

Meeting of the Board of Directors

To be held in public

Thursday 3 August 2017 at 9.00 am

Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital

AGENDA

REF	ITEM	LEAD	PAPER	PURPOSE OF PAPER/ UPDATE
1	Welcome and introductions: George Richardson, Public Elected Governor Dianne Hughes, Public Elected Governor Nicola Sheehan, Staff Elected Governor	Chair	VERBAL	Note
2	Apologies for absence: Richard Hopkin, Non-Executive Director Helen Barker, COO – Kristina Rutherford, Director of Operations to attend	Chair	VERBAL	Note
3	Declaration of interests	All	VERBAL	Receive
Transforming and improving patient care – no items				
4	Full Business Case	Chief Executive	APP A	Approve
Standing items				
5	Minutes of the previous meeting held on 6 July 2017	Chair	APP B	Approve
6	Action log and matters arising:	Chair	APP C	Review
7	Chairman's Report a. Nomination and Remuneration Committee (COG) Update on NED Appointments b. Executive Director of Workforce and OD	Chair	VERBAL	Note
8	Chief Executive's Report: a. The Long Term Sustainability of the NHS and Adult Social Care' – House of Lords publication	Chief Executive	APP D	Note
Keeping the base safe				
9	CQC Update on Action Plan (Deep-dive) – Paediatrics presented by:- Mr Martin Debono, Divisional Director Anne-Marie Henshaw, Assoc. Director of Nursing Rob Aitchison, Director of Operations	Executive Director of Nursing	Presentation	Approve
10	Quarterly Quality Report focussing on	Deputy Director	Presentation	Note

	Nasogastric Tube Risk and Falls – presented by:- Lindsay Rudge Andrew Hardy Janette Cockroft Lisa Fox	of Nursing		
11	High Level Risk Register	Executive Director of Nursing	APP E TO FOLLOW	Approve
12	Risk Management Policy	Company Secretary	APP F	Approve
13	Complaints Policy	Company Secretary	APP G	Approve
14	Freedom to Speak/Whistleblowing Update	Executive Director of Workforce & OD	VERBAL	Note
15	Integrated Performance Report	Chief Operating Officer	APP H	Approve
Financial Sustainability				
16	Month 3 – 2017-2018 – Financial Narrative	Executive Director of Finance	APP I	Approve
A workforce for the future				
17	Medical Revalidation and Appraisal	Executive Medical Director	APP J	Information
18	Workplace Race Equality Standard (WRES) 2017	Executive Director of Workforce and OD	APP K	Information
19	Update from sub-committees and receipt of minutes & papers <ul style="list-style-type: none"> ▪ Draft Quality Committee – minutes of 3.7.17 and verbal update from meeting 31.7.17 ▪ Finance and Performance Committee – minutes of 4.7.17 and verbal update from meeting 1.8.17 ▪ Workforce Well Led Committee - - verbal update from meeting 13.7.17 ▪ Audit and Risk Committee Minutes – verbal update from meeting 19.7.17 ▪ Draft Minutes Board of Directors/Council of Governors Annual General Meeting – 20.7.17 		APP L	Receive
Date and time of next meeting Thursday 7 September 2017 commencing at 9.00 am Venue: Boardroom, Huddersfield Royal Infirmary				

Resolution

The Board resolves that representatives of the press and public be excluded from the meeting at this point on the grounds that the confidential nature of the business to be transacted means that publicity of the matters being reviewed would be prejudicial to public interest. (Section 1(2) Public Bodies (Admission to Meetings Act 1960).

Approved Minute

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Cover Sheet

Meeting: Board of Directors	Report Author: Kathy Bray, Board Secretary
Date: Thursday, 3rd August 2017	Sponsoring Director: Victoria Pickles, Company Secretary
Title and brief summary: FULL BUSINESS CASE - The Board is asked to receive and formally approve the Full Business Case	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The purpose of this report is to request that the Trust Board approves the attached Full Business Case (FBC) for the reconfiguration of Calderdale and Huddersfield NHS Foundation Trust hospital services, resulting in the FBC being passed to NHS Improvement and our two local Clinical Commissioning Groups (CCGs) for next stage approvals over the next couple of months.

Main Body

Purpose:

The purpose of this report is to request that the Trust Board approves the attached Full Business Case (FBC) for the reconfiguration of Calderdale and Huddersfield NHS Foundation Trust hospital services, resulting in the FBC being passed to NHS Improvement and our two local Clinical Commissioning Groups (CCGs) for next stage approvals over the next couple of months.

Background/Overview:

- Please see attached report

The Issue:

- Please see attached report

Next Steps:

Subject to Board approval of the FBC the Trust will then formally submit the FBC to NHS Improvement. Calderdale and Greater Huddersfield CCGs governing bodies will meet in the next two months to consider whether the FBC is in line with the model that was consulted on; is affordable and provides a sustainable plan not only for the Trust but the wider Calderdale and Greater Huddersfield System of care.

Should these steps be followed it is anticipated that the FBC will then be forwarded to the Secretary of State's office as a part of his deliberations with regard to the referral from the JHOSC.

Recommendations:

The Board is requested to approve the Full Business Case and its submission to NHS Improvement and our two CCGs for further approval(s).

Appendix

Attachment:

[FBC Board report.pdf](#)

REPORT TO BOARD OF DIRECTORS MEETING

Thursday 3 August 2017

APPROVAL OF THE FULL BUSINESS CASE

1. PURPOSE OF THE REPORT

The purpose of this report is to request that the Trust Board approves the attached Full Business Case (FBC) for the reconfiguration of Calderdale and Huddersfield NHS Foundation Trust hospital services, resulting in the FBC being passed to NHS Improvement and our two local Clinical Commissioning Groups (CCGs) for next stage approvals over the next couple of months.

2. CONTEXT

- 2.1. In 2015, the Trust was placed under an enforcement undertaking by its then regulator Monitor (now NHS Improvement) and was required to produce a five year strategic and sustainability plan which was approved by the Trust Board in December 2015. It should be noted that the enforcement undertaking is still formally in place at the time of writing this report.
- 2.2. The five year strategic plan described that the existing hospital service model was challenged by a number of significant and interconnected quality, safety, workforce and financial risks. The plan proposed a future hospital service model that would mitigate these risks by consolidating the provision of emergency and unplanned services at Calderdale Royal Hospital (CRH) and providing planned hospital services at Huddersfield Royal Infirmary (HRI). The service model proposed was agreed with Clinical Commissioners and endorsed by the Yorkshire and Humber Clinical Senate.
- 2.3. During 2016, Calderdale and Greater Huddersfield CCGs led the “Right Care, Right Time, Right Place” formal public consultation on the proposals and subsequently made the decision that the proposals should be further developed in a full business case. NHS Improvement (NHSI) and NHS England (NHSE) confirmed support for the Trust to develop the Full Business Case for the reconfiguration of hospital services.
- 2.4. Through the process of consultation members of the public along with Members of Parliament have expressed a high level of concern about the proposed changes in the hospital service model. In particular, a belief that services in the broader Kirklees Council catchment area and for the town of Huddersfield will be reduced as result of these changes.
- 2.5. As an example of this depth of feeling, the most recent deputations made at the recent Joint Health Overview and Scrutiny Committee (JHOSC) is

captured on webcast at the following link: https://kirklees.public-i.tv/core/portal/webcast_interactive/286084/start_time/301000.

3. SUMMARY CONTENT

- 3.1. Given the regulatory expenditure cap and approvals process of £50,000 imposed on NHS Trusts regarding the use of external consultancy firms to undertake work such as business case development, the FBC has largely been developed by CHFT staff with support from NHS Improvement, NHS England and the Department of Health. It has subsequently been through a process of review and development with the CHFT Board during July and discussed at summary level with representatives of the two CCGs in preparation for submission to this August Board meeting.
- 3.2. The purpose of the Full Business Case as agreed with NHS Improvement, NHS England and our local CCGs is to:
- Provide a plan for improving the quality and safety of hospital services provided by the Trust;
 - Make best possible use of the total Trust estate;
 - Eliminate the Trust's underlying deficit and contribute to improvement of the wider system affordability and sustainability;
 - Secure NHS Improvement, NHS England, Department of Health and Department of Treasury approval to progress a proposed capital funding option to implement estate developments that will enable the reconfiguration of hospital services.
- 3.3. The key summary points contained within the FBC are:
- The proposed clinical model and its impact on patient activity remains largely unchanged from what was consulted on with local people.
 - We anticipate that patient activity across both hospital sites will equate to 721,000 (430,000 at CRH and 291,000 at HRI).
 - Across both sites there would be 738 beds and 20 theatres overall; with 8 theatres and 64 beds at the new build Acre Mills facility and this is based on a clinically led belief that many more elective procedures will be day cases and more complex surgery will be done at CRH where there will be access to intensive care.
 - It is not anticipated that there will be a need for compulsory redundancies as a part of these proposals but it is estimated that the workforce will reduce through retirements and personal job choice by a total of 479 staff over the next decade.
 - The FBC compares the financial implications of maintaining our current two hospital sites as they exist now against the proposed model. This shows that HRI needs around £94M worth of maintenance to keep it going for the next 10 years. After that it would need to be rebuilt at a cost of around £379M. The proposed model would cost around £298M.
 - The most likely way that the new buildings will be funded is through PFI2 as we have been advised that there is no publicly financed capital funding available from the Departments of Health and Treasury.

- The proposed reconfiguration of our hospital services would enable the Trust to achieve and maintain a financial surplus in eight years' time (by 2024/25).

4. JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

- 4.1. On Friday 21 July 2017 the Joint Health Overview and Scrutiny Committee (JHOSC) met to look at the responses from the Trust and the two local Clinical Commissioning Groups to their 19 recommendations.
- 4.2. The JHOSC confirmed that maintaining the status quo is not an option and that they understand the clinical and quality case for change. However, the JHOSC voted by 5 votes to 3 in favour of exercising its right to refer the proposed reconfiguration to the Secretary of State for Health on the grounds that:
 - It is not satisfied with the adequacy of content of the consultation with the Joint Committee.
 - The amended proposals presented to the Joint Committee are not consistent with the proposals originally consulted on by the CCGs in 2016.
 - It considers that the proposal would not be in the interests of the people of Calderdale and Greater Huddersfield and hence not in the interests of the health service in the area.
- 4.3. With this in mind, we have considered the potential future procurement risk associated with full publication of the FBC. However, we believe at this stage that the need for local people to know and scrutinise the detail of the business case takes precedent. Therefore, we have made the FBC publicly available in its entirety without any form of redaction.
- 4.4. As referenced earlier in this report there were a number of very important deputations from a number of local stakeholders including campaign groups, politicians and the Local Medical Committee (LMC) of Huddersfield. It is important that we continue to recognise the strength of feeling and we will continue to work with JHOSC, Members of Parliament; campaign groups and local people as the process of referral is undertaken by the Secretary of State.

5. NEXT STEPS

- 5.1. Subject to Board approval of the FBC, the Trust will then formally submit the FBC to NHS Improvement. Calderdale and Greater Huddersfield CCGs' governing bodies will meet in the next two months to consider whether the FBC is in line with the model that was consulted on; is affordable; and provides a sustainable plan not only for the Trust but the wider Calderdale and Greater Huddersfield System of care.
- 5.2. Should these steps be followed it is anticipated that the FBC will then be forwarded to the Secretary of State's office as a part of his deliberations with regard to the referral from the JHOSC.

6. RECOMMENDATION

Members of the Trust Board are requested to approve the content of the Full Business Case and its submission to NHS Improvement and our two CCGs for further approval(s).



Reconfiguration of
Calderdale and Huddersfield NHS
Foundation Trust Hospital Services

Full Business Case

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1 | Executive Summary >>

1 | Executive Summary

» 1.1 Introduction

Calderdale and Huddersfield NHS Foundation Trust (CHFT) provides hospital services at Calderdale Royal Hospital (CRH) and at Huddersfield Royal Infirmary (HRI). The distance between the two hospitals is approximately five miles. For several years the Trust has experienced a number of interconnected clinical, operational and financial challenges. Significant risks have been identified if there is no change to the current configuration of services. In 2014 the Trust developed a Strategic Outline Case (SOC) and an Outline Business Case (OBC) describing proposals for the reconfiguration of hospital services across the two sites that would mitigate these risks.

On the 14th January 2015, the Trust was placed under an enforcement undertaking by its then regulator Monitor (now NHS Improvement). As a result the Trust was required to produce a Turnaround Plan and was authorised by Monitor to use Ernst & Young to produce a five year strategic and sustainability plan which was approved by the Trust Board in December 2015 and submitted to Monitor and to Greater Huddersfield and Calderdale Clinical Commissioning Group (CCGs). During 2016 the CCGs led the Right Care, Right Time, Right Place formal public consultation on the proposals for the future configuration of hospital and community services in Calderdale and Huddersfield. Subsequently the CCGs made the decision to progress the proposed changes to a Full Business Case (FBC). In April 2017 NHS Improvement (NHSI) and NHS England (NHSE) confirmed support for the Trust to develop a Full Business Case for the reconfiguration of hospital services.

The purpose of this Full Business Case is to:

1. provide a plan for improving the quality and safety of hospital services provided by the Trust;
2. eliminate the Trust's underlying deficit;
3. make best possible use of the total Trust estate including the existing Private Finance Initiative (PFI);
4. contribute to improvement of the wider system affordability and sustainability;
5. secure NHS Improvement, NHS England, and Department of Health Treasury approval to progress a proposed capital funding option to implement estate developments that will enable the reconfiguration of hospital services.

» 1.2 Strategic Context

People in Calderdale and Greater Huddersfield are living longer lives, however, more people are likely to have multiple long term conditions thereby increasing the demand on the health and social system.

Nationally there has been a rapid rise in demand for hospital nurses and difficulties in recruiting consultants in several specialties. Growing shortages of qualified clinical staff has resulted in increased use of agency and other temporary workers to fill vacancies, and this has increased NHS expenditure. At CHFT the current dual site configuration of services exacerbates the challenge of being able to recruit and retain staff and is placing a heavy reliance on agency staff equating to over £20m last financial year. Reconfiguration of the Trust's services will address these challenges, reduce the overall workforce capacity required and diminish the current reliance on temporary staffing.

The national NHS provider deficit is significantly higher than was planned and the National Audit Office report on Financial Sustainability from 22 November 2016 indicates that the NHS is financially unsustainable. CHFT has a significant underlying deficit and is reliant on financial support from the Department of Health to provide the cash to pay creditors and staff. Structural costs associated with the dual site configuration of services (which require higher workforce expenditure) and the high finance costs of the PFI are key factors driving the underlying deficit.

The cost of commissioning services is not affordable to the CCGs in Calderdale and Greater Huddersfield.

Nationally the increasing demand for services and financial stress is having an impact on access to NHS services and quality of care. CHFT has delivered a high level of performance against national access targets during 2016/17. However the sustainability of this is fragile as it is reliant on continued high agency staff use and cost.

Collaborative work across West Yorkshire to develop and implement sustainability and transformation plans (STP) is taking place. The proposed reconfiguration of hospital services in Calderdale and Huddersfield described in this FBC is included in the West Yorkshire STP as one of the potential solutions that could contribute to closing financial, care and quality gaps in West Yorkshire.

» 1.3 Clinical Case for Change

There is a compelling clinical case for the reconfiguration of the Trust's services in order to improve the safety and quality of services and to ensure the sustainable provision of acute and emergency services in the future. The current dual site model of hospital services provided by CHFT does not, and cannot, meet national guidance. Reconfiguration of CHFT hospital services is required to co-locate acute and emergency services for adults and children on a single hospital site and planned (elective) services for adults on the other site.

The key drivers for change are:

- The Trust is not able to provide a sustainable clinical model of provision across two Emergency Departments (EDs);
- The Trust is not able substantively to recruit to meet the medical rotas of the two sites.
- The Trust is not compliant with many standards for Children and Young People in Emergency Care settings;
- Too many planned operations are cancelled as surgeons need to respond to meet the needs of emergency patients;
- Patients experience inter-hospital transfers and a number of moves between wards that can result in a longer length of stay in hospital and increased risk of a poor experience and outcomes;
- The Trust carries a high risk in terms of the condition and reliability of its buildings at HRI. The age and condition of the estate means that they are not clinically fit for purpose. Without a significant capital injection in backlog maintenance and a plan for a rebuild of the whole site in the next 10-15 years, there is a high risk of failure of critical estate services and the consequent impact on service delivery.

A number of external independent clinical reviews of the Trust (e.g. the Royal College of Physicians) have recommended that staying the same is not possible unless there is a major injection of both permanent staffing and financial resources beyond that which is known to be available from Government, and on that basis, service reconfiguration is needed.

» 1.4 Future Hospital Services Model

The proposed model of care for the future provision of hospital services in Calderdale and Greater Huddersfield described in this FBC is consistent with the model that has been endorsed by the Yorkshire and Humber Clinical Senate, and was publically consulted on during 2016. The model will ensure clinical service adjacencies that optimise the quality of hospital patient care and address the challenges and sustainability issues described in the clinical case for change. The model proposes that planned services are delivered at one hospital and that emergency and unplanned services are provided at the other hospital with both sites providing urgent care.

NHSI and NHSE have advised the Trust and CCGs that a review of the clinical model during development of the FBC should be supportive of the clinical model that was consulted on, but that this could be amended if this improved quality, affordability and/or reduced timescales. Two variations to the clinical model that was consulted on are described and included in the Financial Case (i.e. the possibility that CHFT may be selected as the second vascular arterial surgery centre in West Yorkshire, and; the planned hospital providing increased out of area elective surgery activity). At the request of NHS England a third variation of providing an additional in-hours emergency service (A&E) at the planned hospital has also been described. However, this variation is not considered to be viable as there is low confidence in being able to recruit the additional staff that would be required, and therefore it would not deliver clinical and workforce benefits, it also does not appear to be financially viable.

» 1.5 Capacity Plan and Implications

An assessment has been undertaken of the impact of the proposed clinical model on future activity and the required clinical capacity (beds, theatres etc.) at the future planned and unplanned hospitals.

The capacity modelling shows that by 2021/22 the future hospital model will require the following to cater for patient activity estimated to be 720,000 visits per annum.

- 738 beds across the two sites (674 at the unplanned care site and 64 at the planned care site)
- 20 theatres (12 at the unplanned site and 8 at the planned site).

The Trust currently has circa 843 beds and 18 theatres. The 105 bed reduction by 2021/22 is planned to be achieved through delivery of improved pathways that enable admission avoidance and reduction in length of stay. This includes CCG's care closer to home and quality, innovation, productivity and prevention (QIPP) assumptions.

» 1.6 Workforce Plan and Implications

The Trust faces considerable workforce challenges which undermine the resilience of clinical services, staff satisfaction and wellbeing, and the Trust's finances. These challenges include non-compliance with Royal College of Emergency Medicine workforce recommendations, intense and fragile clinical rotas, and recruitment and retention challenges resulting in a heavy reliance on locum and agency staff. These challenges arise specifically due to the current dual-site service model. The reconfiguration of services will enable compliance with workforce standards. The Trust will then be in a better position to meet standards around 7-day working, and enable the delivery of specialty rotas. This should reduce workload pressure and stress on staff, and is likely to impact favourably on the Trust's ability to recruit and retain staff, thus reducing the current reliance on temporary staffing.

The workforce plan shows that over the next ten years (FY18 – FY27) the Trust's whole time equivalent (WTE) staff establishment will reduce by 479. Business as usual turnover of staff (15%) will be sufficient to achieve this reduction in wtes without the need for compulsory redundancies. The planned reduction in staffing is lower than the 966 wte reduction that was previously modelled in the Trust's five year strategic plan.

The change in the workforce profile will be enabled and achieved by the following:

- I. service reconfiguration and redesign;
- II. recruitment and retention to reduce agency spend;
- III. recruiting new professional roles (e.g. Physician Associates);
- IV. job evaluation to ensure clinically qualified staff are practising to the full extent of their education and training (instead of spending time doing something that could effectively be done by someone else);
- V. optimising the availability, utilisation and productivity of the entire workforce creating more time to care.

» 1.7 Hospital Estate Plan

The Trust's current estate at Calderdale Royal Hospital and Huddersfield Royal Infirmary varies considerably between the two sites. CRH is a 1990s PFI development with limited backlog maintenance requirement, whilst HRI is a 1960s build that has time expired buildings with significant backlog maintenance requirements.

The previous five year strategic and sustainability plan determined there is an overwhelming benefit of reconfiguring services to implement the future proposed model of care. The choice between HRI and CRH as the unplanned care site is primarily financial, with CRH as the unplanned care site currently estimated to be providing the most positive financial impact.

The proposed estate option is for Calderdale Royal Hospital to be developed as the unplanned hospital with Huddersfield Royal Infirmary (Acre Mills) as the planned hospital. The expected estate cost to implement the future service model option is £298m. To proceed with the existing model the anticipated cost would be around £379m.

» 1.8 Economic case

Assessment of the financial (net present cost and equivalent annual cost) and non-financial benefits of the proposed service and estate model compared to continuing the existing service model and, in relation to the capital funding source, has been undertaken.

Both NHS England and NHS Improvement have declared that no public money for capital is available. We have also been advised that the financing options available to support reconfiguration are limited by whether the capital spend is incurred against the national 'Capital Departmental Expenditure Limit ('CDEL'). The utilisation of PFI as a financing vehicle allows the Trust to access available resource without incurring capital cost against CDEL.

Continuing with the existing service model does not achieve this as this option is reliant on the Independent Trust Financing Facility (ITFF) as PFI cannot be utilised for backlog maintenance which would be required during the ten year period ahead of a new build HRI. (The new build at HRI could be funded via ITFF or PFI, in this FBC ITFF is the assumed funding vehicle).

The combined financial and non-financial economic appraisal demonstrates that the development of CRH as the unplanned hospital, with a planned hospital development at HRI (Acre Mill) provides economic value for money (VFM) advantage compared to continuing with the existing service model, and that PFI is the proposed option for capital funding.

» 1.9 Financial Case

To implement the proposed service and estate model:

- the Trust would require capital spend on reconfiguration of £297.6m with this financed through PFI (£276.6m) and ITFF (£21m);
- this would enable the Trust to achieve financial surplus in Year 8 (2024/25) and maintain financial surplus at circa £6m per annum thereafter.

This compares to the existing service model option where:

- the Trust would require a capital spend of £94.5m for back-log maintenance and £379.5m for a new HRI build;
- this would enable the Trust to achieve financial surplus in Year 16 (2032/33) and maintain financial surplus at circa £6m per annum thereafter.

» 1.10 Commissioner Affordability

Greater Huddersfield and Calderdale CCGs have QIPP and care closer to home plans to improve quality and reduce activity for the Trust and drive down the overall cost of healthcare spend. The Trust has shared and discussed the activity, growth and inflation assumptions of the FBC with Greater Huddersfield and Calderdale CCGs. This has identified differences on the assumed Trust clinical contract income levels when compared to the CCGs' five year plans. This is mainly due to a £11.5m difference on QIPP assumptions in FY18 that requires in-year resolution. The Trust is committed to supporting the CCGs to deliver a financially sustainable solution for the local health system and is working with commissioners to deliver these in-year QIPP savings. The affordability gap grows by £7m between FY18 and FY22 and it is assumed in this FBC that as the £7m is identified, costs will be removed at 100% rate.

» 1.11 Conclusion and Recommendation

This FBC proposes a plan that will improve the quality and safety of hospital services; eliminate the Trust's underlying deficit in year 8 (FY25); and deliver economic and affordability benefits compared to continuing with the existing model of hospital care.

It is recommended that both NHS Improvement and NHS England support CHFT's FBC and request Department of Health and Treasury approval to progress implementation of the proposed service and estate model.

2 | Introduction >>

2 | Introduction

» 2.1 Overview and Background

Calderdale and Huddersfield NHS Foundation Trust (CHFT) provides hospital services at Calderdale Royal Hospital (1990s PFI site in Halifax) and at Huddersfield Royal Infirmary (1960s Trust building in Huddersfield). The distance between the two hospitals is approximately 5 miles. The Trust also provides integrated community services for the Calderdale area.

Both hospitals provide accident and emergency services, outpatient and day-case services, acute inpatient medical services and level 3 intensive care for adults. Some services are delivered at one site only (e.g. stroke, cardiology, trauma, paediatrics, acute surgery, elective orthopaedics and maternity).

For a number of years CHFT has experienced clinical, operational and financial challenges associated with the dual site provision of services and significant risks have been identified if there is no change to the current configuration of services. These include:

Safety and Quality Risks

- Inability to maintain a sustainable model for delivery of ED and acute medical inpatient services and the recruitment and retention of staff in these areas;
- Inability to provide Paediatric services compliant with national safety standards (separate site working for paediatric medical and surgical care and no dedicated paediatric ED facility);
- Requirement for a high level of inter-hospital transfers that potentially compromises safety of care
- Inability to deliver optimal outcomes of care (e.g. SHMI) and maintenance of CQC 'requires improvement' status.

Financial Risks

- Inability to sustainably reduce the underlying deficit of the Trust and thereby increasing the deficit of the local and wider West Yorkshire health economy both of which are already strained.
- An indefinite requirement for interest-bearing loans and/or fee-bearing public dividend capital ('PDC') from the Department of Health to maintain the two sites in their current configuration;
- An increasing requirement for capital support for essential buildings works to maintain the 1960s Huddersfield Royal Infirmary building.

On the 14th January 2015, the Trust was placed under an enforcement undertaking by its then regulator Monitor (now NHS Improvement). As a result the Trust was required to produce a Turnaround Plan and was authorised by Monitor to use Ernst & Young to produce a five year strategic and sustainability plan which was approved by the Trust Board in December 2015 and submitted to Monitor and to Greater Huddersfield and Calderdale CCGs.

In February 2016 Monitor provided written feedback of their high level review of the five year strategic plan. The feedback confirmed that "Monitor has undertaken a high level review of the Trust five year strategic plan to provide early feedback in advance of the development of the FBC. Monitor will undertake a further detailed review on submission of the FBC (subject to confirmation of DH support and sufficient development of the FBC). We expect that the FBC document will be written in the 5-case model format".

During 2016 the CCGs led the Right Care, Right Time, Right Place formal public consultation on the proposals for the future configuration of hospital and community services in Calderdale and Huddersfield. Subsequently the CCGs made the decision to progress the proposed changes to a Full Business Case (FBC). In April 2017 NHS Improvement (NHSI) and NHS England (NHSE) confirmed support for the Trust to develop a Full Business Case for the reconfiguration of hospital services.

The five year strategic plan proposed a new model of hospital service delivery to consolidate the provision of emergency and unplanned services at Calderdale Royal Hospital (CRH) and provide planned hospital services at Huddersfield Royal Infirmary (HRI). The service model developed was agreed with Clinical Commissioners and endorsed by the Yorkshire and Humber Clinical Senate.

The plan clarified the financial implications of supporting reconfiguration of CHFT services compared to the 'as is' or base case. This showed that:

- the proposed option yielded a recurrent deficit of £9.5m from FY22 onwards. Whilst this represented an improvement of £18.0m against the base case deficit of £27.5m it did not return the Trust to a breakeven or surplus position over the forecast period.
- the proposed reconfiguration of services would require £200m additional capital investment compared to the 'as is' however this would yield a £18m revenue benefit per annum that would mean a potential financial payback of investment in 10-11 years. Also this would deliver significant wider economic benefits related to quality, safety and workforce resilience.
- continuing with the current operating model would require £156m capital investment (largely to address backlog maintenance) and this would not deliver any reduction in the underlying deficit or improvement of the quality and safety of service delivery.

Overall the Trust's five year strategic plan for the future configuration of hospital services was developed on the basis that it would:

- Improve the clinical quality and safety of service delivery;
- Redesign services so that the Trust is operationally viable across two sites;
- Reduce the Trust's underlying deficit and as a result improve both local and West Yorkshire system financial sustainability;
- Make best possible use of the total Trust estate and PFI.

Using the Trust's five year strategic plan the CCGs developed a pre-consultation business case and subsequently led the Right Care, Right Time, Right Place formal public consultation on proposals for the future configuration of hospital and community services in Calderdale and Huddersfield. Public consultation concluded in June 2016 and in October the CCGs made the decision to progress the proposed changes to Full Business Case (FBC).

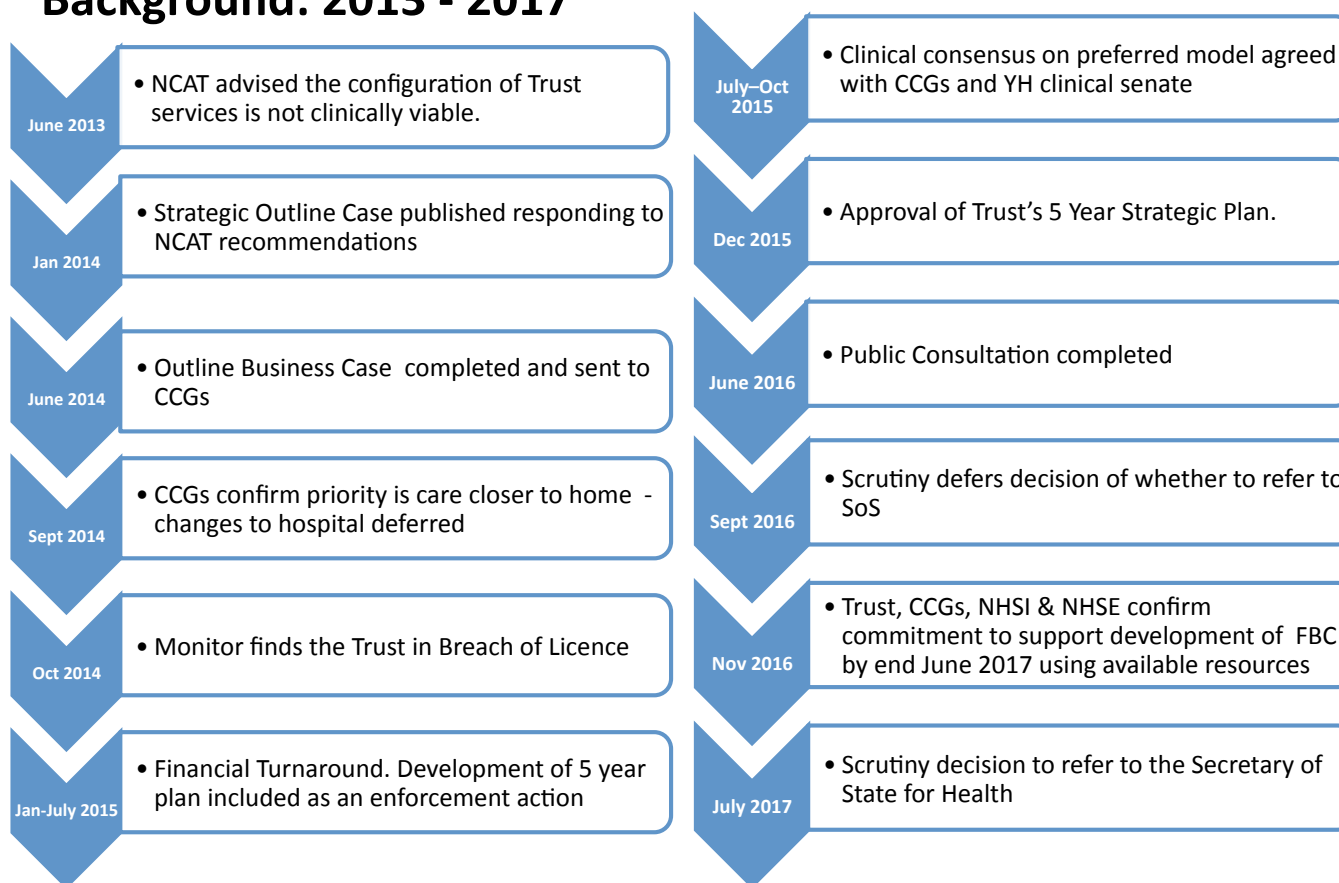
In November 2016 Calderdale and Kirklees Council Joint Health & Social Care Scrutiny Committee (JHSC) considered the findings of the public consultation and made nineteen recommendations requesting the CCGs and Trust provide further information.

On 21 July 2017 the JHSC agreed that maintaining the status quo is not an option and that they understand the clinical and quality case for change. However the JHSC voted 5 to 3 in favour of exercising its right to refer the proposed reconfiguration to the Secretary of State for Health on the grounds that:

- It is not satisfied with the adequacy of content of the consultation with the Joint Committee.
- The amended proposals presented to the Joint Committee are not consistent with the proposals originally consulted on by the CCGs in 2016.
- It considers that the proposal would not be in the interests of the people of Calderdale and Greater Huddersfield and hence not in the interests of the health service in the area.

A summary timeline of this extensive previous work is provided as follows:

Background: 2013 - 2017



» 2.2 Advice and Support from NHSI and NHSE on Development of the FBC

In April 2017 NHS Improvement and NHS England Regional Directors for the North of England jointly reviewed the work previously undertaken and confirmed the following in a letter to the Trust and CCGs:

1. The status quo is not sustainable and the health economy will need to reconfigure to ensure clinical and financial sustainability. NHSI and NHSE will support the system to achieve these aims.
2. Public capital will not be available for the proposed model and therefore other options for funding will need to be explored.
3. NHSI and NHSE are supportive of the intent to pursue joint venture and PF2 options for capital and would need to understand the mechanisms to deliver solutions for both of these and any wider impact.
4. The plans will need to be affordable for both the Trust and CCGs and as such the wider system health economy (affordability assumes delivery of NHS Constitution standards in a way consistent with the 5 year forward view delivery plan).
5. Any review of the plans should be supportive of the clinical model that has been consulted on but could be amended if this improves affordability and/or reduces timescales. Significant variation from the current proposed model may require consideration of whether further consultation is required.
6. The proposals will need to have an agreed timeline and plan on day one to deliver financial balance in the future as well as stretching and challenging plans to improve the position from now until then. Any changes might need to be accelerated so that a balanced position is achieved as soon as is practical.

NHSI and NHSE have also provided the Trust with specific direct input and support in development of this FBC as shown below:

Review of the clinical case for change and proposed future service model	Members of the Clinical Advisory Group: Chair - Joint Medical Director, NHS England – North (Yorkshire and the Humber) Programme Manager Clinical Strategy, NHS England - North (Yorkshire and Humber) Consultant in Public Health Specialised Commissioning, Public Health England, Yorkshire and the Humber Centre Deputy Director Healthcare, Public Health England, Yorkshire and the Humber Medical Director, Doncaster and Bassetlaw NHS FT and Council Member Acute Physician, County Durham & Darlington NHS FT Clinical Director Yorkshire and the Humber Clinical Networks Senate Manager, NHS England – North (Yorkshire and the Humber) Consultant Liaison Psychiatrist, York Liaison Mental Health Team and the Y&H MH clinical network lead
Development of activity and capacity models	Senior Economist, NHS Improvement Intelligence Analyst, NHS Improvement
Advice on Estates	NHS England Property Appraisal Unit Community Health Partnerships
Advice on PFI	Deputy Head, Private Finance Unit, Procurement, Investment and Commercial Division, Department of Health

» 2.3 Purpose of the FBC

Building on the Trust's five year strategic plan and the advice provided by NHSI and NHSE this Full Business Case:

- refreshes the strategic, clinical, operational and financial case for change;
- confirms the proposed future model of hospital services;
- identifies potential sources of capital funding to enable implementation of the proposed changes and explores the commercial opportunities and process to progress different options;
- provides an appraisal of the potential funding options to identify a proposed funding option;
- assesses the impact of the proposed service model and funding option on the Trust's underlying deficit and longer term sustainability.
- describes the impact on the wider system affordability and sustainability.

The purpose of the FBC is to:

- provide a plan for improving the quality and safety of hospital services provided by the Trust;
- eliminate the Trust's underlying deficit;
- comply with the NHSI / Monitor Enforcement Notice placed on the Trust;
- make best possible use of the total Trust estate and PFI;
- contribute to improvement of the wider system affordability and sustainability;
- secure NHS Improvement and Treasury approval to progress the proposed funding option to implement the proposed estate development and reconfiguration of hospital services.

3 | Strategic Context >>

3 | Strategic Context

» 3.1 Summary

This chapter outlines the 'as is' strategic context for the development of this FBC. It provides information in relation to:

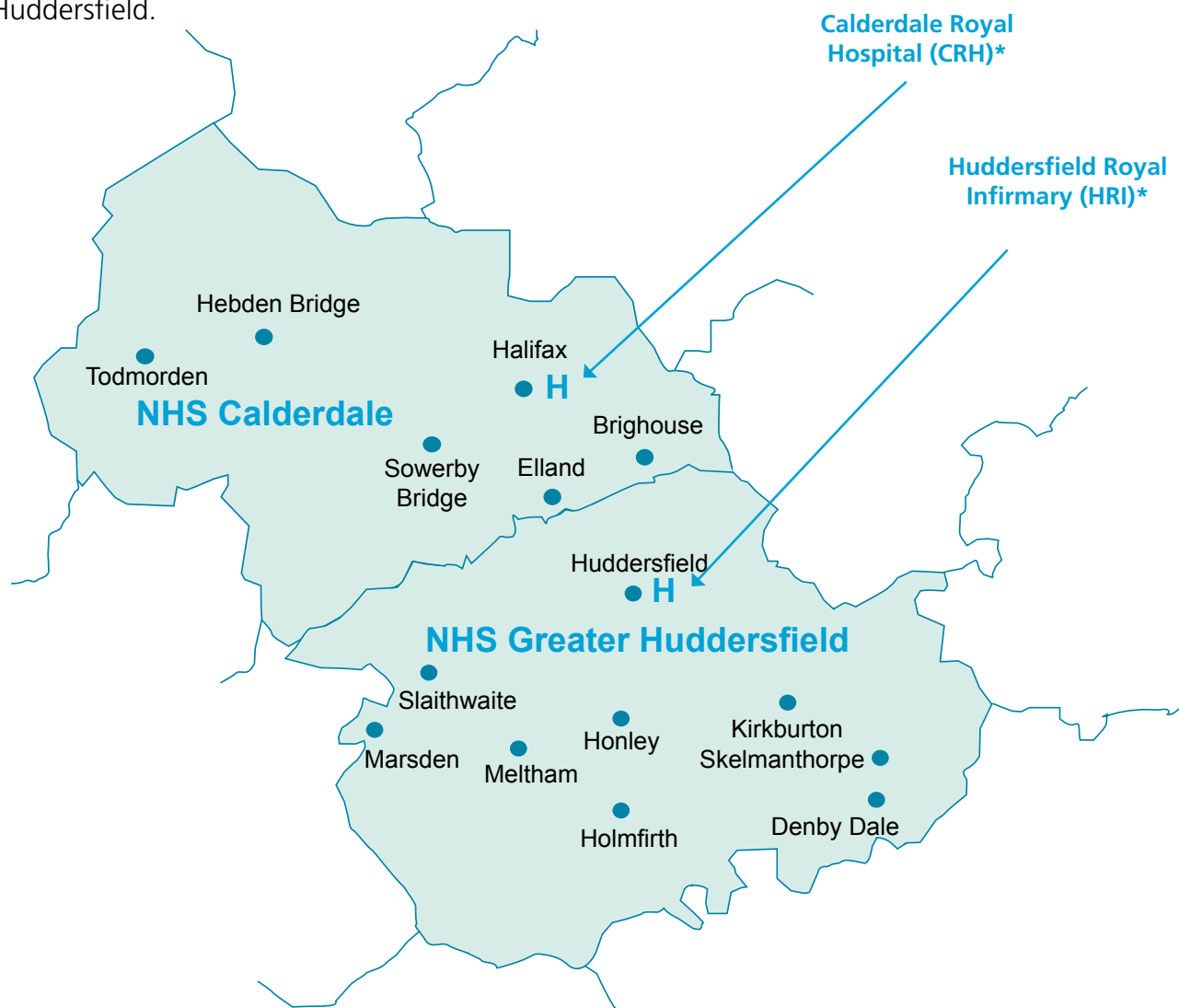
- the needs of the population served by the Trust;
- National policy and financial conditions;
- the West Yorkshire Sustainability and Transformation Partnership;
- the West Yorkshire Association of Acute Trusts;
- NHSE Specialised Service Commissioning;
- Calderdale and Huddersfield health and social care economy (local commissioning);
- CHFT's current service provision, strategic objectives and performance.

In summary the strategic context for this FBC is that:

- Our local people are living longer lives, however more people are likely to have multiple long term conditions thereby increasing the demand on the health and social system and those involved in the provision of care.
- Nationally there has been a rapid rise in demand for hospital nurses and difficulties in recruiting consultants in the mainstream specialties of emergency medicine, acute general medicine and diagnostic services. This has been further complicated with the enforcement of IR35. Growing shortages of qualified clinical staff has resulted in increased use of agency and other temporary workers to fill vacancies and this has increased NHS expenditure. At CHFT the current dual site configuration of services is exacerbating the challenges in being able to recruit and retain staff. Reconfiguration of the Trust's services will address these challenges and reduce the overall workforce capacity required and the current reliance on temporary staffing.
- The national NHS provider deficit is significantly higher than was planned and indicates that the NHS is currently both unaffordable and unsustainable. CHFT has a significant underlying deficit and is reliant on financial support from the Department of Health to provide the cash to pay creditors and staff. Structural costs associated with the dual site configuration of services (which require higher workforce expenditure) and the high finance costs of the PFI are key factors driving the underlying deficit.
- The cost of commissioning services is not affordable to the CCGs in Calderdale and Huddersfield and as a result they are not compliant with NHS business rules.
- Nationally the increasing demand for services and financial stress is having an impact on access to NHS services and quality of care. In 2016/17 CHFT has delivered a high level of performance against national access targets. However the sustainability of this is fragile as it is reliant on continued high agency staff use and cost. The CQC has rated the Trust as requires improvement. Nationally 43% of acute Trusts are rated as either 'inadequate' or 'requires improvement'.
- Collaborative work across West Yorkshire to develop and implement sustainability and transformation plans is taking place. The proposed reconfiguration of hospital services in Calderdale and Huddersfield described in this FBC is included in the West Yorkshire STP as one of the potential solutions that could contribute to closing the financial, care and quality gaps in West Yorkshire.

» 3.2 The Population Served by the Trust

This FBC relates to the provision of hospital and community services in Calderdale and Greater Huddersfield.



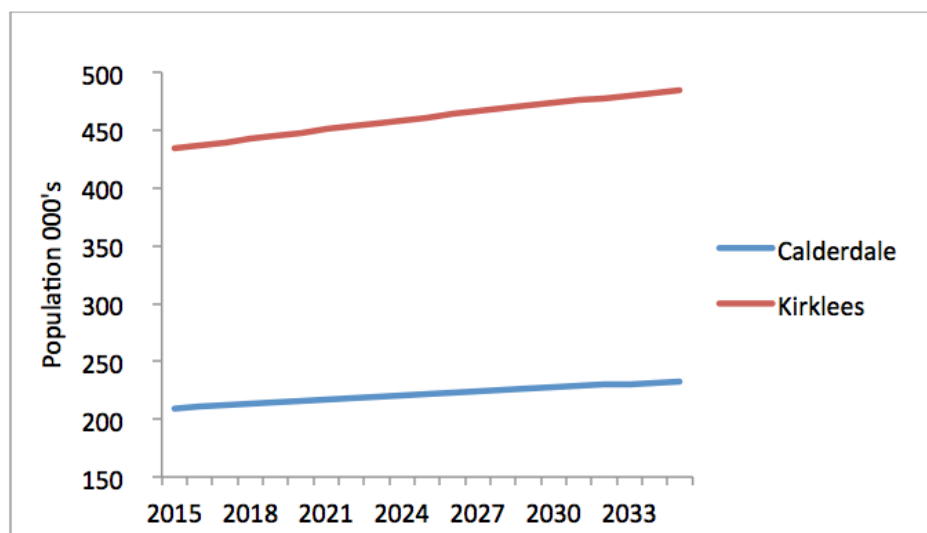
In Greater Huddersfield 80% of the resident population demand for hospital based services is referred to CHFT and in the case of Calderdale this is 88%.

The health economy does not operate in isolation or within defined boundaries and therefore changes to service provision in neighbouring localities (for example across West Yorkshire) may have an impact on the Trust's services and provision. Similarly changes made as part of this programme of work may also impact on neighbouring health economies.

3.2.1 Health Needs of the Population Served

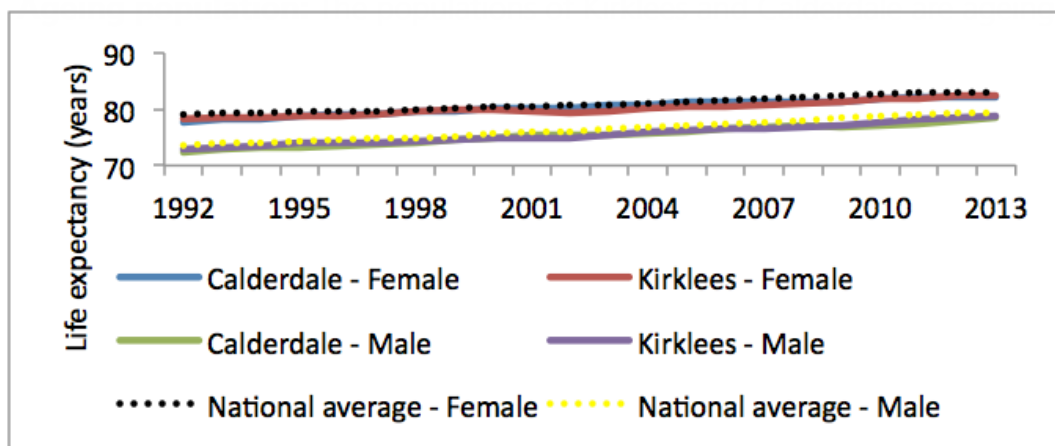
In Calderdale and Greater Huddersfield the size of the population and life expectancy is increasing. Many people now live well into their 80s and 90s. Lifestyles are also impacting on health needs. Smoking is still the UK's largest cause of preventable illness and early death, obesity is increasing and is associated with health issues such as diabetes and cardiovascular disease. Clinical Commissioning Groups and the two Councils in Calderdale and Kirklees have drawn up Joint Strategic Needs Assessments (JSNA) which identify common themes that drive the health needs of the local populations. These are:

Population Growth: The population for Kirklees is c. 434,000 and for Calderdale is c. 209,000, giving a combined population of c. 643,000 people. This is forecast to increase by 12% in Calderdale and 13% in Kirklees by 2037; which is consistent with England's expected population growth of 14%.



Forecast population in Kirklees and Calderdale. Source: Office of National Statistics, 2012 based subnational population projections for local authorities in England

Life expectancy: Average life expectancy in Kirklees and Calderdale has increased year-on-year.



Life expectancy in Kirklees and Calderdale, 1992 to 2013. Office of National Statistics, Life Expectancy at Birth and at Age 65, by Local Areas in England and Wales, 1991-93 to 2012-14

In 2012 there were 102,000 people aged 65 years and over (16% of the population). This is forecast to increase to 169,000 people over the age of 65 years by 2037 (23% of the population). These increases represent a compound annual growth rate of 2% for the 65 plus age group and 0.5% for the full population. This is a significant challenge, as the likelihood of having long term conditions increases with age and so does the likelihood of having multiple conditions, increasing the demand on the health system. The Kirklees Joint Strategic Needs Assessment (JSNA) 2013 reports that by the age of 55-64, one in four people had at least one of the long term conditions identified in the Current Living in Kirklees 2012 survey (e.g. diabetes, respiratory disease). Additionally, by the age of 75, almost two in three had two or more conditions. In Calderdale and Kirklees it is estimated there are circa 2,400 people and circa 4,200 people respectively living with dementia. Statistics show that more people in Calderdale are admitted to long-term residential care than in other parts of the country.

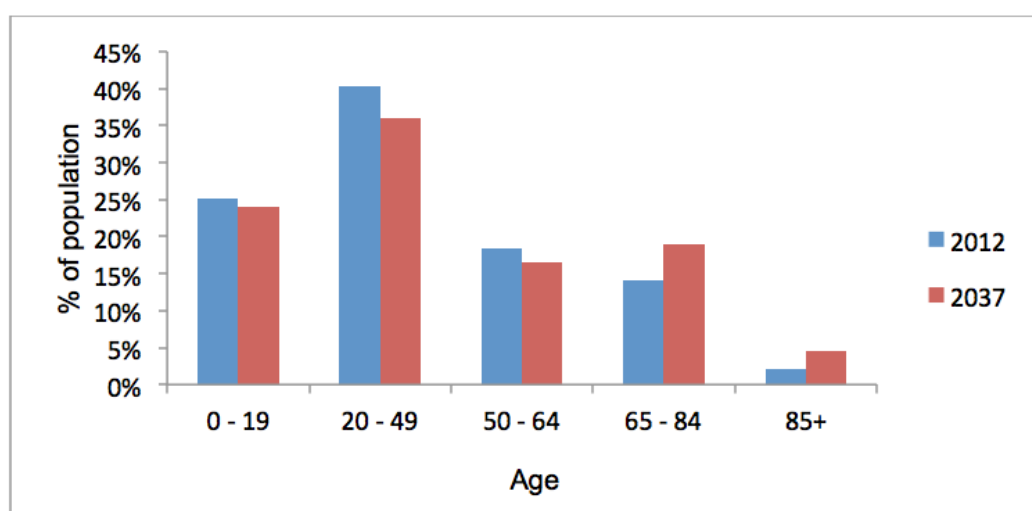


Figure 5: Forecast population ageing in Kirklees and Calderdale.
Source: Office of National Statistics, 2012 based subnational population projections for local authorities in England

Levels of deprivation: There are high poverty and deprivation levels in Huddersfield along with higher rates of unhealthy eating and levels of exercise and higher disease burden. The infant mortality rate for Calderdale is significantly higher than the England average (7.7 per 1,000 live births compared to 4.6 per 1,000 live births).

Health profiles: The JSNA for the Greater Huddersfield area identified frailty, emotional welfare, obesity and cardio-vascular disease (CVD) as cause for specific concern locally. Priority areas for Calderdale in their JSNA include the management of long term conditions such as diabetes, asthma and epilepsy, mental health and the abuse of alcohol.

Lifestyle factors: Smoking prevalence and the harm caused by alcohol and obesity is increasing. There is rising childhood obesity and it is estimated that 40% of all illness in Calderdale can be attributed to lifestyle factors. In the Greater Huddersfield area, 52% of adults are overweight or obese and 20% of children are overweight or obese.

» 3.3 National context

The following provides a summary of strategic issues at a national level that are impacting on the Trust and have been taken into account in developing this FBC.

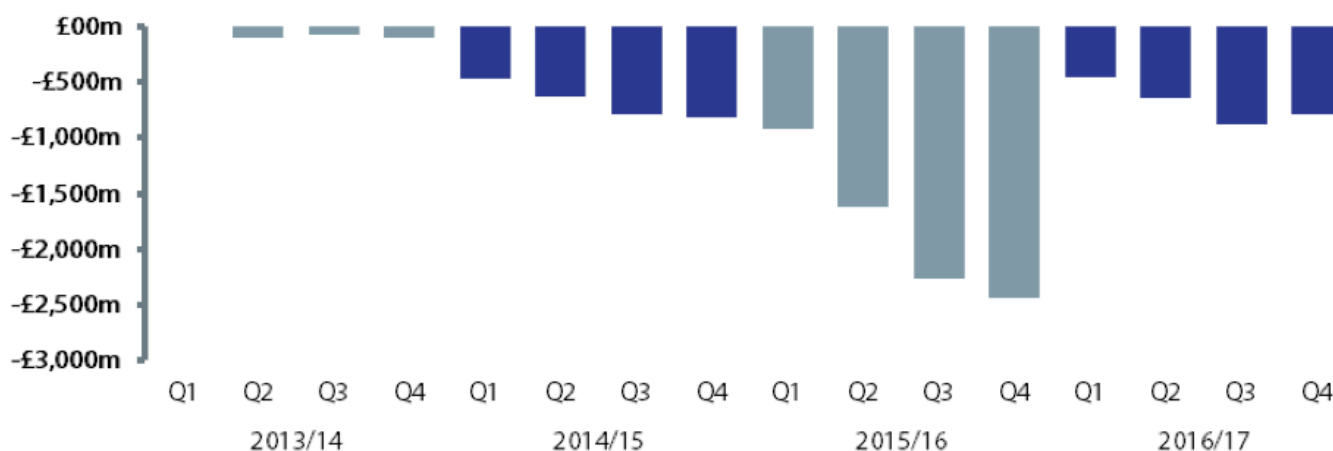
NHS financial challenges:

In 2015/16 NHS Commissioners and Trusts reported a combined deficit of £1.85 billion. This was made up of Trust deficits of £2.45 billion, CCGs overspend of £15m, and NHS England under-spend of £614m. The majority of NHS trusts in England reported a deficit and were reliant on financial support (loans) from the Department of Health to provide the cash they need to pay creditors, staff and to fund essential building works.

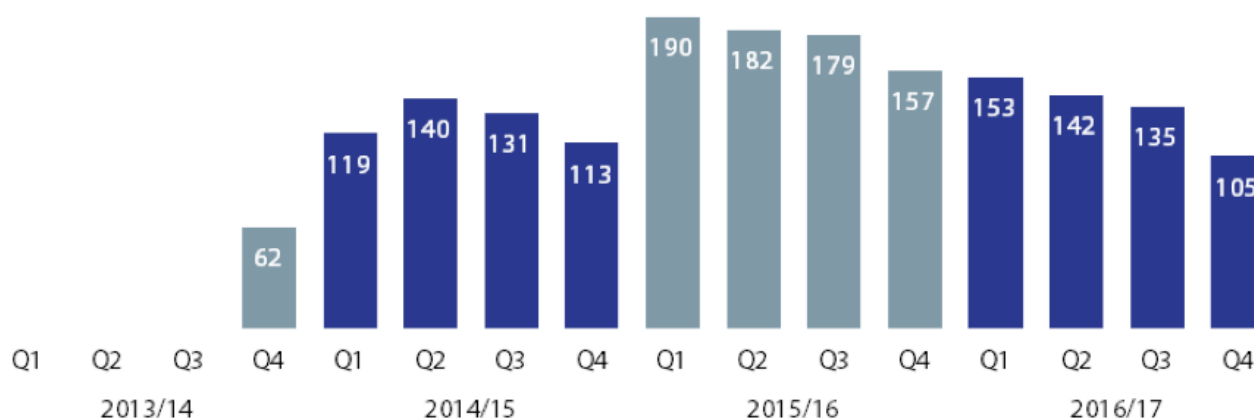
In July 2016 NHS England and NHS Improvement described a financial 'reset' of the NHS detailing actions designed to support the NHS to achieve financial sustainability and improve operational performance (Strengthening Financial Performance & Accountability in 2016/17). £1.8bn of Sustainability and Transformation Funding (STF) was made available to support providers in reaching financial balance whilst improving performance and productivity of NHS services. Trusts were required to engage in service transformational change to: tackle paybill growth and reduce agency staff costs; implement Lord Carter's recommendations on back office and pathology consolidation; and address unsustainable services through collaboration with other providers. Specifically the financial reset, confirmed actions to support NHS providers in cutting the annual NHS provider deficit in 2016/17 to no more than £580m and deliver a balanced starting position for 2017/18 based on the full year effect of the measures taken.

The 16/17 year end outturn was £211m worse than the aggregate provider plan deficit of £580m and indicates that the NHS is currently both unaffordable and unsustainable.

YTD surplus/deficit for FT and trust sector combined



Number of providers in deficit



(source: NHS Providers – 2016/17 Quarter 4 Finance and Performance)

Although there are increased resources available for the NHS in 2017/18 and 2018/19, the level of growth is significantly less than has previously been available to the NHS (3.6% in 16/17 compared to 1.3% for 17/18). Therefore, the expectation is that providers and commissioners will need to have a relentless focus on efficiency in 2017/18 and 2018/19.

The NHS capital environment is also very challenged with publically financed capital resources severely constrained at £360m. Provider capital plans need to be consistent with clinical strategy and clearly provide for the delivery of safe, productive services with business cases that demonstrate affordability and value for money. Providers are expected to continue to procure capital assets more efficiently, maximise and accelerate disposals and extend asset lives.

Increasing operational service pressures:

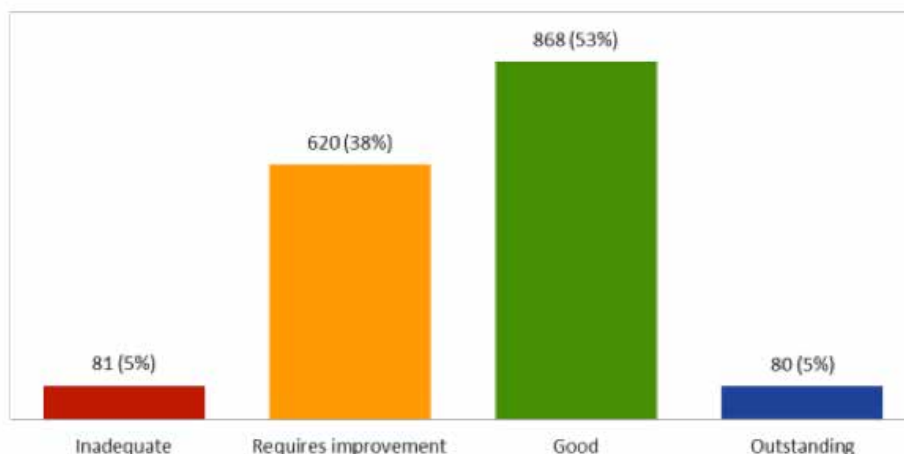
Increasing demand for services and financial stress is having an impact on access to NHS services and quality of care. During 2016/17 Trusts' performance against important NHS access targets has worsened.

A&E departments have seen exceptionally high numbers of attendances on a daily basis throughout the winter period and bed capacity constraints due to high occupancy rates and delayed transfers of care have resulted in many patients requiring admission waiting significantly longer in A&E departments for a bed. In December 2016, acute providers also had to open on average 2,600 escalation beds per day without extra funding to cope with the record level of emergency demand. High emergency admissions have also led to planned elective work being displaced or cancelled. In March 2017 85.1% (target 95%) of patients were seen within 4 hours in type 1 A&E departments.

Trusts continue to fail to achieve the national referral to treatment standard (RTT). At the end of March 2017 90.3% of patients waiting to start treatment (incomplete pathways) waited up to 18 weeks, thus not meeting the 92% standard. The number of patients waiting to start treatment at the end of March 2017 was 3.73 million patients and of those, 1,529 patients were waiting more than 52 weeks.

Increasing quality expectations:

In recent years there has been increasing scrutiny of Trusts, hospitals, departments and individual healthcare professionals. Rolling inspections by the Care Quality Commission (CQC), the Francis report, the Keogh Review, and the Seven Day Services review have all increased the focus on maintaining high standards of care at all times. This requires significant changes to health service culture and working practices in the context of a constrained funding environment. The CQC has inspected all acute hospital trusts in England. In March 2017 the CQC published their findings from the end of this programme of comprehensive inspections as summarised in the following diagram. This shows that just under half (43%) of all acute Trusts in England are currently rated as inadequate or requiring improvement.



(source: CQC ratings data as at 31 December 2016)

Clinical Workforce Challenges:

Since publication of the Francis Report there has been a rapid rise in demand for hospital nurses. Higher levels of patient activity and levels of sickness (acuity) in hospitals along with new requirements concerning safe and effective staffing levels has changed the national demand for nurses. There are also difficulties in recruiting consultants in the mainstream specialties of emergency medicine, acute general medicine, diagnostic services and psychiatry.

There is evidence that Brexit is having an impact on workforce supply. The number of EU nationals registering as nurses in the UK has fallen by 96 per cent since the referendum, with just 46 EU nurses registering with the Nursery and Midwifery Council in April 2017. There has also been a fall in the number of EU nationals taking jobs in the social care sector.

Growing shortages of qualified clinical staff has resulted in Trusts making increased use of agency and other temporary workers to fill vacancies. In 2016/17 NHS Improvement introduced new rules on agency workers to help providers address the impact of this trend on their costs.

A change to the IR35 tax system in April 2017 has resulted in some Trusts facing a struggle to attract temporary staff - particularly in hospital A&E departments (which account for almost a fifth of the NHS expenditure on locum doctors).

Pressure on Adult Social Care:

The combination of a growing and ageing population, increasingly complex care needs, reductions in funding to local government and increases in core care costs have placed adult social care services under increasing pressure. Councils have sought to protect social care budgets. However, as the scope for savings efficiencies has reduced they have had to manage social care funding pressures by implementing service reductions, smaller care packages, stricter eligibility criteria, and reducing the prices paid to providers in both the independent and voluntary sectors.

Due to reductions in social care services, more people who need care are not having their needs met. There is also evidence that care providers are facing quality challenges and the care provider market is shrinking and becoming increasingly fragile. Furthermore, in some areas a lack of suitable care provision is adding to pressures in the NHS.

In 2015 and 2016 the Government announced three new sources of funding for Councils with responsibility for adult social care. However even with this additional funding (from the Social Care Precept, Better Care Fund and the Adult Social Care Support Grant) it was estimated that social care faces a funding shortfall of at least £2.6 billion by 2019/20.

In March 2017, the Government announced an additional £2 billion funding for adult social care in England over the next three years with £1 billion available in 2017/18. The funding will be supplemented by measures to ensure Councils facing the greatest challenges are identified and supported, and to ensure more joined up working with the NHS.

NHS Priorities in 2017/18:

In March 2017 the *Next Steps on the NHS Five Year Forward View* was published. This confirmed that within the constraints of the requirement to deliver financial balance across the NHS, the 2017/18 national service improvement priorities for the NHS are:

- improving A&E performance
- strengthening access to high quality GP services and primary care
- Improving cancer services and mental health services.

The report stated that 'whilst the NHS and the Government remain committed to short waits for routine operations there is likely to be continued pressure on waiting times for routine care and some providers' waiting times will grow'. To deliver these goals, in 2017/18 it is expected that work is undertaken through partnerships of care providers and commissioners in an area (Sustainability and Transformation Partnerships) and that some of these partnerships will be able to go further and more fully integrate their services and funding to establish Accountable Care Systems.

» 3.4 The West Yorkshire Sustainability and Transformation Partnership

In December 2015 joint planning guidance was issued by NHS England, NHS Improvement, the Care Quality Commission, Health Education England, the National Institute of Health and Care Excellence and Public Health England. This required that health and care systems work together to develop place based five year sustainability and transformation plans to meet the needs of local populations and reduce gaps in services related to:

- health and wellbeing;
- care and quality; and
- funding and efficiency.

Across England 44 geographical STP footprints were established. CHFT is a member of the West Yorkshire Sustainability and Transformation Partnership covering a population of 2.6 million people. The partnership includes: all of the six acute trusts (five in West Yorkshire plus Harrogate), the eleven CCGs, mental health and community providers, Yorkshire Ambulance Service, local authorities, primary care federations and Healthwatch organisations across West Yorkshire.

In October 2016 the West Yorkshire STP was completed and described the following vision:

- Every place will be a healthy place, with a focus on prevention and health inequalities;
- Work with local communities to build community assets and resilience for health;
- People will be supported to self-care as a standard offer, with technology a key to supporting people in their communities;
- Care will be person centred, simpler and easier to navigate;
- There will be joined-up community place-based services across mental and physical health and social care including close working with voluntary and community sector;
- Local services will merge into accountable care systems to help keep people well;
- Acute needs will be met through services that are “safe sized” with an acute centre in every major urban area, connected to a smaller number of centres of excellence providing specialist care;
- Actively engage people in planning, design and delivery of care;
- Move to a single commissioning arrangement between CCGs and local authorities;
- Share back office functions, where possible, to drive efficiencies to enable investment in services;
- Local services will merge into accountable care systems to help keep people well.

The West Yorkshire STP included local plans for: Bradford District and Craven, Calderdale, Harrogate and Rural District, Kirklees, Leeds and Wakefield. Nine West Yorkshire-wide priority areas for collaboration and transformation were also described: acute hospital collaboration, cancer, mental health, prevention ‘at scale’, primary and community care, specialised commissioning, standardisation of commissioning policies, stroke, and urgent and emergency care.

The STP confirmed that the demand for and cost of services in West Yorkshire, if unmanaged will drive a funding gap of £1.07bn by 2021 for health and social care. However by working together to redesign and reconfigure services the STP also identified solutions that could reduce the health and social care funding gap to £91m by 2021.

The proposed reconfiguration of hospital services in Calderdale and Huddersfield is included in the West Yorkshire STP as one of the potential solutions that could contribute to closing both the financial and care and quality gaps in West Yorkshire. The STP confirms that transformational capital funding will be required to enable service reconfiguration and to address long term structural and estate challenges in West Yorkshire.

» 3.5 The West Yorkshire Association of Acute Trusts (WYAAT)

Established during 2016 the West Yorkshire Association of Acute Trusts (WYAAT) is a collaboration which brings together NHS trusts delivering acute hospital services from across West Yorkshire and Harrogate to drive forward the best possible care for patients.

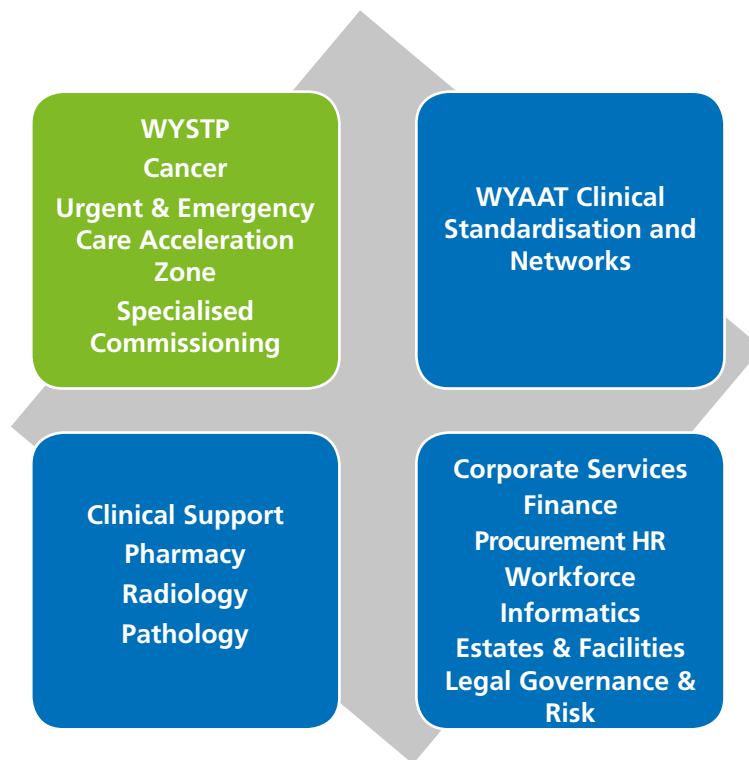
Membership of WYAAT includes: Airedale NHS Foundation Trust, Bradford Teaching Hospitals NHS Foundation Trust, Calderdale and Huddersfield NHS Foundation Trust, Harrogate and District NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust and Mid Yorkshire Hospitals NHS Trust. Formal governance arrangements to enable collective decision making (including a Committee in Common) and a shared PMO function have been established.

The vision of WYAAT is to create a region-wide efficient and sustainable healthcare system that embraces the latest thinking and best practice consistently delivering the highest quality of care and outcomes for patients. The purpose of the collaborative programme is to reduce variation and deliver sustainable services to a standardised model which is efficient and of high quality.

The five key areas of work of the WYAAT Collaborative Programme approach are shown below and these are all included in the West Yorkshire STP.

1. Developing a 'Centres of Excellence' approach to higher acuity specialties e.g. hyper-acute stroke, neurology, cancer, vascular, ENT, eliminating avoidable cost of duplication and driving standardisation.
2. Developing West Yorkshire and Harrogate standardised operating procedures and pathways across services, building on current best practice and using "Getting it Right First Time" (GIRFT) to drive out variations in quality as well as operational efficiency and facilitating safer free movement of bank staff across providers.
3. Collaborating to develop clinical networks and creating alliances as a vehicle (e.g. hyper acute stroke, cancer etc.) which will protect local access for patients whilst consolidating skills (and therefore resilience) and reducing operational cost of duplicated facilities. Using GIRFT, outcome variation data and WYAAT work on sustainable services to identify the case for change for specific services, the model being based on the 'chain' concept.
4. Developing workforce planning at scale to secure the pipeline of fit for purpose staff and improved productivity, managing workforce risk at system level, and supporting free movement of bank and agency staff under single shared Bank arrangements with the aim of reducing spend on agency and reduce the administration costs of the flexible workforce.
5. Delivering economies of scale in back office and support functions e.g. procurement, pathology services, estates and facilities management, and other infrastructure e.g. IT. The default position being consolidation.

.WYAAT has agreed four priority work streams which are shown as follows:



» 3.6 NHS England Specialised Commissioning

NHS England commissions 149 specialised services with a value of £15.6 billion (15% of NHS spending). Specialised services are provided in relatively few hospitals and accessed by comparatively small numbers of patients, but usually with catchment populations of more than one million. CHFT provides the following specialised services: vascular surgery and vascular interventional radiology services, neonatal intensive care, HIV, chemotherapy, bone anchored hearing aids (BAHA), cardiac MRI, and implantable cardiac devices.

From April 2017 many specialised services will continue to be commissioned by NHSE at a national level however NHSE will also start to work more closely with Sustainability and Transformation Partnerships to deliver benefits from more place-based commissioning on an STP footprint. Central to NHSE's approach to this is maintaining national service standards, outcomes and accountability for specialised services whilst also providing local flexibility in the design and delivery of these services.

The linking of Specialised Commissioning with STP footprints is intended to enable a whole system, pathway led, approach to provision and commissioning of services, particularly where transformational change is required. NHSE has undertaken specialised services sustainability audits in each of the STP footprints and the findings of these audits will inform STP work streams around future hospital configuration.

NHSE Review of Vascular Services

In 2016/17 NHSE undertook a review of vascular specialised services across Yorkshire and Humber. The recommendations arising from this for West Yorkshire were that:

- there should be two specialist arterial vascular services with one of the existing centres transitioning to a fully integrated 'spoke' service, in line with NHS England's service specification (currently there are three hospitals providing these services in West Yorkshire - Leeds, Bradford and CHFT);
- Work will need to be undertaken between WYAAT and commissioners to agree:
 - Location of arterial sites
 - Safe and sustainable transition of arterial workload
 - Provision of hub and spoke model and sustainability of clinical interdependencies
 - Clinical leadership and workforce considerations

During 2017 this work has been led by WYAAT and it has been confirmed that clinicians across West Yorkshire want to work together as 'team vascular' and need organisational boundaries to be broken down to deliver the best model in the future. Specific agreements that have been reached related to this are:

- to develop a West Yorkshire vascular network working as a West Yorkshire team with sub specialist team(s);
- West Yorkshire needs two strong arterial centres which are well utilised - this is not centralising service in Leeds;
- the case mix in the two centres will reflect the specialist tertiary service provision and Major Trauma Centre status of Leeds;
- governance will be based on parity of esteem between partner organisations and a Memorandum of Understanding covering governance, decision making, clinical model, workforce plan and operating principles will be agreed;
- work will start with joint appointments for the West Yorkshire service including the university;
- the network model will consider development of local services and potential spokes including partner Trusts in West Yorkshire;
- there will be a shared financial model with risk gain share;
- there is need to develop the process for identifying the location of the second arterial centre but also it is recognised there is need to start collaborative working to build trust and confidence.

The outcome of the Specialised Commissioning review of vascular services and the WYAAT led response to this will have an impact on the future scope of vascular services provided by CHFT.

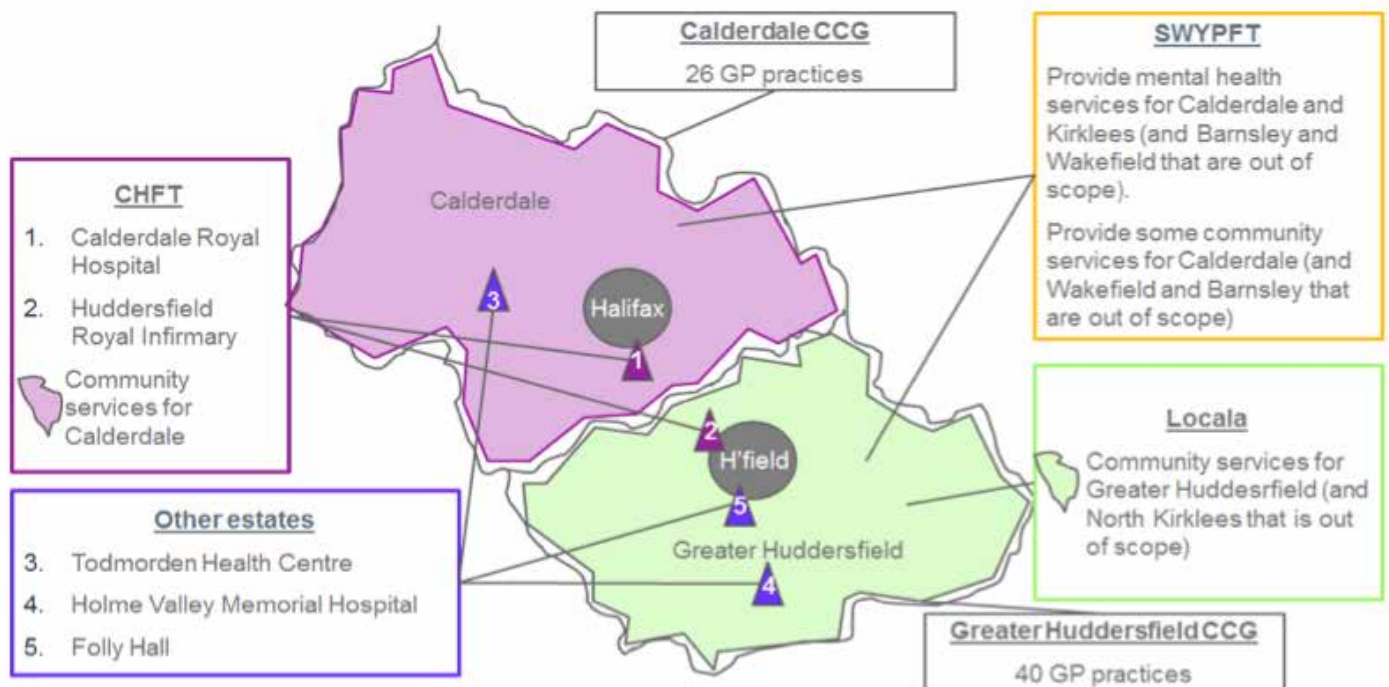
It is possible that Bradford Teaching Hospitals NHS Foundation Trust may be selected as the second vascular arterial site for West Yorkshire and CHFT would then be an integrated 'spoke' site for vascular services.

Conversely it is possible that CHFT may be selected as the second vascular arterial service site. If that was the case there would be additional clinical capacity requirements. On the grounds of not wishing to exclude the possibility of CHFT being selected as the second vascular arterial site this Full Business Case has considered and included these potential additional capacity requirements.

» 3.7 The Calderdale and Huddersfield Health & Social Care Economy

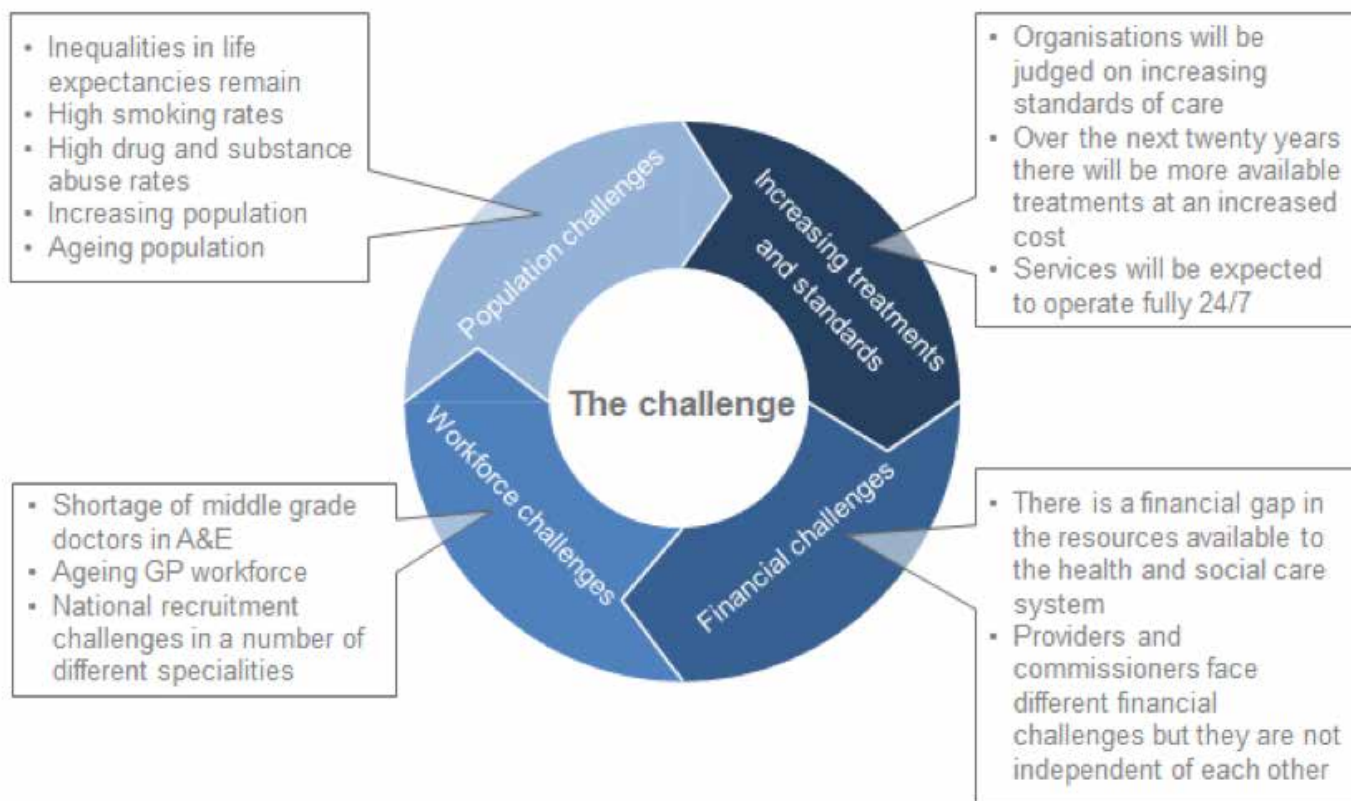
NHS Calderdale CCG and NHS Greater Huddersfield CCG commission the majority of hospital and community health services for the Calderdale and Huddersfield population.

Current view of the main sites and providers for acute, mental health and community health service provision in Calderdale and Greater Huddersfield



Both CCGs are facing significant challenges to ensure that the services commissioned are high quality, safe, sustainable and affordable.

Demands on the Health and Social Care System in Calderdale and Huddersfield are increasing



Doing nothing is not an option. To meet the needs of the future, a radical change in the way in which services are currently delivered to the local population today is needed.

The cost of health and social care in Calderdale and Huddersfield is now more than £600 million a year and while that figure is set to continue to grow, increasing demand, inflation and the introduction of new drugs and treatments mean costs are increasing faster. For the CCGs, the local challenge across both Calderdale and Greater Huddersfield was quantified in the Commissioners Pre-Consultation Business Case as £59.7m between 2015/16 and 2021/22. The funding available to the CCGs will be insufficient to cover the rising demand for health services, the cost of inflation and any other future investments aimed at improving patient outcomes. Despite increasing resources available, growth in expenditure exceeds this.

NHS business rules require that CCGs deliver a 1% surplus or a 1% improvement on expenditure compared to 2016/17. Neither CCG is currently able to meet the business rules and has agreed financial recovery plans with NHSE. This means that the NHS in Calderdale and Huddersfield is currently both unaffordable and unsustainable.

Calderdale CCG's financial plan is a £0.4m deficit for 2017/18 and this assumes that the CCG will be able to deliver £11.5m of efficiency (QIPP) savings. The Greater Huddersfield CCG 2017/18 financial plan is for a deficit of £3.7m and this is based on assumed delivery of £13.5m QIPP savings. The QIPP plans are largely based on delivery of efficiencies associated with shifting services from acute care to communities and closer to patients' homes.

The CCGs have developed five year transformation plans to improve: the quality and safety of care; outcomes for patients, and; service affordability and sustainability. The plans comprise three interlinked pieces of work: Calderdale Care Closer to Home Programme; Greater Huddersfield Care Closer to Home Programme, and; the Hospital Services Programme.

Care Closer to Home

- In March 2015, Calderdale CCG published a detailed plan for 2015/16 which set out how the Care Closer to Home model would be delivered. In August 2015 the CCG received evidence about the early success of the care closer to home work, and subsequently Calderdale CCG, together with partners, was successful in its application to be a Multi-speciality Care Provider Vanguard site although the NHS England funding for this ceased prematurely a year later.
- During 2014 Greater Huddersfield CCG and North Kirklees CCG undertook a joint procurement exercise and in July 2015 appointed Locala Community Partnerships as the lead provider for Care Closer to Home. Delivery of the new Care Closer to Home service commenced on 1 October 2015 but in keeping with the broader health economy has challenges in maintaining quality linked to being able to recruit suitably qualified nursing staff.

Hospital Services Programme

- In parallel with the above, Calderdale CCG and Greater Huddersfield CCG developed proposals for the future configuration of Hospital Services. During 2016 the CCGs led the *Right Care, Right Time, Right Place* formal public consultation on proposals for the future configuration of hospital and community services in Calderdale and Huddersfield. In October 2016 the CCGs made the decision to ask the Trust progress the proposed changes to the FBC.

The Kirklees and Calderdale Health and Wellbeing Boards have both been proactive in considering the changes needed to improve health and wellbeing of the local population and reduce health inequalities. Both Boards have agreed local sustainability and transformation plans (and these are included in the West Yorkshire STP). The Calderdale and Kirklees local STPs share common themes of focusing on: preventative services; self-care; early intervention, and; using community assets to reduce the public need to visit hospital. The proposed reconfiguration of the hospital services provided by CHFT is included in both local STPs.

» 3.8 Calderdale and Huddersfield Foundation Trust (CHFT)

3.8.1 Overview

The Trust was formed in 2001, combining Calderdale Royal Hospital and Huddersfield Royal Infirmary to deliver hospital services for the populations of Calderdale and Greater Huddersfield. Since then the Trust has expanded beyond hospital based services and also provides a range of community services in Calderdale. The

Trust achieved Foundation Trust status in 2006, which allowed the Trust to tailor its services and develop as the local health economy evolved. The Trust has approximately 843 inpatient beds, employs c.6,000 staff and the annual expenditure in 2016/17 was £366m.

The Trust is a 24/7 provider of a range of hospital services that includes: acute medicine, stroke, level 2 trauma, paediatrics, cardiology, interventional radiology, vascular surgery, critical care, obstetric services, orthopaedics, general surgery, gynaecology, and urology.

Some services are provided at both hospital sites whilst others are provided on a single site only as shown below.

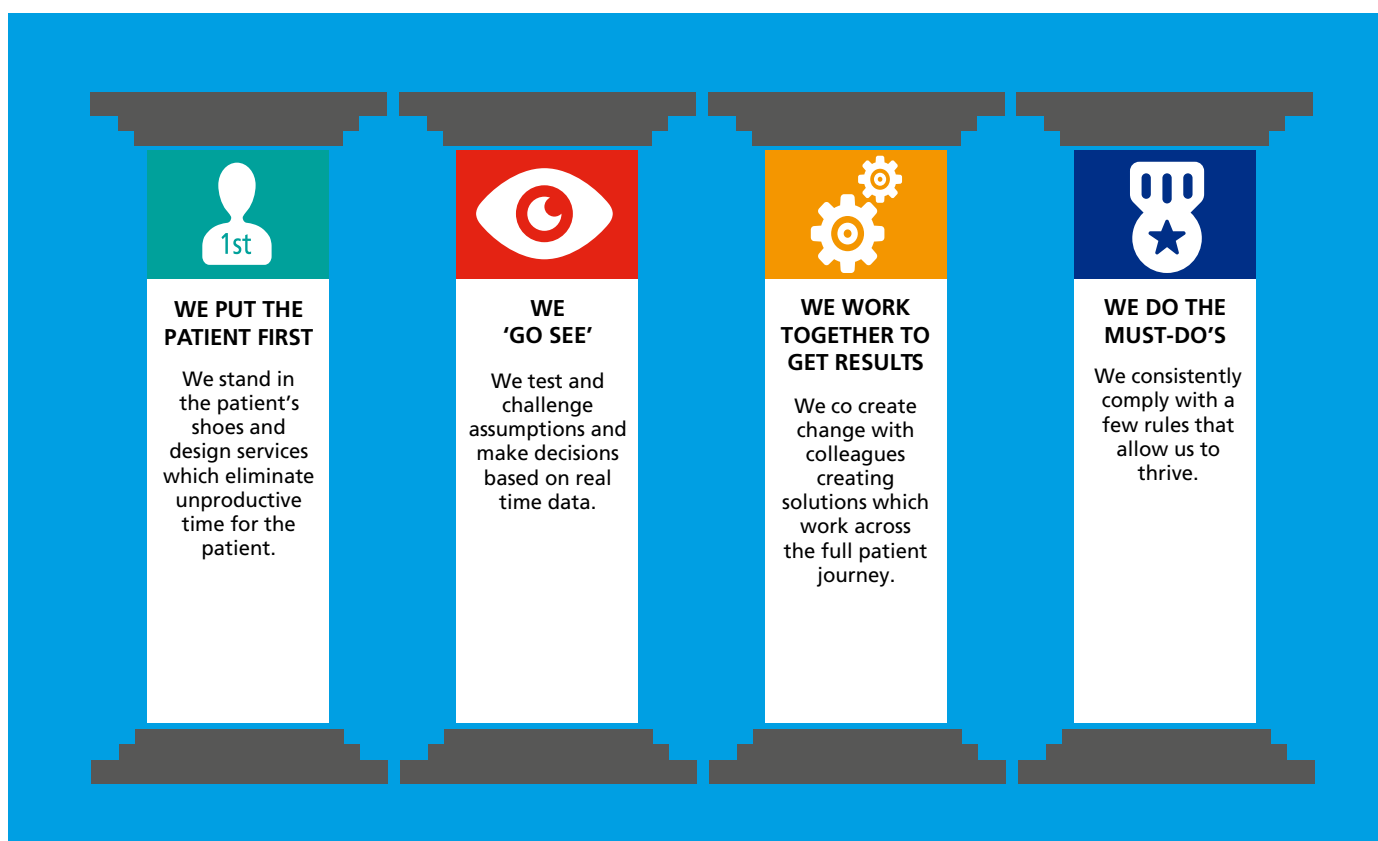
Huddersfield	Both Sites		Calderdale
Unplanned general surgery	Emergency Care	Critical Care	Stroke
Trauma	Maternity (Midwife Led Unit)	Elderly Care	
Vascular Surgery	ENT and audiology	Acute Medical Unit / Ambulatory / Short Stay Unit	Consultant Led obstetrics
Urology	Cardiology	Respiratory	
Planned & Unplanned complex colo-rectal, upper GI and bariatric surgery	Gastroenterology	Diabetes	Planned surgery (most)
Paediatrics Surgery	Neurology	Rheumatology	Paediatric Medicine
Acute Haematology	Dermatology	Pain	
Acute Oncology	Ophthalmology and orthoptics	Planned general surgery (excluding complex)	Breast
Interventional radiology	Elective Orthopaedics	Plastics (inpatients seen at Bradford)	Gynaecology (includes GAU)
Pharmacy procurement	Maxillofacial procedures	Outpatients	Assisted Conception
	Endoscopy	Theatres and anaesthetics	
	Interventional cardiology	Radiology	
	Pathology	Pharmacy dispensing	
	Pharmacy – Aseptic & Radiopharmacy		

Current Configuration of Services Across HRI and CRH

3.8.2 CHFT Vision and Values

The Trust's Vision is strongly patient and clinically focussed, and provides the context for the current and proposed future clinical and operating models described in this FBC. The Trust's vision is: ***"Together we will deliver outstanding compassionate care to the communities we serve"***.

This vision is underpinned by the four fundamental behaviours which guide all Trust employees in the way they work:



3.8.3 CHFT Strategic objectives




The key objectives of the Trust over the next five years are shown in the following diagram.

5 Year Strategy				
Our Vision	<i>Together we will deliver outstanding compassionate care to the communities we serve</i>			
Our behaviours	We put the patient first / We go see / We do the must dos / We work together to get results			
Our goals (The result)	Transforming and improving patient care	Keeping the base safe	A workforce for the future	Financial sustainability
Our response	Our patients and the public will be involved in their treatment and we will use their feedback to develop services for the future	We will have achieved a CQC rating of outstanding	We will have a workforce of the right shape and size with the capability and capacity to deliver safe, high quality services	We will have implemented the five year plan
	We will have commenced implementation of an agreed reconfiguration of integrated hospital and community services	We will be compliant with NHS Improvement standards	We will be widely recognised as an employer of choice through frowning our own and attracting talented people to join our team	We will be financially sustainable with the ability to invest for the future
	We will meet all relevant 7 day working standards and our SHMI will be 100 or less	We will consistently achieve all national and local patient performance targets	Engaging our people and involving them in decisions that affect the Trust will be the norm	We will understand our markets and have a clear plan of how we grow our business
	We will have a robust interoperable electronic patient record which is used by patients and clinicians alike	We will be fully compliant with health and safety standards		

3.8.4 CHFT Estate

The Trust is a large hospital and community multi-site organisation. Hospital services are provided from:

- Huddersfield Royal Infirmary and Acre Mill in Huddersfield.
- Calderdale Royal Hospital in Halifax.

Site name	Site information
<p>Huddersfield Royal Infirmary</p> 	<p>Trust owned site and building. 28 acre site with approximately 420 beds and 9 theatres. A new outpatient facility at Acre Mill opened in 2015. Estate is overall in poor condition with significant backlog of maintenance for time expired buildings of £95m.</p>
<p>Calderdale Royal Hospital</p> 	<p>Ownership of the site and building is split between the Trust and the PFI provider. 19 acre constrained site with approximately 450 CHFT beds and 7 theatres. SWYPFT have 54 inpatient acute psychiatric beds. The existing PFI arrangement at Calderdale runs until 2061. The revenue cost of this is circa £10m per annum, with an additional cost of £10m per annum for hard and soft facilities management. There is a break clause in 2031 which is associated with significant exit costs.</p>
<p>Acre Mill</p> 	<p>The Trust with development partners Henry Boot undertook the development of Acre Mills which opened in 2015. Located across the road from Huddersfield Royal Infirmary it is the base for outpatient appointments in Huddersfield.</p>

Examples of properties where the Trust provides Community services in Calderdale:



St John's Health Centre



Broad Street



Todmorden Health Centre

Huddersfield Royal Infirmary

Huddersfield Royal Infirmary opened in 1965. The hospital offers a full range of day case and outpatient services and an accident and emergency department. It is also the specialist centre for emergency surgery, planned complex surgery and emergency paediatric surgery for the people of Huddersfield and Calderdale.

In 2013, the Trust commissioned a 6 facet survey from NIFES Consulting group that identified the extent of capital works required to bring HRI to condition B status in accordance with the Department of Health Estate code. The survey concluded that the estate is overall in poor condition with significant backlog of maintenance for time expired buildings. The survey identified statutory items across the site that required immediate remedial action in large parts of the estate as well as key factor impacting on operational performance.

A significant investment is required to resolve the functional suitability of the estate. This has been driven through changes in service provision and size of teams that has meant the parts of the current estate are too small or were constructed and designed for another function which does not provide a suitable layout and space for services.

Since the 6 facet surveys were carried out in 2013 there has been a further deterioration of the estates building and engineering service infrastructure and space/functional suitability. This has been compounded by significant constraints on capital investment for backlog maintenance due to financial pressures.

The Trust carries a high risk in terms of the condition and reliability of its building and engineering services infrastructure at HRI. The age and condition of the estate is such that without significant capital injection in backlog maintenance there is a high risk of failure of critical services such as power supply, heating, hot and cold water services and medical gas services.

It has been estimated that £95m would be required to bring the HRI estate to a category B level.

Calderdale Royal Hospital

Calderdale Royal Hospital opened in 2001. The hospital offers a full range of outpatient facilities as well as inpatient areas including Surgical, Medical, Maternity, ICU, Coronary Care and Children's wards. The Dales Unit on the Calderdale Royal Hospital site is occupied by South West Yorkshire Partnership Foundation Trust and includes three in-patient wards as well as a number of outpatient services.

The site was one of the first hospitals built through Private Finance Initiatives (PFI). The PFI arrangement runs until 2061 having been entered into over a 60 year term with a break clause after 30 years.

In 1998 the agreement to build a Private Finance Initiative (PFI) funded hospital in Calderdale was signed. Work commenced in January 1999 and the building was handed over to the Trust in March 2001. Parts of the old Halifax General Hospital buildings were retained and refurbished and in general these are used for office accommodation.

The hospital was built by the Catalyst Healthcare consortium, which then comprised the Lend Lease Corporation, Bovis Lend Lease Limited, ISS Mediclean Limited, the British Linen Bank Limited and the French bank Societe Generale. Bovis Lend Lease provided the design and construction services. As part of the PFI agreement the Special Purpose Company (SPC) has agreements in place with Engie for estates maintenance, life cycle and variation work and with iss for the provision of catering, cleaning, portering, security, car park management, switchboard and linen distribution. The Trust works closely with all parties to ensure close and open partnership working.

The revenue costs of the site include interest and hard and soft facilities management. The total revenue cost for FY17 is expected to be c£23m. The backlog maintenance is managed through the PFI contract and supported by regular capital lifecycle payments into the PFI provider.

There are limited backlog maintenance issues of note and the building is assessed to be compliant to NHS Estates Code condition B.

3.8.5 Workforce

The Trust employs circa 6,000 staff and faces considerable workforce challenges which undermine the resilience of clinical services, staff satisfaction and well-being, and the Trust's finances.

The Trust is not currently able to substantively recruit to meet the rotas of the two sites. There are 77 wte vacancies in the medical and dental group, and 187 wte in the nursing and midwifery group. A number of recruitment processes have failed due to lack of applicants. Vacancy rates are driving unacceptable levels of agency and locum staffing costs. In 2016/17 total Trust agency spend was £23m.

Due to a national shortage of skilled people, the Trust has been seeking to maximise opportunities for recruitment and, more specifically, retention of staff. Both of these activities are directly affected by the current configuration and dual site rotas – this is more severe in certain specialties. The Trust is actively undertaking recruitment of qualified practitioners in the UK, the EU, and internationally. However, there are a number of other specific factors related to the dual site configuration of services at CHFT that are impacting on the ability to recruit and retain staff.

These include:

- Consultant staff are exiting the Trust in emergency medicine and other medical specialties. The reason given for their departure is the current configuration of Trust services across two sites, which compromises the quality of care, and constrains the opportunity for sub-specialisation. This also negatively impacts on workload and the frequency of on-call responsibilities.
- Dual site running, particularly in relation to out of hours rotas, increasing the reliance on junior and/or temporary staff. The reliance on middle grade doctors results in less specialist input into patient care, thus not meeting NHS England standards. The widespread use of locums / temporary staff can lead to lack of continuity of care, and a negative impact on staff morale and sickness absence rates.
- Changes to the IR35 tax system in April 2017 has resulted in the Trust facing additional challenges to attract temporary staff. This has impacted on a number of services such as dermatology.

3.8.6 Finance

Historically the Trust has delivered a financial surplus. In 2014/15, CHFT submitted a plan to deliver surplus however by quarter 2 the Trust recognised this was not achievable and Monitor confirmed the Trust was in breach of its licence.

Through a formal turn-around and recovery process during 2014/15 the Trust delivered a revised deficit plan and also subsequently achieved the agreed (deficit) financial plan for 2015/16.

The Trust has delivered the 2016/17 control total - a year end deficit of £16m. After exclusion of a number of agreed items from the control total and application of the STF incentive payment the Trust has reported the 2016/17 final year end position as a deficit of £13.79m.

Achievement of the control total deficit in 2016/17 was after receipt of £12.7m national Sustainability and Transformation Funding (STF). Based on the assumption that this funding will not be available from 2019/20 onwards the full underlying deficit that the Trust needs to eliminate is c £27m. The Trust has previously worked closely with Monitor and PwC to assess the causes of the underlying deficit. This identified that structural costs associated with the dual site configuration of services (which require higher workforce expenditure) and the high finance costs of the PFI were key factors driving the underlying deficit. To secure future financial sustainability the Trust needs to implement reconfiguration of hospital services and optimise the utilisation of the Trust's PFI and non-PFI estate.

The Trust's control total for 2017/18 is £15.9m (after £10.1m STF funding) and this drives the total CIP required in 2017/18 to £20m (5.3% of Trust operating expenses). Over the past three years the Trust has a track record of delivering against the objectives that the organisation signs up to. It is in the context of historic delivery; long term strategic change enabled by these reconfiguration plans, and the future opportunities afforded the organisation by working collaboratively across the region, that the Trust will strive to achieve the £15.9m control total set by NHSI for 2017/18. However, the likelihood of achievement of this control total is considered by the Trust Board of Directors to be high risk.

3.8.7 Electronic Patient Record

The Trust Board approved in January 2015 to invest in an integrated electronic patient record capability in collaboration with Bradford Teaching Hospitals NHS Foundation Trust ('BTHFT') hosted remotely by Cerner. In April 2015 the Trust awarded the contract to Cerner and the preparatory work for implementation of Cerner's Millennium EPR system commenced. On the 1st May 2017 the system went live across the Trust.

This EPR implementation forms a major component of the Trust's IM&T-enabled Modernisation Programme. By comparison with most Trusts in England, CHFT's roll out of EPR has been "digitally deep" which means that reliance on existing paper based methods is comparatively light. Staff have been truly amazing and resilient to this change and we thank those patients whose care has been impacted for working with us. As EPR is embedded and its use optimised over the next few years it will enable the Trust to transform the delivery of clinical services. The intended quality, efficiency and financial benefits have been modelled and taken into account in this FBC.

The key benefits to be delivered over time include for example:-

- Patients (and clinicians)being able to see their information in one place;
- Improvement in patient care and safety;
- Reduction in variation of clinical working practices;
- Reduction in inappropriate ordering of tests and reduced number of tests;
- More efficient bed management;
- Reduction in pharmacy and drug costs;
- Efficiencies in administration processes;
- Increased clinical workforce productivity;
- Reduction in litigation risks and costs.

The EPR has also been developed so that it can share information across other systems such as those used in Primary Care and the community meaning that there will be patient quality and efficiency opportunities across the broader health footprint.

3.8.8 Performance

NHSI Single Oversight Framework Segmentation







In October 2016 NHSI implemented the Single Oversight Framework. Each trust is segmented into one of four categories that describe the level of support they need across the five themes of quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capability. NHSI have confirmed the Framework does not give a performance assessment in its own right.

CHFT is currently in segment 3 which is described as:

“Providers receiving mandated support for significant concerns: there is actual or suspected breach of licence, and a Regional Support Group has agreed to seek formal undertakings from the provider or the Provider Regulation Committee has agreed to impose regulatory requirements.”

Care Quality Commission

In August 2016 the CQC published the findings of its inspection of the hospital and community services provide by CHFT. Overall, the CQC rated the trust as requires improvement.

Overall rating for this trust	Requires improvement	
Are services at this trust safe?	Requires improvement	
Are services at this trust effective?	Requires improvement	
Are services at this trust caring?	Good	
Are services at this trust responsive?	Good	
Are services at this trust well-led?	Requires improvement	

Detailed actions to immediately respond to all the CQC findings and recommendations have been implemented and the Trust is awaiting a further inspection visit from the CQC to assess the impact of these actions.

Access to Services

CHFT is currently amongst the top performing acute Trusts nationally for its overall performance on the Emergency Care Standard, Referral to Treatment (RTT) and Cancer standards. However this excellent performance is in the context of the Trust's total Agency expenditure in 2016/17 of £23m reflecting the difficulty in recruiting and retaining staff due to the onerous nature of current rotas. The sustainability of performance is fragile due to the need to reduce Agency expenditure levels significantly during 2017/18 and beyond. CHFT is also beginning to see an impact on access performance in early 2017 due to a reduction in the availability of temporary staff following the recent IR35 tax changes for locums which is a subject of discussion across the West Yorkshire health economy.

Maximum time of 18 weeks from point of referral to treatment (RTT) - patients on an incomplete pathway:

During 2016/17 the Trust has consistently achieved a higher level of performance against the national target that 92% of patients have a referral to treatment time of less than 18 weeks. Overall performance for the year 16/17 was 95.14%. In May 2017 the Trust's RTT performance for the percentage of incomplete pathways less than 18 weeks was 94.3% despite the EPR implementation.

Emergency care standard:

During 2016/17 CHFT has consistently been nationally ranked as one of the top twenty Trusts for performance to treat, admit or discharge 95% of Emergency Department attendees within 4 hours. The Trust achieved the 2016/17 STF performance trajectory agreed with NHSI for this target. The Trust's aggregate performance for the year was 94.2%. The Trust has been an active participant in the West Yorkshire A&E Accelerator Zone initiative and actions enabled by this resulted in the Trust achieving 97% performance in March 2017. In May 2017 the Trust's Emergency care standard performance was 85.1%.

Cancer waiting times:

Overall during 2016/17 national cancer standards were met by the at Trust level:

- the target that 93% or more of suspected cancers have a first outpatient appointment within two weeks was achieved.
- the target for referral to a specialist within two weeks for exhibited breast symptoms where cancer is not initially suspected was achieved in every month except April 2016.
- the 62 Day GP Referral to Treatment target of 85% was consistently achieved during 2016/17.
- the 62 Day Referral from Screening to Treatment of 90% was achieved in all but 3 months. Due to low number of patients a small number of breaches has a significant effect on performance.
- the maximum 6-week wait for diagnostic procedures target of 99% was consistently achieved during 2016/17.

In May 2017 performance against the two week wait from referral to date first seen standard reduced to 84%. This the first time in over 12 months that the Trust has not achieved the standard.

National safety metrics

The national safety metrics were devised to give an 'at a glance' view of the current performance of a Trust. The most recent performance for CHFT is shown below.

Metric	CHFT (year to date)	Target (year to date)
MRSA	2 cases	0 cases
Clostridium difficile	27 cases	21 cases
Hospital Standardised Mortality Rate (1 year rolling data January to December 2016)	101.55	100.00
Local SHMI – relative risk (1 year rolling data October 2015 to September 2016)	108	100

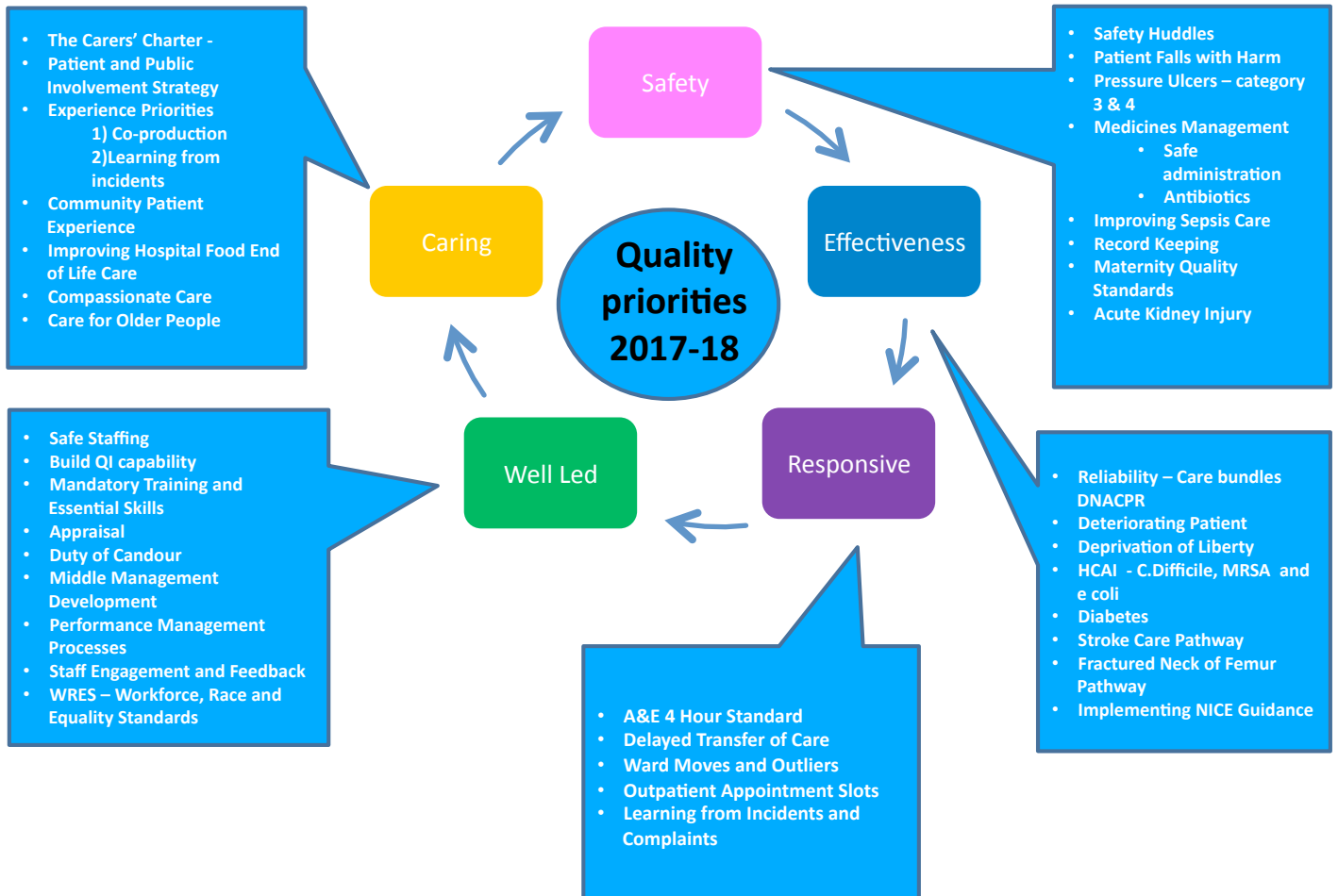
Management of quality

As part of its continued commitment to improving quality across the organisation, the Trust identified the following Quality Account priorities in 2016/17:

Improvement Domain	Improvement Priority	Were we successful in 2016/17?
Safety	Falls (Introduction of Safety Huddles)	Yes
Effectiveness	Implementation of Hospital out of Hours (HOOP)	Yes
Experience	Understanding the Community Experience	Yes

The previous areas shown and others form the Trust's wider quality strategy which is illustrated as follows:

A Framework for Quality Improvement 2017-18



4 | The Clinical Case for Change >>

4 | The Clinical Case for Change

» 4.1 Summary

There is a compelling clinical case for the reconfiguration of the Trust's services to improve the safety and quality of services and to ensure the sustainable provision of acute, emergency and community services in the future. The current dual site model of hospital services provided by CHFT does not, and cannot, meet national guidance. Staying the same is not possible as highlighted already in this document. Reconfiguration of CHFT hospital services is required to co-locate acute and emergency services for adults and children on a single hospital site and planned (elective) services for adults on the other site.

The key drivers for change are:

- The Trust is not able to provide a sustainable clinical model of provision across two Emergency Departments (EDs).
- The Trust is not able to substantively recruit to meet the medical rotas of the two sites.
- The Trust is not compliant with many standards for Children and Young People in Emergency Care settings.
- Too many planned operations are cancelled as surgeons need to respond to meet the needs of emergency patients.
- Patients experience inter-hospital transfers and a number of moves between wards that can result in a longer length of stay in hospital and increased risk of a poor experience and outcomes.
- The Trust carries a high risk in terms of the condition and reliability of its buildings at HRI. The age and condition of the estate means that they are not clinically fit for purpose. Without a significant capital injection in backlog maintenance and a plan for a rebuild of the whole site in the next 10-15 years, there is a high risk of failure of critical estate services and the consequent impact on service delivery.

A number of external independent clinical reviews of the Trust have recommended that staying the same is not really possible and service reconfiguration is needed.

This includes:

- The National Clinical Advisory Team;
- The Royal College of Physicians;
- Yorkshire and Humber Clinical Senate;
- NHS England and NHS Improvement.

Kirklees and Calderdale Joint Health Overview and Scrutiny Committee have also stated in their report that "the Committee accepts that the status quo is not an option and wishes to see improvements in the quality of services provided through hospitals, care closer to home provision and primary care".

The Case for Change has previously been described (in the documents listed below) and was fundamental to the *Right Care, Right Time, Right Place* formal public consultation led by the CCGs in 2016.

- 2014 Strategic Outline Case
- 2014 Outline Business Case
- 2015 Five Year Strategic Plan
- 2016 Calderdale and Greater Huddersfield CCGs Pre-Consultation Business Case

In April 2017 NHS Improvement and NHS England Regional Directors for the North of England confirmed that the 'status quo is not sustainable and the health economy will need to reconfigure to ensure clinical and financial sustainability'.

» 4.2 Challenges of the current configuration of hospital services

As described in section 3.8 CHFT provides hospital services at Calderdale Royal Hospital (CRH) and Huddersfield Royal Infirmary (HRI). The Trust is a 24/7 provider of a range of hospital services that includes: acute medicine, stroke, level 2 trauma, paediatrics, cardiology, interventional radiology, vascular surgery, critical care, obstetrics, orthopaedics, general surgery, gynaecology, and urology.

Both hospitals provide accident and emergency services, outpatient and day-case services, acute inpatient medical services and level 3 intensive care for adults. Some services are delivered at one site only (e.g. stroke, vascular cardiology, trauma, paediatrics and maternity).

As a consequence of the dual site configuration of services the Trust is experiencing a number of challenges in ensuring delivery of consistent, safe, high quality care. These can broadly be divided into the following categories:

- Quality and safety
- Workforce
- Operational performance

4.2.1 Quality and Safety Challenges:

- For people that have a serious life-threatening illness or injury and need emergency services it is not possible to guarantee the consistent presence of senior doctors seven days a week. The Trust's high level of concern with regards to continued delivery of services has resulted in the Trust developing a contingency plan should there be an urgent need to temporarily close one of the ED sites on the grounds of safety. This has been shared with local CCGs, overview and scrutiny committees and NHS Improvement.
- The two emergency departments at Calderdale Royal Hospital and Huddersfield Royal infirmary are non-compliant with many of the standards for Children and Young People in Emergency Care settings with regards to having ready access to paediatric specialist trained staff. An additional challenge faced by the Trust due to the current configuration across both sites includes meeting the Royal College standard of a consultant paediatrician being present and readily available in the hospital during times of peak activity, seven days a week.
- Paediatric medicine and surgery are not co-located on the same hospital site. This means that currently children that have urgent medical and surgical needs do not receive shared care from a consultant surgeon and a paediatrician. It also means that if an urgent consultant paediatric opinion is required out of hours, a consultant paediatrician on call for Calderdale Royal Hospital may have to attend Huddersfield Royal Infirmary whilst also being on call for acute paediatrics and neonatology at Calderdale Royal Hospital.

- There is often a need for inter hospital transfer of patients due to not all the expertise needed to manage certain conditions being co-located (i.e. trauma, vascular and acute surgery, oncology and haematology are at Huddersfield and stroke, paediatrics and obstetrics are at Halifax). Also, for people with multiple medical problems when they are admitted to hospital too many people experience a number of moves between wards, a longer length of stay in hospital, and increased risk of a poor experience and outcomes.
- Some planned operations are cancelled as surgeons need to respond to meet the needs of emergency patients.

4.2.2 Workforce challenges:

Vacancy rates are driving unacceptable levels of agency and locum staffing costs. The Trust is not currently able to substantively recruit to meet the rotas of the two sites, and a number of recruitment processes have failed due to lack of applicants. Consultant staff are exiting the Trust in Emergency Medicine and other Medical specialties. The reason given for their departure is the current configuration of Trust services across two sites. This compromises the quality of care that can be provided, and impacts on workload and frequency of on-call responsibilities. The Friends and Family Test shows that in Q4 2016/17 63% of Trust staff would recommend the Trust as a place to work. This is lower than the Trust's percentage score in Q4 2015/16 and compares less favourably to the national average percentage score of other acute Trusts (66%, Q4 16/17).

Dual site running, particularly in relation to out of hours rotas, is increasing the reliance on junior and/or temporary staff. The reliance on middle grade doctors results in less specialist input into patient care, thus not meeting NHS England standards. The widespread use of locums / temporary staff can result in a lack of continuity of care, and a negative impact on staff morale and sickness absence rates. This is particularly challenging in emergency medicine, critical care, acute medicine, and radiology.

Further information on the workforce challenges that are associated with dual hospital site working and are experienced within services is provided below.

Emergency Medicine

The Trust is experiencing the effects of a national shortage of emergency doctors at both consultant and middle grade levels. The current consultant pool is stretched covering vacancies which the Trust is unable to recruit to. As a result, the two emergency departments are heavily reliant on cover from locum middle grade doctors.

The Trust risk register documents the risk of poor clinical decision making due to the dependence on locum middle grade doctors at weekends and on nights resulting in possible harm to patients, extended length of stay and increased complaints. Double running of emergency medical services leads to very thinly spread middle grade cover particularly out of hours and nights. It is also difficult to flex other staff including nursing and allied health professional staff across two emergency sites. There have been particular difficulties recruiting to middle grade posts in ED leading to a workforce gap of 6 WTE posts against an establishment of 10. The number of consultants across both sites is also below establishment. There is a gap of 3 consultants with 9 being in post compared to an establishment of 12 (FY17 plan).

This leaves the service heavily reliant on consultant locum cover. However despite this there is still insufficient locum cover to fill the consultant gap.

In recent months the Trust has experienced the resignation of Consultant grade staff in Emergency Medicine and other Medical specialties and the reasons given by individuals has been the current configuration of services across two sites.

More recently a change to the IR35 tax system in April 2017 has resulted in the Trust struggling to retain existing locums or attract additional temporary doctors and nurses to work in ED.

Acute Medicine

The Trust is currently unable to substantively recruit to meet the rotas of the two sites. A number of recruitment processes have failed due to lack of applicants who are put off by the physical working environment compared to other Trusts.

The turnover of medical staff in the Trust is increasing with Consultant staff exiting the Trust and giving reasons that their decision is due to the current configuration of Trust services across two sites and that this compromises the quality of care that can be provided and impacts on workload and frequency of on-call responsibilities.

The Trust is unable to deliver specialty-specific rotas. This means that specialist consultants are covering general medical on-calls.

The current on-call rotas for medical consultants is 1:5 which hinders recruitment and retention of the medical workforce further exacerbating challenges with operational delivery.

Radiology

The Trust has tried and failed to recruit, resulting in a service which is being stretched beyond capacity to meet the growing demand for diagnostics across both sites. To ensure that patient quality does not suffer, the Trust is incurring a significant cost pressure through outsourcing some of its radiology work to the private sector.

Critical Care

The provision of critical care at each site means that the Trust is not currently fully compliant with NHS England service specification for critical care which includes reference to workforce standards. It is also difficult to flex staff (according to the demand for critical care) across two units.

4.2.3 Performance Challenges:

In 2016/17 CHFT has been one of the top performing acute Trusts nationally for its overall performance on the Emergency Care Standard, Referral to Treatment (RTT) and Cancer standards. However there are a number of areas of operational performance that are not achieving national targets and dual site configuration of services is believed to be a key reason. This includes:

- The local Standardised Hospital Mortality Index (SHMI) - relative risk (1yr rolling data) based on the latest official release for October 2015 – September 2016 is 108 (compared to England average of 100).
- The 95% A&E four hour access target is not being achieved, overall full year performance for 2016/17 was 94%.
- There were 152 patients who were medically fit for discharge but remained as inpatients in February 2017.

The Trust's performance is also in the context of total agency expenditure in 2016/17 of £23m reflecting the difficulty in recruiting and retaining staff due to the onerous nature of current rotas. The sustainability of performance is therefore very fragile due to the need to reduce agency expenditure levels significantly during 2017/18 and beyond.

» 4.3 External Review Findings and Recommendations:

Independent inspections and review of services have recognised the operational, quality, and workforce challenges described above. All of the reviews have recommended that reconfiguration of services is needed to improve outcomes and safety.

4.3.1 The National Clinical Advisory Team:

In June 2013 the National Clinical Advisory Team (NCAT) visited Calderdale and Huddersfield Foundation Trust and recommended that a one acute care site option was the best for the future safety, value and sustainability of health care. This change would enable an increased senior doctor (consultant) presence for extended hours over 7 days, minimise the use of locum middle-grade doctors and reduce the need for inter-hospital transfer of patients. The Team also strongly supported commissioners enhancing primary and community based services for the same high quality reasons and advised that NHS services of the future cannot be of high value to patients unless more care is delivered out of hospital. A full copy of the NCAT report has previously been published and is available on the Trust's website.

4.3.2 Royal College of Physicians Invited Service Review of the Care of Older People:

In February 2016 the Trust invited the Royal College of Physicians to review the care provided for elderly people at CHFT.

The review team reported that they were highly impressed by the level of commitment demonstrated by the care of the elderly teams at CHFT in attempting to provide high quality care to patients. However the review team agreed with staff that services for elderly people are overstretched and under resourced. They considered the consultant workforce, particularly in CRH, was fragile and this was because there has been an extended period of time in which the team has had to rely on locum consultants. It was the opinion of the review team that the fragility of the workforce had impacted negatively on the development of the service and resulted in elements of the service becoming outdated.

The review team concluded the care of the elderly team would very much benefit in the medium and long term of being located on a single hospital site. Staff working within the service also supported this view. The review team believe that the service would be able to better utilise their resources from a single site. The review team queried, whether the Trust and the service could afford to wait five years to move the care of the elderly services to one site and whether this needed to take place much sooner given the concerns over the fragility of the workforce.

4.3.3 Royal College of Physicians Invited Service Review of Respiratory Medicine Service:

In April 2016 the Trust invited the Royal College of Physicians to assess the Respiratory Medicine Service provided by CHFT.

The main focus of this review was to consider concerns over the respiratory team's elevated hospital standardised mortality ratio (HSMR) for chronic obstructive pulmonary disease (COPD) and community acquired pneumonia (CAP). The review team was asked to provide the Trust with an independent and external view on whether there is good governance within the respiratory team and whether the provision of care is appropriate. In addition, the Trust requested the review to identify any areas of concern as well as suggest improvements to the current pathways of care.

