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Securing Quality in Health Services

Feasibility Analysis Report

28 March 2014
Private & Confidential

Version 1.62



NHS Darlington Clinical Commissioning Group
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28 March 2014

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Dear Sirs,

Feasibility Analysis

In accordance with the ConsultancyONE Framework agreement for Consultancy (the "Framework Agreement") and the scope of work for the Feasibility Analysis as outlined in the Letter of Appointment dated 28 June 2013 ("the Contract"), we enclose our Feasibility Analysis report dated 27 January 2014 (the "Report").

The Report is confidential to Darlington Clinical Commissioning Group ("the CCG") and is subject to the restrictions on use specified in the Contract. No party is entitled to rely on the Report for any purpose whatsoever and we accept no responsibility or liability to any party in respect of the contents of this Report.

The Report must not, save as expressly provided for in the Contract, be recited or referred to in any document, or copied or made available (in whole or in part) to any other person, with the exception of members of the SeQIHS Programme Board.

The CCG is responsible for determining whether the scope of our work is sufficient for its purposes and we make no representation regarding the sufficiency of these procedures for the CCG's purposes. If we were to perform additional procedures, other matters might come to our attention that would be reported to the CCG.

We have assumed that the information provided to us and management's representations are complete, accurate and reliable; we have not independently audited, verified or confirmed their accuracy, completeness or reliability.

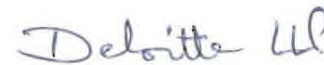
In particular, no detailed testing regarding the accuracy of the clinical, operational, financial and workforce information has been performed.

The forecast workforce numbers have been modelled using your workforce model developed in Phase 1. We have not updated the Models for any events or transactions which may have occurred subsequent to the date of the Models.

We take no responsibility for the validity of the assumptions, the accuracy of the computations or the reasonableness and achievability of any projections comprised in the Model.

The matters raised in this report are only those that came to our attention during the course of our work and are not necessarily a comprehensive statement of all the strengths or weaknesses that may exist or all improvements that might be made. Any recommendations for improvements should be assessed by the CCG for their full impact before they are implemented.

Yours faithfully



Deloitte LLP

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1. Executive Summary

Background to the work – Acute Services Quality Legacy Project

The feasibility assessment presented in this document relates to work that started back in May 2012.

Project Background

In May 2012 the County Durham PCT, Darlington PCT and the Tees¹ PCTs began jointly the Acute Services Quality Legacy Project (“ASQLP”). The objectives of this project were to:

- Reach consensus on the clinical quality standards in acute services to be commissioned, using levels of national best practice as a starting point;
- Identify opportunities for meeting these standards; and
- Assess the financial environment and workforce constraints in which such improvements may take place.

These objectives were delivered through three work streams; a clinical standards assessment, a workforce assessment and an economic assessment.

The scope of the project included secondary and tertiary care services at County Durham and Darlington NHS FT, North Tees and Hartlepool NHS FT and South Tees Hospitals NHS FT, in five clinical areas:

1. Acute Paediatrics, Maternity and Neonatology (APMN);
2. Acute medicine;
3. Acute surgery;
4. Intensive care; and
5. End of Life.

Developing the clinical standards

Cross-organisational Clinical Advisory Groups (CAGs) were established with senior clinical representation from each of the acute Trusts within the project scope. These groups were given a clear set of mandates and objectives to develop a set of clinical standards to which they thought the Trusts should be aspiring.

Each group started with a review of all relevant recent documents published by national bodies such as the Royal Colleges. From these, a concise set of standards were distilled against which each Trust conducted a self assessment.

In addition the CAGs advised commissioners on indicators for current performance and a realistic level of achievement for inclusion in CQUIN measures and other means of service developments. The Acute Paediatrics, Maternity and Neonatal CAG went one step further and also identified preferred configurations for these services on an organisational agnostic basis.

¹ Tees PCTs covering Middlesbrough, Redcar and Cleveland, Hartlepool and Stockton on Tees

Key findings from ASQLP

Following completion of the work in the ASQLP a number of key findings emerged:

- Clinical consensus was reached on the clinical standards that the providers across Durham, Darlington and Tees should achieve for;
 - Acute Paediatrics, Maternity and Neonatology (APMN);
 - Acute medicine, surgery and intensive care; and
 - End of life.
- All Trusts recognised that there were still standards they were not meeting and acknowledged the need to improve. Providers asked for the opportunity to take action to implement the clinical standards that had not been attained at the time of the ASQLP review;
- The workforce modelling that focused on APMN identified medical staff shortages against the current service configurations in light of the agreed standards for Paediatrics, Obstetrics and Neonatology;
- The economic assessment identified a growing financial pressure due to an ageing population and an increased demand for health care. Financial modelling indicated that the majority of the financial risk sat with providers rather than commissioners due to future assumptions around the tariff.

Feasibility analysis – Securing Quality in Health Services (SeQiHS)

CCGs agreed to build on the work from ASQLP and take this work forward in line with the duty placed upon them to commission high quality sustainable services.

Project scope

Following completion of the ASQLP, the Programme Board overseeing its delivery considered the next steps. These broadly fell into two options:

- Look at alternative configurations for how health services are delivered across Durham, Darlington and Tees to deliver improved compliance with the agreed clinical standards; or
- Give the opportunity to the acute Trusts within the project to demonstrate their ability to meet the agreed clinical quality standards over the coming years.

After careful consideration the Programme Board opted for the second option. Therefore the scope of Phase Two was to carry out a feasibility analysis of the implications of implementing the clinical quality standards, starting from the baseline identified through the self assessment in ASQLP. An overview of the whole programme is presented below:



Deloitte were commissioned to undertake a feasibility analysis around the implementation of the recommendations of the ASQLP and to produce a report detailing the outcomes. Specifically:

- Reconfirm the commitment to the key clinical standards agreed as part of the ASQLP project across each of the clinical areas;
- For each of the clinical standards to carry out an independent assessment at each hospital site of the timetable for implementing the standards including;
 - Reviewing the financial implications of implementing each standard;
 - Assessing the workforce implications around implementation; and
 - Evaluating the achievability of planned milestones and critically assessing the risks.
- For APMN reconfirm and refresh the workforce model developed as part of ASQLP; and
- Carry out an overall analysis of the financial affordability of implementing the standards across the patch in the context of a range of potential commissioner allocations in future years.

Approach

Through a series of workshops involving Clinicians, Senior Managers, Workforce and Finance representatives at each Trust the full list of standards has been confirmed, current delivery of standards has been reviewed and a clinical view of the feasibility of implementing the agreed standards given the workforce and other known constraints has been established. This was done by seeking answers to five key questions for each area:

- Is the Trust still committed to delivering the clinical quality standards agreed in Phase 1?
- Has the Trust's position in relation to the attainment of the clinical quality standards changed since the previous self-assessment?
- For those standards where the Trust's self-assessment has changed, what plans have been put in place to deliver this change?
- For those standards where the Trust is only partially or not meeting the standard, what plans are in place to meet these standards by 2015?
- For those standards where the Trust is only partially or not meeting the standard and no plan exists to deliver the standard by 2015, what feasibility assessments have been conducted and/or what issues have been considered (clinical, operational, HR, financial)?

We assessed the potential financial constraints of delivering the standards through considering the following:-

- Establishing a detailed baseline of 2012/13 income and expenditure by service area to demonstrate the underlying financial performance of the services impacted by the agreed clinical standards covered by this review; and
- Assessing the financial implications of implementing the agreed clinical standards on providers to demonstrate the impact this would have on their financial viability.

We assessed the potential workforce constraints of delivering the standards through considering the following :-

- Updating existing workforce models from Phase 1 with revised planning assumptions;
- Analysing workforce model outputs on a site by site basis; and
- Utilising the output of the workforce models to assess the number of viable sites given the workforce capacity.

In light of Commissioners' commitment to driving up quality across the patch the Feasibility Analysis has looked to highlight which clinical quality standards cannot be met by 2015, allowing Commissioners to come to a conclusion about the possible solutions for these challenges. A number of these clinical quality standards will be incorporated into the contracting round (up until 31st March 2014), through incentivising performance via CQUINs that directly relate to the clinical quality standards.

Clinical Standards

Overall the Trusts are meeting, or have plans in place to meet, c.68% of the Clinical Standards agreed by April 2015.

In some cases commissioners incentives such as CQUIN might prove to support the implementation of additional standards. There are however 7 key themes or areas which all the Trusts are failing to meet and will struggle to achieve without a change of approach either in funding or collaborative working across providers. These 7 key areas are:

- Providing extended access to diagnostic services both OOH and at weekends (a vital requirement of moving towards a 7/7 hospital²);
- Providing extended access to other support services such as Physiotherapy, Pharmacy and Social Services both OOH and at weekends (a vital requirement of moving towards a 7/7 hospital);
- Access to Interventional Radiology is currently extremely limited at all providers. Arrangements for OOH cover and on-call need to be developed;
- Workforce to provide 10 WTE on each level of middle grade medical rotas (impacting APMN, Acute Surgery and Medicine services)*;
- Trusts are close to achieving the 98 hours consultant cover at all Maternity units within the region. However they are a long way from achieving the 168 hours best practice and clinical ambition agreed by the Clinical Advisory Group;
- The majority of the agreed End of Life care standards are not going to be met by two of the Trusts; and
- Volume of Neonatology services across DDT means all providers fail to meet occupancy and staffing standards.

All the above key areas were identified in phase 1 as being particularly challenging.

Trusts have shown an improvement in applicable standards over the last year and are predicting further improvements between now and 2015. The table (top right) shows the break down of standards being met across each of the sites. It should be noted that North Tees and Hartlepool have improved above average as a result of the implementation of the 2 into 1 savings seeing acute services and resources consolidated onto the North Tees site allowing greater compliance with standards and a reduction in applicable standards at the Hartlepool site.

There are still around 32% of the standards which are not expected to be met across all the sites and this includes 18 standards that will not be met by any Trust in the region (although 4 relate to Neonates and 2 PICU leaving 11 generic standards).

The cost of meeting many of these standards are largely cover based. i.e. providing access to a particular service regardless of the volume of patients. Therefore costs will not directly scale with activity and economies of scale will only be achieved through site rationalisation.

² 7/7 hospital = Hospital operating 7 days out of 7.

	CDDFT		NTHFT		STFT		Overall
	UHND	DMH	NTH	HAR	JCUH	FHN	Total
Standards Met (2012)	69	69	87	13	88	64	390
Standards Met (2013)	74	78	107	20	102	72	453
Standards Met (2015 expected)	93	90	132	25	104	73	516
Standards Not Met (2015 expected)	45	48	16	3	59	69	241
% met by Trust	64%	65%	84%	92%	60%	50%	68%
Improvement 2012 - 2015	14%	15%	25%	46%	6%	5%	17%

Alignment to 7 day working

The Future Hospital Commission aims to develop a new model of care that delivers safe, high-quality care for patients across 7 days. Since the agreement of the clinical standards across Durham, Darlington and Tees, in December 2013, Sir Bruce Keogh published proposals which set out 10 new clinical standards for hospitals.

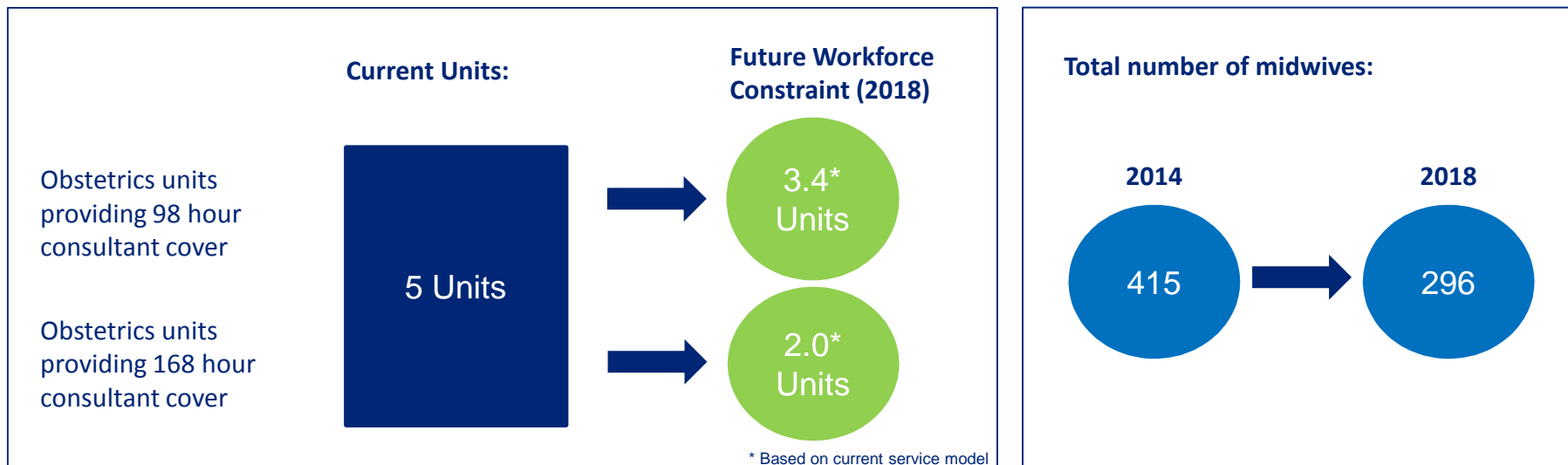
There is strong alignment between these and the standards agreed by the CAGs. In particular:

- All emergency admissions to be seen by a consultant within a maximum of 14 hours and wherever possible and appropriate, care should be consultant delivered;
- Seven day access to diagnostic tests, such as X-rays, ultrasound, MRI scans and pathology;
- Patients in intensive care and other high dependency units to be reviewed by a consultant twice a day; and
- Weekend access to multi-disciplinary teams, which include expert nurses, physiotherapists and other support staff.

** Some Trusts such as NTHFT are using additional consultants to backfill the middle grade rotas although the extent to which this is sustainable is not known with a decreasing consultant workforce.*

Workforce: Maternity

The overall size of the medical and nursing workforce is forecast to decrease; rota consolidation may be the only viable option to achieve the quality standards.



Across Durham, Darlington and Tees there are currently 5 fully operational Obstetrics units. This may change as the future of obstetric services at the Friarage site is currently subject to public consultation with the outcome due in March 2014 with no outcome at the time of printing this report. The current commissioner proposals are to establish a Midwife led unit at the Friarage with all other births moving to nearby hospitals including DMH and JCUH. Clinical standards based around the number of births dictate that all Trusts should provide 98 hour consultant cover on maternity units and that for units with greater than 4000 births that should be 168 hour cover. Currently only JCUH which requires 168 hour cover is meeting the standards. None of the other four sites are achieving the 98 hour targets although some are close.

Furthermore in Phase 1 the clinical aspiration of the Clinical Advisory Group was to deliver 168 hour consultant care at all obstetric units, regardless of births, as this was seen as best practice. A commitment was made to meet 98 hours by early 2014 and then 168 by April 2015. North Tees and Hartlepool have a plans in place to achieve 98 hour cover by the end of 2014 and County Durham and Darlington are close to achieving this and are looking to develop a business case to achieve this standard in the future although at the time of reporting can't confirm that they will achieve by April 2015. However neither of the two Trusts have any robust plans to achieve the 168 hour target.

The workforce model developed in Phase 1 predicts that by 2018 that the current workforce across the patch will only be able to sustain 3.4 units at 98 hour cover and only 2.0 units at the full 168 hour cover therefore it may not be possible even with additional funding that the Trusts will be able to deliver this standard consistently across all current sites.

