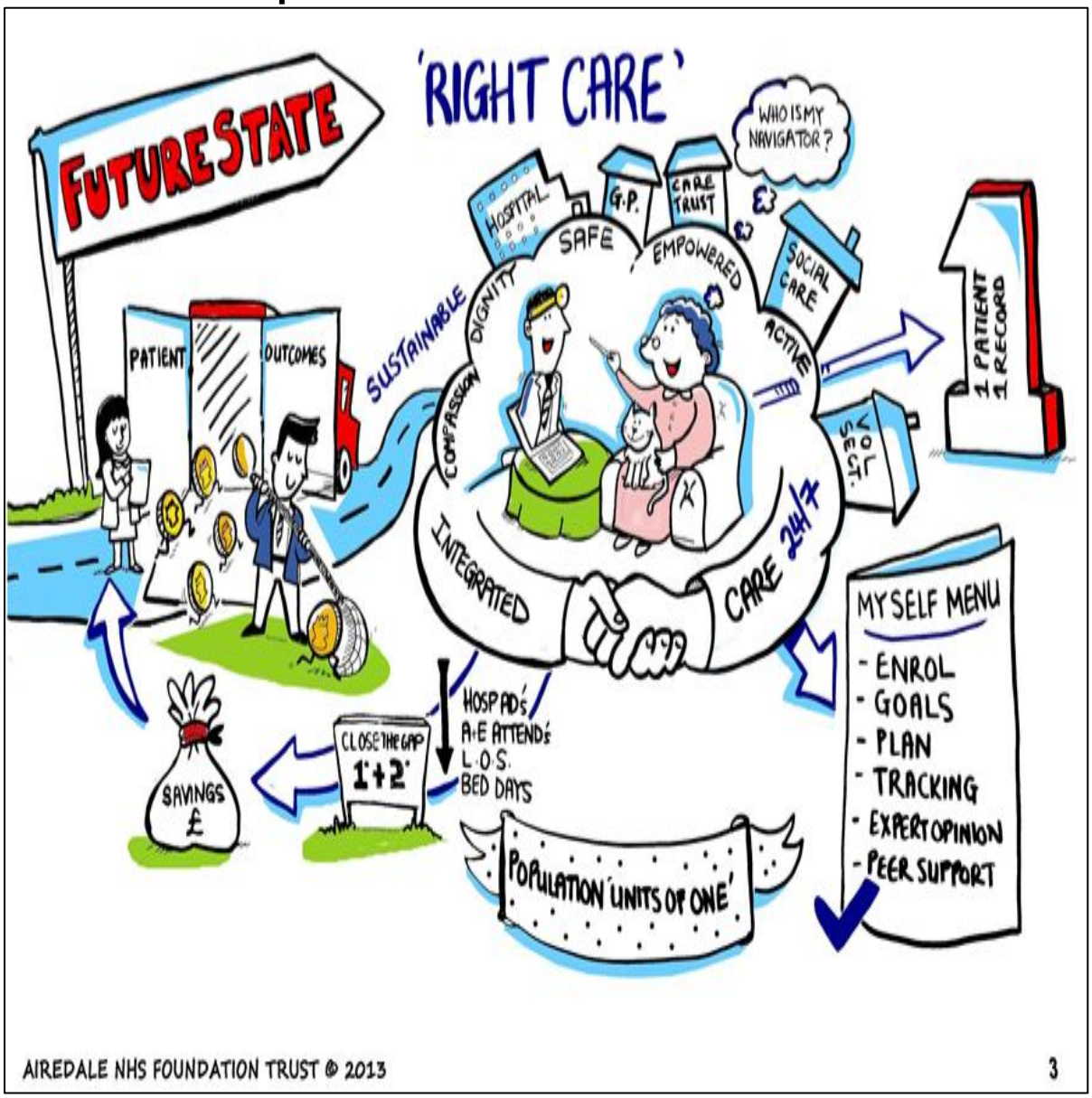
Airedale NHS
NHS Foundation Trust

Strategic Plan Document
for 2014/2015 to 2018/2019

Airedale NHS Foundation Trust

Care in people's homes through data driven, person orchestrated services



Strategic Plan for y/e 31 March 2015 to 2019

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

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Date	**26th June 2014**

The attached Strategic Plan is intended to reflect the Trust's business plan over the next five 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; and**
- **The 'declaration of sustainability' is true to the best of its knowledge.**

Approved on behalf of the Board of Directors by:

Name *(Chair)*	**Michael Luger**

Signature 

Name *(Chief Executive)*	**Bridget Fletcher**

Signature 

Name *(Finance Director)*	**Andrew Copley**

Signature 

Preface

Realising our Right Care ambitions

The magnitude of the challenges facing health and social care is well documented and understood and requires a radical response. **W**e have to think differently if we are going to better meet the needs of the communities we serve, set against unprecedented efficiency challenges.

In developing our 5 year Strategic Plan we have risen to the challenge to be bold in the relentless pursuit of our Right Care vision.

Right Care is a health and social system-wide approach to care with the patient, around the patient and for the patient. Driven by the needs of each person, not those of professionals or organisations, **Right Care** wraps itself around the individual **in a way that is right for them and makes them feel empowered, active and safe. Care is provided by a range of care providers - dependent upon the needs of the individual - utilizing community assets and enabled by technology to both improve the patient experience through a more integrated, right first time offer that makes the best use of tax payer resources.**

This plan is bold and ambitious and builds on our track record of improving patient experience; delivering low cost, high quality, safe care; driving innovation and integration including providing more care at home; system leadership; effective partnerships; transforming the workforce and strong corporate and clinical governance.

Despite our success, we know more of the same will not be enough to achieve what we need to do to guarantee sustainable services. Together with our partners we need to step up a gear and transform at pace and scale if we are to realise our **Right Care** ambitions over the next 5 years.

We are committed to making the changes that are within our direct control. We will do everything within our power to support, influence, enable and lead (where necessary) the local system. For those changes outwith our control and sphere of direct influence, we will take every opportunity (including this submission) to lobby for change including alignment of incentives and creation of the right levers and enablers so we can achieve our **Right Care** vision and deliver sustainable services for our local population.

To deliver everything we have to do, this plan, which includes delivering efficiencies of £30m over the period, relies on a number of critical success factors that require local system wide and national support and leadership as follows:

Local:

Transformation: ***because integration alone will not deliver the radical change required***

- Appetite to make radical commissioning decisions
- Agreement of providers to transform in partnership and at pace
- Reform of primary and secondary care to achieve our closing the gap aspirations
- Use of the Better Care Fund to enable transformation rather than balance Local Authority financial gap

Demand: ***because emergency activity is growing at an unprecedented rate***

- The underlying 3% growth in acute sector emergency activity will be demand managed across the health economy to a sustainable level – failure of the system to manage demand to address growth poses a significant risk.

National:

Regulation: ***because we can't regulate local health economies into sustainability***

- Shift focus from system failure/turnaround to accelerating conditions for sustainability

Financial Levers: ***because we need to shift from perverse incentives to enabling and rewarding the changes we aspire to***

- National contracting and funding architecture will change to incentivise transformation
- There will be no unforeseen changes to national contracting and funding architecture which increases our efficiency challenge
- Transitional funding to support managing residual fixed costs where necessary and to pump prime changes
- Shift from the current rudementary non differential savings requirement to a more comprehensive, evidence based, equitable approach

Workforce transformation: ***because 70% of spend is tied up in workforce***

- Support to change boundaries of roles at pace
- Medical education and training to support shift from specialisation to generalisation
- Use Agenda for Change, GP and consultant contracts as national levers to enable the transformation we need

Organisational Form*: because one size doesn't fit all*

- Support to create new organisational forms e.g. Accountable Care Organisations/Chains/Mutuals to facilitate implementation of new care models and enable transformation at pace
- Governance and regulatory arrangements that support new organisational forms
- Making it easier to close the gap between primary and secondary care
- Small hospitals facilitated to be sustainable i.e. access to evidence of what works

We are committed to delivering our bold plan and look to our partners – locally and nationally – to support us to realise our ambitions for our local population.

Declaration of Sustainability

The Board declares that, on the basis of the plans as set out in this document, the Trust will be financially, operationally and clinically sustainable according to current regulatory standards in one, three and five years time.

Confirmed (subject to caveats noted below)

This 5 year Strategic Plan builds on the work already completed in our 2 year Operational Plan submitted to Monitor in April 2014. The Trust Board of Directors have considered the Foundation Trusts current position, as well as the challenges facing all organisations in the Local Health and Care Economy over the next five years. Based on the detail contained within this plan, the Board consider the Foundation Trust to be clinically, operationally and financially viable over the five years 2014/2015 to 2018/2019 on the following basis;

- We have reviewed in detail the strategic context and direction over the next five years and its potential impact including on our current market position, the healthcare needs of our population, the requirements of key stakeholders and financial framework within which the whole health and care sector needs to operate;
- We have a clear shared ambition, vision and clinical strategy **(Right Care)** with our partners in the health and care economy that is centred around empowering patients in their requirements, underpinned by an approach to quality and safety improvement which allows us to respond in the best way to the challenges ahead for our patients and the public;
- Through cross-organisational engagement we have ensured our vision, strategy and plans are progressing with stakeholders in the health and care economy, including how we plan to deliver our own sustainability whilst contributing towards the economic and operational viability across the Unit of Planning;
- We recognise there are key elements we need to develop including the potential for a new Organisational Form, pursuing greater partnership opportunities with other providers, the need to address the workforce challenges ahead through redesigned ways of working and further developments to close the gap between primary and secondary care.
- Responding to the challenges, we have started work across the district to look at co-creating new models of care, such as through the use of Extensivists and Enhanced Primary Care. We have also set out plans for how the use of Better Care Funding could potentially support transformation and the greater integration of services through new ways of working together;
- Our operational plans are focused on the need to respond with solutions to the current demands and national policy developments. We have reviewed service options and agreed a five year outlook that transforms the way services are to be provided (e.g. emergency care), ensures the greater integration of services (as defined in our clinical strategy) and sets out a proposed service configuration so that we can ensure services provide high quality, safe care in a sustainable way;

Supporting strategies regarding workforce development, IM&T and Estates are in place or being developed.

- Our Operational Plan set out a financial position, based on key inputs and recognised assumptions, to deliver a strong position going forward. The Board have revisited our assumptions for 2014/2015 to 2015/2016 and consider these prudent, so overall they remain unchanged with only relatively minor amendments to individual points of delivery. This five year plan further develops our efficiency approach through both transactional and transformational means (Right Care Portfolio) to ensure our financial plan supports the continuity of services, except where highlighted.
- Overall our position is set against the touchstone of our Board commitment to patients.

At this time, our assumptions in this plan are based on the current published guidance; material changes to these will require us to further assess the above statement.

Declaration of Sustainability - Key Caveats

As outlined in the Preface to our plan, we are committed to making changes that are within our direct control. We will do everything within our power to support, influence, enable and lead other stakeholders, but ultimately we require our partners to work with us and transform at pace and scale if we are to realise the full scale of our **Future State Right Care** ambitions over the next 5 years.

The above Declaration of Sustainability is therefore predicated on the following critical success factors being sufficiently progressed both locally and nationally to support delivery of the overall plan. Without these being addressed, we shall not be in a position to realise the full scale of our **Right Care** vision ambitions or fully ensure sustainable services for our local population.

Critical Success Factor	**Key Risks and Areas Of Concern**
Transformation: ***because integration alone will not deliver the radical change required***	We have highlighted in this plan the need to radically alter the current hospital dominated delivery model to one based on diversified services, designed in partnership with our commissioners, stakeholders and community, delivered at the most appropriate point for patients. This requires significant focus and engagement from all our partners. We recognise it is not possible to sustain all of the current service configuration and existing models of care across the health and care economy over the next five years and this requires all organisations to be prepared to make radical decisions, including the potential decommissioning of some services. We have highlighted some specific areas in our plan for developing alliances and partnerships with other providers to build greater service resilience and sustainability. This requires the support of our partners to

	take these proposals forward and to implement them. We see a significant opportunity for developing a different service offer in conjunction with primary care, providing greater choice for patients with a more flexible, innovative approach, using new models of care. We need to have the flexibility to develop such arrangements, including a funding framework that supports implementation and development. We have also been involved in constructing plans to further support the transformation of services with the potential use of Better Care Funding. Ensuring the relevant and proportionate level of funding is awarded for health organisations to deliver required changes is crucial to supporting the start of the significant transformation required. Further pooling of the health and care budgets would inevitably impact on future secondary care allocations – this has not been factored into this plan and would create issues regarding the longer term viability of our financial plan.
Demand: ***because emergency activity is growing at an unprecedented rate***	As noted, emergency services have been significantly affected by increases in demand and acuity over the past year. Following the substantial pressures across the whole health system, one of the key elements of our Clinical Strategy is the priority to deliver a different whole health system model of urgent care. The growth in emergency activity must be demand managed going forward to provide greater stability and minimise disruption whilst ensuring that patients are seen and treated in the most appropriate setting. In this plan we have set out the changes being taken forward including to the way emergency care is provided at the Foundation Trust. Supported by our partners, it is also essential to significantly develop the infrastructure and management of urgent care across the whole health economy, through revised models including further increasing the use of assistive technologies such as Telemedicine.
Regulation: ***because we can't regulate local health economies into sustainability***	At a national level we need support from regulatory bodies to help shift the focus from system failure and turn around to accelerating conditions for sustainability.
Financial Levers: ***because we need to shift from perverse incentives to***	We need the existing national contracting and funding architecture to change to incentivise transformation, with amendments that do not further increase our current level of efficiency challenge as a result of tariff changes, inflationary assumptions or through the disproportionate use of penalties or sanctions.

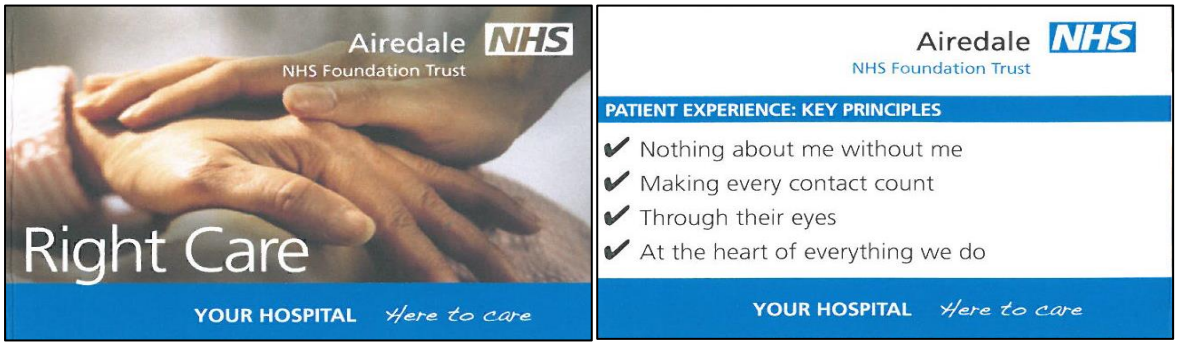
enabling and rewarding the changes we aspire to	We also require commissioners to consider introducing new tariff structures to support elective work, the expansion of year of care models for people with long term conditions, alternative funding arrangements for emergency and urgent care and to look at ways to jointly manage financial risk across the sector, including the potential for transitional funding and residual support to support changes.
Workforce transformation: ***because 70% of spend is tied up in workforce***	There is a need to address the significant workforce challenges ahead, with an ageing workforce, increasing levels of sub-specialisation and national shortfalls in available clinical staff. Nationally, there is a need for reform of the GP and consultant contracts to support transformation rather than be a barrier, for medical education and training to support a shift from specialisation to generalisation and a need to review Agenda For Change terms and conditions. These are essential to support the changes in future workforce planning aligned to delivering a sustainable service offer.
Organisational Form*: because one size doesn't fit all*	We see the significant opportunities for developing vertical integration in pursuit of our **Future State Right Care Strategy.** However we require other partners support in progressing this as well. We need an approach that enables us to close the gap between primary and secondary care and one which supports small hospitals to be sustainable. This does not mean we are planning for the status quo. We are particularly keen to explore the Accountable Care Organisation model such as that deployed in Northumbria, with the potential for groups of providers to deliver care to a defined population, providing quality outcomes within an agreed budget. Again, providing this in partnership with others is critical to being part of a sustainable health and care economy going forward.

In this plan we have identified a number of potential opportunities through our Right Care Portfolio to address the Foundation Trusts projected £29.9m efficiency requirements over the five years.

Taking a prudent view, we would risk assess the potential shortfall on these opportunities at this stage to be about £14.6m. With additional premium costs to service annual increasing levels of demand, the total gap could be as high as £18m across the period of the plan.

Whilst we do have contingencies in place, these may well be required to service increasing expenditure pressures (e.g. workforce). This makes the delivery of the critical success factors above essential to supporting the closing of this gap over the five years.

1. Vision



In 2013/2014, the Trust Board of Directors set out an overarching vision of **Right Care** for the Foundation Trust and highlighted this through establishing four key principles relating to further improving the Patient Experience, as shown in the illustration above.

In setting out this approach, the intention is to;

- Simplify the Foundation Trusts vision statement to ensure clarity, recognition and ownership amongst all key stakeholders;
- Respond to the current demands and challenges in the health and care system, by reaffirming the key value that we are about and continuously working towards;
- Provide a central theme to support the strategy the Foundation Trust is developing;

Looking ahead to the next five years, the **Right Care** vision is embedded at the heart of the Foundation Trusts overall approach and this has also been adopted by our partners in the local health economy.

This is in line with the national vision set out in the NHS England guidance Everyone Counts: Planning for Patients 2014/2015 to 2018/2019 of providing high quality care for all, now and for future generations.

As outlined in the forthcoming sections, we have assessed the current national, regional and local context and challenges and in response have adapted the strategic approach to be taken in delivering this vision over the next five years.

This is set out in the following sections of this plan and shows how we plan to develop our **Future State Right Care** approach, empowering patients in orchestrating services around their needs and in doing so being able to access compassionate, safe, dignified care.

In our **Future State Right Care** strategy, services are integrated around the individual patient needs, not those of the organisations providing the care. Patients are able to access support 24 hours a day, 7 days a week, 365 days a year, utilising innovative technology to help reduce the need for hospital care, where appropriate.

Health and social care partners, everyone involved in meeting the individual patient needs, work together and integrate around the needs of the individual.

As an organisation this is how we will sustain and secure our future.