The review found that the Trust has some very good respiratory care and has made some innovative service developments e.g. endobronchial ultrasound. However, it recommended that services are now consolidated and improved before new ventures are taken on.

Overall, the review team found that the respiratory care service at the CHFT was under-resourced and understaffed. Currently there are five consultants working within the team (three substantive and two locums), but for a catchment area of around 420,000 it would be expected that there would be around seven or eight respiratory consultants. In addition, the review team found that the specialty team currently had around half the number of beds that would be expected for a unit of this size, which would be expected to be around 56 beds for a Trust of this size. It was found that because of these reasons patients with respiratory illnesses such as CAP and COPD were often treated on non-specialty wards. The review team concluded that these patients were probably less well served by not having their treatment on a specialty ward given by appropriately skilled staff.

The review team concluded that in an ideal situation the cardiology and respiratory services should be co-located on the same site so that the pathway for the breathless patient would be clearer, and patients with mixed cardio-respiratory disease could access both specialist services on one site. Overall, the review team were firmly of the opinion that the respiratory team would benefit from having inpatient services located on one site as they considered this would improve cover arrangements of patients (particularly at weekends), would facilitate a sharing of skill sets and a move to 7-day service.

4.3.4 Royal College of Obstetricians and Gynaecologists Invited Service Review of Maternity Services:

In July 2016 the Trust invited the Royal College of Obstetricians and Gynaecologists (RCOG) to review maternity services. There were a number of conclusions and recommendations from the review which included that a review of the model of access to the second acute maternity theatre should be undertaken.

4.3.5 Care Quality Commission:

In August 2016 the CQC published the findings of its inspection of the hospital and community services provide by CHFT. Overall, the CQC rated the trust as requires improvement. Detailed actions to immediately respond to all the CQC findings and recommendations have been implemented and the Trust is awaiting a further inspection visit from the CQC to assess the impact of these actions.

There were a number of the CQC findings (examples given below) that are relevant to this case for change, and the Trust believes would be more sustainably addressed in the longer term through the co-location of all acute and emergency services for adult and children on a single hospital site.

- *Medical staffing numbers did not meet national guidance in the emergency departments across both sites.*
- *The accident and emergency departments' provision for paediatric patients was limited with only one paediatric qualified staff member on duty across both sites and limited facilities available for children and young people.*
- *The Trust should ensure that children are seen in an appropriate environment by staff that are suitably skilled, qualified and experienced.*
- *It was difficult to determine how the emergency service had planned services to meet the needs of local children and young people at Huddersfield Royal Infirmary. There was no clear rationale or model of care for the services provided on the paediatric assessment unit. The trust must review the model of care for the services provided on the paediatric assessment unit at Huddersfield Royal Infirmary.*
- *Staff shortages to both nursing and medical staff meant there was high usage of agency and locum staff.*
- *The Trust must review the provision of a second emergency obstetric theatre to ensure patients receive appropriate care.*
- *Critical Care nurse and medical staffing was good at the time of inspection however we found areas of non-compliance with intensive care standards for all staff groups. Recruitment and retention of nursing staff had been challenging for the unit and morale had suffered as a consequence.*

4.3.6 Other External Review of the Clinical Case for Change:

In March 2017 the Joint Medical Director for NHS England (North) convened a forum of external clinical leaders (listed in section 2.2) to meet with the Trust and advise on the clinical case for change. Feedback from this confirmed that:

- The Trust has good outcomes across a range of key indicators but has one of the highest spends on agency staff in the country.
- Outcomes are likely to decline without service changes.
- There are two major drivers; firstly is the increasing subspecialisation in medicine with a decline in the ability of physicians and surgeons to care for patients with a wide range of disorders. Secondly, is the ability of the trust to attract and retain medics willing to work across two sites with frequent on call.
- A single acute care site will enable the trust to offer more attractive rotas and to better offer subspecialised care to patients when it is needed.
- To sustain and improve clinical outcomes in the longer term, manage workforce pressures and attract and retain the staff needed, a reconfigured service is needed.

» 4.4 The Benefits of Reconfiguring Hospital Services

The current dual site model of hospital services provided by CHFT does not, and cannot, meet national standards. Reconfiguration of CHFT hospital services is required to co-locate acute and emergency services for adults and children on a single hospital site and planned (elective) services for adults on the other site. This would enable the Trust to sustainably address the quality, operational and workforce challenges described above and deliver a number of expected benefits that includes:

- Ensuring paediatric medicine and surgery are located on one site thus facilitating the provision of shared senior paediatric and surgical care for children and young people. This would enable more streamlined care and more efficient deployment of the paediatric workforce. It would also enable the Trust to conform with Royal College standards for Children and Young people in Emergency Care settings.
- A single critical care unit will enable the Trust in being better able to respond to the NHSE critical care workforce standards thus supporting the delivery of improved patient outcomes for critical and complex care patients.
- Avoiding the need to spread the senior medical workforce thinly across two sites will ensure that the Trust is able to improve access to senior medical decision making and offers a more substantial approach to reducing its above national average hospital mortality ratios.
- The reconfiguration of acute medicine onto one site, to support the activity of a single ED, would have the advantage of reducing inter-hospital transfers which currently take place frequently for acute medical admissions when one or other site has reached its maximum medical bed capacity. Eliminating transfers of medical patients will improve safety, optimise patient flow in ED, shorten waits to definitive care, reduce ED breaches of the four-hour target, and reduce the workload on the ambulance service which is currently responsible for providing these transfers.
- Providing planned services, including surgery, in a dedicated site that supports access to treatment, surgery or therapy input will minimize the risk of disruption from emergency cases.

- Consolidation into a single emergency department will enable the Trust to meet the Royal College of Emergency Medicine workforce recommendations and ensure compliance with patient to staffing ratios. This will improve the likelihood of survival and a good recovery for patients.
- A single emergency department, and separation into unplanned and planned services, will enable the Trust to leverage its workforce more efficiently and leave the Trust in a better position to meet standards around 7-day working in the future and the realisation of specialty rotas. In turn this will reduce workload pressures on staff and improve the resilience of services in areas such as acute medicine, critical care, paediatrics and radiology. This is also likely to impact favourably on the Trust's ability to recruit and retain staff and reduce current reliance on temporary staffing.
- Will enable mental health, primary care and social care services to target their hospital based service delivery more effectively as opposed to managing the spread of services across existing sites.
- As part of progressing the STP, reconfiguration helps to safeguard the provision of unplanned (blue-light) care in this part of West Yorkshire.

5 | The Future Hospital Services Model >>

5 | The Future Hospital Services Model

» 5.1 Summary

The Trust and CCGs have agreed a model of care for the future provision of hospital services in Calderdale and Greater Huddersfield that will ensure clinical service adjacencies that optimise the quality of hospital patient care and address the challenges and sustainability issues described in the clinical case for change (section 4).

The agreed model of care (described in this chapter) proposes that planned hospital services would be delivered on one site and that emergency and unplanned hospital services would be provided on the other site. Both sites would offer urgent care.

The clinical model was endorsed by the Yorkshire and Humber Clinical Senate and public consultation on the model was completed in June 2016.

Three variations to the clinical model that was consulted on are described in this chapter and financial sensitivity testing of these is included in the Financial Case (section 12).

» 5.2 The Clinical Model that was used in Public Consultation

The agreed model of care is that planned hospital services would be delivered at one hospital site and that emergency and unplanned hospital services would be provided on the other site. Both hospitals would offer urgent care twenty four hours a day and seven days a week.

The emergency and unplanned hospital

This hospital will specialise in providing treatment for people who have a serious or life threatening emergency care need and will provide accident and emergency services, major surgery, critical care, acute general and specialist medicine, inpatient paediatric services and complex maternity services. The hospital will bring together on one site the necessary acute facilities and expertise, twenty four hours a day and seven days a week to maximise people's chances of survival and a good recovery. Ambulance services will transport people with serious or life threatening conditions to the nearest appropriate emergency department. People who suffer a myocardial infarction or major trauma, and are picked up in an ambulance, will continue to be transferred directly to specialist services in Leeds.

The planned hospital

This hospital will provide scheduled support, treatments and surgery. It will also provide urgent care and minor injury services twenty four hours a day and seven days a week. The urgent care centre will offer walk-in access for people requiring treatments for things such as sprains and strains; broken bones; wound infections; minor burns and scalds. It has been determined that circa 50% of people that currently attend A&E could be treated in an urgent care centre.

An overview of the future hospital services model across two sites is shown below:



Planned Care Hospital – 24/7 urgent care centre, diagnostics (x-ray and bloods), planned medical & surgical day cases, endoscopy, breast services, ophthalmology, planned orthopaedic inpatient surgery, outpatient services, therapies, midwifery-led maternity unit.

Emergency & Unplanned Care Hospital – adult and paediatric emergency departments, 24/7 urgent care centre, diagnostics (including CT/MRI), obstetrics, inpatient paediatrics, midwifery-led maternity unit, acute endoscopy, critical care unit, complex and unplanned surgery (for patients who may need critical care after surgery) inpatient acute medical services (e.g respiratory, stroke, oncology, cardiology).

Mental Health Liaison Services will be provided throughout both hospitals including ED and the Urgent Care Services. The CCGs currently commission these services from South West Yorkshire Partnership Foundation Trust (SWYPFT) and in the future hospital model of care this will continue to be an integral part of the model recognising that mental and physical health are inextricably linked. Similarly CHFT will continue to work very closely with specialist Child and Adolescent Mental Health Services (also provided by SWYPFT) and with Locala Community Partnerships.

The key features of the future clinical model are described as follows in relation to: urgent care, emergency and unplanned care, planned care, maternity care and paediatric care.

5.2.1 Key Features of the Future Urgent Care model are:

There will be a consistent 24/7 Urgent Care Centre (UCC) at both of the hospitals in Calderdale and Greater Huddersfield. All patients will be encouraged to use existing primary care access and 111 for initial access to urgent care. Urgent Care Centres will not be considered the right place to go in a medical emergency (when 999 should be used), but will have protocols in place with the ambulance service if such events occur.

The urgent care centres will be able to treat the following:

Minor injuries	Minor illnesses
Bites/stings	Allergy (including anaphylaxis)
Burns and scalds	Dermatological conditions
Contusion/abrasion	ENT conditions
Diagnosis not classifiable	Infectious disease
Dislocation/fracture/joint injury	Local infection
Foreign body	Ophthalmological conditions
Head injury	Psychiatric conditions
Laceration	Social problem (includes chronic alcoholism and homelessness)
Muscle/tendon injury	Soft tissue inflammation
Nerve injury	
Sprain/ligament injury	

The UCC will provide clinical triage for all “walk-in” patients and redirection if appropriate. Patients with life-threatening illness and injury will be taken by ambulance directly to the Emergency Department (or to a specialist emergency / trauma centre such as Leeds).

The centres will be led by a clinician with the knowledge and skills to undertake triage and autonomous decision making regarding the next steps in an individual’s care. Diagnostic facilities (including Point of Care and X-Ray) to support triage and decision making will be available. Direct access to specialist support from the Emergency Department will be available to both UCCs (if on the other site this will be via technology).

All children will have clinical triage within 15 minutes to ensure a child is in the correct place to receive treatment. The UCCs will comply with the Royal College ‘Standards for Children and Young People in Emergency Care settings’. Protocols will be in place for 111 and the Ambulance service to ensure that any children with injury or illness requiring emergency care is directed to the specialist Paediatric Emergency Department (paediatric surgery and acute inpatient medical care will be co-located with the Emergency Department).

The Urgent Care Centre(s) will manage children 5 years and older with minor injuries and those children considered to have minor illness after triage by 111. All other children will be redirected to the Paediatric Emergency Department. Children under 5 years old will automatically be directed to the Paediatric Emergency Department. In instances where children who are ill, have serious injury or are under five years old present at an UCC they will be quickly triaged, stabilised and if necessary transported to the Paediatric ED or the Tertiary centre as required.

5.2.2 Key Features of the Future Emergency and Unplanned Care Model:

There will be a single unified Emergency Department for Calderdale and Greater Huddersfield providing emergency/acute medicine and accident and emergency services. There will be a dedicated Paediatric Emergency Department for Calderdale and Greater Huddersfield which will have facilities that comply with the standards for Children and Young People in Emergency Care Settings.

Access to emergency care will be via triage, an urgent care centre or via an ambulance. Specialist emergency care will continue to be provided on a West Yorkshire basis. This means that, as happens now, certain specialisms, such as severe trauma, will be provided at specialist emergency care centres (such as Leeds) that are best skilled and equipped to deal with them.

The single unified Emergency Department will provide treatment for people who have serious or life threatening emergency care needs. The Department will bring together on one site all the necessary acute facilities and expertise 24/7 to maximise people's likelihood of survival and a good recovery. This will reduce or eliminate the need for people to transfer between sites.

There are key clinical interdependencies and relationships between ED, acute medical services and surgical services, and critical care. The on-site support specialties required by any one of these four services define the clinically recommended minimum range of services required for any 'emergency centre'. Therefore, in the proposed model the following services are collocated with the ED:

- Acute / general / elderly medicine
- Respiratory (including bronchoscopy)
- Obstetrics / gynaecology
- Neonatology (SCBU) / paediatrics (including surgery)
- Upper and Lower GI surgery (including acute endoscopy)
- Trauma & orthopaedics
- ICU / 24hr anaesthetics
- Urology
- Gastroenterology
- ENT
- Cardiology (including CCU)
- Hyper acute stroke services
- X-ray, USS, MRI, CT, other diagnostics 24/7
- Microbiology / haematology / biochemistry
- Occupational therapy
- Physiotherapy

5.2.3 Key Features of the Future Planned Care Model:

The planned care hospital will provide:

- Outpatient care for adults and children
- Day case surgery for adults
- Some inpatient orthopaedic surgery for adults
- Therapy services (physiotherapy, occupational therapy, speech therapy and dietetics)
- Endoscopy

Planned care will be delivered in Hospital only when it cannot be delivered elsewhere in the community. There will be continuing work to deliver an increasing proportion of appropriate planned treatments and surgery as day-cases or as out-patient procedures.

The planned care centre will aim to optimise the potential benefits of the separation of planned and unplanned surgery. This should eliminate disruption from non-elective activity and create an environment in which standardisation of care processes and their systematic audit is promoted leading to better outcomes for the patient and an improved patient experience.

Patients that require complex surgery or it is known that they will require critical care after surgery will be treated at the unplanned care site. The pre-operative assessment and selection of patients appropriate for receiving surgery on the planned site will mitigate the risk of complications and deterioration of patient at the planned site.

5.2.4 Key Features of the Future Maternity Model of Care:

Extended ante-natal, intra partum and post-natal care will be provided in the community where possible and choice will be offered in relation to where the birth takes place.

Midwifery led maternity services will be provided on both hospital sites.

Consultant led obstetrics and neo-natal care will provided on the same site as the Emergency Department.

5.2.5 Key Features of the Future Paediatric Model of Care:

Both hospitals will provide urgent care and will be able to treat children 5 years and older with minor injuries and those children considered to have minor illness after triage by 111. All other children will be redirected to the Paediatric Emergency Department. Children under 5 years old will automatically be directed to the Paediatric Emergency Department. In instances where children who are ill, have serious injury or are under five years old present at an UCC they will be quickly triaged, stabilised and if necessary transported to the Paediatric ED.

Inpatient paediatric medical and surgical services will be co-located at the hospital site that provides the Paediatric Emergency Department and the obstetric services reflecting the critical interdependencies between paediatric and maternity services and emergency care.

The paediatric services will work closely with and receive support from specialist Child and Adolescent Mental Health Services (CAMHS).

» 5.3 Benefits of the Future Model

There is no degradation of any existing services anticipated as a result of the proposed model. Some services may experience a change in the location at which the service is delivered. However, there is anticipated to be significant associated improvements in quality as a result of the implementation of the model, particularly through the consolidation of all acute services onto the unplanned care site.

Without service reconfiguration, hospital services will not have the capacity and concentration of expertise to maintain current service delivery let alone being able to offer a consistent 7 day a week service and the changes in pathways and medical intervention that will deliver better outcomes.

The benefits of reconfiguration of services will be evidenced over time by: reductions in harm; reductions in mortality within services; a reduction in incidents and serious incidents; and improvements in patient experience. From a quality perspective, the case for change is a signal of the Trust's ambition to develop the capability to meet and surpass good standards of care and create the opportunity to move to 'best in class' standards for services and pathways. This will help to address the inequality of outcomes for patients living in different areas covered by the Trust's services.

The following is a list of the key benefits the reconfiguration will enable:

- Improve the quality of patient care as a result of the Trust being able to meet Royal College guidelines on senior medical cover.
- Improve the quality of patient experience through a more streamlined, efficient patient pathway as a result of acute services being co-located.
- Support development of urgent care centres which will be equipped to care for patients with minor injuries and / or illnesses in a more timely, efficient way, thus reducing the demands on the Trust Emergency Department.
- Realise the patient outcome benefits from co-location of acute services and consolidation of paediatrics with complex obstetrics through a more streamlined approach for providing senior medical oversight.
- Enable the Trust to meet the Royal College of Emergency Medicine guidance on senior medical workforce cover through consolidation of rotas.
- Enable the Trust to meet Royal College standards for Children and Young People in Emergency Care settings.
- Reduce the reliance on locum and temporary staff to cover vacancies and workforce pressures as a result of running two district general hospitals.
- Make the Trust a more attractive place to work thus improving the recruitment and retention of staff.

» 5.4 Potential Variations to the Future Hospital Services Model

Three variations to the clinical model that was consulted on (and described above) are detailed as follows. Financial sensitivity testing of these variations is included in the Financial Case of this FBC (section 12).

CHFT as a Vascular Arterial Surgery and Interventional Radiology Hub Site

As described in section 3.6 NHSE has undertaken review of vascular specialised services across Yorkshire and Humber. The recommendations arising from this require a reduction in West Yorkshire from currently three hospitals (LTHFT, BTHFT and CHFT) providing specialised arterial vascular services to two hospitals (with one of the existing hospitals providing a fully integrated 'spoke' service).

On the grounds of not wishing to exclude the possibility of CHFT being selected as the second vascular arterial site this Full Business Case has considered and included the potential additional capacity requirements. This is one of the variants to the model consulted on that is tested in the Financial Case assessing the impact on the Trust's future viability based on assumed income and investment in workforce and estate facilities this would require. The services would be provided from the unplanned care hospital site.

CHFT as an Elective Hub Site

WYAAT has identified that all acute Trusts in West Yorkshire are experiencing significant pressure in delivering 18 week RTT and that there is reliance on outsourced private sector capacity or temporary staffing which is driving additional cost pressures. A workstream for releasing WYAAT providers capacity to undertake additional elective activity that is currently contracted to the private sector has been initiated.

The specific aims of this are:

- Delivering high quality clinical pathways and operational models to the 'best in class' including optimal performance and use of resources;
- Delivering nationally recognised excellence in terms of clinical outcomes and professional standards;
- Working as a group to develop processes to retain as much NHS activity as possible within the WYAAT Trusts by optimising the capacity and configuration for elective services with agreed risk/gain share (using estate and workforce in a flexible model across the WYAAT footprint).

CHFT / WYAAT as a provider of additional elective activity (Hub) serving a larger catchment area is one of the variants to the model consulted on that is tested in the Financial Case assessing the impact of this on the Trust's viability based on assumed additional income and investment in workforce and estate facilities this would require. The services would be provided from the planned care hospital site.

Enhancing the Planned Hospital Model to offer In-hours ED service

Based on the suggestion of NHS England, the potential of the planned care hospital to provide Emergency Department services for adults between 9am and 6.30pm, seven days a week, is one of the variants to the model consulted on that is tested in the Financial Case. This variant has previously been rejected on the grounds that it cannot deliver the clinical and workforce benefits associated with the proposed consolidation of all emergency services at the unplanned hospital. The FBC provides assessment of the financial impact of this option.

6 | Capacity Plan and Implications >>

6 | Capacity Plan and Implications

» 6.1 Summary

This chapter provides an assessment of the impact of the Clinical Model on core future activity, based on the proposed service and patient flow changes and quantifies the required clinical capacity (beds, theatres etc.) that will be required at the future Planned and Unplanned Care Hospitals.

The key planning assumptions previously used in the Trusts 5 Year Strategic Plan have been reviewed and updated. A range of clinical and management colleagues across the Trust have been fully involved with the review to ensure ownership and engagement in the process and outputs. Using the updated planning assumptions detailed modelling of activity across the five years to 2021/22 has been completed. The Trust has been supported by a Senior Economist and an Intelligence Analyst at NHSI to do this work.

The modelling output is that by 2021/22 the future hospital model will require:

- 738 beds across the two sites (674 at the unplanned care site and 64 at the planned care site)
- 20 theatres (12 at the unplanned site and 8 at the planned site).

The Trust currently has circa 843 beds and 18 theatres.

The 105 bed reduction by 2021/22 is achieved through delivery of improved pathways that enable admission avoidance and reduction in length of stay, this includes CCG's QIPP assumptions. (The previously modelled 2021/22 bed requirement in the 5 Year Strategic Plan was 732.)

The additional 2 theatres required is associated with provision of one additional obstetric theatre, which responds to CQC recommendations, and the provision of a hybrid theatre for vascular services which is on the basis that it is possible that CHFT may be selected as the second vascular arterial surgery provider in West Yorkshire. (The previously modelled 2021/22 theatre requirement in the 5 Year Strategic Plan was 18).

» 6.2 Key Planning Assumptions for Activity, Productivity and Clinical Model

The detail below highlights the key assumptions that have been used to model the proposed option.

- All modelling has been based on the forecast activity for FY16/17 (as at month 9)
- Growth has been modelled in accordance with the Trust financial assumptions: 1-2% annual activity growth per annum
- The starting bed baseline for modelling is from 1st April 2017
- All movements will occur in year 5 on the basis that reconfiguration will require a capital build
- Ambulances will go to the nearest emergency care centre (ECC)
- Patients not appropriate to be seen at the UCC are diverted to the next nearest ECC department based on travel time
- Walk-ins are assumed to continue to attend the emergency department they currently attend
- Patients attending the UCC that require admission or more acute treatment are transferred to the ECC

- Wherever patients attend an ECC that is where patients will be admitted.
- An additional 30 winter pressure beds have been included to provide resilience to manage seasonality variations. This is in line with the seasonal swing identified by the Medicine division.
- Significant delivery of commissioner QIPP will be realised (resulting in a 6% reduction in non-elective medical admissions per annum for three years starting from year 19/20)
- Length of stay (LOS) reductions to deliver upper quartile performance.
- Bed occupancy to be applied as follows:
 - Medicine: 90%
 - Surgery: Utilise current occupancy level – 86.4%
 - FSS: 60% for paediatrics and maternity, 90% for gynaecology
- Current average theatre utilisation (i.e. reflecting current usage of theatres) and a 4 hours sessions
- Impact of EPR – efficiency assumption to support reduced bed base, optimises bed utilisation and efficiency through improved treatment and care pathways.
- Impact of 25 rehab beds being provided in community rather than acute trust site
- Expansion of ambulatory care pathways – reducing bed requirement in year 5 (21/22)
- Reconfiguration is anticipated to have a modest, but material, impact on neighbouring providers. (See separate table)
- No growth in elective market share is assumed in relation to the Trust's 'core' activity and capacity requirement. (There is a possible variation to the model that would result in growth of elective market share and this is described at section 6.9).
- 18 critical care beds in total (an increase of 5 beds from current provision with capacity to increase to 22 beds)

» 6.3 Modelling Outputs

The modelling was designed to provide the following outputs:

- Activity requirements
- Bed capacity requirements
- Number of theatre sessions required in order to inform theatre requirements
- The number of consultant vs midwife-led births at each site
- Breakdown of ECC vs UCC attendances (based on the minor injuries/ minor illnesses criteria)

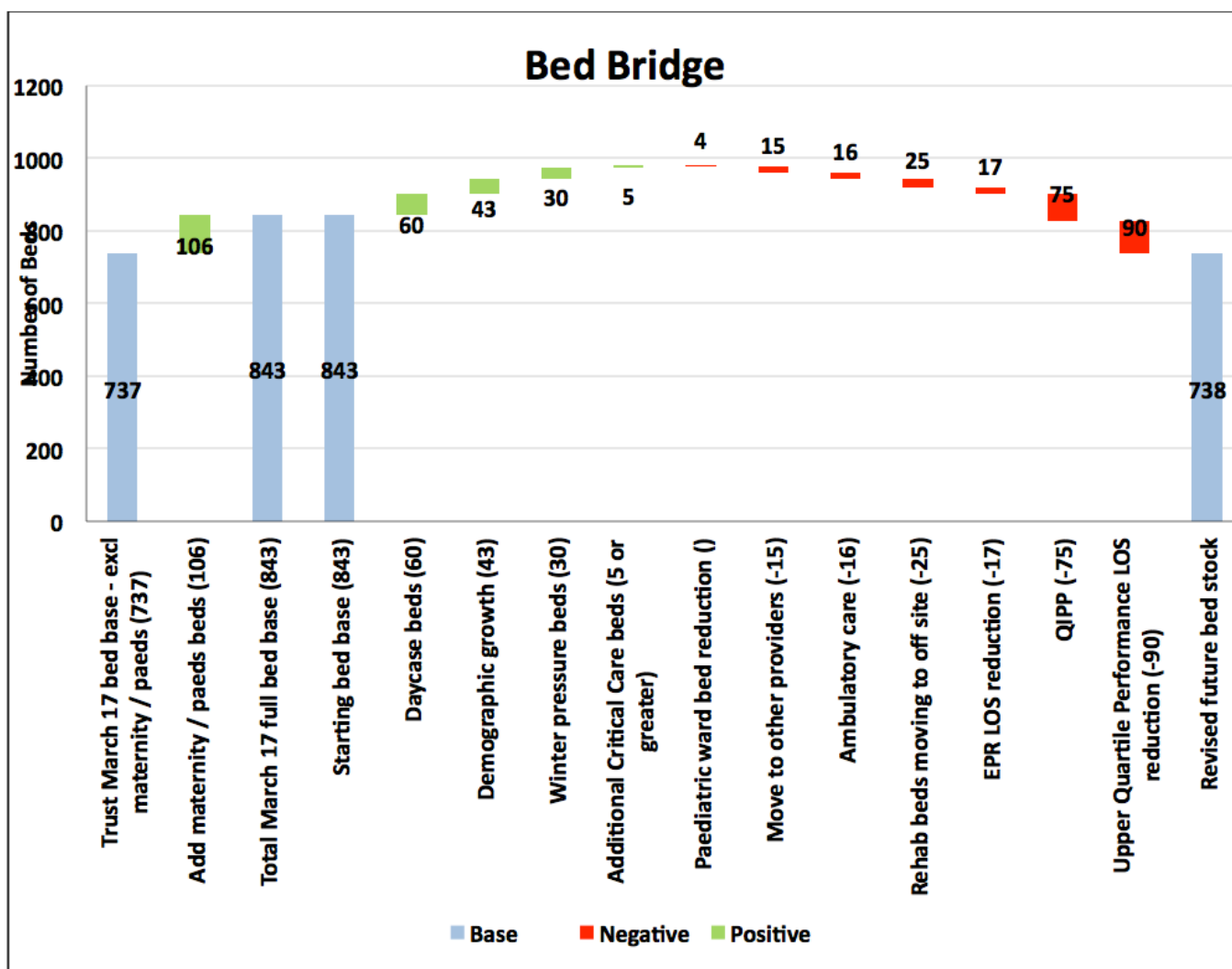
The above outputs have been utilised to prepare the cost model which identifies the total cost (revenue, capital, requirements and income) for the proposed option of CRH as the unplanned site and detailed in the economic case. A summary of the clinical activity requirement is shown in the following table.

Type of Activity	Site	Existing Model 2016/2017	Proposed Model 2021/2022
A&E and Urgent Care	CRH	77485 (A&E and urgent)	119374 (A&E and urgent)
	HRI	73867 (A&E and urgent)	38685 (urgent)
	Trust	151352	158059
Outpatients	CRH	219197	230378
	HRI	202655	212992
	Trust	421852	443370
Admissions	CRH	70278	80739
	HRI	50292	38892
	Trust	120570	119631
TOTAL		693774	721060

» 6.4 Bed Capacity Requirements

At present, there are circa 843 beds (*) located at the two sites. Modelling indicates that the Trust would require a total bed base of 738 beds if CRH was the unplanned care site. The graph below starts from the agreed starting bed base as of March 2017.

(*) for the purpose of modelling work all day case activity taking place in the trust has been assessed as 0.5 of a bed day for each day case (with the exception of Oncology and Haematology day cases where assessed a 0). This day case activity includes the high volume day case work within areas such as day surgery and procedure units, endoscopy departments and pain management.



Changes in CHFT bed numbers over the 5 years for CRH as the unplanned care site

Division	Unplanned Care	Planned Care	Total
Surgical (excluding critical care)	158	53	211
Critical care	18	0	18
Medical	331	5	336
Paediatrics (includes NICU)	67	0	67
Gynaecology	7	3	10
Maternity	63	2	65
Other (winter pressure beds)	30	0	30
TOTAL	674	64	738

Divisional – level beds required at each site in 21/22 (note: roundings included and therefore numbers do not exactly sum)

Impact on other providers in 2021/22

Travel times of patients were calculated to both the Calderdale and Huddersfield sites, along with other local emergency care providers based on patient postcodes. For all patients that arrived in an ambulance, the travel times were used to determine the closest Emergency Care Centre and it was assumed that patients currently being treated at the planned care site, would be treated at the nearest Emergency Care Centre in the future. These patients are also assumed to have their inpatient care (if required) at the same provider. The tables below show that the impact of reconfiguration at CHFT will result in activity shifts to neighbouring providers, leading to an increased total bed requirement across neighbouring trusts of 15 beds irrespective of which site option is selected.

Final Location	A & E	Emergency Admissions	Beds
Barnsley General Hospital	2861	971	12.3
Royal Blackburn Hospital	201	47	0.5
Bradford Royal Infirmary	152	44	0.5
The Royal Oldham Hospital	145	55	1.4
Pinderfields General Hospital	138	29	0.2
Leeds General Infirmary	117	26	0.3
Pontefract General Infirmary	38	13	0.0
St James's University Hospital	26	2	0.0
Trafford General Hospital	26	3	0.0
Fairfield General Hospital	19	4	0.0
Manchester Royal Infirmary	15	2	0.0
North Manchester	8	2	0.0
TOTAL	3746	1198	15.2

» 6.5 Theatre Requirements

The theatre requirements in 2021/22 that are predicted by the model are shown below. These are based on elective theatres operating two four hour sessions per day, 5 days per week over 49 weeks.

This includes one 24 hour emergency theatre ('CEPOD'), one trauma theatre and one emergency obstetrics and gynaecology theatre.

Estate option	Non-elective theatres	Elective (other)	Day case theatres	Procedure room	Total
Unplanned Care	6	4.5	1.5	0	12
Planned Care	0	3	4	1	8

Predicted future theatre breakdown as informed by the modelling

Note: The non-elective theatres at CRH include CEPOD, trauma, obs & gynae, vascular / hybrid, Acute. The CEPOD theatre refers to a dedicated 24 hour emergency theatre established in response to the National Confidential Enquiry into Patient Outcome and Death.

The table below shows the weekly theatre requirements.

Specialty / List Type	Unplanned day surgery	Unplanned inpatient	Planned day surgery	Planned inpatient
General Surgery	0.14	1.74	1	0.47
Urology	0.26	0.91	0.13	-
Orthopaedics	-	0.1	1.1	2.2
Ear, Nose & Throat	0.36	0.67	0.14	-
Ophthalmology	0.09	0.2	1.8	0.01
Maxillofacial Surgery	0.27	-	0.54	-
Plastic Surgery	-	-	0	-
Trauma	-	1.5	-	-
CEPOD	-	1	-	-
Acute	-	1	-	-
Vascular / Hybrid	-	1	-	-
Obstetric / Gynae	0.11	2.7	0.31	0.02
TOTAL	1.23	10.81	5.0	2.7

Weekly Theatre requirements

» 6.6 Emergency and Urgent Care Attendances

The Clinical Model proposes there will be an urgent care centre co-located at each hospital site. The urgent care centres will operate 24 hours a day and be available to care for adults with minor injuries and illnesses and children over the age of 5 years with minor injuries only. The modelling indicates that total emergency attendances will not vary significantly under reconfiguration, even with the provision of the urgent care centres.

Site	Age Group	ECC Attendances	UCC Attendances	Total
Huddersfield Royal Infirmary	Paediatrics		7,086	7,086
	Adults		31,599	31,599
Total Huddersfield Royal Infirmary		0	38,685	38,685
Calderdale Royal Hospital	Paediatrics	20,562	8,013	28,574
	Adults	59,150	31,650	90,800
Total Calderdale Royal Hospital		79,711	39,662	119,374
TOTAL		79,711	78,347	158,059

Predicted emergency / urgent care activity with CRH as the unplanned care site in 2021/22

Please note that included in the attendances detailed above are some 18,673 attendances that will have initially presented at the UCC located on the planned site, but due to their clinical condition will need to be transferred across to the Emergency Care Centre at the Unplanned site. These patients are included in the ECC attendances above only. Further breakdown is as follows:

Age	Injury Type	Attendances at the ECC transferred from UCC at the Planned site
Under 5	Major	1273
	Minor Illness	788
	Minor injury	3393
Under 5 Total		5455
5 to 16	Major	1094
	Minor Illness	680
5 to 16 Total		1774
Adult	Major	11445
GRAND TOTAL		18673

» 6.7 Births

In the outline model of care for hospital services, each site will continue to have a midwife-led birthing unit. Complex obstetrics will be cared for on the unplanned care site.

» 6.8 Clinical Involvement in the Capacity Modelling

In developing this FBC there has been extensive engagement and involvement of clinical colleagues in the Trust. Meetings have taken place with every specialty to review the planning assumptions that were used in 2015/16 to produce the 5 Year Strategic Plan and these have been updated and modified as required to reflect specific changes in practice or learning since the Five Year Strategic Plan was produced. These changes are reflected in the planning assumptions detailed in section 6.2. Planning assumption summary sheets were produced for each specialty and these were signed off by clinical colleagues and at Divisional level. Similarly the outputs that the application of the planning assumptions generated (number of beds, theatres etc. on each site) were shared and discussed with clinical and Divisional colleagues.

This further clinical involvement has informed changes to the planning assumptions since the five year strategic plan. In all cases the reason for the change has been related to ensuring that the proposed future model will offer optimal safety, quality and outcomes for patient care. The changes are:

- the provision of some inpatient surgery activity has been moved to the unplanned site with the planned site offering an increased range of day case surgery;
- the assumption that patients with a length of stay greater than 10 days at the unplanned hospital could be transferred ('step-down') to the planned hospital was removed.

However the overall level of patient activity that will be delivered at the future planned hospital i.e. 290,569 patient visits per annum, has not significantly changed from the activity previously modelled for this in the five year strategic plan i.e. 290,800 patient visits per annum. (The term 'visits' includes a mix of attendances and admission activity.)

» 6.9 Capacity Implications of Potential Variations to the Future Service Model

The activity and capacity implications of two possible variations to the clinical model that was consulted on are provided as follows. Financial sensitivity testing of these variations is included in the Financial Case (chapter 12).

CHFT as a Vascular Arterial Service Hub Site

On the grounds of not wishing to exclude the possibility of CHFT being selected as the second vascular arterial site in West Yorkshire (see section 3.6) capacity modelling for this has been undertaken. This has determined that if CHFT is selected as an arterial surgery site there will be requirement for an additional 4.67 beds (based on 90% occupancy) and 5.69 additional 4 hour surgery sessions per week (based on 49 weeks per year) at the unplanned hospital site.

As described previously in this chapter the unplanned hospital includes an additional hybrid theatre that will accommodate the additional vascular surgery capacity.

Within the proposed estate development at CRH (see chapter 8) there is sufficient flexibility to provide the additional 5 beds that would be required if CHFT is selected as an arterial surgery centre.

CHFT as an Elective Surgery Hub Site

To model the possible additional elective activity that could be provided at the planned care hospital the following assumptions have been used:

- the total elective surgery activity that is currently provided by local Trust's was determined and uplifted for expected demographic growth between FY19 and FY42;
- an average tariff by the treatment specialty for this activity was determined;
- an assumption of what proportion of this activity might in future flow to CHFT from FY22 to FY42 was then applied. This started at 0.5% in FY22 and increased to 2% by FY42.
- an additional marginal cost at 70% was applied (increased pay and non-pay cost of delivering this extra activity), consistent with other financial modelling;
- no extra capital for this was applied within the modelling as it is assumed that this will be delivered within the existing estate footprint of the new planned hospital using out of hours and weekend working;
- this enabled an additional annual contribution (i.e. income net of cost) to be determined and the benefit of this has been applied as an upside in the financial case (chapter 12).

7 | Workforce Plan and Implications >>

7. Workforce Plan and Implications

» 7.1 Summary

The Trust employs circa 6,000 staff and faces considerable workforce challenges which undermine the resilience of clinical services, staff satisfaction and wellbeing, and the Trust's finances. These challenges include non-compliance with Royal College of Emergency Medicine workforce recommendations, intense and fragile clinical rotas, recruitment and retention challenges resulting in a heavy reliance on locum and agency staff. These challenges arise in large part due to the current dual-site service model alongside national shortages. The reconfiguration of services will enable compliance with workforce standards. The Trust will then be in a better position to meet standards around 7-day working, and enable the delivery of specialty rotas. This should reduce workload pressure and stress on staff and is likely to impact favourably on the Trust's ability to recruit and retain staff, thus reducing the current reliance on temporary staffing.

This chapter describes: the workforce challenges the Trust is facing; the key initiatives that will address these challenges; the assumptions that have been used to develop the workforce plan; the workforce plan, and; the workforce benefits associated with the reconfiguration of services across the two hospital sites.

The workforce plan shows that over the next ten years (FY18 – FY27) the Trust's whole time equivalent staff establishment will reduce by 479 wte. The planned reduction in staffing is lower than the 966 wte reduction that was previously modelled in the Trust's five year strategic plan.

Business as usual turnover of staff (15%) will be sufficient to achieve this reduction in wtes without the need for compulsory redundancies. In addition the Trust's wte workforce establishment budgets include some provision for agency and temporary staffing. Therefore a proportion of the planned wte reduction can be achieved through a reduction in agency staffing rather than reduction of the permanent workforce.

The changes in the Trust's workforce over the ten year period will be enabled and achieved by the following:

- service reconfiguration and redesign;
- recruitment and retention;
- new professional roles;
- job evaluation;
- staff utilisation and productivity.

» 7.2 Workforce Challenges

There is a local and national shortage in the supply of medical and nursing staff and the Trust's demand for these roles is increased by dual-site running. This increases the number of staff required and also affects the Trust's ability to attract and retain clinical professionals in key specialties. This puts significant pressure on the need for bank and agency staff (in 2016/17 total Trust agency spend was £23m); results in less specialist input to patient care, and; means the Trust is not compliant with a number of NHS England workforce standards.

Workforce Recruitment and Retention:

The turnover of medical staff is decreasing (from 16.32% in April 2016 to 10.99% in March 2017). However, whilst the Trust is improving its ability to recruit and retain staff, there is an underlying issue with the ability to fill workforce numbers and a number of recruitment processes have failed due to lack of applicants. Consultant staff in emergency medicine and other medical specialties have left the Trust. The reason given for their departure is that the current configuration of Trust services across two sites compromises the quality of care that can be provided, and impacts on workload and frequency of on-call responsibilities. The Friends and Family Test shows that in Q4 2016/17 63% of Trust staff would recommend the Trust as a place to work. This is lower than the Trust's percentage score in Q4 2015/16 and compares less favourably to the national average percentage score of other acute Trusts (66%, Q4 16/17).

Non-Compliance with Workforce Standards:

The Trust is not currently able to guarantee the consistent presence of senior doctors in the two emergency departments seven days a week. The Trust's high level of concern with regards to continued delivery of services due to workforce shortages has resulted in the need to develop a contingency plan should there be an urgent need to temporarily close one of the Emergency Departments on the grounds of safety.

The two Emergency Departments are also non-compliant with many of the standards for Children and Young People in Emergency Care settings with regards to having ready access to paediatric specialist trained staff. Paediatric medicine and surgery are not co-located on the same hospital site, and this means that currently children with urgent medical and surgical needs do not receive shared care from a consultant surgeon and a paediatrician. It also means that if an urgent consultant paediatric opinion is required out of hours, a consultant paediatrician on call for Calderdale Royal Hospital may have to attend Huddersfield Royal Infirmary, whilst also being on call for acute paediatrics and neonatology at Calderdale Royal Hospital.

» 7.3 Addressing the Workforce Challenges

In January 2017 the Trust's 5-year Workforce Strategy was approved. The aim of the strategy is to ensure the Trust has *'a workforce of the right shape and size with the commitment, capability and capacity to deliver safe, efficient, high quality patient care'*. The workforce strategy focusses on the following areas: recruitment and retention; workforce planning to improve staff availability; utilisation and effectiveness; reducing reliance on temporary staffing; improving attendance management; strengthening colleague engagement; organisational development and leadership.

The workforce challenges that have been highlighted above will mainly be addressed through the reconfiguration of clinical services across the two hospital sites. Whilst other initiatives that are not reliant on the reconfiguration of services will also have an impact on the size and capability of the Trust's workforce over the next ten years, we believe that service reconfiguration would allow the Trust to maximise the opportunity to strengthen workforce efficiency and sustainability.

Planned changes in the Trust's workforce profile will be enabled and achieved by the following:

Service Reconfiguration and Redesign

The reconfiguration of the Trust's services to the planned and unplanned hospitals and collaboration with other hospitals in West Yorkshire provides opportunity to improve the quality and resilience of clinical services and also the development of shared models of 'back-office' and support services. These changes will impact on the Trust's workforce profile.

Examples include:

- Commissioner led QIPP schemes and the development of Care Closer to Home will reduce admissions to hospital and enable reductions in hospital length of stay and bed capacity. This will reduce the workforce required in hospital.
- Collaboration with other hospitals across West Yorkshire will enable development of shared support services (e.g. pathology, pharmacy, estates and IM&T) that will realise efficiencies and enable reduction in workforce capacity.
- The clinical model of urgent care at the planned hospital does not assume that CHFT will be the proposed provider of these services and this could reduce the Trust workforce required.
- Changes in West Yorkshire models of provision of vascular services and elective surgery (associated with collaboration with other hospitals) will enable standardisation and efficiencies such as reduced length of stay to be delivered and could reduce the workforce required

Recruitment and Retention

Maximising the Trust's ability to recruit and retain clinical staff within key hospital and community specialties, coupled with the opportunity presented by a more attractive working environment will reduce reliance on Agency staffing. This will be enhanced following reconfiguration. The Trust is also interested in developing increased opportunities for the Trust's workforce in relation to research, education, training, and digital health that are likely to enable increased rates of recruitment and retention of staff.

New Professional Roles

The introduction of new roles across the Trust such as physician's associates, emergency care practitioners and advanced nurse practitioners will reduce reliance on non-consultant grade medical staff in areas of shortage and allow for better retention of clinical staff as new career structures are developed.

New apprenticeship routes across the Trust will contribute to the internal development of staff. This will increase the attractiveness of working for the Trust, fill a wide variety of positions with committed staff who want to develop within the Trust and provide an ongoing talent pool to fill vacancies as they arise. This will include the development of Associate and Assistant Practitioner roles as well as more traditional apprentice routes in administration, health and social care.

Job Evaluation

Effective workforce planning and competency-based job evaluation throughout the Trust will ensure that clinical professionals and their teams are supported in the most efficient and effective way. This will generate the opportunity for new roles to be created enabling skill and grade mix workforce changes. Important to this will be ensuring that clinically qualified staff are able to practice to the full extent of their education and training (instead of spending time doing something that could effectively be done by someone else).

Utilisation and Productivity

The opportunity to maximise workforce productivity will be enabled by a number of key initiatives following the introduction of the Cerner Millennium Electronic Patient Record. These initiatives are focussed upon standardisation of clinical practice and staff rostering and this will be further enhanced following service reconfiguration.

With regard to clinical rota resilience, rota frequency will reduce immediately with the consolidation of planned and unplanned services on to single sites thereby reducing the workload strain on staff and improving the resilience of services. Relevant services include ED, acute medicine, critical care, paediatrics and radiology.

In respect of the sub-specialisation of clinical services, the critical mass achieved through consolidation of unplanned patients and workforce onto one site will allow greater opportunities for sub-specialisation of the workforce. This will improve the attractiveness of employment in the Trust and enhance the quality and safety of clinical services for patients. Relevant services include paediatrics and trauma sub-specialisation in ED, and acute medicine.

» 7.4 Key Assumptions Used to Develop the Workforce Plan

The following key assumptions have been used to quantify the workforce impacts of the above initiatives on the staffing base over the ten years of the planning period and the reconfiguration of the Trust's services into planned and unplanned sites.

The workforce staffing assumptions for 2017 – 2019 previously submitted to NHSI provide the starting point for modelling of workforce impacts. The FBC provides additional workforce plans for years 3 to 10.

In line with the capacity modelling outputs (detailed in chapter 6) the workforce capacity modelling takes account of a 105 bed reduction by 2021/22 delivered by improved pathways that enable admission avoidance and reduction in length of stay.

Consolidation of services onto a planned and un-planned site will generate efficiencies within the workforce. Specific savings will be made by a reduction in on-call intensity and medical rotas. There may also be some savings in clinical staffing numbers.

There will be a number of clerical staff released through delivery of benefits from the Electronic Patient Record (EPR) implementation process. This will be realised in years 2 & 3.

There will be some cost reduction achieved through retirement of experienced older staff members and appropriate re-banding of posts where it is safe to do so. Whilst this will not impact on headcount or wtes, there will be short-term savings on workforce costs.

Junior doctor ratios for the reconfigured sites will be based on national models.

In line with national best practice nurse staffing ratios will continue to be determined based on patient needs and acuity and professional judgement. All wards will have minimum nurse to patient ratios of 1:8 daytime and 1:10 night, with the exceptions of ITU; Level 2 = 1:2, Level 3 = 1:1 and Paediatric wards 1:4.

The use of a reviewed skills mix will be critical to the delivery of the new models of care across the planned and un-planned care sites. This will include the development of apprenticeships at all levels, as well as advanced practitioners.

The trust will work collaboratively with a variety of voluntary organisations to increase the opportunities for voluntary work and community involvement within the remodeled hospital sites. As part of the WYAAT collaboration we will review the delivery of support services such as estates and facilities, health informatics and various clinical networks to agree where economies of scale can contribute towards longer term cost savings.

As part of the WYAAT collaboration, and on the back of current work we will review the delivery of potential shared back office functions.

Calderdale and Huddersfield NHS Foundation Trust will continue to provide existing vascular services (including arterial surgery) and will continue to deliver stroke services. These two services are currently being reviewed across West Yorkshire. The vascular assumption is based on not wishing to exclude the possibility of CHFT being selected as the second vascular arterial site in West Yorkshire (see section 3.6).

A review of outpatient services will take place with the aim of delivering new models of care and reducing follow-up appointments through the introduction of fast-track access for existing patients in areas such as Gastroenterology, Respiratory, Diabetes and other long-term conditions. We will work with mental health, primary and social care and other local provider services to develop efficiencies in service provision.

We will work with other local provider organisations, including primary care to generate effective and efficient delivery of back-office functions for the whole of Calderdale and Huddersfield.

No redundancy costs have been included in reconfiguration costs in the financial case, despite the projected reduction in wtes arising from the reconfiguration. Instead it is assumed that business as usual turnover of staff, currently at 15%, will be sufficient to achieve the necessary reduction in wtes without the need for compulsory redundancies.

The workforce requirements relating to delivering the reconfiguration of clinical services, including double running costs, are non-recurrent, and as such do not contribute to the overall movement in wtes.

Delivery of the plan is dependent on the upskilling / reskilling of a number of people to fill new and developing roles across the organisation. Recruitment to new roles, such as physician associates is dependent on sufficient places being commissioned with local universities to fulfil the need within the Trust environment. The current plan allows for 12 PAs to be recruited for each of the next 3 – 4 years and discussions are being held with local higher education institutions (HEI) to ensure that this is sustainable and that the workforce can be released or recruited to fill these roles. There will be a similar requirement for emergency care practitioners (ECP) and operating department practitioners (ODP). Development of the nurse associate and nursing assistant at band 4 will also have a similar requirement, although these can, be delivered internally as a personal development route for staff through apprenticeships.

» 7.5 The Workforce Plan

The two year workforce plan for FY18 – FY19 previously submitted to NHSI provides the starting point for modelling of workforce impacts. This showed a reduction in staff during the two period of 325 wte.

The table below describes additional changes in staffing wte over years 3 to 10 (i.e. FY20 – FY27), and highlights the main factors contributing to the changes in workforce. This shows a further reduction of 154 whole time equivalent staff.

Taken together the total planned reduction in whole time equivalent staff during the ten years (FY18 - FY27) is 479.

	Change in Whole time Equivalent Headcount								Total
	2019/20 Yr3	2020/21 Yr4	2021/22 Yr5	2022/23 Yr6	2023/24 Yr7	2024/25 Yr8	2025/26 Yr9	2026/27 Yr10	
Activity Growth (demographic and impact of reconfiguration at MidYorks)	68	46	46	44	43	42	42	42	352
Reduction in hospital beds (QIPP)	-53	-50	-47						-150
Urgent Care (if Trust not the preferred provider)			-13						-13
WYAAT Pharmacy collaboration	-1								-1
WYAAT Pathology collaboration	-5								-5
WYAAT Elective Surgery standardisation	-3	-3	-4						-10
Delivery of additional Elective Surgery			11	15	22	32			80
West Yorks Vascular collaboration			-4	-10					-14
Job Evaluation	-17	-17	-17	-17	-17	-17	-17	-17	-136
Productivity	-18	-19	-12	-18	-18	-18	-26	-26	-154
EPR, Standardisation, T/O, Rostering				-35	-41	-49			-125
TOTAL CHANGE	-28	-43	-40	-21	-11	-10	-1	-1	-154

Note: the table above contains roundings and therefore the figures do not exactly sum.

The financial impact of these changes over the ten years is a circa £30m reduction in the Trusts paybill. The modelling of this is included in the Financial Case (chapter 12).

» 7.6 The Workforce Benefits of Reconfiguration

Having an effective and engaged workforce is one of the key drivers for reconfiguring services across the two hospital sites. As such there are a number of benefits that will be derived from the move to a planned and an unplanned care site. These are summarised below:

Royal College of Emergency Medicine recommendations / standards: the standards for Children and Young People in Emergency Care settings, Critical Care workforce standards and Emergency Department consultant and paediatric nursing cover recommendations will be satisfied through the consolidation of the unplanned service workforce on to one site. The reconfiguration will ensure paediatric surgery and medicine are provided from a single site, and therefore patients will benefit from improved shared care of surgeons and paediatricians.

Clinical rota resilience: rota frequency will reduce immediately with the consolidation of unplanned services and workforce on to one site thereby reducing the workload strain on staff and improving the resilience of services. Relevant services include ED, Acute Medicine, Critical Care, Paediatrics and Radiology.

Sub-specialisation of clinical services: the critical mass achieved through consolidating of unplanned patients and workforce onto one site will allow greater opportunities for sub-specialisation of the workforce improving the attractiveness of employment at the Trust and enhanced clinical services for patients. Relevant services include Paediatrics and Trauma sub-specialisation in ED, and Acute Medicine.

Skill mix / role improvements: the Advanced/Extended scope Practitioner role will be further refined and deployed in the Trust to reduce reliance on the middle-grade doctor workforce across many specialties including ED, acute medicine, and paediatrics. There would be an opportunity for Radiography staff to be trained to work across a number of areas, such as plain x-ray and acute head scanning, which would provide broader development opportunities. Also, through development of a new musculo-skeletal service the Trust will be able to better attract and retain highly experienced therapist roles.

Improving junior doctor training, oversight and supervision: junior doctor training and supervision is anticipated to improve for all clinical services being consolidated on to one site given the increased throughput of activity, and the increased non-locum consultant presence on site. This will also apply to other clinicians in training.

Recruitment, retention and locum reliance: it is anticipated that improvements in the key areas already described, such as rotas and extended roles, will improve the attractiveness of the Trust to future and existing staff. This will increase recruitment opportunities and reduce staff turnover. In turn, this will reduce the Trust's considerable reliance on locum and agency staff.

Long term sickness absence: the factors above allow for more effective service planning. This, together with other measures to support staff returning from absence, will help to reduce stress for staff and mitigate the Trust's long term sickness absence challenge.

Agency and Locum spend: in 2016 NHS Improvement introduced a cap on the amount any Trust could spend on Agency workers within the financial year. This cap has been revised for the 2017/18 financial year and the workforce plans take this into consideration, with an aim to achieve this in-year.

Quality of Care: the changes listed above will all contribute to delivery of improved outcomes for patients, will help to reduce length of stay and improve clinical compliance rates.

Continued improvements post reconfiguration: Most of the reconfiguration savings are achieved at the beginning of year five when the hospitals move to the planned and unplanned care sites. Following the move, there are opportunities to achieve additional cost savings and improvements in quality, impacting across the whole of clinical services which could not be achieved without the site reconfiguration. The reduction in on-call payments from robust single site medical rotas will release costs as will other improvements in consultant job-planning. There may also be opportunities to gain additional economies of scale in medical services where the use of advanced practitioners operating in new care pathways, can be used to fill difficult to recruit middle and junior grade doctors. This will reduce reliance on agency and locum staff and will be facilitated by senior clinical support being focused on one site to offer supervision and clinical mentoring. This will also further support those junior doctors developing their skills through the CESR (certificate of eligibility for specialist registration) route. We anticipate additional savings in years 6 to 10.

8 | Hospital Estate Plan >>

8 | Hospital Estate Plan

» 8.1 Summary

The Trust's existing estate at Calderdale Royal Hospital and Huddersfield Royal Infirmary varies considerably between the two sites with CRH being a condition B 1990s PFI development with no backlog maintenance requirement whilst HRI is a 1960s build that has time expired buildings with significant backlog maintenance requirement to achieve condition B.

The proposed estate option is for Calderdale Royal Hospital to be developed as the unplanned hospital with Huddersfield Royal Infirmary (Acre Mill) as the planned hospital. The expected estate cost to implement the future service model option is £297m.

Continuing with the existing service model provided at CRH and HRI would require £95m of capital funding across years FY19-FY23 to meet the back-log maintenance requirements of the existing HRI site.

In addition the Trust has been advised (Lendlease Consulting Limited) that it would be required to build a new HRI after 10 years as the building is 'time-expired'. The cost of building a new HRI has been assessed as £379.5m.

» 8.2 The Trust's Hospital Estate

The Trust is a community and hospital multi-site organisation. It provides services from a number of buildings across the geographical CCG areas of Calderdale and Greater Huddersfield.

Acute hospital services are provided from two sites which are approximately 5 miles apart: Huddersfield Royal Infirmary (HRI) in Huddersfield and Calderdale Royal Hospital (CRH) in Halifax.

Pennine Property Partnership (a property joint venture of the Trust with Henry Boot Developments) undertook the development of Acre Mill (which is located across the road from HRI). Acre Mill was opened as an outpatient centre in 2015.

Both hospital sites contain clinical and non-clinical accommodation and this varies considerably in terms of type, age and quality.

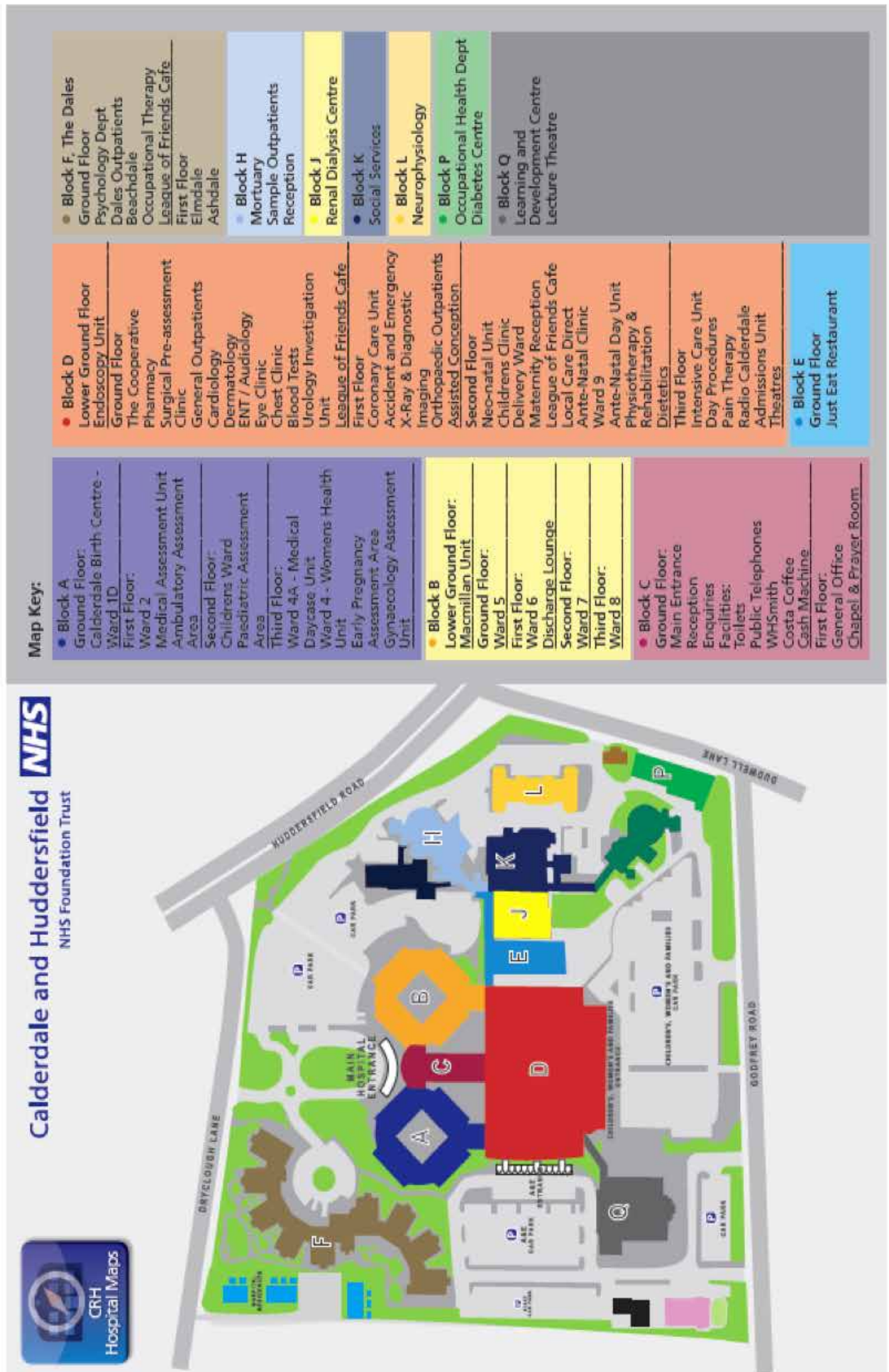


Huddersfield Royal Infirmary



Calderdale Royal Hospital

8.2.1 Calderdale Royal Hospital



Calderdale Royal Hospital has a gross floor area of 59,817m² across a site with land area of 7.36 acres.

CRH is based in close proximity to Halifax town centre and opened in 2001. The hospital offers a full range of outpatient facilities as well as inpatient areas including Surgical, Medical, Maternity, ICU, Coronary Care and Children's wards. CRH has circa 450 beds and 9 theatres including 8 main theatres and an emergency Obstetrics theatre. The Dales Unit on the Calderdale Royal Hospital site is occupied by South West Yorkshire Partnership Foundation Trust and includes three in-patient wards as well as a number of outpatient services.

The site was one of the first hospitals built through Private Finance Initiatives (PFI). The PFI arrangement runs until 2061 having been entered into over a 60 year term with a break clause after 30 years.

In 1998 the agreement to build a Private Finance Initiative (PFI) funded hospital in Calderdale was signed. Work commenced in January 1999 and the building was handed over to the Trust in March 2001. Parts of the old Halifax General Hospital buildings were retained and refurbished and in general these are used for office accommodation. The hospital was built by the Catalyst Healthcare consortium, which then comprised the Lend Lease Corporation, Bovis Lend Lease Limited, ISS Mediclean Limited, the British Linen Bank Limited and the French bank Societe Generale. Bovis Lend Lease provided the design and construction services.

As part of the PFI agreement the Special Purpose Company (SPC) has agreements in place with Engie for estates maintenance, life cycle and variation work and with ISS for the provision of catering, cleaning, portering, security, car park management, switchboard and linen distribution. The Trust works closely with all parties to ensure close and open partnership working.

In 2005 the car parking facility was extended to include the South Car Park and barrier car parking was introduced to try to assist with access to the hospital for patients and visitors.

In 2010 a new Endoscopy Unit Was Completed And Two Years Later Saw The Development Of A New Angio Suite Incorporating State Of The Art Catheter Lab at Calderdale. In 2013 the installation of a new CT Scanner took place and a year later a new coronary care advanced pacing theatre opened. In 2015 the child development unit was completely refurbished to allow the merger of the services from Huddersfield and Calderdale.

Through the Engie life cycle programme new chiller units were installed in the roof plant area in 2009 bringing improved efficiency and noise management by modern pump technology and controls. In the last 5 years Theatre operating lights; Passenger Lift cars; CCTV; Security Access systems; Fire detection; Doors & Windows have all received replacement and upgrade through Planned Life Cycle investment. The whole site is subject to planned replacement of flooring; fitted furniture and redecoration resulting in NHS Estates Code condition B being confirmed through 3rd party surveys and routine audit.

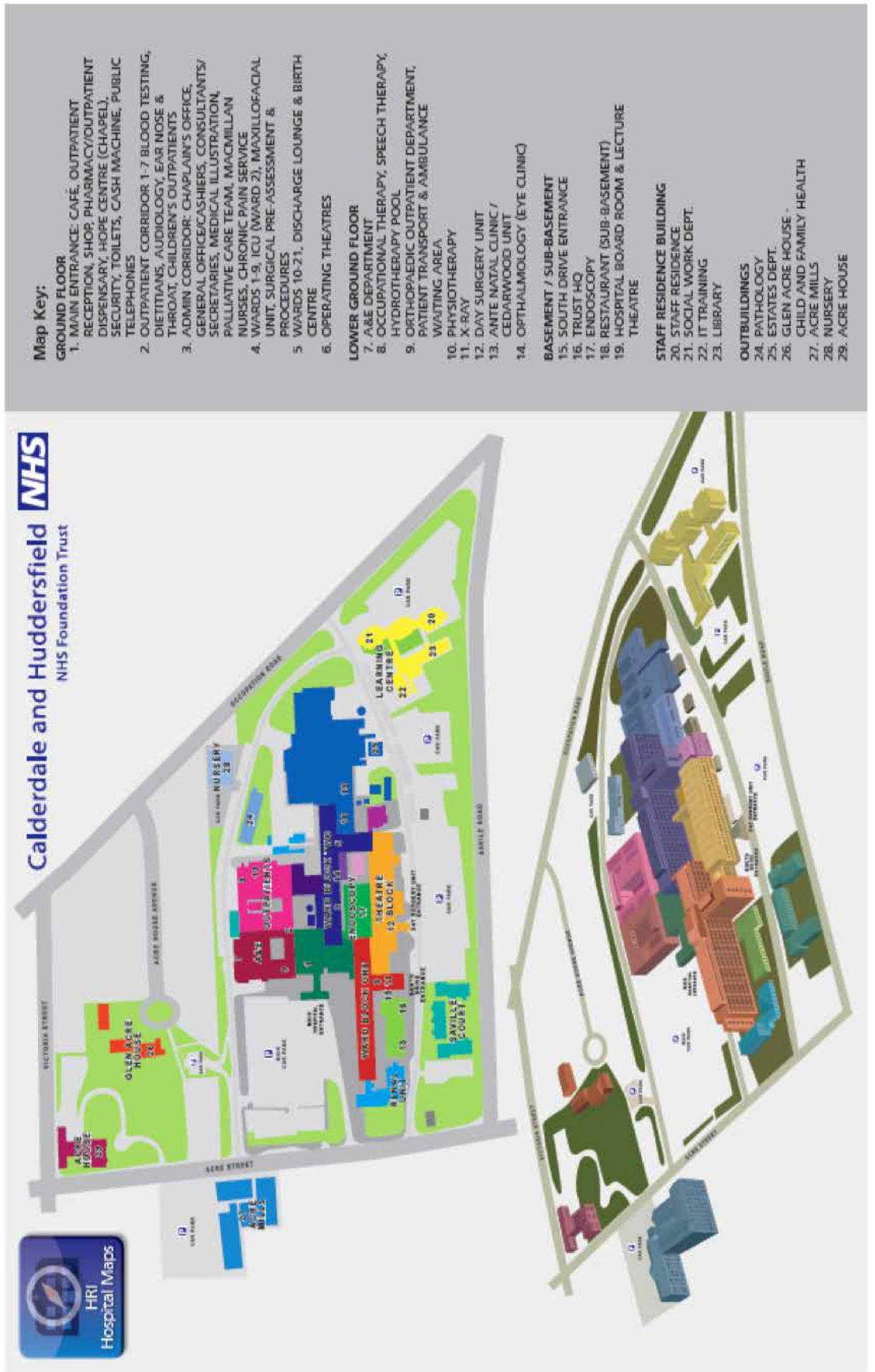
In January 2016 Engie began a medical gas plant replacement program which has seen the upgrade of 4bar medical air, 7bar surgical air and vacuum plant bringing new equipment and increased resilience to the site. This work also coincided With The Upgrade And Replacement Of Critical Ventilation Systems Incorporating Requirements Of The Most Recent Healthcare Technical Guidance.

The revenue costs of the site include interest and hard and soft facilities management. The total revenue cost for FY17 is expected to be circa £23m. The backlog maintenance is managed through the PFI contract and supported by regular capital lifecycle payments into the PFI provider.

CRH Backlog maintenance

Building maintenance is managed through the SPC and funded through regular planned lifecycle payments. There is limited backlog maintenance of note and the building is compliant to NHS Estates Code condition B.

8.2.2 Huddersfield Royal Infirmary



Huddersfield Royal Infirmary has a gross floor area of 67,493m² across a site with land area of 16.77 acres.

Huddersfield Royal Infirmary is about two miles from Huddersfield town centre. The main hospital first opened its doors in 1965 and since then many millions have been invested in the site to modernise and extend it.

The hospital offers a full range of day case and outpatient services; an accident and emergency department, and critical care. It is the centre for emergency surgery, planned complex surgery and emergency paediatric surgery for the people of Greater Huddersfield and Calderdale (these services are not currently provided at CRH). It also provides a full range of diagnostic services including magnetic resonance imaging (MRI).

Recent major developments have included the opening of a £3.4 million urology unit and investment in a £500,000 state-of-the-art CT (computerised tomography) scanner and suite.

Early in 2008 the new Huddersfield Family Birth Centre opened at the hospital, offering a warm and friendly environment for women and their partners.

In 2008 an £8 million pharmacy manufacturing unit opened on the site which produces pharmaceutical products for people across the country and is expected to continue to provide services in the future.

A new state of the art endoscopy unit was built in 2011 and the trust embarked on a scheme to replace the ageing calorifiers with plate heat exchangers which was completed in 2015. In 2016 we completed a full upgrade of services for oncology outpatients and day case patients in the newly named Greenlea Ward.

A full refurbishment of inpatient theatres was completed in 2017, bringing the main theatres into a full compliant state.

The Trust owns the Acre Mill site opposite Huddersfield Royal Infirmary and this new development for out patients' services was opened in 2015, freeing up valuable space on the main hospital site for expansion.

The Trust has upgraded many of the inpatient wards, giving us additional single rooms with en-suite facilities.

However although there has been significant investment, the core building is considered to be beyond its useful life and is time expired. Financial pressures have placed significant restraints on capital investment in recent years and as a result, the backlog of maintenance for time expired buildings requirement has grown.

HRI Backlog of maintenance for time expired buildings

Backlog maintenance, with regards to the HRI site, refers to the costs associated with time expired buildings. The cost described in this section is the minimum investment required to bring the estate to a category B level.

In 2015 the Trust commissioned a 6 facet survey from NIFES Consulting Group, this was updated by Lendlease Consulting in 2015. It identified the extent of capital works required to bring HRI to condition B status in accordance with the Department of Health Estate code.

The survey concluded that the Estate is overall in poor condition with significant backlog of maintenance for time expired buildings. The survey identified statutory items across the site that required immediate remedial action in large parts of the estate as well as key factor impacting on operational performance.

A significant investment is required to resolve the functional suitability of the estate. This has been driven through changes in service provision and size of teams that has meant the parts of the current estate are too small or were constructed and designed for another function which does not provide a suitable layout and space for services.

The 2015 survey estimated the costs to bring the estate to a level B at £95m.

Since the update to the 6 facet survey was carried out in 2015 there has been a further deterioration of the estates building and engineering service infrastructure and space/functional suitability. This has been compounded by significant national restraints placed on the Trust capital investment for backlog maintenance due to financial pressures.

The Trust now carries a high risk in terms of the condition and reliability of its building and engineering services infrastructure at HRI. The age and condition of the estate is such that without significant capital injection in backlog maintenance and a plan for a rebuild of the whole site in the next 10-15 years, there is a high risk of failure of critical services such as power supply, heating, hot and cold water services and medical gas services. The building and engineer service were designed in the 1960s and based on a demand and capacity model at that time. Since this time, further increase in load requirements have seen greater demand on system capacity and ability to provide the high levels of resilience required on an acute hospital site. Any additional load resulting from extensions to the building would result in further pressure on the system infrastructure.

Some of the major risks that could impact on the viability and operation of the site include:

- Corroded service pipework that could potentially fail - expediting the required repairs could cause significant disruption to patient services and care due to the location of asbestos in the building.
- Roof repairs are required throughout the building – there has been an increase in water leakage into the building and patient areas including wards and treatment areas.
- Power supplies require significant work – although there have been improvements; there still remains further work required to secure a robust supply.
- Fire safety – although improved, there still remains a significant investment requirement for compartmentation, fire detection and alarm systems.

- The vast majority of windows require replacements – there are multiple instances of windows leaking and allowing a significant draft to penetrate into the building having a severe effect on the patient environment, comfort and experience.
- Asbestos removal –The Trust has strong management processes in place around the asbestos within the hospital infrastructure. The requirement for asbestos removal, should any infrastructure repairs be required, could have a major impact on the provision of patient services and care.
- The building cannot have any more holes drilled into floors to replace pipework. This is because it is making the fundamental structure unsafe, and structural engineers have advised us to not make any more holes. This means that we cannot replace pipework, and it is almost impossible to do the upgrade work required.
- “Concrete cancer” in a number of areas as water has seeped behind the stone façade. Concrete is crumbling away in these areas.

The 6 facet surveys were reassessed as part of the Cost Management Plan in support of the various estates reconfiguration options being assessed as part of this plan. The report produced by Lendlease Consulting Limited in November 2015, identified that £95m would be required with the vast majority required immediately. This would not however repair the structure of the building, which makes it time limited (10 years at most).

The backlog maintenance requirement is a key consideration in determining the capital investment required under each of the proposed estate options to deliver the future hospital services model.

» 8.3 Capital expenditure for CRH as the unplanned care site and Acre Mill as the planned care site

In 2015 as part of the Trust’s five year strategic plan an estates option appraisal was undertaken. This determined that the proposed estate option for the future service model is for Calderdale Royal Hospital to be developed as the unplanned hospital and Huddersfield Royal Infirmary (the Acre Mills site) as the planned hospital.

In May 2017 Lendlease Consulting provided the Trust with a Feasibility Cost Model of the expected build costs for the future service model in the re-development of the CRH and Acre Mill sites. (This work was previously undertaken in 2015 but needed to be updated). The cost estimates were based on the gross internal floor areas derived from a schedule of accommodation prepared by a Healthcare Planner in discussion with the Trust on the required clinical activity and capacity for each of the options.

The estate cost model provides for:

Beds:

A total of 750 beds across the two sites. Within this total is included 18 ICU beds with the ability to increase this to 22 in future years. This total bed number of 750 is slightly more (12 beds) than the 738 identified as required in chapter 6. This is due to additional bed capacity being planned in ward units of 29 beds per ward resulting in additional beds rather than too few. This also provides sufficient flexibility to provide the additional 5 beds that would be required if CHFT is selected as an arterial surgery centre.

Theatres:

A total of 20 theatres (12 at CRH and 8 at Acre Mill). The Trust currently has 18 theatres across the two sites and the capacity of 20 includes an additional obstetric theatre and a hybrid theatre at CRH.

Car-Parking:

A cost allowance has been made to provide a mix of multi-storey (175 spaces) and surface (100) car parking spaces at Acre Mill, and 600 multi storey spaces at CRH. This allowance was based on a benchmark norm for car parking spaces. CRH currently has 787 car parking spaces. The proposed development would build an additional 600 space multi-story car park, and establish an additional 80 spaces at Dryclough Close (both subject to planning permissions). This would give a total of 1467 spaces. It is estimated that the development of the CRH site would result in a loss of 134 spaces. The net total parking spaces would therefore be 1,333 representing a growth of 546 compared to current (787).

In order to keep capital requirements to a minimum the plan assumes minimal change of existing buildings at CRH and an appropriate level of derogation to ensure compliance with the necessary statutory standards.

8.3.1 Total Build Development Costs for the Future Model

The development costs for the future model of unplanned care at CRH and planned care services provided at the Acre Mill site in Huddersfield is shown below (this does not include backlog maintenance of HRI during the development or income from the HRI sale / disposal).

Future Model	Forecast Out-turn Cost (£)
HRI Planned Site on Acre Mill	121,070,193
CRH Unplanned Site	176,547,597
Total	297,617,790

Estate Cost Summary of the Proposed Option

The cost summary below provides a high level overview of the cost components.

Element	FBC CRH Cost (£)	FBC HRI Cost (£)	FBC Total Cost (£)
HRI (Acre Mills)		£53,965,600	£53,965,600
CRH	£77,298,800		£77,298,800
Site infrastructure	£2,975,360	£3,989,420	£6,964,780
Traffic management	£115,948	£80,948	£196,897
External works	£700,120	£668,140	£1,368,260
Service diversions	£140,000	£90,000	£230,000
Access and logistics	£173,922	£121,423	£295,345
Car parking	£6,000,000	£1,950,000	£7,950,000
Links	£1,575,000	£75,000	£1,650,000
Sustainability	£686,756	£539,656	£1,226,412
Section 106/278	£772,988	£539,656	£1,312,644
Sub-total	£90,438,894	£62,019,843	£152,458,738
Preliminaries	£12,661,445	£8,682,778	£21,344,223
Fees	£12,372,041	£8,484,315	£20,856,355
Non works costs	£1,546,505	£1,060,539	£2,607,044
Equipment costs	£5,155,017	£3,535,131	£8,690,148
Planning contingency	£18,326,085	£12,567,391	£30,893,476
Optimism bias (13%)	£18,264,998	£12,525,500	£30,790,498
Sub-total	£158,764,985	£108,875,497	£267,640,482
Inflation	£17,782,612	£12,194,696	£29,977,308
VAT (Excluding Fees)	£32,835,112	£22,517,176	£55,352,287
VAT recovery	(£32,835,112)	(£22,517,176)	(£55,352,287)
Total	£176,547,597	£121,070,193	£297,617,790
Backlog maintenance	-	£11,818,000	£11,818,000
Total (including backlog)	£176,547,597	£132,888,193	£309,435,790
HRI disposal	-	-	(7,000,000)
Total capital requirement	£176,547,597	£132,888,193	£302,435,790

8.3.2 Phasing of Capital Costs

It may be that the Department of Health's approval and approach to funding could require phasing of build and capital costs. This is based on a three year construction period. The start year would be 2019.

» 8.4 Site Capacity for the Future Model

8.4.1 Calderdale Royal Hospital

Work has been undertaken (by the Trust and an external estates advisor) that has confirmed that whilst the CRH site is constrained it is of sufficient size to be able to accommodate the additional estate and clinical capacity to deliver the new clinical service model for unplanned and emergency services. A potential outline implementation plan for the new build has been developed that aims to keep any disruption of hospital operations to a minimum and also minimises third party and neighbourhood impact.

8.4.2 Acre Mill

The development of the planned care service hospital is based on new build on the Acre Mill site where the Trust owns sufficient land to accommodate the transition to the new estate and required clinical capacity. The main HRI site would be demolished and the land sold.

» 8.5 Estate Costs of Continuing with the Existing Service Model

Continuing with the existing service model provided at CRH and HRI would require £95m of capital funding across years FY19-FY23 to meet the back-log maintenance requirements of the existing HRI site. In addition the Trust has been advised that it would be required to build a new HRI after 10 years as the building is 'time-expired' and it will not be possible to maintain the building beyond ten years.

The cost of building a new HRI has been assessed as £379m.

This has been determined using the gross internal floor areas required and the costs for the various functional areas that have been benchmarked against comparable healthcare schemes built over the past 5 years.

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9 | The Financial Case for Change >>

9 | The Financial Case for Change

» 9.1 Summary

This chapter summarises the national and local financial context for the FBC and highlights that the local health and care system is both unaffordable and unsustainable.

Financial modelling work under-taken in 2015 and described in the Trust's 5 Year Strategic Plan identified that a significant reduction of the Trust's under-lying deficit could be delivered by the reconfiguration of hospital services. However the work undertaken in 2015 did not return the Trust to a breakeven or a surplus position over the 5 year forecast period.

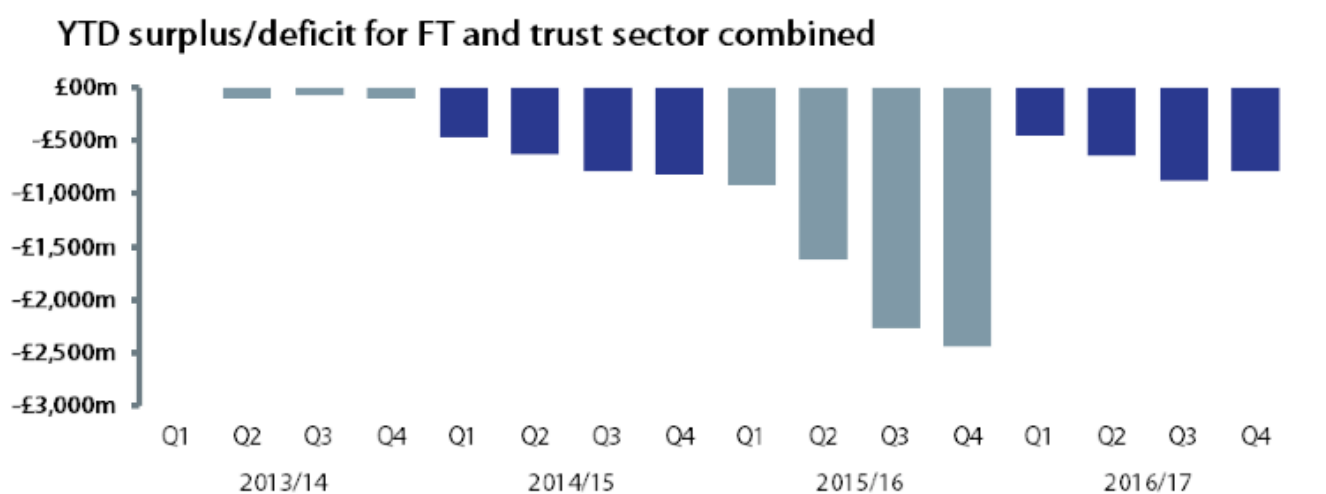
The 5 year strategic plan therefore generated a requirement to undertake further modelling of the financial impact of implementing the future service model with the aim of eliminating the Trust's underlying deficit.

» 9.2 Financial Context

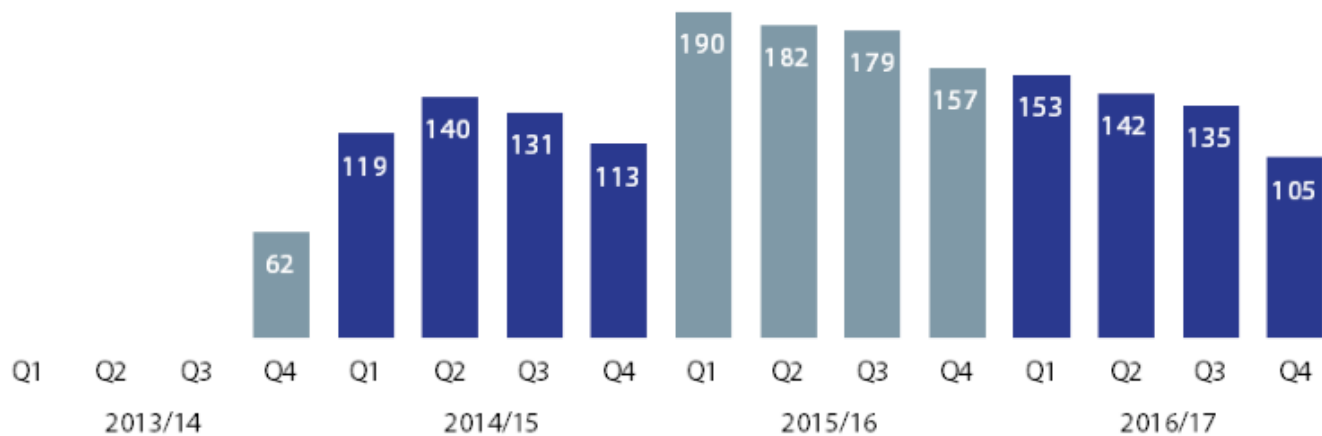
9.2.1 National

People are living longer lives and more people are likely to have multiple long term conditions thereby increasing the demand on the NHS and social care system. Nationally there has been a rapid rise in demand for hospital nurses and difficulties in recruiting consultants in mainstream specialties. Growing shortages of qualified clinical staff has increased use of agency and other temporary workers to fill vacancies and increased NHS expenditure.

The 16/17 year end outturn was £211m worse than the aggregate provider plan deficit of £580m and indicates that the NHS is currently both unaffordable and unsustainable. According to the National Audit Office this autumn position would have been considerably worse if the £1.8bn of Sustainability transformation funding had not been available.



Number of providers in deficit



(source: NHS Providers – 2016/17 Quarter 4 Finance and Performance)

(source: NHS Providers – 2016/17 Quarter 4 Finance and Performance)

Although there are increased resources available for the NHS in 2017/18 and 2018/19, the level of growth is significantly less than has previously been available to the NHS (3.6% in 16/17 compared to 1.3% for 17/18). Therefore, the expectation is that providers and commissioners will need to have a relentless focus on efficiency in 2017/18 and 2018/19.

The NHS capital environment is also very challenged with capital resources severely constrained at £360m. Provider capital plans need to be consistent with clinical strategy and clearly provide for the delivery of safe, productive services with business cases that demonstrate affordability and value for money. Providers are expected to continue to procure capital assets more efficiently; maximise and accelerate disposals, and; extend asset lives.

9.2.2 Calderdale and Huddersfield Health and Social Care System

The cost of commissioning services is not affordable to the CCGs in Calderdale and Huddersfield and as a result they are not compliant with NHS Business rules. The total affordability challenge across both CCGs is circa £59m by 2021/22. Both CCGs have agreed financial recovery plans with NHSE. This means that the NHS in Calderdale and Huddersfield is currently both unaffordable and unsustainable.

9.2.3 CHFT

The Trust delivered the 2016/17 control total - a year end deficit of £16m. After exclusion of a number of agreed items from the control total and application of the STF incentive payment the Trust has reported the 2016/17 final year end position as a deficit of £13.79. Achievement of the control total deficit in 2016/17 was after receipt of £12.7m Sustainability and Transformation Funding (STF).

The Trust's control total for 2017/18 is £15.9m (after £10.1m STF funding) and this drives the total CIP required in 2017/18 to £20m (5.3% of Trust operating expenses). Over the past three years the Trust has a track record of delivering against the objectives that the organisation signs up to. It is in the context of historic delivery; long term strategic change enabled by these reconfiguration plans; and the future opportunities afforded the organisation by working collaboratively across the region that the Trust will strive to achieve the £15.9m control total set by NHSI for 2017/18. However, the Trust Board considers likelihood of achievement of this control total to be high risk in common with many other Trusts from across the country.

» 9.3 CHFT Underlying Deficit

Based on the assumption that Sustainability and Transformation Funding will not be available from 2019/20 onwards the full underlying deficit that the Trust needs to eliminate is circa £26m. The Trust is reliant on financial support from the Department of Health to provide the cash to pay creditors and staff.

The Trust has previously worked closely with Monitor and PwC to assess the causes of the underlying deficit. This identified that structural costs associated with the dual site configuration of services (which require higher workforce expenditure) and the high finance costs of the PFI at Calderdale Royal Hospital are key factors driving the underlying deficit. To secure future financial sustainability the Trust needs to implement reconfiguration of hospital services and optimise the utilisation of the Trust's PFI and non-PFI estate.

9.3.1 Work Undertaken in the five year Strategic Plan to Reduce the Deficit

In 2015 the Trust's five year strategic plan proposed a new model of hospital service delivery to consolidate the provision of emergency and unplanned services at Calderdale Royal Hospital (CRH) and provide planned hospital services at Huddersfield Royal Infirmary (HRI).

The plan clarified the financial implications of supporting reconfiguration of CHFT services compared to the 'as is' or base case. This showed that:

- the proposed option yielded a recurrent deficit of £9.5m from FY22 onwards. Whilst this represented an improvement of £18.0m against the base case deficit of £27.5m it did not return the Trust to a breakeven or surplus position over the forecast period.
- the proposed reconfiguration of services would require £200m additional capital investment compared to the 'as is' however this would yield a £18.0m revenue benefit per annum that would mean a potential financial payback of investment in 10-11 years. Also this would deliver significant wider economic benefits related to quality, safety and workforce resilience.
- continuing with the current operating model would require £156m capital investment (largely to

address backlog maintenance) and this would not deliver any reduction in the underlying deficit or improvement of the quality and safety of service delivery.

9.4 The Case for Change and Purpose of FBC

Plans for the reconfiguration of services need to be affordable for both the Trust and CCGs and have an agreed timeline to deliver financial balance in the future.

Both NHSE and NHSI have made it clear that public capital will not be available for the proposed model and therefore other options for funding needed to be explored.

The following chapters of this Full Business Case build on the work previously undertaken in the five year strategic plan and:

- identify potential sources of capital funding for the reconfiguration of the Trust's services;
- provide an economic appraisal to identify a proposed funding option;
- explore the commercial opportunities to progress the proposed funding option;
- model the impact of the proposed funding option on eliminating the Trust's underlying deficit, and; describes the impact on wider system affordability.

The modelling included in the following chapters of this business case shows that by implementing the future service model the Trust could achieve financial surplus in Year 8 (2024/25) and maintain financial surplus at circa £6m per annum thereafter.

10 | The Economic case >>

10 | The Economic case

» 10.1 Summary

The 5 Year Strategic Plan developed in 2015 concluded that the most favourable economic and financial option for the Trust was the development of CRH as the unplanned hospital and HRI as the planned hospital (the detail of this appraisal is available on request).

The purpose of the economic case described in this chapter of the FBC is to assess the value for money of this future service model (i.e. CRH as the unplanned hospital, HRI as the planned hospital) compared to continuing with the existing service model and in relation to the capital investment funding routes available for delivery.

This Chapter includes:

- Identification and assessment of the potential available funding options for the capital build investment
- overview of the key features of private finance initiatives (including advantages and disadvantages)
- explanation of the economic appraisal / evaluation methodology that has been used
- the findings of the financial and non-financial appraisal / evaluation undertaken
- The conclusion of this chapter is that the development of CRH as the unplanned hospital, with a planned hospital development at HRI provides economic (VFM) advantage compared to continuing with the existing service model. It also concludes that PFI is the proposed option for funding the capital build investment required.

» 10.2 Assessment of Potential Funding Options

In delivering the future service model option of CRH as the unplanned care site, with HRI being the planned site, evaluation is required of the funding options for the capital build costs. In tandem with experts from the Department of Health the Trust has given consideration to the following potential funding solutions:

- Public Dividend Capital (PDC) - i.e. Treasury cash funded purchase;
- Independent Trust Financing Facility (ITFF) Loan - funding through the Independent Trust Financing Facility (ITFF), as assumed within the 5 Year Strategic Plan;
- Public Works Loans Board (PWLB)/Bonds - discussions have taken place with Calderdale Borough Council who would consider supporting a loan to fund the development;
- Private Finance Initiative (PFI)/PF2 – private financing, similar to how Calderdale Royal Hospital was developed but under different terms and conditions than the original PFI agreement;
- PFI and Joint Venture (JV) - this combines the PFI with a joint venture vehicle, established with CHFT membership on its board and alongside Henry Boot PLC, to raise funds in support of required developments.

The Trust has through discussions with the Department of Health and NHS Improvement, sought to evaluate the feasibility of these sources of funding and has set out an initial evaluation of each of these options. This is shown in the following table.

10.2.1 Financing Options Overview

	Existing Model	Public Dividend Capital	ITFF	PWLB	PFI	PFI & JV
Strategic Fit	✘	✓	✓	✓	✓	✓
Efficiency of estate utilisation	✘	✓	✓	✓	✓	✓
Accounting treatment	✘	✘	✘	✘	✓	✘
Flexibility	✘	✓	✓	✓	✓	✓
Patient experience	✘	✓	✓	✓	✓	✓
Timescales	✘	✓	✓	✓	✓	✓
Pass/Fail	Fail	Fail	Fail	Fail	Pass	Fail

The key criteria differentiator within this assessment is 'Accounting Treatment' and the restrictions that the Treasury/Department of Health has on available capital resources to support the Trust's reconfiguration. It is clear that the financing options available to support reconfiguration are limited by whether the capital spend is incurred against the national 'Capital Departmental Expenditure Limit (CDEL) as the Trust has received a clear statement that funding options should be explored that do not incur expenditure against the CDEL budget.

On the basis of the above assessment of the financial options, the economic case provides an evaluation of PFI sourced funding alongside continuing with the existing service model. The Trust recognises that there are a number of delivery variations of a PFI contract and these are articulated in detail within chapter 11 - the Commercial Case.

10.2.2 Key Features of Private Finance Initiatives

Overview

Traditionally Public Private Partnership (PPP) projects which underpin PFIs have been used by governments to deliver infrastructure through utilisation of private finance to fund both construction and ongoing capital replacement requirements and enabling the public sector access to the discipline, skills and expertise of the private sector.

With limited capital in the health financing system and the requirement to deliver new or significantly refurbished estate and associated capital spending, PPP infrastructure funding is a viable option given the restrictions on balance sheet classification and rebalancing the financial position of the NHS. It potentially offers a practical delivery vehicle to assist and drive the level of investment required to transform the health estate and support new models of care. That said and for the avoidance of doubt, the public at large are skeptical about PFIs in this health economy because of the perceived impact of existing PFI arrangements.

Under a PPP structure, rather than funding the capital expenditure directly (e.g. from cash reserves or borrowing), the entity wishing to create the asset contracts with a third party (usually an entity specifically set up for the purpose – the Special Purpose Vehicle or SPV) for it to procure, design, build, finance and maintain the capital infrastructure. The procuring authority then pays an availability charge to use the asset (the unitary charge). The SPV is usually responsible for maintaining the asset (supply of hard facilities management – hard FM) for which it earns a further charge and may also supply services such as cleaning, catering, laundry etc. (soft FM) which are also incorporated in the unitary charge.

The objective of PPPs is to provide a better allocation of risk between the procuring authority and the SPV delivering the serviced asset. Early deals were also off balance sheet and the provision of services alongside the availability of the asset allowed recovery of VAT on construction and the unitary charge. This went some way to offsetting the higher cost of borrowing the SPV had to pay to raise finance relative to traditional government sources.

In December 2012 the government launched 'PF2 – A new approach to public private partnerships'. PF2 incorporating a range of changes to improve the previous Private Finance Initiative (PFI) model. Notable differences include:

- The government takes a minority equity stake in schemes (albeit pari passu) with private investors;
- Excluding services such as catering and cleaning which are procured separately on shorter contracts to facilitate flexibility;
- Increased standardisation of contractual documentation and centralisation of procurement expertise;
- Set time limits for the procurement to drive down costs for both bidders and the procuring authority; and
- Greater transparency in respect of the future liabilities created by a deal and also public sector participation in windfall gains when private sector interests are sold into secondary markets.

Advantages and disadvantages of Private Finance Initiatives

In a typical PFI project, the private sector party is constituted as a Special Purpose Vehicle (SPV), which manages and finances the design, build and operation of a new facility. The financing of the initial capital investment (i.e. the capital required to pay transaction costs, buy land and build the infrastructure) is provided by a combination of share capital and loan stock from the owners of the SPV, together with senior debt from banks or bond-holders. The return on both equity and debt capital is sourced from the periodic charge, which is paid by the Trust from the point at which the contracted facility is available for use.

Advantages

- ✓ Accelerated Delivery: The procurement timetable for PF2 has been capped at 18 months from tender to completion.
- ✓ Public sector equity: The Government will take a minority equity stake in the delivery vehicle alongside the proposed private sector partner. The aim of this is to secure a more collaborative approach, better partnership working, and the ability of the Public Sector to participate in equity returns.
- ✓ Greater transparency: The Trust's partner will be obliged to provide forecasting information as well as costing data on an open book basis.
- ✓ Flexible service provision: Although hard FM services will be included in any procurement, soft FM services will not. This will allow the Trust to determine the best route to secure these services.
- ✓ Appropriate risk allocation: Improved value for money is achieved through a more appropriate allocation of risk and greater management of risk by the public sector.
- ✓ Limiting excess profits: The public sector has a greater entitlement to participate in refinancing gains and to share in lifecycling surpluses.

Disadvantages

- ✗ Higher cost of finance than borrowing from direct government sources;
- ✗ The prospect of delivering the asset using private finance may discourage a challenging approach to evaluating whether this route is value for money;
- ✗ Reduced contract flexibility - the bank loans used to finance construction require a long payback period. This results in long service contracts which may be difficult to change;
- ✗ The Trust pays for the risk transfer inherent in PFI contracts but ultimate risk lies with the Trust;
- ✗ PFI is inherently complicated which can add to timescales and reliance on advisers;
- ✗ High termination costs reflecting long service contracts;
- ✗ Increased commercial risks due to long contract period and the high monetary values of contracts;
- ✗ Public perception of PFIs is not generally positive.

» 10.3 Appraisal / Evaluation Methodology

Continuing with the existing service model is non-viable in the long-term as it does not meet any of the core requirements of the Trust, nor is the finance available to support the required capital investment to sustain safe services. It serves however as a baseline to assess the benefit of the evaluated option. This option will therefore be known as Option A. Option A includes the receipt of capital funding for the back-log maintenance from the Independent Trust Financing Facility (ITFF) Loan. The future service model option will be evaluated under a PFI funding model.

In addition to the economic evaluation each option has been assessed against the following criteria as part of the non-financial evaluation:

Category	Investment Objective	Benefits criteria
Strategic Fit	Supports the delivery of the Trusts Vision, business and service strategy and aids delivery of the STP strategy/vision	Create inpatient capacity and supports the planned and unplanned clinical service strategy
Efficiency of estate utilisation	Utilising the surplus estate and potentially other owned assets and land to finance the development	Full utilisation of Estate, efficient use of sites and improvement in physical condition Flexibility and creativity in the use of the Estate
Accounting treatment	Impact of the accounting treatment both from an NHS wide perspective and Trust	Balance sheet impact and treasury capital budget.
Flexibility	Provide alternative sources of capital solutions	Flexibility in how schemes are delivered
Patient experience	Support the delivery of an improvement in the patient experience of services and clinical care	Continuous improvement in estate to provide new ways of working
		Improved quality of the environment for patients
Timescales	The timing of developments to support service delivery and reduced revenue impact	Extent of disruption and timing of when developments can commence

The above criteria will be scored on the following basis:

Detail	Score
Does not deliver any project benefits	0
Some/minimum benefits delivered	2
Less than half the benefits delivered	4
Around half the benefits are delivered	6
All project benefits delivered but some risk of failure	8
All project benefits delivered with no risk of failure	10

Each of the evaluated options has been based on:

- The base year and price year is FY18;
- Prices exclude non-recoverable VAT;
- Cash flows are discounted by 3.5% per annum;
- Although, build/refurbishment timelines are different a 65 year appraisal period has been used, which reflects the re-development period plus 60 years of operation; and
- An alternate period of 45 years is also included.

10.3.1 Cost

There are a number of steps involved in arriving at a proposed economic option. Traditional discounted cash flows across the following categories are considered for each option:

- Capital Outlays: for new builds or refurbishment are applied by year of spend.
- Land or building sales - recorded in the year(s) in which they are estimated to be realised.
- An estimate of the residual value of an asset - at the end of the lifespan to represent an estimate of an asset's value at that time, i.e. 60 years.
- Capital and revenue lifecycle costs - of maintaining estate assets.
- The Trust's capital programme - for new and replacement assets.
- Revenue cost cash flows - across clinical, non-clinical and estates costs across the lifetime.
- Transitional costs - declared separately and consider non-recurrent or ad-hoc spends.
- Externalities – costs have been reflected within the evaluation for the impact of the case on other external parties.

The sum of these discounted results creates a Net Present Cost (NPC) and an Equivalent Annual Cost (EAC) by option. A ranking occurs with the lowest NPC receiving the proposed option status.

10.3.2 Revenue Costs

Revenue costs have been driven from the 2017/18 and 2018/19 operational plan submitted to NHSI in March 2017 for the base year and reflects activity changes for future modelled years. All other options have been considered to assess the degree to which they might be different to the baseline position.

Typical areas considered include:

- Transition costs for reconfiguration – non-recurring, project and dual running forecasts have been modelled. These costs are estimated at £10.1m;
- Project management costs across the Trust;
- Dual running staffing costs, backfill and training costs; and
- Revenue lifecycle estimates over a 65 year period.

10.3.3 Capital costs

Capital cash-flow is specific to each option and includes:

- Estimates for new capital build;
- Major refurbishment estimates;
- Land disposal;
- Capital lifecycle trajectories;
- Internal replacement capital programme forecasts; and
- Internal new and replacement equipment requirements.

Each option has been considered discretely. External advisors have updated new capital build forecasts and refurbishment in the existing service option which takes account of £94.5m of backlog maintenance as well as a capital build over a significant timeline. In addition to the cost of backlog maintenance capital costs of £379.5m have been modelled in year 10, 11 and 12 for a new build at HRI to replace the existing infrastructure as addressing the backlog maintenance does not address the underlying condition of the asset infrastructure which the Trust has been advised would be beyond repair by FY27.

In both the existing service model option A and the future service model option B additional funding is required associated with the purchase of the existing CRH PFI. This is referred to as a bullet payment and is included in the analysis as funded through ITFF loan over a 25 year period.

10.3.4 Residual Value Calculations

An estimate of the value of new build assets has been included to discount costs over 45 and 65 years. Residual values for estate have been assumed to be equivalent to the value of land for each site. This assumption is consistent within both options.

10.3.5 Externalities

The impact on other organisations has been considered and modelled within the economic assessment. The key example of this is the impact on other providers as activity transfers to the Trust post reconfiguration.

The economic case excludes the impact on commissioners of QIPP delivery as the cost of enabling QIPP delivery is unknown at this point. This is excluded in both Option A and Option B and therefore does not become a differentiator within the economic assessment. Equally if QIPP delivery costs become known it is anticipated that they would be allocated by the same amount across each option.

» 10.4 Non-financial Benefit Analysis

Each of the identified funding methods have been evaluated against the identified criteria, the summary of this assessment is detailed below:

Category	Existing Model	PFI
	Option A	Option B
Strategic Fit	2	8
Efficiency of estate utilisation	2	6
	2	6
Accounting treatment	0	8
Flexibility	2	4
Patient experience	2	8
	2	8
Timescales	2	6
	14	54

The basis for the scoring above is articulated throughout the FBC however the key summary justification for these scores is outlined below:

- Strategic Fit – The delivery of Option B meets the clinical case for change and the strategic direction of the Trust to meet the needs of the local patients and vision of the West Yorkshire STP. The Existing Service Model option does not achieve the clinical case for change and will leave the Trust with unsustainable clinical services.
- Efficiency of estate utilisation – The current configuration of estate does not effectively and efficiently utilise the estate resource. The delivery of Option B would allow the Trust to maximise the efficient use of its estate and improve the Trusts performance on the NHS Estates and Facilities dashboard, supporting the delivery of efficiencies identified as part of the Lord Carter of Cole's review of NHS efficiencies.
- Accounting treatment – The utilisation of PFI as a financing vehicle allows the Trust to access available resource without incurring capital cost against the national Capital Expenditure Departmental Limit. Continuing with the existing service model does not achieve this as this option is reliant on ITFF funding as PFI cannot be utilised for backlog maintenance which would be required during the ten year period ahead of a new build HRI. (The new build at HRI in Option A could be funded via ITFF or PFI. In this FBC ITFF is the assumed funding vehicle).
- Flexibility – Option B enables the Trust to flex the clinical workforce and estate footprint to best deliver services to our patients to meet our clinical direction. In Option A the Trust continues to operate in the status quo which limits the use of clinical staff and estate.
- Patient experience – Option B will ensure that the patient receives the highest standard of patient care in estate surroundings fit for the 21st century. This advantage is offset by patient travel distance being impacted post reconfiguration. Continuing with the existing service model option reduces the opportunity of the Trust to deliver an improved patient experience.
- Timescales – Utilising a PFI agreement for the delivery of the estate investment allows the Trust to access the discipline, skills and expertise of the private sector to deliver the project build. This skill set is offset by a potentially prolonged negotiation period for a PFI agreement to draw to close, which has been detailed further within the Commercial Case. Continuing with the existing service model option may be achievable in a short term however in considering the strategic aims of the Trust; this option does not deliver these aims.

Non-financial analysis conclusion

The conclusion from the non-financial analysis is that PFI funding for the development of the Calderdale Royal Hospital and Huddersfield site is the preferred option.

» 10.5 Net Present Cost and Equivalent Annual Cost Analysis

The table below provides a summary of the Net Present Cost (NPC) and Equivalent Annual Cost (EAC) for each of the options under evaluation, assessed over 65 years.

£m	Existing Model		PFI
	Option A	Option B	
Net Present Cost (NPC)	£10,880.9	£10,391.2	
Equivalent Annual Cost (EAC)	£404.2	£386.0	
EAC Variance	+18.2	+0.0	
Rank	2	1	

The table below provides a summary of the Net Present Cost (NPC) and Equivalent Annual Cost (EAC) for each of the options under evaluation, assessed over 45 years.

£m	Existing Model		PFI
	Option A	Option B	
Net Present Cost (NPC)	£9,490.9	£9,079.4	
Equivalent Annual Cost (EAC)	£405.3	£387.7	
EAC Variance	+17.6	+0.0	
Rank	2	1	

Net Present Cost and Equivalent Annual Cost conclusion

The conclusion from the Net Present Cost and Equivalent Annual Cost assessment is to move to the future service model financed through PFI. This conclusion is drawn when assessed at both 65 years and 45 years.

» 10.6 Combined Economic and Non-Financial Evaluation

The table below considers the impact of the qualitative and quantitative assessment.

£m	Existing Model		PFI
	Option A	Option B	
EAC (65 years)	£404.2	£386.0	
Non-financial benefits points	14	54	
Cost per benefit point	£28.9	£7.1	
Rank	2	1	

The combined economic and non-financial evaluation demonstrates that the proposed option has a lower cost per benefit point in addition to a lower EAC and a higher non-financial benefit points score.

West Yorkshire Health Economy Benefits

The reconfiguration of services to provide planned and unplanned services across the HRI and CRH sites is aligned to the Sustainability and Transformation Plan for West Yorkshire and Harrogate (WYSTP).

The WYSTP covers all of the six acute trusts (five in West Yorkshire plus Harrogate) and the eleven CCGs and will be delivered by local health and care organisations working together across the region to support changes needed to improve services for the 2.6 million people who live here.

STP partners continue to work with staff, stakeholders and the public to build the plan, ensuring the involvement of as many stakeholders as possible in future conversations around the draft proposals. The STP aims to address the health and wellbeing gap across our local populations with a focus on supporting people to live longer; healthier lives and ensuring a good and equitable service for all, no matter where you live.

The draft proposals also stress the importance of improving people's health, through better coordination of services, whilst improving the quality of care received.

The STP builds on local plans that have been developed in each of the six local boroughs covered. They attempt to tackle long standing issues and improve care. They look at prevention, better coordinated services, preventing unnecessary hospital admissions and supporting people to stay well. Service transformation through the reconfiguration of services across CRH and HRI forms a significant part of the WYSTP, where aims and objectives will not be achieved without the reconfiguration of the Trust's services.

» 10.7 Conclusions of the Economic Case

It can be concluded that Option B is the preferred option. The previous analysis reaffirms the case for change set out within the Full Business Case (i.e. that the development of CRH as the unplanned hospital, with a planned hospital development at HRI provides economic (VFM) advantage compared to the existing service model and that PFI is the proposed option for funding).

11 | The Commercial Case >>

11 | The Commercial Case

» 11.1 Summary

The Economic Case (Chapter 10) concluded that private financing of the capital build investment required to develop CRH as the unplanned hospital and HRI as the planned hospital is the proposed funding option available to the Trust at this time.

The Commercial Case described in this chapter provides an assessment of the potential procurement options available to the Trust to secure private finance for the investment.

The choice of a procurement route must meet the Trust's needs, project requirements and ensure the optimal transfer of risk from the Trust. An important consideration relative to this is the Trust's current legal and contractual arrangements for the current PFI at Calderdale Royal Hospital. The Trust also wishes to ensure that the procurement strategy and contract(s) support the development of collaborative relationships between the Trust and its suppliers.

This chapter concludes that the most likely procurement routes are:

- The reconfiguration of the existing CRH building facilities will be procured by way of a variation of the existing PFI Project.
- The new build at CRH and new build at HRI will be procured via new PF2 arrangements. This could be via a single procurement or separate contracts for CRH and HRI.

Each of the procurement options described in this chapter has its own merits in terms of cost, quality, resource and ease of implementation. The broad approach and risks of each is described.

» 11.2 The Capital Estate Investment Required

The Trust has considered the elements of capital that is required for the development. This requirement can be described as:

- Reconfiguration of the existing CRH site; infrastructure works required to the existing CRH building to integrate the existing site into the new build, including the expansion of hospital areas e.g. Emergency Department.
- New build works at CRH; capital build required to increase the estate footprint to accommodate the increase in activity from centralising unplanned care on the CRH site.
- New build works at HRI; capital build required to deliver the planned care activity and replace the ageing HRI estate.

» 11.3 Potential Procurement Options

PFI funding has a number of delivery options that could arise through the procurement process. The options identified are:

- Option 1a: **Procure** a new PFI partner for the reconfiguration work of the existing CRH building **and** for the new build at CRH **and** HRI sites, retaining the existing PFI partner for the current CRH PFI.
- Option 1b: **Procure** a new PFI partner for the reconfiguration work of the existing CRH building **and** for the new build at CRH and a **separate** PFI partner for the HRI site, retaining the existing PFI partner for the current CRH PFI.
- Option 1c: **Variation** to the existing CRH PFI contract to procure the new build at CRH, and procure a **new** PFI partner for the development at HRI.
- Option 1d: **Variation** to the existing CRH PFI contract to procure the required reconfiguration work of the existing CRH building and procure a new PFI partner for the new build at CRH **and** HRI sites, retaining the existing PFI partner for the current CRH PFI.
- Option 1e: **Variation** to the existing CRH PFI contract to procure the required reconfiguration work of the existing CRH building and procure a new PFI partner for the new build at CRH and a **separate** PFI partner for the HRI site, retaining the existing PFI partner for the current CRH PFI.
- Option 1f: **Variation** to the existing CRH PFI contract to procure the new build at CRH and HRI site.
- Option 1g: **Variation** to the existing CRH PFI contract to procure the new build at CRH and HRI site whilst renegotiating the Trusts existing PFI contract to refinance and update the existing contract terms to align to the most up to date PFI contract terms.
- Option 1h: **Terminate** the existing CRH PFI contract and procure a new PFI for the existing estate, reconfiguration works and new CRH build, and a separate new PFI partner for the HRI site.
- Option 1i: **Terminate** the existing CRH PFI contract and procure a new PFI for the existing estate, reconfiguration works and new CRH and HRI build.

» 11.4 Assessment of Procurement Options

The Trust has sought to understand the details of each option to ensure that they are feasible and has taken legal advice under legal professional privilege on this. The following table summarises assessment of each of the options.

Description	Initial Feasibility	Comments
Option 1a: Procure a new PFI partner for the reconfiguration work of the existing CRH building and for the new build at CRH and HRI sites, retaining the existing PFI partner for the current CRH PFI.	✘	Reconfiguration work of the existing building at CRH cannot be done within a new joint PF2, but must be via the existing PFI arrangement for CRH.
Option 1b: Procure a new PFI partner for the reconfiguration work of the existing CRH building and for the new build at CRH and a separate PFI partner for the HRI site, retaining the existing PFI partner for the current CRH PFI.	✘	Reconfiguration work of the existing building at CRH cannot be done within a new joint PF2, but must be via the existing PFI arrangement for CRH.
Option 1c: Variation to the existing CRH PFI contract to procure the new build at CRH, and procure a new PFI partner for the development at HRI.	✘	Procurement legislation does not allow such a significant variation to the existing PFI contract to cover the capital costs within this business case.
Option 1d: Variation to the existing CRH PFI contract to procure the required reconfiguration work of the existing CRH building and procure a new PFI partner for the new build at CRH and HRI sites, retaining the existing PFI partner for the current CRH PFI.	✔	Amend the red-line within the existing CRH PFI contract to enable build works to interface with the existing PFI building. Procure a new PF2 covering both CRH and HRI builds.
Option 1e: Variation to the existing CRH PFI contract to procure the required reconfiguration work of the existing CRH building and procure a new PFI partner for the new build at CRH and a separate PFI partner for the HRI site, retaining the existing PFI partner for the current CRH PFI.	✔	Amend the red-line within the existing CRH PFI contract to enable build works to interface with the existing PFI building. Procure a new PF2 covering CRH and a separate PF2 for HRI build.
Option 1f: Variation to the existing CRH PFI contract to procure the new build at CRH and HRI site.	✘	Procurement legislation does not allow such a significant variation to the existing PFI contract to cover the capital costs within this business case. In addition the initial procurement for CRH did not include within its scope build at the HRI site.
Option 1g: Variation to the existing CRH PFI contract to procure the new build at CRH and HRI site whilst renegotiating the Trusts existing PFI contract to refinance and update the existing contract terms to align to the most up to date PFI contract terms.	✘	Procurement concerns of resetting the existing PFI contract without a new competition.

Description	Initial Feasibility	Comments
Option 1h: Terminate the existing CRH PFI contract and procure a new PFI for the existing estate, reconfiguration works and new CRH build, and a separate new PFI partner for the HRI site.	✘	The termination of the existing PFI contract would create a charge against the Capital Departmental Expenditure Limit (CDEL) and therefore isn't feasible.
Option 1i: Terminate the existing CRH PFI contract and procure a new PFI for the existing estate, reconfiguration works and new CRH and HRI build.	✘	The termination of the existing PFI contract would create a charge against the Capital Departmental Expenditure Limit (CDEL) and therefore isn't feasible.

» 11.5 Procurement options that will be taken forward

The assessment above has informed the conclusion that only Options 1d and Option 1e offer viable procurement options. The explanation of this conclusion (based on legal advice) is provided below.

1. The variation of the existing CRH facilities will be procured by way of a variation of the existing PFI Project with Concessionco. The Trust has been advised that the most cost effective way of funding this would be through an ITFF loan. This has been modelled with a 25 year payback period.
2. Concessionco does not have exclusivity to carry out post-construction completion works variations or varied services under the terms of the existing PFI Project Agreement. The development of the New CRH and the New HRI by way of an amendment to the existing PFI (Project Agreement with Concessionco) is therefore unlikely to be permitted under procurement law. Consequently the development of the New CRH and New HRI will be procured via separate PF2 arrangements.
3. The Trust has flexibility to deliver its proposals in respect of the New CRH and the New HRI outside the scope of its existing PFI arrangements at CRH and to procure both under a single procurement process which would:
 - › Avoid duplicating procurement costs;
 - › Improve the likelihood of delivering both developments in accordance with a timetable determined by the Trust;
 - › Optimise the cost of private sector funding; and
 - › Create a single counterparty for the Trust to deal with.

However, it is possible for them to be procured separately and to follow different models. The procurement approach will therefore allow for flexibility and provide the opportunity for providers to bid for CRH, HRI or CRH and HRI.

» 11.6 Key risks of the procurement options

Issue	Variation (existing CRH facilities)	PF2 (New CRH and New HRI)
Estimated Timeline	18 months, but timetable will be influenced by the length of time it takes to agree the terms of a procurement process.	Capped at 18 months from ITT to financial close.
Risk Transfer	Only achievable to the extent that the existing Project Agreement is updated to address weaknesses.	Will deliver an acceptable risk transfer position with which the market is familiar.
Balance Sheet Treatment	Deliver an off balance sheet position.	Deliver an off balance sheet position.
Procurement Position	Procurement compliance position is clear.	Procurement compliance position is clear.
Costs	Could be disproportionate to the value of the variation given the need to negotiate a new variation process and an amended Project Agreement.	Included within the FBC based on an estimate at £1m, non-recurrently.
Interface	Interface will be required with the New CRH. Terms will need to be agreed with both Concessionco and any new provider in respect of the New CRH.	Interface will be required with the Existing CRH. Terms will need to be agreed with both Concessionco and any new provider in respect of the New CRH.

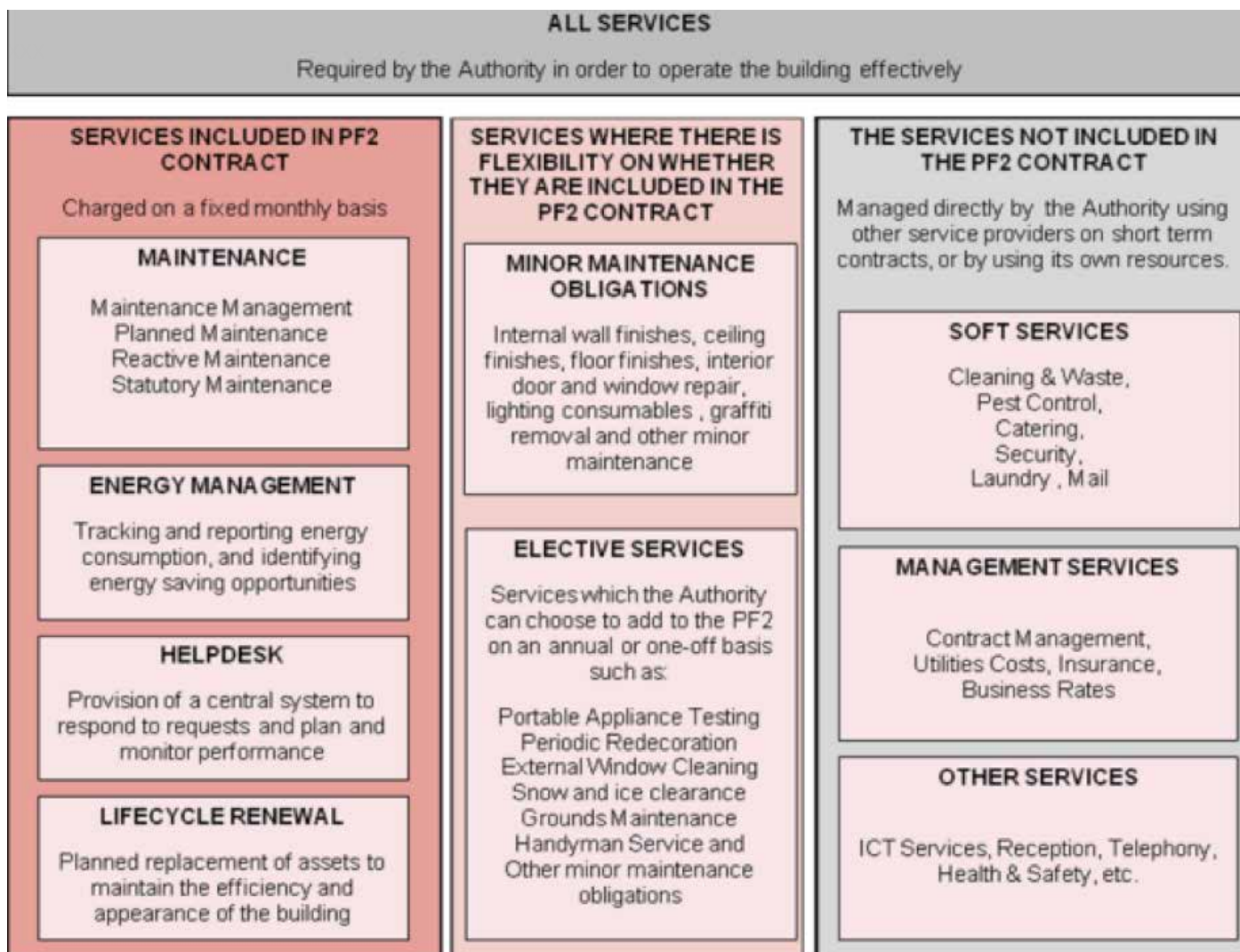
» 11.7 Scope of the PF2 contract (New CRH and New HRI)

The planned (HRI) and unplanned (CRH) hospital sites will form the basis of the PF2 contract(s).

The following is an extract from Treasury guidance setting out the approach to be taken to structuring PF2 contracts and the allocation of risks between the public and private sector. The Trust's approach will be in keeping with this guidance.

The Trust will carefully consider the factors influencing the scope of hard and soft facilities and services to be incorporated into the PF2 contract(s). The main consideration will be to ensure best value for money.

In developing its procurement approach the Trust will also take account of work across the West Yorkshire Association of Acute Trusts (as described in section 3.5) regarding the development of wider collaborative approaches to achieve efficiencies and economies of scale in the delivery of Estates & Facilities Management and Information Technology.



