Calderdale and Huddersfield NHS
NHS Foundation Trust

Operational Plan Document for 2014-16

Calderdale and Huddersfield NHS Foundation Trust

1.1 Operational Plan for y/e 31 March 2015 and 2016

This document completed by (and Monitor queries to be directed to):

Name	**Lesley Hill**
Job Title	**Director of Planning, Performance, Estates and Facilities**
e-mail address	**Lesley.hill@cht.nhs.uk**
Tel. no. for contact	**01484 356908**
Date	**4 April 2014**

The attached Operational Plan is intended to reflect the Trust's business plan over the next two years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- **The Operational Plan is an accurate reflection of the current shared vision of the Trust Board having had regard to the views of the Council of Governors and is underpinned by the strategic plan;**
- **The Operational Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The Operational Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans; and**
- **All plans discussed and any numbers quoted in the Operational Plan directly relate to the Trust's financial template submission.**

Approved on behalf of the Board of Directors by:

Name (Chair)	Mr Andrew Haigh

Signature 

Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Mr Owen Williams

Signature 

Approved on behalf of the Board of Directors by:

Name (Finance Director)	Mr Keith Griffiths

Signature 

CONTENTS:

1. Executive Summary

Vision - The Trust's vision is: **'We will work with partner organisations to understand the individual needs of patients and together, deliver outstanding compassionate care which transforms the welfare of the communities we serve.'**

Strategic environment - Our delivery of this vision through the operational plan is within the context of the strategic environment in which we operate. This is shaped by the national financial picture with the ongoing need to reduce the public deficit and increasing challenge to maintain the NHS funding ring fence. A bigger challenge will come for the Trust in 2015/16 as resources are realigned across Health and Social Care into the Better Care Fund. These factors sit alongside the need to invest in clinical staffing ratios, provide services 7 days a week and respond to increasing demand.

In this challenging context, in order to continue to deliver outstanding compassionate care, the Trust recognises the need to change. A whole system response to the economic context of increasing demand for services and reducing resources is needed. This needs to deliver significant improvements in quality, safety and outcomes for people and be aligned with and inform the use of the Better Care Fund.

Working with partner organisations - Our approach, therefore, is to work with partners to develop and implement bold and transformative long-term strategies and plans for services that otherwise may become financially unsustainable and result in a decline in the safety and quality of patient care. This approach is exemplified by the work the Trust is doing in partnership with South West Yorkshire Partnership NHS Foundation Trust and Locala Community Partnerships to develop an outline business case for system transformation across Calderdale and Huddersfield.

This offers a proposal for a new way of working that will deliver more self-care, more integrated care closer to home, and a reconfiguration of hospital services. Changes in the configuration of services will be a key enabler for 7 day working. This proposal describes the longer term vision for service delivery which will be expounded in the Strategic Plan to be submitted to Monitor in June 2014. The Operational Plan described in this document outlines the steps that the Trust is taking in the first two years of this journey.

Transformational change - The Trust has developed an ambitious transformational improvement programme designed to achieve the following key aims, with respect to quality of care for patients:

- Reduce mortality rates in hospital
- Improve patient experience and safety
- Provide better care for less cost
- Reduce the number of unnecessary emergency admissions
- Improve patient flow and reduce hospital unnecessary waits for care

This change will be delivered through a combination of working closely with partners and improving our internal systems and processes, adopting lean methodologies and learning from other organisations.

These improvements will be enabled through an IM&T modernisation programme, central to which is the need to put the patient at the heart of everything we do and one of the underpinning principles of the programme is that 'Real time patient information will always be at hand for us and our partners to provide the best seamless care'.

Keeping the Base Safe - In these times of rapid system change we need to ensure that we do not lose sight of the basics, we must keep the operational, quality and financial base safe and sustainable. Our aim is to improve access to care for patients and prioritise their safety, thereby also ensuring our regulatory compliance.

2. Strategic Context

2.1 Strategic Context and Direction

This section of the two year operational plan provides a high-level summary of the Trust's strategic context and the plans to respond to this. The Trust's five year strategic plan, which will be submitted in June 2014, will expand and provide additional detail in relation to this.

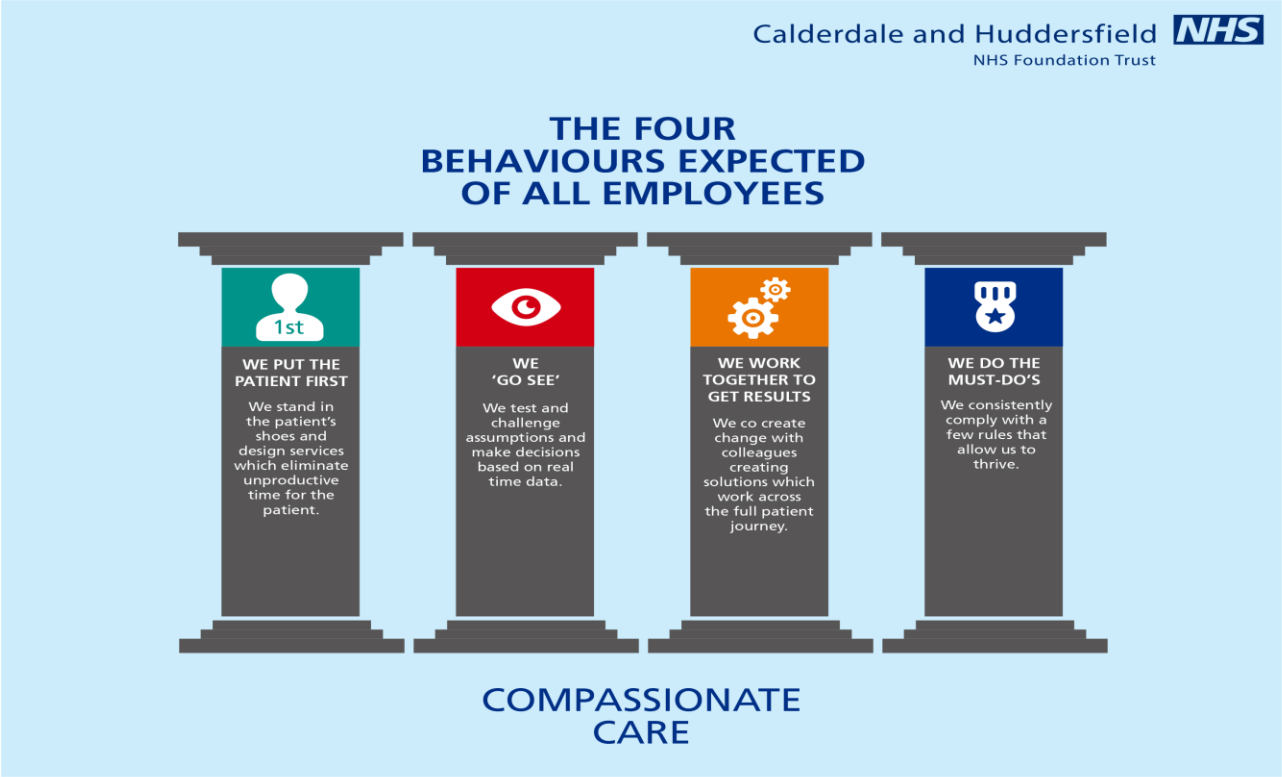
Calderdale and Huddersfield NHS Foundation Trust has recently refined its vision and values to ensure that the work it carries out always 'puts the patient first' and the Trust is working hard to improve the patient experience.

The Trust's vision is: **'We will work with partner organisations to understand the individual needs of patients and together, deliver outstanding compassionate care which transforms the welfare of the communities we serve.'**

The Trust's vision is clear, that it will treat patients as individuals and deliver excellent and compassionate care to each and every one of them. However, the Trust recognises that it cannot do this alone and has been working closely with the six other health and social care organisations across the areas of Calderdale and Greater Huddersfield, to ensure that we work towards seamless joined-up care for our communities, whatever their health and social care needs.

Backing this up is the Trust's values, the four pillars of behaviour that it expects all employees to follow. The four pillars have been introduced to the Trust over the past year and we are working hard to embed them into the organisation so that every member of staff understands their responsibilities.

The four pillars are:



Our strategic plan involves three main areas. These are: **transforming care**; **keeping the base safe**; and **improvement and innovation through strategic alliance**.

Transforming Care – Our aim is for our patients and our staff to be able to positively describe what our 'vision' means to them. We will treat our patients, staff and partners in a way that we would expect to be treated ourselves. We will use our resources (financial, human and estate) as a driver for change, rather than as a constraint.

We are doing this by:

1. Rolling out our 'Courage to Put the Patient First' (CPPF) LEAN action plan.
2. Implementing our colleague engagement plan.
3. Developing state-of-the-art outpatient services at Acre Mills.
4. Working to deliver the Trust's Efficiency Programme Board (EPB) activity.
5. Modernising and prioritising our approach to patient engagement and complaints handling.