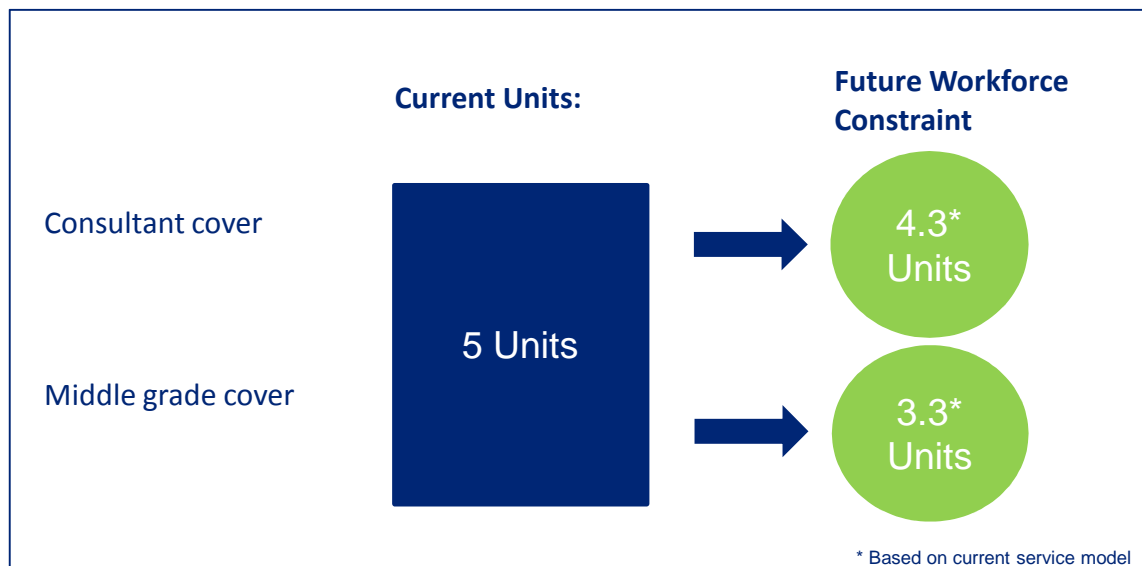
The model shows that the overall shape of the medical workforce is forecast to decrease in a number of key workforce categories. The consultant workforce is set to decrease by 17% between 2013 and 2018. The tier one workforce is set to shrink by 22% in line with projected reductions in future trainee intakes.

Nationally a high percentage of midwives are approaching the 55 typical retirement age, locally Trusts have an even higher than average percentage of midwives over 50. Whilst changes to the pension regime may encourage individuals to stay in the workforce for longer, there remains a significant risk that retirements will create a material reduction in the midwifery workforce. Estimating future retirement rates suggests that this exit will be materially larger than the trainee intake available. Without action the size of the core midwifery workforce will shrink rather than grow to meet increases in demand and quality standards. The model suggests a 29% reduction over the next 5 years.

The scale of the challenge is such that the overall conclusion is similar regardless of adjustments in assumptions on trainees, promotions and retirements. There are actions individual Trusts can take to address medical shortages such as the use of locums and using senior grades to back fill lower tiers however both have significant drawbacks in terms of adding additional financial pressure and its broadly recognised that the use of locums bring added risks in terms of quality of care due to staff often being unfamiliar with facilities. Therefore rota consolidation may be the only viable option to achieve the clinical quality standards.

Workforce: Paediatrics

The overall size of the medical workforce is forecast to increase, marginally, over the period although the consultant workforce is set to decrease over the period.



Paediatric services are currently offered at all 5 Acute sites across the Durham, Darlington and Tees area. This may reduce to four sites as the future of paediatric services at the Friarage site is currently subject to public consultation with no decision at the time of printing this report. The current proposals are to move to a SSPAU only at the Friarage site with all inpatient activity transferring to JCUH or DMH.

Collectively there is currently a shortage of Middle Tier Doctors within Paediatrics across the Durham, Darlington and Tees area. In particular many Trusts are suffering a significant shortage of middle tiers with extra consultants being drafted in to backfill rotas (e.g. at North Tees and Hartlepool).

The workforce model predicts that by 2018 the current workforce across the patch will only be able to sustain 3.3 units based on the middle grade numbers.

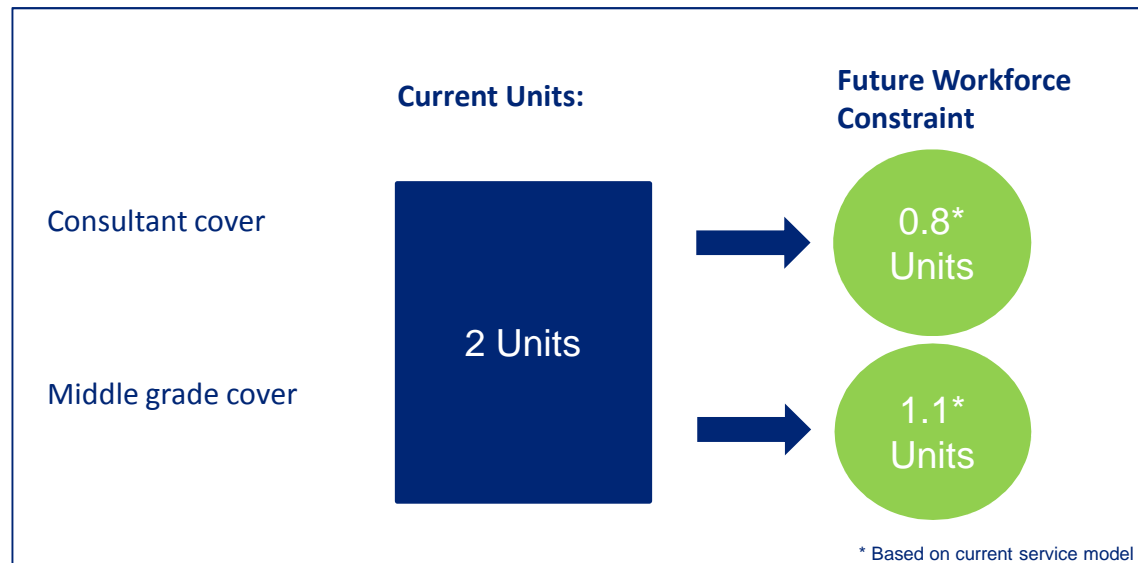
The overall trend is that medical workforce is forecast to increase marginally over the period. The consultant workforce however will fall by 29% during the period 2013 to 2018 whilst the middle grades will increase by 58%. It's worth noting that there have been discussion around changes to

the qualification requirements for future promotions to consultant grade. If these guidelines become more strict or limiting in years to come then this might have a more profound impact on the consultant workforce. The tier one junior doctors is expected to grow slightly by 14%.

There are actions individual Trusts can take to address medical shortages such as the use of locums and using senior grades to back fill lower tiers however both have significant drawbacks in terms of adding additional financial pressure and it's broadly recognised that the use of locums bring added risks in terms of quality of care due to staff often being unfamiliar with facilities. Therefore rota consolidation appears necessary if quality standards are to be achieved for middle grades. Career planning will be required to smooth progression and ensure appropriate utilisation of skills.

Workforce: Neonatology

The model projects a gap for all workforce groups; the consultant workforce is set to decrease over the period.



There are currently two Neonatal units within the Durham, Darlington and Tees area situated at North Tees Hospital and at the James Cook University Hospital. Currently both sites struggle to meet occupancy and staffing targets for Neonatology. Current provision of activity across two sites dilutes specialist skill and capacity making standards harder to achieve. For example the standards suggest a unit should be a minimum of 8 beds running constantly at 80% utilisation.

Already both Trusts rely heavily on ANNPs to back fill tier 1 rotas although they are not a quick fix solution due to training requirements and once trained there is a high risk of them moving on. The future workforce model suggests that collectively the patch will struggle to have enough staff in 2018 to provide the service from 1 site whilst meeting the clinical quality standards of 8 WTE on each tier of the rota.

The overall medical workforce is forecast to increase marginally over the next 5 years. During this time the consultant workforce is expected to shrink by 20% whilst the middle grade are expected to increase by 106% subject to potential changes to promotions to consultant grades becoming more strict in years to come. Tier one is also expected to increase by 69% during the period.

In spite of the projected increase in tier 1 and tier 2 doctors a gap for all medical workforce groups is still projected.

Currently both sites are operating with between 4 – 5 WTE consultants on the rota when the clinical standard suggests 8 WTE is required.

Recent changes to the economic context

“Ever since the foundation of the NHS, it has worked to improve services and the quality of care available to patients and the public. The NHS has a responsibility to ensure that services are high quality, sustainable and, as a publicly funded institution, one that provides value for money to the taxpayer.” NHS England, Planning and delivering Service Changes for Patients 2013.

Health pressures - Commissioners

Since issuing the AQLP report greater clarity has emerged with regard to the financial pressures facing both CCGs and NHS providers.

Key drivers for the CCG challenge include:

- Demand growing consistently above demographic trend;
- Better Care Fund (BCF) transfer of NHS funding for jointly commissioned health and social care reducing CCG funding allocations by 3% in 2015/16;
- New “Fair shares” indicative allocations diverting funding away from Hospital care (reducing across Durham, Darlington and Tees by £50m or 3.27%); and
- The indirect impact of additional activity arising as a result of on-going cuts to social care budgets.

Health pressures - Providers

Key drivers for the Provider challenge include:

- A growing recognition by both Monitor and Providers that future year on year cost savings cannot be delivered without transformational change in the model of care;
- Potential reduction in demand and funding due to BCF; and
- Increased awareness of the financial implications of introducing the agreed best practice clinical standards.

Local Authority pressures

Local Authorities are facing very significant financial pressures which are having a deep impact on planned future social care spend. Many local authorities are struggling to develop balanced medium term financial plans. Key drivers for this challenge include:

- Comprehensive Spending Review (CSR) 2010 – significant reductions in grant funding to 2014/15;
- 2013/14 – new finance regime (retained business rates – public health) – risks, uncertainties and opportunities;
- Budget 2013 – further reductions in 2014/15;
- Spending Review 2013 – 15% real term reduction in funding assessment for 2015/16, further substantial reductions to follow;
- Spending Review 2013 – Health & Social Care(HSC) Better Care Fund; and
- Proposed Council tax freeze.

“THE OVERALL EFFICIENCY CHALLENGE COULD BE AS HIGH AS 5-6% IN 2015/16 COMPARED TO THE CURRENT 4% REQUIRED EFFICIENCY IN 2013/14.”

Source: NHS England “A Call to Action”

Finance

The NHS has a responsibility to ensure that services are high quality, sustainable and, as a publicly funded institution, one that provides value for money to the taxpayer.”

Acute Surgery across Durham Darlington and Tees generates a £7.6m loss whilst Acute Medicine yields a £5.1m surplus. Non Elective Acute Surgery and Medicine both generate deficits after the allocation of overheads of £2.9m and £13.5m respectively.

Across Durham, Darlington and Tees there are currently 5 fully operational Surgical units.

The surgical services generate a cumulative positive contribution of £39.5m however after the allocation of depreciation and apportionment of overheads a deficit of £7.6m is returned.

Non Elective Surgical Services operate at a higher loss margin than Acute Surgical Services in total. This is to be expected due to the higher costs associated with providing a broader capability to a wide range of potential surgical interventions.

Acute Medical Services generate a cumulative positive contribution of £64.1m and after the allocation of depreciation and apportionment of overheads a net surplus of £5.1m is returned. It should be noted that two of the three Trusts return a net surplus in this clinical area with only one Trust recording a net deficit.

Non elective acute medical services operate at a loss margin of 8.5%. The main driver for this is the large net deficit recorded at James Cook University Hospital. This is due to JCUH being the main tertiary centre for the DDT region and hence receiving the more complex medical cases.

APMN across the region generates a loss of £19.4m. The majority of this loss is a result of the high overheads across the 5 Obstetric units within the patch.

APMN as a whole across Durham, Darlington and Tees generates a £19.4m loss. Non elective care forms £11.1m of this deficit. The greatest proportion (51%) comes from Obstetrics (Maternity) which makes a £5.7m loss on Non-elective activity, closely followed by paediatrics (£3.1m) and then Neonatology (£1.3m).

However in all cases they are generating a positive contribution, before allocation of overheads, to the patch of £16.7m. This would indicate that rationalising to a smaller number of sites would reduce the amount of overheads and in turn reduce the residual losses generated across the patch.

At a Trust level NTHFT is the only provider making a negative contribution prior to the allocation of overheads.

APMN DDT Financial Overview

£000	DDT* Trust Total	DDTAPMN Total	% of DDT Total	DDT APMN NEL	% of DDT Total
2012/13					
Income	1,223,474	119,685	10%	71,496	6%
Total Direct and Indirect Costs	(929,412)	(102,929)	11%	(60,364)	6%
Contribution	294,062	16,756	6%	11,132	4%
Total Overheads	(290,190)	(36,144)	12%	(22,249)	8%
Surplus / Deficit	3,871	(19,388)		(11,117)	
% Margin	0.32%	-16.20%		-15.55%	

*DDT: Durham, Darlington and Tees region

None of the Trusts have been able to fully cost implementation of all the standards.

Additional investment is required to facilitate attainment of the following key standards:-

- APMN Medical and nursing rota's;
- 7 day access to pharmacy;
- Extended access to MRI at weekends and out of hours;
- Delivering 7 day ambulatory care;
- Extended access to respiratory and physiotherapy services; and
- Enhanced out reach services.

One of the Trusts has calculated that additional funding of c.£10m per year would result in an additional 9.5% of standards being met across their two sites. However it should be noted there will still be a large proportion of the standards which will not be met and where additional finance alone will not facilitate attainment of these standards.

Conclusion

- All the Providers and Commissioners are fully committed to achieving the clinical standards agreed in Phase 1, recognising they are the right things to do in order to improve quality and patient experience across County Durham, Darlington and Tees. It is recognised by all stakeholders that appropriate monitoring mechanisms will need to be established to ensure confidence of delivery;
- Attainment of the agreed clinical standards has improved across the health economy since completion of Phase 1, however the Feasibility Analysis has identified that at best only 68% of the clinical standards will be implemented by April 2015, even though significant financial investments have been and are planned to be made. Trusts expect to fail to deliver the remaining 32% because of a lack of key resources such as money or staff or because of the scale of the challenge is not achievable without a system wide solution;
- The workforce assessment in Phase 1 identified that the current configuration of Acute Paediatric, Maternity and Paediatrics services was unsustainable, and that a reduced number of sites was the only long term solution. This was a view shared by the APMN Clinical Advisory Group and the workforce assessment conducted in Phase Two continues to support this view, particularly in relation to Obstetrics;
- Whilst the financial position of individual providers and commissioners is variable, from a system wide perspective the financial challenge has significantly worsened since Phase 1 of the work. This is consistent with the national position and is supported by recent announcements from both Monitor and NHS England, such as “A call to action”. The current financial context is extremely challenging for NHS organisations particularly with the expected tariff efficiency factors, rising demand and impact of the Better Care Fund and CCG funding allocations.
- Initial analysis of the standards indicates that significant funding would be required on a recurrent basis in order to deliver a small proportion more of the standards (in addition to the substantial investments already made). This is demonstrated through the work undertaken by CDDFT where a further £9.7m of recurrent funding would be required to support a 9% improvement in meeting the clinical standards. This demonstrates that implementation of the standards without reconfiguration of services is likely to result in a financially unsustainable health economy;
- The CCGs need to make a decision to either accept the current levels of adoption of the clinical standards (and the risk of deterioration in compliance with these standards as financial pressures increase in the system) or to consider options for reconfiguration to deliver the clinical standards within a more financially sustainable model.



2. Summary of Clinical Standards

Clinical Standards

Overall the Trusts are meeting, or have plans in place to meet, c.68% of the Clinical Standards agreed by April 2015.

Trusts have shown an improvement in applicable standards over the last year and are predicting further improvements between now and 2015.

The table (top right) shows the break down of standards being met across each of the sites. It should be noted that North Tees and Hartlepool have improved above average as a result of the implementation of the 2 into 1 savings seeing acute services and resources consolidated onto the North Tees site allowing greater compliance with standards and a reduction in applicable standards at the Hartlepool site.

