DGFT Operating Plan 2017/18 – 2018/19

Section One: Activity Planning

1.1 Returns are underpinned by agreed planning assumptions with explanation about how these assumptions compare with expected growth rates in 2016/17.

The period that has been used for baseline modelling for the majority of activity is August 2015 to July 2016. The Trust has tried to use a consistent period for the block and variable items, using the same period as above and adjusting for working days where relevant. Key points include:

- there are four fewer working days in 2017/18 than 2016/17;
- the latest PSS toolkit/supplementary logic has been used to differentiate between CCG and Specialised Service activity;
- the latest consultation tariff (released on 3/11/16) has been used;
- 0.1% uplift to non-PbR prices/blocks has been applied with the exception of blocks relating to staff where the Trust has used an uplift of 2.1%;
- growth rates have been calculated based on the IHAM model for Dudley CCG and have been applied as follows: August to March element of baseline uplifted to 2016/17 levels (Outpatients 3.5%, Electives 1.7%, Non Electives 2.2%, A&E 2.0%) to give a consistent 2016/17 baseline. This has then been validated against a current forecast outturn position;
- the revised baseline has then been uplifted for 2017/18 growth estimates (Outpatients 3.4%, Electives 1.7%, Non Electives 1.9%, A&E 1.9%);
- once the 2018/19 baseline has been agreed, the intention will be to uplift this for 2018/19 growth estimates (Outpatients 3.4%, Electives 1.7%, Non Electives 1.9%, A&E 2.0%);
- pathology growth has been added at 6.0% per annum;
- imaging growth correlates with the activity estimated within a business case for a Community Imaging Hub linked to delivery of the diagnostic wait targets.

The following items have also now been incorporated into the model:

- validation from Medicine and Surgery Divisions with adjustments factored in to address any anomalies;
- high cost drug costs reflecting a degree of horizon scanning by the Pharmacy department;
- the Wheelchair contract sum has been removed following notice of the Trust's intention to terminate the service on 31st March 2017;
- the sexual health contract with Dudley MBC has been reduced following a recent tender exercise;
- assumption for the Trust to become the lead provider for Breast Screening locally as well as an expansion to cover Staffordshire;
- additional community activity which may have been understated following an in-year migration from NCRS to the Trust Patient Administration System;
- the impact of a 'medically fit for discharge ward' to address the growing problem of delayed transfers of care by providing a less intensive nursing but a more rehabilitation-focused environment;
- CCG QIPP schemes although these will require to be robustly assessed and the implications jointly agreed/managed. The QIPP schemes broadly offset the growth for the host commissioner.
- the activity submitted reconciles with STP assumptions.

1.2 There is sufficient capacity to deliver the level of activity that has been agreed with commissioners, indicating plans for using the independent sector to deliver activity, highlighting volumes and type of activity.

Contract discussions with Dudley CCG have been undertaken in a positive spirit and the contract for 2017/18 and 2018/19 will be signed by 23rd December, 2016. A key agreement will be how the economy shares the risk on the contract linked to levels of growth and QIPP and this will require a high degree of collaboration. The QIPP schemes proposed by the CCG include:

- for Elective Care, some Right Care inspired proposals in MSK services where national indicators show Dudley CCG has a relatively high spending level. The Clinical Strategy Review group is to look at this area to identify where savings can be made, although this will not be exclusively with Dudley Group as the CCG has a large contract with a local private sector provider;

- proposals to change referrals to Outpatient services to electronic referrals utilising Advice and Guidance protocols to generate activity savings and simplify the process for GPs and Consultants;
- for Non-elective Care, the Vanguard initiative has developed proposals for the Falls Service, Palliative Care and in Care Homes where the "Airedale" initiative is being commissioned by the CCG with the aim of reducing the number of non-elective admissions from Nursing/Care Homes. This latter initiative will be supplemented by a frail and elderly community team.

The CCG's objective is to reduce activity levels for 2017/18 to the out-turn levels for 2016/17. The Trust is working actively with the CCG to develop proposals to deliver these, but will be careful to ensure that sufficient capacity exists to deliver higher levels of activity in-year if these schemes are either slow to implement, or do not deliver the reductions in activity that are expected. Care will be taken with the contract management terms to ensure risk is fairly apportioned between the Trust and the CCG.

No impact of the MCP has been included in the financial plans at this stage. Agreement has been made with the CCG that this will form a contract variation when the MCP goes live. The current assumptions are that any service transfers from the Trust to the MCP will be cost neutral.

