Calderdale and Huddersfield NHS
NHS Foundation Trust

Strategic Plan Document for 2014-2019

Calderdale and Huddersfield NHS Foundation Trust

Public report

Contents

1. Overview

This document builds on the two year operational plan and details the areas of focus over the next five years to deliver financial, operational and clinical sustainability.

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.'

Working with partner organisations - Our approach 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 approach to system transformation across Calderdale and Huddersfield.

This approach 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 approach takes into consideration the longer term vision for services.

Five scenarios are being reviewed and will be developed over the coming months to inform the strategic direction of the Trust :-

i. Continue with the existing hospital and community service model and configuration.

ii. Implement the community and hospital service model proposed with Huddersfield Royal Infirmary as the site for acute and emergency care and Calderdale Royal Hospital as the site for planned hospital care.

iii. Implement the community and hospital service model with Calderdale Royal Hospital as the site for acute and emergency care and Huddersfield Royal Infirmary as the site for planned hospital care.

iv. Continue with the existing community service model and change emergency hospital care provided locally so that those people needing specialist treatments are transferred to a major emergency centre outside the local area. Huddersfield Royal Infirmary and Calderdale Royal Hospital would offer 'see and initiate treatment' services with people needing specialist treatments transferred to specialist centres. This would reduce demand at the local emergency centres in Halifax and Huddersfield.

v. Any other ideas for changing services resulting from extensive engagement with a wide range of stakeholders, including patients and the public.

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
- Provision of more out of hospital 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. The table below summarises the outputs to be delivered in the future.

Outline Business Case for Change

Strategic Plans – To support the sustainability of the organisation the Trust has developed a strategic plan with a new model of service delivery which will provide care within a planned and unplanned site, with strengthened and extended services provided in the community and from community hubs.
Key service changes have been identified which reflect capacity and demand for beds over the coming years. Workforce and estate will need to be re-modelled to support the new models of care delivery.

The key milestones for delivery over the next four years identify the need to develop more robust planning and development of the preferred way forward, supported by detailed service, estate and financial analysis. Over the coming months plans to mitigate the key risks associated with delivering the plan will be developed. Key risks identified :-

- Workforce transformation
- Capital procurement process
- Service reconfiguration and transfers
- Social care impact and delivering a comprehensive community model
- Primary care transformation

Continued communication and engagement with key stakeholders has been identified as a key priority to the delivery of the strategic plan.

2. Market analysis and context

The Trust recognises the challenging environment in which it operates and the need to change how it delivers its services against this background. With the growth in population and the changing demography there is a need to transform how services are provided in the future.

The Trust has acknowledged the change in the market and the development of the Any Qualified Provider model (AQP). We aspire to be the provider of choice, carrying out regular service reviews, being aware of our competitors, building on our strengths and developing strategies to mitigate our weaknesses.

To deliver our vision CHFT recognises the need to understand both the external strategic environment and internal strengths and weaknesses. This allows the Trust to develop a strategic response that will support not only the Trust but the wider health economy.

Strategic 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 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.

Local Health Economy Context

The areas of Calderdale and Huddersfield have seen many changes in recent years, with populations and life expectancy both increasing.

Older people are some of the most frequent users of health and social care within the local health economy and have more long-term conditions such as heart disease, diabetes and breathing problems. Modern lifestyles are also creating new health issues. Smoking is still the UK's largest cause of preventable illness and early death. Obesity is increasing and brings health issues such as diabetes and cardiovascular disease.

There are huge inequalities in health across the area, with average life expectancy in some parts being five years longer for men and two years longer for women than in others.

The cost of health and social care in Calderdale and Huddersfield is now more than £400 million per year and increasing demand, inflation and the introduction of new drugs and treatments means costs are increasing faster than income.

The health and social care organisations have been working together on the Calderdale and Huddersfield Strategic Review, which encourages innovation and transformation to address the shared challenge of meeting the increasing needs of an ageing population with limited and reducing resources. The seven partner organisations are:

Calderdale and Huddersfield NHS Foundation Trust;
Calderdale Clinical Commissioning Group (CCG);
Calderdale Council;
Greater Huddersfield CCG;
Kirklees Council;
Locala Community Partnerships; and
South West Yorkshire Partnership NHS Foundation Trust.

