

**Strategic Plan Document for 2013-14**

**Calderdale and Huddersfield NHS Foundation Trust**

# Strategic Plan for y/e 31 March 2014 (and 2015, 2016)

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

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Date	30 May 2013

**The attached Strategic Plan is intended to reflect the Trust's business plan over the next three 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 Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;
- The Strategic 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 Strategic 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;
- All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission.

Approved on behalf of the Board of Directors by:

Name (Chair)	Mr Andrew Haigh
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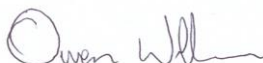
Signature



Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Mr Owen Williams
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Signature



Approved on behalf of the Board of Directors by:

Name (Finance Director)	Mr Keith Griffiths
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**Signature**

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## 1. Strategic context and direction

### 1.1 Strategic position within the local health economy

In 2013/14 the local Clinical Commissioning Groups (CCG) are Calderdale CCG and the Greater Huddersfield CCG. The trust works with two Local Authorities, Calderdale and Kirklees. Each Local Authority hosts a Health and Wellbeing Board which leads on improving the strategic coordination of commissioning across the NHS, social care and related children's and public health services.

Monitor continues its role as regulator of foundation trusts. The compliance agenda will get more onerous in 2013/14, as evidenced by Monitor's increased activity with trusts and the emphasis on the role that the Board plays across the 10 domains of Quality Governance. CHFT will continue to work closely with Monitor to ensure we meet the compliance agenda on behalf of our patients, staff and wider partners. We will implement the recommendations of the Francis report.

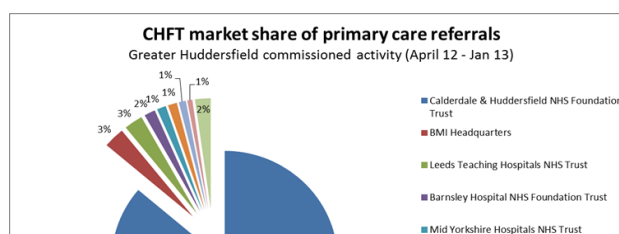
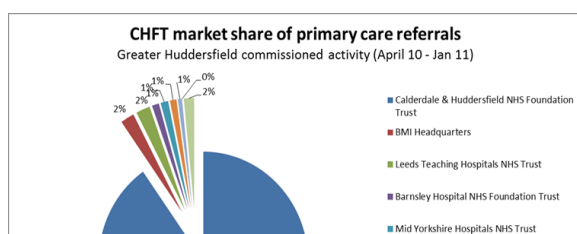
In 2013/14 CHFT will continue to focus on strong strategic alliances to improve patient care. CHFT will continue to work in partnership with other local health and social care providers on the Health and Social Care Strategic Review (the Strategic Review), a programme led by local commissioners to review current service provision across the health and social care community. The objective of the review is to ensure service models are safe and sustainable for the future. The NHS Outcomes Framework (gateway ref 16886) will be used together with the Adult Social Care Outcomes Framework and the Public Health Outcomes Framework to ensure we work in partnership in the context of national and local policy. Representatives from Calderdale and Huddersfield NHS Foundation Trust are, together with representatives from both Local Authorities, both CCGs, and local providers Locala and South West Yorkshire Partnerships NHS Foundation Trust working to develop service plans. The Programme timetable is to develop service models in partnership with the public and staff.

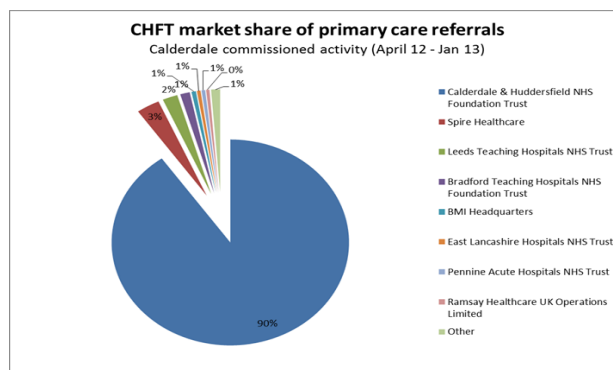
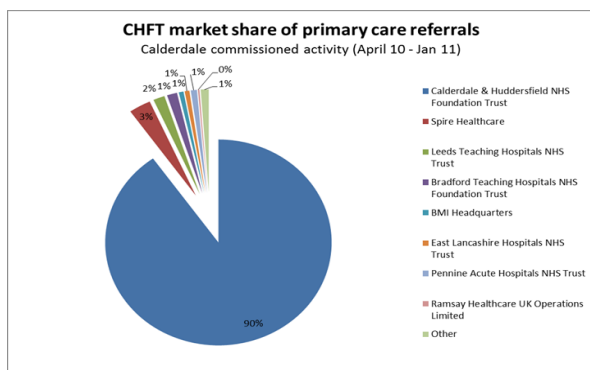
CHFT is now developing a closer working model with Mid Yorkshire Hospitals NHS Trust. Discussions are being held at clinical specialty level to ensure both Trusts and patients benefit from our close proximity. CHFT's wider service strategy is also being developed in the knowledge of plans for services at Mid Yorkshire. The principle of a hospital provider group is good and we will continue to work with East Lancashire NHS Trust and other partners depending on geographic opportunities. Mid Yorkshire Hospitals NHS Trust and South West Yorkshire Partnership NHS Foundation Trust provide partnering opportunities for the delivery of clinical services. The local policy framework is complex and CHFT will continue to influence it to create partnering opportunities.

The population in the locality continues to grow and so also does life expectancy, with more people now living into their 80s and 90s. This is important for the demand on health and social care services as many of these older people are likely to develop one or more long term conditions such as heart disease, diabetes and breathing problems. In Calderdale the population is expected to increase by 16.8% to 236,700 by 2030 (based on 2010 figures). Similarly in Kirklees, the population is expected to increase by 12% to 483,000 by 2030 (based on 2010 figures). As the population grows we can expect to see more people living for longer with age related conditions.

### 1.2 Market share analysis

The charts over present CHFT market share of referrals for the past 2 years by CCG area, and the main competitors in each area. In summary CHFT market share has maintained at 90% in Calderdale and decreased from 90% to 86% in Greater Huddersfield. There is no single main competitor in either area and private provision demonstrates no significant increase in that period.