1.3 Plans are sufficient to deliver, or achieve, recovery milestones for all key operational standards, in particular A&E, RTT, incomplete, cancer, diagnostics and mental health waiting times. They should also refer to any explicit plans agreed with commissioners around:

- **extra capacity as part of winter resilience plans (e.g. extra escalation beds);**
- **arrangements for managing unplanned changes in demand.**

Divisions will show how capacity plans are capable of producing both the contracted and the higher level of activity in 2017/18 through the budget setting exercise in January and February 2017. Additional budgets will be made available to ensure capacity is sufficient. Capacity modelling tools developed by NHSI and NHSE are being used to maximise the use of existing facilities. As such, there are no explicit plans to use the independent sector and the Trust viewpoint is that internal plans provide sufficient activity to deliver the key operational standards. There are no plans agreed with the CCG regarding extra capacity as part of winter resilience. However, CCG/public health campaigns are in place relating to winter healthcare, the Trust has internal plans in place for additional winter demand and is discussing arrangements for improving DTOCs with the Local Authority to ensure patient flow and bed availability during the period of winter pressures.

Section Two: Quality Planning

2.1 Approach to quality governance

- **Description of organisation-wide improvement approach to achieving a good or outstanding CQC rating including underpinning governance processes:** Two Quality and Safety Reviews are undertaken every month covering every area on a rotational basis. Senior clinical staff, Governors and Directors visit each area for half a day to check the performance of the area and to gain staff views on patient safety using the CQC fundamental standards as a framework. In addition, as themes arise across different areas, targeted assessments are undertaken up to twice a month across a group of wards, after which local and corporate action plans are drawn up, implemented as required and monitored by the Trust Board Quality Committee.
- **Details of the quality improvement governance system, from ward to board, with details of how assurance and progress against the plan are monitored:** The organisation and structure of Trust services and departments have been devised to support the successful delivery of corporate objectives, Trust Values, and the Quality Improvement Strategy, the latter of which is being reviewed. This includes: clear reporting lines (leadership and supervision); clear accountabilities for teams and individuals; decision-making as near to front line service delivery as possible; avoidance of duplication; clear lines of communication. The reporting system for quality issues is *via* the divisional governance groups, through to the trust-wide Quality and Safety Group, then onto the Board Quality Committee.
- **How quality improvement capacity and capability will be built in the organisation to implement and sustain change:** The Trust continues to strengthen its systems of learning to ensure improvement and change using a variety of methods such as internal risk assessments, learning events and transformation projects. The Trust has a number of specific support posts both within the community and hospital that support staff to monitor standards and improve quality of care. The quality improvement and governance framework of the Trust is such that relevant sub-committees of the Board receive reports and discuss the outcomes of a wide range of quality improvement monitoring and auditing across the Trust ensuring that quality improvement remains an on-going priority activity of the Trust. The key quality co-ordinating committee is the Clinical Quality, Safety and Patient Experience Committee with other sub-committees, such as the Finance and Performance Committee, having overlapping membership to ensure a co-ordinated approach for the Trust moving forward. This combined approach links with co-operative endeavours with local providers (e.g. Black Country Alliance (BCA)) to ensure that the Trust is a dynamic organisation, always striving to improve and change.
- **Measures being used to demonstrate and evidence the impact of the investment in quality improvement:** The Trust has a performance dashboard which contains a variety of quality indicators which are RAG-rated. This allows Board members and department/ward based staff to monitor both Trust and local performance against this range of indicators. In addition, the Trust Board Quality Committee monitors the indicators monthly and triangulates this with information from other sources (e.g. incidents, clinical audit results, complaints, other patient feedback) and take action as required.

2.2 Summary of quality improvement plan

- **National Clinical Audits:** The Trust has a wide-ranging clinical audit programme which focuses on 'must do' activity, including NCEPOD, national clinical audits and those audits providing assurance of compliance with NICE guidance. As in the last few years, the Trust plans to participate in all of the national audits relevant to its services and will note these in the Annual Quality Account.
- **The four priority standards for seven-day hospital services:** Delivering services 24/7 is a key part of the plan in line with the strategic goal to drive service improvement, innovation and transformation and key standards have been incorporated into current service delivery and wider strategic plans. Improving the time and frequency in which patients are seen by a consultant is incorporated into professional standards and monitored by the use of a daily ward round checklist and a programme of Quality and Safety Reviews led by the Chief Nurse and Medical Director. Along with regional partners as part of the BCA, the provision of 7 day Interventional Radiology services has been piloted and will be extended. Working together with BCA partners will make the provision of safe and effective 7 day services more achievable.
- **Safe staffing:** The Trust continues to comply with the relevant national requirements. The Board monitors the Trust's shift by shift staffing position monthly and the results of the Safer Nursing Tool exercise every six months to ensure it is continually aware of the nurse staffing situation.
- **Care hours per patient day**: This new metric is calculated and the Trust will assess its relative situation once comparative data is made available. The ward element of the Model Hospital will be piloted and will be used following an assessment of its usefulness in achieving the goal of effective staffing.