This five year strategy sets out our approach and the solutions we are generating through;

- **Market Analysis and Context**; Assessing the current long term strategic context and direction, the economic position of the Local Health Economy and our own financial framework, the current demands and trends in activity, the healthcare needs of the population and our position in the health and care market;
- **Clinical Strategy and Quality Improvement**; Setting out our **Future State Right Care Strategy** to transform the way health and care is provided for our population, underpinned by a Quality Improvement framework to ensure our services remain safe and improve the patient experience;
- **Risks to Sustainability, Strategic Options and Strategic Plans**; In light of the market analysis and context, the strategic options we have considered and our plans for developing new models of care in partnership with our stakeholders, the requirement to drive through the transformation of urgent and emergency care across the district, delivering greater levels of integration across the Unit of Planning supported through Better Care Funding
- **Financial Framework;** Meeting our financial obligations;
- **Capital Investment**; How we plan to further invest in our clinical services, providing modern, high quality, state of the art buildings and equipment and implementing innovative technology solutions to transform care.

The key principles underpinning the delivery of both this vision and strategy in the years ahead also remain similar to those outlined over the previous couple of years;

- Safety, quality, patient experience and staff engagement are at the centre of everything the organisation does;
- The need to be serious about efficiency and business control in order to be viable;
- Transforming care is critical to the delivery our strategy, through developing our existing services whilst also co-designing and delivering new ways of working in conjunction with our partners;
- Ensuring the care of the vulnerable, elderly, patients with dementia and those with nutrition needs are given priority focus.
- Ensuring a greater focus on clinical leadership, engagement and outcomes.
- Ensuring the value of the Airedale brand is retained in the community and beyond.
- The requirement to adapt the size and shape of the workforce and estate in response to the updated service strategy.

Overall, our vision is about an approach focussed on embedding the key principles of good experience, by continuously assessing the impact and outcome for patients in the way services are provided and to which our Board are fully committed to delivering;

"…we overtly demonstrate by our actions and behaviours that we understand the impact of our decisions on patients…" AFT Board reflecting on Francis Report

2. Market Analysis and Context

A. Strategic Context and Direction: The Long Term Challenge

In constructing this plan, the Board of Directors have considered the key health and social care strategic and policy drivers, as well as the current and future challenges. These in turn have influenced the development of our strategy and plan. Key considerations include;

- **New senior leadership** at the top of the NHS, the impact on the overall strategic direction, clarification of priorities and in particular the current focus on the positive value and role of smaller hospitals for patients in the health and care system;
- **Sustainability of health and social care economies** in the face of the affordability challenge, which with sustained flat funding at a national level requires a £30bn reduction by 2020/2021. In addition, recent announcements suggest a further gap of around £2bn nationally that shall further impact on secondary care organisations across the next five years. In the Bradford, Airedale, Wharfedale and Craven District (in line with our Health and Well Being Board footprint) this amounts to a £364m reduction over the five years to 2018/2019;
- **Demographic impact** of a growing, ageing, population, with increasing numbers of people suffering from dementia, long term conditions and clinical multi-morbidities;
- **Sustainability of the District General Hospital model** and the viability of smaller organisations in the current economic climate without change;
- **Financial Frameworks –** Potential opportunity for introducing new funding models as an enabler rather than a barrier to supporting service transformation. These could include new tariff structures for some elective conditions, the expansion of year of care models for people with long term conditions, alternative funding arrangements for emergency and urgent care and jointly managing financial risk across the sector. Future focus is also likely to include how various performance incentive schemes are structured, supporting further improvements in quality and outcomes;
- **Better Care Fund** – Concern that whilst this supports transformation it won't necessarily reduce the overall levels of demand in the short term for health and care services. The potential for stricter criteria against which the impact outcomes shall be measured have also been considered;
- **Competition** – Increasing appetite for flexibility and competition across the sector;
- **Increasing demands and expectations** - meeting the requirement for greater efficiencies whilst delivering an increased quality of service experience for patients;
- **Increasing public confidence and participation**, empowering the public, increased openness and transparency in particular on safety and quality, an intense public interest and focus, responding to national reports e.g. Francis, Berwick;
- **Safe Staffing Levels** – Increasing national focus that may require future investment;
- **Push for centralisation** challenging the approach towards larger volumes and increased clinical thresholds;
- **Increase in and impact of specialist commissioning** with the development of a five year national strategy in July 2014, the potential shift in what is defined as specialised, how this is organised and greater amounts of this work being commissioned by CCG's;
- **Primary Care Commissioning** – Potential for a different model in future where there might be fewer individual practices and increasing CCG collaborative work;

- **Organisational Forms** – Consideration of various options (Chains, Federations, Joint Ventures, Franchises), assessing what is required going forward, the potential for full partnerships and concept of an Accountable Care Organisation.
- **New Models of Care** - Centralist v Extensivist: What is the optimum size, shape and configuration required? Potential to be involved in accelerator programmes to help get significant transformational schemes up and running as an exemplar site;
- **System leadership** – Maturity of the new model nationally and locally to support the required pace of transformation. The implementation of Health and Well Being Boards as decision makers and Provider level involvement creates significant opportunities for change. Health and Well Being Boards will have a crucial role to play in future years in terms of local system leadership and it is essential to support their development. There is also a need to promote health requirements alongside Local Authority priority areas (e.g. reducing inequality and poverty).
- **Reconfiguration plans** – Movement in policy towards supporting the development of Provider Chains, Centres of Excellence and links with Academic Health Science Networks rather than formal mergers and acquisitions;
- **Addressing financial meltdown predictions** predicted to occur during the timeline of this planning cycle;
- **Managing the current focus on short term delivery** (e.g. A&E 4 hour standard) with an understanding that the Performance Management of the health and care sector is likely to get even tighter going forward;
- A greater push for **increasing care closer to or at home 24/7/365**, **7 day working, further developing Community assets** and **Service Integration Plans** with a need to assess / address the affordability of progressing**;**
- Assessing the impact of and future plans for **innovative assistive technologies**;
- **Public Health** approach to measuring and managing not just the flow of health care consumption but the stock of population health risk (which in time would convert into future health care consumption).
- **Private sector provision** in the geographical area;
- **Changing clinical behaviours** through organisational development, further developing our clinical leadership and ensuring our clinicians are fully involved in developing and implementing our plans;
- **Workforce and pay transformation**: Ensuring we have the right skill mix within the workforce to reflect shifts in service provision and having succession arrangements in place. In addition we have assessed the current approach to reviewing national terms and conditions and the requirement to work with the Unions;
- **Changing planning horizon**; Development of two and five year plans, co-designed on a health and care economy footprint with partners, consistent across the Local Health Economy and the requirement to deliver these at pace;
- **Delivery of key priorities**; NHS Constitution, Provider License and Risk Assessment Framework, Care Quality Commission framework, NHS Mandate, Clinical Outcomes Framework, Everyone Counts: Planning For Patients 2014/2015 to 2018/2019.

Monitor Small Hospital Review

In addition, we have considered some of the key outcomes from the recently commissioned Monitor Small Hospital review, including;

- Increasing scale may not resolve problems and mergers may not be the answer;
- Emerging view that it is possibly better to focus on core services development and reduce the long tail of smaller specialties;
- Remote rural areas may need to consider creative ways to develop new tariffs to support service delivery, transformation and sustainability;
- Costs of 24/7 consultant delivered care may have greater impact on small providers and so require different thinking on the approach to be taken;
- Some services may require a different skill mix to provide the same quality of care;
- Centralisation of some specialties in fewer larger centres may create opportunities to gain more volumes in the core specialties left in smaller hospitals;
- Greater opportunities to develop integrated care, creating new service provision and new markets;

"New technologies such as telemedicine might also help. For example, Airedale Hospital NHS Foundation Trust runs a centre for telehealth: a video-based clinical consultation platform for outpatient and follow-up appointments. The system was introduced in 2006 and was first used in prisons. It has since been expanded to include nursing and residential care homes as well as supporting people with Chronic Obstructive Pulmonary Disease (COPD) in their own homes. It is now being considered for other services such as mental health, pain management and end-of-life care. Airedale Hospital NHS Foundation Trust told us that this service has led to a 69% reduction in A&E attendances from care homes and a 60% reduction in A&E attendances from COPD patients in the past 12 months. The system is currently in approximately 15 prisons and 220 nursing homes and supports around 3,100 patients".

Monitor Small Hospital Review

"Our smaller acute hospitals tend to have an average of around 400 inpatient beds, and there is little convincing evidence that the minimum efficient scale is higher than that".

Simon Stevens, NHS Chief Executive

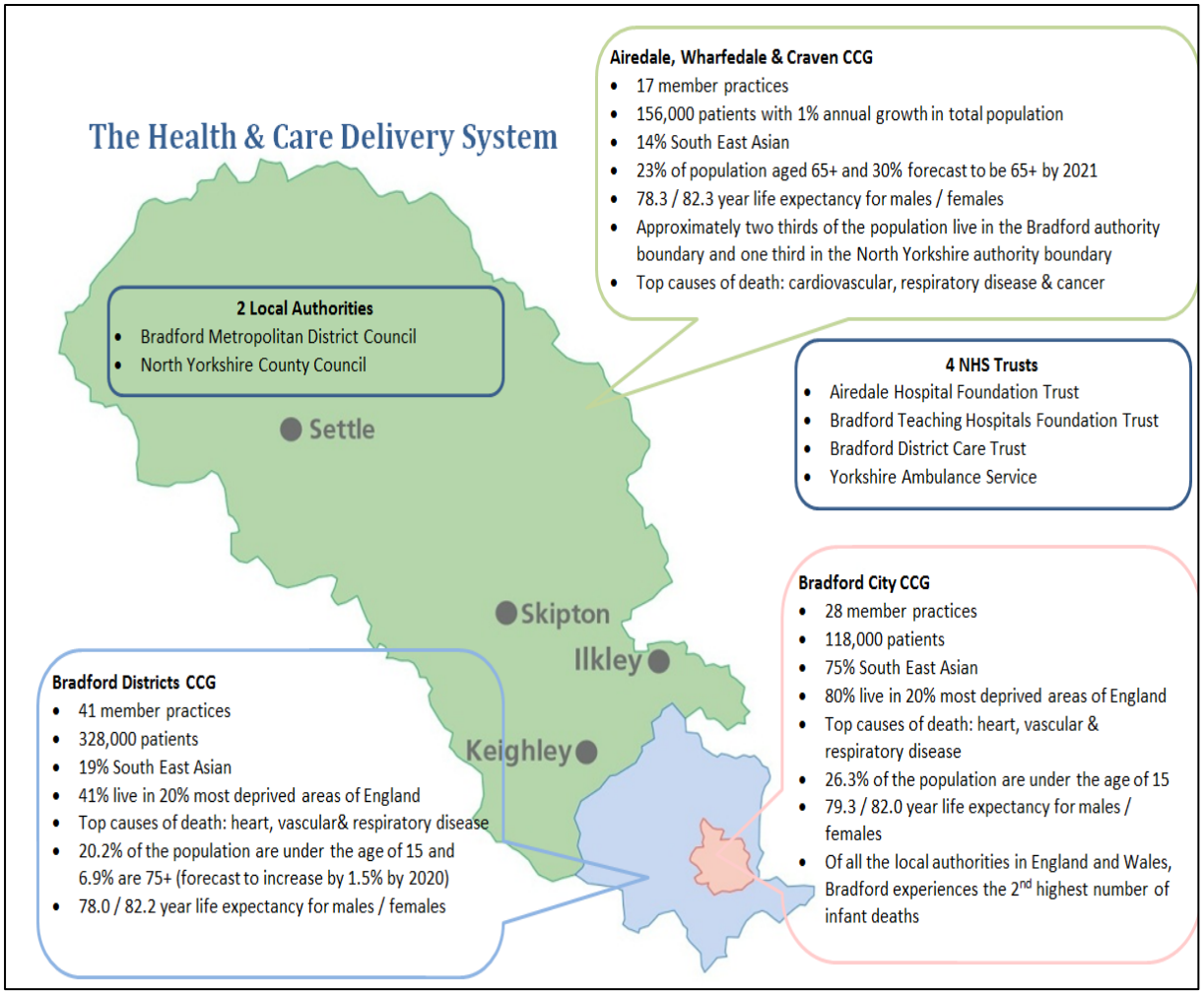
"Small general hospitals appear to be much loved and economically important parts of local communities. Where services are centralised it needs to be for the right reasons, based on evidence and having tested the scope for alternative and imaginative models. New ideas such as networked models; enhanced roles for academic health science centres; the use of telemedicine to connect specialists; the integration of hospitals into the local community, social care and primary care system; and the recently floated idea of chains, all offer alternative and more immediately realisable solutions".

Nigel Edwards, Kings Fund

B. Local Health Economy Financial Framework 2014/2015 to 2018/2019

Alongside other organisations in the Airedale, Bradford, Wharfedale and Craven health and care economy, we have been contributing to the initial development of a five year strategy for the districts Unit of Planning. To date this has developed an overarching strategic view for submission to NHS England in June that is to be followed up with a more detailed plan in September.

The Local Health Economy Unit of Planning covers the following areas and organisations;



The detail highlighted on the previous pages reflects a summary of the main challenges being faced over the next five years both within individual organisations and across the Local Health Economy.

The estimated funding deficit in the Bradford, Airedale, Wharfedale and Craven District is approximately £364m by 2018/2019, based on commissioner and provider cash releasing efficiencies of at least 4% per annum for the next 5 years and Local Authority funding reductions in social care.

Following work completed involving all stakeholders and reported through to the Health and Well Being Board, this is summarised in the table and graph below;

Bradford and District:
The need to transform health & social care to respond to population change & financial challenge

Not only is the population of Bradford & Airedale growing and changing in a way that will increase the demand for health and social care, but the district faces unprecedented financial challenges. Whilst responding to **increasing demand** we must make **significant savings** and continue to **improve the quality** of services and outcomes achieved.

NHS:
–By 2019 demand for NHS services will outstrip supply (assuming funding and population changes at the predicted rate)
–Nationally it is predicted that £30bn of efficiencies will be required to ensure that the NHS can meet this demand
–Alongside finding these efficiencies we need to ensure sure the continuous improvement of quality and outcomes
COUNCIL:
–Proposal – reduce LA budget by £115m over 3 years (assumes use of £15m Better care fund) – this will be achieved through reducing the budget.

By 2018/19 we need to save **£364million** across the health and social care economy in Bradford & Airedale.

	2014/15	2015/16	2016/17	2017/18	2018/19	Total
Local authority	£38m	£51m	£26m	£26m	£26m	£167m
Health						
• NHS Providers	£32m	£25m	£26m	£26	£26	£135m
• CCGs	£8m	£13m	£9m	£7m	£7m	£43.5m
• NHS England – Direct Commissioning	£3m	£2m	£2m	£2m	£2m	£11m
• NHS England – Specialist Services	£3m	£1m	£1m	£1m	£1m	£7m
Total Health	**£46m**	**£41m**	**£38m**	**£36m**	**£36m**	**£197m**
TOTAL	**£84m**	**£92m**	**£64m**	**£62m**	**£62m**	**£364m**

To respond to population changes and financial challenge **large-scale transformational change** is needed in the way in which we deliver health and social care.

Source: Bradford Metropolitan District Council

This projected position is at a time where there are continuing increases in the demand for services, an ageing population with a greater prevalence of long term conditions and higher levels of public and patient expectation about access to and the quality and safety of services being provided. All of these are expected to continue to increase over the five years of this plan. The £364m position reflects the do nothing scenario.

Each of the individual organisations with the Local Health Economy are currently working on plans within their own area which should significantly reduce the size of the overall district gap. For example, incorporated in the figure above is the Foundation Trusts own efficiency requirement of £29.9m over the 5 years and through our Right Care Portfolio we have already identified potential opportunities of £28m in schemes. Taking individual organisation plans into account, there will however still be a gap to close to ensure sustainability across the Unit of Planning.

As outlined in this plan, there are a number of areas where strategic options have been considered and where plans are being developed in collaboration with our partners that shall further contribute to closing the gap by progressing the required transformation at pace and scale. This includes setting out and delivering our shared ambition for our local communities, to improve health and well being, to radically transform the health and care delivery system, developing more community based care to better meet individual needs, further improving the overall experience for patients, all set against the significant financial challenge facing local health and care economies over the next five years.

Examples of our approach include;

- Co-designing and implementing new models of care (e.g. for frail, elderly, vulnerable patients) through holistic, co-ordinated, care;
- Helping patients self manage their care and be better supported at or closer to home;
- Transforming the way urgent and emergency care is provided across the district;
- Ensuring services are configured so they can provide high quality safe services for patients in the right setting and in a sustainable way
- Greater collaborative working between Providers and potential partners through networked arrangements in response to current service line positions, supporting progression towards 7 day working and closing the gap between primary and secondary care;
- The need to address key levers to delivering all of the above (e.g. ensuring partnership engagement)
- Completely transforming the way some existing services are provided (e.g. Outpatients)

The draft submission of the Local Health Economy 5 year Strategic Plan is being forwarded to NHS England on 20th June. The full, detailed plan is due to be submitted to NHS England in September and through the district wide planning groups, further work is taking place over the next three months to further progress these areas.

C. Airedale NHS Foundation Trust Financial Framework 2014/2015 to 2018/2019
The Foundation Trusts main high level financial planning assumptions for the next five years are as follows;

Across the five years 2014/2015 to 2018/2019, we are currently anticipating the overall size of the financial envelope for our main commissioning CCG's shall be broadly in line with the 2013/2014 base allocation, after adjusting for any growth and pooling arrangements to support Better Care Funding for transformation.

This position assumes there is no additional impact on secondary care allocations to support Better Care Funding to those already factored in. The recent announcement suggesting a further gap of around £2bn nationally that shall further impact on secondary care organisations across the next five years has not yet been factored into this plan. Furthermore, the model above assumes Non-Elective activity, which has shown increases in both demand and acuity over the past few years, remains in line with 2013/2014 levels.

Our key planning assumptions for tariff inflation, efficiency requirements and growth assume a steady state for 2014/2015 and 2015/2016, with slightly increased inflationary pressures and reduced growth assumptions across the period 2016/2017 to 2018/2019.

The pressures around increased pension contributions and auto enrolment have now been calculated and included from 2015/2016.

