Heart of England NHS
NHS Foundation Trust

Operational Plan for 2017 to 2019

Building healthier lives

1. Introduction

This document sets out the draft Operational Plan submission for the 2017/18 and 2018/19 financial years for Heart of England NHS Foundation Trust (HEFT).

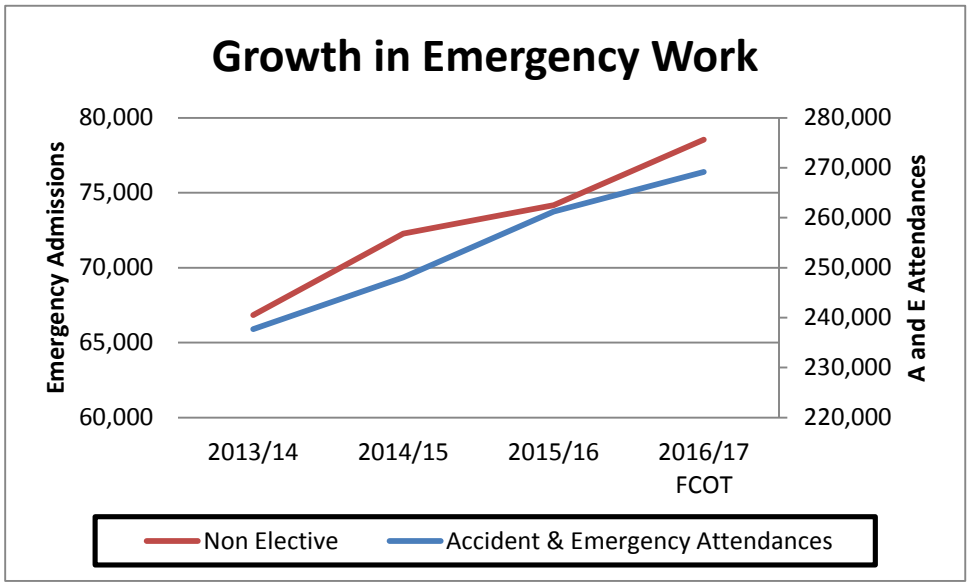
Due to the stronger than expected financial performance and improved run rate over recent months, the Trust has updated the 2016/17 year end forecast within the month 8 reporting submission to meet the (£13.6m) control total deficit. As such, the financial plan for 2017/18 commences using a forecast outturn for 2016/17 of (£13.6m).

This plan accepts the 2017/18 control total deficit of (£7.5m) including the £21.3m Sustainability and Transformation Fund (STF) and the associated conditions. The Trust then proposes a control total surplus of £0.6m for 2018/19 (post £21.3m STF) in line with the projected savings included within the Financial Recovery Plan (FRP).

2. Activity Planning

2.1 Operational Planning

Heart of England NHS Foundation Trust has seen a year on year increase in demand, in particular in Emergency activity as demonstrated in the table below, a trend which has continued throughout 2016/17.



In order to establish the anticipated demand during 2017/18, the Trust has used the following approach:

- Use of Month 4 year to date activity, at HRG and Point of Delivery (PoD) level, to inform a forecast out-turn level of activity, adjusted for agreed counting and coding changes and seasonally adjusted

- Reviewed prior three years of activity to inform a trend growth percentage for 2017/18 for each specialty by PoD
- Adjustments made for specific growth in 2017/18 for example recovery plans for key operational standards, management of follow up backlog, service developments, new services, national initiatives (e.g. NICE guidelines)
- Review of calculated activity to ensure the level is sufficient to deliver access standards

The divisional teams discussed proposed adjustments to the trend analysis with the income and contracting team. The results of this work and the assumptions made were then challenged by the Executive Director of Operations and the Interim Associate Director of Finance in individual divisional Confirm and Challenge meetings. The aim of this challenge was to ensure plans will allow delivery of access targets together with ensuring plans are realistic with regards the capacity within the Trust.

The divisional plans were then combined to inform the Trustwide plan which formed the basis of proposals to the CCG commissioners. At the point that the draft plan was submitted the Trust assumed no reduction for QIPP schemes.

Contracts have now been agreed which include some QIPP reductions in the price activity matrix but much of the implementation detail still needs to be finalised. The Trust is committed to working with commissioners to achieve this between January and March 2017. At this stage, circa 30% of the QIPP has been reflected in the plan albeit some further work is required to map the reductions in cost. The remaining schemes have not been included due to the late agreement and lack of detail. In overall terms the plan income figure is higher than the contract value by circa £12m. This does not present a risk to achievement of the control total as:

- The Trust is confident it could disinvest premium costs in the areas covered by the QIPP schemes, should activity reductions occur.
- The plan includes an expenditure provision of circa £11m for expected net growth which could offset any QIPP reductions.
- The contract terms ensure that the Trust is paid for activity above contract under PBR if QIPP does not deliver the planned reductions.

2.2 Capacity Modelling

The Demand and Capacity Group is in the process of reviewing the Trust efficiency metrics and comparing against benchmark organisations. Areas are being benchmarked using Albatross and Lord Carter metrics and include:

- Theatre Productivity – following the work prepared as part of the Financial Recovery Plan, the Trust continues to review opportunities for improvement
- Length of Stay – the Trust's Length of Stay Group has detailed action plans in order to improve performance
- Outpatient Clinic Capacity – full modelling of required capacity is underway to ensure baseline activity can be provided within job plans/substantively staffed clinics
- Diagnostic Modelling – impact of the growth activity on diagnostics to be modelled including the impact of Direct Access testing

The activity modelled following the process described in section 2.1 above, will be mapped against metrics agreed following the capacity modelling described to ensure the required capacity is available at the earliest opportunity.

At this point, the Trust believes that there is sufficient elective capacity internally to deliver the required activity and as such the use of the private sector is not anticipated beyond the current modest level. The Trust is currently developing a case to expand the Supported Integrated Discharge team in order to aid the Trust's patient flow and further reduce length of stay in light of the significant discharge delays arising from insufficient non-acute health and social care capacity. Diagnostic capacity within endoscopy will continue to be supported via the mobile endoscopy unit at the Birmingham Heartlands Hospital until the substantive solution is available.

