South Tees Hospitals NHS
NHS Foundation Trust

Operational Plan

Executive Summary

South Tees Hospitals NHS Foundation Trust continues to focus on enhancing our strong tradition and culture of clinically led continuous improvement in quality and safety, enhancing the specialised services we provide and ensuring greater integration of our acute and community services. Our plan sets out the key short term challenges faced by the health economies we serve and how we are responding to these in terms of quality, operational capability and financially.

Our plan is developed through an annual integrated planning cycle built on a comprehensive analysis of our current situation looking at both external factors and internal issues.

For 2014/15, the most important issue facing the Trust is planning for a sustainable future as the NHS as a whole and the local health economies we serve face their toughest ever two years. Our plan last year reflected our response to a surge in emergency demand well above the general trend which led to huge pressure on our emergency capacity and elective programme during the winter of 2012/13. The plan described investment in additional capacity – 50 additional beds and more clinical staff at front of house. Whilst this investment has been successful in maintaining the quality and responsiveness of our urgent and emergency services (the Trust has coped very well during winter 2013/14) there have been difficulties throughout the last financial year in achieving elements of the 18-week target and there are growing pressures on our finances as we try to balance our strategic goal of continuous quality improvement with the requirement to find year on year efficiencies in the way that we operate. Developing and implementing a forward financial plan which will underpin continuing quality improvement and ensure that we can consistently meet the 18 week target is our key immediate priority. To support this we are working through an intensive process to develop a financial improvement plan drawing on external advice and support and working in strategic partnerships with health, local authorities, and third sector partners.

More than in any previous plan, this working with commissioners and local authorities will be a key success factor as we jointly respond to a very challenging financial environment and, specifically, work towards more fully integrated health and social care as we develop proposals under the banner of the Better Care Fund. This offers opportunities for different ways of working – but also poses a risk if these plans do not achieve the whole system transformational change needed to respond to the transfer of funds from health to social care which is planned for 2015/16.

There will also be much work to do with our clinical teams to respond to service reviews initiated by NHS England in respect of specialised services. It is difficult to assess the impact of the national planning assumption that the number of Specialised Services Centres will reduce (to 15-30 centres). The emphasis on “planning bundles” of linked services forming a logical basis for centres chimes well with the Trust’s comprehensive and complementary range of specialised services and provides a coherent basis for the Trust to continue to serve as a centre in the key areas of major trauma, cancer, heart and neurosurgical services for the populations we serve in the Tees Valley, Darlington, south and east Durham the northern most districts of North Yorkshire.

We recognised that maintaining our outstanding performance on healthcare associated infections from 2012/13 (no MRSA infections and 49 cases of Clostridium Difficile) into 2013/14 would be a key challenge and the Trust has now comprehensively reviewed how it protects patients from hospital acquired infections to ensure that it continues to reduce incidence throughout the period of the plan.

The formal consultation on changes to paediatric and maternity services at the Friarage Hospital has concluded with Hambleton, Richmondshire and Whitby CCG Governing Body supporting a change to a midwifery led unit and short stay paediatric assessment unit but we await the outcome of a second referral to the Independent Reconfiguration Panel by North Yorkshire and York Scrutiny of Health Committee and as yet have no indication of when this may be received.

Strategy

Although the plan identifies some serious risks and issues for the Trust to address, and our strategic programme to achieve financial sustainability is our key priority, we will continue to make progress across all of our seven strategic programmes:

- Trust Capacity Plan – ensuring capacity matches demand, to meet the peak seasonal demands for emergency care during the winter and elective capacity issues to meet and sustain performance targets;

- Quality and patient safety – making progress on our key patient safety themes, improving and standardising surgical pre-assessment services, implementing capacity plans in gastroenterology and MRI scanning to support improved access, patient experience and clinical functionality;

- Specialised services growth - increasing capacity in cardiothoracic services and renal services; enhancing the resilience of trauma services and neurosciences;

- Improving the patient pathway – continuing to work to improve the internal, patient pathway especially admission avoidance and reducing length of stay, acute front of house and discharge processes across all hospital sites, working with clinical commissioning groups and local authorities to develop their strategies to enhance services in the community and reduce emergency admissions;

- Transforming the care we deliver – a strategic road map has been developed which sets out a programme of investment in IT infrastructure to provide a platform for the deployment of systems to support improvements to the Trust's clinical digital capability with benefits to clinical care;

- Innovation, research and development – taking a leading role in developing the North East and Cumbria academic health sciences network and rolling out the Trust's new research and development strategy to increase the volume and profile of the Trust's research;

- Financial sustainability – to be financially secure in order to invest in services and environmental improvements to improve quality of care.

Key Financial Data:

The Trust's income from clinical activities will increase in 2014/15 as a result of contracts which recognise demographic growth and agreed developments. The Trust is, however, currently forecasting a worsening of the £5.2 million deficit at year end 2013/14 to a projected £29.8 million in 2014/15. This is in part because of a shortfall in the productivity and efficiency (P and E) programme in 2013/14 and because an increased level of cost compared to 2013/14 has been built into the plan to sustain quality, deliver the capacity needed to meet commissioned demand and achieve compliance with key performance targets. The Trust has not as yet identified productivity and efficiency savings and cost improvements sufficient to offset this increase. The identified P and E programme is currently £11.8 million (2.2%) and £11.3 million (2%) in 2015/16. If no improvement in the forecast outturn is achieved, and if the level of P and E identified for 2015/16 does not increase, the deficit will worsen to £50 million in 2015/16. A Continuity of Service Risk Rating (COSRR) of 1 has been declared for 2014/15 and it is currently anticipated that this will apply also to 2015/16.

The Board, after closely scrutinising the financial plan, believes £29.8 million is a worst case figure and is taking action to reduce the deficit going into 2015/16. A programme within the Trust to develop recovery plans is being put in place and collaborative work with strategic partners on transformation of health and social system across the Tees Valley and North Yorkshire, essential for future sustainability and continued quality improvement, is underway.

Whilst these plans are implemented, the Trust's financial plan will need to be underpinned by Public Dividend Capital (PDC) support to bridge the cash shortfall until the Trust is able to generate its own cash surplus, targeted for 2016/17 and we are in dialogue with Monitor about this support.

Operational Plan

A Local Context

Local Health & Social Care Economy

The Trust has worked with its health and social care partners to understand the challenges facing the local health economy for the next two years.

The Trust's principal CCG commissioners form two Units of Planning:

- **South Tees CCG** (which acts as lead commissioner for Hartlepool and Stockton CCG, Darlington CCG, Durham Dales and Easington CCG, North Durham CCG in respect of their activity with the Trust) and whose catchment covers the local authorities of Middlesbrough and Redcar and Cleveland;

- **Hambleton, Richmondshire and Whitby CCG** (which acts as lead commissioner for other North Yorkshire CCGs) for whom the local authority is North Yorkshire County Council.

In addition, approximately 40% of the Trust's contract income is derived from Specialised Commissioning led by Cumbria, Northumbria and Tyne and Wear Area Team.

There is a high level of engagement with commissioners and partner agencies across demonstrated through:

- Executive team to team meetings with CCGs and Cumbria, Northumbria and Tyne and Wear (CNTW) and Durham, Darlington and Tees (DDT) Area Teams;
- Unit of Planning meetings bringing together CCGS, local authorities and other Providers across the Durham and Darlington Area Team;
- Trust participation in the Integrated Commissioning Board for North Yorkshire which brings together providers, CCGs and local authorities;
- Participation in Urgent Care Boards in both Tees and North Yorkshire localities;
- Membership of Health and Well Being Boards in Middlesbrough, Redcar and Cleveland and attendance at the North Yorkshire HWB where providers are represented by Harrogate NHS FT;

The Trust is engaged with South Tees and HRW CCGs in their strategic change programmes which have similar aims :

- For South Tees, IMProVE spans health and social care and aims to shift towards preventative care, enabling patients to remain at home for longer while managing their own conditions in a supported way. The CCG begins a formal consultation in April 2014 on future use of the community estate with the aim getting the right facilities in the right place and releasing resources for reinvestment in alternative models of community care to support the reductions in hospital admission.
- HRW CCG are undergoing a public engagement on a vision for services which will respond to the demographics and rural nature of the CCGs catchment area. Following engagement they plan to work with partners to determine the extent to which a shift of resources is needed from acute into community services; the shape of community services, (there are currently community facilities in both Thirsk and Northallerton); the scope to move to integrated provision for intermediate and community care.

There are strategic programmes across the Darlington, County Durham and Tees :

- Securing Quality in Health Care Services (SeQIHS) project brings together commissioners, providers and local authorities with the aim of developing and evaluating options during 2014/15 to secure high quality health care for the populations of County Durham, Darlington and Tees. The focus of this work is on acute medicine and surgery, urgent and emergency care, maternity, acute paediatrics and neonatal services, intensive care and end of life care.
- The Chief Executives of the Trusts serving South Tees, the CCG and local authorities are working together through an Integration Partnership Board which will drive the integration agenda.

Financial Allocations

The Trust's main source of income is primarily from a few core NHS Commissioners, so the National Health Service settlement and commissioner allocations are of key importance for the Trust's financial planning. Traditionally income flows for the Trust have been positive and in 2013/14 income targets were exceeded, largely due to overperformance on specialised service contracts. However, looking ahead across the two years of this Operational Plan it is apparent that the allocations to be received by our main commissioners and the new commitments in terms of the Better Care Fund, mean that the Trust can no longer rely on growth in income to ensure a robust financial position.

Local CCG and NHS England Allocations 2014/15, 2015/16

The two year funding allocations for 2014/15 and 2015/16 published by NHS England gave uplifts of 3.1% for 2014/15 and 2.3% for 2015/16.

The revised fair share formula for CCG and primary care allocations, with an agreed pace of change was published on 20 December 2013 and revised later for a further adjustment for inequalities to target additional resource to areas with poorer outcomes.

