Mid Cheshire Hospitals NHS
NHS Foundation Trust

Clinical Service Strategy

February 2011
Version: Approved 7.2.11

Contents

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Purpose of this document

This document sets the direction for MCHFT's clinical services from 2011 – 2014/15.

It is based on the revision of 2010 – 2014/15 Clinical Service Strategy (CSS)

It sets out:

- The operating environment in which MCHFT must deliver services over the remaining four years of the strategy.
- The local market – the context in which MCHFT will play a full and committed role.
- MCHFT'S organisational vision, values and objectives - which guide everything we do.
- Key changes for MCHFT- to deliver the vision.
- The key clinical service developments across divisions and support services.

Stakeholders - Outcomes and Key Questions

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Stakeholder	Outcomes (from the strategy process)	Key stakeholder questions
• Trust Board	• The Board owns the strategy: ▪ Understands the national, regional & local context ▪ Owns the vision for the Trust (it's role within the Health Economy; services it will provide, etc.) ▪ Understands the key local challenges & major changes required ▪ Agrees the strategic plan (route map for the remaining four years of the strategy) ▪ Agrees the priority actions for 2011/12	• What will our patients require locally from services (demographics, etc)? • What services can/should/will we provide in 3-5 years time? • What is our aim re quality of service? • What is the level of clinical performance we can achieve? • How will we balance the books? • Who, for what and where will we develop partnerships? • What will our workforce look like? • What will our infrastructure look like?
• Divisions • Consultant body • Staff	• Understand the strategy (& the rationale) • Understand why services will need to change in they way and where they are delivered • Recognise the pace of change required • Understand the priority actions & their part in delivering the strategy	
• Governors/Public • Our current and potential partners • Commissioning consortia and GP's	• Develop an engagement Plan to enable partners to : ▪ Understand the strategy (& the rationale) ▪ Understand 'what's in it for them' ▪ Are engaged in how they can contribute to delivering the overall vision ▪ Understand the importance we will place on developing partnerships	

The Strategic Planning Process

The planning process for this strategy began in 2009. The CSS was approved by MCHFT Trust Board in 2010.

A full review of the strategy to include: progress delivered during 2010, changes to the environment and operating framework priorities has been completed.

Each Division has considered each specialty in relation to:

- Quality benchmarks
- Performance against national targets and productivity standards
- Meeting financial criteria & market share

In doing so, Divisions have considered:

- Clinical developments within the specialty
- Capacity and Demand requirements
- Workforce issues
- Infrastructure requirements

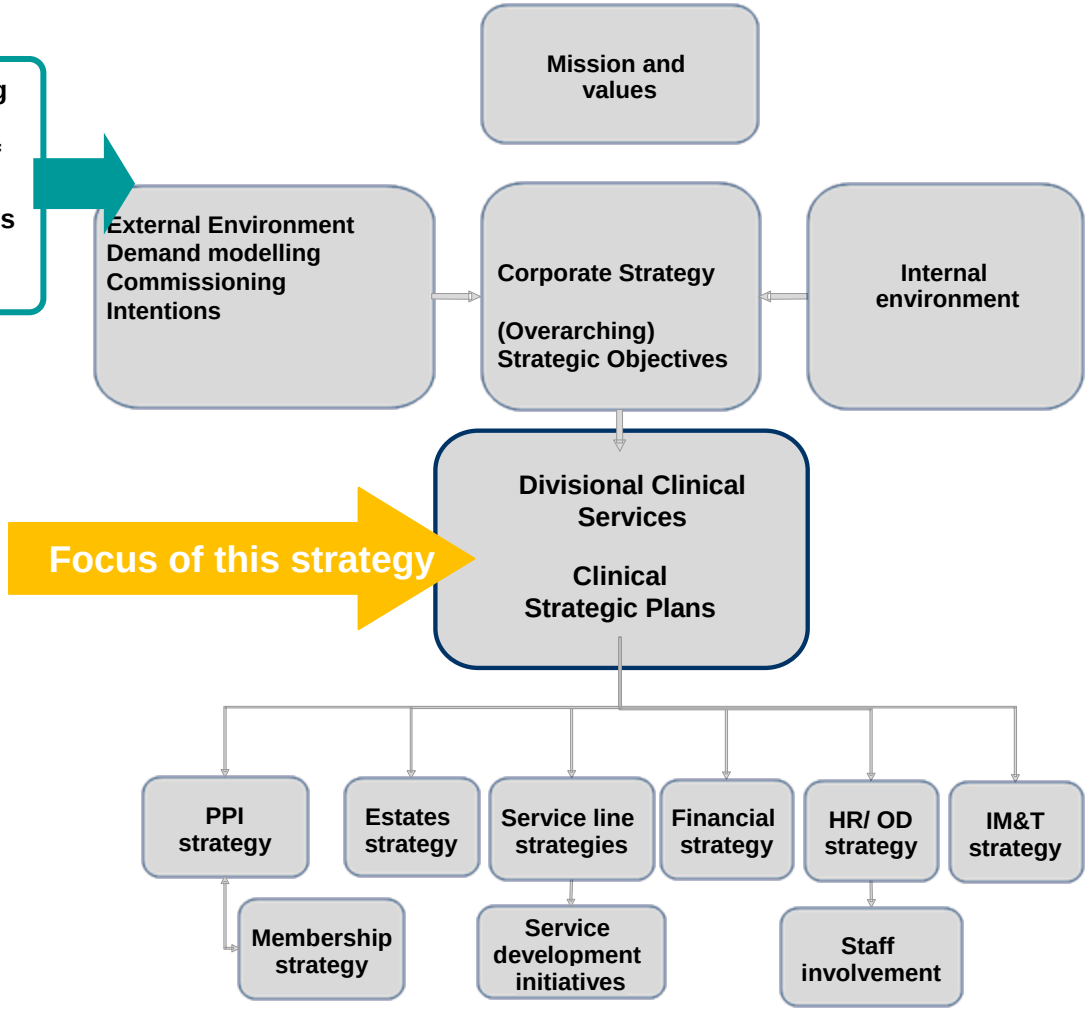
Further meetings involving Senior Divisional leads, Executives, Trust Board, Governors and Commissioning Consortia have further evaluated the key principles, priorities and direction of travel for the Trust in completion of this strategy.

This has subsequently been reviewed in detail by the Trust Strategy Group

This document therefore forms the basis of this Revised Clinical Strategy (2011-2014) from which the Trust will develop workplans, timescales and accountable officers for its delivery.

The Strategic Planning Process

The process of developing the clinical strategy has considered the context of the internal and external environments and MCHFT's overarching corporate vision



All supporting and enabling strategies and plans will also be developed / revised as necessary

The Vision for MCHFT remains unchanged:

'To be a reputable provider of high quality, safe, cost effective and sustainable healthcare services'

The Trust has six strategic objectives.

- Quality, Safety and Experience
- Strong progressive FT
- Organisational Delivery
- Workforce development and effectiveness
- Fit for purpose infrastructure
- Emergency preparedness

The key challenge of the strategy is to deliver these objectives which focus on maintaining high quality care, financial viability , improved efficiency and local sustainable services in an increasingly financially challenged environment.

Executive Summary – The Key Challenges

Effectiveness of services delivered will be based upon:

- Quality – we deliver services whose performance is on a par or better than peer working towards top quartile performance in all areas
- Efficiency – we deliver services that meet or exceed national targets for performance
- Financial balance – we deliver services that achieve a minimum 2% surplus to allow for capital investment, or are acknowledged to be a core service which must be protected
- Partnerships – we will find new ways of collaborating with others to deliver services which are sustainable, cost effective and as far as possible delivered locally
- Configuration –we will deliver services that are closer to home or for complex surgery at partner tertiary care hospitals thus reducing the current footprint

Our Mission therefore is to deliver:

The right things, in the right way, in the right place, by the right person, in the right time and at the right cost

However these challenges are set in a context of:

- Rapid and large scale reduction in health and social care funding
- Increased expectation of the public and monitoring of standards
- An increasingly aging population
- An increasing capability and cost of medicine to treat disease
- An infrastructure developed over thirty years ago which is progressively no longer fit for purpose
- A changing employee relations environment reflecting public service changes.

Executive Summary – Key Principles of Strategy

The Board have agreed the following key principles

Quality- Ten out of 10 – programme to deliver and monitor quality of services including: Hospital Standard Mortality rates, Cancer wait times and Hospital acquired infections.

Efficiency

- To achieve all national standards and targets, improve day case rates where further opportunity presents and continue to reduce length of stay for inpatients

Financial Balance

- To ensure that we work with commissioners to maintain cost effective services that are affordable across the health economy, whilst achieving financial balance with a target of 2% expenditure surplus or a full understanding and acceptance for services not achieving this.

Configuration:

- To continually monitor our bed base to further reduce over the next 3 years through a reduction in length of stay, increased day case rates and pathways of care that maintain care in the community, thus reducing admissions.
- To focus investment plans to improve infrastructure according to agreed priority areas.
- To refocus delivery of services to reduce as appropriate the number of outpatients seen within the hospital over the next 3 years, through pathway redesign and moving services into the community.