- **Mental health standards (early intervention in Psychosis and Improving Access to Psychological Therapies):** The clinical lead for Mental Health, who is part of the Trust Safeguarding framework, is working with local adult and child mental health providers to ensure that effective systems are in place to implement these standards.
- **Actions from the Better Births review:** The Trust has undertaken a gap analysis against the national standards and the outstanding actions are being monitored. In addition, the Trust is part of the Black Country STP which has established a 'better birth' sub group to look at comparing and sharing best practice in relation to the priorities set out in 'better births.'
- **Improving the quality of mortality review and Serious Incident investigation and subsequent learning and action**: All deaths in the hospital are reviewed using the unique Mortality Tracking System and the aim is to have 85% of deaths reviewed by the team responsible for that patient's care within 12 weeks. For 2017/2019, the mortality review process will be expanded building on the engagement with GP and CCG colleagues to include primary care.
- **Anti-microbial resistance**: The Trust is working to achieve the relevant the National CQUIN in reducing overall antibiotic and specific broad spectrum agent usage and is emphasising the need for effective prescribing and documenting of clinical indications. These are audited on an on-going basis.
- **Infection prevention and control**: The Trust continues to work towards achieving the national MRSA and *C. difficile* targets and is moving to adopt the *C. difficile* assessment tool to understand better avoidable/unavoidable cases so that learning is improved and cases are reduced. Any national requirements/targets in the next two years that are introduced for monitoring and reducing *E. coli* targets will be implemented. This topic is a key element of the Trust's 'Sign-up to Safety' action plan (which also includes deteriorating patient, mortality, medications, falls and pressure ulcers).
- **Falls:** The Trust aims to encourage engagement around moving falls from a mainly nursing issue towards a multi professional focus; re-energise falls prevention and management within the Trust; ensure that staff have the information and tools to reduce injurious in-patient falls and improve reporting and care; work in collaboration with NHSI to begin redesign of the NHSI falls collaborative; and maintain a falls rate (with and without harm) that is below the national falls average per 1,000 occupied bed days.
- **Sepsis:** As outlined in the national CQUIN, the Trust is continuing its work to increase timely identification of sepsis and the timely treatment of sepsis both in emergency and in-patient areas. This initiative is led be a trust-wide multidisciplinary group and a dedicated nurse practitioner.
- **Pressure ulcers:** One of the quality priorities of the Trust is effective reduction and management of avoidable pressure ulcers both in the hospital and within community services. Measureable reduction targets have been set which are monitored quarterly by the Board.
- **End of life care:** The Trust is committed to transform end of life care, not only in acute settings but in the wider community, working together with colleagues in primary care, hospices and social care to meet the following goals across all settings - improve the quality of care and patient, family and carer experience; improve decision making, planning and communication; improve education and training of the workforce. An End of Life Action Plan is being developed based on recommendations taken from a) National Care of the Dying Audit 2016, b) Trust End of Life Mandatory training audit, c) NICE Guidance (NG31 Dec 15) Care of dying adults in the last days of life and d) VOICES survey of bereaved relatives.
- **Patient experience:** A variety of methods to gain patient feedback are used across all specialties and groups. One of the Trust's quality priorities is achieving better than national average Friends and Family Test scores across all eight areas and this is generally being achieved, although there is a rectification plan in place to improve the response rate. This is reported monthly to the Board by the Chief Executive.
- **National CQUINs**: In order to achieve National CQUIN targets, robust systems are in place to monitor and improve performance.
- **Confirmation that the provider's quality priorities are consistent with STPs**: The Trust monitors that its quality plan and its priorities are consistent with the aspirations of the STP.

2.3 Summary of the quality impact assessment process

- **Description of governance structure surrounding scheme creation, acceptance and monitoring of implementation and its impact (positive or negative**)
- **A description of governance structure - how frontline/business unit-level clinicians are creating schemes and what challenge there is regarding potential risks and acceptance of schemes; the QIA process and whether this is assessed against the three core quality domains (safety, effectiveness and experience) or the wider five CQC domains (safe, effective, responsive, caring and well led), allowing insight into staff impact; how schemes received executive sign-off by the medical and nursing directors (including an articulation of whether all schemes are seen, or whether there is a risk-based process to sign off such as monetary value, risk score, etc):** All new projects require

