NHS
Hull University Teaching Hospitals
NHS Trust

OPERATIONAL PLAN 2022-2023

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Remarkable people.
Extraordinary place.

Hull University Teaching Hospitals NHS Trust

Operational Plan 2022/23

1. Introduction

Hull University Teaching Hospitals NHS Trust (HUTH Trust) is situated in the geographical area of Kingston upon Hull and the East Riding of Yorkshire. The Trust employs 8,195 WTE staff (March 2022), has an annual turnover of £792m (2021/22) and operates from two main sites - Hull Royal Infirmary and Castle Hill Hospital – whilst delivering a number of outpatient services from locations across the local health economy area.

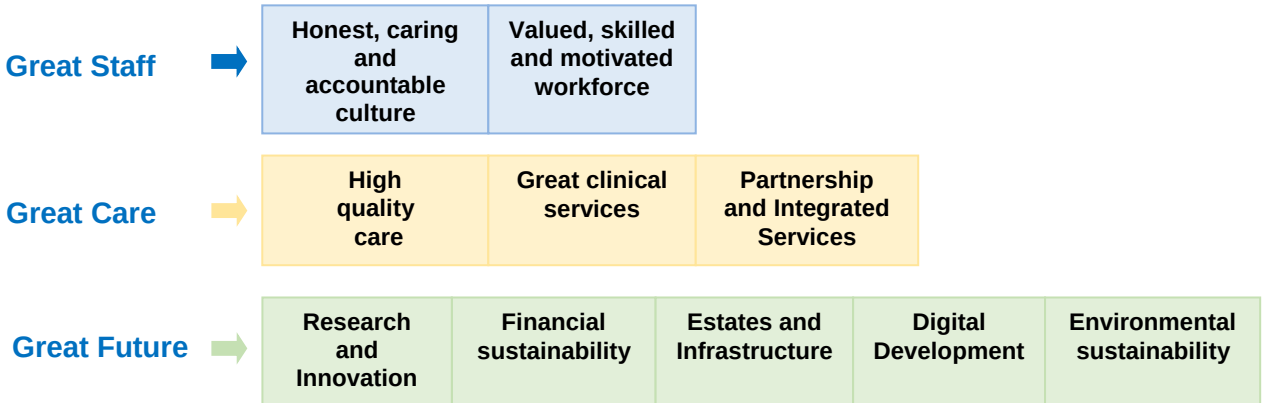
The Trust's secondary care service portfolio is comprehensive, covering the major medical and surgical specialties, routine and specialist diagnostic services and other clinical support services. These services are provided primarily to a catchment population of approximately 600,000 in the Hull and East Riding of Yorkshire area.

The Trust provides specialist and tertiary services to a catchment population of between 1.05 million and 1.25 million extending from Scarborough in North Yorkshire to Grimsby and Scunthorpe in North East and North Lincolnshire respectively. The only major services not provided locally are transplant surgery, major burns and some specialist paediatric services.

2. Vision, Values and Goals

Our vision is *'Great Staff, Great Care, Great Future'*, as we believe that by developing an innovative, skilled and caring workforce, we can deliver great care to our patients and a great future for our employees, our Trust and our community.

We have developed a set of organisational values - *'Care, Honesty, Accountability'* - in conjunction with our staff and these form the basis of a Staff Charter which sets out the behaviours which staff expect from each other and what staff can expect from the Trust in return. The values are reflected in our organisational goals for 2022-2025



On 1st March 2019 the Trust formally changed its name to Hull University Teaching Hospitals NHS Trust in order to strengthen links with Hull University, particularly in respect of teaching and academic opportunities, and to bring about positive benefits in respect of recruitment, especially in relation to clinical posts across medical, nursing and professions allied to health. Research and innovation features as one of our organisational goals as it reflects the Trust's aspiration to be a research centre of excellence, engendering an innovation culture.

3. National Operational Planning Requirements 2022-23

3.1 Humber and North Yorkshire Health and Care Partnership (HNY HCP)

In February 2021 the Health and Social Care secretary, with the support of NHS England, set out new proposals to bring health and care services closer together to build back better from the impact of the Covid-19 pandemic by improving care and tackling health inequalities. The measures set out in the Government's White Paper: 'Integration and Innovation: Working together to improve health and social care for all' seek to modernise the legal framework to make the health and care system fit for the future and put in place targeted improvements for the delivery of public health and social care. It will support local health and care systems to deliver higher quality care to their communities, in a way that is less legally bureaucratic, more accountable and more joined up, by bringing together the NHS, local government and partners to tackle the needs of their communities as a whole. The proposals build on the NHS' recommendations for legislative
change in the NHS Long Term Plan.

During 2021/22 measures were put in place to create statutory Integrated Care Systems (ICSs). These will comprise an ICS Health and Care Partnership and an ICS NHS Body. The ICS NHS body will be responsible for the day to day running of the ICS, while the ICS Health and Care Partnership will bring together systems to support integration and develop a plan to address the local health, public health, and social care needs. These statutory bodies will come into effect on 1st July 2022.

As part of the progressive development of ICSs, place-based and provider collaboration arrangements, including Primary Care Networks (PCNs), are playing an increasingly important role in the co-ordination and delivery of joined-up care across local populations.

The Humber and North Yorkshire Health and Care Partnership (HNY HCP) covers the geographical areas of North Yorkshire and York; Hull and the East Riding of Yorkshire; North East Lincolnshire and North Lincolnshire. Its Long Term Plan 2019-2024 sets out the Partnership's ambition to 'Start Well, Live Well and Age Well'. This means shifting the focus of our work from picking people up when they fall to helping to prevent them from becoming unwell in the first place and supporting more people to manage their health and wellbeing at home so they can get on with living happy and fulfilling lives.