Both of our principal CCGs remain (as do all CCGs in the North East) above target, however, a pace of change adjustment has been applied with all CCGs receiving a minimum uplift in 2014/15 of 2.14% and 1.70% in 2015/16. The CCGs revenue resource forecast provide a firm forecast for 2014/15 and 2015/16.

	2013/14		2014/15		2015/16
	Baseline	**Growth (@2.14%)**	**Baseline**	**Growth (@1.7%)**	**Baseline**
	£m	**£m**	**£m**	**£m**	**£m**
South Tees CCG	376.9	8.1	385.0	6.6	391.6
HRW CCG	169.4	3.6	173.0	2.9	175.9

When combined with the national tariff deflators of -1.5% and -1.8% for each of the next two years the CCG's will have 'real terms' growth of around 3.2% in 2014/15 and 3.5% in 2015/16 to meet any growth in secondary care demand and other pressures such as primary care prescribing budgets.

This funding growth needs to be viewed in the context of the challenge of projected demands on the system from demographics. Locally the projected demographic change indicates large increases in activity for the elderly offset partially by projected reductions in younger age groups. These demographic only projections give much lower increases than the NHS England projections. However it is noted that 61% of Trust beds and 35% of Theatre time is utilised by patients aged 65 years and over. The highest projected increases in the elderly are in Hambleton and Richmondshire (where a 30% increase is the number of people over the age of 65 projected by 2021) with the South of Tees area showing about half the same level of growth.

Both CCGs will find it challenging to meet the forecasted pressures into 2105/16, before the impact of the Better Care Fund (see below) is taken into account.

Specialised Commissioners Allocations

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

Local Authority Allocations

Middlesbrough Borough Council will be required to save £74m over the next 4 years and in excess of £100m up until 2019/2020.

Redcar & Cleveland's Annual Formula Grant will, by 2019/20, be £29.412m less than it is in 2013/14, a medium term reduction of 37.3%. The formula grant reduction is an aspect of and contribution to an overall budget reduction of £33.8m.

North Yorkshire County Council's budget will reduce by a third (circa £169 million) between 2011 and 2019. The social care budget will be required to release recurrent savings of £21.5 million from its 2013/14 level of £138 million having released some £27 million in the four years to 2015.

The impact of these reductions in Local Authority Budgets on the provision of social care services and the wider support available in the local health and social care system could be considerable and is a matter of grave concern. The establishment of the Better Care Fund for 2014-2016, acknowledges this is a national problem and aims to ameliorate some of the negative implications that could otherwise occur on acute capacity, if inadequate services are available to support patients in their own homes to prevent admission and facilitate hospital discharge.

Better Care Fund (BCF) Implications

A significant financial factor in both financial and operational planning terms during the next two years is the national establishment of the Better Care Fund as noted above. This requires an integrated health and social care plan to be formulated, in partnership with providers and approved through local Health and Well Being Boards.

Nationally there is a £3.8 billion budget in 2015/16, that includes reablement and carers break funding from CCGs along with approximately 3% from CCG baseline resources. Locally this means:

Better Care Fund 2015/16	Social Care Fund	Carers and Reablement	CCG Baseline Resources	Total Better Care Fund
	£000's	**£000's**	**£000's**	**£000's**
South Tees CCG	£6,775	£2,563	£11,506	£20,844
HRW CCG	£2,829	£1,151	£5,171	£9,152

For South Tees CCG the assumption contained within the submission is that £8.5 million of the £11.5m transfer from CCG baseline resources comes from expenditure currently incurred with South Tees Trust on emergency activity. For HRW CCG the Trust has not been given clear working assumptions on reduced income, but based on the same proportion of emergency admissions being reduced as for South Tees CCG, would give a minimum reduction of £2.8m.

The Trust will need to be able to respond to these planned shifts of income from CCGs and match expenditure accordingly, as the plans come to fruition. If successful, the BCF initiatives will result in a significant shift in the Trust's traditional income flows and will drive the Trust to reprofile its service delivery models. The establishment of the Integrated Medical Care Clinical Centre from 1 April 2014 as part of the programme of internal restructuring of the Clinical Divisions, will assist in the joined up operational and strategic planning that will be required to meet this challenge. Particular emphasis is already being given to admission avoidance schemes with the Trust working in partnership with its local CCGs and Local Authorities to develop whole systems solutions.

Procurement, Choice & Competition

The changing ethos towards market testing through formal tendering and procurement for service provision, will increasingly impact upon the Trust's income stability. During 2013/14 the Tees based local authorities reviewed all of the services currently commissioned from the Trust and notified their intent to decommission these services, bring them in house or put the services out to tender. For 2014/15 the Trust has been given a range of short-term contract extensions whilst tender processes are undertaken. The opportunity to expand our service delivery into other areas will be kept under active review, subject to strategic fit with the organisations priorities. Contracts for the two APMS practices run by the Trust have been extended to 31 March 2015, but these services will also be put out to tender during 2014/15.

Patient flow and market share for elective surgery also impacts upon potential income. Action has been taken by the Trust to improve bed capacity to avoid cancelling elective surgery due to bed pressures. The ability to grow Trust capacity in key specialty areas to provide competitive waiting times for patients prioritising rapid access over local access, will be important for maintaining optimum income levels.

Analysis of elective activity shows that the Trust's market share has reduced from 83.6% in 2010 to 80.8% in 2013. In the same period, independent sector providers' market share has grown from 6.2% to 8.1%. The most significant growth has been in gastroenterology, orthopaedics and urology.

Tertiary service activity levels have remained largely static over the last three years (growth of 1%) whereas other tertiary providers have seen activity growth levels of between 4% to 9%.

B Short Term Challenges

The Trust faces a range of challenges over the time period 2014/15 – 2015/16, including resolution of current performance challenges, increasing financial pressures and new challenges from the national improvement agenda.

These include:

- Managing capacity to sustain quality, meet national performance targets and match commissioner requirements
- Implementation of specific improvement plans to meet and sustain national performance targets
- Implementation of the Better Care Fund and impact upon Trust services
- Specialised Services: Commissioning through Evaluation and Derogations
- Achievement of the Seven Days a Week standards for Urgent and Emergency Care
- A number of specific local reconfiguration and service improvement challenges

Further detail on these challenges and the plans being developed to address them are outlined below:

Capacity & Demand

During 2013/14 the Trust experienced a significant mismatch of capacity and demand. Across the North East, and at times nationally, winter 2012/13 saw a surge in emergency demand well above the general trend which led to huge pressure on our emergency capacity and elective programme. In part this enormous pressure is a result of the poor public health status of our health community. Recent public health reports have demonstrated that respiratory illness for the winter 2012/13 was higher across the North East of England than elsewhere in the country and that Middlesbrough had the highest numbers of illness within the North East. This had a clear impact on the Trust mortality figures during this period. In response to these pressures, the Trust invested in additional capacity to maintain the quality of our services and support achievement of national targets, particularly around 18-weeks and Accident & Emergency.

This programme of investment and extensive work on discharge planning appears to have brought success, in that patient flow has been much better over the winter of 2014/15 with no repeat of the unprecedented level of disruption and surgical cancellations resulting from bed pressures that the Trust experienced in 2013/14. It is acknowledged that this winter has been much milder than the last and the extent to which the improvement is due to weather is unclear – neighbouring Trusts have however experienced a greater level of pressure than we have which suggests that the improvement is due in part to improved systems and more bed capacity.

The Trust is however still managing the fall out implications of cancelled surgery in 2012/13 and the need to address the backlog this has created on waiting lists in key specialties. Remedial plans to generate additional capacity have been put in place, but it became apparent through more detailed modelling work at sub-specialty level that full compliance with national standards could not be achieved until the end of quarter 2 in 2014/15. Furthermore risks to sustaining this position once achieved are high and all surgical specialties have stressed the importance of maintaining access to the required bed base and additional theatre sessions, if they are to be successful in delivering the required activity to guarantee national target delivery. In some cases demand supports the need to recruit additional consultants, some in areas of national shortage (eg. spinal surgery)

In its financial planning and in working with commissioners on the requirements of the Better Care Fund the Trust has to exercise caution in assumptions about the potential for reductions in its acute capacity.

Improvement Plans to meet and sustain Performance Targets:

During 2013/14 the Trust has faced a number of challenges, which have resulted in a review by Monitor of whether the Trust is in breach of its license to operate:

- 18 week RTT delivery for admitted patients – the Trust's plan is to achieve compliance at an aggregate level by end of May 2014, but at specialty level, full compliance will be achieved by end October 2014 for Cardiology, end June 2014 for Plastic Surgery / Orthopaedic Foot & Ankle and for Spinal work the trust has made a proposal to commissioners to close the service to new referrals.
- C difficile targets – the Trust achieved a 30% reduction in incidence of C difficile in 2012/13 resulting in a challenging target of 37 for 2013/14 compared to a target of 80 in the previous year. The Trust has been off trajectory during 2013/14 and is currently projecting a year end position of 57 cases by the end of March 2014. The 2014/15 target has now been set at 49 cases.
- Never Events – during the period 2013/14 the Trust reported 3 never events, and has reported a total of 8 since 2010.
- Financial position – the Trust performance against the Continuity of Service Risk Ratings has deteriorated in year from 3 to 2.

In addition other areas have been under extreme pressure for delivery and have been kept under close scrutiny by the Trust to minimise breaches and maintain standards of delivery:

- Cancer targets - 62 day first definitive treatment and the 62 day screening target.
- A&E 4 hour waits – in common with other acute hospitals across the country the Trust faces high levels of demand and pressures on maintaining ambulance turnaround times and timely admission for those patients who require a bed.

The Trust is currently awaiting the results of deliberations of Monitor as to whether it is in breach of its licence and what requirements will be placed upon the organisation.

Actions taken to address the 18 week RTT, A&E and Cancer target pressures are described in the Operational Section of this plan.

Actions taken to address C Difficile and Never Events are described in the Quality Section of this plan.

