Harrogate and District NHS
NHS Foundation Trust

Strategic Plan Document for 2013-14

Harrogate and District 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	**30th May 2013**

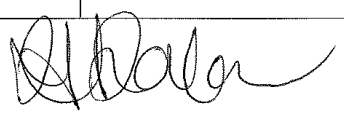
The attached Strategic Plan is intended to reflect the Trust's business plan over the next three years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

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.**

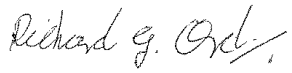
Approved on behalf of the Board of Directors by:

Name *(Chair)*	Sandra Dodson

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Richard Ord

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Jonathan Coulter

Signature 

Strategic Context and Direction	**1. The Trust's strategic position within the Local Health Economy** Overview Harrogate and District NHS Foundation Trust (HDFT) has commissioning arrangements with a number of commissioners, the main ones being Harrogate and Rural District (HaRD) Clinical Commissioning Group (CCG), Leeds CCGs North and West, North Yorkshire County Council (NYCC) and NHS England. HaRD CCG commissions services with a number of GP practices located in the main centres of population with satellite surgeries provided in the more rural areas of the locality, together with two health centres in the more rural areas of Boroughbridge and Pateley Bridge. A community based hospital is located in the City of Ripon to which the Trust provides a range of core general services including an inpatient ward, outpatient services, diagnostics and therapy services. In relation to Leeds CCGs, the Trust provides a range of outreach outpatient services at Wetherby Health Centre, an Orthopaedic out patient service at Street Lane GP practice and ENT outpatient services at Chapeltown Health Centre for Leeds North CCG. The Trust has also recently established outreach clinics at Yeadon Health Centre for Leeds West CCG, primarily for the elective specialities of orthopaedics, general surgery and urology and looking to establish maternity services in the locality later in the year. With regard to NYCC, the following services are currently commissioned from the Trust: • School Nursing • Smoking Cessation • Sexual Health • Dental Services – Public Health element In relation to NHS England, the following services are currently commissioned from the Trust: • Health Visitors 0-5 Service • Prison Healthcare • Salaried Dental Services Other adjacent acute providers include York Teaching Hospitals NHS Foundation Trust (YTHFT), which is over 20 miles from Harrogate, Leeds Teaching Hospitals NHS Trust (LTHT), which is approximately 16 miles from Harrogate and Airedale NHS Foundation Trust (AFT), which is approximately 25 miles from Harrogate. HDFT has a number of established clinical links with LTHT. These include: • Coronary Heart Disease • Plastic Surgery • Neurology • Specialist Cancer Services Access With regard to YTHFT, a number of services are delivered within a formal clinical alliance programme. These include: • Breast and Cervical Screening • ENT • Microbiology • Non-surgical Oncology • Oral & Maxillofacial Surgery • Renal Medicine • Urology • Dermatology • GUM/Sexual Health Services • Neurophysiology • Ophthalmology • Orthodontics • Rheumatology • Vascular HDFT also participates in clinical networks ensuring that high quality care is provided in a range of specialities, and where appropriate, can be provided as close to peoples homes as possible. These clinical networks include Cancer Care (Yorkshire Cancer Network), Trauma, Coronary Heart Disease, Critical Care and Neonatal Intensive Care. The Trust has also recently established an alliance with AFT to provide Dermatology services. North Yorkshire Clinical Services Review In 2012 NHS North Yorkshire and York, together with Chief Executives from the acute Trusts in North Yorkshire, commissioned a major review of clinical services across North Yorkshire. The outcome of this review, published in January 2013, provided a high level clinical strategy with a number of emerging strategic themes in the range of clinical areas that CCGs and acute Trusts could take forward. The key themes were agreed as follows:

- Primary Care

Maximise value for money by preventing patients being admitted to hospital and facilitating earlier discharge.

Care for people in their own homes through transformational schemes, such as the introduction of assistive technology and near patient testing.

- Community Care

Transfer appropriate acute services into the community e.g. specialist care supporting long term conditions and frail elderly services. Develop integrated health and social care community teams.

Introduce models of care with the primary and acute sector to support patients through the system to enable appropriate discharge.

Develop models of care to support improvements in dementia care.

- Planned Care

Manage demand through the use of clinical thresholds, shared decision making and patient decision aids.

Ensure collaboration between Acute Trusts to develop joint clinical networks and alliances or where feasible create centres of excellence.

- Maternity/Paediatrics

Ensure consultant led maternity services are sited on at least three sites, Harrogate, York and Scarborough.

Review the provision of midwifery led birthing units.

Review paediatric inpatients in line with maternity services.

- Urgent Care

In line with national and Royal College guidance and existing clinical networks, review the provision of urgent care across North Yorkshire and York, including minor injury units.

Review provision of emergency surgery and agree optimum models for urgent care.

Examine the potential of A&E departments to develop an integrated model of care.

Consider the impact of any changes in urgent care on the trauma network.

It is within this context that the Trust has reviewed its strategic direction and developed the strategic plan for the next three to five years, linking closely with its key stakeholders to ensure it is in tandem with the strategic plan for the local health economy.

2. An overview of the Trust's key competitors and an assessment of the Trust's key areas of strengths and weaknesses

The Trust has made an assessment of its likely competitors within the local health economy and undertaken a detailed assessment of the strengths and weaknesses of the Trust against each competitor. The key competitors to the Trust are:-

- Leeds Teaching Hospitals NHS Trust
- York Teaching Hospitals NHS Foundation Trust
- Local GP practices
- The Private Sector providers in Harrogate and Leeds

A major strength for the Trust is the excellent reputation it holds in the health community, providing high quality services, short waiting times and good standards of care. It is against these key strengths that an assessment has been made of the potential threats the Trust faces from the competitors identified above.

<u>Leeds Teaching Hospitals NHS Trust</u>

The quality of service provided by HDFT with short waiting times, good location and ability to deliver the required work for Leeds, places the organisation in a position of strength.

The Trust has an excellent relationship with Leeds Commissioners delivering a significant amount of activity, as there is insufficient secondary care capacity in Leeds. As a result, the Leeds North and West CCGs have increased the contracted activity levels with HDFT, giving the Trust a larger market share. The main area of increase is in elective surgery, particularly Orthopaedics, General Surgery and Urology. Discussions are on-going in relation to maternity services to develop a full maternity pathway of antenatal, delivery and post natal care.

York Teaching Hospitals NHS Foundation Trust

HDFT already works closely with YTHFT through a series of clinical service alliances, but has an understanding that in some areas both organisations will compete with each other for services and activity. However, as the organisations are over 20 miles apart, with the area between sparsely populated, neither organisation views the other as a major threat. As part of the recommendations of the North Yorkshire Clinical Services Review, both Trusts have agreed to work collaboratively to determine any areas where increased joint working could be undertaken. Both organisations have agreed a work programme to be taken forward over the next 6/12 months which will explore opportunities for greater collaboration over the next two to five years.

GPs

There is the potential for some GP practices to consider undertaking more outpatient activity in the future, particularly in relation to the management of follow ups and minor surgery. The Trust welcomes this potential development, as the reduction in follow up activity would release capacity in secondary care which could then be made available to Leeds commissioners.

Private Sector Providers in Harrogate and Leeds

Although the main private provider in Harrogate is a competitor it only has limited capacity, undertaking a small number of specialist procedures, general out-patient and elective activity that the Trust does not provide. It does therefore not present a major threat to HDFT. Having a local private provider does support the ability of the Trust to recruit high quality consultant staff. In relation to Leeds private providers, these are seen as competitors, however, given the significant levels of activity that needs to be undertaken in the Leeds locality, this is not seen as a major challenge and does not have an effect on the Trust.

Community Services

The Trust successfully acquired a range of local and pan North Yorkshire community services in April 2011 through the Transfer of Community Services (TCS) process carried out by NHS North Yorkshire and York. The community services contract was for a three year term and the Trust has 12 months to run on this contract before the services are likely to be re-tendered, unless commissioners agree to extend the contract term.

As an organisation that is committed to integrated services across hospital and community care, the strategy of the Trust is to positively continue to deliver the full range of community services we currently provide. However, commissioners have indicated that unless community services are fully integrated with other provider services, the services could be subject to a retender exercise. The Trust is therefore currently reviewing the community services it manages and is actively pursuing changes to the way these services are delivered to ensure the Trust is in the best position possible to successfully continue to provide these services in the future.

HDFT has already been advised that some of the more specialist services, e.g. Prison Health and Wheelchair Services are likely to be formally tendered or subject to the Any Qualified Provider (AQP) process.

At present, the Trust provides GP Out of Hours services across North Yorkshire, with the exception of Scarborough and the East Coast. A review of the service is being undertaken in each locality. If the service is provided on a locality basis, HDFT would wish to continue to provide the urgent care services to the HaRD population and this is supported by the local CCG. However, should it be determined that the service is to be provided on a county wide basis, as at present, the Trust would still be interested in providing this service.

In relation to Children's services, NYCC was keen for one provider to provide the services conterminously with the council when the TCS transfer took place. The biggest challenge now relates to changes that are occurring with regard to the commissioning of Children's services. A new Director of Children's services has been appointed at the County Council and commissioning of the service is now divided between the CCG area team and Public Health. These changes could potentially result in a review of priorities, which could impact on the way that services are commissioned in the future.

3. Forecast health, demographic, and demand changes

The average life span in England and Wales has increased by around 10 years in recent decades. A corresponding increase in elderly people has been seen in the local population. Data published by NHS England in 2012 indicated that HaRD CCG had a higher proportion of people aged 40 years and over than the national average and a significantly higher proportion of females aged 85 years and over.
The Trust has seen a corresponding increase in non-elective admissions for elderly patients over recent years. Overall the number of non-elective admissions has increased by 16% during the last five years and

the number of admissions for patients aged 85 years or over has increased by 33% during the same period.

With national population forecasts indicating a continuation of this trend, the Trust expects to see the non-elective admission growth, particularly for elderly patients, to continue.

Historical growth in referrals over the last four years has shown an average 2.4% year on year increase in elective demand. The Trust has recently set up additional outreach clinics in Leeds West (Trauma & Orthopaedics, Urology and General Surgery) and anticipates a step change in elective growth in these specialties as a result. Trust plans for 2013/14 predict 6% growth in referrals overall, with the majority of the growth from outside the North Yorkshire area**.** Further expansion of services to the Leeds West population is planned, in particular the expansion of maternity services offered to this area.

4. Impact assessment of market share trends over the life of the plan.

The Trust has recently acquired a new marketing tool which enables it to assess referral patterns by GP practice. The Trust is using this information system to determine the referral pathways across a range of specialities. It will be particularly useful in relation to the Leeds activity as it will assist the organisation in establishing the areas where it can most influence GP referral trends.

The Trust has made an assessment of the market share it wishes to attract, particularly from the Leeds area, over the next three years across a number of key specialities and this is attached at Appendix 1.

5. An overview of the key changes to local commissioning strategy and intentions and their anticipated impact on the Trust.

The Trust recognises that in the changing environment of the NHS it will be necessary to be innovative in the way healthcare is delivered. No longer can the current model of hospital dominated delivery of care continue unchanged. A hospital need to offer a diverse service model at the appropriate point for patients if it is to respond to the requirements of commissioners in the future. The Trust acknowledges therefore that the way some services are currently delivered will need to change.

The North Yorkshire Clinical Services Review highlighted a number of initiatives that need to be explored as detailed previously in the document. The Trust continues to work with local commissioners and acute Trusts, e.g. York and Leeds, to examine how services will be delivered. It is recognised that in some instances there could be a need to reconfigure services.