The Trust's role in delivering this plan is to work openly and collaboratively with partners to support the development of new models of care and the closer integration of health and social care services. Examples of this include the development of Humber-wide secondary care services in association with Northern Lincolnshire and Goole Hospitals NHS Trust through delivery of the Interim Clinical Plan and the Humber Acute Services Review. Both aim to deliver robust and sustainable clinical services for the local population in the short, medium and longer term.

3.2 Operational Planning 2022-23

The NHS Priorities and Operational Planning Guidance 2022/23 was published in late December 2021 and identified that the goal for 2022/23 was to significantly increase the number of people we are able to treat and care for in a timely way. The priorities for the NHS for the coming year were identified as:

A. Invest in the workforce
B. Respond to COVID-19 ever more effectively
C. Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards.
D. Improve the responsiveness of urgent and emergency care (UEC) and build community care capacity
E. Improve timely access to primary

F. Improve mental health services and services for people with a learning disability and/or autistic people
G. Continue to develop our approach to population health management, prevent ill health and address health inequalities
H. Exploit the potential of digital technologies to transform the delivery of care and patient outcomes
I. Make the most effective use of our resources – moving back to and beyond pre-pandemic levels of productivity when the context allows this.
J. Establish Integrated Care Boards and collaborative system working.

The specific operational requirements were:

- 10% more elective activity than before the Pandemic (2019/20 baseline)
- 20% more diagnostic activity against 2019/20 baseline
- 52+ week waits eliminated by March 2025.
- Eliminate 104 week waits by July 2022
- Eliminate waits of over 78 weeks by April 2023, and of over 65 weeks by March 2024.
- Long-waiting patients will be offered further choice about their care
- 95% of patients needing a diagnostic test receive it within six weeks by March 2025.
- By March 2024, 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.
- Local systems to return the number of people waiting more than 62 days from an urgent referral back to pre-pandemic levels by March 2023.
- Reduce outpatient waiting times by transforming the model of care and making greater use of technology.

4. Activity Planning and Service Developments

4.1 Capacity and Demand

The Trust has developed its workload forecasts and service delivery plans for 2022/23 using recognised capacity and demand models.

The Trust is planning to deliver 98% of the 2019/20 baseline value from within operational core capacity. A further 0.8% has been identified from the additional day surgery capacity which will come on line from Q4 2022/23, internal premium capacity (eg WLIs) 0.6% and the provision of Independent Sector capacity (insourcing and outsourcing) 2.7%. Work is underway to identify further measures such as mutual aid to close the remaining 1.9% gap.

Overall the cost estimates for delivering 104%, which is bridging from the 98% from core capacity are as follows:

- £5.3M IS Provider
- £1.6M Diagnostic capacity
- £1.5M Extra day case capacity from 4 theatres from Q4
- £1.7M Internal premium pay initiatives – WLI/locum
- £3.7M Required to close the gap to get to 104%

£13.8M

Changes to Infection Prevention and Control guidance may afford some opportunities in-year to increase productivity, however no activity assumptions have been included in the plans at this stage.

4.2 Activity Plan

The tables below provide a summary of the Trust's activity forecasts for 2022/23 as a percentage of the 2019/20 baseline. During April 2022 the Trust will be making a change to

the coding of Same Day Emergency Care (SDEC) activity from an outpatient attendance to a zero length of stay elective spell. This coding change is reflected in the tables.

Domain: Outpatients	Baseline 2019/20	Plan 2022/23	As % of 2019/20 baseline
All attendances	807455	801869	99%
All face to face	781226	634026	81%
Non face to face	26229	167843	640%
Face to Face: New attends	255342	200754	79%
Face to Face: Follow ups	525884	433272	82%
Non F2F: New attends	1788	50125	2803%
Non F2F: Follow ups	24441	117718	482%
Patient initiated follow ups		21338	
1st outpt spec acute	227418	199525	88%
1st outpt with procedures	38309	47227	123%
Follow up spec acute	426894	424279	99%
Follow up spec acute with procedures	74395	116678	157%

Domain	Baseline 2019/20	Plan 2022/23	As % of 2019/20 baseline
Elective Spells	90058	95309	106%
day cases (adults)	74420	79815	107%
ordinary spells	15638	15494	99%
day cases (under 18 years)	2774	2692	97%
ordinary spells (under 18 years)	655	626	96%
Referrals			
Total (GP and non GP)	171639	171642	100%
GP referrals	117920	117922	100%
Non GP referrals	53719	53720	100%
A&E attendances	137450	137450	100%
Non-Elective Spells	57144	64183	112%
LOS of zero days	12491	23258	186%
LOS of 1 day or more	44653	40925	92%
Covid LOS of 1 or more days	39	1460	3744%
Non Covid LOS of 1 or more days	44614	39465	88%

Other coding changes since 2019/20 have included:

- The transfer of Northern Lincolnshire and Goole NHS Foundation Trust's Neurology activity to HUTH during 2021/22.
- Transfer of 250 Haematology patients from NLaG to HUTH at the end of March 2022.
- Conversion of Ophthalmology inpatient ward to day cases has resulted in all activity now being recorded as day cases.

It is anticipated that further transfers of activity will take place during 2022/23 as a result of the creation of Humber-wide acute services as part of the Interim Clinical Plan between HUTH and NLaG. Any such changes will be the subject of a contract variation.

The Trust will not achieve the required 110% of elective activity outlined in the national planning guidance. Elective capacity has been significantly impacted by:

- Infection Prevention and Control measures as a result of Covid-19. This is particularly the case in Vascular Surgery and Gynaecology (elective inpatients).