At the start of the review, four care streams were set up to look at children's care, long-term care, planned care and unplanned care. The care streams engaged local patients, carers, the third sector, public representatives and staff. The findings from the engagement work informed the development of a number of plans for improvements to the health and social care system.

Demography and health needs

The population for Greater Huddersfield is 245,000 and for Calderdale is 213,000 giving a combined population of 458,000 people.

The growth in population means that more people will require access to health and social care services. Much of this demand will come from older people as this cohort of the population are likely to develop one or more long term conditions such as dementia, heart disease, diabetes and respiratory problems.

The challenge for health and social care in providing high quality and effective services is exacerbated by the aging and expanding population, but also as modern lifestyles are also creating more ill health across all ages of the population. Unhealthy eating and lack of exercise are contributing to increased prevalence of obesity, diabetes and cardiovascular disease in the population. The impact of this is generating additional demand for health and social care services.

Commissioners and providers are already taking action to address the increasing and changing profile of needs, however without transformational change the current arrangements for health and social care service provision will not be able to meet the increasing and changing demands placed upon it in the future.

Competitor analysis

The Trust carries out a regular review of services, specifically focussed on the commercial risks and opportunities applicable to each service area. 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

Revised guidance relating to the use of the market has seen local and national Commissioners increasingly use competitive tendering processes in order to procure existing or new services.

The use of competition within the current environment can be categorised in the following ways:

Any Qualified Provider model (AQP) - Audiology and Non-Obstetric Ultrasound/MRI are the only services procured under this method to date by the Trust's two main Commissioners. Following the initial national mandate to use AQP Commissioners have

not used AQP again and have no further plans to use this procurement method at this stage.

Commissioning of existing CHFT provided services – 'testing the market' for those services currently provided by CHFT is one way in which Commissioners are able to respond to concerns regarding services or feedback relating to services.

Newly Commissioned services – There are a number of examples of significant new services where Commissioners have chosen to 'test the market' rather than select CHFT as the chosen provider by default. This approach can most logically be explained as a response to competition legislation challenging Commissioners to take this approach.

Local authority commissioned services – Calderdale and Kirklees local authorities have recently taken over Commissioning responsibility for a number of public health services previously commissioned by Clinical Commissioning Groups (CCGs), examples including Sexual Health Services and School Nursing. The local authority have articulated their plans to regularly test the market for the services they Commission, explaining this will support their ability to demonstrate value for money on a regular basis.

3. Sustainability and strategic options

There are a number of challenges and constraints facing the Trust which impact on the Trusts ability to deliver sustainable services into the future. Access to services, workforce constraints and the estate infrastructure are highlighted as constraints within the plan. The clinical evidence base and financial constraints, challenge the Trusts ability to provide a safe, quality service for patients that is financially sustainable. Working with partner organisations the development of five potential scenarios for future service delivery have been developed which are aligned with the broader local health economy.

Issues impacting on sustainability

a) Seven day access to services

The NHS Services, Seven Days a Week Forum, Chaired by the National Medical Director, was established in February 2013 to consider how NHS services can be improved to provide a more responsive and patient centred service across the seven day week. The Forum's review points to significant variation in outcomes for patients admitted to hospitals at the weekend across the NHS in England. This variation is seen in mortality rates, patient experience, length of hospital stay and re-admission rates

Currently there is a limited range of community services available out of hours and across seven days week (mainly GP Out of Hours Service, district nursing and mental health crisis response). This is a constraint in being able to respond and support people's needs in the community and enable them to stay at home. It also means that in the evenings and at weekends hospital based care may be the only service option for people.

In the Hospital the provision of 7 day working in emergency and acute services is the focus of attention. In some areas (Women's services) the standards are already reached. Within surgery workforce planning and new ways of working are being designed to meet this standard, but are not currently completed. There are particular pressures in the two A&E departments related to both middle grade and senior doctor presence for extended working hours seven days a week. Currently at weekends the two Accident and Emergency Departments do not have on-site Consultants in Emergency Medicine. For acute medicine, whilst major changes in working patterns have already contributed to an increased consultant presence over the day, the changes inherent in the outline business case will provide the opportunity to more fully meet the expectations of 7 day services by bringing teams together.