2.3 Trajectories for Key Operational Standards

During 2016/17 nearly all of the improvement trajectories relating to access targets have been achieved. The exception to this is expected to be the A&E 4 hour target. The A&E trajectory was set based on the following improvements being made external to the Trust:

- Delayed Transfers of Care rates reducing to 2.5% representing the NHSE stretch target from the 2015/16 baseline at the point of agreement
- CCG led provider and commissioner working groups established to implement GP front door model at BHH and GHH

- Based on Trust proposed contract plan for 2016/17 with seasonal adjustment. Any growth in excess of this puts the trajectory at risk
- Significant deviations in seasonal profile (as seen in 2015/16 actuals) will affect trajectory delivery

A&E attendances have grown by 4.2% in excess of the growth included within the contract plan and emergency admissions have grown by 1.5% in excess of the plan. Therefore the demand management schemes have not proved to slow the activity growth and the number of delayed transfers of care have not been reduced in line with the trajectory requirements. As such the improvement trajectory for 2016/17 is at risk.

The starting point for 2017/18 trajectory is 84% which is 1% lower than the likely outturn for quarter 3 of 2016/17 albeit December 2016 is forecast to be circa 80%. As discussed in section 2.1 above, discussions with commissioners are at an early stage and as yet minimal information has been received on the proposed demand management schemes. However, this plan indicates that if the planned QIPP interventions for the reduction of ED attendances deliver as intended, the Trust can achieve 90% by March 2018 as detailed in appendix 1. This trajectory is subject to a number of caveats and assumptions as detailed in the appendix.

For other performance targets, the Trust expects to continue to achieve the national targets subject to a number of risks which may impact delivery as follows:

- Increase in demand beyond modelled/assumed level in LDP
- Attrition/absence rate above normal levels i.e. increase in sickness absence, recruitment challenges for hard to reach professions
- Further junior doctor strikes and lost activity
- Further significant equipment failure beyond planned downtime (given the aged nature of the Trust's equipment)
- Increase in elective cancellations to support emergency pathway
- Change in NICE guidelines/national campaigns not supported by commissioning plan including 2 week waits
- Major internal incident resulting in business continuity within Outpatient Departments and Theatre Areas reducing activity levels
- Delayed Transfers of Care reducing elective and emergency bed capacity
- Increase in unbundled extending the non-admitted pathway
- Increase in C.diff resulting in ward closures impacting the admitted pathway
- Fines levied for underperformance where the value impedes Trust capacity investment decisions

- Cost/logistical constraints in delivering identified capacity solution

2.4 Flexibility to Meet Unplanned Changes in Demand

The Trust's operational plans are based upon a seasonally variable bed model and capacity plan (elective and non-elective). There is also the identification of planned flex beds bought on line at identified thresholds where demand materially rises above plan. Seasonal phasing of elective activity and the CCGs agreed utilisation of the independent sector at pre-determined periods offset the increased bed occupancy levels. This approach has seen the Trust turnaround performance against all mandated Cancer standards, RTT and Diagnostics within the last 12 months.

The Trust also commission's its own supported discharge services via a range of providers although is planning to consolidate these whilst increasing service provision throughout the coming year. This will be mapped to the overall demand and capacity model in an attempt to better support delivery of the 4 hour performance trajectory.

Across the wider system in recent months there has been the unplanned rapid closure of a significant number of enhanced assessment beds and other out of hospital capacity such as dementia beds all of which alter the baseline system capacity. This increases the numbers of delayed discharges within the local Acute Trusts thus impairing hospital capacity plans. Contingencies to overcome this are being worked through via the A&E Delivery Board and the BSOL STP. Outputs will feed into the Trust's operational improvement trajectories for 2017/18.

Executive led internally focused improvement work streams are in place and focus on:

- Emergency and Acute Care Improvements
- Length of Stay Improvements
- Scheduled Care Improvements

These work streams and their associated sub-groups drive the improvements in productivity, efficiency and performance necessary to provide greater flexibility in dealing with activity growth and unplanned changes in demand. They also capture the relevant elements of the financial recovery programme.

For unplanned changes in demand for elective services the Trust tracks the leading indicators of referrals and the new to follow-up ratios to inform commissioners of the changes to planned activity. This will inform

discussions about how best we should both prioritise internal and external capacity to meet the demand.

3. Quality Planning

3.1 Approach to Quality Governance

The Trust's Interim Deputy Chief Executive / Medical Director (DCE/MD) is the named executive lead for Clinical Quality. The DCE/MD leads the focus on quality, safety and the continual reduction of avoidable harm and developing sustainable systems that deliver high quality reliable healthcare. These systems are centered on patients and are devoted to learning, acknowledging the freedom to evolve locally and become rooted in a culture relentlessly focused on safety at every level. The DCE/MD chairs the Trust's Clinical Quality Monitoring Group where all aspects of clinical quality are monitored, discussed, challenged and driven forward. A monthly report to the Board of Directors (or Clinical Quality Committee) ensures that the Board is informed and able to take action, if required, in relation to matters of clinical quality and quality governance.

Key to the Trust's quality improvement is the programme of Executive Root Cause Analysis (RCA) and Board of Directors' Governance Visits. A wide range of identified omissions in care continue to be reviewed at the regular Executive Care Omissions RCA meetings chaired by the Chief Executive. Cases are selected for review from a range of sources including an increasing number put forward by senior medical and nursing staff: wards selected for review, missed or delayed medication, serious incidents, serious complaints, infection incidents, incomplete observations and cross-divisional issues.

3.2 Care Quality Commission (CQC) Rating

The Trust underwent CQC Assessment in October 2016. The initial feedback did not report any immediate patient safety issues. It is likely that the Trust rating will remain "Requires Improvement" but will have more areas rated "Good". On receipt of the final report the Trust will deliver all improvements via the divisional teams with clear Executive Leadership. Following completion of the required CQC service self-assessment, the Trust is now rolling out a revised compliance framework that allows individual services to self-assess against the CQC's standards and identify areas for improvement.

3.3 Care Quality Reporting

A monthly assurance report is presented to the Chief Executive's Group by the Chief Nurse and then on to the Board of Directors meeting detailing

monitoring against all of the Trust quality improvement areas. The key performance indicators cover all of the care quality elements of the single oversight framework, in addition to local and contractual indicators. The paper also updates on progress of Trust Quality improvement projects for example improving time form prescription to administration of stat dose antibiotics and timely administration of Parkinson's medication.

Where performance is consistently below target or trajectory an individual quality improvement plan is requested and shared with the commissioning CCG's.