Partnerships:

- To develop robust and effective partnerships with each of the commissioning consortia to ensure agreed alignment between the clinical priorities of the Trust and those of the consortia, reflecting the overall health needs of the population served.
- Partnerships with primary care, social care and public health will support delivery of health care outside of hospital. This will support a reduction in admissions and readmissions, ensure effective use of resources available and improve patient experience .
- Pathway redesign - to work with partners to develop services nearer to patients homes by increasing secondary care provision in the community by 2012.
- To develop partnerships with other acute providers which may include: General Surgery, Urology, ENT, Vascular and Trauma, Ophthalmology and Gynaecology to ensure continued quality and financial viability by 2012.
- UHNS partnership - MCHFT will require close partnership with a tertiary Hospital. The preferred partner will be University Hospital of North Staffordshire.
- Healthcare Groups - we will assess the prospect of working with East Cheshire Trust (ECT) and Stockport FT to deliver some services through HCG's
- Staff engagement ,including with staff side colleagues, will be a key focus in all we do.

1.Strategic Context - The National Operating Framework

The operating environment 2011 – 2015 will be shaped by…

Key national policies and initiatives, especially:

- Equality and Excellence: Liberating the NHS
- Transforming Community Services.
- The development of Commissioning Consortia to replace PCT's as commissioners.
- All Acute Hospitals will be a Foundation Trust or run by a Foundation Trust

Local implementation of national policies and initiatives:

- Local commissioners' strategies and plans.
- Specialist commissioning.
- The development of Tertiary Centres and Care in the Community

The global economic situation and resulting contraction in public spending at national & local level.

The combined impact of these point to an operating environment that will…

- Require greater emphasis on quality focussing on patient safety; patient experience; and effectiveness of care. Patients' perception of the quality of care they receive will directly impact on funding.
- Require holistic and collaborative approaches to service delivery, achieved by developing partnerships with a range of partners, depending on local need and integrated services.
- Demand improved choice: providing patients with an informed choice of treatment and provider and piloting personal health budgets.
- Continue to push for improved access to services: including better services in the community and closer to patients' homes.
- Require financial savings, productivity and efficiency on a scale not seen before leading to downward pressure on tariffs, decommissioning of some services, increased market testing/tendering, 'activity caps' and tariff unbundling.
- Require a focus on effective staff engagement to enable a scale and pace of change to take place.

1. Strategic Context - The Regional Challenges

For the Northwest

- £2.5-3 billion is required to be removed from the budget.
- Seven Regional Pathway groups have been set up in sub regions to speed the change required.
- Quality, Innovation, Productivity and Prevention (QIPP) are seen as the method of delivery.

For the local health economy

- £135 million required saving over the next five years.
- £32 million was required in 2010/11. It is unclear of impact on 2011 /12 but there remains a substantial shortfall against commissioning needs
- There continues to be a drive to redirect resources more to community provision to reduce admissions and readmissions in the acute hospital

1. Strategic Context - Local Health Needs

In order to understand what services we should provide, we must consider the needs of the local population.

The Demographics of our local population include:

- The fastest growing aging population in the Northwest (85 yr + will increase by 40%).
- Our catchment area contains over half of the most deprived areas within our local health Authorities. Deprivation is known to increase the risk to health significantly.
- Increase in long term conditions.
- Higher rates of cardio vascular disease (37% of deaths) particularly stroke .
- Higher rates of dementia.
- Higher rates of cancer (26% of deaths).
- Alcohol related disease significantly higher than national average.
- Alcohol related admissions to rise by 67% by 2013.
- Higher rate of falls than national average.
- 3500 - 4000 will attend the Emergency Department due to a fall.

1. Strategic Context - The Drivers For Change

The context in which we operate will continue to be multifaceted and include the following factors:

- **Clinical** – the factors which dictate clinical practice and its development.
- **Financial** – the availability of finance to support the clinical activity, development of services and necessary Infrastructure
- **Political** - both national and/or local factors, which influence the direction and the requirements of clinical care.
- **Infrastructure** – the availability of the appropriate environment and staff to provide care in the appropriate settings.

These key drivers are described in the following pages...

1. Strategic Context - Clinical Drivers

Demographics, medical advancements and changes in clinical practice

- We have one of the fastest growing elderly population in the country.
- The increasing capability and cost of medicine to treat disease.
- Increasing national guidance to centralise highly complex and low volume surgical services

Medical training:

- The introduction of Modernising Medical Careers and the European Working Time Directive (EWTD) has led to significant change to workforce models, the impact of which is not yet fully embedded
- It's immediate effects has resulted in increased demands on Consultant time for patient care and out of hours commitments.
- Technical and scientific practice e.g. laparoscopic surgery, combined with new training practices leads to a reduction in productivity.
- Increasing sub-specialisation against generalisation impacts on surgery (specifically General Surgery and Orthopaedics) and non-elective care of medical patients, limiting the holistic management of patients particularly the elderly

Vertical and Horizontal Integration: In order to deliver sustainable and affordable services there is a growing need for health providers to deliver services differently, in an integrated manner. This can be categorised as:

- **Vertical integration** – Services and organisational cultures need to develop so that patients experience the delivery of care in a seamless way across Acute, Primary care, Community Health, Social Care and third sector providers. This will ensure patients receive effective care in the appropriate place and by the appropriate provider. This type of integration is most suited to those requiring medical specialties e.g. those patients with long-term conditions or those requiring complex elderly care, much of which can be delivered in a community setting.
- **Horizontal integration** - Specialties will integrate across geographic areas to ensure provision to a population size which delivers clinical best practice and is financially viable. Typically this is more likely to be surgical services and some diagnostics. Increasingly populations of 1 million are required in order to provide viable services especially for Urology, Cancer surgery, ENT, and Gynaecology. Other services such as Pathology are increasingly working within a horizontal framework.

1. Strategic Context – Financial & Political

Financial:

- The National Operating Framework identifies that £15-20 billion will be removed from the NHS budget by 2013/14.
- Locally the PCT faces a significant challenge with historical spend being higher than income. This is expected to remain a significant risk over the next 5 years as income reduces further.
- The impact on MCHFT is estimated to be as much as 10% of our current income (up to £13 million).
- Typically 70% of our costs are workforce related.
- Our reference costs are below national averages (but rising) as we invest in clinical services
- We need to create cash generation in the region of £5-6 million per year if we are to invest in our aging infrastructure

Political:

- The National Operating Framework is clear that 20% of the budget will be removed and this will be achieved through three key actions:
  - Improving quality whilst improving productivity using innovation and prevention to drive and connect them (QIPP).
  - Clinicians and managers working across boundaries
  - Acting now and for the long
  - The drive for greater access, improved quality and target achievement will continue. These changes will be achieved through:
    - Moving care closer to home
    - Fewer acute beds
    - Reduced unit costs
    - Standardisation of pathways
    - Tariff based on assumed levels of day case activity and are maximum values which can be negotiated locally
    - Tariff changes on non-acute care
- Locally the Trust need to undertake a full impact assessment to understand the risk to maintaining viable and sustainable services as a result of the significant changes being implemented .

1. Strategic Context – Infrastructure

Significant issues exist with our physical infrastructure.

- Two thirds of the hospitals buildings were developed between 1965-74, thus the infrastructure requires updating to an indicative cost of £62 million in the next 15years.
- Many of the buildings particularly the OPD, Theatres, Critical Care and NICU facilities are not fit for modern practice. In addition, the Wards do not comply with modern spatial guidance standards.
- The Trust has during 2010 reviewed proposals to develop a new hospital jointly between ourselves and East Cheshire Trust. This proposal is no longer viable due to the current economic environment and funding process for capital projects in the NHS.
- During 2009 the Trust received four Fire Enforcement Notices – the current remedial programme requires a recurring investment of £1.4m for asbestos removal/fire stopping and £1.2m for recurring ward upgrades, i.e. £2.6m recurring in total.
- The capital programme has approximately £3.5 million per year (Depreciation) in order to upgrade or maintain existing services. Any top-up must come from generating an operational surplus or from borrowings.

Options Appraisal

- An option appraisal has been carried out as part of the Estates Strategy considering the following:-
  - Do nothing (maintain capital assets as originally designed – Cost £62 million)
  - Phased rebuild Wards, OPD, Theatres/ICU, NICU (Cost £135 million)
  - Build a new hospital – (Cost £250 million)
- The above options determined over a 50 year NPV indicate that a Phased rebuild is the most cost effective solution. However, these calculations are based on updating the aforementioned Wards, OPD, Theatres/ICU, NICU and do not fully consider changes to service delivery.