In 2012/13 Any Qualified Provider (AQP) was rolled out to give patients more choice and control. It builds on and extends the existing choice of provider for elective care introduced in 2007. CHFT will continue to evaluate opportunities under AQP on a case by case basis. So far AQP has not had a significant impact on demand.

In 2012/13 the Trust Board agreed specific objectives in accordance with our statutory responsibilities to comply with the Equality Act 2010. These objectives are focused on easy access to services, ensuring the Trust understands data to inform service improvement and training in staff attitude and behaviour.

The challenges facing the health economy will only be achieved through successful partnership working with our colleagues in primary care, local authority and other provider organisations. Close working within the new structure, outlined above, will continue to be critical to ensure we continue to provide excellent health services across the local community.

### ***1.3 Threats and opportunities from competition, changes in commissioning intentions***

Key External Threat	Risk to/impact on the strategy	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
Reduction in overall real term healthcare funding and the wider economic environment including the impact of Local Authority funding on Social Services	<p>Risk to keeping the base safe.</p> <p>Risk response to funding issues may destabilise service if service redesign does not keep pace.</p> <p>Risk to establishing</p>	<p>The Trust continues to monitor the wider NHS to identify funding risks not anticipated.</p> <p>Actions being taken to mitigate risk include partnership working with other providers to refine service delivery, move to community provision to support</p>	The Trust has an excellent track record of working in challenging times and would anticipate that its partnership strategy and approach will enable it to meet the challenges ahead.	<p>Progress is reported monthly through the Board.</p> <p>Overall accountability for this risk area sits with the Board of Directors.</p>

Key External Threat	Risk to/impact on the strategy	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
	strategic alliances as organisations change in response to funding.	knowledge and self care by patients, formation of hospital group or partnership opportunities with other providers, ongoing close financial management.		
Tariff changes	<p>Risk to keeping the base safe</p> <p>Efficiency requirements within the national tariff are set at levels over the levels currently forecast.</p> <p>Further changes are made to the tariff structure which reduces the Trust's income with no associated reduction in costs.</p>	<p>Downside scenario planning undertaken, the available options include generating additional efficiency savings, reducing the levels of surplus planned for and additional prioritisation of capital expenditure.</p> <p>Three-year financial plans are based on a realistic assessment of the likely financial challenges via national tariff changes.</p>	The Trust expects to be able to deliver the financial plan as outlined in this submission.	<p>Accountability for the overall financial position sits with the Chief Executive, supported by the Board of Directors.</p> <p>The Board of Directors are fully informed of the impact of tariff changes and the Trust's proposed response.</p>
Innovation and technology	<p>Risk to keeping the base safe.</p> <p>Development of new technology that is high cost to Trust or Commissioners and impacts on financial balance of health community.</p> <p>Development of technology or service innovation that impacts significantly on pathways of care and location of service</p>	<p>All technology service developments included in the business plan and discussed in commissioning forums.</p> <p>Multi-organisational Transformational Board oversees pathway development and implementation of telemedicine</p>	The Trust expects all innovation and technology to be included in the business plan and discussed and agreed with partner organisations prior to implementation	Developments discussed and approved through divisional and Executive Board structure.

Key External Threat	Risk to/impact on the strategy	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
	provision.			
Changes in national policy or law – changes to commissioning organisations	<p>Risk to strategic alliances and service integration as organisations change.</p> <p>The move to Clinical Commissioning Groups and creation of Health and Well-being Boards creates a risk that opportunities may be missed as the new organisations are developed, also a risk that new bodies may not sign up to existing strategic direction.</p>	The Trust is working closely with partners through the strategic review and other forums to avoid these risks and ensure we understand key responsibilities and accountabilities in the new structure.	The Trust has a strong track record of working in partnership with commissioners and other healthcare providers and is confident it can support partner organisations as they go through significant change and maintain commitment to patients and the local population.	Accountability for partnership working sits with the Chief Executive and Board of Directors. The Trust works within existing multi organisational structures to ensure continued communication.
<p>Loss of business through any qualified provider or other tendering of services</p> <p>Nationally no requirement for further services to go through AQP but it may become a local strategy.</p>	<p>Risk to keeping the base safe.</p> <p>Actual activity levels fall below plan adversely impacting on the organisation financially.</p> <p>Loss of specific services in totality.</p>	<p>Review patient and GP satisfaction to maintain referral base.</p> <p>Identify new Commissioners where Trust can be any qualified provider.</p> <p>Identify potential high risk services and develop strategy to withdraw costs if services are lost.</p>	High patient and GP satisfaction of our services. Patients choose and recommend CHFT as their provider of care. Increased range of services delivered from CHFT. Attract out of area referrals.	Monthly review of referral levels. Reported to Board of Directors through divisional structure. Accountability through divisional structure.
Demand management and commissioning intention changes;	<p>Risk to integrating our services and internal reconfiguration.</p> <p>Successful demand management strategies put in place by</p>	Continued close working with Commissioners to ensure understanding of long term service strategy allowing for timely changes in capacity and change implemented throughout the	Advanced notification of changes to commissioning strategy to allow Trust to make necessary service changes.	Delivered through multi-organisational meeting structure, Contracting Board and Contracting Committee.

Key External Threat	Risk to/impact on the strategy	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
	Commissioners, significantly reducing demand on service.  Changes in commissioning intentions	patient pathway.		
Commissioners' financial position deteriorates	Risk to keeping the base safe.  Commissioner becomes unable to support the strategic direction of the Trust and the wider health and social care economy.	Shared and agreed strategic direction. Open relationship that alerts early to any problems.  Residual risk is low.	That this is a low risk to the Trust's strategic priorities.	That commissioner is able to continue to support plans. Directors of Finance and Commissioning and Partnerships.
Quality incentives / penalties such as failure to meet CQUIN	Risk to keeping the base safe.  Financial planning made on the basis that quality incentives will be achieved. Failure to deliver will result in a shortfall of required income to the trust.	Planning to deliver financial incentive schemes such as CQUIN is a core part of Trust business. Delivery is monitored at Board level on a monthly basis and early action can be taken if delivery is off track.  Residual risk of none delivery and no remedial action is low.	That this is low risk to the Trust strategic priorities.	Delivery of quality incentives. Accountable through Board of Directors.

#### **1.4 Calderdale and Huddersfield Vision**

The design of the Trust's vision for the future was built on a simple model called the three Rs which is shown in the following table and is self-explanatory.



