NHS
Bradford District Care
NHS Foundation Trust

# Operational Plan 2019/20

Bradford District Care NHS Foundation Trust

# Contents

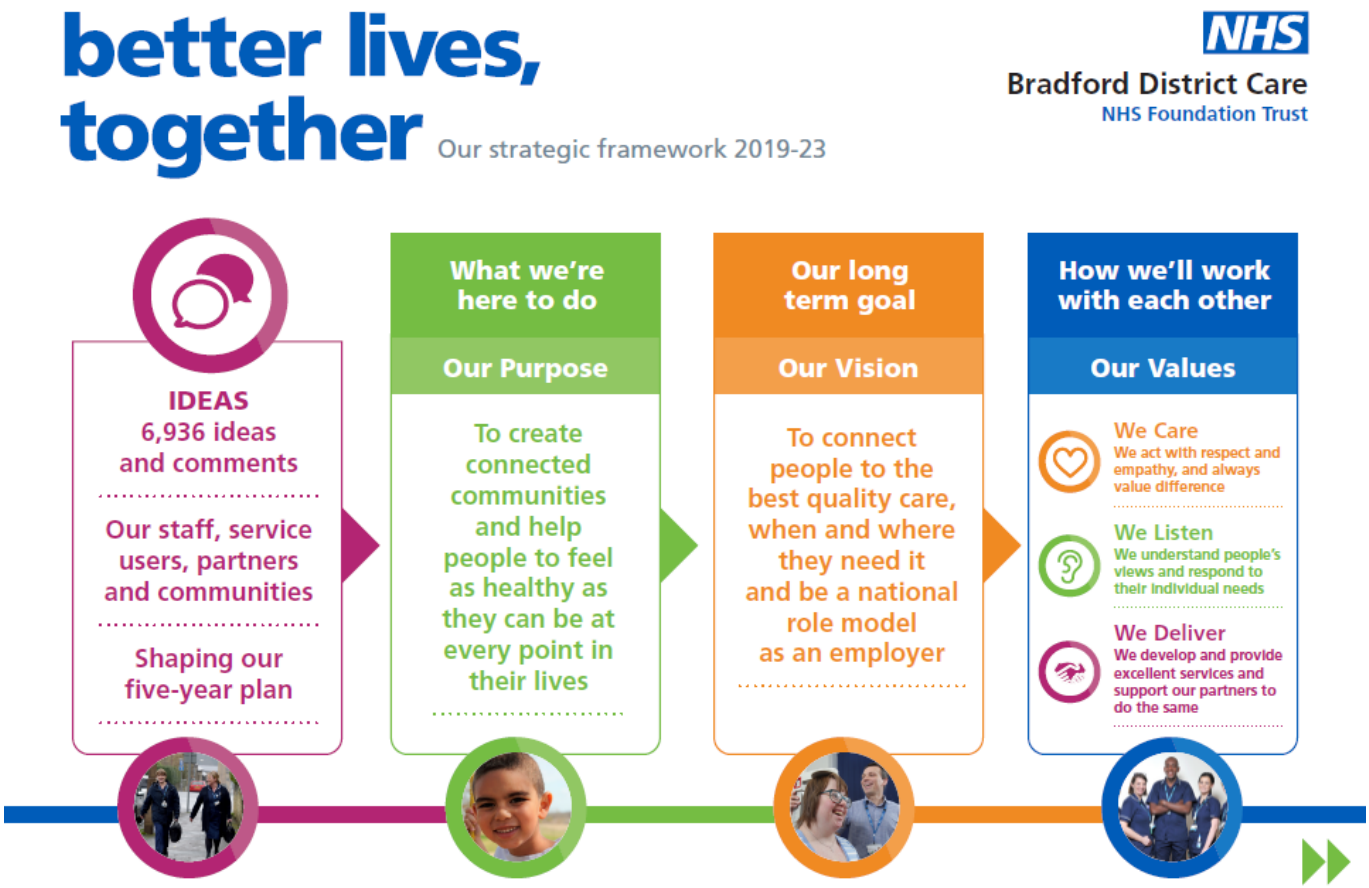
# 1. STRATEGIC FRAMEWORK

In February 2019 we launched the Trust's new strategic framework and our ambitions for the next five years (2019-23). This framework reflects the views of our staff, key partners and local communities, who have all been actively involved in developing our new vision and values, and our long term strategic plan.

Our services touch every part of the wider health and social care sector. We know that for some, the health and care environment can be a complex place to navigate and in conversations with our stakeholders when developing our strategic framework, they have said that we are well placed to help people make sense of this. We are seeking to build on this to better co-ordinate and connect people to the right care across the communities we serve. Working seamlessly with others, we will make it easier for people to get services where and when they need them, ideally in the community, to improve their experiences and outcomes, and support recovery and wellbeing.

A number of ambitious enabling programmes covering key areas will help us to bring this to life. These include community engagement, continuous quality improvement, digital transformation, leadership and staff development, estates, service innovation and growth.

The strategic framework is summarised below. There is a more detailed strategic framework on the Trust website.



# better lives, together

Our strategic framework 2019-23

NHS
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## What will we do to achieve our vision

### Our goals

**Our services**

To provide seamless access to the best care

To provide excellent quality services

**Our community**

To provide our staff with the best places to work

To support people to live to their fullest potential, to be as healthy as possible

## We will do this by:

**Improving**

**Innovating**

**Growing**

## For services and communities...

We are a partner of choice and service users' first point of call

We are well led and well managed

Work is meaningful

Our workplace is fit for purpose

## With great ....

Service user experience and outcomes

Staff satisfaction

Regulator ratings

External recognition

## Bringing it all together


Everything we do over the next five years will contribute to one or more of these four goals to achieve our vision of connecting people to the best quality care, when and where they need it, and be the best place to work

# 2. QUALITY

*All our staff will continue to maintain a focus on our three Quality Goals:*

- *SAFE "we will continually improve the safety of our services"*
- *EFFECTIVE "we will strive to achieve excellent outcomes across all our services"*
- *PERSONAL "we will make our services more responsive by involving service users, carers and staff"*

## 2.1 APPROACH TO QUALITY IMPROVEMENT, LEADERSHIP AND GOVERNANCE

"For improvement to flourish it must be carefully cultivated in a rich soil bed (a receptive organisation), given constant attention (sustained leadership), assured the right amounts of light (training and support) and water (measurement and data) and protected from damage." (Shortell et al, 1998).

Improving quality and reducing costs are two sides of the same coin and the potential benefit is greater if there is a systematic improvement approach.

Studies have shown that board commitment to improvement is linked to higher quality care so, in December 2017, the Trust Board was one of the first in the country to pilot a module from NHS Improvement's new 'Leading For Improvement' programme and the learning from that session has inspired our re-focussed approach to Quality Improvement (QI).

The Trust is implementing a formal Quality Improvement System (The Care Trust Way) based on the Virginia Mason Production System approach. We are being supported by Tees, Esk and Wear Valleys NHS Foundation Trust, which has over ten years' experience of successfully implementing this method. A number of our senior team have already undertaken Certified Leader Training (CLT) and we will roll out further training for significant numbers of staff over the next 12 months. In June we will begin a rolling programme of Rapid Process Improvement Workshops (RPIW). We have begun to institute weekly 'report outs' at the Senior Leadership Group and will gradually embed these at all levels of the organisation.