1. Strategic Context – Infrastructure

Victoria Infirmary

- The Victoria Infirmary remains a strategic stronghold for MCHFT, and must be central to all infrastructure decisions made.
- The loss of the inpatient unit has resulted in significant public dissatisfaction which is shared by the Trust. The Trust therefore remains committed to supporting all stakeholder efforts to identify suitable resources to rebuild a fit for purpose inpatient unit in Northwich
- Many of the buildings particularly the OPD, hydrotherapy pool , endoscopy and diagnostic units remain fit for purpose. The Trust continues to evaluate the utilisation of this facility to ensure as much expansion of services as possible can be delivered from this site for this population.
- The capital programme continues to include provision for backlog maintenance for our community hospital

2. Our Vision

Services we provide:

- Whilst it is theoretically possible that MCHFT could exist as an outpatient and day case facility, due to our geographical location this has been discounted. An Emergency Department (ED) is required in order to manage the acute illness and trauma you would typically find in a population the size of our catchment area.
- As represented in the figure below, the portfolio of services delivered have been collated onto those that are **Core** i.e. must be delivered if providing full ED services, those that are **Central,** i.e. those that form the additional portfolio of services to the Trust and are key to our ongoing clinical service strategy and those that are **Discretionary** in that they are currently provided by the organisation but could be delivered by ourselves or others largely in community settings.
- This range of services are currently provided by the Trust and are listed as the mandated portfolio of services approved by Monitor .
- Patients are prepared to travel for specialised surgery, cancer care etc but for the majority of services would want and prefer local access. Again this does not have to be in a hospital setting but it does open the debate wider as to the type of services we may want/need to provide in the future

Core Services:

- Emergency Department
- Anaesthesia and Critical Care
- Acute Medicine
  - Gastroenterology
  - Cardiology
  - Care of Elderly
  - Respiratory
- Emergency Surgery
- Acute Paediatrics
- Diagnostic Imaging
- Biochemistry & Haematology

Central Services:

- Orthopaedics
- General Surgery
  - UGI
  - Colorectal
  - Vascular
  - Breast
- Urology
- Obstetrics & NICU

Discretionary Services:

- Dermatology
- Pathology (other)
- Diabetes
- Ophthalmology
- ENT
- Cancer Services
- Pain Service
- Gynaecology
- Audiology
- Sexual Health
- Occupational Health
- Rheumatology
- Community Paediatrics
- IVF
- Paediatric Audiology
- Intermediate care
- Rehabilitation

3. Current Situation – Financial Overview & CIP Challenge

Financial Overview

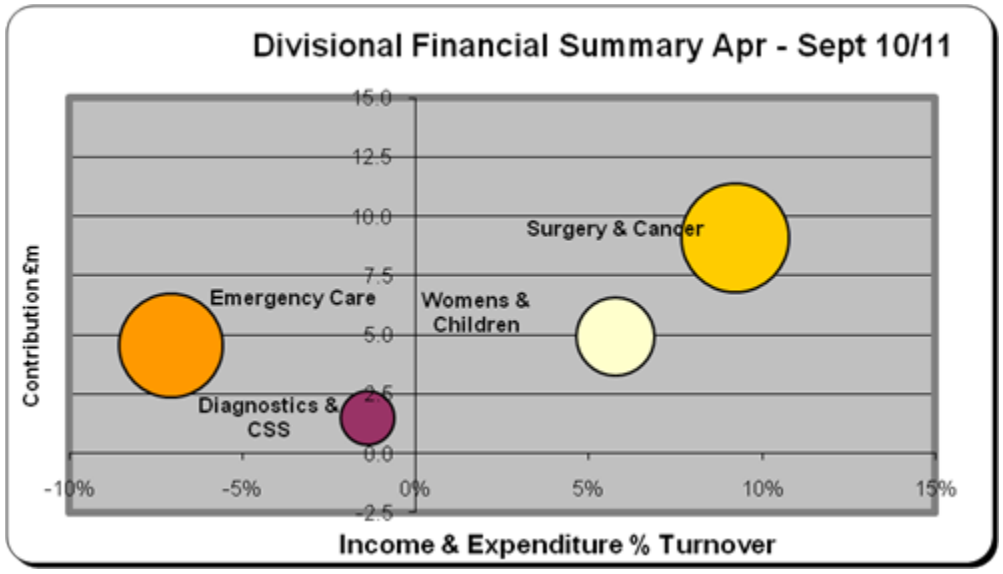
- The Board and local stakeholders are aware of the economic climate. The operating framework details that £15-20 billion will be removed from the NHS budget by 2013/14
- The impact of the Tariff efficiency of 4% and penalties for readmissions leaves the Trust requiring a cost improvement in 2011-12 of £8.5m to simply stand still prior to any service developments / investments
- Typically 70% of our costs are workforce related. Our reference costs are below national averages (but rising) which suggests traditional approaches to cost reduction will not be appropriate.

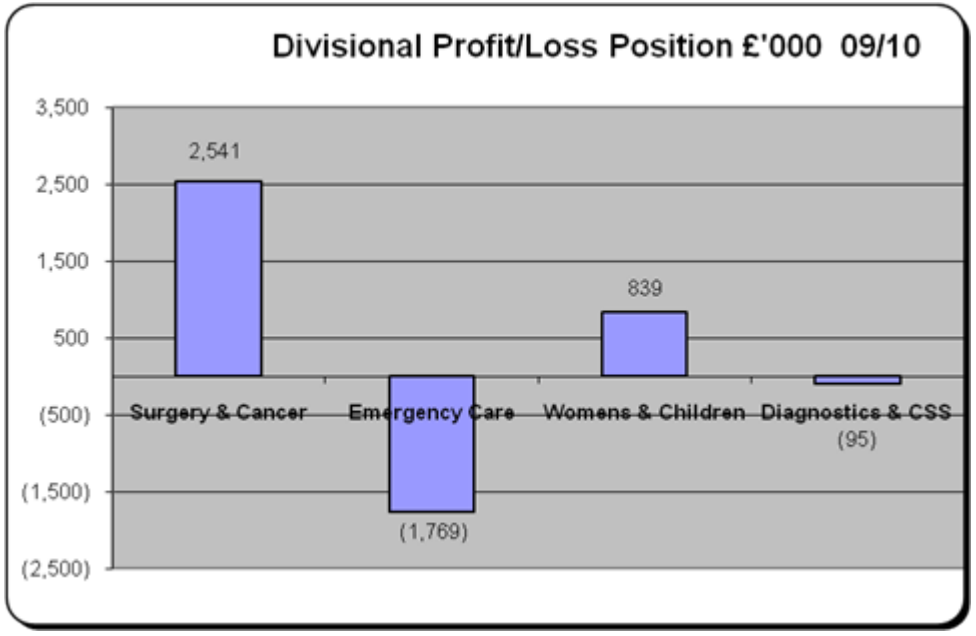
CIP Challenge

- All specialties make a contribution, hence the case for disinvestment is weak unless new services can be delivered to replace lost contribution.
- The CIP requirement for 2011-12 equates to £8.5 million with similar levels being required over the next 3 years.
- 2010 – 11 CIP had a focus on removing excess costs. Future CIPs need to be focussed on different ways of working across and between organisations
- A focus on increasing productivity and reducing waste is required to deliver sustainable cost improvement that protects front line services, quality and patient safety.
- Patient Level Costing will provide the tools to focus on where efficiencies can be delivered by highlighting where costs are high. It will allow specialties to focus on different levels of cost, e.g. Sub-specialty, cost type (nursing, drugs, etc), procedure or patient cohort. Key Performance Indicators (KPI's) can be developed from the system to support efficiency targets, e.g. Nursing cost per bed day.

3. Current Situation – Finance: Divisional Analysis

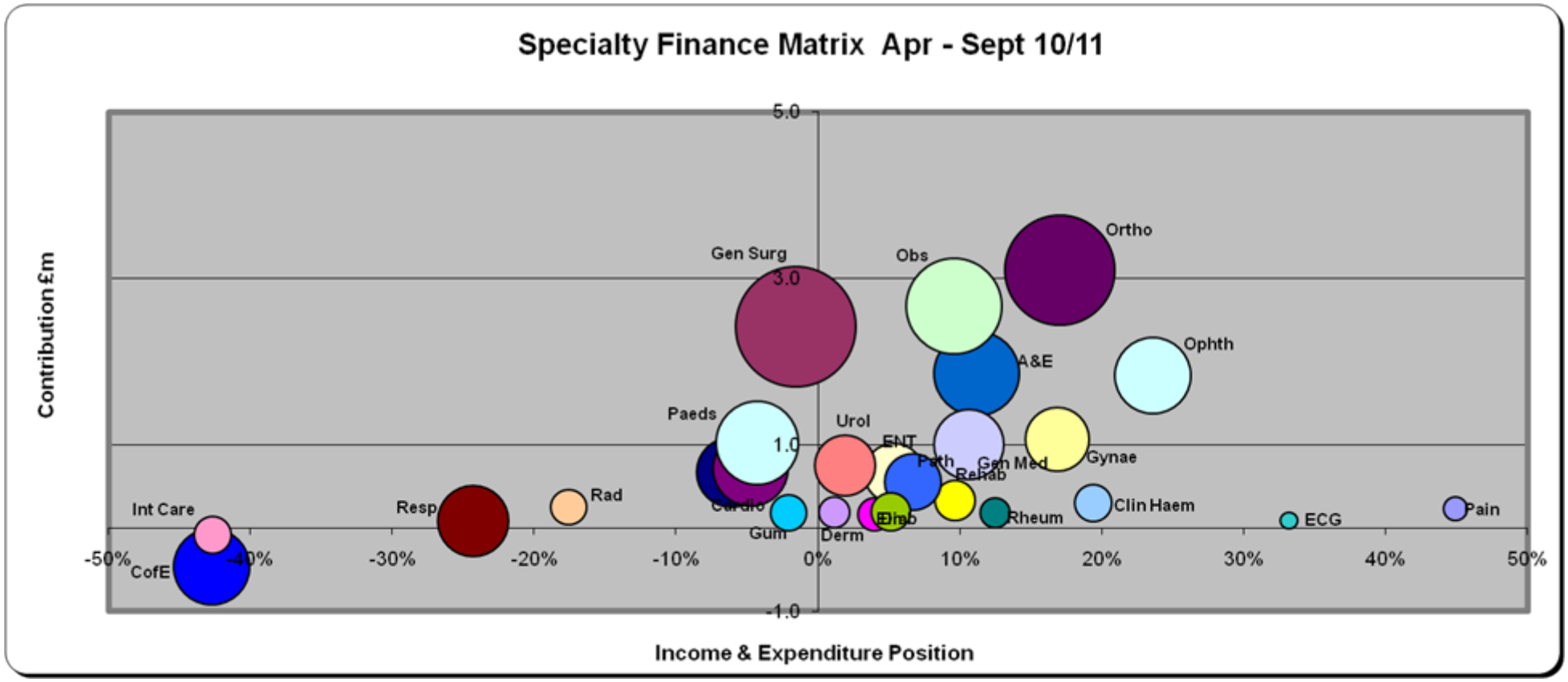
The table below shows the budgeted Income & Expenditure position of each Division . Those above the line make a positive return and those below the line a deficit. The Trust target is that each specialty makes a 2% return on turnover. Emergency Care Division is particularly challenged as a result of changes to tariff (ie funded for growth against 08-09 outturn at only 30% marginal cost)





