Calderdale and Huddersfield NHS
NHS Foundation Trust

Delivering the forward view – Operational plan 2016/17

1. Overview

This operational plan outlines CHFTs approach to activity, quality, workforce and financial planning for 2016/17. The plan builds on the five year strategic plan approved by the Trust Board at its meeting on 29th December and submitted to Monitor.

The Trust has faced significant financial, operational and clinical challenges over the last two years. In 2014/15 a Continuity of Service Risk Rating of 2 and an unplanned deficit of at Quarter 2, resulted in a breach of the Trust's license in January 2015. In 2015/16, whilst the deficit position extended to £21m, this was delivered successfully in line with the original plan, adjusted for one-off consultancy support costs. The plan for 2016/17 has been developed based on reasonable and realistic assumptions for activity and capacity, supported by work with the CCGs on income assumptions and clarity on risks and contingency planning.

The main challenges currently facing the Trust are:

Financial challenges;

- The Trusts underlying deficit position with provision of dual site services across two sites, resulting in duplication of costs.
- Associated high levels of running costs in terms of backlog maintenance and PFI contracts.

Operational challenges;

- The challenge of recruitment and retention for an adequate workforce of substantive staff to meet demand, together with dual site working stretching capacity which impacts on operational performance

Clinical challenges;

- The provision of dual site services impacting on the quality of care provided to patients.
- Current configuration of services is not in line with NCAT's recommendation or the Clinical Consensus Model.
- Emergency departments do not meet Royal College recommendations / standards.
- The Trust suffers from a larger than average HSMR.

System wide challenges;

- The challenge of winter pressures with a high volume of urgent and emergency care activity and delay in discharge of patients which has the potential to impact on the delivery of elective activity from the current bed base within the Trust.
- System wide planning and leadership across the wider health economy in support of emergency care planning across primary, secondary and social care services.

All of the challenges above are faced in a difficult financial environment for health and social care, coupled with a growing and ageing population. These challenges present a compelling case for change and this one year plan highlights the start of that journey.

2. Approach to activity Planning

In setting the 2016-17 clinical activity and income plan the Trust has engaged fully its Clinical Divisions to ensure clinical ownership and engagement of the activity and associated delivery. This includes ensuring a joint understanding of changes in National tariff and the impact this will have on the plan together with how contract negotiations with Commissioners will be approached.

Activity Planning

- The 2016-17 activity plan is based upon the 2015-16 expected forecast outturn at Specialty and Point of Delivery level, with non-recurrent and decommissioned areas removed and full-year impacts of capacity and service changes e.g. new consultant capacity and CIPs built in. This gives a baseline or 'normalised' level of activity for 2016/17.
- Demographic growth is applied at Specialty and Point of Delivery level and only removed if there is demonstrable evidence that growth will not happen.
- Referral growth is reviewed as part of assessing this growth. Where growth is expected to be above demographic levels, this is included as an addition.
- The impact of any further known activity or service changes is quantified at clinical division level to be overlaid above the baseline position.
- Activity will be fully profiled taking into account seasonal variation, annual leave, bank holidays and other impacts including EPR.
- Divisional Directors sign off of the activity plan at, specialty, site and point of delivery level via Divisional Board which is part of the ownership and engagement process.
- At speciality level, the IST modelling tools have been used to undertake detailed capacity planning. Specialties include trauma and orthopaedics, ENT, ophthalmology and general surgery.
- Demographic growth has been applied based upon the Interserve projections jointly agreed by the Trust and commissioners in 2012. Additional growth has been applied to areas where the trend anticipates that demand will exceed this level.
- The plan recognises the effects of the Greater Huddersfield CCG and North Kirklees CCG commissioning decision for Care Closer to Home and the subsequent transfer of some community services to an alternative provider.

Capacity and workforce planning

- The capacity to deliver all activity has been identified and aligned to include the required bed numbers, out-patient clinic attendances, and theatre and diagnostics capacity.
- IST modelling has been undertaken in key specialities to fully reflect workforce plans and consultant job plans.
- Capacity is seasonally adjusted in line with the activity, taking into account seasonal variation, annual leave, bank holidays and other impacts including the implementation of EPR.

- The Trust has recently introduced a workforce planning template which will be the principle means through which bottom up workforce planning and monitoring will be achieved.

Contract negotiations with commissioners

- The activity and income plan signed off by the Divisions, inclusive of growth and priced at 2016-17 national tariffs has been the start point for negotiation with Commissioners.
- The contract negotiation process has allowed for constructive discussion regarding service demand and models of care into 2016-17.
- Whilst there is a recognised difference in the Commissioner and CHFT expectation of demand and delivery of CCG QIPP in 2016-17, there is agreement to operate under a full Payment by Results contract and a firm commitment to joint working on the delivery of QIPP and CIP.

3. Approach to quality planning

a) Approach to quality improvement

- Each year the Trust works with the commissioners to agree what should be included in the local contract including CQUIN priorities. These cover key clinical priorities and build upon our strategic aims. Additionally we work with our members to agree the priorities to be included in the Quality Account.
- The Care Quality Commission Intelligent Monitoring reports also provide a framework for determining quality priorities. A full inspection took place in March 2016. under the new regulations. Early indications suggest the Trust performed well against the framework. The full and detailed report is expected in May/June 2016.Preparations for the inspection, included a mock inspection, with a number of areas identified to focus improvement effort.
- The Trust is working with the Yorkshire and Humber Improvement Academy to deliver improvements using a structured methodology. The Trust has a number of clinical fellows working to support this.

    - **Safety Huddles,** their implementation and effectiveness, specifically on reducing the incidence of pressure ulcers and falls.

    - **Hospital at Night**, we plan to implement a Hospital at Night and weekend model of care to reduce mortality and improve standards of care.

    - **Medication Management**, specifically self-management of the diabetic patient and other patients with long term conditions.

    - **Acute Kidney Injury**, safe discharge planning and onward management planning for patients diagnosed with AKI.

    - **Sepsis**, identification of sepsis through screening and improving outcomes through the timely delivery of antibiotics.