Extract from: HM Treasury, Standardisation of PF2 Contracts

» 11.8 PF2 contract

The Trust will seek to adopt the standard terms and conditions of the PF2 contract from the Department of Health. Further legal and Department of Health input will be required following approval of this business case.

» 11.9 Market Soundings

The ability of the Trust to secure value for money through a PF2 procurement will be influenced by the ability to attract sufficient credible bidders to generate and maintain meaningful competition throughout the procurement process. Accordingly, the Project will be carefully marketed to attract potential bidders. Whilst the Trust will offer the market the option of separate developments for New CRH and New HRI, it is anticipated that a combined PF2 agreement for both CRH and HRI will be more attractive to the market and offer the Trust favourable financial terms for the contract.

Pre-market engagement

PF2 as the procurement approach requires the Trust to complete the competitive stage of the Competitive Dialogue process in less than 18 months which is considerably shorter than was previously anticipated. Treasury guidelines on 'lean procurement' under PF2 propose the use of significant pre-market engagement prior to issue of the OJEU notice to ensure that bidders will enter the process well prepared. This process has been incorporated into the overall programme.

Objectives of the Pre-Market Engagement Plan

The objectives will be to:

Present the prequalification process to ensure the bidders can prepare;

- Enable discussion about scope and commercial issues to ensure that the project is attractive to bidders;
- Enable discussion about public sector equity funding;
- Explain proposed design methodology, including tight, prescriptive timescales so that bidders can resource it; and
- Discuss proposed Bid Deliverables and evaluation criteria at each stage.

The aim is to assist bidders to be well prepared prior to the entering the process allowing the overall procurement programme to be reduced.

Pre-Market Engagement Process

It is proposed that a Project Initiation Notice (PIN) will be posted in the Official Journal of the European Union 3 – 4 weeks prior to the formal OJEU notice. The PIN will present a brief project description and give notice of engagement events / opportunities including the following:

- Half day introduction to the project supported by a brochure and questionnaire to seek comments;
- Opportunity to book a two hour meeting for the potential bidder project team and the project team; and
- A final event to confirm timelines, scope, procurement methodology and information from HMT on proposed public sector equity stakes.
- Careful planning will be required to ensure alignment with approval timescales so that the final meeting takes place after HMT approval and announcement of equity participation percentages.

Post OJEU Open Day

The Trust will host an open day following publication of the OJEU notice at which the Trust Board will provide a detailed description of the project, covering for example:

- The Case for Change;
- PSC functional content and design;
- Project specific issues; and
- Procurement process and timetable.

The Trust also plans to run a supply chain engagement event. All parties who have made contact with the Trust will be invited to attend as well as local companies that may be interested in bidding for work as part of the supply chain. This will provide an opportunity for the Trust to actively support development of networks between potential bid teams and local business. It will also provide opportunities to maintain general contact with bidders.

Competitive Dialogue

The legal basis under which the procurement is to be concluded is the EU procurement regime (set out in Directive 2004/18/EC (the Directive) pursuant to the Public Contracts Regulations 2006 (SI 2006/5) (as amended) using the Competitive Dialogue procedure. PF2 guidance has been developed to support delivery of a 'lean procurement process'.

» 11.10 Trust Capability and Approach

The Trust has experience of major procurement projects on a competitive dialogue basis with, for example, a significant contract for the Trust's Electronic Patient Record, across two Trusts with Bradford Teaching Hospitals NHS Foundation Trust as our partner.

Project management and governance arrangements will be established and the Trust will seek legal support to detail, plan and navigate through the Procurement approach post approval of the business case. A Final Business Case will be developed once the procurement process reaches financial close that will demonstrate the value for money of the final concluded procurement method.

12 | Financial Case >>

12 | Financial Case

» 12.1. Introduction

The financial case within the 5 Year Strategic Plan was underpinned by the Trust's draft plan for FY17, presented to Monitor on 24 November 2015. The section below provides an overview of the key financial changes that have arisen since the approval of the 5 Year Strategic Plan, the key changes being:

- Sustainability and Transformation Funding;
 - Electronic Patient Record (EPR); and
 - Depreciation on backlog maintenance.
- Section 12.2 provides details of each of these changes and the implication of these on the 5 Year Strategic Plan.

The preparation of the 'Future Service Option' modelled within the financial case have been modelled based on the NHS Improvement Operational Planning and Contracting Guidance 2017-19 with assumptions made to evaluate the financial case over a 25 year period.

The Trust recognises its current deficit financial position and that the Existing Service model option leaves the Trust with an unsustainable clinical model and an inferior financial outlook when compared to the Future Service Option. The Future Service Option allows the Trust to transform its clinical model whilst improving the overall financial outlook for the Trust.

The financial models and assumptions used within the financial case are derived from the Trust's activity trajectories which are integrated within the Trust's operational plans.

The Future Service Option demonstrates a return on investment and enables the Trust to return to a cash generating financial position, an improving financial position when compared with continuing with the Existing Service model consideration.

» 12.2 Financial case update on the 5 Year Strategic Plan

The 5 Year Strategic Plan modelled the financial implication of the Future Service option and outlined a deficit of £39.0m for FY17. The table below provides comparison of the Income and Expenditure FY17 5 Year Strategic Plan vs. the FY17 Actual:

£m	FY17 5 Year Plan	FY17 Actual
Income	361.2	373.3
Pay	(241.7)	(241.1)
Non Pay	(126.5)	(124.7)
EBITDA	(7.0)	9.45
Non-Operating Expenditure	(32.0)	(23.3)
Surplus/(Deficit)	(39.0)	(13.8)
Less items excluded from Control Total	-	(2.3)
Surplus/(Deficit)	(39.0)	(16.1)

12.2.1 Key I&E movements between five-year strategic plan and actual for FY17

The financial values within the FBC are based on the actual income and expenditure for FY17. The key movements between the five year strategic plan and the FBC financial values are:

£m	FY17 5 Year Plan
FY17 5 Year Strategic Plan Surplus/(Deficit)	(39.0)
Sustainability and Transformation Funding	12.7
Electronic Patient Record (EPR)	5.0
Depreciation on backlog maintenance	5.2
FY17 Actual	(16.1)

Sustainability and Transformation Funding (STF)

As part of the Spending Review the Chancellor identified £10 billion for the NHS's future plan. Of this funding £1.8 billion has been identified to help trusts reduce their deficits and allow them to focus on transforming services to deliver excellent care for patients every day of the week. Receipt of this funding was contingent on the Trust delivering a number of conditions. NHS Improvement confirmed that the Trust met the set conditions for receipt of the monies and received £12.7m of STF income in FY17. For FY18 STF funding has been confirmed at £10.1m, subject to conditions and acceptance of a control total deficit of £15.9m. Consistent with the Trust's Operational Plan, receipt of STF monies have been assumed in FY19 at £10.1m. As per NHSI guidance no further STF funding is assumed.

Electronic Patient Record (EPR)

The 5 Year Strategic Plan included a possible £5.0m clinical income risk associated with the EPR implementation. This was due to a potential loss in productivity during the implementation of the new patient record system. This assumption was based on experience of other providers implementing a similar system. As the go-live date progressed into FY18 the income reduction did not materialise in FY17. The Trust continues to outline a potential income reduction/mitigation costs as part of the EPR programme.

Depreciation on backlog maintenance

The proposed option of CRH being the unplanned site included costs being incurred on HRI on backlog maintenance. This outlined £15.5m capital expenditure in FY17, depreciated over three years prior to the disposal of buildings on the HRI site. In finalising the FY17 plan this depreciation cost was removed as the Trust would seek to impair these costs at the point of HRI disposal. On this basis this depreciation was not within the FY17 actual expenditure. This treatment would result in asset impairment in FY22 for the HRI site.

12.2.2 Key Statement of Financial Position (SoFP) movements between 5 Year Strategic Plan and Actual for FY17

The table below provides comparison of the SoFP FY17 5 Year Strategic Plan vs. the FY17 Actual:

£m	FY17 5 Year Plan	FY17 Actual
Property, Plant and Equipment	248.6	239.0
Inventories	6.1	6.7
NHS Trade Receivables	3.2	7.2
Non NHS Trade Receivables	2.3	6.9
Other Current Assets	10.8	12.4
Cash and Cash Equivalents	(48.7)	1.9
Current assets	(26.3)	35.2
Total assets	222.3	274.2
Current Liabilities	(40.7)	(48.9)
Non-Current Liabilities	(115.5)	(139.0)
Total Liabilities	(156.2)	187.9
Net assets employed	66.1	86.3
Public dividend capital	115.7	116.2
Retained Earnings (Accumulated Losses)	(85.7)	(67.4)
Revaluation reserve	36.1	37.5
Total taxpayers' equity	66.1	86.3

Property, Plant and Equipment (PPE)

The key movement on PPE from the 5 Year Strategic Plan to the FY17 Actual was an impairment on the Trusts asset value alongside a reduction in the planned capital expenditure.

Cash and Cash Equivalents

The key variant within the Statement of Financial Position is on Cash and Cash Equivalents where the Trust's cash position is favourable to that modelled within the FBC. The key reason for this is the receipt of Sustainability and Transformation Funding of £12.7m, Electronic Patient Record costs of £5m and other minor movements in cash totaling £2.3m. In addition the revenue support funding is shown in liabilities rather than a negative cash position.

Non-Current Liabilities

Non-current liabilities requirements reflects a reduction in loan liabilities associated with the reduced cash requirements following receipt of STF funding.

» 12.3. Current financial performance - Month 3 FY18

The Month 3 planned position is a deficit of £8.00m on a control total basis, including year to date Sustainability and Transformation funding (STF) of £1.52m. This is in line with the plan submitted to NHS I. However, the financial position remains extremely precarious with activity and income below planned levels. EPR implementation continues to have a significant impact on both productivity and the capture of activity data. Additional workforce challenges including the adherence to IR35 guidance have impacted upon both performance and activity, which in turn have impacted upon the financial performance. Receipt of full STF funding has been assumed but year to date performance against the accident and emergency 4 hour standard has not been met which could lead to loss of STF funds. An appeal is in place citing exceptional circumstances relating to the introduction of EPR. After actions that are still being taken to capture and record activity that has been delivered, the underlying movement away from the year to date plan is £2.6m at month 3. Non recurrent measures have been taken to recover the year to date position but these are not sustainable and 50% of the Trust total contingency fund for 2017/18 has been allocated.

CIP of £2.15m has been delivered at month 3 against a plan of £2.32m, an underperformance of £0.17m. The Trust is forecasting full achievement of the £20m CIP target for the financial year. However there remains significant risk to delivery of this plan.

Total reported agency spend in June was £1.46m; as planned and in line with the NHS Improvement Agency Ceiling, however this value excludes agency expenditure capitalised as part of EPR implementation costs. The number of reported Agency Cap breaches remained very high, but was slightly lower than the level seen in May.

Capital expenditure to month 3 was £4.6m against a plan of £5.3m. The main area of spend to date was on EPR as planned.

Cash held at month 3 was £1.9m in line with plan.

The forecast continues to assume that the Trust will achieve its Control Total and secure the £10.1m STF allocation. However, the forecast assumes that activity returns to the planned level from July, with no further EPR related income losses. It also assumes that the remaining £3.2m of unidentified CIP is delivered. The risk of failing to achieve our target deficit of £15.9m therefore remains extremely high and further action is required to stabilise the financial position. Delivery of the financial plan has been escalated on the Trust risk register and is now the highest possible risk and highest recorded risk for the Trust. Delivery of the planned deficit with the current service configuration and estate remains extremely challenging.

» 12.4. FY18 financial performance - Forecast

The Trust continues to forecast delivery of the planned deficit control total of £15.9m (excluding exceptional impairment costs).

The key risks associated with delivery of the FY18 plan are:

- Planned activity delivery and commissioner affordability: Planned activity levels differ from Commissioner contracts due to a different assessment of QIPP. If commissioners are successful in delivering these plans, the Trust will need to ensure that costs are reduced to compensate any associated loss of income.
- EPR: Any adverse revenue impact of EPR implementation and training will have to be included within the £15.9m Control Total. There remains a risk around loss of income and managing any costs that cannot be capitalised.
- CQUIN: The forecast assumes full delivery against CQUIN targets.
- CIP risk: The £20m CIP target has a delivery risk and the Trust forecast assumes delivery.
- Sustainability and Transformation Funding (STF): The Trust is awaiting final confirmation of the performance criteria and trajectory for the A&E 4 hour wait target. It is likely that the full 30% Access Target element of the STF funding will be reliant on achievement of this A&E target. Current guidance suggests that the Trust will be expected to maintain a level of performance at least as high as that achieved in FY17.

» 12.5. Financial assumptions overview

12.5.1 Key assumptions underpinning the Financial Case

The Financial Case modelled is based on the Trust's FY18 and FY19 Operational Plan. The other key assumptions within the Financial Case are detailed below:

12.5.2 Key I&E assumptions

The key assumptions within the forecast are:

- That the Trust will achieve the necessary conditions to secure the £10.1m Sustainability & Transformation Fund (STF) allocation which is intrinsic to and contingent upon delivery of the planned deficit. This is consistent in 2018/19.
- That the Trust will achieve cost improvement savings of £20m for FY18 and £15.9m for FY19.
- That any adverse non recurrent revenue impact of the EPR implementation will either be capitalised or offset by additional savings in FY18.
- Against payment of £1m Apprentice Levy, £0.9m assumed to be recoverable through the Apprentice Levy fund.

12.5.3 Key Growth Assumptions

CHFT has undertaken an activity forecasting exercise to understand the likely impact of demographic growth. The table below shows the demographic growth assumptions used by the Trust. Non-demographic factors have also been incorporated. For FY18-FY23 the assumptions are based on the review performed by Interserve jointly for the Trust and Calderdale and Huddersfield Clinical Commissioning Group's (CCG's). The demographics are assumed to continue at the same rate from FY23-FY42.

Discussions have been held with the Trust's two main commissioners, Greater Huddersfield CCG (GHCCG) and Calderdale CCG (CCCG), to ascertain any material differences in forecasting assumptions. The Trust and CCGs' assumptions on activity growth appear to be materially consistent, with the main differences being in relation to QIPP.

Point of delivery	FY17	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY42
Year	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 25
Elective	1.33%	1.33%	1.33%	1.15%	1.15%	1.15%	1.15%	1.15%	1.15%	1.15%	1.15%	1.15%
Day case	1.28%	1.28%	1.28%	1.06%	1.06%	1.06%	1.06%	1.06%	1.06%	1.06%	1.06%	1.06%
Non-elective	0.96%	0.96%	0.96%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%
Outpatient	1.09%	1.09%	1.09%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%
A&E	0.73%	0.73%	0.73%	0.81%	0.81%	0.81%	0.81%	0.81%	0.81%	0.81%	0.81%	0.81%
Other tariff	1.02%	1.02%	1.02%	0.96%	0.96%	0.96%	0.96%	0.96%	0.96%	0.96%	0.96%	0.96%
Non-tariff	1.02%	1.02%	1.02%	0.96%	0.96%	0.96%	0.96%	0.96%	0.96%	0.96%	0.96%	0.96%
Community	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%

The CCGs have identified £49m of income reduction associated with planned QIPP across the first five year period of the plan. However, within the financial plan the Trust has assumed QIPP and bed reduction CIP of £3.5m and £1.6m respectively in FY18 and a further £3m and £0.7m respectively in FY19, totaling £8.8m income reduction across the two years. A further £13.1m income reduction associated with QIPP has been assumed in FY20-FY22, this is based on a 6% reduction in non-elective medical admissions, shift to ambulatory care, reduction in acute based rehabilitation and the movement to upper quartile length of stay. Any QIPP delivered in addition to the QIPP described above is assumed to be delivered on the basis that the Trust can reduce costs at the same rate as the income reduction.

The Trust continue to work with its Commissioners to deliver QIPP and address the overall affordability of healthcare in Calderdale and Huddersfield.

12.5.4 Commissioner Affordability

The Trust has shared the activity, growth and inflation assumptions of the FBC with its two key commissioners for transparency and to ensure overall affordability of the FBC for the West Yorkshire healthcare sector. The following table sets out the clinical income values per commissioner over the five year period.

£m	FY17	FY18	FY19	FY20	FY21	FY22
Year	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
CHFT Greater Huddersfield CCG Income	123.7	124.4	125.2	125.5	126.9	125.4
CHFT Calderdale CCG Income	139.6	139.3	139.7	140.5	141.7	140.3
CHFT Clinical Income	263.3	263.7	264.9	265.5	268.6	265.7
Greater Huddersfield CCG	123.7	118.6	116.6	116.4	118.0	118.9
Calderdale CCG	139.6	133.6	131.2	128.6	128.9	128.3
CCG Clinical Income	263.3	252.2	247.8	245.0	246.9	247.2
Greater Huddersfield CCG variance	-	(5.8)	(8.6)	(9.1)	(8.9)	(6.5)
Calderdale CCG variance	-	(5.7)	(8.5)	(11.4)	(12.8)	(12.0)
Difference	-	(11.5)	(17.1)	(20.5)	(21.7)	(18.5)

For FY17 the Trust and Commissioners agreed a financial position for the year, reflecting the activity commissioned and provided for the year. The difference in assumptions between the Trust and its two main commissioners arise as a consequence of the financial constraints facing each of the commissioners. Each of the CCGs have QIPP plans to reduce activity for the Trust and drive down the overall cost of healthcare spend over the five year period. The Trust and commissioners have planned for different contract values in FY18 due to differences on QIPP assumptions. The financial impact of this difference is reflected throughout the five year period.

The Trust is committed to delivering a financially sustainable solution for the health sector in West Yorkshire. Through the Calderdale and Greater Huddersfield Transformation Group the Trust is working with commissioners to identify and deliver QIPP that delivers financial savings for the health system i.e. both the commissioners', and providers', expenditure is reduced through the delivery of the QIPP.

It is key to note that the commissioner affordability gap grows by £7m between FY18 and FY22. Over 50% of the overall affordability requires in year resolution. It is assumed that as the £7m is identified, costs will be removed at 100% rate.

12.5.5 Financial assumptions

The projections laid out in the Financial Case include a number of assumptions around how the Trust operates:

- **Pay/Non-pay split** – where costs have not been able to be directly attributed to pay and non-pay categories, these have been split on a proportionate basis to pay/non-pay expenditure.
- **Marginal cost** – the assumption has been that any growth or movement in activity, other than QIPP, will have a marginal cost impact of 70%.
- **QIPP** – the Trust has assumed 80% marginal cost associated with activity lost through QIPP schemes for financial years FY20-FY22. Any QIPP delivered in addition to the identified schemes is assumed to have cost reduction equivalent to the value in income reduction.
- **Working capital** – none of the options is assumed to have any significant impact on the Trust's working capital policy (i.e. payables and receivables days remain constant throughout the Plan period).

12.5.6 Economic assumptions

The Trust has also made a number of economic assumptions governing cost inflation and tariff deflation. These are presented below.

	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28-FY42
Year	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 25
Clinical Income	0.1%	0.1%	0%	1.0%	1.0%	0%	0%	0%	0%	0%	0%
Other Income	1.0%	2.0%	2.0%	3.0%	3.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Pay & Incremental drift	2.0%	2.0%	2.0%	3.0%	3.0%	1.6%	1.6%	1.6%	1.6%	1.6%	1.6%
Drugs	1.0%	2.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
CNST	18%	18%	10%	10%	10%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Clinical Supplies & Other non-pay	1.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

The bases for these assumptions are as follows:

- **Clinical Income** – tariff deflation has been assumed to be between 0% and 1.0% throughout the period FY18 to FY42, this is based on planning guidance for FY18-FY22;
- **Other Income** – inflation based on planning guidance to FY22, continuing at 2% pa.;
- **Pay inflation and Incremental drift** – pay inflation for all staff is assumed to rise to 2.0% per annum by FY20, increasing further to 3.0% by FY22 based on planning guidance for FY18-FY22;
- **Drugs** – the figures presented above are for routine pharmacy drug issues and represent a cost pressure to the Trust. Inflation relating to high-cost drugs, which are pass-through in nature are off-set by corresponding income;

- **Clinical Negligence Scheme for Trusts (CNST)** – inflation based on the Trust’s historical experience of CNST increases, reducing to 10% pa. for FY20-FY22, reducing further to 3% from FY23; and
- **Clinical Supplies & Other non-pay** – inflation based on planning guidance to FY22, continuing at 2% pa.

These assumptions were based on the information available to the Trust at the time of developing the Plan and are based on the NHS Improvement Economic Assumptions (published 23 March 2016). Any changes that may arise on these assumptions in the future will not materially impact the financial option appraisal since changes to such assumptions will impact the Existing Service model and Future Service Option materially equally.

12.5.7 Capital assumptions

Estimates for capital expenditure were obtained from the work undertaken by Lendlease Consulting for the costs associated with CRH and HRI. Capital expenditure estimates are based on the gross internal floor areas of the respective buildings, taken from the Schedule of Accommodation produced by the Healthcare Planner following confirmation of the proposed service changes under the Proposed Option.

Impairment of capital expenditure a 15% impairment of the expenditure on new works (i.e. capital expenditure excluding backlog maintenance) is assumed on completion of the works (in FY22).

Depreciation policy for capital expenditure

- Reconfiguration capital – depreciated over 40 years;
- Backlog maintenance capital – depreciated over 34 years (current average for HRI).

Asset disposals – the disposal of assets on the HRI site under the Future Service Option occurs in FY23. The disposal proceeds of £7m are based on external quantity surveyor reports. Losses on disposal are based on projected net replacement costs from the Trust’s Fixed Asset Register (FAR). The £7m is assumed to fund further capital in FY23 and FY24.

Capital estimate inclusions – all of the below are pro-rated across the breakdown of capital provided by the Quantity Surveyor:

- Preliminary costs – 14%;
- Professional fees – 12%;
- Non-works costs – 1.5%;
- Capital equipment costs – 5%;
- Planning contingency – 15%;
- Optimism bias – 13%;
- Value Added Tax (VAT) – 20%;

Revaluations – revaluations have been assumed to occur to the Trust’s estate. The estate is first revalued five years after being brought on to the Statement of Financial Position, with the first revaluation occurring in FY26, and then annually thereafter to maintain the estimated market value of the estate.

Cash assumptions

Throughout each of the modelled options the Trust is reliant on Revenue Support Loan in the period prior to returning to financial surplus. This has been modelled with an interest charge of 1.5%, which is the current rate of the borrowing for the Trust for this facility. The Trust’s Revenue Support Loan is assumed in the future service model Option B to be written off following the Trust’s reconfiguration, in FY23. This is in FY33 in the existing service model Option A. The write off of revenue support loan is assumed to be through receipt of PDC.

Financing assumptions

Option A – ITFF funding

- Back-log maintenance of £94.5m funded through ITFF loan;
- New build HRI - £379.5m in FY22-FY25;
- ITFF capital loan rate – 1.40%;
- Loan term – 25 years.

Option B – PFI & ITFF funding

- Back-log maintenance of £11.8m funded through Trust resources and ITFF loan of £8.1m in FY20 and FY21;
- Capital costs - £297.6m capital cost for both sites, split between variation to the existing site at £21m (ITFF) and new capital works at £276.6m (PFI);
- ITFF loan for variation to existing estate (£21m) at CRH funded at 1.40% for 25 years;
- ITFF loan to fund Trust capital requirements of £4.6m across the business case, until FY32;
- The disposal of HRI for £7m in FY23 is assumed to fund Trust capital over FY23 and FY24;
- PFI Concession length - 40 years, calculating repayments based on equal interest and principal ('EIP');
- Site area - 46,213 M2 for both sites;
- Hard FM & Lifecycle costs - Annual Hard FM costs of £23.30per m² and lifecycle costs of £27.57 per m² based on benchmark data;
- Operational start date – April 2021.

» 12.6. Summary Financial Expenditure

The summary financial impact of the Future Service Option is outlined in the table below:

£m	FY23	FY27	FY42
	Future Service	Future Service	Future Service
	Option B	Option B	Option B
	£m	£m	£m
Total Revenue	386.1	414.4	500.8
Total Operating Expenditure	(356.4)	(367.2)	(452.7)
EBITDA	29.7	47.2	48.2
Total Non-operating Expenses	(41.5)	(41.2)	(41.8)
Net Surplus / (Deficit)	(11.9)	6.0	6.4
<i>Net Surplus / (Deficit) margin (%)</i>	<i>(3.1%)</i>	0.0	0.0
FY23 Cumulative normalised Surplus / (Deficit)	(95.5)		
FY27 Cumulative normalised Surplus / (Deficit)		(81.7)	
FY 42 Cumulative normalised Surplus / (Deficit)			16.0

The total capital expenditure on the reconfiguration of services is £297.6m of capital expenditure (excluding back-log maintenance).

» 12.7. Capital Costs

The table below is the capital expenditure plans submitted to NHS Improvement in March 2017, with the addition of the expenditure planned on the Option A strategic reconfiguration. Detailed capital planning has been performed by the Trust for FY18 and FY19, with FY20 and beyond identified against a single capital programme line.

£m	FY17	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY42
	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 25
Estates and backlog maintenance	6.7	3.2	1.4	5.2	5.2							
Strategic Reconfiguration						297.6						
Information Technology	5.1	1.9	1.3									
EPR	7.4	3.4										
Equipment	3.4	3.3	1.2									
PFI – Lifecycle	1.4	1.5	1.5	1.6	1.7	0.3	0.0	0.0	0.0	0.4	0.6	0.7
Capital Programme		0.9	3.8	4.9	4.8	5.0	5.0	5.0	5.0	5.0	5.0	15.9
HRI disposal							(7.0)					
Total	24.0	14.2	9.2	11.7	11.7		(2.0)	5.0	5.0	5.4	5.6	16.6

Ongoing replacement and maintenance capital expenditure in FY20 and FY42 have been assumed to be £5m per annum, with the difference in available resource funded through ITFF loan.

12.7.1. Detailed Capital Plan – Future Service Model Option

The table below provides a detailed analysis of the costs associated with the Future Service option.

Element	FBC CRH Cost (£)	FBC HRI Cost (£)	FBC Total Cost (£)
HRI (Acre Mills)		£53,965,600	£53,965,600
CRH	£77,298,800		£77,298,800
Site infrastructure	£2,975,360	£3,989,420	£6,964,780
Traffic management	£115,948	£80,948	£196,897
External works	£700,120	£668,140	£1,368,260
Service diversions	£140,000	£90,000	£230,000
Access and logistics	£173,922	£121,423	£295,345
Car parking	£6,000,000	£1,950,000	£7,950,000
Links	£1,575,000	£75,000	£1,650,000
Sustainability	£686,756	£539,656	£1,226,412
Section 106/278	£772,988	£539,656	£1,312,644
Sub-total	£90,438,894	£62,019,843	£152,458,738
Preliminaries	£12,661,445	£8,682,778	£21,344,223
Fees	£12,372,041	£8,484,315	£20,856,355
Non works costs	£1,546,505	£1,060,539	£2,607,044
Equipment costs	£5,155,017	£3,535,131	£8,690,148
Planning contingency	£18,326,085	£12,567,391	£30,893,476
Optimism bias (13%)	£18,264,998	£12,525,500	£30,790,498
Sub-total	£158,764,985	£108,875,497	£267,640,482
Inflation	£17,782,612	£12,194,696	£29,977,308
VAT (Excluding Fees)	£32,835,112	£22,517,176	£55,352,287
VAT recovery	-£32,835,112	-£22,517,176	-£55,352,287
Total	£176,547,597	£121,070,193	£297,617,790
Backlog maintenance	-	£11,818,000	£11,818,000
Total (including backlog)	£176,547,597	£132,888,193	£309,435,790
HRI disposal	-	-	(7,000,000)
Total capital requirement	£176,547,597	£132,888,193	£302,435,790

12.7.2 Impairment

The capital investment in new buildings typically costs more than the value of the building. The assumption used within the financial model is a reduction in asset value of 15%. In addition an impairment of the existing HRI site, recognising the anticipated lower valuation once the land is disposed of. The impairment for HRI of £75.2m is offset by an existing revaluation reserve for HRI of £23.6m.

£m	FY22
CRH Unplanned site	£26.6
HRI Planned site	£18.1
HRI existing site	£75.2
Total Impairment	£119.9
Revaluation reserve	(£23.6)
Impairment Charge to I&E	£96.3

The impairment charge arising from reconfiguration has been treated as an exceptional item within the financial model.

»» 12.8. Detailed Financial Expenditure - Affordability (Option B - Future Service Model Option)

The activity, workforce and capital plans are modelled within the financial expenditure table below:

12.8.1 Income and Expenditure Account

£m	FY17	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY42
	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 25
Clinical Revenue	332.8	334.7	337.7	330.6	335.0	332.1	341.8	349.3	358.6	362.9	367.4	442.0
Non Protected/Non Mandatory Clinical Revenue	10.9	7.0	7.1	7.1	7.3	7.4	7.5	7.6	7.7	7.7	7.8	9.2
Other Revenue	31.6	33.1	33.6	34.2	35.2	36.2	36.8	37.3	37.9	38.5	39.2	49.7
Total Revenue	375.3	374.7	378.4	371.9	377.4	375.8	386.1	394.3	404.2	409.2	414.4	500.8
Workforce Expenditure	(241.1)	(241.1)	(237.7)	(235.3)	(236.0)	(232.6)	(222.8)	(220.4)	(219.0)	(220.2)	(222.1)	(253.2)
Drugs	(32.9)	(35.3)	(34.9)	(35.8)	(36.8)	(37.8)	(38.8)	(39.9)	(41.0)	(42.1)	(43.3)	(65.3)
Clinical Supplies & Services	(32.7)	(32.8)	(32.1)	(31.8)	(31.5)	(29.0)	(30.2)	(31.1)	(32.4)	(32.6)	(32.8)	(38.5)
Other Expenses	(47.1)	(44.3)	(48.5)	(49.6)	(51.7)	(49.2)	(49.0)	(49.5)	(50.3)	(51.3)	(52.7)	(92.6)
PFI Operating Expenses	(12.0)	(12.2)	(12.5)	(12.7)	(13.0)	(15.3)	(15.6)	(15.9)	(16.2)	(16.1)	(16.3)	(3.1)
Total Operating Expenditure	(365.8)	(365.6)	(365.7)	(365.2)	(368.9)	(363.9)	(356.4)	(356.8)	(358.8)	(362.3)	(367.2)	(452.7)
EBITDA	9.5	9.1	12.7	6.7	8.5	11.8	29.7	37.5	45.4	47.0	47.2	48.2
EBITDA Margin (%)	2.5%	2.4%	3.4%	1.8%	2.2%	3.2%	7.7%	9.5%	11.2%	11.5%	11.4%	9.6%
Gain/(loss) on asset disposals	(0.2)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Impairment Losses (Reversals) net	1.0	(14.0)	0.0	0.0	0.0	(96.3)	0.0	0.0	0.0	0.0	0.0	0.0
Total Depreciation & Amortisation	(10.1)	(10.8)	(11.6)	(11.7)	(11.8)	(15.4)	(15.4)	(15.4)	(15.4)	(15.4)	(15.5)	(20.8)
Interest / Contingent Rent on PFI leases & liabilities	(10.8)	(11.0)	(11.1)	(11.2)	(11.3)	(23.7)	(24.4)	(24.9)	(24.9)	(24.9)	(24.9)	(12.9)
Interest payable on Loans	(1.1)	(1.6)	(1.9)	(1.8)	(2.1)	(2.6)	(1.9)	(0.9)	(0.9)	(0.9)	(0.8)	(0.3)
PDC Dividend	(2.5)	(1.8)	(1.0)	(0.2)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.3)	(8.1)
Other Non-Operating	0.4	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Total Non-operating Expenses	(23.2)	(38.9)	(25.4)	(24.7)	(25.0)	(137.8)	(41.5)	(41.0)	(41.0)	(41.0)	(41.2)	(41.8)
Net Surplus / (Deficit)	(13.8)	(29.8)	(12.7)	(18.0)	(16.5)	(126.0)	(11.9)	(3.6)	4.3	6.0	6.0	6.4
Net Surplus / (Deficit) margin (%)	(4%)	(8%)	(3%)	(5%)	(4%)	(34%)	(3%)	(1%)	0	0	0	0
Normalised (excluding impairments / Disposals)	(14.6)	(15.8)	(12.7)	(18.0)	(16.5)	(29.7)	(11.9)	(3.6)	4.3	6.0	6.0	6.4

Option B – Future Service Model Financial overview

Financial modelling of the Future Service model option shows the Trust return to financial surplus in FY25, with the surplus increasing further in FY26 as the benefits of reconfiguration are realised. The Trust plan to invest in transformation and developments as surpluses exceed 2% of revenue.

Revenue increases year on year by the growth in activity assumed along with the clinical income tariff increases. This is somewhat offset by QIPP delivery across the financial plan. The Trust's workforce expenditure decreases in FY18-FY27 through delivery of QIPP and CIP across the period, including delivery of skills mix to ensure the Trust has a workforce to meet the clinical requirements. PFI leases increases in FY22 as the new PFI buildings at HRI and CRH come into operation from 1 April 2021. Other changes in the income and cost base are driven by the economic assumptions.

Impairments arise in the financial plan in FY18 associated with the review of the carrying value of the Trust's Electronic Patient Record and in FY22 as a consequence of the estate reconfiguration. Impairment arises from the impairing the existing HRI site and both new capital builds on completion.

12.8.2. Cost Improvement Programme (CIP)

The Trust has strong governance processes for the planning, monitoring and delivery of CIP and a track record of achievement. This was confirmed by NHSI following their CIP 'deep-dive' visit to the Trust in June 2017.

The Trust allocates CIP targets to operational and corporate divisions using a range of national and local benchmarking data in a deliberate approach to ensure allocation of CIP targets is based on evidence of where there may be efficiency opportunity (as opposed to simply a pro-rata share of target to budgets). 'Portfolio' opportunities (cross cutting or transformational schemes that impact on more than one operational division or require external partnerships) are led by an Executive Director who is accountable for delivery.

Based on the targets allocated individual CIP schemes are progressed through detailed planning stages with weekly formal review of progress undertaken by the Trust's Turnaround Executive and monthly review at the Trust's Finance and Performance Committee.

In the three years FY15 to FY17 annual CIP delivery has ranged between £14m and £18m per annum resulting in a total of £46m efficiency savings realised across the three year period.

The FY18 CIP plan assumes the Trust delivers £20m in CIP and revenue generation schemes. It is in the context of successful historic delivery of CIP; long term strategic change enabled by the reconfiguration plans; and the future opportunities afforded the organisation by working collaboratively across the region that the Trust will strive to achieve the £15.9m control total set by NHSI for FY18.

The FY19 CIP plan assumes delivery of £15.4m CIP and internal, as well as West Yorkshire wide, planning will support this.

In addition to CIP delivery from FY19 the Trust will also deliver WYAAT and other savings as outlined below.

West Yorkshire Association of Acute Trusts (WYAAT) savings initiatives

WYAAT has agreed a key objective of collaborating to develop West Yorkshire and Harrogate standardised operating procedures and pathways across services, building on current best practice and using “Getting it Right First Time” (GIRFT) to drive out variations in quality as well as operational efficiency and facilitating safer free movement of bank staff across providers. Orthopaedics has been selected as one of the first areas to work on. The specific deliverables of this work are:

- Improved aggregate RTT performance;
- Increased orthopaedic activity and reduced subcontracting to non NHS providers;
- Achievement of optimal performance indicators e.g. day case rate, length of stay, cancelled operations, new to review out patient appointments, extended lengths of inpatient stay, conversion rates, cancelled/repeat out patient appointments;
- Reduce West Yorkshire reference cost for high volume elective orthopaedic procedures;
- Reduced total workforce and consumable costs (reduced use of bank and agency);
- Reduce the overall cost of orthopaedic services by between £4.2m and £9m.

As part of the ‘Back-office’ function review, the Trust is working with WYAAT colleagues to deliver financial and operational efficiencies across Information Technology services and Estates and Facilities services. It is anticipated through a shared delivery model financial efficiencies will be realised. This will assist the West Yorkshire Trusts in delivering Carter identified opportunities, align clinical, estate and IM&T services, increase development opportunities for staff whilst sharing best practice and drive standards of service up.

Reconfiguration benefits

WYAAT has identified that all acute Trusts in West Yorkshire are experiencing significant pressure in delivering 18 week RTT and that there is reliance on outsourced independent sector capacity or temporary staffing which is driving additional cost pressures. A workstream for releasing WYAAT providers capacity to undertake additional elective activity that is currently contracted to the independent sector has been initiated. The specific aims of this are:

- Delivering high quality clinical pathways and operational models to optimise performance and use of resources;
- Delivering nationally recognised excellence in terms of clinical outcomes and professional standards;
- Working as a group to develop processes to legally retain as much NHS activity as possible within the WYAAT Trusts by optimising the capacity and configuration for elective services with agreed risk/gain share (using estate and workforce in a flexible model across the WYAAT footprint).

The development of planned care site will enable the Trust to offer capacity to undertake additional elective work (repatriated from the independent sector and out of area) optimising utilisation of the planned care facilities out of hours and at weekends.

WYAAT has agreed to establish a West Yorkshire Vascular network that will provide a two arterial centre model for West Yorkshire, with centres and spoke sites that are attractive and sustainable. The network will deliver a number of qualitative and efficiency benefits (such as reduction in LoS, reduction in agency costs, reduction in re-admissions) enabled by:

- Set up of sub-specialty teams across organisational boundaries;
 - Specialist Multi-Disciplinary Teams
 - Representation from all organisations
 - Fluidity of workforce
 - Sharing of skills
- Joint appointments;
- Joint clinical governance and oversight;
- Collaboration in Research and Innovation;
- Collaboration in training and teaching.

Most of the reconfiguration savings are achieved at the beginning of year five, when the hospitals move to the planned and unplanned care sites. Following the move there are opportunities to achieve additional cost savings and improvements in quality, impacting across the whole of clinical services, which could not be achieved without the site reconfiguration. The reduction in on-call payments from robust single site medical rotas for example will release costs. There may also be opportunities to gain additional economies of scale in medical services, where the use of advanced practitioners can be used to fill difficult to recruit to middle and junior grade doctors, further reducing reliance on agency and locum staff. The ability to do this is enhanced and enabled by senior clinical support being focused on one site, to offer supervision and clinical mentoring. This will also further support junior doctors developing their skills through the Certificate of Eligibility for Specialist Registration (CESR) route. This will result in additional savings in FY23-FY27.

Other initiatives

From FY22 the local system will have embedded new ways of working in Greater Huddersfield and Calderdale across community and hospital services. This collaboration will enable efficiencies to be achieved in relation to administration, management, and property costs.

12.8.3. Cost Improvement Programme (CIP)

The table below outlines the required CIP across the period FY17 – FY42.

£m	FY17	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY42
	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 25
	Actual	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
Planned CIP	14.0	20.0	15.4	7.2	7.3	7.3	11.3	11.1	10.9	6.4	6.4	7.8
WYAAT & Other Strategic Opportunities			0.5	2.8	2.2	4.4	4.6	1.3	1.5			
TOTAL – Planned efficiencies	14.0	20.0	15.9	10.0	9.5	11.7	15.9	12.4	12.4	6.4	6.4	7.8
Planned cumulative efficiencies	14.0	20.0	35.9	45.9	55.4	67.1	83.0	95.4	107.8	114.2	120.6	228.6
Efficiency % of Operating Expenditure	3.8%	5.4%	4.3%	2.7%	2.5%	3.2%	4.4%	3.4%	3.4%	1.7%	1.7%	1.7%

Between FY18 and FY42, CHFT will need to identify new cost reductions amounting to £228.6m to meet the CIP efficiency requirement.

12.8.4 Use of Resources (UoR) metrics – New compliance regime - Single Oversight Framework NHS Improvement

NHSI has now introduced the Single Oversight Framework (SOF). Where previously a separate Finance rating (the FSRR) and Governance rating were issued, these are brought together under the SOF. This considers 5 themes: Quality of Care; Finance and use of resources; Operational performance; Strategic change; Leadership and improvement capability. The Finance element of this system is the Use of Resources score and the constituent parts of this measure are described below.

- **Liquidity:** days of operating costs held in cash or cash-equivalent forms (cash in the bank less payables plus receivables, on the presumption these can be immediately converted into cash);
- **Capital servicing capacity:** the degree to which the organisation's generated income covers its financing obligations a measure of the Trust's ability to afford its debt - in this sense payments against debts include PDC payments, interest and loan repayments and PFI interest, PFI contingent rent and PFI capital repayments;
- **Income and expenditure (I&E) margin:** the degree to which the organisation is operating at a surplus/deficit (measured against the Control Total which excludes impairments, gains/losses on disposal and donated assets);
- **Variance from plan in relation to I&E margin:** variance between a foundation trust's planned I&E margin in its annual forward plan and its actual I&E margin within the year (again measured against the Control Total which excludes impairments, gains/losses on disposal and donated assets);
- **Agency:** measurement of actual agency usage against the original agency ceiling set by NHSI at the planning stage at £16.86m. A distance from target of greater than 50% results in the lowest rating of 4 against this metric.

	FY17	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY42
	Actual	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
Liquidity	4	4	4	4	4	4	4	4	4	4	4	4
Capital servicing capacity	4	4	4	4	4	4	4	4	4	4	4	3
I&E Margin	4	4	4	4	4	4	4	3	1	1	1	1
I&E Margin variance	1	1	1	1	1	1	1	1	1	1	1	1
Agency	4	1	1	1	1	1	1	1	1	1	1	1
Overall UoR score	3	3	3	3	3	3	3	3	2	2	2	2

The financial plan within the case improves the Trust's I&E Margin post reconfiguration as the Trust moves to financial surplus in FY25. The I&E surplus improves the I&E margin score from a current score of 4 to a 3 in FY24 and a 1 in FY25. This drives an overall improvement in the Use of Resources score to a 2 score in FY25. The Liquidity score remains at a score of 4 throughout the financial period, with the Capital Servicing Capacity score improving from a score of 4 to a 3 in FY33. This change is driven by the final payment on the existing CRH PFI. The financial plan assumes the Trust remains within the agency ceiling throughout the financial plan, therefore scoring a 1 throughout the plan.

12.8.5. Statement of Financial Position over 25 years (FY18 – FY42)

fm	FY17	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY42
	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 25
Property, Plant and Equipment	239.0	224.9	222.9	223.4	223.7	391.7	374.7	364.8	354.8	375.3	375.9	438.3
Inventories	6.7	6.6	6.6	6.6	6.6	6.6	6.6	6.6	6.6	6.6	6.6	6.6
NHS Trade Receivables	7.2	9.5	9.5	9.5	9.5	9.5	9.5	9.5	9.5	9.5	9.5	9.5
Non NHS Trade Receivables	6.9	4.9	4.9	4.9	4.9	4.9	4.9	4.9	4.9	4.9	4.9	4.9
Other Current Assets	12.4	8.2	8.2	8.2	8.2	8.2	8.2	8.2	8.2	8.2	8.2	8.2
Cash and Cash Equivalents	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	7.2
Current assets	35.2	31.0	31.1	31.1	31.0	31.0	31.0	31.0	31.0	31.1	31.1	36.4
Total assets	274.2	255.9	254.0	254.5	254.7	422.7	405.8	395.8	385.9	406.4	407.0	474.7
Current Liabilities	(48.9)	(41.7)	(40.9)	(41.4)	(49.9)	(49.8)	(49.1)	(49.4)	(49.6)	(50.0)	(50.4)	(44.6)
Non-Current Liabilities	(139.0)	(163.1)	(174.6)	(192.6)	(200.8)	(518.6)	(374.7)	(368.0)	(353.5)	(337.7)	(321.8)	(147.6)
Total Liabilities	(187.9)	(204.8)	(215.6)	(234.0)	(250.8)	(568.4)	(423.8)	(417.4)	(403.1)	(387.6)	(372.2)	(192.2)
Net assets employed	86.3	51.2	38.4	20.5	3.9	(145.6)	(18.0)	(21.6)	(17.3)	18.7	34.7	282.5
Public dividend capital	116.2	116.2	116.2	116.2	116.2	116.2	255.7	255.7	255.7	255.7	255.7	255.7
Retained Earnings (Accumulated Losses)	(67.4)	(99.8)	(112.5)	(130.5)	(147.0)	(273.0)	(284.8)	(288.4)	(284.1)	(278.1)	(272.1)	(174.3)
Revaluation reserve	37.5	34.7	34.7	34.7	34.7	11.1	11.1	11.1	11.1	41.1	51.1	201.1
Total taxpayers' equity	86.3	51.2	38.4	20.5	3.9	(145.6)	(18.0)	(21.6)	(17.3)	18.7	34.7	282.5

The Statement of Financial Position (SoFP) working capital is assumed consistent throughout the financial plan. The key movements within the SoFP arise in FY22 as the assets and liabilities associated with the new PFI are captured on the SOFP. The improvement in the SoFP post reconfiguration arises as the debt is written off. As the Trust returns to financial surplus in FY25 the balance sheet position improves year on year.

12.8.6. Cash flow statement

£m	FY17	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY42
	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 25
Cash flows from operating activities	9.2	8.8	12.4	6.4	8.2	11.6	29.4	37.2	45.1	46.7	46.9	47.8
Cash generated from (used in) operations	(6.5)	0.3	2.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Cash generated from (used in) investing activities	(16.8)	(19.3)	(11.7)	(11.7)	(11.6)	(26.2)	2.0	(5.0)	(5.0)	(5.4)	(5.5)	(16.5)
Cash generated from (used in) financing activities	14.1	10.2	(3.2)	5.2	3.4	14.7	(31.4)	(32.2)	(40.1)	(41.3)	(41.3)	(30.4)
Increase/ (decrease) in cash and cash equivalents	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.8

The cash position of the Trust, detailed above shows the improvement in the cash position as a consequence of the Trust returning to financial balance in FY25.

FY23 sees an increase in cash used in financing activities, driven by the interest element of the PFI agreements and a reduction in the cash drawn down for Revenue Support Loan as the Trust returns to financial surplus and generates cash from operating activities.

12.8.7. Sensitivity Analysis

The Trust has considered variants to the business case as sensitivities based on the potential opportunities and risks that may arise within the local health economy. The following table highlights the bottom line deficit projections for the Future Service option. In the table below, the following non recurrent items have then been stripped out of these deficits to show the underlying (recurrent) deficit positions in each year:

- Impairments of £14m in FY18 and £96.3m in FY22;
- Non-recurrent costs of £10m.

Deficit £'m	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY42
Proposed option Deficit	(29.8)	(12.7)	(18.0)	(16.5)	(126.0)	(11.9)	(3.6)	4.3	6.0	6.0	6.4
Impairments	14.0	0.0	0.0	0.0	96.3	0.0	0.0	0.0	0.0	0.0	0.0
Non-recurrent costs	-	0.3	0.5	2.1	6.9	0.2					
Normalised (deficit)/ surplus	(15.8)	(12.4)	(17.5)	(14.4)	(22.8)	(11.7)	(3.6)	4.3	6.0	6.0	6.4

The downside and upside sensitivities bridge from the underlying financials are indicated above.

Downside sensitivities

The following downside scenarios have been considered by the Trust:

- **Downside 1 – Increase in dual running costs**

The Trust has assumed non-recurrent transition costs of £10.1m associated with the reconfiguration. This is assumed are pay costs, consistent with the 5 Year Strategic Plan to support transitional project management. These costs are based on an initial assessment however this estimate could increase over and above, for the sensitivity this has been assumed to increase to £15m.

- **Downside 2 – Non-delivery of CIP target in 2017/18 and 2018/19**

The Trust has delivery of CIP throughout the financial modelling, with the required CIP based on the 2017-19 Operational Plan and NHSI planning guidance where available. Tariff efficiencies are driving a 2% efficiency requirement however the Trust has planned CIP above this level for FY18 and FY19. The impact of delivering less CIP than planned in FY18 and FY19 has been modelled as a downside sensitivity.

- **Downside 3 – Failure to meet targets associated with Sustainability and Transformation Funding (STF)**

The Trust has assumed receipt of STF in FY18 and FY19 of £10.1m and £10.1m respectively. Receipt of this funding is conditional to the Trust meeting criteria. £3m of the STF is associated with financial and operational performed in the final quarter of the year. Given this is both financially and operationally the most challenging period of the year it has been modelled that the conditions of this fund is not achieved in FY18 and FY19.

- **Downside 4 – Enhancing the Planned HRI Hospital model**

Developing the planned care site to provide an Emergency Department for adults between 9am and 6.30pm seven days a week. The clinical case for change supports the reconfiguration to a planned and unplanned site to ensure sustainability in service. The downside case outlines the additional cost pressure upon the Trust from enhancing the HRI hospital model.

- **Downside 5 – Failure to decrease agency costs in line with trajectories**

The Trust historically has high levels of agency spend. In FY17 this was at £24m. For FY18 the Trust has planned to achieve its agency ceiling set by NHS Improvement, at £16.9m. Given the Trust's difficulty to attract staff within the current clinical configuration the Trust has modelled the incremental cost implication of employing agency staff in substantive positions.

£m	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY42
Normalised (deficit)/ surplus	(15.8)	(12.4)	(17.5)	(15.4)	(22.8)	(11.7)	(3.6)	4.3	6.0	6.0	6.4
Increase in dual running site costs		(0.2)	(0.3)	(0.7)	(4.5)	(0.1)					
Non-delivery of CIP target prior to reconfiguration	(3.0)	(5.0)									
Failure to achieve STF targets	(3.0)	(3.0)									
Enhanced HRI Hospital					(7.4)	(7.5)	(7.7)	(7.9)	(8.0)	(8.2)	(9.4)
Failure to achieve agency ceiling	(4.2)	(3.8)	(3.2)	(2.7)	(2.2)	(1.7)	(1.8)	(1.9)	(2.0)	(2.1)	(2.9)
Sub - total movement	(10.2)	(12.0)	(3.5)	(3.4)	(14.1)	(9.3)	(9.5)	(9.8)	(10.0)	(10.3)	(12.3)
Downside case surplus/ (deficit)	(26.0)	(24.4)	(21.0)	(18.8)	(36.9)	(21.0)	(13.1)	(5.5)	(4.0)	(4.3)	(5.9)

The table highlights the overall impact of the above downside sensitivities on the underlying financial position, increasing the cost base across the financial plan. The Trust's financial position in later years would be mitigated by less investment in developments, mitigating the downside case.

Upside sensitivities

The following downside scenarios have been considered by the Trust:

- **Upside 1 – Sustainability and Transformation Fund**

The Trust is currently in receipt of Sustainability and Transformation Fund (STF) monies for meeting targets set. This is planned at £10.1m in FY18 and FY19 as the monies have been received non-recurrently. A potential upside could be the receipt of STF monies beyond FY19.

- **Upside 2 – Increased CIP**
The Trust has forecast increased CIP delivery in FY23-FY25 post reconfiguration. A potential upside is that the Trust can sustain this level of CIP for five years post reconfiguration rather than the three years currently modelled.
- **Upside 3 – Independent Sector Patient Income (ISPI)**
Changes to Commissioning clinical thresholds, growth in regional and national waiting lists is likely to have an impact on the demand for independent healthcare. The Trust would seek to maximise utilisation of existing resources to meet the anticipated growth in independent sector patient income. For the purpose of the sensitivity independent sector patient income has been assumed to grow per annum, with this work being delivered through utilising three session days and 7-day services.

£m	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY42
Normalised (deficit)/surplus	(15.8)	(12.4)	(17.5)	(15.4)	(22.8)	(11.7)	(3.6)	4.3	6.0	6.0	6.4
<i>Sustainability and Transformation Funding (STF)</i>			10.1	10.1	10.1	10.1	10.1	10.1	10.1	10.1	
<i>Increased CIP for a further two years</i>									5.0	5.0	
<i>Independent Sector Patient Income</i>		0.1	0.3	0.3	0.5	0.8	0.9	1.1	1.3	1.5	2.9
Sub - total movement	0.0	0.1	10.4	10.4	10.6	10.9	11.0	11.2	16.4	16.6	2.9
Upside case surplus (deficit)	(15.8)	(12.3)	(7.1)	(5.0)	(12.2)	(0.8)	7.4	15.5	22.4	22.6	9.3

The table highlights the overall impact of the above upside sensitivities on the financial position, improving the financial position to a surplus in FY24, a year earlier than within the financial plan. The table above shows surplus of £7.4m-£22.6m in years FY25-FY27 however the Trust would likely plan to invest in transformation and developments should the surplus exceed 2% of revenue.

» 12.9. Detailed Financial Expenditure - Affordability (Option A - Existing Service Model)

For comparison, the activity, workforce and capital plans for the Existing Model Option are modelled within the financial expenditure table below:

12.9.1. Income and Expenditure Account

£m	FY17	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY42
	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 25
Clinical Revenue	332.8	334.7	337.7	330.6	335.0	332.8	336.9	341.0	345.1	349.3	353.6	425.9
Non Protected/Non Mandatory Clinical Revenue	10.9	7.0	7.1	7.1	7.3	7.4	7.5	7.6	7.7	7.7	7.8	9.2
Other Revenue	31.6	33.1	33.6	34.2	35.2	36.2	36.8	37.3	37.9	38.5	39.2	49.7
Total Revenue	375.3	374.7	378.4	371.9	377.4	376.4	381.1	385.9	390.7	395.6	400.6	484.7
Workforce Expenditure	(241.1)	(241.1)	(237.7)	(235.1)	(235.2)	(228.7)	(227.6)	(228.3)	(229.0)	(229.7)	(230.4)	(251.8)
Drugs	(32.9)	(35.3)	(34.9)	(35.8)	(36.8)	(37.8)	(38.8)	(39.9)	(41.0)	(42.1)	(43.3)	(65.3)
Clinical Supplies & Services	(32.7)	(32.8)	(32.1)	(31.8)	(31.5)	(29.6)	(29.6)	(29.8)	(30.0)	(30.1)	(30.3)	(33.2)
Other Expenses	(47.1)	(44.3)	(48.5)	(49.6)	(50.7)	(51.7)	(51.7)	(52.5)	(53.3)	(54.0)	(54.8)	(89.9)
PFI Operating Expenses	(12.0)	(12.2)	(12.5)	(12.7)	(13.0)	(13.0)	(13.2)	(13.4)	(13.7)	(14.0)	(14.2)	0.0
Total Operating Expenditure	(365.8)	(365.6)	(365.7)	(365.0)	(367.1)	(360.7)	(360.9)	(363.9)	(366.9)	(370.0)	(373.1)	(440.2)
EBITDA	9.5	9.1	12.7	6.9	10.3	15.7	20.2	22.0	23.8	25.7	27.5	44.6
<i>EBITDA Margin (%)</i>	2.5%	2.4%	3.4%	1.9%	2.7%	4.2%	5.3%	5.7%	6.1%	6.5%	6.9%	9.2%
Gain/(loss) on asset disposals	(0.2)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Impairment Losses (Reversals) net	1.0	(14.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Depreciation & Amortisation	(10.1)	(10.8)	(11.6)	(12.2)	(12.7)	(13.3)	(13.8)	(13.8)	(13.8)	(13.8)	(13.8)	(23.3)
Interest / Contingent Rent on PFI leases & liabilities	(10.8)	(11.0)	(11.1)	(11.2)	(11.3)	(12.1)	(12.3)	(12.3)	(12.3)	(12.2)	(12.2)	0.0
Interest payable on Loans	(1.1)	(1.6)	(2.1)	(2.2)	(2.7)	(3.1)	(3.4)	(3.6)	(3.6)	(3.6)	(3.6)	(3.5)
PDC Dividend	(2.5)	(1.8)	(1.0)	(0.2)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(11.6)
Other Non-Operating	0.4	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Total Non-operating Expenses	(23.2)	(38.9)	(25.6)	(25.5)	(26.4)	(28.2)	(29.3)	(29.4)	(29.5)	(29.4)	(29.4)	(38.2)
Net Surplus / (Deficit)	(13.8)	(29.8)	(12.9)	(18.6)	(16.2)	(12.5)	(9.0)	(7.4)	(5.6)	(3.8)	(1.8)	6.4
Net Surplus / (Deficit) margin (%)	(4%)	(8%)	(3%)	(5%)	(4%)	(3%)	(2%)	(2%)	(1%)	(1%)	(0%)	0
Normalised (excluding impairments / Disposals)	(14.6)	(15.8)	(12.9)	(18.6)	(16.2)	(12.5)	(9.0)	(7.4)	(5.6)	(3.8)	(1.8)	6.4

Option A – Existing Service Model Financial overview

The Trust continues to forecast a deficit from the current financial year (FY18) through to FY32 where, in FY33 the Trust returns to financial surplus following the final repayment of debt on the existing CRH PFI. The Trust then maintains a steady financial surplus of between £5.9m and £6.8m throughout the financial modelling. The cumulative deficit of the existing service model case is £137m from FY18 to FY42. The Trust has assumed receipt of revenue support loans to meet its obligations throughout the period. The existing service model option assumes that the Trust is able to deliver 2% annual efficiencies year on year to meet the CIP requirements.

The Existing Service Model option includes within the assumption that the Trust is in receipt of £94.5m of capital loans from the ITFF across years FY19-FY23 to meet the back-log maintenance requirements of the existing HRI site. In addition the Trust would be required to build a new HRI capital after 10 years. The new HRI build is assumed to be funded from the ITFF in FY28-FY30 at a cost of £379.5m.

» 12.10. Financial affordability conclusion

The table below provides a comparison of the affordability compared to the Existing Service Model position.

12.10.1. Income and Expenditure Existing Service Model vs. Future Service Option

£m	FY23		FY27		FY42		FY42	
	Existing Model	Proposed	Existing Model	Proposed	Existing Model	Proposed	Variance	Variance
	Option A	Option B	Option A	Option B	Option A	Option B	Option A	Option B
	£m	£m	£m	£m	£m	£m	£m	£m
Total Revenue	381.1	386.1	400.6	414.4	484.7	500.8	16.1	16.1
Total Operating Expenditure	(360.9)	(356.4)	(373.1)	(367.2)	(440.2)	(452.7)	(12.5)	(12.5)
EBITDA	20.2	29.7	27.5	47.2	44.6	48.2	3.6	3.6
Total Non-operating Expenses	(29.3)	(41.5)	(29.4)	(41.2)	(38.2)	(41.8)	(3.6)	(3.6)
Net Surplus / (Deficit)	(9.0)	(11.9)	(1.8)	6.0	6.4	6.4	(0.0)	(0.0)
Net Surplus / (Deficit) margin (%)	(2.4%)	(3.1%)	(0.5%)	0.0	0.0	0.0	(0.0%)	(0.0%)
FY23 Cumulative normalised Surplus / (Deficit)	(85.0)	(95.5)	(103.6)	(81.7)				
FY27 Cumulative normalised Surplus / (Deficit)					21.8			
FY 42 Cumulative normalised Surplus / (Deficit)					(66.0)	16.0	82.0	82.0

The Future Service option demonstrates a surplus in FY27 compared with a deficit in the Option A due to the additional savings available to the Trust post reconfiguration. Over the modelled 25 years the cumulative normalised deficit is £82m better within the Option B case.

12.10.2. Statement of Financial Position Existing Service Model vs. Future Service Option

£m	FY23	FY23	FY23	FY27	FY27	FY27	FY42	FY42	FY42
	Existing Model	Future Service	Variance	Existing Model	Future Service	Variance	Existing Model	Future Service	Variance
	Option A	Option B	Option A	Option A	Option B	Option A	Option A	Option B	Option A
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Property, Plant and Equipment	291.4	374.7	83.3	288.1	375.9	87.8	605.2	432.0	(173.2)
Current Assets	31.0	31.0	0.0	31.0	31.1	0.0	34.4	35.5	1.1
Total Assets	322.5	405.8	83.3	319.1	407.0	87.8	639.6	467.5	(172.1)
Current Liabilities	(42.9)	(49.1)	(6.2)	(43.7)	(50.4)	(6.7)	(41.3)	(44.6)	(3.3)
Non-Current Liabilities	(297.6)	(374.7)	(77.2)	(282.0)	(321.8)	(39.8)	(260.5)	(156.7)	103.7
Total Liabilities	(340.4)	(423.8)	(83.4)	(325.7)	(372.2)	(46.5)	(301.8)	(201.4)	100.4
Net Assets employed	(18.0)	(18.0)	(0.1)	(6.6)	34.7	41.3	337.8	266.1	(71.7)
Public dividend capital	116.2	255.7	139.5	116.2	255.7	139.5	296.3	255.7	(40.6)
Retained Earnings (Accumulated Losses)	(168.9)	(284.8)	(115.9)	(187.5)	(272.1)	(84.6)	(213.2)	(180.7)	32.5
Revaluation reserve	34.7	11.1	(23.6)	64.7	51.1	(13.6)	254.7	191.1	(63.6)
Total taxpayers' equity	(18.0)	(18.0)	(0.1)	(6.6)	34.7	41.3	337.8	266.1	(71.7)

The Future Service Option shows an improvement in the Statement of Financial Position (SoFP) when compared with the Existing Service Model option. This is as a consequence of the return to financial surplus being sooner, in FY25 when compared to the Existing Service Model option. By FY42 the SoFP is stronger in asset base due to the assumed investment in a new HRI hospital, which is at a greater cost than the asset investment in the Future Service Option. This improved asset base is offset by greater accumulated losses as a consequence of the longer time required to return to financial surplus and an increase in non-current liabilities, reflecting the loan to build the new HRI in the Existing Service Model case.

12.10.3. Funding requirements Existing Service Model vs. Future Service Option

£m	Existing Model	Future Service	Variance
	Option A	Option B	
	£m	£m	
Independent Trust Financing Facility (ITFF)	531	65	(466)
Revenue Support Loan	142	116	(26)
PFI borrowing	-	276.6	276.6
Total funding requirement	673	457.6	(215.4)

The Future Service option requires £215.4m less funding support than the Existing Service Model option. The required funding is significantly met through PFI sources as opposed to Treasury loans.

» 12.11. Conclusions of the Financial Case

It can be concluded that the Option B is the favourable option. The Future Service Option demonstrates overall affordability for the investment and enables the Trust to return to financial balance earlier than under the Existing Service Model case.

Whilst there is an increase in the overall capital cost of the build when compared to the 5 Year Strategic Plan, the financial plan demonstrates that savings enabled through reconfiguration present a favourable case compared to the Existing Service Model. Downside scenarios test the sensitivity of the plan however the Trust retains overall affordability within the financial plan.

The financial plan identifies differences on assumed clinical contract income levels when compared to the CCG's five year plans. This arises through QIPP assumptions in FY18. The Trust continues to work with the West Yorkshire healthcare system to ensure financial affordability for the health system.

The CIP is consistent with the national efficiency requirements reflecting assumptions of cost inflation and price deflation. The additional investment in the estate enables greater efficiencies to be realised in years FY23-FY25 through greater operational efficiency and transformation.

The modelled unitary payment will be refined as the Trust goes to market through procurement. This will be reflected within a Final Business Case.

13 | Management and Governance >>

13 | Management and Governance

» 13.1 Summary

The purpose of this section case is to describe the systems and processes that will be established to ensure the successful implementation of the proposed option for the configuration of the Trust's hospital services. This is structured across the following key areas:

Programme Management and Governance	how the programme will be managed including reporting and accountability arrangements and the use of special advisors
Programme Timeline	the key phases of work and the programme timeline
Risk Management	the approach to management of risk and the risk register
Benefits Realisation and Post Project Evaluation	arrangements for ongoing review of benefits

» 13.2 Management and Governance

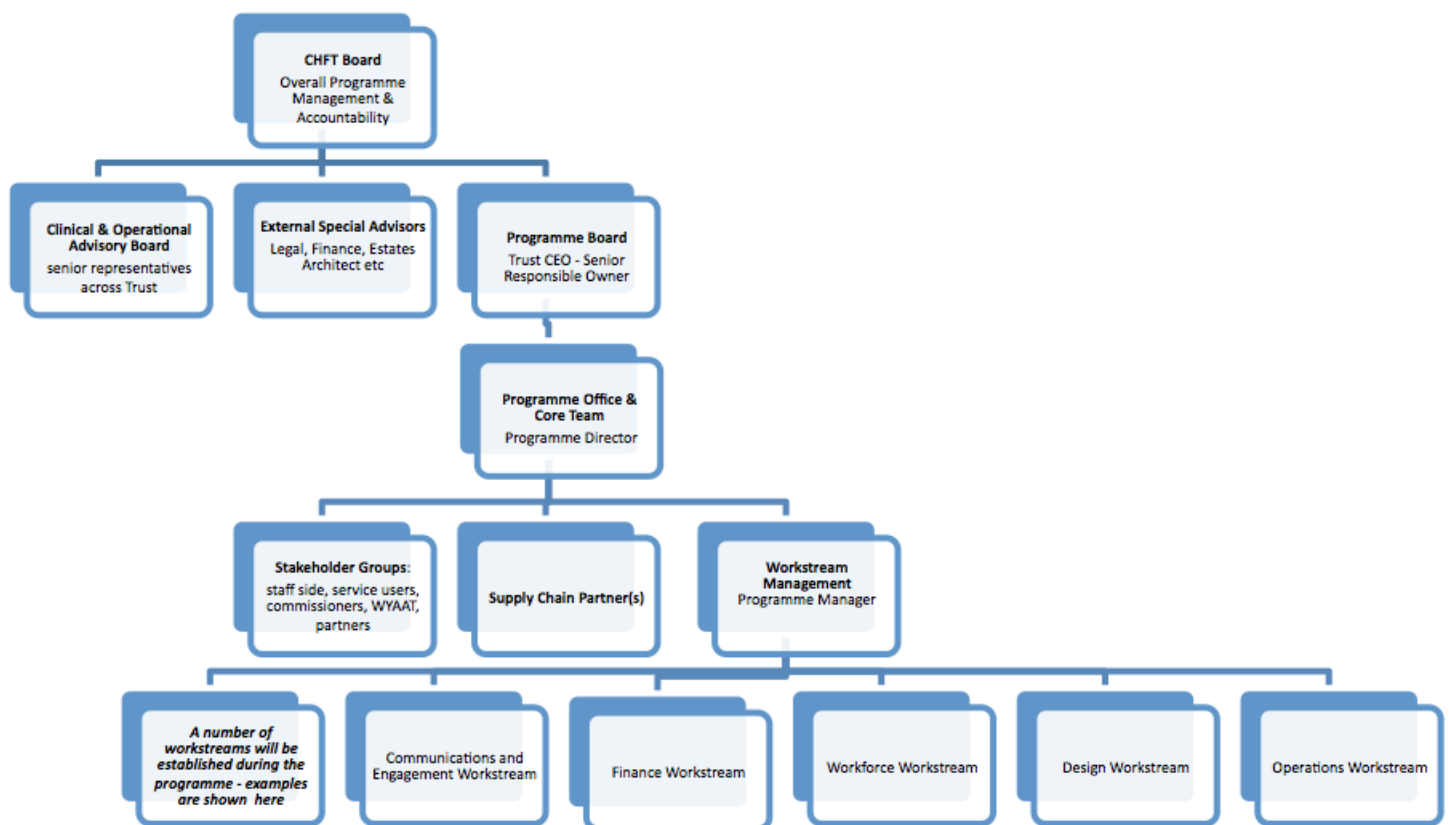
The Trust's management and governance of the programme will be aligned with best practice described in the Treasury recommended methodology for programme management i.e. Managing Successful Programmes (MSP). The over-arching programme management will focus on the delivery of the key financial and non-financial benefits and outcomes associated with the reconfiguration of hospital services.

PRINCE 2 project methodology will be used to manage underpinning project life cycles from start-up to closure to ensure project planning and monitoring are carried out rigorously. The project management will focus on delivery of the key enabling actions and outputs that support achievement of the overarching programme benefits and outcomes.

Subject to Treasury approval to implement the FBC an Integrated Assurance and Approval Plan (IAAP) will be developed. This will detail the planning, coordination and provision of assurance activities and Treasury approval points (gateways) throughout the programme.

13.2.1 Governance Structure

The following diagram provides an overview of the programme structure. The structure is designed to ensure there is one overall Senior Responsible Owner, one Programme Director and one Programme Manager each with the required authority and responsibility to manage the programme on behalf of the Trust. The programme structure is explained in more detail below.



CHFT Board will have overall responsibility and accountability for the programme ensuring that the project has a viable and affordable business case that will deliver value for money and best quality healthcare through effective management of the procurement process and implementation of the proposed configuration of services. The Board will seek assurance from the Senior Responsible Owner and Programme Board on any aspect of the programme that may pose a risk to successfully achieving the investment objectives and realisation of the expected benefits.

The **Programme Board** will be chaired by an independent chair. The Chief Executive / Senior Responsible Owner (SRO) and will lead the programme implementation. The Programme Board will have Non-Executive and Executive Directors (including the Programme Director) as members and also include representation from Trust senior clinicians and external specialist / technical advisors. Representatives from NHSE, NHSI, DH, CCGs and WYAAAT will be invited to be members of the Programme Board as well as two patient representatives.

The Programme Board will approve and manage the programme plan and sign off the key outputs and decisions at each stage of the project including:

- Patient and staff communications and engagement
- the competitive dialogue process and procurement;
- review of all the key deliverables and the activities required to deliver them;
- the activities required to validate the quality of the deliverables;
- the resources and time needed for all activities and any need for people with specific capabilities and competencies;
- the dependencies between activities and any associated constraints when activities will occur;
- the points at which progress will be monitored, controlled and reviewed;
- the provision of regular reports, updates and assurance to CHFT Board, NHSI and Treasury;
- maintenance of a detailed risk register and mitigation of risk factors affecting the successful delivery of the project;
- maintenance of a benefits realisation register and monitoring of delivery.
- considering and recommending to the Trust Board any changes to the project scope, budget or timescale if required;
- review of serious issues, which have reached threshold level;
- broker relationships with stakeholders within and outside the project to maintain positive support for the programme;
- maintain awareness of the broader strategic perspective advising the SRO on how it may affect the project.

External Specialist Advisors – implementation of the proposed configuration will require a complex programme of work and the Trust will secure the necessary external specialist expertise and advice that is required. This will include for example: legal, procurement, project management, private finance, estates, architects, health planning, facilities management, equipping, town planning, engineering, traffic and transport, quantity surveying, life cycle analysis, health and safety etc. The external advisors will provide advice to the SRO, the Programme Director, the Programme Board, and the Trust Board and will advise and inform work undertaken by the project work stream groups.

Clinical & Operational Advisory Board – this will be a clinical and operational leadership committee comprising senior representatives of the Clinical Divisions who manage the operational services of the Trust; General Practice doctors; Directors of Social Care; and Executive Directors (DoN, MD, COO). They will provide leadership within the organisation to ensure successful delivery of the project and assurance to the Programme Board and the Trust Board about the project. The group will provide guidance to the Project Director and ensure that Trust operational resources will be available to support the project. The group will:

- Provide leadership, mandate and focus within the Trust ensuring that clinical objectives inform and drive effective delivery of the competitive dialogue process;
- Provide advice to the Programme Director, Programme Board and Trust Board, raising any concerns and providing expert opinion to support decision making;
- Support resolution of issues at organisational level when required;
- Support resolution of issues which impact on the Trust involving senior external stakeholders, the press; Government, arm's length bodies etc.;

- Provide assessment of serious issues;
- Ensure that project plans are achievable and facilitate delivery as required; and
- Review the risk register on a quarterly basis and / or at key milestones and advise the Programme Board prior to approval and help to mitigate risks at organisational level.

The **Programme Office and Core Team** will be led by the Programme Director and proactively drive delivery of the programme plan and critical path. It will provide programme management support to the work streams and will be responsible for the management of all programme management processes, including preparing and managing papers for governance arrangements, proactive risk and issue management and progress reporting.

The programme office will have sufficient resource capability and capacity available to effectively support the programme, recognising the scale, complexity and likely fast-paced nature of the programme. This will include a core team within the programme office with the necessary skills for:

- Planning and delivering the Competitive Dialogue and bid evaluation process and all other activities to financial close;
- Developing, maintaining and implementing project plans;
- Co-ordinating working groups and evaluation teams as required;
- Monitoring progress and reporting to the Programme Board and the Clinical and Operational Advisory Board;
- Managing issues as they arise in line with the issue management policy and escalating those above threshold to the Programme Board;
- Managing change control;
- Managing project advisors, ensuring that their contribution is well understood and that the Trust obtains best advice and value;
- Managing risks in line with project risk management strategy; and
- Ensuring effective development and delivery of the Engagement and Communications Plan

Key Stakeholder Groups – the programme office and core team will proactively work to ensure the engagement, involvement and coordination of key stakeholder groups input to the programme. Significant communication and engagement has taken place over the last two years. The programme will continue actively engaging with stakeholders through the next phases and during implementation. This will include for example:

- **Calderdale and Kirklees Health and Wellbeing Boards** – ensuring that implementation of the proposed changes are aligned with Health and Wellbeing Board's plans of how best to meet the needs of their local population and tackle local inequalities in health.
- **Calderdale and Kirklees Joint Overview and Scrutiny Committee** – ensuring that implementation is consistent with the changes that have been consulted on.
- **Greater Huddersfield and Calderdale CCGs (or subsequent Accountable Care Organisations)** – ensuring that clinical commissioners are fully involved and informed of the implementation plans and progress.
- **Patients, Public and local Healthwatch** – ensuring that patients are well informed about what changes are proposed, have a say in how they are to be delivered and, ultimately, are fully aware of which services will be delivered from which locations in the future.
- **Other Providers** – communication and involvement of other providers that are impacted by the changes and/or are critical to implementation (e.g. ambulance services, mental health, primary care, WYAAT and neighbouring acute hospitals).

- **NHS staff** – actively engaging with staff to ensure they are fully aware of the implementation plans and able to contribute to the plans promoting their central role in making these changes happen.
- **Clinicians** – will be actively involved in the planning and implementation of service change to ensure patient safety is not compromised as changes are made
- **Local Authorities** – work with partners in social care to co-design and begin to deliver the transformation to Out of Hospital services which is critical to the success of the reconfiguration programme

As part of the programme design and mobilisation phase the stakeholder engagement plan will be updated to provide a comprehensive view of planned events and activities throughout FBC implementation

Supply Chain Partner(s) – the success of the programme is reliant on effective supply chain partner(s) that will provide funding and estates solutions to enable implementation of the proposed configuration of hospital services. The Programme Office and Core Team will in accordance, with the 'partnering' principle, ensure there are regular meetings between senior managers in the Trust and supplier organisation(s). These meetings will formally monitor and report to the Programme Board the service streams and outputs which are being contracted for and progress against the implementation timescales which have been agreed for their delivery.

Project work streams will have a senior sponsor who will also be a member of the Programme Board. Whilst the sponsor will remain accountable for the work stream, it is expected that they will delegate responsibility for the day-to-day management of, and delivery against, the work stream plan and critical path, to a work stream lead. The Programme Manager (and other members of the Programme Office and Core Team) will support and monitor progress of the work streams against agreed milestones and report this to the Programme Board. The structural chart above shows an example of the range of work streams that may be required. This will vary at different stages of the Programme and other work streams will also be established.

13.2.2 Roles and responsibilities

The Chief Executive Officer (Senior Responsible Owner for this project), Director of Finance and the Trust's Chair will ensure strong leadership for the project. The Programme will be supported by a Programme Director and a fully resourced Programme Office and Core Team, of appropriately experienced and qualified individuals. The programme will be managed in line with best practice ensuring that roles and responsibilities are clearly defined. Decision making will be transparent and will be documented to ensure a robust audit trail is maintained.

The Senior Responsible Owner (SRO)

The Chief Executive Officer undertakes the SRO role for this project. The SRO is personally accountable for the success of the project ensuring that the project meets its objectives and delivers benefits. The SRO will ensure that the project maintains business focus in a changing healthcare context and that risks are managed effectively.

The Programme Director

The Programme Director is responsible for day to day decision making on behalf of the SRO and setting high standards for delivery of the project.

The Programme Manager

The Programme Manager will coordinate the activities of the Programme Office and Core Team on a day to day basis and is responsible for ensuring that:

- The procurement and engagement runs smoothly;
- Requests for information, issues and changes are managed appropriately;
- Project standards are maintained; and
- The project budget is managed effectively.

The Core Team will meet weekly, or as required, to co-ordinate the work required. It reports to the Programme Board.

» 13.3 Timeline

A high level overview of the programme timeline and key milestones up to 2021/22 is shown below. During this five year period the capital investment and estates build work will be completed enabling the opening of the planned and unplanned hospitals.

Full optimisation of the financial and quality benefits associated with the reconfiguration of hospital services will continue beyond year 5. The Trust will continue to programme manage and monitor the realisation of benefits beyond 2021/22.

		Project plan and timeline																				
Phases	Summary	2017/18				2018/19				2019/20				2020/21				2021/22				
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Approval	Approval of FBC by Trust Board																					
	Approval of FBC by NHSI																					
	Scrutiny and wider engagement																					
Planning	Planning consent applied																					
	Outline Planning consent approved																					
	Full planning consent																					
	Appointment of legal and financial advisors																					
Procurement	Market engagement																					
	OJEU advert notice published																					
	Initiation to participate in dialogue																					
	Interim bids received sept																					
	Draft final bids																					
	Approval of Generic Appointment Business Case and Close Dialogue																					
	Receipt of final bids																					
	Approval of Preferred bidder/bidders for CRH and HRI																					
	Financial Close																					
	Design work for new build																					
	Variation to contract with CRH PFI																					
	Construction	Construction work at CRH under variation of PFI																				
Commence infrastructure works																						
Commence main construction programme																						
Practical Completion ready to hand over																						
Marketing and Sale of surplus estate																						
Handover	Planned and Unplanned Hospitals Fully Open																					

» 13.4 Risk Management

Programme Risks

The Programme Board will ensure that robust arrangements for the on-going management of risk during the key phases of the programme are established. This will include independent assessment and audit activities. Strategies for the active and effective management of risk will include:

- identifying possible risks in advance and putting mechanisms in place to minimise the likelihood of them materialising with adverse effects;
- having rigorous processes in place to monitor the risks, and access to reliable, up to-date information about the risks;
- having agreed actions to control or mitigate against the adverse consequences of the risks, if they should materialise;
- ensuring that decision-making processes during the programme are supported by a framework for risk analysis and evaluation.

To identify the specific risks the programme will use a number of approaches that will include:

- structured review meetings involving the programme board, the clinical and operational advisory board and the programme management team. This will encourage participation and ownership of the risks by key personnel;
- risk audit interviews – conducted by experienced managers and/or external specialist advisers, with all those involved in the programme;
- risk workshops – including all members of the project team and wider staff and stakeholder partners.

The following generic categories of risk will be considered to assist the identification of a comprehensive register of risks specific to the programme.

Generic Risks	Description
Patient Risk	The risk that patients are adversely impacted (for example in terms of patient experience, safety and outcomes of care) during transition and implementation of the proposed future service model.
Business risk	The risk that the Trust cannot meet its business imperatives (e.g. quality, safety, performance standards).
Reputational risk	The risk that there will be an undermining of patient and public /media perception of the Trust's ability to fulfil its business requirements – for example, adverse publicity concerning an operational problem.
Service risk	The risk that the new service model and estate solution is not fit for purpose.
Design risk	The risk that design cannot deliver the services to the required quality standards.

Generic Risks	Description
Planning risk	The risk that the implementation fails to adhere to the terms of the planning permission or that detailed planning cannot be obtained; or, if obtained, can only be implemented at costs greater than in the original budget.
Build risk	The risk that the construction of physical assets is not completed on time, to budget and to specification.
Project intelligence risk	The risk that the quality of initial intelligence (for example, preliminary site investigation) will impact on the likelihood of unforeseen problems occurring.
Decant risk	The risk arising in accommodation projects relating to the need to decant staff and patients from one site to another
Environmental risk	The risk that the project has a major impact on its adjacent areas.
Procurement risk	The risk that procurement fails to identify a supply chain partner and /or secure appropriate contractual arrangements.
Operational risk	The risk that operating costs vary from budget and that performance standards slip or that a service cannot be provided.
Demand risk	The risk that the demand for a service does not match the levels planned, projected or assumed.
Volume risk	The risk that actual usage of the service varies from the levels forecast.
Maintenance risk	The risk that the costs of keeping the assets in good condition vary from budget.
Technology risk	The risk that changes in technology result in services being provided using sub-optimal technical solutions.
Funding risk	The risk that the availability of funding leads to delays and reductions in scope as a result of reduced monies.
Residual value risk	The risk relating to the uncertainty of the values of physical assets at the end of the contract period.
Economic risk	The risk that project outcomes are sensitive to economic influences – for example, where actual inflation differs from assumed inflation rates.
Financial and Affordability risk	The risk that the project costs of transition and implementation exceed the budget plan for this. Also the risk that implementation of the proposed future model does not generate the anticipated level of efficiency savings.
Legislative risk	The risk that legislative change increases costs.
Policy risk	The risk of changes in policy direction leading to unforeseen change.

The key risks identified will be entered into a risk register. Each risk will be scored 1-5 in terms of its likelihood and the severity of its consequences this will be the inherent risk (i.e. risk exposure with no

mitigation). Once a risk has been scored, the controls and mitigation actions available will be analysed and a mitigation owner identified. The actions required to mitigate the risk will be identified in the risk register, with named responsible officers and information on progress. A residual score will also be included, showing how progress on mitigation has affected the level of risk.

On a monthly basis the Programme Board will review the risk register. All programme risks with a risk score of 15 or more (calculated by multiplying likelihood by consequence) will be escalated on a monthly basis to the Trust Board. The role of the Trust Board will be to assure itself that all risks are accurately identified and mitigated adequately.

Current Risks

Progress of the proposed reconfiguration of hospital services is currently included on the Trust's high level risk register and has a risk score of 20. The risk is related to not being able to progress service reconfiguration due to the requirements of the consultation process and as a consequence that there are delays in addressing important quality, safety and sustainability issues e.g.:

- patient safety risks associated with dual site services and not having critical clinical service adjacencies;
- compliance with emergency medicine standards;
- compliance with paediatric standards;
- compliance with critical care Standards;
- inability to meet 7 day working standards;
- difficulties in recruiting and retaining a medical workforce (continued and increased reliance on middle grades and locums);
- increased gaps in middle grade doctor rotas;
- delays in the Trust's financial recovery plan and continued reliance for a longer period on financial support from the Department of Health to provide the cash to pay creditors and staff;
- inability to contribute to improvement and achievement of the local and West Yorkshire system affordability;
- inability to sustain the condition and reliability of building and engineering services infrastructure at HRI;
- risk of negative impact on the Trust's reputation.

The Trust Board will continue to regularly review these risks and the interim necessary actions that are required to mitigate these risk as far as it is possible to do so.

» 13.5 Benefits Realisation

The ultimate responsibility for the delivery of the programme benefits rests with the SRO for the project. The Programme Board will agree a benefits realisation strategy setting out arrangements for the identification of potential benefits, their planning, modelling and tracking. It will also include a framework that assigns responsibilities for the actual realisation of benefits throughout the key phases of the programme.

A Cost Benefit Analysis (CBA) methodology will be used during the programme and be based on best practice described in the Treasury's Green Book. The CBA will estimate the overall public value created by the programme including economic benefits to individuals and society; and wider social welfare/wellbeing benefits. It will also determine the financial impacts for the Trust and estimate the financial impacts across partner agencies affected. The Programme Board will receive regular update and review of the CBA.

All benefits will be entered into a benefits realisation register. For each benefit this will include the following information:

- Service feature (what aspect of the programme will give rise to the benefit – to facilitate monitoring);
- Potential dis-benefits;
- Activities required (to secure benefit);
- Responsible officer;
- Performance measure;
- Target improvement (expected level of change);
- Full-year value;
- Timescale for realisation of the benefit.

On a monthly basis the Programme Board will review the benefits register. Any expected benefits that are 'off-track' will be escalated on a monthly basis to the Trust Board. The role of the Trust Board will be to assure itself that all benefits are accurately identified and their realisation is being effectively managed.

Some of the key programme benefits that will be included on the register include:

1. Improving the quality of patient experience through more streamlined, efficient patient pathways as a result of the reconfiguration of planned and unplanned services.
2. Realising patient outcome benefits from co-location of acute services and consolidation of paediatrics with complex obstetrics through a more streamlined approach for providing senior medical oversight.
3. Supporting the development of urgent care centres which will be equipped to care for patients with minor injuries and / or illnesses in a more timely, efficient way, thus reducing the demands on the Trust emergency department.
4. Enabling the Trust to meet the Royal College of Emergency Medicine standards on senior medical workforce cover through consolidation of rotas.
5. Enabling the Trust to meet Royal College standards for Children and Young People in Emergency Care settings.
6. Reducing the reliance on locum and temporary staff to cover vacancies and workforce pressures as a result of running two district general hospitals.
7. Making the Trust a more attractive place to work thus improving the recruitment and retention of staff.
8. Improving clinical rota resilience: rota frequency will reduce immediately with the consolidation of unplanned services and workforce on to one site thereby reducing the workload strain on staff and improving the resilience of services. Relevant services include emergency department, acute medicine, critical care, paediatrics and radiology.
9. Enabling sub-specialisation of clinical services: the critical mass achieved through consolidating of unplanned patients and workforce onto one site will allow greater opportunities for sub-specialisation of the workforce improving the attractiveness of employment at the Trust and enhanced clinical services for patients. Relevant services include paediatrics and trauma sub-specialisation in emergency department, and acute medicine.

10. Improving skill mix / role improvements: Advanced/Extended scope Practitioner role will be further refined and deployed in the Trust to reduce reliance on the middle-grade doctor workforce across many specialties including ED, acute medicine, and paediatrics.
11. Improving junior doctor training, oversight and supervision: junior doctor training and supervision is anticipated to improve for all clinical services being consolidated on to one site given the increased throughput of activity, and the increased non-locum consultant presence on site. This will also apply to other clinicians in training.
12. Reducing long term sickness absence: the benefits above will allow for more effective service planning. This, together with other measures to support staff returning from absence, will help to reduce stress for staff and reduce the Trust's long term sickness absence challenge.
13. Improving the patient care and staff working environment.
14. Elimination of estates backlog maintenance issues - securing the longer term safety and viability of the Trust's estate.
15. Elimination of the Trust's deficit and enabling wider system affordability and resilience.

14 | Glossary

Abbreviation or Term	Meaning
A&E	Accident and Emergency Services - also known as emergency department or casualty deals with genuine life-threatening emergencies.
Amortisation	Amortisation - refers to recognising the cost of an asset over its useful economic life.
ANP	Advanced Nurse Practitioner - a registered nurse who has acquired the expert knowledge base, decision-making skills and clinical competencies for expanded practice.
Back-office	Back Office – support services such as finance, human resources, information technology, estates etc.
Bullet Payment	Bullet Payment – termination payment in relation to the existing PFI at CRH.
BTHFT	Bradford Teaching Hospital NHS Foundation Trust
CAP	Community Acquired Pneumonia - refers to pneumonia (any of several lung diseases) contracted by a person that has not recently been in contact with hospital services.
CCG	Clinical Commissioning Group - clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.
CDEL	Capital Department Expenditure Limit – a Treasury control total for public spending on capital.
CEPOD	Confidential Enquiry into Patient Outcome and Death – national review of the quality of the delivery of anaesthesia and surgery and the perioperative care of patients.
CESR	Certificate of Eligibility for Specialist Registration – a route to entry onto the Specialist Register for those doctors who have not followed an approved training programme.
CHFT	Calderdale and Huddersfield NHS Foundation Trust
CIP	Cost Improvement Plan – efficiency savings.
Concessionco	Concessionco – the existing PFI provider for CRH.
Condition B	Condition B – refers to the NHS estate rankings from A to D that are used to describe building compliance with mandatory fire safety requirements and statutory safety legislation. The ranking category of 'B' means there is compliance with all necessary mandatory fire safety requirements and statutory safety legislation with minor deviations of a non-serious nature.
COO	Chief Operating Officer – an Executive Director responsible for ensuring that the Trust delivers key operational and strategic objectives and actions.
COPD	Chronic Obstructive Pulmonary Disease - the name for a group of lung conditions that cause breathing difficulties.
CRH	Calderdale Royal Hospital
CT	Computed Tomography - a body scan that uses X-rays and a computer to create detailed images of the inside of the body.

CQC	Care Quality Commission - an executive non-departmental public body of the Department of Health that regulates and inspects health and social care services in England.
Depreciation	Depreciation - method of allocating the cost of a tangible asset over its useful life.
Derogation	Derogation - an exemption from or relaxation of a rule.
DH	Department of Health – a Ministerial Department of the Government responsible for government policy on health and adult social care matters in England.
DoN	Director of Nursing - an Executive Director responsible for the strategic planning of nursing and for assessing, evaluating and setting nursing care standards and objectives for the Trust.
DTOC	Delayed Transfers of Care – a delayed transfer of care is when a patient is ready to be discharged from hospital and is still occupying a hospital bed.
EAC	Equivalent Annual Cost - the annual cost of owning, operating and maintaining an asset over its entire life.
EBITDA	Earnings Before Interest Tax Depreciation and Amortisation - net income with interest, taxes, depreciation and amortisation added back to it. EBITDA is used to analyse and compare profitability between Trusts because it eliminates the effects of financing and accounting decisions.
ECP	Emergency Care Practitioner – clinical staff that have additional academic qualifications, with enhanced skills in medical assessment and extra clinical skills over and above those of a standard paramedic, qualified nurse or other ambulance crew.
ED	Emergency Department - also known as Accident and Emergency or casualty deals with genuine life-threatening emergencies.
EPR	Electronic Patient Record - an electronic record of the health care of a single individual.
EU	European Union - a political and economic union of 28 member states located primarily in Europe.
FBC	Full Business Case – this term is used in Treasury guidance regarding the development of capital business cases. It is associated with a required framework and structure to be used to enable clear thinking about capital spending proposals and a structured process for appraising, developing and planning to deliver best public value. Business Cases are required to be developed at four sequential stages of planning – the strategic outline case, the outline business case, the full business case and the final business case.
FFT	Friends and Family Test – a national feedback tool that surveys people who use NHS services and staff working in the NHS to provide feedback on their experience. It asks people if they would recommend the services and offers a range of responses.

FY	Full Year – in this business case this refers to the 12 month period ending March.
GIRFT	Getting it Right First Time - a national programme, led by frontline clinicians, created to help improve the quality of medical and clinical care within the NHS by identifying and reducing unwarranted variations in service and practice.
GP	General Practitioner - a doctor based in the community who treats patients with minor or chronic illnesses and refers those with serious conditions to a hospital.
Hard FM	Hard Facilities Management – Hard facilities management refers to services required which relate to the physical fabric of a building and cannot be removed. They ensure the safety and welfare of employees and generally are required by law (e.g. fire safety, mechanical engineering, electrical systems).
HEI	Higher Education Institution – refers to a level of education that is provided by universities, community colleges, and other collegiate level institutions that award academic degrees or professional certifications.
HOOP	Hospital Out of Hours - patient care that uses both a multi-professional and multispecialty approach to delivering care at night and out of hours.
HRI	Huddersfield Royal Infirmary
HSMR	Hospital Standardised Mortality Ratio - the ratio of the observed to expected in hospital deaths, multiplied by 100.
ICU	Intensive Care Unit - a department of a hospital in which patients who are dangerously ill are kept under constant observation.
ICT	Information and Communications Technology - refers to technologies that provide access to information through telecommunications. It is similar to Information Technology (IT), but focuses primarily on communication technologies. This includes the Internet, wireless networks, cell phones, and other communication mediums.
Impairment	Impairment – is the accounting treatment whereby the value of an asset is reduced to its current market value.
IR35	Inland Revenue 35 - a Government change in taxation rules to counter tax avoidance in the area of personal service provision.
IT	Information Technology - the use of any computers, storage, networking and other physical devices, infrastructure and processes to create, process, store, secure and exchange all forms of electronic data.
I&E	Income and Expenditure – a record showing the amounts of money coming into and going out of an organisation
IM&T	Information Management & Technology – the distribution, organisation and control of technology.
ITFF	Independent Trust Financing Facility – a mechanism for the Government to provide loans to Trusts. Trusts in receipt of ITFF incur borrowing costs. These loans are repayable.

JHSC	Joint Health Scrutiny Committee - scrutiny is a function of local authorities and Joint health scrutiny means the coming together of more than one local authority to undertake this function.
JSNA	Joint Strategic Needs Assessment - the current and future health and care needs of local populations to inform and guide the planning and commissioning of health, well-being and social care services within a local authority area.
LoS	Length of Stay – how long a patient is admitted to hospital for.
LTFM	Long Term Financial Model – a strategic financial plan for a period longer than one year.
MD	Medical Director – an Executive Director with responsibilities such as leading the formation and implementation of clinical strategy, taking a lead on clinical standards, providing clinical advice to the board, and providing professional leadership and being a bridge between medical staff and the board.
MRI	Magnetic Resonance Imaging - a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.
NCAT	National Clinical Advisory Team – provided a pool of clinical experts to support, advise and guide the local NHS on local service reconfiguration proposals to ensure safe, effective and accessible services for patients. NCAT has now ceased to exist and has been replaced with other mechanisms of service review.
NHSE	National Health Service England - oversees the budget, planning, delivery and day-to-day operation of the commissioning side of the NHS in England.
NHSI	National Health Service Improvement – the national regulator responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care.
NPV	Net Present Value - is the difference between the present value of cash inflows and the present value of cash outflows. NPV is used in capital budgeting to analyse the profitability of a projected investment or project.
OBC	Outline Business Case - this term is used in Treasury guidance regarding the development of capital business cases. It is associated with a required framework and structure to be used to enable clear thinking about capital spending proposals and a structured process for appraising, developing and planning to deliver best public value. Business Cases are required to be developed at four sequential stages of planning – the strategic outline case, the outline business case, the full business case and the final business case.
ODP	Operating Department Practitioner - a vital part of the multidisciplinary operating theatre team, providing patient-focused care during anaesthesia, surgery and recovery, responding to patients' physical and psychological needs.

Off Balance Sheet	Off Balance Sheet - is an accounting method where certain assets or liabilities are recorded in a way that does not recognise them on the organisations balance sheet.
pari passu	pari passu - a Latin phrase meaning "equal footing" that describes situations where two or more assets, securities, creditors or obligations are equally managed without any display of preference.
PDC	Public Dividend Capital - a form of long-term government finance which was initially provided to NHS trusts when they were first formed to enable them to purchase the Trust's assets from the Secretary of State.
PFI	Private Finance Initiative - a method of providing funds for major capital investments where private firms are contracted to complete and manage public projects. Under a private finance initiative, the private company, instead of the government, handles the up-front costs.
PF2	Private Finance Two – a new approach to public private partnerships, that follows the reform of the Private Finance Initiative (PFI).
PPE	Property, Plant and Equipment - is a term that describes an account on the balance sheet. The PP&E account is a summation of all a company's purchases of property, manufacturing plants and pieces of equipment to that point in time, less any amortisation.
PWLB	Public Works Load Board - a statutory body of the UK Government that provides loans to public bodies from the National Loans Fund.
QIPP	Quality, Innovation, Productivity and Prevention - the umbrella term used to describe the approach the NHS is taking at local, regional and national levels to reform its operations and redesign services in light of the economic climate.
RCOG	Royal College of Obstetricians and Gynaecologists - a professional association of people who work in the field of obstetrics and gynaecology, i.e. pregnancy, childbirth, and female sexual and reproductive health. The College promotes standards of care by a programme of research, publication, and review and is responsible for developing the framework and curriculum of post graduate training.
Red-line	Red-line – the site / land area at CRH that is included within the existing PFI agreement.
Revenue Support Loan	Revenue Support Loan – financial support from the Department of Health to provide the cash for ongoing business.
RTT	Referral to Treatment – this is a measure of how long patients wait for services. The waiting time starts from the point the hospital or service receives the referral and ends if a clinician or patient decides no treatment is necessary, or when the treatment begins.
SHMI	Summary Hospital-level Mortality Indicator - the ratio of the observed to expected deaths following discharge from hospital, multiplied by 100.

SOC	Strategic Outline Case - this term is used in Treasury guidance regarding the development of capital business cases. It is associated with a required framework and structure to be used to enable clear thinking about capital spending proposals and a structured process for appraising, developing and planning to deliver best public value. Business Cases are required to be developed at four sequential stages of planning – the strategic outline case, the outline business case, the full business case and the final business case.
SoFP	Statement of Financial Position - is another name for the balance sheet. It is one of the main financial statements and it reports an entity's assets, liabilities, and the difference in their totals.
Soft FM	Soft Facilities Management - refers to services which make the workplace more pleasant or secure to work in. They are not compulsory and can be added and removed as necessary (e.g. catering, cleaning).
SPC	Special Purpose Company - function as subsidiary entities for larger parent organisations and are typically used to finance new operations and capital at favorable terms.
SRO	Senior Responsible Owner - the visible owner of the overall change, accountable for successful delivery and is recognised as the key leadership figure in driving the change forward.
STF	Sustainability and Transformation Funding - a fund to support financial balance and also to enable new investment in key priorities.
STP	Sustainability and Transformation Plan - five year plans covering all aspects of NHS spending in England. Forty-four geographical areas have been identified as the geographical 'footprints' on which the plans are based.
Sub-specialisation	Sub-specialisation - a particular area of expertise within a specialism. For example vascular surgery is a subspecialty of the specialism of general surgery.
SWYPFT	South West Yorkshire Partnership Foundation Trust
UCC	Urgent Care Centre - a walk-in NHS service for patients whose condition is urgent enough that they cannot wait for the next GP appointment (usually within 48 hours) but who do not need emergency treatment at the emergency department (A&E).
VFM	Value for Money - the most advantageous combination of cost, quality, benefits and sustainability to meet requirements.
WTE	Whole Time Equivalent - The ratio of the total number of paid hours during a period divided by the number of available working hours in that period. The ratio units are whole time equivalent employees - one WTE is equivalent to one employee working full-time.
WYAAT	West Yorkshire Association of Acute Trusts – a collaborative association of the acute Trusts in West Yorkshire and Harrogate.



Calderdale and Huddersfield
NHS Foundation Trust

Approved Minute

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Cover Sheet

Meeting: Board of Directors	Report Author: Kathy Bray, Board Secretary
Date: Thursday, 3rd August 2017	Sponsoring Director: Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 6.7.17 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 6.7.17.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 6.7.17.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 6.7.17.

Appendix

Attachment:

[draft BOD MINS - PUBLIC - 6.7.17.pdf](#)

Minutes of the Public Board Meeting held on Thursday 6 July 2017 in the Large Training Room, Learning Centre, Calderdale Royal Hospital.

PRESENT

Andrew Haigh	Chairman
Owen Williams	Chief Executive
Brendan Brown	Executive Director of Nursing and Acting Chief Executive
Dr David Anderson	Non-Executive Director
Helen Barker	Chief Operating Officer
Gary Boothby	Executive Director of Finance
Dr David Birkenhead	Medical Director
Karen Heaton	Non-Executive Director
Lesley Hill	Executive Director of Planning, Estates and Facilities
Richard Hopkin	Non-Executive Director
Dr Linda Patterson	Non-Executive Director
Prof Peter Roberts	Non-Executive Director
Jan Wilson	Non-Executive Director

IN ATTENDANCE

Anna Basford	Director of Transformation and Partnerships
Kathy Bray	Board Secretary (minute taker)
Mandy Griffin	Director of The Health Informatics Service
Victoria Pickles	Company Secretary
Dr Julie O’Riordan	Divisional Director (for item 6)
Mary Hytch	Matron
Jason Eddleston	Deputy Director of Workforce & OD (for item 18)

OBSERVER

Di Wharmby	Publicly Elected Membership Councillor
Kristina Rutherford	Director of Operations
Paul Cooney	Member of public

93/17 WELCOME AND INTRODUCTIONS
The Chair welcomed everyone to the meeting.

94/17 APOLOGIES FOR ABSENCE
Apologies were received from:
Phil Oldfield

95/17 DECLARATIONS OF INTEREST
There were no declarations of interest to note.

96/17 MINUTES OF THE MEETING HELD ON 1 JUNE 2017
OUTCOME: The minutes of the meeting were approved as a correct record.

97/17 MATTERS ARISING FROM THE MINUTES / ACTION LOG
There were no matters arising which had not been actioned or included on the agenda.

98/17

CQC UPDATE ON ACTION – CRITICAL CARE

As agreed at a previous Board meeting Julie O’Riordan, Divisional Director and Matron Mary Hytch attended the meeting to update the Board on the progress with the CQC Action Plan around Critical Care Services.

The presentation highlighted the actions undertaken to address the the recommendations from the inspection, and actions for the future around the CQC domains:-

- Safe/Well-led: Nurse staffing/supportive and approachable management team
- Safe: Medical Staffing
- Effective: Post Registration Award in Critical Care Nursing and Intensive Care
- Effective: Pharmacy, Dietetics and Physiotherapy
- Responsive: Access and Flow
- Responsive: Meeting the needs of local people

The discussions concluded that:-

- Good progress had been made over the last 12 months
- Continue to build on achievements – aiming for Celebrating Success with the Critical Care Follow-up
- Have attracted critical care experienced nursing staff through external recruitment and hope to continue to build on reputation. This has also helped with the retention of staff.
- Continue to maintain high standards in relation to infection control performance.
- Low numbers of complaints.
- Welcome mock CQC inspection currently being organized.
- CQC relationship management team to visit department in August.

The Board thanked the team for attending and felt assured that the work undertaken to date had improved the patient experience and that a culture which treated scrutiny as normal business would ensure further improvements in the future.

The Board was reminded that it would receive a deep-dive into progress of the CQC Action plan in Paediatrics at the August Meeting.

OUTCOME: The Board RECEIVED and NOTED the progress with the Critical Care CQC Action Plan and welcomed an update from Paediatrics at the next meeting.

ACTION: BOD Agenda Item – August 2017.

99/17

CHAIRMAN’S REPORT

a. NHS Confederation Conference

Jan Wilson, Non-Executive Director/Deputy Chair updated the Board on her attendance at the NHS Confederation which she had attended on behalf of the Chair. Simon Stevens, NHS England Chief Executive and Secretary of State for Health Jeremy Hunt had attended and the items discussed included workforce, Brexit, acute care organisations, STPs, diversity and equality.

The Chief Executive reported that the Trust was hoping to hold an event around diversity and equality to make this mainstream conversation.

b. Council of Governors – Chairs Meeting

The Chairman reported that the Council of Governor Chairs of the Divisional Reference Groups had met on the 3 July 2017 and the following issues had been discussed:-

- Staff turnover in Medicine

- Communication from professionals – getting it right, particularly around Mental Health
- Perinatal Tears – level 4 – need to address this to ensure reduced incidents.

OUTCOME: The Board **NOTED** the update from the Chair

100/17 CHIEF EXECUTIVE’S REPORT

a. CQC ‘Driving Improvement – Case studies from eight NHS Trusts’

The Chief Executive explained that the report had been circulated to highlight the CQC review of eight trusts which had made a significant improvement on their rating following inspection and to understand whether there were any common themes and what lessons could be learned and connectivity with the staff survey which was to be discussed later in the meeting.

The key issues highlighted included:

- Leadership to support staff and promote visibility to the wider organization
- Need to engage with staff to move cultural change
- Public and patient involvement
- CQC engagement on a regular basis rather than inspection regime.

The Executive Director of Nursing advised that a quality improvement strategy was being developed but it was noted that this was not one strategy to fit all and CHFT would be reviewing any gaps prior to the next CQC inspection.

OUTCOME: The Board **NOTED** the update from the Chief Executive.

101/17 HIGH LEVEL RISKS REGISTER

The Executive Director of Nursing reported the risks scoring 15 or above within the organisation. These had been discussed in detail at the Executive Board, Quality Committee and Risk and Compliance Group.

These were:-

- 6967 (25): Non delivery of 2017/18 financial plan
- 2827 (20): Over-reliance on locum middle grade doctors in A&E
- 6345 (20): Staffing risk, nursing and medical
- 6131 (20): Service reconfiguration
- 5806 (20): Urgent estates schemes not undertaken
- 6968 (20): Cash flow risk
- 6969 (20): Capital programme
- 6903 (20): Estates/ ICU risk, HRI

Risks with increased score

6967 Non delivery of 2017/18 financial plan has increased from 20 to 25.

Risks with reduced scores

There were no risks with reduced scores.

New risks

There has been one new risk added to the high level risk register in June following discussion at the Risk and Compliance Group on 20 June 2017.

This was a risk related to completion of mandatory training, risk 6977, scored at 16.

Closed risks

Risk 6503, previously scored at 20, delivery of Electronic Patient Record Programme, has been reduced to its target risk score of 5 following implementation and is proposed for closure.

It was noted that an additional item had been circulated regarding the fire risk following the advice received after the Grenfell Tower flats fire. The Executive Director of Planning, Estates and Facilities reported that an initial risk assessment of CHFT has been carried out on the 19 June 2017. The risk assessment established a number of CHFT building facades are fitted with cladding. However, the types of cladding were not deemed hazardous. On the 25th June 2017 the local operational West Yorkshire Fire and Rescue (WYFR) team visited HRI and were assured with the controls in place. They did not deem CHFT as having an urgent fire safety risk. It was noted that Capital works continues across CHFT with the ongoing fire alarm upgrade, fire compartmentation works and emergency lighting. It was agreed that the letter of assurance would be circulated to the Board along with further information as this is received.

ACTION: Executive Director of Planning, Estates & Facilities

It was noted that discussions had taken place at the last Quality Committee and Dr Linda Patterson reported that it had been agreed that an update on falls be brought to the August Board of Directors Meeting.

ACTION: BOD AGENDA ITEM – AUGUST 2017

OUTCOME: The Board **APPROVED** the High Level Risk Register.

102/17

BOARD ASSURANCE FRAMEWORK

The Company Secretary presented the Board Assurance Framework. The key issues following the updates which had been reflected in the paper were discussed.

For the next review the following risks would be considered for inclusion in the BAF:

- Whether the risks associated with IR 35 are sufficiently reflected in the current BAF
- The increasing importance being placed on Carter efficiencies by NHS Improvement
- The role of patient and public involvement and the requirements included in the new CQC well led inspection guidance.
- As it is two years since this version of the BAF was adopted by the Board, the Company Secretary and Head of Risk and Governance will be undertaking a review to ensure that it remains fit for purpose, working with colleagues from across West Yorkshire and Harrogate.

It was noted that this had been discussed at the last Finance and Performance Committee meeting and discussion took place regarding the ability for the Board to report the financial position in the same way as last year, in view of current capital risks. It was agreed that the description within the BAF would be reviewed. It was acknowledged that the Trust has strong robust governance arrangements in place. The document would be reviewed and returned to the Board in September.

ACTION: Company Secretary – BOD Agenda Item Sept 2017

OUTCOME: The Board **APPROVED** the updated Board Assurance Framework.

103/17

PROGRESS AGAINST THE ONE YEAR PLAN YEAR ENDING 2018

The Company Secretary reported that the paper described the progress made against each of the 20 objectives and identifies where the Board should expect to receive more detailed assurance of how the work is progressing.

The report highlighted that of the 20 deliverables:

- None were rated red
- Six were rated amber
- 14 were rated green
- None have been fully completed

It was noted that this was an expected position at this point in the year.

Arrangements had been made for the Plan to be discussed at the Board of Directors / Council of Governors workshop on 18 July 2017, following which the Board will receive quarterly updates on progress. Risks to the delivery of any of the objectives would be identified in the Board Assurance Framework and the risk register.

OUTCOME: The Board **NOTED** the progress against delivery of the one year plan for year ending 2018.

ACTION: BOD AGENDA ITEM – NOVEMBER 2017

104/17

CARE OF THE ACUTELY ILL PATIENT REPORT

The Executive Medical Director presented the updated Care of the Acutely Ill Patient Report and reminded the Board of the overall aim of the programme to reduce mortality. It was noted that this is divided into six themes:

- 1) Investigating causes of mortality and learning from findings
- 2) Reliability in clinical care
- 3) Early recognition and treatment of deteriorating patients.
- 4) End of life care
- 5) Caring for frail patients
- 6) Clinical coding

The Executive Medical Director reported that HSMR and SHMI continue to fall. It was noted that challenges of EPR had resulted in delayed mortality reviews but these were now getting on track and an update would be provided to the Board.

Following the discussions at previous meetings around care of patients with sepsis, the Executive Medical Director confirmed that a new sepsis management team had now been set up and work was underway to re-establish work in A/E and wards, although it was noted that the implementation of the EPR system would highlight Sepsis Patients to enable immediate care to commence.

The Chief Executive wished to thank all colleagues, particularly in MAU and would encourage all clinicians to use the EPR system to its full potential.

105/17

DIRECTOR OF INFECTION, PREVENTION AND CONTROL (DIPC) ANNUAL REPORT

The Executive Medical Director presented the DIPC Annual Report

It was noted that this year has seen a number of challenges with an increase in post 72-hour Clostridium difficile Toxin (CDT) positive cases and two MRSA bloodstream infections.

The key points from the report were noted:

- The Trust complies with The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and associated guidance (updated 2015) and associated Care Quality Commission (CQC) guidance. Compliance is demonstrated through a self-assessed HCAI programme of work and audit for 2016/17 that includes the 10 criteria identified in the code.
- There were two trust apportioned Methicillin-Resistant Staphylococcus aureus (MRSA) bacteraemias reported against a ceiling target of zero.
- There were 32 trust apportioned Clostridium difficile toxin (CDT) positive cases this year against a ceiling target of 21. All were subject to Root Cause Analyses (RCA) – eight were identified as potentially avoidable owing to 'lapses in care' identified at RCA. Lapses in care principally related to antibiotic prescribing out with policy and poor documentation. Areas for improvement feed into the Trust and Divisional HCAI action plans.
- There were 13 Trust attributed Methicillin-sensitive Staphylococcus aureus

(MSSA) bacteraemias, which is an increase from 9 during 2015/16.

- The trust reported 48 E.coli bacteraemia infections demonstrating an increase on last year's performance of 25. Analysis of all cases has not demonstrated a common underlying cause. Detailed collaborative work within the health economy during the forthcoming year will be established.
- A parainfluenza outbreak on SCBU was investigated as a Serious Incident (SI).
- An MRSA cross transmission incident on Ward 11 HRI was investigated as an SI. There were 19 wards affected (either closed or restricted) with viral gastroenteritis, resulting in 264 bed days lost.
- Hand hygiene and bare below elbow (BBE) compliance was audited monthly by infection control link practitioners. The overall percentage of hand hygiene compliance for the year was 98.9%.
- The Trust participated in mandatory three month orthopaedic surgical site infection surveillance (SSIS), and extended this to six months for some procedures with post discharge surveillance.
- Two patients were identified as carrying Carbenpenemase-producing enterobacteriaceae (CPE) via the Trust screening programme during 2016/17.
- All core policies, as required by the Hygiene Code 2008 (DH 2010), have been reviewed and have been published on the Trust Intranet and Internet sites.
- Nine policies have been approved at Executive Board during 2016/17.

OUTCOME: The Board **RECEIVED** and **NOTED** the DIPC Report

106/17

GUARDIAN OF SAFE WORKING HOURS QUARTERLY REPORT

Miss Tamsyn Grey, Guardian of Safe Working Hours for the Trust presented the 2nd quarterly report as at May 2017. The key issues from the report were discussed:-

It was noted that there was still a significant problem with some supervisors not addressing exception reports despite reminders and offers of additional training

There was no admin support provided to the Guardian of Safe Working Hours with regard to managing the flow of exception reports. It was agreed that the Executive Medical Director and Tamsyn Grey would discuss this outside the meeting and bring an update to the Board in September.

ACTION: BOD AGENDA ITEM SEPTEMBER 2017

It was noted that among doctors on the contract so far, the majority of exception reports have fallen within the Surgery and Anaesthetics division. Three fines had been issued on the general/urology/vascular surgery F1 rota. In common with other Trusts, a significant number of vacancies were using agency locums to fill gaps.

It was noted that Tamsyn had resigned from the Guardian role and arrangements were being made to find a successor. The Board thanked Tamsyn for undertaking the role and appreciated the time commitments required to fulfil the role.

OUTCOME: The Board **RECEIVED** and **NOTED** the Guardian of Safe Working Hours quarterly report.

107/17

INTEGRATED PERFORMANCE REPORT

The Chief Operating Officer highlighted the key points of operational performance for May 2017. It was noted that this report had been discussed in detail at the Executive Board, Quality Committee and Finance and Performance Committee.

The key highlights from the report were noted:-

- May's Performance Score had fallen to 61% for the Trust.
- The SAFE domain remains GREEN although harm free care and pressure ulcers have deteriorated.

- The RESPONSIVE domain remains Amber failing to meet the Emergency Care Standard and the two week wait target which was missed for the first time in over 12 months.
- CARING had deteriorated to RED due to a number of Friends and Family Trust targets being missed.
- EPR had impacted on the provision of several indicators this month including 18 weeks admitted and non-admitted, VTE, coding and day case rates.

The Board acknowledged that this had been a challenging time due to EPR implementation, although it was noted that this was not the only cause of concern.

Concern was raised regarding the cancer waits. It was noted that targets had not been met due to EPR bookings and high volumes of agency staff leaving. Work was underway with the Divisions to look at pathways and a deep-dive was being undertaken within Executive Board.

OUTCOME: The Board **RECEIVED** the Integrated Board Report and **NOTED** the key areas of performance for May 2017.

108/17

MONTH 2 – 2017-2018 FINANCIAL NARRATIVE

The Executive Director of Finance presented the Month 2 Financial Narrative which had been submitted to NHS Improvement.

Key Issues:

The planned position is a deficit of £6.14m on a control total basis, including year to date Sustainability and Transformation funding (STF) of £1.01m.

The final planning submission made to NHSI on 30th March 2017 was an indicator of the Trust's commitment to do all within its power to deliver the £15.9m control total deficit. However, as was communicated from January when the control total was appealed, the Board had number of concerns regarding the scale of this challenge. Whilst appreciating the overall NHS Provider sector position, it was hoped that a revised control total could be considered. The key risks to delivery were outlined as the abnormal costs of implementation or short term loss of income as a result of EPR implementation and the scale of the CIP challenge at £20m, 5.3%.

At month 2 the Trust is able to report delivery of the financial plan but there are a number of assumptions with material value that are being made within this. These assumptions relate to clinical activity capture and coding in the Trust's new EPR system and therefore income recovery. Securing the reported income relies on a significant number of detailed actions being undertaken.

In addition the year to date position is reliant upon a number of non-recurrent income and expenditure benefits which cannot be replicated going forwards. Thus, in order to continue to forecast delivery of the financial plan, recovery actions are required.

Summary:

- Delivery of CIP of £1.31m against the planned level of £1.43m.
- Contingency reserves of £0.66m have been released against pressures.
- Capital expenditure of £3.08m, this is below the planned level of £3.66m.
- Cash balance of £1.90m as planned.
- Use of Resources score of level 3, in line with the plan.

OUTCOME: The Board **NOTED** the contents of the report.

109/17

2016 STAFF SURVEY ACTION PLAN

The Deputy Director of Workforce and OD presented the 2016 Staff Survey Action Plan.

The paper described the approach to responding to the colleague feedback provided through the 2016 staff survey. It was noted that this had been discussed in detail at the Workforce Well-Led Committee in June 2017.

An additional Workforce Race Equality Scheme action plan had been developed and this was being shared with the Workforce Well-Led Committee.

The response rate had been good and active consideration was being given to the 2017-18 approach to boost participation rates.

Two themes had emerged from the survey:-

1. Cultural barometer – work was underway within the Trust
2. Work with teams to look at impact of engagement – staff to have tools to help engagement.

Dr Linda Patterson reported that she was happy to help with this work and the Deputy Director of Workforce and OD agreed to include her in any discussions.

OUTCOME: The Board APPROVED the content of the response and supported the approach.

110/17

ELDERLY CARE STRATEGY

The Chief Operating Officer presented the Calderdale and Greater Huddersfield Five Year Strategy for Older and Frail People.

It was noted that following the Invited Service Review report into Elderly Care a series of workshops had been held with system partners. A strategy was developed that aligned with the principles of the Right Care, Right Time, Right Place with a focus on community care and consolidation of inpatient services that allows development of high quality assessment and inpatient care.

The vision for caring and supporting older or frail people in Calderdale and Greater Huddersfield Health and Social services is that they receive the right care, by the right person, in the right place and at the right time. Care will be accessible, coordinated, timely, compassionate, person centered and goal orientated

In order to achieve this we will focus on:

- Prevention: Ensure regular assessments of frail older people or people in care homes to detect deterioration in health status early
- Personalised: Support individuals to enable independent, satisfying, quality of life
- Integration: Develop multidisciplinary, integrated community ageing teams (ICAT) with trusted assessments and shared care plans to improve coordination of care and reduce the number of assessments needed
- Think Home First!: Support and care for people in their own home or environment and reduce referrals to hospital. Develop alternative assessment and care settings to hospital.
- Hospital without walls: When hospital care is needed patients will be seen and assessed by staff specialising in caring for older, frail people. In-hospital patients will be encouraged to maintain their usual levels of independence
- Avoid delays: Each delayed discharge from hospital will be treated as a system failure and managed through an integrated discharge team.

The Board agreed that this was a good piece of work and noted that this had been discussed at the March Quality Committee. It was suggested that the impact of the

voluntary sector might be explored further and Prof Roberts identified that he was happy to help with case studies.

OUTCOME: The Board APPROVED the Elderly Care Strategy

111/17

UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES

The Board received an update from each of the sub-committees who had met prior to the Board meeting.

a. Quality Committee

Dr Linda Patterson, Chair of the Quality Committee reported on the items discussed at the meeting held on 3 July 2017 which had not been previously covered on the Board's agenda:-

Falls – update to August BoD Meeting

Sepsis – improvement noted.

Learning from serious incidents

Never event in surgery – action plan and learning in place

OUTCOME: The Board **RECEIVED** the minutes from the meeting held on 31.5.17 and the verbal update of the meeting held on 3.7.17.

b. Finance and Performance Committee

On behalf of Phil Oldfield, Chair of the Finance and Performance Committee, Richard Hopkin reported on the items discussed at the meeting held on 4 July 2017:-

Radiology presentation – capacity and reporting issues for 2018-19 and onwards

Community presentation – challenges due to complexity of services/budgets

EPR – benefits realisation programme – workshop arranged.