As noted in our two year Operational Plan, the Foundation Trust has taken the decision to plan for balance over the next two years whilst focusing on sustainability and quality of services. Then, as work around the strategic direction takes shape in years 3 to 5, it is expected that small surpluses will be generated without impacting on quality. Our overall growth assumptions across the five years of this plan are broadly in line with the national assumptions regarding revenue resource growth and demographic changes;

National Assumptions Area	2014/2015	2015/2016	2016/2017	2017/2018	2018/2019
Revenue Resource Growth	2.15%	1.70%	1.80%	1.70%	1.70%
Demographic Growth	1.00%	1.00%	1.00%	1.00%	1.00%

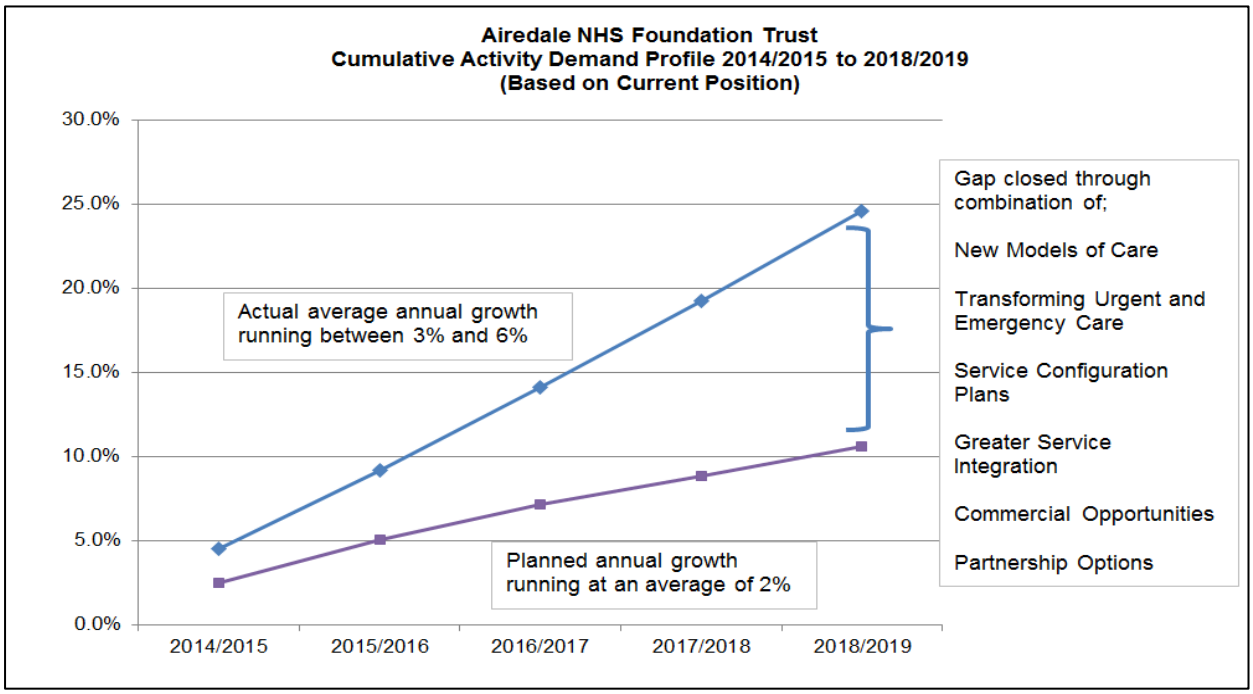
Activity Trends
Over the previous three years, activity levels for Airedale NHS Foundation Trust have increased/decreased across the main points of delivery as follows;

- Emergency activity is increasing at an average rate of 7.4% per year (and over the past five years running at an average rate of 3% increase per annum)
- Inpatient Elective activity is reducing at an average rate of 2.9% per year
- Day Case Elective activity is increasing at an average rate of 6.0% per year
- First Outpatients activity is increasing at an average rate of 2.4% per year

Within this, specific examples of some of the changes in demand reflecting changes in the healthcare needs of the population include;

- Average annual increase in Diabetes and Endocrinology Outpatient activity of 17.5%
- Average annual increase for Gastroenterology Day Case activity of 7.5%
- Average annual increases for Ophthalmology Day Case activity of 20%

Financial Plan, Efficiency Requirements and Continuity of Services



As highlighted above, our overall approach in this 5 year plan is to assume an annual activity growth of 2%. This is set against historical increases of between 3% and 6% each year and we plan to close this gap through a number of strategic options.

The impact of the transformation work is critical to the delivery of our overall strategy. Anticipated reductions over time as a result of this work (e.g. for non-elective activity) are also important to support development in other areas (e.g. shorter waits for planned care).

Based on the planned annual growth levels, the position shows that we need to generate £29.9m of efficiency savings over the five years 2014/2015 and 2018/2019 to ensure (assuming all other factors are on plan) a Continuity of Services Risk Rating of 3.

In our strategic planning process we have focussed on identifying schemes to support this through a mixture of;

- In line with Monitor planning assumptions a 2% internal transactional group level cost improvement programme;
- The development of transformational schemes through our Right Care Portfolio.

Across both models a number of key items are covered including increasing productivity, skill mix, procurement savings, greater use of innovation and technology, income generation and a number of partnership opportunities. In delivering the above plan, the Foundation Trust anticipates being able to maintain a strong cash balance.

D. Healthcare Needs Assessment

Work from the Public Health Analysis Team has highlighted the following current state and future needs assessment for the local population;

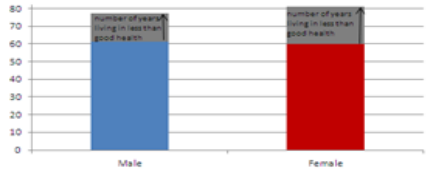
Bradford and District: The Current Population

People are living **longer.** In men the average life expectancy is 78 – this compares to 81 in women.

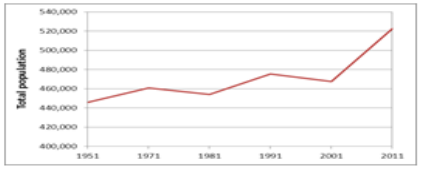
Life Expectancy in males and females in Bradford and Airedale

People – especially women - live a significant proportion of their lives in **poor health.**

Life Expectancy and Healthy Life Expectancy in males and females in Bradford and Airedale



Over the last 60 years the population of Bradford and Airedale has grown significantly – in the last ten years alone the population has grown by **11%** - that's a **rate of growth faster** than observed for a long time.



Fast growing age groups in the last 10 years

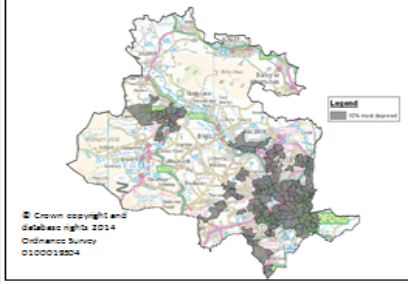
23% increase in the number of 0-4 year olds

26% increase in the number of 55-59 year olds

17% increase in the number of over 85s

157,287 people or **31%** of the population- live in areas included in the 10% most deprived in England.

One in ten people provide some level of unpaid care.



Over **12,400** older people need assistance in maintaining independent living.

A further **8,200** people require help with one or more activities of daily living.

Almost **38,000** children live in relative poverty; that is **27%** of the population aged 18 years and under

Public Health Analysis Team — City of Bradford Metropolitan District Council

Bradford and District: Wider determinants of health

The health and well-being of a population is greatly shaped by a wide variety of social, economic and environmental factors; improvements in health outcomes cannot be made without action on the **wider determinants of health**.

27% of Bradford households have an annual household income less than **£15,000**. In some areas of the district the proportion is as high as **40%**.

12.6 % of all households in Bradford and Airedale live in fuel poverty.

That is more than **25,000** households, and is the **highest rate** in Yorkshire and the Humber.

In extreme cases fuel poverty can lead to a deterioration in health requiring hospital admission and sometimes death **(excess winter deaths)** – especially in the elderly and those with long-term conditions such as COPD.

Between August 2011 and July 2012 there were **318 excess winter deaths – 141** of these were in people aged 85+.

10% of houses in the district are overcrowded.

Overcrowding can impact on family relationships, child development and health.

Independent research suggests the **economic downturn** is likely to have **lasting consequences** on health and wellbeing (Source: UCL Institute of Health Equity).

5.5% of 16-18 year olds are not in education, employment or training (NEETs) – this is **lower** than the proportion regionally and nationally.

48.8% of children achieve a good level of development at the end of reception, however, the proportion of children achieving a good level of development varies across the district.

Educational attainment is improving, but remains lower than England and similar areas, and thus remains one of the biggest challenges to the district – **52%** of pupils gain 5+ A*-C grade GCSEs inc. English and Maths.

Public Health Analysis Team — City of Bradford Metropolitan District Council

Bradford and District: Lifestyle factors

People's health behaviours are widely known to affect their health and risk of **dying early**.

56,891 adults, equivalent to **12%** of the population aged 17+, are registered as obese.

However, estimates suggest that as many as **88,000** adults in Bradford & Airedale are obese.

10% of young people are regular smokers by the time they reach **Year 10.**

32 young people aged 11-15 years old take up smoking **every week** in Bradford & Airedale.

50% of adults achieve at least 150 minutes of physical activity per week in accordance with UK Chief Medical Officer recommended guidelines on physical activity.

More disadvantaged groups are more likely to have a **cluster of unhealthy behaviours** – smoking, drinking, low consumption of fruit and vegetables, low levels of physical activity.

19.3% of drinkers drink more than the recommended safe limits.

Hospital admissions due to alcohol related harm increased by **34%** between 2008 and 2011.

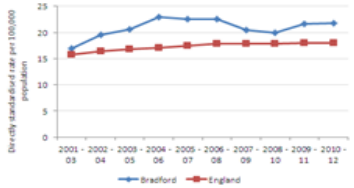
Smoking rates have fallen over the years, however:

1 in 5 adults in Bradford and Airedale still smoke

And inequalities remain: **1 in 3** routine and manual workers smoke.

1 in every 2 smokers will **die** from a smoking related disease

Premature mortality (under 75 mortality rate) from liver disease is the 3rd highest in the region, and may be moving away from the England rate.



22% of children are overweight or obese when measured in Reception.

35% of children are overweight or obese when measured in Year 6.

Obesity levels are **highest** in some of the more **deprived** wards in Bradford and Airedale.

Bradford and District: Long term conditions (LTCs)

Treatment and care for people with long-term conditions is estimated to take up around

£7 in every £10 **£££££££**

of total health and social care expenditure

People with LTCs now account for approximately:

50% of all GP appointments

64% of all outpatient appointments and over

70% of all inpatient bed days

Research suggests that approximately **one in four** patients in acute hospitals have dementia – and that these needs are not currently well responded to.

More and more people live with more than one LTC – this is often known as multi-morbidity. This is important because people with **multi-morbidity**:

have ↑ problems with the coordination of their care;

experience ↑ medical errors; and

are ↑ likely to be admitted to hospital.

About **1,000** people a year or **3 people every day** experience a stroke in Bradford & Airedale. As a result many experience long lasting consequences and require assistance with daily living.

Every stroke costs health and social care more than **£12,000** in the **first year** alone.

Between **25%** and **50%** of people with high blood pressure do not have their blood pressure adequately controlled. **1/3** of patients with **diabetes** have poorly controlled blood pressure, resulting in potentially avoidable hospital admissions.

QOF Disease Registers

Quality and Outcomes Framework (QOF) registers are a count of the cases known to primary care. The actual number of people who have these conditions is likely to be higher than recorded on the QOF register.

For example, although there are **3,714** people on the dementia register, it is estimated that there are at least **6,000** people in Bradford and Airedale with **dementia**. (Source: Bradford District Dementia Action Alliance)

Bradford and District: Health and Social Care use

2,400 people received short-term support by way of rehabilitation and re-ablement last year.

Each year **11,500** people receive longer-term services – **8,500** at any one time.

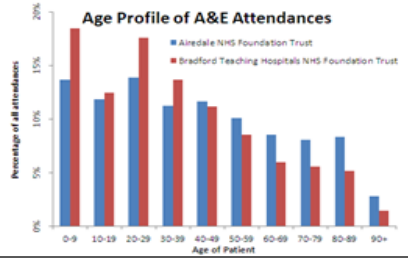
1,940 people are supported to live in residential or nursing homes

90% of patient contacts with the NHS occur in primary care.

In Bradford & Airedale there are an estimated **3.4 million** contacts with **primary care** each year.

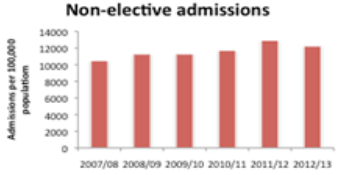
The number of contacts is expected to increase as the population increases and grows older – this is despite a **real terms decrease in funding** for primary care.

There are **more than 190,000** A&E attendances each year at the two hospital trusts.



However, the age profile of those attending A&E at the two trusts is very different: At BTHFT, **18%** of those who attend are aged under 10. At Airedale, it's only **14%.** Conversely, at Airedale **19%** of those who attend are aged over 70. At BTHFT, it's **12%**.

Historically **non-elective (unplanned) admission rates** have **increased** year on year; however, in the last year there has been a **small reduction**.

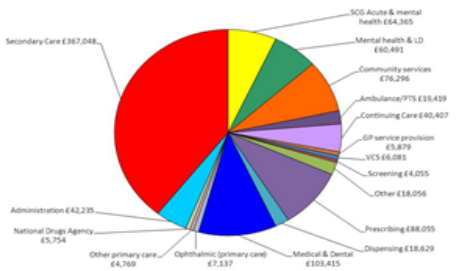


The Kings Fund estimates that ambulatory care-sensitive conditions (ACSCs) account for **1 in every 6** emergency hospital admissions in England – these cases could potentially have been managed in primary care. Rates also tend to be higher in areas which are **more deprived**.

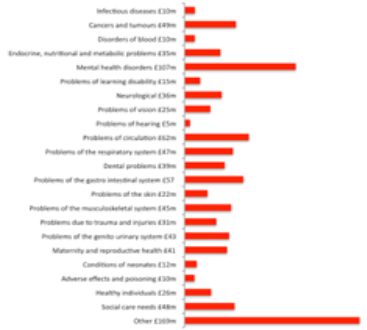
Bradford and District: Where we spend our money

Each year we spend around **£932 million** on health services for the population of Bradford & Airedale.

Health spend by service type (£000s)



Health spend by programme budget category

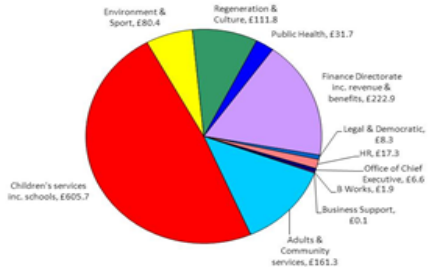


Mental Health is one of the **highest areas of spend** - £107 million.

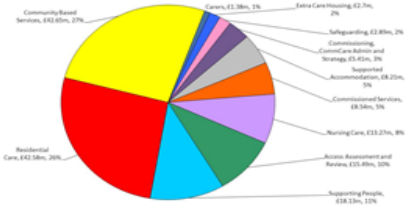
The local authority spends around **£1.2 billion** each year

Each year we spend around **£160 million** on social care for adults across the district

Local Authority Gross Expenditure (£000s)



Adult Social Care Budget (£000s)



Bradford and District: Future Population

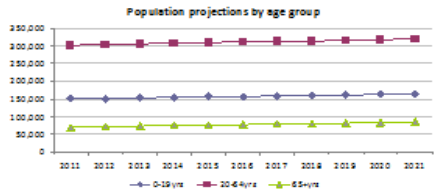
The population of Bradford and Airedale is growing – **by 2019** it is expected to increase by **7%.**

The population is ageing. By 2019 there will be:

12,013 more people aged 65+

2,194 more people aged 85+

As well as more older people, the **number of children** is also expected to **increase**. By 2019 there will be 4,525 more children aged 0-4 than at present



There will be an increasing number of older people **living on their own.** Living alone is a significant predictor of hospital admission.

The working age population is not expected to ⇧ at the same pace as the older population. Age dependency ratios will become more and more important.

Will the working age population be able to care for older relatives?

There is a significant amount of uncertainty around the role of older people in the community in 20 years time. Much will depend on the health of the population as they enter old age, highlighting the importance of healthy ageing.

Impact on housing: with an increasing older population we need appropriate accommodation to support people to live independently in their own homes, meaning they are less reliant on health and care services.

Demographic change will mean that:

- The number of frail elderly will ↑
- The number of people with LTCs will ↑
- The number of people with more than 1 LTC will ↑

An increasing number of frail older people will have care needs and require **support to live at home**.

It is predicted that by 2020:

- Over **15,500** people aged 65+ will be unable to manage at least one activity on their own.
- **22,300** people aged 65+ will experience a fall, with **1,730** admitted to hospital as a result.
- More than **6,000** people aged 65+ will have dementia.
- More than **2,000** people age 65+ will have a longstanding health condition caused by a stroke.
- **7,153** people aged 65+ will be living with moderate or severe visual impairment.

As a result of the changing dynamics of Bradford and Airedale, A&E, inpatient and outpatient **hospital services** are expected to experience a **5% increase in cost and activity**.

Non-elective (i.e. unplanned) services will see the **greatest increases** with a 5.4% increase in costs and 5.5% increase in activity (Source: Public Health)

Public Health Analysis Team — City of Bradford Metropolitan District Council

Key Points for consideration;

- Population – If population is fully engaged with Districts health promotion approach there is the potential for an extra 5 years of life expectancy going forward (and 3 years additional life expectancy if this continues as at present);
- Existence of health inequalities across the District;
- 1 in 10 people likely to become carers in the future;
- Poverty – Focus on reducing child poverty and the potential downstream impacts;
- Uncertainty on long term effects of economic downturn, but potential impact on how people access primary and secondary care;
- Increased interest from employers on health of workforce;
- Lifestyle issues continue to cause number of Long Term Conditions;
- Clustering of unhealthy behaviours in certain parts of population expected to continue. Drinking beyond safe limits expected to increase with potential impact on multiple clinical areas e.g. liver disease, hypertension;
- Childhood obesity stabilising, but unclear if this shall continue. Adult obesity less positive – Expected that 1 in 3 people shall be obese by 2019 and likely to be 30,000 more cases of heart disease, stroke.
- Long Term Conditions – In future older people may be healthier due to previous success in reducing prevalence of smoking and general improvements in wider factors such as education and income.

E. Developing The Strategic Approach Across The Local Health Economy

In light of the position outlined in Sections A to D, there is recognition amongst stakeholders that health and social care organisations need to work together if the growing demands on the health and care delivery system are to be met, whilst at the same time achieving savings on the scale highlighted in a sustainable way. This presents an unprecedented challenge to the local health and care economy and requires a radical approach to be delivered at pace in transforming service delivery over the next few years.