    - **Vanguard**, contribution to the delivery of high quality care closer to home by working with providers of care both within and out of the hospital setting. The Urgent care vanguard covers the wider health economy whilst within Calderdale the focus is with a multispecialty community provider vanguard.

- **Complaints**, improving the quality of the response to complaints and increasing learning from complaints.

- **Community Experience**, developing new methods to gain insight into the experiences of patient undergoing community care in addition to the use of the Friends and Family Test.

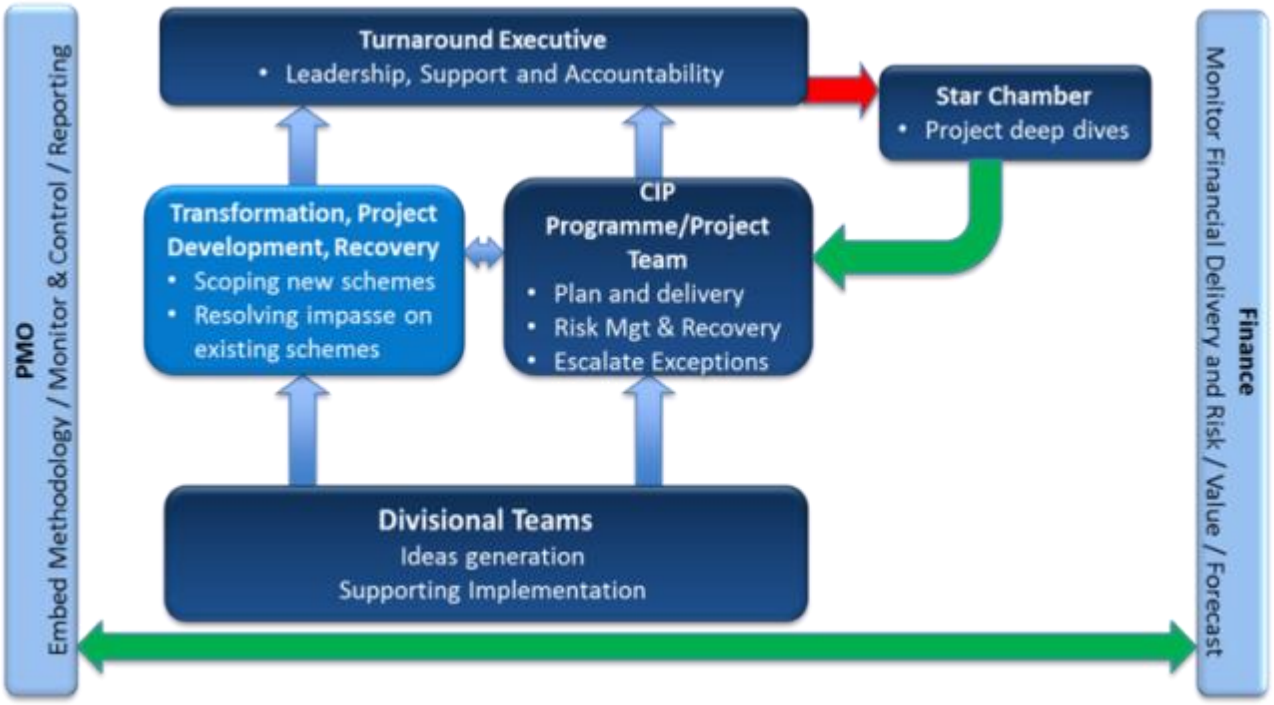
- **Ensuring Responsiveness**, we anticipate that the CQC inspection will highlight some areas for improvement, these will be included in our plans for 16/17.

b) Seven day services

- As part of the Trusts strategic direction the focus is on high quality care 24 hours a day, 7 days a week through service transformation and reconfiguration. This will result in improved access to out of hours care through better integration and service redesign.
- The plan assumes safety and quality of service provision as a priority in line with Monitor guidance. It is assumed that the development of seven day services will be cost neutral or explicitly funded by the Commissioners.
- This will be facilitated by optimising the deployment of clinical staff and services to improve safety, service quality, patients experience and improved outcomes.
- A key enabler of this will be development of joint care pathways with partners to ensure seamless care is delivered in primary, community care and third sector settings. It is anticipated that this will also reduce in-patient mortality by improving the access to senior medical staff and associated support services.

c) Quality impact assessment process

- As part of the ongoing development of the CIP governance process, the Trust has moved to a portfolio based approach. Each division within the Trust is responsible for delivery of CIPs within their division, but there is also accountability at an executive leadership level with each portfolio having an Executive sponsor as well as dedicated PMO support.
- For 2016/17, CIP schemes have been categorised into 12 portfolios. For each of these portfolios there is a project team. The Project Team is an **internal** function made up of an executive sponsor, clinical lead, project lead and project manager.
- The Project team as a whole is responsible for the implementation and delivery of CIP plans by the means of structured planning, decision making and reporting. They will report to the PMO, on a weekly basis to update on the progress of CIP Project Plans and flag any variances to the PMO on an exception basis.



CHFT CIP reporting and governance structure

- In addition to the governance above, all CIPs will be taken through a Quality Impact Assessment process. The purpose of the QIA is to provide assurance that all risks to quality and performance have been considered at the planning stage of any service change and periodically refreshed throughout the business cycle. This will ensure that the impact of the service change on quality and performance will be accurately assessed and managed.
- The QIA process involves an initial assessment (gateway 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.
- **Gateway 1** Initial QIA is to be completed at the scoping stage for all projects in order to progress through Gateway 1. Key Stakeholders will provide scrutiny and comments on the QIA prior to review and approval by a nominated Clinical Lead. For Gateway 1, quality is split into 5 categories to be individually considered.
- **Gateway 2** QIA is to be fully completed at project planning and development stage for all projects in order to pass through Gateway 2. The QIA should be completed and reviewed alongside completion of the Project Workbook to reflect the latest intelligence available at the time. All quality risks should have mitigating actions that should be clearly demonstrated in the Milestones tab or have KPI's linked to them. Key Stakeholders will provide scrutiny and commentary on development of the QIA prior to review and approval by the Exec Sponsor and Clinical Lead. The scheme is then ready for review at the Trust's Quality Panel.
- **Quality Panel approval:** The Quality Panel is headed by the Director of Nursing. It consists of a panel of key staff made of a minimum of 3 of the following: Director of Nursing, Associate Director of Nursing, Medical Director, Infection Control Nurse, Divisional Director, Consultant, Non-Exec Directors, Membership Counsellor, Expert Patient, Matrons.