The responsibility for quality improvement has been delegated to the Divisional teams but delivery is monitored at bi-monthly Divisional Performance Review Meetings which are chaired by the Chief Executive and attended by executive directors and the senior management team of the divisions.

In an attempt to increase the capacity and capability to deliver patient level quality improvement programmes the Trust is collaborating with a neighbouring Trust to train a group of consultant staff who will then supervise and lead medical and multidisciplinary teams who, in turn, will design and deliver quality improvement initiatives.

3.4 Summary of the Quality Improvement Plan

National Initiatives

The Trust's quality plans for key national initiatives are outlined below:

National Audits

Data is submitted to all mandatory national clinical audits. Outlying performance is referred back to the clinical area for investigation and remediation if appropriate. The Trust will report on national audit completion and learning outcomes from national audits at the Clinical Quality Monitoring Group.

Infection prevention and control

The Trust has a robust governance framework to deliver assurance of compliance with the Health and Social Care act, with specific improvement plans relating to reducing the risk of MRSA and C.Diff. These actions are monitored internally via the operational infection prevention group and Trust Infection prevention committee. The Chief Nurse holds executive responsibility for IPC and is supported by a consultant microbiologist who takes the role of Director for Infection prevention and control. The Trust works

closely with the commissioners undertaking RCAs of any serious incidence of infection, in addition to working with Public Health England for a number of specific areas such as TB, and CPE.

Anti-Microbial Resistance

The Trust is performing well in line with the national Antimicrobial Resistance (AMR) CQUIN 2016/17 to reduce total antimicrobial use in the Trust. Regular review of patients on antimicrobials is actively monitored by audits and these are used to identify areas where further improvement and intervention is required. Local antimicrobial resistance data is analysed and applied to optimise antimicrobial guidelines to ensure the best care is given to patients.

Sepsis

The Trust has a multi professional delivery group who are setting the framework to enable the Trust to deliver the national CQUIN in 2016/17 and this is expected to continue in 2017/19. Progress includes the redesign of SEPSIS package to ensure delivery of upgraded CQUIN and associated training tools, including a video which won an HEALEO award in 2016.

Tissue Viability

Avoidable Grade 2 and 3 Pressure Ulcers: The number of avoidable grade 2 and 3 pressure ulcers reduced significantly in year and remain on trajectory against the contract for year end. The embedding of the trust wide grade 2 avoidability checklists has contributed to this reduction of harm for patients.

The Trust has a monthly audit programme that monitors compliance with all nursing and midwifery documentation - Tissue viability metrics were compliant at 95% in October 2016 with repositioning frequency adhered to at 85% for the third month in a row in q3. A planned shared tissue viability learning event took place in partnership with the University Hospitals Birmingham Tissue Viability Team in September 2016. The event consisted of a review of performance, teamwork, systems and education and prevention in clinical practice. Shared learning took place across all four hospitals. The Trust has agreed the following actions:

- Review the size and capacity of the Tissue Viability Team to ensure capacity for wider education and training;
- Introduce a revised grading system by April 2017;
- Review numbers of patients versus numbers of pressure ulcers;
- Split data into harm by medical devices and non-medical devices;
- Introduce an electronic referral system.

The introduction of a quarterly Executive RCA Forum led by the Chief Nurse aims to identify any missed opportunities in care for all hospital acquired pressure ulcers grades 3 and above. A CCG themed review took place in June 2016. An assessment of 15 patients' documentation was undertaken. Overall findings were good with three recommendations that are currently being implemented; distribution of patient education leaflets, an audit of available lifting equipment and enhancement of staff education. An annual peer review of tissue care has also been introduced.

End of life care

A Baseline EOLC gap analysis has been undertaken using the new CQC standards. Initial acute trust recommendations have been identified against national standards. There are plans in place to further scope EOLC across acute trust and community services over the coming months with a view to seek opportunities for further integration. The Trust is currently in the process of writing an integrated Palliative and End of Life Strategy covering acute trust and Solihull community services. Work has already begun mapping both sectors to the National Ambitions document. The Trust is also an early adopter of the Resuscitation Council RESPECT process.

Seven Day Services

The Trust's assessment of its compliance with the four priority clinical standards for Seven Day Services shows that it is compliant or partially-compliant with all the standards with the exception of timely consultant review although this continues to improve through regular audit and action planning.

The Trust continues to work with its commissioners to seek the additional funding to allow it to address the areas of non-compliance. The Trust has mitigation plans to allay the risks associated with the areas of non-compliance and these will allow the Trust to continue to offer safe, high quality care around the clock. The Trust is participating in the programme of seven day service self-assessment surveys and showed strong performance in the most recent survey

Safe Staffing and Care Hours per Patient Day

The Trust is fully compliant with the NHSQB recommendations for safe staffing. In line with the Carter recommendations, e-rostering KPIs are reported to the Trust Board on a monthly basis and demonstrate safe and effective deployment of staff. Nurse staffing levels are reported monthly to Nursing and Midwifery Board and quarterly to Board of Directors. Both UNIFY compliance and CHPPD actual v CHPPD required are reported. Each ward is also RAG rated and any remedial actions needed are requested

from the division responsible for that ward and monitored by Nursing and Midwifery care quality committee and Divisional Review Meetings. The Trust is the lead employer for a pilot of the role of the Nursing associate, and a programme to increase its established Advanced Clinical Practitioner cadre.

Mortality Review

All Clinical Directorates hold Mortality and Morbidity Meetings. All deaths are reviewed (except elderly care where a representative cross–section of deaths and any deaths where care issues have been highlighted are reviewed). Medical Examiners review all death certifications and will highlight any area of potential learning or sub-optimal care. Immediate review of all deaths in patients undergoing elective surgery occurs. The electronic recording of M&M meetings is being piloted. This will facilitate the identification of themes and dissemination of learning. The Trust produces a “Mortality and Morbidity Journal” which further communicates learning across the Trust.

Following successful pilots, the Trust plans to expand the Medical Examiner review process to include investigation of all patient deaths. This will include expanding the number of Consultant Medical Examiners, a new, improved electronic scrutiny review form, new reports to enable the outcomes of Medical Examiner investigations to be easily analysed, a new process for reviewing the outcomes of Medical Examiner investigations taking into account national guidance and more closely aligned with specialty Mortality and Morbidity (M&M) meetings and the Clinical Quality Monitoring Group and regular reporting to the Clinical Commissioning Group on outcomes of Medical Examiner reviews.