<u>Harrogate and Rural District CCG</u>

HaRD CCG is committed to supporting the sustainability of the Trust and maintaining local provision of services, whilst recognising the need for increased levels of activity to be undertaken outside of the hospital.

The HaRD CCGs commissioning strategy therefore is to reduce the demand into secondary care through:

- Preventing hospital admissions
- Facilitating early discharge
- Caring for people in their own homes
- Providing more community based services and reducing acute services
- Developing integrated health and social care community teams
- Continuing to develop clinical thresholds

Whilst the Trust supports this approach, it considers that their plans to reduce absolute levels of hospital activity are challenging, particularly given the demographics of an ageing population. The Trust takes the view that it would be more appropriate and realistic to aim to limit the level of growth in this area. Despite this reservation however, the Trust has a good working relationship with its local commissioner and will continue to work closely together with the CCG.

HaRD CCG has identified three main Quality, Innovation, Productivity and Prevention (QIPP) initiatives for 2013/14, namely:

- Threshold management – continuing to manage demand for elective activity
- Reduction in follow up outpatient attendances
- Reduction in non-elective activity

With regard to threshold management, the Trust will continue to work with the CCG on this initiative and do its utmost to achieve the CCGs aim. The Trust has already helped to develop clinical thresholds in Orthopaedics which are currently in place and being adhered to locally across primary and secondary care. However, based on previous years' activity, the Trust is of the view that the further reductions in

elective activity proposed by the CCG will be very difficult to deliver and the levels of demand for elective care will continue to increase. In relation to outpatient follow up reductions, the Trust fully supports this approach, as this will release outpatient capacity that can be made available for Leeds patients.

The Trust is also supportive of reducing non elective activity, particularly in view of the tariff arrangements currently in place. This will require re-investment by the CCG into community services which the Trust also provides.

The Trust has responded to the AQP tenders for non-obstetric ultrasound and podiatry in the last 12 months and has been successful on both occasions. The Trust is aware that HaRD CCG has indicated that they intend to issue an AQP tender for wheelchair services in the future. Whilst this could impact on the Trust, with other private providers tendering for the services, this is considered to be a low risk. This is because the service is a stand alone service and does not make as significant a financial contribution as other services.

The Trust is aware of NHS England's intention to tender for primary medical services into Northallerton and Askham Grange prisons with effect from 1 April 2014. The Trust will consider its response to this invitation to tender when it is received. Again, as prison services are relatively separate services and do not make a significant financial contribution, our strategy and financial position will not be materially affected.

<u>Leeds North & West CCGs</u>

With regard to the Leeds CCGs, agreement has been reached for the Trust to undertake more elective activity, particularly in relation to Orthopaedics, General Surgery and Urology. This additional activity has been factored into the agreed contract for services for 2013/14. The Trust is also in discussions with Leeds CCGs regarding the provision of a full maternity pathway. The CCGs recognise that a number of patients are identifying Harrogate as their hospital of choice. The CCGs are welcoming new providers into their localities, acknowledging that LTHT has capacity constraints and therefore HaRD CCG is supportive of the Trust providing services to Leeds patients, particularly across the surgical specialities.

Leeds CCGs have not identified specific QIPP plans with HDFT. At present both Leeds CCG organisations are experiencing difficulties in delivering the levels of activity required with Leeds Teaching Hospitals NHS Trust and have therefore approached HDFT to undertake this work.

6. An explanation of how the Trust has factored these considerations into its strategy

The Trust has reviewed its strategic vision and objectives as part of the development of the 2013/14 business plan. A series of workshops and time out sessions have been held with key stakeholders, the Board of Directors and Council of Governors to consider the future vision for the organisation, ensuring that it delivers national priorities and local commissioner requirements.

The vision for the organisation can be summarised as follows:

- Drive forward improvements in quality
- Develop more integrated community based services
- Work with partners to develop joint service strategy
- Expand secondary care into Leeds

Our strategy is therefore clearly in line with the commissioning intentions of our main commissioners (Harrogate and Leeds CCGs) and has been developed through discussion and collaboration with each organisation. The Trust is now actively engaged with local commissioning groups to implement this strategy, with a view to introducing different models of care across the health community.

7. An Analysis of how the Trust's demand profile and activity mix has evolved over recent years and what changes are forecast

Historical growth in referrals over the last five years shows an average 2.4% year on year increase in elective demand. The Trust started outreach clinics in Wetherby in 2009/10 and saw a corresponding step change increase in out of area elective activity within that financial year. The Trust has recently established outreach clinics in Yeadon in Leeds West in the specialties where it has experienced growth; Trauma & Orthopaedics, Urology and General Surgery. The Trust anticipates a further step change in elective growth in these specialties as a result. Trust plans for 2013/14 predict 6% growth in referrals overall, with the majority of the growth from outside the North Yorkshire area.

Further expansion of services to Leeds North and West population is planned, in particular the expansion of Maternity Services offered to this area.
Non-elective admissions have increased by 16% during the last five years and the number of admissions for patients aged 85 years or over has increased by 33% during the same period. The main areas of growth for non-elective admissions have been General Surgery, General Medicine and Paediatrics. The

Trust anticipates non-elective admission growth to continue, due to demographic trends in the ageing population, despite the local Care Closer to Home initiative around reducing unnecessary hospital admissions.

8. How the Trust is diversifying its income streams

The Trust continues to explore opportunities to diversify its income streams, as well as looking to enhance commissioner income through growing its market share, particularly with Leeds CCGs.

Research continues to be a high priority within the Trust, with the number of patients participating in research approved by the Research Ethics Committee increasing by 283 to 2,024 between April 2012 and February 2013.

The continuing expansion of research into different clinical areas reflects investment in infrastructure, excellent collaboration between the Trust and the North East Yorkshire and Northern Lincolnshire Comprehensive Local Research Network (NEYNL CLRN) and a clear commitment by the Trust to support and participate in research.

In relation to private patient income, the Trust has a 10 bed private patient unit which is currently undergoing a refurbishment programme. At present the income from private patients is £1.4m and the Elective Care Directorate is currently undertaking a review of its services, with a view to attracting more private patients.

With regards to intellectual property rights, the Infection Control Team in the Trust has developed an Infection Prevention Workbook which provides a comprehensive guide to infection prevention. A total of 40,000 copies have been sold over the last three years generating an income in the region of £65,000. Over the next two years, the Team aims to increase sales to circa £280,000.

9. Collaboration, Integration and Patient Choice

The North Yorkshire Clinical Services Review actively engaged with key stakeholders across the local health economy to review services to deliver a clinically sustainable and financially viable health and social care system for the local population.

Outcomes of the review were informed by detailed discussions involving clinicians and stakeholders from across health and social care organisations to determine how services could be provided across North Yorkshire in a sustainable, safe and efficient manner. The Trust is now actively developing plans which will enable the organisation to continue to be sustainable in the long term. These proposals are documented in greater detail in the section on clinical sustainability.

As part of this work, the Trust will continue to work with YTHFT to explore opportunities through the well-established clinical service alliances for greater collaboration.

One of the Trust's strategic objectives is to continue to improve the quality of services that it provides. A key enabler of delivering improved services for patients is to work in collaboration with our partners and the Trust is working hard to develop "partnerships with purpose". This means striving to ensure that there are clear and tangible benefits and improvements as a direct result of working together to deliver services. The Trust has many examples of how partnership working is enabling the organisation to offer more cohesive and integrated services, which are more responsive, efficient and take account of the views and experiences of patients. These include:

- Harrogate Dementia collaborative - a partnership with Tees Esk and Wear Valleys NHS Foundation Trust (TEWV), NYCC and HaRD CCG to improve services for people with dementia and their families and carers.
- Healthy Ripon – this is examining the future of services at Ripon Community Hospital (RCH). A shared plan for the development of services has now been developed and a series of work groups are taking forward key initiatives in the Ripon and Rural areas. These include a young people's group, a Getting Ripon Active Forum, an estates group to look at opportunities to maximise facilities and resources in the area, and work with the wide range of voluntary sector organisations that already support the local community.
- Call to Action national strategy for Health Visiting – In North Yorkshire the strategy is being delivered building on the positive working relationship with Children's services in NYCC.
- Long term conditions strategy – The Trust is working with partners in social care and primary care to develop services and pathways of care to support people close to home and make best use of our combined resources. Events with older people in Ripon and Harrogate showed us that whilst our quality of care is good, there is sometimes duplication between agencies, and confusion about who co-ordinates the care for people who need access to more than one service. Work will continue in 2013/14 to take this work forward with a view to reducing duplication and developing greater integration between services and clinical teams.

- Integrated Care Teams – The Trust is working closely with our colleagues in NYCC to develop integrated teams of health and social care professionals who work together to provide a range of services to our communities. This builds on the close working relationships already in place between community nursing teams and social care colleagues providing re-ablement services and home care support and will enable us to optimise our resources, co-ordinate care for the individuals we support, and provide more joined up care provision.

The Trust is fully committed to building a collaborative culture of change and innovation in the organisation and the wider health community. Over the three year planning period, the Trust will continue to build on the partnership arrangements outline and also develop further integrated services, for example, in Urgent Care.

With regard to patient choice, a number of people already choose HDFT for their treatment, due to the high quality of patient care it provides. With the excellent reputation that the Trust currently holds, there are clearly significant opportunities to attract increased numbers of patients into the Trust. HDFT will continue to actively market its services, building on the links that have now been established with Leeds commissioners with a view to increasing the outreach clinics provided in the Leeds area e.g. Yeadon, Wetherby and Otley.

Approach taken to quality (including patient safety, clinical effectiveness and patient experience)

10. Quality

There are no current quality concerns in relation to Care Quality Commission (CQC) or other standards.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

In August 2012, the Trust was subject to a routine inspection and the results in relation to the relevant outcomes were as follows:

CQC Outcome	Result
Outcome 01: Respecting and involving people who use services	Compliant
Outcome 05: Meeting nutritional needs	Compliant
Outcome 07: Safeguarding people who use services from abuse	Compliant
Outcome 13: Staffing	Compliant
Outcome 21: Records	Compliant

The CQC also carried out a visit in February 2013 to monitor Section 120 of the Mental Health Act 1983 in acute hospitals. The CQC were satisfied that the Trust has the systems and processes in place to manage the detention of patients with mental disorder, and that the Trust is continuing to develop its working relationship with the mental health service provider to enhance the care of mentally disordered patients. The Trust is working with commissioners and partners to take forward three recommendations.

The Trust was successful in achieving Level 3 of the NHS Litigation Authority (NHSLA) Risk Management Standards in March 2013. This assessment included services across the integrated organisation, which is a significant achievement.

The Trust's governance structure and assurance mechanisms enable data to be reviewed relating to all elements of quality, patient experience, patient safety and effectiveness of care. Data, performance metrics, audit results, survey results and inspection reports indicate whether services are being provided to the appropriate standards. If deficiencies are identified, improvement plans and additional monitoring and data capture is introduced. The key Trust governance structures and systems are described below.

The organisational structure for delivering integrated governance (incorporating clinical, research, information, financial, risk management and performance elements) and the systems that underpin them are explicitly designed to ensure safe, high quality care and to give appropriate warning of deterioration in standards or performance to enable early intervention to take place.

