestones already identified to take this set of initiatives further:

Specific milestones for the above to be confirmed in early quarter 1 2014/15:

- Frail Elderly (to incorporate Dementia and Fragility Fracture)
- Older persons' team in community and front of house practitioners in A&E and EAU (2016)
- Revised medical staffing to cover community activity (2014 onwards)
- Older Persons' Team in care homes (OPTIN) service for Stockton, collaborative working with CCGs to develop supportive care home service and implementation of Better Care Fund initiatives (2016)
- Increase capacity to ensure all patients aged 65 and over have a cognitive dementia assessment (2016)
- At least 90% of patients with fractured neck of femur to be admitted to a dedicated ward within two hours via nurse led pathway (2014)

### **Development of Planned Care Services and Associated Pathways**

- Review delivery of elective procedures to ensure optimum use of theatres and safe clinical pathways across both hospital sites. This will inform the implementation of a new service delivery model. (2014/15)
- Continue to enhance the service model for pre-assessment with the aim of further reducing cancelled operations on the day. (December 2014)
- Further development and review of Urology services to deliver care closer to home and more significantly minimal intervention procedures, under advanced technology, in an alternative setting. (2014 onwards)
- Development of Breast services and procedures in line with best practice guidance. (2014)
- Further development of the EndoBronchial Ultrasound Service (EBUS) to ensure that maintenance of excellent clinical quality indicators as recommended by the leading centre for EBUS. (2014 onwards)
- Further development of the Bariatric services. (2014/15 – 200 procedures)
- Review the provision and service delivery model with regard to of revision surgery in Orthopaedics (Prof Briggs report). (2014/15)

### **Development of Unplanned Care Services and Associated Pathways**

- Development of integrated emergency pathways between acute hospital provision and primary and community care settings in line with Momentum Pathways to Healthcare to address admission avoidance and readmissions. (2014 onwards)
- Further develop direct admission pathways: chest pain, breathlessness and palpitations, to prevent unnecessary steps and appropriate specialist assessment and intervention. (2014 onwards)
- Development of Majors Nurse Practitioners in A&E to ensure an efficient workforce. (2014)

- To further develop a 24 hour specialist children's emergency department that will run separately from the adult Emergency Department. (2014/15)
- To extend the opening hours for ambulatory care, to enable a further reduction in avoidable admissions, appropriately managing patients in the right place the first time in line with the NHS Outcomes Framework; therefore enabling a further reduction in bed stock. (2014 onwards)
- Further development of the acute cardiology service, including relocation of the catheterisation lab and enhancing the quality of cardiac diagnostics such as CT scanning. (2014)
- Development of the Fragility Fracture service in line with best practice; a pilot throughout 2013 will inform the required changes with medical and orthopaedic services. (2014)
- Reorganise the delivery of trauma services to ensure the delivery model is equipped to provide the right skill mix for the complexity of patients. (2014)

### **Development of Women's and Children's Services**

- Development of 'Pregnancy, Birth and Beyond' programme introducing active birth and hypno-birthing classes. (2014/15)
- Development of midwifery caseload management 24/7 teams in Hartlepool. (2014)
- Development of a midwife lead for asylum seekers. (June 2014)
- Review and re-design of pathways for urgo-gynae, vaginal bleeds and chronic pelvic pain. (2014)
- Further development of transition process from paediatric diabetes care to adult services in line with peer review requirements. (2014)
- Provide 98 hours Obstetric Consultant cover within the Delivery Suite in line with SeQIHS and national recommendations. (2014)
- Review delivery of an alternative paediatric assessment and triage model to support enhanced pathways and a reduction in inpatient beds. (2014)

All services, clinical, community and support, remain innovative and dynamic in embracing the opportunities set out in the NHS and indeed the Trust.

### **Development of Diagnostic and Support Services**

- Pharmacy upgrade to include Electronic Prescribing and Medicines Administration. (2014/15)
- Collaborative delivery of Pathology services with South Tees Foundation Trust, within a legal framework, addressing the requirements of competition and choice. (2015/16)
- Reinvest overnight radiographic hours into weekend CT, to increase the availability of and access to CT scanning for in-patients. (2014 onwards)
- Introduction of Gastro Intestinal Endoscopic Ultrasound service. (June 2014)
- Further development and roll out of early implementation plan for extended bowel screening service in line with national policy. (2014 onwards)

### **Development of Step Down Services**

- Development of integrated health and social care step-up community support services. (2015/16)
- Development and delivery of an integrated estates plan incorporating the transfer of the Holdforth Unit into a community setting. (2015/16)
- Delivery of Community Led Step-down Facilities.

As part of the capacity planning to support the development of the Outline Business Case for the new hospital, a detailed review of the existing bed base identified the opportunity for the provision of less acute facilities to aid the next stages of recovery for patients no longer requiring intense acute medical care. A range of scenarios were modelled, culminating in a step down proposal, as outlined in section 1.5.3.1,

As outlined in section 1.3.1, the first stage in the development of this model, as part of Service Transformation Phase 1, was the establishment of the Holdforth Unit at the University Hospital of Hartlepool which provides 30 step-down beds. The model and the associated staff skill mix will be developed in phases to enable this provision to be transferred to a community setting in due course. It is planned to provide a second, smaller unit at the University Hospital of North Tees as the next stage of the development.

The estimated bed reductions associated with the delivery of the Better Care Fund activity changes, see Appendix 1 (within section 1.11 Commercial and Confidential), align with the Trust's future plans for the delivery of step-down facilities within the community setting.

#### **1.5.4.2 Clinical Sustainability**

Clinical sustainability is an issue consistently reviewed by lead clinicians and the Executive Management Team.

The Trust has worked with other provider organisations and local clinical networks to ensure potential optimisation of the standards of service delivery and examples of networked services include urology, cardiology and oncology.

The Trust joined with two partner provider organisations to develop and deliver a new bariatric surgery service across the Teeswide area. This has proved to be a successful service, with 200 procedures planned to be carried out at North Tees hospital in the 2014/15. The Trust continues to work with partner organisations to introduce innovative solutions to advance the services provided to the local population. Areas currently being reviewed are intraoperative radiotherapy for breast surgery and interventional radiology.