- The high level of 'No Criteria to Reside' (NCTR) patients in the Trust (c.140-160 at any one time) has necessitated the utilisation of wards C9/C9A (35 beds) and C16 (28 bed plus 2 HOB) to house these patients pending discharge. This has resulted in no core capacity for elective orthopaedics at Castle Hill Hospital and has severely impacted on the core capacity for breast surgery, gynaecology and plastic surgery. An assumption has been made that Suite 20 (social care ward) will become available from May 2022 onwards (21 beds) which will release ward C16 for elective inpatients.

- The Trust has three medical wards assigned to Covid-19 patients currently reducing non-elective medical capacity at HRI. This has resulted in medical outliers on surgical wards impacting adversely on elective surgical capacity.

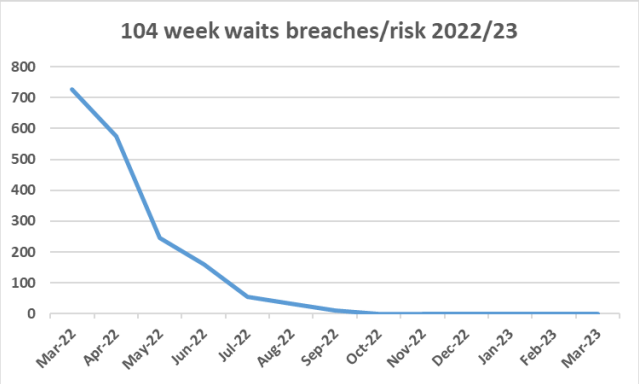
The lack of elective capacity is reflected in the Trust's trajectory in terms of its RTT pathway performance (see below).

Domain	Baseline 2019/20	Plan 2022/23	As % of 2019/20 baseline	Comment
RTT				
52 weeks and over		5312		as at end of March 2023
78 weeks and over		0		at March 2023
104 weeks and over		0		at October 2022
Number of incomplete pathways		63453		at March 2023
Completed Admitted Pathways	44536	44030	99%	
Completed Non Admitted	170290	176250	103%	
Number of new RTT pathways	211509	224193	106%	
Diagnostics				
MRI	26577	30786	116%	
CT	54050	61181	113%	
Non obstetric ultrasound	58636	48363	82%	
Colonoscopy	3931	4409	112%	
Flexi sigmoidoscopy	2051	2574	125%	
Gastroscopy	5784	5750	99%	
Echocardiography	5276	6079	115%	

In addition, diagnostic capacity is not expected to achieve the 120% (when compared to 2019/20 baseline) in all key areas. In non-obstetric ultrasound there has been a significant reduction in referrals over the last two years and this is not expected to recover in 2022/23.

Increased endoscopy capacity following the opening of the Allam Digestive Diseases development at Castle Hill Hospital has been factored into the forecasts.

The Trust has been the focus of intense scrutiny from NHSE/I and the system in relation to its performance against the 104 weeks wait trajectory. Zero 104 week waits will not be achieved by the target date of 30 June 2022. The Trust and commissioners have agreed a revised trajectory of zero 104 week waits by October 2022.



The Trust is seeking to create additional capacity to address the longest waits through mutual aid, waiting list initiatives and use of the Independent Sector (insourcing and outsourcing). Advantage will also be taken of the additional day case capacity expected in Q4 2022/23 when Phase 1 of the new Day Surgery development at CHH is completed (circa 1,662 cases).

Risks to delivery of the elective recovery programme include:

- Continuing high levels of NCTR patients due to the lack of social care services and placements in the community, resulting in a lack of elective bed availability
- Lack of theatre and ICU capacity
- Insufficient independent sector capacity to meet needs (including insufficient funding to meet costs of IS)
- Insufficient mutual aid capacity
- Insufficient staff to meet needs eg recruitment, redeployment, sickness absence.

As at 20 March 2022, the total number of people on the waiting list with suspected cancer was 1,585, of which 315 people (19.9%) had waiting in excess of 62 days. Specific challenges are in relation to Computed Tomography (CT) and CT Colonography (CTC) capacity, pathology turnaround times and access to elective beds. However, it must be stressed that cancer patients have always been prioritised. The Trust has a recovery plan in place to reduce the number of people waiting back to pre-pandemic levels by March 2023 (130 people as at February 2020). Key actions include:

- Consultant-led triage
- Administration process review in Radiology department (CTC)
- CTC demand and capacity analysis: slot utilisation
- Additional tracking resource to reduce the numbers on the PTL
- Review of guidelines for tracking staff to remove patients from the PTL following test results (clinically agreed)
- Review of Pathology turnaround times
- Cancer Transformation Programme including Colorectal, Upper GI, Lung, Head and Neck and Prostate.
- Standard of Care are being developed with the HNY Cancer Alliance.

4.3 Reducing Health Inequalities

The Trust has in place BI reports set up to identify and monitor health inequalities metrics including those patients on waiting lists. These reports are refreshed daily and reported on monthly. Tracking of patients on waiting list processes are in place, which includes proactive engagement with patients who are identified as having health inequalities.

The Trust has undertaken a review of its RTT waiting times by level of deprivation and by ethnicity. The RTT Wait is disproportionately split at Treatment Function level with Occupational Therapy having a Median Wait of 21 weeks whereas the other quintiles see a range from 2 to 5 weeks (January 2022 position).

Quintile Median	Deprivation Quintile				
Treatment Function	Q1	Q2	Q3	Q4	Q5
140 - Oral surgery	18	20	15	19	
141 - Restorative dentistry	12	34	22	13	
143 - Orthodontics	38	38	41	42	
172 - Cardiac surgery	32	28	30	25	
310 - Audiological medicine	50	28		28	
314 - Rehabilitation	6	20	5	3	
651 - Occupational therapy	21	2	2	5	
840 - Audiology	52	67	47	56	

In the Ethnicity modelling, a number of specialties have a disproportionate split; with a specific highlight against Orthodontics.