- The Board of Directors places a strong emphasis on effective communication "Ward to Board" and this is reflected in the management and governance structures of the Trust.
- At the heart of the structures are the three clinical directorates, which provide the majority of the Trust's services. The Clinical Directors attend the Board of Director meetings each month and provide a strong link between the Board and front line multi-disciplinary staff.
- The Trust wide Quality and Governance Group has strong representation from both senior staff within the Directorates and at corporate level and whilst this group does not report formally to the Board there is a direct line of accountability to the Senior Management Team of the Trust.
- A Quality and Governance Group for each Clinical Directorate is in place and the content of these meetings reflects both local specialty matters and cross cutting Trust clinical and non-clinical priorities.
- Quality of Care teams are in place across the organisation and report to the Directorate Quality and Governance Group. The focus of these teams is on continual service improvement.
- An important element within the governance structure now and previously is the separation of

	operational and scrutiny functions. The operational elements are described above. The scrutiny or assurance elements include the Audit Committee, which is a formally constituted sub-committee of the Board of Directors. This committee provides independent assurance on governance and controls including internal and external audit. • The Audit Committee is supported by the Standards Group. This group is responsible for ensuring that recommendations from external reports, audits, visits and regulators including the CQC are met and that data from the Trust to outside agencies is quality assured. The Standards Group also provides assurance to the Directors and Audit Committee in relation to clinical audit. It is accountable to the Director Team, but minutes are received at the Audit Committee. • The Corporate Risk Review process is well established within the organisation. Departmental and Directorate risk registers are reviewed to enable the Board of Directors to be advised on the principle risks and the plans in place to reduce or mitigate the risks. • The Assurance Framework is produced annually within the Trust and draws together progress on the Trust's strategic objectives, the Care Quality Commissions outcomes and the Corporate Risk Register's principle risks. An update on progress is produced every six months.
Clinical Strategy (Consistent with information contained within the Trust's published Quality Account).	**11. Clinical Strategy** <u>Service Line Management Strategy</u> The Trust has a clear clinical strategy for the next three to five years which focuses on providing high quality, safe and sustainable services to its local population of Harrogate and Leeds North and West as well as the wider North Yorkshire patch for the community services we provide. Key to this strategic objective is ensuring that the Trust can deliver care on a seven day a week basis in a safe environment. This was identified as a key enabler within the recent North Yorkshire Clinical Services Review and is essential in all areas of the hospital, as well as in community services. Discussions have been held widely across the Trust from clinical directorate level upwards to the Board of Directors regarding the developments that need to be implemented in order to deliver the clinical strategy for the organisation. There is recognition that in some specialities there are opportunities to increase our catchment population and attract patients from outside of the traditional boundaries. The Trust recognises that increasing our catchment area with the Leeds CCGs is key to ensuring the Trust's clinical and financial sustainability in the longer term. Through increasing the catchment area and activity, investment can be made in the infrastructure required to support seven day a week services and ensure clinical staff maintain their necessary skills. The Trust's Clinical Strategy therefore is to increase secondary care activity with the Leeds CCGs. New outpatient clinics have now been established in Yeadon Health Centre for a range of elective services including Orthopaedics, General Surgery and Urology. Discussions are on-going with regard to expanding Maternity services into Leeds West later in the year. The Trust has also recently secured trauma unit status, having undergone an accreditation process in April 2012. Detailed work is on-going to review to deliver new service models of care in four key areas: • Urgent Care • Emergency Surgery • Maternity/Paediatrics • Elderly Care Plans have been developed for each speciality in line with the North Yorkshire Clinical Services Review, which will be implemented over the planning period. Details of the infrastructure changes are documented later in this plan as part of the section on clinical sustainability. The Trust is also aware that good quality care needs to be delivered across the organisation including our inpatient wards. Last year the organisation undertook a detailed re-configuration of its inpatient wards, with a view to reducing our bed capacity and investing in our community infrastructure to enable patients to be treated closer to their homes. Whilst this has proved to be successful, it has highlighted that there still continues to be pressure on our inpatient wards, particularly medical and elderly beds. The Trust has experienced increases in non-elective activity over the winter, with high bed occupancy levels, which has resulted in the need to re-establish 16 beds on Granby ward for non-elective patients. In conjunction with this work, the Trust has taken the opportunity to review the ward nursing establishments across the Trust taking into account the ratio of the average 1:1.4 nurses per bed standard set by the Royal College of Nursing. As a result the Trust has strengthened its nursing establishment, increasing the number of nurses employed in the Trust by 33. Other key initiatives to be taken forward as part of the Trust's Clinical Strategy include: • Improving the management of people with long term conditions • Developing Children's services

With regard to long term conditions, the prime objective for the Trust is to work with partner organisations to develop services and pathways of care which enable people to be supported in their own homes.

In order to deliver this objective, the Trust is developing a strategy which will provide secondary care input to primary care, commissioning and social care services. This service model will require greater integration across health and social care.

The Trust delivers Children's services across North Yorkshire and aims to continue to increase community capacity with the roll out of the 'call to action' programme for Health Visiting. Over the planning period, the Trust will recruit an additional three Health Visitors to support the service in 2013/14, as well as further investment in subsequent years in line with the Call to Action programme. In addition, work will continue with the Local Authority regarding the potential for greater integration with Children's centres.

In developing the clinical and service line strategy for the organisation, the Trust has taken a number of factors into account. These include:

- Commissioner requests, for example Bradford CCGs have contracted the Trust to provide hip arthroscopy services.
- Benchmarking of our reference costs and managerial costs against tariff to ensure that services are making the necessary contribution. This has been particularly significant in relation to maternity services with the introduction of the new maternity pathway tariff.
- Identification of the demand for services through benchmarking our performance e.g. access times against other competitors including the private sector.

Clinical Workforce Strategy

The Trust continues to implement a range of workforce initiatives to sustain continuous improvement to the quality of our services whilst delivering on-going efficiency programmes. In the main, this comprises skill mix reviews for the future delivery of services and the introduction of a sustainable Consultant delivered service model of secondary care for all our patients that provides consistently high quality and equitable care, on a seven day per week basis.

In order to remain clinically sustainable whilst striving to deliver a seven day per week service the Trust has recently carried out a full service review taking into consideration external guidance such as recommendations from Royal Colleges. The outcome of this work is categorised into four key areas which is detailed in the 'Clinical Sustainability' section below.

Workforce establishment is managed through a weekly vacancy control group. The Trust actively continues to recruit where necessary to ensure a full establishment in specific areas such as Health Visiting, in-patient ward Nursing and Midwifery. The Trust follows good practice by regularly reviewing ward nurse staffing levels to ensure that these are set at an appropriate level to provide high standards of nursing care. Within the Trust, there has been investment in front line ward nursing in each of the last three years, as well as an increase in the number of medical staff employed.

Most recently, a full adult ward Nurse staffing review has been undertaken. The Trust can demonstrate how staffing levels compare with the Royal College of Nursing best practice standards. Significant investment has been made in 2013/14 with further resources identified for 2014/15 to support increased nursing levels on the adult wards.

Projects have commenced within Directorates to establish a sustainable seven day Consultant delivered service. This is in response to not only Royal College and other educational recommendations but also patient expectations to have access to senior members of clinical teams seven days per week. With increasing levels of activity and the complexity of the work required, a radical re-think of the way our workforce is deployed is required in order for a consistent service to be delivered, irrespective of the time or day of the week. The immediate availability of a senior opinion, particularly for the support, education and training of junior medical staff, is critical for the safe and effective management of patient care and the continued Deanery approval of all junior medical staff positions in the Trust. The national directive of reduction in trainee doctor posts has led to Directorates reviewing clinical workload, evaluating the skill mix of clinical teams and to plan piloting of posts such as advanced nurse practitioners and reablement assistants to support the medical team structure and introduction of seven day Consultant working.

Several initiatives are on-going to support the delivery of care closer to our patients and service users' homes. Following last years successful programme, a second cohort of healthcare support workers are undertaking a Qualification and Credit Framework (QCF) programme in conjunction with Wakefield College to support them in developing competencies to facilitate re-enablement. This releases nursing/physiotherapy resource and facilitates the safe and efficient discharge of patients. Completion of this programme will bring the total number of reablement assistants to 43. Building a critical mass of staff with this new skills-mix is one of the components in delivering the Care Closer to Home strategy for the organisation. This strategy is further supported with the devolution of therapists across the clinical

directorates. Staff key to the discharge process are now closer to the patient pathway and empowered to make decisions pivotal to the discharge process.
The unscheduled care model is currently being reviewed with a view to developing a fully integrated primary and secondary care urgent care model delivered from an urgent care hub. There will be a single point of access incorporating NHS 111. This will include developing further skill mix options which will see an expansion of senior urgent care practitioners and emergency nurse practitioners. An innovative succession planning arrangement is in place to recruit middle grade doctors in the Emergency Department.

The Trust recognises that continuing to develop effective leaders and managers is critical to the performance of the Trust. The Trust is working with the Local Education and Training Board, Health Education England and the NHS Leadership Academy by enabling leaders from all levels within the Trust to participate in various accredited leadership and development programmes. The Trust has been selected and is one of only a small number within the region to participate in the highly prestigious team coaching programme. A number of coaches have been appointed and are undergoing the accreditation programme. Areas/teams for the deployment of coaches have already been identified.

Further investment will be made in the Trust's clinical skills facility in order to extend the range and number of clinical skills training available to staff, including comprehensive induction programmes for all Health Care Assistants.

The Trust is recognised as an Investor in People (IiP) and is due to be re-accredited in December 2013. Since original accreditation in 2010, the Trust has grown substantially in size due to the integration of community services. This programme will assist in maintaining the Trust's ranking as one of the top 20% nationally for overall levels of staff engagement as detailed in the annual staff survey.

The Trust utilises the Centre for Workforce Intelligence and other tools such as 'ewin' and 'iview' to benchmark workforce data and workforce trajectories against Trusts of a similar size. The benchmarked data is reviewed monthly by the Board of Directors and provided to service commissioners. Areas indicating good practice are explored and adopted where appropriate.

<u>Workforce Pressures</u>

In recent months we have observed a slight upward trend with the Trust's sickness absence rate. Whilst still favourable in comparison to the Yorkshire and Humber region average there are opportunities for improvement. The sickness policy has recently been revised and the new policy was launched in January 2013 having been the subject of detailed consultation with our trade union partners. The new policy places more emphasis on health and wellbeing and when possible offers rapid access to treatment to expedite return to work. There is an expectation that if this policy is utilised fully then it will reduce sickness absence. Over the planning period of the next three years, the Trust is setting a target to reduce sickness in front line areas to 3%.

Following amendments to the Agenda for Change terms and conditions, line managers will be assessed on their managerial performance under a range of developed Key Performance Indicators such as proactive application of the revised sickness policy, local compliance with mandatory training, induction for staff and appraisal. These will form the basis of standard objectives in every manager's appraisal and achievement to a satisfactory standard will be required in order to be awarded their incremental progression.

The need to curtail the utilisation of temporary staff is also a priority for the Trust over the forthcoming 12 to 24 months, to both improve quality and improve efficiency. Several work streams are underway to reduce demand for temporary staff including pro-active management of sickness absence, efficient rota coordination and utilisation of an increased internal bank facility. When it is determined that the Trust requires an external locum, having satisfied the revised protocol to request a locum, they will be obtained through a master vendor offering reduced agency costs.