Issues regarding the severe financial constraints the organisation faces in continuing to operate are described in the Financial Plan and Productivity, efficiency and P and E sections.

Better Care Fund (BCF)

Better Care Fund plans have been developed by the two local Units of Planning in response to the national planning requirements. Details of these initial plans and the initiatives they compromise are given below. Whilst the potential benefits of the initiative the fund will generate and the joint working it engenders are clear there are also risks to the Trust in terms of financial and operational challenges.

South Tees CCG and Partners

The South Tees vision for the BCF is based on:

- all care being planned care;
- reductions in non-elective interventions;
- principles of 'IMProVE'

Specific initiatives included within the scope of their plan are:

Implementation of IMProVE (Integrated Management and Proactive Care for the Vulnerable and Elderly) described above .

Making Better Use of Community Estate

From the engagement work outlined above, and from the work already undertaken by the multi-agency IMProVE group, there is recognition that in order to implement new models of care, the CCG will be required to work alongside key partners, to make better use of existing community estate. To enable this, the CCG will be undertaking a formal consultation with the public setting out the case for change and presenting potential options of future service delivery to provide:

- Step-down patient rehabilitation.
- Step –up care.
- MDT assessment units to provide local rapid assessment and comprehensive diagnostics for elderly patients.
- A greater range of out-patient services with supporting diagnostics to help clinicians make quicker decisions.
- Medical day units providing simple care locally, IV antibiotics, blood transfusions, and potentially some cancer therapies.

The CCG have described that delivering this model is likely to lead to:

- Potential closure of hospital beds.
- Potential closure of community hospitals.
- Potential to commission beds from elsewhere – independent sector.
- More community nurses, social care workers and therapists working in the community.
- Opportunities to commission new or different services from a range of providers including the voluntary sector.
- Increasing the responsiveness and skill mix of community staff.
- Better supported patients, living independent lives.

Formal consultation around service re-configuration and estate options commences end of April 2014 to end July 2014, with option decision and development of implementation plan in September 2014.

Exploration and Implementation of Single Point of Contact and / or Access for professionals, service users and carers.

Integrated Health and social care assessment hub (Step up / step down) to reduce admissions to residential care and nursing homes locally which are well above the national average (the area is a high user of urgent care services, including A&E and non-elective) through provision of interventions at the earliest opportunity to assist in their return home to the most appropriate care setting.

Supporting Independence through reablement to manage current activity and mitigate future demand.

Provision of support across the health and social pathway for carers
South Tees has £1.2 million to support initiatives in 2014/15.

Hambleton, Richmondshire & Whitby CCG and Partners

HRW CCG are signatories to the Better Care Fund (BCF) for North Yorkshire Health and Well Being Board which covers six clinical commissioning groups, six acute hospital trusts and three mental health trusts.

The minimum required value of the North Yorkshire BCF pooled budget in 2014/15 is £11.109 million (the actual agreed value of the budget is £15.452 million) and £39.828 million in 2015/16.

The BCF plan currently identifies eight broad categories:

- Social care base budget protection.
- County wide infrastructure projects (data sharing, equipment services).
- County wide changes built upon.
- New models and transforming services.
- Prevention strategies and early intervention models.
- Community development – resilience models.
- Maximising admission reduction and timely and safe discharge from hospital.
- Covering mandated but as yet undefined costs- eg Care Bill.

HRW has a share of Health and Social Care reserves accumulated across North Yorkshire from 2010 to 2013/14 of £3.6 million which is available to spend on locality initiatives:

Commitment in 2013/14	2013/14 Cost (£'000)	2014/15 Cost (£'000)
Overnight Fast Response Service	306.0	423.0
Day time therapy	142.0	142.0
Integrated Teams project	50.0	0
Project manager	53.0	53.0
Hospital case management	104.0	115.0
District nursing	167.0	333.0
Total	**822.0**	**1,066**

The total expenditure for locality initiatives in 2013/14 will be £822K, with a balance of £2.8 million available in 2014/15 New schemes will be essential if the local health economy is able to successfully reduce acute care costs ahead of 2015/16, when the BCF comes into full effect.

The Trust has been working with the CCG and Local Authority (LA) to identify the range of proposals which constitute spend against available health and social care reserves and the forthcoming Fund.

Proposals for investment developed by HRW CCG working with the Trust and Local Authority include:

- Preventative schemes linked to Public Health.
- Support to grow and develop the Voluntary Sector through a more co-ordinated approach.
- Additional capacity and new treatments within community-based nursing and rehabilitation services, such as district nursing, therapies and fast response.
- Developments in mental health services to improve access to psychological therapies, liaison psychiatry and a dementia collaborative approach.

- Urgent care solutions to prevent arrival at A&E or facilitate integration with GP out-of-hours services.
- Underpinning solutions such as information management and technology, equipment services and use of telemedicine.

Impact of the Better Care Fund on the Trust

The BCF relies on £11.68 million of existing health resources for South Tees and £5.171 for Hambleton, Richmondshire & Whitby. National planning assumptions made a link between the fund and a 15% reduction in emergency admissions. For South Tees CCG there is an assumption that £8 million will be funded through reduction in emergency admissions into South Tees Hospitals.

The impact of the Better Care Fund in terms of its impact on health resources is manageable for 2014/15 although South Tees CCG are seeking a reduction in emergency admissions to "get ahead of the curve" before 2015/16 which given the underlying trend in admissions is challenging.

For 2015/16, the Trust has modelled emergency admission activity, identifying which areas are amenable to potential change through BCF initiatives and the impact this might be expected to have upon acute capacity, if these deliver as anticipated by the BCF plan. It should be noted that the HRW CCG assumptions are extrapolated from the South Tees CCG figures and activity to a higher financial value may need to be found to contribute to their pooled budget requirements, as these figures look light.

This modelling shows that:

- To release the required £8 million from South Tees' and an assumed £2.8 million from HRW's allocations, a 20% reduction in emergency admissions (40,099) will be required.
- This equated to a reduction of 98 beds.

In summary the challenges the Trust faces from the BCF are:

- The pace of change – the plans in place to date are admitted by all parties involved to be at an initial stage and will require highly effective joint working to form a plan to support the required changes in 2015/16;
- Demand projections currently show a trend of continuing increases in emergency admissions;
- South Tees CCG aspiration to target a 3% reduction in emergency admissions at the Trust in 2014/15. The main driver for this in addition to the measures contained within the Better Care Fund submission is an incentive scheme for primary care and actions agreed by the Trust to support admission avoidance. There remains a significant challenge even to reverse the upward trend, before achieving a reduction in admission rates;
- The Trust's planning assumptions for 2015/16 are that admissions equivalent to demographic growth (approximately 1%) can be avoided through co-ordinated action across primary, community secondary and social care, but as outlined, there is a high degree of risk in this assumption. As shown above, our initial analysis suggests that reductions in emergency admissions greater than 15% would be needed to generate the levels of cost reduction needed by the CCGs to support release of their baseline funding into the Fund;
- There are limited funds available as a contingency to support phased reduction in acute sector capacity or to act as a buffer, should the pace of change lag behind CCG expectations in 2015/16;
- Our previous experience of emergency admission pressures on bed capacity and corresponding consequences of cancelled electives on patients and waiting time targets. The Trust is therefore not currently planning on taking out the bed capacity that would be indicated by our modelling, in advance of seeing real evidence of the impact of the BCF initiatives on presenting emergency demand. However, the ability to rapidly reduce expenditure in line with reductions in income, if the BCF programme is successful, will be an issue for the Trust.

Specialised Commissioning

In the 2013/14 plan, the Trust recognised that the National service specifications and policies were being produced and the Trust's services would be expected to meet the specifications, or agree time limited derogations and action plans for full compliance by the 31 March 2015. Initial reviews of the draft specifications did not indicate significant non-compliance and the agreed derogations are limited in nature in a small range of services and have recently been reviewed and updated ahead of inclusion in the 2014/5 contract:

- Major Trauma
- Complex Spinal Surgery
- Peritoneal Dialysis
- Acute Kidney injury (AKI)
- Cancer – Teenage and Young Adult (TYA)
- Chemotherapy Adult
- Chemotherapy TYA
- Complex Gynaecology – severe endometriosis
- Paediatric Surgery – Chronic Pain

Further specifications were reviewed and derogations submitted in March 2014 for the following services:

- Adult Ophthalmology
- Paediatric Ophthalmology
- Specialised Orthopaedics

Further review / derogation will be required on the services below, both of which may have more of an impact on the Trust to gain compliance:

- Prosthetics
- Morbid Obesity

National service reviews are to take place in a number of specialised services, which the Trust provides:

- Some cancer services
- Vascular surgery
- Interventional cardiology
- Endocrinology
- Complex colorectal services
- Bariatric Surgery (contracted extended to March 2015, tender summer 2014)
- Neonatal Critical Care
- Neonatal and Paediatric Critical Care Retrieval

There is as yet very limited information about the substance of these reviews which means it is not possible to assess the short or long term implications on the Trust's strategy.

It is difficult to assess the short term challenge posed by the national planning assumption that the number of Specialised Services Centres will reduce (to 15-30 centres). The emphasis on "planning bundles" of linked services forming a logical basis for centres (major trauma, etc.) chimes well with the Trust comprehensive and complementary range of specialised services and provides a coherent basis for the Trust to continue as a centre in the key areas of major trauma, cancer, heart and neurosurgical services and as the detail of service reviews and national policy become clearer the Trust will continue to pursue its strategy of specialised service provision for the populations we serve in the Tees Valley, south and east Durham the northernmost districts of North Yorkshire.

Seven day working

An initial analysis has been undertaken of the Trust's delivery against the 10 national clinical standards for urgent and emergency care over 7 days. This has identified where there are apparent gaps against the standards and their attribution points, to inform the Trust regarding the scale of challenge that is faced for full delivery. However, for a number of the Clinical Standards, it is not currently possible to evidence levels of compliance over all the elements of the standards, at all hospital sites and or at weekends as discrete from weekdays, so mechanisms to audit these areas need to be developed, to identify the true Trust baseline position. It is noted that not all of the standards readily lend themselves to audit and the composite nature of the standards means that partial compliance is likely for some standards.