- The panel is convened when projects or programmes require sign off. The Project Lead attends the panel to answer queries. Following review, the panel will make one of three recommendations:
    1. Project approved for mobilisation
    2. Project approved following the recommended changes being made
    3. Project not approved. The project could re-submit following major review or project stopped.
- **Ongoing monitoring** of quality risks and metrics as defined in the Gateway 2 QIA will be reported via the project team and PMO Dashboard process to the Exec Sponsor and Turnaround Executive.

d) Triangulation of indicators

- The governance structure in place within the Trust captures quality impacts through both the Quality committee and the QIA panel which reports into both the quality committee and Turnaround Executive.
- The review of the financial plan is monitored on a monthly basis through the Trust Board, supported by a detailed finance sub-committee to review the wider service and performance issues of the Trust. A full performance report is reviewed at both Executive Board and Trust Board on a monthly basis.
- The development of a workforce strategy, aligned to the future service requirements identified in the five year plan, together with the efficiency and CIP requirements will be reported through Turnaround Executive on a quarterly basis
- The governance arrangements put in place for CIP in the Trust ensures there is comprehensive and effective oversight of the quality and performance impacts on the workforce of proposed and approved CIP activities. The arrangements include quality impact assessments (described above) the purpose of which is to provide assurance that all risks have been considered at the planning stage of any service change and periodically refreshed throughout the business cycle. This ensures that the impact of the service change on quality and performance will be accurately assessed and managed.

4. Approach to work force planning

Workforce planning and clinical engagement

- The Trust has a devolved divisional management structure in place with clinical engagement at the heart of its business planning process covering activity, work force and finance.
- The Trust has been nationally recognised as a leader in terms of its devolved clinical decision making and engagement. The Trust operates through a clinically led divisional structure where medical, nursing and AHP colleagues lead the development of plans for their divisional activity and ensure that this takes account of clinical and support service dependencies.
- The Trust has recently introduced a workforce planning template which will be the principle means through which bottom up workforce planning will be achieved.
- This will be fully embedded through 2016/17 in order to ensure that the overall workforce plan reflects the clinical service plan and financial plan. The current work force numbers reflect the requirements to support safe service delivery and revenue generating

schemes, together with a move from agency usage to a substantive workforce. Further detailed work is ongoing to refine the total workforce numbers and trajectories on a month by month basis.

- As the Trust develops its five year strategic plan the workforce development plan will be a key focus as the workforce drives a significant cost in the organisation.
- The Board of Directors and the Executive Board receives workforce data, including a number of KPIs, on a monthly basis and it is intended to augment these with workforce modelling data over the next 12 months to track the way in which the workforce is changing both in size and skill mix to match the overall workforce plan.
- The Trust faces considerable workforce challenges to the potential detriment of the resilience of clinical services, staff satisfaction and health and to the Trust finances. As such, workforce is one of the key factors in supporting future reconfiguration of services and is a high priority for the Trust in 2016/17 in the development of a robust workforce strategy and plan.

Operational challenges

- The Trust, along with other NHS Trusts, is struggling to fill vacancies in the workforce due to a national shortage of skilled people. Services are expected to be put under increased pressures in the future due to forecast population growth and aging populations. The current issues facing the Trust are listed below;
- **Provision of emergency doctors:** the Trust's current consultant pool is too far stretched to cover vacancies to which the Trust has been unable to recruit. In addition to consultant pressures it is challenging to find the correctly skilled staff are worsened by the fact that there is currently a national shortage. In the last 5 years the Trust has only been able to provide a rota of 7 doctors, with locums filling in the gaps, the two Emergency Departments require a rota of 12 speciality doctors.
- **Flexibility of deploying staff across two sites:** Services that are split across the two locations make it difficult for vacancies or absence to be filled at short notice. In particular, the dual running of emergency medical services leads to thinly spread middle grade cover, particularly out of hours and at night.
- **Increased sickness / absence:** The Trust has a below 4% target on sickness and in the period between 2015 Q3 to 2016 Q2, each quarter has reported sickness being above this figure.
- **Recruitment and retention pressures:** A number of divisions are struggling to recruit and retain a substantive workforce, this impacts quality of care and patient experience. The lack of workforce also impacts the ability to implement speciality-specific rotas and delivers an on call rota of 1:5 which impacts current staff experience and hinders further recruitment. The recruitment difficulties in Surgery & Anaesthetics (N.B. not related to dual site working) have more recently led to a shortfall in elective and day case activity due to difficulty securing NHS locums.
- **High levels of locum staff:** Owing to vacancies and high sickness absence amongst the workforce, a high level of locum staff is used to fill gaps in the workforce. This is expensive, provides a disjointed service to patients and is not sustainable in the future.

Governance processes

- The Trust has tightened its governance processes over the last 18 months with the introduction of a nursing workforce group, a medical workforce group, a workforce expenditure group.
- The key focus for the improved governance arrangements has been to ensure management of vacancies, address operational recruitment, retention and development pressures together with tracking reliance on locum and agency spend.
- All of this activity focuses on the overarching need to keep patients and colleagues safe and cared for in an environment that has compassion and colleague health and wellbeing at its core.
- A Workforce Committee as a sub-committee of the Board of Directors has been established
- The Quality Committee, a sub-committee of the Board assesses workforce plans, and requests deep dives into high risk areas such as medical workforce gaps, to gain assurance, on behalf of the Board, that action plans to meet medical workforce pressures are in place and that actions continue to be progressed.
- Workforce risks are identified, maintained and monitored through the Trust's risk register. The corporate risk register is routinely reviewed by the Quality Committee and reported to the Board of Directors. The Workforce Committee will regularly consider workforce risks and ensure that assurance is provided in relation to action and mitigation. Operationally, risks are managed through individual divisional structures and progress monitored by the Risk and Assurance Committee. The Executive Board receives reports on corporate risk register items monthly.