<u>Clinical Sustainability</u>

The Trust is examining its current hospital delivery model to develop innovative ways of providing services at the most appropriate point for patients. The Trust has undertaken an internal review of services to assess its clinical sustainability. The detailed work carried out by the Trust has taken into account the guidance from the Royal Colleges and also the Contingency Planning Team reports that have recently been published. Overall, the Trust has identified four key areas where further detailed work has to be undertaken to ensure services can continue to be delivered on a sustainable basis, 24 hours, seven days a week. The areas to be addressed are:

- Urgent Care
- Emergency Surgery
- Maternity/Paediatrics
- Elderly Care

- Urgent Care

HDFT currently provides a range of urgent care services for patients from the main Harrogate District Hospital (HDH) site and a number of community locations across North Yorkshire. The Trust has a fully functioning Emergency Department (ED), Minor Injury Units (MIU) at Ripon and Selby and is the provider for GP Out of Hours Services (GPOOH) across North Yorkshire, including HaRD, Selby and York and Hambleton and Richmondshire. It recognises that in the future the provision of MIUs could be reviewed, with potential closure of these facilities.

The Trust is therefore reviewing its current provision across North Yorkshire to ensure that the model of services is clinically safe and sustainable in the future.

The ED at HDFT serves a population of 306,000 and saw a total of 47,171 attendances in 2012/13. In addition, the Trust also manages the MIU services in Ripon and Selby which received 6,995 contacts and 15,402 contacts respectively in 2012/13.

At present the Trust is in the process of implementing a six whole time equivalent (WTE) consultant model that provides consultant clinical cover from 8am to 8pm Monday to Friday, with six hours of clinical cover on Saturday, Sunday and Bank holidays. There is a full on call service outside these core hours.

In addition there is a reliance on locum doctors in the ED and this is increasing nationally despite pressures in the NHS to reduce costs. In order to successfully fill the middle grade rota, HDFT currently employs locum doctors, but recognises that this arrangement is not sustainable in the longer term. The Trust has therefore implemented its own internal training programme to develop Trust doctors into specialty doctors in the future.

The Trust recognises that there is also a need to review nursing and support staff workforce to ensure sustainability to support the medical staff in the department. Having the most appropriate skilled nursing/practitioner workforce will enable a clinically sustainable urgent care model. This will include reviewing the role of nursing staff, Emergency Nurse Practitioners (ENP), Senior Urgent Care Practitioners and support staff amongst others.

The Trust is taking part in a local review of primary, secondary, community health, social care and urgent care provision across the local health community. This is being coordinated by the local Urgent Care Board on which all organisations (commissioners and providers) are represented. This review will set out proposals for the best way of organising care that meets the needs of patients requiring in hours or out of hours urgent care. As well as recommending a model to deliver and sustain seven day working, the review will also aim to find the balance between providing excellent clinical care in serious complex emergencies and maintaining and improving local access to services for less serious problems.

The review will need to be in line with recommendations contained in the recent North Yorkshire Clinical Services Review and the national review of urgent and emergency services in England which is being conducted by Sir Bruce Keogh. This national review will aim to help shape emergency and urgent care services for the future and put in place arrangements that meet the needs of patients.

The objectives of the national review reflect the local strategic direction and vision for the development of a fully integrated primary and secondary care urgent care model delivered from an Urgent Care Hub (UCH) based on the HDH site. There will be a single point of access incorporating NHS111.

In 2014/15, work will begin to enable co-location and integration of the Clinical Assessment Team (CAT), with the ED service to allow acute medical cases to be managed by our Acute Medicine Physicians working alongside the Emergency Medicine Consultants. This will enable quicker access to appropriate care in particular diagnostics.

There will be an expansion in the nursing workforce over the planning period to enable a fully functioning and robust ENP service provided from 8am to 10pm.There will also be a further review of the ED nursing workforce in relation to the role and function of band 5, 6 and 7 nurses, ENPs and Senior Urgent Care Practitioners.

These further workforce reviews will coincide with a review of the role and function of the MIUs at Ripon and Selby.

Implementation of NHS111 was due to commence across North Yorkshire from 9 April 2013. This is delayed until possibly the beginning of June 2013 when it will be fully incorporated in the GPOOH service provision.

A new model for the OOH provision will be developed to improve the quality and responsiveness of the service but also to integrate more fully other urgent care services. This will include developing further skill mix options (e.g. use of more Senior Urgent Care Practitioners, paramedics, use of community pharmacy etc), as part of the delivery of care.

- Maternity and Paediatric Services

Maternity

The Trust provides maternity services to the urban areas of Harrogate, Knaresborough, Boroughbridge, Pateley Bridge and Ripon as well as all of the rural areas in between. It also provides services to the catchment population of Wetherby, with a number of women choosing to have their babies at Harrogate.

The North Yorkshire Clinical Services Review concluded that there should continue to be Consultant led maternity services at Harrogate, York and Scarborough.

In the last five to ten years women from out of the area including Wetherby and Otley have also chosen to "book" and give birth at Harrogate. Overall, the Trust currently carries out 2,100 deliveries per annum.

At present the Trust has a total of six Consultant Obstetricians/ Gynaecologists, as well as a middle grade tier of 7.5 WTE doctors, and has not experienced any difficulty in recruiting to these posts. The Trust is planning to increase the number of consultants to support this anticipated increase in activity over the next three years.

The plan over the next three years is for this service to grow and discussions are on-going with Leeds West CCG for the Trust to provide a full maternity pathway including ante natal, delivery and post natal care for women in the locality. This is a new service which the Trust anticipates will start to be introduced later this year as an outreach service.

As indicated previously the Trust already provides maternity services to the Leeds North CCG. Discussions are on-going with the CCG regarding providing the full maternity pathway this year and as a result the Trust will provide ante natal and post natal clinics as an outreach service.

A formal consultation exercise is taking place in the Hambleton and Richmondshire CCG area regarding the future of maternity and paediatric services at the Friarage Hospital in Northallerton. It is expected that the outcome of this consultation will be that the maternity unit will become a midwifery led unit. As a result, it is likely that some women living to the north of Harrogate will choose to have their maternity care at Harrogate rather that travel to Middlesbrough.

Based on these changes to commissioning arrangements across the patch it is expected that the number of births at Harrogate will increase from 2,100 to 2,600 over that next three to five years. The projected increases are detailed below:

Location	**2013/14**	**2014/15**	**2015/16**	**Total**
Harrogate	26	27	27	80
Leeds	50	100	150	300
Northallerton	35	70	150	120
Total	111	170	327	500

As the Trust will be planning to increase the number of births to approximately 2,600 per annum it will need to deliver 60hrs/week labour ward cover. The recruitment of two additional Obstetric Consultants into the department in 2014/15 and 2015/16 will enable this level of cover to be delivered and ensure that the service continues to be sustainable in the longer term. An additional two midwives will be recruited to support the maternity service in 2013/14, with a further midwife appointed in 2015/16.

As a result of the increased number of births in Harrogate, it will be necessary to review the physical capacity in both the maternity unit and neo natal accommodation. Additional delivery beds will need to be provided on the HDH site to cater for the increased activity. The Trust recognises the need to adapt and extend the existing delivery facilities and this also includes the development of a midwifery led facility for woman on low risk care pathways. The existing antenatal clinic is considered to have sufficient capacity to meet the increasing demand, as the majority of the increased antenatal and post natal activity will be delivered through outreach services in Yeadon and Wetherby. Options for the alterations to the maternity facilities will be considered over the planning period and factored into the capital strategy in future years as solutions are agreed.

Paediatrics

HDFT currently provides inpatient paediatric services via the sixteen bed Woodlands Ward and seven cot Special Care Baby Unit. The catchment population of the unit is around 200,000 and in 2012/13 there were 3,244 non elective admissions for children aged 0-18 at HDFT. The unit is staffed by six paediatric consultants (5.67WTE), five non training career grade doctors, two career grade SpRs and seven SHOs.

A consultant of the week rota is in place to provide day time support to the inpatient wards between 08:30 and 17:30 on weekdays and 08:30 – 12:00 on weekends.

Out of hours cover is provided in a rota system; tier two middle grade rota means there is 24/hr middle grade availability on the paediatric unit; tier three Consultant rota means a Consultant is available on site within 30 minutes out of hours.

Whilst the Trust currently provides 24 hour consultant availability within 30 minutes it does not meet the Royal College of Paediatrics and Child Health (RCPCH) requirement for consultant presence 16-24 hours a day or currently employ enough consultants to implement this, nor does it meet the minimum of eight people on a tier one or two rota.

Facing the Future published by RCPCH in April 2011 is a review of Paediatric Services which anticipates that in the future, Deaneries will choose to concentrate their tier two trainees in units that see the most patients, meaning that trainees may be removed from very small and small units (<2500 admissions per annum). There is also concern about a lack of non-training career grade doctors available to staff tier two rotas.

In 2012/13 consultants were present on site at HDFT for around 40% of the total admissions to Woodlands Ward (based on 09:30-17:30 weekdays; 08:30-1200 weekends, consultant of the week system). In order to meet RCPCH guidance around consultant delivered care HDFT would need to extend the hours of consultant presence on site and there are a number of potential ways to do this including consultant working twilight shifts, or a resident consultant on call working an overnight shift.

The preferred model at HDFT is to develop a resident consultant on call rota to enable 24/7 paediatric consultant presence meaning a paediatrician will be onsite for 100% of paediatric admissions to the Trust. In order to implement this model the Trust will need to increase the number of Consultant paediatricians from six currently to between eight and ten paediatricians in the future. Implementing 24/7 Consultant cover will also require the paediatric medical staffing model to change from a three tier rota system currently to two tiers (tier one junior and tier two consultant) in the future meaning there is likely to be a reduction in non-training middle grade doctors.

Discussions will continue with the Paediatric Consultants over the coming months to develop the model and options for further consideration and implementation to enable a clinically sustainable models to be provided in the long term.

Based on the potential increase in maternity activity, an assessment has been made regarding the likely impact this will have on paediatric services within the Trust, particularly in relation to neo natal services. The anticipated activity increase is summarised below:

Current baseline - neo natal activity	**Activity Forescast 2013/14**	**Activity Forecast 2014/15**	**Activity Forecast 2015/16**
139	156	178	204

This change in activity will help support the strengthening of Consultant numbers over the three year planning period.

- Emergency Surgery

HDFT provides General Surgical services to the Harrogate and District population of approximately 200,000. Given its close proximity to the Leeds and Bradford conurbations, this catchment population increases significantly as Harrogate is the hospital of choice for many people in these localities.

The Trust envisages that the levels of activity will grow in future years and has recently agreed with Leeds West CCG to provide outreach services for General Surgery at Yeadon Health Centre. Outreach clinics are already provided for General Surgery in Wetherby and there is a potential for this also to increase.

The Trust currently has six General Surgeons, three specialising in Colorectal Surgery, and one in Upper GI and two in Breast Surgery. The consultants are supported by a middle grade tier, with nine middle grades. All of the General Surgeons deliver the Emergency Surgery service through a sustainable on call rota. All six are laparoscopic trained and fully competent in abdominal surgery. Every emergency patient is assessed by a consultant within twelve hours in line with best practice. When undertaking laparotomies for high risk patients a consultant is always present.

The Trust also has well established clinical alliances with YTHFT in relation to Vascular Services and Breast Screening. The Trust manages the bowel screening programme on behalf of North and West Yorkshire and acts as the regional administrative centre. The endoscopy unit has full JAG accreditation.

In addition to General Surgery, the Trust also undertakes non specialist paediatric surgery, meeting all the current standards, providing separate elective lists for paediatric surgery and dedicated anaesthetic support. All specialist paediatric surgery is undertaken in Leeds.

Overall, the Trust has a group of highly motivated and well trained General Surgeons and has no difficulty in recruiting at both Consultant and Middle grade level.

The Trust offers high quality surgical services performing well against the quality markers. Mortality rates are low compared to the national average.