Ethnicity Median	Ethnicity Category				
Treatment Function	Asian	Black	Mixed	Other	Wh
101 - Urology	12	22	14	16	
103 - Breast surgery	11	2	2	2	
104 - Colorectal surgery	9	10	23	20	
140 - Oral surgery	13	29	17	17	
143 - Orthodontics	50	100	37	24	
219 - Paediatric plastic surgery		49	10		
410 - Rheumatology	18	0	3	13	
650 - Physiotherapy		12	34		

Specific areas of focus in 2022/23 by which the Trust will seek to reduce health inequalities include:

- Participation in prevention programmes include Lung Health Check, Bowel Screening, AAA Screening, Breast Screening. For example: The HUTH Bowel Screening Hub is working with GP practices, agencies, mental health, prisons, learning disabilities, including the homeless, to increase opportunities for these groups to participate within the Bowel Cancer Screening Programme.
- Digital Inclusion - clinically appropriate patients will be offered either telephone or virtual appointments using Attend Anywhere. However, if this is not suitable for the patient, the appointment will be converted to face to face. It is recognised that not all patients are digitally mature, and that not all have access to digital communication devices due to the high levels of social deprivation. The provision of digital devices is being considered as part of the development of new services which rely on digital monitoring to support patient treatment (eg cardiology tele-monitoring to support virtual ward)
- Core20Plus5 – The Trust is working with system partners in relation to Maternity Services.
- Development of the Respiratory Exacerbation Service providing specialist respiratory care and treatment to patients who have been admitted to hospital and can be discharged and supported to manage their exacerbation at home (Early Supported Discharge - ESD) and to prevent those who are exacerbating from being admitted to hospital.

4.4 Service Developments and Transformational Change

The Trust recognises that changes are needed to the way in which clinical services are configured, delivered and resourced. In 2018/19 the Trust was successful in its bid for Wave 4 capital investment to improve the urgent and emergency care pathways within the Hull Royal Infirmary through the reconfiguration of accommodation and the procurement of additional diagnostic equipment, including MRI and CT. As these works near completion in 2022/23, the Trust will continue to focus on measures to improve patient safety and flow between the Emergency Department and other acute services within the hospital.

Across all departments operational arrangements are being systematically reviewed and revised in order to maximise productivity and contribute to the achievement of cash releasing efficiency savings. Each Health Group has drawn up an integrated programme of service developments that will deliver significant safety, quality and financial benefits, aligned to the delivery of the Humber and North Yorkshire Long Term Plan. These service developments include:

- **Surgical Services**
  - Continued development of surgical Same Day Emergency Care
  - Further development as a Major Trauma Centre, including review of patient pathways, theatre and bed capacity.
  - Development of Endoscopy Services, including optimising the benefits of the new Digestive Diseases Unit
  - Partnership working with NLAG and York FTs on the further development of Urology Services across the Humber and North Yorkshire HCP.
  - Partnership working with York FT on the development of the HNY Vascular Service Development Network, including collaboration on plans for new hybrid theatres at HUTH and York
  - Continued review and improvements to the productivity of Trust theatres.

- **Medical Services**
  - Support the development of sustainable regional services for cardiology, neurology and stroke.
  - Further development of the hyper acute stroke service to ensure compliance with best practice standards
  - Respiratory Exacerbation Service – including Virtual Ward
  - Increased Spirometry and lung function diagnostics capacity through the use of the Clinicabin
  - Development of the Heart Failure pathway with CHCP

- **Emergency Medicine**
  - Deliver the benefits of the investment in the reconfiguration of the Ground Floor of the Hull Royal Infirmary to facilitate the flow of urgent and emergency care admissions from the Emergency Department to the acute assessment areas, including revised patient pathways and expansion of SDEC
  - Further development of the Urgent Treatment Centre stream in the ED.

- **Family and Women's Services**
  - Continued participation in the HNY Local Maternity System (LMS) and delivery of the ambitions within Better Births (2016) and the recommendations of the Ockendon Report.
  - Reconfiguration of the Neonatal Unit to better meet the recommendations of the Y&H ODN Neonatal Critical Care Review
  - Reconfiguration of facilities to deliver sufficient physical outpatient/ambulatory space for Children's Services, Gynaecological Services and Maternity Services.
  - Plastic Surgery - Creation of a Regional Hand Unit to address both trauma and elective hand surgery

- **Clinical Support Services**
  - Increase the Queen's centre bed base by opening ward 29 in preparation for the transfer of activity from the South Bank.
  - Develop plans to increase the hours of the Day Treatment Unit within the Queen's Centre
  - Extend the opening hours of the Queen's Centre Acute Assessment Unit and increase capacity in line with development of new facilities.
  - Relocation of radio-pharmacy from HRI to CHH.
  - Development of Psychological Services
  - Effective procurement and commissioning of replacement Radiology and Radiotherapy equipment.
  - Work in collaboration with partners within the ICS to form an imaging network, in line with 'Transforming Imaging Services in England: A National Strategy for Imaging Networks'. This will include the developing strategy around Rapid Diagnostic Centres and community diagnostic hubs.

4.5 Winter Plan

As in previous years, the Trust will seek to continually strengthen both its internal arrangements for the management of Winter Pressures and to work with local providers and

commissioners across health and social care to ensure a robust and comprehensive system response. This will be undertaken in the context of 'Living with Covid'.