b) Workforce

The national shortage of key elements of the workforce is one of the four main challenges recognised by the strategic review. Changing demographics, higher expectations and standards regarding access to care, (for example greater consultant presence and 24/7 access) and the shift of care outside of hospitals are contributing to the challenging workforce picture at a national level. Areas of particular concern nationally include

- Size of the nursing workforce and the potential decrease in nursing workforce size driven by aging nursing workforce and fewer people training to be nurses
- Recruitment difficulties in emergency, geriatric, and psychiatric medicine
- The forecast undersupply of GPs

At a regional level, system wide problems are being addressed by organisations with the help of Health Education Yorkshire and the Humber; however the solutions are not instant. Immediate workforce challenges persist, and across Calderdale and Huddersfield organisations are already taking action to address specific recruitment and retention issues at a local level. These issues and actions include:

- Challenges in being able to provide senior doctor presence for extended (16) hours seven days a week on both hospital sites. As a result of the national workforce shortage in

emergency middle grade doctors the two A&E departments have a high use of locum doctors (for example the two A&Es require a middle grade rota of 12 doctors and in the last 5 years there has only been a maximum of 7 doctors with gaps in the rota filled by locums). There is currently no on site consultant presence in the two Accident and Emergency Departments at weekends. The College of Emergency Medicine recommends a minimum of 10 Consultants in Emergency Medicine per emergency department. Currently there are 5 in Halifax and 5 in Huddersfield.

- We know that across the region there will be a significant shortage in the number of paediatric specialist doctors in training starting from August 2015. The likely impact on Calderdale and Huddersfield Foundation Trust is that whilst 11 middle grade paediatric doctors are needed to cover existing rotas there will be a 75% reduction in their availability.

- The shortage of elements of the workforce has required a review of how we deliver services either through the deployment of alternative practitioners into traditionally medical roles or senior medical staff filling gaps in rotas or a combination of both. This creates additional need because of constraints around working time regulations and location of the specialty. The problem therefore is not only one of supply and demand but also of how flexibly and effectively we can deploy staff in our current service models.

- One possible response to the recruitment and retention challenge is to develop collaborative strategies with partners to design new ways of working and joint care pathways. This is crucial where we need to sustain medical on call arrangements to provide safe care. Examples of this approach include: vascular surgery services (CHFT partnered with Bradford), CHFT works in partnership with Leeds to deliver satellite renal services, joint working with Mid Yorkshire Hospitals Trust to provide Bariatric Surgery and Assisted Conception Services, exploring options for joint working of CHFT, Locala and GPs to provide comprehensive dermatology services for our local population.

- CHFT is considering a further overseas recruitment campaign which has proved successful in the past.

c) Estate

Estate is an enabler to support service change. The overall aim of the service model in the future is to deliver more care in people's homes or close to home. The aim of the estates model is to support this when people do need to come into hospital or community facilities and ensure that

- The estate is high quality and supports people to receive clinical services at the right time, in the right place, and that the environment of care is high quality and therapeutically appropriate
- Technology is available both on the hospital sites and in the community to support the proposed service model
- The estates model is sustainable for at least the next 30 years
- Significant energy savings will be achieved as the Trust more intensively uses its modern, energy efficicent estate and reduces occupancy within the older estate

The proposed service changes will require an increase in capacity and facilities on the unplanned hospital site and rationalisation of estate elsewhere in the system

Even in the absence of any service reconfiguration there is still a requirement to bring the current estate to a good (level B) standard. There are a number of buildings within the estate which require upgrade or re-provision, and some that will be surplus to requirement once the health community has better access to and use of technology.

d) Information Technology

Patients should have compatible digital records so their health information can follow them around the health and social care system. This means that in the vast majority of cases, whether a patient needs a GP, hospital or a care home, the professionals involved in their care can see their history at the touch of a button and share crucial information. A recent report produced by Price Waterhouse

Coopers for the Department of Health (January 2013) demonstrate the potential benefits of making better use of technology. This includes national cost savings of more than £4billion, freeing up professionals' time to spend caring for patients and helping patients take control of their own care. The actions required are that:

- By March 2015 - everyone who wishes will be able to get online access to their own health records held by their GP.
- Adoption of paperless referrals - instead of sending a letter to the hospital when referring a patient to hospital, the GP can send an email instead.
- Clear plans to be in place to enable secure linking of these electronic health and care records wherever they are held, so there is as complete a record as possible of the care someone receives.
- Clear plans to be in place for those records to be able to follow individuals, with their consent, to any part of the NHS or social care system.
- By April 2018 - digital information to be fully available across NHS and social care services.