3. Current Situation – Finance: Specialty Analysis

The table below shows the budgeted relative financial position of each specialty according to the level of contribution (y axis) and their I&E position (x axis). Those to the left of the y axis have an I&E deficit but because they are above the x axis, they make a positive contribution. The size of the 'bubble' represents the level of turnover in the specialty. For example, General Surgery makes a deficit but has a positive contribution and is of a material size in terms of turnover, whereas Intermediate Care makes a loss, a marginal contribution but is small scale in terms of turnover.



3. Current Situation – Finance: Investments 2011/12

The Board and Senior Divisional teams have not yet determined what financial investments will be undertaken during

2011-12.

Further work is currently being undertaken to identify priorities and this section will be updated once commissioning agreements and contracting has been completed in April 2011.

3. Current Situation – Workforce

Workforce issues: Significant issues exist within all workforce areas. This is unlikely to change over the term of this strategy and therefore the Trust is evaluating alternative workforce models as a priority in order to sustain delivery of services. The challenges are summarised as:

Medical Workforce: Modernising medical careers:
•Increasing sub specialisation of doctor training presenting gaps in middle grade rotas and shortage of Consultants for on call rotas
•DGH generalist role becoming unattractive in specialist world
•Recruitment and retention remains a challenge
• Due to the lack of qualified Doctors, there has been an over-reliance on the use of Junior Doctors to supplement rota.
• National shortages of Consultant and Non-Consultant posts within services where service demand frequently exceeds capacity

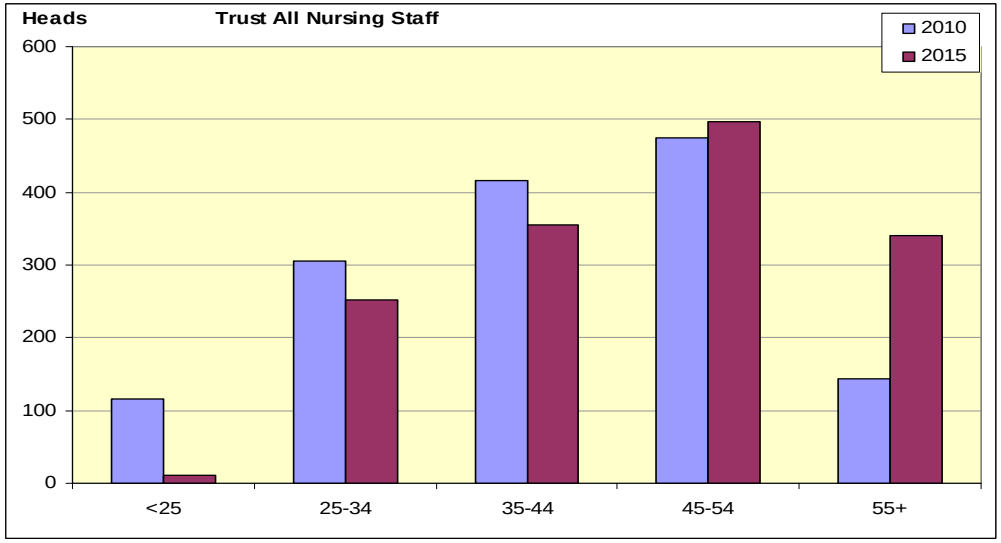
Nursing Workforce:
•Seasonal variation on service capacity and demand , leading to the need for alternative ways of working, eg annualised hours
•Increased need for Advanced Nursing Practitioners to support Consultants and provide continuity of care:
•There is a shortage of advanced skill level in the available labour market, hence a requirement to develop the unqualified nursing workforce.
•Nursing movements to degree level education for career entry potential impacts on the supply of qualified nurses
•Up-skilling of the current Nursing workforce to ensure satisfactory qualification level
•Meeting needs of 'Maternity Matters' through workforce design

Allied Health Professionals (AHP) Workforce :
•Introduction of a new healthcare science pathway – Modernising Scientific Careers
•Development of new training and education programmes, including academic and workplace-based training,
•National shortage of AHP roles within services where service demand frequently exceeds workforce capacity:
•Demographics indicate significant retirements over next 3 - 5 years which need to be planned

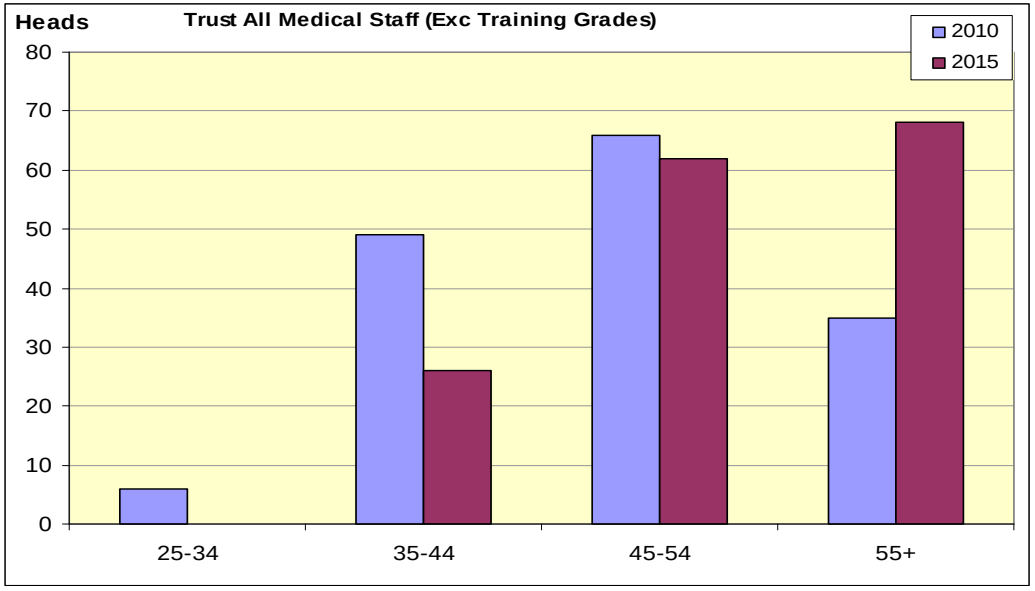
General workforce issues:
•Availability of capable and suitably experienced individuals who can occupy senior and service management roles
•Ageing internal and external demographics – workforce demand and supply disparities
•Regional impacts of the change of funding for medical and non-medical training posts

3. Current Situation – Workforce: ageing profiles

Age profiling of our Nurses shows expected retirement peak in 5 – 10 years



Age profiling of our Doctors shows a shortage of younger doctors coming through the system



3. Current Situation – Partnership Working

- The previous sections demonstrate that the Board considers that for the majority of our services, partnership working will be the practice by which the Trust delivers its portfolio of services and maintains provision of those services locally across both South Cheshire and Vale Royal
- The introduction of commissioning consortia provides the opportunity for MCHFT to develop strong, mutually beneficial partnerships that will transform the delivery of services provided . These developments will be clinically led and offer opportunities for new ways of working across organisations.
- MCHFT has a well established portfolio of partners and already provide a range of services with others or for others in partnership. In future, we may need to consider working with fewer partners to ensure the most accessible and cost effective services for our patients.
- For those services where vertical integration is appropriate closer ties will need to be developed with Primary care, Community and Social Care and third sector providers. We need to develop close relationships with local partners to influence the direction of travel, developing a flexible approach to either deliver services ourselves in community settings or to support the commissioning of services by others.
- The Board has also indicated its intent to review opportunities to develop closer links with ECT and Stockport FT as part of a Health Care Group which may lead to an eventual merger of some services through horizontal integration. However, this will not be sufficient to sustain all services, and other strategic partnerships are needed.
- University Hospitals of North Staffordshire (UHNS) remains the Boards preferred partner as it provides a range of services that complement the portfolio of a DGH, is developing a proven track record of working well with MCHFT and is geographically the most accessible for the majority of our population. Divisions are expected to consider UHNS in any partnership working.
- The aims of any such mergers or partnerships will be to maintain as much of the services locally as possible whilst ensuring they meet quality standards and are cost effective delivering economies of scale and synergistic attributes

The following tables detail current and potential partnership arrangements

3. Current Situation – Partnership Working

The main drivers for developing partnerships are:

Clinical:

- Sub specialisation
- MMC/EWTD
- National guidance e.g. IOG, National policies e.g. PBC etc
- Recruitment issues e.g. Clinical Haematology
- Clinical need e.g. Neurology

Financial:

- The inability to sustain cost effective services in particular for 24/7 services**.**

Potential Shared Services	Partner (s)
Pathology	UHNS & Mid Staffs
Radiology	ECT
Breast	ECT & Stockport
ENT	TBC
Vascular	TBC
Sexual Health	ECT

The table below identifies existing partnership working...