From the initial assessment undertaken, the Trust has areas of good performance on acute admitting wards for rapid consultant assessment and for access to diagnostics for emergency/ critical patients across 7 days a week, but access to diagnostics for non-urgent cases, MDT assessment and referral for inpatient specialist opinion are not uniformly available at weekends.

For 2014/15 a local CQUIN measure has been agreed with the CCGs to establish compliance against Standard 2 on consultant assessment following emergency admission across four key specialties that admit directly onto wards (Paediatrics, Cardiology, General Surgery and Trauma & Orthopaedics). This will provide assurance to the Trust on whether patients are receiving equitable access to rapid consultant led care, regardless of their point of admission.

Further work on defining and auditing the 10 Clinical Standards will be undertaken during 2014/15, to establish the baseline and identify areas for improvement during 2015/16. Some areas including the provision of specialist consultant led care are expected to be particularly problematic to address. It is unlikely that these standards can be met in full without significant financial investment, additional recruitment and changes to national terms and conditions for consultant contracts and other staff groups**.** It is anticipated that in some areas constraints regarding available workforce would also present a barrier to full compliance based on current service configuration. The intention is to identify those areas where improvement can be made without additional investment and areas where improvement in seven day delivery would have the maximum impact on patient outcomes and patient flow through services. This analysis will then support the Trust Board in further deliberations on the longer term strategic direction.

Specific Local Reconfiguration & Service Improvement Issues:

Improving the Patient Pathway (IPP) – the Trust had an intense focus on this programme during 2013/14 and has seen significant and sustained improvement in the associated key performance indicators for outlying bed days, delayed discharges, elective inpatient cancellations, bed occupancy rates and emergency readmissions. Particular benefits have been seen in terms of reducing delayed discharges. The IPP programme was instigated to pull together the work programme from three key initiatives, namely Transforming Community Services (TCS), the diagnostic work undertaken by McKinsey's in 2011 and the Bed Utilisation Review. In 2013/14 the Hospital Case Management (HCM) which was approved as a proof of concept project in July 2012, was combined with investment in an A&E therapy team and single point of referral as an integrated package. The wider programme of initiatives included:

- redesign and standardisation of processes with partner agencies
- development of a discharge framework with roles, responsibilities and accountabilities
- an extensive programme of discharge improvement workshops
- use of the MEDWORXX web-based resource utilisation tool

The expanded and integrated HCM team function at two levels: directly co-ordinating discharge planning and arrangements with the ward team for patients on case managed wards and offering discharge advice and support to non-case management wards for complex discharges. The nurses within the team also undertake the continuing healthcare (CHC) assessments and attend the Decision Support Tool (DST) meetings. The single point of referral acts as a co-ordinating centre for all transfers to community hospitals, intermediate care and CHC assessments.

Although it has not been possible to unequivocally demonstrate the proof of concept of case management given the number of variables in the emergency health care system, there was a general recognition by partners of the qualitative benefits that the case managers had brought and that reverting to former processes and levels of resource in the team would have a negative impact upon bed capacity, patient flow and quality of discharge. Acknowledging these benefits, which are in line with their strategic priorities to reduce unnecessary usage of acute hospital provision, both South Tees and HRW CCGs have agreed to invest in the continuation of these programmes during 2014/15, allowing for further review of their benefits and the longer term need.

Paediatrics and Obstetrics – the consultation on changes to services at Friarage Hospital Northallerton, ended in December 2013 and the Governing Body of HRW CCG has agreed the implementation of a change to a paediatric short stay assessment unit and midwifery led unit. NYY Scrutiny of Health Committee has however referred this decision to the Secretary of State for consideration by the Independent Review Panel (the second referral to the IRP). There are severe operational pressure on the obstetric service in particular because of difficulties in covering tier 2 rotas and both services are on the Trust's risk register and being regularly reviewed by the Medical Director.

Transforming the Care we Deliver – the Trust previously identified that there was potential to significantly improve the delivery of clinical care, by investment in a comprehensive programme of IT investment as an enabler to the system. Unfortunately despite considerable investment of management and clinical time in a procurement programme, the Trust was unable to identify a provider that could deliver the required benefits within an affordable envelope. Building on the work done during procurement, a strategic road map has been developed which sets out a programme of investment in infrastructure to provide a platform for the deployment of systems to support improvements to the Trust's clinical digital capability with benefits to clinical care.

The roadmap aims to achieve the technical infrastructure and the deployment of the proposed solutions over a 5 year period; however this is clearly dependent upon the level of available funding. The capital allocation currently proposed (£1.6 million in 2014/15 and £2 million per annum hereafter). The trust has been successful in securing £1m from the Nurse Technology Fund to support the implementation of the Vital Signs system and this will provide significant support to the roadmap and was also successful in its bid for community devices. Further bids will be submitted to the Nurse Technology and the Safer Hospitals, Safer Wards fund when the criteria are made available. However it is likely that additional sources of funding will be needed, especially for some of the larger clinical systems such as electronic document and records management (EDRM).

Overall the 5 year plan provides the capability for the organisation to move from a level 1 to level 7 (the highest) score on the international HIMMS[1] benchmarking tool.

Pharmacy: significant shortfalls have been identified in staffing provision through benchmarking with other trusts. The service has identified the positive contribution that could be made to improved clinical care, through additional investment in service capacity including: optimal prescribing, improved patient adherence to prescribed medicines, reducing adverse drug reactions and interactions, medicines administration errors, improving interface communications and savings in drug usage costs. Particular needs are compliance with NICE recommendations on medicines reconciliation and adherence and to meet the recommendations of the Cancer Peer Review to provide a robust Chemotherapy aseptic manufacturing unit that can provide a timely and responsive service to maintain patient flow. Given the scale of the investment required (c.£1.6m) phased

[1] Healthcare Information and Management Systems Society digital maturity benchmarking tool for Europe.

investment proposals have been developed, but even phased investment in this area will be a challenge given the Trust's financial position and the Trust has agreement from its lead commissioner to explore support in this area during 2014/15.

System Issues:

Collaborative Working and Fragmentation of Commissioning – the Trust has faced issues throughout the year in dealing with the complexity of the new commissioner environment, which has significantly added to the bureaucracy, pressures and time required, to negotiate and agree changes to service delivery and contracts. Patient pathways and services may now be spread across two or three commissioners, leading to protracted debates about responsibility for commissioning between Local Authorities, Area Teams, CCGs and Specialised Commissioners. The Trust will continue to work constructively and collaboratively to overcome these issues in 2014/15 and beyond.

C. Quality Plans

Whilst acknowledging the constraints of the financial position and the other short term challenges identified above, the Trust remains committed to delivering high quality care as described in our ambition statement:

"We will deliver high quality, safe and continuously improving services."

Quality of care and patient safety is the core transformational theme which underpins the development of the Trust's values and objectives.

Strategic Objectives: Over the next two years we will build on our vision and model of care to deliver both the Health Outcomes Framework and the national ambition of effective integration between health and social care. This work is captured in three, interlinked and interdependent, strategic objectives:

World-class outcomes: To continuously reduce our mortality rate and to be in the best quartile for mortality in the North of England
For different services and specialties, high quality outcomes will be defined in different ways, but for the Trust overall minimising the number of deaths associated with hospital care is the key measure of the quality of the outcomes we achieve. We have set our objectives as to continuously reduce our unadjusted mortality rate year on year and to be in the top 25% of trusts in northern England for our risk adjusted mortality (measured using the Standardised Hospital Mortality Index, SHMI).

Supporting this improvement there are a number of areas of work:

- Weekly reviews of all deaths in hospital in now in place using a standardised tool to identify preventable deaths, the trust is pioneering this work in the North East and is one of a few trusts nationally to have this process established.
- Early diagnosis and 7 day working
- Introducing the respiratory care bundle
- Developing care pathways for frail elderly patients with a hub which will review the need for admission and arrange for the relevant services to support patients outside of hospital and avoid unnecessary admission
- Roll out of the critical care outreach team
- Improving care at the end of life and reducing the admission of terminally ill patients.
- Launch of the COPD pathway
- On-going implementation of the trusts cancer strategy

Dependable patient safety: To deliver care free from avoidable harm for all patients
As a healthcare provider our first duty to our patients is to do no harm. Patient safety, which we define as care free from avoidable harm, is our highest priority. Prevalence audits using the NHS safety thermometer shows that the trust is delivering 92% harm free care, to drive this higher the areas for focus are:

- Further driving down healthcare associated infections
- Eliminate all service associated grade 3 and 4 pressure ulcers
- Bi-annual nurse staffing and patient acuity reviews
- The implementation of a ward quality accreditation system
- Rolling out the newly launched Dementia Strategy and developing a local dementia collaborative with GPs, care homes, other providers, local authorities etc for South of Tees

The third strand of quality is to deliver an outstanding experience for all patients
Our values of putting the patient at the centre of everything we do and of continuous service improvement make it clear that everyone has responsibility for delivering an outstanding patient experience and we must consider the patient experience in everything we do and in every service development and improvement project we undertake. The Patient Experience Strategy provides us with a framework for engaging with patients' about our services to capture and understand their views, make improvements in partnership with them and assess the impact of the improvements. Each Board meeting starts with a patient story. We are also building on our commitment to be open and honest with our patients and deliver our 'duty of candour', we have redesigned the Trusts website to make it easier for patients to access information about services and we are participating in the national Transparency project. Further initiatives to improve patient experience include:

- Roll out of the friends and family test to community services, out patients, day cases and staff
- Implementation of a real time patient experience project.
- Publication of a summary of complaints and the actions taken and lessons learnt on the trusts website.

Underpinning Strategies: These work streams are underpinned by a number of strategies; the nursing and midwifery strategy, the patient experience strategy, the dementia strategy, the infection prevention and control strategy, and the risk management and patient safety strategies.