The Trust will continue to provide Commissioner Requested Services, within the expected standards, notwithstanding the impact of the national review of specialised services.

## **1.6 Productivity and Service Efficiency Delivery**

### **1.6.1 Operational Performance**

The Trust is committed to developing and improving service quality and efficiency. The track record of delivery has seen substantial efficiency gains, as outlined in section 1.5.2.1.

Given the substantial efficiency record and the RCI (94) position, the Trust recognises the challenge and specifically the need to speed up the pace of change and therefore continues to explore and deliver new and better ways of providing patient care. The Trust is in a prime position to further develop community services, evident in the Clinical Services Strategy and to promote integration of care to enable and capitalise on improved efficiency across the system, in line with the principles of the Better Care Fund.

The current economic climate, with the requirement for substantial efficiency savings alongside the overall objective of moving to a new single site hospital, poses more challenging requirements over the next two years. Penalties against locally agreed performance standards also drive improvements in efficiency.

Effective surge management remains a priority within the emergency preparedness agenda, and as such the Trust has a well-developed flexible capacity plan to accommodate surges in demand which is reviewed each year to reflect lessons learnt.

The Trust strives to reduce inappropriate waste across the organisation, utilising operational efficiencies as a key driver to achieve the cost improvement deliverables, whilst maintaining safe, quality services.

The Trust aims to deliver ‘best in class’ against a number of key efficiency indicators, with an Operational Efficiencies Working Group in place to review, develop and implement new ways of working. The operational efficiency agenda reviews performance across a number of key indicators, with progress to date outlined in table 7.

A number of bench marking tools are utilised to monitor the organisation’s position against both national and peer group performance. These include Healthcare Evaluation Data (HED), North East Quality Observatory System (NEQOS) reports and the NHS Better Care, Better Value Indicators dashboard.

The Trust endeavours to continue with its success in managing service improvements to deliver the operational efficiencies through projects identified and implemented using LEAN methodology to diagnose and drive change in patient pathway management. The Trust will continue to implement efficiency initiatives to support the delivery of the SIEP agenda.

The Trust set 3 year stretch targets for key operational efficiency indicators in 2012/13, based on Peer/National performance. Table 7 gives an overview of the Trust’s performance to date against each target and the expected reductions over the next 2 years.

The Trust is making good progress towards achieving the set targets, with a number of the indicators already above the 2014/15 expected. The Trust will continue to monitor the set targets based on ‘best in class’ and update to create further challenge going forward.

**Table 7: Operational Efficiency Targets**

Efficiency KPI	Baseline 2010/11	Actual 2011/12	Actual 2012/13	Actual 2013/14	Target 2014/15	Target 2015/16	Peer/National Average	Stretch Target Description
New DNA (consultant led)	6.31%	5.95%	6.03%	6.51%	5.6	5.4	6.9	10% reduction
Review DNA (consultant led)	12.40%	10.41%	10.51%	9.58%	9.5	9	8.8	Peer average
New to Review Ratio (consultant led)	1.82	1.83	1.74	1.54	1.5	1.45	2.15	Locally agreed with CCG
Pre-op Stays (1 day)	12.64	9.18	7.94	5.51	5.2	4.7	N/A	10% reduction
ALoS Elective	2.8	2.7	2.8	2.7	2.6	2.4	3.3	Best in Peer Group
ALOs Emergency	4.3	3.93	3.89	3.58	3.6	3.5	4.4	Best in Peer Group
% Ambulatory Care	6.8%	15.5%	18.7%	19.6%	19.8%	20%	N/A	No comparative data available
Daycase rates (BAD Basket)	66.5%	71.5%	73.7%	74.4%	77%	79%	78.1	National average
Beds (G&A)	672	629	598	592	585	575	N/A	New Hospital Build (2012 model)
Readmissions within 30 days	8.5	7.9	8.1	8.0	7.9	7.7	7.7	Peer average

The development of fully integrated care pathways will further support the delivery of robust, streamlined, efficient services, reducing unnecessary admissions to hospital, improving discharge processes and reducing lengths of stay.

## 1.6.2 Operational Requirements to Support Demand Management

The Trust closely monitors capacity versus demand across clinical services, and has implemented a number of service models to support the delivery of seasonal variances in activity. It is recognised that to make best use of resources there must be flexibility in the system. This enables valuable supporting structures to be used appropriately across the peaks and troughs in pressures. This includes;

- Flexible bed base – both weekday/weekend and to support emergency preparedness.
- Nurse led and telephone review appointments – reduce pressures on consultant teams.
- Direct to test referrals – reduce pressures on outpatient appointments and streamline diagnostic pathways.
- One Stop clinics – streamline outpatient, diagnostic, Referral to Treatment and Cancer pathways.
- Ambulatory care pathways – reduce pressures on base wards.

- Direct to ward emergency admissions for specific pathways – reduce pressures on A&E.
- Theatre allocation – all theatres now used for both inpatient and day case procedures to improve utilisation.
- Single Point of Access (SPA) – Community Single Point of Access implemented to ensure community referrals are assigned to the most appropriate service.
- Teams Around the Practice (TAPS) – Community teams assigned to GP practices to provide dedicated support services.
- Community Integrated Assessment Team (CIAT) – Community multidisciplinary teams to support delivery of full assessments in the home.

The Trust will continue to implement service pathway reviews across '*in hospital*' and '*out of hospital*' care, to support the delivery of fully integrated pathways, in line with national policy and revised funding allocation across the local health economy, see section 1.5.

### **1.6.3 Capacity and Capability**

The pace of change, the enormity of the challenges and competing priorities over the next two years has not been underestimated by the Board of Directors. The Trust risks placing disproportionate focus on its longer term strategy and without the required significant focus on core operations there is a risk that the Trust's performance may deteriorate.

The Trust maintains a strong focus on improving quality in the current two site configuration – there are clear measures of improvement in the quality of patient care including Healthcare Associated Infections (HCAI) and management of the deteriorating patient:

- Regular reporting and a strong governance and improvement culture enables early detection off variance and appropriate management and planning.
- The Trust advocates strong clinical leadership and is continuously improving the enablers to ensure the success of Service Line Management and a devolved structure of decision making.
- The Trust is committed to talent management and leadership opportunities to ensure the leaders of the future are encouraged to emerge.