In the report on the perioperative care of the higher risk general surgical patient from the Royal College of Surgeons, it highlights that the group of patients most at risk as a result of emergency surgery and the unscheduled management of complications are those patients having major gastro intestinal and vascular procedures. In relation to HDFT, the Trust has a group of general surgeons who are fully competent in managing patients having abdominal surgery and the subsequent peri-operative pathway. With regard to Vascular Services, the Trust is part of a well established clinical alliance with YTHFT.

As indicated previously the Trust envisages both elective and non-elective activity increasing over the next three years, as more patients for the Leeds North and West catchment area choose to have their surgery in Harrogate. A projection of the activity is detailed below:

Type of admission	**2013/14**	**2014/15**	**2015/16**
Elective admissions - inpatient	769	784	808
Elective admissions - day case	6080	6398	6520
Non-elective admissions	2065	2085	2115

The Trust recognises that it will need to further expand its number of Consultant General Surgeons over the next two/three years to meet this increase in demand. In 2014/15, the Trust will look to recruit a seventh Consultant Surgeon for Upper GI, with an eighth appointment in 2015/16 specialising in breast re-construction. All of the Consultants will take part in the general surgical on call rota. This will present the Trust with the opportunity to review the arrangements for the provision of emergency surgery, potentially moving to a surgeon of the day type model, but continuing to provide safe high quality emergency surgery on a sustainable basis.

- Elderly Care

The Trust currently provides Elderly Care Services to a population of 250,000 with 22,500 of these being over the age of 75. The number of frail elderly people in hospital is increasing year on year and is expected to grow by 20% by 2020.

At present the Trust employs four elderly care physicians, one with a specific interest in stroke care. In addition, there is currently a locum consultant covering the post vacated by one of the Consultant physicians who transferred to Orthogeriatric Services in January 2012. An appointment has been made in May 2013.

Work commenced in 2012/13 in relation to improving the availability of Consultants over the weekends to ensure that the Trust can deliver a seven day a week service on a sustainable basis. When undertaking a review of services to confirm the Trust's sustainability going forward, elderly medicine was highlighted as an area where further work was required. In addition, the Deanery has also requested assurance that the Trust is meeting its requirements and providing good quality junior doctor training opportunities.

The Trust has therefore developed a model which will address the sustainability issues and provide the necessary assurance in relation to junior doctor training.

The service model can be summarised as follows:

- The delivery of a daily acute elderly ward round to be provided on Monday to Friday (including prospective cover).
- Provision of Consultant delivered care to elderly care beds including Multi-Disciplinary Team meetings Monday to Friday
- General medical/elderly ward round for post-acute patients on a Saturday and Sunday.
- Introduction of a twilight shift, utilising FY2 doctors, currently based in general practice.
- Provision of ortho-geriatric service including prospective cover.
- Prospective cover for the Stroke physician, in relation to elderly patients not in the acute stroke unit
- Provision of a community geriatric service 12 hours per week (including prospective cover).

The provision of an additional consultant post in 2013/14 will enable this service model to be delivered.

Productivity & Efficiency

12. An Overview of Potential Productivity and Efficiency Gains Built Into Plans

National benchmarking data suggests that the Trust's length of stay is lower than average for elective admissions, but higher than average for non-elective admissions (5.8 days compared to the national average of 5.4 days). However, the data also shows that the Trust has a comparatively low proportion of

zero length of stay admissions (21.1% against an average of 26.7%) due to the local model of managing patients via a clinical assessment unit. This will have a detrimental impact on our overall non-elective length of stay when compared to trusts with higher levels of zero length of stay admissions.

Additionally, as we continue to progress the Care Closer to Home initiative in the coming years, we are likely to see further increases in our non-elective average length of stay as the cohort of patients who are admitted to hospital as an emergency will be more clinically complex, with the less complex patients being managed at home or within the community.

The Trust routinely monitors its theatre utilisation. During 2012/13, overall utilisation of elective operating sessions was 81%. The Trust continues to participate in The Productive Operating Theatre initiative to optimise utilisation levels working towards an 85% level.

Average bed occupancy at the Trust has increased in recent years. Average occupancy in adult medical and surgical wards has increased by 3% in the last 12 months. The Trust is reviewing bed numbers, particularly across medical wards to ensure these are at the right level.

Data published nationally by the Health and Social Care Information Centre for standardised emergency readmissions suggest that HDFT performs slightly better than average. Local data shows that the number of emergency readmissions within 30 days reduced by 1% between 2011/12 and 2012/13. The Trust will continue to monitor readmissions to ensure they are kept to a minimum.

The Trust recently purchased a clinical performance and mortality monitoring tool, “Healthcare Evaluation Data (HED)”. The tool enables national, regional and peer group benchmarking across a variety of indicators. By using the tool, the Trust has identified the following areas to review as potential productivity and efficiency gains:

- Elective pre-operative length of stay
- Percentage of inpatients with a long length of stay (>30 days)
- Length of stay for certain diagnosis groups
- Day case rates for certain procedures

13. CIP governance

The Trust has a track record of delivering CIP, as demonstrated by the Trust’s financial performance over several years. The same methodology for identification and delivery of CIPs has successfully been in place over a long period of time, and this was strengthened during 2012/13 by the creation of a central Efficiency Group. This group, chaired by the Finance Director and with representation from all Clinical Directorates and Corporate Directorate, is accountable to the Strategic Implementation Group (chaired by the Chief Executive). The role of the Efficiency Group is to identify and monitor delivery of CIP schemes that are cross Trust and require coordination between Directorates. The savings generated are shared between Directorates once validated. Directorates therefore work both individually to deliver their efficiency programme and also in partnership with others where this has been identified as the most effective mechanism for achievement.

The Finance Director, through formal structures set out in the Accountability Framework, is responsible for ensuring Directorate plans are agreed and delivered. Regular cross Directorate meetings with devolved Finance Managers ensure that larger efficiency schemes are co-ordinated. For specific cross Trust transformational projects, such as a ward reconfiguration, a project group drawn from Directorates and led by an Executive Director is responsible for ensuring delivery of plans.

Detailed plans are agreed at Directorate level before the start of the planning period and the risk assessed as high, medium or low risk of delivery. These plans are signed off by the Board of Directors following assessment at Directorate Quality, Finance and Performance meetings, where the quality and performance impact of all schemes is considered. On a monthly basis, Directorates report against the delivery of each scheme and these form part of the monthly finance report to the Board of Directors where progress, risk and actions are discussed. See section 16 in relation to Quality Impact Assessment. A finance committee with non-executive involvement has also been created to oversee delivery of the financial plan and this includes CIP delivery.

14. CIP profile

The Trust has a number of schemes which are led by a central Efficiency Group:

- Improvements to the process and reduction in the usage of medical locums
- Reductions in cost of short term absence
- Reduction in cost of staff travel and rationalisation of community estate
- Procurement saving

In addition, each of the Directorates has a significant number of CIP schemes, of which the larger schemes include:

- Redesign of the wheelchair maintenance service and review of the reuse of wheelchairs
- Drugs savings in relation to the provision of homecare rather than in-hospital drugs
- Increased activity in the Trust's neuro-rehabilitation facility
- Delivery of increased activity at lower than planned marginal cost
- Saving on CNST premium due to increased level of performance against CNST standards
- Reduction in posts in the Corporate Directorate
- Reduction in the use of energy due to improved efficiency within the Trust's Combined Heat and Power plant

For details of the large schemes, please see Appendix 2.

15. CIP enablers

The Trust management structure consists of three Clinical Directorates and the Corporate Directorate. Each Directorate has a CIP target for delivery. The three Clinical Directorates are led by clinicians together with professional managers and this senior management team leads the identification of CIP schemes. As a result, the Clinical Director is involved in the identification of CIP schemes from the earliest stages. In addition, all CIPs are discussed with the relevant budget holder, who is often a clinician, depending on the service.

The CIP schemes are put through a challenge process with the Finance Director as they are developed. Once they are developed, the Chief Nurse and Medical Director discuss the schemes with the Directorate Senior Management Teams to ensure that there is no impact on clinical quality as a result of the proposals.

There are a number of enabling investments which support some of the CIP schemes:

- Significant investment in mobile working technology to support community teams, and to reduce the number of times staff need to return to base
- Corporate support in obtaining additional facilities to deliver outreach clinics in Leeds
- Investment in the Day Surgery Theatre to increase capacity for additional activity
- Investment in the quality of the private patient suite to drive additional private patient income

The process for identifying, delivering and monitoring CIPs is on-going throughout the year, but the agreement of each Directorates efficiency programme is a key task, which is addressed as part of the development of the Trust's overall Business Plan.

The Trust takes forward some transformational initiatives which are implemented Trust wide overseen by a Steering Group with representatives from both Corporate and Clinical teams involved at each stage of development. In addition, the Clinical and Corporate Directorates have their own CIPs to deliver and identify areas where these savings can be achieved. These Clinical Directorate schemes are agreed and reviewed with the Executive Directors, Chief Nurse and Medical Director to ensure that quality and performance standards are not compromised. The efficiency programmes are included within the Directorate Business Plans, which are signed off by each Directorate Board prior to implementation. Clinical engagement is considered essential to the successful delivery of these plans.

16. Quality Impact of CIPs

Assessing the quality impact of CIPs is initially undertaken early in the planning process, when Clinical Directorate Boards generate potential efficiency saving proposals. The Clinical Directorate Boards include a strong clinical membership and proposals are filtered against the need to maintain quality before being proposed as schemes to progress further. CIP plans from Directorates are then shared and challenged by the Trust-wide planning group and are also debated through the monthly Quality, Performance and Finance meetings where the Finance Director, Chief Nurse, and Director of Performance & Delivery meet with the Clinical Directorate management team.

Following the development of proposals into firm CIP plans, the Directorate undertake their own quality impact assessment, with each scheme assessed and risk scored against the criteria of patient outcomes, patient experience and patient safety. These assessments are signed off by the Clinical Director and submitted to the Chief Nurse and Medical Director for further challenge and scrutiny. The Chief Nurse and Medical Director then sign off the CIP plans of each Directorate once they are satisfied that there is no impact on quality.

The next stage in the process is the sharing of the risk assessed and approved CIP plans with the local CCG so that they can also gain assurance in relation to the quality impact of efficiency schemes. The final step is the submission of the CIP plans to the Board of Directors as part of the Annual Plan for the year that is then approved before submission to Monitor at the end of May each year.

During the year, the CIP schemes are reviewed each month as part of the Quality, Performance and Finance meetings which are a key part of the Trust's accountability arrangements. The schemes are

	monitored for delivery and any impact on the quality of services provided. The monthly review also forms a part of the monthly Board report prepared by the Finance Director.
Financial & Investment Strategy	**17. Assessment of the Trust's Financial Position** The Trust delivered a surplus for 2012/13, although lower than originally planned. This is in part due to the increased costs relating to additional staffing in the last quarter of the financial year. These additional staffing costs can be grouped into three main areas: • Increased infrastructure to deliver additional activity • Management of the winter activity pressures • Increased absence levels amongst permanent staff The first of these groups is key to delivery of the 2013/14 planned levels of activity and the Trust has included these costs within the 2013/14 expenditure plans. The Trust had intended to reduce the bed base in 2012/13 but has revised this plan due to increases in activity and a review of the necessary bed capacity to continue to deliver high quality care. This resulted in costs above plan in 2012/13, but these costs are planned for in 2013/14. There is a strong focus within the Trust on reducing the levels of absence and the costs of absence, through additional expert resource, tighter controls on establishments and improvements in procurement of agency staff. This will reduce the level of costs of staff in the coming months. From an income point of view, the Trust has agreed a significant increase (16%) in the value of the contract with the CCGs covering Leeds. This reflects the Trust's strategy to increase activity in Leeds and is supported by the move to offer outreach clinics in Yeadon. In relation to the HaRD CCG, the Trust remains in constructive negotiations and anticipates agreeing an acceptable contract value over the coming weeks. As a result of these actions, the Trust is in a good position going into 2013/14, although it is clear that the financial environment is becoming more difficult.