Quality Account: The Trust has consulted with a range of stakeholders on the quality priorities for the Trust's Quality Account. This involved surveys of staff, patients and carers and a workshop to seek the views of governors and external stakeholders including commissioners, Health and Wellbeing Boards and Healthwatch.

Feedback from the consultation process was shared with the Board where it was decided that the Trust will seek to represent a broader selection of the quality priorities identified by the consultation process in the Quality Account than in previous years. The final selection is to be presented to the Quality Assurance Committee and Board in April, it will consist of three groups of improvement initiatives:

- <u>Sign up to safety</u>
- Reduce the number of pressure ulcers acquired during our care
- Reduce the number of C. Difficile infections contracted during our care
- Reduce the risk of process errors through standardisation
- Ensuring the right staff with the right skills are delivering care in the right place

- <u>Right care, right place, right time</u>
- Improving the recognition and treatment of the deteriorating patient
- Improving nutrition for patients with dementia and / or in the community

- Ensuring that patients are treated in a timely way
- Improving access to care, when it's needed, 7 days per week

- At the heart of the matter
- Caring with compassion
- Improving the quality and timeliness of complaint responses

CQUIN goals are developed through discussion with commissioners to reflect the local commissioning intentions. For 2014/15 these include improvements to the discharge process, further focus on the acutely ill patient, COPD and care bundles for respiratory disease and catheter care.

CQC: the CQC has assessed all of the Trust's registered locations over the last 24 months, no concerns have been raised and in all inspections the care met the standards which were assessed. The feedback provided by patients and their relatives to the inspectors was excellent. The current CQC Intelligent Monitoring Report places the Trust in band 4 for risk to quality. The Trust plans to hold a mock CQC assessment using the new assessment process so that it is prepared for future CQC visits.

Commissioner Assurance: Commissioners have raised concerns during the year in relation to never events, C.difficile and the referral to treatment time. The Trust has worked with the commissioners during the course of the year to further investigate these issues and provide assurance through Board to Board meetings, focus groups and CCG visits to clinical areas. Action plans are in place to address these concerns and the trust has commissioned a number of external reviews to provide a further level of assurance that these plans are robust and that actions taken to date have been effective, the CCGs and area teams are actively monitoring the delivery of these plans.

Assessment of Risks to Quality: The quality risks over the next two years include the challenges in providing care to an aging population across one locality with high levels of deprivation and one locality which covers a wide rural geographical area. There is a risk that the multi-agency strategic planning required to respond to the creation of the Better Care Fund does not create sufficient viable alternatives to hospital admission for elderly, non-elective patients by 2015/16. The Trust is actively engaged with local partners to develop a shared plan.

C Difficile - The Trust has a strong record of achieving sustained reduction in the incidence of C Difficile. To ensure continued improvement, two external reviews were carried out in December 2013. Key areas of focus were:

- Further increasing medical involvement in RCAs and shared learning
- Reviewing the quality of the estate
- More antimicrobial prescribing audits
- Greater focus on diarrhoeal management and faecal sampling
- Further tighten hand hygiene compliance monitoring
- Instigated cleaning services review (with assurance around National Cleaning Standards)

For cleaning, there has been extra investment in high risk areas and deep cleaning including the use of Hydrogen Peroxide vapour and/or ozone.

A Director-led awareness programme reinforced messages about C difficile to all staff groups with over 1,000 staff trained since January 2014. There are Trust-wide briefings on current status with have been completed.

It is normal Trust practice to take assurance reports to the Board where there are concerns about performance, with weekly information shared with all Board members, as well as a well-established programme of safety walkabouts with executive and governor attendance. A detailed C difficile action plan is in place and monitored by the Infection Prevention Action Group.

Never Events - The national picture is that during 2012/2013 there were 326 (NHS England) Never Events of which 2 were reported by South Tees Hospitals. In 2013/14 the Trust reported 3 never events, the national picture for the full year is not yet available. Between December 2010 and June 2013 we had 8 never events (6 of these were surgical). The last event in South Tees was eight months ago.

We have reviewed each event, ensure learning across the whole Trust, and taken actions (discussed with CCG and area team). There has been a review of events as a whole (including documentation/ processes through NEQOS) and we have sought external independent review by Patrick Mitchell and Elaine Maxwell who are nationally known as experts in this field. The conclusion of their review was: *"There is good evidence that the trust has investigated the Never Events and implemented changes. Furthermore we consider the on-going risk of Never Events to have been much reduced by the actions taken…….and consequently going forward we consider the trust to be exceptionally safe."*

Patrick Mitchell PhD FRCS and Elaine Maxwell PhD RN
November 2013

From these reviews we have assurance that the Trust has a strong corporate safety culture.

Pressure Ulcers: The Trust has seen an increase in the number of grade 3 and 4 pressure ulcers developing in patients while in our care. Thematic analysis has shown this is linked to increasing severity clinical condition, and complexity of co-morbidities. A pressure ulcer action plan is in place and additional staff have been employed to support additional education in pressure ulcer prevention. The trust and CCGs have collaborated to undertake a review of pressure ulcer care and the action plan reflects this work.

Electronic Patient Record: The Trust does not have an electronic patient record and the increasing demand for additional clinical data to support clinical benchmarking, coding and evidence clinical process measures places a burden on clinical time. The Trust is doing further work to stream line documentation and reduce duplication and is prioritising IT infrastructure investment to maximise the technological support to clinical staff.

Tracking of Quality & Safety Measures: The indicators and measures used to track the trust's quality and safety objectives are reported through patient safety and quality dashboards. The dashboards are produced at trust, divisional and ward level. The dashboards integrate the traditional measures of quality and safety with workforce metrics and patient experience feedback through the friends and family test. Quality improvement targets are determined by the Trust's strategies and the divisional patient safety and quality action plans. Improvement targets are RAG rated and focus on outcomes rather than processes.

Monitoring of Performance: Performance against quality standards is discussed at the quarterly governance reviews, and reported at divisional level within the divisional governance reports. Quality is communicated to the Board of Directors, Board of Governors and Commissioners via the Quality Report. Progress with CQUIN is reviewed regularly by the Management Group and the Board in the Performance Report. In 2014/15 the trust will be introducing a ward quality accreditation system using the quality dashboards combined with ward-based assessments of standards of care. The outcome of these will feed into the quarterly performance reviews.

Quality Governance Framework: During 2013/14 the Trust reviewed its quality governance framework, taking account of best practice guidance; Quality Governance; Guidance for Boards of NHS provider Organisations. Monitor. 2013, Quality Governance in the NHS; a guide for provider boards. National Quality Board 2011, The Healthy NHS Board, Principles for Good Governance, National Leadership Council 2013. Following this review the Board approved a revised committee structure which was introduced in January 2014.

The Trust assesses compliance with Monitors Quality Governance Framework on a quarterly basis through the Quality Assurance Committee which reports to the Board. During the year the Board development programme included a workshop to review the mechanisms by which the Board is assured. In addition a workshop took place with the trust's governors to discuss the requirements for quality governance and quality assurance.

Risks to the delivery of the corporate objectives (including quality and safety risks) are included in the Board Assurance Framework and the Corporate risk register which are reviewed at the Board.

Francis, Keogh & Berwick Reviews: The Trust undertook an analysis of the impact of the recommendations of the Francis Enquiry in February 2013, this work was then built on to incorporate the findings from the Keogh and Berwick reviews and then further refined to reflect the other national quality reviews and the Government's response. Many of the recommendations were already reflected in the quality work streams described above. The key areas for focus for the trust are grouped within the following categories:

- Transparency – how we share information on safety and quality issues with patients, the public and staff.
- Using real time patient experience feedback
- Strengthening the processes for reviewing deaths in hospital.
- Improving the way we engage with patients and the public on planning and developing services

Clwyd/ Hart Review: this national review of complaints which was co-authored by the Trust's Chief Executive informed the Trust's review of its processes, which was undertaken in consultation with the Governors and members of Healthwatch. The Trust is establishing an independent complaints review panel.

D. Operational Requirements and Capacity

The Trust has assessed its activity and demand pressures and the inputs (physical and workforce capacity) needed to address these over the next two years:

Predicted Demand

Overall, the Trust is expecting steady growth in acute hospital activity across the broad range of services. Growth is driven by general demographic growth (particularly for over 75 year olds where activity growth is 3 times the rate of population growth) plus growth in specific services, such as radiotherapy, interventional cardiology, lower GI endoscopy, cancer awareness campaigns etc, driven by commissioning intentions to meet national guidance on expected levels of demand for our population. Activity changes due to demographic growth have been calculated by analysis of ONS prevalence rates for 5 year age bands for each specialty, point of delivery and geographic area. Overall this generates around 1% growth in activity per year.

In addition service developments to ensure that the Trust is offering patients the best treatment options contribute to the general increase in acute activity. Activity growth is partially offset by commissioners' demand management plans and plans to enhance community services and move acute activity closer to home. In total the Trust is predicting outpatient growth of 2%, elective growth of 1.4% and non-elective growth of 1.3%.

A comparison of commissioner demand plans with our own estimates was undertaken to highlight any significant differences between plans in order to agree realistic baselines for 2014/15 contracts. Differences have have largely been resolved so that there is a broadly agreed position between commissioner and Trust assumptions (where there are differences these are highlighted in Section F).

As noted above in the Better Care Fund section, the continuing demand for non-elective work contradicts BCF requirements and needs a system wide solution. Initial steps are in place but there is a lack of confidence in scale and pace of proposed change to meet this challenge.

Elective Programme & Capacity

In response to the demand projections, the Clinical Centres reviewed their capacity requirements for 2014/15 and 2015/16 and the ability to deliver this level of activity whilst maintaining national standards on waiting times. The main area of risk that the Trust faces in meeting commissioners' requirements and the terms of its licence is in meeting and sustaining delivery of the 18 week admitted target. A number of speciality and sub-specialty areas were identified as having insufficient capacity to meet all projected demand, based on this exercise. Options to meet these shortfalls were identified by the specialty areas through a combination of longer term solutions based on increased consultant, bed and theatre capacity as well as interim solutions until the preferred substantive model can be delivered. The Trust's preferred strategy, in line with that of its commissioners is to accept the presenting levels of patient demand and utilise resources in partnership with the independent sector where in-house capacity is insufficient or uneconomic.