Existing Shared Service	Partner
UGI	UHNS
Ophthalmology	ECT
Urology	Stockport
ENT	ECT
Cancer services	Multiple
Paediatrics	Alderhey
Diabetes	ECT
Dermatology	Ashfields
Clinical Haematology	UHNS
Pathology	ECT
Cardiology	UHSM/UHNS
Neurology	UHNS

4. Changes Required to Deliver the Strategy

As a Trust we must:

- **Quality** - through the Ten out of 10 programme, ensure all staff understand their contribution to the quality agenda.
- **Partnerships** - we must develop sustainable partnerships to ensure that we can continue to provide a broad range of services locally.
  - We will need to develop new ways of working with commissioning consortia to develop integrated health care service across providers that deliver the necessary savings required as well as ensuring delivery of safe clinical services.
  - Ensure as much of our services are provided locally, closer to the communities they service and to recognising that to ensure we meet standards of quality and cost effectiveness some services will be provided by other providers and may not be on the MCHFT sites.
  - Engage in developing partnerships with local councils, consortia and public stakeholders to influence together the future model of how services will be delivered , ensuring all opportunities are utilised to expand services locally including those delivered at Victoria Infirmary
- **Finance** - recognise and accept that we must deliver both good quality services and financial balance.
  - In real terms over the next three years we will need to reduce our costs by approximately 6% (£8million) each year.
  - This will be achieved by (i) improved efficiency (ii) significant clinical service redesign (iii) whole health and social economy working.
- **Efficiency** - we must deliver services that perform in the upper quartile of efficiency including as measures by Better Care Better Value:
  - Length of stay
  - Readmission rate
  - Hospital acquired Infection rates (no avoidable MRSA or C. difficile infections)
  - Day case rates
  - Year on Year reduction in non elective admissions
  - Year on Year reduction against current bed base.

5. Strategic Plans – Overview & Direction of Travel

Overview

- The foundations of the Trusts ability to achieve its strategic goals are based upon Quality, Efficiency and Financial performance.
- Having the right workforce and infrastructure is critical to delivery of these objectives.
- The Divisions have carried out reviews for each of their specialties against these foundations and highlighted key priorities and areas for further work / development
- The Board and senior Divisional staff have considered the specialities and how partnership working, investment or disinvestment would ensure acceptable levels of performance whilst maintaining as much of the services locally as possible.
- The summary results of these reviews are described in this section with more detailed operational plans included in Appendix 1

Direction of Travel - remains consistent...

- Downsize the mother ship
- Services delivered at VIN remain a key factor of this CSS
- Focus on care closer to home
- Partnership development
- Radical change is only chance of some form of independent survival

And, now recognises...

Two distinct but interlinked strategies

- **Non Elective Care**
- **Elective Care**

Non elective care will remain a core function of the Trust
(MCHFT will remain default provider of choice)

- Requires an integrated whole system approach for Non Elective Care
  - Lowest total system cost
  - Driven by quality & safety

- Vertical integration across system

- Pathway Redesign
  - Admission avoidance & facilitated discharge
  - Specialty Management & Discharge
    (including reduced length of stay)

- Must become financially sustainable

Dec-11

Internal Developments:
- **Divisional Leadership**
- **7 day, 24 hr care (incl. critical care outreach)**
- **Acute Care (Short stay, EAU re-provision)**
- **NEL surgical care**

Dec-12

Integrated work with commissioning consortia / health authority:
- **Admission avoidance projects – alcohol, nursing home management, ED health & social care assessments,**
- **Effective & timely discharge – IDT, home IV service**
- **Pathway redesign**

Dec-13

Vertical integration across whole system (GP, community, acute, social, voluntary, ...):
- **Health & Social Care Group**
- **Whole system leadership**
- **Whole system 7 day, 24 hr care**

Will be a competitive market - “any willing provider”
(battleground for multiple providers)

Driven by:

- Quality & safety (primary strategic objective)
- Value for money (price) – locally negotiable
- Service capability
- Ease of use & access (for GPs & Patients)
- Cost effectiveness (scale)
- Is valued by patents & wider community

Therefore, we need

An appropriate portfolio of Elective services which support our Non Elective Care responsibilities

To deliver this we must be:

- Proactive and market our services
- Develop strong relationships with commissioning consortia

Dec-11

Internal Developments:
- **Develop robust systems for capacity and demand planning & monitoring**
- **Review and agree services discretional to the organisation**
- **Agree programme for continuous improvement at specialty level including theatres, ophthalmology, critical outreach and reducing LOS**

Dec-12

Integrated work with commissioning consortia / health authority and other acute providers
- **Service Redesign to meet patient and commissioner needs to include: ophthalmology, orthopaedics, gynaecology and delivery of community services including dermatology, rheumatology and sexual health**
- **Service review to identify services where the Trust should consider disinvestment and work with commissioners to identify a partnership arrangement or alternative provider .**

Dec-13

Vertical & Horizontal integration
- **Develop care pathways across whole system (GP, community, acute, social, voluntary.**
- **Develop Healthcare Groups to improve quality of services, achieve sustainability and efficiencies through economies of scale. To include: pathology, ENT, urology, breast and vascular services**

5. Strategic Plans

- The following plans are summary templates of the key priority areas agreed through the strategy development .

- Detailed divisional templates for each priority with key milestones, project scopes and accountable officers are detailed in Appendix 1 (PAGES 40 TO 65).

5. Strategic Plan Emergency Care – Overview of Key Priorities

Mid Cheshire Hospitals NHS
NHS Foundation Trust

2010/11

Emergency Admissions

- No short stay ward, acute physician vacancies , EAU not fit for purpose – same sex accommodation, Social support infrastructure limited – no alternative but to admit

Length of Stay

- Currently higher than peer, limited care pathways in place, management plans not always robust, existing bed base is unaffordable

Care of Elderly

- Constraints in delivery of stroke and TIA service
- Falls and bone agenda not being delivered
- Aging population with increased incidence of dementia, negative trading account

Short stay ward to be developed, capital investment for EAU identified, rapid access clinics to be developed and care pathways agreed

Management plans to be audited and improved through reduced reliance on junior doctors, care pathways to be developed where not currently available and diagnostic SLA's to be agreed

Development of collaborative pathways, reduced reliance on junior doctors, higher level of Consultant delivered care

2013/14

- Right patient, right setting, first time, EAU fit for purpose – financial penalties not incurred, Short stay ward in place, Full compliment of acute physicians in post, Agreed pathways implemented for acute conditions resulting in reduction in LOS and inappropriate admissions
- LOS on or below peer, reduced bed base, cross organisational working to reduce admissions, consultant delivered service
- Consultant delivered service with special interest in mental health, national and local NSF standards delivered, SLA with partners agreed and in place eg stroke

5. Strategic Plan Surgery and Cancer: Overview of Key Priorities

Mid Cheshire Hospitals NHS
NHS Foundation Trust

2010/11

- **Ophthalmology**
  No agreed commissioned pathways, capacity severely compromised to meet demand, Increasing referrals and patient dissatisfaction with service provision, poor staff morale and working in unacceptable environment
- **Anaesthesia**
  Insufficient workforce to meet service needs particularly in out of hours, out reach critical care and obstetrics services,
- **General Surgery**
  No agreed plan for vascular surgery, uncertain out of hours provision for general surgery, opportunity for laparoscopic surgery expansion

Review with commissioners care pathways for primary and secondary care provision. Agree robust capacity and demand plan and assess financial model. Implement new integrated service across organisations.