In some cases incentives such as CQUIN might prove to support the implementation of additional standards. There are however 7 key themes or areas which all the Trusts are failing to meet and will struggle to achieve without a change of approach either in funding or collaborative working across providers. These 7 key areas are:

- Providing extended access to diagnostic services both OOH and at weekends (a vital requirement of moving towards a 7/7 hospital);
- Providing extended access to other support services such as Physio, Pharmacy and Social Services both OOH and at weekends (a vital requirement of moving towards a 7/7 hospital);
- Access to Interventional Radiology is currently extremely limited at all providers. Arrangements for OOH cover and on-call need to be developed;
- Workforce to provide 10 WTE on each level of middle grade medical rotas (impacting APMN, Acute Surgery and Medicine services)*;
- Trusts are close to achieving the 98 hours consultant cover at all Maternity units within the region. However they are a long way from achieving the 168 hours best practice and clinical ambition agreed by the Clinical Advisory Group;
- The majority of the agreed End of Life care standards are not going to be met by two of the Trusts; and
- Volume of Neonatology services in the region means all providers fail to meet occupancy and staffing standards.

	CDDFT		NTHFT		STFT		Overall
	UHND	DMH	NTH	HAR	JCUH	FHN	Total
Standards Met (2012)	69	69	87	13	88	64	390
Standards Met (2013)	74	78	107	20	102	72	453
Standards Met (2015 expected)	93	90	134	25	104	73	516
Standards Not Met (2015 expected)	46	49	14	3	59	69	244
% met by Trust	67%	65%	90%	92%	60%	50%	68%
Improvement 2012 - 2015	17%	15%	32%	46%	6%	5%	17%

Acute Surgery

Overall the Trusts are meeting, or have plans in place to meet, c.76% of the Acute Surgery Clinical Standards agreed by April 2015.

General progress against standards

All Trusts have shown an improvement over the last year and are predicting further improvements between now and 2015 in Acute Surgery. 85 standards are now met, 19 more than in 2012, with an expected increase to 102 by 2015. This will amount to an overall 28 point improvement in compliance across all sites between 2012 and 2015.

Site specific progress

The table (right) shows the break down of standards being met across each of the sites. North Tees has improved the most, again thanks to reconfiguration, with the lowest improvement seen across the South Tees sites, which also have the lowest levels of compliance.

However there is still around 24% of the standards which are not expected to be met across all the sites and this includes 2 standards that will not be met by any Trust in the region (relating to interventional radiology and 7 day access to social services).

Acute Surgery	DDT Total	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
Standards Met (2012)	64	15	15	10	N/A	14	10
Standards Met (2013)	85	18	18	18	N/A	18	13
Standards Met (2015 expected)	102	23	23	24	N/A	18	14
Standards Not Met (2015 expected)	32	4	4	3	N/A	9	12
% met by Trust	76%	85%	85%	89%	N/A	67%	54%
Improvement 2012 - 2015	28pp	30pp	30pp	52pp	N/A	15pp	15pp

Acute Surgery

Expected compliance with Clinical Standards by April 2015:

Ref	Indicator	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
1	All emergency surgical admissions to be seen and assessed by a relevant consultant with 12 hours of admission to a ward or assessment unit under a surgical team. Suggested reliability target of 90% .	✓	✓	✓	N/A	✓	✗
2	A clear multi-disciplinary assessment to be undertaken within 12 hours and a treatment or management plan to be in place within 24 hours (for complex needs patients see 23 and 24).For the majority of surgical patients, a surgical and nursing assessment is sufficient to satisfy this requirement.	✓	✓	✓	N/A	✓	✗
3	All patients admitted acutely to be continually assessed using a validated early warning system (EWS). Consultant involvement is required for patients who reach trigger criteria, with 'consultant involvement' to be clearly defined in Trust protocols. consultant involvement for patients considered 'high risk' to be within one hour.	✓	✓	✓	N/A	✓	✓
4	When on-take, a consultant and their team are to be completely freed from any other clinical duties or elective commitments.	✓	✓	✓	N/A	✓	✗
5	In order to meet the demands for consultant delivered care, senior decision making and leadership on the acute surgical unit to cover extended day working, seven days a week, amounting to a minimum of 70 hours per week.	✓	✓	✓	N/A	✓	✓
6	All patients on acute medical and surgical units to be seen and reviewed by a consultant during twice daily ward rounds, including all acutely ill patients directly transferred, or others who deteriorate.	✓	✓	✓	N/A	✓	✗
7	All hospitals admitting medical and surgical emergencies to have access to all key diagnostic services in a timely manner 24 hours a day, seven days a week to support clinical decision making: <ul style="list-style-type: none"> · Critical – imaging and reporting within 1 hour · Urgent – imaging and reporting within 12 hours · All non-urgent – within 24 hours 	✗	✗	✓	N/A	✗	✗
8	All hospitals admitting medical and surgical emergencies to have access to interventional radiology 24 hours a day, seven days a week: <ul style="list-style-type: none"> · Critical patients – 1 hour · Non-critical patients – 12 hours 	✗	✗	✗	N/A	✗	N/A
9	Rotas to be constructed to maximise continuity of care for all patients in an acute medical and surgical environment. A single consultant is to retain responsibility for a single patient on the acute medical/surgical unit. Subsequent transfer or discharge must be based on clinical need.	✓	✓	✓	N/A	✓	✓

Acute Surgery

Expected compliance with Clinical Standards by April 2015:

Ref	Indicator	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
10	A unitary document to be in place, issued at the point of entry, which is used by all healthcare professionals and all specialties throughout the emergency pathway.	✗	✗	✓	N/A	✓	✓
11	Patients admitted for unscheduled care to be nursed and managed in an acute medical/surgical unit, a specialty ward relevant to the patient's clinical need, or critical care environment.	✓	✓	✓	N/A	✗	✗
12	All admitted patients to have discharge planning and an estimated discharge date as part of their management plan as soon as possible and no later than 24 hours post-admission. A policy is to be in place to access social services seven days per week. Patients to be discharged to their named GP.	✓	✓	✗	N/A	✗	✗
13	All hospitals admitting emergency general surgery patients to have access to a fully staffed emergency theatre immediately available and a consultant on site within 30 minutes at any time of the day or night.	✓	✓	✓	N/A	✗	✗
14	All patients admitted as emergencies are discussed with the responsible consultant if immediate surgery is being considered. For each surgical patient, a consultant takes an active decision in delegating responsibility for an emergency surgical procedure to appropriately trained junior or speciality surgeons. This decision is recorded in the notes and available for audit.	✓	✓	✓	N/A	✓	✓
15	All patients considered as 'high risk' to have their operation carried out under the direct supervision of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is made to optimise peri-operative care. High risk is defined as where the risk of mortality is greater than 10%.	✓	✓	✓	N/A	✓	✓
16	All patients undergoing emergency surgery to be discussed with consultant anaesthetist. Where the severity assessment score is ASA3 and above, anaesthesia is to be provided by a consultant anaesthetist.	✓	✓	✓	N/A	✓	✓
17	The majority of emergency general surgery to be done on planned emergency lists on the day that the surgery was originally planned. The date, time and decision maker should be documented clearly in the patient's notes and any delays to emergency surgery and the reasons why recorded. Any operations that are carried out at night are to meet NCEPOD classifications and be under the direct supervision of a consultant surgeon.	✓	✓	✓	N/A	✗	✓
18	All referrals to intensive care to be made from a consultant to consultant.	✓	✓	✓	N/A	✓	✓

Acute Surgery

Expected compliance with Clinical Standards by April 2015:

Ref	Indicator	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
19	A structured process to be in place for the medical handover of patients twice a day. These arrangements to also be in place for the handover of patients at each change of responsible consultant/medical team. Changes in treatment plans are to be communicated to nursing and therapy staff as soon as possible if they are not involved in the handover discussions.	✓	✓	✓	N/A	✓	✓
20	Consultant-led communication and information to be provided to patients and to include the provision of patient information leaflets.	✓	✓	✓	N/A	✓	✓
21	Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item on board agenda and findings are disseminated.	✓	✓	✓	N/A	✓	✓
22	All acute medical and surgical units to have provision for ambulatory emergency care.	✓	✓	✓	N/A	✗	✗
23	Prompt screening of all complex needs inpatients to take place by a multi- professional team which has access to pharmacy and therapy services, including physiotherapy and occupational therapy, seven days a week within an overnight rota for respiratory physiotherapy.	✗	✗	✓	N/A	✗	✗
24	Single call access for mental health referrals to be available 24 hours a day, seven days a week with a maximum response time of 30 minutes.	✓	✓	✗	N/A	✗	✗
25	Hospitals admitting emergency patients to have access to comprehensive 24 hour endoscopy services that has a formal consultant rota 24 hours a day, seven days a week.	✓	✓	✓	N/A	✓	✗
26	Training to be delivered in a supportive environment with appropriate, graded consultant supervision,	✓	✓	✓	N/A	✓	✓
27	There should be a minimum 8 person rota for all acute sites.	✓	✓	✓	N/A	✓	✓

Acute Medicine

Overall the Trusts are meeting, or have plans in place to meet, c.63% of the Clinical Standards for Acute Medicine agreed by April 2015.

General progress against standards

All Trusts have shown an improvement over the last year and are predicting further improvements between now and 2015 in Acute Medicine. 56 standards are now met, 23 more than in 2012, with an expected increase to 73 by 2015. This will amount to an overall 34 point improvement in compliance across all sites between 2012 and 2015.

Site specific progress

The table (right) shows the break down of standards being met across each of the sites. UHND, DMH and NTH have all seen a high level of improvement, with 43% forecast by 2015, and North Tees hospitals forecasting to be compliant with 91% of standards by April 2015. The South Tees Friarage site is currently least compliant, and is also forecasting the lowest level of improvement across the group.

However there is still around 37% of the standards which are not expected to be met across all the sites and this includes two standards that will not be met by any Trust in the region (relating to interventional radiology and access to mental health crises support within 30 minutes).

Acute Medicine	DDT Total	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
Standards Met (2012)	33	5	5	11	N/A	6	6
Standards Met (2013)	56	11	11	14	N/A	12	8
Standards Met (2015 expected)	73	15	15	21	N/A	14	8
Standards Not Met (2015 expected)	42	8	8	2	N/A	9	15
% met by Trust	63%	65%	65%	91%	N/A	61%	35%
Improvement 2012 - 2015	34pp	43pp	43pp	43pp	N/A	35pp	9pp

Acute Medicine

Expected compliance with Clinical Standards by April 2015:

Ref	Indicator	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
1	All emergency admissions to be seen and assessed by a relevant consultant (those who are designated by the organisation and capable of making an appropriate decision) within: in hours: 4 hours of the decision to admit within the Trust out of hours: 12 hours of the decision to admit within the Trust, or within 14 hours of the time of arrival at hospital.	✓	✓	✓	N/A	✓	✗
2	A clear multi-disciplinary assessment (required composition to be defined in local protocols) to be undertaken and a clear case management plan (to include differential diagnosis, investigations, escalation of care, treatment and expected date of discharge) to be in place within 4 hours in hours and within 12 out of hours , or within 14 hours of the time of arrival at hospital out of hours .	✗	✗	✓	N/A	✓	✗
3	All patients admitted acutely are to be assessed using a validated early warning system (National Early Warning Score (RCP 2012)), with clear escalation processes followed for patients who reach trigger criteria as defined in local protocols. Consultant involvement for patients considered 'high risk' is to be within one hour.	✓	✓	✓	N/A	✓	✓
4	When on-take, a consultant and their team are to be completely freed from any other clinical duties or elective commitments.	✗	✗	✓	N/A	✓	✗
5	In order to meet the demands for consultant delivered care, senior decision making and leadership on the acute medical/surgical unit to cover extended day working, seven days a week. CAG amended to: In order to meet the demands for consultant delivered care, senior decision making and leadership on the acute medical unit to cover extended day working, for a minimum of 12 hours (e.g. 8am-8pm), seven days a week.	✓	✓	✓	N/A	✓	✗
6	All patients on acute medical units to be seen by a consultant on a morning ward round followed by relevant and targeted patient reviews .	✓	✓	✓	N/A	✓	✗
7	All hospitals admitting medical emergencies to have access to all key diagnostic services (CT, MRI, Ultrasound and Plain Radiology) in a timely manner 24 hours a day, seven days a week to support clinical decision making: · Critical – imaging and reporting within 1 hour of request · Non-critical - imaging and reporting within 12hours of request	✗	✗	✓	N/A	✗	✗
8	All hospitals admitting medical and surgical emergencies to have access to interventional radiology 24 hours a day, seven days a week: · Critical patients – 1 hour · Non-critical patients – 12 hours	✗	✗	✗	N/A	✗	✗

Acute Medicine

Expected compliance with Clinical Standards by April 2015:

Ref	Indicator	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
9	Rotas to be constructed, with adequate time for hand over to ensure that all relevant clinical information is transferred between individuals and teams, to maximise continuity of care for all patients in an acute medical and surgical environment. A single consultant is to retain responsibility for a single patient on the acute medical/surgical unit. Subsequent transfer or discharge must be based on clinical need.	✓	✓	✓	N/A	✓	✓
10	A unitary document to be in place, issued at the point of entry (including A&E), which is used by all healthcare professionals and all specialties throughout the emergency pathway.	✓	✓	✓	N/A	✗	✗
11	Patients admitted for unscheduled care to be nursed and managed in an acute medical unit, specialty areas which are relevant to the patients' needs , or critical care environment.	✓	✓	✓	N/A	✗	✗
12	Patients to be discharged to their named GP with a complete discharge summary sent within 24 hours.	✓	✓	✓	N/A	✗	✗
13	All referrals to intensive care to be made with the involvement of a consultant both in the referring and receiving teams.	✗	✗	✓	N/A	✓	✓
14	Responsibility is with individuals to ensure that there is a handover of patient information to each successive carer within every team structure - a structured process is to be in place for any such handover. Changes in treatment plans are to be communicated to nursing and therapy staff as soon as possible if they are not involved in the handover discussions.	✓	✓	✓	N/A	✓	✓
15	Consultant-led communication and information to be provided to patients and to include the provision of patient information leaflets.	✓	✓	✓	N/A	✓	✓
16	Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item on board agenda and findings are disseminated.	✓	✓	✓	N/A	TBC	TBC

Acute Medicine

Expected compliance with Clinical Standards by April 2015:

Ref	Indicator	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
17	Patients should always be admitted or transferred to the most appropriate ward for their clinical needs.	✘	✘	✓	N/A	✘	✘
18	All acute medical units to have provision for ambulatory emergency care, seven days a week and have access to therapy services within a similar timeframe. Patients treated in these facilities must receive care which is compliant with standards 1 (on admission consultant assessments), 2 (multi-disciplinary assessment and management plans) and 3 (Early warning system).	✓	✓	✓	N/A	✓	✘
19	Prompt screening of all complex needs inpatients to take place by a multi- professional team which has same-day access to pharmacy and therapy services, including physiotherapy and occupational therapy, seven days a week with an overnight rota for respiratory physiotherapy.	✘	✘	✓	N/A	✘	✘
20	Single call access for mental health referrals to be available 24 hours a day, seven days a week with a maximum adequate clinical response time of 30 minutes.	✘	✘	✘	N/A	✘	✘
21	Hospitals admitting emergency patients to have access to comprehensive 24 hour upper GI services that has a formal consultant rota 24 hours a day, seven days a week.	✓	✓	✓	N/A	✓	✓
22	All hospitals dealing with complex acute medicine to have onsite access level 1, 2 and 3 critical care services.	✓	✓	✓	N/A	✓	✓
23	Training to be delivered in a supportive environment with appropriate consultant supervision	✓	✓	✓	N/A	✓	✓

Maternity

Overall the Trusts are meeting, or have plans in place to meet, c.82% of the Clinical Standards agreed in Maternity by April 2015.