In response, the following groups have been established to provide cross organisational strategic planning for specific areas across the district;

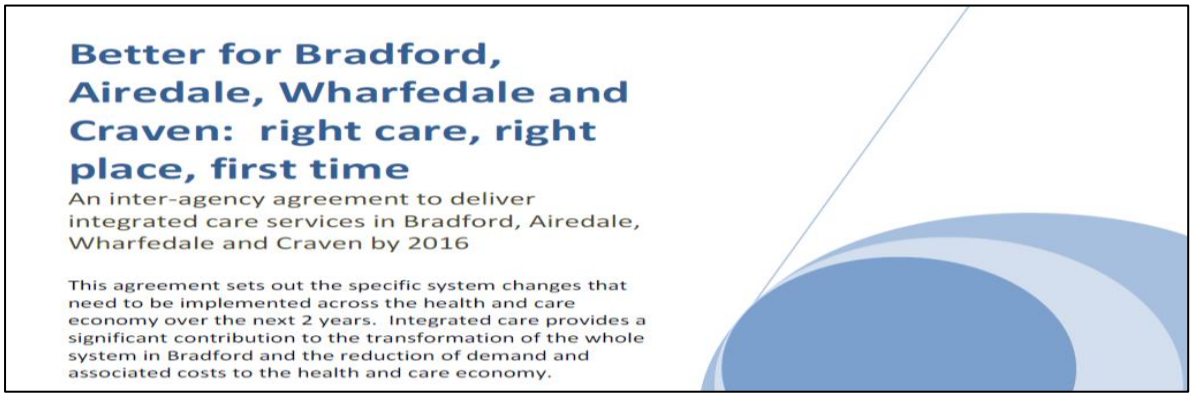
Integration and Change Board (ICB) – Chief Executive and Director level engagement across the district, focussed on system leadership and setting the strategic direction for the next two to five years across the Unit of Planning. The overall aim of the work is to create a sustainable health and care economy that supports people to be healthy, well and independent. Board level commitments are in place to support partnership working towards delivering this and the Foundation Trust is promoting its **Future State Right Care** approach in the development of the approach.

There are a number of challenges to overcome, including;

- Health and care economy financial challenge estimated as £364m over the next 5 years;
- Demographic impact on demand for health and care services over next 5 years;
- Need to address the workforce challenges ahead, including increasing levels of specialist work and national shortfalls in clinical staff;
- Both patient engagement and involvement needs to be strengthened to understand and support the priorities and ensure ownership of the proposed interventions;
- Implementing and delivering the radical transformation required through engagement and ownership of the front line teams, support of local community and delivery of whole system at pace and scale;
- Requirement for developing new models of care;
- Responding to increased focus on national standards (e.g. A&E) and increasing requirements (e.g. 7 day working);
- Sustainability – Viability of Provider and Commissioner landscape over long term;
- Clinical Commissioners - Lack of whole system commissioning;
- Need to close the gap between primary and secondary care
- Potential impact of direct and specialist commissioning;
- Lack of system wide workforce and estates strategies at this stage;
- Access to primary care and inconsistent model of delivery;
- Impact on Organisation Form as a result of changes to service models;
- Need to transform current urgent care system;
- Sustainability of some clinical services;
- Focus on current operational delivery at the expense of planning for the future;

The approach taking place is developing a shared view of values, principles and objectives that are being set out and worked towards in partnership. Joint health and social care plans

to utilise the Better Care Funding are also being co-ordinated through the Integration and Change Board before presentation to the Health and Wellbeing Board.



The objectives shall include the areas listed in Section 3b of this plan and need to address key elements including;

- Funding flows to support the transformation and delivery of different models of care;
- Assessing the correct organisational form going forward;
- Developing the provider landscape model;
- Assessing sustainability linked to service reviews and partnership options;
- Developing system leadership across the local Health and Care Economy

Feedback from the public and patients are essential to the development and implementation and so engagement is crucial in the design and delivery (e.g. using individual patient stories, patient networks and events, Health and Well Being hubs, Voluntary and Community Sector events, focus groups and joint events with the Local Authority).

Urgent Care Board - Director level engagement across the district to agree strategic urgent care plans, winter funding arrangements, supporting the delivery of the Winter Plan and the transformation of urgent and emergency care infrastructure requirements. Following recent gateway announcements, including to how supporting funding flows will be managed, this work shall now be part of the new System Resilience Groups.

Transformation and Integration Group (TIG) - Director level engagement at individual district level to agree key strategic requirements supporting the transformation and integration agenda.

Integrated Care Programme for Adults – This group is focussing on two main areas; the further integration of community services and the integration of intermediate care services. Through this group, we are currently involved in the shared electronic patient record accelerator project for the district that supports the **Future State Right Care** approach.

Through a number of these groups, the longer term planning for sustainability has started and is progressing including assessing the optimum model of organisational form required for future years (e.g. collaboration/partnerships/chain).

Commissioning Landscape

The commissioning landscape through the new Health and Care system means the current main commissioners for the Foundation Trust are as follows;

- Airedale, Wharfedale and Craven CCG are our main CCG commissioner and are hosting contract arrangements for 2014/2015.
- Bradford District and Bradford City CCG's that cover key areas on the surrounding boundaries including Bingley and Baildon, are associates.
- East Lancashire CCG including areas such as Colne and Pendle, is an associate.
- North Leeds CCG, that covers the key area of Menston, is an associate.
- NHS England Area Teams from the South and West Yorkshire regions are commissioning specialist services, secondary care dental, immunisation, screening and Offender Health.
- The Local Authority organisational footprint has three Health and Well Being Boards covering Bradford Metropolitan District Council, North Yorkshire County Council and Lancashire County Council. These are central to the Better Care Funding allocations.

Commissioning Intentions

The CCG Commissioning Intentions, as highlighted in our two Year Operational Plan, give an indication of local CCG priorities for both 2014/2015 and 2015/2016 and indicate how the CCG's intend to commission, develop and improve services to realise the **Future State Right Care** vision for provision of health and social care services for the population of Airedale, Wharfedale and Craven both in the medium and longer term.

The key strategic objectives for the CCG's take into account the Joint Strategic Needs Assessment for Bradford, Airedale and Craven, NHS Outcomes Framework and additional evidence based benchmarked data, all of which underpin the commissioning intentions to;

- Transform Urgent Care
- Transform Planned Care
- Transform Mental Health Services
- Reduce Health Inequalities and Increase Health Promotion
- Achieve Excellence in Prescribing and Medicine Management
- Maintain Safe, High Quality and Effective Care

The population is projected to increase and in alignment with the national trend the population growth of the older adult is expected to rise at a higher rate. Along with the rise in the population size, there will be an increase in care requirements for people in particular with long term conditions, ambulatory care sensitive conditions and cognitive impairment and dementia. Given the increasingly tighter financial environment in which both health and care have to operate, the need to transform and radically redesign services at pace and scale to meet the future care needs of the population, and ensure sustainability of service provision has never been as critical. Some of the key commissioning priorities in the next two years include;

- Mortality Surveillance notes that overall mortality at Airedale NHS Foundation Trust is 2% lower than the national average given the patient case-mix. This equates to 25 fewer deaths per year than the average number for the case-mix. However mortality

amongst patients with a primary diagnosis of COPD at the Foundation Trust was higher than nationally and there were 18 more deaths per year than average among patients with this diagnosis. In view of this, respiratory quality improvement, pathway development and pulmonary rehabilitation are a service development priority for our CCG's.

- This focus on integrated working will also extend to the recognition, diagnosis and treatment of people with dementia.
- YPHO, Commissioning for Value and Right Care Packs 2012 for Airedale, Wharfedale and Craven CCG indicates a higher prevalence / worse outcomes for chronic heart disease, atrial fibrillation, heart failure and stroke and higher prevalence of TIA and dementia.
- Prevalence of Chronic Obstructive Pulmonary Disease, diabetes and asthma is above the England average, but average for the district.
- Whilst having a higher than average prevalence of epilepsy, the neurological spend per weighted head of population is low, with a corresponding higher than average mortality.
- Paediatric admissions for asthma and LRTI (Lower Respiratory Tract Infection) compare poorly with the national average**.**
- Unplanned hospitalisation for chronic ambulatory sensitive conditions (adults) is significantly worse than the national average.

These indicators have been taken into account when considering the CCGs commissioning intentions and service development plans for 2014/2015 and 2015/2016. The economic, demographic, health and social care challenges of a growing population cannot be solved in isolation and these issues can only be considered as a whole health and social care system. Commissioners and providers are therefore developing strategies which align across the health and social care economy. In recognition of this, the local system leaders through the Transformation and Integration Group (TIG) have committed to deliver a new system of care and have taken a collaborative, partnership approach to develop an ambitious vision **'The Future State – Right Care'.** To deliver this, together, will require a vibrant, innovative and sustainable health and care economy, informed by clinical engagement and assured by clinical governance and the Health and Wellbeing Board.

In future years Commissioners shall also have a greater focus of Mandate and Outcomes Framework requirements;

10 CC Work

In addition, in our Strategic Plans, we have considered the potential impact of the collaborative working currently taking place across all 10CCG's in West Yorkshire looking at the potential for collaborative planning and commissioning on a West Yorkshire footprint covering;

- Stroke
- Paediatrics
- Cancer
- Emergency Care

NHS England Commissioning

A five year national strategy for specialist commissioning is due to be published by NHS England in July 2014 together with revised arrangements for how this activity is likely to be commissioned going forward.

As highlighted in some national reviews, there is an expectation that some specialist services may be centralised into a smaller number of units over the next 2 years. At the same time, the scope of what is categorised as specialist is likely to change with a number of services transferring back to being commissioned by CCG's in future which presents possible opportunities as highlighted below.

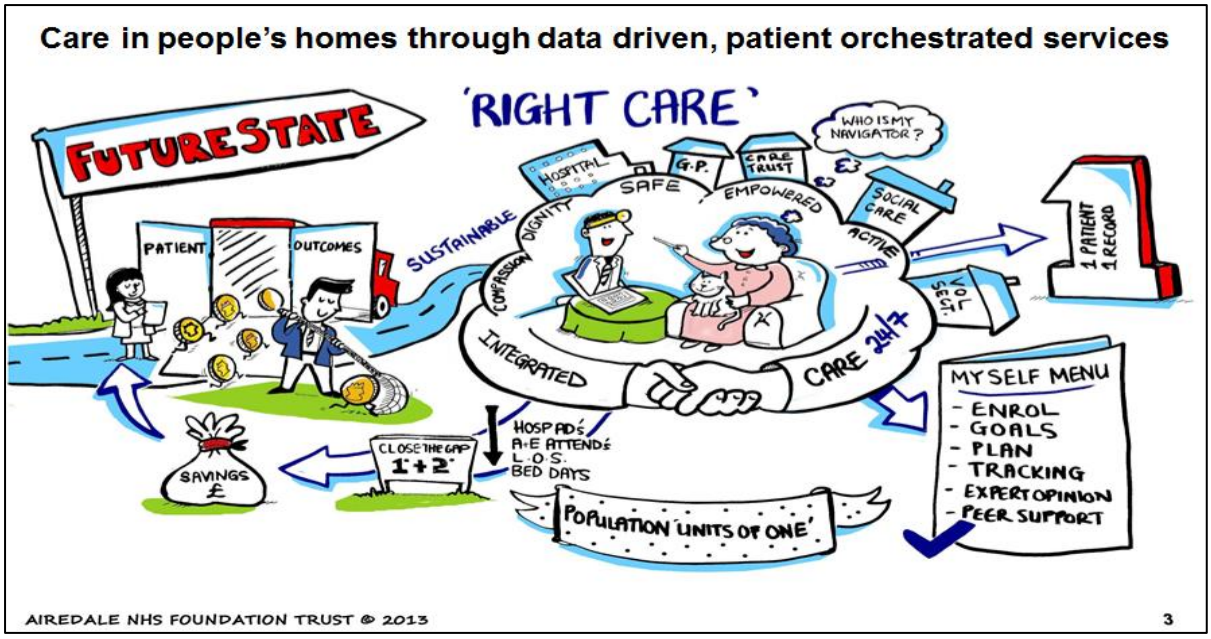
Whilst this presents potential service configuration changes, for example in Vascular Surgery and Stroke, our current expectation is that we shall continue to provide the majority of these services.

In total, these services currently amount to approximately £10.4m of income. As highlighted in our two year Operational Plan, there is a potential risk regarding the payment mechanism for Chemotherapy Services, which is currently being reviewed by NHS England. The total value of risk is up to £3.5m with the current model for drug costs likely to change. In line with the NHS England commissioning intentions, we expect any change to be managed with reasonable levels of transition. We have agreed a £1m transition for 2014/2015, however the period over which the remaining amount would transition still needs to be agreed. The potential for Chemotherapy services to return to CCG commissioning presents an opportunity to consider a local payment methodology which could be beneficial to supporting sustainability going forward.

At the present time, Neonatal Critical Care Services are completing derogation by training three staff members over 2014/2015 and 2015/2016 in order to meet required service ratios in the national service specification**.** The cost of backfill is not seen as material (maximum £25k) and should secure income in the short term of approximately £1.8m per year. Overall, mitigation shall require detailed risk assessments for down side planning (clinical, financial and strategic) in the event that the service model for these areas is different in the future (i.e. the potential for service reconfiguration into larger specialist centres).

3. Clinical Strategy and Quality Improvement

A. Clinical Strategy Right Care



Building on our progress, the Trust Board of Directors have given considerable thought through strategic planning sessions in year, to our future and the next steps in our journey as we strive to meet all the challenges highlighted in the previous sections. We have also engaged widely with our stakeholders on this approach and have an agreed shared ambition for patients.

We want our local community to trust us to always provide the **Right Care**, with our focus on putting patients at the heart of everything we do. We need to enable patients to be in control of their health and care and respond to their needs and wants in a way that best suits them, when it is safe to do so.

As set out in the diagram above, our patient is at the heart of the picture, supported at home in a way that best meets their needs, enabled by technology. In **Future State Right Care**, the patient accesses compassionate, safe care that empowers them, helps make them active and which retains their dignity. Care is integrated around the patient needs, not those of the organisations providing the care. In this approach, patients are able to access support 24/7/365, either at or closer to home, utilising community level support and technology where appropriate.

We plan to build on our ground breaking work using telemedicine to support patients with long term conditions at home and in nursing, residential care homes and hospices, which is having a significant impact in terms of avoiding hospital admissions and reducing A&E attendances. Health and social care partners, everyone involved in meeting the patients needs, work together and integrate around the needs of the individual. Our work through our service transformation programme to date, to develop multi-disciplinary integrated community based teams building on the great work of the Airedale and Craven Collaborative Team (ACT) puts us in a great position to achieve this integration ambition for our local community.

In **Right Care**, the patient has help to navigate them through the system which can often appear confusing and fragmented.

Supporting the patient through their self care goals is key to how we will cope with growing population demand – supporting individuals like this patient to achieve their life goals by helping to build independence and confidence.

Central to achieving the **Right Care** vision is the development of one patient, one record, with the various health and social care providers all having access to one patient record. With our recent investment in a new Patient Administration System and a significant central allocation received for the Safer Hospitals Safer Wards programme, we are one of the first hospitals in the country to have a shared record with primary care. This is soon to be followed with social services also being integrated with this system. This will really help avoid duplication, enable front line teams to make quicker decisions and better communicate with other services, which in turn improves safety and enhances patient experience. This also helps to close the gap between primary and secondary care.

Having shared records and self care devices will help us build up a detailed picture of the health status of our local population's health status. This in turn helps us better understand their needs and helps us respond to population needs in a better way, tailored to the needs of the individual.

Impact

Our own results from work in the community and telemedicine are demonstrating the impact **Right Care** can have for an individual patient as well as for the rest of the health and social care economy.

Reductions in A&E attendances, avoidance of hospital admissions, reductions in length of stay and actual bed days make for a much better patient experience and outcome and free up resources for reinvestment which help support sustainability.

Evidence from self care programmes also demonstrates similar results in terms of reductions in hospital use and show increased confidence and sense of well being in individual patients.

Patients, their carers and health care professionals often share their frustration at the duplication and delay due to handoffs between GPs and hospitals. We believe working in the way described with a single shared patient record, multi-disciplinary integrated teams and care closer to home helps reduce the gap between primary and secondary care.

Sustainability

By working in this way, we can see a way to enable individual patients improve their health and well being as well as care experience. This in turn reduces demand for care, generating savings for reinvestment and to cope with growing demand in a climate of reducing resources.

This is how we will sustain and secure our future.

We start our journey towards achieving this vision over the next five years from a solid base.

During 2013/2014 we were one of the first wave of NHS Trusts to be visited as part of the new approach to how the Care Quality Commission inspects acute hospitals. The Trusts were chosen as collectively they represented the variation in NHS hospital care in England and Airedale NHS Foundation Trust was chosen for inspection due to its low risk scores. The news for Airedale was positive with the report highlighting many areas of good practice which showed safe and effective care that was well led and responsive to the needs of our patients. The Care Quality Commission found much to commend the hospital. They also found some areas of practice that could improve, which we are currently looking at, although there were no actions arising that the Foundation Trust must take in response.

We have a strong financial position, plan and healthy cash balance and have delivered the majority of our service performance requirements.

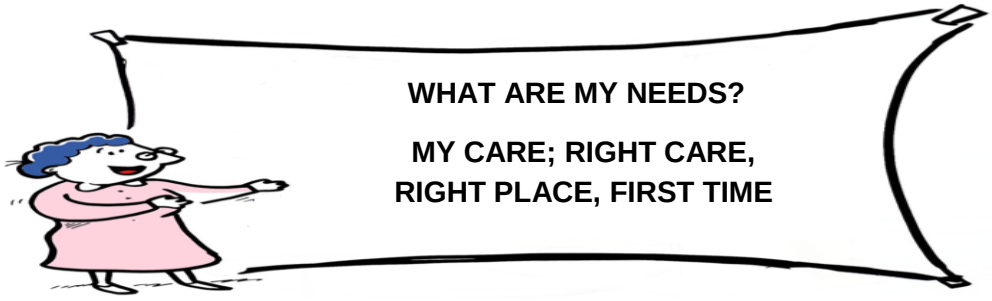
Over the past few years, we have made GP and Local Authority engagement and developing good relationships with commissioners (both health and social care) a key priority and look forward to continuing to strengthen these partnerships. Executive Directors also meet regularly with our local MP's and attend and support the Overview and Scrutiny process.