Clinical strategy and local healthcare system commissioning strategies

- The Trust is working closely with its clinical commissioners to design a service model that is sustainable now and into the future. This is fundamentally driven by the current service configuration across two main hospital sites being undeliverable in workforce, financial and, ultimately, quality terms.
- The difficulties with workforce recruitment have been well rehearsed over many months with the Trust's commissioners and have given rise to the recent proposals to configure services in a different way.
- A decision by commissioners to consult on proposals for hospital services reconfiguration has been recently approved. The consultation process will run until 21st June 2016. The Trust's clinical strategy and local health care system commissioning strategies will need to be considered together in the development of a future workforce configuration that supports a different service offering across hospital, community, primary care and social care arenas.

Workforce transformation programmes and productivity schemes including impact on workforce by staff group

- The Trust is planning to improve its staff skill-mix and workforce plan to meet current activity requirements effectively and provide a platform for growth.
- The Trust is reviewing its bank and agency usage with a plan to reduce bank and agency costs and deliver sustainable sickness/absence reduction.
- The Trust will employ broader strategic workforce initiatives to improve the quality and resilience of clinical services and improve opportunities for workforce.

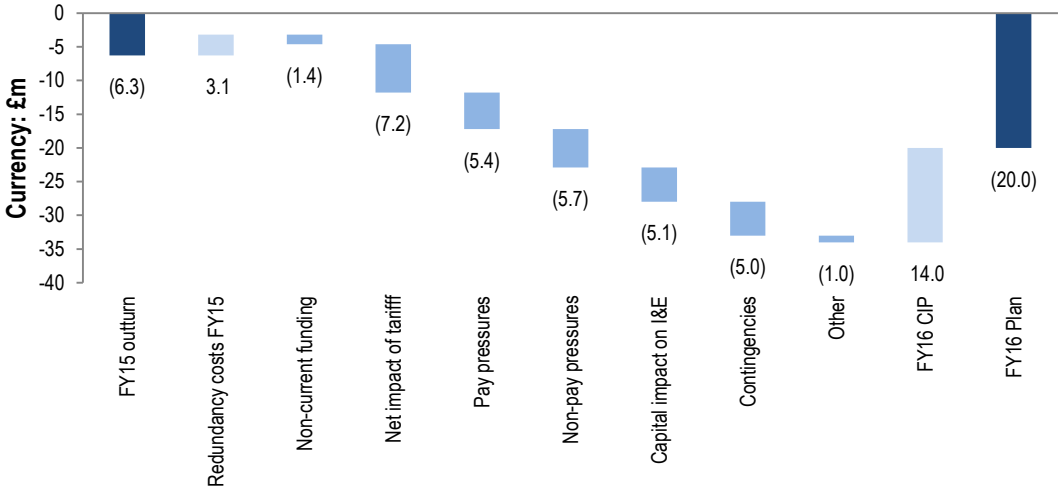
The key activities during 2016/17 are:-

- Community collaboration with Pennine GP Alliance, Radiology pooling with West Yorkshire's Association of Acute Trusts, shared provision of pathology service across the patch, Primary care collaboration and integration, workforce skill mix changes and the use of technology (e.g. Telehealth and Telemedicine).
- The development of a workforce strategy and plan which will reflect the overall financial envelop taking into consideration the change in service delivery models through QUIPP and a move for more out of hospital care into a community setting.
- It is assumed that business as usual turnover of staff, currently at 15.4%, will be sufficient to achieve the necessary reduction in wte without the need for redundancies
- Improve the skill mix of current CHFT staff through training and multi-skilling to enhance role resilience and flexibility.
- Increase efficiency through improved rota management and agile working.
- Consider collaboration with other organisations
- Build on the activities of the CIP to drive further cost savings in locum spend.
- Reduce staff absenteeism by 0.5%
- Bring current locum spending within Monitor cap rules

5. Approach to financial planning

Background - 2016/17 financial challenge

The Trust's 2015/16 plan submitted to Monitor showed a deficit position of £20.0m (excluding restructuring costs). The Trust faced a £5.9m reduction in the income quantum arising from contract underperformance delivered in 2014/15 and the subsequent move to a tariff-based contract. Pay costs pressures of £5.4m included £1.7m of safer staffing requirements. Non-pay cost pressures amounted to £5.7m, incorporating £2.2m of full-year revenue effects of capital programmes.



Bridge - FY15 Outturn to FY16 Plan

In 2015/16 the Trust saw a significant increase number of non-elective admissions versus planned levels as a result of reduced out of hospital nursing home capacity, which applied both cost and operational pressures. The pre-audited 2015/16 year end position is a deficit

of a £21m, in line with the original plan, adjusted for one-off consultancy support costs. This position is the step off point for 2016/17 planning.

2016/17 financial challenges

The Trust brought forward its annual planning process to coincide with the development of the five year strategic plan. Monitor has been involved with the development of this strategic plan along with the Trust supported by external consultancy support provided by EY. The final operational plan for 2016/17 is an evolution of the iteration of the plan shared through Monitor with Treasury in December 2015, updated to reflect the latest national planning guidance and other material issues which impact the financial modelling.

In summary these changes are as follows:

1. Update of tariff in line with national planning guidance – change in the income assumption from -1.8% to +1.1% in 2016/17, bringing a movement of £8.9m (£4.4m increase as opposed to previously anticipated £5.4m loss).

2. Recognition of £2.9m additional costs in respect of CNST contributions notified to CHFT from the NHSLA following completion of the five year plan (£4.1m actual increase in contributions versus a previously assumed £1.2m increase).