OUTCOME: The Board **RECEIVED** the verbal update from 4.7.17 and the minutes of the meeting held on 30.5.17.

c. Workforce Well-Led Committee

Karen Heaton, Chair of the Workforce Well-Led Committee reported on the items discussed at the meeting held 8 June 2017 and the minutes had been circulated with the agenda.

OUTCOME: The Board **RECEIVED** the minutes of the meeting held on 8 June 2017.

112/17

DATE AND TIME OF NEXT MEETING

The next meeting was confirmed as Thursday 3 August 2017 commencing at 9.00 am in the Large Training Room, Learning Centre, Calderdale Royal Hospital.

The Chair closed the public meeting at 12:00pm.

Approved Minute

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Cover Sheet

Meeting: Board of Directors	Report Author: Kathy Bray, Board Secretary
Date: Thursday, 3rd August 2017	Sponsoring Director: Victoria Pickles, Company Secretary
Title and brief summary: ACTION LOG - The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 27 July 2017.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 27 July 2017.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 27 July 2017.

Appendix

Attachment:

[DRAFT ACTION LOG - BOD - PUBLIC - As at 1 AUGUST 2017.pdf](#)

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 August 2017 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
165/16 3.11.16	BOARD ASSURANCE FRAMEWORK It was agreed to bring the Board Assurance Framework to the Board in February and for the Company Secretary to review other organisations' BAFs to assess the types of risks included	VP	1.12.16 It was agreed that the Company Secretary would undertake a deep dive of the top themes and bring back to the Board anything which would benefit changing on the BAF in February 2017. 2.2.17 Compliance with NHSI was discussed and the Board questioned whether this was still relevant. It was agreed that this would be further discussed through the Finance and Performance Committee. 2.3.17 Presented to the Finance & Performance Committee prior to Board in June. 1.6.17 It was noted that the BAF would be brought to the July BOD Meeting. 6.7.17 Description of Capital Risk within BAF to be reviewed and document returned to BOD in September 2017	7.9.17		
175/16 3.11.16	UPDATE FROM SUB-COMMITTEES Audit and Risk Committee – DECLARATIONS OF INTEREST The Company Secretary explained that there would be a change to the declarations of interest	VP	2.2.17 The Company Secretary advised that Guidance was still awaited. It was requested that this remain open on the Action Log for a report to come back in March 2017.	TBC		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 August 2017 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	policy as new guidance was due to be published in December. An update would be brought to a future Board meeting.		<p>3.2.17 It was noted that this item would be taken to the Audit and Risk Committee in April with a proposed solution.</p> <p>1.6.17 New guidance to be discussed at WEB in June and taken to the July ARC. It was agreed that the revised policy would be brought to the August/Sept 2017 BOD.</p>			
31/17 2.2.17	<p>WHISTLEBLOWING ANNUAL REPORT It was agreed that a greater awareness of the Raising Concerns/Whistleblowing process was required in the Trust and this would be taken through the Workforce Well-led Committee and reported back to the Board.</p>	IW		3.8.17		
28/17 2.2.17	<p>RISK REGISTER Board agreed that a review of the EPR risk and its relation to a potential CQC re-inspection be considered alongside a review of the narrative at year-end in order to archive risks as appropriate and identify tolerance ratings for endemic risks. It was agreed that this would be undertaken by BB and VP and would be taken through the Audit and Risk Committee for review before returning to Board in June 2017.</p>	BB	<p>2.3.17 Discussion took place regarding the nasogastric tube risk and it was agreed that a position statement would be brought to the Board in June.</p> <p>6.4.17 Dr Linda Patterson reported that discussion had taken place at the Quality Committee regarding the nasogastric tube risk and it was noted that a task and finish group had been convened to oversee the outstanding work and a further report was expected to the June Board meeting.</p>	July/Aug 2017		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 August 2017 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
			<p>1.6.17 It was noted that further would was being undertaken and the Board would receive a position statement on the nasogastric tube risk at a future meeting (July or August)</p>			
9/17 5.1.17	<p>INTERNATIONAL STAFF The Acting Chief Executive reported that discussions had taken place regarding abuse towards international staff from patients or their families. The Board agreed that this would not be tolerated and the Executive Director of Workforce and OD agreed that a system would be put in place to safeguard against this via NHS Protect.</p>	IW	<p>2.3.17 The Executive Director of Workforce and OD reported that work was still being undertaken nationally and once this was complete feedback would be brought to the Board.</p>	TBC		
2.3.17 49/17	<p>CARE OF THE ACUTELY ILL PATIENT – CULTURE The Executive Medical Director presented the updated Care of the Acutely Ill Patient Report and reminded the Board on the overall aim of the programme to reduce mortality. It was noted that this is divided into six themes: 1) Investigating causes of mortality and learning from findings 2) Reliability in clinical care 3) Early recognition and treatment of deteriorating patients.</p>	DB	<p>6.7.17 The Executive Medical Director confirmed that a new management team had now been set up and work was underway to re-establish work in A/E and WARDS, although it was noted that the implementation of the EPR system would highlight Sepsis patients to enable immediate care to commence.</p>	6.7.17		3.8.17

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 August 2017 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	<p>4) End of life care 5) Caring for frail patients 6) Clinical coding</p> <p>The Executive Medical Director reported that HSMR is currently falling and is now 103.76 however it remains a concern. There is evidence that the improvement work has contributed to the reduction of HSMR over the last year and this would continue to be monitored.</p> <p>Discussion took place regarding Sepsis and as discussed at the last meeting, the Executive Medical Director reported that work continued to be undertaken regarding this to ensure that all staff treated sepsis as a medical emergency. It was agreed that an update would be brought to the Board to assure the Board that attitudes and behaviours were being addressed in the Trust to ensure that the care of the Sepsis patient was made a priority.</p>					
6.4.17 66/17	<p>CQC UPDATE ON ACTION PLAN It was noted that deep dives would be undertaken into the Action plan key themes:- Maternity, CDU</p>	BB		1.6.17 – Maternity 6.7.17 – Critical		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 August 2017 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	and ICU to the next three Board meetings.			Care 3.8.17 – Paediatrics		
1.6.17 83/17g	BOARD TO WARD VISITS The Company Secretary advised that reports were being obtained from the Executive Team following the visits undertaken during March-May and a formal report would be brought back to the Board.	VP		TBC		
1.6.17 87/17	HOSPITAL PHARMACY SPECIALS (HPS) ANNUAL REPORT The Annual Report was received and production development noted. The DoF reported that in order for the service to undertake large scale products, significant investment was required and a Business Strategy would be brought to the Board later in the summer.	GB		TBC		
1.6.17 90/17	HARD TRUTHS – DISCHARGE PROCESS As part of the Hard Truths paper, discussion took place regarding the new discharge processes which had recently being introduced with the help of Age Concern. It was agreed that once the service had been evaluated. The COO would	HB		26.10.17 CoG Meeting		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 August 2017 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	report to the October CoG Meeting and give an update.					
6.7.17 106/17	<p>GUARDIAN OF SAFE WORKING</p> <p>It was noted that there was still a significant problem with some supervisors not addressing exception reports despite reminders and offers of additional training</p> <p>There was no admin support provided to the Guardian of Safe Working Hours with regard to managing the flow of exception reports. It was agreed that the Executive Medical Director and Tamsyn Grey would discuss this outside the meeting and bring an update to the Board in September.</p>			7.9.17		

Approved Minute

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Cover Sheet

Meeting: Board of Directors	Report Author: Kathy Bray, Board Secretary
Date: Thursday, 3rd August 2017	Sponsoring Director: Victoria Pickles, Company Secretary
Title and brief summary: CHIEF EXECUTIVES REPORT - AUGUST 2017 - The Board is asked to receive and note the contents of the House of Lords publication "The Long Term Sustainability of the NHS and Adult Social Care"	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive and note the contents of the House of Lords publication "The Long Term Sustainability of the NHS and Adult Social Care"

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to receive and note the contents of the House of Lords publication "The Long Term Sustainability of the NHS and Adult Social Care"

Appendix

Attachment:

[House NHS Sustainability Report.pdf](#)



HOUSE OF LORDS

Select Committee on the
Long-term Sustainability of the NHS

Report of Session 2016–17

The Long-term Sustainability of the NHS and Adult Social Care

Ordered to be printed 28 March 2017 and published 5 April 2017

Published by the Authority of the House of Lords

Select Committee on the Long-term Sustainability of the NHS

The Select Committee on the Long-term Sustainability of the NHS was appointed by the House of Lords on 25 May 2016 to consider the long-term sustainability of the National Health Service.

Membership

The Members of the Select Committee on the Long-term Sustainability of the NHS are:

[Baroness Blackstone](#)

[Lord Bradley](#)

[Lord Bishop of Carlisle](#)

[Lord Kakkar](#)

[Lord Lipsey](#)

[Lord Mawhinney](#)

[Lord McColl of Dulwich](#)

[Lord Patel \(Chairman\)](#)

[Baroness Redfern](#)

[Lord Ribeiro](#)

[Lord Scriven](#)

[Lord Turnberg](#)

[Lord Warner](#)

[Lord Willis of Knaresborough](#)

Declarations of interest

See Appendix 1.

A full list of Members' interests can be found in the Register of Lords' Interests:

<http://www.parliament.uk/mps-lords-and-offices/standards-and-interests/register-of-lords-interests>

Publications

All publications of the Committee are available at:

<http://www.parliament.uk/nhs-sustainability>

Parliament Live

Live coverage of debates and public sessions of the Committee's meetings are available at:

<http://www.parliamentlive.tv>

Further information

Further information about the House of Lords and its committees, including guidance to witnesses, details of current inquiries and forthcoming meetings is available at:

<http://www.parliament.uk/business/lords>

Committee staff

The staff who worked on this Committee were Patrick Milner (Clerk), Emily Greenwood (Policy Analyst until October 2016) and Beth Hooper (Policy Analyst from October 2016) and Thom Cheminais (Committee Assistant until November 2016) and Vivienne Roach (Committee Assistant from November 2016).

Contact details

All correspondence should be addressed to the Select Committee on the Long-term Sustainability of the NHS, Committee Office, House of Lords, London SW1A 0PW. Telephone 020 7219 6968. Email hlnhssustainability@parliament.uk

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Evidence is published online at <http://www.parliament.uk/nhs-sustainability> and available for inspection at the Parliamentary Archives (020 7129 3074).

Q in footnotes refers to a question in oral evidence.

SUMMARY

A culture of short-termism and an Office for Health and Care Sustainability

A culture of short-termism seems to prevail in the NHS and adult social care. The short-sightedness of successive governments is reflected in a Department of Health that is unable or unwilling to think beyond the next few years. The Department of Health, over a number of years, has failed in this regard. Almost everyone involved in the health service and social care system seems to be absorbed by the day-to-day struggles, leaving the future to ‘take care of itself’. A new political consensus on the future of the health and care system is desperately needed and this should emerge as a result of Government-initiated cross-party talks and a robust national conversation.

To build on this consensus, we recommend the establishment of an Office for Health and Care Sustainability. It should play no part in the operation of the health and care systems, or make decisions, but should be given the independence to speak freely about issues relating to its remit. It should look 15–20 years ahead and report to Parliament, initially focusing on: (1) the monitoring of and publication of authoritative data relating to changing demographic trends, disease profiles and the expected pace of change relating to future service demand; (2) the workforce and skills mix implications of these changes; and (3) the stability of health and adult social care funding allocations relative to that demand, including the alignment between health and adult social care funding. The body should be established in statute before the end of this Parliament.

Transforming services

Service transformation is at the heart of securing the long-term future of the health and care systems. It is dependent on long-term planning, broad consultation, appropriate systems of governance and local accountability. The model of primary care will need to change, secondary care will need to be reshaped and specialised services consolidated further. Importantly, a renewed drive to realise integrated health and social care is badly needed. However, the statutory framework is frustrating this agenda and in order for real progress to be made reform is needed to reduce fragmentation and the regulatory burden. Service transformation will be key to delivering a more integrated health and social care system and although there are some positive examples in some areas, there is more to be done. With policy now increasingly focused on integrated, place-based care we see no case for the continued existence of two separate national bodies and recommend that NHS England and NHS Improvement are merged to create a new body with streamlined and simplified regulatory functions. This merged body should include strong representation from local government.

Realistic and consistent funding for health and adult social care

We are clear that a tax-funded, free-at-the-point-of-use NHS should remain in place as the most appropriate model for the delivery of sustainable health services. In coming years this will require a shift in government priorities or increases in taxation. We are also clear that health spending beyond 2020 needs to increase at least in line with growth in GDP in real-terms. We heard that publicly-funded adult social care is in crisis. The additional funding for social care announced in the 2017 Budget is welcome and means funding for social

care will increase by more than 2% a year for the next three years. This is more than the increase for NHS funding. However it is clearly insufficient to make up for many years of underfunding and the rapid rise in pressures on the system. The Government needs to provide further funding between now and 2020. Beyond 2020 a key principle of the long-term settlement for social care should be that funding increases reflect changing need and are, as a minimum, aligned with the rate of increase for NHS funding.

Funding for health and adult social care over the past 25 years has been too volatile and poorly co-ordinated between the two systems, and this should be addressed as a matter of priority. We recommend that the budgetary responsibility for adult social care at a national level should be transferred to the Department of Health which should be renamed the 'Department of Health and Care'. This should allow money and other resources to be marshalled within a unified policy setting at national level. We acknowledge the difficulties with integrating budgets at a local level but this is achievable. The Government should undertake a review and bring forward changes in order to make this happen.

We support a funding system for social care that enables those who can afford it to pay for the care they need but with the costs falling on individuals capped in the manner proposed by the Dilnot Commission. We also call on the Government to implement as quickly as practicable, and no later than the first session of the next Parliament, new mechanisms to make it easier for people to save and pay for their own care. The Government should, in the development of its forthcoming green paper on the future of social care, give serious consideration to the introduction of an insurance-based scheme which would start in middle age to cover care costs.

The absence of long-term workforce planning

We are concerned by the absence of any comprehensive national long-term strategy to secure the appropriately skilled, well-trained and committed workforce that the health and care system will need over the next 10–15 years. In our view this represents the biggest internal threat to the sustainability of the NHS. Health Education England has been unable to deliver. It needs to be substantially strengthened and transformed into a new single, integrated strategic workforce planning body for health and social care which should always look ten years ahead, on a rolling basis. This will enable it to produce and implement a joined-up place-based national strategy for the health and social care workforce, which utilises a greater proportion of the domestic labour market. Health Education England's independence should be guaranteed, it should be supported by a protected budget and it should be given greater budgetary freedom. It will need enhanced skills and a board that includes representation from all parts of the health and care system.

The evidence was clear that too little attention has been paid to training the existing workforce and a radical reform of many training courses for medical recruits is desperately needed. Health Education England should take the lead on changing the culture of conservatism which prevails among those who educate and train the health and social care workforce. It should convene a forum of the Royal Colleges, the General Medical Council, the Nursing and Midwifery Council, higher education institutions, other education providers, social care providers and local government representatives to investigate how medical

and social care education and ongoing training courses can be reformed and streamlined. We also heard repeatedly of the linkage between over-burdensome regulation, unnecessary bureaucracy, a prolonged period of pay restraint, low levels of morale and retention problems. We call on the Government to bring forward legislation to urgently reform the system regulators and the system of regulation for health and social care professionals.

Innovation, technology and productivity

Currently, leaders in the NHS seem to be incapable of driving the much needed change in levels of productivity, uptake of innovation, effective use of data and the adoption of new technologies. Understandably, too much management and clinical attention is focussed on the here and now and there are too few incentives to look ahead to the longer term. It is not clear who is ultimately responsible for driving innovation and ensuring consistency in the assessment and the adoption of new technological approaches. The Government should make it clear that the adoption of innovation and technology, after appropriate appraisal, across the NHS is a priority and it should decide who is ultimately responsible for this overall agenda. It should also identify the bodies and areas within the NHS which are falling behind in the innovation and technology agenda and make it clear that there will be funding and service delivery consequences for those who repeatedly fail to engage.

Unwarranted levels of variations in patient outcomes are unacceptably undermining the effectiveness and efficiency of the NHS and there is no plan to bring about a greater consistency in levels of performance. The Government should require a newly unified NHS England and NHS Improvement to work with commissioners to achieve greater levels of consistency in NHS efficiency and performance at a local level. There is an immediate opportunity in the implementation of Sustainability and Transformation Plans to take this forward. Greater levels of investment and service responsibility should be given to those who improve the most.

Public health, prevention and patient responsibility

We are of the firm opinion that continued cuts to the public health budget are not only short-sighted but counter-productive. There is a grave risk that the burden of disease will increase if these cuts continue, a trend which is bound to result in a greater strain on all services. The Government should restore the funds which have been cut in recent years and maintain ring-fenced national and local public health budgets for at least the next 10 years. Governments should not cite unwillingness to behave as a ‘nanny state’ as an excuse for inaction on the major public health issues, including obesity. Importantly, the Government should be clear with the public that access to the NHS involves patient responsibilities as well as patient rights. The NHS Constitution should be redrafted and relaunched with a greater emphasis on these often overlooked individual responsibilities. The Government should also redouble its efforts to educate the public about the true costs to the NHS of poor lifestyle choices.

Time and resource constraints meant that we were not able to look at each and every issue in as much detail as they deserved. Nevertheless, we hope that our conclusions and recommendations, which can be found at the end of the report, will provide a starting point for others who continue to work to secure the long-term sustainability of both the NHS and adult social care.

The Long-term Sustainability of the NHS and Adult Social Care

CHAPTER 1: INTRODUCTION

Headline after headline

1. Our NHS, our ‘national religion’, is in crisis and the adult social care system is on the brink of collapse. No one who listened to the evidence presented by the vast array of expert witnesses who appeared before us can be in any doubt about this. Immediate measures are undisputedly needed to alleviate the situation in the short term. Our task, however, was different. We took—indeed our terms of reference stipulated that we should take—a longer-term view. The questions we asked were: How can we retain the basic principles of the NHS: healthcare largely free-at-the-point-of-use, for all citizens? How can we secure an adult social care system which meets the needs of a rapidly changing population? Ultimately can we get beyond today and envisage a long-term future for an integrated health and care service?
2. Our conclusion could not be clearer. Is the NHS and adult social care system sustainable? Yes, it is. Is it sustainable as it is today? No, it is not. Things need to change.
3. The NHS has been serving the nation well for almost 70 years. We were told that it is increasingly effective, affordable and a net asset for the country as a whole.¹ Remarkably, the founding principles which underpinned Aneurin Bevan’s pioneering NHS of 1948 are taken to be as valid today as they were then—that the NHS should provide a comprehensive service, available to all. The service one receives should depend on clinical need, not the ability to pay.²
4. The NHS has survived a long series of crises since its foundation. Accusations of underfunding, back-door privatisation and unnecessary reorganisations, together with claims that inefficient clinical and administrative practices prevail, have plagued successive Secretaries of State for Health. Many of our witnesses portrayed an NHS which is now at breaking point.
5. The House of Commons Public Accounts Committee (PAC) recently reported on the financial sustainability of the NHS. It found that the financial performance of NHS bodies had ‘worsened considerably’. NHS trusts’ deficits had reached £2.5 billion in 2015/16, up from an £859 million deficit in 2014/15. According to the PAC two-thirds of NHS trusts (65%) and NHS foundation trusts (66%) reported deficits in 2015/16, up from 44% of NHS trusts and 51% of NHS foundation trusts in the previous financial year.³ This downward spiral cannot continue.

1 Q 285 (Simon Stevens)

2 Department of Health, ‘The NHS Constitution for England’: <https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england#principles-that-guide-the-nhs> [accessed 28 March 2017]

3 House of Commons Committee of Public Accounts, *Financial Sustainability of the NHS* (Forty Third Report, Session 2016–17, HC 887)

6. This, together with increased demand, is stretching the NHS's ability to cope. Headline after headline report that key NHS targets are being missed; performance against the four-hour Accident and Emergency (A&E) waiting time targets is worsening, as is performance against the ambulance response time standards and the target requiring patients to be treated within 18 weeks of referral.⁴
7. Increasing demand from an ageing population, when coupled with cuts to local authority funding, is placing immense pressure on adult social care services. Shortfalls in social care provision are placing an unprecedented and increasingly unmanageable strain on the NHS. A health service being forced to cope with higher demand and increasingly complex patient needs, as well as trying to secure its own financial sustainability, is being asked to achieve the impossible. The evidence we received was clear: a social care system in crisis will only exacerbate the funding and resource pressures on the health service, but a lasting settlement for social care has the potential to alleviate some of those pressures. The social care crisis is deepening, and unless it is tackled, the health service will not be able to survive in its present form.

Beyond the here and now

8. Beyond the immediate financial and operational pressures, we heard evidence of other challenges which, if left unaddressed, pose a serious threat to the long-term sustainability of the health and social care systems.
9. The UK has historically spent less on health when compared with the Organisation for Economic Co-operation and Development (OECD) averages. UK health spending per head is markedly lower than other countries such as France, Germany, Sweden and The Netherlands.⁵ The UK also performs poorly in comparison with other countries on many indicators of acute care, achieving worse outcomes for survival from stroke and heart attacks.⁶ It continues to lag behind comparable European counterparts for cancer survival over five years and 10 years.⁷ We heard that the UK also has fewer hospital beds, fewer doctors and fewer nurses per head than the OECD averages.⁸
10. Low productivity in the health and care systems remains an endemic problem and there are wide variations in provider performance. The Care Quality Commission's (CQC) latest report *The State of health care and adult social care in England 2015/16* concluded that the quality of care provided across England still varies considerably "both within and between different services."⁹ We heard that there is variation present in the system that is wholly unwarranted and which "cannot be explained by variation in need or explicit choice of populations or individuals."¹⁰ Action must be taken to change this.

4 House of Commons Committee of Public Accounts, *Financial Sustainability of the NHS* (Forty Third Report of Session 2016–17, HC 887)

5 The Health Foundation, 'How does the UK compare internationally for health funding, staffing and hospital beds?': <http://www.health.org.uk/chart-how-does-uk-compare-internationally-health-funding-staffing-and-hospital-beds> [accessed 28 March 2017]

6 Q 70 (Ian Forde)

7 Q 70 (Professor Alistair McGuire)

8 Q 70 (Ian Forde)

9 Care Quality Commission, *The state of health care and adult social care in England 2015/16* (12 October 2016): http://www.cqc.org.uk/sites/default/files/20161019_stateofcare1516_web.pdf [accessed 28 March 2017]

10 Q 60 (Sir Muir Gray)

11. Significant health inequalities persist. This is felt markedly in the pronounced inequalities between the treatment of physical and mental health; people with severe and prolonged mental illness are at risk of dying, on average, 15 to 20 years earlier than others.¹¹ The reductions in health inequalities called for by the Marmot Review have yet to be realised.¹²
12. Innovative technologies can produce both large cost savings and more effective treatment. Yet the evidence highlighted that the NHS is often a slow adopter of new technologies. We heard that there is significant under-use of technology, data and digitisation, which slows innovation and reduces levels of productivity.¹³
13. The public is committed to the NHS as a service which is tax-funded and free-at-the-point-of-use. However, a recent opinion poll conducted by Ipsos MORI showed that the future of the NHS is an increasing concern, with 55% of people—the highest figure they have ever recorded—saying they expected the NHS to deteriorate over the longer term.¹⁴ There has been an entrenched reluctance to engage in a serious conversation with citizens about how the system they have grown used to will need to change to meet new challenges. People need to be educated to take responsibility for their own health. Politicians need to be honest that with patient rights come patient responsibilities.
14. We were afforded the rare opportunity to look beyond the immediate pressures facing the health and social care systems and instead focus on how to ensure they are sustained in the long term. We asked many of our witnesses what the perfect health system would look like in 10 to 15 years' time. The answers we received were consistent; fully integrated health and social care services, more care delivered in primary and community settings, a greater focus on prevention, supported by adequate and reliable funding—all of which should provide seamless, patient-centred care. Although there was widespread agreement on the vision for the health and social care system of the future, we are clear that this cannot be delivered as things stand.
15. Short-term funding fixes will not suffice. Neither will tinkering around the edges of service delivery. We believe that, in order to achieve long-term sustainability of the NHS, we need:
 - **Radical service transformation:** The needs of patients have changed and so the system needs to change with them. There is widespread agreement on the vision—integrated health and care services delivering more care in primary and community settings—but service fragmentation and volatile funding allocations are making the necessary service transformation difficult.
 - **Long-term funding solutions for the NHS and adult social care:** Funding for both health and social care needs to be more stable and predictable, with better alignment between the allocations for health and social care. This should help to support longer-term, strategic planning for both services.

11 Written evidence from Mind ([NHS0179](#))

12 [Q 322](#) (Professor Sir Michael Marmot) and The Marmot Review, *Fair Society Healthy Lives* (February 2010): <http://www.parliament.uk/documents/fair-society-healthy-lives-full-report.pdf> [accessed 28 March 2017]; the report identified striking levels of health inequalities across the country.

13 [Q 72](#) (Professor Alistair McGuire)

14 [Q 105](#) (Ben Page)

- **Immediate and sustained action on adult social care:** The funding crisis in adult social care threatens to overwhelm the NHS and will undermine any efforts to transform the system as a whole. A long-term financial settlement—preferably one on which the political parties can agree—is needed to put social care on a sustainable footing. A long-term programme, with clear leadership, governance and accountability for the better integration of health and social care, is the single instrument that would do most to enable the NHS to break through to a sustainable future.
16. It is our firm belief that the NHS can be sustained and, indeed, that it should be sustained. However, unless the issues outlined above are addressed as a matter of urgency, there is a real danger that the NHS will be rendered incapable of delivering on its much-cherished foundational principles.
 17. This crisis is different from the other crises. Whatever short-term measures may be implemented to muddle through today, a better tomorrow is going to require a more radical change. Of course, more money will be required, but political and professional conservatism is as much a threat to long-term sustainability as a lack of funding. In this report we set out a holistic plan for long-term change that should deliver a flourishing health and care service not only for ourselves, but for our children and grandchildren.

The inquiry and the Committee's work

18. In March 2016 the Liaison Committee recommended that the House should appoint an *ad hoc* committee to consider the long-term sustainability of the NHS. On 25 May 2016 we were appointed and ordered to report by 31 March 2017.¹⁵ We started work in June 2016 and took the decision early on to focus on the following themes, structuring our Call for Evidence document accordingly:
 - (1) resource issues, including funding, productivity and demand management;
 - (2) workforce, especially supply, retention and skills;
 - (3) models of service delivery and integration;
 - (4) prevention and public engagement; and
 - (5) digitisation of big data, services and informatics.
19. The broad scope and relatively long timeframe for the inquiry afforded us the opportunity to examine cross-cutting issues such as planning, the quality of political leadership, and consensus-building, which have often been overlooked in other, more narrowly defined parliamentary inquiries or government-initiated reviews.
20. Although we were appointed with the clear remit of considering “the long-term sustainability of the National Health Service”, as the inquiry developed, we were struck by the inextricable link between the NHS and the provision of social care. The evidence we received was clear that a social care system in crisis would only exacerbate the funding and resource pressures on the

¹⁵ Liaison Committee, *New investigative committee activity* (3rd Report, Session 2015–16, HL Paper 113) and House of Lords Minutes of Proceedings, [25 May 2016](#)

health service, and that a lasting settlement for social care had the potential to alleviate some of those pressures. It would therefore have been impossible to carry out this task without investigating the inter-related nature of health and social care and the need for a lasting settlement for both. Consequently, much of our evidence-gathering and deliberations focused on this important issue.

21. We gathered a wide range of evidence from a large number of individuals and organisations. We received 192 written submissions and heard from well over 100 witnesses in oral evidence sessions between July and December 2016. The level of public engagement was noteworthy; members of the public submitted over 3,000 letters and emails in the final stages of the inquiry with many personal reflections and heartfelt opinions. We would like to place on the record our sincere thanks to all those who contributed to the inquiry by appearing before us in Westminster, by taking the time to submit written evidence or through sending personal correspondence.
22. Health is a devolved matter in the United Kingdom. Consequently, much of the evidence we received and the corresponding conclusions and recommendations we have drawn focus on the situation in England. It is our hope, however, that where applicable, the devolved administrations and those who work in and make use of the NHS throughout the entire United Kingdom may find in this report a set of worthwhile reflections on the future of health and social care provision in all four constituent nations.
23. The following six chapters contain conclusions and recommendations aimed not only at the UK Government, but politicians of all parties, those who work in the NHS, those who represent them and those who make use of its services. The report begins with a consideration of what service transformation is required to support the long-term sustainability of the NHS and adult social care systems (Chapter 2). The workforce is the lifeblood of the NHS and this is discussed in Chapter 3 before the controversial matter of funding for both the NHS and adult social care is considered in Chapter 4. Attention is then given to levels of productivity and the NHS's approach to innovation and the uptake of new technologies (Chapter 5). The move from an 'illness service' to a 'wellness service' and the role of the patient is considered next in Chapter 6. The report concludes with a discussion of political leadership, the need for a cross-party consensus on the way forward and a call for a longer-term solution to funding and planning (Chapter 7).
24. The members of the Committee are listed in Appendix 1, along with declared interests. The witnesses and those who submitted written evidence are listed in Appendix 2. The Call for Evidence is given in Appendix 3. All evidence is published online on the Committee's website.
25. We were ably assisted in our work by two specialist advisers. Anita Charlesworth, Chief Economist at the Health Foundation, was an invaluable aide as the inquiry progressed and Emma Norris, Programme Director at the Institute for Government, was particularly helpful with an audit of independent and semi-independent public bodies, details of which can be found in Appendix 5. We are deeply grateful to both of them. We are also grateful to the staff who worked on the Committee: Patrick Milner (Clerk); Emily Greenwood (Policy Analyst to October 2016); Beth Hooper (Policy Analyst from October 2016); Thomas Cheminais (Committee Assistant to November 2016); and Vivienne Roach (Committee Assistant from November 2016).

CHAPTER 2: SERVICE TRANSFORMATION

26. Increased longevity of life was one of the triumphs of the 20th century. The challenge for today is to ensure that those extra years are healthy years. The health service in this country—in common with most of those in the developed world—was designed primarily to treat short-term episodes of ill health and today continues to operate around individual conditions and body parts. Consequently, it is less adapted for frail, elderly people with multiple health conditions.
27. If the system is going to adapt to meet the patient needs and demands of the future, radical service transformation is required. There is wide agreement on the vision for the health system of the future—effective primary and community services, secondary services free from inappropriate use, and more joined-up working between health and social care services—but we were told repeatedly of the barriers that prevent this transformation. If the vision is to become a reality it will require clear direction from the centre but also strong support for local co-operation and place-based commissioning.
28. This chapter sets out the case for service transformation and explores some of the existing efforts. It considers how the different components of the system need to change, examines the progress of integration of the health and social care services and considers what barriers need to be overcome to support the system to adapt to meet demands over the next 10 to 15 years.

The case for service transformation

29. While the NHS has evolved considerably since its inception in 1948, the drivers of change—from demographic factors and changing disease patterns, to technological and medical advances, income effects and increasing relative health care costs—are intensifying at a relentless pace and fuelling rising public expectations. The system, which was originally designed to treat short-term episodes of ill health is now caring for a patient population with more long-term conditions, more co-morbidities and increasingly complex needs.

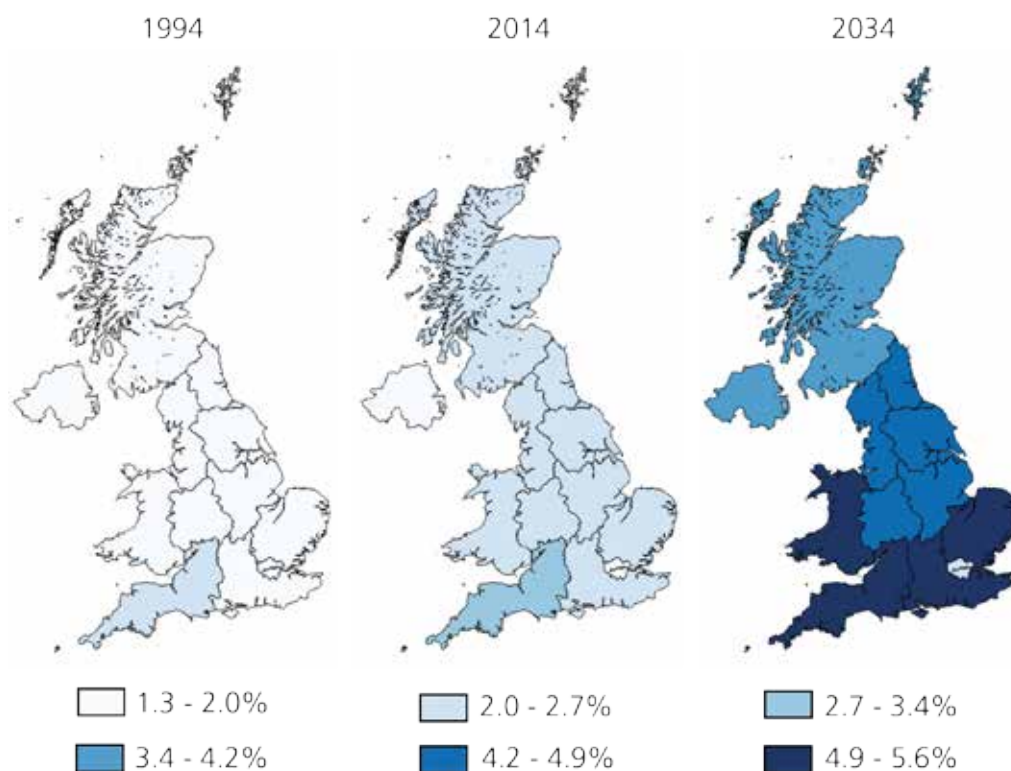
Box 1: Demographic and Disease Change

Demographic changes will contribute significantly to the levels of demand placed on health and care services over the next 10 to 15 years, and beyond. As the population ages, there will be a likely change to the prevalence of some major diseases and an increase in the number of people with more than one long-term condition.

An ageing population

The Office for National Statistics (ONS) forecasts that the proportion of individuals aged 65 years and over will increase from 18.0% of the population in 2016 to 26.1% in 2066. Growth will be particularly strong among the oldest individuals, with the share of the population aged 85 years and above set to increase from 2.4% to 7.1% over the same period. Figure 1 illustrates the historic and projected changes in the proportion of the population of people aged over 85.

Figure 1: Proportion of the population in the UK aged 85 in 1994, 2014 and (projected for) 2034



Source: ONS data cited in written evidence from Professor Chris Whitty ([NHS0194](#))

Changes to the burden of disease

Professor Chris Whitty, Chief Scientific Adviser at the Department of Health, detailed the likely change in disease mix expected over the next 20 years. In his view it was reasonable to expect the continuation of some of the trends seen in the last 30 years. For example, improvements in primary and secondary prevention mean that the incidence of cardiovascular disease (heart disease, acute stroke, some vascular dementia) and some major cancers (for example lung, cervical, gastric) will reduce.

Other diseases are likely to reduce in incidence but increase in prevalence due to better survival—stroke is an example. This will have significant implications for the skill mix needed in the professions 20 years on. Meanwhile some diseases will increase in prevalence due to successes in other areas (for example some infectious diseases and some cancers). Professor Whitty suggested that the most prominent of these will most likely be dementia.

Sources: ONS figures cited in Institute for Fiscal studies, *IFS Green Budget, UK health and social care spending* (7 February 2017): <https://www.ifs.org.uk/uploads/publications/budgets/gb2017/gb2017ch5.pdf> [accessed 28 March 2017] and written evidence from Professor Chris Whitty ([NHS0194](#))

30. There was widespread agreement throughout our evidence that the NHS's current delivery model was outdated and struggling to keep pace with the changes outlined in Box 1. Michael Macdonnell, Director of Strategy at NHS England, told us: "If we had to recreate the system, none of us would recreate what we currently have."¹⁶
31. The issue of whether the health system and the models of care within it reflect the needs of the patients it cares for is of central importance. Underpinning much of the evidence we received was a clear agreement that without the necessary service transformation, tantamount to a "fundamental reinvention of the delivery model",¹⁷ greater sustainability could not be achieved.

The vision

32. We asked many of our witnesses the same question—what does the healthcare system of 2030 look like and what do we need to get there? As a result, we were able to obtain a very clear articulation of what key components a sustainable system would need to include. A number of consistent themes emerged:
- (1) The urgent need to shift more care away from the acute sector into primary and community settings;
 - (2) Widespread support for closer integration of health and social care services (as far as organisation and budgets are concerned); and
 - (3) The need to resolve the current fragmentation of the health system, which is making the provision of co-ordinated care impossible and frustrating efforts to move toward place-based systems of care.
33. A conclusive shift away from hospital-based care towards delivering care through primary and community-based services was perhaps the most prominent of the calls for service transformation. The Department of Health confirmed that: "Our focus and interest are in how you shift activity and resources from acute to community settings."¹⁸ Public Health England echoed this, stating that: "What we are looking for to happen over the next few years is new, more integrated services outside of the acute setting done at scale in primary and community settings."¹⁹
34. The evidence was also overwhelmingly in favour of the integration of health and social care services and budgets, with more of these services, including mental health services, provided on a community basis. The Royal College of Nursing was one of many witnesses that suggested that integration was central to the long-term sustainability of the health and care system, and critical to facilitating positive system change, stating that:

"The reality is that the failure to fund either effectively, or address people's needs through design and delivery of integrated services, is negatively impacting both funding and outcomes. We must consider these aspects of care and support as fundamentally connected and interdependent, rather than seeing them in isolation from one another."²⁰

16 [Q 47](#) (Michael Macdonnell)

17 [Q 128](#) (Tom Kibasi)

18 [Q 3](#) (Graham Duncan)

19 [Q 246](#) (Adrian Masters)

20 Written evidence from the Royal College of Nursing ([NHS0149](#))

Service transformation: the current situation

The Five Year Forward View

35. The current strategic vision for the NHS is set out in the Five Year Forward View which was published in October 2014. It was published under the leadership of its current Chief Executive, Simon Stevens of NHS England, and outlines a vision for the future of the NHS based around new models of care. It focuses on a number of themes such as the importance of public health and ill-health prevention, empowering patients and communities, strengthening primary care and making further efficiencies within the health service.
36. A core aim of the Five Year Forward View was to undertake “radical action to transform the way NHS care is provided.”²¹ To achieve this, it set out how NHS England would “support and stimulate the creation of a number of major new care models” to help meet the changing needs of patients.²² Some of the new models include:
- Multispecialty Community Provider: This model permits groups of general practitioners to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care services to create integrated out-of-hospital care.
 - Primary and Acute Care Systems: This model combines, for the first time, general practice and hospital services, allowing single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services.
 - Urgent and emergency care networks: Under this model, the urgent and emergency care system will be simplified to provide more integration between A&E and other services. Changes include the development of hospital networks with access to specialist centres, new partnership options for smaller hospitals and a greater use of pharmacists.²³
37. These new models of care are being delivered through a series of ‘vanguard’ sites across the country. Michael Macdonnell told us that: “The new care models programme is based on a vision of where we want to get to.”²⁴
38. The general direction of travel set out in the Five Year Forward View was strongly supported as a basis for making the NHS more sustainable. Organisations including the Academy of Medical Royal Colleges, the Faculty of Public Health and the Shelford Group all indicated in their submissions that they agreed with the vision for service transformation outlined in the Forward View.²⁵

21 NHS England, *The Five Year Forward View* (October 2014), p 14: <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf> [accessed 28 March 2017]

22 *Ibid.*

23 NHS England, ‘The Five Year Forward View—the executive summary’: <https://www.england.nhs.uk/ourwork/futurenhs/nhs-five-year-forward-view-web-version/5yfv-exec-sum/> [accessed 28 March 2017]

24 Q 44 (Michael Macdonnell)

25 Written evidence from the Academy of Medical Royal Colleges (NHS0139), the Faculty of Public Health (NHS0154) and the Shelford Group (NHS0134)

39. We were told that there were plans to extend the Five Year Forward View. Simon Stevens, told us that NHS England would publish a set of proposals, which would be “a manifesto if you like, for what going into the next Parliament it should look like over the medium term.” Mr Stevens indicated that it was likely that this would be published in the near future.²⁶
40. Despite the assurance that the Forward View would be revisited we were concerned that there appeared to be a significant lack of long-term thinking around how the momentum on service transformation will be maintained. As the Health Foundation emphasised:
- “Delivering the vision and funding set out in the Forward View is a necessary step towards a sustainable health care system but not a sufficient one. Beyond the Forward View, action will be needed to secure a high quality, sustainable health and care system for the 2020s.”²⁷
41. NHS Providers raised similar concerns and told us that:
- “... there is no clarity about how the government’s commitment to integrate care by 2020 will be delivered and a real lack of vision and strategy for integration or service reconfiguration beyond this period to 2035.”²⁸
42. It appears that in terms of service transformation (and in other areas we outline later in this report) the view of policymakers is set no further than 2020. Chris Wormald, Permanent Secretary at the Department of Health, confirmed that:
- “Of course like any Government department our primary focus is on delivering the manifesto right now. Our focus is unashamedly on the next five years delivering the five year forward view ... We are not in the business of publishing long term plans, future visions of the health service beyond the current Parliament but we are in the process of a constant horizon scanning.”²⁹
43. **Most people agree that key aspects of the service delivery model for the NHS need to change. There is also broad agreement on how this should happen. The general direction of NHS England’s Five Year Forward View commands widespread support and, if fully realised, will place the NHS on a far more sustainable footing, especially if greater public support can be achieved.**
44. **The Five Year Forward View appeared to be the only example of strategic planning for the future of the health service. This is clearly short-sighted. Without a longer-term strategy for service transformation, which goes beyond 2020, any short-term progress achieved through the Five Year Forward View will be put at risk.**
45. ***The Department of Health and NHS England, in partnership with the Department of Communities and Local Government, the Local Government Association and the Association of Directors of Adult Social Services, should agree a medium-term plan that sets out the action required to deliver sustained service transformation at a local level. This plan should cover the period up to at least 2025, be supported by dedicated funds and be implemented following a full public consultation.***

26 [Q 278](#) (Simon Stevens)

27 Written evidence from the Health Foundation ([NHS0172](#))

28 Written evidence from NHS Providers ([NHS0110](#))

29 [Q 250](#) (Chris Wormald)

Sustainability and Transformation Plans

46. Sustainability and Transformation Plans (STPs) were announced in December 2015. As a result, NHS organisations and local authorities in different parts of England have been required to produce a multi-year ‘place-based plan’ showing how local services will evolve and become sustainable over the next five years—ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.
47. Final plans from the 44 STP areas were submitted in October 2016. The plans are likely to be assessed and approved in phases, depending on their quality. From April 2017, STPs will become the single application and approval process for accessing NHS transformation funding, with the best plans set to receive funds more quickly.³⁰ STPs were described by the Department of Health as a “genuine attempt to go for place-based commissioning ... trying to involve the local NHS plus social care plus public health, to bring them all together to plan on a five-year, more strategic basis.”³¹
48. We noted that the Department of Health and NHS England were clear that they saw STPs as a key way in which to tackle some of the system’s most significant pressures and were central to realising the vision set out in the Five Year Forward View. In November 2016, Simon Stevens said:
- “The Five Year Forward View is a vitally important plan. It’s about the move to accountable care organisations, about the move to prevention and not cure. And it has the support of the NHS, and it is vital that we stick with that plan and implement it. And there will be lots of challenges and lots of bumps in the road but the sustainability and transformation plans are the way that we implement the Five Year Forward View and it is vital we stick with them.”³²
49. Amongst our witnesses, though there was broad support for STPs and their role in securing the sustainability of the NHS, some witnesses expressed concerns about the STP process.

Lack of governance

50. Currently, STPs have no statutory basis. However, several individual statutory organisations, such as clinical commissioning groups, will be involved in each Plan. There is, therefore, considerable ambiguity around the governance of STPs which threatens to undermine the ability of STP areas to drive changes to services. Sir Robert Naylor, former Chief Executive of the University College London Hospitals NHS Foundation Trust, said:
- “There are, however, a number of challenges that STPs will need to overcome if they are to deliver the improvements that the NHS needs. The first is about governance and engagement. STPs have been set up relatively quickly, with multiple conflicts of interest and without a statutory basis. That will not give them the authority they will need to drive through difficult decisions about service changes and distribution of financial risks. They will be unable to deliver significant estate

30 The King’s Fund, ‘Sustainability and transformation plans (STPs) explained’: <https://www.kingsfund.org.uk/topics/integrated-care/sustainability-transformation-plans-explained> [accessed 28 March 2017]

31 Q 13 (Dr Edward Scully)

32 GP Online, ‘STPs ‘vital’ for future of NHS, Jeremy Hunt MP has told health leaders’: <http://www.gponline.com/stps-vital-future-nhs-jeremy-hunt-tells-health-leaders/article/1415100> [accessed 28 March 2017]

changes, including investment in primary care, because the majority of assets are ‘owned’ by the acute foundation trusts who are not responsible for the whole patient pathway.”³³

Insufficient investment for both sustainability and transformation

51. The scale of the financial challenge facing both the health and care systems makes it extremely difficult to achieve the service transformation that so many agree is needed. Concerns were raised that, although STPs were regarded as an important mechanism to help transform the way care is delivered, without sufficient investment, they would not be able to achieve sustainable change.
52. When asked whether the transformation fund (the funding that has been made available to support the implementation of the Five Year Forward View through STPs) would be sufficient, Richard Murray, Director of Policy at The King’s Fund, told us: “At the moment, no. Much of the transformation funding that is available will end up being directed at deficits in the acute sector.”³⁴
53. In this year’s Budget, published on 8 March, the Chancellor of the Exchequer announced £325 million of new capital funding for STPs. The investment will be allocated to the ‘strongest’ STPs and will be spread over three years, with further funding to be considered in the autumn.³⁵ While this additional funding is welcome, we agree with those who have described this as falling short of what is required, given the significant amount of new capital investment that the plans are likely to need over the next five years, which has been estimated at around £10 billion.³⁶ There is a real risk that the funds which will be made available to STPs will be swallowed up by efforts to sustain local services instead of transforming them.
54. In its recent report on the progress of STPs, *Sustainability and transformation plans, from ambitious proposals to credible plans* (February 2017), The King’s Fund concluded that:

“The context in which STPs have emerged is much more challenging than when the Forward View was published, with the NHS now facing huge financial and operational pressures. The changes outlined in STPs could help address these pressures, but there is a risk that work to sustain services will crowd out efforts to transform care.”³⁷

33 Written evidence from Sir Robert Naylor ([NHS0181](#))

34 [Q 26](#) (Richard Murray)

35 HM Treasury, *Spring Budget 2017* (March 2017), p 48: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/597467/spring_budget_2017_web.pdf [accessed 28 March 2017]

36 The Health Service Journal, ‘Leading STPs to get ‘very modest’ £325 million capital funding’ (8 March 2017): <https://www.hsj.co.uk/sectors/commissioning/leading-stps-to-get-very-modest-325m-capital-funding/7016338.article> [accessed 28 March 2017]

37 The King’s Fund, *Delivering sustainability and transformation plans From ambitious proposals to credible plans* (21 February 2017): https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/STPs_proposals_to_plans_Kings_Fund_Feb_2017_0.pdf [accessed 28 March 2017]

Lack of engagement

55. For place-based commissioning to work, NHS organisations will need to work closely with local partners including local authorities, the voluntary sector and the public. The Local Government Association told us that “It is vital that time is invested in engaging councillors and MPs in the development stage of Sustainability and Transformation Plans, to ensure that communities’ wishes are understood, and to minimise the likelihood of challenge or delay to proposals.”³⁸
56. We were therefore concerned to hear reports that in some STPs areas there has been a lack of engagement with councillors and communities in the planning process. The King’s Fund research on the progress of STPs highlighted that engagement with local authorities had been patchy, stating that “The strength and depth of local authority involvement in the plans has varied between STP footprints, ranging from strong involvement in decision-making and planning to very weak involvement in all aspects of the process.”³⁹
57. We also received evidence demonstrating a lack of public involvement in these developments. The Chief Executive of the Patients Association, Katherine Murphy, told us that, regarding STPs:
- “... the public were not consulted on what services should be provided in their local communities. The public are very willing to become involved. They want to be involved; they want to be consulted and talked to and given the correct information. They would like to be involved in an open, transparent and meaningful way. They understand the reasons why services have to be cut within the NHS. What they fail to understand is why such major plans are being drawn up without any consultation with patients and the public.”⁴⁰
58. **We applaud the move towards more place-based commissioning which delivers integrated health and social care services. At this early stage it would be premature to make a judgement about the current effectiveness of Sustainability and Transformation Plans but we doubt the ability of a non-statutory governance structure to secure sustainable change for the medium and longer term. NHS England, with the support of the Department of Health, should ensure that all 44 Sustainability and Transformation Plan areas have robust governance arrangements in place which include all stakeholders, including NHS organisations, local government, the voluntary sector and the public.**
59. **We are concerned by the reported lack of engagement with either local authorities or the wider public in the preparation of Sustainability and Transformation Plans. This will deter buy-in at a local level and jeopardise ongoing political support.**

38 Written evidence from the Local Government Association ([NHS0125](#))

39 The King’s Fund, *Sustainability and transformation plans in the NHS, How are they being developed in practice?* (November 2016), p 34: https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/STPs_in_NHS_Kings_Fund_Nov_2016_final.pdf [accessed 28 March 2017]

40 [Q 179](#) (Katherine Murphy)

Devolution

60. In addition to STPs, we heard evidence about initiatives to devolve more responsibility for health and social care to local areas as another way of encouraging bespoke local solutions to service transformation. We heard evidence from individuals involved in perhaps the most high profile of these devolution projects—the devolution of health and social care spending to Greater Manchester—which is outlined in more detail in Box 2.

Box 2: Greater Manchester Health and Social Care Devolution

The Greater Manchester Agreement, signed in November 2014, set out new powers over transport, housing, planning and policing for the Greater Manchester Combined Authority.

In April 2016 the region became the first in the country to take control of its combined health and social care budgets. Following the signing of a memorandum of understanding Greater Manchester now controls the full devolution of a budget of around £6 billion in 2016/17.

A new strategic board, the Greater Manchester Health and Social Care Partnership, was created to take charge of the £6 billion health and social care budget. The Partnership comprises 37 NHS organisations and councils, including:

- 10 local authorities;
- 12 clinical commissioning groups; and
- 15 trusts and foundation trusts.

Source: Greater Manchester Health and Social Care Partnership, *Taking charge of our Health and Social Care in Greater Manchester* (December 2015): <http://www.gmhsc.org.uk/assets/GM-Strategic-Plan-Final.pdf> [accessed 28 March 2017]

61. Sir Howard Bernstein, Chief Executive of Manchester City Council, told us how devolution of health was working there:

“We are seeking to join up community services with social care, mental health and primary care in order to provide the integrated offer that is necessary, not only to support a transformation in our population’s health through prevention and early intervention but in effect, to reduce the demand for services in our hospitals. That is how we see this strategy.”⁴¹

62. There were, however, doubts expressed as to how well the Greater Manchester example could be rolled out in other areas⁴². Baroness Cavendish of Little Venice told us:

“Manchester is I’m afraid unique. I don’t think there is any other part of this country that has the same constellation of talent in terms of the NHS and local authorities. I don’t believe there is anywhere else that has the same political impetus because it is essentially a political construct so what we are doing at the moment is we are basing our aspiration for STPs upon a hope that politicians in local areas will be able to come together in a way they are doing in Manchester. I think it would be very foolish to expect anyone else to adopt the Manchester model.”⁴³

41 [Q 225](#) (Sir Howard Bernstein)

42 [Q 41](#) (Michael Macdonnell), [Q 251](#) (Chris Wormald), [Q 266](#) and [Q 269](#) (Baroness Cavendish of Little Venice), [Q 284](#) (Simon Stevens) and [Q 316](#) (Mark Britnell)

43 [Q 226](#) (Baroness Cavendish of Little Venice)

63. **The evidence was mixed on the contribution of devolution to the long-term sustainability of health and social care. There are undoubtedly lessons to be learnt from devolution, but the evidence was not clear on how well the model in Greater Manchester could be replicated nationally especially as many, if not most, of the Sustainability and Transformation Plans (STPs) are for much smaller populations than that of Greater Manchester.**

Achieving service transformation

64. Current efforts on service transformation have largely prioritised the changes which need to be made to ensure existing services in the community are used more effectively to moderate demand for hospital care,⁴⁴ and changes to improve the integration of health and social care services to provide more comprehensive and joined-up care to patients.
65. The necessary service transformation is happening but belatedly and, we fear, at an inadequate scale and pace. Efforts to transform the way care is delivered are being seriously hindered by the fragmented nature of the current governance system and a considerable degree of uncertainty over who is responsible for driving service transformation as distinct from current service delivery.

Changes to models of care

Primary and community care

66. The Five Year Forward View states that primary care will remain “the foundation of NHS care.”⁴⁵ However, we received a considerable amount of evidence on the current pressures within primary care, and the resulting impact of those pressures on other parts of the system.
67. The Royal College of General Practitioners highlighted the most pressing issues facing general practice:
- Despite an increase in demand, investment in general practice has declined. Since 2005/06 the level of investment in general practice as a proportion of the NHS budget has declined from 10.7% to a record low of 8.4% in 2011/12.
 - The failure of GP recruitment to keep pace with demand is set to leave a shortfall of 9,940 GPs across the UK by 2020.
 - Retention of GPs is also a problem. The College has identified 594 practices across the UK where 75% of the GPs are aged 55 and over— with the retirement of so many GPs a present danger for these practices, the College has identified them as being at risk of closure by 2020. Nationwide, the proportion of GPs aged 55 or over in 2015 was 20.8% in England, 19.9% in Scotland, 23% in Wales and 25.2% in Northern Ireland.

44 The King’s Fund, *Delivering sustainability and transformation plans, From ambitious proposals to credible plans* (February 2017): https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/STPs_proposals_to_plans_Kings_Fund_Feb_2017_0.pdf [accessed 28 March 2017]

45 NHS England, ‘Five Year Forward View’: <https://www.england.nhs.uk/ourwork/futurenhs/nhs-five-year-forward-view-web-version/5yfv-ch3/> [accessed 28 March 2017]

- The ratio of practice nurses is failing to keep pace with increased demand and complexity with 2.7 Full Time Equivalent nurses for every 10,000 patients in England in 2014/15, the same ratio as in 2010/11. As well as this, the practice nurse workforce is ageing, with 31% of practice nurses aged 55 or over in 2014/15.⁴⁶
68. These challenges are frustrating efforts to deliver more care in primary and community settings in order to reduce pressures in the acute sector. There were concerns that the current longstanding model of primary care is not fit for the purpose of delivering the desired shift away from the acute sector. We heard that there has been historic and damaging underfunding of the primary care sector, as highlighted in NHS England's *General Practice Forward View*, which stated that over the past ten years governments have "cut the share of funding for primary care and [grown] the number of hospital specialists three times faster than GPs." This has had an impact on GP workload and added to "growing patient concerns about convenient access."⁴⁷ A clear message from the evidence was that the model of primary care required urgent reform to deliver the required service transformation. The *General Practice Forward View* acknowledged this, highlighting a report by the Primary Care Foundation and the NHS Alliance, which stated that:
- "The strength of British general practice is its personal response to a dedicated patient list; its weakness is its failure to develop consistent systems that free up time and resources to devote to improving care for patients. The current shift towards groups of practices working together offers a major opportunity to tackle the frustrations that so many people feel in accessing care in general practice."⁴⁸
69. We found broad support for the new Multispecialty Community Provider care model and, in particular, the move towards GP practices working at scale to deliver extended services through federations. Dame Julie Moore, Chief Executive of University Hospitals Birmingham NHS Foundation Trust, told us:
- "... the model that we expect them [GPs] to operate sometimes is no longer fit for this day and age. The demands placed on primary care are huge and demand is outstripping that. We need to look at new models of primary care and how we work more closely together in 24-hour services and actually relieve some of the pressure ... we can only do that by working in bigger centres, working together and providing round-the-clock access that patients now need. I think we need to look again at the whole model of provision."⁴⁹
70. Similarly, Chris Hopson, Chief Executive of NHS Providers, suggested that:
- "... there is a widespread agreement that the 1948-bequeathed structure of a bunch of single-handed practices led by individual GPs is unable to provide the kind and scale of primary care that we now need, and there is a rapidly growing development where people are coming together in GP federations which make it easier and more effective to then link up all these different parts of health and social care."⁵⁰

46 Written evidence from the Royal College of General Practitioners (NHS0078)

47 NHS England, *General Practice Forward View* (April 2017): <https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf> [accessed 28 March 2017]

48 Primary Care Foundation and NHS Alliance, *Making Time in General Practice* (October 2015): <http://www.nhsalliance.org/wp-content/uploads/2015/10/Making-Time-in-General-Practice-FULL-REPORT-01-10-15.pdf> [accessed 28 March 2017]

49 Q 174 (Dame Julie Moore)

50 Q 92 (Chris Hopson)

71. The suitability of the current independent contractor status of most GPs was questioned. Dr Clare Gerada, General Practitioner and former Chair of the Royal College of General Practitioners, suggested this arrangement “was not fit for purpose.”⁵¹ Sir Sam Everington, Chair of the NHS Tower Hamlets clinical commissioning group, suggested that this could be resolved by considering local contracts: “If you are to shift that care out of hospital with ... different solutions around the country, you have to come up with locally sensitive contracts to make that happen.”⁵²
72. The Chair of the Royal College of General Practitioners, Dr Helen Stokes-Lampard, agreed: “We all have to be realistic about what the future holds, and, whilst personally I love the partnership-led model of general practice, I know it is not likely to be fit for the long-term future and that we have to have local solutions for local problems.”⁵³
73. Lord Darzi of Denham also commented on the contractual arrangements within general practice:
- “What we got wrong in the original polyclinic ... is that we described what this looked like, a federation, but we never really looked at the business model. In the NHS we are not good at business model innovation. We look at technological process innovation, but there are many business models that you can use to ignite the interest in primary care, whether they are partnership or employment models. We have to understand that the primary care community and leadership are also very divided; we can stratify them into those who would like employment contracts and those who would like to build partnerships.”⁵⁴
74. Despite a clear move from GPs in some areas towards operating in federations, there appeared to be little support or direction from the centre to drive this agenda. Beyond the Five Year Forward View, clear and determined leadership from the centre is required to identify a process for adapting the primary care model and its contractual basis to ensure it has the flexibility to meet the needs of patients in the future. It was not obvious to us who is going to provide this leadership.
75. In addition, we heard that there is a clear case for reforming the primary care workforce so that a range of other healthcare professionals such as nurses, community pharmacists and mental health counsellors can work in a team alongside GPs to support their work. Professor Maureen Baker, Former Chair of the Royal College of General Practitioners, emphasised the need for “high-level nursing skills in the community” and highlighted the suggestion of “a model used in the US where you have colleagues who support the doctor in doing a lot of admin, form filling and basic clinical tasks.” Professor Baker stated that: “We are saying we need this range of skills, we need GPs—we need as many GPs as we can get—and we need other colleagues to work so that they have the right workforce with the skills that 21st century patients need in the community.”⁵⁵

51 [Q 187](#) (Dr Clare Gerada)

52 [Q 187](#) (Sir Sam Everington)

53 [Q 209](#) (Dr Helen Stokes-Lampard)

54 [Q 267](#) (Lord Darzi of Denham)

55 [Q 188](#) (Professor Maureen Baker)

76. ***The traditional small business model of general practice is no longer fit for purpose and is inhibiting change. NHS England, with the help of the Department of Health and the profession, should conduct a review to examine alternative models and their contractual implications. The review should assess the merits of engaging more GPs through direct employment which would reflect arrangements elsewhere in the NHS.***

Secondary care

77. Over-reliance on the acute sector is a serious threat to the financial sustainability of health and care services. NHS Clinical Commissioners told us: “We are concerned that without a significant reduction in expensive hospital activity and a transformation in health and care delivery that makes better use of available resources the NHS will be unable to adequately respond to changing population needs.”⁵⁶
78. Those secondary care hospitals which serve towns and small conurbations provide a range of services for their local populations and face different sets of problems from specialised hospitals or units. In providing acute surgical, orthopaedic, medical and obstetric care for seriously ill patients, many of whom enter through A&E Departments, their facilities are vulnerable to being overwhelmed by patients with long-term care needs that are not being met by community services. Such hospitals house expensive diagnostic and therapeutic resources, such as imaging and operating theatres, and these may be used inefficiently when patients remain in hospital unnecessarily, reducing the availability of beds for other patients in need. There is also ongoing concern around levels of productivity within this sector, as highlighted by the Carter Review.⁵⁷
79. The continued pressures on the acute hospital inpatient sector require a reshaping of secondary care to meet the needs of an increasingly ageing population. Many of these people live with multiple chronic conditions and are increasingly finding themselves being cared for in high-cost and inappropriate hospital settings.
80. ***We acknowledge that over-reliance on the acute hospital inpatient sector is a serious threat to the financial sustainability of health and care services. This sector should be radically reshaped in terms of service provision but changes to the number, size and distribution of secondary care services should always reflect the needs of the local population. Any changes should take place following a broad consultation.***

Specialised services

81. A number of witnesses highlighted examples in the NHS where some specialised services, such as for cancer or cardiac surgery, had been concentrated into fewer hospitals to improve the quality of care, efficiency and effectiveness. It was suggested that further consolidation of specialised services should be a key consideration for future service transformation.

56 Written evidence from NHS Clinical Commissioners ([NHS0159](#))

57 Lord Carter of Coles, *Operational productivity and performance in England NHS acute hospitals: Unwarranted variations, An independent report for the Department of Health by Lord Carter of Coles* (February 2018): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf [accessed 28 March 2017]

82. Specialised and highly specialised hospitals tend to be found in large city conurbations. Although there is a danger of duplication from services located within relatively short distances of each other, there is little doubt that focusing such expensive specialised services in specific areas ensures high levels of expertise and care. The success of centralising services that dealt with stroke, trauma and heart attacks was highlighted. Sir Cyril Chantler, an eminent paediatrician, highlighted the provision of centralised, specialised services in London, stating that: “London has gone from being one of the more dangerous capital cities in which to have a stroke to perhaps the safest.”⁵⁸
83. Professor Andrew Street, from the Centre of Health Economics at the University of York, expressed disappointment that there had been a missed opportunity for further service transformation over the last 10 to 15 years, but cited the consolidation of specialised services as a success:
- “You mentioned in the previous session the development of treatment centres as a different model of delivering care; small, self-contained, specialising in particular treatments, and although they were expensive to set up in the first place, they now tend to deliver high-quality care at a lower cost, with lower lengths of stay and better outcomes for patients, than they would if they had gone through the normal run of the hospital sector.”⁵⁹
84. The Specialised Healthcare Alliance, however, warned that there was still work to be done and that further progress on consolidation of specialised services was being impeded by a number of issues:
- “... attempts to reconfigure specialised care provision have typically met competing provider interests, political interventions and regulatory barriers preventing service change. Challenges such as these have historically stymied progress towards specialised services consolidation.”⁶⁰
85. **The drive to consolidate specialised services is a necessary part of overall service transformation. However, as with primary care, we were left with no clear picture of how specialised service consolidation will be delivered in the medium and the longer term.**
- Integrating health and social care*
86. For the most part, in England, health and social care services are separate. NHS England is responsible for healthcare and local authorities are responsible for means-tested social care. With the population ageing and the prevalence of long-term conditions and co-morbidities increasing, more and more patients require both health and social care. The separation between the two is becoming increasingly problematic.
87. Improved integration between health and social care services is often put forward as a way of reducing costs, easing the pressure on commonly-used services and delivering a better overall experience for patients.⁶¹ NHS

58 Written evidence from Sir Cyril Chantler ([NHS0187](#))

59 [Q 80](#) (Professor Andrew Street)

60 Written evidence from the Specialised Healthcare Alliance ([NHS0042](#))

61 National Collaboration for Integrated Care and Support, *Integrated Care and Support: Our Shared Commitment* (May 2013), p 1: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198748/DEFINITIVE_FINAL_VERSION_Integrated_Care_and_Support_-_Our_Shared_Commitment_2013-05-13.pdf [accessed 28 March 2017]

England's approach to integration policy uses the following definition of integrated care:

“... person-centred, coordinated, and tailored to the needs and preferences of the individual, their carer and family. It means moving away from episodic care to a more holistic approach to health, care and support needs, that puts the needs and experience of people at the centre of how services are organised and delivered.”⁶²

Progress on integration

88. In England, recent policy efforts have been focused on encouraging local areas to co-ordinate resources and enabling financial integration between health and social care services. In April 2015 the Government launched the Better Care Fund, a joint initiative between the Department of Health, the Department for Communities and Local Government, NHS England and the Local Government Association. The Fund requires local health bodies and local authorities in each area to pool funding, a minimum of £3.8 billion in 2015/16 and £3.9 billion in 2016/17. Local bodies are required to produce joint plans for integrating services and to submit these plans to NHS England. Many areas chose to go beyond the minimum pooled funding requirements, resulting in a total of £5.3 billion being pooled in 2015/16 and £5.8 billion in 2016/17.⁶³
89. A recent report by the National Audit Office (NAO) cast doubt on the effectiveness of the Government's plan for integrated health and social care services. While it acknowledged that the Fund had been successful in incentivising local areas to work together, with more than 90% of local areas agreeing or strongly agreeing that the delivery of their plan had improved joint working, the NAO report was clear that the Government's policy on integration had not delivered on its ambitions of releasing savings, reducing emergency admissions and delayed discharges and, crucially, delivering better outcomes for patients. The report concluded:
- “... progress with integration of health and social care has, to date, been slower and less successful than envisaged and has not delivered all of the expected benefits for patients, the NHS or local authorities. As a result, the government's plan for integrated health and social care services across England by 2020 is at significant risk.”⁶⁴
90. Although the NAO's report was published after we had finished taking evidence, many of the witnesses conveyed the same sense that, despite a long history of initiatives aimed at joining up health and social care services, progress had been incredibly slow. Some witnesses presented the difficulty of integrating budgets as almost insurmountable; system-wide integrated services were still very far from being a reality. Integration policy has been discussed for decades but it was clear from the evidence that there was a degree of frustration at the lack of progress on the integration of either funding or service delivery.

62 NHS England, 'Integrated care and support': <https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/> [accessed 28 March 2017]

63 The National Audit Office, *Health and social care integration* (Session 2016–17, HC 1011)

64 National Audit Office, Press Release: 'Health and social care integration', 8 February 2017: <https://www.nao.org.uk/press-release/health-and-social-care-integration/> [accessed 28 March 2017]

91. Many of the sources of evidence were in agreement that better integration of health and social care services would support improved patient experience. Chris Hopson told us that: “What it [integration] does relatively quickly, it seems, is produce a better quality of patient and service-user experience.”⁶⁵ What was less clear was whether integration offered the potential for substantial cost savings. Dr Edward Scully, Deputy Director, Integrated Care at the Department of Health, told us:

“My own take is that the potential for savings through integration of health and social care is not what people have set out; it is more limited. It is not a utopia or a panacea for releasing savings.”⁶⁶

92. Despite the uncertainty over the direct financial savings that might be released through improved integration, it is nonetheless viewed as a vital element of service transformation. Overcoming the barriers to improved integration will be central to securing the long-term sustainability of both health and care services. Dr Sarah Wollaston MP, Chair of the House of Commons Health Select Committee, told us:

“I think that if we continue to have a very fragmented model we will be missing many opportunities to commission much more logically for health and social care ... By having separated, fragmented systems for health and social care, we are wasting energy and money and are not meeting people’s needs, so I think that should be a clear priority for the future.”⁶⁷

93. The complex and fragmented organisational arrangements of health and care services are making the integration of services much more difficult. With budgets and staff in different organisations, coherent governance of, and accountability for, service transformation is extremely challenging. Sir Cyril Chantler described an “overall strategic uncertainty” which was apparent to us in the lack of clarity over who was primarily responsible for securing service integration as part of wider service transformation.⁶⁸ For too long integration has seemed everybody’s responsibility and nobody’s responsibility.

94. **Although recent efforts to promote joined-up health and social care services have delivered mixed results, integrated health and social care with greater emphasis on primary and community services still presents the best model for delivering patient-centred, seamless care. Although there is disagreement on the financial gains to be derived from this integration, the benefits to patients are a clear justification for continuing to pursue this agenda.**

Challenges to integration

95. The Health and Social Care Act 2012 introduced wide-ranging reforms to the NHS which included a radical restructuring of the health system. The Act established a new executive non-departmental public body called NHS England, to oversee the budget, planning and delivery of the commissioning side of the NHS; clinically led statutory NHS bodies (clinical commissioning groups) responsible for planning and commissioning of health care services

65 [Q 96](#) (Chris Hopson)

66 [Q 13](#) (Dr Edward Scully)

67 [Q 291](#) (Dr Sarah Wollaston MP)

68 Written evidence from Sir Cyril Chantler ([NHS0187](#))

locally; established Public Health England and Healthwatch England; and introduced provider regulation on competition issues, overseen by Monitor, which was later merged with other organisations under an umbrella organisation as NHS Improvement.

96. Many witnesses suggested that the restructuring of the system by the Health and Social Care Act 2012 had resulted in an extensive fragmentation of services. This, witnesses argued, was continuing to act as a serious impediment to devolution, integration and new ways of working. The Centre for Health and the Public Interest suggested that the Act's provisions were frustrating the current efforts on service transformation, stating that:

“The Five Year Forward View’s central aim is better integration of the NHS. But the provisions of the Health and Social Care Act of 2012 are aimed at promoting competition, the opposite of integration. In trying to achieve the aims of the [Five Year Forward View] commissioners and providers have to ‘work around’ the Act, working against its aims but in conformity with its legal provisions. Planning is thus being undertaken by ad hoc groups of local commissioners and providers working outside any legal framework and doing only what the Act does not explicitly forbid. Informal and unaccountable government of this kind tends to produce bad policies as well as being prone to conflicts of interest and corruption.”⁶⁹

97. Similarly the PHG Foundation suggested that the Health and Social Care Act 2012 had made service transformation and an integrated approach to delivering care harder to achieve, as:

“... the financial and organisational independence of hospital trusts (reinforced by the Health and Social Care Act 2012) results in misaligned incentives to compete, not co-operate and to a drive to develop ‘distinctive’ services rather than learn from and adopt best practice developed elsewhere.”⁷⁰

98. The King’s Fund recently highlighted, in its report *Delivering sustainability and transformation plans*, that amendments were needed to the aspects of the Act that were not aligned with the aims of the Five Year Forward View and STPs. It suggested that:

“The sections of the Act relating to market regulation would particularly benefit from review, both in relation to the role of the CMA [Competition and Markets Authority] and requirements on commissioners to use competitive processes in procuring new care models. There is also a need to recognise more formally the role that STPs are expected to play alongside the boards of NHS organisations and local authorities.”⁷¹

99. **The Health and Social Care Act 2012 has created a fragmented system which is frustrating efforts to achieve further integration and the service transformation aims of the Five Year Forward View.**

69 Written evidence from the Centre for Health and the Public Interest ([NHS0050](#))

70 Written evidence from the PHG Foundation ([NHS0080](#))

71 The King’s Fund, *Delivering sustainability and transformation plans From ambitious proposals to credible plans* (21 February 2017): https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/STPs_proposals_to_plans_Kings_Fund_Feb_2017_0.pdf [accessed 28 March 2017]

100. *NHS England and the Department of Health should launch a public consultation on what legislative modifications could be made to the Health and Social Care Act 2012 which would remove the obstacles to new ways of working, accelerate the desired service transformation and secure better governance and accountability for achieving system-wide integrated services.*
101. **Service transformation is dependent on long-term planning, broad consultation, appropriate systems of governance and local accountability. The model of primary care will need to change, secondary care will need to be reshaped and specialised services consolidated further. Importantly, a renewed drive to realise integrated health and social care is desperately needed. However, the statutory framework is frustrating this agenda and in order for real progress to be made the national system is in need of reform to reduce fragmentation and the regulatory burden.**
102. *With policy now increasingly focused on integrated, place-based care we see no case for the continued existence of two separate national bodies and recommend that NHS England and NHS Improvement should be merged to create a new body with streamlined and simplified regulatory functions. This merged body should include strong representation from local government.*

CHAPTER 3: WORKFORCE

103. Those who work in the NHS and adult social care are the lifeblood of the organisations they serve. The NHS is dependent on a reliable supply of appropriately skilled and highly motivated individuals to meet the ever increasing demand for care. The NHS website described the scale of the current workforce of the NHS in England as follows:

“The NHS employs more than 1.5 million people, putting it in the top five of the world’s largest workforces ... The NHS in England is the biggest part of the system by far, catering to a population of 54.3 million and employing around 1.2 million people.”⁷²

It is estimated that some two-thirds of the health service budget goes on salaries and wages for staff.⁷³ However, the Association of Directors of Adult Social Services (ADASS) reminded us that there are more employed in adult social care than there are in the NHS.⁷⁴

104. Changing models of care require a flexible workforce that can adapt to new ways of working, but appropriate training and a healthy morale are critical if this workforce of the future is to be delivered. This chapter will look at issues such as planning, skill mix and training and the relationship between regulation, pay and morale.

Workforce strategy

The aspiration

105. Like any large organisation, workforce planning in the NHS is critical. The length of time and investment required to educate certain medical professionals means that this planning must take place over a long timeframe. An accurate estimation of future demand is also important. The Five Year Forward View summarises this critical requirement:

“Health care depends on people—nurses, porters, consultants and receptionists, scientists and therapists and many others. We can design innovative new care models, but they simply won’t become a reality unless we have a workforce with the right numbers, skills, values and behaviours to deliver it.”⁷⁵

106. The content relating to workforce in the Five Year Forward View is a positive step forward and the leadership shown by the Chief Executive of NHS England, Simon Stevens, should be applauded in this regard. The document speaks of moving away from a more specialised workforce towards a more holistic clinical approach and the need to move to more community-based working. It also acknowledges the need to plug the skills gap in the workforce, to invest more in training and to help employees work across organisational and sector boundaries. Future-proofing the workforce is also highlighted

72 NHS, ‘The NHS in England: About the National Health Service (NHS)’: <http://www.nhs.uk/NHSEngland/thenhs/about/Pages/overview.aspx> [accessed 28 March 2017]

73 NHS Improvement, *Submission to the NHS Pay Review Body and the Review on Doctors’ and Dentists’ Remuneration* (September 2016): https://improvement.nhs.uk/uploads/documents/NHS_Improvement_submission_to_DDRB_and_NHS_PRB_Sept_2016.pdf [accessed 28 March 2017]

74 Written evidence from The Association of Directors of Adult Social Services (ADASS) (NHS0072)

75 NHS England, *Five Year Forward View* (October 2014), pp 29–30: <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf> [accessed 28 March 2017]

and the Five Year Forward View references the Shape of Training Review⁷⁶ for the medical profession and the Shape of Caring Review⁷⁷ for nursing, both of which sought to reform the way in which the workforce is trained.

A sound evidence base

107. A robust evidence base projecting future demand is required if workforce planning is to be carried out in a reliable manner. Gavin Larner, Director of Workforce at the Department of Health, described a piece of work called Horizon 2035⁷⁸ which was commissioned by the Department. He outlined the work of the project as follows:

“It has been trying to extend the global factors ... to see what the position will look like in the mid-2030s. A team of economists has been looking quite carefully at the evidence base. It concludes that, with the ageing population and the further spread of chronic disease through all age groups—beyond just older age groups—an estimated 3 billion extra care hours will be needed by 2035 and demand for care could rise twice as fast as population by that time. Its conclusion based on that is that you will need a lot more [lower paid staff] than we currently have, to cope ...”⁷⁹

108. The challenges posed by this demographic trend are well understood and reliable data to illustrate the ageing population is readily available, as described in Chapter 2. However, despite this, we were told that no workforce costings associated with this demographic trend had been calculated.⁸⁰ This compartmentalised and silo-thinking mentality emerged as a general theme from the evidence we received. The move to a unified vision for the medium-term in the Five Year Forward View was, undoubtedly, a positive development when it was published in 2014. But from the evidence we received, a longer-term, centralised strategy which joined-up workforce planning with other challenges faced by the NHS, such as financial sustainability and the adoption of new technologies, for example, appeared to be absent. In fact, we received no evidence to suggest that workforce planning was linked to financial planning in any meaningful way at all. This appeared to be because longer-term financial planning or service planning was not taking place at all or because there were conflicting interests within the bodies controlling the limited workforce planning that was taking place.⁸¹ For example, there was a clear conflict between the desire of Health Education England (HEE) to educate and train more staff and the opposing objective of NHS Improvement to seek cost reductions wherever possible.

76 The Shape of Training Review, also known as ‘The Greenaway Report’, looked at potential reforms to the structure of postgraduate medical education and training across the UK. Shape of Training, *Shape of Training: Securing the future of excellent patient care* (October 2013): http://www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf [accessed 28 March 2017]

77 The Shape of Caring Review, also known as ‘Raising the Bar’, looked at how to ensure that throughout their careers nurses and care assistants receive consistent high quality education and training to support high quality care. Health Education England, *Raising the Bar: Shape of Caring: A Review of the Future Education and Training of Registered Nurses and Care Assistants* (March 2015): <https://www.hee.nhs.uk/sites/default/files/documents/2348-Shape-of-caring-review-FINAL.pdf> [accessed 28 March 2017]

78 This report highlighted interim findings from Horizon 2035, a piece of work commissioned by the Department of Health to consider how a series of challenges and opportunities may combine in the future and impact the health, public health and social care workforce. Centre for Workforce Intelligence, *Horizon 2035 – Future demand for skills: initial results* (August 2015): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/507498/CfWI_Horizon_2035_Future_demand_for_skills.pdf [accessed 28 March 2017]

79 Q 4 (Gavin Larner)

80 Q 7 (Gavin Larner)

81 Q 26 (Dr Jennifer Dixon)

Health Education England

109. HEE is a non-departmental public body and its website describes its core purpose as follows:

“Health Education England (HEE) exists for one reason only: to support the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place.”⁸²

110. Professor Ian Cumming, Chief Executive of HEE, told us about the importance of joined-up planning:

“... you need to make sure the service and workforce planning are properly joined-up, so we need commissioners’ intentions aligned with those who will be delivering the service, aligned with workforce planning. We also need to recognise that workforce planning has to be a very long-term strategy ... Of course, medical students entering university this year will become consultants in about 13 to 15 years, so the plans we are making at the moment on the numbers entering medical school will not have an impact on the workforce until 2030–31. We have produced a document called Framework 15, which takes a 15-year forward look, specifically designed around the medical workforce, to ask what we believe patients’ needs will be in 15 years’ time, and how we make sure that we are training doctors and other healthcare professionals to work in that timescale and not training people to work in the health service that we have today—because it will look very different.”⁸³

111. The evidence we received outlining the ongoing work within HEE was encouraging, but we were not presented with any examples of the body being able to influence a shift in the allocation of financial resources to make workforce planning a reality, or any evidence that the Department of Health was providing leadership in this area. Indeed, instead of workforce planning which was based on sound demographic data driving expenditure, short-term thinking seemed to be a real driver of supply. The Government frequently repeat that they have secured 9,500 more doctors and 6,900 more nurses since 2010, a flagship feature of the 2015 Conservative Party Manifesto,⁸⁴ but there is no evidence to suggest that these numbers were agreed to meet an identified demand based on specific demographic data or calculations. Dr Sarah Wollaston MP, the Chair of the House of Commons Health Select Committee, was disappointed to note that HEE’s budget had been cut in real terms, and we echo this sentiment.⁸⁵

82 Health Education England, ‘About us’: <https://www.hee.nhs.uk/about-us> [accessed 28 March 2017]

83 [Q 130](#) (Professor Ian Cumming)

84 The Conservative Party, *The Conservative Party Manifesto* (2015), p 38: <https://s3-cu-west-1.amazonaws.com/manifesto2015/ConservativeManifesto2015.pdf> [accessed 28 March 2017]

85 [Q 287](#) (Dr Sarah Wollaston MP)

112. The failure to prioritise workforce planning can result in gaps in the current workforce. Candace Imison, Director of Policy at the Nuffield Trust, told us that if this trend continued “there will be very obvious gaps in the medical workforce.”⁸⁶ The Royal College of Physicians told us of the increasing prevalence of consultants covering gaps in trainee rotas and that “together with a shortage of nurses, this has left our hospitals chronically understaffed. This increases pressure on NHS staff, impeding morale and puts patient care at risk.”⁸⁷ According to Mind, almost half of community mental health teams had staffing levels judged to be less than adequate in 2013–14.⁸⁸ The Royal College of Midwives told us that they have:

“... used the Birthrate Plus methodology to assess the adequacy of the size of the midwifery workforce; our current assessment is that midwifery services in England are 3,500 [whole time equivalent] midwives short of what would be needed to ensure that every woman could receive 1:1 midwifery care in labour, as clinically recommended.”⁸⁹

Workforce gaps are clearly a continuing case for concern, both in the NHS and in the adult social care sector. Skills for Care is an independent charity in receipt of public funds which is largely responsible for supporting organisations to develop their adult social care workforce in England. Care England argued that HEE should be given a role in social care workforce planning too: “In order to protect long-term NHS sustainability, HEE must start planning for the social care workforce now ...”⁹⁰

Overseas workers and Brexit

113. The NHS and social care workforce draws on global talent and relies on a steady stream of immigration. The Recruitment and Employment Confederation told us that:

“The latest data from the Health and Social Care Information Centre (June 2016) reports that 57,608 staff employed in NHS Trusts and Clinical Commissioning Groups in England declare their nationality to be from a European Union member state—71,510 staff are from non-EU member states; collectively accounting for around 11% of all staff ... A similar picture is found in social care—Skills for Care (2015): *The State of the Adult Social Care Sector and Workforce in England*—reports that 5% of adult social care staff are from EU countries and 11% are from non-EU countries.”⁹¹

114. Because of the long-established dependence on overseas recruitment, there was considerable anxiety expressed about the impact of the United Kingdom’s exit from the European Union and the prospect of tighter immigration rules.⁹² There is a strong case in the short term for the Government to do all it can to reassure those who may be affected by the United Kingdom’s exit from the

86 [Q 152](#) (Candace Imison)

87 Written evidence from the Royal College of Physicians ([NHS0065](#))

88 Written evidence from Mind ([NHS0179](#))

89 Written evidence from the Royal College of Midwives ([NHS0067](#))

90 Written evidence from Care England ([NHS0089](#))

91 Written evidence from the Recruitment and Employment Confederation ([NHS0052](#)) and Skills for Care, *The state of the adult social care sector and workforce in England* (March 2015): <http://www.skillsforcare.org.uk/Document-library/NMDS-SC,-workforce-intelligence-and-innovation/NMDS-SC/State-of-2014-ENGLAND-WEB-FINAL.pdf> [accessed 28 March 2017]

92 [Q 132](#) (Danny Mortimer), [Q 160](#) (Dr Mark Porter), [Q 171](#) (Dame Julie Moore) and [Q 288](#) (Dr Sarah Wollaston MP)

European Union to mitigate against an exodus of overseas workers. In the longer term, the Government should go to greater lengths to secure a reliable supply of well-trained professionals and other health and social care workers from within this country.

115. Professor Ian Cumming told us about the reliance on overseas workers:

“From our perspective, we believe that, as the fifth-largest economy in the world, we have a moral duty to produce the healthcare workforce that we require for our National Health Service, and we should not be reliant on recruiting from other countries. That is absolutely not the same as saying that we do not welcome the opportunity for people from other countries to come and learn here and work with us.”⁹³

116. Independent Age called on the Government to ensure that all EEA migrants currently working in social care in the UK had the right to remain post-Brexit and that any future migrant social care workers were appropriately recognised in any new approach to migration. They outlined the potential consequences of a workforce gap in the social care sector:

“The implications of a social care workforce gap of between 350,000 and 1.1 million workers for older and disabled people are clear—far fewer will be able to access the care they need to live meaningful, independent lives.”⁹⁴

117. We were encouraged that this aspiration was expressed by the Secretary of State for Health:

“I would say that workforce planning is an area where we have failed, and successive governments have failed to get this right. Brexit will be a catalyst to get this right, because we are going to be standing on our own two feet and we will have to start thinking much harder without the automatic access to the European labour pool that we have taken for granted for many years. That is an area where we need to be much more strategic than we have been. Being able to announce 1,500 medical places is only a start, but that was four months after the Brexit vote. I think that shows there is a serious effort going into being more strategic in our workforce planning, but there is lots more to do.”⁹⁵

118. He also said:

“... if, as I suggest to you, over the coming decades we will need to spend a greater proportion of our GDP on health and social care, we will need more doctors and nurses. Doctors take six years to train and nurses take three years to train, and we need to start thinking about that now, because the truth is, even while we are in the EU and we can import as many doctors and nurses as we wish from EU countries without restrictions, we still have rota gaps; we still cannot find enough of them, because every country is facing the same problem. One of the most important reasons for taking a longer-term view is to be able to be more strategic about our workforce planning.”⁹⁶

93 [Q 132](#) (Professor Ian Cumming)

94 Written evidence from Independent Age ([NHS0053](#))

95 [Q 313](#) (Jeremy Hunt MP)

96 [Q 303](#) (Jeremy Hunt MP)

119. **We are concerned by the absence of any comprehensive national long-term strategy to secure the appropriately skilled, well-trained and committed workforce that the health and care system will need over the next 10–15 years. In our view this represents the biggest internal threat to the sustainability of the NHS. Much of the work being carried out to reshape the workforce is fragmented across different bodies with little strategic direction from the Department of Health. Although we recognise that Health Education England has undertaken some work looking at long-term planning for the workforce, this is clearly not enough. Health Education England has been unable to deliver.**
120. *We recommend that, as a matter of urgency, the Government acknowledges the shortcomings of current workforce planning. Health Education England, both nationally and through the network of local education and training boards, should be substantially strengthened and transformed into a new single, integrated strategic workforce planning body for health and social care. This will enable it to produce and implement a joined-up place-based national strategy for the health and social care workforce, and it should always look 10 years ahead, on a rolling basis. Consideration should be given to its name to better reflect its revised function.*
121. *Health Education England’s independence should be guaranteed and supported by a protected budget with greater budgetary freedom. It will need enhanced skills and a board that includes representation from all parts of the health and care system.*
122. *Workforce strategy has been poor with too much reliance on overseas recruitment. The Government should outline its strategy for ensuring that a greater proportion of the health and care workforce comes from the domestic labour market and should report on progress against this target.*
123. *In the light of the result of the EU referendum, we recommend that the Government takes steps to reassure and retain overseas-trained staff working in the NHS and adult social care who are now understandably concerned about their future.*

Skill mix and training

Skill mix and evolving roles

124. Securing the right numbers of staff is not enough. Appropriately trained and skilled individuals are critical and, from the evidence we heard, there was broad agreement that more needed to be done to improve the education and training of the current workforce. Striking this balance between investing in a new workforce and developing the current workforce will be key. As we noted above with disappointment, the body charged with responsibility for this, HEE, has had its underlying budget cut in real terms.⁹⁷ The figures announced in the 2015 Spending Review redefined NHS spending, from what used to be the totality of the Department of Health’s budget to mean NHS England’s budget only. Other health spending not included in NHS England’s budget—for example, spending on public health, education and

training—was excluded. As The King’s Fund, the Nuffield Trust and the Health Foundation said at the time, HEE’s budget was likely to be frozen in real terms.⁹⁸

125. The way in which the workforce is trained has a direct impact on the way it functions. When questioned about the length of time it currently takes to train certain medical professionals, Professor Wendy Reid, Director of Education and Quality at HEE, spoke about work associated with the Shape of Training Review.⁹⁹ We heard from Dell EMC that some education providers required individuals to repeat training they had already completed elsewhere.¹⁰⁰ A number of organisations also highlighted the serious challenge posed by high attrition rates for trainee medical professionals.¹⁰¹ We were, therefore, pleased to hear that NHS Improvement was planning to conduct a review of the drivers of medical workforce attrition and how retention in general could be improved.¹⁰² There is also a strong case for appealing to those who have already left the workforce to return.
126. Overall, however, we were unconvinced that HEE’s work with the Royal Colleges, higher education providers and others involved in influencing the way in which the workforce is educated and continually trained was persuasive or strong enough and, from the evidence they provided, we were disappointed that they were not displaying a clear lead on radically changing the way the medical workforce is educated and trained.¹⁰³
127. We heard consistently that there was a skill mix problem with the current workforce. There was a broad recognition that the workforce of 2030 would need be different—that the skill mix would need to change—and some agreement that the NHS needed to get the balance right between generalists and specialists. Witnesses also highlighted that, in part, the workforce of 2030 was already in operation. Professor Ian Cumming told us that:

“... the majority of people who will be working for the NHS in 20 years’ time are in employment at the moment, so more than 50% of the people who we will have delivering care are actually our current employees. One mistake that we must not make is just to focus on the future workforce, and people coming through the education and training system. If we are to deliver transformation, we must focus on the people whom we currently employ, and I do not think we have given that enough attention. That is why perhaps the pace of change has not been as quick as we would like it to be.”¹⁰⁴

98 The King’s Fund, the Nuffield Trust and the Health Foundation, *The Spending Review: what does it mean for health and social care?* (December 2015): http://www.health.org.uk/sites/health/files/Spending-Review-Nuffield-Health-Kings-Fund-December-2015_spending_review_what_does_it_mean_for_health_and_social_care.pdf [accessed 28 March 2017] and also see Health Service Journal ‘Exclusive: HEE budget freeze will have ‘consequences’ for NHS’: <https://www.hsj.co.uk/topics/spending-review-2015/exclusive-hee-budget-freeze-will-have-consequences-for-nhs/7000603.article> [accessed 28 March 2017]

99 [Q 130](#) (Professor Wendy Reid)

100 Written evidence from Dell EMC ([NHS0070](#))

101 Written evidence from The Association of Anaesthetists of Great Britain and Ireland (AAGBI) Group of Anaesthetists in Training (GAT) ([NHS0115](#)), The Faculty of Public Health ([NHS0154](#)), The Royal College of Emergency Medicine ([NHS0029](#)), The Royal College of Midwives ([NHS0067](#)) and The Royal College of Paediatrics and Child Health ([NHS0133](#))

102 Written evidence from NHS Improvement ([NHS0107](#))

103 [Q 130](#) (Professor Ian Cumming and Professor Wendy Reid)

104 [Q 131](#) (Professor Ian Cumming)

128. Candace Imison, Director of Policy at the Nuffield Trust, described the current situation:

“The point I would like to get across about future sustainability to leave in the Committee’s heads is the degree of skills mismatch that we currently have in the workforce. A very powerful study was done across the whole OECD that showed that 51% of doctors and 43% of nurses felt they were underskilled for what they are currently doing, whilst 76% of doctors and 79% of nurses felt that elements of their role were overskilled. That tells us that our roles are not designed correctly for the skills of the staff that sit within them.”¹⁰⁵

129. Without sufficient flexibility, the way in which the workforce is educated and trained can limit the type of roles they are able to perform. Consequently, there were calls for greater flexibility and mobility between specialties in medicine and between different types of health care professionals, including the allied health professions. Richard Murray, Director of Policy at The King’s Fund, spoke about the challenges and opportunities created by new roles emerging within the workforce:

“The challenges as you look out into the future, alongside the demand and affordability piece, are particularly around new roles. We have an old model of consultants, nurses and more junior staff. As you look out—particularly reflecting the changing demographic needs of the population—is that appropriate? It is very difficult for a planner to know now, as some of the roles are nascent roles that are not with us yet.”¹⁰⁶

130. Ian Eardley, Vice-President of the Royal College of Surgeons, also pointed out the opportunity presented by new non-medical roles and suggested that the NHS needed to “take a longer-term view on workforce planning with a potentially increased role for a non-medical workforce to provide medical and social care.”¹⁰⁷ Professor Cathy Warwick, Chief Executive of the Royal College of Midwives, whilst acknowledging the proper role of medically trained professionals, argued that support roles were crucial:

“From my point of view, the greatest threat to maternity services is not having enough midwives. We now know from global research that if you are going to maintain the health and well-being of women and babies, they need midwifery input, and that is best delivered by midwives. It is not protectionism. The fact is that investing in midwives leads to higher-quality care. However, I would add that those midwives need to be well supported by highly qualified, well-trained, competent maternity support workers, and we need to focus on that workforce as well and help them reach the required standard. We also need to ensure that our maternity services have sufficient clerical support. Midwives are currently spending up to 50% of their time doing non-clinical duties, and that is absolutely shocking.”¹⁰⁸

We wholeheartedly endorse this view and would encourage all those in the health and care system to embrace the opportunities for different ways of working made possible by emerging workforce and support roles.

105 [Q 150](#) (Candace Imison)

106 [Q 24](#) (Richard Murray)

107 [Q 206](#) (Ian Eardley)

108 [Q 212](#) (Professor Cathy Warwick)

131. Natalie Beswetherick, Director of Practice & Development at the Chartered Society of Physiotherapy, saw these new roles as key to the sustainability of the workforce and told us that the Government must be held to account for its promise to deliver more of these new roles:

“... we need national accountability for the 10,000 workforce expansion for allied health professionals and nurses that was made in the last comprehensive spending review, and at the moment there is no accountability to deliver that. Without that workforce across allied health professions and nurses, we will not be able to get that sustainability in future.”¹⁰⁹

132. New roles can bring new challenges and require people to adapt the way they work. Gavin Larner, Director of Workforce at the Department of Health, told us about the reticence on the part of some to fully embrace these new roles:

“... there are strong culturally conservative parts of our healthcare system, where the different professional tribes see particular ways of delivering services. That is not necessarily always a self-regarding thing—it can be a genuine concern about what they feel is the best place to deliver the safest care.”¹¹⁰

133. Professor Sir John Bell, Regius Professor of Medicine at the University of Oxford, echoed this point:

“I am sorry to say the workforce in the healthcare system is hugely, in a sense, unionised; they are deeply conservative; they do not want to change what they do; they are dug in ... it is this heavily—”unionised” is probably the wrong word—consolidated view of healthcare workers who form groups and tribes within a healthcare system where they defend each other, defend their space, and they do not want to change. Worse than that, we train people to be highly focused on doing one thing and if we want them to be doing something else later in their careers, they will fight for their lives to stay doing what they were doing, even though we all know it is not cost-effective, so it is a real issue.”¹¹¹

We are clear that the current situation is totally unacceptable and will fail to deliver the services that patients will need in the future. This should be a major concern for all those working in the health service and those who represent them. The conservative culture which exists in some quarters should be challenged by political, professional and managerial leaders.

134. *A transformed Health Education England should use its greater budgetary freedom to review current commissioning and funding mechanisms to explore how initial and ongoing education and training might achieve a more multi-professional skill mix among the workforce and be underpinned by a place-based approach.*
135. **There has been too great a reluctance by successive governments to address the changing skill mix required to respond to a changing patient population and too little attention paid to workforce planning, education and training, all of which are necessary for delivering efficiency, productivity and overall value for money.**

109 [Q 223](#) (Natalie Beswetherick)

110 [Q 11](#) (Gavin Larner)

111 [Q 238](#) (Professor Sir John Bell)

136. *Health Education England should take the lead on changing the culture of conservatism which prevails among those who educate and train the health and social care workforce. It should convene a forum of the Royal Colleges, the General Medical Council, the Nursing and Midwifery Council, higher education institutions, other education providers, social care providers and local government representatives to investigate how medical and social care education and ongoing training courses can be reformed. Many are too lengthy, involve unnecessary repetition and do not meet the needs of a workforce which will have to be more flexible, agile and responsive to changing need.*
137. *Given the move to a more localised and place-based approach to the provision of health and social care, a more flexible approach to the make-up of the workforce is required. Professional bodies, education providers and regulators should embrace the opportunities for different ways of working made possible by emerging, often non-medical, workforce roles and should not be afraid of challenging the traditional allocation of responsibilities within professions.*

Regulation, morale and pay

The role of regulation

138. Health and care provided through the NHS is regulated by two system regulators and nine main professional regulators.¹¹² We heard a great deal about the impact of over-burdensome regulation—both systemic and professional—on workforce morale and retention. The evidence we received suggested that out-of-date professional regulation hampered the development of new practitioners such as nurse associates and physician assistants, and that an overly interventionist approach to regulation was creating an unnecessary and restrictive administrative burden on other clinicians.
139. Professor Sir Mike Richards, Chief Inspector of Hospitals at the CQC, told us that the work of the CQC was more valued than one might expect. He admitted, however, that things needed to change:

“... even among general practitioners, going back to the question of whether we get good or bad press, 57% of them say that it has been beneficial and had a good impact, so it is not all that you may hear. What we will do at the end of our first round is look at the whole process of how we do general practice inspection. We have set out our new strategy overall for the CQC, which includes having a more targeted and tailored approach ... we will need to be lighter on our feet and we will need to target those places where the problems are greatest, but we will adapt so that we can inspect and regulate new models of care. With those new models of care, we are saying, ‘Please tell us what you are planning so that we can plan the regulation with you.’”¹¹³

112 The two system regulators are NHS Improvement and the Care Quality Commission (CQC). The nine health and care regulators register health and care professionals working in occupations that statute has said must be regulated. They are the General Chiropractic Council (GCC), the General Dental Council (GDC), the General Medical Council (GMC), the General Optical Council (GOC), the General Osteopathic Council (GOsC), the Health and Care Professions Council (HCPC), the Nursing and Midwifery Council (NMC), the General Pharmaceutical Council (GPhC) and the Pharmaceutical Society of Northern Ireland (PSNI).

113 [Q 262](#) (Professor Sir Mike Richards)

This approach is encouraging. It is our view that system regulators need to adapt to changing ways of working and develop the ability to engage with place-based care and not simply with fixed institutions and bodies. System regulators should be willing to adapt to the present reality of the way in which health and care is delivered.

140. Dr Clare Gerada, General Practitioner and former Chair of the Royal College of General Practitioners, told us about the effects of the Health and Social Care Act 2012:

“We live in a bureaucratic jungle. It is terrible. Every single day is full of box-ticking and reporting. Even I do not now know what I am meant to do. I discovered the other day that I have not done my heavy lifting training, which will make me non-CQC-compliant. I have to go and do it. It is dreadful in there. It certainly has not released us from the bureaucratic nightmare.”¹¹⁴

In fact, Professor Maureen Baker, former Chair of the Royal College of General Practitioners, argued that in recent years she had actually seen an increase in bureaucracy.¹¹⁵

141. A solution was proposed by Baroness Cavendish of Little Venice:

“One thing that could be done from the centre which is very simple, which I am always going on about, is to reduce bureaucracy. The amount of paperwork and pressure put on the front line by central government and the whole of this landscape of quangos is utterly unacceptable. I find that people in the centre of government or in the quangos have no understanding of that, have no overview of how the amount of data they require overlaps with the amount of data other people require. Other people have recommended endlessly that we need one single data set that should be required by all of these public agencies from all of these providers, whether they are in health or social care. I am not saying that that is the answer but I think you would find productivity would increase dramatically.”¹¹⁶

142. It is clear to us that such a simple development would radically change the workload of those struggling to comply with the many overlapping and competing requirements of different regulators. In a letter to the Chairman dated 15 February 2017, the Chief Executive of the CQC, Sir David Behan, told us that they intended to take steps to alleviate the pressure of regulation. These steps would include, among other things, reducing duplication, requiring only one data return from GPs and reducing the frequency of inspections for those GP practices rated good and outstanding.¹¹⁷ This was welcome news and we look forward to seeing these changes implemented.

114 [Q 189](#) (Dr Clare Gerada)

115 [Q 189](#) (Professor Maureen Baker)

116 [Q 270](#) (Baroness Cavendish of Little Venice)

117 Letter from the Chief Executive of the CQC, Sir David Behan, to the Chairman, 15 February 2017: <https://www.parliament.uk/documents/lords-committees/NHS-Sustainability/CQC%20letter%20from%20Sir%20David%20Behan.pdf> [accessed 28 March 2017]

143. Another proposal was to reduce the number of regulators. Professor Dame Sue Bailey, Chair of the Academy of Medical Royal Colleges, argued:

“There are nine regulators and I do not see why they cannot go down to two. In terms of CQC, we need to move to an inspection of a whole system of care and place-based health ... We need a reduced number of professional regulators. For instance, if we are going to get physician associates up there and recognised, some of the big regulators need to decide who is going to do that. Inspections need to be separate but they need to work together better.”¹¹⁸

144. Professor Cathy Warwick, Chief Executive of the Royal College of Midwives, told us that:

“I think I would say we need far less constraints around the workforce; we need to enable our workforce to work in far more innovative, enterprising sorts of ways. At the moment the regulatory and government structures make that incredibly difficult ... We need a framework which is much looser and allows grass-roots innovation ...”¹¹⁹

145. The point was echoed by Sir Cyril Chantler, the eminent paediatrician:

“I am not against regulation; regulation is important. There are just too many of them all trying to do the same thing. There are too many agencies as part of the central system of the National Health Service now. I do not want them reorganised but a bit of rationalisation would be quite useful.”¹²⁰

He went on to speculate about the structural cause:

“... I think it comes from the nature of the top-down organisation of a healthcare system funded through taxation, which is what Beveridge and Bevan put in place. It is the right model but with it comes a responsibility upwards which leads to downward control.”¹²¹

146. In April 2014 the Law Commission, Scottish Law Commission and Northern Ireland Law Commission published their report *Regulation of Health Care Professionals: Regulation of Social Care Professionals in England*.¹²² The report included a draft bill to reform the legal framework around the regulation of health care professionals. The draft bill envisaged a single legal framework for all the regulators of health and social care professionals. The existing governing legislation (such as the Medical Act 1983, the Dentists Act 1984 and the Nursing and Midwifery Order 2001) would be repealed, and replaced with a single Act of Parliament to provide the legal framework for all regulated professionals. The Government has yet to bring a bill forward, though a Private Members’ Bill has been introduced in the House of Lords encouraging them to do so. The Regulation of Health and Social Care Professions Etc. Bill [HL] was introduced by Lord Hunt of Kings Heath and received its first reading in the House of Lords on 26 May 2016,

118 [Q 202](#) (Professor Dame Sue Bailey)

119 [Q 215](#) (Professor Cathy Warwick)

120 [Q 270](#) (Sir Cyril Chantler)

121 [Q 267](#) (Sir Cyril Chantler)

122 Law Commissions, *Regulation of Health Care Professionals: Regulation of Social Care Professionals in England*, Cm 8839 (April 2014): http://www.lawcom.gov.uk/wp-content/uploads/2015/03/lc345_regulation_of_healthcare_professionals.pdf [accessed 28 March 2017]

and received its second reading on 3 February 2017. The Bill, if passed, would require the Government to bring forward legislation giving effect to the recommendations of the Law Commission, Scottish Law Commission and Northern Ireland Law Commission in their report. We wholeheartedly support the objectives of the Bill.

Morale, pay and retention

147. Dr Mark Britnell, Partner and Chairman at the Global Health Practice at KPMG, told us that one of the most important things for a sustainable health system was staff morale and he exhorted us to “love your workforce and motivate and direct it properly.”¹²³ Baroness Cavendish of Little Venice spoke at some length about the morale problems in the NHS:

“... we need to reignite enthusiasm, and there is a morale problem in the NHS. However, what I saw in No. 10 for the first time ever ... was a bunch of really talented people, clinicians and chief executives, who for the first time seemed to be genuinely determined to change things ... On the one hand, you have people who are extremely concerned—the financial situation is dire, people are in deficit, there is a concern that deficit will become normalised—and on the other hand there is a group of people who want to grab the opportunity to change. The gap is that we have not provided a sufficiently clear template to them for what to do, and there are some very bright people out there who are very busy, and they do not want to have to reinvent the entire wheel again in their patch.”¹²⁴

148. We were particularly concerned to hear from Sir Cyril Chantler that there was a climate of fear amongst the workforce which was being created by excessive levels of top-down accountability and over-regulation.¹²⁵
149. We received evidence on the lengthy period of pay restraint experienced by health and care staff and the consequential impact of this pay restraint on morale. This was a particular problem for those who were often at the lower end of the pay scale such as nurses, other healthcare workers and social care workers. It was clearly a relevant factor in the low levels of morale and significant staff retention problems we heard about. Sam Higginson, Director of Strategic Finance at NHS England, told us that the working efficiency calculations within the Department of Health assumed that pay restraint would continue up to 2019/20. Michael Macdonnell, Director of Strategy at NHS England conceded that in his opinion, 10 years of prolonged pay restraint were bound to have long-term effects on workforce morale.¹²⁶
150. Professor Alan Manning, Member of the Migration Advisory Committee, told us that:

“If one is focusing on long-term sustainability and the workforce side, I worry that pay gets determined as a residual. There is a bit of temptation to think, ‘This is the health service we would like to provide, this is the amount of money we have been given and, therefore, this is what we can afford to pay our workforce’. In the long run, you have to pay your workforce what makes these professions attractive to recruit and retain them, given the other choices that people have, and you cannot control how much those other choices pay.”¹²⁷

123 [Q 318](#) (Dr Mark Britnell)

124 [Q 267](#) (Baroness Cavendish of Little Venice)

125 [Q 266](#) (Sir Cyril Chantler)

126 [Q 32](#) (Sam Higginson and Michael Macdonnell)

127 [Q 134](#) (Professor Alan Manning)

151. There were concerns expressed about the capacity of the NHS to retain domestically-trained staff because of low pay and morale and the competitiveness of the international market for scarce clinical skills. The evidence suggested this was a particular issue in nursing, where the proportion of nurses leaving services increased from 6.8% in 2010–11 to 9.2% in 2014–15.¹²⁸ This link between pay and retention was developed by Dr Jennifer Dixon, Chief Executive of the Health Foundation:

“Our work has shown that there are a lot of things that could be done locally to improve retention—not just for nursing staff but for others. HR management is a pretty underpowered profession. We just do not devote enough thinking in national or local policy to the wellbeing and motivation of staff, even though they are our biggest asset. Overall, if you look at the figures for staff joining and leaving the NHS, in some years the percentage joining and leaving is more or less the same, so you have a big leaky bucket.”¹²⁹

152. ADASS told us that retention in the adult social care workforce was also a problem: “Those who feel they are underpaid for difficult and often emotionally draining work are liable to seek alternative employment.”¹³⁰
153. **There is an indisputable link between a prolonged period of pay restraint, over-burdensome regulation and unnecessary bureaucracy on the one hand and low levels of morale and workforce retention on the other. We recognise the necessity of public sector pay restraint when public expenditure is under considerable pressure. However, by the end of this Parliament, pay will have been constrained for almost a decade.**
154. *We recommend that the Government commissions a formal independent review with the involvement of the Department of Health, the pay review bodies and health and care employers to review pay policy with a particular regard to its impact on the morale and retention of health and care staff.*
155. *The current regulatory landscape is not fit for purpose. In the short term, we urge the Government to bring forward legislation in this Parliament to modernise the system of regulation of health and social care professionals and place them under a single legal framework as envisaged by the 2014 draft Law Commission Bill. The Government should also introduce legislation to modernise the system regulators to take account of our recommendation that NHS England and NHS Improvement be merged and to reflect the clear move towards place-based care.*

128 Written evidence from UNISON ([NHS0081](#))

129 [Q 25](#) (Dr Jennifer Dixon)

130 Written evidence from The Association of Directors of Adult Social Services (ADASS) ([NHS0072](#))

CHAPTER 4: FUNDING THE NHS AND ADULT SOCIAL CARE

156. The issue of funding was, inevitably, a prominent theme within the evidence we received and getting this right will clearly be critical for the long-term sustainability of both the health and care systems.
157. The model of social care provision is very different from that of the NHS. Whereas NHS care is free-at-the-point-of-use, publically funded adult social care is means-tested and primarily funded through local government, through a mix of central government grants and local revenue. However, the inextricable link between the sustainability of the NHS and the adult social care system means that the financial provision for both systems cannot be considered in isolation from one another.
158. We were determined to hear and consider an extensive range of opinion about what level of funding the NHS and adult social care needs, how additional funding might be generated to help both services overcome the current financial strain, and how funding should be allocated to ensure the health and care systems remained sustainable in the long-term. This chapter sets out the range of options we heard in the evidence for how the NHS and adult social care could be placed on a more financially sustainable footing, before setting out our consideration on how health and social care funding might be better aligned to ease the pressures felt by both services.

NHS funding

159. We recognise that this is a period of extreme financial challenge for the health service and that this strain is being felt across the system. There is very real, very serious concern about the current state of NHS finances. Given the long-term focus of this inquiry, our examination of issues related to funding was not focused on the current funding envelope, but rather on whether the way in which the health service receives funding is conducive to the long-term sustainability of the system—in particular, have we got the right funding model and does the system receive funding in a way which will allow it to meet patient need over the longer-term?

NHS funding sources

160. The evidence to support the retention of general taxation as the principal method of funding the NHS was robust and consistent, leaving us in no doubt that this was the preferred approach for healthcare professionals, experts, parliamentarians and the public alike. We believe that it is also the right approach. Simon Stevens, Chief Executive of NHS England, echoed this:

“... a tax-funded National Health Service as a funding mechanism has served this country well since 1948. It has produced a steadily improving and expanding National Health Service and has done so in an equitable way that is highly valued by the people of this country.”

161. The Secretary of State for Health also confirmed his desire to see governments continue with the current model, which he described as “a sensible choice ... probably the choice that is closest to what most British people want.”¹³¹

162. We fully recognise that public support for a free-at-the-point-of-use service, funded through general taxation, is dedicated and unwavering—the public is, as Ben Page, Chief Executive of Ipsos MORI explained “... completely wedded to the idea of a free, universal NHS.”¹³² This support was clearly communicated through the substantial level of correspondence we received at the end of our inquiry.

Alternative funding models

163. We heard a range of evidence regarding the different funding models that were employed by different health systems around the world including: general taxation (UK); social insurance through employer/employee contributions (France, Germany); compulsory social insurance (Switzerland); and voluntary insurance (USA). We also received evidence about the options for mechanisms to raise additional funding.
164. The advantages and disadvantages of moving to an alternative funding model were explored over the course of the inquiry. However, there was general agreement that this would not be a viable solution for the UK. Lord Willets informed us that, in a previous role as a policy adviser to a past government, he had considered alternative arrangements for health funding including “co-payment, private insurance—all those conventional options” but concluded that: “a nationwide risk pool to fund healthcare was a perfectly reasonable arrangement, and that the costs of moving from what we had to some other system were very high.”¹³³
165. John Appleby, Director of Research and Chief Economist at the Nuffield Trust, also highlighted some of the issues related to alternative sources of funding for health, stating that:

“If you want to switch the proportions of funding from different sources—from public to private, from collective to more individual—that raises a whole lot of distributional and equity issues. From the evidence and from looking at other countries, there is, in a sense, a trade-off between different sources of funding.”¹³⁴

166. The Department of Health was clear that it intended to continue with the current funding model—a view we wholeheartedly support. Andrew Baigent, Director of Finance at the Department of Health, explained that the Government was very clear that it saw health spending being tax-funded and was not exploring any other options at this time.¹³⁵ The evidence for maintaining general taxation as the principal funding source was reinforced by the lack of any evidence that made the case conclusively for any alternative funding models. A recent OECD report, which compared healthcare systems around the world stated:

“... there is no healthcare system that performs systematically better in delivering cost-effective health care. It may thus be less the type of system that matters but rather how it is managed. Both market-based and more centralised command-and-control systems show strengths and weaknesses.”¹³⁶

132 [Q 105](#) (Ben Page)

133 [Q 118](#) (Lord Willets)

134 [Q 55](#) (John Appleby)

135 [Q 2](#) (Andrew Baigent)

136 *OECD 2010, Health care systems: Getting more value for money*, OECD Economics Department Policy Notes, No. 2, p 3: <https://www.oecd.org/eco/growth/46508904.pdf> [accessed 28 March 2017]

167. In fact, there was nothing in the evidence that suggested any one system for funding health care was systematically better than another in terms of efficiency or performance. Dr Jennifer Dixon, Chief Executive of the Health Foundation, told us about:

“... a very good study by Mark Pearson, from the OECD, that clumped health systems into different archetypes: market-based systems, national health systems, Bismarckian systems and heterogeneous systems. When he looked at the performance of those systems, including efficiency measures, he found that no one archetype outperformed another and that there was more variation within archetypes than across them. His conclusion was that a health system that is seriously trying to improve performance should not necessarily look to any other system but should work with what it has.”¹³⁷

168. We were not persuaded of any link between the way you choose to collect the money to fund a health service and performance. Instead it seemed that, as Ian Forde from the OECD, explained “much more important is how you spend the money once you have collected it, which really determines performance and sustainability.” This view was supported by Nigel Edwards, Chief Executive of the Nuffield Trust, who said: “There is no immediate link between how you collect money and how efficiently it is disbursed.”¹³⁸ Similarly, John Appleby of the Nuffield Trust, explained that there are “probably 5 or 10 different factors that would explain relative performance between health systems, including their performance on productivity, but I would not lay much emphasis on the source of funding as driving that.”¹³⁹
169. **International evidence shows that a tax-funded, single payer model of paying for healthcare has substantial advantages in terms of universal coverage and overall efficiency. There was no evidence to suggest that alternative systems such as social insurance would deliver a more sustainable health service. Sustainability depends on the level of funding and, crucially, how those funds are used.**
170. *We strongly recommend that a tax-funded, free-at-the-point-of-use NHS should remain in place as the most appropriate model for delivery of sustainable health services both now and in the future.*

Generating additional sources of funding

171. Despite the widespread support for maintaining the current funding model, we were also acutely aware of the concerns raised about the current financial pressures being felt by the health and care services. Many witnesses suggested that the current state of NHS finances was significantly worse than it had been in previous years. The Health Foundation highlighted that:

“The 2015 Comprehensive Spending Review confirmed that 2010/11 to 2020/21 will be the most austere decade for the NHS in its history. After accounting for inflation and population growth, spend per head for the English NHS will be similar in 2020/21 to what it was 2010/11 ... rising by an average of 0.2% a year in real-terms.”¹⁴⁰

137 [Q 23](#) (Dr Jennifer Dixon)

138 [Q 23](#) (Nigel Edwards)

139 [Q 56](#) (John Appleby)

140 Written evidence from the Health Foundation ([NHS0172](#))

172. This view was supported by the National Audit Office's (NAO) report *Financial Sustainability of the NHS*, which gave a summary of the financial position of NHS England, clinical commissioning groups, NHS trusts and NHS foundation trusts. The key findings in the NAO's analysis of the trends in the financial performance of NHS bodies were:
- In 2015–16, NHS commissioners, NHS trusts and NHS foundation trusts reported a combined deficit of £1.85 billion.
 - The financial position of NHS bodies overall had continued to decline.
 - The number of NHS bodies reporting a deficit rose significantly between 2014–15 and 2015–16.¹⁴¹
173. NHS England has suggested that the current financial envelope fell short of what was required. In evidence given to the House of Commons Health Select Committee, the Chief Executive, Simon Stevens, was asked if he felt that the “NHS has been given everything it has asked for” by the Chair, Dr Sarah Wollaston MP. Mr Stevens responded by saying:
- “For years 1 and 5, yes, you could say that we were kind of in the zone, but for the next three years we did not get the funding that the NHS had requested. This is not a controversial statement. It is what I have already said to the Public Accounts Committee, so it is not a new statement. As a result, we have a bigger hill to climb. It is going to be a more challenging 2017–18 and 2019–20.”¹⁴²
174. A recent report by the House of Commons Public Accounts Committee has also expressed concern over the use of capital budgets to fund day-to-day spending, which has happened for the second year in a row. The report stated that the Department of Health moved £950 million out of its separate £4.5 billion capital budget to its revenue budget in 2015–16, to fund day-to-day activities, and had confirmed that it would need to do so again to balance its budget in 2016/17 and in future years. The Committee stated that this could “result in ill-equipped and inefficient hospitals” and recommended that the Department of Health, NHS England and NHS Improvement should “call a halt to crisis driven transfers out of capital budgets.”¹⁴³
175. In recognition of the significant strain on finances, both in health and across all public services, we also sought views on the viability of generating additional funding for the NHS from alternative sources, to supplement the funding generated by general taxation.
176. The possibility of introducing additional charges for some procedures as a means of generating additional revenue for the NHS was discussed by several witnesses. However, amongst the evidence we received there was little to suggest that introducing further charges into the system would have much impact on the volume of resources available for healthcare.

141 National Audit Office, *Financial sustainability of the NHS* (Session 2016–17, HC 785)

142 Oral evidence taken before the Health Select Committee, 18 October 2016 (Session 2015–16), [Q 66](#) (Simon Stevens)

143 House of Commons Committee of Public Accounts, *Financial sustainability of the NHS* (Forty Third Report, Session 2016–17, HC 887)

177. Overwhelmingly the evidence weighed against the introduction of further charging. Of greatest concern was the risk that user charges could limit access and have a negative impact on efficiency and equity. The Barker Review, which was commissioned in 2013 to consider the sustainability of the NHS and social care models, noted that the international evidence on the impact of charging—how far it controls unnecessary demand—was “frustratingly weak.” However, it cited a study in the United States in the 1960s which found that charging had a serious adverse effect on those who were both poor and suffering from poor health. The Barker Review concluded that introducing further charges into the health system “would fail the criterion of equity”.¹⁴⁴
178. Much of the evidence reiterated this view. The Children and Young People’s Mental Health Coalition, the British Psychological Society and the Royal College of Ophthalmologists all expressed concerns that additional charges could create inequality between socio-economic groups and potentially mean that people would be unable to afford treatment.¹⁴⁵ Ian Forde, from the OECD, was equally critical about the possibility of the introduction of additional charges:
- “The evidence does not support that as a policy option. It is bad for equity, because it damages people on lower incomes, and it is bad for health, because in the long run it increases health costs because people forgo primary care and preventive care when they need it and wait till they are sicker further down the line and end up costing more money. There is good evidence that increasing dependence on out-of-pocket payments is not a good option.”¹⁴⁶
179. While there was little support for the notion of introducing additional charges for the health service as a way to raise additional revenue, we found there were a number of serious and considered calls to examine whether some form of hypothecated tax for the NHS would help to secure more long-term financial sustainability.
180. We heard a range of views on how hypothecation might work for the NHS. These ranged from suggestions for the introduction of a ‘soft’ hypothecation, using additional revenues from a given tax to supplement NHS funding, to a ‘hard’ approach, where all of the revenue from one tax (which some witnesses proposed could be National Insurance), would be used to fund the NHS.
181. The strongest advantage of hypothecation appeared to be the greater transparency it would provide of the link between taxation and government spending, which witnesses suggested could help improve the public’s understanding of expenditure on the NHS. This could help to facilitate a better debate about how much the electorate were willing to pay for the health service.¹⁴⁷ The key disadvantage we heard was that hypothecation could potentially undermine the ability of governments to deal with the economic

144 The King’s Fund, Commission on the Future of Health and Social care in England, *A new settlement for health and social care* (2014), p 25: https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Commission%20Final%20%20interactive.pdf [accessed 28 March 2017]

145 Written evidence from Children and Young People’s Mental Health Coalition (NHS0058); The British Psychological Society (NHS0057) and The Royal College of Ophthalmologists (NHS0032)

146 Q 70 (Ian Forde)

147 Written evidence from Lord Macpherson of Earl’s Court (NHS0177)

cycle, restricting the flexibility they have to allocate resources as they see fit.¹⁴⁸ This evidence is set out in more detail in Appendix 4.