18. Key Financial Priorities and Investments

The key priorities for the organisation are:

- Strengthening quality, especially on inpatient wards
- Undertaking additional activity, particularly for Leeds commissioners
- Improving our physical environment

The key revenue financial investments included in the plan to deliver these priorities for 2013/14 are:

- £600k investment in nurse staffing levels on wards to further improve quality and move towards the Royal College of Nursing recommended staffing levels
- £900k investment to permanently establish a 16 bed ward to meet demand levels
- £110k investment in additional consultant staffing in the Emergency Department to increase quality and ensure urgent care priorities are delivered
- £120k investment in Health Visitors
- £181k investment in Community Stroke Team
- Investments in infrastructure to deliver additional activity:

Specialty	**Investment**
Gastroenterology	3.5 additional Consultant PA's
Cardiology	0.5 WTE Cardiology Consultant 2.0 WTE Band 6 posts
Dermatology	1.0 WTE Consultant Band 5, Band 2 and Medical Secretary post
Clinical Oncology	5 additional Consultant PA's
Day Surgery Unit	11.3 WTE Day Surgery Theatre staff to support new theatre 2 WTE Consultant Anaesthetist posts
General Surgery	6th General Surgeon post Nurse Endoscopist
Urology	Locum Consultant
Orthopaedics	9th and 10th Consultant posts
Radiology	1 WTE Consultant Radiologist
Wensleydale Ward	Increased nursing establishment to increase bed base from 23 beds to 28 beds
Maternity	0.5 WTE Midwife 2.0 WTE Care Support Workers

Priorities for years two and three have been outlined and in particular include:

- Staffing to support clinical sustainability as highlighted in section 11
- Additional infrastructure to deliver additional activity
- Expansion of health visitor service in line with the Call to Action programme
- Roll out of strengthened nursing establishment on our inpatient wards

19. Financial Risk Assessment

Key risks to achieving the financial strategy and mitigations.

Nature of Risk	Likelihood	Mitigating /control actions
Acute and Community services contract Achievement of income from HaRD CCG for the acute services and community services contract	Medium	In the event that the Trust cannot agree a contract in line with the planning assumptions included in the plan, contingency plans are in place which include utilising the planning contingency and Trust surplus to address the deficit. The Contract with NHS Leeds is agreed in principle above the planned levels. Finally the Trust could defer implementing some of the service and capital priorities included in the plan for 2013/14 and manage the infrastructure costs on a non-recurrent basis.
CCG seeking to reduce emergency activity but without investment in community The CCG has indicated an intention to reduce the levels of emergency activity seen within the Trust. This would require additional investment in the community services, which may not be forthcoming.	Medium	The Trust has good relationships with the local CCG, and will maintain a dialogue to try to ensure plans are robust and deliverable.
New Monitor Risk Assessment Framework The proposed Monitor RAF places greater emphasis on liquidity than the existing FRR. Cash flow and the management of debtors and creditors will become more important. If the Trust drops below a level 4, Monitor will require monthly monitoring of performance.	Medium	The capital programme could be delayed to some extent. The working capital facility is available in 2013/14. The FTFF have confirmed that the £1.5m loan is available for the MRI scanner. Non-essential non-pay expenditure would have to be reduced and some service developments could be deferred.
Changing commissioning arrangements The introduction of the new commissioning arrangements could result in services not being commissioned.	Medium	The Trust has good relationships with the local CCG as staff have transferred from the existing commissioners. Relationships with other new commissioners, including the Commissioning Board Area Teams have been actively established by the Trust's Finance team to ensure continuity of services. There is a general acknowledgement that in the first year of the new arrangements, services will transfer on a like for like basis. HDFT is a high performing organisation with a good reputation for providing high quality services.
Cash flow Non-payment by commissioners for activity delivered or lack of expenditure control internally causing cash shortages	Medium	Capital programme could be delayed. Working capital facility available.
Expenditure control Ability to deliver the agreed levels of Cost Improvement Programme (CIP)	Medium	The Trust's has a track record of delivering CIP and overall expenditure control has generally proved successful in previous years. A piece of work is currently being undertaken to emphasise and embed expenditure controls on pay. The leaner management structures and accountability framework internally will ensure that cost control has sufficient emphasis. The financial plan includes uncommitted reserves as contingency together with a small amount for developments which will not be released unless

		expenditure is controlled.
Reduction in quality of services In the move to improve efficiency, the quality of services in the hospital and the community is compromised. This would result in a reduction in our ratings, poor reputation, noncompliance with national standards etc. This in turn would result in a reduction in activity as patients choose not to come to HDFT for their treatment.	Low	Specific investment is included in the plan for improvements in quality. The plan recognises that there is a lead time for improving the quality of services and gaining efficiencies that come as result. Any changes are phased in the plan and the financial gains included at the appropriate stage. The performance and quality standards of the Trust will continue to be monitored rigorously through the performance group to ensure high standards are maintained and enhanced where possible. This includes rigorous pursuit of patient safety improvements through the Patient Safety First campaign. The efficiency programme has been signed off at Directorate level by Clinical Directors and clinicians have been involved in development of efficiency plans from the early stages.
Activity growth The Trust's ability to continue to increase activity to enable growth year on year with our commissioners, particularly Leeds CCGs.	Medium	The percentage growth is based on historic trends and demographic assumptions, together with a step change delivered through the move to provide services locally to Leeds West patients in Yeadon. The demographic assumptions have been agreed with Leeds CCGs as part of agreeing contracts for 2013/14. It is likely, as in previous years, that the Leeds CCGs will become more reliant on HDFT to assist them in delivering their standards e.g. 18 weeks. In the event that the HaRD CCG activity is below plan, experience indicates that it is very likely that the Leeds CCGs would take up this capacity. Whilst activity is likely to grow, HaRD CCG have indicated further and more restrictive thresholds will be needed due to the funding being constrained in future years. The Trust is engaged with HaRD CCG in discussing clinical thresholds and has worked together in the past successfully to ensure activity is appropriate and clinically beneficial.
Sustainability of services Inability to continue to provide key services due to issues of recruitment and clinical critical mass, and efficiency of provision	Medium	Look to strengthen through greater collaborative working e.g. with YTHFT. Alternatively the Trust would have to take the decision with commissioners as to whether the service would continue to be subsidised or should no longer be provided by HDFT. Alliances are also in place with Airedale and LTHT.
Insufficient Capacity The Trust does not have sufficient staffing resources or physical accommodation to be able to deliver the required levels of activity either in the hospital or the community	Medium	Look to recruit staff wherever possible or link with other organisations e.g. through alliances. In relation to the physical estate examine the potential of using the existing Macmillan Dales Unit which will be vacated on completion of the new cancer unit. The new theatre is to be commissioned in May 2013.. Work is on-going to improve utilisation of the community estate.
Maintaining high performance across the organisation Potential to fail to meet performance standards due to more stringent targets, constrained resources and reduction in management capacity.	Medium	Continued use of robust performance management regime currently embedded. Agreed timeline of schemes to be implemented to avoid loss of focus on maintaining day to day service provision. Experience and capability of senior staff within the Trust to deliver required performance standards.
Community Services Contract Potential loss of the community services we currently provide, as a result of the CCGs/local authority/other commissioners deciding to retender for these services.	Medium	Further integration with hospital services. Service redesign programmes being implemented to ensure continued quality improvement. Very strong relationships with local authority and Clinical Commissioning Groups.

Appendix 1: Financial commentary (NOT FOR PUBLICATION)

- **Income**

The principal drivers of income within the planning period relate to demographic growth for the local population of the HaRD CCG, accompanied by a step change in secondary care activity delivered for the Leeds North and West CCGs. In addition, the plan assumes growth in our community services which are commissioned by CCGs, NHS England, and the Local Authority which offsets the assumed tariff reduction.

The demographic growth assumption is based upon historic trends and has been triangulated through the work undertaken by KPMG as part of the North Yorkshire Clinical Services Review which reported in January. This growth includes an element of activity expansion that relates to new treatments, particularly in relation to oncology activity and diagnostics linked to screening programmes.

The step change in activity for the Leeds CCGs (a 16% increase in activity) has been agreed with the commissioners in Leeds and is reflected in the agreed contract value. The key areas of growth are in orthopaedics (where around 50% of our elective activity is from outside of the HaRD CCG area), general surgery, and urology, with outreach clinics now in place from April in Yeadon Health Centre. An increase in maternity activity is also planned for later this year in Leeds as our midwifery service is expanded into outreach facilities in both Leeds West and North - this will enable the Trust to provide the whole maternity pathway in these areas and benefit from the recent national tariff changes in maternity.

The planned level of income has been agreed for all contracts with the exception of contracts with CCGs who formally were part of NHS North Yorkshire and York. These contracts (acute and community) total £107m and the current offer from the CCG is for a total contract value £109m. The gap of £4m equates to around 3% of clinical income not currently secured.

The risk to planned income relates to:

- CCG QiPP assumptions of £1.7m
- Potential tendering of community services
- Delivery of planned best practice tariffs

These risks are mitigated in a number of ways. These include through working with the CCG to agree joint activity management schemes that are realistic and focus in particular on emergency activity where the trust only receives 30% tariff, early discussions with the local CCG in relation to community services and their commitment to support the Trust in this area wherever possible, and a robust internal performance management process with clinical directorates in relation to achievement of best practice income. Our income assumptions are also prudent in that there is no assumption of any reinvestment of the 70% emergency tariff income that is retained by the CCG - this amounts to around £1.8m which has previously been used to offset the PCT financial position in North Yorkshire but will certainly be available in 2014/15 once the local CCG has repaid historic debt in 2013/14.

In relation to performance contractual fines, our anticipated level of performance and delivery of key indicators such as waiting times and infection control mean that we are not planning to lose income as a result of these measures.

In terms of income generation in 2013/14, our secondary care activity growth is planned to generate £5.3m gross income with associated revenue infrastructure costs of £3.6m, resulting in a net contribution of £1.7m. The opening of the new day surgery theatre in June will also support the additional activity delivery plans. In terms of community income generation, re-ablement funds of £0.46m are planned to be received, £0.4m funding to offset community cost pressures and demand growth is planned, and the Trust will also receive an additional £0.12m for the Health Visiting service as part of the national Call to Action strategy.

The Trust delivered its income plan for 2012/13.

In terms of non-recurrent income received in 2012/13, the Trust appropriately accounted for income previously deferred totalling £2m, which helped offset the loss of CQUIN income from North Yorkshire PCT following an agreement reached for 2012/13 only to assist the financial stability of the whole health economy. The Trust also received £0.4m winter pressures funding which helped to mitigate additional costs of staffing capacity over the winter period.

The underlying income and expenditure surplus planned for each year of the planning period is £1.7m in 2013/14, £2.4m in 2014/15 and £3.1m in 2015/16. The Trust will receive a significant charitable contribution to our new Cancer unit which is being constructed during 2013/14 which will increase the planned surplus for 2013/14 only on a non-recurrent basis by £4.2m.