Keeping the Base Safe – Our aim is to improve access to care for patients and prioritise their safety, thereby also ensuring our regulatory compliance. We will improve real time patient information being at hand for us and our partners to provide the best and seamless care.

We are doing this by:

1. Implementing action plans for both the Urgent Care Board and Care of the Acutely Ill Patient.
2. Actively seeking a partner to modernise our IM&T systems and install an Electronic Patient Record.
3. Reviewing and making changes to our governance arrangements.
4. Implementing a health and safety action plan to make sure we have safe and suitable premises.
5. Improving our commercial intelligence about future commissioning risks/opportunities.

Improvement and Innovation through Strategic Alliance – Our aim is to improve patient outcomes and experience through active and strategic collaboration within and outside Calderdale and Huddersfield NHS Foundation Trust.

We are doing this by:

1. Working together with South West Yorkshire Partnership NHS Foundation Trust and Locala Community Partnerships towards obtaining Clinical Commissioning Group / Health and Wellbeing Board / NHS England approval for implementation of our strategic review business case.
2. Working in collaboration to improve:
   i. Bariatric Surgery and Assisted Conception, with Mid Yorkshire Hospitals NHS Trust;
   ii. Sexual Health Services, with Locala Community Partnerships and Mid Yorkshire Hospitals NHS Trust;
   iii. Psychiatric liaison services through implementing the Rapid Assessment Interface and Discharge (RAID) programme with South West Yorkshire Partnerships NHS Foundation Trust.

2.2 The Short Term Challenge

To deliver our vision we recognise that we need to understand both the external strategic environment and our internal strengths and weaknesses. This will allow us to develop a strategic response that will support not only the Trust but also the wider health and social care system sustainability.

Our approach, therefore, is to work with partners to develop and implement bold and transformative long-term strategies and plans for services that otherwise may become financially unsustainable and result in a decline in the safety and quality of patient care. Whilst supporting the development of collaborative approaches we are also considering our response to competitive procurement processes where this has been determined by commissioners as the preferred approach.

This section of the plan provides the following summary information:

i. Overview of the strategic environment impacting on the Trust.
ii. Summary assessment of the potential impact on Trust services
iii. Summary of the strategic responses the Trust is developing. These will be more fully described in the five year strategic plan in June 2014.

2.3 The national and local strategic environment impacting on the Trust

The table below summarises the key local and national strategic factors impacting on the Trust's development of a longer term service and financial strategic plan.

Strategic Issue	Summary
National economic context	Nationally the country continues to recover from the economic crisis, public spending continues to be reduced in key areas. The national spending review in 2013 identified further reductions for local government and no growth for health. The financial context for delivery of health and social care will continue to be challenging. Over the past two years the seven health and social care organisations in Greater Huddersfield and Calderdale have been working together through the strategic review. The purpose of this is to encourage innovation and transformation to address the shared challenge of meeting the increasing needs of an ageing population with limited and reducing resources. The level of financial challenge across the Greater Huddersfield and Calderdale health and social care economy over the next 5 years is described in two ways: firstly the level of internal efficiency requirement within providers of £120m; and secondly an estimated financial impact of demographic changes of £43m for the whole of the health and social care spend of £647m.
The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry	The report of the failings at Mid Staffordshire Trust and the associated reports by Sir Bruce Keogh (Review into the Care and Quality of Treatment provided by 14 Hospital Trusts in England) and Don Berwick (Improving the Safety of Patients in England) describe the actions needed to ensure there is a clear focus on providing safe and compassionate care. These reviews and reports have informed development of the Trust's strategy and approach of how we can and must improve the safety of hospital care and reduce mortality.
The Keogh Urgent and Emergency Care Review	The report sets the strategic direction for the provision of urgent and emergency services in England over the next five years. The report sets a direction that over the next five years there will be changes in the way that A&E services are provided. Of the 140 A&Es currently across England 40 – 70 major emergency centres will be established. The Trust needs to prepare and develop a response to this direction.
The National Clinical Advisory Team recommendations	In June 2013 the National Clinical Advisory Team visited Calderdale and Huddersfield NHS Foundation Trust and, following a comprehensive review, recommended that a one acute care site option is the best for the future safety, value and sustainability of healthcare. This change will enable an increased senior doctor (consultant) presence for extended hours over 7 days, minimise the use of locum middle-grade doctors and will reduce the need for inter-hospital transfer of patients.
The NHS Services, Seven Days a Week Forum chaired by the National Medical Director	The Forum's review identifies there is unacceptable variation in outcomes across the NHS in England for patients admitted to hospitals at the weekend. For patients admitted at weekends there is an increased mortality rate, poor patient experience and increased length of hospital stay and re-admission rates. The Forum proposes that clinical standards are adopted and fully implemented by 2016/17 to support the NHS to drive up clinical outcomes and improve patient experience at weekends. Under the present configuration of services, delivering the clinical standards for urgent and emergency in-patients at weekends is likely to add to overall hospital costs. The Forum recommends that reconfiguration of services and integrated working of hospital, community and primary care services may substantially reduce these costs.

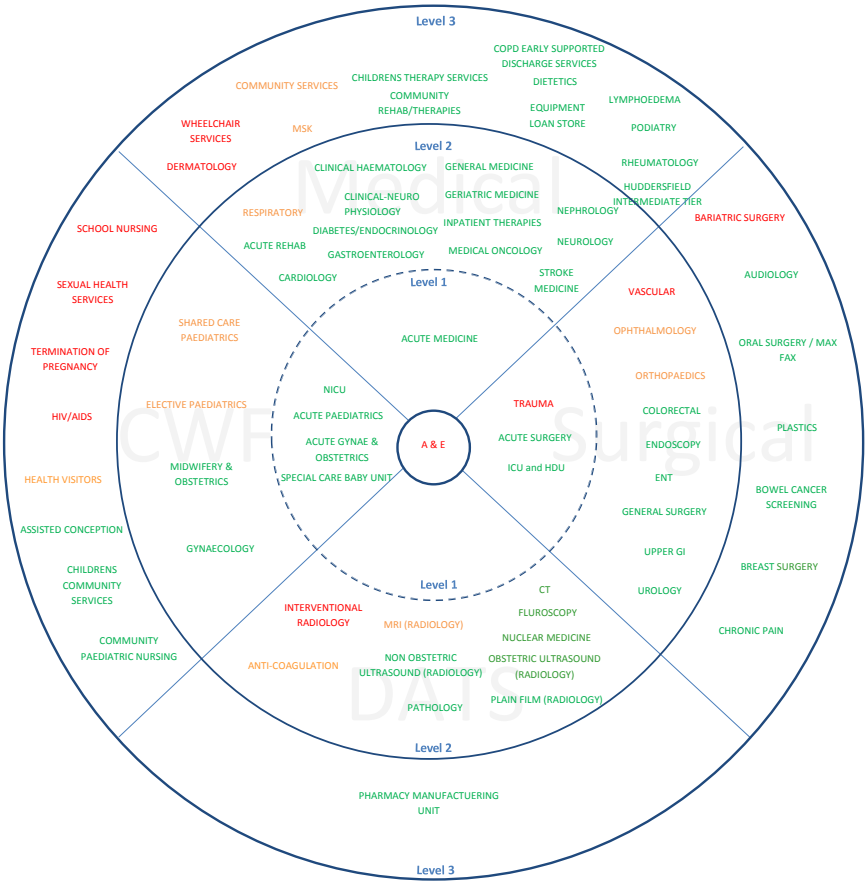
The Better Care Fund	Nationally it has been agreed that £3.8bn of NHS funding will transfer to Local Authorities to create a single pooled budget for health and social care. The aim of this is that the fund should be an important catalyst for change, and enable the move towards more preventative, community-based care to help to keep people out of hospital and in community settings for longer. The Trust needs to work with Local Authorities and CCGs to develop plans for the use of the Better Care Fund.
Royal College of Physicians Future Hospital Commission report: Caring for Medical Patients	This publication by the Royal College of Physicians provides an evidence base and case studies of the benefits associated with changing the way we care for people with medical needs by integrating care across hospital, community and social care services.
NHS England Specialist Commissioning Strategy	NHS England is developing a specialist commissioning strategy and work plan for the year ahead. The focus for this will be on concentrating services (15/30 sites), reducing costs, improving quality and delivering seamless pathways with local services. It is expected that a formal procurement for vascular and bariatric surgery will be undertaken in 2014/15. The Trust needs to understand and respond to the impact of these commissioning intentions.
Commissioners Intentions for Market Competition	At the time of preparing this plan the Trust has been notified of the following intentions for competitive procurement in 2014 • sexual health services in Calderdale and Kirklees • wheelchair services across Calderdale and Kirklees • NHS England may undertake competitive procurement for bariatric surgery and vascular surgery services. There are currently no other confirmed competitive processes planned at this time. However possible likely other areas include health visiting and school nursing, and specialist service reviews for cardiology, HIV, and ophthalmology. Termination of pregnancy service is at the time of writing currently in a competitive tender process.
The draft Health and Social Care Bill and 'Dilnot' Report	The government's proposals for social care funding reform (due to come into effect in 2016) will place a cap on the social care costs paid by an individual. The impact of this will further increase funding pressure for Local Authorities and as a result the wider health and social care system.
Information and Management and Technology	There are a number of national policy directives that set a clear direction and evidence base for increased use of technology in health and social care delivery to improve, patient safety, experience and efficiency of services. The Trust needs to develop proposals for optimising the use of technology to enhance the effectiveness and efficiency of service provision.
Health and Demographic Change	Demographic changes locally are projected to be in line with national trends of growth, driven by growth in the over 65 and 75 years groups. Between 2010 and 2012 the number of patients living within our two main localities of Calderdale and Greater Huddersfield grew by approximately 1%. 16% of our local population are aged over 65 years and 7% of these are 75 years and older. Estimates suggest that by 2030 23% of the local population will be 65 years or over.