Quality Impact Assessment (QIA) approval and agreed standard processes and procedures are in place for QIA of all new projects. The Trust has an explicit governance framework for this and a Standard Operating Procedure sets out the agreed processes and procedures. After an opportunity is identified by a member of staff/business unit, the Clinical Lead will undertake an initial assessment of the new idea and either approve or reject it following an assessment of quality and risk impact. The Project Management Office (PMO) presents the new idea to the Executive Team who discuss the idea and appoints an Executive Lead, Project Lead and Clinical Lead to develop a Project Initiation Document (PID) for Transformation Executive Committee (TEC) approval. The Executive and Project Leads work with the nominated Clinical Lead to complete the PID and QIA. The PID is reviewed by the TEC and is either approved or rejected. Approved PIDs are submitted for QIA assessment by the Director of Nursing and Medical Director who assess each of the Quality Risks and the associated KPIs and either approve the PID and Quality Risks and supporting KPIs; approve the PID but adjust or add to the Quality Risks with further mitigations/or KPIs; decline the PID and Quality Risks/or KPIs. Following the TEC and QIA review, all PIDs that are 'approved' and 'approved with additional risks and KPIs' are formally entered and monitored through the Cost Improvement Summary Tracker. The Head of Information and the Assistant Director of Finance provide monthly Performance Dashboards of the KPIs listed on the QIA form. Project Leads use the Directorate/Project Meetings to discuss the current status of the KPIs and clinical leads attend to assess Quality Risk scores and the impact on Quality and Risk using the KPI data in line with the Clinical Assessment Framework. Risks are structured around the Trust's six key objectives which encapsulate the five CQC domains. High risks are escalated through the Confirm and Challenge meetings with the Executive Sponsor which assesses whether the Trust should discontinue a project(s) based on the level of (combined) risk to quality. If this is the case, the Executive Sponsor for the project will prepare an Exception Report for TEC to review and formalise the decisions agreed at the Confirm and Challenge Meeting. All Quality Risks are reviewed and updated each month by the Project Leads who use current KPI data to inform Quality Risk scores in the Project Pack which are returned to the PMO. If TEC agrees to remove a project on the grounds of quality, the PMO will record this in the Cost Improvement Savings Tracker. The PMO and Director of Strategy & Performance report the risk decisions to the Finance and Performance Committee.

- **Identification of key performance metrics aligned to specific schemes to facilitate early sight of potential impact on quality of care:** The QIA template is structured around the trust's six strategic priorities with risks listed under each, along with the risk score, mitigating actions and target score, and quality indicators. This enables early sight of potential impact on the quality of care and is reviewed using the processes and governance described above.
- **How baseline data have been recorded before implementation of the change, including the duration of this data:** To ensure the Trust continues to monitor and manage the Quality of its services in line with the Clinical Assessment Framework, all project leads establish strong working relationships with the Information Department to triangulate any quality and performance trends alongside their projects.
- **How the board receives oversight of any potential cumulative impact of several schemes on a particular pathway, service, team or professional group:** If there is any potential cumulative impact of several schemes on a particular pathway, service, team or professional group, this is identified at TEC where it is reviewed and escalated accordingly.

2.4 Summary of triangulation of quality with workforce and finance

- Capacity plans for all divisions are being agreed with them in January and February 2017 as part of the detailed budget setting process once the contract with the CCG has been agreed. All CIP schemes are reviewed by the Medical Director and Chief Nurse following a well-established QIA process.

Section Three: Workforce Planning

3.1 **Articulation of workforce planning methodology linked to strategic aims of the provider.** Workforce planning is supported by local management involvement. Divisional Management Teams consider their future service plans alongside assumed activity to assess the resource required. These plans are considered by the finance and workforce teams, with confirm and challenge to ensure governance arrangements are in place. Supporting business cases for workforce are written. In addition, other Divisional Management Teams make an assessment alongside their workforce plans to ensure any implications for cross-functional working are recognised and managed. Areas of difficulty in recruiting to certain posts are considered at a local and corporate level. The workforce plan outlines innovative ways to support service delivery, supporting different ways of working and less traditional roles to support capacity. It also ensures that support for safe and caring services is continued, and efficiencies and good value for money are delivered. The plan considers areas that attract high temporary staffing costs in order to reduce these costs and support greater sustainability with a substantive workforce. Cost improvements that have been identified are impact-assessed by the Nursing and Medical Directors to assess risk and impact on services. We expect that initiatives to support workforce planning will keep vacancy rates within the 10% target set, with some areas recognised as having higher percentages of hard to fill posts than others.

3.2 Workforce Strategy developed with staff guidance. A corporate 'People Plan' underpins the principles of workforce planning and the recruitment/retention required to support 'hard to recruit' areas. The Plan supports the concept of a sustainable workforce and has particular emphasis on supporting best practice initiatives for staff recruitment and retention. This is supported within the remit of the Workforce and Staff Engagement Committee and, at an operational level, by a sub-committee which provides specific support for areas where there are 'hard to fill' issues or particular issues regarding staff retention.

3.3 **Robust governance process to offer assurance and approval and act as a means of assessing performance against plan year.** The Workforce and Staff Engagement Committee provides an accountability framework based on the detail of the plan and assesses progress within the remit of a Trust Board committee.