There is currently no cohesive approach to information technology (IT) across Calderdale and Greater Huddersfield and as such the current IT profile for health and social care provider organisations across the region is not optimal for the provision of joined up care. Each of the organisations has their own hardware and software set up, with limited inter-connectivity between providers.

This has two main impacts on staff delivering care:

- The need for dual-entry - duplication of effort and increased potential for error
- The inability to access aspects of patient records – e.g. Locala community services can access most GP systems for patient records but cannot access SWYPFT or CHFT records.

The potential impact for patients is that as a result staff do not have all the information needed to deliver joined up and safe care. Patients may have to 'tell their story' more than once. As a consequence both the experience and safety of care is comprised.

e) clinical evidence base risk

Of particular importance is that the National Clinical Advisory Team recommended in June 2013 that a one acute care site option is the best for the future safety, value and sustainability of health care. 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 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.

In 2005/06 a partial reconfiguration of some hospital services was implemented to provide acute surgery and trauma services at Huddersfield Royal Infirmary and consultant led obstetric services at Calderdale Royal Hospital. These changes were made for the same clinical reasons as described in thi plan i.e. that the concentration and co-location of specialist expertise was necessary to improve the safety and clinical outcomes of these services. The clinical evidence base for this was recognised and supported by Commissioners at that time. The changes made in 2005 have resulted in improved outcomes

f) Financial sustainability

The health and social care economy is facing significant challenges where change will be needed to improve outcomes and quality for service users and allow for a sustainable and effective health and social care economy.

The initial impact of the national reduction in levels of funding for public sector services manifested itself as a £20bn cost reduction challenge, dubbed the 'Nicholson Challenge', for the whole NHS to be achieved by 2014/15, as well as a significant reduction in local authority central funding equivalent to ~25% over 3 years. The latest economic projections suggest that the government

spending review scheduled for 2015 will result in the NHS and local authorities needing to deliver savings at a similar, if not higher level than those previously achieved. This will represent a significant funding pressure.

NHS England forecasts that an additional £30bn of NHS efficiencies will need to be found by 2020/21.

This will require significant change in the way the Health and Social Care system is shaped and operates to deliver the scale of what is required.
The scale of the financial and clinical challenge is a significant one as there is inadequate resource across health and social care to safely and effectively meet the increased demand for services if we continue to deliver care in the same way. The status quo is unaffordable in terms of the dual running of certain services across the HRI and CRH sites and the pressure that this puts upon the Trust in terms of both constrained clinical and financial resources, limiting the opportunity to release efficiencies.

Strategic options

Through a process of discussion with clinical staff that currently provide the services and with Clinical Commissioners five possible planning scenarios have been identified to consider how services need to change in the future to provide a financially, operationally and clinically sustainable future.

Senario 1 represents continuing with current model of services. The risk to sustainability and the national and local context highlighted above identify reasons why this is not feasible

- Local people and staff have identified the need for service change.
- There are gaps in current services and we are not able to guarantee the best safety, quality and outcomes for people.
- Services are not clinically and financially sustainable into the future.

Scenario 4 requires a national and regional reconfiguration of Accident and Emergency services. At the time of preparing the strategic plan there is insufficient detail to be able to undertake economic evaluation of this option. More importantly this option represents a reduction in the provision of local emergency services across Calderdale and Huddersfield. Since publication of the Strategic Outline Case in February 2014, local people and stakeholders have clearly expressed their view of the importance of continuing to deliver local accident and emergency services providing that we are able to assure the clinical quality and outcomes of these services.

Scenario 5 reflects the opportunity through public consultation to identify other possible options and scenarios. At the time of writing the plan there is insufficient information to be able to progress this plan..

There are therefore **two short-listed scenarios (senarios 2 and 3)** that will be developed over the coming months

2. **Implement the community and hospital service model proposed with Huddersfield Royal Infirmary as the site for acute and emergency care and Calderdale Royal Hospital as the site for planned hospital care.**

3. **Implement the community and hospital service model with Calderdale Royal Hospital as the site for acute and emergency care and Huddersfield Royal Infirmary as the site for planned hospital care.**

   The reconfiguration of services proposed presents opportunities to improve the quality and safety for patients, together with increasing efficiency and reduction in costs in particular via:
   - Reducing the number of secondary care beds, in an acute setting, by improving internal efficiency and providing alternative provision in the community;

- Improving the efficiency and productivity of community services by having an integrated provider service based on community localities;
- Reducing the overall reliance on statutory services through the promotion of alternative capacity and models of self-care.