2.4 Assessment of the potential impact of Strategic Context on Trust Services

The diagram on page 9 provides an overview of the potential impact of the strategic context on our services. This shows the services currently provided by the Trust and grouping of these into three service

levels / categories. In this analysis each service is RAG rated to indicate the perceived level of commercial risk.

Clinical Services Model – Calderdale and Huddersfield NHS FT (January 2014)



Level definitions

Level 1 services

- Services that only CHFT can offer to the acutely unwell patient in our catchment area

Level 2 services

- Services which support the continued provision of Level 1 service
- In order to ensure Level 1 services remain clinically and financially viable those services Level 2 services need to continue to be provided by CHFT

Level 3 services

- There is potential to vary the range and scope of those Level 3 services CHFT provide in order to ensure each service is fit for purpose in the longer term

Services key

Red - anticipated short term commercial risk (requires action)

Amber - medium to long term commercial risk (requires consideration and awareness)

Green - no identified commercial risk at this stage

The Trust carries out a regular review of services, specifically focussed on the commercial risks and opportunities applicable to each of these services. This assessment is carried out at least twice a year with this intelligence used to highlight those services which may be at immediate or longer term commercial risk. An appropriate response is then made to in order to mitigate risks or maximise any development opportunities. A revised Commercial Strategy will also be introduced early in 2014/15 to further enhance the Trust's approach in this area. This strategy will use a range of intelligence including information about service quality and outcomes, patient safety and benchmarking to develop proposed future business models and response.

2.5 Competitor intentions

The Trust is located between two large West Yorkshire providers of hospital services (Mid Yorkshire Hospitals NHS Trust and Bradford Teaching Hospitals NHS Foundation Trust). The Trust's nearest Tertiary provider is Leeds Teaching Hospitals NHS Trust, which is approximately 20 miles away. The surrounding areas also include large providers such as the Sheffield Teaching Hospitals NHS Foundation Trust and a number of large hospital Trusts in the Greater Manchester area. We provide services across the footprint of two hospital sites, with both of these sites benefiting from good transport links.

Mid Yorkshire Hospitals NHS Trust is to reconfigure its provision of services across its hospital sites over the planning period, with the Dewsbury A&E to be replaced by a Minor Injuries Unit. CHFT anticipates an increase in activity on the back of these changes. This is detailed at section 4.1, Activity and demand.

Within the immediate Trust footprint there are two successful independent sector providers offering a range of NHS and non-NHS services. The proportion of NHS (Choose and Book) work carried out by

these providers, particularly within elective Orthopaedics, has increased during the last few years. There are a number of other independent providers offering services within the broader West Yorkshire area.

2.6 Summary of Trust Strategic Response

Based on the review of the local and national strategic context and the impact this could have on the viability and sustainability of a wide range of our services, the following has been identified as the important strategic responses. More detail will be provided in the Strategic Plan submitted in June 2014.

Issue	Trust Strategic Response	Next Steps
Whole System Change A whole system response to the economic context of increasing demand for services and reducing resources is needed. This needs to deliver significant improvements in quality, safety and outcomes for people and be aligned with and inform the use of the Better Care Fund.	We have worked in partnership with South West Yorkshire Partnership NHS Foundation Trust and Locala Community Partnerships to develop a Strategic Outline Case for system transformation across Calderdale and Huddersfield. This has drawn on significant public and stakeholder engagement over the past 2 years. It offers a proposal for a new way of working that will deliver increased quality of care for patients through more self-care, more integrated care closer to home, and; a reconfiguration of hospital services. Changes in the configuration of services will be a key enabler for 7 day working. The high level economic case suggests system wide recurrent efficiency savings of circa £50m may be possible. Detailed work on capital affordability is needed. CCGs have confirmed support for the clinical model and evidence base for the service proposal.	The Strategic Outline Case was submitted to Health and Wellbeing Boards and Scrutiny Panels in February 2014. The Strategic Outline Business Case will be completed by May 2014. Formal public consultation will then be undertaken.
Emergency Care The Trust needs to respond to the National Clinical Advisory Team recommendations regarding the configuration of emergency and urgent care services and also prepare for wider changes in urgent and emergency care services as described in the national Keogh review of emergency care.	The Strategic Outline Case described above details a proposal for the reconfiguration of urgent and emergency care services across Huddersfield and Calderdale. Sir Bruce Keogh's Urgent and Emergency Care Report provides evidence that the co-location of emergency and acute medical and surgical expertise can enable significant improvements in survival and recovery outcomes despite an initial increased travel time to the A&E department. The report also sets a direction that over the next five years there will be changes in the way that A&E services are provided. Of the 140 A&Es currently across England, 40 – 70 major emergency centres will be established. The SOC proposes that the development of a single emergency and acute site for Greater Huddersfield and Calderdale would strengthen the current provision model	The Strategic Outline Case was submitted to Health and Wellbeing Boards and Scrutiny Panels in February 2014. The Strategic Outline Business Case will be completed by May 2014. Formal public consultation will then be undertaken.

	and enable us to prepare and respond to this wider strategic direction.	
Specialist Services The Trust needs to respond to NHS England's Strategic Commissioning Intentions.	There are two specialist service areas (Bariatric Surgery and Vascular Surgery) where NHS England commissioning intentions create a risk to the continued provision of these services by the Trust. In both cases NHS England has confirmed intent to reduce the number of providers and it is probable that a competitive procurement may be undertaken. The Trust has established an internal vascular surgery steering group to assess the clinical and financial impact and develop an approach to respond. This may result in the Trust competing with Bradford and Leeds to be the preferred hub site for arterial vascular surgery. The Trust is working with Mid Yorkshire Hospitals regarding the development of collaborative proposals for the delivery of Bariatric Surgery that will meet commissioner requirements. NHS England plan to review the provision of HIV, cardiology and ophthalmology services to create strategic network models. This will change the traditional contracting arrangements between commissioners and providers.	Work is on-going to assess and prepare a response to commissioner intentions. Publication of the NHS England national strategy and work plan is needed to inform the process and timescale for next steps.
Local Competitive Procurements The Trust needs to determine its response to Commissioner competitive procurements	Our focus is to continue to secure existing services in our current catchment area and, where strategically aligned to Trust objectives, to extend our geographical reach and service portfolio by bidding independently or through collaboration with suitable partners. At the time of preparing this plan there are two competitive procurements that have been notified to the Trust. These relate to services that the Trust fully or partly currently provides. • Sexual health services across Calderdale and Kirklees – the Trust currently provides this service in Calderdale and will submit a tender for continued provision. In Kirklees the service is partly delivered by the Trust with Mid Yorkshire Hospitals and Locala also providing elements of the	On-going work. Sexual health tenders are due for submission October 2014 Wheelchair services. Dates for tender submission have not yet been notified.

	service. The Trust is currently working with Locala and Mid Yorkshire Hospitals to explore and determine the benefit of jointly tendering for the service in Kirklees. • Wheelchair services across Calderdale and Kirklees. Internal service and financial assessment of wheelchair services is currently underway and will inform a decision of whether to tender for this service.	
Service Development and Improvement There are a number of key strategic service developments that the Trust is progressing to demonstrate new ways of working that will improve service and financial viability and sustainability. **Partnership and Collaboration** In many of these developments we are working in collaboration with a range of local health and social care providers to enhance the quality of care for local patients.	The Trust is progressing the following strategic service developments: • RAID Psychiatric Liaison Service – implementation of a 24 hour 7 day service at both hospital sites in partnership with South West Yorkshire Partnership NHS Foundation Trust. This should realise both qualitative and system-wide efficiency savings. • In Vitro Fertilisation – exploring collaborative working with Mid Yorkshire Hospitals to enhance access and improve service resilience. • Elective Orthopaedic Surgery - exploring collaborative working with Mid Yorkshire Hospitals to improve service resilience and enhance access for patients. • Dermatology – working with Locala and Greater Huddersfield CCG to implement an integrated model that provides care closer to home. • Respiratory – working with Locala and Calderdale and Greater Huddersfield CCGs to implement an integrated model offering integrated care and improved outcomes for patients • Bariatric Surgery - exploring collaborative working with Mid Yorkshire Hospitals to improve service resilience and enhance access for patients. • Termination of Pregnancy – the Trust has submitted a tender in partnership with Marie Stopes International for the provision of these services in Huddersfield. If the tender is successful this will enable implementation of a new model of service. • Care Home Liaison (Quest for Quality) - in 2013 the Trust successfully tendered for delivery of support to care homes in Calderdale. The Trust is working in partnership with Airedale	On-going work to scope and implement new models and optimise the impact on service quality and financial viability.