3.4 **Well-modelled alignment with financial and service activity plans to ensure the proposed workforce levels are affordable, sufficient and able to deliver efficient and safe care to patients.** An established mechanism is in place for supporting annual service planning and there are also opportunities for Divisional Management teams to submit business cases for new developments for consideration at the Trust Executive Committee. In many instances, the business cases have workforce implications and therefore the Director of HR, alongside the Director of Finance, Medical Director and Chief Nurse, collectively ensure the workforce levels are affordable, sufficient and able to deliver safe care to patients. An established Vacancy Authorisation Process is also in place where weekly confirm and challenge meetings review vacancies to ensure affordable workforce levels, while maintaining and enhancing safe care to patients. This panel consists of the Director of HR, the Chief Operating Officer and the Chief Nurse.

3.5 **Achievement of workforce efficiency, capitalising on collaboration opportunities to increase workforce productivity within STPs and inform subsequent CIP development.** The Trust supports cooperative working across the region and is actively involved in BCA and STP initiatives, enabling sharing of best practice and collaboration for both nursing and AHP recruitment. Collaborative working will reduce dependency on agency and reduce temporary staff costs as by working together, agency costs can be reduced and greater efficiencies in back office functions can be achieved. This supports enhanced recruitment and development of better ways of working for the Bank Team as an alternative to agency costs. This is supported by enhancing employee well-being initiatives alongside greater focus on management of absence in order to support sustainable high levels of attendance.

3.6 **Detail the required workforce transformation and support to the current workforce, underpinned by new care models and redesigned pathways, detailing specific staff group issues.** The Trust has seen success in the development of new areas of workforce sustainability in order to support capacity and enhance quality, including the development of Band 4 Assistant Nursing posts which provide a career structure and support clinical areas with a consistent and sustainable skilled workforce. This role will continue to be developed including how it fits with traditional nursing and Care Support Worker roles. There has been dependency on agency and bank nursing over the last 12 months, much of which has been based on high levels of vacancies at Band 5 and particularly Band 6. This has raised greater focus on how the current substantive resource is managed to ensure high standards of care and to minimise future dependency on agency staff. Since September 2016, the Trust has demonstrated good progress with a clear focus on managing the current resource alongside sustained recruitment campaigns to reduce the vacancy rate. These changes have reduced turnover

and led to consistently low sickness absence. International recruitment, particularly from the Philippines, led to issues regarding ILETS language tests and visas making the initiative difficult to fulfil. There are recruitment issues for some Allied Health Professionals (Speech & language Therapists, Radiographers). Focused recruitment campaigns highlight the benefits of working in Dudley and promote the positive development opportunities. There have been initiatives supporting recruitment of middle grade medical staff in areas with high vacancies and continued development of Physician Assistants, including initiation of MTI recruitment with the Royal College of Physicians in Pakistan.

3.7 **Plans for any new workforce initiatives agreed with partners and funded specifically for 2017/18 and 2018/19** Nursing specific initiatives developed alongside the Trust's BCA partners include:

- **exploring collaborative recruitment initiatives** to remove duplicate effort and avoid local competition and recruitment costs;
- **agreeing areas of collaborative working on new roles.** We are a national test site for the Associate Nurse role. The BCA is collaborating to reduce duplication of effort, costs of developing roles and of education/training, and may create standard roles that are recognised and interchangeable across the BCA. It is hoped that Band 4 roles will be developed beyond those in the Associate Nurse Test site and with the benefit of the economies of scale, look to develop these roles in Critical care, Neonates, Theatres, ED, Community, Maternity, Paediatrics and Outpatients, with collaborative, sustainable approaches to advanced practice development/associated roles;
- **agreeing a collaborative approach to education/development**. Learning Beyond Registration funding from Health Education West Midlands is used to provide internal training. Money is also 'drawn down' for apprenticeships and other 'non-professional' level education. Duplicate training, unfilled places, oversubscribed training and nurses/midwives not being able to access training/development are issues resolvable by offering better quality and access through pooling resources and may enhance retention/recruitment;
- **exploring joint initiatives/work experience with schools and colleges** to promote the BCA as a fantastic place to train and develop as a healthcare professional;
- **exploring exit interviews/opportunities for learning** to offer alternatives within the BCA when it is known that someone is unhappy in their role; where there has been a breakdown in relationships; or where roles are being reduced.

3.8 **Activity to support delivery of workforce plans in conjunction with local workforce advisory boards** Links are established within the locality to support workforce boards and to ensure they work together to develop plans and initiatives to support the future workforce for the whole health economy. Dudley is a significant contributor and this will develop further over the next two years alongside greater levels of BCA collaboration.

3.9 **Engagement with commissioners to ensure alignment with the future workforce strategy of their local health system.** There are regular workforce updates to commissioners. Excellent working relationships are in place to share workforce risks while at the same time providing assurance that workforce recruitment, retention and development meet the needs of the service and provide high standards of care. The MCP consultation is still ongoing but the Trust and local stakeholders initiated staff engagement meetings to prepare for the future changes and ensure the right skills are in place to manage what is likely to be a complex process.