Investigating and Learning from Serious Incidents

A new Serious Investigation Framework has been developed including a more robust investigation process and round-table discussion. The Clinical Governance team produce learning tools such as “Lesson of the Month”

Following completion of all SI investigations a “SI at a Glance” report is produced by the Investigations Team. This is a one page summary of the SI which includes key findings, recommendations, Trust wide learning. This is disseminated by the Safety & Engagement Manager.

Previously there has been a 6 monthly SI Themes and Trends report produced. This currently undergoing a review with a plan to become a quarterly report due to the number of SI investigations, and to also reflect the organisation structural changes; Divisional structure.

A theme identified last year was the delayed administration of time critical medicines. Because of this a significant effort has been put into improving the

timely administration of antibiotic first doses and medications for the treatment of Parkinson's disease. Each patient area now has a bleep which alerts a designated nurse when medication is due. Performance has improved from 48% to 80% and 65% to 75% respectively. Less well performing areas are identified and remedial action taken.

Maternity Care

In collaboration with the Birmingham Women's Hospital, the Trust is actively delivering the recommendations from "Better Births" and the Birmingham United Maternity Programme (BUMP) has gained early adopter status to support its delivery. The BUMP model is intended to radically redesign the Maternity and New-born System of care across the STP footprint, which will deliver improved outcomes for women, their babies, their families and the wider population including:

- A decrease in infant mortality
- An increase in homebirth and MLU births
- Improved experience for women as a result of reduced waiting times and better access to facilities
- Improved capacity across the STP
- Care closer to home

BUMP will also promote greater choice of:

- Elements of care
- Place of birth
- Additional services based on individual wishes e.g. extensive breastfeeding

Falls

Through a range of quality improvement initiatives, the Trust has consistently met the Royal College of Physicians recognised expected falls per 1000 bed days. Quality improvement is now focused upon reducing the number of patients who fall more than once, pain control for patients who fall and improving dementia, delirium and continence care, all of which contribute to the root cause of falls.

Patient Experience

The Trust has delivered a twelve month quality improvement plan to improve how the Trust handles and responds to complaints. This has involved a revised policy, a revised structure with roles and responsibilities for supporting the divisional teams, revised track and escalation procedure and

training programme. The performance against the Trust policy is reported to Trust Board on a monthly basis and an aggregated report of complaints concerns, FFT, learning and improvements presented on a quarterly basis.

Safeguarding

The Trust Board receive an annual report that provides an overview of the activity and achievements in relation to safeguarding adults and children and an account of the priorities and plans for 2016/17. The reporting covers both Safeguarding adults with care and support needs, and Safeguarding children. Safeguarding has been a priority for the Trust in the past year and many achievements have been made. These include:

- Increased investment in the Specialist Safeguarding Team to enable greater support to the frontline staff
- Engagement of the whole workforce in safeguarding education and increased the access or staff to training and a range of educational resources
- Enhanced audit activity to capture how effectively safeguarding arrangements are being discharged throughout the organisation.

3.5 Summary of Quality Impact Assessment Process

In response to a previous limited assurance internal audit opinion on CIP processes, the Trusts processes have been redesigned. The revised process has been reviewed with internal audit who have updated their opinion to moderate assurance as a result.

A new system has been introduced which provides a single repository for all schemes, including documentation of quality impact assessment, that requires approval by both the Chief Nurse and the Medical Director to confirm that a scheme does not negatively impact on quality of care prior to being implemented.

The initial ideas are developed within the divisional triumvirates involving clinicians, nursing, management, workforce and finance teams before progressing through the senior management teams. The senior management teams then present the schemes to the monthly CIP Steering Group which is attended by executive directors offering an opportunity to challenge the schemes being developed or to share learning/opportunities across the divisional teams.

Once a scheme is developed, including a full schedule of actions and milestones for delivery, the divisional senior management team will approve it's submission to the Chief Nurse and Medical Director. All information will be available for the Chief Nurse and Medical Director to review and will only

be completed, and released to progress, if they are satisfied that there is not a detrimental impact on quality of care.

Monthly reports are presented to the CIP Steering Group detailing the stage at which schemes are and when schemes have been approved. As the Trust progress, it is intended that this monthly report will include detail on milestone achievement and key performance indicators.

This process applies to all identified opportunities and they are assessed against the three core quality domains safety, effectiveness and experience.

3.6 Summary of Triangulation of Quality with Workforce and Finance

The Trust has implemented a new programme of regular reporting which provides assurance to the Board of Directors that the interconnections and commonalities between finance, quality and performance measures are considered and where necessary acted on.

The Chief Executive chairs bi-monthly Divisional Performance Reviews, attended by Executive Directors, at which the divisional senior management team are required to present on an exception basis across a number of indicators. The indicators covered include (not exhaustive):

- Clinical indicators as described above
- Performance information
- Workforce KPIs including sickness, vacancy rate, voluntary turnover, time to recruit, appraisal rates, mandatory training levels
- Finance information including expenditure variances, activity/healthcare income delivery and projections, CIP delivery and improvement/action plans

The Trust has a large degree of internal monitoring to allow for early indications of service issues and providing remedial opportunities. This is facilitated by a range of reports and processes along the hierarchy of clinical and managerial tiers ranging from individual appraisals and feedback to Trust Board performance reports by exception at intervals. The streamlining of Board subcommittees covering performance, clinical quality and care quality has ensured the Board of Directors has greater visibility on all issues and most notably quality. In this way, the Board has a clearer line of sight on all key issues and risks.

4. Workforce Planning

The Trust's workforce is circa 10,500 staff plus bank workers and is both highly valued and diverse. The workforce strategy is built on a series of overarching workforce priorities devised in advance of the current partnership working

arrangements with University Hospitals Birmingham NHS Foundation Trust (UHB), with actions to deliver the strategy being progressed.

The workforce strategy, and the assumptions made in devising the workforce response, will need to be reviewed taking into account the future working relationship with UHB and the broader issues impacting the STP workforce.

4.1 Planning Summary

NHSI Plan (Staff in Post)
Overall the plan shows a moderate increase in the substantive workforce of 90 WTE in year 1 and 87 WTE in year 2 from 9225.7 to 9316.1 WTE (Year 1) and 9316.1 to 9402.7 WTE (Year 2).

This is associated with increases in Senior Medics, Adult Nursing, support to Nursing, Radiology and ACPs (though noting the associated decrease in junior medic posts).