	NHS Foundation Trust. This will involve delivery of more community- based services and the use of telemedicine to support delivery. • Integrated end of life services – in 2013 the Trust successfully tendered for delivery of enhanced end of life service to the population of Calderdale. This bid was submitted in partnership with our local hospice (Overgate) and the national end of life charity Marie Curie.	
IM&T Modernisation Programme The Trust is implementing an IM&T Modernisation programme that will transform the way clinical services are delivered to patients	Central to the Trust's IM&T Modernisation Programme is the need to put the patient at the heart of everything we do and one of the underpinning principles of the programme is that 'real time patient information will always be at hand for us and our partners to provide the best seamless care'. • The introduction of an integrated Electronic Patient Record (EPR), alongside a number of clinical and non-clinical IT solutions will be core to this transformation programme.	The Trust is currently in the process of securing a supplier for the EPR project. The intention is to become a HIMSS Level 6 hospital in 2015/16.

3. Quality Plans & Transformation

3.1 Our quality goals

The Trust has identified a number of quality goals that it aims to achieve over the next two years. These are summarised below:

National quality standards

- Deliver MRSA and CDifficile targets
- Maintain registration with the CQC with no restrictions on our licences and no warning notices.
- Deliver all national CQUINs
- Redesign our workforce to deliver high quality services 24 hours a day and 7 days per week.
- Work towards recommended clinical staffing ratios.

Local quality goals

- Deliver our transformational improvement programme and the quality goals embedded therein (below)
- Deliver all local CQUINs
- Ensure all CIPs have a Quality Impact Assessment.
- Review our quality assurance structure and processes to improve assurance on quality.
- Improve the way we respond to, and learn from, complaints. The Trust is reviewing and implementing a new complaints management process in the first two quarters of 2014/15, which will be performance managed through the Quality Committee.
- Deliver the goals identified within the Quality Account as our 2014/15 priorities. These are:
    - **Safety**: Improve the quality of care as measured by the HSMR – this priority will encompass a wide range of quality improvement activity in the Trust;
    - **Effectiveness**: Ensure IV antibiotics are given correctly and on time and improving the care of patients with diabetes;
    - **Experience**: Self management for patients with long term pain.

3.2 Transformational Improvement Programme

The Trust has developed an ambitious transformational improvement programme which is designed to achieve the following key aims, with respect to quality of care for patients:

- **Reduce mortality rates in hospital**
- **Improve patient experience and safety**
- **Provide better care for less cost**
- **Reduce the number of unnecessary emergency admissions**
- **Improve patient flow and reduce hospital unnecessary waits for care**

Our key programmes for the next two years, and beyond, are as follows:

3.2.1 Care of the Acutely Ill Patient

The overarching aim of this programme is to reduce our hospital standard mortality rate by 10 points by September 2014. Three of the seven overarching themes of the programme require strong transformational approaches. These three themes are:

a) **Improving consistency of care (implementing care bundles and pathways)**

The aim of this theme is to improve clinical quality and track improvements against evidence-based standards. Specific examples would include reducing deaths from VTE, sepsis, COPD, pneumonia, fractured neck of femur, acute renal failure and intracranial injury.

We are also aiming to improve end of life care and reduce harm from falls, cardiac arrest, pressure ulcers and missed doses.

Individual measures and work streams are being established for all these areas.

b) **Efficient and effective patient flow**
By improving patient flow, patients will more often receive the right care, at the right time and in the right place. Four specific actions have been agreed under this theme. They are:
i) Minimising patient transfers
ii) Monitor the number of patient moves and outliers
iii) Review patient placement standards
iv) Develop a proactive discharge process

c) **Optimise senior level involvement in out of hours care**
The aim of this theme is to have plans in place which allow for consistent high quality care delivered regardless of the time of day or day of the week.

3.2.2 Courage to Put the Patient First

The Courage to Put the Patient First (CPPF) programme builds on the Trust's association with the Lean Enterprise Academy (LEA) and will help to deliver all of our transformation aims.

A key part of the programme is designed to establish an emergency intervention team where senior (consultant) decision makers improve clinical decision making in A&E to prevent unnecessary admissions and speed up clinical care to the acutely ill patient.

In order to ensure our operational arrangements support this new way of working we will fully implement the LEA improvement bundles in 2014. These are:
a) Plan for Every Patient, across medical and surgical wards including MAU, SAU and A&E
b) Plan for Every Patient on a Green Cross Pathway, across medical and surgical wards. A green cross represents a patient who is medically fit for discharge but whose discharge is delayed. There can be a number of reasons for the delay but often it is because the patient cannot return home and needs a package of care on discharge.
c) Design and implement job plans for discharge co-ordinators
d) Design and implement operational stability during winter months
e) Refine the level discharge process
f) Ensure pharmacy, radiology and pathology services work to maximise efficiency through aligning supply and demand

3.2.3 Emergency Care Intensive Support Team (ECIST)

The national ECIST team visited the Trust in winter (2013) to make recommendations on how to improve the care for emergency patients in our hospitals. Their report complements the CPPF improvement programme, in which they recommend the strengthening of the ambulatory care element of our MAUs. We believe that patient flow, and therefore the patient experience, will be enhanced by increasing the capacity and senior decision making in our ambulatory services.

During 2014 our Medical Division will work with the urgent care board to see how these services can be transformed to meet these recommendations.

3.2.4 Elective Care Pathway

During 2014 the LEA will work with our planned care services to map the current elective pathways and establish how they might be re-engineered in order to reduce bottlenecks and unnecessary waits – thereby improving efficiency and the patient experience. This work will complement our review of outpatients by Newton.

3.2.5 Changing the way we work in Outpatient Services and Radiology

During 2014 we will work with Newton, a company specialising in delivering rapid, sustainable,

financially measurable improvements, to look at our processes in outpatients and radiology. A programme board has been established and this work has already started.

The key objectives are:

a) To improve patient experience in outpatient clinics by reducing waiting lists and delays in clinics
b) To train a team of Trust employees and empower them to deliver the programme
c) To increase capacity in outpatient clinics, CT and MRI, without increasing costs
d) To release savings across these service areas.

The Trust will see a newly refurbished mill, Acre Mills, completed by the end of 2014 to form a state-of-the-art outpatients facility. Services will start to move into the building in the last quarter of 2014/15 and will ensure a better and more streamlined environment and experience for patients.

3.2.6 Rapid Assessment Interface and Discharge (RAID) psychiatric liaison service

The development of this service is in collaboration with South West Yorkshire Partnership NHS Foundation Trust and will improve outcomes for patients and efficiency and utilisation of acute beds. It will provide a 24 hour, 7 day a week mental health liaison service for those being treated for physical health problems within the acute hospital setting.

The model of service is based upon the evaluation and findings of the RAID service provided at City Hospital in Birmingham. The service will;

a) Reduce admissions and readmissions
b) Reduce length of stay
c) Increase the rate of discharge of people to their own homes
d) Reduce the psychological distress experienced
e) Increase patient and staff satisfaction

3.3 National and Local Commissioning Priorities

Commissioning intentions are referenced elsewhere in this document in relation to services that are subject to market competition. Specifically in relation to quality, the Commissioning for Quality and Innovation (CQUIN) framework enables commissioners to reward excellence by linking a proportion of the Trust's income to the achievement of local quality improvement goals. In order to ensure effective management of this area the Trust has established a CQUIN group to ensure oversight and performance management of CQUIN delivery.

The CQUINs identified for 2014/15 cover a broad range of areas and reflect those priorities specified at a national level and supported by local priorities identified in partnership between Commissioners and the Trust. In planning for 2014/15 the Trust has continued to work closely with local commissioners to develop a programme of clinically-led, CQUIN quality indicators which are consistent with the key challenges faced locally.

There are three nationally defined CQUIN goals for 2014/15:

- Improving dementia and delirium care, including sustained improvement in finding people with dementia, assessing and investigating their symptoms and referring them for support where appropriate
- Reducing the prevalence of pressure ulcers across the health economy, using the NHS Safety Thermometer tool as an enabler to measure this improvement
- Friends and Family test, continued development of this initiative in rolling this out to patients visiting outpatients and theatre for a daycase procedure.
-

These national areas are complemented by further locally developed CQUIN indicators and will include the following areas of focus:

- Improving the management of patients presenting with Asthma and Pneumonia, through the use of

national, evidence-based care bundles.