3.10 **Affordable plans for implementing the four priority standards for seven-day hospital services by March 2018/March 2020.** The BCA and Wolverhampton have piloted and plan to expand, the provision of seven day Interventional Radiology services locally resourced through a rota system between the Trusts. The provision of safe and effective 7 day services is more achievable through collaborative working with partners. A Trust plan is being developed to drive implementation of seven-day hospital services

Section Four: Financial Planning

4.1 Financial forecasts and modelling

Trust agreed with NHS Improvement a revised Control figure of £2.442m for 2017/18 and £1.640 for 2018/19. Plans have been set on this basis.

DUDLEY GROUP 23rd DECEMBER 2016 BUDGETS £m

A summary of the key financial plan figures completed in the financial templates are set out in the table below:

	Forecast 16/17	Plan 17/18	Plan 18/19
	£000	£000	£000
Patient Care Income	£316,962	£327,433	£331,757
Other Operating Income	£21,504	£21,118	£22,132
Employee Expenses	-£202,135	-£206,985	-£209,068
Other Operating Expenses	-£123,722	-£125,731	-£128,986
Operating Surplus/(Deficit)	**£12,609**	**£15,835**	**£15,835**
Finance Costs	-£13,309	-£13,393	-£14,195
Underlying Surplus/(Deficit)	**-£700**	**£2,442**	**£1,640**
STF Funding	£10,500	£8,574	£8,574
Final Surplus/(Deficit)	**£9,800**	**£11,016**	**£10,214**

The key features of these budgets are:

- the higher income base reflects the calculated impact of HRG4+ in 2017/18 and increase in the cost of pass-through drugs, as well as additional capacity to meet an anticipated continued rise in activity in both years;
- a contract has been agreed with Dudley CCG for £204.7m for 2017-18 which has been calculated on agreed activity levels and projections, but then abated with QIPP schemes which reduce activity by £4.7m.
- a CQUIN reserve of £1.2m has been created as a risk reserve in line with the requirement within the operating plan guidance to hold 0.5% of the CQUIN funds;
- the additional pay costs include the anticipated pay awards in both years, together with an estimate of the cost of the apprentice levy as well as the anticipated cost of additional 'manpower' to meet anticipated activity increases;
- non-pay costs rise in line with inflation and include a contingency of £0.5m. The figures for CNST are based on the latest communication from the NHS Litigation Authority;
- the budgets include the impact of removing the associated costs linked to the Wheelchair contract termination;
- given the austere financial environment, only essential developments have been included within plans. These include the impact of an Obstetric business case linked to quality issues; an EPR business case to address the current risk of operating via an unsupported IT system and to provide the platform for the delivery of future efficiencies; and an Imaging business case to cater for a significant increase in demand and an over-reliance on mobile imaging facilities;
- additional costs linked to the breast screening expansion for Staffordshire and taking the lead relationship locally have also been factored into the budgets;
- all costs have been abated by anticipated cost improvement programmes in both years as follows (see Section 4.2).

The Trust's cash position takes account of the anticipated purchase of a new EPR system to replace the previous system which is no longer being supported. In addition, a proposed expansion to MRI and CT facilities will take place in 2017/18.

The Overall Plan Risk Ratings for the Year show that the Trust is anticipating a score of 1 in both years.

Plan Risk Ratings	Expected Sign	03PLANM12 Plan 31/03/18 YTD Rating	03PLANFY Plan 31/03/19 Year Ending Rating
Capital Service Cover rating	+	2	3
Liquidity rating	+	1	1
I&E Margin rating	+	1	1
Variance From Control total rating	+	1	1
Agency rating	+	1	1

Overall Plan Risk Ratings	Expected Sign	03PLANM12 Plan 31/03/18 Month 12 Rating	03PLANFY Plan 31/03/19 Year Ending Rating
Overall rating unrounded	+	1.20	1.40
If unrounded score ends in 0.5	+	0.00	0.00
Plan Risk Ratings before overrides	+	1	1
Plan Risk Ratings overrides:			
Any ratings in table 6 with a score of 4 override - if any 4s "trigg show here		No Trigger	No Trigger
Any ratings in table 6 with a score of 4 override - maximum score c of 3 if any rating in table 6 scored as a 4	+	1	1
Control total override - Control total accepted		Yes	Yes
Control total override - Planned or Forecast deficit		No	No
Control total override - Maximum score		N/A	N/A
Is Trust under Financial Special Measures		No	No
Plan Risk Ratings after overrides	+	1	1

4.2 Efficiency savings for 2017/18 to 2018/19

The internal Trust efficiency plan equates to 3.84% in 2017/18 and 2.6% in 2018/19. A summary of the identified schemes within the plan are set out in the table below. Schemes include local efficiency plans as well as ideas developed alongside partners within the Black Country Alliance and the wider STP. The plans seek to embrace the Carter benchmarks and include Pathology redesign/Managed Service Contract, Back Office review, Estates/PFI rationalisation, Medicines Management Optimisation and key areas of procurement. Other saving plans focus on reducing agency, skill mix reviews, reviewing service provision which includes outpatient optimisation and consultant job planning. Best practice tariffs are explored continually for increased income opportunities that deliver an improved patient experience. The impact of delivering the anticipated growth in a more efficient manner has been incorporated into the plans.