The Bank and Agency workforce shows an associated decrease of 133 WTE in year 1 and 86 WTE in year 2. The additional reduction is related to non-clinical temporary staffing usage.

4.2 Workforce Strategy

The Trust's underpinning workforce strategy is based on the following strategic workforce priorities:

- Leadership – devising clear leadership strategies and building current and future leadership capacity based on leadership models aligned to Trust values and behaviours
- Education and development – devising clear and accessible career pathways aligned to organisational and individual requirements and which enable the growth of internal talent
- Engagement and well-being – valuing diversity and promoting an inclusive and supportive work environments which equip all staff to engage, be empowered and able to challenge
- Organisational design – clear authority and accountability frameworks which underpin effective and affordable organisational structure, aligned to workforce plans which enable the Trust to access and retain sufficient volumes of skilled and qualified staff, particularly in hard to recruit areas
- Recruitment, resourcing and attraction – creating brand HEFT, which supports innovative recruitment and attraction solutions, and equips the Trust to compete for and retain quality staff

- Workforce performance – strengthen the links between workforce performance and operational effectiveness, and improving the availability and relevance of workforce data to drive improved management decision making, clinical effectiveness and efficiency

4.3 Governance

Oversight of the Trust's strategic workforce agenda sits with the Trust's Strategic Workforce Group (SWG) chaired by the Director of Workforce. Membership of the group includes executive directors and heads of profession. The group is responsible for monitoring the implementation of key workforce projects, including workforce planning, role redesign, inclusion, development and organisational and behavioural change.

The Group has had a key role in supporting workforce transformation and the culture and behavioural change necessary to drive performance improvements and enhanced patient care. This has occurred during a period of real challenge which has seen increased external scrutiny and partnership working with UHB.

The last 6 months has seen real performance improvement in the organisation with significant progress in relation to workforce KPI's and staff engagement metrics, including time to hire, and staff experience. These changes have enabled the Trust to take a much more positive approach to tackling recruitment and retention issues and initiate creative solutions to workforce problems – including successful campaigns to attract international nursing and medical applicants (European qualified nursing campaign, International Fellowship scheme with UHB) and provision of pastoral care support to new nurse graduates.

The SWG, supported by divisional and corporate review meetings and Finance recovery board, provides the governance structure against which oversight and monitoring of the workforce plan submission and workforce strategy is monitored.

4.4 Workforce Efficiency and Collaboration

The Trust has implemented performance improvements and efficiency in relation to mandatory training as part of its membership of the West Midlands streamlining project. Existing mandatory training programmes have been reduced by circa 50% with provision available through new on line learning platforms, reducing time clinical staff are away from the front line and enhancing productivity and patient experience.

In addition the Trust is collaborating with UHB and other STP partners to model delivery of a shared apprentice programme in response to the new

apprenticeship levy and creating new apprentice roles for front line and non-clinical roles. The Trust is registered as an 'employer provider' on the Register of Apprenticeship Training Providers, to enable delivery of internal training and contract with specialist training providers.

Separately, working collaboratively with UHB on the equality and diversity agenda given the overlaps between the two organisations including actions to support improved staff experience - which support the staff survey (dignity at work), workforce race equality scheme (access to equal opportunity, reducing discrimination) and LGBT workforce initiatives (Stonewall index).

4.5 Cost Improvement Programmes

2017 will see implementation of the Trust's review of administrative and clerical structures in line with a similar programme of work with UHB. Based on recommendations following an external review this will introduce a consistent structure of admin teams across the organization with standardised job descriptions, creating clearer accountability and reducing overlap.

The impact of this project financially is reflected in the plan. In addition, having restructured and realigned our operational management structures and achieving reductions in management posts and layers, the Trust is reviewing converting midwifery or qualified nursing posts to associate / assistant / support roles**.**

Non frontline (corporate) functions have also undertaken reviews of their structures and a combination of MARS programme and post rationalisation, plus minimisation of reliance on admin and clerical agency approaches have been deployed. Corporate functions continue to review structures in line with CIPs for 2017/18 and the impact of this has been included in the workforce plan assumptions.

4.6 New Roles / Ways of Working and Workforce Initiatives

The Trust's new apprentice programme gives access to a broad range of apprenticeship frameworks enabling the Trust to build talent pipelines, forge greater links with local communities and schools and address the impact of our ageing workforce. The intention is to create over 200 opportunities, and fit these roles into new career frameworks covering both clinical specialities and non-frontline support functions, at various levels up to and including degree / professional qualification.

The apprentice programme will be delivered in partnership with UHB whilst also exploring a broader STP footprint approach in line with the objectives of developing generic apprentice roles, leading to later specialisation supported

by access to work experience placements across health and social care partner organisations.

The Advanced Clinical Practitioner (ACP) programme (up to A4C 8a/b level) offers the opportunity to up-skill existing registered nurses and Allied Health Professional's (AHPs) and deploy these roles to help manage the whole range of conditions at a generalist level for all ages and across the acuity and speciality spectrum. The programme is intended to:

- Provide further career development for existing clinical professionals
- Respond to the key workforce challenges identified within the Skills for Health workforce report for the Birmingham and Solihull health economy
- Respond to retention issues at this level, and in part respond to the national shortage of middle grade doctors
- Support plans to further reduce reliance on medical locums

Oversight of the delivery of this programme is managed through a dedicated extended and advanced practice project board, reporting to the Strategic Workforce Group.

Efficiency improvements in rota management and job planning are currently being delivered through the use of e-rostering and electronic job planning. The Trust is further developing job planning frameworks for other clinical professionals designed to improve capacity planning and enhance clinical productivity, as well as pursuing existing processes for engagement and deployment of bank staff including potential shared nurse and HCA bank worker provision across STP partners.

5. Financial Planning

5.1 2017/18 and 2018/19 Financial Plan Summary

The Trust's 2017/18 financial plan forecasts a financial deficit of (£7.5m) in line with the control total communicated to the Trust in November 2016. This is based on an assessment of the draft payment by results tariff published in September 2016 and includes the Trust's £21.3m general allocation from the Sustainability and Transformation Fund (STF).

The Trust's 2018/19 financial plan forecasts a financial surplus £0.6m, including the Trust's £21.3m general allocation from the STF and assuming full delivery of year 3 of the Trust's Financial Recovery Plan. This meets the

NHSI requirement to set a control total that delivers demonstrable improvement beyond the 2017/18 position, and achieves the following:

- Delivery of the full value efficiencies agreed as part of the FRP submission.
- Delivery of a position for 2018/19 that is £21.8m better than the FRP assumption, which was a (£21.2m) deficit. This difference includes £9.6m of extra STF but the remainder represents additional improvement delivered by the Trust.
- Achieving the overall stated FRP aspiration of overall breakeven by the end of year 3 of the recovery period.