4.6 Continuing Response to Covid

The Trust has a response plan which sets out all of the key arrangements and policies that are guiding our response to Covid-19. The plan seeks to ensure:

- The spread of Covid-19 is minimised
- That essential emergency and urgent core activities are maintained
- The creation of pathways and capacity to effectively care for large volumes of Covid 19 patients requiring general hospital and critical care
- To minimise morbidity and mortality from Covid-19 among patients and staff
- To optimise deployment of staff, planning for the impact of self-isolation and Covid-19
- To provide staff with training and support to undertake their duties
- To provide the best possible environment and equipment for staff to undertake their duties
- To ensure staff have access to appropriate personal protective equipment
- Effective management of the incident through the Covid-19 Command Structure
- Providing timely, authoritative and up-to-date information (that complements wider national messages) to service users, staff and partner agencies
- Return to normal working after a Covid-19 wave as rapidly and effectively as possible.

5. Workforce Plan 2022/23

The Trust's Workforce Plan for 2022/23 sees an increase in the total staffing establishment of 132.61 wte by March 2023 from a baseline of 8,195.5 wte. This includes increases across all staff groups, including Nursing & Midwifery (+39.13 wte), Scientific and Technical (+19.6 wte), Support to Clinical Staff (51.64 wte), (Medical staff (+22.24 wte).

	Establishment	Establishment	Variance
	Year End (31-Mar-22)	Year End (31-Mar-23)	
Workforce (WTE)	**Total WTE**	**Total WTE**	**Total WTE**
Total Workforce (WTE)	**8195.5**	**8328.11**	**132.61**
Registered nursing, midwifery and health visiting staff (substantive total)	2386.58	2425.71	**39.13**
Registered scientific, therapeutic and technical staff	1012.63	1032.23	**19.6**
Registered ambulance service staff	0	0	**0**
Support to clinical staff	1591.5	1643.14	**51.64**
Total NHS infrastructure support	1977.02	1977.02	**0**
Medical and dental	1227.17	1249.41	**22.24**
Any other staff	0.6	0.6	**0**
Substantive WTE	8195.5	8328.11	**132.61**
Registered nursing, midwifery and health visiting staff (substantive total)	2386.58	2425.71	**39.13**
Registered scientific, therapeutic and technical staff (substantive total)	1012.63	1032.23	**19.6**
Registered ambulance service staff (substantive total)	0	0	**0**
Support to clinical staff (substantive total)	1591.5	1643.14	**51.64**
Total NHS infrastructure support (substantive total)	1977.02	1977.02	**0**
Medical and dental (substantive total)	1227.17	1249.41	**22.24**
Any other staff (substantive total)	0.6	0.6	**0**

The increases reflect recruitment to support service developments and increased capacity requirements (eg the new Cardiology ward, new Day Surgery Unit and social care ward). They also reflect requirements to increase staffing to achieve compliance with clinical standards such as 'Facing the Future' in Paediatrics and Ockenden in maternity services.

The supply, recruitment and retention of staff is a key priority for the Trust. HUTH will continue with apprenticeship programmes, clinical and non-clinical, including apprentice

nurse degree, apprentice nurse associate, ODP apprentices and apprentice health care support worker. Registered Nursing within Theatres are up-skilled to complete the Anaesthetic training module to be dual-skilled Peri-operative Practitioners. The Trust is offering enhanced recruitment packages for Consultant posts in Anaesthetics and Intensive Care, and utilising the MTI scheme and in-house CESR Fellowships to support succession-planning for medical roles.

The Trust will continue with international recruitment for registered staff, particularly nurses, and other recruitment campaigns nationally for registered staff. We will also continue with national and international recruitment of medical staff and partnerships with the College of Physicians and Surgeons in Pakistan and Sri Ramachandra University, India.

The Trust supports the retention of international recruits through the “Stay and Thrive” programme which promotes Hull and supports the staff member in moving up in their career.

The Trust is strengthening its Advanced Practice workforce including Advanced Clinical Practitioner (ACPs) and Physician Associate (PAs) over the next 12 months. We are converting vacancies to ACPs and PAs in Acute, Elderly and Cardiology Medicine and have a well-established ACCP team in Critical Care. There is an Anaesthesia Associate Team, which has converted further vacant Anaesthesia posts to Trainee Anaesthesia Associate roles for expansion.

After two years of the Covid-19 pandemic staff are feeling exhausted and disengaged from being redeployed / looking after other patient groups, so their appetite or ability to innovate and be more efficient / productive will not be as strong. The Trust has a comprehensive Health and Wellbeing support programme in place, where staff have access to a 24hr 7 day a week advice helpline, counselling services, occupational health services, pastoral and spiritual care, organisational development interventions for individuals, teams including Schwartz rounds, psychology support and more intensive support from our mental health provider (Resilience Hub).

The Trust is also holding Executive Forum meetings for staff feedback to improve our services and working environments.

The Trust will be reviewing our organisational values and holding manager briefing sessions in the summer to reinforce Trust expectations to deliver safe and quality care, delivering activity and performance within our financial cost envelope and ensuring our people are supported, developed and well led.

The Trust will be reviewing its People Strategy later this year and will continue to deliver the 4 workforce themes from the National People Plan.

5.1 Workforce Planning

The workforce planning framework and methodology used by the Trust is the Calderdale Framework and the Six Steps methodology. This provides a systematic, objective method of reviewing skill, role and service design and is used to examine past trends, understand current and future challenges, and forecast future workforce needs. The Framework incorporates a clinical risk assessment.

The Trust’s workforce planning is also informed by the ongoing review of clinical services, local population demographic change, commissioner intentions, capacity and demand modelling, strategic partnerships, the intelligence received from the Yorkshire and Humber workforce planning network, national policy and education and training establishments.

Health Groups and Divisions receive workforce intelligence packs, which include intelligence from the Electronic Staff Record (ESR), e-Job Planning and e-Rostering systems. Through the production of workforce plans and use of the intelligence data, opportunities for new roles will continue to be identified, including Apprenticeships, Nurse Associates, Advanced Clinical Practitioners and Physicians' Associates.