However for a small number of sub-specialty areas the Trust has identified that it is unable to meet all the demand, even utilising these options. Discussions have been held with Commissioners regarding the temporary closure of the current services to new referrals, to avoid breaches of national waiting times at specialty level. This approach was not accepted by Commissioners, but a joint arrangement has been agreed to address the demand and capacity imbalance for the challenged areas: spinal surgery, foot and ankle surgery and an excess of plastic surgery procedures requiring general anaesthetic (GA)

Throughout 2013-14 the trust has concentrated on its RTT recovery programme. This is expected to deliver at aggregate level in Q2 2014-15. Work is now underway to ensure a robust sustainability plan is in place. This approach is supported with expertise from the Interim Support Team (IST).

The Trust has shared the result of its internal capacity modelling, the challenges faced, potential solutions and impact with the commissioners:

- Spinal Surgery - severe capacity issues, with long waits and an urgent need for replacement consultant appointments, which are being pursued but recruitment remains a long term challenge. If all other specialities meet their trajectories the Trust will meet the 90% target overall, but the increasing level of backlog in this sub-specialism is of significant concern. The Neuroscience service is able to provide some capacity to help address the waiting list position for appropriate patients requiring decompression and discectomies. However, alternative sources of provision are needed for new spinal referrals for a period of at least 6-9 months, excluding scoliosis and tumours, neurological deficit and trauma, which would still be seen by the Trust.
- Orthopaedic foot and ankle surgery – referral levels are static but consultant vacancies have resulted in a mismatch between capacity and demand. Options to close the gap include additional weekend working, use of independent sector for appropriate cases and potential for a locum. However it is anticipated that alternative provision is needed for a period of at least 12 months, whilst the service is reviewed and decisions made whether alternative flows should be maintained in the future.
- Plastic surgery – the waiting list backlog needs to be eliminated and a replacement surgeon is being sought. At least two additional GA and four LA theatre sessions/ week are required. Some of the LA capacity can be created internally through productivity measures. However to avoid continued breaching of waiting time standards, the service needs to reduce the range of services offered and alternative provision is required for new referrals for breast augmentation, reduction and abdominoplasty for an estimated period of 12 months.

The joint approach to addressing these challenges involves:

- Commissioners and their Commissioning Support Units identifying alternative providers and capacity beyond that already identified by the Trust, to meet the specific case-mix requirements
- Investigation of a potential slot system
- Clinical engagement between primary and secondary care, to facilitate GP understanding of the current capacity constraints and need to manage referral flows appropriately
- Expediting implementation of planned back pain pathways to address demand for spinal surgery
- Commissioners and Provider to raise awareness of national pressure areas via clinical networks and NHS England.

As noted above, Orthopaedics has severe pressures upon capacity and a recommendation from the IST to reduce the waiting list by at last 600 cases. Three new consultants have been appointed, but the service also has specialist consultant vacancies which they have been unable to fill. Business cases are being developed to increase capacity to meet the presenting demand, and the service will continue to utilise the independent sector in 2014/15 to bridge the gap. The need to identify alternative providers for new referrals in the sub-specialisms of spinal and fore-foot work is an essential part of managing delivery of the recovery plan (see above). Planned actions to address the issues mean that going forward to 2015/16 capacity and demand will be better matched.

Other areas where plans are in place for 2014/15 and which require continued focused attention include cardiac surgery, the electrophysiology service, plastic surgery, oral surgery, urology and pain management. The trust continues to work with the IST on developing plans to address these issues and the internal capability to manage independently on a sustainable basis.

Theatre Capacity

Work on an additional theatre will reach completion in April 2014. The principal rationale for the additional capacity is to support the re-designation of a theatre adjacent to the central delivery suite which has been in use as a day theatre but which is required as an obstetric theatre to respond to the increase in deliveries the Trust has experienced in recent years and the changes planned at the Friarage Hospital which will increase activity at JCUH. After this change has been effected there will be five unallocated sessions available. A business case is being finalised to explore the use of this capacity to create additional emergency sessions which has been a long term objective to meet National Confidential Enquiry into Patient Outcome and Death (NCEPOD) requirements. The premise is that there will be other capacity benefits (reducing pressure on beds) but this needs to be demonstrated given the pressing requirement for more elective sessions. . To support the capacity and demand programme the theatre team is increasingly working over a 6-7 day period.

Beds

The Trust invested in additional bed capacity at JCUH leading up to winter 2013/14 in response to the serious flow pressures experienced the previous winter. The benefits of this have been experienced this winter with much reduced pressure on beds and as a result better flow through A & E and fewer surgical cancellations. Whether this is due in part to a milder winter is difficult to establish. Extensive and successful work to revise discharge arrangements means that there is growing confidence that the Trust can plan to reduce bed capacity in a phased way. For 2014/15 the plan is:

Friarage Hospital

The elective/surgical bed base will remain untouched. Although it was not fully utilised in 2013-14 the orthopaedic team has plans to increase its programme in 2014-15 and while this is built up the surgical centre will use the available capacity to maximise its programme.

The introduction of the clinical decisions unit (CDU) in 2013 combined with improved access to community services has resulted in reduced use of non-elective beds during the summer

months. The Integrated Care Centre has been asked to consider closing 6 beds on the FHN site during the summer months (May to November) with staff to be deployed in FHN to offset NHS Professionals spend.

Community hospitals
Beds will reduce in the summer months in line with planned maintenance closures and historic patterns of demand. Further consideration of permanent bed requirements will be needed .in line with CCG commissioning intentions for 2015-16. .

The James Cook University Hospital
The JCUH bed base will be realigned to support increased demand for elective surgical capacity to meet RTT access times while at the same time ensuring sufficient bed capacity to meet anticipated winter surge demand (an estimated 40+ beds during the period January to March each year).

To deliver this programme will require considerable management time and effort including substantial support from the HR team and intensive service improvement input. A number of service improvement initiatives have already been identified to drive this forward.

In addition to the 2014-15 initiatives identified above this programme will create capacity to reduce the bed base further in 2015-16.

A&E and Front of House:
High levels of demand continue to put pressure on A&E. As part of the package of winter response measures, the Trust increased the number of resuscitation bays available (with funding from CCGs for physical changes) in addition to increased extended nurse practitioner (ENP) resource and consultant time. Achievement of 4 hour target has been achieved for the Trust as a whole, but this has been supported by the positive contribution being made by the Urgent Care Centres/ Minor Injury Units in the Community Hospitals and the Walk In Service at Resolution Health Centre. Delivery at the JCUH and FHN sites has remained under severe pressure and the need to invest in this service has been identified as a priority area and business cases are currently under development to examine the longer term need for a resilient staffing structure. However, the ability to implement these proposals is high risk due to both financial and recruitment constraints.

The South Tees CCG continue to hold the aspiration to reduce the pressure and activity levels at JCUH A&E, the urgent care centres (UCC) and walk in centres (WIC), to deliver better value from health economy resources. The Trust will collaborate with the CCG as members of their Urgent Care Workstream to develop plans to work with GPs, to optimise the benefits of the NHS 111 system and the potential to co-locate the WIC with JCUH A&E. Some of these solutions will however require public consultation on service change and reconfiguration if agreed to be pursued further.

At the JCUH the ambulatory care model run by the acute physician team ensures that a significant number of admissions are avoided each year with rapid access to a consultant opinion and supporting investigations. Work continues to develop this approach with increased input from the care of the elderly team starting in April 2014, the successful pilot of a surgical opinion available to the acute admissions team and a new acute medical clinic to be launched in April. In addition the use of therapist to support the A&E and acute assessment unit has proved beneficial ensuring immediate support mechanisms can be put in place to avoid admission wherever possible.

The Trust has made changes at FHN including introducing a successful Clinical Decisions Unit and changes to medical cover arrangements in A and E. Growing difficulty in obtaining and retaining trainee doctors in Acute Medicine at FHN and a consequent reliance on locums is however driving a need for review of current staffing arrangements. HRW CCG is keen to work with the Trust on this agenda during 2014/15.

Cancer Services:

The trust has successfully met all the cancer targets with the exception of the 62 day first definitive treatment and the 62 day screening target. Shared screening breaches are small in number. The main reason for the 62 day first definitive treatment breaches is late referrals (representing 31% of breaches), diagnostic pathway delays/complex tumour pathways (19% of breaches) and patient choice (19% of breaches). Looking ahead the trust expects to be compliant with all the cancer targets although the 62 day first definitive treatment target remains challenging. Action plans are continually reviewed and updated to improve the position going forward.

Service Specific Expansion:

Specific areas of capacity expansion being pursued during the two years of this plan include:

- **Gastroenterology** – continued implementation of phased business plan to increase capacity to match growth in demand;
- **Catheter laboratory** – increase to four catheter laboratories now completed and assumptions about modelled increases in activity agreed with specialised commissioners;
- **Renal** – business case agreed for increase in workforce to cope with demand, assumptions agreed with commissioners.
- implementation of a strategy for MRI which in 2014/15 will involve the use of a mobile unit at FHN providing local access for the first time and providing temporary additional capacity whilst an existing 1.5 Tesla machine at JCUH is replaced with 3 Tesla capability which will both provide additional capacity and improved clinical functionality. Fund raising is underway for a third general MRI to be permanently sited at FHN to keep pace with demand and offer a local service to HRW CCG..
- **Critical Care** – the Trust opened additional HDU beds in a new centralised facility during 2013. The roll out of the critical care outreach service is now complete. There is a need to evaluate the impact of these changes on the Trust's critical care capacity and a detailed evaluation and review will take place mid-way through 2014/15 with advice to the Board thereafter.
- **Community Service** Infrastructure: in line with their strategic intention to provide more care closer to home and reduce usage of the acute sector, the CCGs invested in a range of community initiatives during 2013/14 and have indicated their intention to continue this approach in 2014/15 and thereafter, linked to the BCF and their Improve and Fit for the Future programmes. Community services such as the Integrated Community Care Team (ICCT) and Rapid Response Team (RRT) will continue in 2014/15 and thereafter subject to further evaluation by the CCG.
- **Pharmacy –** as highlighted above, the need for a significant programme of investment in pharmacy services on a phased basis to help improve medicines management for patients, patient flow and the provision of chemotherapy aseptic dispensing has been identified. In year discussions will be held with local commissioners regarding financial support to enable the first phases of this programme to be implemented.