The Trust is pursuing a portfolio management approach to project and priority delivery and coordination, to enable a well governed and appropriately resourced plan moving forward. A Portfolio Manager has been appointed to manage the process using a pragmatic and facilitative approach.

In addition to regular updates to the Board of Directors to assure of the capacity and capability requirements the SLM operating model will be further progressed, this year:

**Continuing to Strengthen the Engagement of Clinicians in Management** – the Trust has increased its compliment of Associate Medical Director posts to strengthen corporate and clinical governance and to reassert the responsibility of individual Clinical Directors within each Directorate. This will assist in strengthening the approach in terms of the clinical and safety agenda.

**The Development of Service Line Reporting and Patient Level Information and Costing** – including a programme of in-depth studies of individual Directorates involving the Lead Clinicians, Directorate Managers, and Directorate Finance Staff. This will improve the validity of patient level data and the intelligent decision making at Directorate level.

**Further Development of the Quarterly Performance Improvement and Management Process** - to include service line reporting, quality and performance measures, activity, cost improvement and Directorate Strategies and business planning objectives i.e. to bring all the tools of service line management together.

This work around developing the tools has raised issues that have led to positive changes in operational and clinical processes. This work will provide a bedrock for a broader Service Line Management Strategy in future years.

## 1.6.4 Workforce Strategy

This Integrated Workforce Strategy sets out the approach the Trust will take to develop and re-profile the workforce to support its strategic objectives by ensuring the Trust's workforce is equipped with the necessary knowledge, skills and experience to deliver the *Momentum: Pathways to Healthcare* Programme. It provides the basis for detailed workforce plans which will deliver the specific actions and accountabilities to take these changes forward over the next two to three years.

The Trusts workforce strategy outlines the approach to be taken to continue to improve staff's ability to deliver high standards and quality of care, whilst also contributing to efficiency and productivity savings and in doing so will provide a robust and sustainable framework by which this can be achieved.

### 1.6.4.1 Workforce Demographics

The Trust has an ageing workforce with almost half (47.69%) of the staff aged 46 or over. Although there are advantages to this, such as an experienced and skilled workforce, the Trust needs to ensure there is robust succession planning to ensure the skills of individuals are passed on once they retire. Conversely, this will assist in the reduction of staffing in the next two years and will be mapped into forecasting where appropriate.

The turnover rate at November 2013 was 10.05% (headcount), accounting for 752 leavers over the period December 2012 to November 2013. Vacancies are usually filled on a like-for-like basis; however some skill mixing also takes place. The use of skill mixing will be explored further in order to meet the targets for a reduction in the workforce.

During 2013/14 a Trust-wide review of staffing requirements was undertaken to inform development of the Long Term Financial Model (LTFM). These workforce projections have been scoped to 2017/18 detailing the year-on-year workforce implications of transformational change and incorporate efficiencies as a result of the planned move from two hospital sites to one.

These workforce projections have been agreed on the basis of a number of assumptions:

- The design and build of a new hospital
- A shift of activity from the acute setting to community
- A reduction in bed numbers in the new hospital
- Theatre utilisation will be based on 7-day working
- Ward areas will have a 3 shift pattern; early, late and night
- There will be a move towards consultant-led services
- Nurse-led services will be expanded
- Seven-day working will be implemented
- Extended days will operate where this benefits the patient

- Opportunities for collaboration, shared services, partnerships and outsourcing will be proactively pursued
- There is an expectation that reception functions will be centralised in the new hospital
- The introduction of new technology will impact significantly on the workforce.

Workforce planning for the opening of the new hospital has already begun to ensure the Trust can take forward planning and financial framework with assurance. A phased approach to changes in the workforce will be adopted, with the introduction of a number of enabling measures, initiatives, and strategies to ensure the workforce has the skills, knowledge and experience to deliver the *Momentum: Pathways to Healthcare* Programme.

#### **1.6.4.2 Workforce Models**

The Trust's nursing workforce model is based on GRASP (Grace Reynolds Application and Study of PETO) methodology, which has been further developed to ensure it is sufficiently flexible to enable patient acuity, quality and safety to be considered alongside operational and financial efficiency and performance. The model focuses on three driving elements; quality, cost effectiveness and effectively managing staffing resources, which aligns with the principles of the Trust's Service Line Management operating model.

This Trust-wide approach to the nursing workforce ensures there is consistency in nursing workforce planning and provides a single, universally understood system, defining roles and responsibilities which can be implemented, monitored and evaluated across each bed-holding directorate.

A six-monthly review process has been built into governance arrangements to enable the impact of any service developments or national policy changes to be modelled through and their impact on the workforce understood. In addition, monitoring reports are taken to the Board of Directors for review and consideration.

The model also enables scenario modelling to be undertaken to inform planning for future organisational change.

During 2014/15, consideration will be given to adopting GRASP methodology more widely across the Trust to incorporate non-clinical areas.

An appropriate medical workforce model will be developed, following implementation of e-job planning and e-rostering during 2014/15.

#### **1.6.5 Workforce Plan**

Over the past twelve months there has been significant focus on the development and refinement of workforce plans and projections to 2017/18, taking account of changes as a result of the Service Improvement and Efficiency Programme (SIEP) and the planned move to a single site hospital.

To achieve the agreed workforce projections, the organisation will continue to take opportunities to shape the workforce through clear structures aligned with the clinical services strategy and care pathways, underpinned by policies and initiatives to ensure we have safe and effective staffing levels.

## **1.6.6 Enablers for Successful Delivery of the Workforce Plan**

There are a number of key enablers that will support the delivery of both the short and long term workforce plan. These include;

- Recruitment
- Redeployment
- Flexible Retirement
- **Collaboration and Outsourcing:** The Trust will proactively seek opportunities for collaboration with other Trusts and for the outsourcing of services.
- Redundancy and Voluntary Severance

The Service Improvement and Efficiency Programme will also play a key role in achieving required savings.

## **1.6.7 NTH Local Improvement System**

The Trust has a history of adopting Lean methodology, tools and techniques as its strategy for service improvement and this will be further enhanced by the creation of the NTH Local Improvement System (LIS), which will see the phasing out of the Lean and Productive Series terminology.