We are establishing a Kaizen Promotion Office (KPO) to facilitate the spread of our Quality Improvement System throughout the Trust and to ensure that we maintain fidelity to our chosen method.

A key component of embedding our chosen Quality Improvement method will be the parallel roll-out of coaching training for staff. We have engaged an experienced agency to help us develop a large cohort of coaches to help other staff develop solution-focussed thinking.

The Trust recognises that this is the start of a long journey of continuous quality improvement. As a priority on the back of recent CQC feedback we are now using our learning in QI to strengthen our assurance processes including escalation from service level through our operational and clinical governance structures through to Board level. We are confident that, if we stay true to our chosen approach, our patients, staff and other stakeholders will reap the rewards, as has been demonstrated in other healthcare providers, both within the NHS and further afield.

Leadership of the Quality Improvement System rests with the entire Board but specific executive responsibility sits with the Chief Operating Officer.

Executive leadership of quality governance is provided by the Director of Nursing. The key functions for ensuring effective quality governance sit within the medical and nursing directorates and include; research, risk management, serious incident management, clinical audit, complaints and litigation management, clinical policy development, implementation of NICE guidance and quality performance monitoring, amongst others. Each function is responsible for ensuring delivery against area specific objectives. They are also responsible for providing appropriate data, information, support and advice at all levels of the organisation.


Excellence in Quality Governance allows for robust Quality Assurance, whereby we provide objective evidence to our patients, staff, carers, commissioners and the wider public that we are delivering the safe, effective and person-centred care which they all expect.

Quality and Safety Groups operate at various levels of the organisation, with responsibility for ensuring that learning, from our internal systems of quality governance and external assessments, is effectively disseminated. The Trust has developed a bespoke 'Learning Network' on the intranet which provides an easily accessible and searchable database of important learning which has emerged through clinical governance processes. A learning network update is standard business at all Quality and Safety Group meetings.

The Quality and Safety Committee (QSC) is the principal committee for monitoring and seeking assurance on clinical and service quality issues including the Trust's quality governance processes; the committee dashboard allows scrutiny of specific quality and safety issues. QSC is accountable to the Board and escalates quality or safety concerns as and when necessary. QSC meets every six weeks and is chaired by a non-executive director. QSC:

- provides assurance to the Board on the quality and safety of clinical services;
- escalates any risk to the delivery of quality to the Board in accordance with the Trust's integrated governance arrangements;
- provides assurance to the Board on CQC regulatory requirements and findings from CQC inspections; and
- receives assurance from a number of sub-groups that report directly to QSC such as: Medicines Management Group; NICE group; Infection, Prevention and Control Committee; Mortality and Duty of Candour Review Group; Safeguarding Forum and the Clinical Audit Steering Group.

Specific methods utilised by the Trust include:

- **Forward to Excellence sessions** regularly bring together Board, senior clinicians and senior managers to consider a key area of quality. At each session, a small number of objectives are identified to ensure that learning is used to improve quality.
- An annual programme of **Board Quality and Safety Walkabouts** pairs a non-executive and executive director to visit services. The primary objective is open and honest discussion with

staff about quality and safety; services receive a letter within one month, detailing discussions and any agreed actions.

The Trust has invested heavily in our Quality Improvement System, and, when combined with strong quality governance we are confident that this will drive up standards across all our services, delivering better, safer care for those who use our services and helping us to improve our CQC rating. We will monitor progress via a range of key performance indicators, tracked where possible, using Statistical Process Control methods.

## 2.2 SUMMARY OF THE QUALITY IMPROVEMENT PLAN

We will:

- Introduce the 'Care Trust Way' to all staff;
- Transform CAMHS services;
- Implement new 0-19 service model;
- Introduce a new approach to talent management;
- Launch a new involvement strategy;
- Transform dementia services;
- Work with local primary care networks to provide flexible, integrated community services;
- Deliver our 'care closer to home' programme to improve the safety and responsiveness of mental health services for working age adults.

In developing the quality improvement plan the Trust has taken into account:

- National and local commissioning priorities;
- Trust quality goals;
- Existing quality concerns and plans to address them;
- Key risks to quality and how these will be managed;
- The West Yorkshire and Harrogate Health and Care Partnership plan; and
- The Gosport Independent Panel Report.

**Top Three Risks to Quality:**

***SystmOne for mental health;*** in 2018 The Trust went live with a new electronic patient record, for mental health, called SystmOne, which replaced our previous electronic record. We have worked through a number of post implementation issues. Now, as we embed the system, there is a risk that we have insufficient in-house capacity and capability to make the necessary configuration changes. As a consequence, it is essential that we prioritise those configuration changes appropriately.

***Medical staffing levels;*** 2018 saw improved recruitment across many areas but recruitment of consultant psychiatrists, particularly in general adult psychiatry, remains a significant challenge with a high percentage of posts filled by locums which increases costs and reduces resilience. Although this reflects a national problem, the Trust is taking a number of actions to mitigate the risk including the introduction of a 'functional' model in adult psychiatry (making jobs more attractive), improved medical leadership opportunities and working with locums to convert them into substantive post-holders.

***Investment in core services;*** the Trust welcomes the new settlement for the NHS and the Long-Term Plan which places a renewed emphasis on mental health and community services. We know that, locally, historic investment in both mental health and community services has failed to keep pace with demand; this is evident from the Trust's low reference costs. We have developed

a clear list of priorities, alongside a compelling narrative, which will see investment in sustainable, resilient core services during 2019/20. The simultaneous introduction of our QI system (as described above) will ensure that the extra investment adds genuine value and is not wasted.

## Existing Quality Concerns

Our February 2018 CQC report gave us an overall rating of 'Requires Improvement' and a number of specific areas where the Trust needed to take action. Whilst the actions have been completed, it will be necessary to maintain a strong focus, particularly around compliance with mental health legislation. The CQC undertook a further inspection of various core services during March 2019 and a well-led inspection in April 2019. The Trust is awaiting publication of the report and will implement any resulting actions. The Trust received correspondence from the CQC on 28 March 2019 highlighting concerns about the quality of care for the regulated activities we provide for the assessment or treatment for persons detained under the Mental Health Act 1983, treatment of disease, disorder or injury. The Trust commenced a significant and immediate Executive-led response that mobilised clinical, operational and corporate staff to consider the findings and develop responses to ensure the safety and quality of our services. Assurance on the Trust's systems and processes was requested by mid-June. Progress will be monitored during 2019/20 by the Trust Board and its Committees.

The restrictive interventions group will maintain oversight of any practices which could be construed as representing a 'blanket restriction' as this continues to be a theme in mental health act inspections.

The Mental Health Legislation Committee will ensure Board-level grip, not only over restrictive interventions, but also the use of restraint, high quality care planning and documentation of Section 17 leave and reading of rights.

## Learning From Deaths

The Trust remains part of a 'Northern Alliance' of nine mental health, learning disability and community providers which is taking forward a single operating model for mortality review. Our 'Learning From Deaths' policy was approved by the Board in September 2017 and we are now publishing mortality data and associated learning on a quarterly basis, in line with national expectations.