182. ***We received some detailed analysis of how hypothecation might work for the NHS. Given the far-reaching implications of hypothecation for systems and services beyond the remit of our inquiry, we were not well-placed to make a firm conclusion on the issue. We recommend that hypothecation be given further consideration by ministers and policymakers.***
183. Although many people did not want to see significant change to the model of funding through taxation, there did need to be some recognition of the need for a debate on what the NHS was able to deliver in relation to the funding it received. Dame Julie Moore, Chief Executive of University Hospitals Birmingham NHS Foundation Trust, proposed: “a public debate about what the NHS is now coping with—the increased complexity, the increased demand—and ... what we are willing to pay for.”¹⁴⁹ Similarly, Mr Chris Hopson, Chief Executive of NHS Providers, stated that:

“My view would be that we need to keep a taxpayer-funded system but increase the funding coming in, in which case we need to think much more carefully about how we build a national consensus around that increase in funding. That requires a much better quality of public debate about what the funding levels for the NHS should be and what the consequences of not increasing funding might be.”¹⁵⁰

NHS funding levels

184. Across countries, regardless of the health care funding model, populations have increasingly chosen to spend a growing share of national wealth on health.
185. Historically public funding for health care has increased faster than economic growth, with the share of UK GDP spent on health more than doubling from 3.5% in 1949/50 to 7.4% in 2015/16. On average, spending has risen by 3.7% a year in real terms (with periods of relatively high and low growth).¹⁵¹ However, the period 2010 to 2020 will see a marked divergence from that trend. The Health Foundation told us that “as part of the government’s priority to close the national fiscal deficit, funding for the UK NHS is currently growing at a slower rate than GDP.”¹⁵²
186. We recognise that growth in health spending has slowed across most of the OECD. Dr Jennifer Dixon told us: “Over the last 20 years, healthcare costs across OECD countries have outstripped GDP growth.”¹⁵³ However, the evidence suggested that the UK has seen a sharper retrenchment in health spending than most of its peers. The OBR projects, based on current spending plans, that UK spending on health and care as a percentage of GDP is due to drop from 7.4% in 2015–2016 to 6.8% in 2020–21.¹⁵⁴

148 *Ibid.*

149 [Q 177](#) (Dame Julie Moore)

150 [Q 97](#) (Chris Hopson)

151 The Health Foundation, ‘Health and social care funding explained’: <http://www.health.org.uk/health-and-social-care-funding-explained> [accessed 28 March 2017]

152 Written evidence from the Health Foundation ([NHS0172](#))

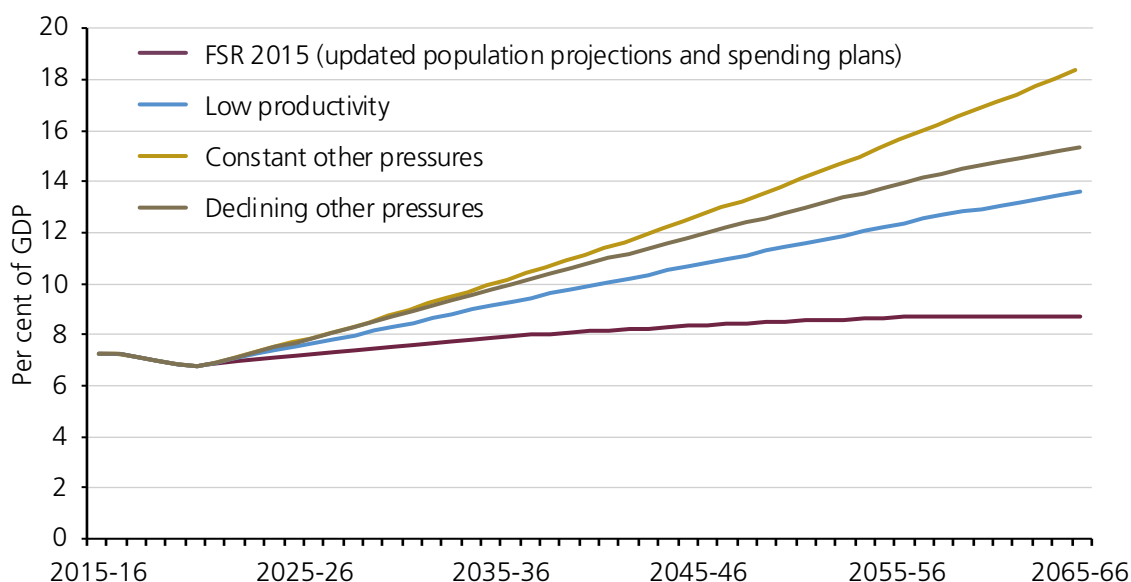
153 [Q 23](#) (Dr Jennifer Dixon)

154 Office for Budget Responsibility, *Fiscal sustainability analytical paper: Fiscal sustainability and public spending on health* (September 2016): http://budgetresponsibility.org.uk/docs/dlm_uploads/Health-FSAP.pdf [accessed 28 March 2017]

Health spending beyond 2020

187. The Office for Budget Responsibility (OBR) produces periodic assessments of long-term fiscal sustainability based on projections of public spending and taxation revenues. The OBR's working paper on *Fiscal sustainability and public spending on health* showed that: "health spending has risen as a share of GDP in most OECD countries, including the UK over the past 40 years. Consistent with the projections of various international institutions, we project that health spending in the UK will continue to rise as a share of GDP in the future."¹⁵⁵
188. Figure 1 outlines the OBR's long-term projections for public spending on health based on its different assumptions for the impact of pressures on the health service.

Figure 2: Office for Budget Responsibility: Long-term projections for health spending (as a % of GDP)¹⁵⁶



Source: Office for Budget Responsibility, *Fiscal sustainability and public spending on health* (September 2016): http://budgetresponsibility.org.uk/docs/dlm_uploads/Health-FSAP.pdf [accessed 28 March 2017]

¹⁵⁵ *Ibid.*

¹⁵⁶ The OBR's graph displays long-term projections on health spending using a number of different scenarios: FSR 2015; low productivity; constant other pressures; and declining other pressures. FSR 2015 (updated population and projections and spending plans) refers to the OBR's updated FSR (Fiscal sustainability report) health spending projection made on the basis of new population projections and detailed spending plans set out since its last report. The low productivity scenario assumes annual health care productivity growth of 1.2%. The OBR states that in order to account for other cost pressures (non-demographic pressures, for example increasing relative health costs and technological advancements) in its long-term spending, it has also used two variants: constant other pressures, which assumes that the additional pressures remain unchanged from 2021–22 onwards. In this scenario, primary and secondary health spending projections grow by 2.7% and 1.2% a year faster than OBR's central projection; and declining other pressures which assumes a linear convergence towards a 1% annual increase by the end of the projection period in each activity. This reflects the significant uncertainty over how pharmaceuticals, medical procedures and technology might evolve over the future. Office for Budget Responsibility, *Fiscal sustainability and public spending on health* (September 2016): http://budgetresponsibility.org.uk/docs/dlm_uploads/Health-FSAP.pdf [accessed 28 March 2017]

189. The Nuffield Trust undertook some analysis of the OBR projections and highlighted the following points:

- The OBR’s projections suggested that public spending on health care in the UK could rise from 7.4% of GDP in 2015/16 to between 8.8% and 8.9% by 2030/31.
- The projected figures were broadly equivalent to a real increase in health spending of just under £100 billion over the next 15 years (from £139 billion to £237 billion in 2015/16 prices).
- The OBR’s longer-term projections of spending on health suggest increased spending over the next fifty years, but they varied widely— from just under 8% of GDP to between 15.5% and 18.5%.
- More than doubling the share of GDP devoted to health care spending over the next 50 years would mean further tough choices about how this should be funded—and what the public might be willing to forgo.¹⁵⁷

190. The views we heard on health spending beyond 2020 were fairly consistent, with broad agreement for the need to increase health funding to more closely match growing pressures and to bring it back more in line with the historic average (on average public spending has risen by 3.7% a year in real terms, but this has not been a continued steady increase over time¹⁵⁸). Richard Murray, Director of Policy at The King’s Fund, said:

“If you are thinking about the long term, there are not many alternatives to paying, over time, to raise the share of GDP that goes on health and social care in the light of demographic change. As you look over long periods of time across the OECD and, of course, within the United Kingdom, that is exactly what you see.”¹⁵⁹

191. Similarly, Nigel Edwards, Chief Executive of the Nuffield Trust, stated that:

“If you add together the increasing complexity of the patients, the growth in the number of people who will die over the next five decades, the changes in the age structure and the increasing demands that will be made just because things are available, it will be very difficult to hold the line much below the historic trend, which has been about 4% growth in the UK. There may even be pressure to drive it above that.”¹⁶⁰

192. **The reduction in health spending as a share of GDP seen over this decade cannot continue beyond 2020 without seriously affecting the quality of and access to care, something which has not been made clear to the public or widely debated.**

193. ***To truly protect the sustainability of the NHS the Government needs to set out plans to increase health funding to match growing and foreseeable financial pressures more realistically. We recommend health spending beyond 2020 should increase at least in line with the growth of GDP and do so in a predictable way in that decade.***

157 The Nuffield Trust, *Is the NHS financially sustainable* (21 September 2016): <https://www.nuffieldtrust.org.uk/files/2017-01/is-the-nhs-financially-sustainable-web-final.pdf> [accessed 28 March 2017]

158 The Health Foundation, ‘Health and social care funding explained’: <http://www.health.org.uk/health-and-social-care-funding-explained#Historic> [accessed 28 March 2017]

159 [Q 23](#) (Richard Murray)

160 [Q 23](#) (Nigel Edwards)

Social care funding

194. The funding crisis in adult social care is worsening to the point of imminent breakdown. As mentioned in Chapter 1, although we were appointed with the explicit remit to examine issues pertaining to the long-term sustainability of the NHS, the sheer volume of evidence we received on the challenges facing adult social care and the impact it had on the NHS meant that our investigation widened in scope. This chapter outlines both a possible short-term and long-term solution.

The current situation

195. Pressures in social care are the greatest external threat to the long-term sustainability of the NHS; the urgent requirement to address the issues in social care is universally acknowledged, but action is needed now.

196. Social care is currently delivered through a combination of public and private providers but the publically funded care is financed from the Department of Communities and Local Government's allocations to local authorities and locally raised finance, principally from council tax. Christina McAnea, Head of Health at UNISON, explained the impact of cuts to local government budgets for the provision of social care:

“... it is not just about funding the NHS, as you have already said, but about funding social care as well to a level that means that you can actually meet need. Over the past few years we have seen a 25% cut in the funding for social care, a 25% reduction in people receiving social care, and an even greater cut in the actual overall budget that is going to local authorities. That has had an immediate impact and an ongoing impact on NHS services.”¹⁶¹

197. The pressures facing social care mean that more people who would otherwise be cared for in the community, in residential homes or in their own home are now presenting in NHS settings, often at GP surgeries or at A&E departments. The adverse impact on the functioning of acute services in hospitals is increasingly serious. In some cases acute services in hospitals are becoming the choice of last resort. The cuts to one public service are placing greater pressure on another.

198. We heard that disquiet about the situation is growing. The Greater Manchester Health and Social Care Partnership which we described in Chapter 2 is delivering real benefits, but even that endeavour is suffering as a result of social care funding pressures. Sir Howard Bernstein, explained that the Partnership had written a letter to the NHS and central Government explaining the severity of the situation:

“Jon Rouse, who is the chief officer for delegation, Lord Peter Smith, who chairs the Health and Social Care Partnership, and I wrote a joint letter to the Secretary of State for Health, copied to the Chancellor and elsewhere, particularly to Simon Stevens, explaining our particular challenges in social care funding, which, unless resolved, will gnaw away at our capability to create the sustainable funding platform that we have committed ourselves to within the next five years.”¹⁶²

161 [Q 159](#) (Christina McAnea)

162 [Q 225](#) (Sir Howard Bernstein)

199. There has been much commentary in the press about the exodus of care home providers and providers of other types of care from the sector. Limited public funds have meant that many have chosen to close. We heard that there is now the serious prospect of a further withdrawal of service providers from publicly-funded adult social care which is likely to damage the effectiveness and sustainability of the NHS.¹⁶³ Not only will this have an adverse effect on the staff who work in the care home sector, it will place greater pressures on families who care for their elderly relatives and confine those who need round-the-clock care in unsuitable settings at a greater cost to the taxpayer.
200. The Government has continually argued that the answer to the social care funding gap lies in the ability of councils to raise the Council Tax precept (the Adult Social Care Precept). In autumn 2016, the Government granted councils the flexibility to raise the precept by up to 3% for two years which would, they argued, provide a further £208 million to spend on adult social care in 2017/18 and £444 million in 2018/19.¹⁶⁴ The Association of Directors of Adult Social Services (ADASS) and UNISON welcomed this flexibility and the improved Better Care Fund, but argued that the Council Tax precept was worth less than the Government claimed.¹⁶⁵ ADASS went on to argue that “those councils least able to raise tax are those with the highest levels of people with social care needs” and that the improved Better Care Fund did not fully address this as “there is no extra money arriving in 2016/17, and [it] only reaches £1.5 billion in 2019/20.”¹⁶⁶ A number of witnesses expressed concern that this option would not produce sufficient resources to halt a further deterioration in services, especially in poorer local authority areas, and that both funding sources were too little, too late.¹⁶⁷
201. In fact, Andrew Haldenby, Director of Reform, argued that there might well be a change of thinking in Government on this issue: “I think the fact that the current Government introduced the new precept on social care in the Autumn Statement indicates that they know that cuts in social care funding have gone too far.”¹⁶⁸

Short-term responses

202. The evidence we received on the required short-term response to the funding crisis in adult social care was clear—the service needs more money. Whilst we acknowledge this is not a long-term solution, multiple witnesses warned that without a swift injection of public funds, the adult social care sector would be pushed to breaking point.
203. Witnesses, notably including Simon Stevens, the Chief Executive of NHS England, argued that increasing social care funding in the short term was a higher priority than providing more money for the NHS. Sir Howard Bernstein echoed this call for increased funding for adult social care¹⁶⁹ as did Professor Keith McNeil, Chief Clinical Information Officer for Health and Social Care and Head of IT for the NHS.¹⁷⁰

163 [Q 99](#) (Sir Andrew Dilnot)

164 Department for Communities and Local Government, ‘Provisional local government finance settlement 2017 to 2018’: <https://www.gov.uk/government/speeches/provisional-local-government-finance-settlement-2017-to-2018> [accessed 28 March 2017]

165 Written evidence from the Association of Directors of Adult Social Services ([NHS0072](#)) and UNISON ([NHS0081](#))

166 Written evidence from the Association of Directors of Adult Social Services ([NHS0072](#))

167 Written evidence from the Association of Directors of Adult Social Services ([NHS0072](#)) and The Care and Support Alliance([NHS0097](#))

168 [Q 79](#) (Andrew Haldenby)

169 [Q 235](#) (Sir Howard Bernstein)

170 [Q 242](#) (Professor Keith McNeil)

204. As part of the Spring Budget 2017, the Chancellor announced that councils would receive an extra £2 billion to fund social care over the next three years. £1 billion of this would be provided in 2017/18. The Budget also set out a commitment for the Government to publish a green paper, which would set out proposals to “put the system on a more secure and sustainable long term footing.”¹⁷¹
205. This funding has been welcomed by some in the sector and this lump sum could provide some short-term relief to the system. However, estimates have put the funding gap for adult social care by the end of the Parliament at more than the amount allocated by the Spring Budget. For example, analysis conducted by the Health Foundation, The King’s Fund and the Nuffield Trust, suggested that the social care funding gap could be between £2.8 billion and £3.5 billion by 2019/2020. More recently, the House of Commons Communities and Local Government Select Committee cited estimates which suggested the funding gap could be between £1.3 and £1.9 billion in 2017/18 alone.¹⁷² We remain unconvinced that the amount allocated so far for the period to 2020 is sufficient to provide a stable platform of adult social care services on which to build a longer-term funding solution.
206. **The additional funding for social care announced in the 2017 Budget is welcome and means funding for social care will increase by more than 2% a year for the next three years. This is more than the increase for NHS funding. However it is clearly insufficient to make up for many years of underfunding and the rapid rise in pressures on the system.**
207. *In order to stem the flow of providers leaving adult social care, meet rising need and help alleviate the crisis in NHS hospitals, the Government needs to provide further funding between now and 2020. This funding should be provided nationally as further increases in council tax to fund social care do not allow funding to be aligned with need. Beyond 2020 a key principle of the long-term settlement for social care should be that funding increases reflect changing need and are, as a minimum, aligned with the rate of increase for NHS funding.*

Aligning health and social care funding

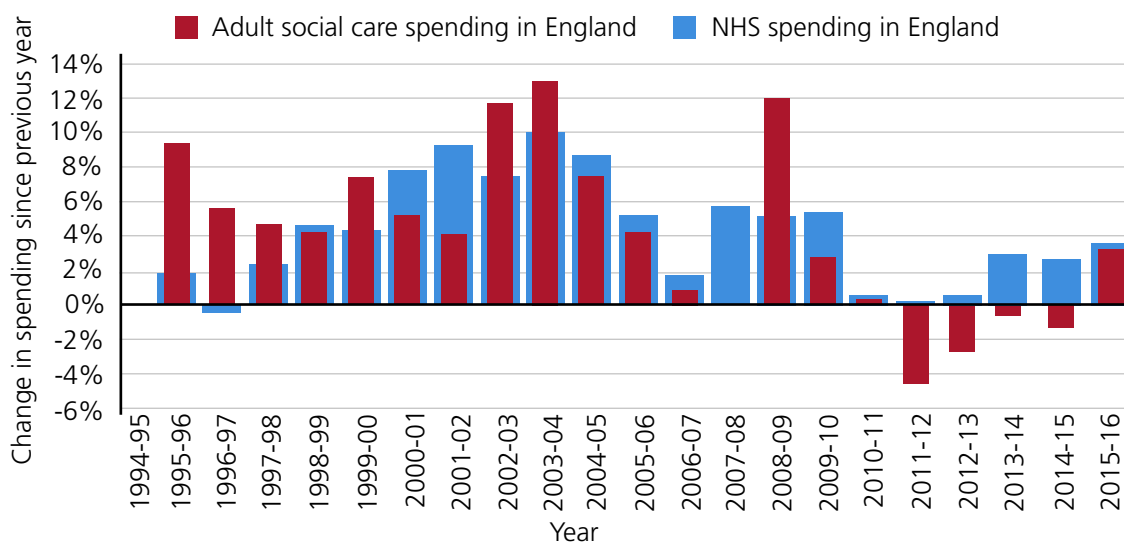
208. Additional funding for the NHS or adult social care alone will not guarantee sustainability. Both systems need immediate support to tackle the current financial difficulties but will also need to be able to undertake considered, longer-term planning to ensure the services can meet the changing needs and demands of the future patient population. We heard compelling evidence to suggest that neither service will be able to do this if two key funding issues are not resolved; the misalignment between the distribution of resources to the NHS and adult social care, and the volatility of funding allocations to both services.

171 HM Treasury, *Spring Budget 2017*, HC 10256, (March 2017), p 48: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/597467/spring_budget_2017_web.pdf [accessed 28 March 2017]

172 House of Commons, Communities and Local Government Committee, *Adult social care: a pre-Budget report* (Eighth Report of Session 2016–17, HC 47)

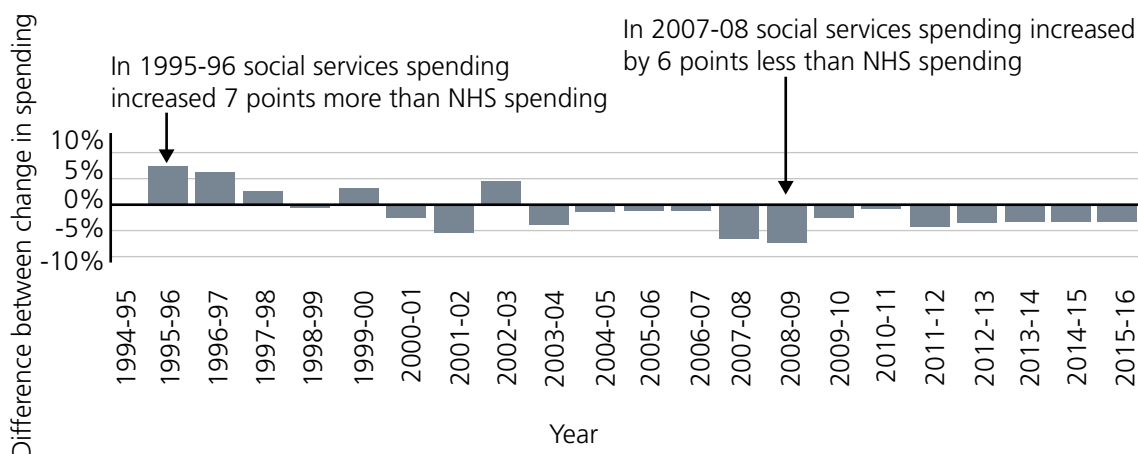
209. The way in which funding has been allocated to the NHS was seen as a key weakness of the UK’s system because there was considerable volatility of spending growth for health due to it being tied to tax receipts, economic performance and political priorities. Figure 3 illustrates the historic volatility in the allocation of funding for the health system and the variation in social care spending.

Figure 3: Yearly change in real terms spending on the NHS and adult social care in England, 1994–2014¹⁷³



Source: Written evidence from the Health Foundation (*NHS0172*) and (*NHS0196*)

Figure 4: Difference between percentage change in spending on the NHS and adult social care, 1994–2014



Source: Written evidence from the Health Foundation (*NHS0172*) and (*NHS0196*)

210. The NHS appears to have gone through numerous cycles of boom-and-bust funding. Short-term financial pressures lead to short-term approaches elsewhere in the system (for example to workforce). We found agreement on this point from both the Department of Health and NHS England. Simon Stevens described how “we bounce off the backs between feast and famine, sugar high and starvation when it comes to the funding of the National Health Service.”¹⁷⁴ This ‘lumpiness’ was seen as detrimental to the efficient longer-term planning and use of taxpayer resources because of

173 Figures 3 and 4 use 2017/18 prices and Her Majesty’s Treasury’s December 2016 GDP deflator.

174 [Q 279](#) (Simon Stevens)

the uncertainty it creates. The Secretary of State for Health, acknowledged the issue, stating: “I think it has been particularly lumpy in the last six years because of the economic context we have been in, which has made it particularly challenging.”¹⁷⁵

211. Figure 4 highlights that the allocation of resources to the NHS and the amount local authorities have available to spend on adult social care has been historically very poorly synchronised. Given that both services continue to deal with very similar demographic and disease profiles, and the interdependent nature of the relationship between the NHS and adult social care services, this seems wholly counterproductive. It creates no stability for either service and prohibits effective long-term planning.

212. Some witnesses suggested that providing more funding certainty to the health system could result in a more effective allocation of resources. Lord Macpherson of Earl’s Court highlighted previous examples to secure greater funding certainty for the health service and other policy areas:

“Since inflation was brought under control in the 1990s, there has been a tendency to move away from annual spending reviews. For example, the 2015 spending review set budgets for the five years from 2016–17 to 2020–21. And there are a number of examples of governments singling out specific programmes for greater long term certainty. In his 2002 Budget, Gordon Brown set five year spending totals for the National Health Service, when other programmes were only settled for three years. There was also—briefly—a ten year transport plan. And more recently the defence equipment budget has been set for a ten year period, with varying degrees of certainty for the outlying years.”¹⁷⁶

213. Lord Macpherson of Earl’s Court went on to suggest that, providing it was underpinned by “end year flexibility” (the right to shift resources between financial years), he saw:

“... much to be said for agreeing funding for the NHS for a five year period at the beginning of each parliament, informed by manifesto commitments, tested by General Election debate and ideally by an independent assessment by the Office for Budgetary responsibility.”¹⁷⁷

214. Mr Stevens appeared supportive of the notion that action should be taken to reduce the volatility of the health funding allocations, stating that: “something that smoothed the funding increases, gave longer-term predictability and, more transparently for the public, connected what was being invested with the results they were getting in the NHS would be a great addition.”¹⁷⁸

215. Dr Sarah Wollaston MP told us that in her opinion this would be best co-ordinated in a unified policy setting in a single Government department.¹⁷⁹ There was also an argument for a unified budget. If the Government is serious about integrating health and social care, it should start at the top. A unified policy setting could also help to ensure that the funding allocated to local authorities is more consistent, given the vital role they play in the introduction of greater place-based approaches to health and care.

175 [Q 303](#) (Jeremy Hunt MP)

176 Written evidence from Lord Macpherson of Earl’s Court ([NHS0177](#))

177 *Ibid.*

178 [Q 279](#) (Simon Stevens)

179 [Q 289](#) (Dr Sarah Wollaston MP)

216. **Funding over the past 25 years has been too volatile and poorly co-ordinated between health and social care. This has resulted in poor value for money and resources being allocated in ways which are inconsistent with patient priorities and needs.**
217. *The budgetary responsibility for adult social care at a national level should be transferred to the Department of Health which should be renamed the ‘Department of Health and Care’. This should allow money and resources to be marshalled and used more effectively as part of an integrated approach to health and care.*
218. *We acknowledge the difficulties with integrating budgets at a local level but this is achievable. The Government should undertake a review and bring forward changes in order to make this happen.*
219. *Regardless of this further work on integrating budgets, the Government should commit to (1) securing greater consistency in the allocation of funding to health and social care at least in line with growth in GDP and (2) reducing the volatility in the overall levels of funding allocated to health and care in order to better align the funding of both services.*
220. *We recommend that the current Government and any successive governments should agree financial settlements for an entire Parliament to improve planning and ensure the effective use of resources. ‘Shadow’ ten year allocations should also be agreed for certain expenditures, such as medical training or significant capital investment programmes that require longer-term planning horizons.*

Longer-term solutions for adult social care

221. The demographic and disease profile up to 2030 and beyond strongly suggested that the demand for adult social care (both publicly and privately funded) would continue to rise. If the funding of this sector becomes destabilised again, as has happened historically, we heard that this will place huge pressures on the NHS and threaten its sustainability.
222. The Prime Minister has acknowledged the need for a longer-term solution on a number of occasions. At Prime Minister’s Questions on 8 February 2017, she said the following:
- “As I have said before, we do need to find a long-term, sustainable solution for social care in this country. I recognise the short-term pressures. That is why we have enabled local authorities to put more money into social care ... But we also need to look long term.”¹⁸⁰
223. Encouragingly, the Secretary of State for Health acknowledged that a longer-term solution for funding adult social care was required. He also spoke of the aspiration that people should save more for the costs of their own care in the longer term:

“I think there is a real commitment in the Government to address the longer-term funding issues in the social care system during this parliament. I do not think we are saying that we want to wait until post-Brexit or until another Parliament. We recognise that this is a really serious issue that needs to be looked at sooner rather than later ... The reality is that putting in place longer-term incentives so that people save more for their social care costs will not make a material difference for decades, but it is still the right thing to do ... We need to find a way, through evening out the variations between different areas, pressing ahead faster with health and social care integration, doing what we can to relieve the pressure being felt everywhere, but I also think this is a time when we need to put in place a long-term settlement for the social care system, absolutely.”¹⁸¹

224. Simon Stevens advocated a much more holistic approach to the issue, drawing together the inter-related subjects of income, housing and care. He suggested that the idea of the pensions triple lock¹⁸² should be re-imagined:

“We need to go beyond just thinking about health and social care funding and think about what is happening in the benefits system, the pension system and so forth. Obviously, we have a triple lock until 2020, which is three different ways in which people’s pensions go up. A new way of thinking about that would be a triple guarantee for old people in this country that would be a guarantee of income, housing and care. I do not think you can think about any one of those in isolation from the other two.”¹⁸³

225. Lord Willetts, Chair of the Resolution Foundation, echoed this point:

“I would like to see a revised triple lock, which did not cover solely the pension and had some revised promise on the uprating of the pension, but included some commitment on the costs of social care. It would be a combination of a national insurance element plus private payment if you had significant assets on top.”¹⁸⁴

226. The traditional response to a funding shortfall in the provision of a public service has been to raise taxes. Dr Stephen Watkins from the Medical Practitioners’ Union Section at Unite argued for the increased taxation of individuals:

“There is no doubt that the introduction of free social care, which we strongly advocate, would necessitate increased taxation and it would necessitate increased taxation of individuals. But it must be noted that people deeply resent the risk to their savings involved in the current systems of social care charges. I think it ought to be possible to persuade people that they are getting good value for money out of the taxation that is necessary to pay for the introduction of free social care. That would be our response.”¹⁸⁵

181 [Q 305](#) (Jeremy Hunt MP)

182 The triple lock is the mechanism currently used by the Government for uprating the Basic State Pension (BSP). Under the triple lock, the BSP is increased each April by either the growth in average earnings, the Consumer Price Index (CPI), or 2.5%, whichever is highest.

183 [Q 281](#) (Simon Stevens)

184 [Q 118](#) (Lord Willetts)

185 [Q 159](#) (Dr Watkins)

People's ability to pay for care

227. There was debate over whether the limited provision of social care should continue to be means-tested. Evidence suggested that a means-tested system with adequate funding was sustainable on the condition that the Dilnot Report¹⁸⁶ proposals were swiftly implemented to provide a more realistic means-test and the capping of individuals' care costs at a sensible level.
228. The Care and Support Commission, led by Sir Andrew Dilnot, published its report in July 2011 (the 'Dilnot Report'). Its recommendations included the introduction of a cap on social care costs "to protect people from extreme care costs" in a range of £25,000 to £50,000, with a suggested rate of £35,000. It also proposed an increase in the upper capital limit for the means-test—below which people are eligible for local authority financial support towards their care costs—from £23,250 to £100,000. The Government accepted the recommendations, but later set the cap at £72,000 and the upper capital limit for the means test at £118,000.
229. Despite repeated assurances that Dilnot's proposals would be implemented, including through a commitment in the Conservative Party's 2015 manifesto,¹⁸⁷ on 17 July 2015, some two and a half months after the General Election, the Government announced a four-year delay in the introduction of the cap on social care costs.¹⁸⁸ In July 2015, Lord Prior of Brampton, Parliamentary Under Secretary of State for Health, cited a cost of £6 billion to implement the cap to care costs over the next 5 years as the reason behind the decision.¹⁸⁹
230. Many witnesses were disappointed at the failure to implement the duty under Section 18(3) of the Care Act 2014 that would have capped spiralling care costs, as proposed by the Dilnot Report. Again, some suggested that the Better Care Fund was alleviating the situation but most of the evidence did not support this assertion. Sir Andrew Dilnot told us that we should: "make sure that the Government introduce a cap on social care while at the same time properly funding the means-testing system. Those things were agreed, legislated for and in the Government's manifesto, so I am very much looking forward to seeing them done in 2020."¹⁹⁰
231. When asked about the future of the Dilnot proposals, Dr Sarah Wollaston MP, Chair of the House of Commons Health Select Committee, echoed Sir Andrew's call:

"[the provisions in the Care Act 2014 were] dumped in, I thought, a disgraceful fashion. Being snuck out as a Written Statement just before parliament rose, I thought, was the wrong way to do this. Even though there had been a clear call for it in response to the introduction of the living wage, it was clearly not going to be possible for them to do both. They have kicked it down the road a bit, but it is still there because we legislated for that ... They cannot keep ducking it ... They need to get

186 Commission on Funding of Care and Support, *Fairer Care Funding* (July 2011): <https://web.archive.org/web/20121019200932/https://www.wp.dh.gov.uk/carecommission/files/2011/07/Fairer-Care-Funding-Report.pdf> [accessed 28 March 2017]

187 The Conservative Party, *The Conservative Party Manifesto* (2015), p 38: <https://s3-eu-west-1.amazonaws.com/manifesto2015/ConservativeManifesto2015.pdf> [accessed 28 March 2017]

188 House of Commons Library, Social care: Announcement delaying introduction of funding reform (including the cap) and other changes until April 2020 (England), Briefing Paper, [No. 7265](#), 6 August 2015

189 Written Statement, [HLWS135](#), Session 2015–16

190 [Q 104](#) (Sir Andrew Dilnot)

to grips with this. Either they need to say, ‘It’s not affordable’ and be honest with the electorate, or they need to be setting out how they are going to fund it ...”¹⁹¹

232. Dame Kate Barker, Chair of the Commission on the Future of Health and Social Care England, argued that social care costs should not deprive people of all they have:

“We have to accept, as I say, that we probably cannot fund everything out of general taxation. People are going to have to cope with some of the ups and downs in their lives with social care, as they do with other things, but they should not have to cope with catastrophic costs, and people who do not have the resources to cope should not be left without any, as I think is happening too much today.”¹⁹²

Other funding streams

233. There were a number of ideas for how new funding streams could be developed to provide funding stability for social care. These included revisiting the pensions triple lock and converting it to a triple guarantee to cover pensions and care costs; incentives to individuals to save and invest to pay for care; a compulsory personal insurance-based system starting in middle age to cover care costs (as in Japan and Germany); and improved arrangements for accessing revenue from housing assets. We did not have the time or expertise to evaluate the merits of these ideas but note that the Government is considering all options and that the answer may lie in a combination of more than one of these.

234. The insurance option arose in evidence time and time again. Professor Julien Forder, Professor of Economics of Social Policy and Director of the Personal Social Services Research Unit at the University of Kent, told us: “it is time to look more seriously at statutory insurance and some form of hypothecation. Since the royal commission in 1999, there have been many attempts to reform social care. I think now is the time to look at statutory insurance very closely.”¹⁹³

235. Lord Willetts asked us to consider the systems in operation elsewhere in the world:

“Interested as I am in a fair deal between the generations, it is social care where we have a real muddle on our hands. I was on the Cabinet Committee that considered Sir Andrew Dilnot’s proposals, which of course have now been so watered down as to be barely happening. On social care, there is some scope for a combination of proper and distinctive public financing—perhaps doing as they did in Germany, with some national insurance element dedicated to covering the cost of social care—plus being explicit about private payment on top of that.”¹⁹⁴

191 [Q 292](#) (Dr Sarah Wollaston MP)

192 [Q 104](#) (Dame Kate Barker)

193 [Q 104](#) (Professor Julien Forder)

194 [Q 118](#) (Lord Willetts)

236. We received a great deal of evidence asking us to examine the possibility of introducing German or Japanese style systems, both of which involve compulsory long-term care insurance which is shared between an employer and employee, much like the workplace pension scheme in the UK. There have also been calls in the media to examine these type of options¹⁹⁵ and we support these calls. The key features of the systems are shown alongside the English system in Table 1.

Table 1: Social care systems in Japan, Germany and England

	Japan	Germany	England
How is the care funded?	<p>National compulsory long-term care insurance (LTCI).</p> <p>Roughly half of long-term care financing comes through taxation and half through premiums.</p> <p>Citizens aged 40 and over pay income-related premiums along with public health insurance premiums.</p> <p>Employers pay the same premium as that of their employees.</p>	<p>Mandatory long-term care insurance (LTCI).</p> <p>There is a contribution rate of 2.35% of gross salary which is shared between employers and employees; people without children pay an additional 0.25%. The contribution rate is set to increase by 0.2% in 2017.</p>	<p>The NHS pays for some long-term care, such as for people with continuing medical needs, but most long-term care is provided by local authorities and the private sector.</p>
Who is covered?	<p>Those aged 65 and over and some disabled people aged 40–64.</p>	<p>Everybody with a physical or mental illness or disability (who has contributed for at least two years) can apply for benefits, (dependent on an evaluation of need and limited to a maximum amount, depending on the level of care).</p>	<p>Local authorities are legally obliged to assess the needs of all people who request it, but, unlike NHS services, state-funded social care is not universal.</p>

195 Rachel Sylvester, 'Social care crisis needs a Japanese solution', *The Times* (6 February 2017) <http://www.thetimes.co.uk/article/social-care-crisis-needs-a-japanese-solution-8pqr2lgnx> [accessed 28 March 2017]

	Japan	Germany	England
What is covered?	<p>The social care system covers home care, respite care, domiciliary care, disability equipment, assistive devices, and home modification.</p> <p>Medical services are covered by the public health insurance system, as are palliative care and hospice care in hospitals, and medical services provided in home palliative care, while nursing services are covered by LTCI.</p>	<p>Beneficiaries can choose between receiving benefits in cash, which they can use to pay family carers, or even to carry out house renovations to make their accommodation accessible; or they can choose to receive in-kind service benefits, where care is provided by an agency under contract to the insurance company.</p> <p>As benefits usually cover approximately 50% of institutional care costs only, people are advised to buy supplementary private LTCI.</p>	<p>With the exception of “reablement” services, some equipment and home modifications (in some areas), residential and home care are needs and means-tested.</p>
Who provides the care?	<p>The majority of home care providers are private; 64% were for-profit, 35% not-for-profit, and 0.4% public in 2013.</p>	<p>Both home care and institutional care are provided almost exclusively by private not-for-profit and for-profit providers.</p>	<p>In 2009, the private sector provided 78% of residential care places for older people and the physically disabled in the UK.</p> <p>The NHS provides end-of-life palliative care at patients’ homes, in hospices (usually run by charitable organisations), in care homes, or in hospitals.</p>

Sources: Commonwealth Fund, (2015) *International Profiles of Health Care Systems* (January 2016): http://www.commonwealthfund.org/~media/files/publications/fund-report/2016/jan/1857_mossialos_intl_profiles_2015_v7.pdf?la=en [accessed 28 March 2017] and The King’s Fund, *The social care and health systems of nine countries* (2014), p 27: <https://www.kingsfund.org.uk/sites/files/kf/media/commission-background-paper-social-care-health-system-other-countries.pdf> [accessed 28 March 2017]

237. There is a clear need to encourage people to take more financial responsibility for the care they receive and to open up new revenue streams to be able to provide this care. The option of some form of compulsory insurance scheme should be given serious consideration.
238. Steve Webb, Director of Policy, Royal London Group, also argued that a more sophisticated solution would be required which did not simply opt for increasing personal taxation through national insurance.
239. **Social care should continue to be underpinned by a means-tested system. Where possible people should be encouraged to take personal responsibility for their own care. We support a funding system that enables those who can afford it to pay for the social care they need but with the costs falling on individuals capped in the manner proposed by the Dilnot Commission.**
240. *The Government should also implement as quickly as practicable, and no later than the first session of the next Parliament, new mechanisms which will make it easier for people to save and pay for their own care. The Government should, in the development of its forthcoming green paper on the future of social care, give serious consideration to the introduction of an insurance-based scheme which would start in middle age to cover care costs.*

CHAPTER 5: INNOVATION, TECHNOLOGY AND PRODUCTIVITY

241. The world is changing and the NHS must adapt if it is to continue to deliver the vital services millions of patients have come to rely on. This chapter highlights the NHS's relative failure to secure the take-up of innovation and new technology at scale and make effective use of data. It also highlights the mixed picture on productivity and the persistent variation in the quality of care and outcomes. Ultimately, strong leadership and a radical culture shift are required.

Innovation and technology

242. The Five Year Forward View speaks of accelerating useful health innovation and exploiting the information revolution. Powerfully, it presents the information revolution alongside the agricultural revolution and the industrial revolution as one of the major economic shifts in human history; but it also acknowledges that the NHS has been slow to adopt information technology because of a tendency to either over-centralise on the one hand or let “a thousand flowers bloom” on the other.¹⁹⁶
243. New technologies are changing what type of care can be provided and how it is delivered. Andy Williams, Chief Executive of NHS Digital, outlined some of the ways in which new technologies would support NHS sustainability:

“In the future, as patients start to have access to their health records and so-called ‘artificial intelligence’ can be used to understand what is wrong with them and to compare their health record to the health records of the broader population, they can come up with smart diagnoses to help the patient understand what they should do next, and it could be to go to A&E or it might not be.

The second is that we can use technology better to create more efficiencies in the way the system works, through interchange and passing information around ... Within hospitals, technology systems can not only improve quality but can increase efficiency and effectiveness.

The third area is a much better use of data generally ... data can be used in all sorts of ways in the future: to understand how effective the system is; to develop new treatments and new drug treatments more effectively; and linking genomics data to phenomics data.”¹⁹⁷

244. Medical advances are constantly changing the way the NHS responds to patient need and the possibilities presented by digital innovations are enormous both for the workforce and patients. However, traditionally, the NHS has been slow to adopt and implement new technology. The evidence suggested that, worryingly, this is still the case. Some argued that this was because of inadequate levels of funding, others argued that this was because of persistent cultures of complacency. Alistair McLellan, Editor of the Health Service Journal, however, reminded us that this was not the case everywhere: “while the NHS faces many challenges, there is also an enormous amount of

196 NHS England, *Five Year Forward View* (October 2014): <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf> P31 [accessed 28 March 2017]

197 [Q 237](#) (Andy Williams)

innovation, endeavour and improvement going on within the service.”¹⁹⁸ Dr Helen Stokes-Lampard, Chair of the Royal College of General Practitioners, also told us that there was a willingness to engage with new technology systems:

“We desperately need to embrace technology. Healthcare professionals love technology generally; it is just getting standardised, joined-up systems that we can use across the board. We want to be able to communicate with each other efficiently and effectively. It needs resource to do that, because IT will help us enormously with our jobs. When I hear that midwives are spending 50% of their time on admin tasks, we know that if we had better IT systems that could be reduced massively.”¹⁹⁹

245. There was disagreement on the possibility for cost savings which could be brought about by the use of new technologies; they might increase levels of productivity but cost more to procure. Some argued that new technologies, such as healthcare and assistive technologies,²⁰⁰ as well as the use of digital health, tele-health²⁰¹ and wearable technologies, had the potential to transform care and could reduce costs and demand on NHS services.²⁰² Professor Keith McNeil, Chief Clinical Information Officer for Health and Social Care and Head of IT for the NHS, provided an illustration:

“... give you a practical example of innovation and costs, when coronary angioplasty came in, which is putting a balloon in a coronary artery to treat a heart attack or a blockage, the previous treatment would be to open someone’s sternum and do an operation. The cost of doing an angiogram is much less than doing an operation, but the angiogram enables that technology to be available to a much wider population, so you get the balance between an individual procedure which is less costly and innovative but is available across a wider population and, in fact, the aggregate cost is greater.”²⁰³

246. Andy Williams, Chief Executive of NHS Digital, argued that there were difficulties in encouraging the uptake of new technology at scale. He pointed to both a silo mentality and a “technology inhibitor”:

“... new technologies quite often get plugged into the existing technology of one of those organisations and it is unique to that, and trying to replicate it somewhere else requires an awful lot of planning, so it is hard and difficult; it is not simple just to take something from here and put it over there. From a technology point of view, over the next few years we have to make that much simpler.”²⁰⁴

198 [Q 333](#) (Alastair McLellan)

199 [Q 213](#) (Dr Helen Stokes-Lampard)

200 Healthcare and assistive technologies include any product or service designed to enable independence for disabled and older people, such as wheelchairs, stairlifts, aids for daily living and artificial limbs.

201 Tele-health is the provision of healthcare remotely by means of telecommunications technology.

202 Written evidence from British Healthcare Trades Association ([NHS0056](#)), Association of Medical Research Charities ([NHS0059](#)), Wellcome Trust ([NHS0051](#)), Association for Clinical Biochemistry and Laboratory ([NHS0043](#)), Doctors for the NHS ([NHS0027](#)), Royal College of Emergency Medicine ([NHS0029](#)), The ASHN Network ([NHS0031](#)), The Royal College of Ophthalmologists ([NHS0032](#)), Institute and Faculty of Actuaries ([NHS0038](#)), The Royal College of Radiologists ([NHS0049](#)) and Mrs Susan Margaret Oliver ([NHS00006](#))

203 [Q 237](#) (Professor Keith McNeil)

204 [Q 239](#) (Andy Williams)

247. Professor Sir John Bell, Regius Professor of Medicine at the University of Oxford, explained that the incentive to innovate was often unclear. He argued that if innovation were to be seen in the context of saving costs, the uptake would be greater:

“I think the fundamental problem with innovation in healthcare is that we do not systematically look for the ways that innovation can extract cost from healthcare systems. In fact, the definition of ‘innovation’ should be to improve outcomes and to save costs, and it saves costs by changing pathways, allowing you to re-profile the workforce, which is essentially where healthcare systems spend all their money, and you should be able to extract very large amounts of money out of the system using those tools.”²⁰⁵

He also explained the importance of applying this across the system:

“it is about being really rigorous about taking innovations and trying to evaluate how you can extract the costs of innovations in a closed system, measuring and evaluating everything and then recommending that across the system. That will make a huge difference.”²⁰⁶

248. The benefits of using new technology are well known but we were told that encouraging uptake was difficult. One possible solution might be a system which would appraise new technologies, come to a decision on cost-effectiveness and need, and then make it clear to providers that implementation should follow. Lord Willetts suggested that providers should be told what was expected of them more broadly:

“... with social care, I look at some of the extraordinary advances in technology, where they can literally track your pattern of electrical use. They can work out when you are turning on a particular device, and register that this person is turning on a kettle between 9.30am and 10am and she has not turned it on and it is 11am, just by monitoring the electricity supply. We need to use technology and embrace the capacity of innovation. We experimented, and one way of making it happen is a list of required innovations that healthcare providers are expected to introduce.”²⁰⁷

It was unclear, however, who should be charged with undertaking such a detailed technical appraisal and imposing the resulting requirements on providers, or whether there were currently any penalties for failing to do so.

249. The PHG Foundation argued for financial incentives to encourage innovation²⁰⁸ and Professor Sir John Bell suggested that the penalty for failing to make progress could be financial:

“It is worth remembering that the Americans did this in a really short timeframe. They, essentially, digitised their entire healthcare system, which, as you know, is chaotic at best, and they did it by incentivising the hospitals and making sure that reimbursement was directly related to the ability to digitise. If the NHS tomorrow said, ‘Do it at whatever pace you like, but you will not get paid if it is not digital data’, I can tell

205 [Q 237](#) (Professor Sir John Bell)

206 [Q 242](#) (Professor Sir John Bell)

207 [Q 128](#) (Lord Willetts)

208 Written evidence from the PHG Foundation ([NHS0080](#))

you that, by Christmas, you would find a lot of stuff had happened. Hospital trusts have a lot of stuff on their plate, so why would they do it when they are doing everything else? There is a bit of a problem in incentivising these places in the way we need to. The American example shows that it can happen really fast.”²⁰⁹

250. **There is a worrying absence of a credible strategy to encourage the uptake of innovation and technology at scale across the NHS. It is not clear who is ultimately responsible for driving innovation and ensuring consistency in the assessment and the adoption of new technological approaches. The provision of appropriate training and development of strong leaders to support this agenda within the NHS will be critical to its success.**
251. *The Government should make it clear that the adoption of innovation and technology, after appropriate appraisal, across the NHS is a priority and it should decide who is ultimately responsible for driving this overall agenda. It should also identify the bodies and areas within the NHS which are falling behind in the innovation and technology agenda and make it clear that there will be funding and service delivery consequences for those who repeatedly fail to engage. This could involve relocating services to places that prove to be more technologically innovative.*

The effective use of data

252. The effective use of data is of critical importance for the long-term sustainability of the NHS. We now know more than ever about the health of patients, but the continued failure to use this data effectively is costing too much money and resulting in unacceptable levels of variations in patient outcomes.
253. The use of Big Data was raised a number of times. Big Data is a term that describes the large volume of data—both structured and unstructured—that flows into an organisation on a day-to-day basis. This may be how many people have booked appointments in certain areas of the country, cancer diagnosis rates or average prescription costs for a specific drug. However, the PHG Foundation pointed out that the existence of Big Data is not enough: “The health service is already awash with ‘big data’, but its inability to standardise it, aggregate it, share it, analyse it and then use it intelligently to drive changes in practice means that its impact on reducing cost and managing demand are limited.”²¹⁰
254. We were told that data sharing and access was also important for continued medical research.²¹¹ The Association of Medical Research Charities explained that “researchers use health information to develop understanding of disease and ill-health, discover new cures and treatments for patients; and improve the care provided by the NHS and provide efficiency and cost savings.”²¹² They continued to say that: “without access to health information, the advancement of medical research will be hampered and with it the benefits to the NHS’s future sustainability.”²¹³

209 Q 241 (Professor Sir John Bell)

210 Written evidence from PHG Foundation (NHS0080)

211 Written evidence from Association of Medical Research Charities (NHS0059), The ASHN Network (NHS0031) and Sense (NHS0048)

212 Written evidence from Association of Medical Research Charities (NHS0059)

213 *Ibid.*

255. The Secretary of State for Health acknowledged that there was still more work to be done in the patient sphere:

“What we do not do at the moment, but it is starting to happen, is allow those records to flow around the NHS, but we have complete histories of people, which is a fantastic asset ... Now we have around two-thirds of A&E departments able to access people’s GP medical records, and next year we will go a step further and introduce what we are calling the Blue Button scheme. At the moment you can access your own record if you go to your GP surgery and get a code, so you can go online and access your record, but from next year we will have a system where you can go online and identify yourself online without having to go to your GP surgery. That will be very significant, because people will be able to download their record on their phone. People with long-term conditions will be able to get engaged in their own treatment ... It will save a lot of time. In short, I think there are some very exciting things happening.”²¹⁴

256. Dr Ron Zimmern, Chair of the PHG Foundation, argued that data sharing went to the heart of the effective use of new technologies:

“No matter what technology you look at—epigenetics, microbio, liquid biopsy—in the end it is about data and data sharing. To do that properly, you have to engage the citizen, you have to break down silos and you have to actively develop leaders. Without that, you will not get the data sharing which is absolutely at the heart of everything that we want to do.”²¹⁵

257. The benefits of data sharing are obvious; it can lead to improved patient engagement and ultimately better overall outcomes. Andy Williams, Chief Executive of NHS Digital, told us: “I think we can do much more, as far as the patient is concerned, by better use of digital technologies to allow patients to understand more, to access their health records and increasingly to use intelligent systems to allow them to look at self-diagnosis.”²¹⁶ The Royal Pharmaceutical Society echoed this point and said that “there should be a shared patient record that all relevant healthcare professionals can read and write to. There needs to be systems and processes in place that enable the electronic referral of patients, and information, between one care setting and another.”²¹⁷

258. Professor Sir John Bell argued that an additional benefit was the ability to track the costs associated with a patient’s treatment pathway:

“The advantage of the digital agenda is that you will be able to capture data on the same patient in primary, secondary and social care, and you will be able to know the captured cost of that whole pathway and then manage that to try to get yourself in a better position in terms of cost reduction.”²¹⁸

259. The Government’s flagship £7.5m *care.data* project aspired to create a giant database of medical records showing how individuals had been cared for across the GP and hospital sectors, and was intended to help them develop new treatments and assess the performance of NHS services. The records

214 [Q 311](#) (Jeremy Hunt MP)

215 [Q 242](#) (Dr Ron Zimmern)

216 [Q 237](#) (Andy Williams)

217 Written evidence from the Royal Pharmaceutical Society ([NHS0077](#))

218 [Q 237](#) (Professor Sir John Bell)

would have been anonymised, removing identifiable data, and would only have revealed the patient's age range, gender and area they lived in. The project was abandoned in the summer of 2016 because of data protection concerns and accusations that the Government had mismanaged the process of public consultation.²¹⁹ The failure to successfully implement *care.data* was cited as a missed opportunity²²⁰ and, although instances of good practice were highlighted, there is clearly still more to be done.

260. Andy Williams, Chief Executive of NHS Digital, agreed that public consultation was key:

“... *care.data*, in part, failed through a lack of public trust in the use of the data that was going to be generated. When we are thinking about the benefits of data in the future, which are enormous, we have to bring the public with us and this comes down to the public having to trust that we are handling their data with care and respecting whether they agree with the use of their data. We have to convince the public that we are doing the right thing and involving them and asking them.”²²¹

261. Professor Sir John Bell said that the key was public consultation at a local level where trust already existed:

“There is an important point here, which is that engagement is unlikely to be done by Government Ministers. It is very likely to be done at a local, not a national level. If you get a letter from these guys—who are terrific, I have to say; NHS Digital are terrific—saying how they are going to use your data for X, Y and Z, you will flip. If somebody in the local GP surgery or the local hospital says, ‘We are going to try to get a system where you can look at your records. Will that be okay with you?’ you are likely to say, ‘Yes that is kind of interesting’. If they say, ‘We would also like a system whereby the hospital consultant can see the GP records and the GP can see the hospital records’, if the patient knows the GP and they know the hospital, they will say, ‘Well, I thought you did that already’, which we do not, and then they will say, ‘Well, of course you can do that because then, when I go to see the consultant, he will know what the GP said and *vice versa*’. If you can build their confidence at a local level, it becomes much easier to make those things associate with each other and you then end up with very powerful master databases, but it is all done with consent on things that will benefit the patient. If this does not benefit patients, it is going nowhere.”²²²

262. ***The failure of the *care.data* project illustrates the inevitable consequences of failing to grapple with important issues relating to personal privacy. NHS Digital and all those responsible for data sharing in the NHS should seek to engage the public effectively in advance of any future large-scale sharing of personal data. Public engagement on data sharing needs to become a priority at a local level for staff in hospitals and the community, and not be left to remote national bodies.***

219 Sarah Knapton, ‘Controversial £7.5 million NHS database scrapped quietly on same day as Chilcot Report’, *The Telegraph* (6 July 2016): <http://www.telegraph.co.uk/science/2016/07/06/controversial-50-million-nhs-database-scrapped-quietly-on-same-d/> [accessed 28 March 2017]

220 Written evidence from Association of Medical Research Charities (NHS0059) and The Royal College of Paediatrics and Child Health (NHS0133)

221 Q 240 (Andy Williams)

222 Q 240 (Professor Sir John Bell)

Productivity and variation

263. Many witnesses also referenced the Carter Review²²³ which set out how non-specialist acute trusts could reduce unwarranted variation in productivity and efficiency across every area in hospitals to save the NHS £5 billion each year by 2020/21. It was clear that, as NHS Improvement emphasised, operational productivity and efficiency were “key components to the sustainability of NHS services”.²²⁴ This view was echoed by the Health Foundation who argued that narrowing the gap between efficiency of the best and the average would make “a substantial contribution to the efficiency challenge in the Forward view”.²²⁵
264. Variable levels of productivity in the health and care systems remain an endemic problem with wide differences in levels of provider performance. Although productivity and efficiency in the NHS has improved over time and although the health system is a national service, there is an unacceptable level of unwarranted variation in what is provided and the costs of providing the same care. This presents a picture of an ineffective and inefficient NHS which is failing patients.
265. There is the potential to do much better in this area. The Office for Budget Responsibility (OBR) projections show that improving the productivity and efficiency of the health system is not simply a requirement of the current period of austerity but a fundamental, long-term imperative for a sustainable NHS. The Carter Review²²⁶ and RightCare programme²²⁷ on NHS efficiency and value reveal how much better the NHS could do. The significant underuse of technology, data and digitalisation is having a direct impact on levels of productivity. According to Dell EMC, better use of data and technology “would improve efficiency in the healthcare sector by between 15% and 60%, resulting in savings to the NHS of between £16.5 billion and £66 billion per year”.²²⁸
266. Sir Muir Gray, Honorary Professor at the Nuffield Department of Primary Care Health Sciences, explained how some of these variations could have a direct impact on patient outcomes:

“I have brought along one of our atlases of variation, which we publish to destabilise the professions, to show huge variation: a fourfold variation in amputation; a twofold variation in the percentage of people dying at home; a fiftyfold variation in knee ligament surgery; and a hundredfold variation in rheumatoid factor interventions—all by people who thought they were doing evidence-based medicine.”²²⁹

223 Lord Carter of Coles, *Operational productivity and performance in England NHS acute hospitals: Unwarranted variations, An independent report for the Department of Health by Lord Carter of Coles*, (February 2018): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf [accessed 28 March 2017]

224 Written evidence from NHS Improvement (NHS0107)

225 Written evidence from the Health Foundation (NHS0172)

226 Lord Carter of Coles, *Operational productivity and performance in England NHS acute hospitals: Unwarranted variations, An independent report for the Department of Health by Lord Carter of Coles*, (February 2018): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf [accessed 28 March 2017]

227 The NHS RightCare programme was set up to assist local health economies to reduce unwarranted variation, using local data and evidence on outcomes, and working in partnership with local organisations. For more information see the NHS RightCare Programme: <https://www.england.nhs.uk/rightcare/programme/> [accessed 28 March 2017]

228 Written evidence from Dell EMC (NHS0070)

229 Q 59 (Sir Muir Gray)

267. He explained to us that the variation in outcomes was often accompanied by a lack of awareness of the true overall costs of treating certain conditions. He placed this in the context of the overall budget allocation:

“There is £115 billion on the table, there is a twofold variation in allocation of money and a tenfold, twentyfold, fiftyfold variation in activity, and we cannot see that explained by need or explicit choice. It is about thinking of programme budgeting and getting clinicians and patient groups together to think about whether we are making the best use of the resources we have for this population ... There is a split between purchasers and providers, and game-playing goes on. We know to the nearest pound what we spend in every hospital. I can tell you what we spend on car parking in the Oxford University hospitals trust because it is in the annual report, but no one you meet in Oxfordshire could tell you how much we are spending on women’s health or on respiratory, because the GP prescribing is over there and the hospital over there.”²³⁰

268. This disjointed approach to tracking costs inevitably leads to different levels of service being delivered in different parts of the country. Sir Muir explained some of the work that was taking place to help the sharing of best practice to reduce unwarranted variation. He spoke of the importance of benchmarking and learning from others working on the same problems in different areas:

“The proportion of people dying at home varies from 78% to 46%, so there is something going on at the local level that is very difficult to recognise. The question is getting people to start looking at where they stand in comparison to others. Both the 78% and the 46% of people will think that they are working their socks off. We have been trying to say to them, ‘Why don’t you go and see these other people and see how they’re doing it?’”²³¹

He went on:

“[The RightCare Team] are going to every CCG and showing them where they are ... We are setting up a casebook, as you would in any well-run organisation, where people can say, ‘Okay, we have a problem with emergency calls in Scunthorpe, and this is what the Blackpool Ambulance Service did’. Learning from within the system needs to be accelerated greatly.”²³²

We believe that such initiatives should become part of the normal way in which clinicians and managers carry out their duties. Those in a position to effect change should be unafraid of questioning local practice.

269. Unwarranted levels of variations in patient outcomes are unacceptably undermining the effectiveness and efficiency of the NHS and there is no plan to bring about a greater consistency in levels of performance. However, there is an immediate opportunity in the implementation of STPs to take this forward. Moreover the professional regulators and professional bodies should consider how they can assist in reducing variation in productivity and outcomes as part of their regular inspections and reporting.

230 [Q 60](#) (Sir Muir Gray)

231 [Q 65](#) (Sir Muir Gray)

232 [Q 64](#) (Sir Muir Gray)

270. *The Government should require a newly unified NHS England and NHS Improvement to work with commissioners to achieve greater levels of consistency in NHS efficiency and performance. Greater levels of investment and service responsibility should be given to those who improve the most.*

Leadership and management

271. We received a large amount of evidence on the enormous potential for cost savings, improved efficiency and higher productivity where new technologies and the effective use of data are harnessed. The evidence was almost always accompanied, however, with a call for stronger leadership and more effective management. Technologies do not implement themselves and innovative ways of working will only be adopted where there is a culture which embraces change. Dr Ron Zimmern articulated this point and noted that individuals had to take a conscious decision to implement change:

“... although innovation is necessary, it is not sufficient. There are huge barriers at the moment to diffusion—although we should not use that word because it is passive and, if you allow it to be passive, it will not happen. Change management is the thing. If we are going to have disruptive change, we need to have change champions. There are issues about both having and developing clinical champions, clinical leadership, managerial champions and managerial leadership for change management. It will not happen by itself. It is an explicit activity.”²³³

272. Andy Williams, Chief Executive of NHS Digital, also pointed to leadership as the answer:

“... this is not a technology challenge; the technology largely exists and will continue to exist. Like everything, it is a people challenge, so the one thing I would point to is to get the leadership at all levels across the system to understand the benefits generally and the benefits in particular to their organisation of these sorts of technologies.”²³⁴

Lord Willetts said: “The NHS is a slow, late adopter of innovation. It seems to be a management challenge: shifting to a new way of doing things is hard to organise.”²³⁵

273. Many witnesses questioned the quality of the current leadership and management in the NHS. Professor Alistair McGuire, Chair in Health Economics at the London School of Economics, argued that improved management was a priority.²³⁶ Dr Sarah Wollaston MP, Chair of the House of Commons Health Select Committee, also pointed to good quality leadership:

“The role of leadership is extraordinary. We have heard time and again that that is what is driving culture change, making things happen and dealing with variation and morale within the workforce. You can make differences and make efficiencies in the way health and care operate, but, without good leadership, that is much more challenging.”²³⁷

233 [Q 238](#) (Dr Ron Zimmern)

234 [Q 242](#) (Andy Williams)

235 [Q 128](#) (Lord Willetts)

236 [Q 75](#) (Professor Alistair McGuire)

237 [Q 291](#) (Dr Sarah Wollaston MP)

274. Sir Muir Gray highlighted a potential distortion in the way certain categories of leader viewed their primary role:

“Changing the culture is more important than changing the model. In Derbyshire, we asked how many people there were with type 2 diabetes, and no one could answer. We asked them what the deficit was and they said £16 million. These are clinicians. Changing the culture is the function of leadership; it is partly behaviour but it is also the language.”²³⁸

275. Professor Sir Mike Richards, Chief Inspector of Hospitals at the CQC, called for leaders from different areas of expertise to come together: “We need to build the cadre of leaders, both clinical and non-clinical. Where we see good leadership and things are happening already, we need to put people working alongside those very good leaders so that they can learn from them.”²³⁹

276. Professor Sir John Bell explained that, in some cases, the cost of maintaining a digital system could be the same as employing people to carry out the work manually and that in many cases the problem was one of the wider prevailing culture. He shared the following anecdote about the same digital system being introduced in different countries:

“... All the savings came from the efficiency of the radiologists who could flick through 10, 20 or 30 X-rays from individual patients or multiple patients much faster, so their efficiency hugely improved. In America, where they introduced the same system, they fired a lot of radiologists. In the UK, everybody just drank more tea and ate doughnuts. That is the problem and that is what you have to fix.”²⁴⁰

277. Understandably, too much management and clinical attention in the NHS is focused on the here and now and there are too few incentives to look ahead to the longer term.

278. *The testing and adoption of new health technologies should be formally integrated into medical and non-medical NHS leadership, education and training at all levels.*

279. *NHS England should develop a system to identify and financially reward organisations and leaders who are instrumental in driving the much needed change in levels of productivity, the uptake of innovation, the effective use of data and the adoption of new technologies.*

238 [Q 68](#) (Sir Muir Gray)

239 [Q 264](#) (Professor Sir Mike Richards)

240 [Q 238](#) (Professor Sir John Bell)

CHAPTER 6: PUBLIC HEALTH, PREVENTION AND PATIENT RESPONSIBILITY

280. Effective public health strategies can deliver an extensive range of benefits, not just to individuals but to communities, the health service and the economy as a whole. We heard, however, that action on public health and prevention in the past has been insufficient and frustratingly slow, and that it is now chronically underfunded. This chapter highlights the multiple concerns raised about the apparent low level of priority assigned to public health and prevention.

Preventable ill health: causes and costs

281. Non-communicable diseases (those not caused by infectious agents, also known as chronic diseases) account for around two-thirds of deaths worldwide.²⁴¹ The four main types of non-communicable disease are cardiovascular disease, cancers, chronic respiratory disease and diabetes. In the UK non-communicable diseases cause an estimated 89% of deaths,²⁴² the most significant cause being the major diseases of the health and circulatory system (coronary heart disease and stroke).²⁴³ These conditions are also, to a significant extent, preventable and the costs, in human, social and economic terms, are largely avoidable. The World Health Organisation identifies the four most important modifiable risk factors for these diseases as tobacco use, physical inactivity, the harmful use of alcohol and unhealthy eating.

282. Social determinants of health (for example economic and social conditions) also contribute significantly to levels of preventable ill health. When it published its report in 2010, the Marmot Review, *Fair Society Healthy Lives* identified striking levels of health inequalities across the country, including that people in the poorest neighbourhoods in England would on average die seven years earlier and spend more of their life living with a disability.²⁴⁴

283. From the evidence we received, it appears that preventative ill health continues to place a significant burden on patients and on the health service, and is undoubtedly a major threat to the long-term sustainability of the NHS. The UK Health Forum warned that: “The current and escalating future burden of non-communicable disease on the NHS is unsustainable.”²⁴⁵ We received a wealth of evidence on the scale of this burden, including that:

- About a third of all deaths are classed as premature. That equates to 44 years of lost life per 1,000 people or 2.6 million years each year across England and Wales.²⁴⁶
- Around 40% of premature mortality in the UK is caused by preventable cardiovascular disease, diabetes, cancer and chronic obstructive pulmonary disease.²⁴⁷

241 World Health Organization, *Global status report on noncommunicable diseases* (2010): http://www.who.int/nmh/publications/ncd_report_full_en.pdf [accessed 28 March 2017]

242 World Health Organization, *Non-communicable Diseases (NCD) Country Profiles* (2014): http://www.who.int/nmh/countries/gbr_en.pdf [accessed 28 March 2017]

243 The King’s Fund, ‘Non-communicable diseases’: <https://www.kingsfund.org.uk/time-to-think-differently/trends/disease-and-disability/non-communicable-diseases> [accessed 28 March 2017]

244 Q 322 (Professor Sir Michael Marmot) and The Marmot Review, *Fair Society Healthy Lives* (2010): <http://www.parliament.uk/documents/fair-society-healthy-lives-full-report.pdf> [accessed 28 March 2017]

245 Written evidence from UK Health Forum (NHS0142)

246 Written evidence from the Local Government Association (NHS0125)

247 Written evidence from UK Health Forum (NHS0142)

- It is estimated that 40% of the burden on health services in England may be preventable through action on the determinants of avoidable chronic conditions.²⁴⁸

Inaction on public health and prevention

284. The Five Year Forward View included a clear commitment on prevention, calling for a “radical upgrade” in prevention and public health.²⁴⁹ It acknowledged that robust action on prevention is long-overdue: “Twelve years ago, Derek Wanless’ health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded and the NHS is on the hook for the consequences.”²⁵⁰
285. Despite this renewed emphasis, we heard repeated concerns that the NHS was still failing on public health and prevention. The Academy of Medical Royal Colleges expressed disappointment at the progress made on the Forward View’s ambition on prevention: “Almost two years after the publication of the Five Year Forward View, there appears to have been little meaningful development; the ‘radical upgrade in prevention’ has failed to materialise.”²⁵¹
286. The lack of progress on prevention was evident in the scale of the burden of some of the key public health issues that witnesses reported. Ian Forde, from the OECD, confirmed that in comparison to other countries, the UK was “poor on public health prevention” stating that harmful drinking and smoking, although improving, were still above the OECD average.²⁵²
287. Mark Davies, Director of Health and Wellbeing at the Department of Health, told us: “We have made lots of improvements in the way we address alcohol, through the Chief Medical Officer and the messages that the industry puts out, and people’s alcohol use, through things like the health checks.”²⁵³ However, witnesses were clear that harmful drinking continues to place a significant burden on the health and care services. Public Health England estimates that around 10.8 million adults in England are drinking at levels that pose some risk to their health²⁵⁴ and that the NHS incurs around £3.5 billion a year in costs related to alcohol.²⁵⁵ While there has been some progress, much more should be done to reduce consumption.
288. There has been some progress with smoking, with smoking prevalence falling to 16.9% in England, a significant fall from previous years.²⁵⁶ However, Action on Smoking Health told us that smoking still costs the NHS an estimated £2 billion a year and remains the major cause of preventable premature death in England, causing around 80,000 premature deaths a year.²⁵⁷

248 Written evidence from the Health Foundation ([NHS0172](#))

249 NHS England, *Five Year Forward View* (October 2014): <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf> [accessed 28 March 2017]

250 *Ibid.*

251 Written evidence from the Academy of Medical Royal Colleges ([NHS0139](#))

252 [Q 70](#) (Ian Forde)

253 [Q 19](#) (Mark Davies)

254 Public Health England, ‘Health matters: harmful drinking and alcohol dependence’: <https://www.gov.uk/government/publications/health-matters-harmful-drinking-and-alcohol-dependence/health-matters-harmful-drinking-and-alcohol-dependence> [accessed 28 March 2017]

255 Public Health England, *Alcohol treatment in England 2013–14* (October 2014), p 3: <http://www.nta.nhs.uk/uploads/adult-alcohol-statistics-2013-14-commentary.pdf> [accessed 28 March 2017]

256 [Q 244](#) (Mark Davies)

257 Written evidence from Action on Smoking and Health ([NHS0146](#))

289. It was also suggested that not enough was being done to address health inequalities. We expected that we would receive evidence to suggest that health inequalities still existed but were disappointed to learn that progress at tackling inequalities and the social determinants of poor health was stalling. Professor Sir Michael Marmot told us:

“If we look at early child development, the decline in child poverty stopped, became flat and is now increasing, and the projections are that child poverty will increase over the next four years ...

On employment and working conditions, the quality of work matters. There has been a rise in the proportion of work-related illness related to stress, depression and anxiety, which is complicated.

There will be increased poverty and increased inequality over the next five years, which will potentially damage health, particularly for families with children; they will be selectively hurt the worst. If you look at the gap between the minimum income standard for healthy living and the national living wage, projected over the next five years, it will be particularly large for families with children and single parents with children; they will be in real poverty, which will, of course, have an adverse effect on early child development.”²⁵⁸

290. We acknowledge that there are multiple serious public health issues, which require more robust action to tackle their impact on both patients and the health service. We felt, however, that two public health issues—mental health and obesity—warranted particular focus. Both conditions affect millions of people in England and both cost the NHS and the wider economy billions of pounds a year, but the progress made in tackling both conditions has been wholly inadequate, with potentially devastating implications for the long-term sustainability of the health and care systems.

Mental health

291. We recognise that mental health has emerged as a more prominent policy priority in recent years and, as a consequence, there have been a number of high profile initiatives aimed at addressing long-standing issues in the provision of mental health services. Since parity of esteem between physical and mental health services was enshrined in the Health and Social Care Act 2012 there has been a renewed emphasis on the need to develop integrated care spanning physical, mental and social needs to improve mental health care and outcomes. Most recently, the Government has responded to the Five Year Forward View for Mental Health (published in February 2016), committing to meeting its recommendations in full, including additional investment of £1 billion a year to improve mental health services.²⁵⁹ At the beginning of this year, the Prime Minister also announced a package of measures aimed at improving mental health support in schools, workplaces and communities.²⁶⁰

258 Q 319 (Professor Sir Michael Marmot)

259 HM Government, *The Government's response to the Five Year Forward View for Mental Health* (January 2017), p 1: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/582120/FYFV_mental_health_government_response.pdf [accessed 28 March 2017]

260 Prime Minister's Office, Press Release: 'Prime Minister unveils plans to transform mental health support', 9 January 2017: <https://www.gov.uk/government/news/prime-minister-unveils-plans-to-transform-mental-health-support> [accessed 28 March 2017]

292. Despite a renewed focus on mental health, witnesses were clear that there is still a persistent and considerable divide between physical and mental health. People with mental health problems continue to receive lower levels of appropriate treatment and achieve poorer outcomes. The charity Mind outlined some of the key issues in the provision and delivery of mental care services, including that:

- Mental health problems cause 23% of all illness in the UK but mental health care receives only 11% of health spending.
- Two-thirds of people with common mental health problems such as anxiety and depression receive no appropriate treatment (compared to a quarter of people with physical health problems).
- There is a lack of access to physical healthcare for people with mental health problems—less than a third of people with schizophrenia in hospital received the recommended assessment of cardiovascular risk in the previous 12 months.²⁶¹

293. Sophie Corlett, Director of External Relations at Mind, told us:

We know that we may have some great healthcare here compared to the rest of the world, but compared to our own healthcare in physical health we do extremely poorly. We have got to the heady heights of a third of people with mental health problems getting mental health care at the moment, which means two-thirds of people do not.²⁶²

294. We also heard that, as well as the disparity in care and outcomes for people with mental health issues, preventative action on mental health has also been limited. Claire Murdoch Director of NHS National Mental Health at NHS England, told us:

“ ... the incidence of undetected, untreated diabetes in this country is something like 8%, so we have more work still to do to reach people around detecting and treating their diabetes, and of course now prevention. The incidence of undetected, untreated mental illness or mental ill-health is thought to be closer to 70% in this country.”²⁶³

295. **We welcome the greater prominence that mental health has received in recent years and we are encouraged by the Government’s commitment to a five-year strategy for mental health. Notwithstanding the progress made, there is still a need for sustained and determined action to close the gap between the care received and outcomes achieved by people with mental and physical health issues. Achieving parity of esteem between the two must remain a top priority for service commissioners and regulators.**

261 Written evidence from Mind ([NHS0179](#))

262 [Q 143](#) (Sophie Corlett)

263 [Q 143](#) (Claire Murdoch)

Obesity

296. The evidence suggested that in comparison to other areas of public health policy, there had been a particular failure, by successive governments, to tackle obesity effectively and a reluctance to take robust action on the issue. As opposed to other public health issues such as smoking, the Government was accused of taking a watered-down approach to obesity and failing to provide consistent nutritional advice to the public. Some argued that governments often cite an unwillingness to behave as a ‘nanny state’ as an excuse for inaction.²⁶⁴
297. Obesity costs the NHS around £5.1 billion a year,²⁶⁵ with an estimated cost to the economy of £27 billion due to its effect on productivity, earnings and welfare payments.²⁶⁶ It is also thought that more than 1 in 20 cancers are linked to being overweight or obese.²⁶⁷ There is widespread recognition that obesity, and the increasing prevalence of obesity, is a significant threat to the sustainability of the health service. In July 2016 Simon Stevens, the Chief Executive of NHS England, warned that:

“... obesity is the new smoking: poor diet is now our biggest avoidable cause of ill health. Piling on the pounds around our children’s waistlines is piling on billions in future NHS costs. We now spend more on obesity than on the police and fire service combined.”²⁶⁸

298. The failure to instigate firm action on obesity and prioritise this as a public health issue was particularly evident in the Government’s recent action on the childhood obesity strategy, which was ongoing at the beginning of our inquiry. In July 2016, Mark Davies, Director of Health and Wellbeing at the Department of Health, assured us that:

“We have been working for many months on a childhood obesity strategy. There is a lot of anticipation about that piece of work. We have one prepared. It has been announced that it will be launched in the summer, but we are still waiting to press the button on it. If and when it is published, we hope that it will be a really cross-sectoral look at all aspects of childhood obesity and all the things that drive it, including behaviour, family attitude, promotion, reformulation of food and what happens in school. We are working on a comprehensive strategy. It is a long-term strategy. If we get it right, it will have intergenerational impact and will stretch way beyond the next five or 10 years.”²⁶⁹

264 Written evidence from Doctors in Unite (the Medical Practitioners’ Union) ([NHS0102](#))

265 Peter Scarborough et al, ‘The economic burden of ill health due to diet, physical inactivity, smoking, alcohol and obesity in the UK: an update to 2006–07 NHS costs’, *Journal of Public Health* (May 2011), pp 1–9: <http://iasnew.onepiecejigsaw.com/uploads/pdf/Economic%20impacts%20docs/pubmed.fdr.033full.pdf> [accessed 28 March 2017]

266 Public Health England, ‘Economic impact’: <https://www.noo.org.uk/LA/impact/economic> [accessed 28 March 2017] cited in written evidence from The King’s Fund ([NHS0717](#))

267 Cancer Research UK, ‘How being overweight causes cancer’: <http://www.cancerresearchuk.org/about-cancer/causes-of-cancer/bodyweight-and-cancer/how-being-overweight-causes-cancer> [accessed 28 March 2017]

268 Simon Stevens, ‘The radical blueprint the NHS needs to survive life after Brexit’ *The Telegraph* (18 July 2016): <http://www.telegraph.co.uk/news/2016/07/18/the-radical-blueprint-the-nhs-needs-to-survive-life-after-brexite> [accessed 28 March 2017]

269 [Q 17](#) (Mark Davies)

299. However, when the strategy was published in August 2016, it received widespread criticism suggesting that its proposals were “weak and watered down”.²⁷⁰ It was also criticised for falling far short of what was required to properly address the issue and failing to reflect the seriousness of the impact that obesity was having on the health service. In its evidence, the Royal College of Physicians expressed its disappointment at the childhood obesity strategy, and warned that a failure to address obesity would have serious implications for the sustainability of the health service:

“Despite a commitment to introduce a levy on sugar sweetened beverages, the RCP is extremely disappointed that after such a long wait for the childhood obesity strategy, the government has published a downgraded plan that fails to address key issues such as marketing and promotion of sugar-filled and unhealthy foods to children.²⁷¹ The estimated cost of obesity to the UK economy is approximately £27bn.²⁷² The consequence of failing to act now is to commit the NHS to greater expense in the future as it struggles to fund care and treatment for obesity-related medical conditions. A strong package of measures and concerted action across all government departments is required to turn the tide on obesity.”²⁷³

300. Similarly, the Academy of Royal Colleges warned that:

“If we do not tackle childhood obesity with the seriousness it deserves, the NHS will face an existential crisis. The decision to water down the childhood obesity strategy suggests that the Government does not take prevention and the sustainability of the NHS seriously.”²⁷⁴

301. A number of witnesses suggested that a renewed, cross-government emphasis was needed to tackle the devastating effects of obesity—the “public health time bomb that needs to be tackled urgently.”²⁷⁵ When asked about the possibility of a nationwide campaign to educate people on the effects of obesity and poor diet the Secretary of State for Health, signalled his support for such a move:

“I think it would be an excellent idea. We have looked very hard at the scientific evidence, and there has been research done by people such as McKinsey as to what policy interventions make the biggest difference. I agree with you that obesity is rapidly overtaking smoking as the biggest public health threat.”²⁷⁶

302. We consider that there is insufficient political recognition, across the parties, of the major threat to the long-term sustainability of the NHS posed by the absence of any credible, well-led and sustained action on obesity, as is already the case for smoking and harmful drinking which makes use of regulatory, tax and nudge techniques.

270 BBC, ‘Childhood obesity: Plan attacked as ‘weak’ and ‘watered down’’: <http://www.bbc.co.uk/news/health-37108767> [accessed 28 March 2017]

271 Royal College of Physicians, ‘RCP president Jane Dacre ‘disappointed’ with government childhood obesity plan’: <https://www.rcplondon.ac.uk/news/rcp-president-jane-dacre-disappointed-government-childhood-obesity-plan> [accessed 28 March 2017]

272 National Obesity Observatory, *The Economic burden of Obesity* (October 2010): http://www.noo.org.uk/uploads/doc/vid_8575_Burdenofobesity151110MG.pdf [accessed 28 March 2017]

273 Written evidence from the Royal College of Physicians (NHS0065)

274 Written evidence from the Academy of Royal Colleges (NHS0139)

275 Written evidence from the Royal College of Obstetricians and Gynaecologists (NHS0093)

276 Q 130 (Jeremy Hunt MP)

303. **There is still widespread dissatisfaction with the prevention agenda. We share the views expressed by many of our witnesses of the need to realise the long-awaited ambition to move from an ‘illness’ to a ‘wellness’ service. The NHS must shift the rhetoric to reality and make genuine progress on refocusing the system towards preventative care.**
304. *We recommend that the Government urgently embarks on a nationwide campaign to highlight the many complications arising from the obesity epidemic, including its links with many chronic diseases. Such a campaign must be a cross-departmental effort, target the entire population and involve those who sell food and drink to the public, especially those whose products are consumed by children.*

Cuts to public health

305. Some public health measures can have an immediate impact. Such is the case with immunisation programmes in the prevention of a range of childhood and adult diseases. Water fluoridation, folic acid supplementation and of increasing dietary vitamin D consumption all have considerable benefits.
306. Adding to our concern that the prevention agenda continues to receive inadequate focus was the fact that many witnesses drew our attention to the cuts that had been made to public health budgets, and the resulting cuts to public health programmes, both locally and nationally.
307. In 2013, much of the responsibility for public health was transferred from the NHS to local authorities through the Health and Social Care Act 2012, supported by ring-fenced public health funding. The House of Commons Health Committee’s report on public health highlighted that the public health landscape had also become more complex.²⁷⁷ This is partly because of the addition of a national and regional public health agency—Public Health England—but also because some public health responsibilities still sit with the NHS through NHS England. The Secretary of State retains ultimate responsibility for both public health and health protection.
308. In June 2015, the Chancellor of the Exchequer announced a range of measures to bring down public debt, which included Department of Health non-NHS savings of £200 million.²⁷⁸ This amounted to a 7% cut to the public health budget. This was followed in the 2015 Spending Review with the announcement of a 3.9% cut per year over the next five years to local authority public health budgets.²⁷⁹ The Health Foundation and Nuffield Trust estimated that only 5.29% of the NHS budget in England was spent on prevention in 2014–15.²⁸⁰

277 Health Select Committee, *Public health post-2013* (Second Report, Session 2016–17, HC 140)

278 HM Treasury, ‘Chancellor announces £4.5 billion of measures to bring down debt’: <https://www.gov.uk/government/news/chancellor-announces-4-billion-of-measures-to-bring-down-debt> [accessed 28 March 2017]

279 QualityWatch, *Focus on: Public health and prevention Has the quality of services changed over recent years?* (April 2016): http://www.qualitywatch.org.uk/sites/files/qualitywatch/field/field_document/FULL%20REPORT_QualityWatch_Public%20health_and_prevention_WEB.pdf [accessed 28 March 2017]

280 *Ibid.*

309. This means that vital public health services that provide front-line preventative care now risk being scaled back or even decommissioned, as local authorities respond to the cuts. Dr Sarah Wollaston said:

“... a lot of what they [local authorities] do is also what we would traditionally think of as front-line health services, such as sexual health and various other prevention services—for example, smoking cessation services. All these kinds of things and health visiting are now sitting within local authorities. If their budgets are being restricted and squeezed, the things that they have to provide as statutory services can continue, but it is the rest of it that is being very severely cut back in prevention services, such as weight management services and stop-smoking services. This, I think, is a real threat to making the changes we want to see going forward of having people leading healthier lives, and it is things around physical activity which, we know and I agree, independently of diet, are very important. All those kinds of services are being cut back, which is a great shame; it is very short-sighted.”²⁸¹

310. The Local Government Association put the cuts into context highlighting that: “public health funding will be cut by 9.7% by 2020/21 in cash terms of £331 million, on top of the £200 million cut in-year for 2015/16 announced in November 2015.”²⁸² UNISON were one of the many voices who pointed to how undermining and potentially damaging reductions in public health spending could be, saying:

“This is likely to prove highly counter-productive, as a failure to tackle issues such as obesity and sexual ill health stores up future costs for the wider NHS.”²⁸³

311. There was some disagreement, however, on the connection between cuts to public health funding and the success of public health initiatives. The Secretary of State for Health, in response to a question on funding for public health said: “I’m afraid I don’t accept that a public health budget being cut automatically means that we are unable to make progress on the big public health issues of the day.”²⁸⁴
312. We were totally unconvinced by this assertion, given the weight of evidence to the contrary. Significant cuts to public health budgets struck us as a false economy and clearly at odds with the core aims on prevention contained in the Five Year Forward View.
313. Given the multiple pressures facing the health and care system we can no longer defer action on prevention. We heard multiple calls for a different approach to prevention, one that takes a longer-term, more strategic view to planning. The UK Health Forum suggested that: “Like the OBR, a joint analytical relationship with the Treasury and PHE” could help with investment in public health measures and “better inform fiscal and economic planning.”²⁸⁵

281 [Q 290](#) (Dr Sarah Wollaston MP)

282 Written evidence from the Local Government Association ([NHS0125](#))

283 Written evidence from UNISON ([NHS0081](#))

284 [Q 310](#) (Jeremy Hunt MP)

285 Written evidence from the UK Health Forum ([NHS0142](#))

314. The Government's failure to invest in public health and the lack of progress on prevention, as evidenced by the significant burden preventative ill health continues to place on patients and the health service, was further evidence of the type of short-sighted, compartmentalised thinking that seems to prevail across health policy. Prevention, as with other areas of NHS policy, seems to be driven by short-term payback rather than longer term sustainability, and subject to shifting prioritisations with each political cycle.
315. *We are of the opinion that a continued failure to both protect and enhance the public health budget is not only short-sighted but counter-productive. Cuts already made could lead to a greater burden of disease and are bound to result in a greater strain on all services. The Government should restore the funds which have been cut in recent years and maintain ring-fenced national and local public health budgets, for at least the next ten years, to allow local authorities to implement sustainable and effective public health measures.*

Patient responsibility

316. The NHS Constitution not only sets out what patients should expect from their health services, but also the responsibilities of patients and the public. It asks the public to: "Please recognise that you can make a significant contribution to your own, and your family's good health and wellbeing, and take personal responsibility for it."²⁸⁶
317. Some witnesses were keen to stress that promoting personal responsibility for health was an important, but largely unfulfilled, aspect to current public health and prevention policy. There were numerous calls for greater investment to be made to empower individuals to take responsibility for their own health. The British Medical Association stressed that:
- "Increasing health literacy, particularly from an early age, is key to achieving public health prevention measures and promoting better awareness of self-care. This will also help to reduce pressure on overstretched health services and support the sustainability of the NHS by preventing ill-health in the long-term."²⁸⁷
318. There was general agreement that a better balance needed to be achieved between the Government's responsibility for implementing effective prevention strategies and public health programmes, and patients taking responsibility for maintaining their own health. The British Dietetic Association alluded to the need for this balance to be readdressed, stating that:
- "Our healthcare system needs to realign itself fundamentally to prevention, even if that involves shifting funding from acute care and regulating to improve the public's diet. At the same time the UK population needs to take greater responsibility for its own health and wellbeing, or face losing the NHS it values so much."²⁸⁸

286 Department of Health, 'The NHS Constitution for England': <https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england#patients-and-the-public-your-responsibilities> [accessed 28 March 2017]

287 Written evidence from the British Medical Association (NHS0116)

288 Written evidence from the British Dietetic Association (NHS0135)

319. We also heard of the role that employers have in supporting people to stay healthy and in helping to reduce demand on the system. Norman Lamb MP raised the role of employers and how they are engaged more in the well-being of their workforces, acknowledging that “we could be achieving much more in terms of good, preventative care in that way.”²⁸⁹ Sophie Corlett from Mind explained the significant role employers have in relation to work-related mental health issues:

“We do quite a lot of work at Mind with employers. Those whom we work with are able to make quite a difference to their workforce well-being generally to make it a healthier workplace but also to support people who do develop mental health problems to stay in work. That does not necessarily always work because sometimes their employee cannot get access to the health services that they need in time, but it may be to hold a job open if somebody does have to fall out of work, to support somebody to work more flexibly while they are unwell or come back at a slower pace—all of those are things that an employer can do.”²⁹⁰

320. *The Government should be clear with the public that access to the NHS involves patient responsibilities as well as patient rights. The NHS Constitution should be redrafted with a greater emphasis on these often overlooked individual responsibilities. The Government should relaunch the Constitution as part of a renewed and sustained drive to improve health literacy and educate the public about their common duty to support the sustainability of the health service, with children, young people, schools, colleges, further education institutions and employers forming a major part of this initiative.*

289 [Q 295](#) (Norman Lamb MP)

290 [Q 145](#) (Sophie Corlett)

CHAPTER 7: TOWARDS A LASTING POLITICAL CONSENSUS

321. The time has come to change the way we approach the provision of health and adult social care. This chapter will highlight the clear lack of long-term planning across the board, including by politicians, and will conclude that further independent oversight and scrutiny is needed, and that a new independent body should be charged with this task.

A culture of short-termism

322. Our inquiry uncovered endemic short-termism in almost every area of policy making. Those charged with planning and making decisions which affect the whole NHS seemed to be plagued by short-term pressures and, as a consequence, lacked the ability to look beyond the ‘here and now’ to the longer term. Long-term planning for NHS and adult social care services is clearly insufficient. This short-termism represents a major threat, and seems to have been a longstanding problem; even when resources were more plentiful, little thought was given to the longer-term problems the NHS faced.
323. As we mentioned in earlier chapters, the most notable exception to this was the Five Year Forward View pioneered by Simon Stevens, Chief Executive of NHS England, but the timescale covered by this document (2015–20) is nearly over. He told us in December 2016 about a forthcoming extension to the document which will look beyond this Parliament:

“In three months’ time, I intend to publish the delivery plan for what the National Health Service will look like for the rest of the Parliament. Probably going into 2018, given that it is important that the strategic questions that this Committee is addressing are out there for public debate, I intend that NHS England will publish a set of proposals, a manifesto if you like, for what going into the next Parliament should look like over the medium term: the kind of timeframe that this Committee is debating.”²⁹¹

This development is encouraging, and although the delivery plan had not been published at the time of writing this report, we await its publication in the near future.

324. Despite this, we were not presented with any of the details of the planning for the NHS (including for funding, social care and the workforce) that goes beyond 2020–21, despite a wealth of evidence on the likely changes in demography, burden of disease and emerging technologies. There appeared to be a prevailing culture of complacency within the Department of Health, including amongst its ministers and officials who did not see the benefit of planning for the long term. This was clearly demonstrated when we took evidence from Chris Wormald, the Permanent Secretary at the Department of Health. Although we questioned him at length on the work taking place in his department on the long-term future of the NHS, revealingly, we were not provided with any concrete examples. Moreover, he questioned whether this was work that should even be taking place in his department explaining that: “Personally, I am not a fan of trying to answer every question from a desk in Whitehall.”²⁹² When we questioned him on what work the department was

291 [Q 278](#) (Simon Stevens)

292 [Q 252](#) (Chris Wormald)

undertaking to plan a system that was more likely to distribute the resources available in line with the service delivery needs of health and social care in the future, he went on to explain that this planning for the future was taking place within the Sustainability and Transformation Plan process. We were unconvinced by the answers he provided and we are left with no choice but to conclude that the Department of Health is failing to plan for the future.

325. **We look forward to the publication in the near future of NHS England’s delivery plan for what the NHS will look like for the rest of the Parliament. This will be a positive development in the short term. We are extremely concerned, however, that the Department of Health is failing to plan for the long-term.**

Building political consensus and engaging the public

326. A lasting political settlement for the NHS and social care was highlighted by a number of witnesses as the main solution to many of the current problems. When we put the prospect of such a settlement to Chris Wormald, however, he expressed scepticism:

“Turning to your question of whether there should be a long-term settlement of that issue, obviously there is a lot of politics in that. There are few more debated topics. My personal view is that there should probably not be. I do not see that you can deal with health spending either economically or in policy terms in isolation from the rest of government. That question of whether you want to invest a greater proportion of GDP as the economy expands is a question of how you prioritise health spending against other forms of public spending and wider economic activity. I am not sure that is a question you can have a long-term answer to.”²⁹³

We are of the clear view that a political consensus on the future of the NHS and social care is not only desirable, it is achievable.

327. Toward the end of the inquiry, we invited the health spokespeople for the three main opposition political parties in Westminster to appear before us; we are grateful for the time they took to speak to us. Norman Lamb MP, the Liberal Democrat Health spokesperson, told us about the failures of the past: “The brutal truth is that none of the political parties at the last election had a solution for the long-term funding challenge of the health and care system. No party proposed any mechanism to increase funding for social care.”²⁹⁴ He went on to argue that a lack of political consensus was doing real harm and inhibiting the ability of those in positions of responsibility to plan for the longer term: “There is a sense of complete inertia. We are sleepwalking towards the edge of the precipice. There is an urgency, therefore, about this.”²⁹⁵
328. Looking to the future, he told us about a piece of work he had commissioned:

“... I have set up an expert panel to advise my party, which will report within six months. It includes the former head of NHS England, the former head of the RCN and many other eminent people, together with two health economists, looking specifically at the case for a hypothecated

293 *Ibid.*

294 [Q 295](#) (Norman Lamb MP)

295 *Ibid.*

health and care tax and the level of that tax that is needed to properly fund the system. We will come out with a policy next year, as soon as the panel has reported, to contribute to this debate.”²⁹⁶

329. Despite this specific example, from the evidence we received we were far from convinced that the political parties have truly bought into a longer-term approach that would inevitably curtail their room for manoeuvre at election times. Dr Philippa Whitford MP, the SNP Shadow Westminster Group Leader (Health) told us:

“When we move towards an election time, people are doing soundbites around the NHS because it is so important to the public and we are not moving forward ...”²⁹⁷

330. We received a number of calls for a commission to be established to help bring about a new political consensus. Mindful of the fact that there have been numerous commissions and reports on different aspects of health and social care provision in the past, we feel that this is not the most effective way to proceed at this time. The public expect political consensus to be delivered as a result of cross-party talks and it is the responsibility of the main political parties finally to come together to make progress on all of the issues examined in this report.

331. Meaningful public consultation will be critical for any political consensus to be accepted by those who work in and use the health and care systems. The Patients Association told us that such an exercise would need to be tailored and multifaceted:

“By its very nature, public engagement cannot be a ‘one size fits all’ model and engagement should be embedded in everyday practice. The public must see the value in engaging in what they want from a health service, which will require real change developed from their contributions.”²⁹⁸

332. There is, of course, a difference between consultation which doesn’t have any tangible influence on the future direction of health and care, and consultation which is actively listened to and has a discernible effect on the formation of policy. Applied Psychology Ltd explained that this would require: “closing what might be described as the ‘credibility gap’ between the public and the planners, by listening to views that are already expressed publicly, and by demonstrating an authentic desire to learn from formal consultations.”²⁹⁹

333. Many called for a ‘national conversation’ on the future of health and care, an aspiration we share. The Academy of Medical Royal Colleges presented the need for a national conversation in the light of the exceptional pressures being faced by the health and care system at present:

“In light of the extreme financial pressures the health and care system in the UK are under and the fundamental changes required to create a sustainable system, there should be a ‘national conversation’ to determine how the shortfall should be funded and what reconfigured services should look like.”³⁰⁰

296 *Ibid.*

297 [Q 297](#) (Dr Philippa Whitford MP)

298 Written evidence from the Patients Association ([NHS0170](#))

299 Written evidence from Applied Psychology Ltd ([NHS0063](#))

300 Written evidence from the Academy of Medical Royal Colleges ([NHS0139](#))

Such a conversation should be truly national and involve people throughout the country, including those involved at all levels of decision-making, as well as those who make up the NHS workforce and, importantly, those who use the health and care system.

334. ***The historic political failure to take a long-term approach to the provision of health and adult social care has been a major stumbling block to longer-term sustainability. Efforts should be made to encourage cross-party consensus. If this consensus is to be accepted by the public it should emerge as a result of committed cross-party talks and a robust national conversation. The Government should seek to initiate these immediately.***

The case for a new body

335. Securing a much awaited political consensus on the way forward for health and social care is important but this is only part of the solution to long-term sustainability. Given the amount of public money spent on health and adult social care, accountability is important. Such accountability, however, should not simply refer to what the money is used to pay for. It should also cover the standard of planning, the way in which money is allocated and the over-arching long-term strategy for the future of health and adult social care provision. Apart from periodic reviews, commissions and parliamentary inquiries, there is currently no individual or body charged with performing this task.
336. When questioned on the merits of creating a new body similar to the Office for Budget Responsibility (OBR) to oversee longer-term health and social care funding and planning, Labour’s Shadow Secretary of State for Health, Jon Ashworth MP, was enthusiastic:

“I am very much attracted to the idea of an OBR-type body which gives periodic reports on the financial pressures on the NHS, what is needed and what are the workforce pressures, and offers a degree of objectivity in the planning which is slightly separate from the political knockabout that inevitably happens in the House of Commons. It is a very sensible idea and is something I would support.”³⁰¹

Following the evidence session, he echoed his call in the press for an OBR-style body for the NHS which would help ensure that the NHS received adequate funding and was not the subject of political rows.³⁰²

337. Simon Stevens, Chief Executive of NHS England, was similarly enthusiastic and pointed out that such an approach might reduce adverse annual variations in funding:

“It is an idea that in some respects has its attractions. With other countries’ systems, which are financed with universal coverage, you get less lumpiness as a by-product of the funding mechanism in its own right. Beveridge³⁰³ systems are more prone to lumpiness, so the question arises: can you overlay the sort of mechanism that you describe?”³⁰⁴

301 [Q 296](#) (Jon Ashworth MP)

302 Jon Ashworth MP, ‘Labour calls for OBR-style watchdog to assess NHS finances’, *The Guardian* (27 December 2016): <https://www.theguardian.com/politics/2016/dec/27/labour-calls-for-obr-style-watchdog-to-assess-nhs-finances> [accessed 28 March 2017]

303 The Beveridge model is named after William Beveridge, whose 1942 report contained the proposals that provided the basis of the modern welfare state, and describes a system where health is provided and financed by the government through taxation.

304 [Q 279](#) (Simon Stevens)

338. We were encouraged to hear the Secretary of State for Health also express interest in the idea. When we questioned him on whether the Government needed more help to plan over the longer term and overcome the ‘five-year groove’, he said “I think there is merit in the direction of travel.”³⁰⁵

339. Dr Philippa Whitford MP told us that such a body should not only be advisory but should be part of the decision-making processes:

“I totally support the idea of an arm’s-length body but you have to remember that the OBR only reports in, it just says, ‘This is what it will cost, you are on track, et cetera’. We get reports on performance from the National Audit Office whereas really what you require is an arm’s-length body that is part of the decision-making so that it does not become nailed down into the five-year cycles. You can never let go of it completely politically, but you can look at setting down what are the aims of an NHS ... on an occasional cycle.”³⁰⁶

340. Robert Chote, Chair of the OBR, explained that there were a number of existing bodies which could provide inspiration:

“If you were setting up a body in health in this area, again, you have that choice between saying, ‘Do you want them to go away and work out what we need?’ or do you want to say, ‘Health can have 9% of GDP to spend in 20 years’ time. What can you deliver for that?’ It could be approached in either or, indeed, both of those ways, if you wanted to. I would have thought models such as the Low Pay Commission or the National Infrastructure Commission would be possible ways of going at this.”³⁰⁷

We were grateful for Mr Chote’s willingness to speak to us about his experiences as Chair of the OBR and were encouraged by his ability to entertain the prospect of a body which may fulfil a similar function for health and care.

An Office for Health and Care Sustainability

341. The NHS is such an iconic part of Britain’s social fabric. If its sustainability is to be assured, a new independent mechanism needs to be created to counter the endemic NHS disease of ‘short-termism’. It is possible to retain overall political control and accountability for the NHS and yet introduce some level of independent scrutiny of the key longer-term issues facing the health and care system. This happened with the advent of the OBR and the National Infrastructure Commission (NIC). The provision of advice on low pay has also been handed to an independent commission. Such a body for health and care may be charged with advising future governments in the light of robust demographic data and changing levels of demand. The time has now come to move in this direction to secure the long-term sustainable health and care system that the public clearly want.

305 [Q 303](#) (Jeremy Hunt MP)

306 [Q 296](#) (Dr Philippa Whitford MP)

307 [Q 275](#) (Robert Chote)

342. We were grateful for the work completed by Emma Norris, one of our Specialist Advisers and Programme Director at the Institute for Government who, on our behalf, carried out an audit of 16 independent and semi-independent public bodies, details of which can be found in Appendix 5. Based on her work we are convinced that there is a strong case for a new, independent standing body enshrined in statute to safeguard the long-term sustainability of the NHS and social care. This body should be named the Office for Health and Care Sustainability.
343. As explained above, the body will need to have a clearly defined and well-understood remit and its work should always be grounded in what are often termed ‘the knowns’, such as the available demographic and disease profile data, for example. It is not our intention to articulate all the specific details of the new body, which need not be very large. Instead, the Government should examine the audit set out in Appendix 5 of the report to determine the remit, governance and composition of the new body before introducing a Bill.
344. *We recommend the establishment, before the end of this Parliament, of an independent standing body named the Office for Health and Care Sustainability to assist the Government in safeguarding the long-term sustainability of an integrated health and adult social care system for England. It should play no part in the operation of the system, or make decisions, but should be given the independence to speak freely about issues relating to its remit. It should report directly to Parliament.*
345. *The new body should be given a clear remit to advise on all matters relating to the long-term sustainability of health and social care. Initially it should focus on three key issues: (1) the monitoring of and publication of authoritative data relating to changing demographic trends, disease profiles and the expected pace of change relating to future service demand; (2) the workforce and skills mix implications of these changes; and (3) the stability of health and adult social care funding allocations relative to that demand, including the alignment between health and adult social care funding. It should continually look 15–20 years ahead.*

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

Service Transformation

Most people agree that key aspects of the service delivery model for the NHS need to change. There is also broad agreement on how this should happen. The general direction of NHS England's Five Year Forward View commands widespread support and, if fully realised, will place the NHS on a far more sustainable footing, especially if greater public support can be achieved. (Paragraph 43)

The Five Year Forward View appeared to be the only example of strategic planning for the future of the health service. This is clearly short-sighted. Without a longer-term strategy for service transformation, which goes beyond 2020, any short-term progress achieved through the Five Year Forward View will be put at risk. (Paragraph 44)

Recommendation 1

The Department of Health and NHS England, in partnership with the Department of Communities and Local Government, the Local Government Association and the Association of Directors of Adult Social Services, should agree a medium-term plan that sets out the action required to deliver sustained service transformation at a local level. This plan should cover the period up to at least 2025, be supported by dedicated funds and be implemented following a full public consultation. (Paragraph 45)

We applaud the move towards more place-based commissioning which delivers integrated health and social care services. At this early stage it would be premature to make a judgement about the current effectiveness of Sustainability and Transformation Plans but we doubt the ability of a non-statutory governance structure to secure sustainable change for the medium and longer term. NHS England, with the support of the Department of Health, should ensure that all 44 Sustainability and Transformation Plan areas have robust governance arrangements in place which include all stakeholders, including NHS organisations, local government, the voluntary sector and the public. (Paragraph 58)

We are concerned by the reported lack of engagement with either local authorities or the wider public in the preparation of Sustainability and Transformation Plans. This will deter buy-in at a local level and jeopardise ongoing political support. (Paragraph 59)

The evidence was mixed on the contribution of devolution to the long-term sustainability of health and social care. There are undoubtedly lessons to be learnt from devolution, but the evidence was not clear on how well the model in Greater Manchester could be replicated nationally especially as many, if not most, of the Sustainability and Transformation Plans (STPs) are for much smaller populations than that of Greater Manchester. (Paragraph 63)

Recommendation 2

The traditional small business model of general practice is no longer fit for purpose and is inhibiting change. NHS England, with the help of the Department of Health and the profession, should conduct a review to examine alternative models and their contractual implications. The review should assess the merits of engaging more GPs through direct employment which would reflect arrangements elsewhere in the NHS. (Paragraph 76)

Recommendation 3

We acknowledge that over-reliance on the acute hospital inpatient sector is a serious threat to the financial sustainability of health and care services. This sector should be radically reshaped in terms of service provision but changes to the number, size and distribution of secondary care services should always reflect the needs of the local population. Any changes should take place following a broad consultation. (Paragraph 80)

The drive to consolidate specialised services is a necessary part of overall service transformation. However, as with primary care, we were left with no clear picture of how specialised service consolidation will be delivered in the medium and the longer term. (Paragraph 85)

Although recent efforts to promote joined-up health and social care services have delivered mixed results, integrated health and social care with greater emphasis on primary and community services still presents the best model for delivering patient-centred, seamless care. Although there is disagreement on the financial gains to be derived from this integration, the benefits to patients are a clear justification for continuing to pursue this agenda. (Paragraph 94)

The Health and Social Care Act 2012 has created a fragmented system which is frustrating efforts to achieve further integration and the service transformation aims of the Five Year Forward View. (Paragraph 99)

Recommendation 4

NHS England and the Department of Health should launch a public consultation on what legislative modifications could be made to the Health and Social Care Act 2012 which would remove the obstacles to new ways of working, accelerate the desired service transformation and secure better governance and accountability for achieving system-wide integrated services. (Paragraph 100)

Service transformation is dependent on long-term planning, broad consultation, appropriate systems of governance and local accountability. The model of primary care will need to change, secondary care will need to be reshaped and specialised services consolidated further. Importantly, a renewed drive to realise integrated health and social care is desperately needed. However, the statutory framework is frustrating this agenda and in order for real progress to be made the national system is in need of reform to reduce fragmentation and the regulatory burden. (Paragraph 101)

Recommendation 5

With policy now increasingly focused on integrated, place-based care we see no case for the continued existence of two separate national bodies and recommend that NHS England and NHS Improvement should be merged to create a new body with streamlined and simplified regulatory functions. This merged body should include strong representation from local government. (Paragraph 102)

Workforce

We are concerned by the absence of any comprehensive national long-term strategy to secure the appropriately skilled, well-trained and committed workforce that the health and care system will need over the next 10-15 years. In our view this represents the biggest internal threat to the sustainability of the NHS. Much of the work being carried out to reshape the workforce is fragmented across different bodies with little strategic direction from the Department of Health. Although we recognise that Health Education England has undertaken some work looking at long-term planning for the workforce, this is clearly not enough. Health Education England has been unable to deliver. (Paragraph 119)

Recommendation 6

We recommend that, as a matter of urgency, the Government acknowledges the shortcomings of current workforce planning. Health Education England, both nationally and through the network of local education and training boards, should be substantially strengthened and transformed into a new single, integrated strategic workforce planning body for health and social care. This will enable it to produce and implement a joined-up place-based national strategy for the health and social care workforce, and it should always look 10 years ahead, on a rolling basis. Consideration should be given to its name to better reflect its revised function. (Paragraph 120)

Recommendation 7

Health Education England's independence should be guaranteed and supported by a protected budget with greater budgetary freedom. It will need enhanced skills and a board that includes representation from all parts of the health and care system. (Paragraph 121)

Recommendation 8

Workforce strategy has been poor with too much reliance on overseas recruitment. The Government should outline its strategy for ensuring that a greater proportion of the health and care workforce comes from the domestic labour market and should report on progress against this target. (Paragraph 122)

Recommendation 9

In the light of the result of the EU referendum, we recommend that the Government takes steps to reassure and retain overseas-trained staff working in the NHS and adult social care who are now understandably concerned about their future. (Paragraph 123)

Recommendation 10

A transformed Health Education England should use its greater budgetary freedom to review current commissioning and funding mechanisms to explore how initial and ongoing education and training might achieve a more multi-professional skill mix among the workforce and be underpinned by a place-based approach. (Paragraph 134)

There has been too great a reluctance by successive governments to address the changing skill mix required to respond to a changing patient population and too little attention paid to workforce planning, education and training, all of which are necessary for delivering efficiency, productivity and overall value for money. (Paragraph 135)

Recommendation 11

Health Education England should take the lead on changing the culture of conservatism which prevails among those who educate and train the health and social care workforce. It should convene a forum of the Royal Colleges, the General Medical Council, the Nursing and Midwifery Council, higher education institutions, other education providers, social care providers and local government representatives to investigate how medical and social care education and ongoing training courses can be reformed. Many are too lengthy, involve unnecessary repetition and do not meet the needs of a workforce which will have to be more flexible, agile and responsive to changing need. (Paragraph 136)

Recommendation 12

Given the move to a more localised and place-based approach to the provision of health and social care, a more flexible approach to the make-up of the workforce is required. Professional bodies, education providers and regulators should embrace the opportunities for different ways of working made possible by emerging, often non-medical, workforce roles and should not be afraid of challenging the traditional allocation of responsibilities within professions. (Paragraph 137)

There is an indisputable link between a prolonged period of pay restraint, overburdensome regulation and unnecessary bureaucracy on the one hand and low levels of morale and workforce retention on the other. We recognise the necessity of public sector pay restraint when public expenditure is under considerable pressure. However, by the end of this Parliament, pay will have been constrained for almost a decade. (Paragraph 153)

Recommendation 13

We recommend that the Government commissions a formal independent review with the involvement of the Department of Health, the pay review bodies and health and care employers to review pay policy with a particular regard to its impact on the morale and retention of health and care staff. (Paragraph 154)

Recommendation 14

The current regulatory landscape is not fit for purpose. In the short term, we urge the Government to bring forward legislation in this Parliament to modernise the system of regulation of health and social care professionals and place them under a single legal framework as envisaged by the 2014 draft Law Commission Bill. The Government should also introduce legislation to modernise the system regulators to take account of our recommendation that NHS England and NHS Improvement be merged and to reflect the clear move towards place-based care. (Paragraph 155)

Funding the NHS and adult social care

International evidence shows that a tax-funded, single payer model of paying for healthcare has substantial advantages in terms of universal coverage and overall efficiency. There was no evidence to suggest that alternative systems such as social insurance would deliver a more sustainable health service. Sustainability depends on the level of funding and, crucially, how those funds are used. (Paragraph 169)

Recommendation 15

We strongly recommend that a tax-funded, free-at-the-point-of-use NHS should remain in place as the most appropriate model for delivery of sustainable health services both now and in the future. (Paragraph 170)

Recommendation 16

We received some detailed analysis of how hypothecation might work for the NHS. Given the far-reaching implications of hypothecation for systems and services beyond the remit of our inquiry, we were not well-placed to make a firm conclusion on the issue. We recommend that hypothecation be given further consideration by ministers and policymakers. (Paragraph 182)

The reduction in health spending as a share of GDP seen over this decade cannot continue beyond 2020 without seriously affecting the quality of and access to care, something which has not been made clear to the public or widely debated. (Paragraph 192)

Recommendation 17

To truly protect the sustainability of the NHS the Government needs to set out plans to increase health funding to match growing and foreseeable financial pressures more realistically. We recommend health spending beyond 2020 should increase at least in line with the growth of GDP and do so in a predictable way in that decade. (Paragraph 193)

The additional funding for social care announced in the 2017 Budget is welcome and means funding for social care will increase by more than 2% a year for the next three years. This is more than the increase for NHS funding. However it is clearly insufficient to make up for many years of underfunding and the rapid rise in pressures on the system. (Paragraph 206)

Recommendation 18

In order to stem the flow of providers leaving adult social care, meet rising need and help alleviate the crisis in NHS hospitals, the Government needs to provide further funding between now and 2020. This funding should be provided nationally as further increases in council tax to fund social care do not allow funding to be aligned with need. Beyond 2020 a key principle of the long-term settlement for social care should be that funding increases reflect changing need and are, as a minimum, aligned with the rate of increase for NHS funding. (Paragraph 207)

Funding over the past 25 years has been too volatile and poorly co-ordinated between health and social care. This has resulted in poor value for money and resources being allocated in ways which are inconsistent with patient priorities and needs. (Paragraph 216)

Recommendation 19

The budgetary responsibility for adult social care at a national level should be transferred to the Department of Health which should be renamed the ‘Department of Health and Care’. This should allow money and resources to be marshalled and used more effectively as part of an integrated approach to health and care. (Paragraph 217)

Recommendation 20

We acknowledge the difficulties with integrating budgets at a local level but this is achievable. The Government should undertake a review and bring forward changes in order to make this happen. (Paragraph 218)

Recommendation 21

Regardless of this further work on integrating budgets, the Government should commit to (1) securing greater consistency in the allocation of funding to health and social care at least in line with growth in GDP and (2) reducing the volatility in the overall levels of funding allocated to health and care in order to better align the funding of both services. (Paragraph 219)

Recommendation 22

We recommend that the current Government and any successive governments should agree financial settlements for an entire Parliament to improve planning and ensure the effective use of resources. ‘Shadow’ ten year allocations should also be agreed for certain expenditures, such as medical training or significant capital investment programmes that require longer-term planning horizons. (Paragraph 220)

Social care should continue to be underpinned by a means-tested system. Where possible people should be encouraged to take personal responsibility for their own care. We support a funding system that enables those who can afford it to pay for the social care they need but with the costs falling on individuals capped in the manner proposed by the Dilnot Commission. (Paragraph 239)

Recommendation 23

The Government should also implement as quickly as practicable, and no later than the first session of the next Parliament, new mechanisms which will make it easier for people to save and pay for their own care. The Government should, in the development of its forthcoming green paper on the future of social care, give serious consideration to the introduction of an insurance-based scheme which would start in middle age to cover care costs. (Paragraph 240)

Innovation, technology and productivity

There is a worrying absence of a credible strategy to encourage the uptake of innovation and technology at scale across the NHS. It is not clear who is ultimately responsible for driving innovation and ensuring consistency in the assessment and the adoption of new technological approaches. The provision of appropriate training and development of strong leaders to support this agenda within the NHS will be critical to its success. (Paragraph 250)

Recommendation 24

The Government should make it clear that the adoption of innovation and technology, after appropriate appraisal, across the NHS is a priority and it should decide who is ultimately responsible for driving this overall agenda. It should also identify the bodies and areas within the NHS which are falling behind in the innovation and technology agenda and make it clear that there will be funding and service delivery consequences for those who repeatedly fail to engage. This could involve relocating services to places that prove to be more technologically innovative. (Paragraph 251)

Recommendation 25

The failure of the care.data project illustrates the inevitable consequences of failing to grapple with important issues relating to personal privacy. NHS Digital and all those responsible for data sharing in the NHS should seek to engage the public effectively in advance of any future large-scale sharing of personal data. Public engagement on data sharing needs to become a priority at a local level for staff in hospitals and the community, and not be left to remote national bodies. (Paragraph 262)

Recommendation 26

The Government should require a newly unified NHS England and NHS Improvement to work with commissioners to achieve greater levels of consistency in NHS efficiency and performance. Greater levels of investment and service responsibility should be given to those who improve the most. (Paragraph 270)

Recommendation 27

The testing and adoption of new health technologies should be formally integrated into medical and non-medical NHS leadership, education and training at all levels. (Paragraph 278)

Recommendation 28

NHS England should develop a system to identify and financially reward organisations and leaders who are instrumental in driving the much needed change in levels of productivity, the uptake of innovation, the effective use of data and the adoption of new technologies. (Paragraph 279)

Public health, prevention and patient responsibility

We welcome the greater prominence that mental health has received in recent years and we are encouraged by the Government's commitment to a five-year strategy for mental health. Notwithstanding the progress made, there is still a need for sustained and determined action to close the gap between the care received and outcomes achieved by people with mental and physical health issues. Achieving parity of esteem between the two must remain a top priority for service commissioners and regulators. (Paragraph 295)

There is still widespread dissatisfaction with the prevention agenda. We share the views expressed by many of our witnesses of the need to realise the long-awaited ambition to move from an 'illness' to a 'wellness' service. The NHS must shift the rhetoric to reality and make genuine progress on refocusing the system towards preventative care. (Paragraph 303)

Recommendation 29

We recommend that the Government urgently embarks on a nationwide campaign to highlight the many complications arising from the obesity epidemic, including its links with many chronic diseases. Such a campaign must be a cross-departmental effort, target the entire population and involve those who sell food and drink to the public, especially those whose products are consumed by children. (Paragraph 304)

Recommendation 30

We are of the opinion that a continued failure to both protect and enhance the public health budget is not only short-sighted but counter-productive. Cuts already made could lead to a greater burden of disease and are bound to result in a greater strain on all services. The Government should restore the funds which have been cut in recent years and maintain ring-fenced national and local public health budgets, for at least the next ten years, to allow local authorities to implement sustainable and effective public health measures. (Paragraph 315)

Recommendation 31

The Government should be clear with the public that access to the NHS involves patient responsibilities as well as patient rights. The NHS Constitution should be redrafted with a greater emphasis on these often overlooked individual responsibilities. The Government should relaunch the Constitution as part of a renewed and sustained drive to improve health literacy and educate the public about their common duty to support the sustainability of the health service, with children, young people, schools, colleges, further education institutions and employers forming a major part of this initiative. (Paragraph 320)

Towards a lasting political consensus

We look forward to the publication in the near future of NHS England's delivery plan for what the NHS will look like for the rest of the Parliament. This will be a positive development in the short term. We are extremely concerned, however, that the Department of Health is failing to plan for the long-term. (Paragraph 325)

Recommendation 32

The historic political failure to take a long-term approach to the provision of health and adult social care has been a major stumbling block to longer-term sustainability. Efforts should be made to encourage cross-party consensus. If this consensus is to be accepted by the public it should emerge as a result of committed cross-party talks and a robust national conversation. The Government should seek to initiate these immediately. (Paragraph 334)

Recommendation 33

We recommend the establishment, before the end of this Parliament, of an independent standing body named the Office for Health and Care Sustainability to assist the Government in safeguarding the long-term sustainability of an integrated health and adult social care system for England. It should play no part in the operation of the system, or make decisions, but should be given the independence to speak freely about issues relating to its remit. It should report directly to Parliament. (Paragraph 344)

Recommendation 34

The new body should be given a clear remit to advise on all matters relating to the long-term sustainability of health and social care. Initially it should focus on three key issues: (1) the monitoring of and publication of authoritative data relating to changing demographic trends, disease profiles and the expected pace of change relating to future service demand; (2) the workforce and skills mix implications of these changes; and (3) the stability of health and adult social care funding allocations relative to that demand, including the alignment between health and adult social care funding. It should continually look 15–20 years ahead. (Paragraph 345)

APPENDIX 1: LIST OF MEMBERS AND DECLARATIONS OF INTEREST

Members

Baroness Blackstone
 Lord Bradley
 Bishop of Carlisle
 Lord Kakkar
 Lord Lipsey
 Lord Mawhinney
 Lord McColl of Dulwich
 Lord Patel (Chairman)
 Baroness Redfern
 Lord Ribeiro
 Lord Scriven
 Lord Turnberg
 Lord Warner
 Lord Willis of Knaresborough

Declarations of interest

Baroness Blackstone
Chair, Great Ormond Street Hospital Foundation Trust
Member, Board of UCL Partners (Academic Health Science Centre)

Lord Bradley
Non-Executive Director, Pennine Care NHS Foundation Trust
Non-Executive Chair, Bury, Tameside and Glossop NHS LIFT Company
Non-Executive Chair, Manchester, Salford and Trafford NHS LIFT Company
Trustee, Centre for Mental Health
Honorary Special Advisor, University of Manchester
Member, Unite

Bishop of Carlisle
Lead bishop for Health and Social Care (with overall oversight of Hospital Chaplaincy)
Associate, Faculty of Public Health
International Advisory Board Member, The Dementia Centre, University of Stirling
Member, All-Party Parliamentary Group on Health in all Policies
Member, All-Party Parliamentary Group on Cancer
Patron, Acorn Christian Healing Foundation
Patron, Association for the Independence of Disabled People
Patron, Burrswood
Patron, Eden Valley Hospice
Patron, Hospice at Home Carlisle and North Lakeland
Patron, The ME Trust
Patron, North West Cancer Research
President, Silloth Nursing and Care Home

Lord Kakkar

Chair, University College London Partners Limited
Practising Surgeon
Professor of Surgery, University College London
Honorary Consultant Surgeon, University College London Hospitals NHS Foundations Trust
Director, Thrombosis Research Institute, London
Commissioner, Royal Hospital Chelsea
Trustee and Governor, King Edward VII's Hospital
Business Ambassador for Healthcare and Life sciences
Fellow, Association of Surgeons Of Great Britain & Ireland
Fellow, King's College, London
Fellow, Royal College of Physicians of Edinburgh
Fellow, Royal College of Surgeons
Fellow, Royal College of Physicians
Honorary Fellow, Harris Manchester College, Oxford
Member, Shape of Training Review (2012–2013)
Member, General Medical Council (Interest ceased on 30 September 2016)
Member, Governing Board of Harris Manchester College, Oxford (Interest ceased on 30 September 2016)
Treasurer, All-Party Parliamentary Group on Global Health

Lord Lipsey

President, Society of Later Life Advisers (SOLLA) (Non-remunerated)

Lord Mawhinney

None relevant to the inquiry

Lord McColl of Dulwich

Fellow, Royal College of Surgeons,
Patron, Royal College of Surgeons
Honorary Fellow, Kings College, London
Honorary Fellow, Royal College of Surgeons, Faculty of Dental Surgery
Retired Professor and Chair Department of Surgery, Guy's and St Thomas' Medical School
Trustee, Wolfson Foundation

Lord Patel

Chancellor, University of Dundee
Retired Professor of Obstetrics & Consultant Obstetrician, Ninewells Hospital, University of Dundee
Fellow, Academy of Medical Sciences
Fellow, Royal Society of Edinburgh
Fellow, Royal College of Obstetricians & Gynaecologists
Honorary Fellow, Royal College of General Practitioners
Honorary Fellow, Royal College of Surgeons
Honorary Fellow, Royal College of Anaesthetists
Honorary Fellow, Royal College of Psychiatrists
Honorary Fellow, Royal College of Physicians of Edinburgh
Honorary Fellow, Royal College of Surgeons of Edinburgh
Honorary Fellow, Royal College of Physicians and Surgeons of Glasgow
Honorary Fellow, Royal College of Physicians of Ireland
Honorary Fellow, Faculty of Public Health

Baroness Redfern

Vice-Chair, The Health Alliance
Councillor, North Lincolnshire Council
Chairman, Health and Wellbeing Board, North Lincolnshire Council
Leader, North Lincolnshire Council (Interest ceased in January 2017)

Lord Ribeiro

Retired General Surgeon (non-practising)
Fellow, the Royal College of Surgeons of Edinburgh (ad hominem)
Fellow, Royal College of Physicians
Fellow, Royal College of Anaesthetists
Fellow, Royal College of Physicians and Surgeons of Glasgow (qua surgeon ad eundem)
Patron, Royal College of Surgeons
Past President, Royal College of Surgeons
Honorary Fellow, Faculty of Dental Surgery
Honorary Fellow, Royal College of Surgeons of Ireland
Honorary Fellow, Faculty of General Dental Practice
Chair, Independent Reconfiguration Panel (NDPB)
Chair, CORESS (confidential reporting system for surgery) (charity)

Lord Scriven

Member, Sheffield City Council
Managing Partner, Scriven Consulting
Clients of Scriven Consulting: Carillion Plc; Maximus UK (past interest); and Cumberledge, Eden & Partners

Lord Turnberg

Fellow, Royal College of Physicians
Fellow, Academy of Medical Sciences
Honorary Fellow, Royal College of Obstetricians & Gynaecologists
Honorary Doctor of Science of the University of Manchester
Honorary Doctor of Science of the University of Salford
Honorary Doctor of Science of the University of Keele
Honorary Doctor of Science of Imperial College, London
Honorary Fellow, Faculty of Sport and Exercise Medicine
Honorary Fellow, Faculty of Public Health
Honorary Fellow, Faculty of Occupational Medicine
Honorary Fellow, Royal College of Physicians of Edinburgh
Honorary Fellow, Royal College of Physicians of Glasgow
Honorary Fellow, Royal College of Surgeons
Honorary Fellow, Royal College of Ophthalmologists
Scientific Advisor, Academy of Medical Research Charities (Interest ceased in December 2016)
Past President Royal College of Physicians
Past Chairman Academy of Medical Royal Colleges
Past Chairman Public Health Laboratory Service
Past Vice-President Academy of Medical Sciences
Past Chairman, Specialist Training Authority
Past President, British Society of Gastroenterology
Past Dean of Medicine, University of Manchester
Past Chairman, Panel reviewing Health Services in London (1997)

Retired Clinician

Retired Professor of Medicine

Trustee of a number of medical charities mostly concerned with research

Lord Warner

Member, Advisory Council of Reform (think tank)

Lord Willis of Knaresborough

Fellow, Royal College of Nursing

Consultant, Nursing and Midwifery Council

Consultant, Health Education England

Chair, National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care for Yorkshire and Humber (CLAHRC YH)

A full list of member's interest can be found in the Register of Lords Interests:

<http://www.parliament.uk/mps-lords-and-offices/standards-and-interests/register-of-lords-interests/>

Anita Charlesworth (Specialist Adviser)

Director of Research and Economics, The Health Foundation

Trustee, Tommy's the Baby Charity

Sits on the editorial board of the Office of Health Economics

Emma Norris (Specialist Adviser)

Programme Director, the Institute for Government

APPENDIX 2: LIST OF WITNESSES

Evidence is published online at <http://www.parliament.uk/nhs-sustainability> and available for inspection at the Parliamentary Archives (020 7219 3074).