Our size and being coterminous with our main commissioner, Airedale, Wharfedale and Craven CCG, is a significant benefit compared to some health economies and our System One shared electronic patient record potential seen as a huge advantage.

We recognise that creating a sustainable local health and social care economy is right for local people and we are innovating and changing to play our part in supporting commissioners to invest their allocations as efficiently as possible through the co-design, promotion, influence and delivery of new approaches to care. We recognise we need to radically alter the current hospital dominated delivery model at pace to one based on diversified services, designed in partnership with our commissioners, stakeholders and community, delivered at the most appropriate point for patients.

We have been promoting our **Right Care Future State** Strategy and this has gained considerable support at a number of levels;
Trust – Right Care Strategy launched and promoted across the Foundation Trust for the best part of a year. We have also put in place supporting portfolio arrangements regarding transformation programmes using the Right Care approach;
Local – Significant engagement with local stakeholders. Our CCG's are now playing a leading role in promoting this strategic approach which is extremely powerful in promoting closer working across primary and secondary care;
National – We have gained recognition as part of NHS Futures, been highlighted in national papers and publications regarding the approach we are pursuing and attracted significant interest from senior leaders and politicians;
International – We have been attracting interest and are gaining an increasing profile at an international level around leadership and innovation in healthcare improvement.

Seeing our Future State Right Care Strategy from a patient's perspective;



Personal Orchestrated Care

- I want to live a life informed about my health and lifestyle with choice and empowerment to express myself in the world I live in, with personal meaning to live as full and an enriched life as possible.
- I want to be treated as an individual with respect, dignity and compassion.
- I have the right to make my own decisions and for my family/carers to be involved and informed with my consent.

In order to do this, I may require:

- Access to information, Health Promotion, Health Education, Prevention, Independence, Care Navigation, Care and Self Care, Maintenance, Provision, Feedback, Empowerment, Engagement, Person centred meaningful goals, Confidence, Self-Orchestrated care which respects my wishes.

In order to fulfil a model based on person centred choice, the following menu will be available to people to support them:

- Systm One - One patient One record, Telemedicine, Telehealth, Health Apps

Patient Navigation & Experience Centre

- PALS, Patient Experience Lead, Patient Information Lead, Equality and Diversity Lead, Volunteers, Telemedicine Hub (Long Term Conditions, Outpatients, Gold Line supporting palliative care, Carer Support, Patient Information Hub, Directory of Services)
- Single Point of Contact: Extensivists, Enhanced Primary Care, Public Health, Voluntary Sector, Integrated Health and Social Care, Community Matron/CNS/Case Managers/ CPN, Expert Patient Programmes / Education /Living with (peer support educational/experiential programmes), Exercise Prescriptions. Healthy living goals/choice, Urgent intervention - right care, right place, first time, Use of Systm One, Communication

Enablers to Support - MY CARE - RIGHT CARE, RIGHT PLACE, FIRST TIME

- Real Time Monitoring, Statutory Surveys, Survey Monkey, NHS Choices, Care Connect, WIFI, Social Media, Rapid Response, Single Point of Contact, Patient Navigation and Experience Centre Post Discharge, Transfer of Care Survey, In Care Surveys, Volunteers Focus Groups, Support Groups, Governors Membership, Communications Department Media Quality Account

Vehicle For Delivery – Our Integrated Health, Social Care and Voluntary Sector Staff

- Care services are there to improve our health and well-being, supporting us to keep mentally and physically well.
- To get better when we are ill and when we cannot fully recover, to stay as well as we can to the end of our lives.
- The NHS works at the limits of science - bringing the highest levels of human knowledge and skill to save lives and improve health.
- Care services touch our lives at times of basic human need, when care and compassion are what matter most (The NHS Constitution).

Right Care Patient Experience - Key Principles

- Nothing about me without me, Making every contact count, Through their eyes, At the heart of everything we do

Services should be: Caring, Effective, Well Led, Safe and Responsive

- Induction, Mandatory update training, Customer care specific training, Right Care Vision and Narrative, Leadership - Board to Ward, Visibility, Empowerment, Organisational Development, Education & Development, Integrated Care Training, Calderdale FW

Principles & Culture across the Organisation

- Our patients, their family/carers are at the heart of all that we do. The impact of decision making at all levels must always be considered in respect of the effect on the patients and their families.
- The Board needs to overtly demonstrate by actions and behaviours that we understand the *impact of our decisions on our patients* - board reports and decisions will consider the impact on the patient.
- The Board must ensure focus on patient health/wellbeing as well as clinical health and wellbeing.
- Directors enhance their visibility and connectivity with patients, families, public and staff across the organisation.
- The Essential Standards of Caring for People with Dignity & Respect are shared, embedded and lived out for the benefit of our patients and public to seek to ensure that people are treated with dignity, respect, care and compassion.
- Trust provides inclusive care and safeguards our patients, being minded to act in their best interests, assessing capacity at all times and ensuring advocacy when indicated.
- Patient experience principles and measures are embedded across all governance structures and the organisation (Ward to Board).
- Our staff are recruited against NHS Core Values and these are incorporated within job descriptions, with performance being monitored against these.
- Staff are challenged in respect of their personal response (to the Francis Report) and this will be measured through their performance and appraisal in respect of care and compassion.
- The Complaints Policy and process has been updated in line with the recommendations from the Clwydd/Hart review of the complaints process across the NHS.
- High quality – safe, effective and personal care is delivered as a given for our patients.

Quality Improvement Framework
Supporting the **Right Care** approach, we are developing our Quality Improvement framework to further provide a clear and effective structure to deliver safe and effective health care.

Principles behind our Quality Improvement Framework
Our Quality Improvement approach is underpinned by three supporting domains:-

Patient Safety
- Will I feel safe?
- Will I be protected from avoidable harm and death?

Patient Experience
- Will I feel cared for?
- Will I be treated with compassion, dignity and respect in a clean, safe and well led environment?

Patient Outcomes and Effective Care
- How will my clinical procedure be carried out?
- What will its results be?
- Is it best practice?
- What about my quality of life after treatment?

The key goals for improving safer care are:
- Reduce avoidable mortality;
- Reduce harm;
- Reliable care

The overriding principles of the Quality Improvement framework include:
- There is clarity of structure and reporting arrangements;
- There is clarity of responsibilities (no gaps, no duplication);
- Board to Ward approach in place;
- Intelligent analysis of data and trends by experts;
- The Quality Account is at the centre of Quality Improvement with ongoing review and expansion to include all core parts of the Organisation;
- Trust Board involvement and assurance

The framework is aiming to further deliver a comprehensive, Trust wide overview of all metrics available to the organisation – the horizontal view.

In addition, the principle of ‘Ward to Board’ communication in Quality Improvement is necessary, and the Clinical Specialty Assurance Committee (sub-committee of the Board of Directors) is being developed to provide this vertical alignment.

Quality Assurance
Our approach to Quality Assurance builds on the key principles outlined in the Monitor Quality Governance Framework.

The Trust Board of Directors receive monthly reports on the key quality indicators in the Quality Improvement Strategy and Quality Account. These indicators are also included in the monthly Integrated Governance Dashboards which show progress for Quality, Safety, Clinical Outcomes, Patient Experience, Finance and Performance, Service Development and Transformation, Staff Engagement and Workforce Development. The positions are reviewed as a whole to assure that one area is not having a materially adverse impact on another.

The Board also receive a detailed quarterly Quality and Safety report on key objectives outlined in the Quality Improvement Strategy, individual patient experience accounts at each of their monthly meetings and are involved in regular Board to Ward quality and safety visits. As a sub-committee to the Board, the Executive Assurance Group (which involves all Executive Directors) oversees the Foundation Trusts Risk Management process on a monthly basis. Key exceptions are reported through to the Board of Directors.

Construction of the Strategic Plan
As in previous years, all Clinical Groups presented their forward plans to the Board of Directors covering the key items in both the 2 Year Operational and 5 Year Strategic Plans. The reviews considered all aspects of service performance, including patient experience, quality and safety, alongside financial and service information. The construction of both the Operational and Strategic Plans is based on the output from this process as well as Board strategy planning sessions and Board to Council meetings to ensure the views of Governors and Members are included. The Operational Plan was presented to Governors in April and the Strategic Plan shall be presented to the Governors at their July meeting. Together they are a central reference point for managing the organisations key objectives.

In addition to developing our own 5 year Strategic Plan, we have supported the development of the overarching 5 year Strategic Plan for the Unit of Planning through the Integration and Change Board. Partners are working together to develop the high level plan for submission in June that shall be followed by a more detailed plan in September.


4. Risks to Sustainability, Strategic Options and Strategic Plans

Having considered the strategic, market and financial context, the development of our Right Care Clinical Strategy and Quality Improvement process, we have considered the risks to sustainability and the potential strategic options in developing our approach over the next five years.

All of these have taken account of four key considerations;

- The need to address the scale of financial challenge across the health and social care economy over the next five years;
- To ensure service resilience in the face of the demands and challenges ahead;
- The requirement for all stakeholders in the health and care economy to drive through the required transformation changes at pace;
- Addressing the workforce transformation required

In doing so, our approach requires us to play our part in responding by;

- Follow our guiding principles;
- Demonstrating appropriate behaviours;
- Understanding our business;
- Considering our options;
- Continuously progressing our **Right Care** strategy;

There are a number of strategic options we have considered. There is recognition nationally that in many places current service models are successful and durable, however in order to address the challenges ahead there are a number of potential new variants that need to be considered.

In this section we set out a summary of the key areas we see as key to securing our sustainability over the next five years.

(a) Developing New Models of Care

We recognise that creating a sustainable local health and social care economy is right for our local population and we are innovating and changing to play our part in supporting commissioners to invest their allocations as efficiently as possible through the co-design, promotion, influence and delivery of new approaches to care.

We recognise we need to radically alter the current hospital dominated delivery model at pace to one based on diversified services, designed in partnership with our commissioners, stakeholders and community, delivered at the most appropriate point for patients.

We want to transform services that leads to a change in traditional health care flows, with fewer hospital admissions, more low level interventions provided through new models of care, all supported by an increased use of technology.

The Extensivist and Enhanced Primary Care Models

The NHS and social care system in its current configuration cannot cope with the expanding demands of the growing, ageing population. It is currently predicted that by 2025, over a quarter of the population in England will have one or more long term condition. The resulting increase in demand, combined with rising costs, contributes to the overall affordability challenge at both a local and national level as highlighted earlier.

In particular, the system is currently struggling to meet requirements of frail, vulnerable and elderly people, often who live alone or who are in nursing or residential care homes and are coping with complex clinical or multiple long term conditions.

Following various national presentations we gave last year regarding our **Right Care** strategy, the Foundation Trust with local health and social care partners were invited to participate in a series of facilitated workshops to explore new models of care. The work, supported by NHS England and facilitated by the Oliver Wyman international consultancy firm, is gathering pace and appears to be enthusing clinicians from both primary, community and secondary care as well as attracting national interest.

NHS England have agreed to fund this work, which supports us as a health and social care economy, to progress the development of new care models which have the potential to transform health and social care systems and improve quality and outcomes.

Initially under the auspices of the Airedale, Wharfedale and Craven Transformation and Integration Group, there is the possibility of this approach being rolled out to reflect the district wide Unit of Planning footprint. There is also an option for the work to become a national accelerator site with additional central resource available to support adoption of change at pace and scale.

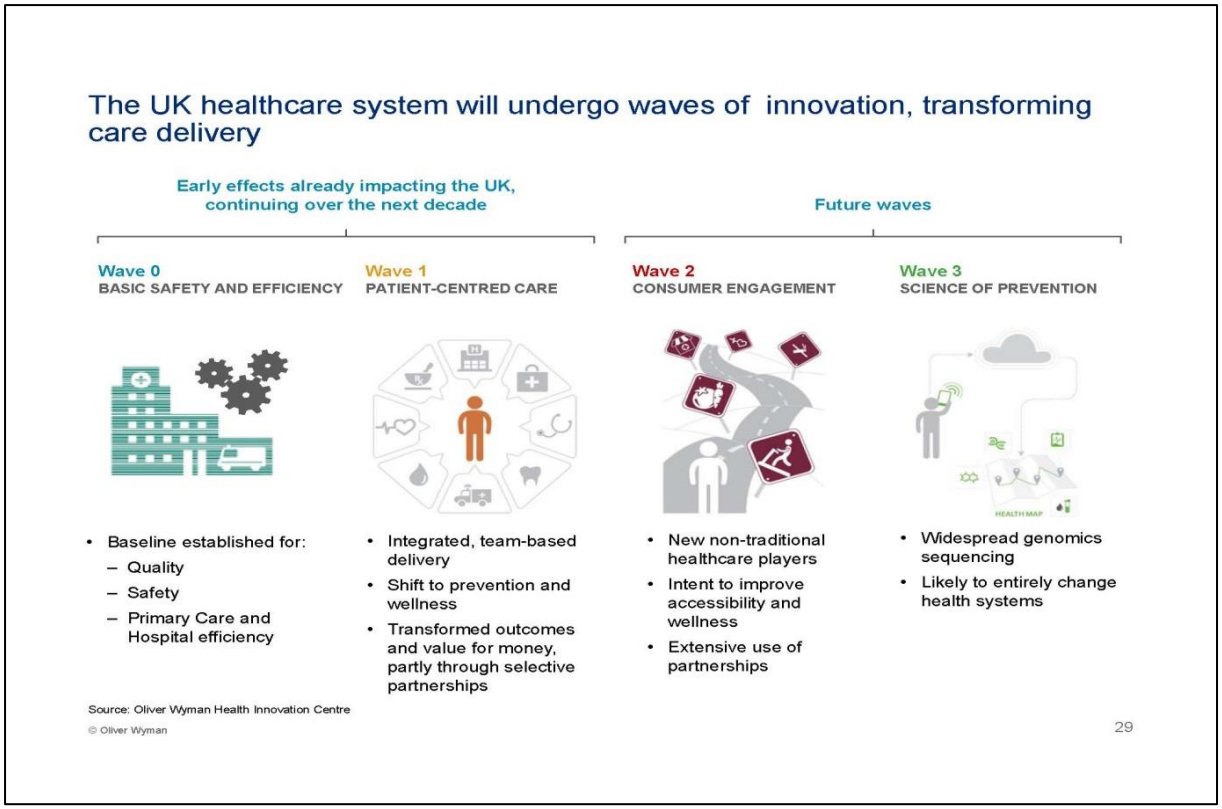
An assessment of key activity and access inputs from across the health and care economy was completed including primary care activity, prescribing levels, diagnostic testing, secondary care activity (emergency, elective, day case, outpatient, A&E) community service, mental health and social care activity. The respective tariff and income generated by point of delivery was also reviewed for each category.

Work with senior clinical leads from across both primary and secondary care has helped inform this work. This has currently led to a conclusion about the potential to pursue two possible options in the locality;

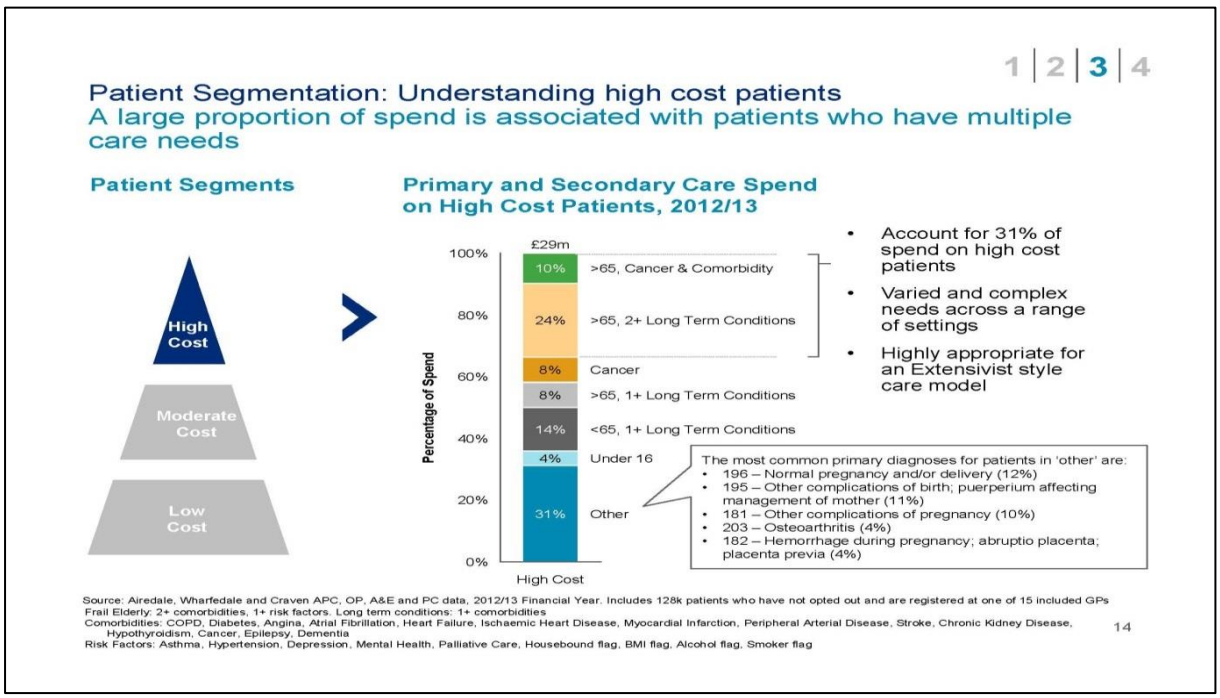
- An **Extensivist model**, providing holistic co-ordinated and comprehensive care to the most frail, elderly and needy patients;
- An **Enhanced Primary Care model** to provide comprehensive and convenient medical care to patients with long term conditions.

A third option, to progress **Ambulatory Surgery** (i.e. Day Case or Outpatient Procedure centres) is continuing to be considered, although at this time requires greater scale to be a viable option.