A Mortality and Duty of Candour Review Group meets on a weekly basis, chaired by the Medical Director; learning from national reports, such as Gosport, is considered by this group. The Trust maintains a high reporting rate for incidents, in line with our culture of openness and learning.

All Serious Incidents and Duty of Candour incidents are discussed monthly at Trust Board. A Board commissioned external review of deaths by suicide, within our inpatient and crisis services, was received and presented to the Trust Board in March 2019, with all recommendations accepted in full and due to be implemented in 2019/20.

## Infection Prevention and Control

The Trust has a comprehensive annual programme in place to reduce healthcare associated infections and will continue to implement this year on year; this includes education, policies and procedures, audits and surveillance. The Trust's infection prevention annual programme includes actions that are relevant to reducing Gram-negative bloodstream infections. The Trust also contributes to the local health and social care economy's district wide joint infection prevention

action plan and to the joint provider and commissioner improvement plan for the reduction of E. coli infections and Gram-negative bloodstream infections.

## 2.3 SUMMARY OF THE QUALITY IMPACT ASSESSMENT PROCESS AND OVERSIGHT OF IMPLEMENTATION

The Trust has a robust Quality Impact Assessment (QIA) process; all change plans are initially assessed by the Medical Director and Director of Nursing and referred to a full panel where potential risks to quality are identified. The panel is chaired by the Medical Director and attended by the Director of Nursing, the project lead, senior clinical staff and senior operational staff. The QIA tool used by the Trust takes a 'tiered' approach with a numerical risk score being applied.

The elements against which the review is undertaken are as follows:

| | | | |
|---|---|---|---|
| Duty of quality | Patient safety | Productivity & innovation | Clinical effectiveness |
| Patient experience | Resource impact | Workforce impact | Privacy impact |

This format encompasses and builds on the five CQC key questions; where any aspect scores eight or above a more in-depth assessment is undertaken; where any aspect is scored at 15 or over the plan will not proceed and further work will be undertaken to mitigate risks. Where any risks to quality are identified, measurable impact assessment indicators are identified; these are 'early warning' indicators to identify whether implementation of the plan is affecting quality. In addition, all QIAs are reviewed by the Medical Director and the Director of Nursing on a six monthly basis, or more frequently if required e.g. where there is a change to the original plan. All completed QIAs and associated indicators are signed off by the Medical Director and the Director of Nursing.

The Board will retain oversight of the cumulative impact of CIPs (in terms of quality and safety) via the Integrated Performance Report (IPR) which is scrutinised at every public Board meeting. The IPR contains information on quality and safety, outcomes, workforce, activity and finance, allowing correlation between all these variables to take place. More detailed scrutiny of the impact of individual CIPs will take place at Board Committee level (usually the Quality and Safety Committee) through their own dashboards or, where necessary, a 'deep dive' process.

Successful delivery of our quality plan will clearly help us to realise both the purpose and vision set out in our new strategic framework and will be dependent upon every member of staff modelling our values (we care, we listen, we deliver).

# 3. WORKFORCE

*Our workforce plans focus on three key areas:*

- ***Ensuring sufficient workforce capacity and capability*** *by attracting people into the workforce (focusing particularly on widening access) developing and retaining them*
- ***Ensuring workforce efficiency, effectiveness and productivity*** *by looking after the health and well-being of our current workforce, ensuring excellent, values driven leadership and being an exemplar employer*
- ***Working in partnership across Bradford District and Craven and the West Yorkshire and Harrogate Health and Care Partnership*** *to support service transformation*

For 2019/20 and beyond the focus is to **optimise and support our workforce**; developing their knowledge and skills to systematically use quality improvement and coaching tools, techniques and methodologies to support quality improvement, service developments and innovation and create an inclusive, diverse and engaging culture.

The Trust has a comprehensive **workforce strategy** that is aligned with the Trust's vision.

**Workforce planning** - Population Centric methodologies are used to support the development of a workforce that is aligned to service and financial plans. The Calderdale competency framework is supporting skill-mix changes. Significant work has been undertaken to ensure that our workforce is aligned to the needs of the local health and social care economy. The Trust is an active member of the local integrated workforce programme board and the West Yorkshire and Harrogate Health and Care Partnership. Workforce projects are being progressed through the Mental Health Workforce Collaborative Group.

The Trust has a number of strategies to **reduce agency expenditure**. The Trust remained below an agency expenditure cap of £6,991k for 2017/18 but use and price/wage cap breaches for medical locums resulted in a breach of the 2018/19 cap. The Trust projects remaining within the reduced cap of £5,083k for 2019/20 however medical locum alternatives and medical price/wage caps present a significant ongoing challenge.

Work is also underway to ensure that the Trust accesses opportunities presented by the Apprenticeship Levy and shared approaches to levy gifting across systems. The Trust is working with Bradford University to ensure that the increase in placement capacity can be met and graduates equipped with the necessary skills and behaviours.

For 2019/20 there will be a continuing focus on **retention and creative solutions to ensuring sufficient workforce supply**. For 2019/20 the priorities are:

- aligning the workforce plan with the new models of care – new roles, skill mix;
- supporting services to implement quality improvement and coaching;
- implementing robust plans to help attract and retain high quality staff;
- equipping managers with competencies to lead effectively and motivate their teams;
- ensuring staff are equipped with the skills to support the Trust's digital strategy;
- ensuring robust talent management and succession plans and planning infrastructure;
- ensuring local objectives as well as Trust wide actions to support a diverse workforce;
- working in health and care partnerships to deliver shared workforce programmes;
- ensuring a reduction in agency staff and delivering effective and efficient care;
- enhancing programmes to support staff health and well-being and reduce sickness;
- increasing leadership visibility and staff engagement across the organisation; and
- developing an open, transparent, diverse and inclusive culture.

## Workforce Challenges

| Workforce challenge | Impact on workforce | Initiatives in place |
|---|---|---|
| Shortage of Mental Health registered nurses | Difficulty in recruiting and retaining staff to the establishment<br>Increase in bank and agency expenditure | • Rolling adverts for nurses<br>• Early engagement with student nurses and offering contracts to year one students/enrol on staff bank<br>• Scoping out new roles to include nurse associates with 14 Nurse Associates already in training<br>• New preceptorship model in place<br>• Rotational posts being developed |
| Medics general adult psychiatry | Difficulty in recruiting to establishment<br>Reliance on agency | • Introduction of the functional model to make roles more attractive and use of Advanced Clinical Practitioners<br>• Improved medical leadership opportunities<br>• Working with locums to convert them into substantive post holders<br>• Nepalese secondment |
| Retaining registered nurses | Recruitment costs<br>Reliance on bank and agency | • Robust preceptorship programme in place<br>• Piloting rotation programme<br>• Comprehensive Health and Wellbeing Strategy<br>• Piloting new starter conversations to increase retention and "stay conversations"<br>• Management / leadership programme in place to support career development and strengthen leadership<br>• 2 shift roster trials to support work-life balance |
| Management capacity | Increased pressure / stress being felt by staff | • Management and Leadership programmes in place<br>• Strengthening of leadership posts within operational structures – introduction of leadership triumvirates |
| Changes to nursing and AHP bursary | Fewer health care support workers training to be nurses<br>Reliance on bank and agency | • Promoting apprenticeship route<br>• Offering career development through new roles such as nurses associates |
| Long Term Plan and the need to recruit more Mental Health Nurses and develop new roles | Reliance on bank and agency | • Exploring the development of Associate Physicians<br>• Use of Advanced Clinical Practitioners<br>• Nursing Associates and nurse apprenticeships<br>• Better use of the Apprenticeship Levy and partnerships including with the VCS<br>• Work in Community Partnerships to support new ways of working |