- **Strategic developments**

The key strategic developments are:

  - Quality improvement
  - Increasing our market share, including outreach services in Yeadon and Wetherby
  - Maintaining clinical sustainability
  - Improving the quality of the physical environment

These developments are summarised in the table below:

Main Service Developments	Resourcing Requirement	Financial Impact	Contribution to the plan	Actions Required	Key Risks	Assessment of Measures
Additional infrastructure to provide additional capacity to deliver additional activity, particularly for Leeds CCGs	Additional consultant time in Gastroenterology, Cardiology, Dermatology, Clinical Haematology, General Surgery, Urology, Orthopaedics, Radiology, Consultant Aneasthetist for new Day New Day Surgery Unit	£1,160k costs	Improve quality of service and expand capacity to deliver more secondary care actively for Leeds	Recruitment process currently ongoing	Failure recruit required numbers	Monitored through monthly Quality, Finance and Performance meetings with Clinical Directorates
	Additional nursing time in Cardiology, Dermatology, General Surgery and on Wensleydale Ward (Orthopaedics)	£542k costs				
	Additional midwifery and care support worker time in maternity	£21k costs				
	Additional investment in support services, such as Pathology, Radiology etc, non-pay and admin & clerical staff	£1,111k costs				
	Additional theatre nurse time for the new day surgery unit	£124k costs				
Increase in Ward Nursing establishment	Additional nursing staff	£1,400k costs	Improve quality of service and expand capacity to deliver more secondary care actively for Leeds	Establishments monitored. Ongoing recruitment.	Failure to recruit required numbers of nursing posts	Monitored through weekly Strategic Implementation Group
Emergency Department	Appointment of additional Emergency Department Consultant	£102k costs	Enhance service delivery and improve patient safety, outcomes and experience. Support development of future urgent care model	Recruitment process currently ongoing	Failure to recruit to consultant post. Low Risk	Monitored through monthly Quality, Finance and Performance meetings with Clinical Directorates
Continue to strengthen **Stroke Services** across the Trust in line with agreed strategic plan for the service	Additional nursing and therapy staff	£181k costs	Delivers Trust strategy to improve quality of service and develop more community based services	Majority of programme implemented. Provisional accreditation secured	Low Risk	Monitored through weekly Strategic Implementation Group
Health Visitors	Additional health visitors in line with the roll out of the Call to Action programme	Anticipated £120k funding and costs	Improve quality of service	Recruitment process currently ongoing	Failure to recruit required numbers	Monitored through monthly Quality, Finance and Performance meetings with Clinical Directorates
Day Surgery Unit	Additional Theatre staffing Additional Consultant Anaesthetist	£5.4m	Improve quality of service and expand capacity to deliver more secondary care actively for Leeds	New facility operational from June 2013	Delay in opening of new unit	Monitored through Site Development meetings
New Sir Robert Ogden Macmillan Cancer Unit	Additional investment in nursing and support services such as phlebotomy, domestic services, radiology and clerical staff.	Total cost of project £9.4m	Improvement in physical environment and opportunity to re-patriate oncology work from Leeds for the local population	On site. New facility due to open early 2014. Commissioning team established. I&E workstream progressing recruitment. Repatriation of activity from Leeds scheduled in 2014/15	Delay in opening of new unit	Monitored through Site Development meetings

Activity Levels and Infrastructure Costs

The Clinical Directorates have identified additional demand which is anticipated for 2013/14. Significant work has been undertaken within Directorates and with the corporate teams to identify the necessary capacity to deliver this additional activity. In particular work is on-going to deliver activity from the Yeadon Health Centre, which will significantly expand the Trust's catchment area into Leeds West. It is anticipated that several specialties, including Orthopaedics, General Surgery and Urology, will deliver outreach outpatient clinics in Yeadon in the short-term, with other specialties and more intensive activity to be developed over time. The total income value of all additional activity above the 2012/13 outturn is expected to be £5.3m.

In order to deliver this additional activity, the Clinical Directorates have identified the developments that are needed and these are detailed below. The total cost of these developments is £3.6m.

The net contribution from this additional activity is therefore £1.7m. Additional quality initiatives and infrastructure are included in the plan.

In addition to the above, the Trust is also working with HaRD CCG regarding the future provision of services at Ripon Community Hospital. HDFT currently provides services to the hospital as part of the community services contract and is working with the CCG and other stakeholders regarding how these services will be configured in the future. The Trust recognises however, that the CCG could decide to tender these services in 2014/15.

- **Activity**

The average life span in England and Wales has increased by around 10 years in recent decades. A corresponding increase in elderly people has been seen in the local population. Data published by NHS England in 2012 indicated

that HaRD CCG had a higher proportion of people aged 40 years and over than the national average and a significantly higher proportion of females aged 85 years and over.

The Trust has seen a corresponding increase in non-elective admissions for elderly patients over recent years. Overall the number of non-elective admissions has increased by 16% during the last five years and the number of admissions for patients aged 85 years or over has increased by 33% during the same period.
The main areas of growth for non-elective admissions have been general surgery, general medicine and paediatrics. The Trust anticipates non-elective admission growth to continue, due to demographic trends in the ageing population, therefore the local Care Closer to Home programme and integration of community services continues to be a priority for the Trust to support managing the non-elective growth within our existing bed base. The Trust is in discussions with the CCG regarding the re-investment of the 70% of tariff retained as a result of non-elective growth above the 2008/09 baseline to support this approach.

Historical growth in referrals over the last 5 years show an average 2.4% year on year increase in elective demand. The Trust started outreach clinics in Wetherby in 2009/10 and saw a corresponding step change increase in out of area elective activity within that financial year. The Trust has recently set up additional outreach clinics in Yeadon in Leeds North West in the specialties where the Trust has experienced growth, Trauma & Orthopaedics, Urology and General Surgery. Between 70% - 80% of the market share from Wetherby GP Practices for these three specialties now come to Harrogate and we anticipate the same being achieved in Yeadon over a three year period. The Trust anticipates a further step change in elective growth in these specialties as a result. Diagnostic services supporting the Yeadon clinics are being provided in alliance with existing local providers and this coupled with clinic attendance enables a large part of the clinical pathway to take place close to the patients home. The Trust is monitoring the clinic utilisation closely to ensure the increase in referrals is in line with plan.

Trust plans for 2013/14 predict 6% growth in referrals overall, with the majority of the growth from outside the North Yorkshire area. Further expansion of services to the Leeds North West population is planned, in particular the expansion of maternity services offered to this area.

An impact assessment of market share trends over the life of the plan is detailed below.

	Current position - Data for most recent 12 months available on HED (Feb 12 - Jan 13)														
	Wetherby, Collingham & Boston Spa practices			Yeadon practices			Yeadon practices 2013/14 estimate			Yeadon practices 2014/15 estimate			Yeadon practices 2015/16 estimate		
Specialty	No. referrals to HDFT	Total referrals	% market share	No. referrals to HDFT	Total referrals	% market share	No. referrals to HDFT	Total referrals	% market share	No. referrals to HDFT	Total referrals	% market share	No. referrals to HDFT	Total referrals	% market share
General surgery	1047	1323	79.1%	22	540	4.1%	157	540	29.1%	292	540	54.1%	427	540	79.1%
Urology	793	976	81.3%	6	344	1.7%	97	344	28.2%	188	344	54.7%	280	344	81.3%
Orthopaedics	455	632	72.0%	99	487	20.3%	183	487	37.6%	267	487	54.8%	351	487	72.0%
Maternity	395	567	69.7%	157	483	32.5%	217	483	44.9%	277	483	57.3%	336	483	69.7%

- **Costs**

The Trust's financial plan is constructed following a clear understanding of the key cost drivers across the organisation.

The key cost driver relates to staffing costs, in particular the pay award for all staff, the incremental progression cost, and the cost of utilising temporary medical or nursing costs when vacancies, sickness or gaps in rotas occur. In terms of pay awards, 1% per year has been included within the plan as has the cost of incremental drift. The Trust, as part of the efficiency programme across all years of the plan, is targeting the cost of staff absence, as well as utilising the new flexibilities within the Agenda for Change terms and conditions to manage the cost of increments and sickness.

The impact of delivering additional activity as the Trust plans a step change in activity from the Leeds area is a cost driver for the organisation and as part of the planning process the levels of activity are modelled by specialty and the infrastructure investment required is calculated. The marginal cost of activity will vary by specialty dependent upon whether a step change in infrastructure is required. In terms of 2013/14, the marginal cost is assessed on average to be around 65% across the Trust due to the infrastructure investments funded in the plan. In years two and three of the plan, a contribution of 50% on average is targeted and the plan reflects this position.
In relation to non-pay, inflation (including specific cost pressures such as energy and clinical negligence insurance) has been assessed as 2% and these have been funded within the plan.

In addition to the activity related costs, the Trust has included within the plan the necessary investment to deliver our strategic priorities, particularly in relation to inpatient ward staffing, where establishments have been reviewed and amended to ensure that high quality care continues to be delivered.
There is no significant non recurrent revenue expenditure included within the plan. There are no plans to undertake significant restructuring of the organisation that would result in material redundancy costs.

Workforce priorities

The Trust continues to explore a variety of initiatives to ensure services are sustainable and quality is maintained. These plans include utilising the amendments to the Agenda for Change terms and conditions of employment to reduce sickness absence and incremental pay awards will be earned rather than provided as an automatic entitlement.

Workforce data is benchmarked against Trusts of a similar size with objectives set at the outset of the financial year. Agreed interim targets track progression and these are reported to the Board of Directors on a monthly basis. Medical workforce productivity is driven through job planning arrangements in each of our Directorates.
Royal College of Nursing standards have informed continued investment into the nursing establishment to ensure there is flexibility across the organisation to manage patient demand / acuity without the need to utilise temporary staff. Underpinning this work will be protocols to inform decisions on minimum staffing levels at any given time thus not impinging upon the quality of service.

The workforce establishment is managed through a weekly vacancy control group and the Trust continues to explore a range of mechanisms to support organisational change programmes.

The Trust recognises the need to further develop and implement new models of selection techniques for greater emphasis on values, behaviours, dignity and respect and language competence of all front line staff. Assessment of language competence for all substantive medical staff is being trialled in line with revalidation requirements.

The Trust's current staff values are to prioritise the patient experience by demonstrating: Respect and Dignity, Compassion, Commitment to quality of care, Working together for patients, Improving lives and ensuring Everyone counts. Underpinning this is a programme of initiatives to ensure there is significant staff engagement in each of these areas.

A culture of transparency is imperative in order to deliver high quality patient and client care. As such staff are actively encouraged to escalate concerns immediately and when incidents do occur, to be open and honest with all concerned. Director Listening events, Team Brief, 'Ask the Director a Question', Patient Safety visits and Director Inspections are all tools used to assist with our duty of candour.

Our intention is to establish mechanisms by which these values and behaviours can be linked to assessment of conduct and capability and therefore in turn be linked to reward by utilising the changes to the national terms and conditions.

A rolling programme of statutory, mandatory and essential skills training is available for all employees to access and is delivered by a blend of face to face and eLearning. Through improved compliance reporting and individual follow-up of training completion, the Trust has achieved a significant positive shift in training compliance over the past 12 months and continues to focus on ensuring the right training is targeted at the right staff groups and to further increase training compliance levels.

The Trust's Remuneration Committee has a key focus on ensuring succession planning arrangements are in place for all key roles within the Trust in order to support business continuity arrangements.

Appraisal compliance has also significantly improved over the past 12-months with the intention to achieve 100% compliance by 2015. The development of an in-house paper-based toolkit which was launched in April 2012 has been well received. The need for an annual appraisal to support revalidation is also contributing to the improved uptake among medical staff.

Finally, the Board of Directors will hold a further Board Development event particularly focused on obtaining the views and comments from a range of our stakeholders in order to assist with developing the quality of services we offer.