- Improving the support given to patients with diabetes, through supporting patients with a secondary diagnosis of diabetes to self-care whilst in hospital and the improvement of advice and support given to patients admitted acutely unwell with diabetic hypoglycaemia.
- Medicine reconciliation, improving the safety and quality of medicine management through improved reconciliation at admission and discharge
- End of life care, improving the identification of those patients who may be in their last year of life and supporting patients to die in a location of their choice.
- Hospital food, working in partnership to improve the quality and sustainability of hospital food.

Additionally, the Trust has worked closely with NHS England to develop a range of CQUINs relating to key areas of the direct and specialist services that we currently provide. These include:

- Timely administration of total parenteral nutrition (TPN) for preterm infants;
- Improvement in monitoring of screening for retinopathy of prematurity;
- Secondary care dental data reporting.

3.4 Existing quality concerns and plans to address them

Care Quality Commission (CQC)

In August 2013/14 the Trust underwent a CQC inspection which resulted in a compliance action with regard to Outcome 10 - Safety and Suitability of Premises. The Trust met all the other standards that were inspected.

The Trust developed an action plan with regard to Outcome 10, which has been implemented. Following a revisit by the CQC to the Trust in early February, assurance has been received from the CQC that it is satisfied that the actions have addressed the shortcomings and the Trust has now been declared to be compliant against all standards.

3.5 Our key quality risks

The Trust has identified a number of risks to quality. These are below:

Risk	Mitigating Actions	Outcome Measures
Lack of robust processes leads to failure to obtain approval for the implementation of the strategic review business case (SOC). Failure to obtain approval for the SOC leads to potential safety and sustainability issues for the Trust.	A robust engagement and public consultation process is being put in place by the Clinical Commissioning Groups (CCGs) to ensure that the correct process is followed in order to ensure that challenge cannot be made on process. The final decision on the strategic outline case topics will be made by the CCGs. Feedback during the engagement phase will be used to shape the Outline Business Case (OBC) which will develop the options for public consultation.	No challenge to the engagement and consultation processes. Approval of the final options that are taken to public consultation once the engagement is complete.
Failure to undertake robust commercial intelligence monitoring leads to a loss of services and missed opportunities, resulting in the	The Trust is currently developing a commercial strategy that should be in place by May 2014. Horizon scanning continues to take place to ensure that all	The Trust will have a commercial strategy in place by May 2014.

loss of local services for patients and potential sustainability issues for the Trust.	services at risk are identified and monitored and any appropriate opportunities are followed up.	
Failure to implement the Trust's health and safety action plan leads to safety issues within the Trust for staff and patients.	The Trust has in place a robust health and safety action plan and has recently updated its health and safety policy and developed a health and safety operational group. This group adds more rigour to the Trust's health and safety monitoring. A whole organisation health and safety training programme has just begun.	The Trust does not have in place any warning or compliance notices relating to health and safety compliance.
Failure to implement the Urgent Care Board and Care of the Acutely Ill action plans leads to failure to meet performance targets, such as A&E waits, issues with bed capacity and patient flow and a rising HSMR.	The Trust has been running a pilot scheme in A&E called EDIT, which has a senior decision maker at the front end. This scheme is due to be expanded for longer periods of the day. The Trust has in place a hospital avoidance team and a number of discharge co-ordinators have recently been appointed to help manage patient flow. Other measures include visual hospital, regular bed meetings and collaborative working with community teams to identify patients most at risk of admission and actions that can be taken to avoid this.	The Trust continues to meet the A&E four-hour performance target. The Trust reduces its HSMR to 94 by September 2014 with continued monitoring and resetting of targets where appropriate. The Trust continues to reduce patient outliers with a view to eliminating them completely.
Failure to deliver the Courage to Put the Patient First (CPPF) action plan. The plan aims to eliminate wasted time, ensuring that patients get what they need, when they need it. Failure to deliver CPPF would lead to a failure to transform care for our patients.	The project is a four year project and has Board sign up and a detailed delivery plan. Progress against the delivery plan is reported to the Trust's Executive Board on a regular basis. Actions include having a core project group leading the work, ensuring staff are engaged and involving patients in the work.	The only time patients will be moved from one ward to another will be for clinical reasons Discharges will be carried out at regular intervals during the day so that patients are discharged when they are ready, and we will also have a bed available to meet demand when the next patient needs it.
Failure to deliver the Trust's Efficiency Programme Board (EPB) activity for 2014/15 will lead to an inability for the Trust to make the developments it needs to ensure it is on track to deliver the Strategic Outline Case (SOC), should it be	The Trust has a Programme Management Office (PMO) in place to work with divisions to deliver savings across the Trust. The PMO works with divisions to ensure that plans are in place for delivery of the Cost Improvement Programmes	The Trust delivers its CIPs as outlined in the financial plan contained within this document.

approved at consultation.	(CIPs).	
Failure to secure a partner to implement IM&T systems and the Electronic Patient Record (EPR) leads to a longer lead-in time for delivery and impacts on the Trust's ability to deliver its SOC proposals.	The Trust is currently undertaking a procurement exercise with a view to having a partner in place by the end of 2014. This exercise is currently on track.	Partner in place by the end of 2014.
Failure to open the new outpatient facility at Acre Mills on time and failure to utilise the building fully, thereby, increasing the financial risk to the Trust and failure to improve the outpatient experience for patients.	The Trust has a project board overseeing the work and implementation of services within the building. The external works are now complete and the internal works have begun with work on schedule to be completed in 2014. Planning is currently ongoing with divisional teams to ensure a smooth transition to the building for those services that will be moving in early 2015.	Handover of the project to be completed by the end of 2014. Services to start to move into Acre Mills by February 2015. Improved patient experience to be measured through patient satisfaction surveys.
Failure to implement the colleague engagement plan leads to low staff morale and lack of buy-in from staff to the organisational change required to improve the quality and sustainability of services for patients.	The colleague engagement plan is being rolled out across the Trust. This work includes ensuring colleagues are able to get involved in shaping change. The plan includes four pillars of behaviour, which have been rolled out to colleagues across the Trust and highlight what is expected of colleagues. These are: We put the patient first; we go see; we work together to get results; and, we do the must-do's. A number of management colleagues have already been trained in a 'work together to get results' programme, which is aimed at co-creating change with staff and partners to create solutions which work across the full patient journey. This work is being further rolled out across the Trust.	A number of tools are in place to measure staff satisfaction and morale. These include the annual staff survey. Real time patient monitoring – which, although feedback from patients, will give the Trust an indication of whether staff are delivering the behaviours expected. The Friends and Family Test for staff, which will be introduced in Q1, will also give an indication of how staff feel about the Trust. The work together, get results programme will be monitored in terms of achieving results, changes in services and breakthrough programmes with staff.
The Trust loses its services due to a lack of partnership working or commissioning arrangements.	The Trust is working with a number of partners in order to ensure services continue to be sustainable. These include	Partnership working enables the Trust to retain local services.

Changes to the commissioning of specialised services leads to a loss of some services to the Trust.	vascular surgery, bariatric surgery, sexual health services and psychiatric liaison services. The Trust is undertaking a service line review and services are being strengthened where appropriate.	
The Trust fails to modernise and prioritise its approach to patient engagement and complaints handling.	A review of the complaints management process is currently taking place and it is expected that a new process will be implemented in Q1 and 2 of 2014/15. A patient engagement strategy is to be developed and in place by the end of September 2014.	Performance monitoring by the Quality Committee on complaints. Patient Engagement Strategy in place by the end of September 2014, with an implementation plan.
Failure to make changes to the Trust's governance arrangements results in governance failure by the Board	The Trust has completed a board development and review with an external company and is now in the process of implementing the changes needed to ensure the Trust is robust in its governance structures and procedures. A company secretary has also been appointed to oversee the Board's governance procedures.	The Trust continues to have a Monitor governance risk rating of green.

3.6 Overview of how the Board derives assurance on the quality of its services and safeguards patient safety

In 2013/14 the Board undertook an independent Board health review process which highlighted a number of strengths of the Board, including its clear commitment to quality and patient safety. The review was conducted by leading governance experts Foresight Partnership, using Monitor's Quality Governance Framework. Several areas for Board development were also highlighted. The review was undertaken in order to ensure that the Board had robust arrangements in place for discharging its duties.

One of the areas highlighted for development was to undertake a review of the Governance structure as this was felt to be too complex and streamlining this would give more clarity on roles and responsibilities. A task and finish group was set up comprising of Executive Directors, Non-Executive Directors and Membership Councillors (CHFT's Governors). The streamlining work is expected to be completed by June 2014. As part of this work, the Quality Committee (formerly the Quality Assurance Board) – the sub-committee of the Board that is responsible for assuring the Board of the quality of its services - is re-visiting its terms of reference and membership to ensure it remains fit for purpose.

The Trust's Audit and Risk Committee and Quality Committee ensure the efficient and effective running of the Trust with a particular focus on the good governance of quality.

A Company Secretary has also recently been appointed and started with the Trust in February 2014. This was also as a result of the review, in order to support the role of the Board and the clarity between executive and non-executive roles.