Review current service provision and workforce model. Agree required service specification and determine gap analysis, Develop business case and timescales to implement required service

Finalise partnership with tertiary vascular centre to deliver network approved vascular services.
Develop workforce model to deliver Consultant led services in subspecialty areas and agree out of hours arrangement for general surgery

- Community delivered services with multidisciplinary teams providing shared care with opportunity to attract additional market share.
- Consultant led service aligned to service needs of the Trust including fit for purpose Critical care unit and fully staffed, 24/7 outreach service .
- Shared On call service for out of hours, centre of excellence for laparoscopic surgery providing nationally recognised training, partnership with tertiary vascular centre in place

5. Strategic Plan Women, Children and Sexual Health Services
Overview of Key Priorities

Mid Cheshire Hospitals NHS
NHS Foundation Trust

2010/11

- **Maternity Services**
  Poor estate, lack of Midwifery led unit, insufficient midwives and anaesthetists recommended for safer childbirth levels, level 1 CNST achieved, stable Middle Grade Rota and 60 hr consultant presence in place.
- **Gynaecology**
  Services fragmented with loss of specialisation and disconnect in some care pathways. Limited use of specialised nurses and opportunities to increase day case surgery.
- **Paediatrics**
  No primary / secondary care shared pathways, neonatal unit is not fit for purpose., insufficient cover for middle grade rota
- **Sexual Health**
  High quality, rapid access services with on site diagnostics, requires commissioning involvement to develop long term strategy

Fit for purpose estates strategy across Division. Business case of MW and anaesthetic staff to be produced in conjunction with Division of S & C. continue to prepare for CNST assessments

Develop with primary care & commissioners agreed local service provision and linked care pathways. Review roles of specialist nurses, undertake finance review in relation to IVF and agree pathways for day case rates

Agree pathways with primary care, review funding structure, develop business case for neo natal charitable funds bid and develop a paediatric acuity model

Review opportunities to develop integrated services with community and across wider footprint, review path links

2013/14

- Provider of Choice for Central and East Cheshire Maternity services on the MCHFT site.
- Reconfiguration and regeneration of estate
- Midwifery led care to be established by 2011 & MLU by 2012.
- Appropriate staffing levels by 2012
- CNST level 3 by 2012.
- Long Term Stability of Middle Grade Rota
- Hub and spoke sexual health services integrated with family planning and screening
- Re developed neonatal unit and integrated paediatric pathways with primary care

5. Strategic Plan – Diagnostics & Clinical Support Services
Overview of Key Priorities

Mid Cheshire Hospitals NHS
NHS Foundation Trust

2010/11

- **Medical Records**
  Purpose built facility, paper health records, issues with quality and safety, appropriately skilled staff, high costs associated with storage and transportation off site
- **Pathology Services**
  Collaborative service with ECT, fully accredited, sustainable partnership with UHNS for clinical haematology, high quality
- **Medical Imaging**
  State of art equipment, cost pressure due to direct access demand, increased use of more complex diagnostics

***Develop business case for electronic records to include access across health economy* for hard (technology) and soft change programme**

Expand network as hub and spoke arrangement, to increase efficiency and reduce cost. Continue to assess service to improve quality including use of remote requesting / reporting across labs and to clinicians

Define core provision, review collaboration opportunities, develop recruitment strategies, develop remote requesting

2013/14

- Paperless electronic documents
- Improved information quality / safety
- Reduced costs of service
- GP access to patient health records
- Pathology network in place by 2012
- Agreed imaging pathways and fully integrated requesting / reporting systems, optimal skill mix and rapid access to support Divisional plans eg LOS, admission avoidance

5. Strategic Plan - Finance – Overview of key Priorities

Mid Cheshire Hospitals NHS
NHS Foundation Trust

2010/11

Trust level surplus of >1% of turnover.

Significant variation at specialty level with specialties having a range of I&E returns from -13% to +21%.

Limited understanding of the drivers of the relative financial position at specialty level with even less understanding at patient, HRG, point of delivery level.

CIP programme identified to deliver 6% efficiency in 2011-12.

Introduce Patient Level Costing and Service Line Reporting performance monitoring/management tool

Identify areas of cost variation at service line, HRG and patient level

Identify cost drivers / inefficient processes that are producing the substandard financial performance

Redesign services to eliminate waste and improve efficiency of delivery

2014/15

Improved or maintained level of Trust surplus.

Majority of specialties produce a 2% return on turnover as a result of improved efficiency.

Trust has a clear understanding of the underlying reason for deficit in any remaining specialty as robust appraisal of efficiency has proven there to be a problem with tariff or the service to be un-economic in terms of scale.

CIP programme identified to deliver required efficiency based on redesign of services and care pathways across organisational boundaries.

6. Strategy Approvals & Next Steps

•Board agree priority areas – December 2010

•Feedback to Divisions – mid January 2011

•Clinical Service Strategy – approved at Board February 2011

•Clinical Service Strategy – Commissioning Consortia approval March 2011

•Divisional strategies & priorities to Divisional Boards March 2011

•Agree Implementation plans – Executives(March 2011)

•Agree Monitoring procedure – Executives(March 2011)

•Launch with Clinical Teams March 11th 2011

•Agree and notify further dates

•Quarterly Progress Reports to Trust Board (July 2011, October 2011, January2012 and April 2012)

Appendix 1. Strategic Plan Emergency Care – Overview of five year plan
Emergency Admissions

Mid Cheshire Hospitals NHS Foundation Trust

2010/11

- **Emergency Admissions**

- Lack of short stay ward
- Single handed acute physician
- Lack of infrastructure to support urgent access to outpatient/diagnostic services
- EAU not fit for purpose – same sex accommodation will encounter financial penalties
- Social support infrastructure limited – no alternative but to admit

Short stay ward to be developed

Capital requirements of EAU to be determined

Urgent access to OPD/Diagnostic services to be developed – admission avoidance strategy to be developed

Care pathways to be agreed across organisational boundaries

2013/14

- Right patient, right setting, first time
- EAU fit for purpose – financial penalties not incurred
- Short stay ward in place
- Full compliment of acute physicians in post
- Agreed pathways for acute conditions agreed
- Reduction in LOS
- Reduction in inappropriate admissions
- Admission avoidance strategies agreed

Appendix 1. Strategic Plan Emergency Care – Key Milestones - 2010/11

Mid Cheshire Hospitals NHS Foundation Trust

Top priorities – Emergency Admissions	*Milestones include…*
1 **Background information needed for admission avoidance schemes in Primary Care (what is available and gaps)**	• Data from NWAS regarding type and demographics • Discussion with GP's (Neil Paul) (Sue Ikin) CECH rep • Review current data – Gap analysis to be undertaken • Report to be available March 2011 • Clinical Pathways to be agreed for specific patient groups John David, Verity Lockett by March 2011
2 **Estates Strategy regarding location of EAU/SSW**	• Financial and capital costing • Alternatives for EAU location • Collaborative working with QMP Steering group, Estates rep, Matron, Senior Manager and Dr Winson/Dr Hammersley QMP Steering Group by January 2011
3 **Workforce Model to support EAU/SSW**	• Emergency Department and Medicine working groups to work collaboratively • Collaborative working with Primary Care, Urgent Care Centre and Out of Hours • Develop models to ensure timely assessment and support to current clinicians Kevin Yoong, Dave Mathews by March 2011

Appendix 1. Strategic Plan Emergency Care – Overview of five year plan
Reduced Length of Stay

Mid Cheshire Hospitals NHS Foundation Trust

2010/11

- **Reduction in Length of Stay**

- Length of stay currently above peer average
- Care pathways for specific patient groups not agreed
- Inexperienced doctors overseeing management of patients out of hours.
- Lack of SLA for diagnostic services
- Management plans not always evident
- Existing organisational bed based aligned to LOS

Management plans in place for all patients

Reduce reliance on junior doctors

Agree pathways across organisational boundaries

SLA for diagnostics to support the development of care pathways

2013/14

- Length of stay at or below peer average .
- Reduction in organisational bed base
- Cross organisational care pathways agreed for specific patients groups – LTC which support delivery of health care in the community
- Consultant delivered service in place
- Delivery of an effective and efficient inpatient service for non elective patients

Appendix 1. Strategic Plan Emergency Care – Key Milestones - 2010/11

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Top priorities – Reduced Length of Stay	*Milestones include…*
1 **Agree clinical pathways which need developing and implementing**	• Top 5 HRG's to be determined – high volume • Care Pathways developed for top 5 HRG's • Information Services and consultants engagement • Tim Dean/Shirley Hammersley March 2011
2 **Expedite discharges in collaboration with provider arm**	• List of solutions – to be determined • Financial implications – redirection of resources • Develop communication pathways/forums with GP's and community based groups i.e. matrons, social services, rehabilitation ,alcohol services etc (IDAT team and Sarah Vaneeathan) Sarah Vaneeathan/IDAT Team by February 2011
3 **Ensure robust Management Plans are implemented in all clinical specialties in ECD and proactively managed by support staff i.e. junior drs/nurses**	• Audit of existing plans – monthly, outcomes to PAD and action for non compliance • Identify areas of non compliance and production of GAP analysis by the end of March (Ali Barnes) • Audit to be undertaken to determine delays in execution of management plans Alison Barnes/Sarah Vaneeathan by March 2011

Appendix 1. Strategic Plan Emergency Care – Overview of five year plan Care of Elderly

Mid Cheshire Hospitals NHS Foundation Trust

2010/11

- **Care of the Elderly**
- Lack of consultant's with a specialist interest in mental health and lack of SLA with MHT
- Constraints in the delivery of stroke/TIA services.
- Falls and Bone Health agenda not met due to lack of resource .
- Aging Population/high rates of dementia/falls/stroke presents increasing demand on non elective services
- Negative trading account position (non elective)

Infrastructure required to deliver national and local standards I.e NSF

Investment to support increased Consultant body with specialist interest Dementia/Mental Health

Development of collaborative pathways .