Strategic service plans

Community Locality Teams

The majority of services in the future will be provided close to home by community locality teams. The teams will work closely with GPs to provide integrated physical health, mental health and social care for extended hours over 7 days a week. This includes 24 hour rapid response services for times when someone's condition deteriorates or there is an increased social care need, but without the need to go to hospital. The teams include specialist doctors, senior nurses, therapists and social care that will be able to provide advice, treatment and care in the community. People will stay well at home and either not need to be admitted to hospital or enable people to be discharged home earlier from hospital. The teams will support people to make full use of technology so that patients and team members have the right information to support care delivery. This will include telehealth, and mobile working.

Two Specialist Community Centres / Hubs

There will be two Community Hubs for the provision of integrated and specialist community services. One of the hubs will be Todmorden Health Centre in Calderdale and the other one will be Holme Valley Memorial Hospital in Kirklees. These hubs in the future could offer more local services such as: walk in centres; outpatient appointments; pharmacy; mental health services; patient support and social groups; sexual health services; community nursing and therapy services, and diagnostics (blood tests and x-ray). The centres will offer a focus for social and patient support activities and will work with voluntary, community and self-help groups to do this.

Two Specialist Hospitals

There will be two specialist hospitals, Calderdale Royal and Huddersfield Royal infirmary. Both hospitals will serve vital roles in the years ahead and will continue to provide a range of general hospital services at both sites. This will include outpatient care for children and adults, urgent care and minor injuries, midwifery led maternity units, and ante-natal and post-natal care. Both hospitals will also provide specialist psychiatric liaison services. This means that the services that people use most frequently will continue to be available at both hospitals or in a local community setting.

In addition each hospital will have a specialist focus. One hospital will specialise in acute and emergency services and one hospital will specialise in care for people who need planned treatments or surgery (e.g. hip or knee operations).

The acute and emergency 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. Trauma, major surgery, critical care, acute general and specialist medicine, inpatient paediatric services and complex maternity services will be provided at the acute and emergency hospital. 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. For example, if you or a member of your family are experiencing a loss of consciousness; acute confused state and fits that are not stopping; persistent, severe chest pain; breathing difficulties; severe bleeding that cannot be stopped, the Acute and Emergency Specialist Hospital is where you would be taken or directed to.

The planned specialist hospital will provide scheduled support, treatments and surgery. It will also provide urgent care and minor injury services that will offer walk-in access. For example, if you or a member of your family are requiring treatment for sprains and strains; broken bones; wound infections; minor burns and scalds; minor head injuries; insect and animal bites; minor eye injuries; injuries to the back; shoulder and chest, you will be able to get care at the Planned Specialist Hospital.

Key features of the change in configuration of services

Both specialist hospitals will provide high quality care 24 hours a day seven days a week. Care will be integrated and coordinated to optimise continuity of care and ensure that people's holistic needs are met. The core principles of hospital inpatient care will be that:

1. Fundamental standards of care will always be met.
2. Patient experience will be valued as much as clinical effectiveness.
3. Responsibility for each patient's care will be clear and communicated.
4. Patients will have effective and timely access to care, including appointments, tests, treatment and moves out of hospital.
5. Patients will not move wards unless this is necessary for their clinical care.
6. Robust arrangements for transferring of care will be in place.
7. Good communication with and about patients will be the norm.
8. Care will be designed to facilitate self-care and health promotion.
9. Services will be tailored to meet the needs of individual patients, including vulnerable patients.
10. All patients will have a care plan that reflects their individual clinical and support needs.
11. Staff will be supported to deliver safe, compassionate care, and committed to improving quality.

Capacity and demand

Over the next ten years there will be growth in demand for hospital activity due to the increasing needs of the population. However the increased demand for hospital based services can be mitigated by new ways of working and implementation of the new service models.