The Annual Governance Statement, which is submitted to Monitor on an annual basis, describes in detail how the Board of Directors derives assurance on quality and safety. The statement, which will next be submitted with the Trust's Annual Report to Monitor at the end of May, describes how the Trust's system of internal control is designed and the management checks and controls in place to manage performance. The Audit and Risk Committee, also a sub-committee of the Board, also has a role in assuring quality and a number of non-executive directors sit on both these committees for continuity purposes.

3.7 What the quality plans mean for the Trust's workforce

Colleague Engagement

The Trust has created an approach to leadership that genuinely leads improvement change within the Trust. We have developed a 'Work Together, Get Results' programme to build a strong and sustainable capacity for engaged change in the Trust, that involves colleagues, partners and patients in co-creating the future of the organisation and the services we deliver. This, along with a number of other engagement tools such as the staff survey, Friends and Family Test, leadership walk rounds, events, staff suggestion scheme and behavioural standards, will ensure our staff are very much engaged in shaping how the Trust does business.

A critical mass of staff is being trained to give them the awareness, confidence and skills they need to use this approach to change and to facilitate others in using this approach. This work is very much part of our 'four pillars' approach, described earlier within this document, which will enable us to deliver our vision.

Service reconfiguration

The Trust is looking at ways that it can reconfigure services to ensure sustainability and improve patient care and experience. The work is looking at areas such as community integration, 7 day working and what new and extended roles will be needed in order to achieve this.

The work, therefore, includes the need to redesign our workforce models to facilitate the delivery of safe and high quality clinical services across organisational and sector boundaries (health and social care) and over extended time periods (to include both 7 day working and extended days). This will include the extending of senior clinical decision-maker presence on site for longer periods and enhanced nursing roles.

In order to do this, we are restructuring care and service pathways, looking at management capacity to deliver and involving staff side representatives in any potential changes we are looking to make.

Keeping the base safe

In order to ensure our patients receive the best care we can give, we are also looking at reducing bank and agency worker spend. This is part of our work to keep the base safe and continue to improve the quality of care we provide.

We are doing this by identifying core workforce numbers, having increased the number of nursing staff, and ensuring staffing levels are appropriate over shifts, daily and weekly working. We are creating a small, agile, flexible working group with the potential to be deployed quickly to ensure we maintain safe and compassionate care for our patients.

100% of the Trust's staff will receive an appraisal with fully resourced appraisal tools available for medical and non-medical employees.

3.8 The Trust's response to Francis, Berwick and Keogh

The Trust's Board of Directors have reviewed the recommendations of the Francis Report and the subsequent reports by Sir Bruce Keogh and Professor Don Berwick.

The Trust is fully committed to the central themes of:

- A structure of fundamental standards and measures of compliance – the Trust is aware of the Department of Health consultation document on 'Introducing Fundamental Standards', which was published on 23 January 2014. Should this be accepted the Trust will implement the changes to the CQC registration regulations included within the consultation document.
- Openness, transparency and candour throughout the system to develop a common culture of being open and honest with patients and regulators.
- Improved support for compassionate, caring and committed nursing.
- Stronger healthcare leadership.

The Trust will continue to strive towards the provision of excellent service in response to these reports.

The Board of Directors received a presentation from the Director of Nursing on the Francis report at its public meeting in March 2013.

The Trust's Board of Directors also received a paper at its Public Board in October 2013, which considered the Berwick and Keogh reports and identified actions for the Trust from this work.

The two reports were published in July and August 2013 and discussion was held with a range of staff who were asked to share their perception of the Trust's reality in relation to the issues the reports identified nationally. Staff were also asked to offer views on what the Trust's response should be to achieve the result of improving the quality, care and safety of our patients. This approach is consistent with the four pillars, the values and behaviours, adopted by the Trust.

The work brought together the 8 ambitions from the Keogh report and the 10 recommendations (9 of which related directly to NHS Trusts) to define a set of 8 key results on which the staff views were sought.

These were:

1. Reduce patient harm and avoidable death
2. Competently use data for quality improvement
3. Involve and listen to patients
4. Confidence in systems of regulation and inspection
5. Participate in professional, academic and management networks
6. Ensure safe staffing levels
7. Involve junior doctor and student nurses
8. Engage all staff

A number of actions were identified from the views sought and these are being taken forward. Examples of this include 'ensure safe staffing levels', which was also identified in the Francis report, our care of the acutely ill action plan and our colleague engagement plan (both described earlier in this document).

To ensure safe staffing levels, the Trust has now developed a standard operating procedure for nurse and midwifery staffing. This will ensure the right level of staff and skill mix is available to deliver safe, effective patient care and to robustly manage staffing levels as part of the operational management of the organisation. It supports the organisation to understand and manage the potential risk associated with staffing levels.

Staffing on individual wards is also to be displayed for both staff and the public to see, following a pilot on two wards of the Trust. This information will identify the planned staffing levels against actual staffing levels in an open and transparent way.

4. Operational Requirements and Capacity

4.1 Activity and demand 2014/15 and 2015/16

The levels of planned clinical activity have been worked up and jointly agreed with all of the Trust's Commissioners. The activity levels incorporate the future levels of growth anticipated due to demographic impact, any divisional intelligence with regard to specific items such as waiting lists and activity and contractual assumptions. The main areas of planned growth are within day case and elective activity and this is predominantly due to increased demand and the delivery of waiting list targets.

For 2015/16, the activity plan contains demographic growth assumptions from modelling work undertaken jointly by Interserve on behalf of the Trust, Greater Huddersfield and Calderdale CCGs. Further local divisional intelligence has been reflected along with the anticipated impact of the reconfiguration of services at Mid Yorkshire Hospitals NHS Trust which can be seen within A&E and non-elective activity.

The 2-year activity plans have taken into account the impact of a range of schemes in support of the organisation's transformational change programme, in particular recognising a reduction in avoidable emergency admissions and patient length of stay.

Point of Delivery	2013-14 Forecast Outturn	2014-15 Plan	% Growth	2015-16 Plan	% Growth
A&E	139,216	141,505	1.6%	156,411	10.5%
Daycase	39,731	40,934	3.0%	41,392	1.1%
Elective	9,211	9,676	5.0%	9,792	1.2%
Non-Elective	49,912	50,642	1.5%	53,878	6.4%
Other non-tariff	1,579,601	1,589,912	0.7%	1,591,253	0.1%
Other tariff	102,448	106,911	4.4%	107,826	0.9%
Outpatient	326,979	327,559	0.2%	330,462	0.9%
Total	**2,247,098**	**2,267,139**	**0.9%**	**2,291,014**	**1.1%**

The Trust plans to achieve all access and performance targets and these have been taken into account in the forward planning of required activity levels. The Trust will also ensure no deterioration from current performance levels and that the absolute maximum referral to treatment time will be 18 weeks in all specialties.

4.2 Capacity

The Trust operates on a clinical divisional structure. Capacity planning is carried out at a divisional level to take advantage of local clinical and managerial intelligence. As the table above illustrates, planned growth in 2014/15 is at a relatively low level across the Trust with varying levels of growth being seen at each point of delivery. The main areas of growth are within daycase and elective activity. This pattern is similar at divisional level, although there are fluctuations across individual specialties.

In light of this, the divisions are planning to absorb the levels of activity growth into existing core bed capacity. This will be supported by opportunities to reduce length of stay through transformational schemes. Further steps to release capacity efficiencies, above and beyond the requirement to cope with activity growth, are described in the Productivity, Efficiency and CIPs section below.

2014/15 activity growth would require an additional 9 daycase and 2 elective lists per week within our Surgery division. The opportunity to absorb this level of growth is linked to the Theatre Productivity Project, maximising use of existing resources using LEAN methodology.

4.3 Key risks

The Trust's capital investment programme is significantly higher from 2014/15 onwards than ever before. These plans have the potential to impact upon the functionality and flow of the organisation. With this in mind the staging of the works will be planned in conjunction with clinical teams to ensure minimal impact on patient journeys and overall experience.

An example of this is the theatre refurbishment programme which commences on the HRI site in 2014/15. In the short term there is a capacity risk as a theatre will be inactive during the course of the refurbishment work. The plans are to cover this temporary capacity gap through evening and weekend working and shift of delivery from inpatient to daycase where possible.

The inpatient bed base fluctuates through the year with peak requirements being in the winter period. There is a risk that the winter capacity requirements exceed the funded level in the plan due to circumstances beyond the control of the Trust such as weather severity and level of acuity of patients. The steps to release capacity efficiencies will mitigate against this pressure and management action will be taken to ensure that contraction of any additional winter capacity is timely.

5. Productivity, Efficiency and Cost Improvement Programmes

5.1 Overview

The Trust's efficiency programme is a combination of both transformational and traditional schemes. The former are directly linked to the transformational improvement programmes described at section 3.2. The Trust is on a journey to deliver a significant Cost Improvement Programme (CIP) challenge of £20m in 2014/15 and £19m in 2015/16. During 2013/14 the Trust introduced its Efficiency Programme Board (EPB) that is focused on delivering recurrent CIP. The key focus of the EPB is:

- Outpatient redesign – improving the efficiency within outpatients through maximising the productivity of clinic time, improving booking efficiencies and reducing DNA rates.
- Theatre productivity – a focus on maximising productive time with theatres, using LEAN methodology.
- Reducing the inpatient bed base supported by a range of schemes to reduce hospital admissions, length of stay and assisted discharge initiatives maximising the use of community services, delivering care closer to home.