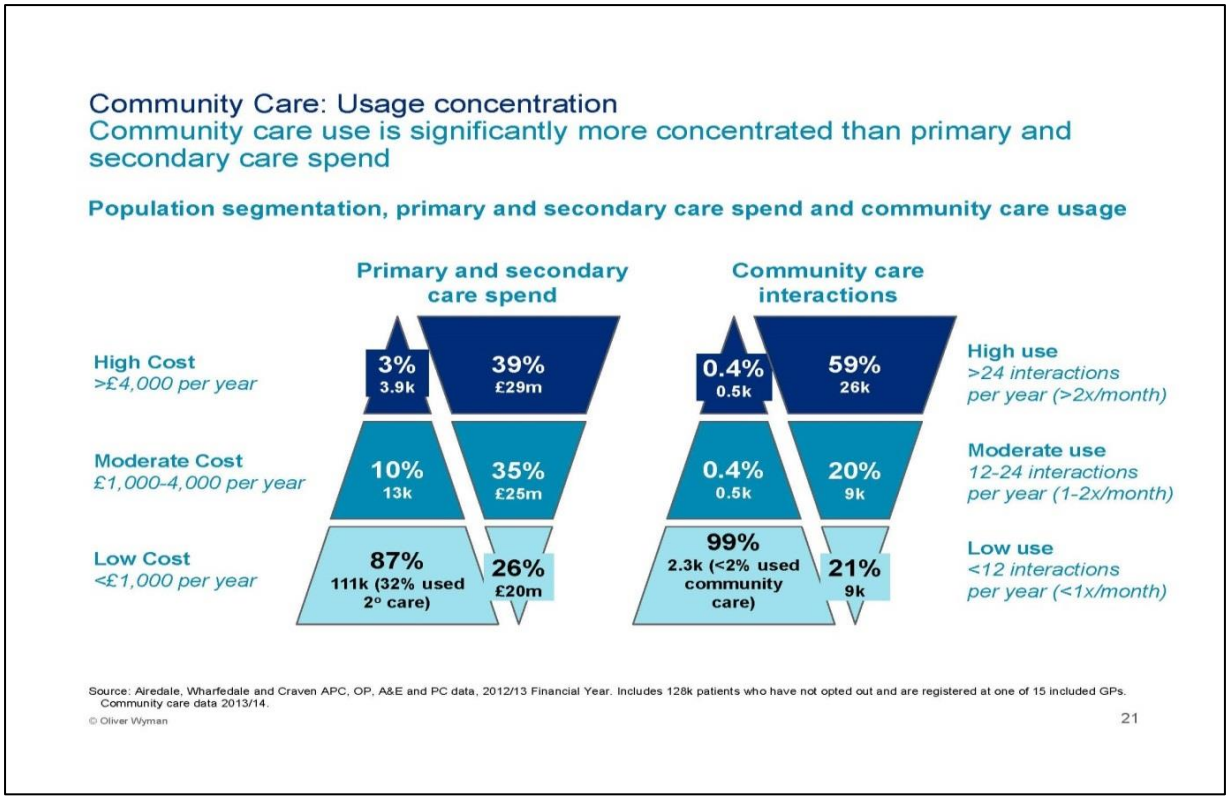
The key summary outputs from the Oliver Wyman© consultancy work completed and which are being considered across the District are highlighted over the next few pages;



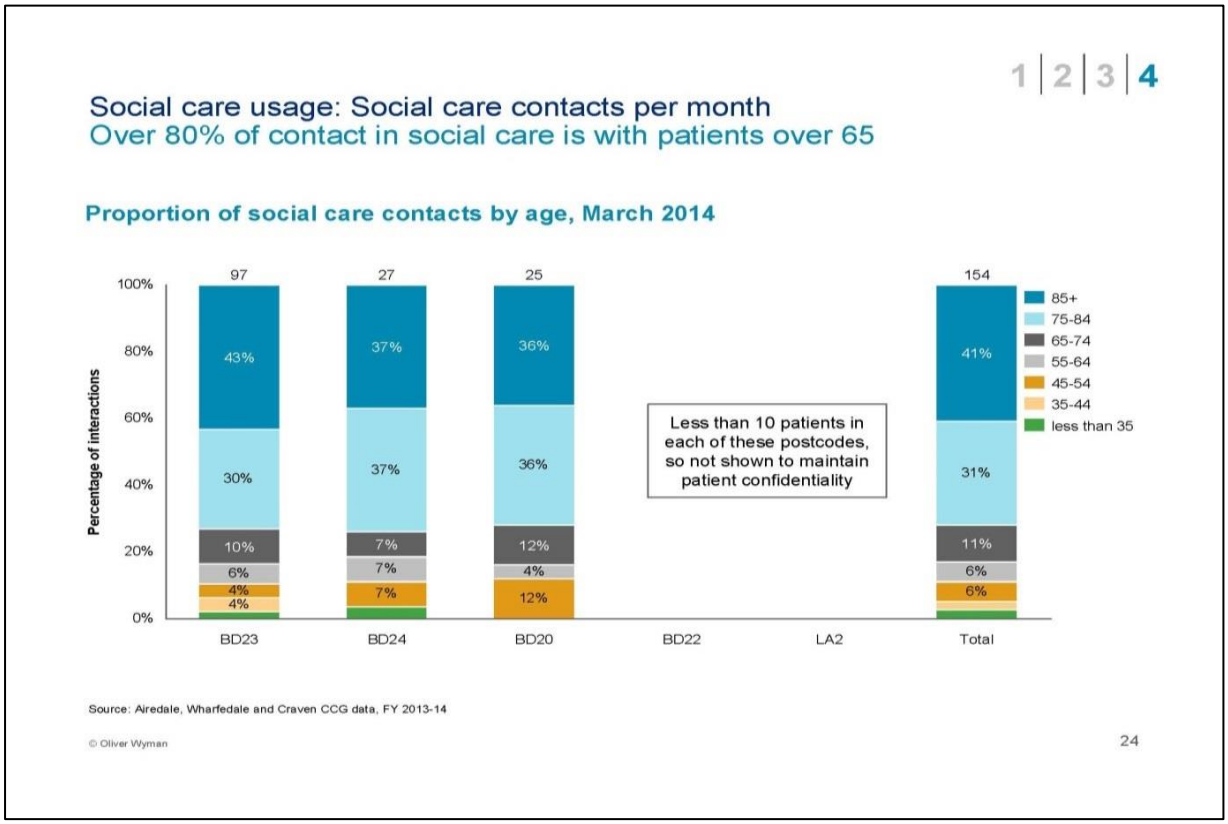
Based on the model above, the Local Health and Care Economy is currently in Waves 0 and 1 (not yet fully completed) and has started initial work on Wave 2. Wave 3 is a longer term aspiration.



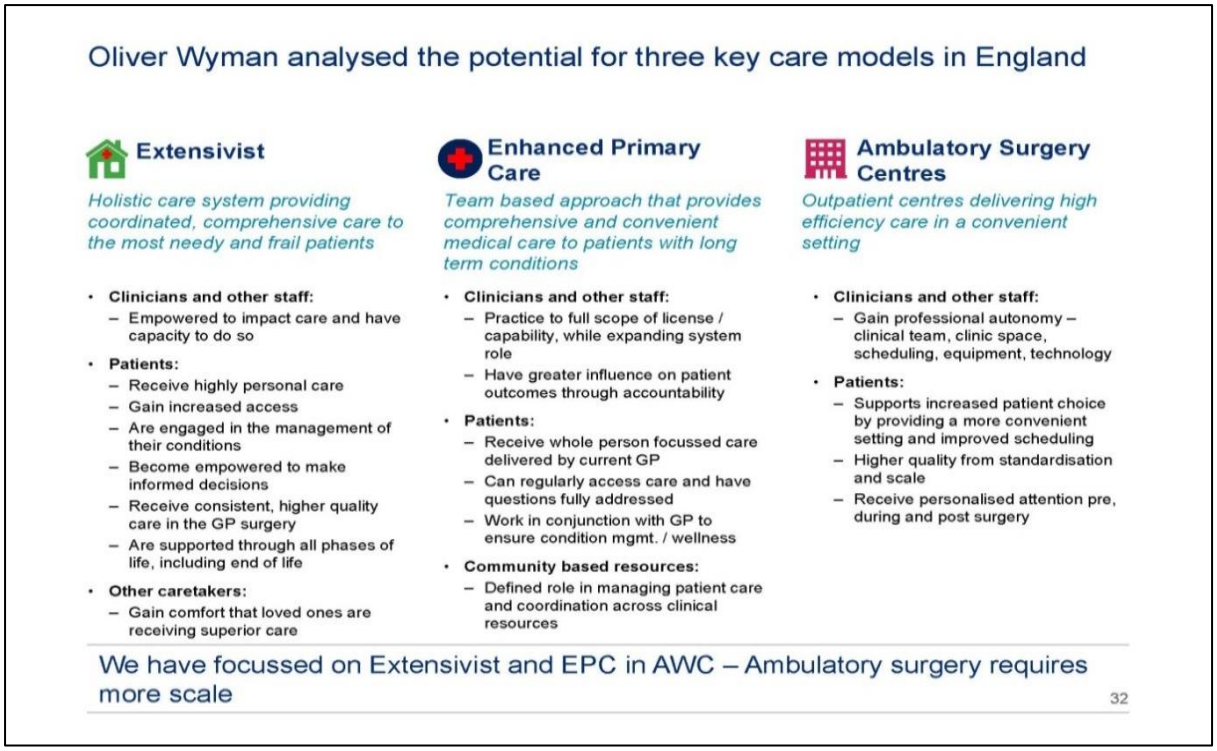
Based on the inputs provided, the analysis completed shows the large proportions of expenditure currently for patients who have multiple, complex care needs and long term conditions.



Analysis of the inputs shows that 3% of the population in the Local Health and Care economy currently account for 39% of primary and secondary care expenditure and 13% of the population account for 74% of the expenditure.



In addition, the joint health and care needs of the population show that over 80% of contact in social care is for patients aged over 65 in long term care.



The conclusion of the work showed the potential for three new potential models of care for the Airedale, Wharfedale and Craven locality to address some of the healthcare needs outlined above, each with a range of potential benefits to patients, clinicians and staff.

Across the district, we are looking at the potential to progress two of these, the Extensivist and Enhanced Primary Care models. These provide best fit to our **Future State Right Care Strategy**, with care arranged for the population as units of one, providing navigation and co-ordination around the health and care system, including mental health.

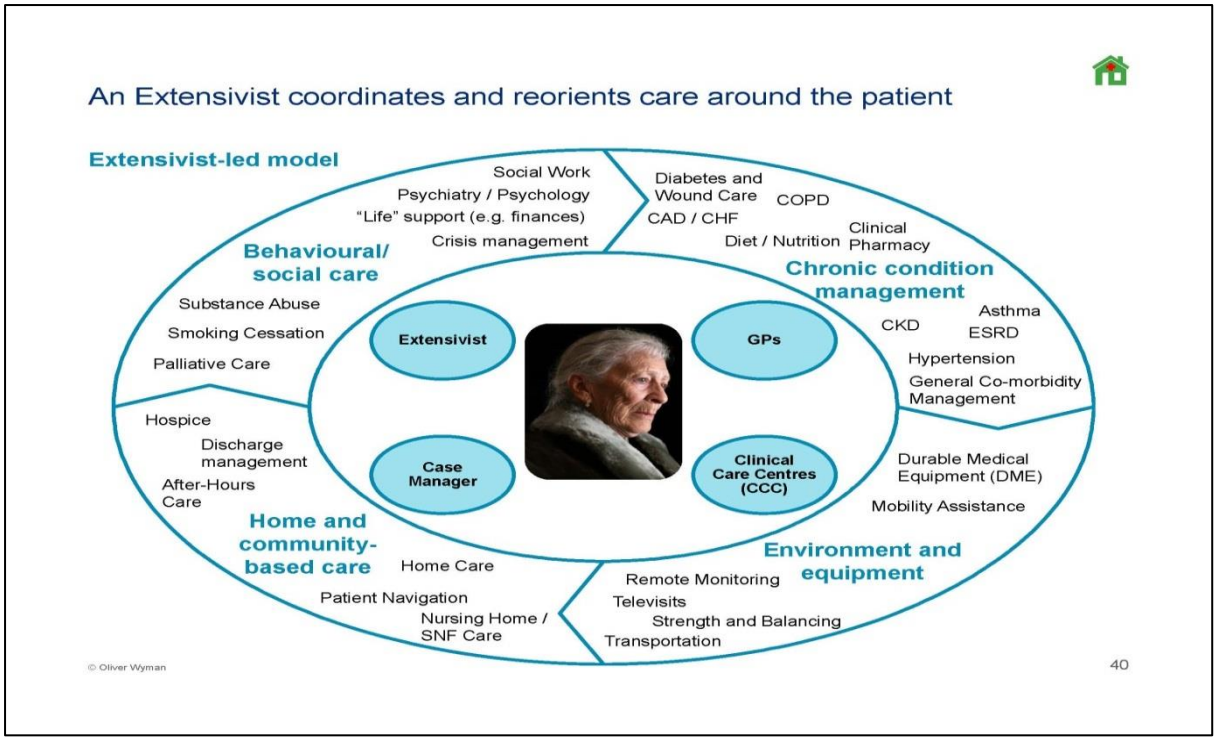
In these models, care is co-ordinated by clinicians who are empowered to make an impact by being able to provide personalised care, having services arranged in a co-ordinated and comprehensive way and with patients and carers who are empowered to make decisions. When established, the approach should ensure patients are provided treatment where and when they need it most, not just defaulting to the traditional care setting.

Work completed within this project to date has shown the powerful advantage of bringing primary and secondary care clinicians together to help design the best model of care.

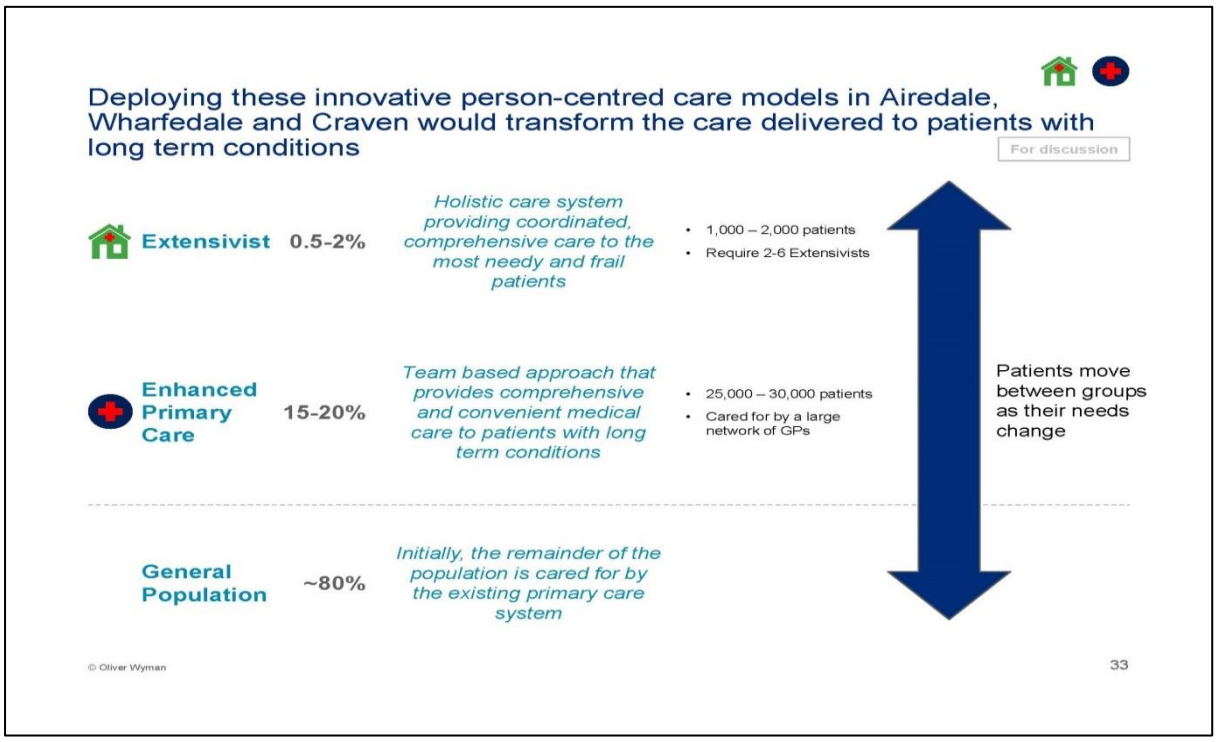
From an economic perspective, the model also suggests that once the system is established there would be potential reductions in demand for secondary care activity. Further work is required to clarify the actual level of anticipated savings so this is currently noted for the potential opportunity that exists. In addition, appropriate Governance arrangements would need to be established.

One additional requirement would be the need to consider moving to a different financial framework to support the delivery of this model.

An Extensivist is empowered to co-ordinate the care planning and service navigation for between 300 to 400 patients and ensure these are centred around the patient.



Based on the inputs from the Airedale, Wharfedale and Craven area, this would mean the need have between 2 and 6 Extensivists to service the population identified for this potential level of care.



Our approach going forward is therefore to continue working on a proposed service plan, in conjunction with our partners, for the development of both identified models, ensuring clarity around the anticipated levels of service provided and economic benefits.

(b) Transforming Urgent and Emergency Care

As noted in our two year Operational Plan, emergency services have been significantly affected by increases in demand and acuity over the past year. Following the substantial pressures across the whole health system and also responding to the national urgent and emergency care review, we shall focus on an approach to providing community wide emergency care through redesigning existing arrangements, supported by innovative technology.

There are three parts to the work we are taking forward;

Focus On Physical Infrastructure - A&E Redevelopment

Work on the £6.4m capital development to provide a new state of the art the Accident and Emergency department has now started and is due to be completed in October 2014. The previous physical environment was old and in need of a major refurbishment. This transformation scheme will enable us to better deal with patient privacy and dignity issues, upscale our ability to assess patients more accurately, support the management of frail and elderly patients and enable us to treat more patients in a timely way. The new unit shall create, amongst other things, separate adult and children's waiting areas, a quiet room for friends and families to use during stressful events and a separate screened entrance for ambulances. Treatment rooms will also be fitted with appropriate technology allowing A&E staff to see the results of X-rays and blood tests at the patient's bedside.

Whilst this is a capital development, its design is crucial to enabling us to fundamentally change our emergency and acute care through redesigned pathways and with different staffing models. The new A&E department will be better equipped to cope with peaks in demand by providing a central staff hub at the heart of the treatment area. It will also enable staff to monitor patients more easily and better observation facilities will reduce the need for unnecessary admissions to hospital.

Given the existing demands on emergency services, the Trust Board of Directors felt this capital development was critical to supporting the full set of actions noted in this section for longer term sustainability, by providing the best physical environment with which to manage non-elective work through the Foundation Trust.