General progress against standards

All Trusts have shown an improvement over the last year and are predicting further improvements between now and 2015 in Maternity. 117 standards are now met, 11 more than in 2012, with an expected increase to 119 by 2015. This will amount to an overall 10pp improvement in compliance across all sites between 2012 and 2015.

Site specific progress

The table (right) shows the break down of standards being met across each of the sites. North Tees has again seen the highest level of improvement, with an increase in compliance of 19% between 2012 and 2015. The highest level of compliance is also at North Tees, with 93% of standards expected to be met by April 2015. The South Tees Friarage site is currently least compliant, expecting to meet 69% of standards by 2015.

19% of the standards are not expected to be met across all the sites and this includes the consultant staffing standard that will only be met at the JCUH site (standard 16 - Established prospective consultant obstetrician presence on each labour ward: By 2014 units with between 2500-4000 births should have 98 hour consultant presence and units of 4000 births + should have 168 hour presence; in recognition of the differing needs of units with less than 4000 deliveries, not all units will require 168-hour presence to ensure the necessary quality and safety standards).

Maternity	DDT Total	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
Standards Met (2012)	106	18	18	20	9	24	17
Standards Met (2013)	117	19	19	24	11	27	18
Standards Met (2015 expected)	122	20	21	27	11	28	18
Standards Not Met (2015 expected)	27	7	6	0	1	3	8
% met by Trust	82%	74%	78%	100%	92%	90%	69%
Improvement 2012 - 2015	11pp	8pp	12pp	25pp	17pp	10pp	4pp

Maternity

Expected compliance with Clinical Standards by April 2015:

Ref	Indicator	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
1	Antenatal care should be provided in a variety of local settings and at times that take account of the demands of the woman's working life and family.	✓	✓	✓	✓	✓	✓
2	All women should be offered a comprehensive, high-quality antenatal screening and diagnostic service, based on the current recommendations of the National Screening Committee, and designed to detect maternal or fetal problems at an early stage.	✓	✓	✓	✓	✓	✓
3	All maternity care providers should ensure that each pregnant woman has two visits early in pregnancy with a midwife who can advise her on her options for care on the basis of an in-depth knowledge of local services.	✓	✓	✓	✓	✓	✓
4	For women with an uncomplicated pregnancy, the number of scheduled antenatal appointments should be planned in accordance NICE Guideline 62 (2008) – uncomplicated nulliparous women: 10 appts; uncomplicated parous women: 7 appts.	✓	✓	✓	✓	✓	✓
5	Women should be able to access promptly adequately equipped Early Pregnancy Assessment Units.	✗	✓	✓	✓	✓	✓
6	Larger obstetrics units (>3500) should provide 23hr EPAUs on weekdays and extended hours at weekends that provide scanning and assessment.	N/A	N/A	N/A	N/A	✗	N/A
7	Commissioners and providers must develop maternity and neonatal care networks.	✓	✓	✓	✓	✓	✓
8	All obstetric units should have direct access to special care baby unit facilities to manage babies requiring ventilation and have a defined rapid access route to neonatal intensive care.	✓	✓	✓	N/A	✓	✓

Maternity

Expected compliance with Clinical Standards by April 2015:

Ref	Indicator	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
9	All new-born infants should have a complete clinical examination within 72 hours of birth.	✓	✓	✓	✓	✓	✓
10	No less than 2500 births per year for a consultant led unit.	✓	✓	✓	N/A	✓	✗
11	Every consultant led unit should have on site haematology, blood transfusion and ITU	✓	✓	✓	N/A	✓	✓
12	Access to second theatre must be available within 20 minutes 24/7.	✗	✗	✓	N/A	✓	✗
13	MLUs should have a throughput of at least 300 births a year to ensure quality.	N/A	N/A	N/A	✗	✓	N/A
14	Free-standing Midwifery Units must have robust admission criteria and transfer protocols; obstetric units should have Alongside Midwifery Units co-located with them.	✗	✗	✓	✓	✓	✗
15	Established prospective consultant obstetrician presence on each labour ward: > All centres should have a minimum of 40 hours consultant presence > Centres with 2500-4000 births should have 60 hour consultant presence > Centres with 4000-5000 births should have 98 hour consultant presence > Centres with >5000 births should have 168 hour consultant presence	✓	✓	✓	N/A	✓	✓
16	Established prospective consultant obstetrician presence on each labour ward: > By 2014 units with between 2500-4000 births should have 98 hour consultant presence and units of 4000 births + should have 168 hour presence > In recognition of the differing needs of units with less than 4000 deliveries, not all units will require 168-hour presence to ensure the necessary quality and safety standards.	✗	✗	✓	N/A	✓	N/A

Maternity

Expected compliance with Clinical Standards by April 2015:

Ref	Indicator	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
17	A consultant obstetrician should be available within 30 minutes outside the hours of consultant presence.	✓	✓	✓	N/A	✓	✓
18	Patients on the labour ward should have four board/team reviews between 8am and 10pm.	✓	✓	✓	N/A	✓	✓
19	There should be a minimum of 10 WTE on medical staff rotas at each level.	✗	✗	✓	N/A	✓	✗
20	There should be consultant attendance at vaginal breach, vaginal twins, C-section at fully dilated	✓	✓	✓	N/A	✓	✓
21	Each woman should receive one-to-one midwifery care during the second stage of labour by a trained midwife or trainee midwife under supervision; the first stage of established labour should be overseen by an appropriately trained professional under the care of a midwife. Admission to the labour ward should be limited to women who are in established labour.	✓	✓	✓	✓	✓	✓
22	To deliver 1:1 care during established labour by an appropriately trained professional under the supervision of a midwife, staffing levels for all midwifery, nursing and support staff for each care setting should be calculated based upon the results of a Birth-rate Plus assessment which is not more than 3 years out of date; as a minimum, the CQC recommended ratio should be adhered to, changing from time to time as the CQC revises its position. Currently, the calculation should be based upon: > Home and birth centre: 1:28 Midwives:births , 6:1 midwife:MCA > Obstetrics units: 1:28 Midwives:births, 4:1 midwife:MCA	✓	✓	✓	✓	✓	✓
23	There should be an identified midwifery team leader on every shift located on the labour ward	✓	✓	✓	✓	✓	✓
24	Consultant obstetric units require a 24-hour anaesthesia and analgesia service with consultant supervision, including: <ul style="list-style-type: none"> • minimum 10 PA/40 hours consultant presence • specialist anaesthetic services (may require additional on-call consultant if no standalone obstetric anaesthetic rota) , • adult high-dependency and access to intensive care, haematology blood transfusion and other district general hospital support services and an integrated obstetric and neonatal care service. 	✓	✓	✓	N/A	✓	✗

Maternity

Expected compliance with Clinical Standards by April 2015:

Ref	Indicator	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
25	A duty anaesthetist of appropriate competency and dedicated only to the labour ward must be immediately available, 24 hours a day, 7 days a week. This anaesthetist will normally have had more than 1 year of experience in anaesthesia and must have been assessed as being competent to undertake such duties. The duty anaesthetist must have access to prompt advice and assistance from a designated consultant anaesthetist whenever required.	✘	✘	✓	N/A	✓	✘
26	Extra anaesthetic cover during periods of heavy workload in addition to the supervising consultant anaesthetist and the duty anaesthetist is required in busier units (more than 5000 births/year, an epidural rate over 35% and a caesarean section rate over 25%, plus tertiary referral centres with a high proportion of high-risk cases).	N/A	N/A	N/A	N/A	✘	N/A
27	For any obstetric unit there should be a separate consultant anaesthetist for each formal elective caesarean section list.	✓	✓	✓	N/A	✓	✓
28	Labour wards should be able to care for Critical care Level 2 (non-ventilated) patients.	✘	✘	✓	N/A	✓	✘
29	There must be 24-hour availability in obstetric units within 30 minutes of a consultant paediatrician (or equivalent staff and associate specialist grade) trained and assessed as competent in neonatal advanced life support.	✓	✓	✓	N/A	✓	✓
30	24 hour paediatric middle grade cover should be available 24/7 to be present at vaginal breach, vaginal twins, C-section at fully dilated.	✓	✓	✓	N/A	✓	✘

Paediatrics

Overall the Trusts are meeting, or have plans in place to meet, c.82% of the Clinical Standards agreed in Paediatrics by April 2015.

General progress against standards

No Trusts have shown an deterioration in standards over the last year and three are predicting further improvements between now and 2015 in Paediatrics. 82 standards are now met, 10 more than in 2012, with an expected increase to 89 by 2015. This will amount to an overall 15 point improvement in compliance across all sites between 2012 and 2015, and means that Paediatrics is one of the most compliant area of those assessed.

Site specific progress

The table (right) shows the break down of standards being met across each of the sites. UHND has seen the highest level of improvement, with an increase in compliance of 32 points between 2012 and 2015. The highest level of compliance is across the North Tees sites, with 100% of standards expected to be met by April 2015. James Cook is currently least compliant, expecting to meet 67% of standards by 2015.

18% of the standards are not expected to be met across all the sites and there are also 6 key standards that are not being met and present significant challenge to all Trusts in the region. These are:

- PICU should have dedicated 24-hr cover by a consultant paediatric intensivist with appropriate training, and additional 24-hr consultant paediatric anaesthetist cover if the intensivist is not an anaesthetist;
- Consultants should not be rostered for any other clinical commitment when covering the PICU during daytime hours. During daytime hours the consultant in charge of the PICU should spend the majority of his or her time on the PICU and must always be immediately available on the PICU;
- No individual consultant paediatrician or anaesthetist practicing PIC should do so for less than 2 DCC PAs per week;
- PICU should provide training for 1st year ICTPICM registrars, and the necessary requirements to equip nursing staff with specific training in paediatric intensive care;
- A Band 7 nurse must be part of the total nursing establishment on every PICU shift. If the PICU has more than 12 beds, they should be supported by 2 Band 6 nurses per shift;
- It was agreed that a minimum number of lists per week should be set for paediatric anaesthetists;
- PICU nurses should be trained in retrieval; and
- It was agreed that a minimum number of cases per annum should be set for paediatric anaesthetists.

Paediatrics	DDT Total	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
Standards Met (2012)	72	11	11	14	1	20	15
Standards Met (2013)	82	15	15	15	2	20	15
Standards Met (2015 expected)	89	17	16	19	2	20	15
Standards Not Met (2015 expected)	19	2	3	0	0	10	4
% met by Trust	82%	89%	84%	100%	100%	67%	79%
Improvement 2012 - 2015	16pp	32pp	26pp	26pp	50pp	0pp	0pp

Paediatrics

Expected compliance with Clinical Standards by April 2015:

Ref	Indicator	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
1	All SSPAUs (Short Stay Paediatric Assessment Units) have access to a paediatric consultant (or equivalent) opinion throughout all the hours they are open.	N/A	N/A	N/A	✓	✓	N/A
2	A paediatric consultant (or equivalent) is present in the hospital during times of peak activity.	✓	✗	✓	N/A	✓	✓
3	Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a paediatrician on the middle grade or consultant rota within four hours of admission.	✓	✓	✓	N/A	✓	✓
4	Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician (or equivalent staff, speciality and associate specialist grade doctor who is trained and assessed as competent in acute paediatric care) within the first 24 hours.	✓	✓	✓	N/A	✗	✓
5	All general paediatric inpatient units adopt an attending consultant (or equivalent) system, most often in the form of the 'consultant of the week' system.	✓	✓	✓	N/A	✓	✓
6	All general acute paediatric rotas are made up of at least ten WTEs, all of whom are WTD compliant.	✗	✗	✓	N/A	✗	✗
7	At least one medical handover in every 24 hours is led by a paediatric consultant (or equivalent).	✓	✓	✓	N/A	✓	✓
8	Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians.	✓	✓	✓	N/A	✓	✓

Paediatrics

Expected compliance with Clinical Standards by April 2015:

Ref	Indicator	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
9	All children and young people, children's social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies) available to provide immediate advice and subsequent assessment, if necessary, for children and young people under 18 years of age where there are child protection concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported with a written report.	✓	✓	✓	N/A	✓	✓
10	PICU should have dedicated 24-hr cover by a consultant paediatric intensivist with appropriate training, and additional 24-hr consultant paediatric anaesthetist cover if the intensivist is not an anaesthetist.	N/A	N/A	N/A	N/A	✗	N/A
11	Consultants should not be rostered for any other clinical commitment when covering the PICU during daytime hours. During daytime hours the consultant in charge of the PICU should spend the majority of his or her time on the PICU and must always be immediately available on the PICU.	N/A	N/A	N/A	N/A	✗	N/A
12	No individual consultant paediatrician or anaesthetist practicing PIC should do so for less than 2 DCC PAs per week.	N/A	N/A	N/A	N/A	✗	N/A
13	PICU should provide training for 1st year ICTPICM registrars, and the necessary requirements to equip nursing staff with specific training in paediatric intensive care.	N/A	N/A	N/A	N/A	✗	N/A
14	All nurses who provide care to children and young people should have a specific qualification in the nursing of children and young people	✓	✓	✓	N/A	✓	✓
15	A minimum of two qualified (registered) children's nurses should be on duty 24 hours-a-day in all children's wards and departments	✓	✓	✓	N/A	✓	✓
16	Each children's ward/department nursing establishment should have a minimum of 1 WTE (whole time equivalent) Band 7 and 2 WTE Band 6 qualified children's nurses.	✓	✓	✓	N/A	✗	✗

Paediatrics

Expected compliance with Clinical Standards by April 2015:

Ref	Indicator	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
17	<p>Paediatric short stay assessment units and inpatient units should apply a dependency model that is validated by commissioners. As a planning guide:</p> <ul style="list-style-type: none"> - Short stay paediatric assessment units (SSPAUs) should plan on a nurse:patient ratio of 1:7. - Inpatient paediatric units should plan on a nurse:patient ratio of 1:4. <p>However, this should not mean that high need patients such as those requiring a trachyostomy should have care provided on a 1: 3 ratio or if a unit is capable of providing CPAP a ratio of 1:2.</p> <p>Note: Its expected that for the ratio to move to a 1:3 as common place community nurse teams would need to take on more complex cases, thus increasing the case-mix complexity of patients admitted to hospital.</p>	✘	✘	✓	✓	✘	✘
18	A Band 7 nurse must be part of the total nursing establishment on every PICU shift. If the PICU has more than 12 beds, they should be supported by 2 Band 6 nurses per shift.	N/A	N/A	N/A	N/A	✘	N/A
19	All senior PICU nurses (Band 6-8) should have a specific qualification in PIC nursing, with over 90% of PICU nurses being Children's Branch trained and at least 75% with a specific qualification in PIC nursing	N/A	N/A	N/A	N/A	✓	N/A
20	PICU nurses should be trained in retrieval	N/A	N/A	N/A	N/A	✘	N/A
21	<p>General Paediatric Surgery in DGHs should be undertaken by surgeons who had undertaken a minimum duration of 6 months GPS training in a recognised post, at year 4 or higher of the then Higher Surgical Training programme in a centre undertaking at least 1 operating list exclusively for children once every two weeks.</p> <p>Exceptions to this are those individuals that have already been working but due to length of service won't meet this requirement.</p>	✓	✓	✓	N/A	✓	✓
22	Paediatric anaesthetist groups should undertake at least 100, ideally greater than 200, paediatric anaesthetic procedures per year.	✓	✓	✓	N/A	✓	✓
23	On each hospital site there should be 24 hour cover by a consultant anaesthetist with paediatric interest who is able to attend within 30 minutes and does not have responsibilities to other hospital sites.	✓	✓	✓	N/A	✓	✘
24	Anaesthetists with no regular paediatric commitment but who have to provide out-of-hours cover for emergency surgery or stabilisation of children prior to transfer should maintain skills in paediatric resuscitation and an appropriate level of CPD in paediatric anaesthesia to meet the requirements of the job.	✓	✓	✓	N/A	✓	✓

Paediatrics

Expected compliance with Clinical Standards by April 2015:

Ref	Indicator	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
25	Children should be anaesthetised by consultants who have regular and relevant paediatric practice sufficient to maintain core competencies. Children may also be anaesthetised by staff or Associate specialist (SAS) anaesthetists or specialty doctors (SDs), provided they fulfil the same criteria and there is a nominated supervising consultant anaesthetist. When trainees anaesthetise children, they should be supervised by a consultant with appropriate experience.	✓	✓	✓	N/A	✓	✓
26	It was agreed that a minimum number of lists per week should be set for paediatric anaesthetists	N/A	N/A	N/A	N/A	N/A	N/A
27	It was agreed that a minimum number of cases per annum should be set for paediatric anaesthetists.	N/A	N/A	N/A	N/A	N/A	N/A
28	Anaesthetists should have a minimum of 6 months Paediatric anaesthesia in care of the poorly child and paediatric surgery, as part of their specialty training. Exceptions to this are those individuals that have already been working but due to length of service won't meet this requirement.	✓	✓	✓	N/A	✓	✓
29	Every child or young person with an acute medical problem who is referred for a paediatric opinion is seen by, or has the case discussed with, a paediatrician on the consultant rota, a paediatrician on the middle grade rota or a registered children's nurse who has completed a recognised programme to be an advanced practitioner.	✓	✓	✓	N/A	✓	✓
30	PICU must have access to the following paediatric subspecialties as per the critical interdependencies framework (see p.10): ENT (including airway management), specialised paediatric surgery, specialised paediatric anaesthesia, clinical haematology, respiratory medicine, cardiology, neurosurgery, metabolic medicine, neurology, major trauma, nephrology, immunological disorders, infectious diseases, urology, gastroenterology.	N/A	N/A	N/A	N/A	✓	N/A
31	PICU must have 24-hr access to radiology, including CT and MRI scanners, with 24-hr reporting available by consultant radiologists and neuro-radiologists.	N/A	N/A	N/A	N/A	✓	N/A
32	There should be technical staff available at all times (24-hr) to the PICU, to service and troubleshoot electronic equipment and other technical services.	N/A	N/A	N/A	N/A	✓	N/A

Neonatology

Overall the Trusts are meeting, or have plans in place to meet, c.45% of the Clinical Standards agreed in Neonatology by April 2015.