<b>REALITY + RESPONSE = RESULT</b>		
<b>How are things now?</b>	<b>What do you need to do?</b>	<b>How do you want things to be?</b>
What is working well, what needs to change or improve? What are the facts and figures? How do other people see the situation? What are the issues you really need to focus on?	What could you do? What will you do - your priorities for action? Will these actions achieve what you want? Will you take these actions or is there something missing?	What will success look like? What do you want? (positive) - not what do you not want? (negative) How precisely will you know you have achieved your goal? What will your actions make possible?

During the latter part of 2012, the Trust undertook a significant review of its current **Reality**. This work involved patients, partners, membership councillors and other stakeholders and included the following inputs:-

- Patient/Staff Survey(s)
- NHS Reform & Monitor Compliance Guidelines & Policy Developments
- Board/Senior Clinical & Managerial Leadership Workshops
- Service Mapping
- Health & Social Care Strategic Review Consideration
- Calderdale Transfer of Community Services Review
- External Stakeholder Research
- East Lancs Review Work
- Mid Yorkshire Hospitals Trust Assignment

The collective diagnosis of these inputs lead the Board of Directors & Membership Council to conclude in November 2012 the following:-

- The compliance agenda will get more onerous, as evidenced by Monitor's increased activity with Trusts and their emphasis on the role that the Board plays.
- We have begun to be more collaborative but more needs to be done.
- We need to do more to take our staff with us to ensure they 'do' the right things.
- The local policy framework is complex - we need to influence it.
- The Board of Directors and various Clinical & Managerial workshops have demonstrated the need for change and unfrozen organisational thinking (i.e. created readiness for change).
- The Transforming of Community Services review has indicated that we have not changed our approach to 'care closer to home' substantially yet.
- The external stakeholder review notes a change in our approach (more collaborative) but would like to see collaboration as something we do naturally for the benefit of the system.
- The principle of a hospital/provider group is good and although we will continue to work with East Lancashire they may not be the right partner for clinical collaboration due to geography.
- Mid Yorkshire seems to provide partnering opportunities for the delivery of Clinical Services and potentially back office functions and provides an immediate opportunity that will build on our current collaborative skills base.
- Internal reconfiguration is still contentious in terms of direction but not contentious in terms of the need to reconfigure services and ways of working. If we continue to work as we are then some of our services will not be sustainable to meet the challenges ahead, e.g. changing demographics.
- The strategy to respond to the current reality needs to be pragmatic and we need to stay 'light on our feet' to respond to emerging threats and opportunities. No single strategic idea will suffice.

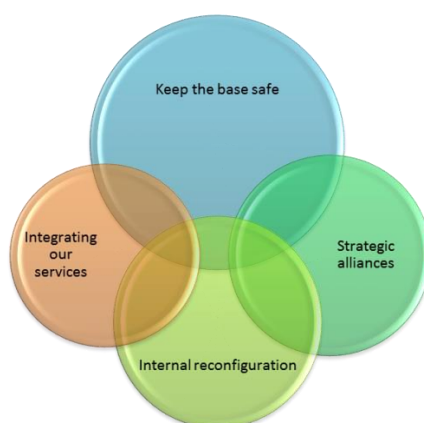
### ***The Vision for Calderdale & Huddersfield Foundation Trust***

After developing our **Reality** conversation, the Board of Directors, Membership Council and our Clinical and Managerial leads set out to describe the future **Result** for the Trust. This included a number of principles which, if the Trust responded appropriately, would produce the following signs of success:-

- Patients and our staff being able to positively describe what 'Your Care, Our Concern' means to them along with their own personal success stories that relate to our values of People, Patients, Partnerships and Pride.
- Living up to the desire for us to be clinically led and treating our patients, staff and partners in a way that we would expect to be treated ourselves.
- Several examples of how we have collaborated in the interests of patients both within and outside CHFT.
- Improvements in real time patient information being at hand for us and our partners to provide the best seamless care.
- Ensuring our regulatory compliance by improving our access to care for patients and prioritising their safety.
- Meeting head on our financial circumstances and using this challenge as a driver for change and not solely as a constraint.

In developing our **Response** to achieve the Trust's desired **Result**, four broad strategic themes emerged which are described as follows:-

- Keeping the base safe ensuring no drop in performance during turbulent times.
- Internal reconfigurations of services and staff utilisation.
- Integrating our services with primary care and social services.
- Establishing strategic alliances with likeminded provider partners.



### ***Response 1 - Keeping the base safe: Ensuring no drop in performance during turbulent times***

The Trust operates in a regulatory and compliance framework which demands adherence to standards of patient safety and quality of care. There has also been a transformation in the expectations of patients and this is writ large in the Francis report which makes it clear that we must seek to continuously improve and move to a model of care which is patient led.

In order to transform what we do it is imperative that the Trust meets its regulatory performance targets whether they are about patient safety and/or the quality of care. Success in compliance enables the Trust to look forward and develop/innovate patient care verses the alternative of becoming internally focused and forever chasing targets due to a lack of non-compliance.

As a part of keeping the base safe we will undertake a continuous improvement approach which will involve patients, doctors, nurses and porters et al in mapping out the current 'door to door' experience for patients. We will then co-develop the future state with the core aim of improving productive patient time and reducing/minimising unproductive patient time.

The post-Francis NHS demands new approaches and responses to the engagement and development of all our people, whether in clinical or non-clinical roles. The focus will be on care and compassion delivered by competent and appropriately qualified people who have the courage to put the patient first and are able

to interpret the aim of 'Your Care, Our Concern' in a way that is real for them. The emerging NHS structural landscape demands new ways of working within a tighter fiscal environment where partnerships and collaboration thrive.

This will become the way we work and it is intended that this **Response** will not only have clear patient benefits but it will also help us to navigate the financial reality that will exist for at least the next decade.

### ***Response 2 - Internal reconfigurations of services and staff utilisation***

As a part of keeping the base safe and enabling the Trust to continually improve care there will inevitably be a need to change the way we work and reconfigure services. This is not just about where services are provided from as "bricks and mortar" don't provide care in themselves. This is about our people and how we change to meet the new demands placed upon us in a patient led world. The following is an example of the responses that will be implemented in due course:-

- Redesigning our workforce to deliver services 24 hours a day and 7 days a week.
- Redesigning our workforce to meet the changes in numbers of doctors and nurses in training.
- Training more nurses and AHPs in the extended scope roles to provide the new workforce.
- Providing more outreach services in the community, from all professional groups.
- Rolling out the pilot models designed to support patients with long term conditions to provide self-care.
- Building our electronic capacity to share records with other providers and access records remotely.
- Ensuring lean is the way we do things around here.