## Workforce Risks

| Workforce risk | Impact | Risk response strategy | Timescales |
|---|---|---|---|
| **11.75% Turnover of band 5 nurses across the Trust with 3.87% of this attributed to staff leaving within the first 12 months.** This is broken down across the services:<br>Adult Physical Health Nurses<br>13.52% Turnover (4.40% of which leave in first 12 months)<br>Mental Health Nurses | High | • Using bank (first) & agency (second) as temporary solution to cover posts.<br>• Identifying reasons for leaving through exit interviews (one of the key reasons is the lack of career development/ promotion).<br>• Preceptorships.<br>• Refreshing starter conversations so that | • Analysis of exit interview feedback and feedback from Director of Nursing found that career development was an issue. The new appraisal process (April 2019) will focus on promotions, career paths and development opportunities. |

| | | | |
|---|---|---|---|
| 11.16% Turnover (3.43% of which leave in first 12 months).<br><br>**12.12% Turnover of Healthcare Support Workers across the Trust with 3.87% of this attributed to staff leaving within the first 12 months.** This is broken down across the services:<br><u>Adult Physical Health HCSW</u><br>12.46% Turnover (2.67% of which leave in first 12 months)<br><u>Community Children's HCSW</u><br>13.06% Turnover (1.91% of which leave in first 12 months)<br><u>Mental Health HCSW</u><br>11.77% Turnover (4.81% of which leave in first 12 months) | High | managers can and do seek early feedback on any issues /concerns the staff may have and then develop plans to address them.<br>• Robust recruitment process for HCSWs to improve the quality of recruits.<br>• Use of apprenticeship levy to provide high quality apprenticeship programmes for HCSWs.<br>• Director of Nursing and District Nursing Clinical Lead meet all new nurse recruits on induction. | • New starter conversations are being refreshed and will be rolled out by Sept 2019 to deal with any issues/concerns earlier.<br>• Piloting of rotational working to test if it will support the retention of staff by the end of 2019.<br>• New preceptorship programme in place to increase support to staff.<br>• New assessment process for HCSWs to improve the quality of staff is in place and will be evaluated by the end of 2019. |
| **Trust sickness rate of 6.24% with 6% of staff currently triggering sickness episodes of 3 in 6 months/ 5 in 12 months.**<br>Key reasons for sickness are:<br>• Anxiety/ Stress / Depression<br>• Musculo-skeletal problems<br>• Gastrointestinal problems | High | • A new Absence Management Policy and training will be rolled out to all managers to improve capability and confidence.<br>• Comprehensive Wellbeing programme is in place and will be promoted during 2019.<br>• Move to 12-hour shifts has reduced sickness from 10.8 %to 0.43% (mainly attributed to short term sickness) across acute inpatient wards. | • Training will be rolled out by Sept 2019 to all staff.<br>• Plans are in place to roll-out 12-hour shift patterns across all wards by June 2019. |
| **15.60% of staff across the Trust (12.93% of clinical staff) are due to retire within next five years** | High | • To encourage staff to retire and return. Those staff planning to retire and recent retirees will be contacted and invited to join the bank and benefits of bank working highlighted.<br>• Development of clear service talent/succession plans to support replacement of staff including new roles and new ways of working. | • New more flexible Retire and Return Policy in place from April 2019. Impact will be measured during the year.<br>• Succession planning and talent management will be incorporated into appraisal process.<br>• Service succession plans will be in place by end 2019. |
| **3 WTE medical posts in Mental Health that have been vacant for over a year.** | High | • Making roles more attractive by moving to a co-designed (with medics) functional model with additional Inpatient staff grade support.<br>• Improving medical leadership opportunities. | • Fixed term contracts for medical posts in mental health will be in place by end April 2019. |

**Long Term Vacancies (hard to fill posts over six months)**

| Description of long-term vacancy | Whole time (WTE) impact | Impact on service delivery | Initiatives in place, with timescales |
|---|---|---|---|
| Mental Health Consultants | 3 WTE | Locum spend | Move to functional model to make the roles more attractive and increase Inpatient support. Development of medical leadership opportunities to provide career development. Pro-active discussions with locums to secure as many as possible into permanent positions including APAs. |
| Specialist estate roles e.g. Electricians | 2 WTE | Agency spend | Recruitment plans are already being progressed to recruit to these posts on a permanent basis (one follows long term sickness). |
| Pharmacy Technician (Dementia Assessment Unit) | 1 WTE | Agency spend | Re banding underway to bring this in line with similar roles in other trusts and make the role more attractive to recruit to. Bringing Pharmacy service in-house from December 2019. |
| Eye Movement Desensitisation and Reprocessing (EMDR) specialist | 1 WTE | Increased costs | Looking at advertising role in specialist journal. |

**Summary**

The Trust has set out its ambition of making Better Lives, Together, creating connected communities and helping people to feel as healthy as they can be at every point in their lives, connecting people to the best quality care, when and where they need it and being a national role model as an employer.

Nationally and locally workforce is recognised to be the primary risk to achieving such a vision. The organisation has set out its 5-year strategy for achieving its strategic objectives. The risks to achieving this are clear – a national shortage of clinical staff driving bank and agency expenditure and impacting on staff health and wellbeing and continuity of patient care, an ageing workforce many of whom are retiring further exacerbating capacity and skills deficits, leaders who are managing these challenges whilst supporting transformation and change to maintain and enhance quality.

Against this backdrop actions to create supportive, values driven leadership, creative approaches to recruitment, retention, staff engagement, workforce planning and talent management, and actions to develop new roles, new ways of working, training programmes and career pathways that maximise the contribution of the existing workforce, whilst attracting diverse new entrants from our local population are crucial steps that feature strongly in our plan for 2019/20.

# 4. SERVICE PRIORITIES

Following the launch of the Trust's new Strategic Framework, 'Better Lives, Together', the Trust has agreed seven operational plan priorities to ensure progress on the Strategic Goals:

**Priorities**

1. We will introduce The Care Trust Way to all staff
2. We will improve access to services
3. We will enable an engaged and valued workforce
4. We will increase service user and carer representation
5. We will work with partners to deliver shared outcomes
6. We will provide freedom to innovate and grow
7. We will be financially sustainable

We have identified 13 Projects to support progress against our key priorities in the first phase of mobilising our Strategy. The projects which are outlined below are part of the delivery of our 5-year strategy and there will be a phased commencement of the projects and programmes.

A number of these will help us to deliver and embed our response to concerns raised with us by the CQC and these are receiving our immediate and sustained attention.

The Trust must also prioritise and progress our Financial Sustainability Programme during 2019/20. This will ensure we are able to sustain a balanced financial position and have strong foundations from which our Strategic Goals can be advanced.