Evidence received by the Committee is listed below in chronological order of oral evidence session and in alphabetical order. Those witnesses marked with a ** gave both oral and written evidence. Those marked with * gave oral evidence and did not submit any written evidence. All other witnesses submitted written evidence only.

Oral evidence in chronological order

**	Department of Health	QQ 1–21
*	Department for Communities and Local Government	
**	Nuffield Trust	QQ 22–31
**	The King’s Fund	
*	The Health Foundation	
**	NHS England	QQ 32–48
**	Public Health England	
*	NHS Improvement	
*	Nuffield Trust	QQ 49–58
**	Sir Muir Gray	QQ 59–68
**	Professor Katherine Checkland	
*	Professor Alistair McGuire	QQ 69–75
*	The Organisation for Economic Co-operation and Development (OECD)	
*	Professor Andrew Street	QQ 76–86
*	Professor Nick Black	
*	Reform	
*	NHS Improvement	
**	NHS Providers	QQ 87–97
*	Association of Directors of Adult Social Services (ADASS)	
*	NHS Confederation	
*	Dame Kate Barker	QQ 98–104
*	Professor Julian Forder	
**	Sir Andrew Dilnot	
*	Ipsos MORI	QQ 105–117
*	Institute for Government	
*	The Rt Hon Frank Field MP	
*	The Rt Hon Lord Willetts	QQ 118–128

- * The Rt Hon Steve Webb
- * Strategic Society Centre
Institute for Public Policy Research
- * Migration Advisory Committee [QQ 129–134](#)
- ** Health Education England
- * NHS Employers
- * Professor Paul Corrigan [QQ 135–142](#)
- * Royal Society of Public Health
- * Jo Moriarty
- ** NHS England [QQ 143–149](#)
- ** Royal College of Psychiatrists
- ** Mind
- ** Nuffield Trust [QQ 150–157](#)
- ** Department of Health
- * Professor James Buchan
- * UNISON [QQ 158–170](#)
- * Dr Stephen Watkins
- * Dr Mark Porter
- * University Hospitals Birmingham NHS Foundation Trust [QQ 171–177](#)
- * Central Manchester University Hospitals NHS Foundation Trust
- * Sheffield Teaching Hospitals NHS Foundation Trust
- ** The Patients Association [QQ 178–184](#)
- ** Independent Age
- * Professor Maureen Baker [QQ 185–190](#)
- * NHS Tower Hamlets CCF
- * Dr Clare Gerada
- ** Academy of Royal Medical Colleges [QQ 191–206](#)
- ** Royal College of Surgeons
- ** Royal College of Physicians
- ** Royal College of General Practitioners [QQ 207–215](#)
- ** Royal College of Nursing
- ** Royal College of Midwives
- ** Chartered Society of Physiotherapy [QQ 216–223](#)
- ** Royal College of Radiologists
- * English Pharmacy Board

* Greater Manchester Health and Social Care Partnership	<u>QQ 224–235</u>
* Manchester City Council	
* Professor Kieran Walshe	
** PHG Foundation	<u>QQ 236–242</u>
** Professor Sir John Bell	
* NHS Digital	
* Department of Health	<u>QQ 243–249</u>
* Public Health England	
* Professor Dame Anne Johnson	
** Department of Health	<u>QQ 250–256</u>
* NHS Improvement	<u>QQ 257–264</u>
** General Medical Council	
Care Quality Commission	
** Nursing and Midwifery Council	
* Baroness Cavendish of Little Venice	<u>QQ 265–271</u>
* Lord Darzi of Denham	
* Sir Cyril Chantler	
* Office for Budget Responsibility	<u>QQ 272–277</u>
* NHS England	<u>QQ 278–285</u>
** House of Commons Health Select Committee	<u>QQ 286–291</u>
* Jon Ashworth MP	<u>QQ 292–300</u>
* Rt Hon Norman Lamb MP	
* Dr Philippa Whitford MP	
* Secretary of State for Health	<u>QQ 301–313</u>
* KPMG	<u>QQ 314–318</u>
* University College London (UCL)	<u>QQ 319–327</u>
* Government Office for Science	
** Department of Health	
** Nicholas Timmins	<u>QQ 328–333</u>
* The Guardian	
* The Lancet	
* The Economist	
* Health Service Journal	

Alphabetical list of all witnesses

	AbbVie	NHS0035
	Association of British Healthcare Industries (ABHI)	NHS0068
	Academy for Healthcare Science	NHS0131
**	Academy of Medical Royal Colleges (QQ 191–206)	NHS0139
	Action on Hearing Loss	NHS0082
	Action on Smoking and Health	NHS0146
	The Academic Health Science Network	NHS0031
	Mr Tom Allison	NHS0024
*	John Appelby (QQ 49–58)	
	Baroness Altmann	NHS0184
	Arthritis and Musculoskeletal Alliance	NHS0087
	Association of Anaesthetists of Great Britain and Ireland	NHS0114
	The Association of Anaesthetists of Great Britain and Ireland (AAGBI) Group of Anaesthetists in Training (GAT)	NHS0115
	The Association of the British Pharmaceutical Industry	NHS0167
	The Association of Child Psychotherapists (ACP)	NHS0066
	Association for Clinical Biochemistry and Laboratory Medicine	NHS0043
	Association of Directors of Adult Social Services (ADASS)	NHS0072
	Association of Independent Healthcare Organisations	NHS0083
	Association of Medical Research Charities	NHS0059
	Association of UK University Hospitals	NHS0150
*	Professor Maureen Baker (QQ 185–190)	
*	Dame Kate Barker (QQ 98–104)	
	Sir David Bell	NHS0020
*	Professor Sir John Bell (QQ 236–242)	
	Mrs Win Betts	NHS0166
*	Professor Nick Black (QQ 76–86)	
	John Boyd	NHS0129
	Juliet Boyd	NHS0126
	Dr Brian Boughton	NHS0012
	British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS)	NHS0015
	British Dental Association	NHS0117
	British Dietetic Association	NHS0135

	British Geriatrics Society	NHS0141
	British Healthcare Trades Association	NHS0056
	British Medical Association	NHS0116
	The British Psychological Society	NHS0057
	British In Vitro Diagnostics Association	NHS0039
	British Society for Histocompatibility and Immunogenetics	NHS0026
*	Professor James Buchan (QQ 150–157)	
	BUPA UK	NHS0099
	Ms Gemma Burford	NHS0112
	Cancer Research UK	NHS0185
	The Care and Support Alliance	NHS0097
	Care England	NHS0089
*	Care Quality Commission (QQ 257–264)	
	Mr Andrew Carmichael	NHS0017
	Sir Andrew Cash	NHS0189
*	Baroness Cavendish of Little Venice (QQ 265–277)	
*	Central Manchester University Hospitals NHS Foundation Trust (QQ 171–177)	
	Centre for Applied Psychology Ltd	NHS0063
	Centre for Health and the Public Interest	NHS0050
	Centre for Mental Health	NHS0079
**	Professor Katherine Checkland (QQ 59–68)	NHS0022
	Mr Adam Chaffer	NHS0144
**	Sir Cyril Chantler (QQ 265–271)	NHS0187
	The Chartered Institute of Public Finance and Accountancy	NHS0041
*	Chartered Society of Physiotherapy (QQ 216–223)	NHS0055
	Children and Young People’s Mental Health Coalition	NHS0058
	The Christie NHS Foundation Trust	NHS0157
	Coeliac UK	NHS0153
*	Department for Communities and Local Government (QQ 1–21)	
	Dr Stephen Clay	NHS0151
	Clinical Council for Eye Health Commissioning	NHS0071
	Professor Jonathan Cohen	NHS0020
	The College of Optometrists	NHS0013
	Mrs Gaynor Collins-Punter	NHS0044

	Dr Brendan Cooper	NHS0132
*	Professor Paul Corrigan (QQ 135–142)	
	Lord Crisp	NHS0176
	Anne Marie Culpan	NHS0190
	Sir Michael Deegan	NHS0189
*	Lord Darzi of Denham (QQ 265–271)	
	Dell EMC	NHS0070
	Mr Bill Dickinson	NHS0074
*	Sir Andrew Dilnot (QQ 98–104)	
	Dispensing Doctors Association	NHS0062
	Doctors For The NHS	NHS0027
	Doctors in Unite (Medical Practitioners’ Union)	NHS0102
	John Eayrs	NHS0161
*	The Economist (QQ 328–333)	
*	English Pharmacy Board (QQ 216–223)	
	Faculty of Dental Surgery	NHS0121
	Faculty of Public Health	NHS0154
	Faculty of Sexual and Reproductive Health	NHS0098
	Dr Laurence Ferry	NHS0046
**	Rt Hon Frank Field MP (QQ 105–117)	NHS0182
	Dr Richard FitzGerald	NHS0016
*	Ian Forde (QQ 69–75)	
*	Professor Julian Forder (QQ 98–104)	
	Dr Florian Gebreiter	NHS0046
**	General Medical Council (QQ 257–264)	NHS0173
	GenoMed Inc	NHS0011
*	Dr Clare Gerada (QQ 185–190)	
**	Professor Sir Muir Gray (QQ 59–68)	NHS0019
*	Greater Manchester Health (QQ 224–235)	
*	Greater Manchester City Council (QQ 224–235)	
	Mrs Alison Griffin	NHS0037
	Professor Frances Griffiths	NHS0152
*	The Guardian (QQ 328–333)	
*	Government Office for Science (QQ 319–327)	
*	Andrew Haldenby (QQ 76–86)	
	Thomas Harrison	NHS0127

	HCL Workforce Solutions	<u>NHS0118</u>
**	Department of Health (QQ 1–21) (QQ 150–157) (QQ 243–49) (QQ 250–26) (QQ 319–327)	<u>NHS0018</u> <u>NHS0175</u>
	The Healthcare Financial Management Association	<u>NHS0090</u>
**	Health Education England (QQ 129–134)	<u>NHS0122</u>
**	The Health Foundation (QQ 22–31)	<u>NHS0172</u>
	Health Research Authority	<u>NHS0143</u>
*	Health Service Journal (QQ 328–333)	
	Hospital Consultants and Specialists Association	<u>NHS0075</u>
*	House of Commons Health Select Committee (QQ 286–291)	
	ID Medical Group Ltd	<u>NHS0076</u>
	Candace Imison	<u>NHS0193</u>
**	Independent Age (QQ 178–184)	<u>NHS0053</u>
*	Ipsos MORI (QQ 105–117)	
	Institute and Faculty of Actuaries	<u>NHS0038</u>
*	Institute for Government (QQ 105–117)	
	Institute of Physics and Engineering in Medicine	<u>NHS0092</u>
	Integrated Care 24	<u>NHS0136</u>
	The Intergenerational Foundation	<u>NHS0148</u>
*	Professor Dame Anne Johnson (QQ 243–249)	
	Paul Johnson	<u>NHS0195</u>
	Keep Our NHS Public	<u>NHS0109</u>
	Kevin Kelleher	<u>NHS0164</u>
**	The King’s Fund (QQ 22–31) (QQ 328–333)	<u>NHS0171</u>
*	KPMG (QQ 314–318)	
	The Lancet	
	Lord Layard	<u>NHS0178</u>
	Lifeways Group	<u>NHS0096</u>
	Local Government Association	<u>NHS0125</u>
	Macmillan Cancer Support	<u>NHS0030</u>
	Lord Macpherson of Earl’s Court	<u>NHS0177</u>
*	Professor Alistair McGuire (QQ 69–75)	
*	Christine McAnea (QQ 158–170)	
	Dr Nick Mann	<u>NHS0028</u>
*	Jeremy Marlow (QQ 76–86)	
	Mr Peter Marsh	<u>NHS0005</u>

	Professor Alison Metcalfe	NHS0147
	Professor Karen Middleton	NHS0191
*	Migration Advisory Committee (QQ 129–134)	
	Dr Elizabeth Sinclair Miller	NHS0138
**	Mind (QQ 143–149)	NHS0179
	Dame Julie Moore	NHS0189
*	Jo Moriarty (QQ 135–142)	
	Professor James Morris	NHS0007
	Mr Malcolm Morrison	NHS0010
	Dr James Murphy	NHS0036
	National Community Hearing Association	NHS0105
	National Health Action Party	NHS0094
	Sir Robert Naylor	NHS0181
	NHS Clinical Commissioners	NHS0159
*	NHS Confederation (QQ 87–97)	
*	NHS Digital (QQ 236–242)	
*	NHS Employers (QQ 129–134)	
**	NHS England (QQ 32–48) (QQ 143–149) (QQ 278–285)	NHS0111
	NHS Improvement	NHS0107
	NHS Partners Network	NHS0040
**	NHS Providers (QQ 87–97)	NHS0110
*	NHS Tower Hamlets CCF (QQ 185–190)	
	Dr Kristian Niemietz	NHS0034
**	Nuffield Trust (QQ 22–31) (QQ 150–157)	NHS0174
**	Nursing and Midwifery Council (QQ 257–264)	NHS0169
	Nutricia: Advanced Medical Nutrition	NHS0101
*	Office for Budget Responsibility (QQ 272–277)	
	Mrs Susan Margaret Oliver RN, MSc, FRCN, OBE	NHS0006
*	Opposition Parties (QQ 292–300)	
	Optical confederation and Local Optical Committee Support Unit	NHS0085
	Dr David Owen	NHS0003
	Oxfordshire Keep our NHS Public	NHS0023
	Paediatric Continence Forum	NHS0054
**	The Patients Association (QQ 178–184)	NHS0170
	Pharmacy voice	NHS0163
*	PHG Foundation (QQ 236–242)	NHS0080

* Dr Mark Porter (QQ 158–170)	
Prederi Ltd	NHS0145
Primary Health Properties	NHS0128
Professional Standards Authority	NHS0168
** Public Health England (QQ 32–48) (QQ 243–249)	NHS0162
Public Health England, Chief Knowledge Officer’s Directorate	NHS0137
Mr Graham Raven	NHS0021
Dr Martyn Read	NHS0008
Recruitment Employment Confederation	NHS0052
Rethink Mental Illness	NHS0156
Kevin Riley Supplementary written evidence	NHS0124 NHS0165
Professor Martin Roland CBE	NHS0009
Helen Ross	NHS0086
Dr Emma Rowland	NHS0091
* Royal Society of Public Health (QQ 135–142)	
The Royal College of Anaesthetists	NHS0073
The Royal College of Emergency Medicine	NHS0029
** The Royal College of General Practitioners (QQ 207–215)	NHS0078
** The Royal College of Midwives(QQ 207–215)	NHS0067
** The Royal College of Nursing(QQ 207–215)	NHS0149
The Royal College of Obstetricians and Gynaecologists	NHS0093
The Royal College of Ophthalmologists	NHS0032
The Royal College of Paediatrics and Child Health	NHS0133
The Royal College of Pathologists	NHS0061
** The Royal College of Physicians (QQ 191–206)	NHS0065
The Royal College of Physicians of Edinburgh	NHS0064
** The Royal College of Psychiatrists (QQ 143–149)	NHS0123
** The Royal College of Radiologists(QQ 216–223)	NHS0049 NHS0192
The Royal College of Speech and Language Therapists	NHS0113
The Royal College of Surgeons of Edinburgh	NHS0180
** The Royal College of Surgeons (QQ 191–206)	NHS0121
The Royal Crescent Surgery, Weymouth, Dorset	NHS0103
The Royal Pharmaceutical Society	NHS0077

- ★ The Secretary of State for Health (QQ 301–313)
Sense [NHS0048](#)
- ★ Sheffield Teaching Hospitals NHS Foundation Trust (QQ 171–177)
Shelford Group [NHS0134](#)
Simple Shared Healthcare Limited [NHS0104](#)
- ★ Social Care Partnership (QQ 224–235)
The Society and College of Radiographers [NHS0186](#)
Specialised Healthcare Alliance [NHS0042](#)
Stephen Smith [NHS0001](#)
Petula Storey [NHS0025](#)
- ★ Strategic Society Centre and Institute for Public Policy (QQ 118–128)
- ★ Professor Andrew Street (QQ 76–86)
Stroke Association [NHS0130](#)
Sustainable Development Unit for NHS England and Public Health England [NHS0140](#)
Telecare Services Association [NHS0106](#)
Dr Tim Taylor [NHS0108](#)
Together for Short Lives [NHS0158](#)
Trade Union Congress [NHS0084](#)
- ★ Nicholas Timmins (QQ 328–333)
UK Health Forum [NHS0142](#)
UNISON [NHS0081](#)
Unite the Union [NHS0100](#)
- ★ University College London (UCL) (QQ 319–327)
- ★ University Hospitals Birmingham NHS Foundation Trust (QQ 171–177)
University of Nottingham [NHS0069](#)
Urgent Health UK [NHS0045](#)
Vanguard Healthcare [NHS0095](#)
Voluntary Organisations Disability Group [NHS0119](#)
Walgreens Boots Alliance [NHS0120](#)
- ★ Dr Stephen Watkins (QQ 158–170)
- ★ The Rt Hon Steve Webb (QQ 118–128)
Wellcome Trust [NHS0051](#)
- ★ Professor Kieran Walshe (QQ 224–235)
Professor Peter Wells [NHS0033](#)

Dr Stephen West	<u>NHS0004</u>
Professor Chris Whitty	<u>NHS0194</u>
Dr Graham Willis	<u>NHS0188</u>
Wilmington Healthcare	<u>NHS0155</u>
Mrs Carole Woodman	<u>NHS0047</u>

APPENDIX 3: CALL FOR EVIDENCE

The Select Committee on the Long-term Sustainability of the NHS of the House of Lords, chaired by Lord Patel, is conducting an inquiry into the sustainability issues facing the NHS and the impact they will have over the next 15–20 years. The Committee invites interested individuals and organisations to submit evidence.

Written evidence is sought by Friday 23 September 2016. The submissions will guide the Committee’s deliberations in oral evidence sessions which will be held later this year and inform the Committee’s final conclusions and recommendations.

Public hearings began in early July and will continue until late December. The Committee aims to report to the House with recommendations by March 2017. The report will receive a response from the UK Government and will be debated in the House.

Background

The terms of reference for the inquiry as set by the House of Lords are “*to consider the long-term sustainability of the NHS*” and to report back to the House by Friday 31 March 2017.

The sustainability of the NHS is a topic of significant political and public interest. There remains a continuing level of support for a national health service which is free-at-the-point-of-use.

Yet the demographics of both England and the UK are changing rapidly. There are estimated to be 51% more people aged 65 and over in England in 2030 compared to 2010. Moreover, 101% more people in England will be aged 85 and over in 2030 compared to 2010. People with three or more long-term conditions in England will increase by over 50% by 2018 compared to 2008.

These demographic changes directly affect healthcare expenditure, potentially putting financial stability and sustainability at risk. In 2015/16 NHS providers ended in deficit for the second year running.

Alongside this, the pace of change in healthcare is dramatic. Developments in drugs and medical technology mean that treatment and prevention are becoming more personalised, opening the door for more targeted treatment of diseases.

The Committee will be looking at UK Government policy and practice. It will consider whether their strategies and planning are sufficiently long-term, and what might usefully be done in practical terms to guarantee the sustainability of the NHS. The Committee will focus its inquiry on five main themes:

- resource issues, including funding, productivity and demand management;
- workforce, especially supply, retention and skills;
- models of service delivery and integration
- prevention and public engagement; and
- digitisation of services, Big Data and informatics.

The Committee will attempt to identify the main problems in each of these areas and explore potential solutions.

The Committee is keen to take evidence from as diverse and as wide a range of stakeholders as possible, from a variety of sectors. This includes, but is not limited to: NHS Trusts and Foundation Trusts; patient organisations and charities; Royal Colleges; academics; local authorities; consultancies; civil society and non-governmental organisations; organisations working in the EU and other international bodies. We would like to hear from as many organisations and people working in these sectors as possible.

The Committee's inquiry will focus on the long-term sustainability of the NHS in relation to the five areas identified above. Submissions which do not address one or more of these issues, or which focus on the past, current, or short-term situation, may not be accepted as evidence.

The Committee will not look at or comment on personal cases. Individuals who wish to seek advice on healthcare-related complaints are encouraged to contact the Parliamentary and Health Service Ombudsman on 0345 015 4033 or at www.ombudsman.org.uk.

Questions

The following questions cover the full focus of the Committee's inquiry. It is not necessary to answer every question in detail in your submission and you are encouraged to share any other information with the Committee that you feel is relevant to the focus of the inquiry. Please consult the staff of the Committee if you have any questions. Submissions should be limited to six pages. You need not address all the questions in your response.

The future healthcare system

1. Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

Resource issues, including funding, productivity, demand management and resource use

2. To what extent is the current funding envelope for the NHS realistic?
 - (a) Does the wider societal value of the healthcare system exceed its monetary cost?
 - (b) What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?
 - (c) What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?
 - (d) Should the scope of what is free-at-the-point-of-use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?

Workforce

3. What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?
 - (a) What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?
 - (b) What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?
 - (c) What are the retention issues for key groups of healthcare workers and how should these be addressed?
4. How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?
 - (a) What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?
 - (b) What are the cost implications of moving towards a workforce that is equipped with a more adaptable skill mix being deployed in the right place at the right time to better meet the needs of patients?
 - (c) What investment model would most speedily enhance and stabilise the workforce?

Models of service delivery and integration

5. What are the practical changes required to provide the population with an integrated National Health and Care Service?
 - (a) How could truly integrated budgets for the NHS and social care work and what changes would be required at national and local levels to make this work smoothly?
 - (b) How can local organisations be incentivised to work together?
 - (c) How can the balance between (a) hospital and community services and (b) mental and physical health and care services be improved?

Prevention and public engagement

6. What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?
 - (a) What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?
 - (b) What should be the role of the State, the individual and local and regional bodies in an enhanced prevention and public health strategy; and what are the key changes required to the present arrangements to support this?
 - (c) Is there a mismatch between the funding and delivery of public health and prevention, compared with the amount of money spent on treatment? How can public health funding be brought more in line with the anticipated need, for instance a period of protection or ring-fencing?

- (d) Should the UK Government legislate for greater industry responsibility to safeguard national health, for example the sugar tax? If so how?
 - (e) By what means can providers be incentivised to keep people healthier for longer therefore requiring a lower level of overall care?
 - (f) What are the barriers to taking on received knowledge about healthy places to live and work?
 - (g) How could technology play a greater role in enhancing prevention and public health?
7. What are the best ways to engage the public in talking about what they want from a health service?

Digitisation of services, Big Data and informatics

8. How can new technologies be used to ensure the sustainability of the NHS?
- (a) What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?
 - (b) What is the role of 'Big Data' in reducing costs and managing demand?
 - (c) What are the barriers to industrial roll out of new technologies and the use of 'Big Data'?
 - (d) How can healthcare providers be incentivised to take up new technologies?
 - (e) Where is investment in technology and informatics most needed?

APPENDIX 4: HYPOTHECATION

In paragraphs 179–182, we noted that some witnesses had proposed hypothecated taxes as a way of generating additional funding for the NHS. Some of the arguments for and against such hypothecation are set out below.

Definition of hypothecation

The hypothecation of a tax is the dedication of revenue raised from a specific tax for a particular programme or service.³⁰⁸ The evidence highlighted three kinds of hypothecation, which included:

- (1) ‘Soft hypothecation’. This involves a commitment to spend any additional revenues from a given tax or change in tax to a specific cause.
- (2) ‘Hard hypothecation’. This involves assigning a proportion of a given revenue stream to a specific programme.
- (3) ‘Full hypothecation’. This involves allocating all of the revenue from one tax to a specific programme.³⁰⁹

The case for and against hypothecation

The strongest advantage of hypothecation appeared to be the greater transparency it would provide of the link between taxation and government spending, which witnesses suggested could help improve the public’s understanding of the tax burden and the amount spent on a service, therefore enabling more of a debate on how much the electorate are willing to pay. Lord Macpherson of Earl’s Court outlined this argument in more detail:

“... the introduction of hypothecation could strengthen public understanding of the trade-offs between taxing and spending at least in relation to health spending. And it might make more palatable the likely tax increases which will be necessary to deal with the demographic pressures which are likely to become increasingly visible during the course of the 2020s. At a time when trust in government has declined, and many citizens feel a disconnect between the taxes they pay and the services they receive, it could help revive citizen engagement. This would be the case especially at election-time, when political parties would have a chance to set out their plans for any hypothecated tax and health spending as a whole.”³¹⁰

The key disadvantage to hypothecation appeared to be concerns that it would potentially undermine the ability of governments to deal with economic cycles. Lord Macpherson of Earl’s Court stated that:

“The case against hypothecation is that it is inherently inefficient. Governments need the flexibility to allocate resources as they see fit, unconstrained by trends in individual taxes, some of which are more buoyant than others while others are more cyclical. It would also constrain changes to the hypothecated tax for wider economic and distributional reasons.”³¹¹

308 Centre Forum, India Keable-Elliott, *Hypothecated taxation and the NHS*, (December 2014): <http://www.centreforum.org/assets/pubs/hypothecated-taxation.pdf> [accessed 28 March 2017]

309 Written evidence from Lord Macpherson of Earl’s Court ([NHS0177](#))

310 *Ibid.*

311 *Ibid.*

Giving effect to hypothecation

The evidence suggested that income tax, National Insurance contributions (NICs) and VAT raise sufficient revenue to be plausible candidates for a hypothecated tax for health spending, with a number of witnesses suggesting the most viable options to be NICs. Lord Macpherson of Earl's Court outlined the various implications of using NICs to fund the health service:

- Many taxpayers already think NICs fund the NHS, which is partially right as some 20% of NIC revenues (£21 billion in 2014–15) are allocated to the NHS, the rest going into the National Insurance Fund to pay for contributory benefits, such as the state retirement pension. This might provide a “good starting point” for any debate about the levels of taxation and health spending.
- For a hypothecated tax to be seen as fair, it could be argued that as many adults as possible should pay it. Lord Macpherson of Earl's Court stated: “Since old people are likely to be the main beneficiaries of increased spending on the NHS ... there is a strong case in fairness for bringing the NICs base more into line with income tax. However, this would have major distributional implications, and the revealed preference of successive governments has been to tread carefully when it comes to the integration of income tax and NICs.”³¹²

How a hypothecated tax for the NHS might work

We received evidence on how “full” hypothecation might work for the NHS. Lord Layard suggested that National Insurance could be turned into “National Health Insurance (NHI).” He explained the process for how this might be implemented:

- (1) “Decide the share of Gross National Product to be spent on health on average over the parliament and thus compute its forecast value in [monetary terms].
- (2) Phase the expenditure over the Parliament.
- (3) Fix the NHI tax rate for the Parliament to raise the (expected) total over the Parliament.
- (4) If in a year Tax exceeds Expenditure, put it in a stabilisation fund; if Expenditure exceeds Tax, finance it from this fund (if possible), otherwise by borrowing. At the end of the parliament, close the fund and transfer the debt to the consolidated National Debt.”³¹³

312 *Ibid.*

313 Written evidence from Lord Layard ([NHS0178](#))

APPENDIX 5: NOTE BY THE SPECIALIST ADVISER, EMMA NORRIS: AN AUDIT OF INDEPENDENT AND SEMI-INDEPENDENT PUBLIC BODIES AND IMPLICATIONS FOR A NEW HEALTH AND SOCIAL CARE BODY

The audit

During the course of the inquiry, the Committee heard the suggestion that a body should be established to guarantee cross-party agreement for long-term health policy and planning. Some witnesses suggested that this may be achieved through an independent body charged with (1) setting the strategic direction of health spending, workforce planning and models of delivery and/or (2) acting as a custodian of accurate data relating to health and social care.

To assist the Committee consider this suggestion in greater detail, I have produced a general audit of the different models on which an independent or semi-independent body established to guarantee the long-term sustainability of the NHS and social care might operate and the different roles such a body might play. I have done this by selecting public bodies from a range of areas—from policing, to social mobility, to infrastructure—and applying to them a series of questions about their purpose, functions, outputs, composition and impact. In doing so I have drawn extensively on work completed within the Institute for Government by Joshua Harris, Jill Rutter and Euan McCarthy. I am most grateful for their efforts.

In total, I surveyed 16 bodies and categorised them according to the following typology, which indicates their primary role:

Body	Abbreviation used in note	Primary role
Audit Commission	AC	Auditor, advisor
Committee on Climate Change	CCC	Analytical advisor, monitor
Education Funding Agency	EFA	Funding distributor, monitor
Higher Education Funding Council for England	HEFCE	Funding distributor, regulator
Independent Commission for Aid Impact	ICAI	Monitor
Low Pay Commission	LPC	Analytical advisor
Migration Advisory Committee	MAC	Analytical advisor
National Audit Office	NAO	Auditor, improvement agency
National Infrastructure Commission	NIC	Analytical advisor, improvement agency
National Police Improvement Agency	NPIA	Technical adviser, improvement agency
National Institute for Health and Care Excellence	NICE	Advisor, regulator

Office for Budget Responsibility	OBR	Analytical forecaster monitor
Ofcom	Ofcom	Regulator
Review Body on Doctors' and Dentists' Remuneration	DDRB	Analytical advisor
Social Mobility Commission	SMC	Analytical advisor, advocate
UK Statistics Authority (including Office for National Statistics)	UKSA ONS	Data producer, regulator

I looked across these sixteen bodies and drew out and analysed common features, before concluding with the implications and questions that arise for a consideration of any potential independent body looking at health and social care. The full audit of each body can be viewed on the Committee's website at www.parliament.uk/nhs-sustainability

Role, purpose and powers

Most independent bodies I considered had a clearly articulated and widely understood scope and purpose. This enabled them to focus, made it clearer what value the body offered, and prevented creeping scope—the lack of this is an existential risk. This proved true in the case of the Audit Commission which was abolished by the Coalition Government in 2015 (announced 2010), in large part at least due to it being seen to have “lost its way” as the then Secretary of State for Communities and Local Government, Eric Pickles, said.³¹⁴ Advisory bodies are typically set up to answer a single or narrow set of questions on which independent expert advice is needed to depoliticise the decision, or resolve conflict.

As the typology above indicates, most bodies I looked at perform an analytical and/or advisory function, some with additional responsibilities as an improvement agency—that is, to support improvements rather than just advise on or monitor them—a regulator or auditor. Of relevance to a potential health body is the monitoring role of bodies which exist to track the implementation of Government performance against a certain standard, such as the CCC with climate commitments and the OBR which assesses whether the Government is on track to meet its fiscal rules.

Irrespective of statutory status (discussed below), all bodies have a written purpose and remit, such as a Framework Agreement, Memorandum of Understanding, or annual remit letter from a minister. Several, like the ICAI, often still have some form of written framework agreement with their sponsoring department.³¹⁵ Those which undertake regular reports will often be guided by a remit letter from their sponsor setting out the terms under which they should work. For example, the

314 N. Timmins and T. Gash, Institute for Government, *Dying to Improve: The Demise of the Audit Commission and Other Improvement Agencies* (March 2014): <https://www.instituteforgovernment.org.uk/sites/default/files/publications/Dying%20to%20Improve%20-%20web.pdf> [accessed 28 March 2017] and BBC News Online, ‘Eric Pickles announces plans to scrap Audit Commission’: <http://www.bbc.co.uk/news/uk-politics-10970008> [accessed 28 March 2017]

315 ICAI, *Framework Agreement*: <http://icai.independent.gov.uk/wp-content/uploads/ICAI-DFID-Framework-Agreement.pdf> [accessed 28 March 2017]

NIC receives one from the Chancellor of the Exchequer³¹⁶ and the DDRB receives one from the Department of Health³¹⁷ as well as from the Chief Secretary to the Treasury setting out Government policy on public sector pay.³¹⁸

The political context is important, and related to the organisation's role and purpose as far as there is consensus agreement on the purpose of the body. This reduces the frictional cost of bodies operating—for example, avoiding diverting attention to combating hostile press attacks or having its independence and impartiality undermined or questioned. But it also provides greater surety of longevity in case there is a change of minister or Government. The NIC, for example, was set up by a Conservative Government but had also been a Labour party manifesto promise following their own independent review of UK infrastructure by Sir John Armitt, who is now Deputy Chair of the NIC, which they commissioned while in opposition.³¹⁹ The difficulty of taking decisions about major infrastructure projects in Government—notably airport capacity and HS2—convinced many of the need of an independent, objective assessment of what infrastructure the UK requires, and what could be done within a set fiscal envelope. The previous Labour Government's Infrastructure Planning Commission was established in October 2009³²⁰ with some of the same functions, but also a remit on planning decisions but never enjoyed cross-party support and was finally abolished by the Coalition Government in 2012³²¹ with its planning functions transferred to the Planning Inspectorate.

Though typically separated from executive functions, some independent bodies take on functions which otherwise would be performed by a department. For example, the OBR took over Treasury responsibility for published fiscal forecasts, and the EFA, while remaining part of the Department for Education and responsible to ministers, has taken over functions previously located in the core department. Few have direct executive powers: NICE's control over drugs and medical technology in the NHS is a rare example.

No independent body I considered had direct control over levels of public spending. It is quite common for Government to use arm's length bodies to distribute funding (as the EFA and HEFCE do in my sample) but none determine the quantum. Some can make recommendations which have implications for Government spending—for example the LPC and the DDRB. But in both cases final decisions rest with Government, not the body, and Government evidence to the DDRB, and other pay review bodies, focuses on affordability.

316 HM Treasury and National Infrastructure Commission, *Remit Letter to the NIC* (23 November 2016) :<https://www.gov.uk/government/publications/remit-letter-to-the-national-infrastructure-commission> [accessed 28 March 2017]

317 Department of Health, DDRB & Office of Manpower Economics, *DDRB remit letter from the Department of Health: 2017 to 2018* (31 August 2016), <https://www.gov.uk/government/publications/ddrb-remit-letter-from-the-department-of-health-2017-to-2018> [accessed 28 March 2017]

318 HM Treasury, *Letter from the Chief Secretary to the Treasury to Pay Review Body chairs* (25 August 2015): <https://www.gov.uk/government/publications/letter-from-chief-secretary-to-the-treasury-to-pay-review-body-chairs> [accessed 28 March 2017]

319 The Labour Party, *The Armitt Review: An independent review of long term infrastructure planning commissioned for Labour's policy review* (September 2013): http://www.policyforum.labour.org.uk/uploads/editor/files/The_Armit_Review_Final_Report.pdf [accessed 28 March 2017]

320 Infrastructure Planning Commission, *National Infrastructure: A planning system fit for the 21st century; Infrastructure Planning Commission end of period report October 2009–March 2010* (26 July 2010): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/247711/0165.pdf [accessed 28 March 2017]

321 Infrastructure Planning Commission, *Infrastructure Planning Commission* (26 July 2010): <https://www.gov.uk/government/organisations/infrastructure-planning-commission> [accessed 28 March 2017]

Where they do not replace departmental functions, but add additional capability, bodies need to have a clear landing point for recommendations. For bodies with an advisory role, this can be direct to ministers (though reports are often, for transparency, also published), parliament (as set out below) or to professionals for whom the advice is intended (such as the NPIA for police). Most bodies can produce additional analysis when requested by ministers, such as the CCC and DDRB.³²²

Parliament is the landing point for several of the bodies I considered, and a parliamentary process of scrutiny offers additional protection against reports being controlled or ‘buried’ by ministers. The NAO provides the analysis and evidence to support the House of Commons Public Accounts Committee, a powerful partnership. Similar to this model, the ICAI has been designed to service a dedicated sub-committee of the House of Commons International Development Select Committee, requiring the Department for International Development to submit its response to ICAI reports to parliament and giving ICAI parliamentary backing to its follow up on how recommendations are implemented. Andrew Mitchell, who as Secretary of State for International Development established the ICAI, later said of it, “Ministers can just sweep inconvenient truths under the carpet. But we set up this Commission to report not to ministers but to the legislature”.³²³ Many of the other bodies are required to lay their reports before parliament which ensures a minimum of transparency.

A small number of bodies I considered have additional mandates to play a more active advocate role within Government or a delivery system. This can be technical, advocating best practice: the Audit Commission recommended best practice at a local level, based on its research, and the NPIA was specifically set up as an improvement agency to support police forces. Or it can be about advocating a cause: the SMC has a mandate to promote social mobility among employers, professions, universities, and schools. However, this advocacy role can lead bodies into more direct conflict with Government and, as was the case for instance with the Sustainable Development Commission (2000–2011), lead to their abolition if ministers no longer see the value in funding an arm’s length critic.³²⁴

Several bodies I considered have an explicit stakeholder engagement role. Sometimes this is simply necessary for the body to perform its role: the EFA and HEFCE must work with the institutions they fund, the NPIA with police, the AC and NAO with the bodies it audited and their service users, and Ofcom with the broadcasters it regulates.

Others exist to independently engage representative stakeholders to build consensus around a decision which otherwise could be politically difficult or controversial. For example, the LPC exists to build consensus around the minimum wage rate and therefore is comprised of employer and employee representatives as well as independents. The DDRB, like other pay review bodies, is intended to resolve conflict between Government and public sector workers by independently setting pay levels, considering the need to motivate and recruit staff as well as the

322 DDRB and Office of Manpower Economics, *Contract reform for consultants and doctors and dentists in training – supporting healthcare services seven days a week* (16 July 2015) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445742/50576_DDRB_report_2015_WEB_book.pdf [accessed 28 March 2017]

323 Institute for Government, ‘Ministers reflect: Andrew Mitchell’: <https://www.instituteforgovernment.org.uk/ministers-reflect/person/andrew-mitchell/> [accessed 28 March 2017]

324 BBC News, ‘UK government axes its sustainability watchdog’: <http://www.bbc.co.uk/news/science-environment-10725394> [accessed 28 March 2017]

department's budget. It is comprised of independent members, albeit many with former health sector (though not clinical) experience, but takes evidence from bodies including the department.

Less typical is an explicit role in direct public engagement—rather than through stakeholder and representative groups—or wider consultation on behalf of Government. NICE does have a 'Citizen's Council' panel of public members to ensure it considers views of the public on a regular basis, as part of a wider programme of public engagement.³²⁵ Most others carry out *ad hoc* consultations or calls for evidence as required, for example recently by the NIC³²⁶ but these are usually targeted at specific groups or interested parties than the general public. HEFCE run the National Student Survey, which is an annual exercise in seeking user views. It is arguable that an independent body carrying out a consultation is more credible than one done by the department—and there are effective tools available to do so—but there is limited evidence of bodies successfully building up meaningful public engagement on an ongoing basis.

Form and status

Form does not determine the success or independence of an organisation but can provide insulation from interference. The Institute for Government has argued that there is a clear case for form following function and that the key determinant of this should be the degree of freedom the body needs from ministerial control to perform its functions effectively. The Institute proposed that the existing classification of arm's length bodies should be overhauled and a new category of "public interest body" should be created for watchdog and regulatory bodies whose credibility depended on their independence from ministers.³²⁷ The Government launched its own review of classifications in 2015 and produced guidance which stresses the organisation form for new bodies should be determined *inter alia* by their need for independence from ministers.³²⁸ The bodies I considered range from executive agencies, which are constituent parts of departments (EFA, NIC) through mostly advisory non-departmental public bodies (NDPBs) to, at the most independent and secure status end of the spectrum, a public corporation (Audit Commission) and parliamentary body (NAO).

Classification matters because institutional arrangement determines how ministers can change the organisation. Some, but not all of the bodies I looked at are grounded in statute. Executive agencies and many advisory NDPBs exist at ministerial discretion, with their staff remaining civil servants; other bodies are usually (but not always) established in statute. Putting bodies on a statutory basis means ministers must pass primary legislation to abolish or substantially change a body.³²⁹ In the absence of a formal institutional separation bodies depend on ministerial forbearance for their actual independence. The recent announcement that the NIC would be made an executive agency of the Treasury—i.e. remaining

325 NICE, 'Get involved': <https://www.nice.org.uk/get-involved> [accessed 28 March 2017]

326 NIC, *National Infrastructure Assessment Call for Evidence* (27 October 2016): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/563516/NIA_call_for_evidence_October_2017.pdf [accessed 28 March 2017]

327 Tom Gash *et al.*, Institute for Government, *Read Before Burning* (July 2010): <https://www.instituteforgovernment.org.uk/sites/default/files/publications/Read%20before%20burning.pdf> [accessed 28 March 2017]

328 Cabinet Office, *Public Bodies Handbook – Part 1: Classification of Public Bodies, Guidance for Departments*: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/519571/Classification-of-Public-Bodies-Guidance-for-Departments.pdf [accessed 28 March 2017]

329 An attempt in the 2010 Public Bodies Reform Bill to provide for ministers to abolish bodies named in a schedule by secondary legislation proved highly contentious and ministers had to withdraw the proposed provision; for instance see HL Deb, 23 November 2010, [cols 1010–1046](#)

a constituent part of it, responsible to and controlled by ministers—raised questions about how long its actual independence will last.³³⁰ Executive Agencies can be absorbed on ministerial whim because there is no constitutional separation between them and their parent department. This has happened with operational delivery agencies, as when the UK Border Agency was reabsorbed back into the Home Office with no warning in 2013. However, even strong statutory protections do not mean bodies can avoid political risk altogether. Being based in statute did not prevent the abolition of the Audit Commission or NPIA, and the Social Mobility Commission lost its original remit for monitoring child poverty.

Statutory status can also prevent organisations from mission creep by constraining its role. For example, in the run up to the 2015 general election there was pressure for the OBR to cost election manifestos, which its Chairman, Robert Chote, explained to parliament was a potentially very complex change to make to its role, and while he supported it in principle, required serious consideration before implementing.³³¹ Since the OBR could not fulfil this role without a change to legislation, this meant the OBR could resist the pressure until and unless parliament deemed otherwise.

Independence

First, the popularity and support for certain independent bodies—especially the OBR currently—and general acceptance of others—like the NAO—suggests they continue to play a useful role for ministers. Indeed, several of the more significant bodies I considered including the OBR, NIC and ICAI were set up by a Government otherwise committed to a ‘bonfire of the quangos’. Of the ICAI, Andrew Mitchell, the then Secretary of State, said later of it, “the ICAI could be very testing and very difficult, but they did a good job, a very important job”.³³² At the most recent Autumn Statement, the Chancellor of the Exchequer, Philip Hammond, remarked that due to the OBR’s forecasts, “gone are the days when the Chancellor could mark his own homework”.³³³ Of course, this does not apply universally to independent bodies and some have fallen out of favour, as the abolition of the Audit Commission and NPIA demonstrates.³³⁴ In his recent book, Ed Balls describes the benefits to politicians of arm’s length bodies: “Following the success of Bank of England independence the idea of handing over power and control to experts and suitable bodies took hold. The Government would establish the objective, the structure and the rules for an institution, but hand over control to an arm’s length agency to make the case-by-case decisions on the basis they would be able to take a long-term, proactive approach, undeterred by short-term political pressures”.³³⁵

330 ‘Chancellor Philip Hammond slammed over misleading claims over National Infrastructure Commission ‘independence’’, *The Independent* (13 October 2016): <http://www.independent.co.uk/news/business/news/government-slammed-over-national-infrastructure-commission-independence-claims-a7359956.html> [accessed 28 March 2017]

331 OBR, *Letter to Chairman of the Treasury Select Committee* (15 January 2014): http://budgetresponsibility.org.uk/docs/dlm_uploads/TSC_pre_election_costings.pdf [accessed 28 March 2017]

332 Institute for Government, ‘Ministers reflect, Andrew Mitchell’: <http://www.instituteforgovernment.org.uk/ministers-reflect/wp-content/uploads/2015/11/Andrew-Mitchell> [accessed 28 March 2017]

333 HC Deb, 23 November 2016, [col 899](#)

334 For a full discussion of the demise of both the Audit Commission and National Police Improvement Agency, see N. Timmins and T. Gash, Institute for Government, *Dying to Improve: The Demise of the Institute for Government, Audit Commission and Other Improvement Agencies* (March 2014): <https://www.instituteforgovernment.org.uk/sites/default/files/publications/Dying%20to%20Improve%20-%20web.pdf> [accessed 28 March 2017]

335 Ed Balls, *Speaking Out: lessons in Life and politics* (London: Hutchinson, 2016), pp 150–151

Small advisory bodies are used to try and take heat out of political arguments or defer decisions: recently this has included the Secretary of State for Health asking the DDRB to review suggested contract changes for doctors³³⁶, and the MAC being commissioned to review Tier 2 visas.³³⁷

Second, bodies differed over the level of autonomy they exercised over their workplan, and whether they have their own power to act, or whether they can only do so at ministerial behest.

- (a) Where their purpose is advisory, it makes sense for this to be on demand, as with the MAC, to avoid producing advice which is not needed. Even where bodies determine their own workload, it is prudent to work on areas which are of relevance and value. However, where bodies have more of a monitoring function it is important that they have significant freedom to determine their own investigations. This is of course crucial for audit bodies like the NAO, and when others are acting in an inspection or regulatory capacity like Ofcom, HEFCE, EFA and the UKSA. But is also important for bodies like the ICAI to be able to have a workplan determined independently of ministers, in that case when it is agreed with the House of Commons International Development Committee.
- (b) Other bodies have a regular rhythm of operation which means their freedom to act is not questioned because they do not need a mandate for each piece of work. For example the OBR is required to produce forecasts and analysis for fiscal events, and annually such as on compliance with the welfare cap. The LPC and DDRB produce annual outputs. The CCC produces annual progress reports to parliament on “meeting carbon budgets”.
- (c) Where bodies act on the basis of ministerial instruction, these are best written and published to ensure transparency and accountability. Many of the bodies work within parameters set by ministers, which are then published: the Charter for Budget Responsibility sets out the Government’s approach to fiscal policy for the OBR for example. The DDRB and NIC both receive remit letters from ministers for each report.

Third, an independent body requires secure funding to avoid ministers neutering it through unscrutinised cuts to its funding—or by withholding resources required to undertake investigations. The NAO, which has its budget direct from parliament, has the most secure funding. But at least bodies with non-ministerial department status have a separately identifiable budget line so that any punitive cuts to its funding following a spat with the minister can be seen. When the Treasury opted to keep the OBR as part of the department (albeit as a body corporate established in statute), it agreed to give it a separate budget line in Treasury accounts for this reason. Those which do not have these protections risk having pressure applied to their funding—or simply having their resource cut along with the department as a savings measure, which may inhibit the ability of the body to perform its function

336 DDRB and Office of Manpower Economics, *Contract reform for consultants and doctors and dentists in training – supporting healthcare services seven days a week* (16 July 2015): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445742/50576_DDRB_report_2015_WEB_book.pdf [accessed 28 March 2017]

337 Migration Advisory Committee, *Review of Tier 2 report: balancing migrant selectivity, investment in skills and impacts on UK productivity and competitiveness* (19 January 2016): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/493039/Tier_2_Report_Review_Version_for_Publishing_FINAL.pdf [accessed 28 March 2017]

as effectively as it would like. Bodies have also been subjected to the wider Cabinet Office controls on spending which can affect their ability to hire consultants. This has been a source of tension between public bodies, departments and the Cabinet Office.³³⁸

Fourth, leaders of independent bodies need to feel sufficiently secure in their post to resist political pressure—and they need to be credible candidates rather than ministerial ‘placemen’. Thus a number of the bodies I considered had legislative safeguards against leaders being ditched unilaterally by ministers, or to prevent inappropriate appointments.

- (a) Parliament has a role in some appointments.³³⁹ The NAO has the strongest protection against the removal of the Comptroller and Auditor General, who as an Officer of the House of Commons can only be appointed or removed by parliament, and the address to appoint can only be moved by the Prime Minister with the agreement of the chair of the House of Commons Public Accounts Committee, which is always an Opposition MP. Other than for parliamentary bodies, the greatest power lies with the House of Commons Treasury Select Committee which both has to approve the appointment of the chair of the OBR and veto their dismissal. In other cases parliament’s role is limited to holding a confirmation hearing. Parliamentary arrangements can have teeth: the Government’s original preferred candidate for Chair of the UK Statistics Authority, Dame Janet Finch, withdrew her candidacy in 2011 after a pre-appointment hearing with the House of Commons Public Administration Select Committee revealed differences in how independence from Government was understood, and it seemed possible that the Committee would not confirm her appointment though a report was not published.³⁴⁰ For the ICAI, ministers decided the final appointment (and indeed, there was controversy that they were given an unranked choice of candidates),³⁴¹ but the House of Commons International Development Committee was represented on the appointment panel.
- (b) UK-wide bodies also have a responsibility to reflect devolved arrangements, and this includes for some either reporting or leadership appointment responsibilities. So the Social Mobility Commission for example includes at least one commissioner each from Northern Ireland, Scotland and Wales. While no safeguard against political interference *per se*, this is another informal block against a body becoming dominated by the Government at Westminster. In such cases the devolved administrations will usually need to agree to chair appointments.

338 Jill Rutter *et al.*, Institute for Government in partnership with the Public Chairs Forum, *It Takes Two* (March 2012): https://www.instituteforgovernment.org.uk/sites/default/files/publications/it_takes_two_final_0.pdf [accessed 28 March 2017]

339 For a fuller discussion of the potential role for parliament in public appointments see A. Paun and D. Atkinson, Institute for Government, *Balancing Act: the right role for parliament in public appointments* (March 2011): <https://www.instituteforgovernment.org.uk/sites/default/files/publications/Balancing%20Act.pdf> [accessed 28 March 2017]

340 Public Administration Select Committee, *Appointment of the Chair of the UK Statistics Authority* (Sixteenth Report, Session 2010–12, HC 910–1)

341 ‘Dr Alison Evans to head Britain’s independent aid watchdog’, *The Independent* (11 December 2014): <https://www.theguardian.com/global-development/2014/dec/11/dr-alison-evans-icai-head-britain-independent-commission-aid-impact-watchdog> [accessed 28 March 2017]

Finally, while independence is important, effective governance is vital for ensuring the body itself acts properly, and maintains focus on its core role. Independent organisations can be the greatest danger to their own independence by acting improperly, and appearing to be unaccountable. The Audit Commission in hindsight had overreached itself while alienating those who would have supported it, reversing a previous record of good engagement with local councils and minister.³⁴² While independence is aided by leaders feeling secure enough in their positions to defy ministers when required, it is important that there are mechanisms for replacing leadership when needed—which is why the Comptroller and Auditor General is now subject to a ten year non-renewable term limit, a change introduced after the previous post-holder, who had been in post for nearly thirty years.

What bodies need to operate

My analysis suggests that as well as the form and safeguards needed to ensure independence, bodies require the following to operate effectively:

- (a) A right of access to information is vital for bodies to do their job. Some of the bodies considered do gather information from those they monitor or regulate which can be used for broader interpretive analysis, as with HEFCE and EFA for sectoral insight, or the NPIA drawing on police data. But a right of access is crucial for those who do not gather the information they require themselves. The DDRB is dependent on bodies submitting evidence to it, such as the BMA and Department for Health. Some have this right in law: for example, the OBR has a statutory right to all Government information required to fulfil its duties.
- (b) The right staff is required for the body to do its job. In most cases this consists of a secretariat plus analytical capacity—the latter needs to be of sufficient calibre and capacity to produce robust material. This can be in-house—as it is with the UKSA which has the ONS as its executive office, and the OBR—or contracted, as with the ICAI. Other models include the DDRB which, alongside the other pay review bodies, is serviced by analysts in the Office for Manpower Economics, and hybrid models which combine their own analytical capacity with contracting specific pieces of analysis, which the LPC does. Indeed, the LPC began with very cautious wage increases in the late 1990s because it discovered the evidence around labour market effects was limited: its commissioning of research since has hugely strengthened this evidence base. Some of these bodies which take on additional functions become very large, especially those with delivery, regulatory and inspection functions like the EFA, HEFCE and the Audit Commission. But those with a tightly defined remit have small dedicated resource: the LPC has nine commissioners and a secretariat of eight, and spent £244,000 on commissioned research in 2015. The point is not the size, but the appropriateness of resource to fulfil its role effectively—and for this resource to be guaranteed.
- (c) Effective leadership is essential, especially chairs for larger bodies to establish them as independent entities, especially in the media, as has happened with the OBR in recent years. This does not always entail appointing ‘big beasts’—the credibility of the LPC depends on effective consensus among the commissioners—so experience of effective chairing rather than representation is the key skill required.

342 Nicholas Timmins and Tom Gash, Institute for Government, *Dying to Improve: The Demise of the Audit Commission and Other Improvement Agencies* (March 2014): <https://www.instituteforgovernment.org.uk/sites/default/files/publications/Dying%20to%20Improve%20-%20web.pdf> [accessed 28 March 2017]

Implications for a new, independent health and social care body

Establishing a new body on health and social care has been the subject of much discussion recently, including in written and oral evidence given to the Committee by figures including Jennifer Dixon from the Health Foundation and Robert Chote from the OBR. Spokespeople from the Labour, Liberal Democrat and Scottish National parties supported some form of independent body to give periodic reports on health and social care funding.³⁴³ The Labour party recently reiterated its support for such a body to report on the level of funding required by the NHS.³⁴⁴ Think tanks including The King's Fund and Health Foundation have also suggested a case for an independent body to advise on health and social care resourcing.³⁴⁵ Think tanks have also mooted other possible roles for an independent body, such as the SMF suggestion of an OBR-style Office for Patient Outcomes to increase accountability for patient outcomes.³⁴⁶

The remit of any new body would need to be carefully considered and clearly agreed. As my analysis indicates, clarity on scope and purpose is critical to a body's potential effectiveness. For a new health body, choices would likely need to include what functions it will perform, for example analytical, advisory, monitoring—or indeed if it would exercise any executive or decision-making function, which is rare for independent bodies. The remit would need to be clearly and widely understood, and would need to fit within the wider landscape of existing health bodies—potentially therefore entailing further changes in the system.

A new body set up to provide an independent and impartial overview of Government policy relating to health and social care is unlikely to be able to adopt wholesale an existing model, such as the OBR, which is most often cited as an example of an effective, influential body some would like emulated in the health and social care sector. However, from considering comparable independent bodies which perform a range of functions, there are key implications for the composition and reporting arrangements of any new independent health body.

First, in terms of the composition of a new body, the key decisions relate to the resource it requires to fulfil its role, and its leadership.

Resource

Bodies I looked at either add new or expert insight (e.g. NICE) or are intended to bring together stakeholders and data to establish consensus positions on controversial issues like the minimum wage level or doctor's pay rates. Would a new body be intended primarily to conduct expert analysis currently missing, or solve a problem of current unresolvable politics or misaligned incentives?

If a body is to undertake its own analysis to inform health and social care decision making, it would need a sufficiently well-resourced analytical capacity—and/or a research budget to commission additional work—in order to do this. The OBR has a budget of £2.6m and staff of 27 civil servants, which is slightly less than the Committee on Climate Change which is a similarly analytically-heavy body but with a relatively narrow remit.

343 [Q 296](#) (Jon Ashworth MP, Norman Lamb MP, Dr Philippa Whitford MP)

344 'Labour calls for OBR-style watchdog to assess NHS finances', *The Guardian* (27 December 2016): <https://www.theguardian.com/politics/2016/dec/27/labour-calls-for-obr-style-watchdog-to-assess-nhs-finances> [accessed 28 March 2017]

345 *Ibid.*

346 Social Market Foundation, *E. Mian, An Office for Patient Outcomes* (April 2016): <http://www.smf.co.uk/wp-content/uploads/2016/04/Social-Market-Foundation-An-Office-for-Patient-Outcomes-Embargoed-0001-050416.pdf> [accessed 28 March 2017]

Leadership

A new body would require effective leadership, of at least a Chair and likely a number of Commissioners too (the comparators started at a minimum of two additional Commissioners) with requisite expertise and credibility to establish the body, build strong relationships with powerful stakeholders—including NHS England, and the Department for Health—and ensure its independence.

Permanence

Is the problem the body is set up to resolve a temporary or permanent one? One option would be to set up a temporary commission—similar to previous attempts to establish consensus on the way forward, such as the Wanless Review—to devise, set out and agree a course of action on health and social care, but then to establish a small, focused independent body to monitor its delivery—for example, of spending against a level of GDP—and act akin to those bodies I looked at which have advisory and monitoring functions, such as the CCC.

Second, my analysis suggested there would be four key decisions to take on reporting arrangements:

Frequency

Most bodies I looked at with a regular reporting rhythm did so annually, such as the LPC and SMC. This includes financial bodies like the EFA and HEFCE.

Initiation

Independent bodies with a similar remit to that which has been proposed for a new body on health and social care usually report on a regular basis, typically annually or alongside an existing timetable, as the OBR does with fiscal events. This should be set out clearly when the body is established. Beyond that, it should also be determined whether ministers, NHS England, or indeed anyone else should be able to request or commission additional analytical work and, if so, under what circumstances. There are good reasons for allowing this, particularly in an area where independent, evidence-based analysis is required. But the process for it should be clear.

If the body is to be given a role which includes a monitoring or inspection function, it should not only be clear that it can initiate this work itself but that the power of ministers to circumscribe it—for example, by denying necessary information—are limited.

Time horizon

If the body is to contribute analysis to, or even have a more direct role in determining future funding of health and social care, there is a choice about how long-term it should report on, for example, whether it should report on future demand.

Purpose

Advisory bodies typically report to ministers, but publish and/or lay before parliament their final reports, including the MAC and NIC. However, others have been deliberately structured to feed into parliamentary scrutiny, most recently the ICAI. This is perhaps most appropriate when, like the ICAI, a body is itself evaluating Government performance and making recommendations. If a body exists to provide independent analysis, then a reporting line more like the MAC, LPC and so on may be more appropriate.

In any case, it should be clear what is expected to happen because of a body's reports: to inform ministerial decisions, to determine a course of action, to report against a target or standard to enable parliamentary and/or public accountability, and so on.

Emma Norris, Specialist Adviser

12 January 2017

APPENDIX 6: LIST OF ACRONYMS

A&E	Accident and Emergency
ADASS	The Association of Directors of Adult Social Services
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
GDP	Gross Domestic Product
GP	General Practitioner
HEE	Health Education England
LTCI	Long-term care insurance
NAO	National Audit Office
NHS	National Health Service
NIC	National Infrastructure Commission
NICs	National Insurance Contributions
NICE	National Institute for Health and Care Excellence
OECD	Organisation for Economic Co-operation and Development
OBR	Office for Budget Responsibility
ONS	Office for National Statistics
PAC	House of Commons Public Accounts Committee
RCN	Royal College of Nursing
RCP	Royal College of Physicians
STP	Sustainability and Transformation Plan

BOARD of DIRECTORS

<p>PAPER TITLE: High Level Risk Register – July 2017</p>	<p>REPORTING AUTHOR: Andrea McCourt</p>
<p>DATE OF MEETING: 3 August 2016</p>	<p>SPONSORING DIRECTOR: Brendan Brown</p>
<p>STRATEGIC DIRECTION – AREA:</p> <ul style="list-style-type: none"> • Keeping the base safe 	<p>ACTIONS REQUESTED:</p> <ul style="list-style-type: none"> • To note
<p>PREVIOUS FORUMS: Risk and Compliance Group 18 July 2017, Executive Board 27.7.17</p>	
<p>EXECUTIVE SUMMARY:</p> <p>The high level risk register is presented on a monthly basis to ensure that the Board of Directors are aware of key risks facing the Trust and is a fundamental part of the Trust's risk management system.</p> <p>The purpose of the high level risk register is to assure the Board of Directors that all risks are accurately identified and mitigated adequately through reviewing the risks identified on the high level risk register.</p> <p>The attached paper includes:</p> <ul style="list-style-type: none"> i. A summary of the Trust risk profile as at 21 July 2017 which identifies the highest scoring risks (between 15 and 25), risks with either an increase or decrease in scores, new and closed risks. ii. The high level risk register which identifies risks and the associated controls and actions to manage these <p>During July no new risks have been added to the high level risk register.</p> <p>Risk 6993 regarding the NHS agency cap was discussed at the Risk and Compliance Group on 21 July, in terms of a reduced risk score. It was agreed that the risk wording would be reviewed by Workforce and Organisational Development and Finance leads and re-presented to the Risk and Compliance Group on 22 August 2017.</p> <p>A reduced score has been agreed for one risk, risk 6886, relating to seven day services, with the risk score reduced from 15 to 10 due to compliance with two standards (standard 6 consultant directed interventions and standard 8, on-going review) and an action plan being developed to address non-compliance with standards 2 and 5. The risk has been removed from the high level risk register and is being managed on the local risk register, with a review in three months.</p> <p>Next Steps</p> <p>The high level risk register is a dynamic document and will continue to be reviewed on a monthly basis and presented to the Board to ensure it is aware of all significant risk facing the organisation.</p> <p>The Audit and Risk Committee Chair and Chief Nurse have agreed the following actions to develop a dynamic approach to managing risks on the high level risk register and Board Assurance Framework (BAF):</p> <ul style="list-style-type: none"> 1. Reviewing comparative information from neighbouring Trusts risk registers and BAFs - to be undertaken initially by internal auditors and thereafter on a quarterly basis by the Company Secretary and Head of Governance and Risk 	

2. Adding entry dates for risks to the BAF so the length that a risk has been present on the BAF is clear and identify any risks with a watching brief / closed date

3. Through the annual assurance report on risk management to the Audit and Risk Committee, summarising movements within both the high level risk register and BAF. include a narrative regarding the management of risks that have been on these risk documents for a prolonged period

4. Reviewing the Board agenda during the year to ensure that the risk register and BAF drive the Board agenda, with sufficient detail on all risks to strategic objectives presented to the Board.

RECOMMENDATION:

Board members are requested to:

- i. Consider, challenge and confirm that potential significant risks within the high level risk register are being appropriately managed
- ii. Approve the current risks on the risk register.
- iii. Advise on any further risk treatment required
- iv. Note the next steps described to develop a dynamic approach to risk

APPENDIX ATTACHED: YES High Level Risk Register – July 2017

HIGH LEVEL RISK REGISTER REPORT

Risks as at 20 July 2017

TOP RISKS
<p>6967 (25): Non delivery of 2017/18 financial plan 2827 (20): Over-reliance on locum middle grade doctors in A&E 6345 (20): Staffing risk, nursing and medical 6131 (20): Service reconfiguration 5806 (20): Urgent estates schemes not undertaken 6968 (20): Cash flow risk 6969 (20): Capital programme 6903 (20): Estates/ ICU risk, HRI</p>
RISKS WITH INCREASED SCORE
<p>6967 Non delivery of 2017/18 financial plan has increased from 20 to 25.</p>
RISKS WITH REDUCED SCORE
<p>Risk 6693, regarding financial penalties and reputational damage due to non compliance with the NHS agency cap rules, has been reduced on the risk register to a score of 12 from 15 during July.</p> <p>The rationale given for this is no adverse publicity since the risk was initiated and further work undertaken to reduce agency spend. The risk remains on the summary risk register list below pending conversations between workforce and organizational development and finance departments regarding the reduced score.</p> <p>Risk 6886, regarding seven day services has been reduced from 15 to 10 as an action plan to address gaps is in development and the Trust is compliant in several areas.</p>
NEW RISKS
<p>One new risk was added to the high level risk register in June following discussion at the Risk and Compliance Group on 20 June 2017 relating to completion of mandatory training, risk 6977, scored at 16.</p>
CLOSED RISKS
<p>Risk 6503, previously scored at 20, delivery of Electronic Patient Record Programme, has been reduced to its target risk score of 5 following implementation and has been closed.</p>

REVISED R&C APPENDIX 3 – High Level Risk Register Summary Report

July 2017 - Summary of High Level Risk Register by type of risk

Risk ref	Strategic Objective	Risk	Executive Lead	MONTH							Jul 17
				Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	
Strategic Risks				Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17
6503	Transforming & Improving Patient Care	Non delivery of Electronic Patient Record Programme - transformation	Director of THIS (MG)	=20	=20	=20	=20	=20	↓ 15	=15	=15
Safety and Quality Risks											
6131	Transforming & Improving Patient Care	Progress of reconfiguration, impact on quality and safety	Director of Commissioning and Partnerships (AB)	↓ 15	↑ 20	=20	=20	=20	=20	=20	=20
4783	Transforming & Improving Patient Care	Outlier on mortality levels	Medical Director (DB)	=16	=16	=16	=16	=16	=16	=16	=16
2827	Developing Our workforce	Over –reliance on locum middle grade doctors in A&E	Medical Director (DB)	=20	=20	=20	=20	=20	=20	=20	=20
6990	Keeping the Base Safe	Not meeting sepsis CQUIN 2017/18	Medical Director (DB)	=16	=16	=16	=16	=16	=16	=16	=16
5862	Keeping the Base Safe	Risk of falls with harm	Director of Nursing	=16	=16	=16	=16	=16	=16	=16	=15
6829	Keeping the Base Safe	Aseptic Pharmacy Unit production	Director of Nursing	=15	=15	=15	=15	=15	=15	=15	=15
5806	Keeping the base safe	Urgent estate work not completed	Director of Estates and Performance (LH)	=20	=20	=20	=20	=20	=20	=20	=20
6300	Keeping the base safe	Risk of being inadequate for some services if CQC improvement actions not delivered	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16	=16	=16
6598	Keeping the base safe	Essential skills training data	Director of Workforce and OD	=16	=16	=16	=16	=16	=16	=16	=16
6977	Keeping the base safe	Mandatory training 2017/18	Director of Workforce and OD	-	-	-	-	-	-	! 16	=16
6903	Keeping the base safe	ICU/Estates joint risk	Director of Estates and Performance (LH)	-	-	-	-	!16	↑ 20	=20	=20
6924	Keeping the base safe	Misplaced naso gastric tube for feeding	Director of Nursing (BB)	-	-	-	!15	=15	=15	=15	=15

REVISED R&C APPENDIX 3 – High Level Risk Register Summary Report

Risk ref	Strategic Objective	Risk	Executive Lead	MONTH								
6715	Keeping the base safe	Poor quality / incomplete documentation	Director of Nursing (BB)	=15	=15	=15	=15	=15	=15	=15	=15	=15
6971	Keeping the base safe	Endoscopy provision	Divisional Director of Surgery and Anaesthetics							!15	= 15	=15
Finance Risks												
6967	Financial sustainability	Non delivery of 2017/18 financial plan	Director of Finance (GB)	=20	=20	=20	=20	=20	=20	=20	=20	↑25
6968	Financial sustainability	Cash flow risk	Director of Finance (GB)	=20	=20	=20	=20	=20	=20	=20	=20	=20
6969	Financial sustainability	Capital programme	Director of Finance (GB)	=15	=15	=15	=15	=15	↑ 20	=20	=20	=20
Performance and Regulation Risks												
6658	Keeping the base safe	Inefficient patient flow	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16	=16	=16	=16
6596	Keeping the base safe	Timeliness of serious incident investigations	Director of Nursing (BB)	=16	=16	=16	=16	=16	=16	=16	=16	=16
6693	Keeping the base safe	Failure to comply with the Monitor cap rules	Director of Workforce (IW)	=15	=15	=15	=15	=15	=15	=15	=15	=15
People Risks												
6345	Keeping the base safe	Staffing - ability to deliver safe and effective high quality care and experience service	Medical Director (DB) ,Director of Nursing (BB), Director of Workforce (IW)	=2 0	=20	=20	=20	=20	=20	=20	=20	=20

KEY: = Same score as last period, ↓ decreased score since last period, ! New risk since last report to Board ↑ increased score since last period

Trust Risk Profile as at 13/07/2017

KEY: = Same score as last period ↓ decreased score since last period
 ! New risk since last period ↑ increased score since last period

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant	Minor	Moderate (3)	Major (4)	Extreme (5)
Highly Likely (5)			= 6693 Failure to comply with monitor staffing cap = 6715 Poor quality / incomplete documentation	= 6345 Staffing risk, nursing and medical	↑ 6967 Not delivering 2017/18 financial plan
Likely (4)				= 4783 Outlier on mortality levels = 6658 Inefficient patient flow = 6300 CQC improvement actions = 6596 Serious Incident investigations = 6598 Essential Skills Training Data = 5862 Falls risk = 6990 CQUIN sepsis ! 6977 mandatory training	= 2827 Over reliance on locum middle grade doctors in A&E = 5806 Urgent estate work not completed = 6131 Service reconfiguration = 6968 Cash Flow risk ! 6903 ICU/ resus estates risk ↑ 6969 Capital programme
Possible (3)					=6841 EPR operational readiness =6829 Pharmacy Aseptic Unit = 6924 Misplaced naso gastric tube = 6503 Non-delivery of EPR programme = 6971 Endoscopy provision
Unlikely (2)					
Rare (1)					

Risk No	Div	Opened	Status	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initial	Current	Target	Further Actions	Review	Target	RC	Exec Dir	Lead
6967	Trustwide	Apr-2017	Active	Financial sustainability	<p>The Trust is planning to deliver a £15.9m deficit in 2017/18. There is a high risk that the Trust fails to achieve its financial plans for 2017/18 due to:</p> <ul style="list-style-type: none"> - £20m (4% efficiency) Cost Improvement Plan challenge is not fully delivered - loss of productivity during EPR implementation phase and unplanned revenue costs - inability to reduce costs should commissioner QIPP plans deliver as per their 1718 plans - income shortfall due to contract sanctions / penalties based on performance measures or failure to achieve CQUIN targets - Non receipt of £10.1m sustainability and transformation funding due to financial or operational performance - expenditure in excess of budgeted levels - agency expenditure and premium in excess of planned and NHS Improvement ceiling level 	<p>Standing Financial Instructions set spending limits</p> <p>Project Management Office in place to support the identification of CIP</p> <p>Turnaround Executive meeting weekly to identify CIP shortfalls and drive remedial action</p> <p>Accurate activity, income and expenditure forecasting</p> <p>Finance and Performance Committee in place to monitor performance and steer necessary actions</p> <p>Executive review of divisional business meetings</p> <p>Budget reviews hold budget holders to account</p> <p>Realistic budget set through divisionally led bottom up approach</p> <p>Financial recovery actions were agreed by Turnaround Executive on 13th June.</p>	<p>Further work ongoing to tighten controls around use of agency staffing.</p> <p>For 2017/18 the Trust has been given a £16.86m ceiling level for agency expenditure by NHS Improvement. Agency spend must be reduced considerably from the level of expenditure seen in 16/17 if the Trust is to deliver the financial plan, not exceed the ceiling and secure the Strategic Transformation Funding.</p>	20 5 x 4	25 5 x 5	15 5 x 3	<p>Whilst the Trust has agreed the 17/18 Control Total of £15.9m, serious concerns about the achievability of this target have been raised with the regulator. It leaves the Trust with a planning gap of £3m that has been added to the £17m CIP target. At 5.3% efficiency this will be extremely challenging to deliver. The organisation currently has plans for only £14.5m of the £17m CIP target and the forecast shows £5.9m as currently unidentified, with only £11.1m at Gateway 2. The year to date position is extremely precarious, with activity and income below the planned level. EPR implementation has had a significant impact on the capture and coding of activity and £2.6m of the assumed income year to date is estimated. There is a risk that this income will not be recovered and that the reduced activity and changes to case mix seen year to date will persist into future months. Underlying expenditure is not below plan and achieving Control Total in the year to date has relied on the release of one third of our Contingency Reserve and a number of non recurrent benefits that are one off in nature and cannot be repeated. Failure to achieve the Control Total in future months would also impact on Sustainability & Transformation funding. There remains a gap between the Trust's activity plan and that of local Commissioners that is linked to QIPP plans. If commissioners are successful in delivering these plans, the Trust will need to ensure that costs are reduced to compensate any associated loss of income.</p>	Jul-2017	Mar-2018	FPC	Gary Boothby	Phillippa Russell
6968	Trustwide	Apr-2017	Active	Financial sustainability	<p>Risk that the Trust will not be able to pay suppliers, staff, PDC and loans due to cash flow timing or an overall shortfall of cash resulting in external scrutiny, significant reputational damage and possible inability to function as going concern.</p>	<ul style="list-style-type: none"> * Agreed £8m capital loan from Independent Trust Financing Facility. * Cash forecasting processes in place to produce detailed 13 week rolling forecasts * Discussed and planned for distressed funding cash support from NHS Improvement * Trust's Standing Operating Procedures for Treasury Management and Accounts Payable give authority to withhold payments to suppliers * Cash management committee in place to review and implement actions to aid treasury management * Revenue support loan has been made available year to date to cover the deficit and delays in the receipt of Sustainability and Transformation funding. 	<p>The level of outstanding debt held by the Trust is being closely monitored but is not entirely within the Trust's ability to control. The majority of this is owed by other NHS organisations.</p>	20 5 x 4	20 5 x 4	15 5 x 3	<p>The Trust plan for 17/18 is reliant on cash support from Department of Heath of £28.80m. £8m of Capital funding has been approved as part of an existing Capital Loan facility, the remaining revenue support loan requirements will have to be applied for on a monthly basis and will be subject to a potentially variable interest rate.</p>	Jul-2017	Mar-2018	FPC	Gary Boothby	Phillippa Russell

6969	Trustwide	Apr-2017	Active	Financial sustainability	<p>Risk that the Trust will have to suspend or curtail its capital programme for 2017/18 due to having insufficient cash to meet ongoing commitments resulting in a failure to develop infrastructure for the organisation.</p> <p>Following a mandate from NHS Improvement to reduce Capital expenditure for 2017/18 due to national funding pressures, the Trust's Capital Programme has been severely curtailed and a number of capital schemes have had to be removed. This has increased the risk to the development and sustainability of services and has the potential to impact on clinical, safety and performance issues.</p>	<p>Agreed £8m capital loan from Independent Trust Financing Facility (ITFF) to support capital programme, specifically the Electronic Patient Record (EPR) investment.</p> <p>Capital programme managed by Capital Management Group and overseen by Commercial investment Strategy Committee, including forecasting and cash payment profiling.</p> <p>Capital Management Group met in May to prioritise the Capital programme. A further review is underway to assess the risk against those Capital schemes that have not been approved and a small contingency remains in place to cover any further changes.</p>		20 5 x 4	20 5 x 4	12 4 x 3	<p>The planned capital expenditure for 17/18 is £14.40m. From a cash perspective, all capital expenditure, including any slippage on the EPR programme, must be contained within available internally generated capital funding, supplemented in 17/18 by the remaining £8m of our pre-approved capital loan facility.</p>	Jul-2017	Mar-2018	FPC	Gary Boothby	Philippa Russell
6903	Estates & Facilities	Dec-2016	Active	Keeping the base safe	<p>Collective ICU & Resus Risk - There is a risk to ICU and Resus from all of the individual risks below due to inadequate access granted to estates maintenance and capital to carry out ward upgrades / life cycling resulting in unplanned failure/ Injuries to patients & staff.</p>	<p>Current mechanical & electrical systems continue to be monitored through a planned preventative maintenance (PPM) regime.</p>	<p>Building, mechanical and electrical systems require life cycling / replacing / upgrading to continue the safe use of ICU & RESUS, currently this is not achievable due to inadequate access and budget constraints.</p>	20 5 x 4	20 5 x 4	0 0 0	<p>May Update - Short term Business Continuity Plans discussed with surgery, contingencies and resilience. Medium / Long term plan to refurbish / move service. RESUS collective risk added to ICU risk.</p> <p>June Update - Business Continuity Plans discussed with surgery, contingencies and resilience. Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime.</p> <p>July Update - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. Our current risks are rising as our CAPEX continues to be reduced.</p>	Aug-2017	Sep-2017	RC	Lesley Hill / David McGarrigan	Chris Davies

5806	Estates & Facilities	May-2015	Active	Keeping the base safe	<p>There is a risk of the current HRI Estate failing to meet the required minimum condition due to the age and condition of the building resulting in a failure of the Trust to achieve full compliance in terms of a number of statutory duties. This could result in the potential closure of some areas which will have a direct impact on patient care, suspension of vital services, delays in treatment, possible closure of buildings, services and wards, harm caused by slips, trips and falls and potential harm from structural failure.</p>	<p>Each of the risks above has an entry on the risk register and details actions for managing the risk. &nbsp;Many of these risks could lead to injury of patients and staff, closure of essential services, and inability for the Trust to deliver vital services.</p> <p>The estate structural and infrastructure continues to be monitored through the annual Authorising's Engineers (AE)/ Independent Advisors (IA) report and subsequent Action Plan. This report details any remedial work and maintenance that should be undertaken where reasonably practicable to do so to ensure the Engineering and structural regime remains safe and sustainable. Statutory compliance actions are prioritised, then risk assessment of other priorities.</p> <p>When any of the above become critical, we can go through the Trust Board for further funding to ensure they are made safe again.</p>	<p>The lack of funding is the main gap in control. Also the time it takes to deliver some of the repairs required.</p> <p>In terms of the structure of HRI, this is beyond repair, so no further major structural work can now be undertaken.</p>	16 4 x 4	20 5 x 4	6 3 x 2	<p>May 17 The estates infrastructure continues to be monitored, repaired and maintained where reasonably practicable to do so within the current budgetary constraints. The 17/18 Capital Plan is currently under review for approval while short term minor projects are being progressed to ensure continuity.</p> <p>June 17 The estates infrastructure continues to be monitored, repaired and maintained where reasonably practicable to do so. The level of risk to the services at HRI is increasing as the number of major building risks increases</p> <p>July Update - Current Mechanical & Electrical Systems continue to be monitored through a Planned Preventative Maintenance (PPM) regime. Our current risks are rising as our CAPEX continues to be reduced.</p>	Aug-2017	Mar-2018	RC	Lesley Hill / David McGarrigan	Paul Gilling / Chris Davies
2827	Medical	Apr-2011	Active	Developing our workforce	<p>There is an over-reliance on locum Middle Grade Doctors at weekends and on nights in A&E due to staffing issues resulting in possible harm to patients, extended length of stay and increased complaints. Locum shifts not being filled by the Flexible Workforce team and gaps not being escalated to the clinical team in a timely manner.</p> <p>***It should be noted that risks 4783 and 6131 should be read in conjunction with this risk.</p>	<p>Associated Specialist and Regular locums for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Part-time MG doctors appointed Where necessary other medical staff re-located to ED Consultants act down into middle grade roles to fill gaps temporarily 4 weeks worth of rota's requested in advance</p>	<p>Difficulty in recruiting Consultants, Middle Grade and longer term locums Relatively high sickness levels amongst locum staff. Flexible Workforce not able to fill gaps</p>	20 4 x 5	20 5 x 4	12 4 x 3	<p>May 2017: 3 long term, full time agency locums are in the process of converting to CHFT bank contracts. 2 additional MGs have been appointed.</p> <p>June 2017: 3 Locum Consultants recruited onto bank contracts (all picking up a line on the MG rota). Awaiting start date of 2 substantive consultants. 2 Middle grade doctors being pursued following successful interview (1 is starting the CESR programme). Experienced ACP recruited - will go onto junior doctor rota. 2 junior doctors being pursued for substantive posts through successful recruitment.</p> <p>July 2017: Start dates of Consultants confirmed. CESR candidate has withdrawn offer however interviewing again on 13 July 2017. Junior doctor posts out for bank recruitment and 2 applicants being pursued. ACP recruitment has been successful</p>	Aug-2017	Aug-2017	WEB	David Birkenhead	Dr Mark Davies/Mrs Caroline Smith

6131	Corporate	Active	Transforming and improving patient care	<p>There is a risk that the Trust will not be able to quickly progress service reconfiguration due to the requirements of a consultation process initiated by local CCG's resulting in delays to important clinical quality and safety issues e.g:</p> <ul style="list-style-type: none"> Compliance with A&E National Guidance Compliance with Paediatric Standards Compliance with Critical Care Standards Speciality level review in Medicine Unable to meeting 7 day standards Difficulties in recruiting and retaining a medical workforce (increased reliance on Middle Grades and Locums) Increased gaps in Middle Grade Doctors Dual site working is one of the causes of the Trust;s underlying deficit. Delays in being able to reconfigure services will impact on the Trust's financial recovery plan. During the period of public consultation there is a risk of an impact on the Trust's reputation. <p>***It should be noted that risks 2827 and 4783 should be read in conjunction with this risk.</p>	<p>The continued funding of medical staff on both sites</p> <ul style="list-style-type: none"> Nurse led service managing Paediatrics Critical care still being managed on both sites High usage of locum doctors Frequent hospital to hospital transfers to ensure access to correct specialties The Trust has developed a contingency plan should it not be able to provide sufficient medical staffing to provide safe A&E services on two sites. Consultant rotas cannot always be filled substantively to sustain services on both sites but locum arrangements used 5 year plan completed in December 2015 and agreed with CCGs. Emergency Pregnancy Assessment and Emergency gynae clinic both changed to be delivered from CRH following public engagement and engagement with Kirklees Overview and scrutiny Committee. Change implemented January 2016. Dual site working additional cost is factored into the trust's financial planning. 	<p>Interim actions to mitigate known clinical risks need to be progressed.</p>	25 5 x 5	20 5 x 4	10 5 x 2	<p>March 2017 update - .JOSC met in February and agreed to meet in July and make a decision on referral to SoS once the full business case is completed</p> <p>June 2017 update - JOSC will meet in July to consider the Trust and CCG responses to the 19 recommendations and will then make a decision on referral to SoS. FBC due to be completed by the end of June and considered through formal governance processes in July before submission to NHS Improvement</p>	Jul-2017	Aug-2017	WEB	Anna Basford	Catherine Riley
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6345	Corporate	Jul-2015	Active	Keeping the base safe	<p>Staffing Risk Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to:</p> <ul style="list-style-type: none"> - lack of nursing staffing as unable to recruit to substantive posts, i.e. not achieving recommended nurse staffing levels (as per Hard Truths/CHPPD and national workforce models) - Inability to adequately staff flexible capacity ward areas - difficult to recruit to Consultant posts in A&E, Acute Medicine, Care of the Elderly, Gastroenterology and Radiology - dual site working and impact on medical staffing rotas - lack of therapy staffing as unable to recruit to Band 5 and Band 6 Physiotherapists, Occupational Therapists, Speech and Language Therapists and Dieticians in both the acute hospital and in the community across a number of different teams <p>resulting in:</p> <ul style="list-style-type: none"> - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives (eg Electronic Patient Record) 	<p>Nurse Staffing To ensure safety across 24 hour period:</p> <ul style="list-style-type: none"> - use of electronic duty roster for nursing staffing, approved by Matrons - risk assessment of nurse staffing levels for each shift and escalation process to Director of Nursing to secure additional staffing - staff redeployment where possible -nursing retention strategy - flexible workforce used for shortfalls (bank/nursing, internal, agency) and weekly report as part of HR workstream <p>Active recruitment activity, including international recruitment</p> <p>Medical Staffing Medical Workforce Group chaired by the Medical Director. Active recruitment activity including international recruitment at Specialty Doctor level - new electronic recruitment system implemented (TRAC) -HR resource to manage medical workforce issues. -Identification of staffing gaps within divisional risk registers, reviewed through divisional governance arrangements</p> <p>Therapy Staffing</p> <ul style="list-style-type: none"> - posts designed to be as flexible as possible - review of skill mix and development of Assistant Practitioners. - flexible working - aim to increase availability of flexible work force through additional resources / bank staff 	<p>Medical Staffing Lack of:</p> <ul style="list-style-type: none"> - job plans to be inputted into electronic system - dedicated resource to implement e-rostering system - centralised medical staffing roster has commenced but not fully integrated into the flexible workforce team - measure to quantify how staffing gaps increase clinical risk for patients <p>Therapy staffing Lack of:</p> <ul style="list-style-type: none"> - workforce plan / strategy for therapy staff identifying level of workforce required - dedicated resource to develop workforce model for therapy staffing - system to identify changes in demand and activity, gaps in staffing and how this is reflected through block contract - flexibility within existing funding to over recruit into posts/ teams with high turnover 	<p>16 4 x 4</p> <p>20 4 x 5</p> <p>9 x 3</p>	<p>June 17</p> <p>Nurse Staffing</p> <ul style="list-style-type: none"> - Applicants from International recruitment trip to the Philippines are progressing. 120 offers were made in country, since March 2017; 3 candidates have withdrawn, 90 are completing their training for the International English Language Test System (IELTS), 20 are due to take their IELTS exam before the end of August and 6 have passed their IELTS and are progressing with their NMC application. - Process for nursing internal moved to the new recruitment system Trac to allow for monitoring and reporting purposes. - All nursing vacancies to include the Head Nurse for Professional & Workforce Development to support the process of advertising within departments as well as centrally. <p>Medical Staffing</p> <ul style="list-style-type: none"> - Since January 2017, the Trust has offered substantive consultant posts in Acute Medicine, Diabetes and Endocrinology, Stroke Medicine, Emergency Medicine and Ophthalmology. Another joint Divisional advert was published in the BMJ on 25 March 2017. As a result of this second collaborative advert, offers have been made to substantive Consultant posts in a number of areas including Emergency Medicine. - There is an advert currently in the BMJ for CESR opportunities in Emergency Medicine. - Work has been undertaken to promote the role of Physician Associates (PAs) within the Trust, and the business case was approved to recruit new PAs across Medical, Surgery and Anaesthetics and Families and Specialist Services. Interviews were held on 10 June and 16 offers were made. The posts will be in Medicine and Surgery. 	Jul-2017	Jan-2018	WF	David Birkenhead, Brendan Brown, Ian Warren	Rachael Pierce
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6596	Corporate	Jan-2016	Active	Keeping the base safe	<p>Risk of not conducting timely investigations into serious incidents (SIs), due to not responding quickly enough to the new national SI framework introduced in March 2015, resulting in delayed learning from incidents, concerns from commissioners and delays in sharing the findings with those affected.</p> <ul style="list-style-type: none"> - Revised Incident Reporting Policy aligns with national framework, with template reports, clarity on process for divisional sign off and Trust sign off of SIs. - Director led panels held weekly to ensure quality assurance of final reports. Meet commissioners monthly on SIs - Patient Safety Quality Boards review of serious incidents, progress and sharing of learning - Accurate weekly information for divisions identifying serious incidents and timescales for completion of reports - Investigator Training - 1 day course held monthly to update investigator skills and align investigations with report requirements. - Recent introduction of Serious Incident Review group chaired by Chief Executive to ensure senior Trust wide oversight and peer challenge of SIs - Investigations Manager to support investigators with timely and robust Serious Incident Investigations reports and action plans - Learning summaries from SIs presented to Quality Committee, Serious Incident Review Group monthly and shared with PSQB leads for divisional learning 	<p>1. Lack of capacity to undertake investigations in a timely way</p> <p>2. Need to improve sharing learning from incidents within and across Divisions</p> <p>3. Training of investigators to increase Trust capacity and capability for investigation</p>	16 4 x 4	16 4 x 4	8 x 2	<p>May 2017</p> <p>Continued focus on closing investigations with 17 submitted during March and April. Information on corporate staff to support investigations being confirmed during May. Any staff requiring training to be offered training date of 28 June. Departure of senior investigations manager in May. Post revised and recruited to with start date of August 2017.</p> <p>June 2017</p> <p>Reviewing capacity of corporate staff to assist with investigations to support clinical investigators.</p> <p>July 2017</p> <p>Progress with sharing learning - bitesize chunks of learning on screen savers weekly and highlighted in staff brief. First themed learning bulletin on falls - issued in July, Sharing Learning-Improving Care.</p> <p>Investigations Training course held on 28 June 2017 - 14 staff trained, mainly nursing staff from medical division and Family and Specialist Services staff, of which 1 registrar, 1 corporate member of staff. Senior Risk Manager commences mid August 2017, exploring alternatives to cover expected risk vacancy in team.</p>	Jul-2017	Sep-2017	QC	Director of Nursing, Brendan Brown	Juliette Cosgrove
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6598	Corporate	Jan-2016	Active	Keeping the base safe	<p>There is a risk of being unable to provide essential skills training data for some subjects and where data is available this is not always set against a target audience. Therefore the organisation cannot be assured that all staff have the relevant essential skills to practice safely. This is due to the data being held in a devolved structure with no required target audience setting mechanism or central gathering/recording process. This will result in a failure to understand essential skills training compliance against set targets across the whole of the organisation.</p> <p>Further essential skills subjects are been identified and added to the list with increasing frequency. This obviously not only extends the period of time the roll out project will take but also leads to a re-prioritisation exercise around establishing which are the key priority essential skills to focus on first.</p>	<p>There is an agreed essential skills matrix now in place and an essential skills project plan to describe and implement the target audience for each essential skills subject. Compliance measurement will be enabled as each target audience (TA) is set although this is a lengthy process within the confines of the current Learning Management System.</p> <p>A database is being completed showing departmental training completion dates. This is to be hosted on the intranet to allow access at department level for updates and will feed into ESR. This is anticipated to be live by June 2017. Brendan Brown / Lindsay Rudge are restricting additions to the list to keep it to a manageable number.</p>	<p>1/ Essential skills training data held is inconsistent and patchy.</p> <p>2/ target audiences setting to allow compliance monitoring against a target is inconsistent and patchy</p> <p>3/ Functionality of the OLM system is limited and cannot facilitate disaggregated target audience setting.</p> <p>4/ There are issues with PC settings which leads to completed e-learning not been recorded as complete.</p> <p>5/ Planned updates to system not due until April 2017 so limitations as above will remain until this time.</p> <p>6/ There are frequent requests for new essential skills to be added with no clear process to approve such requests.</p> <p>7/ Heavy focus on EPR training and implementation has an impact on staff being able to complete essential skills training due to time and resource implications.</p> <p>8/ Now all clinical staff have been issued a bank contract there are some discrepancies with competencies assigned to bank position but not their substantive post. These are small in number.</p>	16 4 x 4	16 4 x 4	12 4 x 3	<p>May 2017</p> <p>ESR Manager Nigel Collins has suggested alternate methodology within OLM to allow compliance reporting in a different way. Blood transfusion essential skills target audience have now been completed as a result of this.</p> <p>June 2017</p> <p>Tissue Viability essential skills e-learning package now available to staff and TA is now set.</p> <p>Clarification is being sought around the issue with competences differing between bank / substantive contracts for some staff members.</p>	Jul-2017	Oct-2017	WF	Ian Warren	Ruth Mason
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6658	Medical	Mar-2016	Active	Keeping the base safe	<p>There is a risk of slow patient flow due to exit block preventing timely admission of patients to the hospital bed base at both HRI and CRH. This results in the following: patient harm and death, increase in mortality of 1.5% per hour wait for a bed; poor patient experience from inability to access an appropriate clinical area for their care, waiting in hospital corridors within the ED with poor privacy and dignity; Risk to delivery of a safe ED service due to lack of capacity to manage and risk assess undifferentiated new ED patients; increased risk of violence and aggression towards staff and other patients; poor staff morale due to frustration of inability to undertake the work for which they are employed; poor compliance with reportable clinical indicators: 4 hour emergency access target; time to initial assessment; ambulance turnaround, resulting in financial penalties</p>	<p>1 Patient flow team supported by on-call Management arrangements to ensure capacity and capability in response to flow pressures. 2 Employed an Unplanned Care Lead to focus across the Organisation bringing expertise and coaching for sustainable improvement .3 Daily reporting to ensure timely awareness of risks. 4 4 Hourly position reports to ensure timely awareness of risks 5 Surge and escalation plan to ensure rapid response. 6 Discharge Team to focus on long stay patients and complex discharges facilitating flow. 7 Active participation in systems forums relating to Urgent Care. 8 Phased capacity plan to ensure reflective of demand therefore facilitating safer flow. 9 Weekly emergency care standard recovery meeting to identify immediate improvement actions 10 Daily safety huddles to pro-actively manage potential risks on wards with early escalation. 11. Programme governance including multi Director attendance at Safer Programme Board and monthly reporting into WEB. 12. Single transfer of care list with agency partners</p>	<p>1. Capacity and capability gaps in patient flow team 2. Very limited pull from social care to support timely discharge 3. Limited used of ambulatory care to support admission avoidance 4. Tolerance of pathway delays internally with inconsistency in documented medical plans 5. Unable to enhance winter resilience in a timely manner due to external funding reductions from 2014/15 levels as escalated to Board, Monitor and local System Resilience Group 6. Roving MDT (which supports discharge of complex patients) ceased pending Systems Resilience Group funding decision. 7. Lack of system resilience funding and a risk that previously agreed funding will be withdrawn. Action internal assessment meeting to understand the risk of this (September w/c 19.9.19.)</p>	<p>20 4 x 5</p> <p>16 4 x 4</p> <p>9 3</p>	<p>May 2017 Performance in month has reduced significantly and longer waits have been experienced by patients this is a consequence of introducing the new EPR. Divisions are developing an action plan which identifies the key blockers, micromanagement in place until the end of the month. June 2017 Flow out of the departments had initially improved at the beginning of the month but with increasing attendances and lower discharges we continue to see increasing waiting times. Further actions taken- Point prevalence on the medical wards to understand delays. Senior attendance on ward rounds offering support and challenge to improve discharge planning. Cancellation of non urgent surgical elective patients.</p>	Jul-2017	Jul-2017	BOD	COO Helen Barker	Bev Walker
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6300	Trustwide	Active	Keeping the base safe	<p>As the Trust has been rated by the CQC, following our inspection, as "requires improvement" there is a risk that if we fail to make the required improvements prior to re inspection we will be judged as inadequate in some services.</p>	<p>-CQC Response Group monitors improvements and progress with actions System for regular assessment of Divisional and Corporate compliance - Routine policies and procedures - Quality Governance Assurance structure - CQC compliance reported in Quarterly Quality and Divisional Board reports -Action plans in place for areas that have been identified as requiring improvements including those areas identified by the CQC during and after the inspection -A fortnightly meeting is being held to monitor progress with the action plans chaired by the Chief Nurse - An external review of the maternity service, by the Royal College of Obstetricians and Gynaecologists, has been conducted and an action plan developed. Nearly all actions have been delivered and assurance gained. The Risk and Compliance Group will now oversee any areas outstanding.</p>	<p>The inspection report has shown us to be in the "requires improvement" category.</p>	16 4 x 4	16 4 x 4	8 4 x 2	<p>May 2017 Year-end position: all of the actions in the plan are rated blue – embedded or green – action complete. There are 3 remaining green actions on the plan; embedded dates for these have been extended from 31.3.17 to Sept / Oct 2017. These are must do actions: Mandatory and Essential Skills Training and Appraisals; Medicines management and should do action: Seven day working in radiology. Progress with these actions will be reported to the Risk and Compliance Group.</p> <p>June 2017 Year end report has been presented to the Board of Directors. Position with the plan remains as the Mary 17 position. Updates are being provided to the Board of Directors by core services rated requires improvement. A number of activities have now commenced to enable the Trust to prepare for a re-inspection this is being overseen by the Risk and Compliance Group. There is no date yet known for re-inspection.</p> <p>July 2017 No date for any inspection known as yet. Plans are being developed to do a review of the data that will be requested as part of the Well Led inspection. Other acute providers have started to have unannounced inspections, these are based upon intelligence the CQC hold on services.</p>	Aug-2017	Dec-2017	WEB	Brendan Brown	Juliette Cosgrove
4783	Corporate	Active	Transforming and improving patient care	<p>Risk of adverse publicity and regulatory intervention due to Trust falling below national standards for mortality as Trust SHIMI position is now outside the expected range; this may be due to issues regarding delivering appropriate standards of care for acutely ill patients/frail elderly patients and failure to correct accurate co-morbidity data for coding and may result in inaccurate reporting of preventable deaths, increased external scrutiny and a possible increase in complaints and claims.</p> <p>***It should be noted that risks 2827 and 6131 should be read in conjunction with this risk.</p>	<p>3 invited service reviews undertaken by Royal College of Physicians on Respiratory Medicine, Stroke and Complex Medicine which will give guidance on areas of further improvement. Action plans for these areas being developed based on preliminary report findings. Outlier areas are monitored (e.g. Stroke, Sepsis and COPD) Outliers are investigated in depth to identify the cause. Improvement work is implemented via an action plan Mortality dashboard analyses data to specific areas Monitoring key coding indicators and actions in place to track coding issues Written mortality review process agreed to clarify roles and to facilitate a greater number of reviews being completed, process for escalation, linking with other investigation processes e.g. SI panel review. Monthly report of findings to CEAM and COG from Sept 2015 (Aug reviews of July deaths) Revised investigation policy clarifies process for learning from all investigations, including mortality reviews, and monitoring of actions CAIP plan revised 2016 and now focusing on 6 key themes: investigating mortality and learning from findings; reliability; early recognition and response to deterioration; end of life care; frailty; and coding. Care bundles in place</p>	<p>Improvement to standardised clinical care not yet consistent. Care bundles not reliably commenced and completed</p>	20 4 x 5	16 4 x 4	12 4 x 3	<p>May 2017 update Mortality Surveillance Group continues to meet monthly. 3rd month with no alerts in SHMI and HSMR</p> <p>June 2017 update HSMR is 100.37 and SHMI 108 and remain in the expected range. Structured Judgement Reviews have replaced our 2nd level reviews from April deaths.</p> <p>July update HSMR is 100.85 and SHMI is 104.73 and both remain in the expected range. Learning from death policy has been drafted and we are on target to implement the requirements of the national programme by September. There is a CUSUM alert on AKI and these cases are being reviewed.</p>	Aug-2017	Sep-2017	COB	David Birkenhead	Juliette Cosgrove

5862	Medical	Aug-2013	Active	Keeping the base safe	There is a risk of significant patient falls due to poor level of patient risk assessment which is not being completed to support clinical judgement, failure to use preventative equipment appropriately and staff training, failure to implement preventative care, lack of equipment, environmental factors, staffing levels below workforce model exacerbated by increased acuity and dependency of patients, resulting in a high number of falls with harm, poor patient experience and increased length of hospital stay.	Falls bundles; Vulnerable adult risk assessment and care plan. Falls monitors, falls beds/chairs, staff visibility on the wards, cohort patients and 1:1 care for patients deemed at high risk. Falls collaborative work on wards deemed as high risk; Staff education. All falls performance (harm and non harm) reported and discussed at Divisional PSQB meetings. Focussed work in the acute medical directorate as the area with the highest number of falls.	Insufficient uptake of education and training of nursing staff, particularly in equipment. Staffing levels due to vacancies and sickness. Inconsistent clinical assessment of patients at risk of falls. Inconsistency and failure to recognise and assess functional risk of patients at risk of falls by registered practitioners. Environmental challenges in some areas due to layout of wards. .	12 4 x 3	16 4 x 4	9 3 3	May update MAU team at CRH are to commence working with NHS Quest to focussed improvement work. All other actions continue as per April update. June update Actions as per plan, team meeting monthly, no improvement noted in falls numbers but there is an improvement in reliability of some care factors. July update Actions as per plan, a sustained improvement has been noted.	Aug-2017	Sep-2017	PSQB	Brendan Brown	Janette Cockroft
6977	Corporate	May-2017	Proposed for Acceptance	Developing our workforce	Risk: - There is a risk that not all colleagues will complete their designated mandatory training within the rolling 12 month period compromising the 100% appraisal target. This risk is exacerbated by the requirement to complete EPR training in the same timeframe and the current unavailability of the National IG e-learning package. Impact: - Colleagues practice without the necessary understanding of how their role contributes to the achievement of strategic direction/objectives and without the knowledge/competence to deliver compassionate care. Due to: - There conflicting demands on colleagues time available for training due to the very important EPR training programme that is currently active in the Trust	All electronic mandatory training programmes are automatically captured on ESR at the time of completion. The number of mandatory training subjects has been reviewed and reduced for 2016 – 2017 Classroom learning sessions for IG have been provisioned for February and March 2017 to offer an alternate to the unavailable IG e-learning package. It is understood that the refreshed National IG e-learning tool will, be available from April 2018 WEB IPR monitoring of compliance data. Quality Committee assurance check Well Led oversight of compliance data identifying 'hot-spot' areas for action Divisional PRM meetings focus on performance and compliance	Sporadic failure on the part of the training data inputters to log appliance data into ESR Amount of immediate real time data for line managers	16 4 x 4	16 4 x 4	4 4 1	A data consolidation exercise for mandatory and essential skills subjects will be conducted by the Business Intelligence team in March 2017 to ensure all compliance data is accurate and captured A pay progression policy approach including mandatory training compliance has been approved by Board.	Aug-2017	Mar-2018	WF	Ian Warren	Ruth Mason

6990	Corporate	Jun-2017	Proposed for Acceptance	Transforming and improving patient care	<p>CQUIN target at risk of not being met for 2017/18 based on current compliance for screening for sepsis, time to antimicrobial and review after 72 hours and risk of non-compliance with NICE guidelines for sepsis.</p> <p>This is due to lack of engagement with processes, lack of process for ward staff to follow and lack of effective communication and working between nursing and medical colleagues.</p> <p>The impact is the increased deterioration in patients condition and increased mortality if sepsis not recognised and treatment initiated within the hour and all of the sepsis 6 requirements delivered. There are also financial penalties.</p>	<p>Awareness and new controls for ward areas Divisional plan, medical leads identified in all divisions</p> <p>-improvement action plan in place, improvements seen in data for 2016/17</p> <p>-stop added to nerve centre to prompt screening</p> <p>-new screening tool and sepsis 6 campaign was launched introducing the BUFALO system</p> <p>-matrons promoting the and challenging for screening in the 9-11 time on wards</p> <p>-sepsis prompt in EPR</p>	<p>Lack of engagement with processes</p> <p>Lack of clear process for ward staff to follow</p> <p>Lack of communication and joined up working between nursing and medical colleagues</p>	<p>16 4 x 4</p>	<p>16 4 x 4</p>	<p>4 4</p>	<p>4 4</p>	<p>Assess impact of EPR sepsis prompt</p> <p>Improve safety huddles to include sepsis</p> <p>Coordinate activity with the Deteriorating Patient Group</p> <p>Strengthen divisional leadership</p>	Sep-2017	Dec-2017	SC	David Birkenhead	Juliette Cosgrove
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6924	Corporate	Feb-2017	Active	Keeping the base safe	<p>Risk of mis-placed nasogastric tube for feeding due to lack of knowledge and training in insertion and ongoing care and management of NG feeding tubes from nursing and medical staff resulting in patients fed into the respiratory tract or pleura and possible death or severe harm</p>	<p>Risk overseen by Nutritional Steering Group Task and finish group established by director of nursing to address elements of NPSA alert 22.7.16 on nasogastric tube misplacement</p> <p>Training package available</p> <p>Nursing staff have been encouraged to undertake self assessment and declaration of competency</p> <p>Check X rays are performed where aspirate is not obtained, or greater than pH5.5</p> <p>Radiology team flag when sighted if tube is in the lung following xray</p> <p>Training and competency package in place for nursing staff identified from high use areas</p>	<p>Initial X Rays are reviewed by medical staff - currently have no record of training or competency assessment for medical staff working at CHFT</p> <p>Daily process for checking is dependent on individuals competency to be performed accurately</p> <p>Training data base is only available through medical device data base and is not monitored for compliance</p> <p>No assurance that all medical and nursing staff who are inserting and managing NG tubes have the competency required to do this</p> <p>No policy in place at CHFT to support guidelines</p>	15	5 x 3	15	5 x 3	8	4	<p>Update 20.6.17</p> <p>x 2 Training for nursing staff in high risk areas has been undertaken and all areas identified are at 75% or over</p> <p>Training added to induction for nursing staff</p> <p>Task and finish group meeting 23.6.17 to work through medical staff training with attendance from associate medical director - training package written and ready to implement</p> <p>Policy in draft delayed - Junior CNS asked to pick up with colleagues locally.</p> <p>Nutritional Policy has had medical review and is awaiting final sign off. NG training continues – slight delay in completion due to EPR training</p> <p>Dr Uka has joined the task and finish group to work through training requirements and plan for medical staff.</p> <p>July Update</p> <p>All areas identified now at 75% or above training compliance with some areas scoring 90% or over. Training and reassessment in these areas will be delivered after 3 years.</p> <p>Further training is ongoing for new staff at induction and sessions have been planned for existing staff.</p> <p>Plan in place to identify 3 key trainers on all other ward areas who will be able to support areas where use is less frequent. Reassessment for this group will be delivered after 12 months.</p> <p>Teaching for medical staff has been timetabled in for early next year – CNS approaching training to ask if this can be expedited.</p> <p>Comms team have been approached to support trust wide communication regarding NG tubes, training and access.</p> <p>CNS plan to launch nutrition event and recruit link nurses across all areas – event planned for September with quarterly link meetings planned.</p> <p>No progress on medical staff training – package is ready to deliver need to agree medical staff sign up. Dr Uka is attending July task and finish group to progress.</p>	Aug-2017	Aug-2017	QC	Brendan Brown,	Jo Middleton
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6829	Family & Specialist Services	Active	Aug-2016	Keeping the base safe	<p>The risk of the Trust having insufficient capacity in 2018 for the Pharmacy Aseptic Dispensing Service to provide approximately 50,000 pa ready to administer injectable medicines with short expiry dates for direct patient care.</p> <p>Due to the HRI and CRH Aseptic dispensing facilities not being compliant with national standards as identified by stat external audits EL (97) 52. The audits are undertaken by the Regional Quality Control Service(SPS) on behalf of NHSE. The latest audit undertaken on 5 April 2017 rated the overall risk assessment to patient safety as high with two major deficiencies. It was strongly recommended that the workload is not increased in the HRI facility and consideration must be given to close the facility if a business case for replacement is not approved.Capital investment is required for the development of the capacity of the CRH unit and the compliance with national standards to enable the closure of the HRI facility.</p>	<p>Rigorous environmental and microbiological monitoring of the current facilities and the introduction of in- process controls to ensure no microbial contamination of final products. Self-audits of the unit</p> <p>External Audits of the HRI unit will be undertaken by the Quality Control Service on behalf of NHSE every 6 months.</p> <p>Audit findings and action plans are reported to the FSS Divisional Board with monitoring of non-compliance.</p> <p>The capacity plan of the HRI unit will not be exceeded.</p> <p>A strategy of buying in ready to administer injectable medicines will be implemented but there are concerns about the sustainability of the current pharmaceutical supply chain.</p>	<p>If a business case for the development of the Aseptic Service is not approved within this financial year then this will result in a 'critical non-compliance' rating for the HRI unit by the external auditors in 2017 creating a major capacity problem in 2018.</p>	15 3 x 5	15 3 x 5	3 x 1	<p>The procurement of manufactured ready to administer injectable medicines when available from commercial suppliers. The first phase will be the procurement of dose- banded chemotherapy as soon as regional procurement contracts have been approved. This will create some capacity.</p> <p>The business case for the future provision of Aseptic Dispensing Services to be produced in July 2017 following the results of the feasibility study at the CRH unit with a view to consideration and approval by the Commercial Investment Strategy Group taking into account commercial procurement of some products. If the business case</p> <p>3 April 2017 Initial Feasibility Study received from Engie but further clarification required on technical specification. Meeting to be arranged with Engie, Pharmacy and Technical expert.The external audit of the HRI Unit is to take place on 5 April and the outcome of this audit will inform risk ratings and timescales.</p> <p>16.May.17 (JD) Costings of feasibility study still awaited. EL Audit of HRI unit took place on 5th April 17 but report has not yet been received due to need for it to be peer-reviewed (expected by 22nd May)</p> <p>25 May 2017.External audit report of HRI Unit received. Overall risk assessment to patient safety is high. Two major deficiencies: One involving in process controls. The other the state of the facility. 'A commitment to gain approval for the development of a new facility must be assured as a matter of urgency.</p> <p>22 June 2017 A draft business case to be presented to the FSS Divisional Performance Meeting on 5 July 2017.</p> <p>6 July 2017.Draft business case received favourable response from</p>	Aug-2017	Oct-2017	DB	Brendan Brown	Mike Cushman
6841	Corporate	Active	Sep-2016	Keeping the base safe	<p>POST GO LIVE</p> <p>Inability to use the system effectively once the extended support mechanisms start to reduce following Early Live Support.</p> <p>Lack of confidence of the system due to any quality and/or performance issues.</p> <p>Efficiency and productivity may reduce due to inexperience of using the system</p> <p>Inability to report against regulatory standards</p> <p>Resulting in:</p> <p>Reputational damage arising from inability to go live with the EPR , financial impact, impact at every point of patient care (appointments, patient flow, records, MDT s, payment) and continued use of paper records which can impact on safe, efficient and effective patient care.</p> <p>National and local targets may be put in jeopardy.</p> <p>Contractual Penalties for the Trust.</p>	<p>Pre go-live</p> <ul style="list-style-type: none"> - A robust governance structure is in place to support the implementation of the EPR, including EPR specific risk register reviewed at weekly EPR meeting. - Weekly EPR operational board with direct escalation to WEB (and sponsoring group) - 90/60/30 day plans will aid control - 1:1 consultant plan <p>Cut over:</p> <ul style="list-style-type: none"> - Strong cut over plan with a developed support structure for BAU post ELS. - Command and control arrangements for cut over (Gold, Silver, Bronze) <p>Post go-live:</p> <ul style="list-style-type: none"> - gap - CYMBIO Support - CHFT Support/BTHFT Programme resource gap covered (£320k capital) 	<ol style="list-style-type: none"> 1. Need to address requests for 'Mop up' Training in some areas 2. Address Hardware requirements (Walk around 23/24th May) 3. Further work from CYMBIO around DQ 4. Time to understand reporting position 	15 5 x 3	15 5 x 3	10 5 x 2	<p>May Update (Post go-live, end of week 3):</p> <p>Position statement: The Trust cut-over to Cerner Millennium EPR successfully on the planned weekend. The cutover plan worked well from an operational perspective with minimal delay with inpatients up and running in most area's prior to Outpatients on the 2nd May. Initial issues were due to End User Access and Role functionality followed by 'How do I?' type questions.</p> <p>Cut-over Risk: Mitigation and controls were effective, clear plans and operational structure (silver command etc) worked well.</p> <p>Post Go-live Risk: The post go-live risks outlined under description still exist at this early stage although initial assessment of the mitigation/controls would suggest the likelihood will reduce post ELS. Additional gaps will be addressed including 'Mop up' training, additional CYMBIO support around DQ and Reporting and a Hardware assessment across both sites.</p> <p>Both the Impact and likelihood scores stay the same until ELS is complete and mitigation is proven.</p> <p>June 2017 Update - In reference to the 'Post go-live' risk. There are still a number of un-resolved issues following ELS. Around 1300 logged on RoD and further issues remaining from Silver Command. A process has been agreed at WEB (15th June) supporting a focused approach in clinical areas with the priority being set by the Divisional Ops Board. There are currently 10 focus areas plus 4 over arching areas (e.g. Access etc).</p> <p>Until these remaining issues are reduced the impact and likelihood of this risk remain the same.</p>	Jul-2017	Sep-2017	RC	Helen Barker	Mandy Griffin

6715	Corporate	Apr-2016	Active	Keeping the base safe	<p>There is a risk to patient safety, outcome and experience due to incomplete or poor quality nursing and medical documentation.</p> <p>Poor documentation can also lead to increased length of stay, lack of escalation when deterioration occurs, poor communication and multidisciplinary working.</p> <p>Monthly clinical record audits (CRAS) with feed back available from ward to board A further qualitative audit is undertaken monthly by Matrons that includes patient understanding . Medical audits are undertaken</p> <p>Analysis and action planning is managed through divisional patient safety and quality board</p> <p>A multi professional clinical documentation group meets bi monthly to ensure new documentation is ratified, standards on documentation are addressed. This group also receives reports and audits with regard to documentation and identifies to the divisions areas (teams, wards departments) of concern as well as any specific areas of concern within a specific standard.</p> <p>Clinical records group monitors performance, highlighting best and worst performing wards and action plans are developed and managed through the divisions, including specific areas for improvement. January Update</p> <p>Work is progressing to devise and implement a ward assurance tool that will audit nursing documentation. The CRAS audits remain suspended. There has been little progress in fluid balance documentation which has been noted by the Director of Nursing as a result he is revising the improvement methodology and leadership to support this.</p> <p>February The Trust now has a cutover and go live date for 1st and 2nd May. Following this a process and reporting mechanism wil</p> <p>March EPR training has commenced</p> <p>May 2017 The Trust has gone live with the EPR on the 1st</p>	<p>The number of audits undertaken can be low Unable to audit to allow and act on findings in real time</p> <p>The discharge documentation is under going review</p> <p>Fluid balance is being reviewed, the evidence base is being examined by the Deputy Director of Nursing</p> <p>Awaiting the ward accreditation review in order to recommence audit (which will not collect comparable information)</p>	<p>20 4 x 5</p> <p>15 3 x 5</p> <p>6 x 2</p> <p>3 x 2</p>	<p>May 2017 The Trust has gone live with the EPR on the 1st May, Matrons are undertaking some audit to ensure compliance. A meeting regarding quality is being chaired by the Chief Nurse to establish understanding and way forward on the 17th May. Professional standards of documentation will improve as the EPR system automatically registers, username, time date, legibility.</p> <p>June 2107 The EPR has been implemented since the 1st May; on the 30th June, the Deputy Director of Nursing is leading a session with the nursing colleagues, the agenda is to review CQC guidance, ascertain how to ensure nurses are using the system to produce excellent nursing records, understand the reports produced from the system and ensure assurance is linked to the ward assurance tool. The intention is that the improvement work identified will be delivered by Matrons supported by the senior nurse team.</p> <p>July 2017 The group to review nursing standards of documentation has reformed and will report through the Nursing Practice Group.. The initial meeting agreed the focus of the work.</p>	Aug-17	Aug-2017	QC	Brendan Brown	Jackie Murphy
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Approved Minute

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Cover Sheet

Meeting: Board of Directors	Report Author: Kathy Bray, Board Secretary
Date: Thursday, 3rd August 2017	Sponsoring Director: Victoria Pickles, Company Secretary
Title and brief summary: RISK MANAGEMENT POLICY - The Board is asked to receive and approve the updated Risk Management Policy	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Risk and Compliance Group Audit and Risk Committee Executive Board	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

Under the Board of Directors' Scheme of Delegation, approval of arrangements for the management of risk are reserved to the Board.