Internal reconfigurations of services and staff utilisation will also be an important part of the delivery of Cash Releasing Efficiency Savings (CRES). To allow safe and informed judgements to be made it is critical that the Trust uses the full range of management intelligences which are available. These include:

- Service Line Management and its development to patient level.
- The use of industry recognised benchmarking tools covering productivity, quality, safety and cost;
- Rapid deployment of IM&T solutions, e.g. e-rostering, electronic patient records;
- A clinically led programme of innovation which will focus on new clinical practices and integration across primary and secondary care e.g. telehealth / more day case surgery;
- Strategic review of the estate to ensure appropriately sized footprint.

### ***Response 3 - Integrating our services with primary care and social services***

In recent years the Trust operated in an environment of comparative financial prosperity and investment in health care services. However, that era has concluded and the future will feature a need for much more organisational collaboration which is focused on meeting the needs of the patient versus the needs of individual organisations themselves.

As a result, we will continue to work as a part of the Strategic Review of Health and Social Care undertaken by the seven organisations who commission and deliver the majority of health and social care services in Calderdale and Huddersfield.

The unequivocal aim of the Strategic Review is to deliver a 'best in class' health and social care system which will have built capacity in our communities, integrates services and has industrialised the use of technology to transform the way we care for, and support people. This transformational change will only be achieved with the active support of our stakeholders and local people.

To ensure this level of integration really exists, yet without undermining the divisional, clinical led structures which are in place, a structured Programme Management Office (PMO) will be introduced. This office will ensure that plans are delivered on time and safely; and when investment is required to make change possible, a real return on that investment is delivered. In addition, the programme as outlined will be consistently communicated to staff and, wherever possible, these same staff empowered to make the necessary changes.

The financial programme will support also this work and this is exemplified by the capital investment programme. This includes a 3 year modernisation programme to provide 'best of breed' Electronic Patient

Record (EPR) information sharing facilities across the local health community and the provision of robust infrastructure that will give access to high performing systems and accurate and timely information.

#### ***Response 4 - Establishing strategic alliances with likeminded provider partners***

Whilst being cognisant of competition rules, the Trust plans to progress appropriate strategic alliances across South West Yorkshire Partnerships NHS Foundation Trust; Airedale NHS Foundation Trust; Mid Yorkshire Hospitals NHS Trust and ; Locala and other relevant providers.

The reason for this is twofold, we are moving to an era of full on specialist commissioning which is evidenced in the most recent funding shift from local Clinical Commissioning Groups to Specialist Commissioners as a part of the national Everyone Counts: Planning for Patients 2013/14. Whilst CHFT only has a comparatively small level of direct funding from specialist commissioning activity the reality is that certain commissioning decisions can have a domino effect on District General Hospital care such as we currently provide. In short the effect that a Specialist Commissioning focus on large regional centres can have is the reduction of the provision of local services for local people.

It is also the case that the reality of reducing resources for all public sector providers into the future makes collaboration for better patient safety and care a must.

#### ***Turning our Trust Vision into Reality***

A vision will just remain a statement of intent if there are not specific actions and/or key milestones for which we are all accountable. The following provides a list of objectives that are based on our four strategic **Responses** and sit with Executive and Divisional Directors. These will be used to ensure that the Vision and its associated **Responses** are delivered. This is by no means an exhaustive list but illustrates how we will performance manage our progress against the Vision and our desired patient outcomes.

It will also be the case that this objective-led approach will form a core part of our approach to key management and personal development tools such as individual appraisal into the future.

Objective	Key Milestones
Keeping the base safe ensuring no drop in performance during turbulent times.	<ul style="list-style-type: none"> <li>• To achieve a Monitor Governance “Green” rating by December 2013.</li> <li>• To have improved our Trust Board effectiveness and performance by June 2014 against the developed June 2013 baseline.</li> <li>• Ensure Achievement of Level 2 maternity CNST and start working on Level 3 by July 2013</li> <li>• That all CWF services engage in Real Time Patient Monitoring (or equivalent) and respond appropriately to improve patient experience by September 2013.</li> <li>• Implement Choose and Book in relevant outpatient services by September 2013.</li> <li>• To maintain a Financial Risk Rating of 3 by March 2014.</li> <li>• Roll out the Productive Community Service modules across all areas of IC &amp; C by April 2014.</li> </ul>
Internal reconfigurations of services and staff utilisation.	<ul style="list-style-type: none"> <li>• Board approval for strategic approach CHFT 3 year modernisation programme to provide a ‘best of breed’ electronic patient record (EPR), information sharing facilities across the local health community by December 2012. - approved</li> <li>• In conjunction with Divisions and in accordance with patient mortality and Royal College principles to have developed a 5 year Board approved clinical workforce strategy by July 2013.</li> <li>• Nursing and residential homes Telemedicine value for money test and roll-out implementation commenced by April 2013.</li> <li>• Development of a robust strategic estates plan, which incorporates the progression of the Health and Social Care Strategic Review and shorter term backlog and on-going maintenance issues by May 2013.</li> <li>• To agree the workforce models to support all active emergencies at HRI</li> </ul>