**Projects**

- ***Implement the Care Trust Way***
  *Roll out our quality improvement approach, that we are calling the Care Trust Way, enabling staff to identify and lead improvements, embed continuous improvement in everything we do, with tools and techniques that are easy to use, with a clear focus on improving patient care.*

- ***Implement Care Closer to Home Business Case***
  *Improve the safety and responsiveness of mental health services for working age adults, including changing the way that general acute psychiatrists work by implementing a functional medical model.*

- ***Implement 0-19 Delivery Model***
  *Implement the new model of care for Bradford 0-19 public health services (children's services and oral health) from 1 August 2019.*

- ***Transform Child and Adolescent Mental Health Services (CAMHS)***
  *Review and transform the CAMHS pathway from entry/assessment, through treatment and to discharge.*

- ***Implement a Talent Management Strategy***
  *Put in place talent management and succession plans for each care group and corporate directorate.*

- ***Implement an Involvement Strategy***
  *Develop, launch and evaluate a new participation and involvement strategy.*

- ***Work with Innovation Partners***
  *Identify and develop digital innovation opportunities.*

- ***Improve Staff Retention***
  *Implement creative approaches to retention and staff engagement and increase the number of apprentices.*

- ***Transform Dementia Pathway***
  *Review and transform the older people's community mental health integrated pathway.*

- ***Embed Clinical Staff within Primary Care***
  *Work with local primary care networks to provide flexible, integrated community services.*

- ***Equality***
  *Implement local objectives as well as Trust wide actions to support workforce equality and a diverse workforce.*

- ***Growth and Business Development***
  *Develop a new business development strategy that will deliver and contribute to improvement, innovation and growth for the Trust.*

- ***Financial Sustainability Programme***
  *Deliver the 2019/20 financial plan and develop a plan that delivers at least a break-even position from 2020/21.*

# 5. FINANCE

## 5.1 SUMMARISED FINANCIAL PLAN: 2019/20

The Trust Board approved the Operational Plan when it met in March 2019. This commits the Trust to delivering a planned deficit of £2.998m in order to attract Provider Sustainability Funding (PSF) of £1.169m and Financial Recovery Funding (FRF) of £1.829m and deliver a composite break-even target, or Control Total. At the point the plan was approved the Trust faced two material unresolved underlying financial risks. These were:

i. A differential recurrent Agenda for Change (AFC) pay deal pressure due to a higher than average proportion of costs relating to pay (cost weight) and Public Health contracts not funded through the national tariff-based AFC funding methodology; and
ii. Given the differential exposure faced by the Trust for AFC pay inflation, a significant concern that the recurrent methodology, beyond 2019/20, for funding increased Employer Pensions contributions is yet to be confirmed.

Despite a helpful Control Total the Trust needs to achieve a planned Cost Reduction requirement of £6.3m, or 4.04%.

The Trust will benefit from £3.2m combined contribution from local CCG commissioners to reflect underlying service cost pressures and £0.27m from NHS England low secure commissioners to reduce a service line shortfall of income over expenditure, or deficit service line position.

The Trust faced underlying recurrent pressures of £3.3m during 2018/19 driven principally by inpatient and medical locum staffing pressures. This reflected a number of factors including; having needed to deliver challenging CIP 'stretch' targets over a number of years due to limited new investment in community physical and mental health services, demographic changes, rising patient acuity, systems pressures meaning that more and increasingly complex patients are being cared for in the community and reductions in Local Authority funding that have led to Public Health contracts being reduced.

Even taking into account a helpful baseline Control Total and a positive contracting outcome, the Trust's plan requires in-year efficiencies of 4.04% and actions to identify 5.9% [a further £2.998m or 1.9%] to return to financial balance from April 2020. CCG commissioners have helpfully recognised the impact of previous low levels of growth through block (fixed income) contracts. Action are needed to secure full recurrent funding for £1.4m Agenda for Change costs on NHS commissioned contracts from April 2020. Discussions continue at a national level in relation to recurrent funding of £0.59m Agenda for Change costs on Public Health contracts.

The Trust is establishing a Sustainability Programme Board to develop a financial recovery plan that will target a break-even position from 2020/21. Key financial drivers of the underlying deficit position (excluding £2.998m PSF and FRF) include the £1.991m pay pressure on AFC, a service line deficit on low secure services, service cost pressures, stranded costs following the de-commissioning of Public Health funded Substance Misuse Services, efficiencies needed deliver contract reductions and offset other inflationary pressures for re-procured 0-19 Services in Bradford and offset other inflationary pressures for 0-19 Services in Wakefield.

CCG core funding allocations for 2019/20 included a significantly higher than average uplift for Bradford City CCG (15.25% compared to 5.65% England average). Airedale Wharfedale and Craven and Bradford Districts CCGs both attracted marginally less than the average (both around 5.4%). The linkage, through national Operational Plan requirements, of CCG uplifts to the level

of new investment in both Mental Health and Community Physical Health provides welcome resourcing of underlying cost pressures, investment in measures to improve the quality and safety of core services and progress on important national priorities for Mental Health.

Tariff Implications: As already referenced, the change in Agenda for Change pay deal funding methodology for 2019/20 to a fixed tariff-based percentage uplift, has had a £1.991m materially adverse effect on the Trust's recurrent position. This is as a consequence of the Trust's differential pay cost weight (of around 80% compared to the 66.7% funded through tariff), operating two Public Health contracts that do not attract NHS tariff uplifts, having a disproportionate number of staff at top of scale and of community-based band 5/6 staffing (where incremental progression steps are the most substantial). This represents a recurrent 1.3% unfunded cost.

**0-19 Bradford Public Health Contract:** Following a procurement exercise initiated in Summer 2018 Bradford Metropolitan District Council awarded the 0-19 Contract for Bradford District to the Trust in February 2019. Due to reductions in Local Authority funding the contract needs to reduce costs by £1.3m in 2019/20 [£2m full year effect]. Taking mobilisation and Agenda for Change pay deal costs into account this represents a challenging reduction. The Trust has just over 5 months within which to mobilise a new service delivery model from 1 August 2019, the contract start date. The contract reduces by a further £988k recurrently from April 2020.

A number of neighbouring 0-19 providers have been recruiting health visitors. This is helping the Trust to transition to a different and reduced staffing model through staff turnover. Rigorous support and oversight will be necessary to implement the very different service model and ways of working. A 0-19 System Partnership Group has been established including representatives from the Trust, Public Health, Prevention and Early Help, Children's Services and the Clinical Commissioning Group to ensure systems oversight and responsiveness across 0-19 provision and including mobilisation to the new models.

**Control Total Implications:** Whilst non-recurrent support, through PSF and FRF funding, is welcome, the level of financial challenge remains considerable and requires a recovery focus reaching beyond 2019/20. The plan includes 2019/20 commissioner contract values and the impacts of revised Royal Institute of Chartered Surveyors guidance in relation to asset lives. This will increase depreciation by an estimated £0.3m annually.

Consistent with national guidance plans exclude the anticipated cost to the Trust of a 6% increase in NHS Pensions Employer Contributions to 20.6%. The recurrent funding of these beyond 2019/20, (when funding will flow nationally direct to the NHS Pensions Agency) is a key concern in relation to the Trust's Financial Recovery plan.