3. Inclusion of non recurrent £11.3m Strategic Transformation Funding

4. Removal of £5.0m non recurrent EPR implementation allowance (at risk)

5. Reduction of general contingency reserves held from £3.0m to £2.0m (at risk)

The first two items described moved the planned deficit in 2016/17 from £39m, as originally modelled by the Trust in conjunction with EY as the baseline year for the longer term planning, to £33m at the draft plan stage in February.

Subsequent to this, after considerable and lengthy discussions, the Board of Directors has decided to accept the £11.3m offer from the Strategic Transformation Fund. Consequently, as is required, the 2016/17 plan is to deliver the control total of £16.15m.

Agreement of the control total of £16.15m only allows for £2m general contingency (previously planned at £3m). No allowance is made for additional one-off costs incurred or income losses as a result of implementation of EPR (previously provided for at £5m which was acknowledged by Monitor as a reasonable assumption).

This leaves the organisation with a challenging 4% CIP of £14m, an ambitious requirement to control and reduce agency spend alongside resolving any issues that arise following the recent CQC visit.

The specific assumptions underpinning this plan are outlined below.

Income

The income plan assumes operation of full Payment by Results tariff arrangements and therefore is fully aligned with the activity plan as described above. As described earlier, the Trust is currently finalising the 2016/17 contract with its main commissioners which will result in a difference in level of demand commissioned when compared to the CHFT plan.

In addition there are some specific issues which remain uncertain in terms of impact:

- Impact of EPR implementation – a possible clinical income risk associated with the EPR implementation. This is due to a potential loss in productivity during the implementation of the new patient record system. This is based on experience of other providers implementing a similar system. The Trust will continue to explore mitigations to this position and at present the plans do not make any specific allowance for this risk;

- Impact of QIPP – whilst the Commissioners have included an expectation of QIPP delivery within the Contract, the loss of income associated with this has not been fully recognised within the CHFT plan. Further joint working is required to fully understand the implementation, impact and timing of the Commissioner QIPP plans and therefore alignment with the Trust CIP programme. Both Commissioner and Provider are fully committed to working jointly together on this.

It is assumed that the non-recurrent Urgent Care Board / System Resilience income is reinvested by commissioners in 2016/17 at a value of £1.97m with costs already assumed. A level of pressure is brought to the bottom line I&E position by the full year impact of services decommissioned in 2015/16 such as Care Closer to Home and the loss of the tender for Sexual Health services.

The income plans assume full achievement of CQUIN targets and no application of contract sanctions. As per contract guidance, a year of neutrality has been agreed with commissioners on counting and coding changes where notice has been given for 2016-17. There is no provision made for any potential further commissioner contract challenges.

Expenditure

Pay

Pay pressures of incremental drift, pension and pay uplift combined are included at £4.1m based on national pay structures and uplifts. Accounting for changes in National Insurance contributions means that the Trust incurs an additional cost of £3.6m, bringing overall pay inflationary pressures to £7.7m.

In addition to inflation, specific pay investments are planned in ‘Hospital at Night’ services and nurse staffing levels in A&E. Both of these are considered essential investments to maintain safe staffing levels, achieve performance targets and improve patient flow through the hospital.

Contingency reserves of £2.0m are reinstated all of which is planned as pay. This is lower than the £3.0m contingency held at the outset of 2015/16 and in the draft 2016/17 operational plan as the organisation looks to balance the mitigation of risks with the challenge to deliver the £16.15m control total.

Non pay and non-operating costs

Non-pay inflation is incorporated at £1.5m is based on a 1% increase generally but recognises differential rates for material contracts such as PFI and decontamination services which are linked to RPI. Over and above standard inflationary pressures the Trust was notified by the NHSLA in late December of an increase of £4.1m to the CNST contributions;

an additional significant pressure, being double the increase allowed for in the make-up of the 2016/17 tariff.

Non-operating costs are driven up by £0.9m through a combination of inflation on non-operating elements of the PFI unitary payment; depreciation; and increased costs of borrowing. There is no assumed cost of restructuring in 2016/17 for redundancy to support CIP programmes; nor is there any assumed cost of specialist external support to progress the implementation of reconfiguration which obviously hinges upon the outcome of treasury approval and public consultation.

Efficiency savings for 2016/17

The 2016/17 position assumes the Trust delivers £14.0m in CIP and revenue generation schemes. This represents double the national efficiency requirement driven through the make-up of tariff and comes on the back of delivery of £18.0m CIP in 2015/16, the majority of which is recurrent.

£4.4m of the CIP and revenue generation schemes are fully developed, £3.3m of schemes are plans in progress and a further £6.3m of opportunity is identified. Focussed management effort is being dedicated to progressing these opportunities through to implementation, this includes pursuing the Lord Carter work described below.

Lord Carter's productivity work programme

Lord Carter of Coles was commissioned to review efficiency across the NHS. The Trust has been notified of 'savings opportunities' of £29.6m identified from this benchmarking exercise. The Trust is keen to embrace this opportunity and this is being put into action through the Trust's Turnaround Executive and PMO structure through the following steps:

> **Director led task and finish group established:** The purpose is to drive the establishment of the plans and the ambition of the projects in terms of time, quality and financials. Prioritisation of the service reviews may be required based on opportunity and best use of resource.
>
> **Divisional review and resource**: The Divisions have plans to review key services and have allocated specific resource to support the work. SLR/PLICS upskilling and retraining will be provided by the SLR team.
>
> **Planning:** An overarching 5 year plan is in development that pulls out all the recommendations, with dates and KPIs from the Lord Carter of Coles paper. This will be overlaid with the other transformational/ strategic changes.
>
> **Baseline information:** Information in response to each of the recommendations is being collated. A gap analysis will be created. Where 16/17 CIP portfolios teams are in place and these map to the 15 recommendations (e.g. procurement, pharmacy, estates) early baseline information is being sought to start a gap analysis against the KPI's in the review.