The EPB has a central resource to monitor the implementation of efficiency initiatives, whilst delivering some of the corporate efficiency schemes. This is supported by divisional finance and clinical teams who hold divisional efficiency meetings frequently to track the progress of individual schemes and identify future efficiency initiatives.

5.2 CIP Governance & Quality Impact Assurance

The Trust's EPB has introduced a Project Management Office (PMO) approach to the delivery of the efficiency target for 2013/14 as opposed to a wholly devolved allocation of efficiency targets, as was the case in 2012/13. The PMO is providing a coordinated approach to delivery of efficiency schemes that are cross divisional, whilst also monitoring the achievement of allocated divisional schemes.

The EPB is chaired by the Director of Operations and is made up of representatives from the Trust's Divisions, Finance, Workforce & Organisational Development, Nursing, Service Improvement Team, Estates, IM&T and the Trust's key commissioners. On a monthly basis the EPB meets to discuss the progress of existing schemes. This provides the oversight, governance and challenge to ensure that the schemes are delivered.

For efficiency schemes an Efficiency Proposal Document (EPD) is to be completed in advance of the scheme commencing. The EPD considers: project definition and objectives; scope, assumptions and stakeholders; resources; quality risks; none-quality risks; equality; risks to delivery; financial appraisal; and formal sign off.

The Quality section provides a summary of the full Quality Impact Assessment (QIA) and allows the scheme proposer to consider: Duty of Quality; Patient Experience; Patient Safety; and Clinical Effectiveness. Each area is assessed for the scheme and given an assessment score. Where a quality risk is identified a full QIA is completed. This process has been agreed within the Trust's key Commissioner.

5.3 Key enablers to transformation and efficiency

IM&T investment

The Trust has for some time recognised the need to move away from paper and a reliance on manual processes to an electronic record with a seamless integration of systems both within and external to the hospital setting. This has been partly achieved using existing systems and developing systems in-house. However, the evidence would suggest that continuing to use existing systems in this way is unlikely to

ever result in a fully integrated Medical Record. As such the Trust Board has sponsored an ambitious, clinically led IM&T Modernisation Programme, supported by our commissioners that will ultimately deliver a digital care environment and fundamentally change the way we deliver services to patients and the public.

The programme started in 2011/12 with the Trust upgrading its IM&T infrastructure and has continued throughout 2013/14, with significant investment from the Trust's capital programme in a maternity system, theatre system, e-rostering, vital signs monitoring software through the Nursing Technology Fund and investment in Wireless technologies with support from the Safer Hospitals, Safer Wards Technology Fund. This investment will be the key enabler of the Trust's journey towards a modern IM&T enabled Trust and will support the move towards a paper light NHS.

In order for the Trust to achieve its strategic goals, particularly transforming care and improving the patient experience it is recognised that the way services are provided must change. It is also recognised that it is essential that the Trust develops an integrated Electronic Patient Record (EPR) to enable this strategy to be delivered. Over the coming 6-12 months the Trust will be seeking to procure an EPR to begin the transformation to a paper light hospital by 2015/16.

The significant investment in IM&T will provide the Trust with the opportunity to transform how the Trust operates, improving patient care and delivering financial and non-financial efficiencies.

Estates investment

The build environment is an enabler to the delivery of clinical excellence. The intention of the development and investment in estate is to develop best practice to support the best clinical outcomes, return on investment and value for money.

The development of the estate will be aligned with the clinical strategy and this will be delivered through:

- Keeping the base safe – improve patient experience whilst delivering statutory compliance
- Transforming care - Reconfiguration of service across a smaller estate footprint, using technology.
- Improvement through strategic alliances - Integration with primary and social care in the use of estate

The key focus over the next two years is to develop site specific plans which deliver full statutory compliance whilst at the same time moving towards the delivery of the strategic outline case for clinical service delivery. A large proportion of the capital spend over the next two years is committed to ensuring the estates infrastructure maintains full statutory compliance.

2014/15 will see the completion of the Acre Mill redevelopment project. The redevelopment of this old mill complex to provide new state of the art outpatient facilities has been undertaken via the Pennine Property Partnership LLP (Joint Venture with the Trust and Henry Boot Developments Ltd).

The layout of the new facility is specifically designed to make efficient use of space through sharing of clinic rooms wherever possible; minimising distance of necessary travel between frequently used spaces; locating support services so that they may be shared by adjacent functional areas; and grouping functional areas with similar system requirements

As well as the physical design, the move of outpatients to Acre Mill will enable changes in the way that services are delivered. Capacity and efficiency will be most significantly improved through the adoption of a three session working day in outpatients. The accommodation requirements for Acre Mill have been modelled on the basis of a 15 session week. This moves the organisation forward in delivering a 7 day working service. The move is also closely aligned with the outpatient redesign work referenced above – improving the efficiency within outpatients through maximising the productivity of clinic time, improving

booking efficiencies and reducing DNA rates.

5.4 Workforce

Given the CIP requirements for 2014/15 and 2015/16, a significant amount of savings will need to be delivered through a reduction in workforce costs. The WTE projections modelled in the Trusts's financial plan provides an indication of the potential reduction in workforce numbers required to deliver the level of savings required.

Cost reductions will be delivered through both a redesign of workforce, which will have no impact on workforce numbers, as well as a planned reduction in workforce numbers. All schemes will be impact assessed to ensure that quality and safety of care delivered to patients is not compromised.

Schemes being investigated with no anticipated impact on workforce numbers include:

- Standardisation of consultant contracts (e.g. increased outpatient productivity following outpatient and diagnostic productivity review, standardisation of SPA's, reduced waiting list initiative payments)
- Skill mix reviews
- Reduction in agency spend (through retraction of beds with the transformational improvement programme and improved controls around booking of agency)
- Increased staff productivity and shift cover through implementation of e-rostering which will reduce non-contracted pay costs whilst improving quality of service delivery

It is anticipated that some level of agency spend is unavoidable in 2014/15 and 2015/16 to ensure staffing levels are able to meet anticipated demand (for example A&E medical staff).

It is planned that a level of savings will be delivered by a reduction in head count. This will be primarily delivered as a result of the clinically led IM&T Modernisation Programme. This programme will improve patient care as well as transforming how the Trust operates and in turn deliver significant efficiencies. Schemes that are planned to reduce the workforce requirement include:

- Electronic Document Management System
- Voice recognition
- E-prescribing
- Community agile working
- Maternity electronic patient record

It is recognised that there is a requirement to ensure that 7 day working and staffing ratios are delivered. It is anticipated that these will be delivered within existing resources through redesign of existing work practices rather than additional investment.

6. Supporting Financial Information

The Trust is operating in a challenging financial environment. This is shaped by the national financial picture with the ongoing need to reduce the public deficit and increasing challenge to maintain the NHS funding ring fence. A bigger test will come for the Trust in 2015/16 as resources are realigned across Health and Social Care into the Better Care Fund. These factors sit alongside the pressures of investing in clinical staffing ratios, providing services 7 days a week and responding to increasing demand.

Our plan is to position ourselves well financially to deal flexibly with these challenges over the two year period of the operational plan and beyond. The plan for 2014/15 is to achieve a £3m I&E surplus, growing to a planned £4m surplus in 2015/16. These plans will continue to evolve throughout the next year as the longer term plans are finalised.

These are just the first two years of a ten year strategic financial plan which looks to reshape the Trust's delivery of services in line with the work we are doing in partnership with South West Yorkshire Partnership NHS Foundation Trust and Locala Community Partnerships to develop an outline business case for system transformation across Calderdale and Huddersfield.

We will invest in transformational capital IM&T and estate schemes in the immediate future which will release savings and enable the Trust to respond in an agile way to the outcome of the outline business case in the longer term.

6.1 Income (and the extent of its alignment with commissioner intentions/plans)

The two clinical income contracts for 2014/15 have been agreed with the main commissioner, Greater Huddersfield CCG, including all associate CCGs and local authorities/councils and also with NHS England including local area teams for directly commissioned, secondary dental and specialised commissioning services.

The activity and income levels in the contract have been built up under PbR rules and have been subject to the price and operational changes as described within the 2014/15 National Tariff Payment System guidance published by NHS England and Monitor. The key elements within this guidance are:

- Tariff price reduction of 1.5%.
- Continuation of the 30% marginal tariff for emergency admissions
- Continuation of the emergency readmissions policy
- CQUIN continues at 2.5% with a reduction of 0.1% applied to the NHS England Specialised Services Contract for the cost of Operational Delivery Networks. CQUIN payments are no longer applicable to high cost drug and device pass-through payments.

The Trust has worked jointly with commissioners throughout the activity and income modelling process and as such the agreed activity and funding within the contract are aligned with commissioner intentions and plans.