There is still some uncertainty in the following areas at this stage of the process, including:

- Pay award notifications
- Finalisation of outstanding detail around 2017/18 and 2018/19 contract negotiations with commissioners, including QIPP schemes and CQUINS.

The plans of (£7.5m) deficit and £0.6m surplus for 2017/18 and 2018/19 respectively represent a challenge to the Trust as detailed in the table below.

	2017/18	2018/19
	£m	£m
Prior Year Forecast Outturn	**(13.6)**	**(7.5)**
Remove STF Allocation	(23.3)	(21.3)
Add Back Prior Year Non Recurrent Adjustments	(1.3)	(1.7)
Impact of Planning Assumptions	(16.1)	(15.6)
Savings within FRP plus Stretch Savings	25.5	25.4
Final Plan pre STF	**(28.8)**	**(20.7)**
General STF funding	21.3	21.3
Submitted Final Plan post STF	**(7.5)**	**0.6**

5.2 Financial Forecasts and Modelling

Key assumptions made whilst developing the financial plan include:

- The Trust achieving the forecast outturn deficit of (£13.6m) for 2016/17
- Local prices are increased by 0.1% in line with national tariff
- Forecast activity growth is paid for in line with Payment by Results rules

- Fines are suspended with the exception of readmissions in line with 2016/17
- CQUIN funding is received at 100% irrespective of delivery and that additional cost is not required to deliver
- Commissioners do not implement QIPP schemes besides genuine reductions in PbR activity
- General STF is received at £21.3m as per the offer
- Full delivery of savings schemes as identified within the Trust's Financial Recovery Plan submitted in May 2016 and additional stretch savings

Forecast Outturn Deficit

The Trust's control total for 2016/17 is a deficit of (£13.6m), assuming full receipt of £23.3m of STF income. The reported forecast at month 7 was a deficit of (£19.0m) with full STF or (£24.8m) if Q4 STF is foregone, as would be the case if the overall control total is not met. This reported forecast has been changed in month 8 to reflect the (£13.6m) deficit in line with the control total, assuming full receipt of the STF income and this forms the basis of the starting point for the 2017/18 plan.

As at month 8 of 2016/17 the Trust has reported a deficit of (£12.5m) which is in line with the plan of (£12.5m) at this point of the year and so is on track against the control total trajectory. Based on the stronger than expected performance in the first half of the year and the improving run rate in recent months it is now projected that the Trust will finish the year with a deficit in the region of (£15.1m) including full STF. This is better than the previous forecast of (£19.0m) but remains worse than the control total of (£13.6m). There are significant risks to this revised forecast including:

- Continued access to the 30% of STF funding that is subject to operational performance. This includes 12.5% relating to A&E for which the Q3 trajectory is at risk and therefore may require a successful appeal to recover lost STF income
- No material loss of CQUIN income in Q3 and Q4 beyond the current projections
- The impact of winter pressures with regard to additional costs or loss of elective income
- Delivery of the Financial Recovery Plan savings, which step up in the second half of the year, in particular in relation to length of stay savings, procurement and nursing

If the Trust can deliver an underlying deficit in the region of (£15.1m) it should then be possible to achieve the control total using non-recurrent flexibility.

Operating Income Plan

Baseline Activity and Income

Contract negotiations with commissioners have moved forward with the organisations having a common understanding of the baseline activity and the growth projections for the coming year. This forms the basis of the contract signed on 23 December 2016.

The assumptions used in the Trusts plan for the baseline activity/income are shown in the table below:

Item	Assumption
2016/17 outturn	Projection based on Month 1-4 actual
2017/18 & 2018/19 tariff	Use September published tariff i.e. average 0.1% increase plus targeted increase for CNST
Other	Apply other business rule changes
2017/18 & 2018/19 local prices	Apply tariff guidance of 0.1% increase
Winter / Non Recurring funding	Assumed no additional funding provided as in 2016/17.

The other main change for 2017/18 is that Non-Emergency Patient Transport will be commissioned directly from 1 April 2017 which results in a £2.7m income reduction for the Trust, with a corresponding reduction in direct expenditure.

Growth Activity and Income Assumptions

The Demand and Capacity Review Group have reviewed trends of demand over the last three years and projected the activity that could reasonably be expected during 2017/18 including the impact of reducing the waiting list backlog as described in section 2 above. Across most areas this growth is anticipated to be between 1% and 2% with some noticeable exceptions in specialties where significant backlogs exist.

The Trust's assessment was shared with commissioners and agreement was reached on the level of growth to include in the contract at a slightly lower level but with terms and conditions to protect the trust from under-commissioning. The contracted growth has been included in the plan.

The commissioners are also progressing with a number of demand management schemes (QIPP) some of which are at a very early stage. Initial information received suggests that there are some schemes which may deliver reductions in activity with the support of the Trust's staff but there are others, which are less well progressed, which appear to be outside of the

control of the Trust and lack the information required to assess the deliverability.

As set out in section 2 above, it is assumed that around 30% of QIPP will deliver but further work is required to refine and agree the assumptions for the remaining schemes. In overall terms the income plan is £11.9m above the total value of contracts signed but the plan currently includes an expenditure provision for growth of £10.5m in 2017/18 which would not be required if the QIPP schemes deliver.