The plan is to move from pre-work to delivery of agreed opportunities by the end of May 2016. This includes allocation of corporate resource, clinical workshops and Gateway 2 approval of changes. This is an ambitious timeline to be owned by Divisions and supported

by Directors. Areas identified through this process will form a key part of the opportunity to deliver £14m efficiencies in 16/17.

Agency rules

The Trust has been targeted with an agency expenditure ceiling of £14.95m for all staff groups for 2016/17. Every effort is being made to reduce the trajectory of agency expenditure and the 2016/17 plans are based on the April capped hourly rates as a maximum, and represent a marked reduction on the agency expenditure incurred in 2015/16 at £16.1m down from £19.9m. However, based on current levels of vacancies and recruitment profiles this is likely to remain extremely challenging whilst the Trust strives to maintain safe staffing levels.

Recruitment difficulties continue to be an issue in certain specialties for medical staff. This is driving additional costs through the requirement to engage agency locum staff in key specialties. Focussed activity is underway to manage attendance of clinical staff through the creation of an attendance management team in late 2015/16. Escalation protocols are in place for the authorisation of agency cover for junior medical posts and nursing shifts. In addition, face to face executive challenge sessions with divisions are ongoing; the profile of when temporary cover arrangements can be safely released is under review; the administration arrangements for booking flexible staff are being centralised for all staff groups to ensure control and use of best practice; and new IT systems are being implemented to streamline processes.

Capital planning

The capital plans for 2016/17 stand at £28.2m. This is lower than the level of investment identified within the baseline year for the five year strategic plan and included within the financial modelling completed by EY, as a result of a process of close scrutiny, challenge and prioritisation. This limits the plans to elements that are contractually committed developments and those which are crucial for ongoing safe delivery of services.

The key areas of investment are summarised in the table below:

Capital Programme 2016/17	£m
Electronic Patient Record investment	4.7
IT systems and infrastructure - EDMS and Single sign on	2.9
Theatres refurbishment programme	2.6
Ward upgrade programme, safety and standards	2.4
Estates - backlog maintenance, safety and compliance	6.0
Medical and other equipment	7.2
PFI lifecycle costs	1.5
Other	0.9
Total	**28.2**

IT investments

The key individual area of IT investment is in the Electronic Patient Record (EPR). This project is contractually committed with our supplier Cerner and the Trust is working in partnership with Bradford NHS FT to implement the transformational new system. The planned 'go live' date for CHFT is October 2016 and following this improvements in clinical practice will be delivered through; added value in identifying clinical performance trends, strengths and weaknesses; enhanced patient information access; and patient monitoring, care and safety. In addition the system will enable delivery of savings across the Trust.

The key financial risks against this project are the potential loss in clinical productivity and therefore income during the implementation phase and the need to release and backfill staff for training. As described above, this risk to I&E is not specifically provided for within the financial plan.

Estates investments

A key factor in the case for reconfiguration beyond 2016/17 is the condition of the current estate at HRI. HRI is 50 years old and requires extensive maintenance and upgrade. This is impacting patient care as there are issues with space and the age and fabric of the building.

In the meantime, in advance of the proposed reconfiguration, a level of ongoing investment is required to maintain a safe environment that is compliant with relevant standards.

Other investments

The two other areas of investment are PFI Lifecycle costs which are unavoidable contractually committed costs; and Medical and Other Equipment. Equipment investments include a replacement MRI scanner at Calderdale Royal Hospital and further requirements most significantly across other radiology and surgical equipment.

Cash

The financial plans incorporate a cash drawdown from the ITFF in April 2016 of £5m to support transformational elements of the capital plans, being notably the investment in EPR. This is against a pre-approved £30m loan facility that the Trust has had in place since 2014/15 and of which £17m has already been called upon prior to 2016/17.

The balance of the capital programme of £23.2m coupled with the I&E deficit will lead to the requirement for further DH cash support in 2016/17 totalling £32.6m. In 2015/16 the Trust agreed with commissioners for the payment of clinical contract income to be brought forwards and paid over eleven rather than the standard twelve months but it is understood that this arrangement is not to be available in 2016/17. As such, the requirement for further external cash support will commence from May 2016, at which point the Trust anticipates calling upon the Working Capital Loan facility in advance of progression to an Interim Support Loan in year. Cash flows against the £11.3m Strategic Transformation Funding are assumed as quarterly payments in arrears.

The Trust will continue to pursue all means to reduce and defer the need for borrowing as has been the case in 2015/16.

6. Links to the emerging ‘ Sustainability and Transformation Plan’

Overall vision

Our overall vision is ***‘Together we will deliver outstanding compassionate care to the communities we serve’.*** This means that :-

- We provide safe care in a clean environment
- Patient care is designed to meet their needs, not ours, and delivered as close to their home as possible.
- Colleagues are competent and compassionate, friendly and welcoming
- We work together with patients, their family and carers to help them take responsibility for their health and wellbeing
- Our treatments are up to date and we embrace change, innovation and new technologies to make sure we remain at the leading edge of care
- We are part of the communities we serve working together to create and sustain health and wealth for the future

We do this by demonstrating our behaviours, known as our four pillars:

- We put the patient first
- We go see
- We do the must-dos
- We work together to get results

Our key objectives are:

- Transforming and improving patient care
- Keeping the base safe
- A workforce for the future; and
- Financial stability

Strategic and operational initiatives

- The Trust has set 15 priority strategic initiatives to support the delivery of a sustainable and transformation plan over the next 5 years that will support the delivery of services and financial stability over the wider health economy.
- A key component of these is hospital reconfiguration, with Calderdale Royal Hospital as the preferred option for an unplanned care site, and Huddersfield Royal Infirmary or Acre Mills as the preferred option for a planned care site.
- This plan is closely linked with proposed local health economy changes and does take into account proposed changes at Dewsbury Hospital. However, it does not include any quantified impact from wider West Yorkshire changes, such as collaborative working and social care changes.
- A key component of the strategic initiatives is the undertaking of more strategic alliances and closer working with other providers, including acute providers, providing the Trust with flexibility to address future challenges.