General progress against standards

Of the Trusts this standard applies to, no Trusts have improved over the last year and two have reduced in compliance due to an enhance understanding of the standard requirements. 9 standards are now met, 2 less than in 2012, and it is expected that these 9 will continue to be met in 2015. This will amount to an overall 8 point deterioration in compliance across all sites between 2012 and 2015.

Site specific progress

The table (right) shows the break down of standards being met across each of the sites. North Tees has seen a deterioration in its compliance since 2012, reducing by 20 points. South Tees' level of compliance has remained static at 60% for James Cook and 50% at the Friarage.

55% of the standards are not expected to be met across all the sites and this includes 4 standards that will not be met by any Trust in the region.

These are:

- Tier 1 – 24/7 - 8 WTE on a rota;
- Tier 2 – 24/7 - 8 WTE on a rota;
- Tier 3 – 14-16/7 – 8 WTE on a rota;
- Nurse:baby staffing ratio; and
- + a number of standards not applicable to any of the Trusts in the region.

Neonatology	DDT Total	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
Standards Met (2012)	11	N/A	N/A	5	N/A	6	N/A
Standards Met (2013)	9	N/A	N/A	3	N/A	6	N/A
Standards Met (2015 expected)	9	N/A	N/A	3	N/A	6	N/A
Standards Not Met (2015 expected)	11	N/A	N/A	7	N/A	4	N/A
% met by Trust	45%	N/A	N/A	30%	N/A	60%	N/A
Improvement 2012 - 2015	-10pp			-20pp		0pp	

Neonatology

Expected compliance with Clinical Standards by April 2015:

Ref	Indicator	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
1	Tier 1 – 24/7 - 8 WTE on a rota ANNPs GP Trainees Foundation Year Doctors Trust doctors ST1-3 trainees	N/A	N/A	✘	N/A	✘	N/A
2	Tier 2 – 24/7 - 8 WTE on a rota ANNPs Trust doctors ST trainees - ST 3 and above SSASG Consultants	N/A	N/A	✘	N/A	✘	N/A
3	Tier 3 – 14-16/7 – 8 WTE on a rota Consultants	N/A	N/A	✘	N/A	✘	N/A
4	NMC registered	N/A	N/A	✓	N/A	✓	N/A
5	NMC registered also QIS	N/A	N/A	✓	N/A	✓	N/A
6	Nurse:baby ratio	N/A	N/A	✘	N/A	✘	N/A
7	Minimum number of registered nurses on duty at all times	N/A	N/A	✓	N/A	✓	N/A
8	Nurse coordinator	N/A	N/A	✘	N/A	✓	N/A
9	Target cot occupancy	N/A	N/A	✘	N/A	✓	N/A
10	Minimum number of cots to ensure high quality	N/A	N/A	✘	N/A	✓	N/A
11	Cots per 1000 births	N/A	N/A	N/A	N/A	N/A	N/A
12	Transport	N/A	N/A	N/A	N/A	N/A	N/A
13	Community neonatal nursing support	N/A	N/A	N/A	N/A	N/A	N/A
14	Outcome data at 32 weeks and 24 months	N/A	N/A	N/A	N/A	N/A	N/A

ITU

Overall the Trusts are meeting, or have plans in place to meet, c.65% of the Clinical Standards agreed in ITU by April 2015.

General progress against standards

There will be an overall 3 point improvement in compliance with these standards between 2012 and 2015. Whilst the number of standards met in 2013 has reduced by 6 since 2012 (from 85 down to 79), this is predominantly related to an increased understanding of what the standards require, rather than a reduction in service. Compliance with required standards is anticipated to increase to 89 by 2015 – a 65% rate across all Trusts.

Site specific progress

The table (right) shows the break down of standards being met across each of the sites. North Tees hospital has seen the largest increase in compliance of all the sites since 2012, increasing by 14points to a full 100% compliance by 2015. The lowest level of compliance is at South Tees' Friarage site, which will stand at 44% by 2015.

DMH has seen a deterioration in compliance, reducing by 7 points since 2012, with 12 standards not met by 2015. 35% of the standards are not expected to be met across all the sites.

ITU		CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
Standards Met (2012)	85	17	17	24	N/A	16	11
Standards Met (2013)	79	10	14	27	N/A	16	12
Standards Met (2015 expected)	90	18	16	28	N/A	16	12
Standards Not Met (2015 expected)	50	10	12	0	N/A	12	15
% met by Trust	65%	64%	55%	100%	N/A	57%	44%
Improvement 2012 - 2015	3pp	4pp	-7pp	14pp		0pp	4pp

ITU

Expected compliance with Clinical Standards by April 2015:

Ref	Indicator	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
1	All Trusts must participate in ICNARC and achieve good clinical outcomes as compared to comparable units.	✓	✓	✓	N/A	✓	✓
2	All Trusts must achieve the following minimum quality indicators targets: Unit acquired MRSA: <1% Unit acquired C.Diff: <2% Out of Hours ward discharges < 5% Early discharges <5% Delayed discharges (4 hour) <10% Early readmissions < 3% Post ITU deaths <10%	✗	✗	✓	N/A	✗	✗
3	Non clinical transfers out of hospital should be a rare event and out of network an SUI.	✓	✓	✓	N/A	✗	✗
4	All Critical Care services must have 24/7 access to an immediately available doctor @ ST3 or above with advanced airway skills (or equivalent, e.g. Advanced Critical Care Practitioners) with no other duties (theatre for example).	✗	✗	✓	N/A	✓	✗
5	All consultants participating the Critical Care rota must do daytime sessions in Critical Care, 2 is considered minimum.	✓	✗	✓	N/A	✓	✗
6	New consultant appointments to critical care rotas should have CCT in Critical Care and FFICM exam.	✓	✓	✓	N/A	✓	✗
7	All critical care units should have consultant sessions and ward rounds in evenings and weekends. Standard 15 PAs for each 8 (or part) level 3 beds as national recommendation.	✓	✓	✓	N/A	✓	✓
8	Each Critical Care Unit should have a named consultant 24 hours per day with no other clinical duties with 2 ward rounds as a minimum, 3 desirable, e.g.0900, 1600 and 2000.	✓	✓	✓	N/A	✓	✗

ITU

Expected compliance with Clinical Standards by April 2015:

Ref	Indicator	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
9	Each admission to critical care should be reviewed by a consultant within 12 hours of admission.	✓	✓	✓	N/A	✓	✓
10	Each Critical Care Unit should have a named Director with sufficient time for administration of the unit. A minimum of 1 session is recommended for each 8 level 3 beds and a whole time director whose job is directed to patient care and management is recommended for units with greater than 20 level 3 beds.	✗	✗	✓	N/A	✗	✗
11	Each patient admitted to critical care should have a named parent specialty consultant whose team or nominated team visits daily until discharge from critical care .	✗	✗	✓	N/A	✗	✓
12	All referrals to critical care should involve discussion with the referring and receiving parent consultant	✗	✗	✓	N/A	✗	✗
13	Level 3 Units should deliver renal support in dialysis or CVVH.	✓	✓	✓	N/A	✓	✗
14	Every patient in an Critical Care must have immediate access to a registered nurse with a post registration qualification in this specific speciality.	✓	✓	✓	N/A	✓	✓
15	Level 3 (ventilated or CVVH) patients should have a minimum of one nurse to one patient.	✓	✓	✓	N/A	✓	✓
16	Level 2 patients should have a minimum of one nurse to two patients.	✓	✓	✓	N/A	✓	✓

ITU

Expected compliance with Clinical Standards by April 2015:

Ref	Indicator	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
17	Larger units (>6 beds) and/or geographically diverse units require a clinical co-ordinator who is a senior critical care qualified nurse who is not allocated a patient on the clinical shift.	✘	✓	✓	N/A	✘	N/A
18	Intensive Care Units should maintain mean occupancy levels of <70% for units of 8 beds or fewer and <80% for larger units.	✘	✘	✓	N/A	✘	✘
19	A Level 3 bed should be available for a new admission requiring it within one hour of the need arising in 90% of cases.	✓	✓	✓	N/A	✘	✘
20	There should be <10% delayed discharges to the wards, where delay is defined as delayed after midday on the day following them deemed suitable for ward transfer by the consultant.	✘	✘	✓	N/A	✘	✘
21	Patient transfers between networked ICUs should be only undertaken on the basis of clinical need, and should be agreed between the referring and accepting intensive care consultant. Transfers outside the network should be avoided.	✓	✓	✓	N/A	✓	✓
22	All Critical Care Units should perform a RCA on unplanned readmissions or early discharges from critical Care areas within a 48 hour period.	✓	✘	✓	N/A	✘	✘
23	The National Early Warning Score (NEWS) should be a standard measured for patient safety for every patient. Clear pathways of referral must be in place (defined in local protocols) for patients who reach trigger criteria.	✓	✓	✓	N/A	✓	✓

ITU

Expected compliance with Clinical Standards by April 2015:

Ref	Indicator	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
24	There should be an acute response team to call, in some smaller hospitals this may be an acute medical response team. In larger hospitals it is recommended that a form of Critical Care Outreach is adopted.	✘	✘	✓	N/A	✘	✘
25	All Trusts should implement the NICE Rehabilitation after Critical Illness (NICE 2009) guidelines, including follow up clinics and 7 day rehab.	✘	✘	✓	N/A	✘	✘
26	All Trusts must comply with the Network evidence based guidelines which should be in place in each unit for management of common critical care conditions e.g. sepsis management as per surviving sepsis guidelines and North East SHA sepsis standards.	✓	✓	✓	N/A	✓	✓
27	The structure of Intensive Care Units should follow HBN 57 and CCUs V4 for all new builds or refurbishment.	✓	✘	✓	N/A	✓	✓
28	All sites admitting emergencies should have the ability to increase their Level 2 and Level 3 capacity to accommodate periods of exceptional need dependant upon local and regional ACEP levels.	✓	✓	✓	N/A	✓	✓

End of Life Care

Overall the Trusts are meeting, or have plans in place to meet, c.38% of the Clinical Standards agreed in EoL care by April 2015. Compliance with these standards varies significantly between providers.

General progress against standards

End of Life Care has the lowest level of compliance with standards across all Trusts. However, there will be an overall 19 point improvement in compliance by April 2015. In addition, the number of standards met in 2013 has increased by 6 since 2012 (from 16 to 22). Compliance with required standards is anticipated to increase again to 32 by 2015 – a 19 point increase across all Trusts.

Site specific progress

The table (right) shows the break down of standards being met across each of the sites. North Tees Hospital has seen the largest increase in compliance of all the sites since 2012, increasing by 64 points to a 86% compliance by 2015. The lowest level of compliance is at County Durham and Darlington, with levels of compliance expected to reduce by 14 points to 7% across both sites between 2012 and 2015.

DMH has seen a deterioration in compliance, reducing by 14 points since 2012, with 13 standards not met by 2015.

62% of the standards are not expected to be met across all the sites but one standard will not be met across any of the Trusts:

- People approaching the end of life are offered timely personalised support for their social, practical and emotional needs, which is appropriate to their preferences, and maximises independence and social participation for as long as possible.

End of Life Care	DDT Total	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
Standards Met (2012)	16	3	3	3	3	2	2
Standards Met (2013)	22	1	1	7	7	3	3
Standards Met (2015 expected)	32	1	1	12	12	3	3
Standards Not Met (2015 expected)	54	13	13	2	2	12	12
% met by Trust	38%	7%	7%	86%	86%	20%	20%
Improvement 2012 - 2015	19pp	-14pp	-14pp	64pp	64pp	7pp	7pp

End of Life Care

Expected compliance with Clinical Standards by April 2015:

Ref	Indicator	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
1	People approaching the end of life are identified in a timely way	✘	✘	✓	✓	✘	✘
2	People approaching the end of life and their families and carers are communicated with, and offered information, in an accessible and sensitive way in response to their needs and preferences.	✘	✘	✓	✓	✘	✘
3	People approaching the end of life are offered comprehensive holistic assessments in response to their changing needs and preferences, with the opportunity to discuss, develop and review a personalised care plan for current and future support and treatment.	✘	✘	✓	✓	✘	✘
4	People approaching the end of life have their physical and specific psychological needs safely, effectively and appropriately met at any time of day or night, including access to medicines and equipment.	✘	✘	✓	✓	✘	✘
5	People approaching the end of life are offered timely personalised support for their social, practical and emotional needs, which is appropriate to their preferences, and maximises independence and social participation for as long as possible.	N/A	N/A	N/A	N/A	N/A	N/A
6	People approaching the end of life are offered spiritual and religious support appropriate to their needs and preferences.	✘	✘	✓	✓	✓	✓
7	Families and carers of people approaching the end of life are offered comprehensive holistic assessments in response to their changing needs and preferences, and holistic support appropriate to their current needs and preferences.	N/A	N/A	N/A	N/A	✘	✘
8	People approaching the end of life receive consistent care that is coordinated effectively across all relevant settings and services at any time of day or night, and delivered by practitioners who are aware of the person's current medical condition, care plan and preferences.	✘	✘	✘	✘	✘	✘
9	People approaching the end of life who experience a crisis at any time of day or night receive prompt, safe and effective urgent care appropriate to their needs and preferences.	✘	✘	✓	✓	✘	✘
10	People approaching the end of life who may benefit from specialist palliative care, are offered this care in a timely way appropriate to their needs and preferences, at any time of day or night.	✘	✘	✘	✘	✘	✘
11	People in the last days of life are identified in a timely way and have their care coordinated and delivered in accordance with their personalised care plan, including rapid access to holistic support, equipment and administration of medication.	✘	✘	✓	✓	✘	✘

End of Life Care

Expected compliance with Clinical Standards by April 2015:

Ref	Indicator	CDDFT		NTHFT		STFT	
		UHND	DMH	NTH	HAR	JCUH	FHN
12	The body of a person who has died is cared for in a culturally sensitive and dignified manner.	✓	✓	✓	✓	✓	✓
13	Families and carers of people who have died receive timely verification and certification of the death.	✗	✗	✓	✓	✗	✗
14	People closely affected by a death are communicated with in a sensitive way and are offered immediate and on-going bereavement, emotional and spiritual support appropriate to their needs and preferences.	✗	✗	✓	✓	✓	✓
15	Health and social care workers have the knowledge, skills and attitudes necessary to be competent to provide high-quality care and support for people approaching the end of life and their families and carers.	✗	✗	✓	✓	✗	✗
16	Generalist and specialist services providing care for people approaching the end of life and their families and carers have a multidisciplinary workforce sufficient in number and skill mix to provide high-quality care and support.	✗	✗	✓	✓	✗	✗

3. Workforce

Introduction

The key conclusions from this work in each of the primary areas of focus are illustrated below:

The quantitative models developed during phase 1 combine workforce data, baseline data and quality standards to provide an insight into three key things: current compliance with agreed quality standards; likely future compliance with standards; and an illustration of the workforce implications of different scenarios.