Reduced reliance on junior doctors

2013/14

- Consultant Delivered Service, reduced reliance on junior medical staff
- Increased consultant body with specialist interest in Dementia
- National and local standards achieved i.e NSF standards for Older People , Falls, Stroke and Mental Health agenda – agreed pathways in place
- SLA with MHT agreed with agreed pathways
- Partnerships in place to support national agenda I.e stroke
- High Quality health care delivered to an ageing population within resources

Appendix 1. Strategic Plan Emergency Care – Key Milestones - 2010/11

Mid Cheshire Hospitals NHS Foundation Trust

Top priorities – Care of Elderly	*Milestones include…*
1 **Development of a falls service linked to admissions avoidance**	• Identify what we have currently and what we need for the future • Demand for service for specific patients • Options paper to be developed (Debbie Slack, Bernadette Bailey, Dr Garcia-Alen). Debbie Slack/Dot Crone/Dr Garcia-Alen by March 2011
2 **Identify and define reasons for inappropriate admissions**	• To obtain information why elderly patients are admitted with a short length of stay (from nursing homes and community) (Lindsay Boyd and Dave Mathews) • Linked to admission avoidance action John David/Loraine Cornes by March 2011
3 **Nurse Led Dementia Service**	

Appendix 1. Strategic Plan Emergency Care – Overview of five year plan
Other Development Plans

Mid Cheshire Hospitals NHS Foundation Trust

2010/11

- **Diabetes, Rheumatology** OPD services
- Services delivered in secondary care setting
- **Cardiology** – pacing
- Single handed consultant delivering pacing service
- Increased number of pacing follow ups impacting on cardio vascular services
- **ECD**
- Trauma Network being revised
- **Respiratory medicine**
- Retirement of lead consultant/succession planning
- **Gastroenterology**
- Lack of GI bleed rota

Move towards community based services with an agreed model for specific patient groups in Diabetes and Rheumatology – collaborative working with commissioners

Need to determine long term commitment to pacing service and impact on support services
Long-term delivery of pacing service agreed - ?
Enhancement of partnership v substantive appointment

Impact of Trauma network to be determined and impact on operational delivery

Succession planning to be in place for respiratory medicine department

Impact of GI rota to be determined

2013/14

- [Summarise where we need to be by end 2013/14]
- Diabetes and Rheumatology OPD services delivered in community setting
- Organisation still benefits from contribution to overheads

Appendix 1. Strategic Plan Surgery and Cancer– Overview of five year plan Ophthalmology

2010/11

- Care of all ophthalmological conditions delivered in hospital by doctors
- Increasing demand (referrals up 6%)
  - Elderly population
  - New services
  - Screening pathways
- Insufficient capacity
  - AMD service
  - Long term follow ups
- Local On call service
- Inadequate physical environment

Develop workforce model to provide multidisciplinary care in community and hospital setting

In conjunction with GP consortia design seamless patient care pathways across primary and secondary care realising financial benefits to the whole health economy

Align subspecialty services to demand with appropriate clinic profiles and job plans

Redesign On call services

2013/14

- Care of long term conditions delivered by multidisciplinary teams in a community setting working in shared care arrangements with opportunity to attract additional market share.
- One stop service for planned care e.g. cataracts, oculoplastics
- Marketable Medical ophthalmology Unit delivering AMD and Medical Retina services
- Shared On call service with North Staffs with shared out of hours care

Appendix 1. Strategic Plan Surgery and Cancer– Overview of five year plan
General Surgery

Mid Cheshire Hospitals NHS Foundation Trust

2010/11

- Regionally recognised colorectal service providing high quality care in substandard environment.
- Low day case laparoscopic Cholecystectomy rates and poor access to surgery for non elective cholecystectomy.
- Elective and limited non elective vascular surgery provided on site with incomplete out of hours cover.
- Unsustainable 1 in 6 rota
- Improving but inefficient use of emergency theatres with above peer LOS for Non elective admissions

Develop workforce model to deliver:
-Consultant led services in subspecialty areas
-Sustainable alternative to junior doctors

Plan infrastructure requirements to support high quality , fit for purpose (clinical and training) marketable laparoscopic service

Finalise partnership with tertiary vascular centre to deliver network approved vascular services.

Develop seamless patient pathways across primary and secondary care realising the financial benefits to the health economy

2013/14

- Centre of excellence for laparascopic surgery- providing marketable, rapid access, high quality care in specialised setting and providing nationally recognised training.
- Partnership with tertiary vascular centre providing outreach vascular presence 5/7 with outpatient, day case and low risk surgery delivered on site and out of hours services delivered at the tertiary centre.
- An increased number of General Surgeons to support streamlined emergency service with timely access to diagnostics, semi-scheduled emergency surgery for NCEPOD 2/3 cases, reduced length of stay and a sustainable workforce at junior level

Appendix 1. Strategic Plan Surgery and Cancer– Overview of five year plan Anaesthesia

Mid Cheshire Hospitals NHS Foundation Trust

2010/11

- Workforce constraints
  - Small but flexible consultant workforce
  - Ageing middle grade workforce
- Service constraints
  - Insufficient consultant emergency cover
  - Insufficient cover for current obstetric model
- Critical care constraints
  - High quality outreach service but not staffed 24/7
  - Critical care cover not meeting network guidelines
- Uncertainty of Chronic pain service

Understand anaesthetic support necessary to enable Trust to deliver planned and unplanned care

Develop workforce model to deliver planned consultant led service for elective, non elective, critical and obstetric care.

Plan infrastructure requirements for critical care unit and develop model to deliver 24/7 fully staffed outreach service

Develop seamless patient pathways in conjunction with primary care to deliver redesigned chronic pain service

2013/14

- Consultant led service aligned to service needs of the Trust
  - Elective care- (Short LOS, high quality, innovative)
  - Non elective care- (Rapid access, reduced LOS, financially effective)
  - Obstetric model- (compliant with national guidance)
- Fit for purpose Critical care unit providing Network compliant critical care cover with fully staffed, 24/7 outreach service
- Seamless, NICE compliant Chronic pain service delivered in conjunction with primary care

Appendix 1. Strategic Plan Surgery and Cancer– Overview of five year plan
Other Development Plans

2010/11

- Breast
  - IOG compliant service delivered by 2 consultants in isolation.
- ENT
  - Shared service with ECT, with most services provided on both sites.
- Urology
  - Insufficient capacity, inefficient on call, new partnership with Stockport
- Orthopaedics
  - High volume elective workload. Ability to deliver trauma challenged by needs for subspecialty service
- Bowel screening
  - Regional bowel screening service with full complement of screening colonoscopists.

Understand implications and benefits of Health care groups and design services across boundaries to deliver high quality efficient financially effective care

Design seamless Orthopaedic pathways across primary and secondary care understanding financial implications of where care is delivered

Market surgical opportunities of the Bowel screening service

2013/14

- Provision of ENT, Breast and Urology services as partner in Health care group with services delivered at different locations in a different way and with more efficient On call services
- Marketable, financially efficient Orthopaedic service delivering rapid access, reduced LOS sub specialised elective care, and working in partnership with major trauma centre to deliver local and tertiary non elective care.
- JAG compliant Bowel Screening service meeting demands of age extension and realising the marketing opportunity of surgical demand.

Appendix 1. Strategic Plan Surgery and Cancer– Key Milestones - 2010/11

Mid Cheshire Hospitals NHS Foundation Trust

Top priorities	*Milestones include…*
1 **Anaesthetic Service Specification to support MCHFT**	• Define workforce model to provide Consultant-led service • Collaboration with other Divisions to understand demand • Develop Critical Care Strategy
2 **Redesign Ophthalmology Pathways**	• Common specification agreed with consortia • Develop multi-disciplinary shared care pathways • Understand workforce model to deliver
3 **Enhance Colorectal Service**	• Develop Business Case for 3rd Colorectal Surgeon • Develop Marketing Strategy • Develop Business Case to support integrated theatre
4 **Doing things differently** **Partnerships** **Breaking down primary/secondary divide**	**Generic Actions:** • Workforce models • On-call • Understanding our service specifications

Appendix 1. Strategic Plan – Overview of five year plan
Maternity Services

Mid Cheshire Hospitals NHS
NHS Foundation Trust

2010/11

- Poor estate
- Lack of Midwifery led unit
- Units is short of recommended safer childbirth levels.
- 6/10 dedicated cons anaesthetist sessions.
- Lack of Out of hour dedicated anaesthetic cover.
- level 1 CNST achieved.
- Stable Middle Grade Rota
- 60 hours consultant presence established now.

Fit for purpose estates strategy : MLU & Day assessment , triage & hotel facilities of an acceptable standard.

Business case of MW and anaesthetic staff to be produced in conjunction with Division of Surgery & Cancer.