Workforce

National Initiatives and Imperatives: there are a number of national drivers affecting workforce planning over the next two years which include:

- A reduction in specialty training posts, especially core surgical training
- Increase of GP registrar posts
- Increase in Health Visitor training and health visitors in post
- IAPT and dementia are high priorities
- Supply for adult branch nursing, post Francis report
- Midwifery training numbers, linked to the 1:28 ratio
- Wider implications of Francis and other inquiries

- Seven day working clinical standards for urgent and emergency care

A number of local drivers will influence the Trust workforce needs during the next two years:

- Improving the Patient Pathway
- Outpatient and Pre-assessment review
- Nursing Ward establishment review
- CCG strategic plans: IMProvE
- Transforming the Care we Deliver
- Identified workforce risks
- Financial Targets/ CIPs
- Capacity Plans as identified above

Previous Growth: the past two years has seen a significant growth in workforce head count at the Trust. Given the Trust's financial position, it is clear that this level of growth is not sustainable and will need to be reversed. The Trust already has vacancy control measures in place, but these will be made more rigorous, with CEO level sign off of any applications. There is however concern that expansion is still needed in certain consultant posts if we are to meet speciality specific targets (and sub-speciality issues) for 18weeks RTT.

Impact of BCF: The final impact of the BCF initiatives on the Trust workforce, over the two years of this plan is still unknown. The Trust has made an estimate of what the BCF could mean in terms of reductions in beds/ wards. It would therefore be expected that there will need to be a corresponding reduction in ward based staff. These reductions will also be a necessary consequence of the financial position of the Trust. In contrast to reductions in acute hospital based staff, the BCF should bring potential for some growth in the community services that the Trust delivers, including redeployment of hospital based therapists and increases in community nursing staff. This will also link to the work of IMProvE for the South Tees area and Fit for the Future for the HRW area.

Non elective and winter pressures: In response to the pressures of winter 2013/14 plans included workforce changes which have been put in place. There were particular difficulties with recruitment in two areas, acute physicians and nurses to support expansion of surgical beds. Our plan reflects the requirement for these plans to be implemented during 2014/15.

Case Managers: As part of the Improving the Patient Pathway work, fixed term additional investment was made by the Trust in case managers to facilitate hospital discharge and reduce length of stay. Whilst it has not been possible to financial quantify their discrete contribution to improving patient flow and use of resource in the Trust, it has been universally acknowledged that these posts have delivered a significant quality benefit to priority wards and cases where they are deployed. The ability of the Trust to maintain these posts at the end of the pilot period, given the financial position was extremely unlikely, but both South Tees and HRW CCGs acknowledged the benefit the team brought to the whole health system and have agreed to fund the additional posts, so these will now remain in post for 2014/15.

A&E: As noted above, there is recognition that a staged investment in A&E in order to maintain its resilience is required and a business plan setting out the options for this will be considered by the Board early in 2014/15.

A&E therapies: as part of the winter pressures package of funding, additional therapists were recruited and deployed to work in A&E. The benefits these posts delivered has been well received and the Trust hopes to secure recurrent funding to maintain these posts through the BCF discussions with commissioners, but this is not confirmed at time of writing of the plan.

Endoscopy: Our plan recognises the pressure that the national bowel cancer awareness campaign . We are planning for an annual 10% increases in lower GI endoscopy each year until 2016/17. A significant investment in additional capacity has been made but recruiting additional consultant staff has proved difficult and this remains an area of concern for 2014/15. Use has been made of the

private sector during 2013/14 to meet the gaps in the interim and this requirement is expected to continue throughout the duration of this plan.

Neurosciences: Nurse recruitment difficulties in Neurosciences has led to bed closures during the latter part of 2013/14 and successful resolution of recruitment and retention in this area is essential for the achievement of our plan in 2014/15 and 2015/16.

Health Visitor Workforce – the Trust is in a strong position for delivery against this national headcount target and will work to maintain this position throughout the two years of this plan.

Pharmacy: As noted above, there is a need for expansion in the pharmacy workforce to meet the improvement programme identified, but this is subject to financial support from commissioners, given the financial position of the Trust. Phases 1 and 2 of the programme identify the need for an additional 40 WTE posts across all grades of staff. Improvements to the Chemotherapy aseptic dispensing service is seen as a priority area and would require an additional 6.6WTE (pharmacists, technicians and ATOs).

External Partnership: The Trust is widening its focus on external partnership oppotunites and the benefits these can bring. The Trust now has over 600 volunteers and this number is increasing, including a number of therapeutic care volunteers enhancing the overall patient experience and the potential to reduce increased healthcare assistants costs. The Trust is in partnership with Redcar and Cleveland Council piloting the concept of community agents. The Trust is also developing links with the voluntary sector regarding improved transport arrangements, again with the potential to reduce taxis/private ambulance costs.

Organisational Improvement Agenda

Underpinning the Trust's operational plan is the organisational improvement agenda:

Service Improvement Strategy

In 2013 the Trust launched a Service Improvement Strategy. As a result of this strategy over 743 staff have already been trained in service improvement techniques and this programme will continue during 2014/15. The benefits of this learning are now being cascaded throughout the organisation, including the comprehensive programme of 33 Rapid Process Improvement Workshops undertaken to look at improvements in Discharge Planning as part of the Improving the Patient Pathway Project. The Trust has established links with Virginia Mason Medical Centre in Seattle to learn from their flagship approach which embeds service improvement at every level throughout an organisation. A number of senior staff within the Trust visited the hospital in 2013/14 to benefit from direct experience.

Corporate Improvement Training Programme

The Trust also has a wider corporate training plan to further build capability across the organisation in both 14/15 and 15/16. This includes internal leadership, team and service improvement development opportunities for staff in the coming year, including programmes specifically designed for the Managing Directors and Chiefs of Service.

Trust Internal Restructure

During 2013/14 the Trust has undertaken an internal restructuring to foster greater integration of services through the formation of seven clinical service centres. The new Clinical Centres led by Chiefs of Service and Managing Directors, become operational on 1 April 2014. The seven centres are:

- Clinical & Diagnostic Services Centre
- Surgical Services Centre
- Women & Children's Centre

- Tertiary services centre
- Trauma, orthopaedics, theatres and anaesthetics centre
- Speciality medicines centre
- Integrated medical care centre

The previous academic centre will align with the directorate of quality assurance aimed at facilitating a strengthened approach to education, training and research. Further work is being done to develop a corporate services centre ensuring the new clinical centres have robust financial IT and HR support. These changes are designed to make the Trust a more effective organisation, so it is fit for the challenges to be faced in the coming years and to address some of the blocks that occurred when services were spread across 13 separate divisions. The aim is to reduce silo management both within the organisation and to aid integration and partnership working across the health and social care system.

E. Productivity, efficiency and CIPs

In 2011, in recognition of the challenging agenda facing the organisation to deliver recurrent cost efficiencies the Trust undertook an intensive programme of work with external support in order to review its efficiency and identify opportunities for future improvements.

Programmes of work were developed which have helped underpin delivery of productivity, efficiency and CIPs:

- Outpatient efficiency
- Patient Flow (leading to bed reductions)
- Medical Productivity (skill mix, pay and agency costs)
- Nursing costs
- Procurement

These have supported delivery of savings over the past three years:

2011/12	£18m	91% of plan	3.7%
2012/13	£20.7m	100% of plan	4.2%
2013/14	estimated £20m	90% of plan	3.9%

The identified CIP programme for 2014/15 is £11.8m, representing 2.2% of the cost base of which 1.8% represents operational cost reductions and 0.4% transformational savings derived from work to improve the patient pathway resulting in £2.4 million of savings from reducing beds. The CIP programme for 2015/16 is currently £11.3 million.

	2014/15	**2015/16**
	(£millions)	**(£millions)**
Business Improvement	1.9	2.6
Medicine Management	0.4	0.6
Procurement	2.1	2.0
Workforce	7.0	6.1
Income	0.4	
Total	**11.8**	**11.3**

In putting together the programme for 2014/15 and 2015/16, the Trust faces constraints:

- Clinical divisions and corporate teams have made significant inroads into their cost base through focusing on the cost effectiveness of staffing and robust management of non-pay costs. As the identified programme for this year shows now require new approaches to make further sustainable improvements;

- The need in the short term to increase capacity to deal with both elective and non-elective demand and achieve sustained compliance against access targets limits our ability to make significant inroads in the immediate future into the bed base of the Trust and to reduce the reliance on expensive temporary medical staff and additional payments.

We have transformational programmes within the Trust which are delivering qualitative benefits and which will support longer term productivity, efficiency and cost reduction:

- Improving the Patient pathway – working with partner agencies to redesign and standardise patient processes and improve discharge
- Transforming the Care We Deliver – driving improved clinical care and releasing efficiencies
- Continuous Improvement Strategy - linking with Virginia Mason Hospital Seattle.
- Collaborative working with other acute partners – there is an initial focus on a new joint venture to deliver pathology services with the intention to develop other partnership arrangements which will start to deliver savings in 2015/16.

The Trust recognises that there is an urgent need to develop a wider programme for delivery of continued traditional savings and to derive benefits from transformational change.