    - Reconfiguration of hospital services
    - Optimise 7-day working within resources
    - Optimise community service model to reduce demand on hospital incorporating gain-share e.g. – diabetes, respiratory, frailty, paediatrics
    - Optimise information technology benefits
    - Reduce hospital and community demand by increasing prevention and self-care support for the population
    - MCP Vanguard - New Care Models that offer integrated community, primary and acute care
    - Develop / invest in strategic partnerships (e.g. GP Federation, voluntary sector, other organisations)
    - Investment in service improvement capability such as Lean and developing Fellowships with IHI / Kings Fund/ Birmingham University
    - Introduce innovative finance structures that enable savings
    - Identification of service development opportunities to ensure we maximise income for the Trust
    - Deliver best in class LOS, DNAs, New to FU ratios and ambulatory care – optimise performance to reduce waste and enable bed reduction
    - Address clinical variation ensuring delivery of consistent standardised evidence based care
    - Workforce and skills planning
    - Reduce Bank & Agency use and deliver sustainable sickness absence reduction
    - Enhancing productivity of community work

Overall expected benefits

The strategic plan directly supports CHFT's strategic objectives, delivering benefits for patients, staff, the Trust and the local health economy.

For patients, there will be:

- Access to clinically sustainable unplanned care services. The Trust will be able to meet current and expected clinical guidelines for the provision of safe and high quality services, with the ability to better provide emergency and other clinical cover.
- There will be reduced agency and locum use, improving patient satisfaction.
- Access to a dedicated centre for planned care, reducing cancellations and length of stay.

For staff, there will be:

- An improvement in clinical cover and rota frequency / intensity, improving recruitment and retention supported by a comprehensive workforce strategy. Improving staff satisfaction will mean that a more positive workforce is able to deliver better quality care.
- The opportunity to develop new skills, and take on new roles.

For the Trust, there will be:

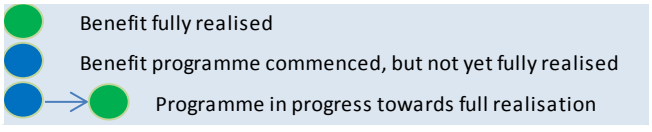
- An improved financial position through optimisation of the estate
- Realisation of £25.4m (nominal) in strategic annual savings across the Trust, with further potential benefits from the clinical reconfiguration.

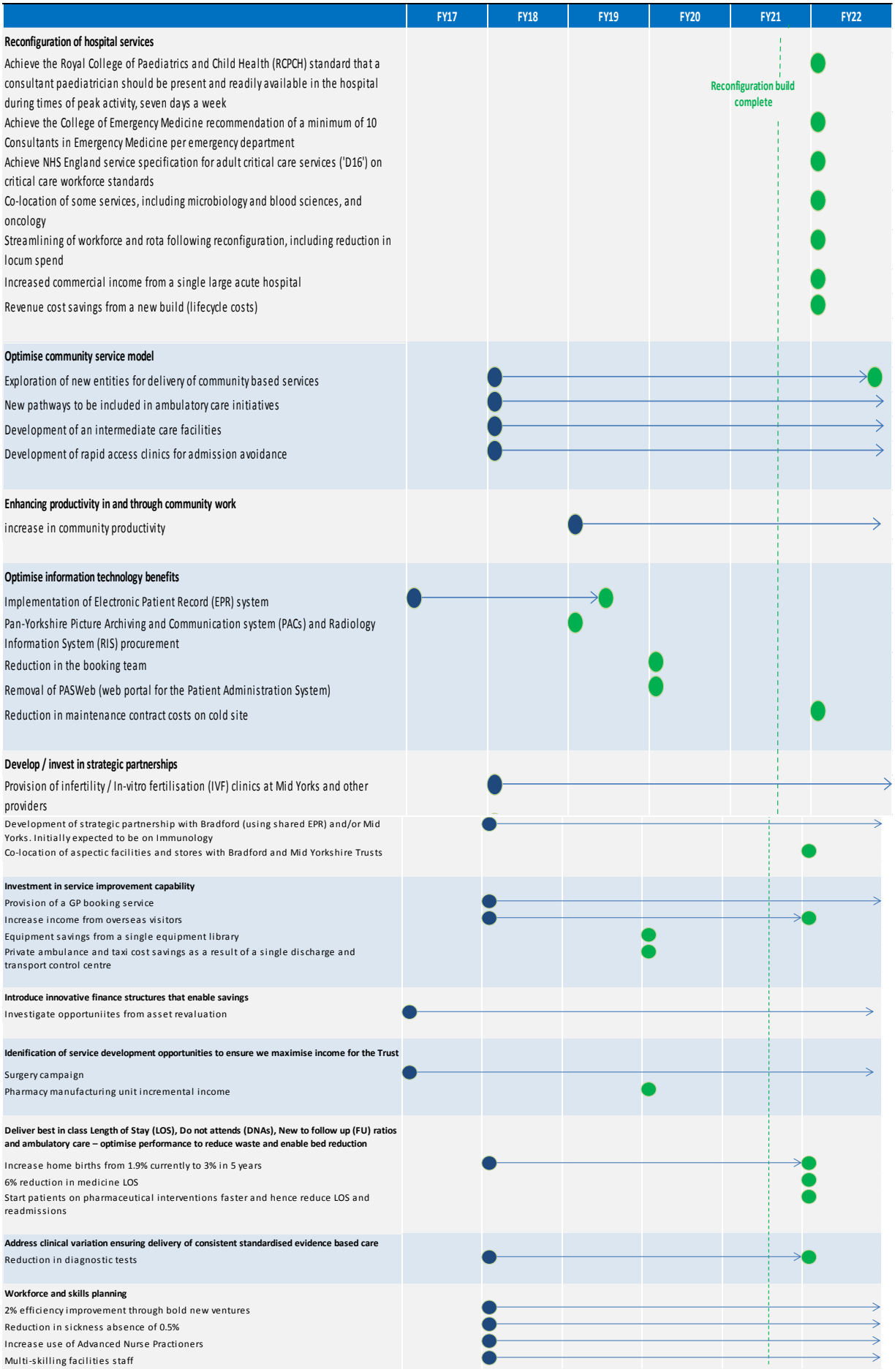
For the local health economy, there will be:

- Redesigned care pathways to enhance quality, reduce ED admissions and appropriately manage lengths of stay, particularly for older people.
- Achievement of commissioner priorities, as the reconfiguration is well aligned with local commissioners' objectives. This includes a net reduction in the acute bed base of 77 beds, reflecting a shift of activity into a community setting.