Ensure the governance structure supports the progress required to achieve CNST level 3. Fit for purpose casenotes

Succession plan NCCG staff replacements with consultants. All new consultant contracts to include Middle Grade rota participation

Vertical integration with primary care commissioners regarding local service provision

2013/14

- Provider of Choice for Central and East Cheshire Maternity services on the MCHFT site.
- Reconfiguration and regeneration of estate
- Midwifery led care to be established by 2011 & MLU by 2012.
- Appropriate Midwifery staffing levels by 2012
- Appropriate levels of Anaesthetic cover by 2012
- CNST level 3 by 2012.
- Long Term Stability of Middle Grade Rota

Appendix 1. Strategic Plan Maternity – Key Milestones - 2010/11

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Top priorities – Maternity Services	*Milestones include…*
1	
Increase consultant anaesthetist and middle grade cover for labour ward	LC/ML & SE to liase with AD/AM &SW from Surgery and cancer to establish business case &timescale for implementation
2	
Establishment of Maternity Led care	• PC to establish working party for MWLC • Maternity Pathways PC to nominate & SMP • LC/SE/ML/SD to look at Estate and map to patient pathway • PC/SE business case 11 WTE midwives
3	
Level 2 and Level 3 CNST	• Notes working group led by KY to ratify new notes by April 2011 • LD Level 2 end 2011 • LD level 3 end 2012.

Appendix 1. Strategic Plan – Overview of five year plan
Gynaecology Services

Mid Cheshire Hospitals NHS
NHS Foundation Trust

2010/11

- Fragmented Gynaecology services. Loss of specialisation
- A disconnect in gynaecology care pathways.
- Some provision of ambulatory and day case gynaecology
- Provision of NHS and privately funded IVF
- Limited use of nurse specialists

Estate Strategy and business case for Gynaecology Unit

Establishment of care pathway groups with local commissioning consortia for both primary and secondary care

Introduction of effective out patient interventions and laparoscopic techniques to increase day case surgery rates.

A full understanding of the finances of both NHS and privately funded IVF and an understanding of commissioning priorities.

Introduction of nurse led clinics across the specialty.

2013/14

- Fit for purpose Gynaecology Unit providing out patient, day case and in patient care to national standards
- Gynaecology pathways informed by national Guidelines giving seamless integration of primary and secondary care.
- Reduced length of stay, increased day case rate.
- A decision about the provision of IVF by MCHFT.
- A more efficient patient centred service
- Increasing termination service

Appendix 1. Strategic Plan Gynaecology– Key Milestones - 2010/11

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Top priorities – Gynaecology Services	*Milestones include…*
1 **Agree pathway development project group, TOR and priority pathways**	• Continue with workgroup for pathways, JP, LC, MH.
2 **Gynaecology unit concept paper**	• Financial viability – needs to be looked at by workgroup SE LC .
3 **Reduce LOS and Increased daycase**	• LC/ML to look at out patient techniques and laparoscopic techniques.

Appendix 1. Strategic Plan – Overview of five year plan
Paediatric Services

Mid Cheshire Hospitals NHS
NHS Foundation Trust

2010/11

- No clarity of pathways between primary care and acute paediatrics.
- Tariff structure does not fit the model.
- Middle Grade cover
- Nursing workforce issues
- Neonatal Unit not fit for purpose.
- Paediatric Surgery is under review

Working with commissioning consortia and GP's to agree pathways

Review of funding structure

Assess options for neonatal unit, agree decision and implement

Develop acuity model for nursing workforce & agree medical model

Develop agreed model with partners for delivery of paediatric surgery which maintains a locally delivered service wherever possible

2013/14

- Gatekeeping admissions in primary care
- Vertical integration of pathways particularly with regard to chronic disease.
- Agree funding structures with with commissioners
- Consultant recruitment to support of the middle grade rota.
- Level 2 neonatal unit. 28 weeks and above within a managed network.
- Agreed model for paediatric surgery agreed and implemented

Appendix 1. Strategic Plan Paediatrics– Key Milestones - 2010/11

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Top priorities Paediatric Services	*Milestones include…*
1 Progress to the Board the NNU business case.	Completed
2 Review Medical / nursing workforce model	Nursing workforce Consultant expansion Middle Grade rota SD/ML/LR/PC/SE.
3 Vertical integration with primary care.	Pet paediatrician SD/PCT/CC

Appendix 1. Strategic Plan – Overview of five year plan
Sexual Health Services

Mid Cheshire Hospitals NHS
NHS Foundation Trust

2010/11

- Innovative “one stop” sexual health service
- The only purpose built facility with immediate diagnostics in this area
- Good team structure with PGD’s to support non medical prescribers
- Poor understanding of the importance of this specialised service by medical profession and commissioners

Consideration of integration with community reproductive health services

Smart systems –pathology requests and linked lab results to electronic record data base

Additional Consultant support to allow specialist registrar training, and additional training doctor facility. Possible links with ‘Community Gynaecology’.

Maintain quality of existing service – consider expansion of new services / increasing geographical footprint.

2013/14

- Hub (MCHFT) and Spoke (Community) provider
- Review integration across whole of Central and Eastern Cheshire – include family planning, screening programme
- Education resource – assist communities in health awareness
- Centralised advice and appointment system for locality.

Appendix 1. Strategic Plan Sexual Health– Key Milestones - 2010/11

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Top priorities – Sexual Health	*Milestones include…*
1 **Effective sexual health board across Mid and East**	Exec to Exec contact with East Cheshire. PCT/Commissioners/Public Health Lead for Sexual health across the health economy. Flagship focused service.
2 **Integration with Gynaecology**	• Explore Community Gynaecology RE & MH • Termination care service expansion LC/JP
3 **Consultant expansion**	• Assess in line with service development of actions 1 & 2. • RE/ML/SE

Appendix 1. Strategic Plan – Diagnostics & Clinical Support Services
Overview of five year plan Medical Records

Mid Cheshire Hospitals NHS Foundation Trust

2010/11

- Purpose built facility
- Paper health records
- Appropriately skilled staff
- Issues with quality & safety
- High costs associated with management, storage and transportation of health records

Develop business case to include access across health economy

Business case to reflect two strands of requirements for hard (technology) and soft change programme to support cultural changes

Expansion to primary care to gain GP tie in

Business opportunities to digitise records for other Trusts

2013/14

- Paperless electronic documents
- Improved information quality / safety
- Reduced costs of service
- GP access to patient health records

Appendix 1. Strategic Plan Gynaecology– Key Milestones - 2010/11

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Top priorities – Medical Records	*Milestones include…*
1 **Business case to be agreed and signed off by Trust Board**	• Project group established with key stake holders and clinical engagement
2 **Learning from similar organisations**	• Visits to St Helens by key staff (clinical and managerial) to understand benefits realised for similar organisations.

Appendix 1. Strategic Plan – Overview of five year plan
Pathology Services

Mid Cheshire Hospitals NHS
NHS Foundation Trust

2010/11

- Successful collaborative arrangements with East Cheshire
- Relative knowledge/ experience of partnership working
- Fully accredited services
- Partnership with UHNS to deliver Clinical Haematology
- Stable workforce

Hub and spoke model to be agreed and implemented

Definition of service agreements – agreed contracts with partner organisations reflecting learning from previous experience

Marketing capability to maintain existing position and exploit opportunities to expand further afield

2013/14

- Expand network:-
  - In line with Carter report
  - Hub and spoke arrangement embedded with partner organisations
- Market services at fringe to maintain market share and exploit opportunities
- Provide competitive service to be provider of choice:-
  - Local service at point of care
  - Rapid turn around times to meet clinical need
  - Competitive prices

Appendix 1. Strategic Plan Pathology– Key Milestones - 2010/11

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Top priorities Pathology Review	*Milestones include…*
1 **Review PWC report**	• Understand content and implications of report • Agree and identify the way forward • Plan for Trust Board signed off
2 **Challenge ownership / leadership**	• Understand organisational form as model for other shared services

Appendix 1. Strategic Plan – Overview of five year plan
Imaging Services

Mid Cheshire Hospitals NHS
NHS Foundation Trust

2010/11

- Forward thinking clinical leadership
- State of the art equipment
- Increased demand in key modalities
- Costs pressures – direct access non-pay
- Recruitment issues in service critical staff

Define core provision

Identify need for expansion (collaboration with other providers)

Marketing capability (availability / service)

Exploit competitive advantage (where / when / to who)

Develop strategies for recruitment/ retention of service critical staff and role extension of radiographers

2013/14

- Early intervention in patient pathway and rapid access to Diagnostics.
- 7 day service irrespective of patient source (1° / 2°)
- To be provider of choice based on :-
  - Quality of care
  - Capability / cutting edge forefront of technology
- Exploit capability – market across region
- Optimal skill mix for service provision

Appendix 1. Strategic Plan Medical Imaging– Key Milestones - 2010/11

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Top priorities – Imaging Services	*Milestones include…*
1 Marketing plan and marketing	• GP visits to be undertaken by Consultant Radiologists • Forge links with GP consortium • Develop marketing plan for current service portfolio
2 Core service definition	• Identify definition of core services • Identify future opportunities • Review capacity / demand
3 Identify need for expansion	• Make links with other providers in Healthcare Group (East Cheshire & Stockport) • Review possibilities of forging partnerships with providers outside Healthcare Group • Identify preferred partnership organisations