The LIS will enable the integration of service improvement into all activities, whether service, operational or developmental, and will bring additional benefits in relation to leadership management, behaviours, culture and values, development and talent.

Directorates will be required, as part of the business planning process, to submit details of any Rapid Process Improvement Workshops (RPIWs) they plan to undertake, from which an annual Trust LIS Plan will be developed.

## **1.6.8 Skill-mix, Role Redesign and New Ways of Working**

The Trust's aim is to secure a stable workforce where the need for continuity is balanced with a requirement to continue to develop the skills and knowledge of the workforce to ensure it is able to respond to the changes and challenges ahead. Skill-mix reviews, role redesign and new ways of working will be considered and reported as part of the six-monthly review process of workforce projections.

## **1.6.9 Benchmarking**

Benchmarking is a crucial element in identifying appropriate staffing requirements for service developments and there is an expectation that all business cases take into account available benchmarking data when considering the impact on the workforce. The Trust is a member of the NHS Benchmarking Network and will continue to participate in benchmarking projects and use the findings to inform service developments and workforce reviews.

## **1.6.10 Delivery and Outcome Measures**

A strong governance and assurance process is in place to progress towards achievement of agreed workforce projections. Month-on-month monitoring is undertaken which is presented on a quarterly basis via a dashboard to the Workforce Steering Group and the Service Transformation Group.

In addition to workforce numbers, specific workforce metrics to be monitored including, sickness absence rates, turnover rates, staff returning on flexi-retirement, use of NHS Professionals, recruitment activity, redeployment activity and collaboration and outsourcing opportunities

**Table 8: Key workforce priorities for 2014/16 are:**

Key Workforce Priority	Contribution to the Overall Strategy	Key Actions and Delivery Risk	Key Resource Requirements	Milestones
To ensure there is a skilled, experienced and affordable workforce committed to providing safe, high quality care to patients which: <ul style="list-style-type: none"> <li>• reflects current needs</li> <li>• supports service transformation</li> <li>• is integrated with service and financial planning (SIEP)</li> <li>• makes best use of available electronic systems to enhance the provision of workforce information</li> <li>• provides the ability to flex the workforce to meet service need</li> </ul>	To support the focus on clinical and patient outcomes  To create a patient-centred organisation demonstrated through patient safety, service quality and Lean delivery	Directorate workforce projections developed to 2017/18, agreed by those professionally accountable  Robust review process in place for workforce projections and nursing workforce establishment  Monthly monitoring and reporting of progress towards workforce projections  Establishment of sub-group to oversee implementation and review post-transformation efficiencies  Benchmarking of services against other Trusts locally and nationally  Support to directorates from workforce planning team in undertaking workforce reviews  Contributions from workforce planning team on work relating to LTFM and OBC	Workforce planning team  Workforce modelling tool for clinical, non-clinical and medical workforce  Engagement of managers across the Trust  Recurrent resources for roll-out of GRASP Non-recurrent resources for implementation of MAPs, e-expenses, e-rostering, e-job planning  Non-recurrent resources for implementation of Allocate software (dependant on approval of business case)	Workforce strategy – April 2014  Development of workforce projections monitoring tool and dashboard – March 2014  Six-monthly reviews of workforce projections and nursing workforce establishment Development of GRASP tool – 2014/15  Full implementation of NHS Professionals Full implementation of MAPs 2015/16

## 1.7 Financial Strategy

### 1.7.1 The Trust's financial strategy and goals over the next two years:

#### 1.7.1.1 Financial Overview

The Trust has a sound and long history of strong financial performance meeting all of its statutory financial duties in every financial year since becoming a Foundation Trust in 2007. The financial strategy over the next two years is about future performance building on the historic success of the past. Strong financial performance is fundamental to the Trust's service aspirations and plans which need to be substantiated within a strong business model.

The operational plan covers the period from 2014/15 to 2015/16. This timeframe encompasses a period of significant change to deliver the objectives of the Momentum '*pathways to healthcare*' Programme leading up to the occupation of a new single site hospital.

The strategy will cover a period of unprecedented economic challenge within the NHS, with the continuing requirement of delivering financial efficiency of up circa £30bn by 2020/21. A fierce and progressive squeeze on public spending will continue with acute Trusts receiving significantly lower rates of growth and the deflation in the tariff being used to curb spending on health-care. Low level investment will require the Trust to focus investment in areas that will both improve services and reduce costs. In addition, evidence suggests that the most effective treatment is very often the most efficient treatment. High quality and value for money are not competing alternatives; they are effectively one and the same.

### **1.7.1.2 Financial Performance 2013/14**

2013/14 has been a challenging year for the Trust with high levels of emergency activity and the need to continuously improve quality and patient experience. This is set against the continuing backdrop of a challenging economic and financial environment and annual operating plan settlement that required the Trust to deliver a £13.957m cost efficiency target.

In light of the above the Board of Directors took a conscious decision to maintain a planned income & expenditure surplus of £3.4m to ensure an appropriate balance between the challenging financial efficiency agenda and the desire to continue to improve quality, patient experience and service performance. This decision recognised an EBITDA margin percentage at the lower end of the spectrum for the acute sector, which is a function in the main of the impact of having no major leases or PFI's.

Due to the twin site nature of the Trust's estate a significant number of medical and surgical services and diagnostic support are duplicated across two sites, this is achieved within a relatively efficient reference cost index of 94 (after the application of the market forces factor). However this signifies that it is becoming increasingly difficult to achieve the challenging cost efficiencies required to generate the planned surplus, without introducing significant transformation of services.

In spite of the above the Trust is on course to deliver another sound financial performance, with a planned operating surplus of £2.496m. Instrumental in this was the delivery of the cost efficiency target alongside the rigorous control of pay and non-pay budgets, with particular emphasis on the control and reduction of agency and locum staff expenditure despite the pressure on beds. The hard work and dedication of the trust's staff has been fundamental to another successful year.

On the 1st April 2013 the Trust acquired Peterlee Community Hospital from the former County Durham PCT. The Trust has historically provided a number of outpatient clinics and community led service clinics from the site and its transfer to the Trust ensures that these services will continue to be provided and expanded to the East Durham population as part of the Trust's overall Momentum Pathway programme.