	Plan 17/18 £000	Plan 18/19 £000
Pay (Skill mix)	£3,647	£3,510
Pay (WTE reductions)	£350	£650
Non pay	£4,588	£3,109
Income (Patient Care Activities)	£2,565	£600
Income (Other operating income)	£1,270	£770
TOTAL	**£12,420**	**£8,639**
CIP as a % of Turnover	***3.84%***	***2.63%***

4.3 Capital planning

The Trust has capital plans to spend £12.458m in 2017/18. For 2018/19, capital plans total £15.866m. The Trust has no surplus assets for disposal during this period. The estates strategy has driven the capital programme. The Trust operates out of PFI buildings, so there is no requirement to fund back log maintenance from capital resources and this is the responsibility of the PFI Company. The capital schemes are summarised below:

IT Programme

The biggest investment over the plan period is the replacement of the Trust's Electronic patient record System.

Community Imaging

The Trust is investing £2.083m in 2017/18 to provide additional MRI and CT capacity. This will involve the redevelopment of existing estate to provide facilities to house an additional MRI scanner and CT scanner.

Replacement Medical Equipment

Total investment of £3.0m in replacement medical equipment is planned during 2017/18 and 2018/19. The Trust has a rolling medical equipment replacement programme and a clear replacement structure which includes a medical devices group which oversees the purchase of all medical equipment. All key stakeholders are involved in the replacement programme, including all wards and departments, the MES provider Siemens and the Trust's Finance Department.

PFI Lifecycle and MTS Replacements

The Total lifecycle plan is £1.747m in 2017/18 and £0.968m in 2018/19. Under IFRS, the Trust has to account for the lifecycle applied to the hospital by the PFI Company which is a technical accounting transaction and the plan is based on information provided by the PFI Company. The Trust is reliant on the PFI Company providing the information to support the application of lifecycle expenditure. The risk is with the PFI Company to maintain the PFI assets to a specific level. In addition, the replacement of existing imaging equipment is also included within the PFI contract and during the plan period, replacement of imaging equipment to the value of £3.283m will take place.

Other Capital Expenditure

The Trust is investing £1.066m during 2017/18 and 2018/19 on other small capital schemes. This spend relates to the lifecycle of the remaining owned estate and minor capital works in the PFI buildings.

Section Five: Link to the Local STP

5.1 How the vision for the local STP is being taken forward through the operational plan

Dudley Group has been an active participant in the detailed planning of the Black Country and West Birmingham STP which sets out how the local area, and the Trust in particular, plans to meet the clinical and financial challenge of the 5 Year Forward View locally. The Black Country's 1.4m population spans five Local Authorities and is served by commissioner and provider organisations with a demonstrable commitment to leading in the transformation of health and care. However, 46% of that population lives in the most deprived areas of the country and this creates some significant health challenges especially in relation to obesity, alcohol and smoking related illnesses. In addition to variation from national averages, there are also material differences in quality and outcomes across the STP footprint and each borough has areas of high performance and areas of particular challenge.

It is clear that current ways of operating are unsustainable. As a more sustainable, healthier and higher quality 2021 approaches, there is the significant advantage of there being a range of transformation initiatives already being active across the footprint. STP partners are committed to learning from these initiatives through a programme of concurrent evaluation that focuses on learning that is transferable across models of care and organisational forms, locally and nationally. Within the STP, individual organisations and partnerships will continue to make the improvements and efficiencies that are directly within their own control, but the overall scale of opportunity will be transformed by partners working together as a single system with a common interest.

5.2 How the 3 – 5 critical transformation programmes articulated in the local STP affect the provider's individual, organisational operational plan

Standardising service delivery and outcomes, as well as reducing variation through horizontal and vertical integration are at the heart of the STP. Mental Health and Learning Disabilities services are part of this integration but are identified as a discrete strand to reinforce parity of esteem. Maternity / Infant health is also an essential focus given challenges around maternal health, neonatal/infant outcomes and maternity capacity.

Elements of the triple challenge are unlikely to be addressed without taking action together on the wider determinants of health. This will be enabled through close working with the West Midlands Combined Authority and a ground-breaking study on the economic impact of health spending has been commissioned through the Strategy Unit and ICF International. It will include the economic impacts of health services defined in terms of both the economic benefits from improved healthcare and the opportunity costs of healthcare failures.