The 2017/18 and 2018/19 operating income plan is summarised below:-

	2017/18		2018/19	
	£m	£m	£m	£m
Forecast Outturn		713.1		726.0
Incremental Changes				
Prior Year Non Recurrent Items	(23.3)		(21.3)	
Healthcare Income Adjustments	11.5		14.8	
Income Generation CIP Schemes	3.5		5.3	
Current Year Non Recurrent Items	21.3		21.3	
		13.0		20.1
Income Target		**726.0**		**746.2**

Operating Expenditure Plan

The assumptions made in the initial 2017/18 and 2018/19 operating expenditure estimates are set out in the table below:

Item	Value 2017/18	Value 2018/19	Assumption
Pay Inflation	£3.9m	£4.0m	Based on 1% uplift of substantive pay bill
Other Pay Pressures	£2.7m	£2.6m	Based on tariff uplift net of 1% pay award
CNST Premium	£2.1m	£4.1m	Based on notification and 17.5% uplift in 2018/19
Clinical Excellence Awards	£0.2m	£0.2m	Based on award in 2016/17
Reduction of Patient Transport Costs	(£2.7m)	£0.0m	100% of income reduction
Apprenticeship Levy	£1.1m	£0.0m	Assumed that half of levy is mitigated through scheme benefits

Other Misc.	£0.3m	£0.1m	
Subtotal Trustwide Costs	***£7.6m***	***£11.0m***	
Specific Non-Pay Inflation	£5.2m	£5.7m	Based on tariff uplift
Healthcare Activity Growth Costs	£8.9m	£9.2m	Assumed 100% of growth income net of income backed costs within service developments
Other Expenditure Reserves	£4.0m	£4.0m	Based on divisional submissions and same level assumed for 2018/19
Service Developments	£2.0m	£2.0m	Based on agreed and developing cases
Total Savings Target including Stretch	(£25.5m)	(£25.4m)	As detailed for years 2 and 3 of the Financial Recovery Plan (including £3.5m and £5.3m respectively of income generation schemes with Operating Income)

The 2017/18 and 2018/19 operating expenditure plan is summarised below:-

	2017/18		2018/19	
	£m	£m	£m	£m
Forecast Outturn*		(720.1)		(726.3)
Incremental Changes				
Prior Year Non Recurrent Items	1.3		1.7	
Trustwide Costs	(7.6)		(11.0)	
Specific Non-Pay Inflation	(5.2)		(5.7)	
Healthcare Activity Related	(8.9)		(9.2)	
Other Expenditure Reserves	(4.0)		(4.0)	
Service Developments	(2.0)		(2.0)	
Total Savings Target including Stretch	22.0		20.1	
Current Year Non Recurrent Costs	(1.8)		0.0	
		(6.2)		(10.0)
Planned Expenditure Budget		**(726.3)**		**(736.3)**

*Forecast as at Month 6

Depreciation has been maintained at the 2016/17 forecast level of £16.0m.

Non-Operating Expenditure

The PDC value has been kept at the 2016/17 value of £6.3m until the impact of the valuation on assets has been completed. There is a small increase in

the interest payable charges assumed across the two years as a result of the Distressed Financing Facility together with the capital loan associated with the ACAD development.

5.3 Efficiency Savings for 2017/18 and 2018/19

As detailed in the Financial Recovery Plan the Trust has set an initial target on the basis of the tariff efficiency requirement (with a higher ask of c4% for corporate departments), which results in CIP targets of £15.3m and £14.9m respectively. This should comprise robust recurrent cash releasing efficiency savings such as:

- Pay savings - relating to a reduction in budgeted establishments, skill mix changes, etc.
- Non Pay savings – procurement savings, volume reductions, etc.
- Cat C income – increase SLA income, trading income etc.

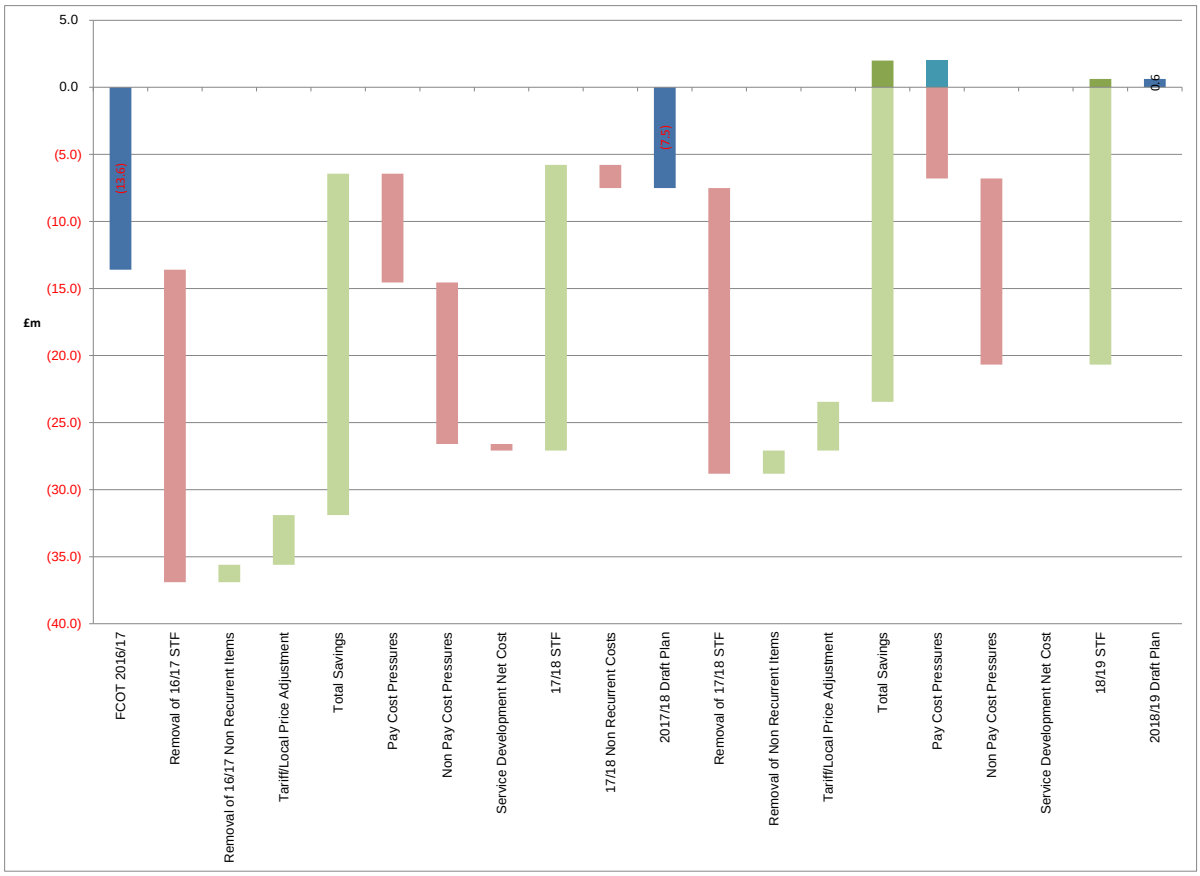
In addition to the local CIP targets, the Trust is also required to deliver the additional efficiencies that were agreed as part of the development of the Financial Recovery Plan (FRP). The savings included within the FRP are £6.3m and £10.5m for 2017/18 and 2018/19 respectively. The main schemes for each of the years are as summarised below.