Activity, finance and workforce plans are developed at a service, divisional and Health Group level and are formally signed off by their respective management teams. The plans are validated by the corporate finance, planning and workforce teams to ensure that they are robust, aligned to the Trust's clinical and organisational strategies and comply with operational planning guidance. They are subject to a 'Confirm and Challenge' process with Executive Directors and support service leads before being signed off by the Executive Management Committee. Performance monitoring is undertaken at each level of the organisation via the monthly performance management framework.

6. Financial Plan

As established in previous planning processes, systems will continue to be the key unit for financial planning purposes to ensure greater collaboration and a collective responsibility for the financial position. All Systems have a breakeven requirement.

The COVID-19 pandemic necessitated the introduction of an interim allocations approach to ensure that systems had sufficient resource to respond to the pandemic. From 2022/23 however, the allocations methodology has been reset to move systems back towards a fair share distribution of resource.

The basis of the allocations for 2022/23 is a build up from the payment received in the second half of 2021/22- annualised for a full year. This is then adjusted to reflect the following:

- **Inflation**
  Inflationary uplift 2.8%
  Efficiency factor -1.1%
  Net Uplift 1.7%

- Covid income reduction of 57% of the H2 methodology
- General growth at 2.3%
- Convergence reduction of 0.5% to reflect the move to a fair shares basis
- Specific allocations for the impact of the Ockenden Review
- Elective Recovery allocations to deliver 104% of the 2019/20 elective activity value.

The Trust has developed a financial plan for 2022/23, however on the basis of the assumptions above, the Trust is not able to deliver a balanced plan at this stage and is currently reporting a £19.1m deficit plan, as shown below:

Statement of comprehensive income (SOCI)	Plan 2022-23 £'000
Operating income from patient care activities	**666,843**
Other operating income	**72,700**
Employee expenses	**(431,916)**
Operating expenses excluding employee expenses	**(303,045)**
OPERATING SURPLUS/(DEFICIT)	**4,582**
FINANCE COSTS	
Finance income	**17**
Finance expense	**(6,184)**
PDC dividends payable/refundable	**(8,195)**
NET FINANCE COSTS	**(14,362)**
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(9,780)**
Remove capital donations/grants/peppercorn lease I&E impact	(9,320)
Adjusted financial performance surplus/(deficit)	**(19,100)**

The main drivers for the deficit are inflation, including £11.7m energy cost increases plus £2.5m for other non-pay inflation cost issues, totalling £14.2m. The Trust also sees an increase in depreciation costs of £2m in 2022/23 due to the growth in the capital programme last year.

The planned level of investments now stand at £4.8m as per table below.

Investment Requirements	22nd April 22 £m
Cardiology Ward	1.5
Other Activity Growth	1.5
Cancer Assessment Unit/Ward 29	0.2
Ockenden	0.8
Allam Endoscopy	0.2
Oncology Workforce	0.3
Phlebotomy	0.1
Paediatric Radiology	0.1
Therapy/nursing Hybrid	0.2
Gross Investments	**4.8**

6.1 Elective Recovery Assumptions

The plan assumes that the Trust can return to 2019/20 elective activity levels by quarter 2 of 2022/23. The revised assumed costs are as per below:

	12th April 22		22nd April 22	
	% 19/20 Baseline	£m	% 19/20 Baseline	£m
Core Capacity	98.0%	-	99.5%	-
Day Surgery Capacity	0.8%	1.5	0.8%	1.5
Internal Premium Capacity	0.6%	1.7	0.6%	1.7
Insourced	2.7%	5.3	2.2%	4.2
Subcontracted	1.9%	3.6	1.0%	1.9
Diagnostic Capacity		1.6		1.6
Social Care Beds		0.0		2.8
C-Section		0.0		0.1
Income from NLAG		0.0		-0.9
Total	**104.0%**	**13.7**	**104.0%**	**12.8**
Unallocated in initial Plan				
Total	**104.0%**	**13.7**	**104.0%**	**12.8**

The initial plan to support the NCTR patients was to open 88 beds to accommodate these patients. The latest plan now assumes that CHCP will put services in place to enable the flow of these patients back home as quickly as possible once ready for discharge. The Trust will retain 40 beds (21 on Ward 20 and 19 on Ward 9) at CHH. This cost of £2.8m is within the plan and expected to be funded from the Elective Recovery Fund, as this will allow the surgical specialties to secure their bed base for delivering additional elective activity, hence this is excluded from the table of investments above.

The plan assumes the Trust will also recharge NLAG for its consultant surgeons and anaesthetists working at Goole for which NLAG will record the activity. NLAG have built the corresponding cost into their plan.

6.2 Efficiency

The Trust has developed a CRES plan in line with NHSEI guidance that combines a mixture of cash releasing savings and improved productivity (that release income to support the position) to a value of £29.7m (4%).

The target is broken down into the following areas:

2021/22 1.1% National Target	£6.1m
2022/23 1.1% National Target	£6.2m
Energy Efficiency	£5.1m
Covid19 spend reduction	£1.5m
Productivity	£4.6m
Central Efficiencies	£8.0m
Less Delivered Recurrently in 2021/22	(£1.8m)
Total	**£29.7m**

The target is broken down by Health Group/Corporate as shown in the following table, which also shows value of schemes identified to date, gross and risk adjusted.