Draft Plan For The Further Development of Assessment Units

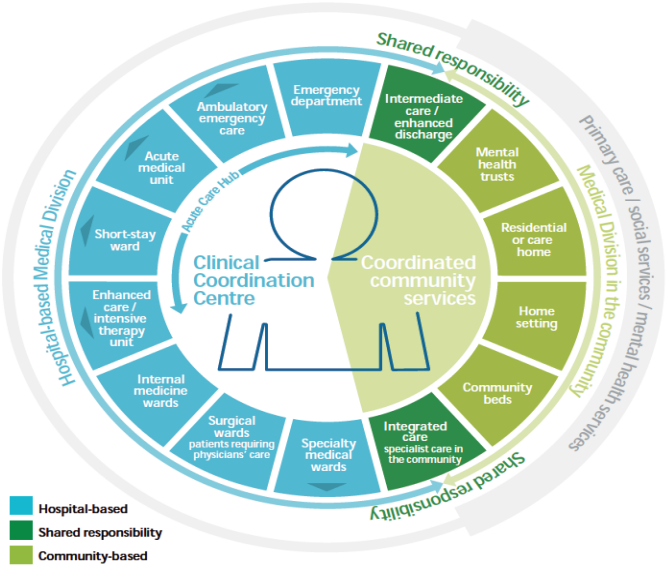
To further support the process and flow of urgent and emergency work, if we are able to relocate the Acute Medical Unit and Ambulatory Care Unit into the current Outpatient department space, as well as house a Minor Injury Unit run by ENP's, we shall be able to;

- Free up some capacity in the Emergency Department currently planned to be used for a minors stream. This may well give us enough space to have some GP patients coming through the Emergency Department as long as out flow was not a problem;
- Flexibility of workforce: Co-location could mean that the Emergency Department team might be able to review patients in a Short Stay Ward (CDU function) as well as AMU doctors working in the Emergency Department reviewing some of the medical patients.

Following the completion of the A&E redevelopment, in 2015/2016 this option shall be considered in detail. If approved it would need to be funded from the Future Developments element of the Capital Programme available from 2015/2016.

Delivering Change - Supported by our partners, to significantly develop the infrastructure and management of urgent care across the whole health economy

This shall be managed through the new System Resilience Group and in future years potentially utilise support through the Urgent Care, Integrated Transformation and Better Care Funding supporting the wider infrastructure. It shall focus on a number of areas including front end triage back to primary care, further developing ambulatory emergency care pathways with primary care, use of assistive technology such as Telemedicine, improving access to specialist medical opinion for primary care, Telemedicine units in Nursing Homes and work with Ambulance Providers.



Source: Royal College of Physicians

Overall Objectives;

- Reduced non-elective admissions;
- Continued reduction in length of stay;
- More ambulatory care rather than Inpatient care;
- Less base ward beds;
- Increased diagnostics at front end of pathways;
- More Consultant delivered care;
- Increased work outside of hospital;
- Enabled by Digital Platform/Technology

Given the sustained demand levels highlighted in Section 2 of this plan, we see the urgent and emergency care strategy being developed across the district as needing to drive through a radical whole system change, providing a different service offer for patients, provided in the most appropriate setting, utilising available clinical skill sets and technology in the most appropriate way and ensuring navigation so that patients are in the right place to be treated.

(c) Transformation and Integration

Better Care Funding

All Health and Well Being Boards were required to submit their Better Care Fund proposals for their respective Units of Planning in April 2014.

Airedale, Wharfedale (part of Airedale, Wharfedale and Craven CCG area), Bradford City and Bradford Districts CCG areas are together coterminous with the City of Bradford Metropolitan District Council (BDC) boundaries.

Craven (part of Airedale, Wharfedale and Craven CCG area) is coterminous with Craven District Council (CDC) and is part of North Yorkshire County Council (NYCC).

As such Airedale, Wharfedale and Craven CCG is party to two Better Care Funds (CBMDC and NYCC). We are therefore working with Airedale, Wharfedale and Craven CCG and other stakeholders in the submission of bids through the Bradford District and North Yorkshire County Council Health and Wellbeing Boards.

The likely value of the Bradford Better Care Fund in 2015/2016 is £37,345m. Priority areas for Bradford's Better Care Fund are 7 day services to support discharge and protecting social services; dementia; falls; maximising independence (intermediate care, rehabilitation and reablement); self-care and prevention; pro-active care and continuity of care. Metrics to demonstrate delivery will include:

- Permanent admission of older people to residential and nursing care reduced
- Proportion of older people still at home 91 days after discharge from hospital into reablement/rehabilitation services increased
- Delayed transfers of care from hospital reduced
- Avoidable emergency admissions reduced

Health and social care partners covering Airedale, Wharfedale and Craven have scoped out priorities for implementation which have been supported in principle by the Airedale, Wharfedale and Craven Transformation and Integration group (TIG) and will be considered by the district wide Integration and Change Board (ICB) for final recommendation to the Health and Well Being Board. Critical to the process is the need to understand the evaluation criteria being developed.

Bradford Metropolitan District Better Care Fund

The proposal submitted for Better Care Funding will be used to make a step-change in the capacity and capability of community services seven days a week.

This supports the ambitions for integrating health and care services and delivering more care at home which is aligned with our own **Future State Right Care** strategy. The overall aims of this are to achieve;

- Better quality person-centred care and a better experience of care;
- The right care in the right place, first time;
- Maximised independence;
- Reduced costs to the local health and care economy;
- A turn in the curve on demand for acute care

The joint proposal supports integration and change programmes, in particular around Urgent and Emergency Care and Integrated Care. These two programmes are closely related because getting care at home right will reduce demand on urgent and emergency care services.

Building on the Right Care principle, the approach is about simplifying a complex system by integrating care around people rather than organisations and increasing the availability of care at home, or closer to home that is capable of responding rapidly and supporting people with complex and urgent needs. This will support manageable demand for secondary care acute services (particularly non-elective demand) and on permanent residential care.

The programme is wide ranging, however use of the Better Care Funding would target the following priority areas for the health and care economy on a seven day basis, achieve better outcomes for people and ultimately manage demand on the whole system more effectively:

Dementia
Delivering an integrated and person/carer centred system that is capable of supporting people with dementia and their carers to receive flexible care that maintains their dignity and supports them in a way that does not compound their disorientation and distress.

Falls
Achieving a whole-system response to falls and investing in an integrated system of primary and secondary prevention that enables people to remain active and mobile.

Maximising independence:
Intermediate care, rehabilitation and reablement
Creating a 7 day integrated system oriented around enabling people to regain and maintain their health, independence and wellbeing. This requires an enabling approach across all

tiers of service from social care packages of care through to complex step-up arrangements to contain and manage escalating need.

Self-care and prevention:

Providing a step-change in the way primary, community, secondary care and social care enable and support people to manage their long-term conditions.

Proactive care and continuity of care:

Through care coordination and case finding supported by predictive risk stratification and integrated care records.

2014/2015 Plan

- Development of an Integrated Digital Care Record across NHS and social care, supported by the Safer Hospitals Safer Wards technology fund. This should lead to a demonstrable drop in unplanned activity expected;
- Improved quality and coordination of discharges across secondary and community/social care services for older people, leading to a reduction in readmissions;
- Continuing emphasis on reablement and rehabilitation, including significant expansion of intermediate care services and early supported discharge services for stroke, orthopaedics and older people;
- Demonstrable increased community-based capacity and capability;
- All people over 75 will have a lead clinician;
- Integrated carers hub in place;
- Telemedicine in 81 care homes across district to reduce unplanned admissions;
- Plan in place to move to a hybrid model of community beds across health and social care;
- Initial shifts towards integrated management arrangement for 21 communities;
- Collective HR/workforce plan agreed across stakeholders;
- Development of commissioning activity to support integration including new payment models;
- Detailed economic modelling undertaken to fully understand the system and financial changes that are required to respond to the economic challenge of the next five years;
- Expanding the programme to include Children's Services;
- Establishing co-production with service users and expansion of practice-based self-care support;

2015/2016 Plan

- Integrated digital care record in place and NHS number used as unique identifier;
- Procurement of integrated community and primary care services model with supporting payment models;
- Integrated Community Teams fully established with demonstrable increase in people cared for outside of hospitals;
- Community teams have delegated authority to deploy resources to meet health and care needs of the local population;

- Workforce planning undertaken across the health and care economy;
- Flagship hybrid intermediate care facility opened in Saltaire, Bradford and in planning for Keighley;
- Integrated rapid response crisis services in place as part of intermediate care tier of services.

North Yorkshire County Council Better Care Fund

The joint bid for the proposed scheme supporting transition to the North Yorkshire Better Care Fund using unutilised social care funding available from North Yorkshire County Council, is currently being agreed.

The schemes all relate to the Craven locality and as part of the transition to the Better Care Fund in 2015/2016, there is the opportunity for schemes that deliver the desired outcomes to be continued and potentially funded through the Better Care Fund. Any extension would require agreement of both the CCG and North Yorkshire County Council.

2014/2015 Planned Areas For Consideration

1) Assistive Technology:

- Expand telemedicine to remaining 12 care homes in Craven
- Provide telemedicine support to End of Life patients
- Provide telemedicine support to 50 Heart Failure patients (admissions in last year)
- Provide telemedicine support to 80 COPD patients (admissions in last year)

2) Quality Improvement in 22 Care Homes in Craven

- Quality improvement support and liaison service (integrate within community teams/collaborative care team)
- Provision of basic observational kit with care home staff, education and training to enhance telemedicine support;
- Provision and development of a resource pack and education sessions – services; access; pathways, protocols

3) Community Specialist Nursing Service

- Extend provision of community cardiac rehabilitation, pulmonary rehabilitation, and heart failure specialist nursing into Craven locality. Move towards 7 day working.

4) Craven Collaborative Care Team

- Additional posts to increase capacity in virtual ward and expand intermediate care bed provision enabling improved discharge, increased out of hours provision, additional rehabilitation, and enhanced MDT approach at Castleberg Community Hospital, preventing/delaying longer term care. This includes mental health nurse, social worker, Advanced Nurse Practitioner, carers support worker and 0.5 WTE GP post.
- Financial assumptions; includes additional costs for unsocial working and moving to 7 day working.

5) Technology Fund

- Creating a technology fund to support and accelerate integration of Health and Social Care information systems, agile working solutions (kit and training), creation and implementation of integrated care plans and integrated care records plus development of risk stratification tool (Combined Predictive Model – CPM) to include links to North Yorkshire social care.

6) Seven Day Working Fund

- Create a 7 day working fund to provide support for providers including primary care, who are willing to consult and negotiate changes in working patterns and terms and conditions to support shift working and additional resource to support 7 day working. This includes diagnostics, primary and community service provision, assessment, care planning and discharge planning.

Dementia

In addition, we are currently progressing integrated plans with Commissioners and other Providers for some non-recurrent funding supporting dementia care and admission avoidance. Further work is currently being completed as this needs to be self-financing beyond 2014/2015.

People Strategy
Transforming the way care is provided, centred on the needs of patient's and carers, is critical to the delivery of the Foundation Trust's Vision and the Right Care Strategy. This will require the development of existing services, diversified models of care both in and out of a hospital setting and new ways of working across organisational boundaries. This transformation will require people at all levels within the Trust to engage with new ways of working and service change; and it will require adaptations to the size and shape of the workforce to respond to changing patient needs. More than ever before, clinical leaders and all staff will need to have the skills and qualities to be able to forge relationships and co-design and deliver services and care in partnership with others in order to improve patient outcomes and experience.

Values
The NHS Constitution values are our values too. They are;

- Working together for patients
- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Everyone counts.

In consultation with staff across the Foundation Trust, we have also developed a set of 'principles' that support these values;

- Responsive to the needs of our patients
- Integrated services
- Getting it right first time
- Here to care
- Technology enabled
- Community wide
- Active participation of staff
- Reducing risk
- Empowering patients

These values and principles will underpin everything we do and will be the foundation of our new 'Deal' with staff based on shared values, rights as well as responsibilities, reward and recognition based on collective and individual contribution towards the Foundation Trust's objectives and strategy.

The People Plan
Our People Plan will support the delivery of the Right Care vision by ensuring the Foundation Trust has the right roles, people, ways of working and strategies for development and reward now and for the future. The success of the People Plan will be measured by its impact on patient experience; staff satisfaction, staff engagement and wellbeing; and efficiency/productivity. The People Plan has four related themes: Well Led; Talented and Skilled; Healthy and Engaged; and Productive Workforce.

Well Led Workforce

The Foundation Trust has a strong and effective Board and Executive Team as evidenced by the 2014 Monitor Board Effectiveness Review, the 2013 Care Quality Commission inspection and the delivery of quality, performance and finance targets. It is however important as the Foundation Trust changes that the senior leadership team are able to effectively lead that change and plan for the future. In the next 5 years key to this will be:

- Senior leadership recruitment and succession planning to replace key long serving Non-Executive Directors as they approach retirement, to refresh skills on the Board to reflect the changing service delivery models and change requirements and to grow our own or bring in from outside, talented individuals who can help move the Trust forward;
- Clinical leadership development to continue the development of the Trust's approach to clinical leadership and further enhance partnership working with other important stakeholders in the health economy;
- Leadership and management skills development – reaching out to all our line managers to ensure they have the skills needed to lead teams and change across the Trust and wider health economy.
- Senior management engagement with staff – with an ever increasing focus on visibility within the Trust and listening to staff on the ground via set piece engagement sessions and 'engagement' becoming an embedded way of working for all senior leaders.

Talented and Skilled Workforce

Future Workforce Design

The Foundation Trust has a relatively stable workforce when compared with other Trusts and other relatively small acute trusts. The Trusts workforce needs will evolve over the next 2 years to reflect new service models, the impact of technology and changes in national and local workforce supply. It is clear that in 5 years' time the size and shape of the workforce will be significantly different to what it is now as we see a continued decline in junior doctor numbers, the shortage of medical staff in a number of specialities, the flexing of traditional role demarcations and health care being provided across traditional organisational boundaries.

In response to these changes and challenges over the next five years the Trust plans to

- Further develop and deploy advanced practitioners roles in nursing, midwifery and therapies to supplement and complement other roles within the Trust and to mitigate the risks associated with reductions in the number of junior doctors in some specialities.
- Develop the clinical workforce to work across traditional and professional boundaries both within and outside a hospital setting, including the development of generic roles, for example community practitioner, to support the provision of an integrated approach to health and social care for patients and partnership working.
- Continue the integration and development of the workforce aligned around services provided in the community, with more nurses and other health care workers working in the community as opposed to a hospital setting. Nurse staffing levels will remain under constant review to ensure safe staffing levels are maintained in line with requirements

and the needs of patients. The expectation is that the current shortage in the supply of suitably qualified nurses in the labour market will be addressed by Health Education England's (HEE) workforce plan that will see an increase in the number of qualified nurses being available in future years.

- Further develop the Health Care Support Worker workforce in line with our Strategy and the recommendations of the Cavendish Review, including the use of senior health care support worker roles.
- In five years' time, changes in the non-clinical workforce will have taken place and new ways of working embedded with an increased use of technology and greater standardisation of administrative and clerical functions. As a result there will be an overall reduction in administrative and clerical posts.

Refreshed Clinical Education and Training

A number of options being considered include;

- Medical workforce design requirements in line with Service Plans;
- Junior Doctors and whether are we going to continue being a training organisation;
- Middle Grades (Potential innovative recruitment and retention approach in conjunction with other Providers);
- Consultants – Identifying current pressures (e.g. diagnostics) and assessing what networked options are required;
- Potential to increase the role of Advanced Nurse Practitioners to take over work of Middle Grades and assessing the correct blend of skill mix required

Improved Recruitment

Whilst our response to the demographic and workforce challenges ahead is primarily a strategic one of transforming the overall service delivery model across the whole health care economy, there will continue to be a need for tactical recruitment interventions to ensure the Foundation Trust is able to recruit the workforce of the future. Increasingly the Trust will look to international recruitment in areas like Australia, New Zealand and South Africa to recruit doctors at all levels where there is a national shortage here. The Trust will also enhance its use of technology to ensure that recruitment advertising sells the Trust in the best possible light to potential applicants and to attract employees who have grown up in the technology age. Recruitment processes will be focused around testing for values as well as technical skills and will be streamlined to ensure gaps are filled quickly.

Talent Management

In order to deliver the Foundation Trust's strategy and objectives going forward, it is essential that we are able to attract and retain talent. The Trust has already established a 'growing talent' programme for staff at Bands 1-7 called 'Rising Stars' which will identify some of the 'stars' of the future and involve them in projects to support Right Care. We will also look to supplement this through the development of talent pipelines and development programmes to grow the future leaders of the organisation in and across professional areas. This will include the use of appraisals and talent management groups to spot and nurture talent and formal succession planning for key roles. Appraisal will be a central feature of the Trust's approach to talent management, will be linked to performance and will ensure

talented individuals get recognised for their contribution and those who are under performing get supported and managed to improve. The expectation is that the Foundation Trust will become a beacon regarding compliance and quality of appraisals over the next 5 years.

The development of our Consultants as clinical leaders, using new approaches including technology, is critical to changes in practice, ways of working and the delivery of Trust strategy. In the next two years, the Trust will build upon the Clinical Director development and coaching programme with a programme of development for Clinical Leads and aspirant future Clinical Directors. This will supplement the extensive coaching programme that is underway targeted at Directors, Clinical Directors, Senior Nurses and health professionals, General Managers and other senior leaders.

Healthy and Engaged Workforce

Research shows a direct link between healthy and engaged staff and patient care and experience. International research has found that senior management interest in employee health and wellbeing is the most influential factor with regards to staff engagement. As a Trust we know we do some things well in this area and have an engagement index above average for similar trusts and lower levels of reported stress than other similar trusts. We also know from the Staff Survey that staff would recommend the Trust as a place to work and receive treatment.

An engaged and healthy workforce remains a top priority. In the last two years the Trust has introduced regular quarterly 'pulse surveys' and Director led listening sessions to gauge levels of staff satisfaction, morale and engagement, in addition to the regular annual staff survey and action planning. The Trust's current engagement index (the overall measure of staff engagement) is 3.8, which is above average for all acute trusts. Our aim is to be in the top 20% of all acute trusts by 2016. Plans include: Trust wide and group level engagement events around the 'Right Care' strategy; the continuation of director listening sessions and introduction of back to ward sessions involving non- executive and executive directors.

The Trust is also refreshing its approach to support staff health and wellbeing through a new 'Wellness Project' in partnership with the Centre for Sports and Exercise Science at Sheffield Hallam, University. This draws on leading edge approaches to health and wellbeing with individual assessments, action planning and workshops around diet, exercise and resilience. Following a pilot the plan is to roll this out as a standard offering during 2014/2015. The Trust will also be providing additional support to established medical staff coping with pressure and stress; and will be developing further plans in response to the outcomes from a staff side sponsored stress survey.