Objective	Key Milestones
	<p>and Oncology day case and Rehab at CRH by June 2013.</p> <ul style="list-style-type: none"> <li>• Work towards provision of routine 7 day therapy services for inpatient areas by June 2013.</li> <li>• Facilitate the enhancement of day case surgery and roll out of Enhanced Recovery Programme (ERP) in surgical specialities by September 2013.</li> <li>• To agree a programme of work to support service prioritisation e.g., Wheelchair Services by September 2013.</li> <li>• Increase the provision of surgical services during evenings and weekends. Moving to 7 day working by December 2013.</li> <li>• Work towards 7day routine diagnostic services by December 2013.</li> <li>• To agree a programme of work that supports further integration of therapy and community services pathways across the Trust to support the delivery of more care in the community by December 2013.</li> <li>• Introduce a maternity PAS system to facilitate safe, effective and efficient working by March 2014.</li> </ul>
Integrating our services with primary care and social services.	<ul style="list-style-type: none"> <li>• Board approval of the Health &amp; Social Care Strategic Review Gateway (HSCR) recommendations by December 2013.</li> <li>• Ensure new HSCSR Programme Management Office arrangements are in place by March 2013. – completed. Revised again in June 2013.</li> <li>• Contribute to and implement new system wide emergency planning procedures by March 2013. Implemented.</li> <li>• To ensure that Transforming Community Services is fully integrated and established as the Families Directorate within CWF Division by April 2013.</li> <li>• To agree the programme of work that supports the wider integration of therapy and community services across CWF, LOCALA, Calderdale Council by June 2013.</li> <li>• Integration of Virtual ward within Surgical Division by September 2013.</li> </ul>
Establishing strategic alliances with likeminded provider partners.	<ul style="list-style-type: none"> <li>• Progress external stakeholder feedback research workshops by February 2013. Completed.</li> <li>• In partnership with Divisions, Commissioners and incorporating financial targets to develop a specialist commissioning strategy which is CHFT Board approved by June 2013.</li> <li>• Progress communications strategy to include the building of commercial marketing capacity to play roles in demand management via digital technology and social media and AQP by May 2013.</li> <li>• Work with corporate leads to look at partnerships with Mid Yorks re Rheumatology Services by April 2013. Ongong.</li> <li>• Continue to support alliances with leads re Stroke Thrombolysis, out of hours rotas by April 2013. Ongoing.</li> <li>• Review services that are likely to be subject to 'any qualified provider' and develop a plan that enables collaborative to support service delivery by April 2013. Ongoing.</li> <li>• Demonstrate efficient collaborative working with Locala in CASH and GUM Services in Kirklees for patients' and both organisations' benefit by June 2013.</li> <li>• Deliver full participation and collaborative working on the PACE project to an outline business case by September 2013.</li> <li>• To have progressed appropriate Board approved memorandums of understanding across SWYPFT; MYHT, Locala and other relevant providers by December 2013.</li> <li>• Explore links with University of Huddersfield to facilitate the training of extended role practitioners by March 2014</li> </ul>

### ***Demand profile and activity mix***

Over the past 2 years the Trust has experienced a relatively static activity profile. Variations have been witnessed within specific points of delivery as slight falls within elective activity have been offset by increases within unplanned activity through increases in attendances at A&E and increases in levels of emergency medical admissions.

In December 2012, the Trust and its local commissioners engaged with Interserve Consulting to complete a strategic review and analysis of the Health and Social Care data of the whole health economy over the next 10 years.

The Trust has joint agreement with the local commissioners that this report and information set will form the basis for the activity plans for 2013/14 and beyond.

In the short term and at a Trust level, activity is forecast to grow by c1% per annum. As has been experienced, larger variations are expected within certain points of delivery. The pressures within unplanned care are expected to continue with increases in activity forecast to be over and above the 1% Trust wide growth figure.

### ***Membership commentary***

The membership of CHFT broadly matches the demographic profile of the population of Calderdale and Kirklees. The Trust has maintained a membership of approximately 10,000 public members over the previous year and intends to maintain this level of membership over the following year. Recruitment activity will include events with the local colleges and university; civic events and recruiting at the main hospital sites.

### ***Regard to the views of Governors***

The Trust confirms it has had regard to the views of governors.

### ***Leadership arrangements and succession plans over the period***

The Board of Directors has seen a number of changes over the last 3 years and will see further change over the period of this Annual Plan including the recruitment of 3 new non-executive directors in the next 12 months. Their portfolios will include patient experience and customer service, service development and new models of care and finance including audit and risk. A new Medical Director has just been appointed from within the organisation and the office of the Medical Director will be strengthened to increase the focus on patient care, safety and experience post Francis. The organisation has developed a new staff engagement strategy with strong leadership at its core and the leadership themes contained in the strategy place the patient at the heart of everything we do.

The Board is developing robust arrangements to test its own effectiveness and is using external support with this from experts with wide experience both in and outside the health and social care sector.

The Trust will continue to refresh its leadership arrangements to ensure that opportunities are offered to talented individuals both home grown and from other NHS organisations or sectors."

### ***Meeting the requirements of the Equality Act 2010***

The Trust has due regard to the General Duties of the Equality Act 2010 as follows:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010.
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The duties are relevant to the protected characteristics listed below:-

- Age
- Disability
- Race

- Sex
- Gender reassignment
- Sexual orientation
- Religion or belief
- Pregnancy and maternity
- Marriage and civil partnership (to a more limited extent)

The Trust is committed to advancing equality of opportunity for staff with protected characteristics. This includes equal opportunity for training, promotion and career development.

The Trust continually reviews its policy framework in order to ensure that it is meeting its legal obligations and providing a supportive workplace environment for all of its employees.

The Trust monitors, for equal opportunities purposes, all applications for employment. This enables us to identify the number of people in employment with a protected characteristic and provides us with an opportunity to engage with them to improve ways of working and the working environment.

The Trust tackles direct and indirect discrimination against staff of all protected characteristics, and minimises the disadvantages suffered by staff with a disability through provision of workplace aids and adaptation. This is demonstrated by the Positive about Disabled People 'two ticks' award, which the Trust has retained for over 10 years.

The Trust's approach to treating people with disabilities fairly is applied throughout our employment practice and takes account of training and development needs for people with a disability at the point of entry to employment as well as those who, during the course of their employment with the Trust, become disabled.

The Trust has a widely recognised employability scheme which has been successful in positively encouraging applications for employment from people with a disability and has placed such applicants in volunteer and paid roles.

The Trust introduced an apprenticeship scheme on 1 October 2012 for all posts at Agenda for Change pay bands 1 and 2. The Trust is an active player in the local job market and, through employment, it can make a significant difference to life opportunities for its local population as well as impacting on health and wellbeing. The apprenticeship scheme should support people with disabilities, those without qualifications, those from ethnic communities and from areas of significant deprivation into the employment market.

## **2. Approach taken to Quality**

### **2.1 An outline of existing quality concerns (CQC or other parties) and plans to address them** **Care Quality Commission**

In August 2012 and in January 2013 the Care Quality Commission (CQC) undertook separate unannounced visits at the Calderdale Royal Hospital (CRH) and Huddersfield Royal Infirmary (HRI) respectively. These visits were to specifically look at diet, nutrition, dignity and safeguarding. On both occasions the Calderdale and Huddersfield NHS Foundation Trust was found to be compliant with all of the standards apart from Outcome 21 – which refers to documentation.