	£000	Schemes Identified £000	Risk Adjusted Schemes Identified £000
Surgery	2,137	1,452	1,452
Medicine	1,762	831	531
Emergency	328	151	151
Family & Women's Health	1,526	413	267
Clinical Support Services	1,987	826	544
Estates, Facilities & Development	716	21	21
Corporate	1,514	570	570
Other	330	192	192
Sub-total	**10,300**	**4,455**	**3,727**
Energy	5,176	5,176	5,176
HEALTH GROUP/CORPORATE TARGET	**15,476**	**9,631**	**8,903**
Productivity / ERF Income	4,600	4,600	4,600
TOTAL INTERNALLY REPORTED EFFICIENCY PROGRAMME	**20,076**	**14,231**	**13,503**
Covid Spend Reduction	1,500	1,500	1,500
Technical Savings	8,000	8,000	8,000
TOTAL EXTERNALLY REPORTED EFFICIENCY PROGRAMME	**29,576**	**23,731**	**23,003**
		80%	**78%**

6.3 Funding outside of envelope - Covid

As in 2021/22, the funding streams for Covid testing and the Covid vaccination programme remains outside of the mainstream allocations and continue to be funded separately, with claims made each month on the basis of reasonable net incremental costs.

6.4 Agency Use

The NHS Long Term Plan outlines the national strategy to continue improving on workforce productivity and reduce the reliance on agency workers. Trusts are therefore expected to take action to reduce agency staff bills, encourage workers back into substantive and bank roles, and move back towards compliance with agency controls. NHS England and NHS Improvement will monitor progress to reinstate controls, including price cap compliance during 2022/23.

6.5 Contracting 2022/23

Unlike the last two years, there is a requirement for contractual documentation to be prepared and signed off at commissioner level for 2022-23. This requirement was relaxed previously due to the pressures of the pandemic.

The updated NHS Standard Contract sets out the national terms and conditions applicable for the 2022/23 financial year and includes schedules covering quality, information and reporting requirements as well as the finance and activity schedules.

Financial envelopes have been agreed with commissioners on the basis of the allocation methodology referenced earlier and that the Trust delivers 104% of the elective baseline value for 2019/20.

It is expected that the contracts will be signed early May with the agreed activity x price schedules that tie back to the financial values at commissioner level.

As a result of the new Health and Care Bill, CCGs will cease to exist and ICBs will come into being on 1 July 2022. Contracts are therefore negotiated and signed, formally, by CCGs, with signed contracts transferring from CCGs to ICBs under the nationally arranged Transfer Schemes provided for in the Bill. There continues to be a separate contract with NHSE/I as the Specialised Commissioner.

7. Capital Plan 2022/23

7.1 Capital Funding

Publication of the ICS envelopes was made during February and this notification confirmed a provider capital allocation for the Humber and North Yorkshire ICS of circa £72.6m. The financial planning guidance for 2022/23 makes it clear that there will be no additional national emergency capital allocation outside of ICS CDEL envelopes. As a consequence, all essential/emergency capital investments will need to be incorporated into organisational capital plans and contained within the ICS CDEL envelope. ICS partners therefore need to achieve system-wide agreement regarding the prioritisation of capital expenditure to ensure that all emergency/essential investments can be progressed.

The notified envelope for the HNY ICS is summarised below, with the corresponding allocations at organisation level, using the national formula.

Capital Expenditure	Humber FT £000	HUTH £000	NLaG £000	York £000	Harrogate £000	Total £000
Funding Formula Allocation (at provider level)	6,140	20,701	13,332	23,335	9,114	72,622

Following successful negotiation, the Trust has received a capital allocation of £20.7m for 2022/23. In addition, the Trust is hoping to secure PDC funding to support the next phase of the Day Surgery build at CHH (£13m in 2023/24 & £15m in 2024/25). The Trust is also expecting a capital allocation against the Technology Funding. This is yet to be allocated; the total Technology Fund for the ICS in 2022/2023 is £7m. The technology fund and any PDC allocations are therefore not included in the initial Trust Capital Programme.

7.2 HUTH Updated Capital Programme

The Trust's current full capital programme is higher than the ICS limit due to the fact that the ICS levels exclude donations, grants, as well as some technical PFI adjustments.

The reconciliation from the above to our full programme is shown below:

	£000
HUTH Capital Programme	33,852
Internal adjustments:	
Donations	-300
Grants	-10160
PFI Capital	-2691
Total HUTH Capital Allocation as per table above	**20,701**
National CDEL Adjustments:	
PFI Residual Interest	1395
TOTAL HUTH CDEL	**22,096**

The full capital programme, along with initial estimates for future years can be seen at Appendix 1. The initial programme for 2022/23 is an assessment based on a “do minimum” basis and makes provision for base allocations for Medical Equipment (£1.6m); IM&T (£2.5m) and Backlog Maintenance (£2m). These allocations have taken into account capital schemes that were brought forward into 21/22 and have been adjusted accordingly.

In addition, provision has been made for the capital schemes that have been carried forward from 21/22 and will continue into 22/23, namely Digestive Suite, CHH (£3.5m); completing phase 1 of the theatres upgrade at HRI (£4m) and completing phase 1 of the Day Surgery scheme (£3m). In addition, the approved business case from 20/21 for developing the Neonatal Intensive Care department was deferred this year and is included in the first draft programme for 22/23. However, the original costings would need to be updated in partnership with the PFI partner given the delays to date.

As part of the Capital Planning process, the Trust has to allocate capital to support the reduction in backlog maintenance (BLM). The BLM Target is set at £5.3m and the schemes highlighted against this target can be seen within Appendix 1.

The capital programme includes an allocation of £10m relating to external grants associated with Energy and Decarbonisation. This is a provisional sum at present and has not been confirmed. The Trust is hoping to secure bids against this in the coming year.

After accounting for the above, there is a residual balance in the capital programme of approximately £2.7m, shown within reserves. The current list of potential investments to be funded by this balance can be seen at Appendix 2. The list of priority schemes in Appendix 2 were identified by the Health Groups and from ambitions documented within the Trust’s refreshed strategy.