The fifteen initiatives will enable the Trust to direct its reconfiguration and consequently improve its future sustainability. Many of these initiative activities will involve reconfiguring multiple services over many years. The table below details the proposed time frame for each initiative and the activities each initiative incorporate. The focus and priority for the annual plan will be on those initiatives falling within FY17 highlighted in the table below. The key areas for 2016/17 are:-

- EPR implementation, the benefits of which will be seen over a 10 year time frame
- Investigate opportunities from asset revaluation
- Surgery campaign with GPs
- PMU income generation




FY17
FY18
FY19
FY20
FY21
FY22
Reconfiguration hospital services
Achieve the Royal College of Paediatrics and Child Health (RCPCH) standard that a consultant paediatrician should be present and readily available in the hospital during times of peak activity, seven days a week
Reconfiguration build complete
Achieve the College of Emergency Medicine recommendation of a minimum of 10 Consultants in Emergency Medicine per emergency department
Achieve NHS England service specification for adult critical care services ('D16') on critical care workforce standards
Co-location of some services, including microbiology and blood sciences, and oncology
Streamlining of workforce and rota following reconfiguration, including reduction in locum spend
Increased commercial income from a single large acute hospital
Revenue cost savings from a new build (lifecycle costs)
Optimise community service model
Exploration of new entities for delivery of community based services
New pathways to be included in ambulatory care initiatives
Development of an intermediate care facilities
Development of rapid access clinics for admission avoidance
Enhancing productivity in and through community work
increase in community productivity
Optimise information technology benefits
Implementation of Electronic Patient Record (EPR) system
Pan-Yorkshire Picture Archiving and Communication system (PACs) and Radiology Information System (RIS) procurement
Reduction in the booking team
Removal of PASWeb (web portal for the Patient Administration System)
Reduction in maintenance contract costs on cold site
Develop / invest in strategic partnerships
Provision of infertility / In-vitro fertilisation (IVF) clinics at Mid Yorks and other providers
Development of strategic partnership with Bradford (using shared EPR) and/or Mid Yorks. Initially expected to be on Immunology
Co-location of aspectic facilities and stores with Bradford and Mid Yorkshire Trusts
Investment in service improvement capability
Provision of a GP booking service
Increase income from overseas visitors
Equipment savings from a single equipment library
Private ambulance and taxi cost savings as a result of a single discharge and transport control centre
Introduce innovative finance structures that enable savings
Investigate opportuniites from asset revaluation
Idenification of service development opportunities to ensure we maximise income for the Trust
Surgery campaign
Pharmacy manufacturing unit incremental income
Deliver best in class Length of Stay (LOS), Do not attends (DNAs), New to follow up (FU) ratios and ambulatory care – optimise performance to reduce waste and enable bed reduction
Increase home births from 1.9% currently to 3% in 5 years
6% reduction in medicine LOS
Start patients on pharmaceutical interventions faster and hence reduce LOS and readmissions
Address clinical variation ensuring delivery of consistent standardised evidence based care
Reduction in diagnostic tests
Workforce and skills planning
2% efficiency improvement through bold new ventures
Reduction in sickness absence of 0.5%
Increase use of Advanced Nurse Practioners
Multi-skilling facilities staff

7. Membership and elections

The membership of Calderdale and Huddersfield NHS Foundation Trust currently stands at 9616 public members and approximately 5,600 staff members. The Membership Council of the Trust comprises 16 publically elected, 6 staff elected and 6 nominated stakeholder Councillors.

Governor elections

Governor elections were held in summer 2015 when 12 seats were eligible to be contested. Following elections, 8 vacancies were filled. Out of the 7 eligible public seats, 2 had no candidates and therefore remain unfilled, and 2 seats were elected unopposed. The Trust currently carries 4 Membership Council vacancies in total.

In addition to these 4 vacancies, 5 seats are due to be contested in the elections of summer 2016. Specifically, 6 will be public seats and 3 will be staff seats. Current staff Membership Councillors will be asked to encourage colleagues to consider standing for vacant seats, and the traditionally hard to fill vacancies in the Dewsbury & Batley area will be specifically targeted via local media.

Training, development and engagement

The Trust offers a range of activities and opportunities for Membership Councillors, members, and the public to engage with its services. These include:

- A comprehensive Membership Councillor induction programme
- A series of seven in-house training sessions. These interactive and informative sessions are delivered by subject experts and cover such topics as 'Understanding Quality in the NHS', 'An Introduction to NHS Finance', 'Improving The Patient Experience
- A programme of four development sessions for Membership Councillors. These sessions are attended by Membership Councillors, the Trust chairman and respective board directors
- Divisional Reference Group meetings, chaired by Membership Councillors to discuss divisional business planning, key priorities, and performance
- Joint workshops between Membership Councillors and the board of directors and again between Membership Councillors and non-executive directors to share insights into their respective roles, and collaborate to ensure effective governance of the Trust.
- Engagement with members through the FT News newsletter; the AGM; the Trust's website; a bespoke 'contact your council' email inbox; member surveys
- Engagement with the public through co-hosting focus group discussions e.g. 'Thinking of Having a Baby?'; patient interviews as part of clinical audits; telephone interviews on development of physiotherapist clinics

Membership Strategy

The Trust's membership is broadly representative of the wider population that the Trust serves. Efforts to maintain this include membership recruitment activities specifically

targeted at a local Muslim youth organisation, and at local college and university events. Following ten years as a Foundation Trust, CHFT plans a membership ‘stocktake’ in 2016 to refresh its approach and methodologies.