The Trust has reflected the £3.145m transfer of Estate in the 2013/14 accounts in line with absorption accounting principles (as outlined in the guidance on Accounting for Estate Transfers by HM Treasury Financial Reporting Manual). Under IFRS and Monitor guidance the transfer has been reflected as an exceptional gain of £3.173m on the face of the income and expenditure statement. There was no cash transaction underpinning this accounting treatment.

As a consequence the Trust's Fixed Asset base has increased by £3.145m based on the District Valuer's valuation and the Trust will report a corresponding £3.145m under "*Other recognised gain and loss*" on the Statement of Comprehensive Income. The Trust has also received IT equipment of £0.028m from the former Tees PCTs which have been accounted in a similar manner as above.

The performance in 2013/14 has enabled the Trust to strengthen its balance sheet and underlying liquidity position for the seventh year in a row since achieving Foundation Trust status.

### **1.7.1.3 Financial outlook for 2014/15 & 2015/16**

The Trust will continue to face challenging years in 2014/15 and 2015/16; the efficiency challenge facing the NHS is unprecedented especially with the continued application of a deflationary tariff. This combined with zero or marginal growth in the economic and financial environment and an increasingly ageing population puts further pressure on the ability to maintain a healthy financial position whilst continuing to deliver high quality safe and caring services to our patient.

The Trust with its local commissioners have agreed plans to ensure the needs of the local population can be met however the ever increasing demand for hospital and community services means that the local health economy and the Trust are facing a period of real terms reductions in funding in 2014/15 and 2015/16.

To deliver the requirements as set out in the Planning guidance 2014/15, The Outcomes Framework, the Annual Operating Plan (AOP) agreed with Clinical Commissioning Groups and internal service developments the Trust is required to deliver a £15.547m cost efficiency target (including £2.8M brought forward from 2013/14). It should be noted that £0.381m and £15.166m relates to revenue generation and cost efficiency respectively.

The size of the efficiency target presents another extremely challenging year ahead for the Trust, by planning in advance, however, a number of initiatives are already progressing improving the likelihood of delivering the efficiencies required.

Following an external review of the Trust's cost efficiency opportunities and internal governance arrangements, detailed plans have been agreed with directorates, quality impact assessments will be completed for all significant change programmes across the Trust and a rigorous performance management framework has been put in place to ensure plans are delivered.

For 2014/15 and 2015/16 the Trust plans to deliver an income and expenditure operational surplus margin of circa £2.660m and £3.2m respectively. This position recognises the need to reverse the downward trend of recent years in the EBITDA margin percentage (4.5% in 2014/15 & 4.9% in 2015/16) and maintain a continuity of services risk rating of 4.

The Trust's medium term financial strategy, linked to the development of the new hospital, continues to drive clinical and operational efficiency, utilising lean management principles and service line management. The Trust will continue to deliver on-going estate rationalisation with associated recurrent savings and non-recurrent savings from land sale proceeds where appropriate. The Trust will pursue savings from back office shared services efficiencies and management cost reductions; enabling the effective and flexible use of the workforce.

Transformational change is required to enable the Trust to continue to deliver high quality, safe and affordable services. A significant programme of change will be delivered in 2014/15 streamlining services and pathways of care across both sites with the emphasis on delivering clinical pathway improvements across acute and community enabling patients to be treated closer to home.

The Trust will strive to deliver the challenging financial agenda and will maintain or improve upon the quality, patient experience and service performance in the difficult years ahead.

The Trust continues to have a strong cash and liquidity base upon which to face this difficult period.

### **1.7.1.4 Summary**

The Trust intends to achieve all of its planned financial performance targets in 2013/14 despite significant increased activity pressures on emergency care. It should be noted however, that the Trust will deliver a smaller surplus (£2.496m) than originally planned in 2013/14 (£3.477m). The challenge to continually deliver efficiencies over the next two years as outlined above will be extremely challenging, but is no different to that facing the majority of Trusts. With sound financial control and management, the Trust is well placed to continue to deliver incremental improvements in the quality of services delivered to our patients and deliver the financial performance targets agreed.

The Trust's underlying recurrent planned financial surplus for the two year period is as follows:

- 2014/15 £2.660 M
- 2015/16 £3.200 M

Within this planned position are a number of significant contingencies which are as follows:

<b>Contingency present in plan assumptions</b>		<b>2014/15</b>	<b>2015/16</b>
	£m		
<b>Pay</b>	£m	(1.419)	(2.000)
<b>Drugs</b>	£m	(0.650)	(0.650)
<b>Clinical Supplies</b>	£m	(0.500)	(0.500)
<b>Non-Clinical Supplies</b>	£m	(0.500)	(0.500)
<b>Misc Other Operating expenses</b>	£m	(0.750)	(0.404)
<b>TOTAL</b>	£m	<b>(3.819)</b>	<b>(4.054)</b>

## 1.7.2 Key Operational Aims for 2014/15 and 2015/16

The primary financial operational aim is to enable and support the Trust in achieving its strategic service vision and in the delivery of its objectives in accordance with Trust values. The two year financial operational plan reflects a period of public sector squeeze, builds on a strong financial base and aims to maximise the opportunities and flexibilities given.

The key operational financial targets are shown below:

- Maintain a continuity of service risk rating at a minimum of 3;
- Achieve EBITDA margin of at least 4.5% with an aim of moving to 9% after the opening of the new hospital;
- Achieve surplus of a minimum of 1% of turnover;
- Achieve at least 2.4% return on assets and for new business aim for 5%, and
- Achieve a liquidity ratio of at least 25 days.

### 1.7.2.1 Income & Expenditure

The Trust aims to sustain current income levels and to increase income through the provision of new and/or enhanced services that meet the needs of service users and commissioners and through commercial opportunities. On new services, the Trust will aim to achieve an EBITDA of at least 7%.

### 1.7.2.2 Efficiency Agenda

Generating cost improvements has been challenging for the Trust over the last two years, however to continue to deliver at the levels required in the tariff, change will continue to be transformational. In response to this challenge, the Trust is implementing a portfolio approach to managing the delivery of efficiencies going forward.