The Trust has, therefore, commissioned McKinsey work with us during May and June 2014 to build on our current programmes and to initiate and implement new programmes which will return the Trust to financial stability and which will be reflected in our Five year Strategic Plan to be submitted in June.

The size of the opportunities can only follow this work with McKinsey, but specifically will be driven by:

- Risk assurance on existing schemes to maximise achievability
- Analysis of cost levers
- Analysis of service line profitability supplemented by analysis of clinical variability
- Comparison with proven success elsewhere

It is planned that we will work then with McKinsey's Recovery Transformation Services team to deliver this programme over an accelerated timescale to reduce the 2014/15 financial gap and build a sustainable financial model going in to 2015/16 and generate further transformational savings.

The scale of the challenge facing the health economies within which we operate is recognised in the commitment to joint work on transformation as set out in section 2 and as we develop our strategic plan this will reflect the analysis and programmes which all agencies are developing.

In 2013/14, the trust has proceeded with plans to develop the Project Assurance Office and has implemented new fit for purpose software to ensure mission critical programmes and projects are managed centrally as a portfolio and with a standardised approach. In 2014/15 CIP will be monitored through the PAO using this tool which reflects and supports the new organisational structure from 1 April 2014. Quality Impact Assessment will be made on the programme and tracked as projects are delivered, demonstrating quality impacts have been considered before a CIP has been implemented, and satisfying the National Quality Board requirements. In particular this will:

- Link directly to delivery of care to patients, assessing the likely occurrence and consequences for safety, quality, human resources and adverse publicity/reputation.
- Assess patient safety, clinical outcomes, patient experience and other quality measures
- Be signed off by Managing Directors and Chiefs of service a clinical centre level and Medical and Nursing Directors at Trust level, prior to review by CCGs.
- Follow a hierarchy for reviewing risks dependent upon their rating, with those rated 'red' only progressed with approval of the medical and nursing directors

Accountability for CIP delivery is with the Board, with the director of Finance the lead Director, reporting on risks to individual projects and the programme.

F. Financial Plan

Activity & Income

The underlying activity assumptions are:

Demographic growth: activity changes due to demographic growth have been calculated by analysis of ONS prevalence rates for 5 year age bands for each specialty, point of delivery and geographic area. Overall this generates a predicted 0.7% growth in activity per year. Emergency admissions and A&E attendances are assumed to remain flat beyond 2014/15 but no further reductions to reflect the impact of BCF have been modelled. These require more work up with CCG's.

Market Share: no significant change anticipated in NHS market share.
Developments: full year effect of prior year developments has been reflected (primarily 4th Cath lab and Radiotherapy expansion). No significant new developments have been modelled, including reconfiguration of services at the Friarage Hospital. This requires further discussion with HRW CCG.

RTT: the plan assumes aggregate RTT compliance will be achieved in 2014/15 and sustained recurrently going forward. A level of non-recurrent activity is required in 2014/15 to achieve this (mainly orthopaedic and surgical specialties) and this is reflected in the 2014/15 income and activity assumptions.

This activity is translated into income using current PbR tariffs adjusted by the notified annual deflator. No structural changes to tariff have been assumed. Income for 2014/15 reflects trust anticipated demand which is higher than aggregate contracted activity levels. The main areas of difference are:

- NEL emergency admissions for South Tees CCG – the contract baseline is £2.4 million less than trust anticipated demand. This is because the CCG have taken a lower start point for demand and then targeted a 2% reduction as a pre-cursor to the full implementation of BCF in 2015/16. The Trust is working with the CCG to develop admission avoidance schemes but at present there is little compelling evidence to support the scale of change the CCG is aiming to achieve. Furthermore it is likely that there will be an investment in enhanced community services via the BCF which will offset some of the impact on Acute activity and income.

- Specialised services – NHS England have set a baseline which is £3.3 million below the Trust demand estimate and reflects the commissioner's affordability challenge.

All contracts for 2014/15 are full PbR and assumed to be full PbR in 2015/16. The main risks to income are:

- The Trust's ability to deliver elective work if emergency activity continues to grow
- Contract penalties

In 2013/14 the Trust received £8 million of non-recurrent monies, including winter pressures. This has been removed from the plan in 2014/15 although there may be funding available again. This would be a bottom line benefit as expenditure has already been assumed.

Expenditure

The Trust's underlying expenditure position in 13/14 is the start point for 14/15 taking into account:

- Full year effect of 13/14 pay increments and part year effect of 14/15 increments and pay awards;
- Full year effect of service developments beginning in 13/14:
- Full year effect of P&E schemes;
- 13/14 Out-turn activity levels adjusted to reflect 14/15 demand plans;
- Removal of non-recurrent costs from 13/14, addition of non-recurrent costs for 14/15.

The same approach has been adopted for 2015/16.

Pay

The start point for workforce related costs is the outturn for 13/14. Pay inflation relates to the part year effect of Agenda for Change increments and a 1% cost of living award and has been adjusted to reflect the national proposal in relation to paying an increment *or* a cost of living award. The plan also includes service developments due to take place during 2014/15. Workforce numbers have been adjusted upward to reflect 2014/15 key service changes and downward to reflect the impact of CIP schemes. Pay and CIP efficiencies have been modelled into 2015/16 in a similar way.

Marginal Costs

Activity plans have been set based on fractional spells. Non–pay budgets have been set based on outturn expenditure and marginal rates used to adjust non-pay budgets for changes in contracted activity. This has been done based on an average speciality marginal cost from trust reference costs data.

Inflation

The national tariff deflators provide an analysis of anticipated inflation factors for the 5 year planning period. The Trust has used these inflation factors in it projections:

Secondary Care Health Cost Inflation
Composition (per national tariff guidance):

	FY 14/15	FY 15/16
Pay	1.00%	1.05%
Drugs	0.50%	0.52%
Other operating costs	0.40%	0.42%
PFI/Capital	0.20%	0.21%
Service development*	0.40%	
	2.50%	2.20%

*assumes one off development in 14/15

Weighted uplift (Trust costs):	FY 14/15	FY 15/16
Pay	1.68%	1.76%
Drugs	6.84%	7.17%
Other operating costs	1.48%	1.55%
PFI/Capital	3.33%	3.48%

Capital programme

The key elements of the capital programme are:

Site Redevelopment (James Cook University Hospital)

The trust has commenced with the refurbishment of the main ward block on the JCUH site, further expenditure of around £8 million is anticipated over the planning period. Additional funding through PFI lifecycle may supplement this expenditure on the basis that the PFI assets do not accord with the Estate Management Code Condition B Rating. The scheme will not re-provide wards on a like for like basis but will seek to improve the patient environment. The Board of Directors is aware that delivery of these improvements relies on a programme of decanting to provide access for contractors and this needs urgent development. A priority in 2014/15 is to undertake infrastructure works which will support future improvements.

In addition, funding has been provided within the above allocation to cover the refurbishment of Women's and Children's accommodation to cover the anticipated movement of Obstetrics and Paediatric Services from the Friarage Hospital.

Decontamination enhancements

The trust plans to spend a further £0.9 million during 2014/15 to complete the upgrade of our decontamination facilities at the Friarage Hospital and maintain on-going compliance with regulations. The scheme involves re-configuration of existing facilities and provision of new equipment. This is fundamental to maintaining service delivery.

Haematology Day Unit & Ward Accommodation

The current haematology accommodation is the worst in the Trust and is not up to the standards we aspire to. There is also insufficient capacity to meet rising demand for haematology. Work has started and will be completed in 2014/15 on a programme to develop a new day unit and ward, including dedicated accommodation for the teenagers and a young adults cancer service.

Estates maintenance, including PFI lifecycle

The trust plans to invest around £38.5m in estates maintenance during the planning period. Under the terms of the PFI scheme this forms part of the Availability Payment in respect to the maintenance reserve account which supports the life cycle replacement costs (£36.6M) The expenditure is planned to maintain the PFI Hospital facilities in accordance with the NHS Estate Management Code Condition B rating in respect to fire, statutory compliance and condition.

A further £1.9m will be invested at the Friarage Hospital (non-PFI). Adequate estates maintenance underpins the delivery of trust objectives including compliance with health and safety standards.

Car parking

The Trust is constructing a new on site car parking facility (326 spaces) to address the under provision of visitor car parking spaces. In addition, an offsite 1,100 staff car parking facility will be constructed on an acquired freehold plot of land adjacent to the site boundary on the James Cook University Hospital. This again addresses the shortfall in staff spaces to serve the needs of the site and provides a new dedicated access road which will alleviate the difficulties faced by patients and staff entering and leaving the site at peak times.

Other Capital Investment

The Trust plans to invest a further £48.6m on other capital spending over the plan period. This includes spend on our planned capital equipment replacement programme, investment in IT and allocations held for unplanned capital spending, for instance due to the failure of major items of capital equipment, X-ray tubes etc.

Liquidity

With a base case assumed income and expenditure deficit of £29.5m (excluding impairments) in 2014/15, the Trust is forecast to fall below its Minimum Acceptable Cash (MAC) limit of £15.2m in September 2014. The indicative base case estimated deficit in 2015/16 will worsen this by a further £48.3m. The Trust will have total borrowing of £143.1 million against its Prudential Borrowing Limit (PBL) of £153.7m at 31 March 2015.

The plan for further savings and financial turnaround being developed with assistance from McKinsey for adoption in May 2014 will narrow the gap in 2014/15 and 2015/16. The Trust has opened a dialogue with Monitor over Public Dividend Capital (PDC) support to bridge the cash shortfall over this period. This will need to support the underlying deficit during the turnaround period as well as the capital expenditure programme, until the Trust is able to generate its own cash surplus.

Risk Ratings

The Trust's Continuity of Service Risk Rating (CoSRR) is expected to remain at 1 over the next two years:

Risk Rating	2014/15	2015/16
Capital Service cover	1	1
Liquidity	1	1
Overall Risk Rating	1	1

The Trust will work with Mckinsey and Monitor to improve the overall risk rating during the planning period.