The Policy has been updated to reflect the revised Risk Management Strategy approved by the Board earlier in the year.

The Risk Management Policy has been reviewed in detail by the Risk and Compliance Group and the Audit and Risk Committee and is recommended to the Board for approval.

Main Body

Purpose:

As above

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to receive and approve the updated Risk Management Policy

Appendix

Attachment:

G-101-2015 - Risk Management Policy v3.pdf

UNIQUE IDENTIFIER NO: G-101-2015
EQUIP-2017-060
Review Date: April 2019
Review Lead: Director of Nursing

Risk Management Policy

Version 3

Important: This document can only be considered valid when viewed on the Trust's Intranet. If this document has been printed or saved to another location, you must check that the version number on your copy matches that of the document online.

UNIQUE IDENTIFIER NO: G-101-2015

EQUIP- 2017-060

Review Date: April 2019

Review Lead: Director of Nursing

Document Summary Table		
Unique Identifier Number	G-101-2015	
Status	Ratified	
Version	3	
Implementation Date	July 2015	
Current/Last Review Dates	April 2017	
Next Formal Review	April 2019	
Sponsor	Director of Nursing	
Author	Head of Governance and Risk	
Where available	Trust Intranet	
Target audience	All Staff	
Ratifying Committees		
Board of Directors		
Executive Board		6 July 2017
Consultation Committees		
Committee Name	Committee Chair	Date
Risk & Compliance Group	Director of Nursing	11 April 2017
Audit and Risk Committee / WEB	Non-Executive Director	19 July 2017
Other Stakeholders Consulted		
Clinical Governance Support Managers		
Does this document map to other Regulatory requirements?		
<i>Regulator details</i>	<i>Regulator standards/numbers etc</i>	
CQC	Regulation 12: Safe care and treatment Regulation 13: Safeguarding Regulation 15: Premises and Equipment Regulation 17: Good Governance Regulation 19: Fit and Proper Persons	
Document Version Control		
Version No		
1	The Risk Management Strategy used to form part of the Trust's Governance Strategy. The Risk process has been removed from this to form its own policy.	
2	Risk Management Policy review in line with scheduled review date	
3	Alignment with Risk Management Strategy December 2016 and EQUIP policy.	

UNIQUE IDENTIFIER NO: G-101-2015
EQUIP- 2017-060
Review Date: April 2019
Review Lead: Director of Nursing

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1. Introduction

Vision and Statement of Intent

The Trust's vision of this strategy is for risk management to be regarded as a highly valuable and useful tool to help the Trust achieve its objectives, with:

Risk management systems understood by staff
Risk management systems embedded into everyday working practice across all parts of the organisation
The Board and its committees assured that risks are managed to achieve the Trust's objectives

The Trust will aim continually to improve the content and maturity of the risk management framework which is a key part of the governance framework.

The Risk Management Policy applies to all categories of risk, both clinical and non-clinical risks. These include, though are not limited to:

Clinical quality / patient safety risks	Operational / performance risks	Financial risks
Health and Safety Risks	Project Risks	Patient Experience Risks
Business Risks	Reputational Risk	Regulatory risks
Governance risks	Workforce Risks	Partnership risks
Information risks	External environment risks	Risks from political change / policy

The Risk Management Strategy details the organisational structure for risk management, the roles and responsibilities of committees responsible for risk (see section 7) and accountabilities for risk management (see section 8).

Within the Risk Management Policy, key responsibilities for operational staff are given at section 4.

This policy should be read in conjunction with the risk management strategy which we aim to embed by the following:





2. Risk Management Objectives

The overall objectives for risk management at the Trust are to establish and support an effective risk management system which ensures that:

- Risks which may adversely affect patients, staff, contractors, the public and the fabric of buildings, are identified, assessed, documented and effectively managed locally to a level as low as possible, using a structured and systematic approach thereby providing a safe environment in which patients can be cared for, staff can work and the public can visit

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- Risks are managed to an acceptable level as defined in the Board's Trust risk appetite and staff have a clear understanding of exposure and the action being taken to manage significant risks
- Risks are regularly reviewed at team, directorate, division and corporate levels by accountable managers, ensuring that risks that are not able to be controlled locally are escalated, (a flowchart of risk escalation is given at section 9.4)
- All staff can undertake risk management in a supportive environment and have access to the tools they need to report, manage and monitor risks effectively – see section 9 for further details
- All staff recognise their personal contribution to risk management
- Assurance on the operation of controls is provided through audit, inspection and gaps in control and risks are identified and actively managed

3. Scope of this Policy

Risk management is everyone's responsibility. This policy applies to all employees, contractors and volunteers. All employees will co-operate with the Trust in managing and keeping risk under prudent control. Specific responsibilities are placed on members of the management team for ensuring the requirements of this policy are met within their respective areas of control. Specific roles and responsibilities for risk management are summarised at Section 4 below.

4. Roles and Responsibilities

In order to achieve the aims of this policy the following roles, accountabilities and responsibilities apply at operational level:

Operational Staff Duties & Responsibilities

4.1 Clinical and Divisional Directors

Clinical and Divisional Directors have a specific responsibility for the identification and prudent control of risks within their sphere of responsibility. They are responsible for ensuring effective systems for risk management within their division and directorates and ensuring that their staff are aware of the risk management policy and their individual responsibilities.

In addition to Divisional Directors and Clinical Directors the divisional management team includes an Associate Director of Nursing and Associate

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Review Lead: Director of Nursing

Divisional Director.

They are responsible for demonstrating and providing leadership of risk management within their division, directorates and teams. They are accountable for:

- Pro-actively identifying, assess, managing and reporting risks in line with Trust processes
- Establishing and sustaining an environment of openness and learning from adverse events to prevent recurrence and creating a positive risk management culture
- Seeking assurance through their governance arrangements of the effectiveness of risk management
- Ensuring clinical risks, health and risks, emergency planning and business continuity risks, project and operational risks are identified and managed.
- That general managers, operational managers, matrons, ward managers, departmental team managers are responsible for ensuring effective systems of risk management and risks registers are in place at all levels.

4.2 All Staff

All staff will:

- Accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that are affected by Trust business
- Be aware of, identify and minimise risks, taking immediate action to reduce hazards or risks
- Identify, assess, manage and control risks in line with Trust policies and procedures
- Be familiar with local policies, procedures, guidance and safe systems of work
- Be aware of their roles and responsibilities within the risk management strategy, policy and supporting policies, eg comply with incident and near miss reporting procedures
- Be responsible for attending mandatory and essential training and relevant educational events
- Undertake risk assessments within their areas of work and notify their line manager of any perceived risks which may not have been assessed

4.3 Contractors and Partners

It is the responsibility of any member of Trust staff who employ contractors, and their partners, to ensure they are aware of the Safe Management of

UNIQUE IDENTIFIER NO: G-101-2015**EQUIP- 2017-060****Review Date: April 2019****Review Lead: Director of Nursing**

Contractors policy and undergo Trust induction via the relevant Estates Department at either HRI or CRH. This will ensure that all contractors working on behalf of the Trust are fully conversant with CHFT's health and safety rules staff member responsible is fully aware of the contractors activity for which they are engaged and, if applicable, are in possession of the contractors risk assessment and method statement for their activity.

4.4 Risk Management Specialists

The Trust has risk management specialists who possess and maintain appropriate qualifications and experience so that competent advice is available to staff. As well as supporting staff manage risks, these specialists create, review and implement policies, procedures and guidelines for the effective control of risks. These include:

Role	Responsibility
Caldicott Guardian Senior Information Risk Owner (SIRO) Information Governance Manager	Information Governance Risks
Company Secretary	Strategic Risks Foundation Trust risks Central alert systems risks
Director of Nursing	Clinical Risk
Director of Infection and Prevention Control (DIPC)	Infection Prevention risks
Medical Director	Safety incidents in NHS screening programmes
Head of Midwifery	Maternity Risks
Emergency Preparedness	Emergency Planning and business continuity risks
Fire Safety Manager Health and Safety Advisor Local Security Management Specialist (LSMS) Director of Estates and Facilities Director of Security	Fire Safety Advice Health and Safety risks Energy, all waste materials and sustainability Security Management
Controlled Drugs Officer Chief Pharmacist Medication Safety Officer	Medicines management Risks
Freedom to Speak Up Guardian	Raising Concerns risk
Patient Experience lead	Patient Experience Risks
Local Counter Fraud Specialist	Fraud Risks
Governance and Risk Team Assistant Director of Quality Head of Governance and Risk Risk Manager, Legal Services Manager Clinical Governance Support Managers / Quality and Safety lead	All risks and risk management tools, processes and training.
Head of Safeguarding / Safeguarding Team	Safeguarding Risks

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Further details on these roles can be found in Appendix 3 of the Risk Management Strategy.

5. Risk Management Process: Risk Registers

All areas assess record and manage risk within their own remit, reporting on the management of risks through the risk register, using the risk grading system detailed at Appendix 4. All risks are linked to strategic objectives.

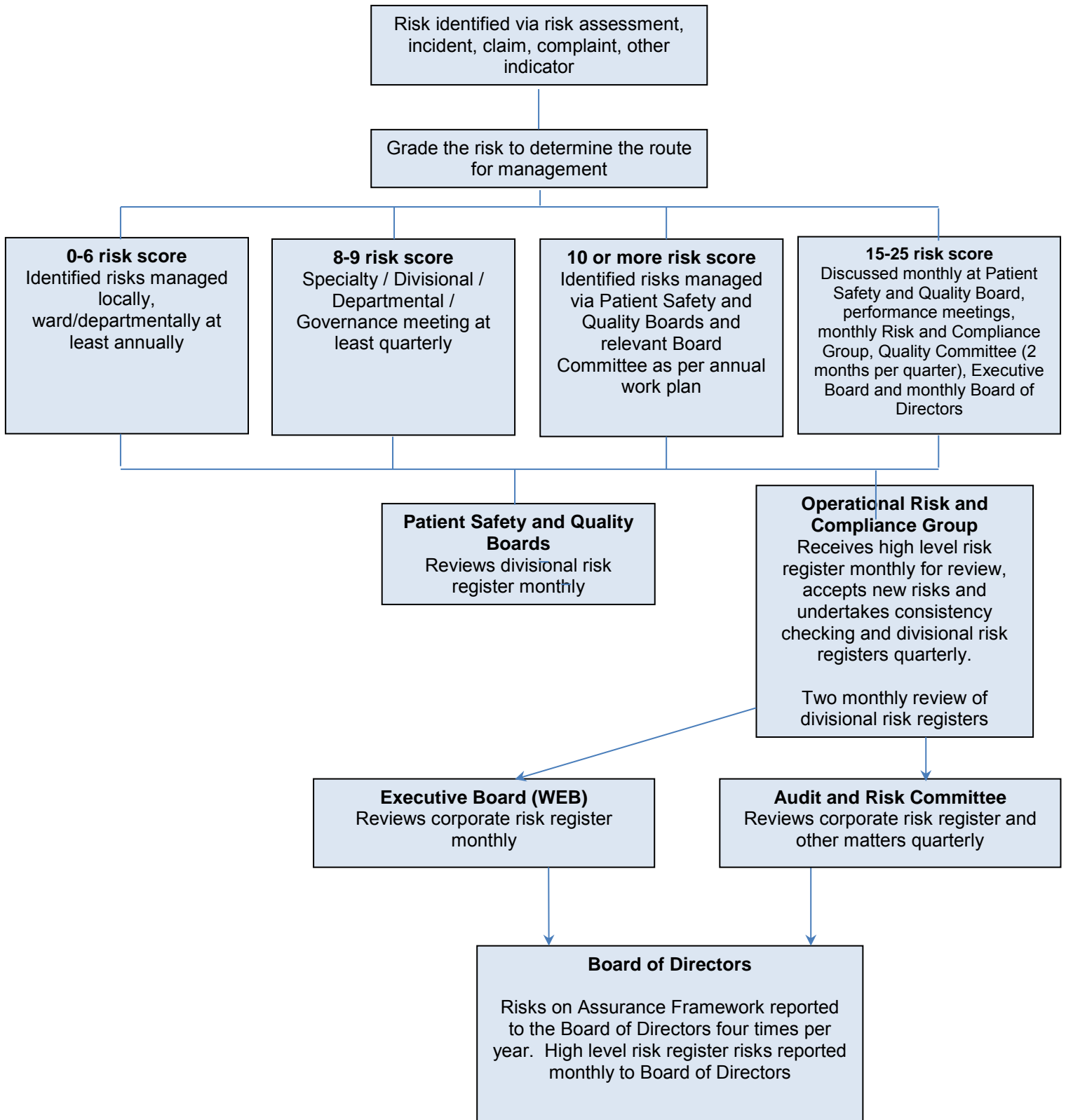
A database is used to capture all risks to the organisation including clinical, organisational, health and safety, financial, business and reputational risks. A framework is in place for assessing, rating and managing risks throughout the Trust, ensuring that risks are captured in a consistent way. Risks can be analysed by risk score, division, directorate and team. Further detail on the process for populating the risk register is given in the Risk Management Policy. It is the responsibility of each division to maintain and monitor their divisional risk registers and ensure they feed into the High level risk register which is an integral part of the Trust's system of internal control.

The High level risk register includes those significant risks which may impact on the Trust's ability to deliver its objectives, with a risk score of 15 or above. These are reviewed on a monthly basis by the Risk and Compliance Group and presented to the Board of Directors.

Divisional, directorate and team risk registers are managed and reviewed by the Divisions, with divisional risk registers reviewed on a regular basis by the Risk and Compliance Group. The performance framework for divisions also includes scrutiny of risks within divisions. The Risk Management Policy details the process for risk register reporting.

The diagram below depicts the flow of risks throughout the organisation from identification to assessment and management according to severity throughout the Trust.

Structure and flow chart for the management of assurance and risk



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Step 1: Determine Priorities

Risk is defined as anything that is stopping or could prevent the Trust from providing safe and sustainable clinical services, and from being successful (for a summary of key terms used in this document see Appendix 1). The Board of Directors and senior management will be clear about objectives for each service and express these in specific, measurable, achievable ways with clear timescales for delivery.

Step 2: Identify Risk

Evaluating what is stopping, or anticipating what could prevent the Trust from achieving stated objectives/strategic priorities, annual plans, financial plans, delivering safe clinical services will identify risk. Risks should not be confused with issues, which are things that have happened, were not planned and require management action.

Risk identification concerns future events; it involves anticipation of failure and is based upon consideration of strengths, weaknesses, opportunities or threats.

Risks need to be clearly described to ensure there is a common understanding by stakeholders of the risk. The recommended way for describing a risk is **risk of.....due toresulting in**, as follows:

Steps to write a risk	
Identify the risk	Risk of
Identify the cause of the risk	Risk due to
Identify the impact of the risk	Risk results in

Appendix 2 includes guidance on how to write a risk.

The identification of risk is an ongoing process and is never static, but is particularly aligned to the annual planning process and compliance requirements.

Staff may draw on a systematic consideration of reasonably foreseeable failures alongside incident trends, complaints, claims, patient/staff surveys, observations, formal notices, audits, clinical benchmarks or national reports to identify risk. This list is not exhaustive. In order to do this the Board of Directors, senior leaders and divisional teams will identify what is uncertain, consider how it may be caused and what impact it may have on the objective and service.

Step 3: Assess Risk

All risks must be assessed in an objective and consistent manner. Risks are

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assessed on the probability, i.e. the likelihood of a risk happening and on what would happen (impact) should the risk occur.

The magnitude of a risk can be estimated by multiplying the severity of impact by the likelihood of the risk occurring using a standard 5x5 risk scoring matrix to score likelihood and impact of a risk.

The Trust procedure uses three risk scores:

- **Initial risk score** - this is the score when the risk is first identified and is assessed with existing controls in place. This score will not change for the lifetime of the risk and is used as a benchmark against which the effect of risk management will be measured
- **Current risk score** - this is the score at the time the risk was last reviewed in line with review dates. It is expected that the current risk score will reduce and move towards the target / residual risk score as action plans to mitigate risks are developed and implemented
- **Target / residual risk score** - this is the score that is expected after the action plan has been fully implemented

Staff should be realistic in the quantification of severity and likelihood and use, where appropriate, relative frequency to consider probability. A guide to calculating target / residual risk and risk scoring matrix guidance is provided at Appendix 4.

Step 4: Respond to the Risk

1

There are a number of different options for responding to a risk . These options are referred to as risk treatment strategies. The main options most likely to be used include:

- **Seek** - this strategy is used when a risk is being pursued in order to achieve an objective or gain advantage. *Seeking risk must only be done in accordance with the Board's appetite for taking risk.*
- **Accept / Tolerate** - this strategy is used when no further mitigating action is planned and the risk exposure is considered tolerable and acceptable. Acceptance of a risk involves maintenance of the risk at its current level (any failure to maintain the risk may lead to increased risk exposure which is not agreed).
- **Avoid / Terminate** - this strategy usually requires the withdrawal from the activity that gives rise to the risk.
- **Transfer** - this strategy involves transferring the risk in part or in full to a third party. This may be achieved through insurance, contracting, service agreements or co-production models of care delivery. *Staff must take advice from the Executive Team before entering into any risk transfer*

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arrangement.

- **Modify** - this strategy involves specific controls designed to change either the severity, likelihood or both. This is the most common strategy adopted for managing risk at the Trust. For this reason, we expand on the nature of control as follows:

The following three types of control are used to modify risk:

- (i) **Prevention/Treatment** - these controls are core controls and are designed to prevent a hazard or problem from occurring. They typically involve policies, procedures, standards, guidelines, training, protective equipment/clothing, pre-procedure checks etc.
- (ii) **Detection** - these controls provide an early warning of core control failure, such as a smoke alarm, incident reports, complaints, performance reports, audits
- (iii) **Contingency** - these controls provide effective reaction in response to a significant control failure or overwhelming event. Contingency controls are designed to maintain resilience.

A combination of all 3 types of control is usually required to keep risk under prudent control.

Step 5: Report Risk

The structure and flow chart for the management of assurance and risk above confirms how risks are reported throughout the organisation.

All risks must be recorded on the Risk Register. It is the responsibility of each division to maintain and monitor their divisional risk registers and ensure they feed into the high level risk register which is an integral part of the Trust's system of internal control and defines the risks which may impact on the Trust's ability to deliver it's objectives.

Risks which score 15 or higher must be brought to the attention of the Head of Risk and Governance for escalation to the appropriate committee for consideration and potential inclusion on the high level risk register. The Risk and Compliance Group will also consider for inclusion on the high level risk register risks scored at 12 as highlighted by the divisions. The high level risk register prioritises risk, populated from risk assessments carried out both at a strategic and operational level.

The Risk and Compliance Group, on behalf of the Audit and Risk Committee and Board, oversees the high level risk register, with identified Board Committees or groups overseeing the management of risks on behalf of the Trust.

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Key outputs from the risk management system will be reported to relevant staff/committees depending on the residual risk score as follows:

- ≥ 15 – each formal meeting of the Board of Directors
- ≥ 10 – [Relevant] Committee of the Board of Directors as part of the Committee's annual work plan
- ≥ 8 – Specialty/Divisional /Departmental Governance meeting at least quarterly
- ≥ 6 – Ward/Departmental Management at least annually

The **Risk & Compliance Group** is a sub-committee of the **Audit and Risk Committee**. It will receive reports to monitor the quality, completeness and utilisation of risk registers, and also to oversee of the distribution of risk across the Trust. Reports will cover the risk description, the residual risk (exposure after control), main controls, date of review and risk owner.

The Quality Committee, which has a specific role for clinical risks, receive the risk register on a monthly basis.

Risk registers from divisions are scrutinised through their Patient Safety Quality Boards and every two months by the Risk and Compliance Group. They are reviewed to ensure that risks within the division and their directorates are captured. Each division reports on their risk registers on a quarterly basis to the Quality Committee. The

The Executive Team will be informed by the Director of Nursing (or relevant Executive Director) of any new significant risk arising at the first meeting opportunity.

Urgent Escalation - in the event of a significant risk arising out with meetings depicted on the structure above, the risk will be thoroughly assessed, reviewed by the relevant Clinical Director, Associate Director of Nursing, Divisional Manager and Executive Director and reported to the Chief Executive (or their deputy) within 24 hours of becoming aware of the risk. The Chief Executive, with support from relevant members of the Executive Team and advisors, will determine the most appropriate course of action to manage the risk. The Chief Executive will assign responsibility to a relevant Executive Director for the management of the risk and the development of mitigation plans. The risk will be formally reviewed by the Executive Team at their next weekly meeting.

Step 6: Review Risk and Risk Closure

Risks will be reviewed at a frequency proportional to the residual risk. Discretion regarding the frequency of review is permitted. As a guideline it is suggested, as a minimum, risk is reviewed as follows:

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- ≥ 15 – at least monthly
- ≥ 10 – at least quarterly
- ≥ 8 – at least bi-annually
- ≤ 6 – annually

Step 7: Risk Closure

A risk can be closed and moved to the closed section of the electronic risk register system for audit purposes when:

- i. There is a change in practice which removes the hazard
- ii. Where the risk / event has passed
- iii. Where it is clear that the action taken to treat a risk eliminates all reasonably foreseeable exposure to that risk

Completion of actions does not necessarily mean that a risk can be eliminated and closed.

Each division should have governance arrangements which define a clear process for authorising the closure of risks by managers / through appropriate directorate / department or divisional meeting and ensure that all staff are aware of this. The reason for closure should be stated on the risk register.

High level risk register - for risks scoring 15 or above which are included within the Corporate Risk Register, risks that are proposed for closure should be reviewed for closure by the Risk and Compliance Group prior to closing the risk.

It is good practice to periodically audit closed risks to satisfy that the risk is no longer present.

6. Training

Risks may be identified pro-actively by managerial review, analysis of incidents, complaints, claims or outcomes of safety inspection and/or audit. Root cause analysis may also be a source of risk identification. To ensure that all risks are identified, accurately described, appropriately controlled and consistently documented the following risk management tools are in place:

a) Risk Register

The Risk Register provides a mechanism for recording details of each risk within a database so that risk records can be analysed and facilitate effective oversight of risk management at all levels. When agreed all risk assessments must be entered onto the risk register.

b) Risk Management Training

Training is required to effectively manage risks in line with the process set

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out above. Bespoke risk management training will be available to teams, tailored to their specific needs. This could include sessions on:

- Operational use of the electronic risk register system and guidance on how to articulate a risk, controls and actions (group or individual)
 - Advice and guidance on management of risk in their area
 - Peer review of risk registers
 - Support with the development of risk registers
- c) The Board of Directors and Senior Managers (which for the purpose of this policy are defined as Directors, Associate Directors, Clinical Directors and Assistant Directors) will receive training and/or briefings on the risk management process by staff from the Governance and Risk team. In addition, supplementary briefings will be provided as required following publication of new guidance or relevant legislation.
- d) Divisional, Ward and Departmental managers will have further more detailed risk management process training incorporating how to use the Risk Register database before access to the database is enabled.
- e) Staff designated to regularly undertake Root Cause Analysis will have the opportunity to undertake Root Cause Analysis training.

7. Trust Equalities Statement

Calderdale and Huddersfield NHS Foundation Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their gender, gender reassignment, race, disability, age, sexual orientation, religion or religious/philosophical belief, marital status or civil partnership.

This policy has been through the Trust's EQUIP (Equality Impact Assessment Process) to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.

8. Monitoring and Audit

The following indicators will form the Key Performance Indicators by which the effectiveness of the Risk Management Process will be evaluated:

- All verified significant risks are reported to the Board of Directors at each formal meeting of the Board

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- All significant risks are reported to and reviewed as a standing agenda item at each formal meeting of a Committee of the Board
- Risks of ≥ 15 are reviewed by the Risk and Compliance Group, with risks of 12 also reviewed when requested by divisions
- Local risk registers are in place, maintained and available for inspection at ward/departmental level
- Local risk registers show details of control, assurances, location, owner, action plan (where necessary) and $\geq 80\%$ of risks are within review date and none are overdue for review by 6 or more months

Compliance with the above will be monitored by the Head of Risk & Governance, reviewed by the Director of Nursing and reported within an annual report submitted to the Quality Committee.

The following mechanisms will be used to monitor compliance with the requirements of this document:

- Evidence of reporting verified significant risk exposures to the Board of Directors at each formal meeting
- Evidence of review of significant risk exposure by the Risk & Compliance Group at each formal meeting of the Group
- Periodic internal audit of any or all aspects of the Risk Management process as determined by the Audit and Risk Committee (risk identification, assessment, control, monitoring and reviews).

9. Associated Documents/Further Reading

This policy/procedure should be read in accordance with the following Trust policies, procedures and guidance:

- Incident Reporting, Investigation and Management policy
- Complaints policy
- Claims policy
- Being Open / Duty of Candour Policy
- Major Incident policy
- Blood Transfusion policy
- Capability policy
- Claims Policy
- Complaints Policy
- Consent Policy
- DOLS
- Electronic Patient Record Standard Operating Procedures
- Emergency Preparedness,
- Inquest Policy
- Mandatory Training Policy
- Managing External Visits Policy
- Maternity Risk Management Strategy
- Medicines Management policies
- Medical Devices policy
- Moving and Handling policy
- Patient Identification policy
- Personal Development Review
- Policy on the Appointment of Medical Locums
- Policy for Developing Policies
- Policy on the implementation of NICE guidelines
- Promoting Good Health at Work

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- | | |
|---|----------------------------------|
| Resilience and Response Policy | Policy |
| • Falls Prevention and Management policy | • Race Equality Scheme |
| • Fire Safety Strategy | • Raising Concerns Policy |
| • Freedom of speech/Whistleblowing policy | • Risk Management Policy |
| • Health and Safety policy | • Safe Management of Contractors |
| • Induction policy | • Safeguarding |
| • Infection Control policies | • Security Policy |
| • Information Governance Strategy and associated policies | • Waste Policy |

All operational policies, procedures and guidance also support the effective management of risk.

Glossary of Terms used within Policy

Risk management will operate under a common language. Adopting standard risk management terms and definitions set out in the Risk Management Code of Practice (BS 31100:2008) will improve consistency and avoid confusion. Common terms may include:

Board Assurance Framework	A document setting out material risk and assurances on the operation of controls to manage those risks	Risk	Effect of uncertainty on objectives
Control	An intervention used to manage risk	Risk acceptance	Informed decision to take a particular risk
Exposure	Extent to which the organisation is subject to an event	Risk aggregation	Process to combine individual risks to obtain more complete understanding of risk
Hazard	Anything that has potential for harm	Risk analysis	Process to comprehend the nature of risk and to determine the level of risk
Incident	Event in which a loss occurred or could have occurred regardless of severity	Risk appetite	Amount and type of desirable risk the organisation is prepared to seek, accept or tolerate
Inherent risk	Exposure arising from a specific risk <u>before</u> any intervention to manage it	Risk assessment	Overall process of risk identification, risk analysis and risk evaluation
Level of Risk	Overall magnitude of a risk. It can be significant, high, moderate, low or very low.	Risk avoidance	Decision not to be involved in, or to withdraw from, an activity based on the level of risk
Material Risk	Most significant risks or those on which the Board or equivalent focuses	Risk management	Coordinated activities to direct and control the organisation with regard to risk
Near Miss	Operational failure that did not result in a loss or give rise to an inadvertent gain	Risk owner	Person or entity with the specific accountability and authority for managing the risk and any associated risk treatments
Operational Risk	The risk of loss or gain, resulting from internal processes, people and systems or from external events	Risk Register	A record of information about identified risks.
Programme Risk	Risk associated with transforming strategy into solutions via a collection of projects	Target Risk	A level of risk being planned for
Residual risk	Current risk. The risk remaining <u>after</u> risk treatment		

Risk Register Guidance - Risk Description

This section describes how to articulate a risk for the risk register.

Risk description should describe the risk, what is causing the risk (i.e. What the risk is due to) and the impact.

The risk should be articulated clearly and concisely with appropriate use of language, suitable for the public and with acronyms spelt out in the first instance.

Think of the risk in 3 parts and write it using the following phrases:

There is a risk of.....

This is due to / caused by.....

Will result in / have an impact on.....

The example below provides a useful guide to help staff define the risk accurately and precisely:

Objective: To travel from Huddersfield Royal Infirmary to Calderdale Royal Hospital for a meeting at a certain time.		
Risk Description		Comment
Failure to get from HRI to CRH for a meeting at a certain time	X	This is simply the converse of the objective
Being late and missing the meeting	X	This is a statement of the impact of the risk and not the risk itself
Eating on the shuttle bus is not allowed so I was hungry	X	This does not impact on the achievement of the objective
Missing the shuttle bus causes me to be late and miss the meeting	√	This is a risk that can be controlled by ensuring I allow enough time to get to the shuttle bus stop
Severe weather prevents the shuttle bus from running and me getting to the meeting	√	This is a risk that I cannot control but against which I can make a contingency plan

Be careful and sensitive about wording of risks as risk register are subject to Freedom of Information requests.

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Appendix 3

Assessing Risk and Calculating Residual Risk

This section describes how to score risks by estimating severity of impact and likelihood of occurrence using a standard 5x5 matrix. Each risk can be measured by multiplying the severity of harm and the likelihood of that harm occurring, i.e. multiplying the consequence / severity score by the likelihood score.

The Trust procedure uses three risk scores:

- **Initial risk score** - this is the score when the risk is first identified and is assessed with existing controls in place. This score will not change for the lifetime of the risk and is used as a benchmark against which the effect of risk management will be measured
- **Current risk score** - this is the score at the time the risk was last reviewed in line with review dates. It is expected that the current risk score will reduce and move towards the target / residual risk score as action plans to mitigate risks are developed and implemented
- **Target / residual risk score** - this is the score that is expected after the action plan has been fully implemented and refers to **the amount of risk remaining after treatment**.

The Trust uses a standard 5 x 5 scoring matrix set out at Appendix 4

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Appendix 4

Risk Grading Matrix

Impact

Impact is graded using a 5-point scale in which 1 represents the least amount of harm, whilst 5 represents catastrophic harm/loss. Each level of severity looks at either the extent of personal injury, total financial loss, damage to reputation or service provision that could result. Consistent assessment requires assessors to be objective and realistic and to use their experience in setting these levels. Select whichever description best fits.

Likelihood

Likelihood is graded using a 5-point scale in which 1 represents an extremely unlikely probability of occurrence, whilst 5 represents a very likely occurrence. In most cases likelihood should be determined by reflecting on the extent and effectiveness of control in place at the time of assessment, and using relative frequency where this is appropriate.

	Impact /Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

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Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/ business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

2 Likelihood score

What is the likelihood of the impact / consequence occurring?

Likelihood score	1	2	3	4	5
Descriptor	Extremely Unlikely	Unlikely	Possible	Likely	Almost certain
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
How often might or / does this happen	Not expected for years	Possible Annual Occurrence	Possible Monthly	Possible to occur weekly	Expected to occur daily
Probability	< 1 in 1000 chance	≥ 1 in 1000 chance	≥ 1 in 100 chance	≥ 1 in 10 chance	≥ 1 in 5 chance

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Differing Risk Scenarios

In most cases the highest degree of severity (i.e. the worst case scenario) will be used in the calculation to determine the residual risk. However, this can be misleading when the probability of the worst case is extremely rare and where a lower degree of harm is more likely to occur. For example, multiple deaths from medication error are an extremely rare occurrence, but minor or moderate harm is more frequently reported and may therefore have a higher residual risk. **Whichever way the residual risk score is determined it is the highest residual risk score that must be referred to on the risk register**

Risk Grading

Risk grading makes it easier to understand the division / directorate / Trust risk profile. It provides a systematic framework to identify the level at which the risks must be managed and overseen in the organisation, prioritise actions and resources to address risk and direct which risks should be on the corporate risk register.

Having assessed and scored the risk using the 5x5 risk scoring matrix, use the table below to grade the risk as very low, low, moderate, high or significant.

Table 3 Risk scoring = Impact / Consequence x likelihood

Consequence	Likelihood				
	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Very Low risk
4 - 6	Low Risk
8 - 12	Medium Risk
10-12	High Risk
15-25	Significant

Approved Minute

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Cover Sheet

Meeting: Board of Directors	Report Author: Kathy Bray, Board Secretary
Date: Thursday, 3rd August 2017	Sponsoring Director: Victoria Pickles, Company Secretary
Title and brief summary: COMPLAINTS POLICY - The Board is asked to receive and approve the updated Complaints Policy	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Risk and Compliance Group Executive Board	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

Under the Board of Director's Scheme of Delegation, approval of the arrangements for the management of complaints is reserved to the Board.

The Board is therefore asked to receive and approve the updated Complaints Policy which has been reviewed by the Risk and Compliance Group and the Executive Board.

Main Body

Purpose:

As above

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to receive and approve the updated Complaints Policy

Appendix

Attachment:

G-106-2015 - Complaints Policy v2.pdf

UNIQUE IDENTIFIER NO: G-106-2015
EQUIP-2017-046
Review Date: July 2019
Review Lead: Director of Nursing

Procedure for Handling Concerns and Complaints

Version 2

Important: This document can only be considered valid when viewed on the Trust's Intranet. If this document has been printed or saved to another location, you must check that the version number on your copy matches that of the document online.

UNIQUE IDENTIFIER NO: G-106-2015

EQUIP-2017-046

Review Date: July 2019

Review Lead: Director of Nursing

Document Summary Table		
Unique Identifier Number	G-106-2015	
Status	Ratified	
Version	2	
Implementation Date	April 2015	
Current/Last Review Dates	April 2017	
Next Formal Review	July 2019	
Sponsor	Director of Nursing	
Author	Patient Advice and Complaints Manager	
Where available	Trust Intranet	
Target audience	All Staff	
Ratifying Committee		
Board of Directors		
Executive Board	6 July 2017	
Consultation Committees		
Committee Name	Committee Chair	Date
Risk and Compliance Group	Director of Nursing	11 April 2017
Patient Experience and Caring Group	Assistant Director, Quality	7 February 2017
Other Stakeholders Consulted		
Does this document map to other Regulator requirements?		
Care Quality Commission	Regulation 16 complaints	
NHS Improvement	Single Outcomes framework	
Document Version Control		
<i>Version no</i>	<i>Details of review/alterations, rationale for document etc</i>	
1	This policy used to form part of the Learning From Experience policy and has been extract to form a standalone policy. This policy has been updated to reflect our current processes and national guidance.	
2	Updated to reflect current practice and 3 gradings for complaints. Addition of information on handling habitual and persistent complainants, cross divisional complaints.	

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1. Introduction

- 1.1** This Policy describes the requirements and Trust procedures for the investigation and management of Concerns and Complaints, received across Calderdale and Huddersfield NHS Foundation Trust (CHFT).

CHFT views complaints positively and is committed to having an effective procedure in place to handle all concerns and complaints. The Trust will take an active approach to seeking people's views, dealing with complaints and using the information received to learn and improve both the experience of our patients and the quality of the service we provide.

Where it is not possible to rectify a problem we will provide an open, accountable and effective complaints service. Concerns and Complaints will be dealt with on an individual manner, and will be investigated fully, transparently and honestly in a timely manner and where required in partnership with other agencies.

CHFT recognises that service users and their representatives have a fundamental right to raise concerns about the services they receive. Accordingly it is expected that staff will not treat service users and their representatives, unfairly as a result of any complaint or concern raised by them. Any complaints, by service users or their representative, of unfair treatment as a result of having made a complaint will be investigated as a separate complaint and appropriate action will be taken.

1.2 Who this policy applies to:

This policy applies to all permanent, locum, agency, bank and voluntary staff of CHFT and any person or persons working in a contractor role acting for or on behalf of CHFT. CHFT employees work very hard to get the job right first time; however, sometimes mistakes can occur. As a CHFT employee you need to follow this policy this policy so that CHFT can ensure compliance to best practice and legal obligations to demonstrate that:

- any service users of CHFT, their family, or members of the public are given the opportunity to seek advice, raise concerns, and/or make a complaint about any of the services it provides
- that a person who raises a complaint, receives a high quality response in a timely manner
- lessons learned from complaints are acted upon and shared throughout the organisation to improve standards of care and prevent avoidable harm/experience
- complaints are investigated and managed in line with:

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- the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
- www.opsi.gov.uk/si/si2009/uksi_20090309_en_1
- the Parliamentary and Health Service Ombudsman's (PHSO): My expectations for raising complaints and concerns 2014 <http://www.ombudsman.org.uk/myexpectations>

1.3 What is covered by this Policy:

This Policy covers concerns and complaints made by service users and their representatives.

1.4 Complaints dealt with under this policy:

A complaint can be made to CHFT about any matter reasonably connected with the exercise of its functions including in particular:

- care or treatment provided
- anything to do with the hospital or healthcare environment
- any member of staff in relation to the care and service they provide
- how services are organised if this has affected treatment or care
- complaints about the CHFT's staff or facilities relating to the care provided to any patient in a private pay bed (but not to the private medical care provided by the Consultant outside their NHS Contract)
- care, treatment or an establishment that has been commissioned by the Trust to provide care on behalf of the NHS

1.5 Complaints that cannot be dealt with under this policy are those:

- Made by a local authority, NHS body or independent provider (service – Service)
- Relating to services not provided by CHFT
- From any current or former NHS employee about any matter relating to their employment
- Requests which are made under a subject access request under the Data Protection Act or a request for information under the Freedom of Information Act
- Which are, or have been, investigated by the Health Service Commissioner under the 1993 Act

NOTE: Where complaints are received from general practitioners regarding a patient, and the general practitioner has the consent of the patient to make the complaint on their behalf; then the complaint will be dealt with under this policy. Where the general practitioner does not have the consent of the patient or wishes to raise concerns about a service then the Patient Advice and Complaints Service/Divisional Team will deal with this outside of NHS Complaints Regulations.

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1.6 Who can complain under this policy

The Local Authority, Social Services and NHS Complaints (England) Regulations 2009 specify that complaints may be made by:

- a person who receives or has received services from CHFT; or
- any person who is affected or likely to be affected by any action, omission or decision of CHFT
- a person who is acting as a representative of:
 - a person who has died
 - a child
 - a person who is unable to make the complaint themselves because of lack of physical incapacity or lack of mental capacity
 - any individual who has otherwise asked the representative to act on their behalf

1.7 Time limit for making a complaint under this Policy

1.7.1 The Local Authority, Social Services and NHS Complaints (England) Regulations 2009 require that a complaint must be made within twelve months of:

- the date on which the matter which is the subject of the complaint occurred; or
- the date on which the complainant became aware of the matter which is the subject of the complaint.

1.7.2 Where a complaint is made outside this time limit the Patient Advice and Complaints Manager / Assistant Patient Advice and Complaints Manger may exercise discretion to waive the time limit where it can be demonstrated, and satisfied that:

- the complainant had good reasons for not making the complaint within the time limit; and
- providing it is still possible to investigate the complaint effectively and fairly.

NOTE: Complaints made outside the established time limits can prove difficult to investigate and extremely problematic to resolve, not least because of the inevitable doubts over memories of events some time previously. This is a relevant factor to be considered in determining whether it will be possible to investigate a 'late' complaint effectively.

1.7.3 If it is not possible to waive the time limit and the complaint is not accepted into the Complaints Procedure, an explanation of this will be provided to the complainant.

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2. Purpose

2.1 The purpose of the policy is to make sure CHFT procedures are fully compliant with the Local Authority, Social Services and NHS Complaints (England) Regulations 2009 meets NHS Litigation Authority (NHSLA) Risk Management Standards for Acute Trusts (RMST) and Care Quality Commission (CQC) Outcome 17 and supports Sections 2a and 3b of the NHS Constitution.

Our approach is to consider issues thoroughly and objectively and share our findings openly, honestly and in a timely manner. This policy and procedure is based on the Local Authority, Social Services and NHS Complaints (England) Regulations 2009 and Principles of Good Complaint Handling from the Parliamentary and Health Service Ombudsman (PHSO).

2.2 Policy Aims

The aim of this policy is to provide all those involved in the complaints process with a clear understanding of CHFT's expectations and requirements. The Trust approach to managing concerns and complaints will be to listen and respond to concerns raised by service users and/or their representatives, to learn from their experiences and improve services accordingly. CHFT's arrangements for the handling of complaints will ensure that:

- Complaints are dealt with efficiently
- Complaints are properly investigated
- Complainants are treated with respect and courtesy
- Complainants will be involved in decisions about how their complaints are handled and considered as far as reasonably possible
- Complainants will be kept updated on the progress of the investigations and if the response is delayed, complainants will be notified and advised when to expect the response will be completed by
- Complainants receive a timely and appropriate response, with an acknowledgement and apology where appropriate for any upset or distress caused
- Complainants are told the outcome of the investigation of their complaint; and
- Following completion of the complaint, action is taken if necessary to ensure lessons are learned and to improve the quality of service provided.

2.3 Key Principles

This policy sets out the following key principles in handling complaints and concerns:

- Complaints and concerns will be dealt with in a fair, flexible and conciliatory manner, encouraging open communication between all parties
- High standards of conduct are expected from all staff at all times to ensure that service users and their representatives will be treated respectfully, courteously and sympathetically
- The requirement to maintain confidentiality during the complaints process will be absolute (unless indicated otherwise); All service users and their families and carers will be advised how they can raise a concern or make a formal complaint via information leaflets and posters available on all wards and clinical service units and the internet
- All people who make complaints will be advised of the various independent support agencies that are available to assist them in making their complaint
- As far as reasonably possible, people who make complaints will be involved in decisions about how their complaints are handled and considered
- CHFT will aim to resolve complaints within CHFT as part of local resolution (first stage of the national complaints procedure), wherever possible
- Complainants receive a meaningful apology when appropriate
- CHFT will co-operate with other organisations when a complaint involves other outside organisations
- No person who makes a complaint will be discriminated against on the grounds of religion, gender, race / ethnicity, disability, age or sexual orientation or because they have made a complaint
- Violence, racial, sexual, verbal or any other forms of harassment are unacceptable and will not be tolerated on the part of staff or people who make complaints

2.4 Support

2.4.1 The needs of those affected are a primary concern for CHFT as part of its processes for the investigation of complaints. It is important that affected patients, staff, families and carers are involved and supported throughout the investigation.

2.4.2 It is important to recognise that complaints investigations can have a significant impact on staff who were involved.

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- 2.4.3 Staff involved in the complaints investigation process must be given support, which may include some or all of the following: Support from their line manager or professional lead, the opportunity to access professional advice from their relevant professional body or union, staff counselling services and occupational health services. They should also be provided with information about the stages of the investigation and how they will be expected to contribute to the process.
- 2.4.4 CHFT recognises that individual members of staff may experience higher levels of stress if they become the subject of a complaint. CHFT is committed to supporting staff through the complaints process by offering guidance and by recognising the opportunities for personal development that may arise from the outcome of complaints. Line managers have the primary responsibility for providing this support to staff and can draw on further advice and guidance from the Patient Advice and Complaints Department. Where necessary, additional support including counselling, can be arranged through the occupational health service. Staff also have access to support from their professional or trade union organisations.
- 2.4.5 CHFT is clear that the investigation itself is separate to any other legal and/or disciplinary process. CHFT will advocate justifiable accountability when required but will operate a policy of zero tolerance for inappropriate blame and those involved must not be unfairly exposed to punitive disciplinary action, increased medico-legal risk or any threat to their registration by virtue of involvement in the investigation process.
- 2.4.6 Staff who are unhappy with the way they have been dealt with under the complaints procedure may raise the matter through the CHFT's Grievance Procedure

3. Definitions

- 3.1 **Concern:** Issues raised which require assistance to reach a swift and satisfactory resolution, usually within 72 hours, but do not require formal investigation.
- 3.2 **Complaint:** According to the Department of Health a 'complaint' is an expression of dissatisfaction about the service which CHFT provides, for which a response must be provided.

4. Open and Honest

- 4.1 The core professional standards are set out in *Good medical practice* for doctors and in *The Code: Standards of conduct, performance and ethics for nurses and midwives* for nurses and midwives. Both *Good medical practice* and the *Code* say that doctors, nurses and midwives must:

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- Be open and honest with patients if something goes wrong with their care
- Act immediately to put matters right if that is possible; and
- Promptly explain to patients what has gone wrong and the likely long-term and short-term effects

NOTE: The NMC and the General Medical Council (GMC) ran a consultation on new joint guidance to help doctors; nurses and midwives comply with their professional duty to be open and honest with patients about their care. The consultation is entitled 'Openness and Honesty when things go wrong: the professional duty of candour.'

4.2 Statutory Duty of Candour

On 1st October 2014, new requirements for a statutory duty of candour came into force for NHS bodies as part of wider regulations developed by the CQC in line with their strategy for 2013-2016, '*Raising standards, putting people first.*' The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity. The CQC can prosecute for a breach of parts 20(2) (a) and 20(3) of this regulation and can move directly to prosecution without first serving a Warning Notice. Additionally, CQC may also take other regulatory action.

Further information can be found in CHFT Duty of Candour Policy.

- 4.3** Failure to adhere to the values and principles set out by CHFT, in relation to complaints handling, may be subject to an internal investigation under HR processes.

5. Accessibility of Patient Advice and Complaints Service

- 5.1** Clear information on how to make a complaint must be made available to the public through leaflets throughout Trust premises and information on the Trust web-site.
- 5.2** All staff dealing with complaints must consider the needs of vulnerable people such as adults with learning difficulties, children, some older people or people with particular disabilities, (such as visual impairment or hearing impairment), and will offer support from relevant agencies to such individuals.

- 5.3 All staff dealing with complaints will consider the need for language or sensory support in order to make sure that the complaints procedure is accessible to all.

6. Receiving a Concern or Complaint

- 6.1 A flowchart setting out the actions to be taken when an issue is raised can be found at Appendix 1.

7. Consent

- 7.1 Where a complaint is made by a representative then they must demonstrate that they have the appropriate authority or consent to act.

- 7.2 Consent is not required from MPs when they act directly on behalf of a constituent as CHFT may assume that the MP has obtained sufficient consent to release relevant confidential information (see section 17 S1 2002 (2905)); however, consent is required when acting on behalf of a third party (e.g. complaint by a daughter on behalf of her mother being represented by the MP).

- 7.3 Where a complaint is made on behalf of a person who has died, The Patient Advice and Complaints Department will check that the person making the complaint is the deceased patient's next of kin or is acting with their authority. Where this is not the case, The Patient Advice and Complaints Department will obtain the consent of the next of kin in writing. In doing so, the Trust will offer the next of kin the opportunity to review the complaint that has been made

- 7.4 Where a representative makes a complaint on behalf of a child or a person who lacks capacity, prior to investigating the complaint CHFT staff will satisfy themselves that there are reasonable grounds for the complaint to be made by the representative rather than by the child or the person who lacks capacity. CHFT staff will also satisfy themselves that the representative is conducting the complaint in the best interests of the person on whose behalf the complaint is being made. If not satisfied, the representative will be notified in writing of the reasons for refusing to investigate the complaint.

- 7.5 **Young people aged 16 and 19** – unless there is clear medical evidence that they lack mental capacity, then their express authority should be obtained before responding to the complaint if it will involve disclosing confidential patient information.

- 7.6 **Children under the age of 16** – if a complaint is made by a child who is 'Gillick competent' (i.e. of sufficient intelligence and maturity to consent to treatment), then their agreement should be obtained before responding to the complaint if doing so will involve disclosing confidential patient information.

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NOTE: Where a complaint is made on behalf of a child under the age of 16 who is not Gillick competent then no authority from the child will be needed to responding to those with parental responsibility.

8. Data Protection

- 8.1** Staff must always be mindful of the Data Protection Act and their NHS responsibilities in terms of patient confidentiality, particularly where a complaint is made by a representative on behalf of another individual. Staff must also be aware that all documents generated in the course of a complaints investigation (including internal memoranda/comments etc) are generally liable to be disclosed under the Data Protection Act or in any subsequent legal claim.
- 8.2** Complaint investigations will be conducted in a confidential manner and only those members of staff who need to be involved in the investigation will be, in order to protect patient and staff confidentiality.
- 8.3** On acknowledgment of the complaint, complainants will be informed that it may be necessary to access their health record and to disclose information within it to those staff conducting the investigation and involved in preparing the response.

9. Independent Complaints Advocacy Service

- 9.1** The NHS Complaints Advocacy Service provides external support to patients to pursue a complaint about their NHS treatment or care.
- 9.2** When receiving a complaint via the Complaints Advocacy Service, the Patient Advice and Complaints Department will ensure that written consent has been received, from the patient, to release information to a Complaints Advocacy Service representative.
- 9.3** CHFT will respect the complainant's wish to be represented and supported by the Complaints Advocacy Service by sending all correspondence to the Complaints Advocacy Service, unless the complainant specifically instructs otherwise.
- 9.4** CHFT will accommodate Complaints Advocacy Service, and other recognised advocacy agencies or support groups when arranging meetings if the person making the complaint feels they require support.
- 9.5** CHFT will promote the services offer by Complaints Advocacy Service, and advise complaints of these services.

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10. Learning from Complaints

- 10.1** CHFT will learn from complaints by identifying trends at a local and strategic level, which will assist in the prevention and recurrence or more serious incidents or other similar complaints occurring in the future.
- 10.2** Trend analysis of complaints as well as benchmarking with other Trusts is fundamental to service improvement.
- 10.3** Divisional Directors, Associate Directors of Nursing, Directors of Operation, General Managers and Matrons are responsible for preparing action plans arising from individual complaints and for ensuring that these are implemented. Action plans should cross reference to actions of other providers (e.g. other NHS Trusts or social services departments) where appropriate.
- 10.4** Learning from complaints is a critical part of complaints management. Lead Investigators will be responsible for providing feedback, in respect of complaint outcomes, to appropriate individuals who can take action and ensure lessons are learned. Lessons are also required to be shared across relevant meetings at ward/department, Directorate, Divisional and Trust level.
- 10.5** Internally, this will be through the provision of reports to Trust Board on a quarterly basis, through the quarterly Complaints Report and by specifically highlighting reports from the Parliamentary and Health Service Ombudsman in these reports.
- 10.6** Each Division within CHFT will devise a structure framework for learning from complaints to ensure that all learning is shared across the Division.

11. Claims for Compensation

- 11.1** Requests for compensation should be processed in accordance with the CHFT's Claim's Policy in line with CNST/NHSLA procedures rather than through the Complaints Procedure.

12. Duties (Roles and Responsibilities)

Ultimately, all staff members within the Trust have responsibilities in relation to complaints management, with certain members of the Trust having specialist functions.

12.1 Board of Directors

The Board of Directors is accountable for ensuring that effective controls are in place to support effective complaints management and organisational learning.

12.2 Chief Executive

12.2.1 The Chief Executive is the responsible person as detailed in the NHS Complaints (England) Regulations 2009. S/he is responsible for ensuring compliance with the arrangements made under these Regulations, and in particular ensuring that action is taken if necessary in the light of the outcome of a complaint. This responsibility may be delegated as appropriate.

12.2.2 The Chief Executive will delegate responsibility for the signing of complaint responses to the following staff in the following order:

- i. Executive Director of Nursing
- ii. Medical Director
- iii. Nominated Executive Director

12.3 Executive Director of Nursing and Medical Director

The Executive Director of Nursing is responsible for complaints management within the Trust. S/he will report regularly to the Trust Board, through the Patient Experience Group, in relation to complaints activity and performance, and will liaise with other senior members of the Trust as required.

12.4 Head of Clinical Governance and Risk

12.4.1 The Head of Clinical Governance and Risk is the senior manager with responsibility for complaints policy development and for managing the procedures for handling complaints in accordance with the regulations.

12.4.2 The Head of Clinical Governance and Risk will ensure that:

- CHFT's complaints handling policy reflects national regulations and guidance
- Systems and processes are sufficient to provide the Chief Executive with assurance that robust arrangements are in place
- CHFT meets all performance standards in respect of complaints management
- Systems are in place to ensure that the Trust Board, Chief Executive and managers throughout CHFT receive regular reports on key performance indicators and are made aware of trends in complaints so that they can take action through the relevant clinical governance and risk management processes

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- An annual report on complaints is provided to the Trust Board and published, to provide an assurance to the Trust Board of compliance with Care Quality Commission outcome 17 and NHSLA Risk Management Standards

12.5 Patient Advice and Complaints Manager

12.5.1 The Patient Advice and Complaints Manager / Assistant Patient Advice and Complaints Manager, supported by the Patient Advice and Complaints administrative staff, are responsible for implementing this policy.

12.5.2 The Patient Advice and Complaints Manager / Assistant Patient Advice and Complaints Manager will ensure that:

- all complaints that are received are triaged (Appendix 2)
- all allegations of abuse or negligence are reviewed in line with CHFT's Safeguarding Adults and Safeguarding Children Policies
- all complaints received are processed in line with this policy
- staff are supported through the complaints process
- appropriate responses to the required standard are prepared in conjunction with Divisional and Directorate staff, within the relevant timescales
- trends in complaints are identified and drawn to the attention of senior managers and regular key performance indicator and trend analysis reports are provided
- they provide support to front line staff in dealing with immediate situations and provide advice to all staff with regard to formal and informal resolution of complaints
- queries or concerns about draft responses are raised with the relevant Division so that an appropriate response is provided to the complainant
- A programme of staff training in complaints handling is developed and implemented across the Trust

12.5.3 The Patient Advice and Complaints Manager and Assistant Patient Advice and Complaints Manager will review and approve all complaint responses, with the assistance of the Clinical Governance Manager, prior to the response being prepared for signature.

12.6 Divisional Directors

12.6.1 Divisional Directors are responsible for ensuring that the standards referred to in this policy are followed for their Division. They will ensure that investigations are undertaken appropriately and in a timely manner. They ensure that the Trust does not suffer reputational or financial penalty due to maladministration of complaints.

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- 12.6.2 Under the direction of the Executive Director of Nursing, Divisional Directors will ensure that their Directorates comply with this Complaints Policy and undertake appropriate investigation, using Root Cause Analysis as necessary.
- 12.6.3 The Divisional Director will ensure that there is an adequate process within the Division for an appropriate investigator to be appointed.
- 12.6.4 The Divisional Director will:
- Quality assure all complaint responses to ensure that they answer all issues raised as honestly and as comprehensively as possible.
 - Ensure an action plan is developed to complete any actions identified in the investigation
 - Ensure compliance with action plans to improve service provision
- 12.6.5 The Divisional Director may nominate a colleague with the Divisional Triumvirate to undertake these duties.

12.7 Divisional Lead for Complaints

The Division will identify a lead for complaints to manage and assist with the investigation of patient complaints in line with this policy, instigating any immediate action required for reasons of health, safety and security. The Divisional Lead will be responsible for ensuring complaints are dealt with in a timely manner.

12.8 Lead Investigator

- 12.8.1 The Division will appoint a lead investigator for each complaint.
- 12.8.2 The Lead Investigator may delegate all or part of the investigation to a suitably qualified and/or experienced colleague, but will retain overall responsibility for the quality and content of the investigation and complaint response.
- 12.8.3 The Lead Investigator will contact the Complainant within 7 calendar days from the date of the acknowledgement of the complaint. The purpose of this contact is for the investigators to:
- Introduce themselves to the Complainant
 - Clarify and agree the issues to be investigated as part of the complaint

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- Explain how the investigation will be conducted
- Advise of the expected timescale for investigation and response, in line with the timescales set out in section 14 of this policy
- Establish with the complainant the method in which they would like to receive the response to their complaint

A file note of this contact should be upload onto the complaint file.

NOTE: The purpose of this contact is NOT to respond to the complaint but to clarify the scope of the investigation with the Complainant.

12.8.4 As far as reasonably possible the Lead Investigator will involve the Complainant in the investigation of the complaint.

12.8.5 The Lead Investigator will ensure timely communication is maintained with anyone raising a complaint or concern

12.8.6 The investigation will be overseen by the Lead Investigator, and may involve collecting verbal or written statements from current or former staff, and examination of the relevant documentation and other sources of evidence. It is important that data is collected systematically, recorded at an appropriate professional standard, and filed according to a logical system. **The data used in the investigation of a complaint is always requested when the Ombudsman undertakes a second stage independent review.**

NOTE: Where verbal statements are taken a file note summarising the conversation should be made and uploaded.

12.8.7 Should the complainant wish to attend a Local Resolution Meeting (LRM), the Lead Investigator must complete a Resolution Report (Appendix 4) detailing the investigation into the complainant's concerns and outcome of the investigation prior to the LRM.

12.8.8 Once the complaint response is completed, the Lead Investigator will ensure that any action and learning is progressed and developed and shared with the relevant staff.

12.9 Patient Advice and Complaints Department

12.9.1 The Trust's Patient Advice and Complaints Department will deal with enquiries and concerns from members of the public and will be the point of contact for anyone wishing to raise a concern orally away from the ward or department.

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12.9.2 If the Patient Advice Team is able to provide a mutually agreeable solution to issues within 72 hours, or with the agreement of the individuals this will be recorded as a concern.

12.9.3 The Patient Advice and Complaints Department will also:

- Administer the CHFT's Patient Advice and Complaints Inbox
- Advise members of the public on the complaint procedure if contacted directly
- Register concerns and complaints received centrally on the CHFT's Information System
- Provide reports to CHFT on compliance with quality indicators associated with complaints
- Offer advice, guidance and training to groups where required
- Facilitate the process with regard to multi-agency complaints
- When required obtain consent from the patient or next of kin, when required.

12.10 All staff

12.10.1 Frontline staff are usually best placed to address issues and complaints raised by those who use CHFT's services. By taking prompt and effective action many issues can be addressed without the need for recourse to the formal complaints procedure. This approach is better for the complainant and for staff. It reduces tension and conflict, demonstrates understanding and empathy and builds confidence in CHFT staff and services.

12.10.2 All staff have a responsibility to ensure that:

- They observe and comply with this policy and associated procedures;
- They proactively address issues raised by those who use CHFT's services in order to minimise the number of complaints.
- Where faced with a verbal concern they make every effort to rectify the problem immediately by:
- Investigating the issues and providing a response;
- Contacting the most appropriate person to find out the information required, if necessary seeking advice from their line manager;
- Passing the issue on to a named person and informing the complainant why they have done so, who this is and when they can expect a

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response.

- They co-operate fully with complaint investigation and resolution;
- They support the implementation of action plans arising from complaints.
- They protect the interests of adults at risk, young people, and children. Reference to the CHFT's Safeguarding Team is advised if staff are unsure about this aspect.

13. Severity Rating

All complaints will be allocated a severity rating of Green, Amber or Red using the likelihood and consequence matrix see Appendix 3.

13.1 Red complaints

13.1.1 Complaints identified as potential red severity will be shared with the Division for a lead investigator to be appointed to make contact with the person making the complaint.

13.1.2 Preliminary investigations will be completed and brought to an initial Red Complaint Investigation Panel.

13.1.3 The Patient Advice and Complaints Department will ensure the Initial Investigation Panel meeting will be arranged to take place at the earliest opportunity, as close to two weeks after receipt of the complaint as possible. Attendance at this meeting will depend on the circumstances of the complaint but, as a minimum, will include:

- A Chair; the Head of Clinical Governance and Risk, and in the absence of the Head of Clinical Governance and Risk the Patient Advice and Complaints Manager / Assistant Patient Advice and Complaints Manager
- The Divisional lead with responsibility for coordinating the subsequent investigation.
- Relevant Divisional members of staff
- Senior member of the Patient Advice and Complaints Department
- Any relevant specialist who can provide expert guidance e.g. pharmacist

13.3.4 The Red Complaint Investigation Panel will review the initial findings and include decisions on the following:

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- The grading of the complaint
- If there is a need to report as a Serious Incident
- The Lead for completion of the response
- Any additional action required prior to completion of the response; including the need for the involvement of Workforce and Organisational Development and whether an external view or review is required.
- Whether there is a requirement for contacting external agencies/professional bodies
- Any further support for staff, in accordance with CHFT policy

13.3.3 A member of the Patient Advice and Complaints Department will complete the Initial Investigation Panel checklist to ensure all issues above have been addressed and file the checklist centrally.

14. Timescale for Responding to Complaints

14.1 CHFT aims to respond to complaints in the following target timeframe:

- Complaints triaged as Green will be responded to within 25 working days from the date of receipt
- Complaints triaged Amber and Red will be responded to within 40 working days from the date of receipt

14.2 Should a complainant request a LRM the lead investigator should make all reasonable attempts to arrange the meeting with the target timeframe set out in 14.1.

14.3 CHFT will amend the target timeframe set out in 14.1 for the following reason:

- Delays caused by an external organisation, whose response is required to complete our investigation and respond to the complainant;
- A LRM has been requested by the complainant and the date agreed is outside of the target timeframe.

14.4 Should 10% of a Division's complaints exceed the target timeframe set out in 14.1 the Associate Nurse Director of that Division, with the aid and assistance of the Patient Advice and Complaints Manager, will present a robust action plan to the Executive Director of Nursing detailing the plans for the Division to get back on track.

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14.5 The action plan required in 14.4 must include :

- the lead investigator for each overdue complaint
- reasons for the delay
- sets taken to move the investigation forward
- expected date of completion

14.6 The Lead Investigator must keep the complainant updated regarding timescales throughout the complaint investigation.

15. Process for Complaints Management

15.1 Receipt of a complaint will be acknowledged by the Patient Advice and Complaints Department within two working days from the date of receipt. Complaints received on or after 14:00 hours will be considered as being received on the next working day.

15.2 The Patient Advice and Complaints Department will register the details of the complaint on the Complaints Management System and emailed to the Division involved within two working from the date of receipt of the Complaint. Following which the Patient Advice and Complaints Department will create a file for the complaint and send this to the Divisional lead.

15.3 The Division will identify a lead investigator for the complaint within 1 working day from receipt of the complaint from the Patient Advice and Complaints Department. Complaints emailed to the Division on or after 14:00 hours will be considered as being received on the next working day of the date of receipt.

15.5 The Lead Investigator will make initial contact, as detailed in 12.8.3, with the complainant within 7 calendar days from the date of the acknowledgement of the complaint.

15.6 The issues will be investigated and a formal written response prepared which will include:

- how the complaint was considered;
- the conclusions reached;
- details of remedial action taken or planned;
- confirmation that the action will address the issues raised;
- an apology where appropriate.

15.7 All formal written responses to a complaint must be signed off by a person detailed in 12.2.2.

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15.8 If the person making the complaint does not wish to receive a formal written response to their complaint the Lead Investigator must complete a Resolution Report Appendix 4. This will be required prior to any agreed LRM.

15.9 The Resolution Report must include:

- concerns clarified with the complainant
- details of how the complaint was considered/investigated
- outcome of the investigation
- details of remedial action taken or planned
- confirmation that the action will address the issue

16. Investigation

16.1 Complaints should be investigated by someone not directly involved in the complaint.

16.2 It is important that during the initial contact, that the person making the complaint understands where the Lead Investigator sits in the organisation in relation to the issues being investigated. If the complainant is not satisfied that there is sufficient impartiality, this will be reviewed by the Divisional Lead and an acceptable alternative identified.

16.3 The investigation will be proportionate to the issues raised. Developing a plan of what information is needed to establish the facts will be essential in complex cases. For example, reviewing records and logs of telephone calls; speaking to staff; checking local and national policies, guidelines and good practice; and seeking advice from professionals or clinicians as relevant.

16.4 It important to remember that information obtained from the complainant is just as important as information obtained from staff when investigating a complaint.

16.5 During the course of a complaint investigation CHFT may need to source advice and assistance. This may take the form of obtaining independent clinical advice to comment on a case during investigation to establish best practice, the Police if a criminal act is suspected, or Social Services if the complaint crosses boundaries of care, HM Coroner or other organisations such as the Equal Rights Commission.

17. Cross-Division Investigations

17.1 Should a complaint involve two or more Divisions within CHFT the Patient Advice and Complaints Manager / Assistant Patient Advice and Complaints Manager will decide which Division should lead the investigation of complaint.

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- 17.2** Should it become apparent through the course of the investigation the Division selected to lead the investigation is not the most appropriate Division, the Division will inform the Patient Advice and Complaints Department of the following:
- the division who is best placed to lead the investigation
 - the investigation which has taken place within the Division
 - names of staff involved in the complaint and the Divisions in which they are part of
 - reason why selected Division is best placed to lead on the investigation
 - what information, if any, will be required from the Division wishing to transfer the complaint
 - confirmation that the complainant has been contacted, and issues have been clarified
- 17.3** The transferring of a complaint to another Division **should not** prevent the complainant from being contacted to clarify issues for investigation. The complainant must be contacted by the Division before the complaint will be transferred.
- 17.4** The Division who has been selected to lead the investigation will appoint a Lead Investigator for the investigation.
- 17.5** Divisions who are involved in the complaint but have not been selected to lead on the investigation will identify the members of their staff, who have been involved in the complaint, within 1 working day from receipt of the complaint from the Patient Advice and Complaints Department. Divisions must ensure that identified staff to provide statements/information to the Lead Investigator for the complaint within a reasonable time ensuring that target timeframes, as detailed in section 14, are met.
- 17.6** The Lead Investigator in a cross-division complaint investigation is responsible for ensuring that the complaint is responded to within the target timeframes, as detailed in section 14.
- 17.7** The Lead Investigator will be required to collate all information required to investigate the complaint, consider this information, make a fair decision on the outcome of the complaint, and draft the response to the complaint.
- 17.8** Upon conclusion of the investigation should the Lead Investigator identify failing or learning for another Division involved in the complaint they will present these to the Patient Advice and Complaints Manager / Assistant Patient Advice Complaints Manager, who in turn will forward these on to the Divisional Lead for that Division and request an action plan and confirmation of how these will be resolved. This will be forwarded to the Lead Investigator for inclusion in the Complaints response.

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17.9 During the course of the investigation of a cross-division complaint, should the Lead Investigator have difficulties in obtaining information from the staff of another Division, the Lead Investigator will escalate this to the Patient Advice and Complaints Department. The Patient Advice and Complaints Department will escalate this to the Divisional Lead of the Division involved and request that urgent action be taken. The Divisional Lead will provide reasons for the delay and assurances that the information will be provided to the Lead Investigator.

17.10 Should the Complainant request an LRM for a cross-division complaint the Lead Investigator will be responsible for ensuring that all Divisions involved in the complaint are represented at the LRM.

NOTE: In the event that an LRM has taken place without a representative from another Division, the Lead Investigator will be responsible for arranging a further LRM with the staff from that Division. The Lead Investigator must attend the further LRM for completeness of their investigation.

18. Cross-Organisation Complaint Investigations

18.1 If the complaint involves another organisation the Patient Advice and Complaints Manager / Assistant Patient Advice and Complaints Manager will review the complaint and decide which organisation is best placed to lead on the investigation of the complaint. This will usually be the organisation to which the majority of the issues pertain and/or if the organisation is considered to be the main cause of the complaint for the complainant.

18.2 The Patient Advice and Complaints Department will advise the Complainant of their right to a joint response and obtain consent from the complainant to share the complaint with the other organisation involved should the complainant agree to a joint investigation.

18.3 The Patient Advice and Complaints Department will be responsible for obtaining a response from the other organisations involved and passing this response to the Lead Investigator for inclusion in the complaints response.

18.4 Should the Complainant request an LRM for a cross-organisation complaint, the Patient Advice and Complaints Department will be responsible for advising the other organisations involved of this request. The Patient Advice and Complaints Department will also be responsible for advising the other organisations involved of the dates for an LRM and arranging their attendance.

18.5 Should another organisation involved in the complaint not be able to attend the LRM or not wish to attend the LRM, the Patient Advice and Complaints Department will be responsible for trying to obtain a written response from the organisation to be read by the Lead Investigator during the LRM.

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18.6 Should delays be occurred due to another organisation involved in the complaint, the Lead Investigator will be responsible for advising the Complainant of these delays and the new timescale for providing a response.

18.7 Where an undertaking has been made to seek comments from another organisation, then a complaint will remain open until such time that the response has been received and provided to the complainant. It will be the responsibility of the Lead Investigator to share the other organisation's response with the complainant.

19. Complaints linked to Incidents

19.1 During the Triage of the complaint the Patient Advice and Complaints Department will check CHFT's computerised incidents database for any linked incidents relating to the complaint.

19.2 Upon triage or during the investigation of a complaint should it become apparent that the incident has occurred and the statutory Duty of Candour is required, the Patient Advice and Complaints Department will advise the complainant that their concerns raised in the formal complaint will be answered as part of the incident investigation and Root Cause Analysis.

19.3 Upon conclusion of an incident investigation, where the statutory Duty of Candour has been required, should the patient and/or family of the patient remain unhappy with the outcome of the investigation, the complainant will be re-opened to capture the Complainant's additional concerns and these will be responded to through the complaints process. In the event that a complaint has never been received, a new complaint file will be opened to capture the additional concerns. The Patient Advice and Complainant Department will advise the Complainant of this.

19.4 Should the Complainant wish to pursue their concerns with the Parliamentary and Health Service Ombudsman (PHSO) the Incident and Complaint files will both be provided to the PHSO.

19.5 All complaints relating to an incident will be linked on CHFT's computerised complaints and incidents database.

20. Complaints Records

20.1 The Complainant is entitled to see all records made during the investigation of a complaint, and may make a Subject Access Request for the file. It is important that the records are factual and avoid jargon. The Lead Investigator should be honest about noting any discrepancies, disputes or gaps and consider whether further action could rectify these.

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- 20.2** The Lead Investigator should make a note of any errors or shortcomings the investigation has exposed, along with the action required to deal with these.
- 20.3** All notes and records made during a complaints investigation should be uploaded onto CHFT's computerised complaints database.
- 20.4** The PHSO receives many complaints that expose inadequate record-keeping, making it difficult to establish facts and impossible to reconcile conflicting accounts of a consultation. Remember that if something is not recorded, the PHSO will assume that it did not take place.
- 20.5** The PHSO may ask CHFT to make financial redress to complainants based on a finding of maladministration and it is therefore vital that file notes detail the actions taken when dealing with a complaint. This **must** include all contact made with the complainant to discuss the complaint issues and the timescale for reply.
- 20.6** A complaint file will consist of the following information:
- The complaint
 - Consent (where the complaint is being made by a person who is not the patient)
 - Correspondence (final copies of letters and any emails, telephone/file notes, generated as a result of the complaint)
 - Statements (any statements obtained for the purpose of investigating the complaint)
 - Copies of relevant clinical records
 - Copies of relevant policies and procedures
 - Action Plan for any outstanding actions
 - Capturing the Learning sheet (to be completed for every complaint)
 - Complaints Quality Assessment Checklist (completed)

21. Make a Fair Decision

- 21.1** The Lead Investigator should make a decision about the complaint that is fair and is supported by the available evidence. The Lead Investigator should take into account any discrepancies or omissions that cannot be reconciled and be honest about these in their response.
- 21.2** Complaints will sometimes be made that cannot be substantiated. If the Lead Investigator is satisfied that this is the case, then the Lead Investigator must explain the reason why and be confident and clear in their response.

DO	AVOID
<ul style="list-style-type: none"> • act proportionately; whilst a document review may be sufficient for straightforward complaints, for more serious or complex complaints consider more extensive action such as involving the complainant (if applicable), holding case conferences or taking fuller notes of interviews with staff. (See Investigation Standards) • be sensitive as well as objective; complainants may be writing at a time of grief and shock but that does not make their concerns invalid or unfair as a result. • challenge your colleagues' responses if they are weak, inconsistent, or do not make sense. 	<ul style="list-style-type: none"> • getting key facts wrong or making assumptions • responding by answering long lists of questions from complainants; try to agree a summary of all the key issues to be addressed first. • fudging the matter, or skating over missing information. The complainant should not have to ask further questions to be satisfied that the response is as comprehensive as it can be. • being defensive. • apologising indirectly. Try and avoid phrases like "we are sorry that you <i>felt</i> the organisation or an individual did something wrong". Apologise directly for what has not gone right instead. e.g I am sorry this was a poor experience for you.

21.3 The complaints procedure is separate from the disciplinary procedure. During the course of a complaint investigation it may become apparent that there are grounds for a disciplinary investigation. Consideration as to whether disciplinary action is warranted is a separate matter, outside of the complaints procedure, and is subject to a separate process of investigation. Similarly, during the course of a complaint investigation, it may become apparent that the matter needs to be referred to another agency (Police, Coroner, Professional body etc). Again, consideration as to whether disciplinary action is warranted is a separate matter, outside of the complaints procedure. These decisions will be taken by line managers. Lead Investigators have a responsibility to draw to the attention of line managers and more senior management any specific issues, concerns or trends where they are of the view that further action separate to the complaints investigation is required.

22. Unresolved Complaints

22.1 Where the Complainant is not satisfied with the response to a complaint, the Patient Advice and Complaints Manger / Assistant Patient Advice and Complaints Manager will review the Complainant's additional concerns and

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decide what action, if any, will be undertaken to resolve the complaint.

22.2 Where the Patient Advice and Complaints Manager / Assistant Patient Advice and Complaints Manager has concluded that CHFT has made all reasonable efforts to resolve the concerns of the Complainant, the Patient Advice and Complaints Manager / Assistant Patient Advice and Complaints Manager will advise the Complainant that they should raise the complaint with the PHSO.

23. Responding to the Parliamentary and Health Service Ombudsman (PHSO)

23.1 The remit of the PHSO is to assess complaint cases where the local resolution has been unsuccessful. Once CHFT has forwarded contact details for the PHSO onto the complainant it is up to the complainant to pursue their case with the PHSO.

23.2 In circumstances whereby the PHSO contacts CHFT for information relating to a complaint that they have been asked to review, the following actions will need to be taken:

- The Complaints Department should contact the relevant service to advise;
- The service should provide all requested documentation and information to the complaints team within a timely fashion;
- The Complaints Department should provide the PHSO with the information requested within the timescale where practicable.

24. Training

24.1 The Patient Advice and Complaints Department will ensure provision of guidance and support for relevant managers, supervisors, and staff to enable them to carry out their duties and responsibilities relating to complaint resolution and management.

24.2 Awareness of the role of all staff in complaints management forms a part of the Trust's mandatory training programme and all staff are informed of their responsibilities through the CHFT's Corporate Induction process.

24.3 The Patient Advice and Complaints Department will provide guidance and training to promote the effective handling of concerns and complaints.

25. Health Records

25.1 The keeping of sufficiently detailed, clear and legible notes and records (whether clinical or non-clinical) is of paramount importance when dealing with complaints. Good note/record keeping can avoid complaints or reduce the potential consequences of them.

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25.2 Complaint records must be kept separate from health records, subject to the need to record any information that is strictly relevant to a patient's health in the patient's records. This applies to all reports and medical reports produced during a complaint investigation.

26. Habitual and Persistent Complainants

26.1 There are a small number of occasions when there is nothing further which can be done to assist a complainant to rectify a real or perceived problem. These complaints take up a disproportionate amount of staff time and resources and dealing with the complainants can cause undue stress to staff.

26.2 Such complaints are considered to be habitual or persistent, by virtue of being unreasonably demanding. Where a complaint meets two or more of the following criteria it may be defined as being a habitual and persistent complainant.

- Persistence by the individual in pursuing an issue or complaint after the NHS complaints procedure has been fully and properly implemented and exhausted;
- Changing the substance of the issue or complaint, continually raising new issues or continually raising further concerns / questions whilst the complaint is being addressed or upon receipt of a response in order to prolong contact (new issues which are significantly different from the original complaint will not be included within this category and may need to be addressed as separate complaints);
- Unwillingness to accept documented factual evidence or to accept that facts can be difficult to verify if a long period of time has elapsed;
- Will not identify the precise subject matter of the complaint;
- Harassing any member of staff or being personally abusive or verbally aggressive or racially abusive (see CHFT's Violence and Aggression Policy) - Meeting this criterion alone will be sufficient to determine the complaint to be unreasonably demanding without the need for a second criterion to be met and to suspend all contact with the complainant;
- Threatening or using actual physical violence (see CHFT's Violence and Aggression Policy) - Meeting this criterion alone will be sufficient to determine the complaint to be unreasonably demanding without the need for a second criterion to be met and to suspend all contact with the complainant;
- Meetings or face-to-face / telephone conversations tape recorded by the complainant without the prior knowledge or consent of other parties involved;
- Unreasonable demands / expectations made and failure to accept these may be unreasonable;

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- Repeated refusal to follow alternative avenues open to the complainant (e.g. refusal to refer the complaint to the PHSO).
- 26.3** CHFT reserves the right to restrict and ultimately end communication on complaints that are classed as habitual and persistent. This approach will only be used after all reasonable measures have been taken to try to resolve the complaint through the NHS complaints procedure with, where appropriate, the involvement of independent advice, support or conciliation services.
- 26.4** It is accepted that in the initial contact a person making a complaint to the Trust may act out of character, for example aggressively, and allowances will normally be made for this. However, unacceptable behaviour that continues through several contacts will be considered against the background of this policy.
- 26.5** When the complaint has been identified as being habitual and persistent the complainant will be advised in writing that their actions are prejudicing the continued investigation of their complaint or that there is nothing further that the Trust can do to assist. The letter from the Patient Advice and Complaints Manager / Assistant Patient Advice and Complaints Manager will clearly identify why the complaint is unreasonably demanding and will list the circumstances in which the individual may legitimately continue to raise their concerns. This might include:
- explaining the complaints procedure and help that is available;
 - imposing a time limit on further discussions;
 - meetings or on drawing the complaint to a conclusion;
 - declining contact with the complainant unless clearly pre-arranged;
 - declining contact with the complainant either in person, by telephone, fax, letter or email, providing one form of contact remains open, or
 - alternatively restrict contact to a third party.
- 26.6** Where these actions do not bring about a change in behaviour and the complainant's behaviour continues, then a report will be prepared for the Chief Executive. The Chief Executive (or nominated deputy) will determine what further action may be taken and will advise the complainant in writing. These actions may include:
- an agreement and code of behaviour for both parties to sign which sets out the circumstances in which the Trust will continue to investigate the complaint
 - declining all further contact regarding the complaint

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- Where appropriate pursuing a legal remedy

26.7 Even after the above steps have been implemented it is important to recognise that further contact from the complainant on different matters is not to be automatically considered unreasonably demanding, unless such contact is of a nature designed to consume staff time to such an extent that it prevents ongoing work and the provision of service to other individuals.

26.8 Withdrawal of habitual and persistent status may be achieved if the complainant demonstrates a more reasonable approach. The Chief Executive (or nominated deputy) will determine whether habitual and persistent status may be withdrawn. If this is the case the complainant will be notified in writing and normal contact will be resumed.

27. Trust Equality Statement

27.1 CHFT aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their gender, race, disability, age, sexual orientation, religion or religious/philosophical belief or marital status.

This policy has been through the Trust's EQUIP (Equality Impact Assessment Process) to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.

28. Monitoring Performance, Compliance and Effectiveness

28.1 Compliance with this policy will be monitored as outlined in the table below:

Criteria	Monitoring Mechanism	Responsible	Frequency	Monitoring Committee
Listening and responding to complaints	Compile reports using Datix information to include: Number of complaints received and compliance with the agreed deadline for complaint response; and analysis of themes	Patient Advice & Complaints Manager	Monthly	Board Performance Report Patient Experience and Caring Group
	Summary of open complaints to Divisional Directors	Patient Advice & Complaints Manager	Weekly	

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	Compile a report using Datix information to include referrals to monitoring bodies	Patient Advice & Complaints Manager	Monthly	Patient Experience and Caring Group
Complainants are not to be treated differently as a result of raising a complaint	Compile reports using patient survey tools to inform: Patient experience as an inpatient and feedback generally	Patient Experience Lead	Quarterly Quality Report	Patient Experience and Caring Group and Quality Report
Improvements made as a result of concerns/complaints being made	Compile report of changes in practice as a result concerns/complaints	Patient Advice & Complaints Manager	Quarterly Complaints Report	Patient Experience and Caring Group Quality Committee

28.2 Annual Complaints Report

28.2.1 As detailed in section 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009 CHFT is required to produce an annual complaints report that:

- (a) specifies the number of complaints which the responsible body received;
- (b) specifies the number of complaints which the responsible body decided were well-founded;
- (c) specifies the number of complaints which the responsible body has been informed have been referred to:
 - (i) the Health Service Commissioner to consider under the 1993 Act; or
 - (ii) the Local Commissioner to consider under the Local Government Act 1974; and
- (d) summarise:
 - (i) the subject matter of complaints that the responsible body received;
 - (ii) any matters of general importance arising out of those complaints, or the way in which the complaints were handled;
 - (iii) any matters where action has been or is to be taken to improve services as a consequence of those complaints.

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28.2.2 The Trust has a duty to send a copy of the report to the Clinical Commissioning Group who commissions services from the Trust and also to ensure that this report is available to any person on request.

28.3 Aggregated analysis

28.3.1 In order that the Trust is able to identify emerging safety and quality themes, an aggregated quality report that includes data from incidents, complaints and claims will be produced on a quarterly basis. The Risk Management Team will be responsible for producing the report and disseminating it to the following committees:

- Quality Committee (sub-committee or the Board, who will review themes and request further action as required)
- Quality Board (Commissioners and Trust Committee for information and assurance)

28.3.2 The minimum requirements for reporting aggregated data will consist of the following:

- Top 3 category themes for incidents, complaints and claims for the quarter being reported.
- Top 3 SI themes for a 6 month period.
- Trust actions in response to identified themes.
- Quantitative analysis of incidents, complaints and claims by Division for the preceding 12 months.

28.3.3 The contents and frequency of aggregated reports provided to Groups and Committees will be subject to an annual review by the Quality Committee, to ensure the minimum reporting requirements are met.

28.3.4 Data in relation to safety lessons and improvements will be disseminated to staff through the Trust newsletter.

29. References

29.1 Supporting References and Bibliography

- Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
- Data Protection Act
- Freedom of Information Act

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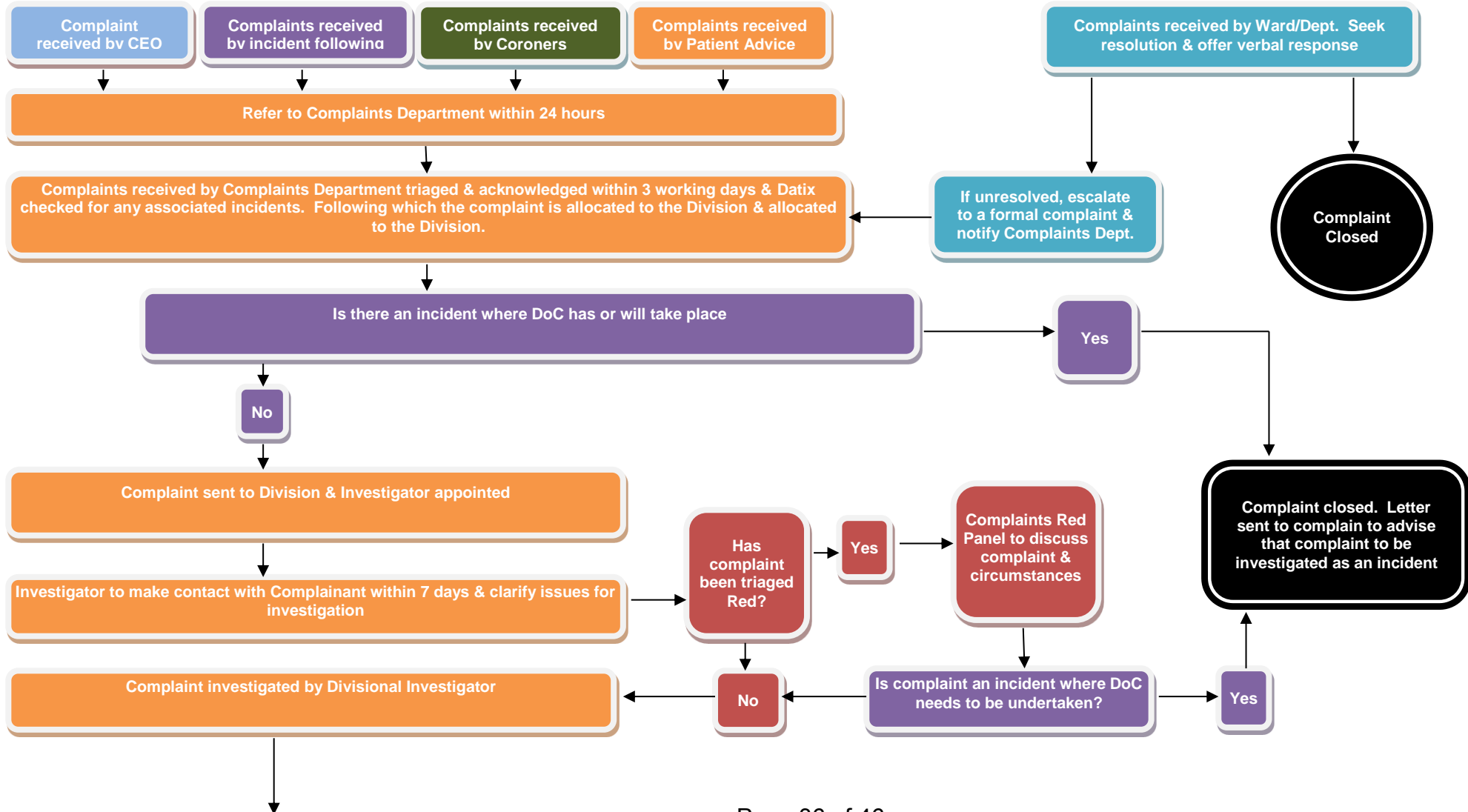
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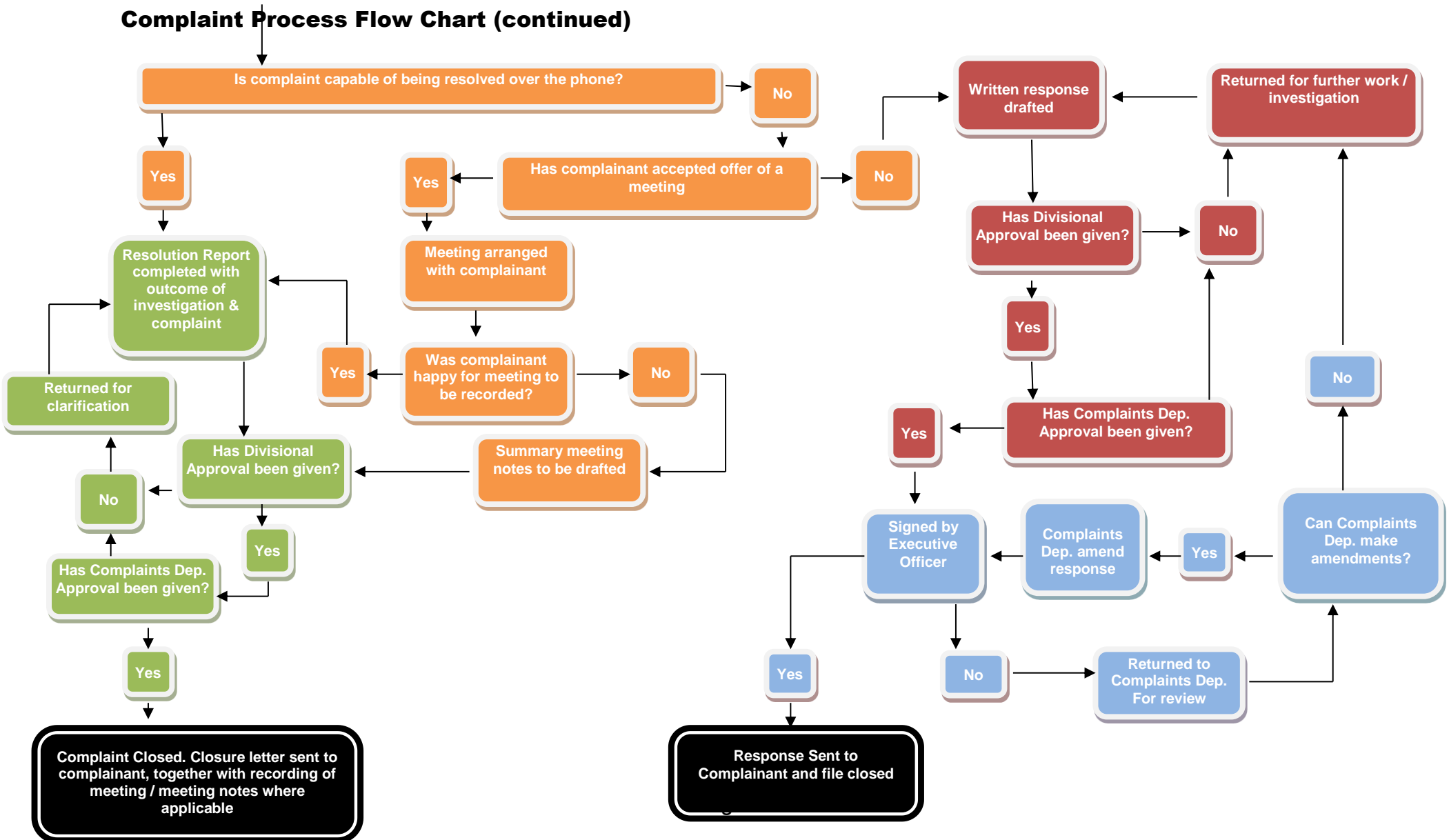
- NHS Constitution (DH, 2009)
- The Principles of Good Complaint Handling (Parliamentary and Health Service Ombudsman, 2008)
- Department of Health (2009) Listening, improving, responding: a guide to better customer care
- NHSLA Litigation Authority guidance about complaints
- My Expectations for Raising Complaints and Concerns (Parliamentary & Health Service Ombudsman, 2014)
- National Health Service Litigation Authority (2002). Litigation Circular No: 02/02: Apologies and Explanations, February 2002.
- NHSLA (2012) NHSLA Risk Management Standards 2013-14 for NHS Trusts.
- Care Quality Commission Core Standards

Complaint Process Flow Chart



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Complaint Process Flow Chart (continued)



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APPENDIX 2

Complaint Triage Form

BASIC DETAILS				DATIX ID:	
Date Received by PACS:		Assessed by:			
Date Reviewed:					
Complainant:		Patient:			
How was complaint received:	Letter / E-mail / Phone call / website / other				
INITIAL REVIEW		Comment			
Is consent required?	Y / N				
Are there safeguarding concerns?	Y / N	Category 1 Concerns? (Low Level)	Category 2 Concerns? (Refer to Karen Hemsworth)		
Are there equality & diversity issues?	Y / N	<i>(Copy all to Ruth Mason, Equality and Diversity lead and Lead for characteristic)</i>			
Does this relate to End of life?	Y / N	Copy to Mary Kiely and Gillian Sykes for awareness			
Does this relate to cancer care?	Y / N	Copy to Julie Hoole for awareness			
Is a Mortality review required? <i>Patients who have died in our care or within 3 months of leaving hospital</i>	Y / N	Advise Carole Hallam and Andrea McCourt			
Is this linked to an incident &/or a PALS? <i>Link records on Datix</i>	Y / N	Incident No: PALS No:			
SEVERITY (see separate guidance for completion)					
CONSEQUENCE	LIKELIHOOD OF RECURRENCE				
	Frequent	Probable	Occasional	Uncommon	Remote
Serious	HIGH	HIGH	HIGH	MEDIUM	MEDIUM
Major	HIGH	HIGH	MEDIUM	MEDIUM	MEDIUM
Moderate	HIGH	MEDIUM	MEDIUM	MEDIUM	LOW
Minor	MEDIUM	MEDIUM	LOW	LOW	LOW
Minimum	LOW	LOW	LOW	LOW	LOW
If HIGH (Red) confirmed by:				Date:	
Is Complaint Panel Required:	YES		NO		
Instructions to Complaints Team / Advice to investigator					
Lead Division:	COMM / CORP / ESTATES / FSS / MED / SAS				
Other Divisions:	COMM / CORP / ESTATES / FSS / MED / SAS				
Does the complaint involve other Organisations?	List all organisations required to comment on the complaint:				

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SUMMARY OF COMPLAINT							
COMPLAINANTS STATED AIMS / DESIRED OUTCOME							
Apologies		Compensation		Disciplinary action		Explanation	
Investigation		Learning		Other:			
Subject of Complaint							
Subject KO41A	Sub-Subject / Issue			Directorate	Division	Staff type	
Clinical Treatment							
Access to treatment or drugs (including decisions made by Commissioners)							
Admissions, discharge and transfers (excluding delayed discharge due to absence of care package)							
Appointments (including delays and cancellations)							
Commissioning Services							
Communications							
Consent to treatment							
End of Life Care							
Facilities Services							
Integrated Care							
Mortuary and post-mortem arrangements							
Patient Care (including Nutrition /							

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Hydration)				
Prescribing errors				
Privacy, dignity and wellbeing				
Restraint				
Staffing numbers				
Staff – Values and Behaviours				
Transport (Ambulances only)				
Trust Administration				
Waiting Times				
Other				

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RISK ASSESSMENT TOOL

The risk assessment tool adopts a 3 step process which first **categorises the consequences** of a complaint then **assesses the likelihood of recurrence** of the incidents or events giving rise to the complaint. Finally a **risk level is assigned** to the complaint.

Consequence Categorisation Table

The following table assists in determining how to categorise the consequence of a complaint or the subject matter of a complaint.

Category	Description
Serious	Issues regarding serious adverse events, long-term damage, grossly substandard care, professional misconduct or death that require investigation. Serious safety issues. Probability of litigation high.
Major	Significant issues of standards, quality of care, or denial of rights. Complaints with clear quality assurance or risk management implications or issues causing lasting detriment that require investigation. Possibility of litigation.
Moderate	Potential to impact on service provision/delivery. Legitimate consumer concern but not causing lasting detriment. Slight potential for litigation.
Minor	Minimum impact and relative minimal risk to the provision of care or the service. No real risk of litigation.
Minimum	No impact or risk to provision of care

Likelihood Categorisation Table

Likelihood	Description
Frequent	Recurring – found or experienced often
Probable	Will probably occur several times a year
Occasional	Happening from time to time – not constant, regular
Uncommon	Rare – unusual but may have happened before
Remote	Isolated or “one off” – slight/vague connection to service provision

Risk Assessment Matrix

Having assessed the consequence and likelihood categories using the tables above, the risk assessment matrix below can be used to determine the level of risk that should be assigned to the complaint.

RISK GRADING					
Consequence	Likelihood of recurrence				
	Frequent	Probable	Occasional	Uncommon	Remote
Serious	HIGH				
Major					
Moderate			MEDIUM		
Minor					
Minimum					LOW

Resolution Report (to be completed when the complainant does not want a written response)		
Datix number		
Investigating Officer		
Complainant Name		
Patient Name (if different to the above)		
Date of first contact with complainant		
Date of informal resolution with complainant		
Complainant satisfied with resolution and closure	YES	NO
Has Learning Action Plan been completed	YES	NO
Key issues of complaint (as agreed with complainant):		
<p>Evidence used to investigate Complaint:</p> <p>Patient Records: (Please list all records and imagines review to investigate complete. These should include the dates of the records)</p> <ul style="list-style-type: none"> • <p>Staff Statements (Please list all staff members including their job titles, who have provided comments. Dates when comments were provided should be included)</p> <ul style="list-style-type: none"> • <p>Policies and Guidelines (Please list all policies and guidelines that are relevant to the treatment being complained about)</p> <ul style="list-style-type: none"> • 		

UNIQUE IDENTIFIER NO: G-106-2015
EQUIP-2017-046
Review Date: July 2019
Review Lead: Director of Nursing

Response to Key Issues of Complaint:

Overall Outcome of the Complaint

Outcome of the complaint:

(delete as appropriate)

Upheld

Partially Upheld

Not upheld

Summary reason for Outcome decision:

Divisional sign off and
verified by:

UNIQUE IDENTIFIER NO: G-106-2015
 EQUIP-2017-046
 Review Date: July 2019
 Review Lead: Director of Nursing

Captured Learning

ACTION PLAN DEVELOPED BY _____ **DATE** _____

ACTION PLAN SIGNED OFF BY _____ **DATE** _____

Issue Identified and the Root Cause/ Contributing Factor	Agreed Action	Level of Recommended action Individual Team Directorate Organisation	By Whom	Planned Action Start Date	Planned Action End Date	Resources Required	Expected Outcome	How will completion be Evidenced and date provided to Complaints Department

Review Date:

Review Lead:

COMPLAINT QUALITY ASSESSMENT CHECKLIST

Divisional Sign Off

DATIX ID		SEVERITY	G	O	R
Author of draft response					
Date response due					
Date draft received					
Communication with Complainant					
Meeting offered	Y	N	If NO why?		
Response Date Agreed	Y	N			
Extension Requested	Y	N	Draft received in target	Y	N
Involvement and Support for Staff					
All staff involved aware of issues and had opportunity to respond					√
Any staff named in the response aware of response being made					
Where appropriate chronology has been established					
Action Plan completed					
How learning will be shared					
Date learning will be shared					
Response Letter					
					√
In line with Duty of Candour			All acronyms explained		
Shows empathy and compassion			No medical/technical jargon		
Includes appropriate apology			Evidence of learning		
Personalised			Spellings and grammar correct		

Reviewed By..... Date.....

ACTION Approved to send to Complaints Team
 Return to Investigator
 Complainant updated if response will be delayed

WRITING A 'FIT FOR PURPOSE' RESPONSE

A 'fit for purpose' response means:

- Writing in plain English. In particular, do not forget to explain any medical or technical terms and make sure you do not use acronyms without explaining what they mean. Consider whether other formats could be made available if requested. Avoid unnecessary adjectives e.g. *It was **clearly** documented - It was documented.*
- Ensure that you address all the key issues you agreed to address at the outset. If some points are not addressed, explain why.
- Explaining the steps taken to investigate the complaint and stating what evidence you have taken into account, including
 - The complainant's account of events;
 - The account of events by the person(s) complained about (if relevant);
 - Relevant documentation, including medical records;
 - Relevant law, policy, guidance and procedures (quote when appropriate); and
 - Any independent clinical or professional advice taken.
- Giving a thorough explanation of what you think happened and, if different, what you think should have happened. State your conclusions based on the evidence. Address any conflicting evidence or lack of evidence. Make sure that your decision is clear.
- Apologising if something has gone wrong. Remember that an apology is not an admission of liability. In many cases a genuine apology and a thorough explanation can resolve a complaint.
- Informing the complainant of any actions you will take as a result of the complaint and of the lessons learnt, and how you will keep the complainant updated if applicable (such as when a policy is updated, training has taken place, or new patient information has been produced).
- Providing any other remedy, including financial redress, as necessary.
- Ensuring that the final response is signed by the responsible person or person authorised to act on his or her behalf, and includes clear signposting to the Health Service Ombudsman (with contact details) in the event that the complainant remains unsatisfied.

Approved Minute

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Cover Sheet

Meeting: Board of Directors	Report Author: Sue Laycock, PA to Chief Operating Officer
Date: Thursday, 3rd August 2017	Sponsoring Director: Helen Barker, Chief Operating Officer
Title and brief summary: Integrated Performance Report - The Board is asked to receive and approve the Integrated Performance Report for June 2017	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Weekly Executive Board (27.7.17)	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

June's Performance Score stands at 58% for the Trust. The CARING domain now AMBER due to improvements in FFT performance. The RESPONSIVE domain remains Amber failing to meet the Emergency Care Standard and both Cancer 2 week wait targets. Issues are a combination of increased referrals through fast track, IR35 and EPR impact. The WORKFORCE domain has fallen 10 points in-month due to underachievement in Mandatory Training.

EPR still continues to impact on the provision of several indicators this month including 18 weeks admitted and non-admitted and VTE

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to receive and approve the Integrated Performance Report for June 2017

Appendix

Attachment:

Board Report June 2017.pdf

Board Report

June 2017



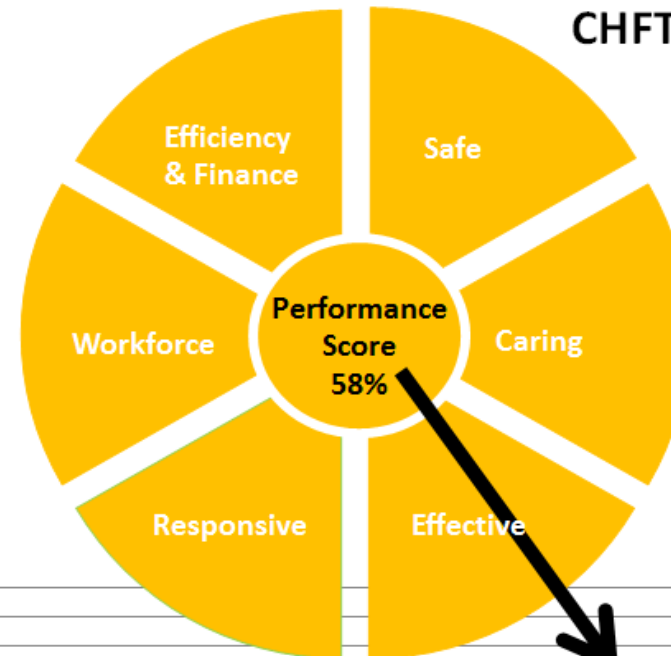
Performance Summary

June

RAG Movement

June's Performance Score stands at 58% for the Trust. The CARING domain now AMBER due to improvements in FFT performance. The RESPONSIVE domain remains Amber failing to meet the Emergency Care Standard and both Cancer 2 week wait targets. Issues are a combination of increased referrals through fast track, IR35 and EPR impact. The WORKFORCE domain has fallen 10 points in-month due to underachievement in Mandatory Training.

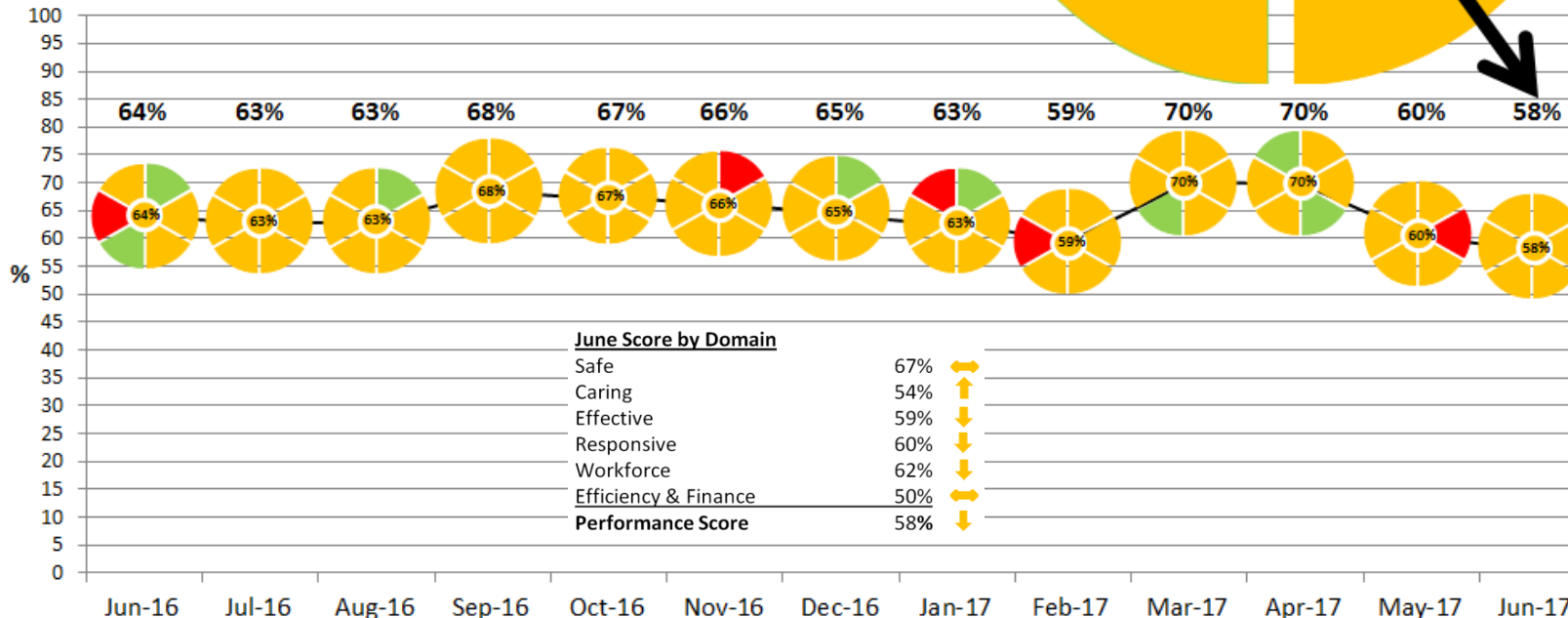
EPR still continues to impact on the provision of several indicators this month including 18 weeks admitted and non-admitted and VTE.



CHFT

SINGLE OVERSIGHT FRAMEWORK

SAFE	Emergency C-Section Rate
VTE Assessments	Never Events
CARING	FFT Maternity
FFT Community FFT OP	FFT IP FFT A&E
Mixed sex accommodation breaches	% Complaints closed
EFFECTIVE	
CDiff Cases	Avoidable Cdiff
MRSA	SHMI
HSMR	HSMR - Weekend
Emergency Readmissions GHCCG	Emergency Readmissions CCCG



RESPONSIVE	Diagnostics 6 weeks
RTT Incomplete Pathways	ECS 4 hours
Cancer 62 day Screening to Treatment	Cancer 62 day Referral to Treatment
FINANCE	
Variance from Plan	Use of Resources
WORKFORCE	
Proportion of Temporary Staff	Sickness
Staff turnover	Executive Turnover

Carter Dashboard

	Current Month Score	Previous Month	Trend	Target
CARING Friends & Family Test (IP Survey) - % would recommend the Service	95.3%	98.3%	↓	96.3%
Inpatient Complaints per 1000 bed days	1.9	2.4	↑	TBC
EFFECTIVE Average Length of Stay - Overall	4.43	4.46	↑	5.17
Delayed Transfers of Care	2.80%	2.70%	↓	5%
Green Cross Patients (Snapshot at month end)	77	119	↑	40
Hospital Standardised Mortality Rate (1 yr Rolling Data)	100.85	101.41	↑	100
Theatre Utilisation (TT) - Trust	81.3%	81.3%	↔	92.5%

MOST IMPROVED

Improved: Total number of Complaints received and re-opened in June was the lowest in over 12 months.

Improved: Number of Category 4 Pressure Ulcers Acquired at CHFT was zero in May, last achieved in December 2016.

Improved: Falls per 1000 bed days was at its lowest position for over 12 months for the second month running.

MOST DETERIORATED

Deteriorated: Cancer performance across Two Week Waits continued to be poor impacting on both day 38 and 62 days. Issues are a combination of increased referrals through fast track, IR35 and EPR impact.

Deteriorated: Number of Incidents with Harm peaked at 219 in June - highest number in over 12 months.

Deteriorated: There were 5 Mixed Sex Accommodation Breaches in ICU in June - highest number for over 12 months.

TREND ARROWS:
Red or Green depending on whether target is being achieved
Arrow upwards means improving month on month
Arrow downwards means deteriorating month on month.

ACTIONS

Action: Escalated performance reviews of each tumour site to deep dive into issues with presentation to Executive Board. Daily review of fast track registration implemented, DNA issues reducing as letter production problems are resolved. All tumour sites reviewing pathways and escalation response to be tracked. 2ww breaches and tracking issues have impacted on 62 day performance with a further deterioration to a fail position expected in July.

Action: This is a higher than usual level of incidents with harm but is still within normal variation. The underlying themes are being explored and will be monitored for any trends.

Action: All Duty of Candour requirements have been met. Root Cause Analysis has been undertaken and an action plan has been put in place.

Arrow direction count



2



8



9

RESPONSIVE % Last Minute Cancellations to Elective Surgery	0.66%	0.93%	↑	0.6%
Emergency Care Standard 4 hours	92.03%	85.11%	↑	95%
% Incomplete Pathways <18 Weeks	92.58%	94.34%	↓	92%
62 Day GP Referral to Treatment	88.1%	91.5%	↓	85%
SAFE % Harm Free Care	93.14%	93.96%	↓	95.0%
Number of Outliers (Bed Days)	537	1045	↑	495
Number of Serious Incidents	6	4	↓	0
Never Events	0	0	↔	0

PEOPLE, MANAGEMENT & CULTURE: WELL-LED

	Current Month Score	Previous Month	Trend	Target
Doctors Hours per Patient Day				
Care Hours per Patient Day	7.5	7.9	↓	
Sickness Absence Rate	3.88%	3.61%	↓	4.0%
Turnover rate (%) (Rolling 12m)	12.97%	12.00%	↓	12.3%
Vacancy	380.54	393.09	↑	NA
FFT Staff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q1	81%	Different division sampled each quarter. Comparisons not applicable		
FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly) Q1	63%	Different division samples each quarter. Comparisons not applicable		

OUR MONEY

	Current Month Score	Previous Month	Trend
Income vs Plan var (£m)	-£4.24	-£2.17	●
Expenditure vs Plan var (£m)	£4.41	£2.29	●
Liquidity (Days)	-22.92	-24.40	●
I&E: Surplus / (Deficit) var - Control Total basis (£m)	£0.02	£0.00	●
CIP var (£m)	-£0.17	-£0.11	●
UOR	3	3	●
Temporary Staffing as a % of Trust Pay Bill	13.51%	12.18%	●

Executive Summary

The report covers the period from June 2016 to allow comparison with historic performance. However the key messages and targets relate to June 2017 for the financial year 2017/18.

Area	Domain
Safe	<ul style="list-style-type: none"> • % Harm Free Care - Performance has dipped again to 93.14% and remains below target. A deep dive review has now been completed and will be shared through divisional teams and improvement leads. • Number of Incidents with Harm - Numbers peaked in June with 219. This is a higher than usual level of incidents with harm but is still within normal variation. The underlying themes are being explored and will be monitored for any trends.
	<ul style="list-style-type: none"> • Complaints closed within timeframe - Of the 54 complaints closed in June, 46% of these were closed within target timeframe. The number of overdue complaints was 29 at the end of June; which was an 11.5% increase from the end of May. This increase was to be expected with the introduction of EPR at the beginning of May, which has had a knock-on effect on workload within the Divisions. The overall percentage for complaints closed within target timeframe last year (2016-17) was 45%. • Friends & Family Test (IP Survey) - % would recommend the Service - this is the first time that performance has dipped below target. The Trust recognises that there are specific clinical areas that need to be targetted to improve performance. • Friends and Family Test Outpatients Survey - % would recommend the Service - Performance has improved to pre-EPR levels but is still not achieving target. • Friends and Family Test A & E Survey - Response Rate - improved to 10.75% in month. The ED team have revisited and refreshed their FFT action plan and refocused the team in encouraging patient participation. • Friends and Family Test A & E Survey - % would recommend the Service - improved in month to 85% just below 86.5% target. • Friends and Family Test Community Survey - Community FFT reported 87% would recommend the service against a 96% national average. 4% of people would not recommend services. The division is waiting for the new server that has been ordered to move to the new web form for collecting FFT data which will provide more accurate and helpful information about how services can be improved. • Mixed Sex Accommodation Breaches - There were 5 breaches in month in ICU. All Duty of Candour requirements have been met. Root Cause Analysis has been undertaken and an action plan has been put in place.
Caring	<ul style="list-style-type: none"> • Total Number of Clostridium Difficile Cases - 4 in month in Medicine. Shared learning has heightened awareness of SIGHT acronym regarding prompt isolation of symptomatic patients. • Number of E.Coli - Post 48 Hours - 5 in month (Medicine 4). Analysis being undertaken by the lead ICPN And Consultant microbiologist.
	<ul style="list-style-type: none"> • Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge - June's performance continued at May's level underachieving against target. A new process is now in place to improve the overall management of Trauma and hip fracture patients. A draft surgical pathway has been developed and circulated to the Consultant body.
Effective	

Background Context

The Electronic Patient Record (EPR) deployed in May is still presenting some challenges within the Trust, particularly in relation to productivity, capacity and the recording and reporting of data. The Trust continues to work through these issues alongside teams from Cymbio who were enlisted during go-live to assist with subsequent data quality issues.

The Appointment team have had a challenging couple of months as they continue to adapt to EPR and new processes for the booking of patients - their hard work is paying off as call wait times continue to improve but some configuration issues remain which result in longer contact time required for each transaction. DNA rates have been reducing in June but overall activity and income are reduced across most points of delivery.

The Medical division is continuing to work through post EPR related issues regarding ECS and the flow of patients through both hospitals. Whilst ECS performance has not been sustained at 95% the Trust is on an upward trajectory. On the back of two very challenging days in June we conducted a deep dive into issues and have now formulated a Trustwide action plan to address themes picked up in this review. This forms the foundation for improvement work in the coming months.

Similarly, the acute admissions units and inpatient wards are continuing to focus on timely discharges and tackling delays on a day to day basis which will help flow; again the action plan referenced above will address the movement of patients through our hospitals.

Clinical leaders within Medicine have initiated a number of action plans improve all aspects of patient experience.

The strategy going forward will be about identifying the one or two actions individual teams need to undertake to make an impact rather than providing broad action plans across the division. This methodology which is intelligence driven is already making an impact and hopefully will provide a marked improvement for the division.

Executive Summary

The report covers the period from June 2016 to allow comparison with historic performance. However the key messages and targets relate to June 2017 for the financial year 2017/18.

Area	Domain
Responsive	<ul style="list-style-type: none"> Emergency Care Standard 4 hours was at 92% for June - still experiencing gaps in service around staffing levels, surge in activity and capacity issues with increased focuss and earlier escalation implemented. Stroke - % Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival has remained at 54.2% in month. 36% Stroke patients were scanned within 1 hour of hospital arrival (where indicated) against 48% target. Two Week Wait From Referral to Date First Seen - missed the 93% target for the 2nd month. Extra Locums have been brought in to meet the increased demand however routine appointments are being cancelled to ensure the 2ww patients are being seen, resulting in routine patients having to wait longer. Two Week Wait From Referral to Date First Seen: Breast Symptoms - missed the 93% for the first time in last 12 months. 38 Day Referral to Tertiary - at 20% still well below the 85% target and below 42.4% achieved in 2016/17.
	<ul style="list-style-type: none"> Return to work Interviews have fallen again in month to 45.13%, worst position in over 12 months. HR Advisers are identifying episodes of sickness absence without return to work interviews being undertaken and will contact line managers to understand the reasons why and encourage them to be completed and recorded without further delay.
Workforce	<ul style="list-style-type: none"> Finance: Reported year to date Deficit position in line with agreed control total of £8.02m, <ul style="list-style-type: none"> Capital expenditure is below plan, Cash position is in line with plan at £1.90m. Delivery of CIP is behind the planned level at £2.15m against a planned level of £2.32m. A Use of Resources score of level 3, in line with the plan. <p>The Month 3 planned position is a deficit of £8m on a control total basis, including year to date Sustainability and Transformation funding (STF) of £1.52m. However, the financial position remains extremely precarious with activity and income even further below the planned level seen last month. EPR implementation continues to have a significant impact on both productivity and the capture of activity data. Prior to any action being taken to assume either clawback of activity capture or overlay of other non-recurrent benefits, the month 3 position was a deficit of £13m, a £5m adverse variance to plan.</p> <p>Month 3 prior to action: adverse variance to plan (£5m) Add back: Assessment of missing activity data £2.4m Non-recurrent benefits M2 £1.1m Non-recurrent benefits M3 £1.5m</p> <p>Month 3 position to report: nil variance to plan £0.0m Total reported agency spend in month was £1.46m; as planned and in line with the NHS Improvement Agency Ceiling, however this value excludes agency expenditure capitalised as part of EPR implementation costs.</p> <p>The number of reported Agency Cap breaches remained very high, but was slightly lower than the level seen in May. The forecast continues to assume that the Trust will achieve its Control Total and secure the £10.1m STF allocation. However, the forecast assumes that activity returns to the planned level from July, with no further EPR relate income losses. It also assumes that the remaining £3.2m of unidentified CIP is delivered. The risk of failing to achieve the target deficit of £15.94m therefore remains extremely high and further action is required to stabilise the financial position.</p>
	<p>Finance</p>

Background Context

Consultant vacancies remain a challenge in Medical specialties particularly AED, Elderly Care and Respiratory which have been further compounded by sickness in Cardiology. Within Surgical specialties Urology and Ophthalmology continue to be underestablished impacting on activity.

Several workforce initiatives have been actioned in month with a large cohort of Physician Associates, Advanced Clinical Practitioners and Cardiophysicologists appointed into training to ensure a more robust clinical workforce in the future, this has been positively received by clinical teams.

A large cohort of Enhanced Care Workers to provide 1:1 care commenced in-month improving care and support to vulnerable patients whilst also reducing agency costs.