Key 2019/20 financial risks include:

- Delivering a cost reduction target of £6.3m, 4.04%, of which around 23% are 'red' rated and of which £693k or 11% are non-recurrent (including £0.5m 'recurrent' non-recurrent schemes);
- Addressing the underlying position to secure financial recovery, mitigated non-recurrently by 2019/20 PSF/FRF of £2.998m;
- The monthly profile and Quality Impact Assessment status of proposed cost reductions;
- The weighting of PSF and FRF towards the final two quarters and 15% PSF funding dependent on the West Yorkshire & Harrogate system meeting its planned financial position;
- Material realised risk resulting from the tariff-based pay inflation funding methodology;
- £2.1m (FYE £2.8m) Local Authority and Public Health funded cash contract reductions and de-commissioning, and unfunded inflationary pressures of £0.59m

**USE OF RESOURCES RATING (UoR):** The plan achieves a risk rating as shown below:

| Use of Resources Risk Rating | Q1 Plan Rating | Q2 Plan Rating | Q3 Plan Rating | Q4 Plan Rating |
|---|---|---|---|---|
| Capital service cover rating | 4 | 3 | 2 | 1 |
| Liquidity rating | 1 | 1 | 1 | 1 |
| I&E margin rating | 4 | 4 | 3 | 2 |
| Variance From Control Total rating | 1 | 1 | 1 | 1 |
| Agency rating | 1 | 1 | 1 | 1 |
| Plan risk rating after overrides | 3 | 3 | 2 | 1 |

Key drivers of the plan phasing that impact on the quarterly UoR metrics shown above are:

- Phasing of £2,998k national support through PSF & FRF, with 65% attributable to quarters 3 and 4 to incentivise delivery of organisation Control Totals; and
- CIP phasing as shown in the table below, with 63% attributable to quarters 3 and 4.

It should be noted that CCG commissioners, as part of a fixed income contract discussion, have agreed to phase associated CQUIN income in twelfths. The implications of CIP and PSF/FRF phasing on the phasing of the Trust's overall financial plan are highlighted below:

| | Position before CIP & PSF/FRF | % | CIP | % | Trust Target Surplus | PSF & FRF | % | Trust Control Total |
|---|---|---|---|---|---|---|---|---|
| Q1 | (480) | 5% | 885 | 14% | 405 | 449 | 15% | **854** |
| Q2 | (2,117) | 23% | 1,499 | 24% | (618) | 600 | 20% | **(18)** |
| Q3 | (2,792) | 30% | 1,872 | 30% | (920) | 900 | 30% | **(20)** |
| Q4 | (3,917) | 42% | 2,053 | 33% | (1,865) | 1,049 | 35% | **(816)** |
| | **(9,306)** | **100%** | **6,309** | **100%** | **(2,998)** | **2,998** | **100%** | **0** |

**INTERNAL ASSURANCE PROCESS:** The operational plan has been developed through engagement with operational and non-clinical teams including developing and 'RAG' rating CIP scheme delivery risks. Senior Leadership Group, 'Top 60' Leader and Care Group engagement processes have ensured regular communication. The Finance Business and Investment Committee undertook a detailed consideration and agreement of plan priorities, key risks, issues and assumptions prior to recommending the plan and Control Total for approval by the Board on 28 March and submission to NHS Improvement on 4 April 2019.

## 5.2 FINANCIAL FORECASTS AND MODELLING

**CONTRACTS WITH COMMISSIONERS OF HEALTHCARE:**

The quantum of new investment with the Trust meets national expectations for mental health and community physical health services and recognises underlying cost pressures from past low levels of investment in community and mental health contracts.

Contract discussions commenced at a health system level for the first time for the 2019/20 planning round during March 2019. For the Trust, contracts include investment in the national Early Intervention in Psychosis (EIP) 56% access standard, but with further Mental Health Investments to be formally approved and transacted by the Mental Health Partnership Board.

**NHS Contracts & National Plan Assumptions:** Income reflects a tariff uplift of 2.7% or £2.8m, providing 3.8% or £3.9m inflation uplift offset by a £1.1m or 1.1% efficiency requirement. 50% of CQUIN funding (1.25% of NHS contract values) has transferred into recurrent contract

baselines. A national tariff abatement of 0.1% for mental health and 0.05% for community services has been applied to fund national supply chain arrangements.

As a result of planning to deliver a deficit Control Total (before PSF/FRF) an additional CIP of £0.7m or 0.5% must be planned; effected via a reduction in the deficit permitted as part of the Control Total.

**Mental Health Investment Standard (MHIS):** The contract secures average investment that marginally exceeds the MHIS for CCG Commissioners. This uplift equates to 8.78% or £5.756m (inclusive of 2.7% tariff). Investment secures:

- Sustainable core provision with £1.97m being targeted to address underlying recurrent adult acute care pathway and medical staffing pressures.
- Progress towards national priorities set out in the Five Year Forward View for Mental Health and to support actions being taken in response to issues highlighted by the CQC. The systems Mental Health Partnership Board will review all new investment proposals.

**Community Health Investment Standard (CHIS)**: The contract secures investment that is marginally above the CHIS for CCG Commissioners. This equates to 7.89% or £2.3m (inclusive of 2.7% tariff). This includes £918k to support underlying cost pressures relating to community physical health services in which only modest demographic investment has been made in the last 5 years and £600k for new priorities including £150k already agreed for Special School Nursing.

Previous investment had not kept pace with population growth, ethnicity, rising acuity, social care pressures, care home sector volatility and a shift of more complex tasks into community settings (with growth in community nursing face to face contacts averaging 7% p.a. in the last 4 years). The impact of ongoing efficiency requirements was evident from West Yorkshire & Harrogate system benchmarking of CCG expenditure. This indicated relative under-investment in community/mental health compared to national averages and target shares and is consistent with low Trust reference costs. The current contract round provides very positive progress and investment in both mental health and community services.

**Commissioning for Quality & Innovation (CQUIN):** Schemes represent 1.25% or £1.4m maximum available annual income to the Trust. Following the publication of CQUIN guidance on 8 March, the Trust has undertaken an initial assessment of deliverability, which will be refined as requirements are clarified.

## EXPENDITURE PLAN

**a) Inflation** of £6m per annum comprises £5.5m pay and £0.5m non-pay:
- £5.5m pay incorporates 2018/19 and 2019/20 AFC pay deal implications [excluding 1% provided at 2018/19 plan].
- £0.5m non-pay includes contract uplifts, utilities, rates, and other price rises.

The methodology for routing recurrent national funding for the AFC pay review body negotiated awards using NHS contract tariff uplifts remains of concern, as highlighted above.

**b) Cost pressures:** The plan leaves a number of unfunded priorities and pressures requiring management as CIPs. The implications of this have been risk-assessed.

**c) Investment in Quality:** Key anticipated investments in quality improvements include:
- Progressing the Trust's recently approved **Quality Improvement** approach as outlined in section 3 above with investment to train certified leaders, on leadership development, establishing a KPO and to implement an established coaching model.
- Securing additional investment for sustainable safe and therapeutic staffing in the adult acute care pathway including via a **'Care Closer to Home'** business case and transition

to a **Functional Medical Model** collectively targeting recovery, reduced length of stay and permanent staffing recruitment to a more therapeutic skills mix;

- Funding to make progress on Mental Health Five Year Forward View requirements including for **Early Intervention in Psychosis** to 56% by March 2020;
- Responding to issues highlighted by the CQC inspection;
- Improvement actions targeting further **reductions in reliance on expensive agency staff**, optimising actions already implemented during the last 3 years; and
- **Capital Investment** including in safe inpatient environments and enabling IM&T.