Initial discussions at the CRAC committee have highlighted the need for the investment for the restaurant at HRI to be worked up given that we no longer have an outsourced provider for this service.

In addition it was suggested that the feasibility budget was increased given the need for more detailed planning and cost estimates for future schemes to ensure the Trust is ready with reasonable plans should future funding become available (for example Bi Plane equipment/enabling scheme).

As referenced earlier, there is an expectation of PDC in year for specific digital schemes as part of the levelling up allocations and funding to progress phase 2 of the Day Surgery Unit, subject to business case approval.

7.3 Capital Risks

The Capital Programme focusses generally on backlog maintenance and replacement. The ability to address the issues identified from the Health Groups and ambitions within the Trust's Strategy is limited due to the amount of capital available to the Trust. Each area of the plan will require detailed management and there is a real challenge in terms of overall coordination to ensure that we are able to deliver this without unduly impacting on our ability to deliver clinical services – especially with the increased waiting lists and priority of elective recovery.

There are a number of risks emerging in terms of schemes that are not currently accommodated within the capital programme. These include IRT4, the Vascular Hybrid Theatre; addressing ward isolation facilities, car parking and risks associated with aged equipment and potential additional IT hardware requirements associated with some of the planned capital developments. In addition, inflationary pressures remain a risk as do the global supply chain issues. These risks will need to be managed from within the existing programme.

Appendix 1 – Capital Programme 2022/2023

CATEGORY	2022/23 Internal £000	2022/23 External £000	2022/23 Total £000
Sources of Funding			
Depreciation	20,200		**20,200**
Grants & Donations - Charitable Funds (General)		300	**300**
Grants & Donations - Salix Grant (TBC if any in 22/23)		10,000	**10,000**
Grants & Donations - NPIC Grant		160	**160**
internal cash	6,265		**6,265**
Internal Cash - ICS slippage (to repay)	(1,100)		**(1,100)**
Interenal Cash - NLAG Slippage	1,000		**1,000**
Sub -Total Funding	**26,365**	**10,460**	**36,825**
Less Capital Loan Repayments	(1,260)		**(1,260)**
Less Capital Element of Finance Lease	(56)		**(56)**
Less Capital Element of IFRIC/PFI - Finance lease Repayment	(1,657)		**(1,657)**
Less Capital Element of IFRIC/PFI - Lifecycle	(2,691)		**(2,691)**
Sub -Total Liabilities	**(5,664)**	**0**	**(5,664)**
TOTAL CAPITAL FUNDING AVAILABLE	**20,701**	**10,460**	**31,161**
Corporate Developments:			
Salix Grant (TBC if any in 22/23)		10,000	**10,000**
NPIC Grant		160	**160**
Theatres Redevelopment CIR	4,000		**4,000**
Matched Funding: Digestive Suite (c/f from 21/22)	3,500		**3,500**
Targeted Investment Fund - Day Surgery (c/f from 21/22)	3,000		**3,000**
FWH - NICU	251		**251**
	10,751	**10,160**	**20,911**
Buildings Maintenance and Compliance:			
Buildings Maintenance and Compliance	2,000		**2,000**
	2,000	**0**	**2,000**
IM&T:			
IT Network Servers/System Replacement	2,500		**2,500**
	2,500	**0**	**2,500**
Medical and Scientific Equipment:			
Planned Equipment Replacements	1,550		**1,550**
	1,550	**0**	**1,550**
Other Allocations:			
Feasibility Work	50		**50**
Spend to Save	300		**300**
Reserves - Other	2,650		**2,650**
Non Medical Equipment	300		**300**
Rev/Cap Transfers	600		**600**
Charitable Funds (General)		300	**300**
PFI Lifecycle	2,691		**2,691**
	6,591	**300**	**6,891**
TOTAL	**23,392**	**10,460**	**33,852**
Less IFRS Impact of PFI/IFRIC 12 Schemes	**(2,691)**	**0**	**(2,691)**
REVISED TOTAL	**20,701**	**10,460**	**31,161**
UNDER (-) OR OVER (+) COMMITMENT	**0**	**0**	**0**

Backlog Maintenance Above	6,000
Backlog Maintenance Target	5,246

Appendix 2 – Capital Programme – Unfunded Potential Investments

CATEGORY	2022/23 External £000	2023/24 External £000	2024/25 External £000
Potential New Schemes - TBC			
Catering HRI	1,000		
Vascular Hybrid Theatre/IRT	3,000		
Post Mortem CT	1,000		
Phase V Redevelopment		500	
Conversion of clinical space to offices	1,200	1,200	2,400
Electrical Generation	1,000	3,500	1,000
Social Care Ward 54 beds	5,000		
Mattress Decontamination		2,500	
Zero Carobn	10,000	10,000	10,000
IRT4	2,575		
Rehab expansion of beds		800	
Car Parking	1,600	1,600	
Fountain Street Decked car park		4,000	
Therapies accommodation	1,000	1,500	
Right sizing bed base/coming out of tower block/more isolation facilities	3,000	3,000	3,000
General Xray room replacement (3 CHH)	1,050		
CTS Xray room			350
HRI T&O Xray room		350	
Fluoroscopy room 5 HRI		800	
Fluoroscopy room 1 CHH			800
	31,425	**29,750**	**17,550**
Buildings Maintenance and Compliance:			
	0	**0**	**0**
IM&T:			
	0	**0**	**0**
Medical and Scientific Equipment:			
Other general equipment replacements	1,000		
Linear Accelerator & Enabling (No 6)			1,700
Gamma Camera 3		1,700	
MRI Optima - CHH replacement		1,750	
ADDITIONAL CT incl enabling			1,500
ADDITIONAL MRI incl enabling			2,000
	1,000	**3,450**	**5,200**
TOTAL	**32,425**	**33,200**	**22,750**