The key capacity issues identified are:

- The forecast impact of demographic growth on non-elective inpatient activity over the 10 year period is 11%. Detailed modelling has shown this can be reduced to 3% through new ways of working that will enable fewer admissions, reduced lengths of stay in hospital and greater levels of support for patients that need it closer to home.
- The forecast impact of demographic growth on Accident and Emergency services over the ten years is 7%. Detailed modelling has shown this can be reduced to 3% through new ways of working.
- A 20% net reduction in hospital beds is possible by working in new ways in the hospital and providing more care and support in the community i.e. decreasing the number of planned care beds by increasing procedures undertaken as day case rather than inpatient procedure, and reduced lengths of stay because patients can be discharged with support in the community.
- There will be a 5% growth in demand for community services due to more care and support provided out of hospital.
- There is a 7% forecast demographic growth in demand for community services.
- There is a 12% community services efficiency opportunity that is possible from working in new ways.
- A high-level assessment of the impact on GPs and Social Care capacity has also been undertaken this estimates a 5% additional capacity requirement to meet the needs of people in the community. An assessment of the requirement for investment related to this has been included in the economic and financial case.

Risks and dependencies

Currently, there are five major risks that have been identified that need to be monitored and managed throughout the strategic planning process of service redesign and reconfiguration. The programme would need to develop robust mitigation for the following risks:

- Delays in implementing workforce transformation, including staff training / migration from acute to community in addition to development of new roles
- Delays to the capital procurement process and/or lack of availability of capital to undertake all the enabling estates and facilities works required for implementation
- Service closure due to safety concerns, impacting on the planned sequencing of service transfer
- Risk that reducing social care resources limits the ability to deliver a comprehensive community model that enables reduction in acute hospital capacity
- Risk that necessary alignment with timescales for primary care transformation not achieved

An underlying theme of the implementation plans for each of the scenarios is that the Out of Hospital services are implemented before the proposed changes are made to acute care and that capacity is created in the receiving organisation before services are moved to that site. Progress on two critical dependencies therefore requires careful monitoring to ensure this happens:

- Out of hospital transformation delivering the reductions in acute hospital activity
- Acute providers achieving efficiency and productivity improvements in their bedded services to create the required additional capacity for the planned site.

3. Financial Plan

The financial picture illustrates the impact of moving towards the new clinical service model including the scale of the capital investment that will be required to facilitate a split planned / unplanned site.

The majority of the capital investment to deliver the required estate footprint to deliver the reconfigured clinical model takes part in this first five years. In the longer term, in addition to the direct impact of reconfiguration on the Trust's income and expenditure there are a number of other related opportunities for additional income and cost savings as a direct and indirect consequence of reconfiguring services.

The following assumptions are incorporated within the financial plans:

Income

- The activity and income levels 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 tariff deflator assumptions are as described above within the Forecast Activity and Funding Analysis section.
- No activity drift or income loss assumed due to moving to a planned and unplanned configuration. This assumption will be tested as part of the FBC process.
- Reduced income is assumed due to out of hospitals care / efficiency of £15.3m over the planning period. This is based upon reductions to length of stay, readmissions, A&E attendances and admission avoidance described within the activity and capacity section of the business case. This is above the assumed income loss due to generic tariff deflation.
- The plan assumes activity drift from Mid Yorkshire Hospitals NHS Trust as a result of their reconfiguration of emergency services of 3,812 A&E attendances with a 37% conversion rate, resulting in 1,410 admissions. This equates to £3.6m additional income. This is assumed from 2015/16 onwards.

Costs

Pay

- Pay costs have been planned to increase in 14/15 and 15/16 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% cost of living allowance for those at the top of pay scales. Subsequent increases for incremental drift and cost of living allowances for years 3-5 have been assumed at 2%.
- A net workforce reduction, after investing in additional staffing needed to provide quality improvements, such as 7 day working and increased nurse staffing levels on wards. This workforce impact has been modelled through into the finance case.
- The activity drift from Mid Yorkshire Hospitals NHS Trust, described above, equates to an additional £1.7m. This is assumed from 2015/16 onwards.

Non Pay

- 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.
- The activity drift from Mid Yorkshire Hospitals NHS Trust described above equates to an

additional £0.7m. This is assumed from 2015/16 onwards.

- An estimation of transitional costs has been made; these are estimated at £1.5m.
- Additional revenue costs to support the significant investment in technology through the Trust IM&T modernisation programme.