### 5.3 COST IMPROVEMENTS 2019/20

All schemes have been RAG-rated for deliverability to inform an initial risk assessment and consideration by the Board of the overall current estimated level and phasing of financial risk.

| RAG | Q1 | Q2 | Q3 | Q4 | Total | RAG % | Trust % |
|---|---|---|---|---|---|---|---|
| | 354 | 297 | 270 | 249 | **1,170** | **19%** | **0.7%** |
| | 492 | 977 | 1,116 | 1,084 | **3,669** | **58%** | **2.4%** |
| | 39 | 177 | 267 | 273 | **756** | **12%** | **0.5%** |
| | 0 | 48 | 219 | 447 | **714** | **11%** | **0.5%** |
| **Quarter £** | **885** | **1,499** | **1,872** | **2,053** | **6,309** | **100%** | **4.0%** |
| **Quarter %** | **14%** | **24%** | **30%** | **33%** | **100%** | | |
| **Trust %** | **0.6%** | **1.0%** | **1.2%** | **1.3%** | **4.0%** | | |

| | Q1 | Q2 | Q3 | Q4 | Total | % | Trust % |
|---|---|---|---|---|---|---|---|
| Non Recurrent | 258 | 171 | 144 | 120 | **693** | **11%** | **0.4%** |
| Recurrent | 627 | 1,328 | 1,728 | 1,932 | **5,615** | **89%** | **3.6%** |
| **Quarter £** | **885** | **1,499** | **1,872** | **2,053** | **6,309** | **100%** | **4.0%** |
| **Quarter %** | **14%** | **24%** | **30%** | **33%** | **100%** | | |
| **Trust %** | **0.6%** | **1.0%** | **1.2%** | **1.3%** | **4.0%** | | |

| QIA RAG Status | Q1 | Q2 | Q3 | Q4 | Total | |
|---|---|---|---|---|---|---|
| Approved | 855 | 1,130 | 1,242 | 1,210 | **4,437** | **70%** |
| CIP Plans that need Scheduling/ Rescheduling for QIA | 30 | 246 | 246 | 236 | **758** | **12%** |
| Need plans to be developed (£339k Low Secure + £375k unidentified) | 0 | 48 | 219 | 447 | **714** | **11%** |
| QIA scheduled for Q2 (Procurement, Virtual Worker, Commercial Training) | 0 | 75 | 165 | 160 | **400** | **6%** |
| **Total** | **885** | **1,499** | **1,872** | **2,053** | **6,309** | **100%** |

Quality Impact Assessment panels were scheduled to ensure high risk/high impact CIPs due to commence during quarter one were reviewed as a priority. The level of anticipated Cost Improvements required is driven by the following:

| Efficiency Requirement | £ m | % |
|---|---|---|
| Underlying Position | 3.27 | **2.1%** |
| Contract Negotiation Target | (3.15) | **-2.0%** |
| 1.1% Tariff | 1.13 | **0.7%** |
| Health Inflationary Pressure - Pay & Non Pay | 1.62 | **1.0%** |
| Public Health Unfunded Inflation | 0.59 | **0.4%** |
| Public Health Contract Reductions | 1.97 | **1.3%** |
| Cost Pressures | 3.63 | **2.3%** |
| Other Contract Changes | 0.26 | **0.2%** |
| **Requirement Excluding Support** | **9.31** | **6.0%** |
| Non Recurrent CNST/Other Control Total Adjustment | 0.00 | **0.0%** |
| Non Recurrent PSF/FRF | (3.00) | **-1.9%** |
| **Requirement After Support** | **6.31** | **4.04%** |

**Cost Improvement Plans (CIPs)** included in the table above reflect Trust work streams that will support wider planning activities to ensure we remain financially sustainable. These include:

**Virtual Organisation**; technology to increase automation, efficiency and productivity;
**Business Growth**; new developments and innovation to grow income and contribution;
**Commissioner Cost Recovery** with a focus on overhead efficiency, national benchmarks, Model Hospital and sustainable core service lines;
**Optimise Our Workforce;** Delivery of the re-procured Early Years' service model, Agency Cost Reductions, Care Closer to Home acute pathway re-design and Functional Medical Model; and
**Reduce the cost of our Estate** via reduced footprints, Early Years hubs and costs.

Through work to agree and implement 2019/20 Strategy deployment priorities (referenced in Section 4. above) the Trust will establish a Sustainability [Financial Recovery] Programme to oversee progress to implement the 2019/20 financial plan, to develop a plan that secures in-year balance from 2020/21 and to draft a 5-year financial plan that is linked to wider 'place' financial recovery planning.

## 5.4 AGENCY RULES

Whilst the Trust remained below an aggregate agency expenditure cap of £6.99m for 2017/18, elevated medical locum requirements and price/wage cap breaches led to a breach of the 2018/19 expenditure cap. Actions to reduce agency costs are described more fully in the workforce section but include recruitment to grow the in-house staff bank, effective E-Rostering, a Care Closer to Home business case focusing on enhancing the adult acute care pathway, resourcing more rapid inpatient staffing recruitment, price negotiation with agencies and use of fixed-term appointments as an alternative to agency and locum bookings.

The Trust's 'Optimise Our Workforce' Sustainability workstream is leading a number of actions, including targeting zero agency use for Health Care Support worker roles. Our agency expenditure cap for 2019/20 reduces to £5,081k. Whilst we forecast being able to achieve the cap, medical vacancies, sickness cover and junior doctor rotation gaps have proved problematic and delivery of this target will require ongoing robust and creative management.

Weekly 'report outs' are being used to ensure more rapid Plan, Do, Study, Act (PDSA) improvement actions, with agency costs being a key metric. The Trust has explored alternatives and secured a seconded Nepalese doctor, fixed term and permanent contracts to secure locum medics to [partially] mitigate this risk. By implementing a Functional Model, which reflects the traditional psychiatry training model, roles are expected to be more attractive. Actions to implement the Functional Model were progressed through a Rapid Improvement week at the beginning of April 2019. The forecast profile of agency costs is shown below:

***Costs (£m) exclude any implications for cost linked to AFC pay awards***

| Staff Group | Q1 | Q2 | Q3 | Q4 | Total |
|---|---|---|---|---|---|
| Registered Nurses | 218 | 233 | 209 | 163 | **823** |
| Allied Health Professionals | 27 | 14 | 4 | 0 | **45** |
| Support to nursing staff | 449 | 332 | 133 | 273 | **1,187** |
| Consultants | 303 | 424 | 378 | 441 | **1,546** |
| Career/Staff Grades | 249 | 215 | 317 | 288 | **1,069** |
| NHS Infrastructure Support | 89 | 103 | 131 | 88 | **411** |
| **Total** | **1,335** | **1,321** | **1,172** | **1,253** | **5,081** |

The Trust has maintained a ban on bookings for non-medical agency staff that would breach national price or wage caps. A weekly virtual panel reviews all price and wage cap breaches and is approved by the Chief Executive.