At the time of the CRH visit in August 2012 specific issues were highlighted following concerns about the completion of DNACPR (Do not attempt cardio pulmonary resuscitation) documentation. In November 2012, following receipt of the compliance report regarding the visit at CRH, the Trust provided the CQC with an action plan. The target date for completion of those actions was 31 December 2012. In March 2013 an action plan was submitted to the CQC in relation to the compliance report following the visit to HRI in January 2013, which had highlighted minor concerns with respect to record keeping. Actions from this are expected to be completed by 31 July 2013.

On 20 March 2013, the CQC made a further unannounced visit to CRH to follow up on their visit in August 2012. The CQC reviewed six sets of patient bedside records and six sets of clinical records which they found to be of an unacceptable standard. The previous action plans had clearly not addressed all the

issues. Therefore, in response to the CQC the Trust prepared an action plan which relates to all clinical documentation, including nursing, medical and therapies. This action plan will also apply to HRI. The previous action plans highlighted specific areas of focus. This action plan is more wide-ranging and relates to all matters of clinical records and applies across all wards and clinical departments, wherever the Trust delivers care. The action plan is fast paced and its effectiveness is being overseen by a Clinical Records Management Group, which will meet weekly initially and until improvement is sustained. Actions to comply with Outcome 21 need to be completed by 31 May 2013.

The Clinical Records Management Group will report directly to the Trust's Quality Assurance Board. From the main action plan, each division has an individual action plan and also every ward now has an action plan following on from baseline audits undertaken by matrons.

Finally, an information governance incident occurred which required reporting to the Information Commissioners Office. A ward handover list was found outside on the ground and handed back to the Trust. Handover sheets are now being removed from the wards.

## **2.2 The Organisation's major quality risks**

The major quality risks have been identified in the Annual Governance Statement and are repeated below:

<b>Risk</b>	<b>Mitigating actions</b>	<b>Outcome measures</b>
<p>Healthcare acquired infections are a major cause of harm and are of concern both to the Board and to our patients and public. Reducing their incidence is both a national and local priority in delivering our strategic intent of safe, personal and effective care.</p> <p>The Trust has a significantly reduced trajectory for numbers of MRSA bacteraemias and C Difficile in 2013/14 which provided a challenge.</p>	<p>The Trust has an Infection Control Performance Board where MRSA and C Difficile levels are monitored and improvement work identified and progress monitored.</p> <p>This accounts to the Board of Directors who review the information monthly to assure themselves that levels are reducing in line with our targets.</p>	<p>2013/14:</p> <p>MRSA : 0</p> <p>C.Difficile : 6</p>
<p>Quality improvement collaboratives do not deliver change at the pace required to improve quality, and ensure compliance with local and national indicators.</p>	<p>There is a clear action plan for achieving the quality goals, with designated leads and timeframes.</p> <p>There are clear roles and accountabilities in relation to quality governance. Responsibilities are cascaded from Board to ward to Board.</p> <p>Quality performance is discussed in detail by the Quality Assurance Board, a Board sub-committee, so that early warning signs of risks to quality are detected, and mitigating actions introduced</p>	<p>2014 All national and local performance indicators are met.</p> <p>Patient satisfaction is improved in accordance with our Quality Strategy.</p> <p>CQC registration is maintained.</p> <p>We deliver what is required under our contract with our Commissioners</p> <p>Ongoing authorisation by Monitor</p>
<p>The move to Clinical Commissioning Groups and</p>	<p>The Trust is working closely with partners through the strategic</p>	<p>The Trust has a strong track record of working in</p>



Risk	Mitigating actions	Outcome measures
creation of Health and Well-being Boards creates a risk that opportunities may be missed as the new organisations are developed, also a risk that new bodies may not sign up to existing strategic direction.	review and other forums to avoid these risks and ensure we understand key responsibilities and accountabilities in the new structure.	partnership with commissioners and other healthcare providers and is confident it can support partner organisations as they go through significant change and maintain commitment to patients and the local population
Risk to the safety of people Who use our services because of poor standards of record keeping, identified by CQC compliance inspections	Pace of training in and Implementation of new nursing documentation accelerated, to ensure compliance with standards by 31/05/13. Letter from CEO/MD/ND to all clinicians reminding them of their responsibilities to ensure that the record is accurate and up to date and reflects the agreed care plan. Continuous audit of record keeping in place across all disciplines.	Entries into clinical records Adhere to and meet professional registration authority requirements for record keeping, resulting in improved patient safety
Risk to compliance with Regulation 15 of Health & Social Care Act 2010  Outcome 10 – Safety and suitability of premises at HRI	Strengthened framework for non-clinical governance. Additional specialist resources secured. Any overdue inspections have been completed.	Annual assurance plan & reports demonstrate compliance with regulatory requirements.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

### ***2.3 An overview of how the Board derives assurance on the quality of its services and safeguards patient safety***

The Trust Board is reviewing its governance arrangements in the light of the recent Care Bill announced in the Queen's Speech. The Trust Board is currently being assessed by Foresight using Monitor's Quality Governance framework as guidance for the assessment. This report will be reviewed by the Board in June 2013. This report will inform the review of governance arrangements.

The Annual Governance Statement submitted to Monitor describes in detail how the Trust Board of Directors currently derives assurance on quality and safety. The statement describes how the system of internal control is designed and how the operational management framework is the primary mechanism by which the Trust achieves its business, financial and service objectives and mitigates risks to achieving them. The Executive Team and Executive Board are responsible for managing performance by a system of management checks and controls, with additional assurance on the effectiveness of the system of internal control being provided to the Quality Assurance Board by the Risk Compliance and Assurance Committee. This Management Committee is responsible for monitoring the Compliance Register, Risk Register, and performance against national standards.

## ***3. Clinical Strategy***

### ***3.1 The Trust's Clinical Strategy over the next 3 years***

The 2012 revision of CHFT's Quality Improvement Strategy included the following strategic goals:

- Year on year reduction in hospital mortality
- Continuous improvement in the percentage of harm free care
- Year on year reduction in healthcare acquired infection
- Year on year increase in the percentage of patients with improved clinical outcomes through receiving reliable, evidence based care
- Year on year increase in the proportion of patients with long term conditions who work with their healthcare professionals to develop self management strategies
- Year on year improvement in patients reporting their satisfaction with the care they receive as inpatients, outpatients, maternity, community and A&E.
- Year on year achievement of financial savings by delivering more effective, efficient and personal care.