The Black Country has a strong track record of delivery and innovation, and hosts or directly interacts with a number of key nationally supported innovations: MCP Vanguards in Dudley and Sandwell & West Birmingham, and the MERIT ACC vanguard. In addition, parallel innovations are underway in Walsall (integrated locality teams model) and Wolverhampton (PACs–type integration). Reconfiguration from five to four acute hospitals through the Midland Metropolitan Hospital development is also underway. Dudley Group's financial dimension in the STP may be summarised as follows:

The Dudley Group NHS Foundation Trust		TOTAL				
		2016/17	2017/18	2018/19	2019/20	2020/21
		£000	£000	£000	£000	£000
Do Nothing	Income	333,627	341,454	348,751	356,638	367,516
	Expenditure	336,136	352,898	369,927	388,541	411,340
	Net Surplus/(Deficit)	(2,509)	(11,445)	(21,176)	(31,903)	(43,824)
Do Something	Income	333,627	337,764	339,066	338,651	336,619
	Expenditure	336,136	343,636	348,585	352,032	357,186
	Net Surplus/(Deficit)	(2,509)	(5,872)	(9,519)	(13,382)	(20,567)

The absolute numbers vary because of timing differences and, in particular, because the impact of HRG4+ was not accounted for in the STP submission. However, the £2.5m deficit in 2017/18 can be broadly reconciled to the break-even position in the draft operating plan when these differences are accounted for.

Dudley Group remains committed to working with local health partners to implement clinically and financially sustainable solutions. In particular, work is taking place relating to the formulation of a Dudley MCP with Dudley GPs and other health partners. Dudley CCG is working towards letting a 10 to 15 year MCP contract from 1st April 2018 for Dudley patients, using a new style MCP contract based on health outcomes rather than more traditional contract currencies. For Dudley Group, this £250m plus annual contract includes £27m per annum of services currently provided by the Trust which would transfer to the new provider, and £50m per annum which would be provided under a sub-contract arrangement. Exact details of timing and partners is yet to be determined, and it is not clear at this stage what impact this will have on the Trust's operational plan and have not been factored into the activity outlined in Section One. It has been agreed with the CCG not to reflect this significant change in the operating plan for 2017-19, and to update the plan once greater clarity is available.

The STF assurance statement is embedded below:

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Section Six: Membership and elections

6.1 Governor elections in 2016/17 and 2017/18

In accordance with the Trust's constitution, Governors are elected for a period of no more than three years and cannot serve for more than 3 terms which meant that in 2016/17 to December 2016, two elections to place, as summarised below:

2016/17 Elections	Governor Constituency	Outcome
Quarter 1	Public – Dudley Central Public – Dudley North Public – Halesowen Staff – Nursing and Midwifery	The elections concluded on Thursday 28th Apri successfully returned the following candidates to each Public – Dudley Central Public – Dudley North Public – Halesowen Staff – Nursing and Midwifery
Quarter 2	No elections	
Quarter 3	Public – Brierley Hill Staff – Nursing and Midwifery Staff – Non clinical Staff	Public – Brierley Hill Staff – Nursing and Midwifery Staff – Non clinical Staff
Quarter 4	There are no elections planned in the last quarter of 2016/17	

Based on the end of the Governor's planned terms of office, the following elections will be undertaken in 2017/18, although further elections would be undertaken if a governor resigned.

2017/18 Planned Elections	
Quarters 1, 2 & 4	No elections planned
Quarter 3	Elections planned for seven public constituencies

6.2 Governor recruitment, training and development and engagement

The training programme is constructed on a modular basis with the modules structured to support newly appointed governors. These modules were run for the newly elected governors from the elections in quarter one across May, June and July, and will be delivered in December for the governors appointed in Quarter Three. Annual training on fire safety and Infection Control is run across two sessions in the year allowing all governors to attend at least one of these sessions. Safeguarding training is also provided. The Council of Governors Governor Development Committee monitors the take up of induction and "mandatory" training, along with overseeing the content of the training programme utilising feedback from those attending the individual modules. In 2016/17 a planned review of training against the resources released by NHS Providers GovernWell took place which resulted in some minor enhancements. The format of the training was changed from sessions on separate days to one day of more focused training based on governor feedback from the council of governors' self-assessment undertaken earlier in 2016/17. A series of engagement events supplement the training and enable Governors to attend strategy workshops with the Board, coupled with presentations from elements of the Trust on their service. The latest one of these was in the area of the Trust's end of life services.

6.3 Membership strategy

The Trust has established a target to ensure Public Membership does not drop below 13,000. In 2016/17, there has been a steady growth in public membership from 13,981 at 31/3/16 to 13,815 at 30/09/16. In-year data base cleansing removes members who are deceased or have moved away. To support the Membership Strategy and to recruit, engage and involve Trust members, patients, carers and the wider community, the Trust utilises a variety of engagement methods to ensure everyone who wishes to be, has the opportunity to be involved and can provide their views and experiences. This includes people who are in the poorest health, in vulnerable circumstances, or who have traditionally not had their voices heard.