Since Phase 1 the model has been refreshed with updated staff numbers and also to allow site specific analysis however the same key findings are evident. The model is hard coded based on predicted growth rates which don't take account of political changes such as the increasing evidence that the service should move towards a fully trained workforce model – these policies will likely require a significant increase for the current demand estimates.

Maternity Observations:

The model shows that the overall shape of the medical workforce is forecast to decrease in a number of key workforce categories. The consultant workforce is set to decrease by 17% between 2013 and 2018. The tier one workforce is set to shrink by 22% in line with projected reductions in future trainee intakes.

Nationally a high percentage of midwives are approaching the 55 typical retirement age, Trusts in the area have an even higher than average percentage of midwives over 50. Whilst changes to the pension regime may encourage individuals to stay in the workforce for longer, there remains a significant risk that retirements will create a material reduction in the midwifery workforce. Estimating future retirement rates suggests that this exit will be materially larger than the trainee intake available. Without action the size of the core midwifery workforce will shrink rather than grow to meet increases in demand and quality standards. The model suggests a 29% reduction over the next 5 years.

The scale of the challenge is such that the overall conclusion is similar regardless of adjustments in assumptions on trainees, promotions and retirements. There are actions individual Trusts can take to address medical shortages such as the use of locums and using senior grades to back fill lower tiers however both have significant drawbacks in terms of adding additional financial pressure and its broadly recognised that the use of locums bring added risks in terms of patient quality due to staff often being unfamiliar with facilities. Therefore rota consolidation may be the only viable option to achieve the clinical quality standards.

Paediatric Observations:

Collectively there is currently a shortage of Middle Tier Doctors within Paediatrics across the Durham, Darlington and Tees area. In particular many Trusts are suffering a significant shortage of middle tiers with extra consultants being drafted in to backfill rotas (e.g. at North Tees and Hartlepool).

The workforce model predicts that by 2018 the current workforce across the patch will only be able to sustain 3.3 units based on the middle grade numbers.

The overall trend is that medical workforce is forecast to increase marginally over the period. The consultant workforce however will fall by 29% during the period 2013 to 2018 whilst the middle grades will increase by 58%. Its worth noting that this might be subject to change if qualification for promotions to consultant grade become more strict or limiting in years to come. The tier one junior doctors is expected to grow slightly by 14%.

There are actions individual Trusts can take to address medical shortages such as the use of locums and using senior grades to back fill lower tiers however both have significant drawbacks in terms of adding additional financial pressure and it's broadly recognised that the use of locums bring added risks in terms of patient quality due to staff often being unfamiliar with facilities. Therefore rota consolidation appears necessary if quality standards are to be achieved for middle grades. Career planning will be required to smooth progression and ensure appropriate utilisation of skills.

Neonatal Observations:

Already NTHFT & STHFT rely heavily on ANNPs to back fill tier 1 rotas although they are not a quick fix solution due to training requirements and that once trained there is a high risk of them moving on. The future workforce model suggests that collectively the patch will struggle to have enough staff in 2018 to provide the service from 1 site whilst meeting the clinical quality standards of 8 WTE on each tier of the rota.

The overall medical workforce is forecast to increase marginally over the next 5 years. During this time the consultant workforce is expected to shrink by 20% whilst the middle grade are expected to increase by 106% subject to potential changes to promotions to consultant grades becoming more strict in years to come. Tier one is also expected to increase by 69% during the period.

In spite of the projected increase in tier 1 and tier 2 doctors a gap for all medical workforce groups is still projected.

Currently both sites are operating with between 4 – 5 WTE consultants on the rota when the clinical standard suggests 8 WTE is required.

Quantitative assessment process

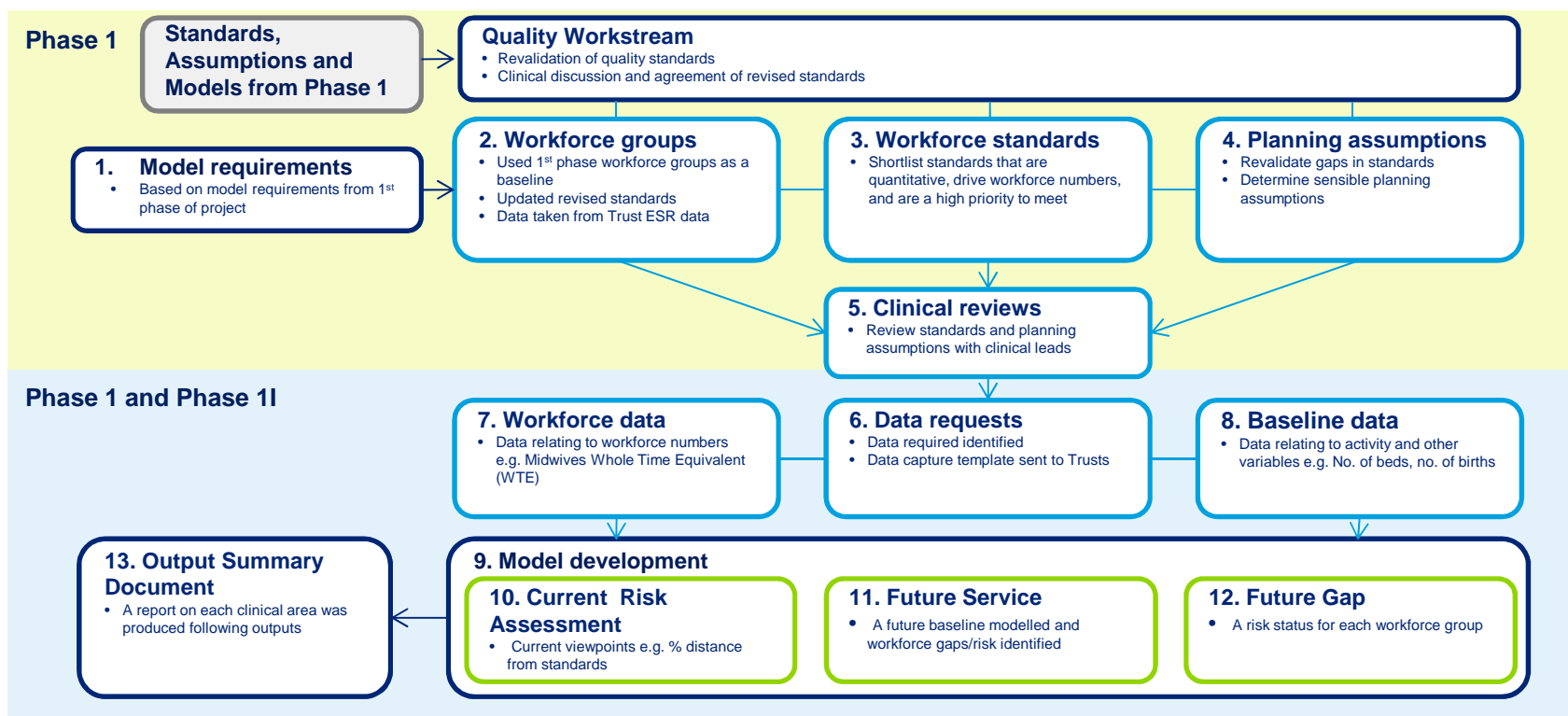
A structured approach was followed to compare likely future workforce levels with those required to meet agreed quality standards (targets)

Overview

The project has focused on using quality standards as the basis of workforce models across 3 clinical areas; Maternity, Paediatrics and Neonatal. The workforce workstream combines two components:

- Qualitative analysis based on national and local workforce intelligence for the 3 areas; and
- Quantitative analysis based on detailed staffing analysis for the areas of Maternity, Paediatrics and Neonatal services.

The quantitative models developed combine workforce data, baseline data and quality standards to provide an insight into three key things: current compliance with agreed quality standards, future service in terms of workforce and the likely hood of future compliance with agreed quality standards. A methodical process was consistently adopted the workforce model and supporting output summary as illustrated below:



Quantitative assessment process

Further explanation of each step of the modelling process is outlined below

Phase 1

1. Model Requirements

- The model adopts a commissioner focus to generate a macro, rather than operational level of detail
- The focus was on generating an overview of workforce at site level for planning purposes, rather than focusing on granular detail such as developing the roster systems

2. Identify Workforce Groups

- Identification of key professional workforce groups for each clinical area were established through an investigation into Trust-level ESR data and from those groups identified in the quality standards
- Workforce groups were split across direct ('core') service professionals such as consultants and supporting ('non-core') service professionals: individuals whose services may be vital but whose expertise was typically sourced from outside of the service

3. Identify Workforce Standards

- Standards were extracted from documentation provided by the Quality Workstream based on their engagement with clinicians
- These were then shortlisted based on specific modelling criteria. These focused on work on those standards that were quantitative and could be used to drive workforce projections (e.g. No. of hospital births to Midwives WTE per annum is 28:1)
- These standards were mapped against the workforce groups

4. Develop Planning Assumptions

- Gaps were identified where no established standards exist, in these areas clinical input was sought to determine appropriate planning assumptions
- Planning assumptions were also used to forecast future workforce changes, e.g. retirement rates, new joiners, sickness levels etc
- Planning assumptions were created based on available healthcare best practice, Subject Matter Expert (SME) input and historic data where possible

5. Clinical Reviews

- A review of shortlisted standards and planning assumptions were completed with clinical leads, other experts and the Quality Workstream team
- A revised list of standards and planning assumptions was agreed

Phase 1 and Phase 1I

6. Data Requests

- Based on shortlisted standards and planning assumptions, a list of data required for modelling was developed
- A data capture template was issued to the Trusts to capture workforce and baseline data
- Information received from Trusts was reviewed and where possible cross checked against ESR and Trust self assessment information

7. Workforce Data

- Workforce data was provided by the Trusts through the Data capture template
- In some cases an ESR position data extract provided by Trusts was used by the project team to populate the Data capture template. This was then verified by the Trusts

8. Baseline Data

- Baseline data was provided by the Trusts through the Data capture template
- In some cases broader regional data was used to fill in gaps in the data supplied by Trusts

Quantitative assessment process

As data was returned, it was fed into individual clinical models which were used to support the analysis

Phase 1 and Phase 2

9. Model Development

- Individual models for each clinical area were developed
- A series of tabs link each standard to the relevant baseline and workforce data.
- A calculation tab is used to pull these together and produce the outputs required in the summary documents

10. Current Risk Assessment (Output 1)

- Quality standards and planning assumptions were applied to workforce and baseline data to produce an indicative of the gap between current practice and standards
- A summary of regional standard gaps were produced to highlight the overall gaps / surpluses
- An exercise was completed to cross reference the current situation against self assessments

11. Future Service (Output 2)

- Using data from North East Quality Observatory Systems (NEQOS) and other sources a future baseline has been modelled up to 2017
- The number of staff required to meet the future quality standards is illustrated and the gaps identified

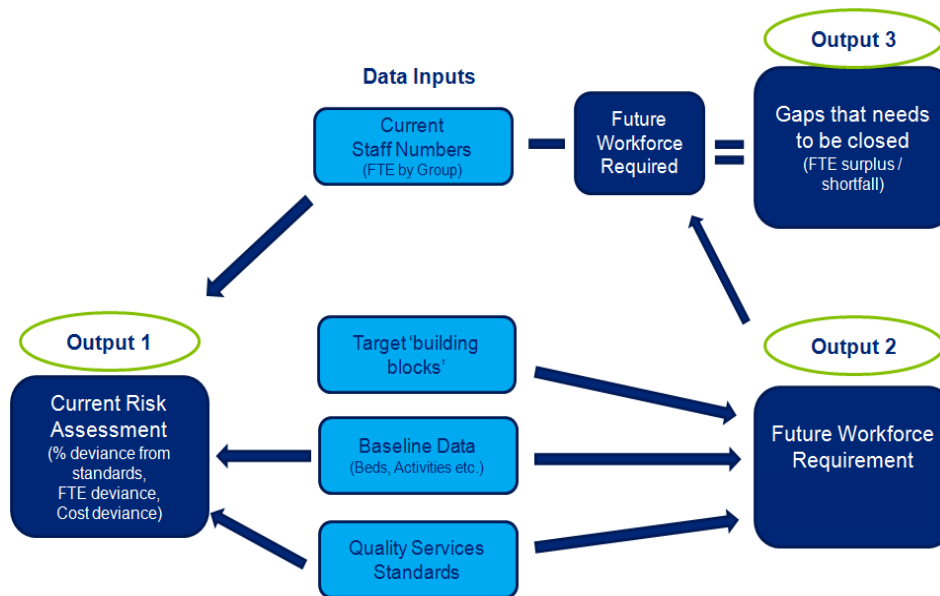
12. Future Gaps (Output 3)

- A regional summary graph was produced to illustrate the gaps identified and a future baseline risk assessment was completed to provide a risk status for each workforce group

13. Output Summary Document

- A supporting report for each of the clinical models this document was produced in line with each of the three model outputs

This diagram illustrates the data inputs required for the different models and how they drive the 3 model outputs:



In many cases we obtained different figures from service personnel, HR and ESR. Figures from senior service personnel were preferred where available.

Maternity Workforce

The model focuses on core service professionals working in Maternity

Maternity – notes of scope of services included

- The majority of standards, staff and activity related to Obstetric units and this provides the core focus for the modelling;
- Both consultant led and midwifery led obstetrics unit are considered within the model and the model can be used to illustrate the workforce impacts of switching between delivery types;
- Gynaecology services are included within the scope of the model, however most national standards infer gynaecology staffing levels on the basis of obstetric activity;
- Assumptions on the split of consultant staff time between obstetric and gynaecology activity were necessary to ensure appropriate labour ward coverage assessments were being undertaken;
- Whilst home births are currently an extremely marginal element of the service provision, modelling of these was included within the scope; and
- Additional logic and further assumptions were made to the existing models in order to highlight future workforce gaps at the site level within North Tees NHS FT.

In Scope Workforce Groups

- We identified 3 core staff groups which are highlighted within the table below:

Staff group	Workforce group
Medical and Dental	Consultants Tier 2 doctors GPVTS Specialty Registrars (ST1-3, SHOs) Foundation Doctors (F2) Foundation Doctors (F1)
Nursing and Midwifery	Midwives Midwife Managers Student Midwives
Other supporting workforce groups	Midwifery care assistants (MCAs)

Out of Scope Workforce Groups

- A variety of workforce groups were considered out of scope due to either:
 - Insufficient data was available to model them effectively; and
 - Insufficient standards existed and appropriate planning assumptions were not forthcoming.
- Out of scope workforce groups include the following:
 - Radiologists ;
 - Radiographers;
 - Anaesthetists;
 - Sonographers – although known to be an area of shortage; and
 - Surgeons.