These goals are monitored and measured through the Quality Improvement Board, with Executive leads for each of the supportive programmes of Safety, Effectiveness, Patient Experience and Exemplar Ward. The project groups, known as Collaboratives, within the Programmes each have goals and improvement measures which aim to deliver the strategic goals. These projects are consistent with our published Quality Account and with the CQUINs agreed with our commissioners. Progress is reported via the Quality Assurance Board, which is a subcommittee of the Board of Directors.

The key changes that the trust is focusing on through all its improvement work are to improve reliability in the delivery of care, to reduce variation, improve quality and minimise waste. The 2 primary strategies for achieving this are the introduction of evidence based bundles, for example, the skin bundle to reduce the incidence of preventable pressure ulcers and care bundles for common conditions such as Chronic Obstructive Pulmonary Disease. By ensuring that the right interventions happen at the right time and in the right order, avoidable harm and deaths can be prevented, as well as improving the overall patient experience.

Building reliability into the system requires significant culture change: strategies to achieve this include communication, training and development plans and performance management systems. Measuring the indicators that matter from ward/department level to the Board of Directors and ensuring consistency of approach from ward to board is key to embedding a focus on quality. The Board uses patient stories to understand the service and members of the Board routinely visit all wards and departments using the IHI's Leadership Walk round approach.

In addition to the use of evidence based bundles, the Trust has formed a successful partnership with the Lean Enterprise Academy and is part of their "door to door" club to facilitate joint learning. Tactics such as the introduction of the Visual Hospital, Plan for Every Patient, Discharge Levelling and proactive flow management through the patient journey have been key to reducing our length of stay and efficiency to that of some of the best in the country.

Over the next 3 years the Trust will continue to build on these firm foundations, centralising quality in the performance framework. Our current work programmes have been aligned to the NHS Outcomes Framework and other priorities for improvement will be identified from the Commissioners, our Quality Assurance Board and from our communities who work with us on the design of the Quality Account. The quality improvement work will increasingly become more systems focused, maximising our potential for improving care through our position as an integrated Trust. Our experience with patient self-management through the Health Foundation's Co-Creating health programme provides a third stream of work to prevent avoidable admissions and to maintain people's health and independence in our local community.

The delivery of the clinical strategy will be supported by a robust service line reporting and management system derived from patient level data ie a Patient Level Information and Costing System (PLICS). The Trust is in the final stages of the development of this system and will have a core operational model available from the end of the first quarter of 2013/14. This will enable a full system deployment within the year. Clinical engagement and clinical leadership will be the key to the success of this and the Trust will utilise the clinically led divisional teams as the conduit for this roll-out. Benefits realisation will give those clinical service lines the ability to connect patient level financial results to patient level clinical outcomes.

### **3.2 Clinical Workforce Strategy**

In support of the Trust's approach to keeping the base safe in turbulent times, there will inevitably be a need to reconfigure clinical services and to change the way we work. A primary focus in this will be how our people are deployed and how they work ensuring that the patient is at the centre of all that we do. The Trust will:-

- Redesign workforce models to facilitate the delivery of safe and high quality clinical services across extended time periods (to include 7 day working and extended days)
- Respond to reductions in doctors in training numbers by supporting increases in enhanced and advanced nursing roles
- Invest in Consultant led services
- Explore, within national and local frameworks, pay, terms and conditions flexibility
- Implement competency frameworks for professional groups and clinical support roles
- Reduce non contracted pay spend
- Appraise all staff (100%) annually and agree key work objectives/personal development plans
- Invest in additional nursing posts
- Improve productivity and good governance through the use of technologies, for example, e-rostering
- Provide more access to outreach services in the community, deploying clinical staff in support
- Further develop the apprenticeship strategy to ensure a continual flow of skilled and motivated individuals into professional/clinical roles
- Manage attendance/competence/behaviour within a comprehensive framework
- Support the health and well being of colleagues
- Implement a comprehensive staff engagement strategy

### **3.3 Clinical Sustainability**

Regarding clinical sustainability bariatric surgery is the one service that could potentially lack critical mass (defined by Royal Colleges etc). The trust is working in partnership with two neighbouring Trusts to develop a network to maintain this service.

Interventional Radiology, Dermatology, A/E and Spinal surgery have been identified as having consultant cover below those levels recommended by Royal Colleges etc. The Trust is working in partnership with local commissioners and tertiary providers to address recruitment in these areas. Both Dermatology and A/E are identified nationally as having a shortfall in available workforce. The Trust is working with commissioners regarding service models to ensure safe provision of services.

The Trust work closely with partner organisations to develop innovative care models to enhance services, examples include:

- virtual ward, a multi-agency and multi-professional approach to supporting patients in the early days post discharge from hospital, to ensure that the discharge from hospital is as successful as it can be for the patient. Now discussing integrating this service with community and ambulatory teams.
- the support and independence team, a collaborative between acute, community and social care providers to maximise patient independence in the community,
- a collaboration between acute care specialists and the intermediate tier provider to reduce the necessity to transfer patients to the acute setting,
- discussions around the development of a frailty unit within the hospital
- discussions around the establishment of a RAID (Rapid Assessment Interface and Discharge) mental health in reach service in the acute settings.
- Ongoing development of inpatient care of dementia patients, including training and implementation of butterfly scheme across all staff groups, continued commitment to delivering the CQUIN regarding identification of dementia and support for carers of patients with dementia.
- Increased senior staffing on site into the evenings to improve decision making and quality of care.
- Increased pharmacy manufacturing unit collaboration and partnerships
- Redesign of anticoagulation service - Review of service is underway with GP colleagues to understand how Self Management Support (SMS) would improve quality

## **4. Productivity and Efficiency**

#### **4.1 Overview of potential productivity and efficiency gains, including financial impact**

The following areas have been identified to deliver productivity and efficiency gains for 2013/14 and beyond:

- Workforce – There are numerous schemes related to workforce planning and management with the main schemes detailed below:
  - Trust wide administration review – The Trust will utilise recent IM&T investments within digital dictation and voice recognition to support a review of delivery models. Recurrent savings of £5m are anticipated.
  - E-rostering – The Trust is procuring an electronic system for rostering time and attendance for all staff. A phased roll-out is planned with ward based nursing staff within the early adoption phase. Recurrent savings of £1m are anticipated.
  - Reductions in non-contracted pay spend – the implementation of e-rostering and the implementation of different ways of working will require a reduction in the use of non-contracted pay spend. Recurrent savings of £4m are anticipated.
  - Clinical and non-clinical skill mix reviews will be undertaken in conjunction with the outcomes of the Health and Social Care strategy review.
- Outpatients – This project contains three strands (i) a capacity and demand review to ensure clinic time and clinic utilisation is maximised; (ii) review the opportunities to centralise and review the 'skill-mix' of the nursing workforce within outpatients and (iii) implement further initiatives to reduce follow-up appointments and 'did not attend' (DNA) rates. Recurrent savings of £1m are anticipated to be realised.
- Theatres – This project includes the procurement of IT systems upgrades to assist in the booking and scheduling of patients and stock management within theatres. There is also a work programme with the Lean Enterprise Academy (LEA) to review demand and capacity and the development of a 'Plan for Every Procedure'. Recurrent savings of £0.4m are anticipated to be realised.
- Collaborative working – Joint working with neighbouring acute Trusts for the provision of pathology services to ensure service resilience but to gain from efficiencies of scale. Recurrent savings of £0.4m.
- Procurement efficiencies – A review of current procurement arrangements, levels and consistency of non-pay spend and exploring alternative routes to market. Recurrent savings of £11m.

#### **4.2 CIP Governance and enablers**

During 2012/13 the Trust delivered savings of £14m that was achieved through concerted management action driven through the Trust's clinical Divisions and corporate strategic planning.

The Trust recognises the considerable efficiency challenges and in response has created an Efficiency Programme Board (EPB) that will follow a Project Management Office (PMO) approach to the delivery of the efficiency target for 2013/14 and beyond. This is a marked difference to prior years where allocations of efficiency targets were devolved throughout the organisation.

The EPB is providing a co-ordinated approach to the delivery of efficiency schemes that are cross-divisional, whilst also monitoring the achievement of allocated divisional schemes. This approach includes a specific central resource to monitor the implementation of efficiency initiatives, whilst delivering some of the corporate efficiency initiatives. The EPB will also co-ordinate the application of non-recurrent funding or investment within IM&T to ensure that value for money is achieved from any investment.

The EPB is supported by divisional teams who hold divisional efficiency meetings frequently to track the progress of individual schemes and identify future efficiency initiatives.

The EPB is chaired by the Director of Operations and membership includes clinical and non-clinical representatives including senior managers from the Trust's main commissioners to ensure tie-in to QIPP schemes.

#### **4.3 Quality impact of CIPs**

The Trust has implemented procedures to ensure there is appropriate Medical and Nursing involvement in the development of CIP plans. Each CIP scheme is reviewed and signed off by the Medical and Nursing Director in advance of the scheme commencing. Where schemes are greater in size and risk, a Quality Impact Assessment is performed to consider the implication under the following headings:

- Duty of Quality
- Patient Experience
- Patient Safety
- Clinical Effectiveness

The assessment considers the likelihood and impact on each area and risk scores each area. This assessment approach of schemes has been agreed with the Trust's key commissioners. Each Quality Impact Assessment is signed off by the Medical and Nursing Director in advance of the scheme commencing. Schemes will not progress without the approval from the Medical and Nursing Directors approval.

Each CIP scheme is also assessed for any implications on equality. Where concerns surrounding equality are identified the Trust has an Equality Impact Assessment that requires completion and sign off.

#### **5. The Trust's financial and investment strategy**

The Trust recognises this period of austerity in public services is likely to continue until 2020, resulting in annual efficiency savings of c5% for the foreseeable future.

The table below summarises the financial performance headlines:

	<b>2013/14</b>	<b>2014/15</b>	<b>2015/16</b>
	<b>£m</b>	<b>£m</b>	<b>£m</b>
<b>Surplus</b>	3.0	3.0	3.0
<b>CIP Requirement</b>	16.4	19.0	13.5
<b>Financial Risk Rating</b>	3	3	3

The Trust's strategy is to ensure a sustainable long term financial position, which is robust and flexible enough to cope with these economic and fiscal pressures, whilst generating surpluses that will be used to develop and modernise the infrastructure of the organisation and above all to provide the best quality of care for patients.

This can be summarised under the banners of the Trust's four key strategic objectives:

##### **Keeping the base safe**

For 2013/14 – 2015/16 the Trust aims to achieve a £3m annual surplus, approximately 1% of turnover (excluding items which are exceptional in nature such as impairments and impairment reversals which do not have a cash impact).

Over the same three year period the Trust is planning to spend £40m in capital expenditure based on service and site strategy requirements and operational priorities in continually improving facilities and services provided by the Trust.

The cash and liquidity position of the Trust is forecast to remain healthy and, as such, the Trust is not planning to utilise any of its authorised borrowing capability to achieve its operational and capital programmes.

### **Internally reconfiguring services**

Internal reconfigurations of services and staff utilisation will be crucial to the delivery of the challenging efficiency programme.

The creation of the EPB will ensure a co-ordinated approach is adopted and will ensure that plans are delivered on time and safely; and when investment is required to make change possible, a real return on that investment is delivered. In addition, the programme as outlined will be consistently communicated to staff and wherever possible, these same staff empowered to make the necessary changes.

### **Integrating our services**

The three year planning period sees the Trust taking partnership and collaboration to a new level. This is the case across primary, secondary and social care as we work together with organisations across the local health economy in implementing the plans developed through the jointly developed local Health and Social Care Strategic Review.

The financial programme needs to support this work and this is exemplified by the capital investment programme. This includes a 3 year modernisation programme to provide 'best of breed' Electronic Patient Record (EPR) information sharing facilities across the local health community and the provision of a robust infrastructure that will give access to high performing systems and accurate and timely information.

It is recognised by the Trust that the scale and impact of this programme will be over and above anything that has gone before. Collaborating with health care partners is critical; as is a real ongoing risk assessment programme.

### **Forming strong strategic alliances**

Whilst being cognisant of competition rules, the Trust plans to progress appropriate strategic alliances across South West Yorkshire Partnerships Foundation Trust; Mid Yorkshire Hospitals NHS Trust, Locala and other relevant providers. These alliances will produce financial efficiencies in line with the Trust's medium to long term financial requirements.

### **Summary**

In summary, the Trust's financial strategy is to:

- achieve an annual surplus to allow for capital investment in technology and modernising infrastructure;
- implement safe and sustainable long term productivity, efficiency and cost reduction initiatives;
- work closely with partners in the local health economy.

These plans and actions will support our duty as a Foundation Trust to operate effectively, efficiently and economically and as a going concern. This in turn will demonstrate good financial governance and delivers a Financial Risk Rating (FRR) at level 3.