In addition we plan to:

- Broaden the range of staff suggestion approaches available with an Airedale Room 101 to help staff stop doing things or to change things that no longer work;
- Implement a new approach to non-pay reward and recognition linked to patient experience, staff engagement and improving efficiency. This will include local individual and team awards; recognition for long service and the first ever Airedale Staff Awards celebration event, which will become an annual event.

Productive Workforce

The Trust needs to continue to deliver and transform whilst managing the financial pressures. It is therefore important that its people systems and approaches lead to greater efficiency and productivity. In the next 5 years there will therefore be a focus on;

- Increasing the productivity of the medical workforce through better job planning and the use of e-rostering;
- A continued focus on managing attendance and reducing the levels of sickness absence through proactive interventions and support;
- Optimisation of existing pay and terms and conditions so that the Trust gets best value from its resources and staff time is utilised effectively thus reducing pressures on the workforce.

As part of the Right Care Workforce Programme, HR will be developing a broader reward and recognition approach in consultation with staff and unions, including further development of the Staff Benefits Scheme, Total Reward statements, consideration of instant rewards for one off significant achievements and a Trust wide recognition and awards event.

7 Day Working

Following the national publication of NHS Services 7 Days a Week, we are currently exploring various models to help try and develop 7 day working over the next few years.

For acute care we are looking to transform the approach through providing an emphasis on increased senior medical presence at both the front and back end of care pathways. To enable this, we need to transform the discharge processes and increase the use of Allied Health Professionals, HDU, CCU and diagnostic provision at weekends.

For planned care, we need to strengthen the infrastructure across most services to have the critical mass to be able to implement 7 day working. Strategic options (e.g. formal service alliances and partnerships) need to be evaluated across 2014/2015 and 2015/2016.

We anticipate requirements around 7 day working are likely to start and be incorporated through existing mechanisms (e.g. service specifications) and so we have assessed the gaps in current service provision. There are a number of key issues to sort out across most parts of the Foundation Trust which will not be possible without substantial investment and even if funding were available there are potential supply chain issues in some areas. Our approach is therefore currently focussed on establishing a set of priority areas to take forward, potentially supported through the use of Better Care Funding.

IM&T Strategy

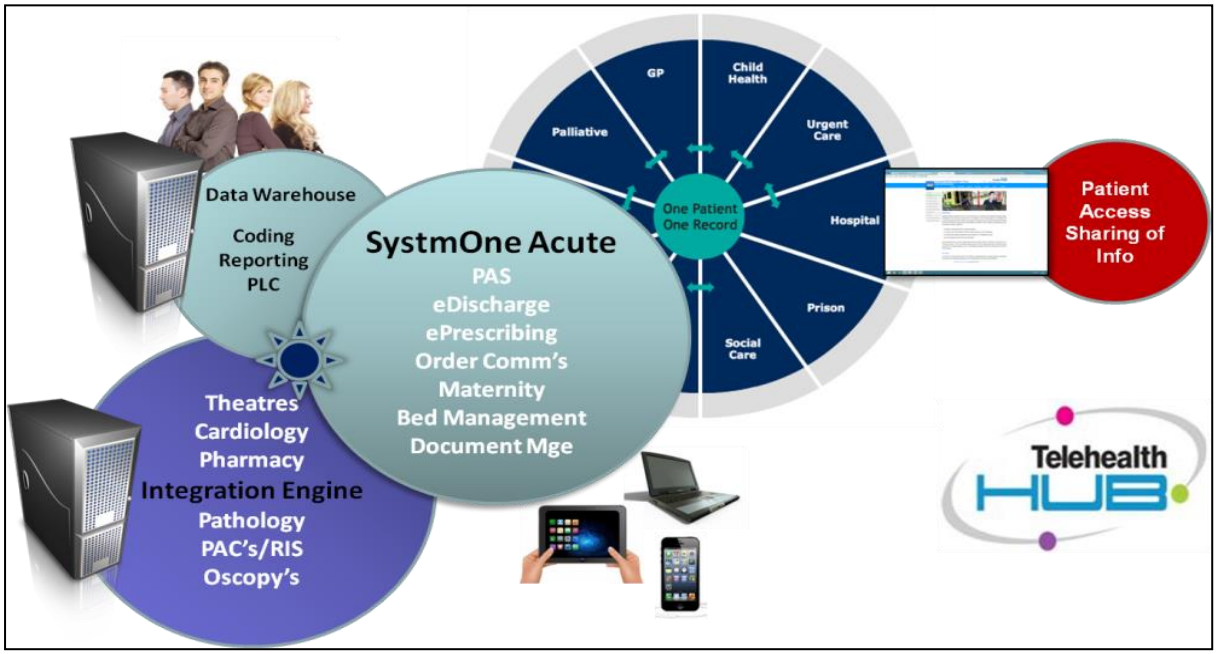
The updated IM&T strategy is designed to support the Foundation Trusts response to the current challenges in the health and care sector and to further address additional areas of development in relation to our own specific information and technology requirements that support the delivery of the Right Care vision and operational objectives of the Trust.

The previous Foundation Trusts IM&T Strategy focused in particular on the design, delivery and implementation of information systems and the supporting infrastructure that have, to date, enabled progression towards the Foundation Trusts key strategic objectives. In particular, the focus placed over the past couple of years was on developing the clinical systems in line with the established roadmap outlined in the National Programme for IT (i.e. developing the Clinical 5; PAS, Bed Management, e-discharge, e-prescribing and Order Communications).

The updated IM&T Strategy sets out how the technology platform needs to be further developed to build on the current position whilst meeting the priorities and challenges ahead, in particular how the approach supports service transformation, improving quality, greater efficiency and allows us to realise our ambition set out in our **Future State Right Care Strategy**.

Importantly, the updated strategy also expands on delivering the requirements of both the national and local information agenda, by further identifying the key challenges and putting in place a set of supporting strategies that allow the Foundation Trust to respond effectively to both through a particular focus on information optimisation.

The approach taken sets out how we plan to respond to the increasing levels of openness and transparency required at individual, service, organisation and sector level in support of the national information requirements, whilst also improving the way in which we produce data and information.



To address specific priorities over the next few years, the key objective areas focus on;

Continued progress towards delivering the digital hospital *Anticipated Outcomes and improvements*
• Reduced use of paper and associated process • Increased access to core clinical and corporate systems • Seamless access to information via a single sign on authentication process, eliminating the need for multiple system logon across a range of disciplines. • Increased direct data entry of patient information into SystmOne and other supporting Clinical applications • Real time retrieval and viewing of clinical and corporate information • Enhanced security of patient information • Seamless access to telemedicine services anywhere within the hospital. • Converged services, voice and data, reduction in management and infrastructure costs and greater utilisation of unified communications, video conferencing, instant messaging • Enables clinicians to operate anywhere across the health care community
Supporting the Integrated service approach through digital technology and information (IDCR) *Anticipated Outcomes and improvements*
• Puts the patient at the centre; empowers the individual to manage their healthcare needs; • An integrated digital care record of for all patients across the whole health community • The means to update, share and exchange real-time information in support of the patient's overall care; • The potential to reduce or replace Outpatient first attendances and follow up appointments through the use of e-consultations e-advice and Telemedicine • Through the use of self-care application diagnosis support, potentially reducing demands on GP and Outpatient follow up requirements; • Enabling self-care management with the Patient, GP, Pharmacist and Consultant which will support the reduction in the wastage in drug prescribing. • Enhanced patient and visitor experience by enabling access to internet based services information kiosks and digital information displays
Developing the Information platform *Anticipated Outcomes and improvements*
• Improved Business Intelligence capabilities • Increased efficiency • Standardisation of reporting • Improved productivity and management control • Meet mandatory requirements • Improved access to information • Simplified data capture • Facilitates team working and knowledge sharing • Streamlined user access.

- Enhanced security and availability of information assets
- Enables external integration with other care providers and systems
- Improved management and decision making of patient care.
- Improved provision of management information, supporting business planning and business cases, patient level costing
- Improved integration of information between PAS and hospital systems
- Enables users to self serve and mine the information that they need, reduces the need for the information team to be involved in low level transactional requests allowing them to focus on more complex analysis and data mining

Optimising and delivering efficient and value based IM&T services

Anticipated Outcomes and improvements

- **Increased Capacity** – enhanced back office information management infrastructure and storage.
- **Sustained Reliability** – improving resilience, infrastructure performance and support services
- **Assurance and Integrity** – stringently audited and accredited networks and applications
- **Enhanced Capability** – meeting the needs of the Trust by delivering projects on time and to budget
- **Availability** – high availability of systems and networked services
- **Flexibility** – flexible use of services to meet the business need
- **Sustainability** – adoption of carbon efficient technologies

Estates Strategy

Our updated Estates Strategy, being developed for July 2014, is a further enabler within the Right Care programme of work. The strategy will be written in response to our clinical and service transformation plans to ensure we have a fit for purpose, rationalised estate, in line with our service requirements and designed to support delivery of care with modern, clean buildings and equipment.

In response to developments in the Right Care Programme, the People Plan, IM&T Strategy and approach to continuously improving the patient experience, the key areas of focus in the Estates Strategy will be:

- Assessment of current position and future requirements
- Priority areas identified (e.g. Patient Experience project improvements e.g. access points; entrances, signposts, car parking)
- Estate Rationalisation
- Ward and Clinical Refurbishment
- Community Infrastructure
- Benchmarking performance
- Environmental approach

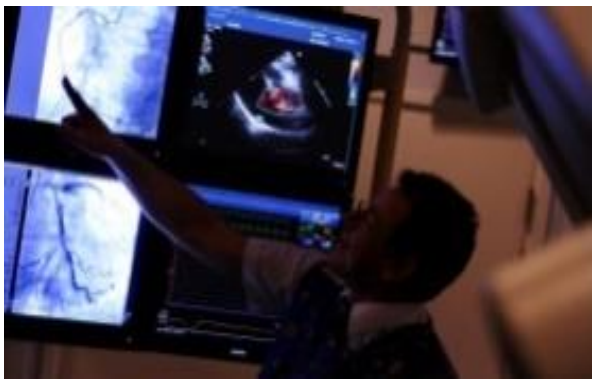
Research and Development

The Foundation Trust receives funding for research via the NIHR Clinical Research Network (CRN) to enable the organisation to participate in high quality research which will be of direct benefit to patients, NHS staff and the public and which will add value to clinical practice and the evidence base.

As a result of this funding it's been possible to double research capacity in the Foundation Trust since 2008 from three specialties in 2008 (Cancer, Stroke and Elderly Care) to 12 specialties currently.

It is a requirement for all NIHR funded organisations to meet the NIHR high level objectives and performance against these objectives will be monitored. In addition to this, the organisation has to meet the requirements of the NHS Operating Framework and the Health and Social Care Act 2012. On the basis of this, the aims for Research and Development at Airedale for the next 5 years can be summarised as follows:

- To promote and facilitate research activities across the Foundation Trust and establish Research and Development as part of the core business of the Trust;
- To improve the research profile of the organisation within the research community and foster a vibrant research culture within the Trust;
- To facilitate the provision of high quality research-related training and education for researchers and those interested and taking part in research;
- To actively promote the engagement of patients and the public in setting the research agenda;
- To achieve an increase of 100% in patient recruitment to clinical trials on the National Portfolio from a baseline of 360 at the end of 2013/2014;
- To achieve all national targets including Research and Development approval times and recruiting patients to time and target;
- To increase the number of industry sponsored clinical trials by 100% from 7 at the end of 2013/2014 to 14 by 2019, with the dual aims of ensuring that Research and Development continues to be a self-sustaining function and to provide a source of income for the Foundation Trust.



Financial Plan 2014/2015 to 2018/2019: Capital Programme

The Foundation Trusts Capital Programme over the next five years is as set out below;

Key capital expenditure priorities	Amounts and timing	Key actions and delivery risk (including finance risks)
Accident and Emergency	**2014/2015** £4.5m	The previous physical environment was old and in need of a major refurbishment. This transformation scheme enable us to better deal with patient privacy and dignity issues, upscale our ability to assess patients more accurately, support the management of frail and elderly patients and enable us to treat more patients in a timely way. The new unit shall create, amongst other things, separate adult and children's waiting areas, a quiet room for friends and families to use during stressful events and a separate screened entrance for ambulances. Treatment rooms will also be fitted with appropriate technology allowing A&E staff to see the results of X-rays and blood tests at the patient's bedside. Whilst this is a capital development, its design is crucial to enabling us to fundamentally change our emergency and acute care through redesigned pathways and with different staffing models. The new A&E department will be better equipped to cope with peaks in demand by providing a central staff hub at the heart of the treatment area. It will also enable staff to monitor patients more easily and better observation facilities will reduce the need for unnecessary admissions to hospital.
Information Technology	**2014/2015** £3,759m **2015/2016 to 2018/2019** £1m	This supports the delivery of the Foundation Trusts 5 year IM&T Strategy. The majority of funding for 2014/2015 is through the Safer Hospitals Safer Wards Technology Fund. To support continued implementation of the Digital Care Programme and core IT infrastructure, an annual capital allocation of £1m has also been included in the programme. **Safer Hospital, Safer Wards Technology Fund** AHNSFT in partnership with BDCT, BTH and Bradford Council submitted a joint application for funding to support the delivery of an integrated digital care record across the whole health community. The outcome of the bid was successful and in addition to the £6m funding awarded, the bid consortium have been selected to be one of NHS England's accelerator sites. The partnership is one of three organisations selected from across the country to demonstrate an exemplar approach towards modernising healthcare through the use of an Integrated Digital Care Record. Key system projects that will enable the delivery of this objective are e-Prescribing/Medicines Administration, e-Discharge, Service Requesting and the digitalisation of paper records. **Core IT Infrastructure** Prioritisation of IT projects over the next five years include the requirement to support a Trust wide pc replacement programme, upgrading the wireless network and server infrastructure to enable the use of technology developments that support clinical services, upgrading the telephony service to a VOIP solution from the PBX system that shall be obsolete in 2015/2016, the PACS (Picture Archiving and Communications System) used in Radiology in 2016/2017 and the need to develop Sharepoint and Public WiFi access.

Estates	**2014/2015** £920,000 **2015/2016 to 2016/2017** £550,000 **2017/2018 to 2018/2019** £430,000	**Maintenance** This covers backlog maintenance and ensuring maintenance and equipment compliance standards are met. There are also some specific Estates projects requiring capital funding. **Accommodation Strategy** Currently the use of the Estate is not optimised. There are a number of vacant and underutilised areas that unnecessarily increase the overall operating costs. One of the key elements of the Estate Strategy is to increase the density of the hospital site. Achieving an increased density of Estate reduces fixed costs such as energy and rates and reduces travel between departments. Many areas across the Estate are used for 50% to 60% of the time but occupy 100% of the space. Increasing utilisation by sharing space with other functions increases the use of the Estate. In addition, making land available within the Estate will generate scope to develop or sell, subject to planning constraints. The first phase of the accommodation strategy is to empty the former Nurses accommodation to allow development of the land and to reduce overhead costs. There is a £150,000 provision in the 2014/2015 capital programme to enable this work. **Nurse Call Handover** The Nurse Handover system requires investment and so an allocation is included from 2014/2015 through to 2016/2017. **Ward Upgrades** Many of the wards within the Foundation Trust are in need of refurbishment having had little investment in recent years. The Foundation Trust receives some complaints about the environment within wards and this was also reflected in the PLACE scores. Patient experience is influenced by the condition of the environment. A refurbished ward with Dementia at the heart of the design will improve patient experience and reduce the number of falls. There is also an intrinsic link between the environment, staff morale and the level of care provided to patients. In 2013, the Foundation Trust secured Dementia funding of £443k which was used to refurbish Wards 4, 6, 7 and 9. A blueprint for ward refurbishments has been used on Wards 18 and 9 which included the following scope: Replacement of flooring, replacement of ceiling tiles, replacement lighting (funded by the Carbon and Energy Fund), painting and decoration (Dementia Friendly), upgraded Nurse's station, replacing damaged windows, new curtains. It is intended to refurbish one additional ward in 2014/2015. There are also a number of other Ward areas, not recently refurbished, that shall be considered for upgrades through the period 2015/2016 to 2018/2019. **Chilled Water Upgrades** The current chillers that provide cooling to the theatres are 15 years old and due for replacement. There will be significant energy savings of approximately 25% when replacing the existing chillers with a modern energy efficient plant. Changes to regulations regarding refrigerants also dictate that this work is essential.

Medical Equipment	**2014/2015** £505,000 **2015/2016 to 2018/2019** £500,000	Provision as required for Medical Engineering equipment replacement. In 2014/2015 this is likely to include the requirement to purchase a Green Light Laser in Urology and Hysteroscopy equipment in Gynaecology.
Pathology (including LIMS)	**2014/2015** £431,000	This covers capital work to expand the existing facility allowing additional work to be completed and the LiMS system. **LiMS / Laboratory Information Management Systems** The existing LIMS – Fordman – is at the end of life and as a result the Pathology department at Airedale is in the process of implementing STARLIMS – a modern, fully integrated and flexible LIMS that will allow the department to more accurately measure and improve services, maintain and evidence compliance, have greater control over their internal processes and offer greater flexibility to service users.
Right Care Projects	**2014/2015** £120,000	Provision in 2014/2015 to support the Right Care portfolio work.
Radiology Room	**2015/2016** £85,000 **2016/2017** £150,000 **2017/2018 and 2018/2019** £100,000	Rooms to be upgraded to accommodate the required equipment replacement.
Future Developments	**2015/2016** £2,365m **2016/2017** £2.3m **2017/2018** £2,470m **2018/2019** £2,470m	These shall be assessed individually through individual business cases at Capital Investment Team. Main considerations are likely to include; • Acute Medical Hub (starting 2015/2016) to further develop urgent and emergency care arrangements with a co-located Emergency Department, Acute Medical Unit, Ambulatory Care Unit and Clinical Decision Unit following completion of the current A&E redevelopment; • Laminar Flow Operating Theatre capacity; • Further developments of clinical buildings supporting progress towards an Ophthalmology centre; • Electronic self-check in and booking reminder service for Outpatients; • Centralised Children's infrastructure, including Ward and Outpatient areas; • Develop Children's Assessment Area; • Upgrading parent facilities NNU; Further upgrade to Maternity facilities; clinical rooms, call systems, entrance to the Labour Ward; Community Services – Estates infrastructure for Craven, Relocation for ACT