The contracts with the two main commissioners, Greater Huddersfield CCG and Calderdale CCG, have been agreed on a fixed cash value basis (at the level informed by the detailed PbR modelling described above). Although contract penalties will be monitored as per the Standard Contract, no adjustments to this fixed contract value will be made.

The fixed value contract totals £254.4m and in line with the policy and approach in 2013/14, includes £3.9m non-recurrent re-investment of emergency re-admission funding.

The fixed contract value assumes full delivery of CQUIN targets at a value of £6.8m. CQUIN targets will be monitored and applied but if CQUIN targets are not achieved, no adjustment to the fixed contract value will be made thereby further minimising the income risk for 2014/15.

In addition to the fixed contract value, the 2014/15 plan with the main commissioners also includes £3.4m funding for business cases relating to demand management and transformational change initiatives and £2.2m re-investment of the retained marginal tariff funding for emergency admissions. The latter will be managed through the commissioner-led Urgent Care Board, which includes representation from the Trust.

The recurrent position for 2015/16 has been derived by using 2014/15 demand and income plans as a baseline (adjusting for non-recurrent funding). This has then been adjusted for demographic growth as identified within the Interserve work, (jointly commissioned by the Trust and commissioners) with an offset of an assumed tariff price deflator of 1.8%. The 2015/16 income plan recognises the shift in funding to the Better Care Fund and an anticipated income impact of schemes as part of our transformational agenda.

6.2 Costs

The Trust is planning to reduce operating expenses over the next two years on the understanding that the efficiency programmes will be delivered in full and on a recurrent basis. Additional inflationary pressures are also expected and have been planned for as described below:

- Pay costs have been planned to increase in line with the recent announcement on agenda for change pay awards with staff receiving either an annual increment, planned at 1.3% (based on local experience) or a 1% for those at the top of pay scales.
- Drugs costs to increase by 1% (excluding High Cost Drugs).
- PFI contract costs to increase in line with RPI estimated at 2.7% for 2014/15 and 3.0% thereafter.
- Utility contracts increased at an estimated 10% per annum.
- Rates to increase at 4% per annum.
- Other non-pay costs planned to increase at 2% per annum.

CIP requirements as described in more detail at section 5 above are:

- £20m in 2014/15
- £19m in 2015/16

It is recognised that this is a challenging level of savings for the Trust to deliver. This level of savings requirement is driven in part by the need to tackle legacy issues from 2013/14 where a proportion of cost improvement programmes were delivered non-recurrently. This is also set in the wider context of planning to continue to deliver an increasing surplus, £3m in 2014/15 increasing to £4m in 2015/16 which will require a stretch CIP target to enable the Trust to emerge from the next two years on a stronger footing for the longer term.

The Trust also recognises the requirement to invest within the specific areas of 7 day services and clinical staffing ratios. These investments will be enabled on a phased approach as a return is released from CIP schemes. This will therefore be delivered through the existing financial envelope through service redesign rather than reinvestment. The transformational nature of these schemes will in themselves change the way that services are delivered to improve quality.

6.3 Contingency built into the plan

A level of contingency reserves are planned for at £4m in each year of the planning period.

Other factors which will mitigate against risk include the agreement of a fixed value clinical income contract with the two main commissioners which means that income levels are known and understood at this planning stage.

It is also acknowledged that non-recurrent opportunities to make savings or maximise income will arise in-year, as they have in 2013/14. Whilst these benefits are not planned for, they will be embraced as they arise in order to offer flexibility, for example against slippage in delivery of CIP schemes against planned timescales.

6.4 Capital plans

The Trust has established an ambitious capital investment programme of £29.20m in 2014/15 and £32.66m in 2015/16, summarised below.

	2014/15 **Total**	2015/16 **Total**
	£m	£m
IM&T		
Electronic Document Management System (EDMS)	3.02	
Electronic Patient Record (EPR)	1.41	9.13
Other Clinical Systems	2.86	2.73
Infrastructure	4.96	3.55
Estates		
Ward Refurbishment	1.70	2.20
Theatre Upgrade	2.00	3.00
PFI Lifecycle	1.07	1.16
Estates improvement plan	2.34	1.07
Vascular laboratory		2.00
Other	7.96	3.73
Medical Equipment	1.89	4.10
Total Capital Expenditure	**29.20**	**32.66**

IM&T

The IM&T investments and their role in enabling transformational change in the way that services are delivered are outlined above at section 5.3. Key investments are in the Electronic Document Management System (EDMS) and Electronic Patient Records (EPR).

Estates

The capital plan supports the business agenda over the next two years with a focus and emphasis on statutory compliance. It supports the ten year strategic direction of service configuration by :-

- Delivering the statutory must do's to keep the base safe.
- Enabling service change to deliver the Trusts strategic direction.
- Putting capital spend at the forefront of the clinical and quality debate.
- Ensuring an emphasis on return on investment to enable service change.

Over the two year planning period, in excess of £14m is planned to be spent in relation to fire, asbestos, mechanical and electrical works.

Significant Estates developments for 2014/15 and 2015/16 include a scheme to upgrade theatre facilities; investment at HRI in the ongoing rolling ward refurbishment programme; investment in the Vascular laboratory; and estate enabling works for a third MRI scanner.

PFI lifecycle costs are also committed to at just over £1m per annum.

6.5 Liquidity

The Trust recognises that liquidity is crucial in both keeping the financial base safe and our ability to fund our ambitious capital investment and transformational programme. Cash planning along with the robust management of working capital will be a cornerstone of maintaining this cash position and will be reflected within the Trust's ambition of maintaining strong performance within the Better Payment Practice Code (BPPC).

The Trust will end 2013/14 with a healthy cash balance of £22m built up through the achievement of I&E surpluses over a number of years. This has been boosted by the Trust's success in securing additional capital funding from Department of Health Technology Funds and the receipt of a grant to support the demolition of St Luke's Hospital site.

The Trust is planning to maintain this strong cash position throughout the two year period whilst recognising the requirements to service the capital and revenue impacts of borrowing from external funds to support the capital investment programme.

The level of external funding is planned at £12m in 2014/15 with a further £18m in 2015/16.

The Trust has held exploratory discussions with the Independent Trust Financing Facility (ITFF) and is confident that the requirements to satisfy the borrowing criteria can be met. The financial plans are based on this external funding being granted from the ITFF with a period of repayment matching the length of the life of the assets that the funding is supporting. The plans are based on an annual interest rate charge of 4% and allows for some financial headroom based on current National Loan Fund interest rates.

6.6 Continuity of Service Risk Rating

A key measure of success for the Trust is achievement of a sound COSRR across the year. The planned COSRR is at level 3 for every quarter of 2014/15 and 2015/16.

Due to the timing of designing and submitting these two year plans, 2013/14 out turn has been based upon our forecast year end Statement of Comprehensive Income, Statement of Cash Flow and Statement of Financial Position at Month 11, February 2014. This excludes any impact of the 2013/14 revaluation of Property, Plant & Equipment, which is exceptional in nature, does not have any cash impact and will not affect the CoSRR.

In order to stress test the sensitivity of the Trust's plans a downside case has been modelled. The following assumptions have been used for 2014/15:

Income 2014/15

- No impact of reduced activity levels on income from the two main commissioners due to the fixed nature of the contract agreement as described above at section 6.1.
- Failure to secure a quarter of the £3.4m funding for business cases relating to demand management and transformational change initiatives and £2.2m re-investment of the retained marginal tariff funding for emergency admissions. This represents a worst case scenario as in actual fact costs are not committed against the majority of this funding pending final agreement of detailed schemes with commissioners.
- Loss of income through services transferring to other providers under AQP and fixed costs remaining with the Trust.
- Reduction in activity against other commissioners where the fixed value contract does not apply, e.g. SCBU activity which is commissioned by NHS England, and associated costs cannot be contracted.

Expenditure 2014/15

- Under delivery of CIP schemes by 25%
- Additional revenue costs driven by the operational challenges of delivering the Trust's capital programme, for example the need to hire mobile patient facilities to decant from the hospital site whilst structural works are underway.
- Additional costs of dealing with winter pressures over and above that built into the plan.

For 2015/16 the following has been assumed:

Income 2015/16

- The contractual arrangements with the two main local CCGs revert to full PbR arrangements from 2015/16
- An additional shift in funding to the Better Care Fund combined with a further income impact of schemes as part of our transformational agenda.

Expenditure 2015/16

- Additional expenditure pressures as described for 2014/15.

In order to mitigate against the above income and expenditure pressures, the first measure would be to release the £4m contingency reserves. This has been modelled against the downside scenario and after this mitigating action the resultant CoSRR for 2014/15 stands at a minimum of level 2 for each quarter of 2014/15 and 2015/16.

Further pro-active measures, over and above those modelled, would also be taken to secure the Trust's cash and liquidity were the above scenarios to come to pass. These would include reprioritising capital expenditure to enable reduced borrowing requirements and robust management of working capital.