	2017/18	2018/19
Radiology Productivity	0.1	0.1
Accommodation	0.5	2.8
Non Pay Savings	1.1	-
Length of Stay Savings	2.5	2.6
Theatre Productivity	0.5	-
Corporate/Admin Savings	0.6	2.0
Clinician Efficiency	1.0	3.1
Grand Total	**6.3**	**10.5**

An additional stretch savings target of £3.9m, above the original FRP assumption, is required in order to achieve the 2017/18 control total of (£7.5m) deficit. The plans include total savings of £25.5m and £25.4m for 2017/18 and 2018/19 respectively.

5.4 Summary Draft Income and Expenditure Position

The table below summarises the 2017/18 and 2018/19 plan based on the income and expenditure assumptions listed above.



5.5 Capital Planning

The Trust has only committed capital expenditure for 2017/18 and 2018/19 to the extent that it can be financed from internally generated funds. This results in a maximum capital programme of circa £16m in line with the forecast depreciation charge.

The exception to this is expenditure on schemes for which external funding has been agreed or is expected to be agreed. For HEFT this currently only includes the ACAD Development. The Trust has received pre-approval from the Department of Health for loan funding for the first phase of this development (enabling works and development of Full Business Case). The full application is due to be submitted in early January 2017 for an initial draw down in February 2017.

The full business case is due to be completed and submitted to Department of Health during quarter 3 of 2017/18 at which point the Trust would expect that approval for the loan for the whole development will be agreed and can progress.

The five year capital programme for the Trust includes the next anticipated estate development of the Tower Block. The Department of Health have

committed to work with the Trust in identifying a funding stream for this development but as yet this work has not begun.

The Capital Prioritisation Group is still in discussion with regards the 2017/18 programme but initial high level allocations are made up of the following key areas:

	2017/18	2018/19
Medical Equipment	4.0	5.0
ICT	2.2	2.5
Facilities/Estates	2.0	3.0
Good Hope Maternity	2.5	0.0
Contingency	5.3	5.5
Subtotal	**16.0**	**16.0**
ACAD Development	2.1	23.3
Grand Total	**18.1**	**39.3**

The detailed list of the capital plan will be submitted, reviewed and discussed at a future meeting of the Board of Directors.

Further options are being explored to aid the modernisation of the equipment across the sites including a proposed Managed Equipment Service for the Endoscopy Suite on the Heartlands site.

5.6 Risks and Caveats

There are a significant number of variables which impact on this financial plan. The main uncertainties and risks include:

- Costs increase during the latter part of the 2016/17 financial year, making it impossible to achieve the (£13.6m) deficit without increased non-recurrent flexibility
- Full delivery of the savings associated with the FRP in 2017/18 and 2018/19 is required
- Losses arising from QIPP or CQUIN as detail is finalised.
- Delivery of a stretch savings target in 2017/18 for which plans are yet to be identified and developed
- Any unforeseen national policy decisions which have an adverse impact in the next two years
- Any significant increases in the rate of inflation as a result of Brexit

6. Link to Sustainability and Transformation Plan

The Birmingham and Solihull Sustainability and Transformation Plan was submitted on 21 October 2016. The programme focuses on delivery in three key areas:

- Creating Efficient Organisations and Infrastructure
- Transformed Primary, Social and Community care (Community Care First)
- Fit for Future Secondary and Tertiary Services

Whilst feedback from NHS England recognises the progress made on building more productive relationships across the system, it highlights that further work is required to develop an integrated health and social care system with an accompanying level of detail that is robust enough for system based operational planning.

Whilst the Trust is in the early stages of working with Commissioners on the potential redesign of a number of clinical pathways, the operational proposals contained within this plan have been prudently based on accurate historic baseline activity, plus growth to achieve national targets based on internal capacity and demand models.

7. Membership and Elections

7.1 Membership Strategy

The Trust has re-visited its membership strategy and is reducing its total membership to a number more in line with other large acute foundation trusts but to maintain representative demographics. The driver behind this is to encourage a more engaged membership.

A Governor committee reviews membership and community engagement matters. The Trust regularly runs community engagement activities both at weekends and on evenings throughout the year which include work with a youth forum and election of a ‘young governor’.

7.2 Governor Elections and Recruitment

In accordance with the Trust’s constitution, the latest Governor elections were held in the summer of 2016 for all seats. Consideration has been given to revise the constitution to provide for one-third of Governors to retire and, if applicable, seek re-election each year, to smooth the potential turnover of Governors, if adopted this will become effective from 2017.

Governor recruitment focused on two areas in the run up to the 2016 elections (1) seeking nominations direct from current members, and (2) community engagement events to encourage non-members to join and nominate. The Trust utilised a mixture of its own and Govern Well resources for both induction and continuing Governor training.

Appendix 1: Accident and Emergency 4 Hour Improvement Trajectory

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Attendances	22,519	22,761	22,876	23,602	21,938	22,269	22,649	21,941	22,430	21,793	20,874	24,267
Breaches	3,603	3,414	3,317	3,304	2,962	2,895	2,831	2,633	2,692	2,615	2,296	2,427
Performance	84.0%	85.0%	85.5%	86.0%	86.5%	87.0%	87.5%	88.0%	88.0%	88.0%	89.0%	90.0%

Assumptions :

Monthly/Quarterly Accident and Emergency attendances no higher than LDP (inc full delivery of agreed NEL QIPP schemes)
Monthly/Quarterly Emergency admissions no higher than LDP (inc full delivery of agreed NEL QIPP schemes)
Total DToC % reduces in line with NHSE requirement (stated in Nov 2016)
Emergency Department conversion rate to emergency admissions do not increase beyond the 2016/17 baseline
No community or social care beds are closed over revised 16/17 baseline
No further reductions in social care provision due to budget constraints
No reduction in reablement capacity (independent sector) from revised 16/17 baseline
No 12 hour trolley waits caused by delays in the mental health pathway
No reduction in RAID or PDU capacity
Bed closures owing to infection issues at or below the 2016/17 baseline
Reported Emergency Department performance to include all valid attendance types
Seasonal variation in line with the 2016/17 actuals
No significant changes in ambulance conveyances from the 2016/17 baseline as a result of organisational changes external to the Trust