- **Capital Expenditure**

HDFT has undertaken a major capital programme over the last 12 months with the completion of a new modular facility for the maxillofacial and orthodontic department, the provision of a third day case theatre and a new car park to support the Sir Robert Ogden Macmillan Centre. The new cancer unit is due to open in early 2014.

The Trust recognises however that in order to meet its strategic objectives further capital investment will be required over the next three years to provide increased capacity and improve the infrastructure at the District Hospital. As a result discussions have taken place with the Clinical Directorates to determine the future estates strategy and the key capital developments that need to be progressed over the planning period. The capital projects to be undertaken can be summarised as follows:

Capital Scheme	Total scheme cost £	Contribution to strategic plan	Timescale	Risk
Replacement of existing MRI scanner	1.5m	Support deliver of additional activity	2013/14	Failure of existing equipment. Impact on waiting times.
Adaptations to the existing Macmillan Dales Unit	1.6m	Improve physical accommodation	2013/14	Overrun of SROC delay scheme and impact on ability to transfer facilities from elsewhere on HDH site for alternative use
Centralisation of decontamination facilities	700k	Improve quality and physical environment	2013/14	Failure to obtain JAG accreditation
Provision of additional endoscopy capacity	3.5m	Improve quality and support additional activity	2014/15	Failure to obtain JAC accreditation. Lack of physical capacity impact on deliver of activity and achievement of waiting time standards
Trust wide infrastructure	250k year one, years two and three to be agreed	Improve physical accommodation	2013-2015	Failure of electrical supply to hospital
New Self Care Renal Unit	700k	Improve quality and physical environment	2013/14	Impact on renal services at York due to lack of capacity
New Sir Robert Ogden Macmillan Centre	9.4m	Improve quality and physical environment	2013/14	Delay in opening of new facility
Completion of Third Day Case Theatre	5.4m	Improve physical environment and provide additional capacity to support activity	2012/13 – 2013/14	Delay in opening could impact on delivering additional activity

All the above schemes are funded through the Trust surplus, with the exception of the MRI scanner which is funded via the Foundation Trust Finance Facility, the self-care renal unit which is being funded from charitable funds by York Teaching Hospitals Foundation Trust and the Sir Robert Ogden Macmillan Centre which is also being funded through charitable donations from Macmillan and Sir Robert Ogden.

In addition to the large capital projects identified above, the Trust also has an intermediate and small schemes programme, which focuses on replacement of medical equipment and maintenance schemes. Both the estates and IT departments have been allocated resources to fund their respective programmes.

The Estates department is in the process of carrying out a condition survey and residence survey to assess backlog maintenance issues and Trust wide infrastructure requirements needed to support future capital developments on the hospital site. This work will be completed in the coming months and will inform future requests for capital funding in the coming years.

With regards to IT, the Trust is currently reviewing its IT strategy, which will inform IT programme priorities for 2014/15 onwards.

In the longer term the Trust recognises that adaptation works at the front of the hospital will be required to accommodate the new urgent care model. This will potentially necessitate the relocation of the existing orthopaedic outpatient department to alternative ground floor accommodation. In addition, with the expansion of maternity services, it is anticipated that changes will be required to provide additional capacity in the unity. Other capital projects that will need to be considered if elective activity continues to increase in line with our strategic objective for increasing secondary care actively with Leeds CCGs, will be the provision of additional theatre capacity and pre-operative assessment facilities. The Trust will continue to develop its estates strategy over the coming months to determine the future capital investment required.

In relation to community facilities, the Trust did not acquire any premises as part of the PCT Estate Transfer process. All the community premises have been transferred to NHS Property Services or are retained by other providers, e.g.: Provider Trust, GPs or private landlords. HDFT continues to explore opportunities to rationalise the estate it occupies and this exercise will continue. With regard to Ripon Community Hospital, the Trust is working with other key stakeholders including the local CCG, North Yorkshire County Council, local GP practices and NHS Property Services, to explore the opportunity to re provide services in Ripon as part of the “Healthy Ripon Project”. Should this initiative prove to be successful it would be possible to vacate the existing Ripon Hospital site and enable health services to be

provided from new facilities. Discussions are continuing with this initiative, with a view to plans being developed over the next 12 months for consideration.

- **Risks and mitigation**

The key downside variables that have been modelled are tariff changes, staff costs including excess cost of temporary staff, CIP delivery and delivery of activity.

In 2013/14, the tariff deflator is known, as is the pay award for staff. Downside assessment has therefore been based around temporary staff, CIP, and activity volumes. In relation to temporary staff, the downside risk is assessed as spending £0.5m in excess of plan on locums and nurse bank staff. This would be as a result of gaps in shifts and rotas caused by vacancies, sickness and other forms of absence. For CIP delivery, a non-achievement of 10% has been assessed (£1.1m), and in relation to additional activity the downside assessment has been assumed as a reduction in assumed financial contribution of 20% (£0.3m).

The mitigations against the downside risk of £1.9m are:

- planning contingency of £0.9m within the plan
- pay contingency of £1.2m
- slippage on planned developments of £0.1m
- waiting list reserve slippage of £0.1m

In addition to the mitigations identified above, the Trust, as part of reviewing and increasing ward establishments, has agreed a new establishment but also a lower, acceptable establishment that would need to be breached before any temporary staff were utilised.

In terms of 2014/15 and 2015/16, similar downside assessments have been made as in 2013/14 but with the addition of a further 0.5% risk relating to tariff deflation and pay costs. There is a clear national planning link between national pay awards and tariff deflator and our plan assumes that pay awards will remain at 1% with a tariff deflator of 1.3%. The downside risk is that this gap (which results in our planned efficiency requirement) is increased by 0.5%, or £0.85m.

The mitigations in year two and three are as per year one, with planning contingency, reserves, and planned development slippage. In addition, the Trust is planning to increase the surplus generated by £0.6m each year, from £1.7m in 2013/14 to £2.3m in 2014/15, and to £2.9m in 2015/16. This is in response to the new Risk Assessment Framework and the intention to create additional liquidity headroom, but it also does provide mitigation against any downside risks.

- **Transactions**

The Trust does not have any planned investments or transactions worth more than 10% of the Trust’s assets, neither revenue nor capital to report.

Appendix 2: Cost Improvement Plans (CIPs) - Top 5 CIP Schemes (NOT FOR PUBLICATION)

Note: this schedule is to provide additional information regarding CIPs. Please refer to CIPs guidance on page 5.

No	Scheme	Scheme description including how scheme will reduce costs	Under-pinning IT / information or management systems	Total savings £m	Phasing over three-year period (£m)			WTE Reduction	Has the scheme been subject to a quality impact assessment (Y/N)	Who is responsible for signing off on the quality impact assessment	Key measure of quality for plan	Scheme Lead
					Yr. 1	Yr. 2	Yr. 3					
1	Increased Income	Increased activity for patients in Leeds	Monitoring tool – Healthcare Evaluation Data (HED)	5.2	2.2	1.5	1.5	0	Yes	Angela Monaghan, Chief Nurse and David Scullion, Medical Director	Inpatient survey Friends and Family Test	Rob Harrison, Director of Performance and Delivery
2	Operational efficiency	Increased efficiency across theatres, outpatients, wards and departments	Use of theatre management system Bluspier Performance Group monitor activity	2.8	1.1	0.4	0.4	12	Yes	Angela Monaghan, Chief Nurse and David Scullion, Medical Director	Bed occupancy, staff sickness levels, complaints	Rob Harrison, Director of Performance and Delivery
3	Procurement savings	Improved procurement and changes in practice	Monitored through the Efficiency Group	2.0	0.8	0.6	0.6	0	Yes	Angela Monaghan, Chief Nurse and David Scullion, Medical Director	Inpatient Survey Friends and Family Test	Jonathan Coulter, Deputy Chief Executive
4	Mobile working	Reduce community estate and travel costs through increased use of technology for mobile working	Roll-out of mobile technology purchased by PCT	0.8	0.4	0.2	0.2	0	Yes	Angela Monaghan, Chief Nurse and David Scullion, Medical Director	Staff Survey	Rob Harrison, Director of Performance and Delivery
5	Staff cost management	Reduced cost of sickness, increments and reduction in premium rate payments	New monitoring arrangements re Managers performance in relation to management of staff sickness	1.6	0.8	0.4	0.4	0	Yes	Angela Monaghan, Chief Nurse and David Scullion, Medical Director	Sickness rates and use of temporary staff	Phillip Marshall, Director of Human Resources

Appendix 3: PFIs costs and utilisation (NOT FOR PUBLICATION)

The Trust does not have and will not have any PFI schemes during the Strategic Plan period.

Appendix 4: Use of external assurance (including internal audit) (NOT FOR PUBLICATION)

North Yorkshire Clinical Services Review
A review was commissioned by all the Chief Executives in North Yorkshire to undertake a review of services. This work was led by KPMG and provided a high level clinical strategy with a number of strategic emerging themes in a range of clinical areas.

Stroke Services Accreditation
Following the peer review undertaken in 2011 and the accreditation visit in May 2012 the Trust has implemented a number of changes with regard to stroke services. A further accreditation visit was held in April 2013 and the Trust was given a provisional accreditation from May 2013 following the new Consultant Neurologist commencing in post.

NHSLA Risk Management Standards
The Trust was assessed against level 3 NHSLA Risk Management Standards in March 2013 and was found to be complaint in 49 out of the total of 50 standards, thus achieving Level three across the Trust.

Trauma Accreditation visit
The Trust received interim designation as a Trauma Unit within the West Yorkshire sub regional Trauma Network. This was based on the submission of a self-assessment against the prescribed standards. Major Trauma Centres have taken part in peer review process to validate the returns and it is likely that the Trust will partake in a peer review as a Trauma Unit within the next year.

Patient Voice Visits
A series of patient voice visits were carried out to review services provided in 2012/13, the outcomes of which are posted on the Trust's website. The Patient Voice group attend quarterly meetings with the Chief Executive, Chairman and Chief Nurse to discuss the visit outcomes and ask any other strategic questions they may have.

Internal Audit

As part of the Audit Plan for 2012/13 agreed by the Audit committee in addition to the regular internal audit coverage the following areas prioritised. The results are detailed below:-

Topic	Assurance Level / significant concerns
Dignity and Nutrition for Older People	Joint audit (between Internal and Clinical Audit) so no assurance level provided. No concerns identified.
Handover (CNST)	Clinical Audit only so no assurance level provided. No significant concern identified.
NHSLA – policies, procedures and protocols	Significant Assurance
Records Management (incl secretary offices)	Significant Assurance
GP OOH – Vehicle, Equipment and Medicine Checking	Limited Assurance – the Trust has now fully implemented the Internal Audit action plan in respect to this report.
Management of legionnaires and associated diseases	Significant Assurance
Review of Pathology Reports (blood spot screening)	Significant Assurance

Other priority areas to be taken forward in 2013/14 by Internal Audit are detailed below:-

- Directorate Risk Management
- Medical Revalidation
- Locum Use and Spend
- Medics Annual Leave and Study Leave
- Provider Licence Compliance
- Community Equipment
- Endoscopy Operational Policy
- Consultant Job Plans
- Risk Assurance Framework
- Energy Management
- SUI's and Complaints

Appendix 5: Commercial or other confidential matters (NOT FOR PUBLICATION)

Consideration has recently been given to the format and structure of the Board of Directors, specifically in relation to the workload of the Non-Executive Directors. As part of the annual succession planning process and review of Board effectiveness, consideration is currently being given to the structure of the Board of Directors to ensure that portfolios are appropriate and that the Board continues to develop and improve. The Council of Governors are aware and will be fully consulted on all relevant matters.