Other assumptions

- Interest charges have been calculated at an interest rate of 3.28% over a period of 25 years from the date of the loan drawdown.
- Contingency reserves are maintained at £4m per annum to mitigate against risk.

Capital plans

A summary of the capital expenditure plans over the five year period is shown below:

	2014/15 Total	2015/16 Total	2016/17 Total	2017/18 Total	2018/19 Total
IT	£m	£m	£m	£m	£m
Electronic Document Management System (EDMS)	3.02	0.00	0.00	0.00	0.00
Electronic Patient Record (EPR)	1.41	9.13	0.07	0.00	0.00
Other Clinical Systems	2.86	2.73	3.77	3.07	1.20
Infrastructure	4.96	3.55	1.70	2.00	2.10
Estates					
Ward Refurbishment	1.87	2.20	2.20	2.20	0.00
Theatre Upgrade & Day Case Theatres	2.00	3.00	2.00	4.50	4.50
PFI Lifecycle	1.07	1.16	1.49	1.59	1.64
Asbestos	0.93	0.05	1.75	1.75	1.75
Statutory compliance	2.34	1.07	6.59	6.95	6.95
Emergency care configuration	0.00	2.00	23.50	23.00	23.00
Vascular laboratory	0.00	2.00	0.00	0.00	0.00
Other	6.86	1.68	3.73	2.92	2.17
Medical Equipment					
Radiology - replacement costs	1.36	1.47	3.92	1.76	0.80
Vascular lab equipment	0.00	0.75	0.00	0.00	0.00
3rd MRI Scanner	0.03	1.45	0.00	0.00	0.00
Other	0.50	0.43	1.24	1.48	1.22
Total Capital Expenditure	**29.20**	**32.66**	**51.95**	**51.22**	**45.34**

Cost Improvement Plans

The impact of the issues described within the above sections result in the need to deliver efficiency savings to remain sustainable as an organisation.

These are mainly driven by inflationary pressures and a reduction in the tariff paid to providers, creating a financial gap of circa 5% that needs to be found through efficiencies.

The efficiency requirement is further heightened through funding significant investments to deliver improved quality of services and mitigating the reduction of income due to out of hospitals care / efficiency models where the full cost cannot be released as tariff is released.

The proposals within the plans equate to an estimated reduction in income due to out of hospitals care / efficiency of £15.3m over the five year period for CHFT. The amount of cost releasable in relation to this in the short to medium term is limited, further increasing the need to deliver internal efficiencies. The Trust is taking a prudent approach on this at present in assuming that additional funds do not flow to support this transitional phase. From a health-economy wide perspective it may be that there is a possibility of reinvesting the released funds to enable change. In the longer term, a leaner site and service delivery model will enable the savings to be released.

The key quality improvements contained within these plans, which are increasing the need to deliver efficiencies, are:

- Investment in providing access to services 7 days a week
- Investment in improving nurse staffing ratios
- Investment in IM&T and estates (including borrowing)

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 key to maintaining this cash position.
The Trust is planning to maintain a strong cash position throughout the planning 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 planned to support investment is shown below:

	2014/15	2015/16	2016/17	2017/18	2018/19
	£'m	£'m	£'m	£'m	£'m
Capital Expenditure	**29.20**	**32.66**	**51.95**	**51.22**	**45.34**
IM&T investments	12.26	15.40	5.54	5.07	3.30
Estate investments	15.05	13.16	41.26	42.91	40.02
Medical equipment	1.89	4.10	5.15	3.24	2.02
Borrowing (cumulative)	**11.94**	**30.26**	**64.42**	**94.88**	**113.19**

The Trust is in discussion with the Independent Trust Financing Facility (ITFF) with regards to access to funds. The discussions to date have indicated that this would be an option and would be predicated upon the affordability assessment.

The loan would be accessed through the ITFF at the Public Works Loan Board rates, currently at 3.28% for borrowing over a 25 year period. These assumptions have been used within the financial analysis.

Continuity of Service Risk Rating
A key measure of success for the Trust is achievement of a sound CoSRR. The planned CoSRR is at level 3 for every year of the planning period as shown below:

	2014/15	2015/16	2016/17	2017/18	2018/19
Capital Service Cover rating	3	3	3	3	3
Liquidity rating	3	3	2	2	2
Continuity of Service risk rating	3	3	3	3	3