For 2014/15 and 2015/16, the efficiency target and consequent plans equates to 5.8% of income, this is above national expectations but reflects the ambition of the Trust to continue to develop services and maintain quality and safety as a key priority.

The Trust has historically set efficiency equitably across Directorates based on the national target on a straight line basis, however in 2014/15 and going forward a strategic approach that incorporates enabling strategies, corporate reviews and directorate specific initiatives has been developed.

The efficiency strategy has been developed alongside service planning and will drive quality improvement, and not in isolation in recognition that high quality and value for money are not competing alternatives.

#### **1.7.2.3 Capital Investment**

The Trust is forecasting continuing investment in its asset base. The key financial assumptions underpinning the approach to capital investment are based on the current financial terms and freedoms of Foundation Trusts.

- Internally generated cash will be the primary source of capital funding. Circa £5.858m of cash from depreciation is available per annum. The Trust will also use generated cash surpluses to support schemes which improve the quality of its service provision.
- The Trust will receive Public Dividend Capital from the '*Safer Wards, Safer Hospitals Fund*' for the implementation of the PAS system, Electronic Prescribing and Electronic Document Management.
- In the longer term, additional funding will be realised through asset disposal for equipment investment in the new hospital.
- The potential for additional funding and alternative solutions through routes such as FTFF, joint ventures and subsidiary companies will be explored to support opportunities and developments going forward.

Revenue affordability will be the key driver for determining the overall capital financing portfolio.

#### **1.7.2.4 Liquidity and Working Capital**

The Trust currently has a sound cash and working capital position. The Trust will ensure that the agreed estates plan does not place undue pressure on the Trust's working capital position. The Trust will ensure that it retains sufficient liquidity in the medium term to ensure a viable financial position under possible and probable downside scenarios.

#### **1.7.2.5 Risks and Mitigation**

The Plan identifies a range of key strategic risks and mitigations (refer to Appendix 2 and 3 for further details). The operational financial strategy is to ensure that the financial consequences of those risks and mitigation strategies are quantified, modelled and understood in terms of deliverability and impact in both service and financial terms.

The Trust has historically taken a prudent approach in managing its overall resources, given the projected financial outlook for the NHS. This approach will be maintained with the Trust's risk appetite appropriately grounded in financial reality and decisions taken with a full understanding of the financial impact.

### **1.7.2.6 Financial Planning and Reporting**

The Trust will continue to strengthen its financial planning, forecasting and reporting. The Trust's financial plan will appropriately reflect the consequences of service plans with individual managers and the Board of Directors giving clarity and ownership for delivering their service plans.

The key enhancement will be the continued refinement of service line reporting and management which will provide the mechanism through which business decision making is devolved to the front line in order to improve resource utilisation, decision making and thus clinical outcomes and the patient experience.

## **1.8 Financial Commentary:**

### **1.8.1 Trust Income**

The Trust's total planned income for 2014/15 is £268.230m, of which £239.692m is derived from NHS Clinical Acute and Community Income. With regards to 2015/16 total planned income is £267.899m, of which £239.077m relates to NHS Clinical Acute and Community Income and reflects the impact of the Better Care Fund.

The Trust has successfully negotiated contracts for 2014/15 with its main commissioners, for whose population the Trust serves. Each of the agreements is underpinned by a legally binding contract, which was agreed before the commencement of the current financial year. Non-contracted activity has been based on historic trends.

Within 2014/15 the Trust has the following contractual sources of income:

- Hartlepool and Stockton CCG account for 68% of the Trusts contractual NHS clinical income.
- County Durham and Darlington CCGs, who also commission both Acute and Community Services account for 15% of the total.
- Specialist Commissioners, Area Team and Public Health England account for the balance of 20%, covering Public Health, Neonatal Care, Bowel Screening, Breast Screening and Community Dental Services.

In addition to the NHS Clinical Acute and Community Income there are other income streams such as:

- Training and Research Income (£8.190m and £8.353m for 2014/15 and 2015/16 respectively).
- Other non SLA income sources such as private patients, injury cost recovery scheme and other private contracts.

The principle drivers of income included within the two year operational plan are:

- Demographic and prevalence changes (Demand Model).
- Emergency activity and Readmissions.
- CCG Commissioning Intentions.
- Impact of Better Care Fund.

The Trust does not rely on any significant income generation schemes, the majority of its non-patient related income comes from catering, car parking and direct access pathology, therefore, does not pose a significant risk for the Trust.

## **1.8.2 Tariff Reform and Efficiency:**

There continues to be a minimum of a 4% efficiency requirement for the NHS which has been built into the national tariff. The net deflator for 2014/15 is 1.5% nationally; however the local impact across the Trust's case-mix is 1.2%. The national assumptions of 1.5% have been reflected in the Monitor Plan.

## **1.8.3 Activity Assumptions**

Activity assumptions for 2014/15 have been agreed and included within the contractual arrangements with the commissioners.

Forward planning assumptions have been based on demand modelling described below:

- The demand plan provides forecast demand activity to underpin the size and scope of existing Trust services, a number of service redesign workshops have been held and these considered age of the population, health of the population, national policy, local policy, impact of medicine/drugs, business opportunity and patient expectation.
- The Trust has reviewed the future demand on services based on changes in the demographic profile using the outputs from the independent work undertaken by Deloittes LLP prior to the PCT demise. The Quality Legacy Document (now underpinning the SeQIHS work) identified estimated population growth for North Tees & Hartlepool NHS Foundation Trust up to 2021, by continuing to work in partnership with the CCG demand management plans have been agreed and the estimated impact is reflected in the activity assumptions modelled by the Trust.
- The single biggest driver for health care demand is the forecast change in the size and age of the population. The impact on the catchment population based on population projections provided by the Office for National Statistics has been included in the Annual Plan income assumptions.

The model assumes:

- Intervention rates remain at current levels, albeit on a different population age demographic using forecasts provided by the Office for National Statistics.  
The Trust achieves lengths of stay that are best in class against peer groups using commercial benchmark software (Dr Foster and HED) and other intelligence and maintains its best in class position as lengths of stay reduce nationally.

The expected rise in emergency admissions that would likely be seen from an ageing population are reduced by 1% per annum to effectively counter the increase through a range of service transformations.