Maternity Workforce

The overall size of the medical workforce is forecast to decrease - rota consolidation could be the only viable option to achieve quality standards.

The summary below predicts the future workforce based on key drivers such as leavers, starters, retirements and promotions. These figures can then be compared with the numbers taken from the clinical standards agreed in phase 1 of the work to evaluate the total number of sustainable units that can be safely staffed given the current and future predicted workforce levels. These are shown on the right hand side of this slide. In both cases the constricting factor is the availability of consultants.

Forecast future workforce availability

Workforce group	2013	2014	2015	2016	2017	2018
Consultants (168 hour cover)	47.5	44.6	42.7	41.4	40.4	39.5
Consultants (98 hour cover)	47.5	44.6	42.7	41.4	40.4	39.5
Tier 2 doctors (including ST 4 & above, SSASG and Trust)	18.8	25.4	29.5	31.0	32.1	32.9
GPVTS	11.0	8.7	8.7	8.7	8.7	8.7
Specialist Registrars (ST 1-3, SHOs)	27.0	22.5	16.0	15.2	15.0	14.9
Foundation Doctors (F2)	4.8	1.2	4.9	5.2	5.3	5.3
Foundation Doctors (F1)	1.0	5.1	5.3	5.3	5.3	5.3
Midwife Managers	29.4	54.5	73.4	88.0	99.1	107.4
Midwives	473.1	415.1	377.8	346.2	319.2	296.4
Student Midwives	13.0	25.0	25.0	25.0	25.0	25.0
Midwifery care assistants (MCAs)	117.5	121.5	125.5	129.5	133.5	137.5

Sustainable units

Standards	2014	2018
19.9	2.2	2.0
11.6	3.8	3.4
10.0	2.5	3.3
2.0	4.4	4.4
4.0	5.6	3.7
2.0	0.6	2.7
2.0	2.6	2.7
7.2	7.6	14.9
107.3	3.9	2.8
5.4	4.6	4.6
26.8	4.5	5.1

Assumptions:

- Assumptions on the split of consultant staff time between obstetric and gynaecology activity were necessary to ensure appropriate labour ward coverage assessments were being undertaken (35%);
- The majority of standards, staff and activity related to Obstetric units and this provides the core focus for the modelling; and
- Both consultant led and midwifery led obstetrics unit are considered within the model and the model can be used to illustrate the workforce impacts of switching between delivery types.

Paediatrics Workforce

The model focuses on core service professionals working in Paediatrics

Scope of service

- The majority of standards in this are focussed on core paediatrics rather than Paediatric Intensive Care Units (PICU) services
- Similarly the majority of standards are based on acute inpatient provision rather than short stay paediatric unit models
- As a result the model is primarily based around Acute Inpatient units with an ability to consider SSPA units – a variety of staffing delivery arrangements (including consultant and nurse led) are perceived as viable

In Scope Workforce Groups

- We identified 3 core staff groups within Paediatrics services which are highlighted below:

Staff group	Workforce group
Medical and Dental	Consultants Tier 2 doctors GPVTS Specialty Registrars (ST1-3, SHOs) Foundation Doctors (F2) Foundation Doctors (F1)
Nursing and Midwifery	Sister/Charge Nurses Specialist Nurse Practitioners Staff Nurses
Other supporting workforce groups	Healthcare assistants

Out of Scope workforce groups

- The focus was on Paediatrics excluding Paediatric Surgery and other sub-specialties where treatment was not led by a consultant.
- A variety of workforce groups were considered out of scope due to either :
 - Not considered as part of the scope of the project;
 - Insufficient data was available to model them effectively; and
 - Insufficient standards existed and appropriate planning assumptions were not forthcoming.
- Out of scope workforce groups include the following:
 - Radiologists;
 - Radiographers;
 - Anaesthetists; and
 - Surgeons.

Paediatrics Workforce

The overall size of the medical workforce is forecast to increase, marginally, over the period although the consultant workforce is set to decrease over the period.

The model below predicts the future workforce based on key drivers such as leavers, starters, retirements and promotions. These figures can then be compared with the numbers taken from the clinical standards agreed in phase 1 of the work to evaluate the total number of sustainable units that can be safely staffed given the current and future predicted workforce levels. These are shown on the right hand side of this slide. In both cases the constricting factor is the availability of consultants.

Forecast future workforce availability

Workforce group	2013	2014	2015	2016	2017	2018
Consultants	60.1	54.7	50.6	47.4	44.7	42.6
Tier 2 doctors (including ST 4 & above, SSASG and Trust)	20.8	25.0	27.8	29.3	31.0	32.8
GPVTS	12.0	13.8	13.8	13.8	13.8	13.8
Specialist Registrars (ST 1-3, SHOs)	23.2	21.1	18.7	20.1	21.3	22.1
Foundation Doctors (F2)	6.0	5.1	8.1	8.4	8.4	8.4
Foundation Doctors (F1)	5.0	8.3	8.4	8.4	8.4	8.4
Sister/Charge Nurses	30.1	32.2	33.9	35.5	36.8	38.0
Staff Nurses	178.1	177.1	176.1	175.3	174.5	173.8
Specialist Nurse Practitioners	12.3	13.7	15.1	16.4	17.6	18.9
Healthcare assistants (HCAs)	63.6	60.2	57.2	54.5	52.1	49.8

Sustainable units

Standards	2014	2018
10.0	5.5	4.3
10.0	2.5	3.3
2.0	6.9	6.9
4.0	5.3	5.5
2.0	2.6	4.2
2.0	4.2	4.2
4.8	6.7	7.9
35.7	5.0	4.9
0.9	15.2	21.0
11.0	5.5	4.5

Assumptions:

- The region is forecasting a very small increase in demand for paediatric services however as the paediatric staffing model is based primarily on beds and occupancy thresholds this does not translate into an increase in workforce demand over the period;
- This forecast does not assume any form of service reconfiguration in terms of increasing use of Specialist Nurse Practitioners (SNPs) or alternative delivery models;
- This forecast does not assume any material changes in bed occupancy levels or length of stays.

Neonates Workforce

The model focuses on core service professionals working in Neonatology

Neonatology – notes of scope of services included

- The majority of standards in this are focused on Intensive Therapy Unit (ITU) services;
- The staffing information collected focused on High Dependency Unit (HDU) and ITU services at James Cook and University Hospital of North Tees;
- For SCBU services there was overlap in workforce with other service areas amongst medical staff; and
- As a result the quantitative model developed focuses on HDU and ITU services – rather than SCBU service provision.

In Scope Workforce Groups

- We identified 3 core staff groups which are highlighted within the table below:

Staff group	Workforce group
Medical and Dental	Consultants Tier 2 doctors GPVTS Specialty Registrars (ST1-3, SHOs) Foundation Doctors (F2) Foundation Doctors (F1)
Nursing and Midwifery	Sister/Charge Nurses Staff Nurses Specialist Nurse Practitioners (ANNPs)
Other supporting workforce groups	Healthcare assistants (MCAs)

Out of Scope Workforce Groups

- A variety of workforce groups were considered out of scope due to either:
 - Insufficient data was available to model them effectively; and
 - Insufficient standards existed and appropriate planning assumptions were not forthcoming.
- Out of scope workforce groups include the following:
 - Radiologists;
 - Radiographers;
 - Anaesthetists; and
 - Surgeons.

Neonates Workforce

A gap for all workforce groups is projected; the consultant workforce is set to decrease over the period.

The model below predicts the future workforce based on key drivers such as leavers, starters, retirements and promotions. These figures can then be compared with the numbers taken from the clinical standards agreed in phase 1 of the work to evaluate the total number of sustainable units that can be safely staffed given the current and future predicted workforce levels. These are shown on the right hand side of this slide. In both cases the constricting factor is the availability of consultants.

Forecast future workforce availability

Workforce group	2013	2014	2015	2016	2017	2018
Consultants	8.4	7.8	7.4	7.1	6.8	6.7
Tier 2 doctors (including ST 4 & above, SSASG and Trust)	4.3	4.9	5.9	6.9	7.9	8.9
GPVTS	0.0	0.0	0.0	0.0	0.0	0.0
Specialist Registrars (ST 1-3, SHOs)	3.3	4.2	4.8	5.2	5.4	5.6
Foundation Doctors (F2)	0.0	0.0	0.0	0.0	0.0	0.0
Foundation Doctors (F1)	0.0	0.0	0.0	0.0	0.0	0.0
Sister/Charge Nurses	22.7	24.5	26.2	27.7	29.0	30.3
Staff Nurses	113.1	111.9	110.8	109.8	109.0	108.2
Specialist Nurse Practitioners	7.6	8.4	9.1	9.7	10.3	10.9
Healthcare assistants (HCAs)	8.1	10.3	12.2	14.0	15.6	17.0

Sustainable units

Standards	2014	2018
8.0	1.0	0.8
8.0	0.6	1.1
0.0	N/a	N/a
4.0	1.1	1.4
0.0	N/a	N/a
0.0	N/a	N/a
9.6	2.6	3.2
43.4	2.6	2.5
4.0	2.1	2.7
4.3	2.4	4.0

Assumptions:

- The majority of standards in this are focused on Intensive Therapy Unit (ITU) services;
- The staffing information collected focused on High Dependency Unit (HDU) and ITU services at James Cook and University Hospital North Tees;
- For SCBU services there was overlap in workforce with other service areas amongst medical staff; and
- As a result the quantitative model developed focuses on HDU and ITU services – rather than SCBU service provision.

4. Finance

Finance – Acute Surgery

Acute Surgery across Durham Darlington and Tees generates a £7.6m loss

Acute Surgery DDT Financial Overview

£000	DDT* Trust Total	DDT Acute Surgery Total	% of DDT Total	DDT Acute Surgery NEL Total	% of DDT Total
2012/13					
Income	1,223,474	181,672	15%	49,707	4%
Total Direct and Indirect Costs	(929,412)	(142,184)	15%	(39,063)	4%
Contribution	294,062	39,488	13%	10,644	4%
Total Overheads	(290,190)	(47,063)	16%	(13,494)	5%
Surplus / Deficit	3,871	(7,575)		(2,850)	
% Margin	0.32%	-4.17%		-5.73%	

*DDTV: Durham, Darlington and Tees region

Across Durham, Darlington and Tees there are currently 5 fully operational Surgical units.

The surgical services generate a cumulative positive contribution to the financial position of the region however after the allocation of depreciation and apportionment of overheads a residual deficit of £7.6m is returned.

Overall Acute Surgery is a loss making service across all three Trusts. The table shows that this is a result of the non-elective surgery costs. The nature of non-elective surgery is that it has high overheads associated with the provision of this service, capable of responding to a wide variety of surgical interventions, without a guaranteed income to support it.

Acute Surgery DDT Financial Overview

£000	DDT* Trust Total	DDT Acute Surgery Total	% of DDT Total	South Tees	% of DDT Acute Surgery Total	North Tees	% of DDT Acute Surgery Total	CDDFT	% of DDT Acute Surgery Total
2012/13									
Income	1,223,474	181,672	15%	87,587	7%	33,082	3%	61,003	5%
Total Direct and Indirect Costs	(929,412)	(142,184)	15%	(70,529)	8%	(24,978)	3%	(46,676)	5%
Contribution	294,062	39,488	13%	17,058	6%	8,103	3%	14,326	5%
Total Overheads	(290,190)	(47,063)	16%	(24,569)	8%	(9,548)	3%	(12,946)	4%
Surplus / Deficit	3,871	(7,575)		(7,510)		(1,445)		1,380	
% Margin	0.32%	-4.17%		-8.57%		-4.37%			

*DDT: Durham, Darlington and Tees region

Finance – Acute Surgery

Non elective Acute Surgery across Durham Darlington and Tees generates a £2.9m loss

NEL Acute Surgery DDT Financial Overview

£000	DDT NEL			% of DDT			% of DDT			% of DDT			
	DDT* Trust Total	Acute Surgery Total	% of DDT Total	South Tees JCUH	Acute Surgery Total	% of DDT Total	South Tees FHN	Acute Surgery Total	% of DDT Total	North Tees Total	Acute Surgery Total	CDDFT Total	% of DDT Total
2012/13													
Income	1,223,474	49,707	4%	17,093	1%		2,778	0%		11,397	1%	18,439	2%
Total Direct and Indirect Costs	(929,412)	(39,063)	4%	(14,882)	2%		(2,785)	0%		(7,286)	1%	(14,109)	2%
Contribution	294,062	10,644	4%	2,211	1%		(7)	0%		4,110	1%	4,330	1%
Total Overheads	(290,190)	(13,494)	5%	(5,578)	2%		(1,166)	0%		(2,837)	1%	(3,913)	1%
Surplus / Deficit	<u>3,871</u>	<u>(2,850)</u>		<u>(3,367)</u>			<u>(1,173)</u>			<u>1,273</u>		<u>417</u>	
% Margin	0.32%	-5.73%		-19.70%			-42.23%			11.17%		2.26%	

*DDT: Durham, Darlington and Tees region

Financial review

The overall Non Elective Deficit for Acute surgery for the patch is £2.9m

- Looking only at Non Elective Activity we can see that James Cook University Hospital still makes a contribution to the Trust of £2.2m but goes on to make a residual loss of £3.4m after overheads are allocated.
- The Friarage however makes a negative contribution to the Trust before apportionment of overheads and has the largest loss margin of -42%.
- Both NTHFT and CDDFT generate a contribution to the Trust and retain a surplus however NTHFT runs at a higher surplus margin indicating it is a more efficient service after the allocation of overheads is accounted for.

Finance – Acute Medicine

Acute Medicine across Durham Darlington and Tees generates a £5.1m surplus

Acute Medicine DDT Financial Overview

£000	DDT* Trust Total	DDT Acute Medicine Total	% of DDT Total	DDT Acute Medicine NEL	% of DDT Total
2012/13					
Income	1,223,474	227,104	19%	158,515	13%
Total Direct and Indirect Costs	(929,412)	(162,957)	18%	(127,147)	14%
Contribution	294,062	64,146	22%	31,368	11%
Total Overheads	(290,190)	(59,016)	20%	(44,885)	15%
Surplus / Deficit	3,871	5,131		(13,518)	
% Margin	0.32%	2.26%		-8.53%	

*DDT: Durham, Darlington and Tees region

Acute Medical Services generate a cumulative positive contribution to the financial position of the region furthermore after the allocation of depreciation and apportionment of overheads a net surplus of £5.1m is returned. It should be noted that two of the three Trusts return a net surplus in this clinical area with only one Trust recording a net deficit.

Non elective acute medical services operate at a loss margin of -8.5%. The main driver for this is the large net deficit recorded at James Cook University Hospital. This is due to JCUH being the main tertiary centre for the DDT region and hence receiving the more complex patients, in response it has higher overheads in order to provide for the wide range of patients presenting.

Acute Medicine DDT Financial Overview

£000	DDT* Trust Total	DDT Acute Medicine Total	% of DDT Total	South Tees	% of DDT Acute Medicine Total	North Tees	% of DDT Acute Medicine Total	CDDFT	% of DDT Acute Medicine Total
2012/13									
Income	1,223,474	227,104	19%	88,137	7%	68,469	6%	70,497	6%
Total Direct and Indirect Costs	(929,412)	(187,986)	20%	(64,740)	7%	(45,274)	5%	(52,943)	6%
Contribution	294,062	39,118	13%	23,397	8%	23,195	8%	17,554	6%
Total Overheads	(290,190)	(33,987)	12%	(26,262)	9%	(17,875)	6%	(14,879)	5%
Surplus / Deficit	3,871	5,131		(2,864)		5,320		2,675	
% Margin	0.32%	2.26%		-3.25%		7.77%		3.79%	

*DDT: Durham, Darlington and Tees region

Finance – Acute Medicine

Non Elective Acute Medicine across Durham Darlington and Tees generates a £13.5m loss with James Cook hospital as the regions tertiary centre generating a £18.5m loss.