The MSK First point of contact went Live 1st June. This service provides triage of all referrals to Orthopaedics with new pathways for joint, pain and muscular conditions so that patients can benefit from conservative treatment wherever possible.

The physiotherapy service has commenced a telephone assessment service. This is intended to reduce the number of people requiring face to face contact with a physiotherapist to shorten waiting times and enable people in need of hands on therapy to receive this in a timely manner.

Pathology and Radiology teams have seen a peak in referrals in June and fast track referrals have also increased putting pressure on support services and impacting on cancer performance.

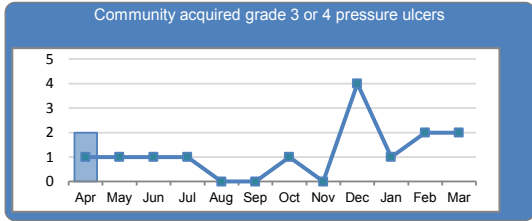
Regulatory reporting continues however internal reports required to support the management of activity are not yet available for operational use impacting on ability to proactively track activity.

Safe, Effective, Caring, Responsive - Community Key messages

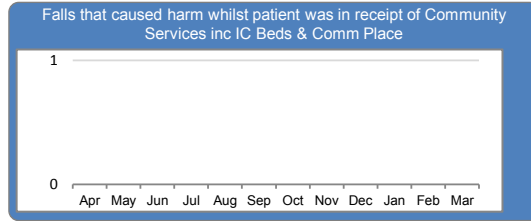
Area	Reality	Response	Result
Safe	<p><u>Wound care</u> Focus on wound care and pressure ulcer management has been undertaken in community in recent months.</p>	<p><u>Wound care</u> New wound care pathways have been developed with the support of the TVN. This links to the CQUIN that requires all wounds to be assessed regularly and care plans reviewed at least every 4 weeks.</p>	<p><u>Wound care</u> We aim to have fully achieved the CQUIN and reduced wound healing rates with the new pathways.</p> <p>By when: Review September 2017 Accountable: ADN</p>
Effective	<p><u>Length of stay in intermediate tier services</u> Length of stay in intermediate tier services has reduced this month and there have been fewer delays into reablement or out of reablement into packages of care.</p>	<p><u>Length of stay in intermediate tier services</u> LOS will continue to be monitored. A new model for intermediate care is being developed to support the new rehab pathway and the reduction in rehabilitation beds in the hospital.</p>	<p><u>Intermediate Tier services</u> Improved intermediate tier service offer will be developed and offered by October 2017.</p> <p>By when: October 2017 Accountable: Intermediate Tier service manager</p>
Caring	<p><u>End of life patients</u> We continue to focus on ensuring that patients are supported appropriately at the end of their life and that they die in their preferred place of death. 3 patients died in the hospice in June when they indicated a preferred place of death was home. All patients deteriorated rapidly and the family requested patient moved to hospice.</p>	<p><u>End of life patients</u> We monitor each patient and review each case where the preferred place of death and the actual place of death are different.</p>	<p><u>End of life patients</u> To support patients and their families so that anyone wishing to die at home gets the support they need to remain at home even when they deteriorate.</p> <p>By when: Review September 2017 Accountable: ADN</p>
Responsiveness	<p><u>Physiotherapy waiting times</u> Physiotherapy waiting times are now at 15 weeks.</p>	<p><u>Physiotherapy waiting times</u> The physiotherapy service has commenced a telephone assessment service. This is intended to reduce the number of people requiring face to face contact with a physiotherapist to shorten waiting times and enable people in need of hands on therapy to receive this in a timely manner.</p>	<p><u>Physiotherapy waiting times</u> Physiotherapy waiting times to return to an acceptable performance level of 6 weeks.</p> <p>By when: September 2017</p>

Dashboard - Community

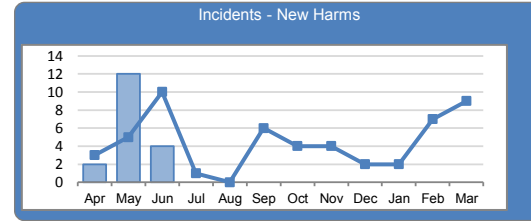
Safe



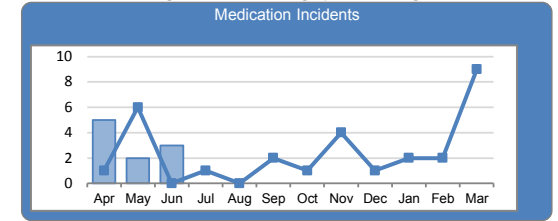
One month in arrears



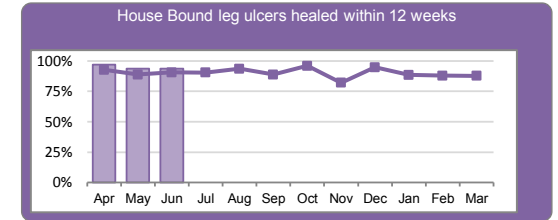
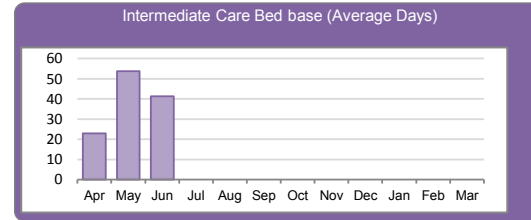
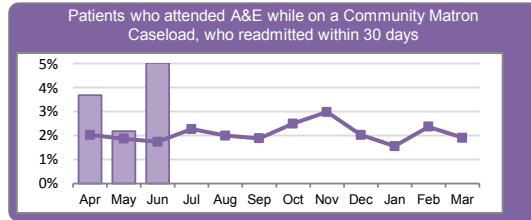
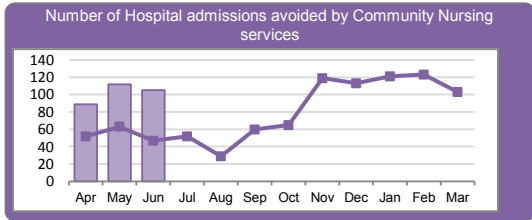
One month in arrears



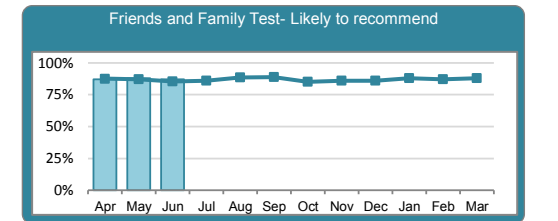
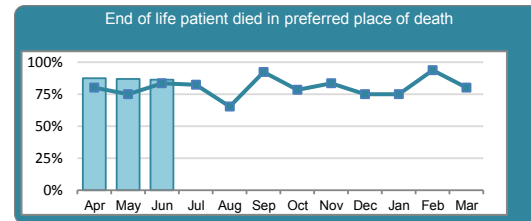
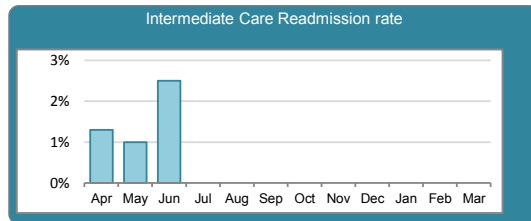
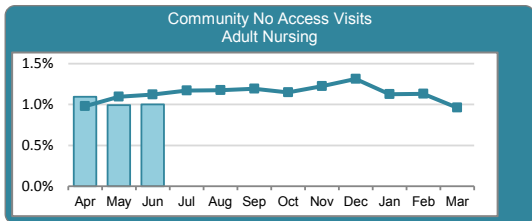
Bar Chart = 17/18 figures Line graph = 16/17 figures



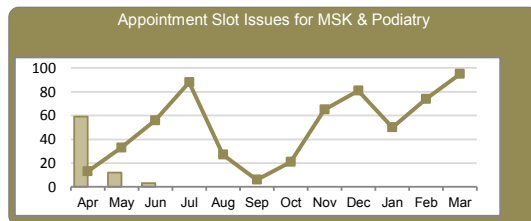
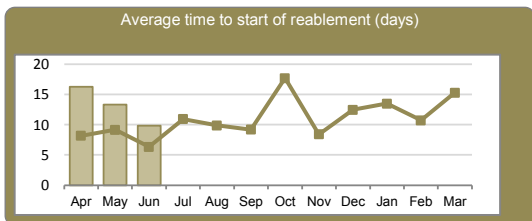
Effective



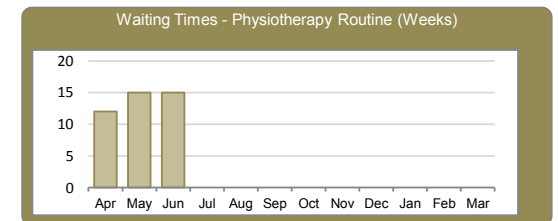
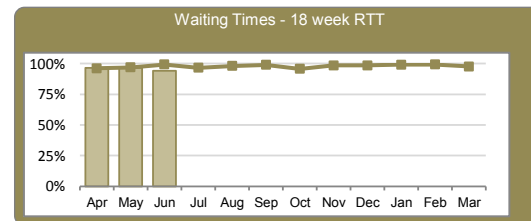
Caring



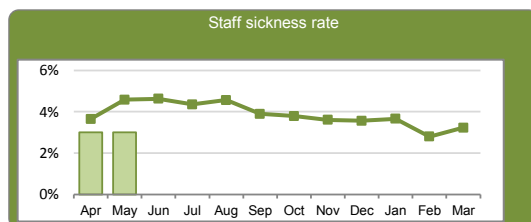
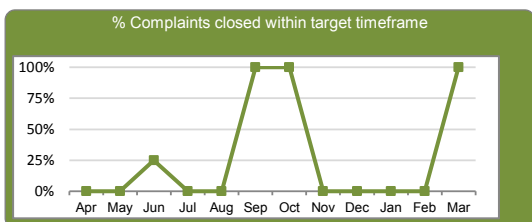
Responsive



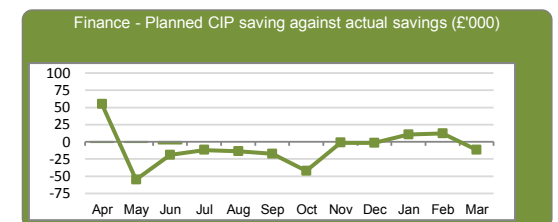
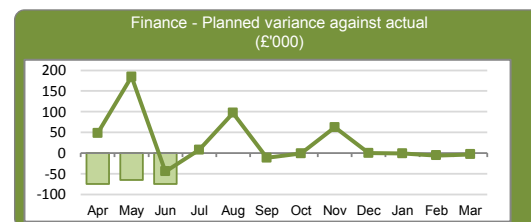
MSK Podiatry



Well Led



One month in arrears



Hard Truths: Safe Staffing Levels

Description	Aggregate Position	Trend	Variation
<p>Registered Staff Day Time</p> <p>Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.</p>	84.56% of expected Registered Nurse hours were achieved for day shifts.		<p>Staffing levels at day <75%</p> <ul style="list-style-type: none"> -WARD 5AD : 73.1% -WARD 5B : 73.2% -WARD 8C : 63.6% -WARD 17 : 61.2% -WARD 19 : 67.7%
<p>Registered Staff Night Time</p> <p>Registered Nurses monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.</p>	92.27% of expected Registered Nurse hours were achieved for night shifts.		<p>Staffing levels at night <75%</p> <ul style="list-style-type: none"> -WARD 12 : 69.1% -WARD 17 : 68.2% -WARD 8AB : 68.3% -WARD 8D : 66.7% -WARD 15 : 68.9%
<p>Clinical Support Worker Day Time</p> <p>Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Day time shifts only.</p>	102.67 % of expected Care Support Worker hours were achieved for night shifts.		<p>Staffing levels at day <75%</p> <ul style="list-style-type: none"> -WARD 8AB : 69.0% -WARD LDRP : 67.5% -WARD NICU : 69.1% -WARD 3ABCD : 66.7% -WARD 18 : 54.5%
<p>Clinical Support Worker Night Time</p> <p>Care Support Worker monthly expected hours by shift versus actual monthly hours per shift only. Night time shifts only.</p>	113.60 % of expected Care Support Worker hours were achieved for night shifts.		<p>Staffing levels at night <75%</p> <ul style="list-style-type: none"> -WARD LDRP : 73.3%

Hard Truths: Safe Staffing Levels (2)

Staffing Levels - Nursing & Clinical Support Workers

Ward	Main Specialty on Each Ward	DAY						NIGHT					
		Registered Nurses		Care Staff		Average Fill Rate - Registered Nurses (%)	Average Fill Rate - Care Staff (%)	Registered Nurses		Care Staff		Average Fill Rate - Registered Nurses (%)	Average Fill Rate - Care Staff (%)
		Expected	Actual	Expected	Actual			Expected	Actual	Expected	Actual		
CRH MAU	GENERAL MEDICINE	2430	2053	1620	1485	84.5%	91.7%	1320	1336.3	990	1023	101.2%	103.3%
HRI MAU	GENERAL MEDICINE	2655	2559	1620	2040	96.4%	125.9%	1320	1529	990	1295	115.8%	130.8%
WARD 2AB	GENERAL MEDICINE	1845	1506.5	1170	1437.2	81.7%	122.8%	1320	1287	660	770	97.5%	116.7%
HRI Ward 5 (previously ward 4)	GERIATRIC MEDICINE	1620	1300.5	1170	1485.5	80.3%	127.0%	990	979	990	1056	98.9%	106.7%
HRI Ward 11 (previously Ward 5)	CARDIOLOGY	2010	1638.5	975	1011	81.5%	103.7%	1320	1309	660	660	99.2%	100.0%
WARD 5AD	GERIATRIC MEDICINE	2070	1513.5	1530	1872.5	73.1%	122.4%	1320	1280	1320	1324	97.0%	100.3%
WARD 5C	GENERAL MEDICINE	1035	961	810	767	92.9%	94.7%	660	660	330	385	100.0%	116.7%
WARD 6	GENERAL MEDICINE	1620	1530	1170	1095	94.4%	93.6%	990	935	660	651	94.4%	98.6%
WARD 6BC	GENERAL MEDICINE	1620	1544	1170	1198	95.3%	102.4%	1320	1293.4	660	810	98.0%	122.7%
WARD 5B	GENERAL MEDICINE	1170	856.5	720	1247.5	73.2%	173.3%	660	660	660	747	100.0%	113.2%
WARD 6A	GENERAL MEDICINE	945	763.5	945	833	80.8%	88.1%	660	660	330	341	100.0%	103.3%
WARD 8C	GENERAL MEDICINE	552	351	504	491.5	63.6%	97.5%	352	293.5	176	154	83.4%	87.5%
WARD CCU	GENERAL MEDICINE	1620	1374.5	360	312.5	84.8%	86.8%	990	991.5	0	0	100.2%	-
WARD 6D	GENERAL MEDICINE	1620	1224	810	838	75.6%	103.5%	957	860	638	627	89.9%	98.3%
WARD 7AD	GENERAL MEDICINE	1620	1387.5	1530	1552.5	85.6%	101.5%	990	979	990	1012	98.9%	102.2%
WARD 7BC	GENERAL MEDICINE	1458	1278	1377	1522.5	87.7%	110.6%	891	891	891	957	100.0%	107.4%
WARD 8	GERIATRIC MEDICINE	1395	1120	1170	1926	80.3%	164.6%	990	825	990	1441	83.3%	145.6%
WARD 12	MEDICAL ONCOLOGY	1458	1111	729	605	76.2%	83.0%	891	616	297	550	69.1%	185.2%
WARD 17	GASTROENTEROLOGY	1980	1211	1170	1129.66	61.2%	96.6%	990	675.5	660	691	68.2%	104.7%
WARD 21	REHABILITATION	1170	946.5	945	1120	80.9%	118.5%	660	660	660	660	100.0%	100.0%
ICU	CRITICAL CARE	3900	3479.5	795	644	89.2%	81.0%	3795	3317.75	0	0	87.4%	-
WARD 3	GENERAL SURGERY	915	917.85	735	754.5	100.3%	102.7%	690	690	345	349	100.0%	101.2%
WARD 8AB	TRAUMA & ORTHOPAEDICS	1034	864	945	652.5	83.6%	69.0%	943	644	253	514.5	68.3%	203.4%
WARD 8D	ENT	795	798.5	795	676	100.4%	85.0%	690	460	0	230	66.7%	-
WARD 10	GENERAL SURGERY	1260	1175	570	749.5	93.3%	131.5%	1035	899	345	851	86.9%	246.7%
WARD 15	GENERAL SURGERY	1516.5	1408	1049	958	92.8%	91.3%	1035	713	345	966	68.9%	280.0%
WARD 19	TRAUMA & ORTHOPAEDICS	1695	1147	1245	1341.5	67.7%	107.8%	1035	955.5	1035	1070.5	92.3%	103.4%
WARD 20	TRAUMA & ORTHOPAEDICS	1870.5	1407	1319.5	1440.5	75.2%	109.2%	966	943	966	915.5	97.6%	94.8%
WARD 22	UROLOGY	1140	1060	1140	1060	93.0%	93.0%	690	690	690	701.5	100.0%	101.7%
SAU HRI	GENERAL SURGERY	1830	1542	943	891.5	84.3%	94.5%	1380	1292.5	345	351	93.7%	101.7%
WARD LDRP	OBSTETRICS	4140	3597	915	617.3	86.9%	67.5%	4140	3564.5	690	506	86.1%	73.3%
WARD NICU	PAEDIATRICS	2175	1935.5	900	622	89.0%	69.1%	2070	1897.5	690	540.5	91.7%	78.3%
WARD 1D	OBSTETRICS	1200	1092.5	345	345	91.0%	100.0%	690	687	345	328	99.6%	95.1%
WARD 3ABCD	PAEDIATRICS	3037.5	2537.5	1170	780	83.5%	66.7%	2415	2397	345	284	99.3%	82.3%
WARD 4C	Gynaecology	690	690	450	383.3	100.0%	85.2%	667	655.5	333.5	333.5	98.3%	100.0%
WARD 9	OBSTETRICS	1035	908.5	345	274.3	87.8%	79.5%	690	690	345	322	100.0%	93.3%
WARD 18	PAEDIATRICS	767	701	132	72	91.4%	54.5%	690	653.5	0	11.5	94.7%	-
Trust		60893.5	51490.35	35288.5	36231.3	84.56%	102.67%	43212	39870	20624.5	23428.5	92.27%	113.60%

Hard Truths: Safe Staffing Levels

Care Hours per Patient Day

STAFFING - CHPPD & FILL RATES (QUALIFIED & UNQUALIFIED STAFF)

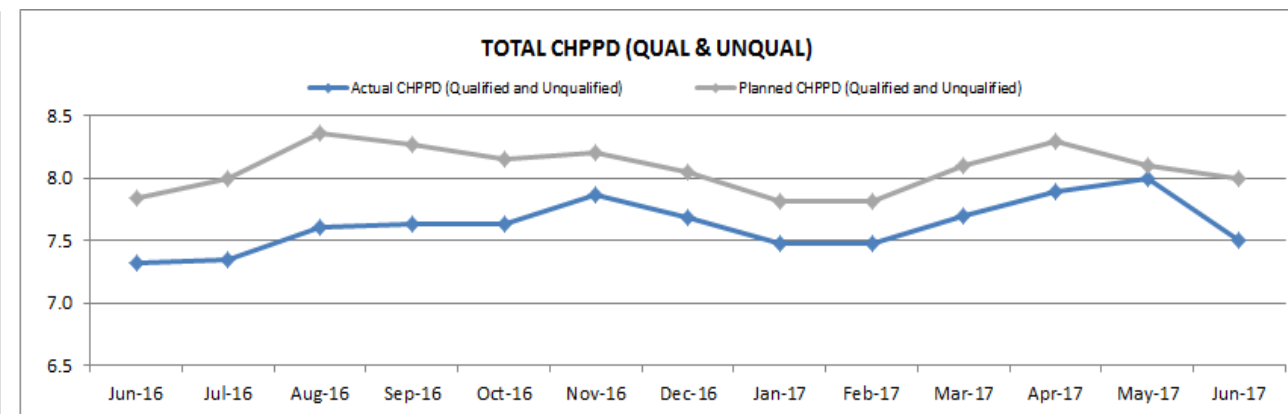
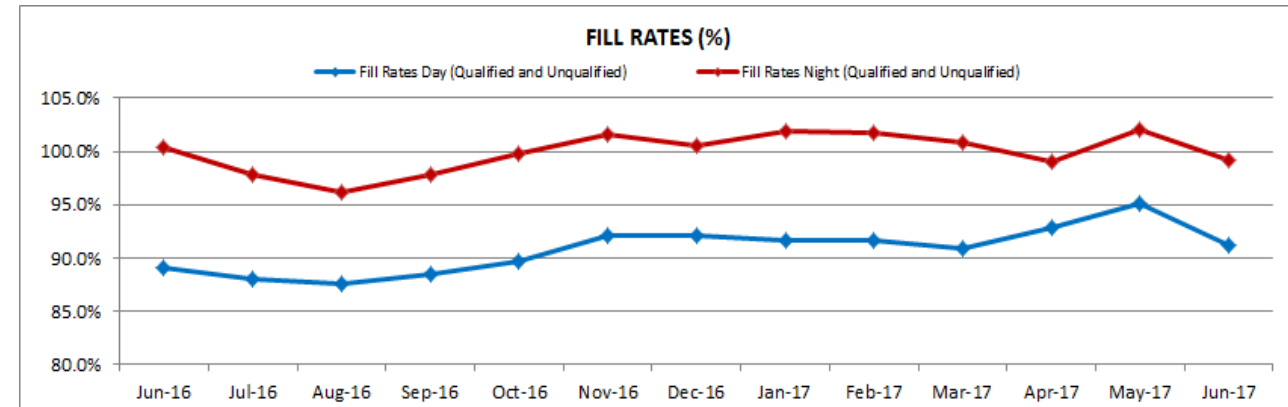
	Apr-17	May-17	Jun-17
Fill Rates Day (Qualified and Unqualified)	92.80%	95.10%	91.20%
Fill Rates Night (Qualified and Unqualified)	99.10%	102.10%	99.20%

	Apr-17	May-17	Jun-17
Planned CHPPD (Qualified and Unqualified)	8.3	8.1	8.0
Actual CHPPD (Qualified and Unqualified)	7.9	8.0	7.5

A review of June 2017 CHPPD data indicates that the combined (RN and carer staff) metric resulted in 27 clinical areas of the 37 reviewed had CHPPD less than planned.

2 areas reported CHPPD as planned. 8 areas' reported CHPPD slightly in excess of those planned.

Areas with CHPPD more than planned was due to additional 1-1's requested throughout the month due to patient acuity in the departments.



Approved Minute

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Cover Sheet

Meeting: Board of Directors	Report Author: Philippa Russell, Senior Finance Manager
Date: Thursday, 3rd August 2017	Sponsoring Director: Gary Boothby, Deputy Director of Finance
Title and brief summary: Financial Commentary for NHS Improvement - Month 3 - The attached commentary was submitted to NHS Improvement on 17th July 2017 alongside the Month 3 Financial Monthly Monitoring return.	
Action required: Note	
Strategic Direction area supported by this paper: Financial Sustainability	
Forums where this paper has previously been considered: Finance and Performance Committee	
Governance Requirements: Financial Sustainability	
Sustainability Implications: None	

Executive Summary

Summary:

For information - see attached.

Main Body

Purpose:

See attached

Background/Overview:

See attached

The Issue:

-

Next Steps:

-

Recommendations:

To Note

Appendix

Attachment:

NHSI Financial Commentary Month 3 Final.pdf

MONTH 3 JUNE 2017, NHS IMPROVEMENT COMMENTARY ON THE FINANCIAL RETURN

The notes below provide a management commentary on the financial position of Calderdale & Huddersfield NHS Foundation Trust at the end of June 2017.

The report is structured into three sections to describe:

- Key messages;
- Detailed commentary for the period with variance analysis against the annual plan as submitted to NHSI;
- Use of Resources rating and forecast.

1. Key Messages

The Month 3 planned position is a deficit of £8.00m on a control total basis, including year to date Sustainability and Transformation funding (STF) of £1.52m.

The final planning submission made to NHSI on 30th March 2017 was an indicator of the Trust's commitment to do all within its power to deliver the £15.9m control total deficit. However, as was communicated from January when the control total was appealed, the Board had a number of concerns regarding the scale of this challenge. Whilst appreciating the overall NHS Provider sector position, it was hoped that a revised control total could be considered. The key risks to delivery were outlined as the abnormal costs of implementation or short term loss of income as a result of EPR implementation and the scale of the CIP challenge at £20m, 5.3%.

As at Month 3 these concerns have not abated. Whilst the Trust is able to report delivery of the financial plan, there are a number of assumptions of a material value that have been made in order to deliver this position. The implementation of EPR continues to have a significant impact on both productivity and the capture of activity data and is driving a material clinical income variance year to date. In addition the year to date position is reliant upon a number of non-recurrent income and expenditure benefits which cannot be replicated going forwards plus the use of 50% of the total contingency reserve available for this financial year.

There is now a significant risk that the Trust will not be able to achieve the 17/18 control total due to a combination of slower than expected recovery following EPR implementation and remaining unidentified CIP of £3.2m. A recovery action plan has been implemented which aims to tackle: the recovery of clinical income at risk due to issues with capture and coding in EPR, the development of Divisional financial recovery plans, a Trust wide establishment review and further tightening of budgetary controls. Every effort will be made to deliver the financial plan, but a continuation of the current situation may make full recovery impossible. Delivery of the financial plan is now the highest risk on the Trust risk register scoring the maximum of 25.

Month 3, June Position (Year to date)

The year to date position at headline level is illustrated below:

Income and Expenditure Summary	Plan £m	Actual £m	Variance £m
Income	92.91	88.68	(4.24)
Expenditure	(94.82)	(90.41)	4.41
EBITDA	(1.90)	(1.74)	0.17
Non-Operating items	(20.09)	(6.29)	13.80
Surplus / (Deficit)	(22.00)	(8.03)	13.97
Less: Items excluded from Control Total	13.98	0.02	(13.95)
Surplus / (Deficit) Control Total basis	(8.02)	(8.00)	0.02

- Delivery of CIP of £2.15m against the planned level of £2.32m.
- Contingency reserves of £1.00m have been released against pressures.
- Capital expenditure of £4.62m, this is below the planned level of £5.43m.
- Cash balance of £1.90m, in line with the plan.
- Use of Resources score of level 3, in line with the plan.

2. Detailed Commentary for the Reporting Period

Statement of Comprehensive Income (SOI)

Operating Income

Operating Income is £4.24m below plan year to date.

NHS Clinical Income

The year to date NHS Clinical income position is £74.33m, £3.81m below the planned level.

The Clinical Contract income position for Month 3 based upon activity coded and captured within EPR is £6.2m below plan. There are a number of areas where activity is either not captured within EPR or a change to patient data is required in order to accurately price the activity. There are also a large number of un-coded spells for which an estimate has had to be made as to the expected price of that activity. EPR implementation also resulted in a temporary decrease in the depth of coding and capture of co-morbidities, impacting across both Emergency Long Stay and A&E income, a reduction in the capture of Best Practice Tariff activity and a resulting impact on the Emergency Threshold. Following discussions with external experts from Cymbio, the Trust's own Health Informatics and Divisional teams, £2.4m of income has been calculated as an estimate of the value of this missing data. The receipt of this income will be reliant on the activity being added or corrected within EPR and an action plan is in place to address a list of issues with this aim.

Following these adjustments, clinical income is still below plan and this appears to be driven by both case mix and activity volumes following implementation of EPR. Further work is being undertaken to identify the impact of HRG4+

The reported position assumes full receipt of STF funding including the 30% linked to A&E performance targets. Performance in the year to date is 90.58% of patients seen within the 4 hour target. This is below the very high levels reported in Quarter 4 of 16/17 and against which our current performance is being compared. The deterioration is as a direct result of both the implementation of EPR and the

adherence to IR35 guidance, and as such should be considered to be exceptional. The Trust is submitting a letter seeking exception for Quarter 1 on this basis. Performance in May dipped to 85.1% but has recovered significantly in June to 92.03%. It is assumed that NHSI will recognise the exceptional nature of the impact of EPR upon A&E performance in Quarter 1 against the backdrop of the Trust's underlying strong A&E performance in 2016/17. Receipt of full STF monies are assumed within the year to date and forecast position.

The Delivery Board sections have not been completed as the Trust is seeking further clarity on this; we are not aware of any requirement or agreement of performance at this level. If this could be clarified we can then review with the delivery Board Chair and respond.

Other income

Overall other income is below plan by £0.42m year to date. This variance is primarily due to lower than planned Cancer Drugs fund income (offset within High Cost Drugs expenditure), slippage in recovery of the Apprentice Levy compared to plan and lower than planned income from ICRU, offset to some extent by increased sales activity within our commercial operations.

Operating expenditure

There is a cumulative £4.41m favourable variance from plan within operating expenditure across the following areas:

Pay costs	£1.65m favourable variance
Drugs costs	£0.31m favourable variance
Clinical supply and other costs	£2.45m favourable variance

Achieving the control total for Month 3 has relied on the release of one half (£1.00m) of our total Contingency Reserve, and a £3.5m credit relating to a negotiated non recurrent refund of PFI facilities management costs, offset by a provision of £1.95m against contract income risks in the year to date position. This is in addition to the non-recurrent benefit of £0.57m relating to prior year creditors and £0.36m of prior year benefits that were released within the Month 2 position and £0.2m non-recurrent income received in Month 1. The total of non-recurrent benefits in the year to date position is £2.69m.

Employee benefits expenses (Pay costs)

Pay costs are £1.65m lower than the planned level in the year to date, primarily due to the release of Contingency Reserves. The Trust has seen a reduction in Agency costs, particularly in Medical Staffing, where IR 35 has resulted in number of doctors transferring onto the payroll, although in some cases this has not resulted in a reduction in cost.

The Trust comfortably achieved the agency ceiling of £4.92m year to date, with total Agency expenditure of £3.95m.

Drug costs

Expenditure year to date on drugs is £0.31m below the planned level. The income and corresponding spend on 'pass through' high cost drugs is £0.70m below plan. Underlying drug budgets are therefore overspent by £0.39m, largely due to additional activity in the Pharmacy Manufacturing Unit which is a commercial operation.

Clinical supply and other costs

Clinical Support costs are £0.89m lower than planned. This underspend reflects some activity related underspend in clinical supplies, as well as a non-recurrent benefit of £0.57m relating to prior year creditors as described above.

Other costs are £1.56m lower than planned due to the £3.5m non recurrent benefit mentioned above offset by an increase in provisions of £2.08m year to date.

Non-operating Items and Restructuring Costs

Non-operating expenditure is £13.80m lower than plan in the year to date. This variance includes the impact of the delay of a planned £14m impairment that is now forecast to be accounted for later in the year. The Trust has also seen higher than planned Depreciation of £0.20m following year end asset revaluations and an increase in PFI Contingent Rent due to March's high level of RPI on which the PFI contract uplift is based.

Cost Improvement Programme (CIP) delivery

In December 2016, the control total for 2017/18 of £15.9m was accepted, which drove the need for a challenging £17m (4.5%) CIP. At that point, the Trust had not agreed the two year 2017 – 2019 contract with its main commissioners. The successful resolution of the contractual position contributed to a further £3m challenge to the Trust's financial position as a result of a compromise reached. The revised income plans drove the need for a further £3m of efficiency savings, bringing the total CIP to £20m (5.3%), a position which the Board believes is extremely challenging.

£2.15m of CIP has been delivered this year against a plan of £2.32m, an under performance of £0.17m. The Trust has now identified £16.8m of savings, a significant improvement compared with that reported in Month 2 and continues to push hard for full delivery of the £20m target. The forecast assumes full delivery of the £20m target, but this remains extremely challenging with £3.2m of savings yet to be identified.

During June, colleagues from NHSI visited to review the process of CIP identification and governance. The governance in place has been commended and as yet no further CIP opportunities have been identified by NHS I following the CIP deep dive.

Statement of Financial Position and Cash Flow

At the end of June 2017 the Trust had a cash balance of £1.90m as planned.

The key cash flow variances for the year to date compared to plan are shown below:

Cash flow variance from plan		Variance £m
Operating activities	Deficit including restructuring	13.97
	Non cash flows in operating deficit	(13.74)
	Other working capital movements	(2.90)
Sub Total		(2.67)
Investing activities	Capital expenditure	0.81
	Movement in capital creditors / Other	(2.11)
Sub Total		(1.30)
Financing activities	Drawdown of external DoH cash support	3.86
	Other financing activities	0.06

	Sub Total	3.92
	Grand Total	(0.04)

Operating activities

Operating activities show an adverse £2.90m variance against the plan. The adverse cash impact of £2.90m working capital variances is offset to some extent by the cash benefit of higher than planned Depreciation charges. The large variance in both the deficit position and non-cash flows is linked to a planned impairment which will now take place later in the year. The working capital variance reflects an increase in receivables, particularly accrued income, due to a delay in receiving the Quarter 4 Sustainability and Transformation funding and the accounting of the £3.5m PFI credit described above. The cash benefit of this credit is likely to fall at least in part into the next financial year and this combined with an increase in Creditors and an increased provisions liability is likely to create a cash pressure for the organisation later in the year. As described in the plan commentary, cash support over and above the level of the planned deficit will be required to settle these liabilities over the next few months.

Investing activities (Capital)

Capital expenditure year to date is £0.81m lower than planned and the resulting cash benefit has offset some of the pressure on working capital described above. Capital creditors have reduced significantly in month with a number of EPR related invoices falling due for payment.

Financing activities

Borrowing to support capital expenditure is £2.5m year to date as planned. In addition the Trust has received £13.69m of Revenue Support linked to deficit funding requirements, this is £3.86m more than planned due to delays in receiving Quarter 4 Sustainability and Transformation funding planned for Month 3.

3. Use of Resources (UOR) rating and forecast

Against the UOR the Trust stands at level 3 in line with plan in year to date and forecast terms.

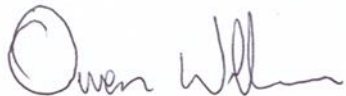
The forecast continues to assume that the Trust will achieve its Control Total and secure the £10.1m STF allocation. However, the risk of failing to achieve our target deficit of £15.94m which was high from the outset, has now increased further despite the Trust taking action to stabilise the financial position.

The forecast assumes:

- That the Trust is able to recover the £2.4m of estimated income in the year to date position.
- That EPR data capture issues are resolved quickly and that clinical activity returns to the planned level from Month 4 or income is recovered by the year end.
- Full achievement of the £20m Cost Improvement programme including the £3.2m currently unidentified.
- Divisional recovery plans can be put in place to maintain the position in line with control total from month 4 to month 12.
- Full achievement of CQUIN targets.
- Securing STF income in full for both the finance (70%) and A&E performance (30%) elements of the target.

- That any further costs relating to EPR implementation, including those to address data capture and booking issues, can be either capitalised or offset by additional savings.
- That a programme of additional budgetary grip and control is successfully implemented as planned.

The scale of the challenge is evident from the above but the Trust continues to seek to maximise opportunities and do all within its power to secure delivery of the control total.



Owen Williams
Chief Executive



Gary Boothby
Executive Director of Finance

Approved Minute

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Cover Sheet

Meeting: Board of Directors	Report Author: Shelley Adrian, PA to Medical Director
Date: Thursday, 3rd August 2017	Sponsoring Director: David Birkenhead, Medical Director
Title and brief summary: MEDICAL REVALIDATION AND APPRAISAL REPORT - The purpose of this report is to update the Board on the progress of the Trust's management of medical appraisal and revalidation.	
Action required: Approve	
Strategic Direction area supported by this paper: A Workforce for the Future	
Forums where this paper has previously been considered: Workforce and Well Led Committee - 13th July 2017	
Governance Requirements: A Workforce for the Future	
Sustainability Implications: None	

Executive Summary

Summary:

The purpose of this report is to update the Board on the progress of the Trust's management of medical appraisal and revalidation since the introduction of revalidation in December 2012. The report will also discuss the 2016/17 appraisal and revalidation year (1st April 2016 – 31st March 2017).

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

Please see attached.

Appendix

Attachment:

Revalidation - Board of Directors - July 2017 3.pdf

BOARD OF DIRECTORS - THURSDAY 3RD AUGUST 2017

REVALIDATION AND APPRAISAL OF NON TRAINING GRADE MEDICAL STAFF

1. Executive Summary

The purpose of this report is to update the Board on the progress of the Trust's management of medical appraisal and revalidation since the introduction of revalidation in December 2012. The report will also discuss the 2016/17 appraisal and revalidation year (1st April 2016 – 31st March 2017).

Summary of key points:

- As at 31st March 2017, 331 doctors had a prescribed connection to Calderdale and Huddersfield NHS Foundation Trust (as compared to 309 on 31st March 2016)
- In the 2016/17 revalidation year (1st April 2016 – 31st March 2017) 20 non training grade medical staff had been allocated a revalidation date by the General Medical Council (GMC), as compared to 94 non training grade medical staff in 2015/2016.
- Based on headcount, 93.3% of non-training grade appraisals were completed and submitted in the appraisal year (93.5% in 2015/2016). 6.3% of non-training grade medical staff were not required to complete an appraisal (due to recently joining the Trust, maternity leave, recent return from secondment etc). This compares to 5.5% in 2015/2016.

2. Background

2.1 Medical revalidation was launched in December 2012 to strengthen the way that doctors are regulated with the aim of improving the quality of care provided to patients. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.

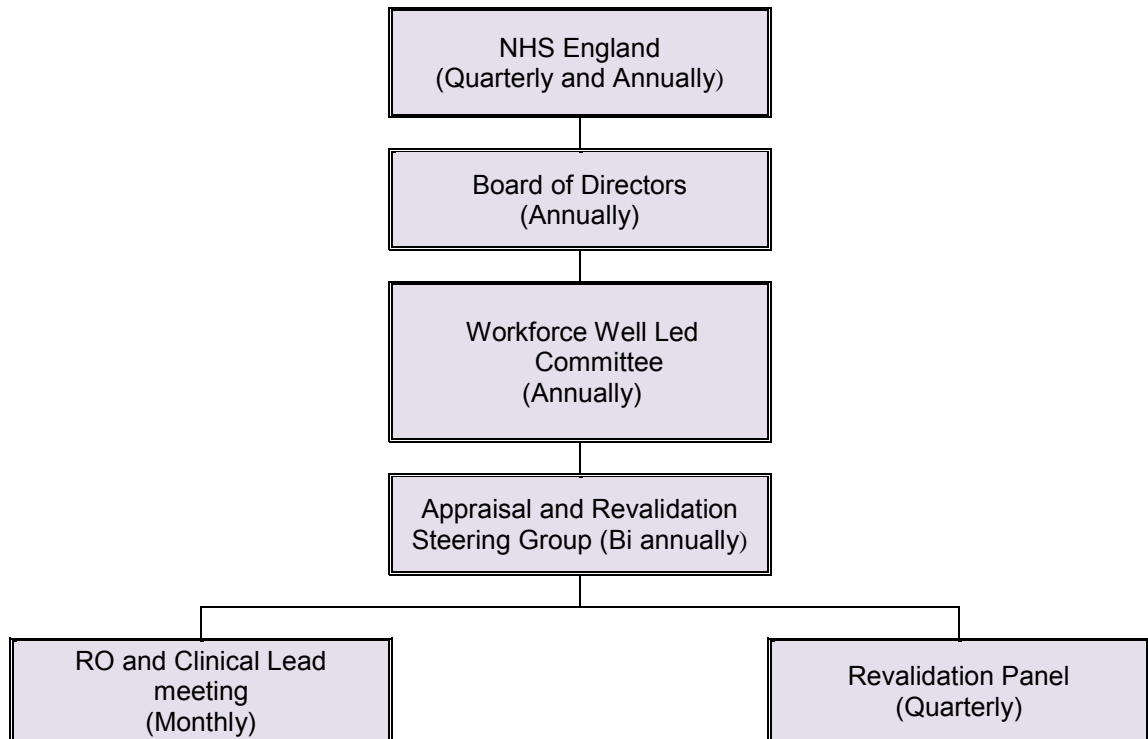
2.2 The Trust has a statutory duty to support the Responsible Officer (Medical Director) in discharging their duties under Responsible Officer Regulations and is expected that the board will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems on place for monitoring the performance and conduct of their doctors;
- confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process;
- ensure that appropriate pre-employment checks are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

2.2 Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.

3. Governance Arrangements

3.1 The Trust’s governance reporting structure for medical appraisal and revalidation is shown below:



3.2 GMC Connect

GMC Connect is the General Medical Councils database used by Designated Bodies (ie Calderdale and Huddersfield NHS Foundation Trust) to view and manage the list of doctors who have a prescribed connection with the Trust.

The database is managed by the Revalidation Office on behalf of the Responsible Officer. The Trust’s Electronic Staff Record (ESR) is used as the main source in relation to starters and leavers.

3.3 Revalidation and Appraisal Steering Group

The Revalidation and Appraisal Steering Group panel meet bi-annually and continue to support the Responsible Officer with the revalidation agenda within the prescribed terms of reference.

4. Medical Appraisal and Revalidation Performance Data

Revalidation Cycles

- 4.1 The first revalidation cycle started in January 2013. All doctors (with the exception of those whose revalidation has been put on hold by the GMC) completed their first revalidation cycle by 31st March 2017 and will have had a recommendation made about their fitness to practise by the Trust's Responsible Officer (the Medical Director).
- 4.2 In the 2016/2017 revalidation year (Year 4) the Responsible Officer has made recommendations for doctors as follows: (see also Appendix A - Audit of Revalidation Recommendations)

Revalidation Cycle (Year 4)	Positive Recommendations	Recommendation Deferred **
Year 4, Quarter 1 (April 2016 – June 2016)	7	1
Year 4, Quarter 2 (July 2016 – September 2016)	1	0
Year 4, Quarter 3 (October 2016 – December 2016)	1	1
Year 4, Quarter 4 (January 2017 – March 2017)	7	2
Total:	16	4

** The reasons for the deferrals were insufficient evidence being presented for a revalidation recommendation to be made. This was usually due to the fact the doctors were relatively new to the organisation and did not provide sufficient or relevant evidence from previous employers for a recommendation to be made

- 4.3 The number of non-training grade medical staff with a revalidation date in Year 4 was significantly lower than in previous years (for example, 94 in 2015/2016, 92 in 2014/2015). This trend was replicated across England. When revalidation was introduced in 2012 designated bodies, whilst not able to select revalidation date were asked to submit cohorts of doctors for revalidation until Year 4 which means the majority of existing medical staff were allocated a revalidation date by the GMC prior to Year 4

Medical Appraisal

- 4.3. Medical Appraisal underpins the revalidation process. Doctors are expected to complete five appraisals within the revalidation cycle.
- 4.4 The appraisal year runs from 1st April – 31st March. The table below shows the compliance rate at the end of the 2016/2017 appraisal year on 31st March 2017 (see also Appendix B – Audit of all missed or incomplete appraisals).

Grade	Number of doctors with prescribed connection to CHFT	Completed Appraisals (1a)	Completed Appraisals (1b)	Approved incomplete or missed appraisal (1b)	Unapproved incomplete or missed appraisal
Consultants (permanent)	234	199	23	11	1
Staff Grade, associate specialist, specialty doctor (permanent)	60	58	0	2	0
Temporary or short term contract holders (all grades)	37	29	0	8	0
Total	331	286	23	21	1

(Doctors with a GMC prescribed connection to CHFT as at 31st March 2017)

1a: Completed appraisals: appraisal meeting between 1st April 2015 and 31st March 2016 for which the appraisal outputs have been agreed between appraiser and appraisee.

1b: Approved or incomplete or missed appraisals: accepted reason for appraisal not taking place (eg joined the Trust within the last 6 months, prolonged leave, maternity leave, sabbatical etc).

Unapproved incomplete or missed appraisal: appraisal expected to be submitted with. No agreement for appraisal to be postponed/delayed.

- 4.5 The appraisal completion rate is based on the number of doctors with a GMC prescribed connection to the Trust. Whilst appraisals were submitted for 93.3% of non-training grade medical staff, 6.3% of doctors were not required to submit an appraisal (for example, they had joined the Trust in the last 6 months, had been on maternity leave etc).

5. Trained Appraisers

- 5.1 Since 1st April 2017 and in line with the revised Appraisal Policy for Non- Training Grade Medical Staff, the Revalidation and Appraisal Office is allocating appraisers to appraisees. The minimum number of appraisees a trained appraiser is required to appraise each year is 5 (the maximum is 10). An audit of appraisers in December 2016 showed that only 19% of trained appraisers were meeting this minimum standard. This revised process has resulted in a more equitable allocation and ensure our appraisers are undertaking sufficient appraisals to retain their skills. All appraisers have been allocated between 5-8 appraisees. It has also meant that some appraisers have stood down from the role. There are now 60 trained appraisers as compared to 79 last year.

6. Quality Assurance of the Process

6.1 The process used to monitor the quality of the medical appraisers is for the doctors to rate their appraisal experience in relation to:

- The organisation of the appraisal
- The appraiser
- The appraisal discussion

All appraisals submitted as part of the revalidation process are reviewed thoroughly by the Revalidation Panel quality assurance group. This involves a comprehensive review of the appraisal form (appraisal inputs and supporting information). (see Appendix C - Quality assurance audit of appraisal inputs and outputs (1st April 2016 - 31st March 2017))

6.2 The Clinical Appraisal and Revalidation lead also routinely quality assures sample of appraisals submitted.

6.3 Access, security and confidentiality

Appraisal folders, supporting information and all correspondence relating to the appraisal and revalidation processes are stored on the Trust network drive. Access to the network drive is restricted to the Responsible Officer, the Clinical Lead for Appraisal and Revalidation, the Assistant Director of Human Resources and the Revalidation Office administrative support. Access to appraisals is in line with the Appraisal Policy for non-training grade medical staff.

6.5 Clinical Governance

Data is provided annually by the Trust to each appraisee to assist with the appraisal process. The DATIX incident reporting system provides basic information relating to serious incidents, complaints and claims where the doctor is named. The Health Informatics department also provide information relating to CHFT activity data, benchmarking data (Dr Foster) and attendance at audit.

7. Action Plan

a) PReP – Appraisal and Revalidation E-Portfolio

A self-service electronic appraisal system for all non-training grade medical staff was introduced from 1st April 2017. It is hoped that this will make the process more streamlined for appraisers and appraisees. It also aids the process for quality assuring the submissions

b) Peer Review

In line with Department of Health guidance we are currently undertaking a process of peer review in conjunction with Bradford and Barnsley. We have recently reviewed the revalidation and appraisal processes at Barnsley and Bradford will be reviewing our systems late summer. The intention is to share good practice.

c) Appraiser Recruitment

We are looking to recruit additional appraisers to replace those who have left the Trust or retired from the role

8 Action Required of the Board

The Board of Directors is asked to:

- (i) receive this report.

Dr David Birkenhead
Medical Director/Responsible Officer
July 2017

Appendix A

Audit of Revalidation Recommendations (1st April 2016 - 31st March 2017)

(Template taken from 'A Framework of Quality Assurance for Responsible Officers and Revalidation – Annex D Annual Board Report Template – June 2014)

Revalidation Recommendations made between 1st April 2016 and 31st March 2017

	Number
Recommendations completed on time (within the GMC recommendation window)	20
Late recommendations (completed but after GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	20
Primary reason for late/missed recommendations For late or missed recommendations only one primary reason may be identified	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctors revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resources or support for responsible officer role	0
Other	
TOTAL SUM OF LATE AND MISSED RECOMMENDATIONS	0

Appendix B

Audit of all missed or incomplete appraisals audit (1st April 2016 - 31st March 2017)

(Template taken from ‘A Framework of Quality Assurance for Responsible Officers and Revalidation – Annex D Annual Board Report Template – June 2014)

Doctors Factors (Total)	Number
Maternity leave during the majority of the ‘appraisal due window’	2
Sickness absence during the majority of the ‘appraisal due’ window’	1
Prolonged leave during the majority of the ‘appraisal due window’	1
Suspension during the majority of the ‘appraisal due window’	0
New starter within 3 months of appraisal due date	11
New starter more than 3 months from the appraisal due date	4
Postponed due to incomplete portfolio/insufficient reporting information	0
Appraisal outputs not signed off by doctor within 28 days	0
Lack of time of doctor	0
Lack of engagement of doctor	1
Other doctors factors (describe)	0
Appraiser Factors (Total)	
Unplanned absence of appraiser	1
Appraisal outputs not signed off by the appraiser within 28 days **	23
Lack of time of appraiser	0
Other appraiser factors (describe)	0
Organisational Factors (Total)	
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0

** NHS England request that we report on the numbers of appraisals not signed by the appraiser within 28 days of the appraisal being completed. However, these appraisals were still recorded as completed since they were submitted within the appraisal year.

Appendix C

Quality assurance audit of appraisal inputs and outputs (1st April 2015 - 31st March 2016)

(Template taken from ‘A Framework of Quality Assurance for Responsible Officers and Revalidation – Annex D Annual Board Report Template – June 2014)

Below is a breakdown of the appraisals audited via the Revalidation process. In addition 10% of all appraisals are audited by the Clinical Lead for Appraisal and revalidation.

Total number of appraisals completed		
309	Number of appraisal portfolios sampled	Number of the sampled appraisal portfolios deemed acceptable against standards
Appraisal Inputs	Number audited	Number acceptable
Scope of work: Has a full scope of practice been described?	20	20
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	20	16
Quality Improvement Activity: Is quality improvement activity compliant with GMC requirements?	20	19
Patient feedback exercise: Has a patient feedback exercise been completed?	20	20
Colleague feedback exercise: Has a colleague feedback exercise been completed?	20	20
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	20	20
Is there sufficient supporting information from all the doctors roles and places of	20	20

work?		
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)	20	20
Appraisal Outputs		
Appraisal Summary	20	20
Appraiser statements	20	20
Personal Development Plan	20	20

Appendix D

**Audit of concerns about a doctor's practice (1st April 2016 - 31st March 2017)
 Non training grade medical staff**

**(Template taken from 'A Framework of Quality Assurance for Responsible
 Officers and Revalidation – Annex D Annual Board Report Template – June 2014)**

Concerns about a doctor's practice	High level	Medium level	Low level	Total
Number of doctors with concerns about their practice in the last 12 months	2	2	5	9
Capability concerns (as the primary category) in the last 12 months	0	1	1	2
Conduct concerns (as the primary category) in the last 12 months	1	1	1	3
Health concerns (as the primary category) in the last 12 months	1	0	3	4

Approved Minute

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Cover Sheet

Meeting: Board of Directors	Report Author: Azizen Khan, Assistant Director of HR
Date: Thursday, 3rd August 2017	Sponsoring Director: Jason Eddleston, Executive Director of Workforce and Organisational Development
Title and brief summary: Workforce Race Equality Standard (WRES) 2017 - The paper sets out the Trust position against the Workforce Race Equality Standard (WRES) for 2017. The Trust is required to publish its position on 1 August 2017.	
Action required: Note	
Strategic Direction area supported by this paper: A Workforce for the Future	
Forums where this paper has previously been considered: The Workforce (Well Led) Committee approved the WRES report for publication at its meeting on 13 July 2017.	
Governance Requirements: A Workforce for the Future	
Sustainability Implications: None	

Executive Summary

Summary:

Please see attached.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to note the report.

Appendix

Attachment:

[BoD 3.8.17 WRES 2017 Paper.pdf](#)

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

BOARD OF DIRECTORS

3 AUGUST 2017

WORKFORCE RACE EQUALITY STANDARD (WRES) 2017

1. Purpose

The paper sets out the Trust position against the Workforce Race Equality Standard (WRES) for 2017. The Trust previously set out its position against the nine indicators included within the standard and published these 1 August 2016. The Trust is required to publish its position again on 1 August 2017.

2. Introduction

The WRES is a national equality standard for employment against which all NHS organisations are assessed. The WRES first became operational from 1 April 2015 and organisations were required to publish their position against it by 1 July 2015. There is a requirement to publish progress against the standard on an annual basis. The standard aims to improve workforce race equality across the NHS. It aims to improve the opportunities, experiences and working environment for Black, Asian and Minority Ethnic (BAME) employees, and in so doing, help lead improvements in the quality of care and satisfaction for all patients.

The WRES requires organisations to develop an action plan to drive forward improvements against the indicators. The Trust developed an action plan for 2016/17 after hearing directly from BAME colleagues about their experience of working in the Trust and what they identified as key areas for improvement. The action plan was approved by the Board of Directors in late May 2016. The WRES action plan for 2017/18 includes some actions carried over from the previous year as well as action areas to focus on as highlighted by the staff survey results.

3. The WRES Indicators

The WRES comprises 9 indicators as detailed below.

Four indicators compare workforce metrics for White and BME staff (1-4), four concentrate on staff survey responses (5-8) and one (9) considers the composition of the Board of Directors.

- | |
|--|
| 1. Percentage of staff in each of the AfC Band 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff. |
| 2. Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts. |
| 3. Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. |

4. Relative likelihood of BME staff accessing non mandatory training and CPD as compared to White staff.
5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.
7. Percentage believing that the Trust provides equal opportunities for career progression or promotion.
8. In the last 12 months have you personally experienced discrimination at work from your manager/team leader or other colleagues?
9. Percentage difference between the organisations' Board voting membership and its overall workforce.

4. WRES report publication

The Trust is required to publish its WRES report on 1 August 2017. The Workforce (Well Led) Committee approved the WRES report for publication at its meeting on 13 July 2017. This is attached at Appendix 1.

5. Conclusion

The Board of Directors is asked to note the WRES report.

Azizen Khan
Assistant Director of HR
July 2017

Workforce Race Equality Standard

REPORTING TEMPLATE (Revised 2016)

Template for completion

Name of organisation Calderdale and Huddersfield NHS Foundation Trust	Date of report: June 2017
Name and title of Board lead for the Workforce Race Equality Standard Jason Eddleston, Deputy Director of Workforce and OD	
Name and contact details of lead manager compiling this report Azizen Khan, Assistant Director of Human Resources	
Names of commissioners this report has been sent to Carol McKenna, Director of Commissioning, Greater Huddersfield CCG and Matt Walsh, Chief Officer, Calderdale CCG	
Name and contact details of co-ordinating commissioner this report has been sent to Carol McKenna, Director of Commissioning, Greater Huddersfield CCG	
Unique URL link on which this report will be found (to be added after submission) http://www.cht.nhs.uk/about-us/equality-and-diversity-at-chft/	
This report has been signed off by on behalf of the Board on (insert name and date) Workforce (Well-Led) Committee 13 July 2017	

Publications Gateway Reference Number: 05067

Report on the WRES indicators

1. Background narrative

a. Any issues of completeness of data

None identified

b. Any matters relating to reliability of comparisons with previous years

None identified

2. Total numbers of staff

a. Employed within this organisation at the date of the report

6087 (as at 31 March 2017)

b. Proportion of BME staff employed within this organisation at the date of the report

14.6%

3. Self-reporting

a. The proportion of total staff who have self-reported their ethnicity

97.7% (5945)

b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity

No

c. Are any steps planned during the current reporting period to improve the level of self-reporting by ethnicity

The Trust has implemented ESR Employee Self Service which allows staff to update their own record. This and further functionality will be promoted further after the rollout of the new ESR portal.

4. Workforce data					
a. What period does the organisation's workforce data refer to?					
1 April 2016 - 31 March 2017					
5. Workforce Race Equality Indicators					
For ease of analysis, as a guide we suggest a maximum of 150 words per indicator.					
	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	For each of these four workforce indicators, the Standard compares the metrics for White and BME staff.				
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	Please see appendix 1a	Please see appendix 1a	Overall the Trust has 14.6% of its workforce from a BME background compared to 14.0% in the previous year. The report for this year shows that there have been small decreases in non-clinical BME staff in AfC Bands 1,2,5,6,7,8a,and 8b. In the category classed as 'under Band 1' (mainly apprentices) has seen a significant increase of BME staff, moving from 22.2% in March 2016 to 50% in March 2017. Band 3 BME staff has shown an increase changing from 5.5% in March 2016 to 8.2% in March 2017.	Links to the Trust's action plan - to improve recruitment processes including having a BME person as a panel member for Band 7 and senior management appointments.

				<p>Clinical BME staff in the category classed as 'under Band 1' and AfC Bands 1 and 4 have seen small reductions, with the largest change within the Under Band 1 category. All other AfC bands have remained constant or increased marginally.</p> <p>Medical BME staff within Consultant and Trainee grades have remained largely constant, with only Career Grades showing a small reduction moving from 75.3% in March 2016 to 71.1% in March 2017.</p>	
2	Relative likelihood of staff being appointed from shortlisting across all posts.	<p>BME = 0.114 White = 0.171</p> <p>White 1.50 times as likely to be appointed.</p>	<p>BME = 0.107 White = 0.146</p> <p>White 1.36 times as likely to be appointed.</p>	The data shows that in a 12 month period (April 2016 to March 2017) the likelihood of BME staff being appointed after being shortlisted has increased. Overall however White staff are now one and a half times more likely to be appointed than BME staff.	Please see Indicator 1
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.	<p>BME = 0.0124 White = 0.0065</p> <p>BME 1.89 times as likely to enter the formal process.</p>	<p>BME = 0.0086 White = 0.0077</p> <p>BME 1.12 times as likely to enter the formal process.</p>	The information shows that the possibility of a BME colleague entering the disciplinary process is almost twice as likely as a White colleague. A significant change from the previous year.	Links to the Trust's action plan - Set out clear and helpful guidelines and standards of behaviour deemed to be acceptable/unacceptable
4	Relative likelihood of staff	BME = 0.851	BME = 0.836	The data shows that there is a	Links to the Trust's action plan - to

	accessing non-mandatory training and CPD.	White = 0.823 White 0.97 times as likely to access non-mandatory training.	White = 0.808 White 0.97 times as likely to access non-mandatory training.	marginally higher uptake of non-mandatory training in the BME workforce.	provide mentoring and coaching. Delivery of the Inclusive Mentoring programme commences on 10 July 2017 and will run through until July 2018. Develop a comprehensive development programme for Agenda for Change pay bands 2 – 7 (clinical and non-clinical) to support them in career progression / promotion. The Trust has invested in the Moving Forward programme for Bands 5/6 delivered by Bradford District Care Trust which commenced in May 2017.
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.				
5	KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White = 27.74% BME = 14.00%	White = 28.42% BME = 28.57%	The average (median) for BME staff within acute Trusts is 26%. In comparison the Trusts ranking is below (better than) the average. The latest survey shows that less than half as many BME staff have experienced harassment, bullying or abuse from patients, relatives or the public in last 12 months when compared to the previous year.	Please see Indicator 3

				White staff have remained largely consistent, with only a minor reduction compared to the previous year.	
6	KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White = 23.97% BME = 23.08%	White = 24.83% BME = 25.00%	The average (median) for BME staff within acute Trusts is 27%. In comparison the Trusts ranking is below (better than) the average. Both White and BME staff have shown reductions when compared to the previous year.	Please see Indicator 3
7	KF21. Percentage believing that trust provides equal opportunities for career progression or promotion.	White = 87.95% BME = 76.47%	White = 86.24% BME = 71.43%	The average (median) for BME staff within acute Trusts is 76%. In comparison the Trusts ranking is consistent with the average. Both White and BME staff have shown increases when compared to the previous year, with BME staff showing a larger improvement.	Please see Indicator 4
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White = 4.75% BME = 14.29%	White = 5.10% BME = 11.11%	The average (median) for BME staff within acute Trusts is 14%. In comparison the Trusts ranking is consistent with the average. White staff have seen a marginal decrease. While BME staff have seen an increase in discrimination.	Please see Indicator 3
	Board representation indicator				

	For this indicator, compare the difference for White and BME staff.				
9	Percentage difference between the organisations' Board voting membership and its overall workforce.	Board BME 6.7%	Board BME 6.7%	There is no change in the BME composition of the Board from 2015/2016 to 2016/2017.	Please see Indicator 1
		Overall Workforce BME 14.6%	Overall Workforce BME 14.0%		
		Difference 7.9%	Difference 7.3%		

Note 1. All provider organisations to whom the NHS Standard Contract applies are required to conduct the NHS Staff Survey. Those organisations that do not undertake the NHS Staff Survey are recommended to do so, or to undertake an equivalent.

Note 2. Please refer to the WRES Technical Guidance for clarification on the precise means for implementing each indicator.

6. Are there any other factors or data which should be taken into consideration in assessing progress?

The Trust held several focus groups with BME colleagues in the early part of 2016 and the feedback received from the groups was directly used to support the development and delivery of the WRES action plan during 2016/17. The Trust established a BME Network in September 2016 and this has been successfully embedded. The BME Network has been critical in the delivery of the 2016/17 action plan and therefore the same approach will be adopted for the 2017/18 action plan. An Executive Director lead will have overall responsibility for each action point.

7. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.

The Trust has developed an action plan for 2017/18 which was approved by the Workforce (Well-Led) Committee on 13 July 2017 – Appendix 1b available at the following link:

<http://www.cht.nhs.uk/about-us/equality-and-diversity-at-cht/>

5. Workforce Race Equality Indicators

1. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.

31 March 2017

	Pay Scale	White %	BME %	Not Stated %
Non-Clinical	Under Band 1	42.9%	50.0%	7.1%
	Band 1	82.4%	14.3%	3.3%
	Band 2	85.8%	11.6%	2.6%
	Band 3	88.3%	8.2%	3.5%
	Band 4	90.3%	8.3%	1.4%
	Band 5	84.2%	15.0%	0.8%
	Band 6	90.9%	6.1%	3.0%
	Band 7	89.6%	7.5%	3.0%
	Band 8a	91.7%	8.3%	0.0%
	Band 8b	96.7%	3.3%	0.0%
	Band 8c	93.8%	6.3%	0.0%
	Band 8d	100.0%	0.0%	0.0%
	Band 9	92.9%	7.1%	0.0%
	VSM*	66.7%	16.7%	16.7%

	Pay Scale	White %	BME %	Not Stated %
Clinical	Under Band 1	87.5%	12.5%	0.0%
	Band 1	90.0%	10.0%	0.0%
	Band 2	83.4%	14.5%	2.1%
	Band 3	87.6%	11.2%	1.2%
	Band 4	87.3%	9.8%	2.9%
	Band 5	84.0%	13.5%	2.4%
	Band 6	91.1%	7.3%	1.6%
	Band 7	92.0%	6.4%	1.6%
	Band 8a	95.2%	2.9%	1.9%
	Band 8b	100.0%	0.0%	0.0%
	Band 8c	100.0%	0.0%	0.0%
	Band 8d	0.0%	0.0%	0.0%
	Band 9	100.0%	0.0%	0.0%
	VSM*	100.0%	0.0%	0.0%
Medical	Consultant	50.2%	47.2%	2.6%
	Career Grade	20.0%	71.1%	8.9%
	Trainee Grade	48.9%	46.2%	4.9%
	Other	0.0%	100.0%	0.0%

Overall Workforce **83.0%** **14.6%** **2.3%**

31 March 2016

	Pay Scale	White %	BME %	Not Stated %
Non-Clinical	Under Band 1	77.8%	22.2%	0.0%
	Band 1	81.7%	15.2%	3.1%
	Band 2	83.4%	13.5%	3.1%
	Band 3	91.5%	5.5%	3.0%
	Band 4	90.4%	7.7%	1.8%
	Band 5	81.4%	17.7%	0.9%
	Band 6	87.7%	10.8%	1.5%
	Band 7	85.0%	10.0%	5.0%
	Band 8a	84.8%	9.1%	6.1%
	Band 8b	81.3%	6.3%	12.5%
	Band 8c	88.2%	5.9%	5.9%
	Band 8d	80.0%	0.0%	20.0%
	Band 9	92.3%	0.0%	7.7%
	VSM*	66.7%	11.1%	22.2%

	Pay Scale	White %	BME %	Not Stated %
Clinical	Under Band 1	77.3%	20.5%	2.3%
	Band 1	87.0%	13.0%	0.0%
	Band 2	84.5%	13.2%	2.3%
	Band 3	90.7%	7.6%	1.7%
	Band 4	87.3%	10.1%	2.5%
	Band 5	85.2%	12.1%	2.7%
	Band 6	90.8%	6.7%	2.5%
	Band 7	93.1%	4.7%	2.2%
	Band 8a	95.6%	2.2%	2.2%
	Band 8b	100.0%	0.0%	0.0%
	Band 8c	100.0%	0.0%	0.0%
	Band 8d	100.0%	0.0%	0.0%
	Band 9	100.0%	0.0%	0.0%
	VSM*	100.0%	0.0%	0.0%
Medical	Consultant	49.1%	46.8%	4.1%
	Career Grade	19.5%	75.3%	5.2%
	Trainee Grade	46.6%	46.6%	6.9%
	Other	0.0%	100.0%	0.0%

Overall Workforce **83.1%** **14.0%** **2.9%**

*VSM = Very Senior Manager. Contains staff in the roles; Chair, Chief Executive, Finance Director, Other Executive Director, Board Level Director, Non Executive Director, Clinical Director - Medical, Medical Director, Director of Nursing, Director of Public Health.

Note - Staff on Local/Senior Manager pay scales have been categorised into AfC bandings based on their full time salary.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST**WORKFORCE RACE EQUALITY STANDARD – ACTION PLAN 2017/18**

WORKFORCE RACE EQUALITY SCHEME (WRES) ACTION PLAN PROGRESS REPORTING TEMPLATE	
Start date:	30 June 2016
Latest update:	10 July 2017
Lead Manager:	Azizen Khan, Assistant Director of HR
Lead Director:	Owen Williams, Chief Executive
Monitoring Committee:	Executive Board / Workforce (Well Led) Committee
Date signed off as complete	

1. delivered
2. on track
3. off track

ACTION	MEASURE	LEAD/ GROUP MEMBERS	TIMESCALE	RAG	PROGRESS
Strengthen the current E&D training to include cultural awareness training (so people understand cultural sensitivities) and how to challenge on issues of equality and diversity (authentic speech)	E&D training brings about a reduction in incidents of racism, discrimination	Lesley Hill Jan Wilson Tahira Shariff	1 April 2018	2	Equality and diversity training to be reviewed to ensure it meets the Trust's needs Equality and diversity e-learning compliance monitored as part of overall mandatory training requirements for 2017/18
Leadership Academy to deliver the Inclusive Mentoring programme during 2017 and a train the trainer programme during 2018	Increase in number of BAME colleagues accessing mentoring and coaching. BAME colleagues feel that they can progress in	Jason Eddleston Azizen Khan Ruth Mason	May 2018	2	The Leadership Academy will be delivering the Inclusive Mentoring programme in the Trust in July 2017. In order for the Trust to become self-sufficient in delivering future programmes a cohort of individuals will be trained as trainers to deliver the

Appendix 1b

ACTION	MEASURE	LEAD/ GROUP MEMBERS	TIMESCALE	RAG	PROGRESS
	their career regardless of race and culture, age, gender or sexuality.				programme in future
Develop a comprehensive development programme for Agenda for Change pay bands 2 – 7 (clinical and non-clinical)	<p>A clear career pathway for BAME colleagues to progress through whilst remaining in employment with the Trust</p> <p>BAME colleagues feeling they are invested in and valued by the Trust</p>	<p>Jason Eddleston Karen Heaton Ruth Mason Mahen Jamookeeah Debi Johnson</p>	June 2018	2	<p>Leadership and management development programme being delivered by Health Skills – Compassionate Leadership in Practice during 2017. This includes two programmes; one for leaders and the second for aspiring leaders.</p> <p>Moving Forward programme being delivered by Bradford District Care Trust. Ten BAME colleagues are on the development programme (Agenda for Change Bands 5 and 6) which commenced in May 2017.</p> <p>The Leadership Academy has launched a one year development programme called Ready Now aimed at senior BAME leaders at Agenda for Change Band 8a or above. Colleagues will be encouraged to apply.</p>
Set out clear and helpful guidelines and standards of behaviours deemed to be acceptable and unacceptable	<p>Fewer incidents of discrimination and racism reported through formal processes, improved staff survey results</p> <p>BAME colleagues</p>	<p>Lesley Hill Karen Heaton June Thomas Teresa Stewart-Lynch</p>	June 2018	2	<p>A CHFT leaflet has been produced with a draft proposal for CHFT behaviours and will be shared across the Trust for feedback.</p> <p>A plan is now in place to engage with staff about the CHFT behaviours identified.</p>

ACTION	MEASURE	LEAD/ GROUP MEMBERS	TIMESCALE	RAG	PROGRESS
	having confidence that the Trust holds a zero tolerance approach to discrimination and racism				

Approved Minute

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Cover Sheet

Meeting: Board of Directors	Report Author: Kathy Bray, Board Secretary
Date: Thursday, 3rd August 2017	Sponsoring Director: Victoria Pickles, Company Secretary
Title and brief summary: UPDATE FROM SUB-COMMITTEES AND RECEIPT OF MINUTES - The Board is asked to receive the updates and minutes from the sub-committees.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: As appropriate	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive the updates and minutes from the sub-committees attached.

Main Body

Purpose:

The Board is asked to receive the updates and minutes from the sub-committees:-

Quality Committee - minutes of 3.7.17 and verbal update from meeting 31.7.17.

Finance and Performance Committee - minutes of 4.7.17 and verbal update from meeting 1.8.17.

Workforce Well-led Committee - verbal update from meeting 13.7.17.

Audit and Risk Committee - verbal update from meeting 19.7.17

Draft Minutes Board of Directors/Council of Governors Annual General Meeting - 20.7.17

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to receive the updates and minutes from the sub-committees:-

Quality Committee - minutes of 3.7.17 and verbal update from meeting 31.7.17.

Finance and Performance Committee - minutes of 4.7.17 and verbal update from meeting 1.8.17.

Workforce Well-led Committee - verbal update from meeting 13.7.17.

Audit and Risk Committee - verbal update from meeting 19.7.17

Draft Minutes Board of Directors/Council of Governors Annual General Meeting - 20.7.17

Appendix

Attachment:

COMBINED UPDATE FROM SUB-COMMITTEES.pdf

QUALITY COMMITTEE

Monday, 3rd July 2017

Discussion Room 3, Learning Centre, Huddersfield Royal Infirmary

IN ATTENDANCE

Dr Linda Patterson	Non-Executive Director (<i>Chair</i>)
Dr David Anderson	Non-Executive Director
Nicola Bailey	PMO and Transformation Programme Manager (<i>For item 119/17 only</i>)
Helen Barker	Chief Operating Officer
Karen Barnett	Director of Operations, Community Division
Gemma Berriman	Head Nurse for Medicine - Service Planning (<i>For Andrew Mooraby</i>)
Dr David Birkenhead	Medical Director
Juliette Cosgrove	Assistant Director for Quality and Safety
Lesley Hill	Executive Director of Planning, Performance, Estates and Facilities
Helen Marshall	Project Manager - Estates (<i>For item 119/17 only</i>)
Andrea McCourt	Head of Governance and Risk
Dr Cornelle Parker	Deputy Medical Director
Catherine Riley	Assistant Director of Service Development - Estates (<i>For item 105/17 only</i>)
Lindsay Rudge	Associate Director of Nursing
Jan Wilson	Non-Executive Director
Michelle Augustine	Governance Administrator (<i>Minutes</i>)

100/17 WELCOME AND INTRODUCTIONS

The Chair welcomed members to the meeting.

101/17 APOLOGIES

Brendan Brown	Executive Director of Nursing
Martin DeBono	Divisional Director, FSS Division
Anne-Marie Henshaw	Associate Nurse Director/Head of Midwifery, FSS Division
Peter Middleton	Membership Councillor
Andrew Mooraby	Assistant Director of Nursing, Medical Division
Dr Ashwin Verma	Divisional Director, Medical Division

102/17 DECLARATIONS OF INTEREST

There were no declarations of interest to note

103/17 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on Monday, 3rd April 2017 were approved as a correct record.

104/17 ACTION LOG AND MATTERS ARISING

Please see action log at the end of the minutes for further updates on actions.

105/17 BUSINESS CASE FOR HOSPITAL RECONFIGURATION CLINICAL MODEL

Catherine Riley was in attendance to present the above report (Appendix B). The report is a refresh of clinical standards relating to the full business case service model, and the quality impact assessment of the model. This was originally developed for the five year plan, and there has been no significant change to the service model since the plan and no significant

change to the quality impact assessment. There is, however, an addition to the clinical standards (standard 87), which focusses on patient experience. Discussion ensued in regard to risks and benefits associated with this business case, and it was agreed that some detailed work is yet to be finalised. Following a lengthy discussion, the business case was not signed off by the Quality Committee, however, the report will be submitted to the Board of Directors as scheduled this week, and will await the decision from the Board. The next steps of the report will also be shared with the Clinical Commissioning Group (CCGs).

OUTCOME: The business case was not signed off by the Quality Committee, and will await decision from the Board of Directors.

106/17 **COMMUNITY DIVISION PATIENT SAFETY AND QUALITY BOARD (PSQB) REPORT**

Karen Barnett was in attendance to present the above quarter 4 report (Appendix C), highlighting the division's commitment to developing its governance framework. Due to the divisional governance lead post being vacated in April 2016 and not being replaced, there are areas where progress is needed, including clinical audit, clinical guidelines development and the review of NICE guidance. This was escalated to the Director of Nursing, and further support from the governance team is planned until August 2017, when a new governance lead will commence in post. A new Associate Director of Nursing also commenced in post in the division in June 2017.

Divisional Patient Safety and Quality Board meetings continue to take place monthly; serious Incident (SI) root cause analysis and investigation reports are completed for serious incidents and orange graded incidents, and the division continues to hold weekly orange / Pressure Ulcer panels; complaints are monitored at weekly meetings, and the division received a CQC rating of good across all areas. Since the visit, the CQC action plan has been monitored and is in place for the must and should do actions and for areas identified by the division and CQC report as requiring further work.

The outcome of the tender for the 0-5 Public Health Early Years (PHEYS) tender in Calderdale was announced in February and Locala was the successful bidder. The community division has agreed to continue to provide the Health Visiting service during Q1 and the process for the transfer of the service and staff commenced in March. The service transferred to the new provider on 1st July 2017. Discussion ensued on support given to colleagues who transferred to Locala.

OUTCOME: The Committee received and noted the report.

107/17 **SEPSIS PERFORMANCE UPDATE**

Juliette Cosgrove presented the above report (Appendix D), highlighting the quarter 4 sepsis performance in relation to the 2016-2017 CQUIN. The main point to note is that there have been improvements over the course of the year, however, there is still some work needed to ensure the accurate capture of inpatient screening during an inpatient stay and increase the level of compliance with the timeliness of antibiotics given and subsequent review. There is expected improvement in 2017-2018, with fundamental benefits from the Electronic Patient Record (EPR), as a way of identifying patients who are septic.

Discussion ensued on the relationship between EPR and the sepsis bundles, and how to use and understand the information produced. It was also stated that work is ongoing in the community on the identification of sepsis and responses to deteriorating patients. It was agreed that this work in progress will be monitored through quarterly review reports submitted to the Clinical Outcomes Group, then subsequently to this Committee.

OUTCOME: The Committee received and noted the report

108/17 FALLS BRIEFING UPDATE

Juliette Cosgrove presented the above report (Appendix E), highlighting the Trust's current position in relation to quality improvement initiatives at throughout April to June 2017 and current performance in relation to falls metrics.

The Trust has seen a step change in the number of falls being reported month on month, from an average of 173 down to 156. This change has been evident and is being maintained. Throughout 2016-2017, a number of interventions began to be embedded and, as anticipated, results began to be seen in quarter 4 including:

- The introduction of a falls lead to build relationships with the Improvement Academy, the falls champion network and a falls prevention equipment company which provides in-house training as and when requested.
- A senior clinical lead taking responsibility for steering the Trusts falls collaborative
- A regular working group has been meeting weekly to progress a number of interventions at pace, with the primary focus being on falls in acute medicine, but through links with the falls champions and the Trustwide remit of the falls lead, surgical areas have also benefited.
- The collaborative is planning an awareness campaign for July 2017 to promote how falls prevention gets attention, national audits were repeated in May 2017, initial findings indicate areas that need improving.

Discussion ensued on the use of electronic equipment, such as falls alarms, and the work that is being mirrored in community. The Improvement Academy have developed joint safety huddles with the intermediate care bed base, which have reduced the number of falls. The falls collaborative were commended for the good work done and the positive impact created. It was suggested that the members of the collaborative are invited to give an update to the Board of Directors, and that an update report is submitted to this Committee in six months' time, or sooner, if there are any significant changes.

ACTION: Update report to be submitted in 6 months' time (Wednesday, 3rd January 2018), however, any significant changes to be reported sooner.

ACTION: That the members of the falls team are invited to give an update to the Board of Directors (preferably 3rd August 2017)

OUTCOME: The Committee received and noted the report

109/17 SERIOUS INCIDENT REPORT

Andrea McCourt presented the above report (Appendix F), highlighting seven new serious incidents reported to the Clinical Commissioning Groups in May / June 2017, up to 23rd June - 4 falls, 1 pressure ulcer, 1 diagnostic incident and 1 maternity incident, all within the medical division.

12 reports were also submitted to commissioners in May and June 2017, the root causes and learning of which are summarised at the end of the report - 3 falls, 2 disruptive/ aggressive/ violent behaviour, 1 screening issue, 1 diagnostic incident, 1 sub-optimal care of deteriorating patient, 2 treatment delays, 1 pressure ulcer and 1 maternity / obstetric incident.

Discussion ensued on investigator capacity. Training is currently available and investigators are being aligned with colleagues who have completed 'good' falls reports in the past. It is sometimes difficult to find a more advanced investigator for more difficult investigations, and the amount of time taken to do work is quite an undertaking. It is important to acknowledge the support that will be given to colleagues who are doing serious incident investigations.

Work is ongoing on producing weekly bite-sized learning bulletins, which are published in the CHFT weekly newsletter, as well as the publication of the first leaflet which will focus on falls. It was suggested that one of the bulletins could focus on the investigation of an incident. Discussion also took place on a section of shared learning from the orange panel meetings. The learning reports from all incidents are shared at divisional Patient Safety and Quality Board (PSQB) meetings as well as the effective investigations intranet page.

ACTION: To circulate the falls learning leaflet to the Quality Committee once completed.

OUTCOME: The Committee received and noted the report

110/17 **CORPORATE RISK REGISTER**

Andrea McCourt presented the high level risk register (Appendix G), as at 23rd June 2017, with a summary of changes from May:

- 8 top risks
- 1 risk with an increased score from 20 to 25
- 3 new risks scored at 20, 15 and 16
- 1 closed risk previously scored at 20, reduced to its target score of 5 and proposed for closure

A copy of the high level risk register by type, and a copy of the risk register were also available.

OUTCOME: The Committee received and noted the report

111/17 **NEVER EVENT 138202 – RETAINED SWAB**

Andrea McCourt gave a presentation, previously taken to the Weekly Executive Board meeting, regarding a serious Incident / surgical never event of a retained swab in theatre. The background to the incident was summarised, as well as the key root causes, contributory factors and actions, with a very robust process now used in theatres.

OUTCOME: The Committee received and noted the presentation.

112/17 **HEALTH AND SAFETY COMMITTEE**

Lesley Hill presented the above report (Appendix I) following the meeting held on 21st June 2017, which highlighted:

- *Fire safety* - the need to review the number of fire wardens and provide training, and assurance received regarding any cladding concerns for CHFT. There is no flammable cladding at CHFT – HRI is covered in stone and CRH is covered in reconstituted stone.
- *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)* reporting - Clarity required on the number of patient related incidents which are to be reported as RIDDOR reportable incidents to the Health and Safety Executive (HSE).
- *Medical device training* - compliance reduced over April / May period as colleagues were training on EPR.
- *Violence and aggression policy* - shared with Committee and approved in principle, next step is to sign off at WEB. Implementation includes security / police / fire safety / counter terrorism / victim support event which will be held on 18th July at HRI Main Entrance.
- *Emergency planning policy* - shared with Committee and approved however, training strategy being developed to ensure robust training in place for Strategic (Gold), Tactical (Silver) and Operational (Bronze) leads and on call colleagues.

- *Business Continuity Policy* – this was shared with the Committee and approved
- Unannounced HSE visit regarding water safety – HSE spent a day, and received positive feedback.

OUTCOME: The Committee received and noted the report

113/17 **CLINICAL OUTCOMES GROUP REPORT**

David Birkenhead presented the above report (Appendix J) following the meeting held on 22nd May 2017, highlighting:

- *Mortality Rate* - The Hospital Standardised Mortality Ratio (HSMR) rate has fallen to 100.37 which is the lowest it has been. This is positive for the organisation, and is a testimony to all involved in the work. The Summary Hospital-level Mortality Indicator (SHMI) has also fallen, now down to 105, previously at 108. This is expected to fall again.
- *Care Bundles* - improvement work is fairly static with a focus on performance, but now needs quality work to be prioritised to move forward. There is an issue with how data can be pulled from EPR, and will have a gap in reporting until resolved.
- *Mortality review process* - screening review performance has fallen. The focus is to ensure we are meeting the requirements of the national process. These requirements include changing the existing protocol to a policy to include family and carer involvement and shared learning.
- *Nasogastric tube training* – the risk regarding nasogastric tube feeding is assessed at 15 on the risk register. Training for registered nurses needs to be mandatory at induction, the plan to implement this is under discussion.
- *Dementia* – good work is ongoing with dementia; recruitment of student volunteers to work alongside the social engagement workers on wards and anticipating excellent objective outcomes from the Prevention of Delirium (POD) pathway
- *Self-administration of medicines* – the CQUIN has been met, and the result of the latest achievement was 97%. A task and finish group will be established to look at the issue of accessing of bedside medication drawers and other medicine management issues, e.g. fridge monitoring, etc.

Congratulations were conveyed to all regarding HSMR.

OUTCOME: The Committee received and noted the report

114/17 **MORTALITY SURVEILLANCE GROUP REPORT**

David Birkenhead presented the above report (Appendix K) following the meeting held on 7th April 2017, highlighting:

- *Learning Disabilities Report* - Matron McKie presented inpatient deaths of adults with a learning disability for 2016/17. 9 deaths have been recorded so far and 3 within the community; of those 9, 7 were recorded as defiantly not avoidable and 1 was part of a red serious investigation.
- *Review of Anaemia outlier alert* – 13 patient deaths in the alert period were reviewed, there were no avoidability concerns noted.

OUTCOME: The Committee received and noted the report

115/17 PATIENT SAFETY GROUP REPORT

Lindsay Rudge presented the above report (Appendix L) highlighting issues raised following meetings held on Thursday, 6th April and Thursday, 1st June 2017:

- Clinical attendance at Thrombosis Committee – now have representative to attend
- Number of outstanding incidents still requiring closure and actions from those – these have now been closed.
- Review of red flag data – incidents have been reported, but the impact of the incident has not been stated and how it relates to harm. Some more work is being done with a decision to be made as to whether this data is captured on Datix or the new rostering system.

A further extraordinary meeting was held on 15th June 2017, with the following issues highlighted:

- Report received from the Radiation Protection Board
- Concerns on venous thromboembolism (VTE) performance and awaiting update from the Thrombosis Group in June. Not assured that data can be extracted as robustly as before, and difficult to understand at the moment.
- Concerns with junior doctor representation into meeting – this will be secured going forward

OUTCOME: The Committee received and noted the report

116/17 COMPLIANCE WITH NICE GUIDANCE

Juliette Cosgrove presented the above report (Appendix M), highlighting progress made with NICE guidance in the last six months:

- Six partially compliant clinical guidelines became fully compliant:
 - Clinical Guideline 139 – Infection Control
 - Clinical Guideline 145 – Spasticity in children and young people
 - Clinical Guideline 152 – Crohn’s Disease
 - NICE Guideline 4 – Safe midwifery staffing for maternity settings
 - NICE Guideline – Menopause: diagnosis and management
 - NICE Guideline 28 – Management of type 2 diabetes in adults
- One guideline moved from partially compliant, to partially compliant with no further action:
 - NICE Guideline 38 – Assessment and management of fractures (non-complex)

The current status of:

NICE Clinical Guidance:

- 114 fully compliant
- 45 partially compliant and working toward full compliance
- 18 not compliant and not working toward full compliance – 18
- 11 awaiting response

NICE Technology Appraisals

- 262 fully compliant
- 24 awaiting response

NICE Interventional Procedures

- 67 fully compliant
- 3 awaiting response

There are still a number of areas of non-compliance; however, it is generally an improving picture. There are areas of good practice which need to be highlighted.

OUTCOMES: The Committee received and noted the report
Progress report to be submitted in six months' time

117/17 **ACCREDITATION SCHEMES REPORT**

Cornelle Parker presented the above report (Appendix N) which shows the Trust's position in terms of accreditation schemes undertaken.

Discussion ensued on where this work should be monitored – the Risk and Compliance Group or the Quality Committee, and it was agreed that it should continue in the Risk and Compliance Group, with an exception report submitted to relevant committees and board meetings. It was also stated that non-clinical reports should also be included, for example, Joint Advisory Group (JAG) accreditations.

The managing external agency visits, inspections and accreditations policy, which is due to be reviewed, will include amendments to reporting route, as well as a flowchart to highlight governance.

OUTCOMES: The Committee received and noted the report.
Exception report to be submitted from Risk and Compliance Group.

118/17 **QUALITY AND PERFORMANCE REPORT**

Helen Barker presented the above report (Appendix O) which summarised May's performance score of 61% for the Trust. The safe domain remains green, although harm free care and pressure ulcers have deteriorated. The responsive domain remains amber, failing to meet the Emergency Care Standard and the two week wait target which was missed for the first time in over 12 months. Caring has deteriorated to red due to a number of Friends and Family Test targets being missed. Electronic Patient Record (EPR) has impacted on the provision of several indicators this month, including 18 weeks admitted and non-admitted, venous thromboembolism (VTE), coding and day case rates.

- Most improved areas were:
 - Sickness Absence rate (%) achieved 3.6% in April (target 4%) with both long and short term sickness achieving target.
 - Friends & Family Test (FFT) (inpatient and Maternity Survey) - % would recommend the Service - although FFT performance has struggled in some areas, these two areas reached a peak in May at 98.3% and 98.6% respectively.
 - Falls per 1000 bed days was at its lowest position for over 12 months.
- Most deteriorated areas were:
 - Friends and Family Test - % response rate (inpatients, outpatients and A&E) and % would recommend the service across outpatients, A&E and Community.
 - Two week wait from referral to date first seen reduced to 84%. First time 93% target has been missed for over 12 months. Key issue for May was reduction in capacity due to last minute departure of agency locums and booking centre pressures post-EPR deployment. Some work will be done with clinical colleagues as the rate of fast-track is increasing.
 - Emergency Care Standard 4 hours. Two areas of pressure, EPR deployment and middle grade doctor capacity.

- Appointment Slot Issues on choose and book increased to 33% in May.
- % harm free care performance has deteriorated in-month to 93.6%. A deep dive review has now been completed and shared through divisional teams and with the improvement leads for falls, pressure ulcers, Catheter-associated urinary tract infections and venous thromboembolism. Improvement plans are to be reviewed and aligned to findings.

OUTCOME: The Committee received and noted the content of the report.

119/17 QUALITY IMPACT ASSESSMENT

Nicola Bailey and Helen Marshall were in attendance to present the 2017 / 2018 Cost Improvement Programme (CIP) Quality Impact Assessment (QIA) summary report (Appendix P).

This year, the QIA process was reviewed and updated in early 2017, resulting in the addition of an initial review stage in the process, with an expansion of the panel membership. A total of 115 schemes will be monitored to deliver efficiency savings in 2017-2018 of £11.5m. 45 schemes have been assessed, with 40 schemes approved, 1 requiring further work before approval and 4 schemes either deferred or not approved. No adverse quality impacts have yet been identified.

Discussion ensued on the 3,6 and 9 month reviews for schemes and the robust processes in place. The Quality Committee were assured with the QIA process and accepted the report.

OUTCOME: The Committee received and noted the content of the report.

120/17 PLAN ON A PAGE 2017/2018

A copy of the 2017/18 plan on a page (Appendix Q) was circulated and accepted.

121/17 ANY OTHER BUSINESS

Dr Anderson reported on the Freedom to speak up: raising concerns (whistleblowing) policy, which from a clinical governance and well-led review perspective, will be an area of scrutiny for the CQC. It was stated that work is being done on routes where concerns are raised.

122/17 MATTERS TO BE REPORTED TO THE BOARD OF DIRECTORS

- Reports received on Quality Impact Assessment and the Full Business Case service model for hospital reconfiguration
- Improvements made in sepsis and work ongoing
- Falls are reducing and suggest collaborative team give an update to the Board of Directors
- Learning received from serious incidents
- Presentation received on never event

123/17 QUALITY COMMITTEE WORK PLAN

The work plan (Appendix R) was circulated and accepted.

NEXT MEETING

Monday, 31st July 2017

3:00 – 5:30 pm

Board Room, Sub Basement, Huddersfield Royal Infirmary

**Minutes of the Finance & Performance Committee held on
Tuesday 4 July 2017 at 8.00am
Room 4, Acre Mill Outpatients building, Huddersfield Royal Infirmary**

PRESENT

Helen Barker	Chief Operating Officer
Anna Basford	Director of Transformation & Partnerships
Gary Boothby	Director of Finance
Richard Hopkin	Non-Executive Director
Phil Oldfield	Non-Executive Director (Chair)

IN ATTENDANCE

Rob Aitchison	Director of Operations – FSS (for Item 098/17)
Kirsty Archer	Deputy Director of Finance
Stuart Baron	Associate Director of Finance
Karen Barnett	Director of Operations – Community (for Item 156/16)
Mandy Griffin	Director of Health Informatics
Andrew Haigh	Chair of the Trust
Brian Moore	Membership Councillor
Betty Sewell	PA (Minutes)

ITEM

WELCOME AND INTRODUCTIONS

094/17 The Chair welcomed attendees to the meeting, it was noted that Helen Barker, Anna Basford and Gary Boothby would leave the meeting at 10.00am in order to attend Scrutiny discussions with the Council. It was agreed that the Agenda would be adjusted accordingly.

095/17 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Vicky Pickles – Company Secretary
Owen Williams – Chief Executive
Jan Wilson – Non-Executive Director

096/17 DECLARATIONS OF INTEREST

There were no declarations of interest.

097/17 MINUTES OF THE MEETING HELD 30 MAY 2017

Subject to a couple of minor changes the Minutes of the meeting held 30 May were approved as an accurate record.

098/17 MATTERS ARISING AND ACTION LOG

087/17 – EPR, Bradford go-live a meeting has taken place and it has been agreed that Bradford will share a benefits report once it has been to their Board. In terms of the risks and mitigations if Bradford's go-live date slips further, it was confirmed that conversations have taken place and further information will be provided at the next meeting.

Radiology Capacity Planning – The Director of Operations for FSS introduced the paper which provided an overview of current capacity and demand across the different radiology modalities as well as describing planning by the service to respond to projected growth for 2017/18 and beyond. It is unclear at the present time to know how successful Demand Management can be within the Radiology Directorate but it is being pursued. The key points from the paper were noted as follows:

MRI

- There are 3 scanners across the Trust available seven days a week.
- Referral growth is anticipating an additional 33 hours of scanning time per week.
- This will be achieved by extending the current opening times.
- For capacity planning, the areas of focus are outpatient and direct access referrals.
- If demand continues to increase, available machine time will be an issue.

CT

- There are also 3 CT scanners, the oldest is sited at CRH and it is envisaged that this will require replacement within the next 6 – 12 months and work is progressing to Business Case stage.
- An additional 12 hours of scanning time per week will be achieved by extending the current opening hours.
- Staffing levels continue to be a risk, however, the service are currently training staff in-house and do not anticipate issues in maintaining the workforce required to extend the current opening hours.

Ultrasound

- Recent months have seen problems in Ultrasound breaching the Trust's 6 week target. The issues have been predominantly caused by staffing and the drive away from using agency staff, this has now been addressed.

Reporting Capacity

- Reporting capacity is the biggest challenge
- National tariff – running at a loss

Helen Barker confirmed that she would discuss with Peter Keogh how we establish KPIs for referrals. Helen also asked for some context, in any future report, with regard to staffing levels with some connection to the Workforce Strategy, also what is mandated nationally.

Discussions took place with regard to demand management and it was confirmed that targets to reduce demand have not been set. However, internal recharges will take place this year and within the planning round Divisions were asked to identify any NICE guidance which was imminent.

The question was asked with regard to the continued growth rate and what would be our longer term plan. It was noted that WYAAT may play into this with regard to regional trusts working together the Trust would also continue to have

conversations with external providers to agree outsourcing arrangements which would help with additional capacity.

It was acknowledged that capital is an issue for the Directorate and discussions with outside providers are going to be key. The financing of an additional CT Scanner was also discussed and whether this could be the focus of a fundraising campaign for Charitable Funds.

ACTION: The next steps for this report would be to come back to this Committee with a firm proposal and the challenges faced for 2018/19 and beyond. **RA – 5 December 2017**

The Committee thanked Rob for a very informative paper which was received and noted by the Committee.

156/16: Community Services – The Director of Operations for Community presented the Committee with a report detailing the service areas we operate within the Community Division and cross-divisional services, with the majority commissioned by Calderdale CCG. It was noted that dashboards for the services are monitored monthly through the Community Performance Review meetings. However, the Division recognise the funding challenges and are being more robust around the activity which is undertaken. It was also noted that the CCGs are reviewing a number of services to ensure they are getting value for money. Within the last financial year the Division has had one service cut which has left only one Heart Failing Nurse within Calderdale which is contrary to Greater Huddersfield who are investing in Heart Failing Nursing.

In terms of Therapy, the first point of contact for MSK in Calderdale went live on the 1 June providing a triage service for all orthopaedic referrals which is intended to reduce the number of elective procedures. Physiotherapy service is a challenge due to the large number of vacancies which has had an impact on our waiting lists. This service has been re-modelled which is hoped will have a positive impact. The challenges and complexities within Children's therapy services were also highlighted and discussed.

It was also reported that there continues to be residual issues that need to be resolved with Locala following CC2H in 2015 and a joint meeting with Commissioners and Locala is planned for next week. It was noted that the Public Health Early Years' service, which was put out to tender in December 2016 has been awarded to Locala and our staff transferred to Locala on the 1st July 2017.

There are opportunities which are developing around the integration agenda and the need for CHFT to be inclusive was discussed. With regard to the Community Place this has been a successful pilot across Social Care and CHFT and due to this success we are looking to offer a Community Place at HRI and discussions are taking place. In depth discussions took place with regard to Social Care across both Calderdale and Greater Huddersfield and it was acknowledged that Community Services are very complex and fragmented.

The Committee thanked Karen for her report which was well received and noted by the Committee.

170/16: Consultant Investment Principles for the future engagement of external consultants – this paper was deferred to the next meeting.

090/17: Forward Planning and Risks associated with the backlog of Capital Schemes – this paper was held until later on the agenda.

099/17 MONTH 02 FINANCE REPORT

The Assistant Director of Finance, took the Committee through the Finance Report for Month 02, the following headlines were noted:

- Income & Expenditure reported a £6.1m deficit in line with plan
- Capital spend is below plan due to the underspend on equipment which will catch up later in the year.
- Cash is in line with plan which is supported by borrowing, a considerable reduction in aged debt is reported this month following year end.

In depth discussions took place with regard to the Income and Expenditure position which is reporting on plan but the underlying position is fragile and is reliant on non-recurrent benefits and Contingency Reserves. The reported Pay expenditure shows an underspend compared to plan although this positive variance is primarily due to the release of Reserves.

The implementation of EPR in May has had a significant impact upon the capture and coding of both admitted and non-admitted activity. A large estimate, which included a line-by-line assessment of the activity based on other IT systems has therefore been required to reflect the anticipated impact of inputting or correcting this backlog within the Cerner system.

It was highlighted that even though activity, driven by outpatients is down, expenditure is not and actions are being taken through the implementation of recovery plans lead by the Turnaround Executive and the Divisional reporting process.

The YTD position assumes full receipt of STF. 70% of this relates to financial position and 30% to ED performance. The ED performance trajectory has not been met but an appeal will be made due to the exceptional circumstances of EPR introduction

The Chief Operating Officer assured the Committee that additional resource is being deployed in a number of areas to ensure we get data migration and coding back on track.

In light of the above and to heighten awareness to the Board and the whole organisation, the Financial Risk to achieve the I&E position has been increased from 20 to 25. A communication plan is being worked up to ensure everyone is aware of the challenges ahead.

101/17 CIP UPDATE

The Director of Transformation & Partnerships updated the Committee with the key headlines:-

- The plan for CIP is £17.3m
- The current forecast to plan is £16.4m, which is a much improved position from previous months
- All, apart from two schemes totalling £1.3m are at GW 2.
- The majority of schemes are RAG rated high-risk.
- It is a much improved position but still more to do
- The stretch target of £20m is high-risk but our focus is achieving the £17.3m plan.
- Star chamber is scheduled around diagnostics
- Six schemes are flagging RED
- Following the visit from NHS I their findings endorsed our process and wanted to share our good practice with other Trusts.

The Director of Finance updated the Committee with regard to Soft FM, this is still being worked through and is being reviewed by external legal advisors.

104/17 INTEGRATED PERFORMANCE REPORT

The Chief Operating Officer reported as follows:-

It was noted that this has been a challenging month and the Trust's performance score for May has fallen to 61%. It was acknowledged that not all issues are EPR related with challenges around IR35 playing through. Caring has deteriorated to RED due to the number of FFT targets being missed.

Re-admissions is being scrutinised to find out what is driving this, one piece of work being asked for is to be clear what is being recorded as a planned and un-planned pathway.

June has been equally challenging for A&E with the combination of EPR and IR35 which is a significant problem, it is not financially or clinically sustainable and a task and finish group around business continuity is being set up. This has been shared with Commissioners.

The 2 week wait failed in May and June once again the biggest issue has been IR35. As a result the Dermatology service is being reviewed

Other issues for F&P Committee

- Deterioration in #NoF has impacted on our ability to recoup the best practice tariff.
- Flow issues have impacted on Stroke.
- A deep-dive will be undertaken with regard to the number of beds in the plan against the actual figure to give assurance for the CIP plan.

The Committee noted the contents of the report and the overall performance score for May.

100/17 NHS IMPROVEMENT VISIT – FEEDBACK

The Director of Finance reported that the correspondence from NHS I following their recent deep-dive into CIP was complimentary and that our governance process is robust. The regulators are aware of the scale of our risk but did not provide us with any more opportunities.

The Committee noted the contents of the correspondence.

The Director of Finance, Director of Transformation & Partnerships and Chief Operating Officer left the meeting.

102/17 EPR UPDATE AND HIGHLIGHT REPORT

The Associate Director of Finance presented the paper which went to the Transformation Board and sets out the financial position up to 31 May 2017. It was noted that the reporting table is slightly different from usual and as part of the hand-over to Bradford they now are taking over more of the admin for the project. The following headlines were noted from the report:-

- Capital overspend against the original business case is consistent with previous reports and includes the VAT on agency costs.
- The key financial risk this month is to ensure everything is captured with regard to the resource to support go-live.
- Shared costs - discussions will take place to understand the reason for the slippage of BTHFT's go-live date to September.

An updated position with regard to Bradford's EPR readiness was provided to the Committee, it was noted that they are RAG rated Yellow which means they are on plan to achieve go-live in September. However, two elements were highlighted which may have an impact on that date namely Pathology and data capturing and deployment of hardware/infrastructure. It was also noted that the quality of data migration from Bradford will be critical for CHFT with regard to productivity.

Discussions took place with regard to CHFT investment in hardware to see future benefits particularly within surgical and theatres. It was acknowledged that revised ways of working could alleviate the situation but it was suggested that Mandy Griffin should have a conversation with Charitable Funds to clarify any funding opportunities.

103/17 EPR BENEFITS

The Director of Health Informatics introduced the paper which identified the current position of the EPR benefits it described the governance arrangements, proposes the way forward to identify future benefits and how this will be effectively managed.

It was agreed that a clearer action plan would come back to the Committee in December.

The Committee received the paper and supported the recommendations within the report.

098/17 090/17: Forward Planning and Risks associated with the backlog of Capital Schemes – The Associate Director of Finance explained that the paper provided the Committee with the Trust’s final capital plan for 2017/18, identifying areas of planned spend and outlining the residual risk of areas where investment was not supported.

The plan has been discussed at WEB and has divisional sign-off, the plan will also be presented to the Commercial Investment and Strategy Committee on the 20 July 2017.

The Committee discussed the level of the risk scores set against the schemes and it was agreed that risks should be reviewed with regard to regulatory risk and what is a health and safety risk.

The Committee noted the paper and recognised the challenge.

105/17 BOARD ASSURANCE/HIGH LEVEL RISKS

The Committee reviewed the BAF and the risks which are owned by the F&P Committee. Following a detailed conversation the following was agreed:-

Risk 019: Failure to maintain a cash flow – **risk rating to be queried**

Risk 021: Failure to deliver the financial forecast position etc. – **agreed the revised risk score of 25**

Risk 022: Failure to secure sufficient capital – **query wording and risk rating**

ACTION: To discuss with the Company Secretary the wording and the rate of score for Risks 019 and 022 - **SB**

106/17 MONTH 02 COMMENTARY ON THE FINANCIAL RETURN TO NHS IMPROVEMENT

The Committee noted the contents of the paper.

107/17 MINUTES FROM SUB-COMMITTEES:

Capital Management Group – Draft Minutes of meeting held 8 June 2017. It was noted that Stuart Baron was in attendance.

The Committee received the Minutes and noted the contents.

108/17 WORK PLAN

The Work Plan was received by the Committee.

109/17 MATTERS FOR THE BOARD AND OTHER COMMITTEES

The Chair of the Committee summarised the following items which had been discussed during the meeting:-

- Radiology – good discussions with regard to capacity and reporting with a further update in December to include how this ties in with the FBC
- Community – the Committee recognised the challenges and difficulty for the Division operating with different commissioners and the scale of services.
- Month 02 is on plan ytd, however, the forecast challenge was acknowledged.
- CIP Programme and high-risk schemes

- EPR – Benefit Realisation programme was discussed, validation of the original plan will take place and will be progressed through PMO. Capital was also discussed and the risk share on Bradford's go-live.
- STF – to receive in full and the risks associated with this
- Feedback from the NHSI visit was positive
- Risks – the Committee agreed the 25 financial risk rating. Rating on capital and cash to be reconsidered.
- Capital – reviewed the risks re revised plan

110/17 ANY OTHER BUSINESS

No items.

DATE AND TIME OF NEXT MEETING

Tuesday 1 August 2017, 9.00am – 12.00noon,

Room 4, Acre Mill Outpatients building, Huddersfield HD3 3AE

DRAFT

**Minutes of the Calderdale & Huddersfield NHS Trust Board of Directors and
Council of Governors Annual General Meeting held
on Thursday 20 July 2017 at 6.00 pm in Meeting Room 3 & 4, 3rd Floor, Acre
Mill Outpatient Building, Huddersfield Royal Infirmary**

PRESENT

Speakers

Mr Andrew Haigh, Chairman
Dr David Birkenhead, Executive Medical Director
Mr Gary Boothby, Executive Director of Finance
Mr Brendan Brown, Executive Director of Nursing/Deputy Chief Executive
Mr Peter Middleton, Publicly Elected Member-Lead Governor
Mr Alastair Newall, Senior Manager – KPMG External Auditors
Mr Owen Williams, Chief Executive

Others present:

Board of Directors

Dr David Anderson, Non-Executive Director
Mrs Helen Barker, Chief Operating Officer
Mrs Anna Basford, Director of Transformation & Partnerships
Mr Jason Eddleston, Executive Director of Workforce & OD
Mrs Mandy Griffin, Director of THIS
Mrs Karen Heaton, Non-Executive Director
Mr Richard Hopkin, Non-Executive Director
Ms Lesley Hill, Executive Director of Planning, Estates & Facilities
Dr Linda Patterson, Non-Executive Director
Mrs Jan Wilson, Non-Executive Director
Mrs Victoria Pickles, Company Secretary

Governors

Mrs Annette Bell
Mrs Dianne Hughes
Mrs Veronica Maher
Mr Bob Metcalfe
Mr Brian Moore
Mrs Lynn Moore
Mr Brian Richardson
Mr George Richardson
Ms Kate Wileman

1. CHAIR'S OPENING STATEMENT AND INTRODUCTIONS

The Chairman opened the meeting by welcoming people to the Acre Mills Outpatient Building. He introduced the speakers and noted that other members of the Board of

Directors and Council of Governors were also present in the audience. The Chairman highlighted the divisional displays showcasing their developments during the year and on behalf of the Board and Governors thanked staff for their support.

2. APOLOGIES

Apologies were received from:

Board of Directors

Mr Philip Oldfield, Non-Executive Director
Prof. Peter Roberts, Non-Executive Director
Mrs Clare Partridge, Engagement Lead – KPMG

Governors

Mr Grenville Horsfall
Dr Mary Kiely
Mr David Longstaff
Mrs Sharon Lowrie
Dr Cath O'Halloran
Graham Ormrod
Mrs Dawn Stephenson

3. ANNUAL REPORT 2016/17

The Chairman reported that the Membership Council had recently agreed a change of title and were now the 'Council of Governors'. He gave thanks to all staff and patients involved in the recent implementation of the Electronic Patient Record (EPR). It was recognised that the implementation had been successful however there had obviously been some difficulties encountered along the way.

He mentioned that the Trust was in the top 20% of Trusts in the country for recognising the contribution our staff make to improving care in this year's annual NHS Staff Survey. The Trust was now in its second year of awarding monthly Star Awards and nominations are being received from colleagues of all disciplines.

The Chairman reported that 2017 would see the finalisation of the full business case for the reconfiguration of hospital services, outlining how healthcare will be provided in our hospitals and community into the future.

The Chairman commented that the NHS financial position is challenging and will continue to be in the future. He thanked the Council of Governors who had completed their tenures along with thanks to the Board, Volunteers and League of Friends for their support throughout the year.

4. ANNUAL ACCOUNTS – APRIL 2015 TO MARCH 2016

Gary Boothby, Executive Director of Finance presented the Annual Accounts, full details of which were available in the Annual Report. It was noted that the details of these had been discussed at the Board of Directors Meeting and these were approved as a correct record.

The key areas were noted:

Planned 2016/17 Position

The Executive Director of Finance explained the planned 2016/17 position with the introduction of control totals and Sustainability and Transformation Fund (STF) which resulted in a planned deficit position of £16.1m.

Financial Context

Over the year the Trust had seen:

- 120,000 inpatients – elective, non-elective and day cases
- 459,000 outpatients
- 151,000 A&E attendances
- 310,000 community contacts

In addition the Trust has a turnover of £375m, the majority of which is spent on staffing with 6,000 colleagues employed by the Trust. There is property and equipment over two hospital sites with a combined value of £234m. The Trust, like others, is facing a challenging financial and operational landscape.

The Trust's Performance in 2016/17 compared to 2015/16:

- 1% more non elective inpatients were treated
- 2.5% more activity was seen in A&E
- 5.1% increase across planned day case and elective activity combined, with a shift towards more day case delivery.

Key Financial Pressures

- High levels of clinical staffing vacancies and national recruitment pressures
- High levels of agency staffing costs
- Commissioner affordability
- Junior Doctors strike action
- CRH Endoscopy Department fire
- EPR Implementation costs

2016/17 Financial Performance

	<u>Plan</u>	<u>Actual</u>
Income and Expenditure	(16.15m)	(16.06m)
Capital Expenditure	28.22m	24.09m
Cash Balance	1.95m	1.94m
Loans	67.87m	61.78m
CIP	14.00m	14.98m
Use of Resources	3	3
Unqualified External Audit Opinion	√	√

2016/17 Capital

Total capital expenditure of £24.1m, invested in:

Theatre refurbishment	£2.0m
Other estates	£4.5m
Electronic Patient Record	£7.4m
Other IT	£4.6m
Equipment	£3.4m

Other

£2.2m

The Future

The Executive Director of Finance explained that the NHS faces unprecedented financial challenges both locally and nationally. Locally the Trust has seen an increased demand for services which will require closer joint working with other organisations across West Yorkshire. He concluded that there were no short term solutions to CHFT's financial deficit.

5. QUALITY REPORT

Brendan Brown, Executive Director of Nursing along with Dr David Birkenhead, Executive Medical Director presented the Quality Report. The presentation highlighted the quality priorities for 2016/17 and their progress:-

- Quality Priorities for 2016/17:- Falls – introduction of Safety Huddles
Implementation of Hospital Out of Hours (HOOP)
Understanding the Community Experience
- CQC Progress since inspection
- Mortality – fall in HSMR and SHMI cases
- Quality Priorities 2017/18 – Strategic aims:-
 - Care of the Acutely Ill Patient Programme
 - End of Life Care Strategy
 - Safe Care
 - Improving Community Service
 - Demonstrate Engagement and Co-Design
- Continued improvement in delivery of national standards and national Reporting data sets
- Continue to be an organisation that is research active and have exceeded targets for recruiting onto the clinical trials.
- Improving Patient Experience – PRASE Study, noise at night project, true patient and service user engagement
- Infection Prevention and Control – rate of c.difficile reduced.
- Engagement and Co-Design – developing a quality improvement network, Quality enthusiasts to underpin approach and methodologies using wide range of QI expertise within and outside of organisation.
- 3 Key Priorities for 2017/18 – sepsis screening, discharge planning, learning from Complaints
- What's next:-
 - Introduction of a Ward Assurance Tool
 - Roll out of a Peripatetic Nursing Team
 - Targeted recruitment
 - Instillation of 'Reminiscence Pods'
 - Introduction of a CHFT safety manual
 - Delivery of a Quality Improvement Strategy

6. EXTERNAL AUDIT OPINION ON ANNUAL REPORT/QUALITY ACCOUNTS

Alastair Newall, Senior Manager from KPMG gave a presentation outlining the work undertaken by the external auditors on the Annual Report and Accounts and the Quality Accounts. He explained the areas focussed on within the Audit were:-

- Financial Statements Audit
- Use of resources
- Review Annual Report and Annual Governance Statement
- Quality Report

Financial Statements and Annual Report

It was noted that within the financial accounts an unqualified audit opinion had been issued. There were no unadjusted audit differences although a few minor amendments were required – none with an impact on the Trust's reported position. There had been recommendations relating to controls operating within some financial systems but no material concerns.

Use of Resources

The Senior Manager for KPMG explained that the audit had concluded that the Trust had:-

- Qualified 'except for' conclusion on the Use of Resources which reflects the breach of licence that the Trust has been in through 2016/17
- Improvements made in many areas and has delivered its financial 'control total' in 2016/17 and exceeded its planned savings for the year.

Review of Annual Report and Annual Governance Statement

The Annual Report and Annual Governance Statement was consistent with financial statements and complied with the FT Annual Reporting Manual (ARM). Some minor amendments and improvements had been suggested.

Quality Report

The content of the Quality report complied with the FT Annual Reporting Manual requirements. Some minor amendments had been suggested and a qualified opinion had been issued with 'except for' the opinion on the basis of the results of the indicator testing.

Three indicators had been tested – including two national priority indicators mandated by NHS Improvement and one locally selected priority:

- A&E 4 hour wait - % of patients with a total time in A&E of 4 hours or less from arrival to admission, transfer or discharge;
- 18 week incomplete pathways - % of incomplete pathways within 18 weeks for patients on incomplete pathways
- Stroke ward admissions - % of stroke patients admitted to a stroke ward within 4 hours.

The conclusion from the testing was:-

- A&E 4 hour wait – no issues identified
- 18 week incomplete pathways – cases had been included in the indicator which were not pathways, one recommendation made, and a qualified assurance opinion given.

- Stroke ward admissions – cases reported as not being admitted within 4 hours but testing indicated that had been, would always lead to an underreporting of performance and quality checking is only focussed on cases that failed, two recommendations made.

7. FORWARD PLAN

Owen Williams welcomed everyone and thanked staff, volunteers and Governors for their work and commitment in caring for patients. He also wished to thank the Board of Directors for their commitment and challenge over the past year throughout the reconfiguration of services consultation.

Looking ahead the Chief Executive reported that the Trust would continue to use the 4 pillars of behaviour to achieve compassionate care:

- we put the patient first
- we work together to get results
- we do the must do's
- we go see

The Chief Executive set out the key areas of work for the Trust over the next year:

- Reconfiguration – he explained that the full business case would be submitted to the commissioners and regulators and that the Joint Overview and Scrutiny Committee was scheduled for the next day.
- Cost Improvement Programme – Work continued both within the Trust and across West Yorkshire to develop a Sustainability and Transformation Plan. These were also being impacted upon by national discussions around the financial challenges in the NHS.
- Electronic Patient Record (EPR) – the Trust had implemented a whole new EPR which was key to ensuring better patient care and help to provide efficient services in the future.
- Care Quality Commission – The Trust's ambition was to keep improving services and to deliver the actions which had been developed following the inspection.

The Chief Executive emphasised that the care given by all staff clinical and non-clinical should not be recognised and thanked all colleagues for their help and support.

He shared a patient story which highlighted the views of a patients relative on their personal experience who had shared information with the Chief Executive so that the organisation could learn from the feedback.

He encouraged the public to continue to keep fighting for services to be retained on the patch and assured everyone present that the Trust would be fighting hard to retain services as locally as possible.

The Chief Executive wished to give particular thanks was given to Andrew Haigh, Chairman whose tenure on the Board was due to finish in Spring 2018.

The Chairman thanked everyone for their contributions and reinforced that it was clear that this current year was going to be just as challenging as 2016/17.

8. ELECTION RESULTS AND APPOINTMENTS

The Chair reported that the second half of the meeting would concentrate on the Membership Council AGM.

a. Council Members

The Chairman reported the results of the elections run by the Electoral Reform Services on behalf of the Trust over the period 20 April to 6 July 2017. This had resulted in five public and 4 staff seats being filled.

It was noted that Brian Moore had been appointed as Lead Governor to take over from Peter Middleton on the 15 September 2017. The Chair thanked Peter for his support as Membership Councillor for the six years and latterly as Lead Governor for the Council of Governors since 2016.

The Chairman extended a welcome to the newly elected and re-elected members along with Kate Wileman who had agreed to stay on for another year on the Reserve Register.

All these appointments could be seen on the Register of Members which was available within the packs. The ballot turnout rate this year was around 12% which was comparable to other trusts.

The Chairman wished to thank the other retiring members who included:- Grenville Horsfall, George Richardson, Mary Kiely, Linda Dawn Salmons and Eileen Hamer. Five Stakeholder representatives had also ended their tenures – Cllr Carole Pattison, Dr Cath O'Halloran, Dawn Stephenson, Bob Metcalfe and David Longstaff.

b. Board of Directors – Non Executive Directors

The Chairman reported that the Nomination and Remuneration Sub Committee (Membership Council) had met on the 18 October 2016 and 8 March 2017 to agree my extension until the Spring of 2018 and to consider three Non- Executive Directors whose tenures were due to expire this year. The Committee had agreed that the tenures of Dr David Anderson should be extended for a further one year period and arrangements were in hand to recruit to the other two positions later in the year.

Those present formally ratified the aforesaid appointments and the new members to the Council of Governors.

9. MEMBERSHIP COUNCIL FORMERLY COUNCIL OF GOVERNOR UPDATE – OVERVIEW OF THE MEMBERSHIP COUNCIL CONTRIBUTION DURING 2015/16

Peter Middleton, Lead Governor gave an overview of the work of the Membership Council during 2016/17. The presentation included:-

- Composition of the Council of Governors
- Governors' Involvement in improving patient experience and outcomes through various forums at Board and Divisional level
- Council of Governors involvement with the Trust in improving quality
- Getting involved with patient and users, feeding back to the Trust and making a difference by seeing improvements.

- Workshops with the Board and Non Executive Directors to enable exchange of views.
- Thanks from the Council of Governors to the volunteers, clinicians, nursing staff, admin staff and management for their hard work and honesty and openness and lastly to Ruth Mason who had taken on a new role at the Trust.

10. QUESTIONS AND ANSWERS

The Chairman gave opportunity for those present to raise any general questions of the Board or Membership Council.

Q Why is there a vacancy for Kirklees Council on Council of Governors?

A We are in talks with them to find a replacement. The position has only been vacant for last three or four months.

Q How has Brexit impacted on recruitment?

A There is anxiety amongst international nurses and we are doing everything in our power to support them in their roles providing care for local people

Q What are your hopes for Joint Overview and Scrutiny Committee tomorrow?

A We welcome the conversation and the scrutiny by local people and will respect the decision.

Q We seem to be changing plans. First Calderdale Royal Hospital (CRH) then Huddersfield Royal Infirmary (HRI) A&E to go, then beds drop. Can you guarantee there will be a hospital at HRI at the end?

A The HRI building is at the end of its life but no one wants to see diminishing services. We have a £16m deficit and we have to make it work given the resources we have. If we don't, then someone else will do it. It is also about clinical safety and lack of doctors in emergency departments. Safety says we must change, finances determine how we change.

Q Primary care is stretched and it's the worst I have known it for 30 years what are the Sustainable Transformation Plans about?

A Not just about HRI and CRH it is about looking at whole of West Yorkshire to provide quality care for the whole population of the area. If we stand still and not let local people decide the change it will be made for us. David Birkenhead said the way forward was better, more joined up working, with GPs, secondary and tertiary care.

Q Elderly people in Meltham are worried they will die if they are ill and need to go further to hospital - to CRH - and are very worried about the proposals. For note.

A Care starts from the time the ambulance arrives. In many cases it is not always beneficial to go to the nearest hospital but to the most suitable hospital.

Q We are trying to mount a legal challenge. We deserve a hospital here in Huddersfield. Eg A 70-year-old man collapsed at the Scarecrow event and waited 1.5 hours in the road for an ambulance. I can see your intentions are honourable (to Owen Williams)

A No-one is flippant about how people feel. Explaining why initially it was CRH A&E to close a few years ago....The context has changed in recent years and money is now a consideration.

11. DATE AND TIME OF NEXT MEETING

It was noted that a provisional date had been set for the next Annual General Meeting - Thursday 19 July 2018. The time and venue would be confirmed nearer the date.

The Chairman thanked everyone for attending and closed the formal meeting at approximately 7.45 pm.

/KB/AGM2017-MINS

DRAFT