This has resulted in very prudent assumptions on income but does correlate with the CCG future plans, these factors have come to fruition in previous iterations of the demand model suggesting that the model and the assumptions on which it is developed are robust.

The activity output from the Trust demand model can be presented in a number of "currencies" such as point of delivery group, Healthcare Resource Group, clinical specialty and bed requirements, therefore providing a sound basis for further development work in areas such as estates and workforce planning.

## **1.8.4 Finance – Costs**

Inflation relating to high cost drugs have been set at 10%. This reflects and matches the on-going cost increase seen as a result of drug enhancements / use, and the implications of NICE drugs recommendations and approvals.

Planned expenditure has been calculated by taking into account:

- The recurrent effect of pay and price increases and the projected impact of incremental progression under the Agenda for Change contract.
- Infrastructure and non-pay budgets set in line with the projected volumes of activity contracted for by CCGs, both in bed holding specialties and clinical support facilities including theatres, pathology and radiology.
- A range of service developments and cost pressures agreed with clinical directorates.

Non pay spend has been rebased commensurate with planned volumes of activity and the internal recharging mechanism operated in 2013/14. This will be further refined to reflect actual workload variations for the internal bed holding specialties and the impact in the key areas of theatres, pathology and radiology, in line with the movement towards a fuller rollout of service line reporting to underpin service line management.

The pay and non-pay spend are underpinned by the detailed purchasing intentions and final activity levels agreed with Commissioners, these have been shared with Directorates. There is a general acceptance that there is sufficient capacity within the system to deliver the contract levels requested by CCGs and national targets for 18 weeks RTT and cancer. The Trust recognises that the targets of 40 set for C Diff and 0 for MRSA (HCAs) will prove challenging in 2014/15, however the CCG have agreed to include this issue within their Service Development Improvement Plan (SDIP) to ensure that local health economy as a whole contributes to the management of this target.

A comprehensive schedule of reserves has been set based on an assessment of the likely impact of:

- Pay and price inflation.
- Drug pressures for both price increases and NICE recommendations.
- The impact of the NHSLA/CNST premium increase.
- A series of reserves and contingencies to cover earmarked developments and pressures.
- A contingency of £1.5 M for any unplanned risks and pressures that present in year.
- Winter Planning / Pressures of £1.0m

Provision for depreciation and the dividend payable to Department of Health on public dividend capital have been set based on the updated asset base taking account of the latest valuation exercise performed by DTZ. The proposed impact of the latest valuation results in a revaluation to the trusts asset base of circa £25m. The interest receivable budget for 2014/15 has been set at £152K to reflect the on-going historically low levels of interest rates and a risk averse policy to investments in the current financial climate - this strategy, and overall performance in this area, will be monitored and informed by the Investment Committee throughout 2014/15 and 2015/16.

## **1.9 Cost Improvement Programme (CIPs) in the Two Year Operational Plan**

### **1.9.1 Historic performance, main drivers and necessary action to ensure further delivery**

The Trust had set an efficiency target of £13.9m in 2013/14. To date (month 11), the Trust has delivered £12.740m (91.3%) in total, of which £8.183m (64%) recurrently and £4.556m (36%) non-recurrently. Historically the Trust has performed well against its CIP but inevitably uses non recurrent measures in year to cope with in-year slippage.

It is anticipated that slippage will occur on some of the larger schemes due to the requirement for infrastructure changes or potential public consultation. Depending upon the extent of the change in service, stakeholder engagement may be required. This is built into project plans if deemed necessary. The Trust has a unallocated contingency reserve of £3.819m and £4.054m built into its 2014/15 and 2015/16 financial plans respectively to cope with any potential slippage.

The Trust is engaged with partner organisations across Teesside to deliver the Momentum Programme, realigning pathways of care and delivering its part in the wider efficiency agenda.

This section outlines the proposed methodology for the Trust to generate, identify and monitor operational efficiency savings, made via the annual Cost Improvement Programme (known internally as Service Improvement and Efficiency Programme, SIEP).

It is a key financial duty of all NHS organisations to deliver on-going financial savings. While organisations have been successfully delivering required savings over recent years, it is becoming more and more difficult to identify and realise cash releasing efficiencies.

## 1.9.2 Governance

### 1.9.2.1 Overview of PMO, leadership and assurance arrangements for the life of the strategic plan

The Trust established a Programme Management Office (PMO) in November 2012 to oversee the delivery of the Trust's Cost Improvement Programme for both the current and future years. The PMO has given the impetus and visibility needed to maintain the focus of the organisation throughout the year on identifying and delivering real cost savings in a recurrent and structured manner.

In the short to medium term, a further focus of this strand will be to lead on the clear delineation between future years "true" CIP plans and expected 2:1 savings from the new hospital build.

Risks are assessed by the project leads; any potential slippage on delivering the CIP is reported at the Service Improvement and Efficiency Programme Board (SIEPB) using a RAG status and action plans developed.

## 1.9.3 CIP Profile

The National expectation is that the local NHS will determine the details of how productivity opportunities will be realised. Areas of focus within the Trust are:

- Use of shared services in back office functions
- Improvements in the use of the NHS estate
- Productivity opportunities through;
  - Better use of technology
  - Mass marketing/industrial engineering
- Prioritising the most effective treatments, reducing errors and waste and stopping low value procedures
- More efficient integrated care through better co-ordination with partners
- Prevention rather than treatment
- Patients taking control
- Better procurement.

Substantial additional savings are to be achieved over the next 5 years to ensure the continued good performance and financial viability of the Trust can be maintained.

Programmes of work to deliver the efficiency target of £15.547m in 2014/15 have been developed with operational and clinical teams across the service. Currently firm plans are in place to deliver schemes totalling £7.3m and further initiatives are being scoped.

### 1.9.3.1 CIP Enablers

The ideas for increasing the efficiency of services are generated through a variety of different methodologies. A workshop was held on 8th November 2013 which was attended by operational management teams, lead clinicians and corporate senior managers. This workshop focused on generating future ideas for delivering efficiencies under the following headings:

- Procurement, £1.4M
- Service redesign/service reviews (outpatients, Phase 2 transformation, Integrated pathways & service reviews) £3.3M
- Workforce (MAPs, Corporate reviews, Specialist Nursing and NHSP), £2.617M;
- Commercial, £0.040M
- Estates, £0.080M
- General (stationery, Corporate services, maintenance contracts, EDM, travel, pharmacy , hospitality), £2.339M and
- Incentives.