NEL Acute Medicine DDT Financial Overview

£000	DDT* Trust Total	DDT NEL		% of DDT		% of DDT		% of DDT		CDDFT	% of DDT Acute Medicine Total
		Acute Medicine Total	% of DDT Total	South Tees JCUH	% of DDT Acute Medicine Total	South Tees FHN	% of DDT Acute Medicine Total	North Tees Total	% of DDT Acute Medicine Total		
2012/13											
Income	1,223,474	158,515	13%	40,931	3%	7,736	1%	53,865	4%	55,984	5%
Total Direct and Indirect Costs	(929,412)	(127,147)	14%	(43,405)	5%	(7,154)	1%	(34,545)	4%	(42,044)	5%
Contribution	294,062	31,368	11%	(2,474)	-1%	582	0%	19,320	7%	13,940	5%
Total Overheads	(290,190)	(44,885)	15%	(16,050)	6%	(2,627)	1%	(14,393)	5%	(11,816)	4%
Surplus / Deficit	3,871	(13,518)		(18,525)		(2,045)		4,928		2,124	
% Margin	0.32%	-8.53%		-45.26%		-26.43%		9.15%		3.79%	

*DDT: Durham, Darlington and Tees region

Financial review

The overall Non Elective Deficit for Acute Medicine for the patch is £13.5m

- Looking only at Non Elective Activity we can see that James Cook University Hospital does not make a positive contribution to the Trust and records a loss of £18.5m. The service at this site runs at a loss margin of -45%. As previously noted this is due to the effect of JCUH being the main tertiary centre for the region and the higher overheads associated with the more complex high cost case mixes.
- Both North Tees and CDDFT generate a contribution to the Trust and retain a surplus however North Tees runs at a higher profit margin indicating it is a more profitable non elective service after the allocation of overheads is accounted for.

Finance – Intensive Care

Intensive Care was not classed as a specific department or directorate within the SLR data of two of the three Trusts. As a result summary aggregate financial analysis has not been performed. Individual commentary can be found within the Trust specific appendices.

Finance – APMN

APMN across Durham Darlington and Tees generates a £19.4m loss

APMN DDT Financial Overview

£000	DDT* Trust Total	DDT APMN Total	% of DDT Total	DDT APMN NEL	% of DDT Total
2012/13					
Income	1,223,474	119,685	10%	71,496	6%
Total Direct and Indirect Costs	<u>(929,412)</u>	<u>(102,929)</u>	11%	<u>-60,364</u>	6%
Contribution	294,062	16,756	6%	11,132	4%
Total Overheads	<u>(290,190)</u>	<u>(36,144)</u>	12%	<u>(22,249)</u>	8%
Surplus / Deficit	<u>3,871</u>	<u>(19,388)</u>		<u>(11,117)</u>	
% Margin	0.32%	-16.20%		-15.55%	

*DDT: Durham, Darlington and Tees region

APMN as a whole across Durham Darlington Tees generates a £19.4m loss. Non elective care forms £11.1m of this deficit. The greatest proportion (51%) comes from Obstetrics (Maternity) which makes a £5.7m loss on Non-elective activity. Closely followed by paediatrics (£3.1m) and then Neonatology (£1.3m).

However in all cases they are generating a positive contribution, before allocation of overheads, to the patch of £16.7m. This would indicate that rationalising to a smaller number of sites would reduce the amount of overheads and in turn reduce the residual losses generated across the patch.

At a Trust level NTHFT is the only provider making a negative contribution prior to the allocation of overheads.

APMN DDT Financial Overview

£000	DDT* Trust Total	DDT APMN Total	% of DDT Total	South Tees	% of DDT APMN Total	North Tees	% of DDT APMN Total	CDDFT	% of DDT APMN Total
2012/13									
Income	1,223,474	119,685	10%	55,392	10%	23,506	2%	40,788	3%
Total Direct and Indirect Costs	<u>(929,412)</u>	<u>(102,929)</u>	11%	<u>(43,566)</u>	11%	<u>(24,536)</u>	3%	<u>(34,827)</u>	4%
Contribution	294,062	16,756	6%	11,825	9%	(1,031)	0%	5,961	2%
Total Overheads	<u>(290,190)</u>	<u>(36,144)</u>	12%	<u>(15,084)</u>	12%	<u>(6,366)</u>	2%	<u>(14,694)</u>	5%
Surplus / Deficit	<u>3,871</u>	<u>(19,388)</u>	-501%	<u>(3,259)</u>	113%	<u>(7,397)</u>	-652845%	<u>(8,733)</u>	134%
% Margin	0.32%	-16.20%		-5.88%		-31.47%		-31.47%	

*DDT: Durham, Darlington and Tees region

Finance – APMN

Non Elective APMN across Durham Darlington and Tees generates a £11.1m loss

NEL APMN DDT Financial Overview

£000	DDT* Trust Total	DDT NEL APMN Total	% of DDT Total	South Tees JCUH	% of DDT APMN Total	South Tees FHN	% of DDT APMN Total	North Tees	% of DDT APMN Total	CDDFT	% of DDT APMN Total
2012/13											
Income	1,223,474	71,496	6%	25,689	2%	4,357	0%	15,951	1%	25,499	2%
Total Direct and Indirect Costs	(929,412)	(60,364)	6%	(20,839)	2%	(4,047)	0%	(13,706)	1%	(21,772)	2%
Contribution	294,062	11,132	4%	4,850	2%	310	0%	2,245	1%	3,727	1%
Total Overheads	(290,190)	(22,249)	8%	(7,202)	2%	(1,235)	0%	(4,626)	2%	(9,186)	3%
Surplus / Deficit	<u>3,871</u>	<u>(11,117)</u>		<u>(2,351)</u>		<u>(925)</u>		<u>(2,381)</u>		<u>(5,459)</u>	
% Margin	0.32%	-15.55%		-9.15%		-21.23%		-14.93%		-21.41%	

*DDT: Durham, Darlington and Tees region

APMN Breakdown of Profit

£000	2012/13
Maternity	(5,712)
Paediatric	(3,058)
Neonatology	(1,352)
PICU	(996)
Total	<u>(11,118)</u>

Financial review

The overall Non Elective Deficit for APMN for the patch is £11.1m

- Looking only at Non Elective Activity we can see that all sites do make a positive contribution to the Trust and are therefore profit making however all record a loss after the apportionment of overheads and allocation of depreciation. There is potential from rationalising the number of sites to generate efficiencies/economies of scale there by reducing the proportion of overheads. This should in turn reduce the size of losses generated by these services.
- APMN services at CDDFT attract the highest loss margin at -21.4% closely followed by the Friarage Hospital at 21.2%.

Finance – Obstetrics

Non Elective Obstetrics across Durham Darlington and Tees generates a £5.7m loss

APMN Breakdown of Profit

£000	2012/13
Maternity	(5,712)
Paediatric	(3,058)
Neonatology	(1,352)
PICU	(996)
Total	(11,118)

NEL Obstetrics and Maternity DDT Financial Overview

£000	DDT* Trust	DDT NEL	% of DDT	South Tees	% of DDT	South Tees	% of DDT	North Tees	% of DDT	CDDFT	% of DDT
	Total	Obstetrics Total	Total	JCUH	Obstetrics Total	FHN	Obstetrics Total	Total	Obstetrics Total	Total	Obstetrics Total
2012/13											
Income	1,223,474	36,248	3%	12,471	1%	2,956	0%	7,047	1%	13,774	1%
Total Direct and Indirect Costs	(929,412)	(29,608)	3%	(10,144)	1%	(2,362)	0%	(6,246)	1%	(10,857)	1%
Contribution	294,062	6,640	2%	2,327	1%	594	0%	802	0%	2,918	1%
Total Overheads	(290,190)	(12,352)	4%	(3,947)	1%	(614)	0%	(1,693)	1%	(6,098)	2%
Surplus / Deficit	3,871	(5,712)		(1,620)		(20)		(892)		(3,180)	
% Margin	0.32%	-15.76%		-12.99%		-0.66%		-12.66%		-23.09%	

Financial review

The overall Non Elective Deficit for NEL Obstetrics for the patch is £5.7m

- The main contributor to the overall loss is CDDFT at 55% of the balance. CDDFT also runs at the highest loss margin.
- All sites do make a positive contribution to the Trust and are therefore profit making however all record a loss after the apportionment of overheads and allocation of depreciation. Reducing the amount of overheads potentially by rationalising the number of sites and would reduce the size of losses generated by these services.

Finance – Paediatrics

Non elective Paediatrics across Durham Darlington and Tees generates a £3.1m loss

APMN Breakdown of Profit

£000	2012/13
Maternity	(5,712)
Paediatric	(3,058)
Neonatology	(1,352)
PICU	(996)
Total	(11,118)

NEL Paediatric DDT Financial Overview

£000	DDT* Trust Total	DDT NEL Paediatric Total	% of DDT Total	South Tees JCUH	% of DDT PaedsTotal	South Tees FHN	% of DDT PaedsTotal	North Tees	% of DDT PaedsTotal	CDDFT	% of DDT PaedsTotal
2012/13											
Income	1,223,474	27,728	2%	7,866	1%	1,202	0%	8,903	1%	9,756	1%
Total Direct and Indirect Costs	(929,412)	(22,813)	2%	(5,957)	1%	(907)	0%	(7,460)	1%	(8,489)	1%
Contribution	294,062	4,915	2%	1,909	1%	295	0%	1,443	0%	1,267	0%
Total Overheads	(290,190)	(7,973)	3%	(2,096)	1%	(392)	0%	(2,933)	1%	(2,552)	1%
Surplus / Deficit	3,871	(3,058)		(187)		(97)		(1,489)		(1,285)	
% Margin	0.32%	-11.03%		-2.38%		-8.08%		-16.73%		-13.17%	

Financial review

The overall Non Elective Deficit for NEL Paediatrics for the patch is £3.1m

- The main contributor to the overall loss is North Tees at 49% of the balance, the Trust also runs the service with the highest loss margin.
- All sites do make a positive contributions however all record a loss after the apportionment of overheads and allocation of depreciation. Reducing the amount of overheads potentially by rationalising the number of sites and would reduce the size of losses generated by these services.

Finance – Neonatology

Neonatology across Durham Darlington and Tees generates a £1.4m loss

APMN Breakdown of Profit

£000	2012/13
Maternity	(5,712)
Paediatric	(3,058)
Neonatology	(1,352)
PICU	(996)
Total	(11,118)

NEL Neonatology DDT Financial Overview

£000	DDT* Trust	DDT NEL	% of DDT	South	% of DDT	South	% of DDT	% of DDT		% of DDT	
	Total	Neonatology		Tees	Neonats	Tees FHN	Neonats	North Tees	Neonats	CDDFT	
	Total	Total	Total	JCUH	Total	Total	Total	Total	Total	Total	
2012/13											
Income	1,223,474	5,907	2%	5,352	0%	199	0%	n/a	n/a	355	0%
Total Direct and Indirect Costs	(929,412)	(5,844)	2%	(4,737)	1%	(778)	0%	n/a	n/a	(329)	0%
Contribution	294,062	62	2%	615	0%	(579)	0%	n/a	n/a	27	0%
Total Overheads	(290,190)	(1,414)	3%	(1,159)	0%	(229)	0%	n/a	n/a	(26)	0%
Surplus / Deficit	3,871	(1,352)		(544)		(808)		n/a		1	
% Margin	0.32%	-22.88%		-10.17%		-405.68%				0.20%	

Financial review

The overall Non Elective Deficit for NEL Neonatology for the patch is £1.4m

- North Tees was unable to separate Neonatology via its SLR data.
- The main contributor to the overall loss is South Tees at the Friarage at 60% of the balance. This service also runs with the highest loss margin of -406%
- Neonatology makes a contribution to the Trust before the apportionment of overheads and application of depreciation at JCUH and marginally at CDDFT.
- After the apportionment of overheads neonatology proceeds to make a loss at STHFT and only a very small surplus at CDDFT (which does not have NICU facilities).

Finance – End of Life

End of Life Care was not classed as a specific department or directorate within the SLR data of two of the three Trusts. As a result summary aggregate financial analysis has not been performed. Individual commentary can be found within the Trust specific appendices.

Finance – Cost of implementation of agreed standards

None of the Trusts have been able to fully cost implementation of all the standards. Deloitte have worked with the Trusts in costing improvements that could be achieved to the key standards through additional funding.

Additional finance would help facilitate attainment of the following standards:-

- 7 day access to pharmacy
- Extended access to MRI at weekends and out of hours.
- Delivering 7 day ambulatory care
- Extended access to respiratory and physiotherapy services
- Enhanced out reach services

Working with one of the Trusts Deloitte have calculated that additional funding of c.£10m per year would result in an additional 9.5% of standards being met across their two sites. However it should be noted there will still be a large proportion of the standards which will not be met and where additional finance alone will not facilitate attainment of these standards.

5. Glossary

Glossary

7/7	Seven day working (NHS Strategic Initiative)
AAU	Acute Assessment Unit
ANNP	Advanced Neonatal Nurse Practitioner
ANP	Advanced Nurse Practitioner
AoMRC	Academy of Medical Royal Colleges
APMN	Acute Paediatrics, Maternity and Neonatology
ARAS	Acute Respiratory Assessment Service
ASQLP	Acute Services Quality Legacy Project
CAG	Clinical Advisory Group
CCG	Clinical Commissioning Group
CNST	Clinical Negligence Scheme for Trusts
CPAP	Continuous Positive Airway Pressure
CPD	Continuing Professional Development
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation Payments
CT	Computerised Tomography
CTPA	Computed Tomography Pulmonary Angiography
DCC	Direct Clinical Care
DGH	District General Hospital
EL	Elective
ENT	Ear Nose and Throat
EPAU	Early Pregnancy Assessment Unit
FHN	Friarage Hospital Northallerton
FT	Foundation Trust
FY1	Foundation Year 1
GI	Gastrointestinal
GPS	General Paediatric Surgery
ICTPICM	Intercollegiate Committee for Training in Paediatric Intensive Care Medicine
ITU	Intensive Therapy Unit
JC/JCUH	James Cook University Hospital
MCA	Maternity Care Assistant
MLU	Midwifery Led Unit
MRI	Magnetic Resonance Imaging
MSK	Musculoskeletal
NCEPOD	National Confidential Enquiry into Patient Outcome and Death

NEL	Non Elective
NEWS	National Early Warning Score
NHDU	Neonatal High Dependency Unit
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NICU	Neonatal Intensive Care Unit
NMC	Nursing and Midwifery Council
NT	University Hospital of North Tees
NTHFT	North Tees and Hartlepool NHS Foundation Trust
OOH	Out of Hours
OT	Occupational Therapy
PA	Programmed Activity
PIC	Paediatric Intensive Care
PICU	Paediatric Intensive Care Unit
PP	Percentage Point
PT	Physiotherapy
QIS	Qualified in Speciality
RAG	Red, Amber, Green
RCN	Royal College of Nursing
RCOG	Royal College of Obstetricians and Gynaecologists
RCP	Royal College of Physicians
RCPHP	Royal College of Paediatrics and Child Health
SAS	Staff or Associate Specialist
SCBU	Special Care Baby Unit
SD	Speciality Doctor
SeQIHS	Securing Quality in Health Services
SHO	Senior House Officer
SLR	Service Line Reporting
SSASG	Staff, Speciality and Associate Specialist Grade
SSPAU	Short Stay Paediatric Assessment Unit
ST	Speciality Trainee
STFT	South Tees NHS Foundation Trust
Tees	Teesside (the areas of Middlesbrough, Stockton-On-Tees, Hartlepool and Redcar and Cleveland)
US	Ultrasound
WTD	Working Time Directive
WTE	Whole Time Equivalent



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