## 5.5 CAPITAL PLAN 2019/20

The Trust's capital programme of £3.7m for 2019/20 will be funded by estimated depreciation of £3.3m supplemented by cash reserves of £0.4m. Capital requests have been rigorously prioritised and risk-assessed to identify key service and business critical schemes. The draft plan includes £2.3m estates schemes, including £1.2m ring-fenced to progress inpatient actions including nurse call alarms and anti-ligature schemes and the introduction of door alarms will be considered. The plan provides for £1.4m IM&T schemes. Leads have reviewed the phasing of the capital programme, especially in the first quarter.

# 6. MEMBERSHIP AND ELECTIONS

- *As at January 2019, the Trust had 9,655 public members and 3,021 staff members.*
- *Our membership 'offer' brings together services users, carers, volunteers and local communities under one membership umbrella, thereby offering greater opportunities for engagement through events planned across the Trust.*
- *During the year, we have seen our Governors play an increasing role in engaging local communities and this will continue with the development of the new membership strategy for 2019-21.*

As a foundation trust, we are accountable to our membership. Members have an opportunity to hold the Trust to account through elected Governors who represent the views of the membership at the highest level within the organisation. The Board takes account of those views when planning strategy. In order to develop and deliver an effective strategy, it is important that the views are representative of the local population and based on knowledge or experience of a service, proposal or healthcare condition.

Our Membership Strategy outlines how the Trust will continue to recruit a representative membership and provide opportunities for members to influence the Trust's plans and services. The current strategy is due for refresh in 2019. Governors discussed areas for potential development in February. The current objectives are to:

- recruit to the Trust those people that have an interest in healthcare, whilst ensuring the membership remains representative of the community;
- engage those members wanting to get involved in the work of the Trust through engagement activities and events; and
- obtain views from the Trust's members about the services provided by the Trust.

The Trust has sought nominations to a number of Governor positions (six Public Governor roles and one Non-Clinical Staff Governor role). Governor nominations have been received for Craven, Shipley, Keighley and the rest of England constituencies, with induction in April with new Governors commencing in post on 1 May 2019. A further campaign will be developed for the outstanding vacancies in Bradford South.

# 7. WEST YORKSHIRE AND HARROGATE HEALTH AND CARE PARTNERSHIP

West Yorkshire and Harrogate Health and Care Partnership was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs). It brings together all health and care organisations in six local places: Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield.

In November 2016 the STP published high level proposals to improve health, reduce care variation and restore and maintain financial balance. Since then the partnership has made significant progress to build capacity and infrastructure and establish the governance arrangements and ways of working that will enable us to achieve our collective aims.

The partnership has already begun to make an impact in other important areas. The West Yorkshire and Harrogate Cancer Alliance Board is a national exemplar and has attracted £12.6 million in funding to transform cancer diagnostics. Mental health trusts have joined in a collaborative (including a committee in common) to strengthen collaborative working and facilitate joint decision making. The partnership has secured £31 million in transformation funding for A&E, cancer, mental health, learning disabilities and diabetes, and £38 million capital from the 2018 autumn budget for CAMHS, pathology, telemedicine, and digital imaging.

In May 2018 NHS England and NHS Improvement announced that the West Yorkshire and Harrogate Health and Care Partnership would be one of four health and care systems to join the Integrated Care System Development Programme. This means we can join leading health and care systems and gain more influence and more control over the way we deliver services and support for the 2.6 million people living in our area.

The West Yorkshire and Harrogate health and care partners have agreed a Memorandum of Understanding to formalise working arrangements and support the next stage of development of the partnership. The Memorandum of Understanding builds on the existing partnership arrangements to establish more robust mutual accountability.

The Trust is actively involved in the **West Yorkshire and Harrogate mental health, learning disabilities and autism programme**. Key areas where we have agreed to work together at West Yorkshire and Harrogate level that will impact in 2019/20 are:

- **Acute Mental Health Pathway (Adults):** We are working as a partnership to ensure that care is provided in the least restrictive environment with more care delivered closer to home. This will also address the significant number of people who have to go out of their local area for inpatient care. We will ensure that people are treated in the community wherever possible but if they do need to go into hospital, they can access care locally and if not they will be cared for in West Yorkshire. The next phase of the work comprises:
  - Effective Inpatient Care: Providers continue to develop and manage the collective acute bed base for West Yorkshire and Harrogate, sharing practice to prevent admissions, reduce length of stay and move towards one inpatient operating model.
  - Psychiatric Intensive Care Unit (PICU): developing a partnership model for PICU, as part of the acute pathway, and a clear understanding of capacity and demand. Work is underway to consider how we best manage demand, including increasing acuity, and stop people going out of area.
  - Crisis/Intensive Home-Based Treatment Services: development of a consistent offer of service across the partnership to keep people in the community and prevent admissions.

- **Complex Care/Rehabilitation Services:** The partnership currently has a large number of service users who are placed away from home in a rehabilitation unit, often in 'locked' units. As a partnership we will work to understand the clinical needs and plan to repatriate patients, prevent future out of area placements and minimise lengths of stay and have bid successfully for national capital.
- **Adult Medium and Low Secure Services:** In response to NHS England's review of adult secure mental health services, the partnership is completing a business case for a future service model, by March 2019.
- **Child and Adolescent Mental Health Services (CAMHS):** The partnership is a new model of care pilot for tertiary mental health services (CAMHS Tier 4). The focus is on preventing unnecessary admissions, reducing out of area placements, with effective management of children and young people in the community. Partners also hope to assume broader responsibilities for commissioning budgets, following an expression of interest to NHS England.
- **Children and Young People's Autism:** Take forward system work on autism and ADHD in children and young people. This is prioritised because of the increasing volume of assessments being requested year on year and the challenges faced by organisations trying to meet this demand.
- **Learning Disabilities - Assessment & Treatment Units (ATU):** Providers and commissioners are collaborating to develop a standard future model for inpatient care. This will operate as a networked service working to the same standards. A business case outlining a future service model is in the final stages of development.
- **Financial Framework:** Work has commenced to determine how we align existing funding streams to the agreed mental health priorities of the partnership and with those of individual placed based plans, including system agreement on how investment costs and efficiency savings will be managed.

The West Yorkshire and Harrogate health and care partnership maintains an ethos of the primacy of local 'place'. The **Bradford District and Craven Health and Social Care system** or 'place' has a strategic vision of 'Happy, Healthy at home'.

To improve population health through integrated health, care and support, we will:
- Deliver our Bradford District and Craven Health and Wellbeing Plan (sustainable services against a backdrop of increasing demand);
- Achieve greater autonomy and control within community partnerships to develop and transform our community based health, care and support services;
- Share collective responsibility for the deployment and management of our resources to secure better outcomes for our population; and
- Develop population health management capabilities to improve prevention and manage avoidable demand.

The local 'place' faces an extremely challenging financial outlook with an anticipated shortfall of income over expenditure of £59.4m. Partners must deliver collectively a system surplus or Control Total of £6.4m by delivering £45.4m cost reductions to attract aggregate national funding (PSF/ FRF) of £20.5m. This reflects the aligned contract assumptions of all health organisations. Actions are now being progressed to define, resource and track progress on a number of key Sustainability Programmes aligned to existing governance arrangements, for example via the established Planned Care Programme.