The ideas generated from the workshop have informed the decision making process for the Directorate and Trust Wide CIP schemes moving forward. Responsibilities for planning, organising and identifying CIPs are determined at the outset and include key personnel from Directorates.

### 1.9.3.2 Quality Impact of CIPs

A Quality Governance Framework has been developed and has been in place since April 2013. The Framework provides assurance to the Board of Directors, Council of Governors, senior managers and clinicians that the essential standards of quality, safety and equality are being delivered by the organisation.

The outcome of each of the Quality Impact Assessments (QIA) will be Red Amber Green (RAG) rated and a Quality Impact Register is kept within the Programme Management Office. An escalation process via the Service Improvement and Efficiency Programme Board is in place for schemes rated amber or red. Evidence will be provided to the CCG on a regular basis to provide assurance regarding quality governance with the Cost Improvement Programme.

## 1.10 Capital Expenditure

The capital programme is funded to the value of £14.142m in 2014/15, and for 2015/16 the capital programme is £6.130M. The capital allocations are categorised into six areas of work:

	2014/15 £M	2015/16 £M
Service Development	2.151	1.584
Cardiac Cath Laboratory	1.388	-
Estates Backlog	1.165	1.000
Medical Equipment	2.032	1.670
ICT & PAS	6.906	0.876
New Hospital Development	0.500	1.000
<b>Total</b>	<b>£ 14.142m</b>	<b>£ 6.130m</b>

### **1.10.1 Capital Expenditure Schemes**

The estates strategy seeks to continually review the estate, maximising its utilisation and disposing of surplus estate where feasible. There is no perceived risk to any of these schemes being completed on time, on budget and meeting expectations of quality, cost improvement and user requirements.

The Trust continues to invest in mobile working solutions for Community Service staff through the use of laptops\tough-books which enable real time data access in patient locations. SystmOne has been deployed and will continue to be rolled out to a number of additional clinical services to improve data capture and reporting streams.

### **1.10.2 Service Development including Transformation**

The Trust is working towards a new single site hospital that is due to be opened in 2018. In the interim period, risks to service continuity have been highlighted requiring the implementation of a service transformation plan that will cover the intervening period. Service Transformation Phase 1 completed on 18 October 2013, with a reduction of 130 beds on the UHH site and the relocation of the associated clinical and support staff to UHNT. This has resulted in the vacating or reduced utilisation of a number of clinical and non-clinical areas at UHH with the remaining wards and services no longer cohesively located across the site. The Trust plans to rationalise the estate in order to bring together the remaining services into a smaller footprint of space and to create, as far as possible, a vibrant centralised area of the hospital. Furthermore, there is a need to maximise the efficient utilisation of space and to reduce overhead/operating costs of the site.

### **1.10.3 Cardiac Catheterisation Laboratory**

Transformation plans for phase 1 continue into 2014/15 and include the transfer of cardiac catheterisation to a dedicated site at UHNT. A stand-alone cardiac catheterisation laboratory is unprecedented in the United Kingdom, both within the NHS and the private sector. This will facilitate the Trust's ambitions to increase the market share in implantable devices and improve the organisation's reputation with GPs, Commissioners and ambulance crews.

### **1.10.4 Estate Backlog Maintenance and Replacement Capex**

A range of backlog measures is programmed to be undertaken during the next two financial years these are broadly categorised as follows:

- **Compliance** includes measures to improve systems and equipment to prevent Legionella and Pseudomonas risks, asbestos removal programmes, modifications to the estate to improve DDA access, removal and replacement of CFC R22 refrigerant gasses. Plans are also being developed for fire compartment at UHNT.
- **Energy Conservation** the Trust has a well-documented carbon management policy with a programme of carbon reduction capital investment plans following extensive and successful partnership work with the Carbon Trust. Capital schemes for the next two years include improved lighting controls, modifications to heating, ventilation and water systems. The Trust endeavours to deliver year on year reductions in carbon emissions of at least 3% per year.
- **Backlog Maintenance** a number of schemes are planned during the year and include electrical resilience, pipework replacement and flood precautions. During the year, the decant ward facility will

enable capital backlog works to be undertaken on a large number of wards to improve the patient environment, hygiene and standards.

- **Patient Experience** includes measures to improve clinical areas and the hospital environment for patients. Specific work includes replacement flooring, improvements to décor, patient call system, new furniture and contaminated waste disposal units.

There is no perceived risk to any of these schemes being completed on time, on budget and meeting expectations of quality and user requirements.

### **1.10.5 Medical Equipment Replacement**

A number of business cases have been developed for a systematic rolling replacement programme for equipment nearing the end of its useful economic life. A summary of the equipment to be replaced is detailed below:

- Critical Care Unit - Monitor replacements and bed replacement program
- Endoscopy – replacement scopes
- Theatres – operating tables, equipment and lighting
- Dental chair and dental cart
- Anaesthetic machinery
- Hysteroscopy equipment
- Gastroscopes and Bronchoscopes, and
- Assessment trolleys.

### **1.10.6 ICT and Patient Administration System**

The main focus of the ICT Capital Programme is the replacement of the Trust's Patient Administration System (PAS). The Trust currently uses an ageing PAS which is expensive to maintain and poorly supported due to its small user base and technological obsolescence. Commercially there is a pressing need to replace this system as the existing support contract expires in March 2015.

The Trust has received notification that it has secured £7.215m PDC in 2014/15 via the Safer Hospitals and Safer Wards Technology Fund.

A government Procurement Service tendering process has involved detailed negotiations with potential suppliers, and this has led to the identification of a preferred provider for a significantly improved new service. The full business case was approved by the Trust Board on 21<sup>st</sup> January 2014.

The implementation of a new PAS system could pose a significant risk to the recording, collection and reporting of data required for payment by results and national reporting of the performance targets for the organisation. The proposed go-live date is May 2015. The project is being strongly governed using PRINCE methodology and risks, issues and benefits will be reported and monitored through the PAS Programme Board.