Bolton NHS
NHS Foundation Trust

Operational Plan Document for 2014-16

Bolton NHS Foundation Trust

Operational Plan for y/e 31 March 2015 and 2016

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

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Date	**3rd April 2014**

In signing below, the Trust is confirming that:

- The Operational Plan is an accurate reflection of the current shared vision of the Trust Board having had regard to the views of the Council of Governors and is underpinned by the strategic plan;
- The Operational Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;
- The Operational Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans; and
- All plans discussed and any numbers quoted in the Operational Plan directly relate to the Trust's financial template submission.

Approved on behalf of the Board of Directors by:

Name *(Chair)*	D Wakefield

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	J Bene

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	S Worthington

Signature 

1 Executive Summary

Introduction

In September 2013 we published a detailed five year plan outlining the Trust's strategic direction to 2018/19.

This operational plan sets out our shorter term operational plan towards implementing our five year strategy. The plan has been developed in consultation with our stakeholders including our commissioners and local authority partners through the Bolton Health and Wellbeing Board our Council of Governors and our staff.

Background

Bolton NHS Foundation Trust provides hospital and community health services to the Bolton population and to a significant catchment area beyond Bolton.

In common with other NHS organisations, Bolton NHS Foundation Trust's outlook for the next two years and beyond is dominated by the twin challenges of improving quality and responding to changing demands on the service, while managing within a static or reducing budget.

Aims

Central to our strategy is our view of the range of services we will be providing. The Trust is clear that it aims to:

- Build on the advantages of being an integrated provider of local hospital and community-based health services to deliver, with our partners, best care for patients throughout their healthcare journeys.
- Focus on prevention, early intervention and keeping people healthy, as well as to provide excellent care for people who need treatment.
- Remain a major provider of A&E, and medical and surgical emergency access services on the RBH site.
- Continue to develop as a centre of excellence for Women's and Children's Services.
- Retain and develop a range of planned diagnostic and treatment services (which are clinically and financially viable, and support the wider provision of services in the Trust).
- The Trust will act in partnership with other organisations to provide and sustain high quality care, when this is the most appropriate solution.

Challenge

The key challenge for the Local Health Economy and the Trust is to ensure we improve outcomes for patients whilst maintaining national standards and targets within increasing financial constraints.

The full implications of Healthier Together are currently unknown, however it is expected that this will lead to considerable service reconfiguration.

There are three strands to Greater Manchester's Healthier Together programme:

- primary care reform particularly with respect to access to urgent care;
- integrated care and
- Hospital reconfiguration.

By 2018/19 the health and social care system across Bolton will look and feel significantly different. The full implementation of the new Integrated Care model will see a major shift in care delivered to individuals within their own homes (or usual place of residence).

Risks

The key risks can be summarised as:

- **Quality** – pressure on beds following reductions could lead to Increased risk of infection, delays in transfer to wards and Increased risk of admission to the wrong specialty ward.
- **Operational performance**- lack of availability of beds has the potential to impact on the four hour target and could result in cancellation of elective activity and failure of 18 week RTT.
- **Financial** - failure to meet national and local targets may lead to loss of income due to Increased fines, Lost elective income and inefficiencies such as underutilisation of theatres
- The **IT infrastructure** both of the hospital and the community needs considerable upgrade. Failure to support the Trust IT strategy may result in reduced opportunities to develop systems to support patients in their own home and reduce length of stay.

Financial position

The Trust incurred a deficit of £14.4m in 2012/13 (after adjusting for impairments and provisions). The plan for 2013/14 was to reduce the deficit to £7.8m. This is forecast to be achieved, at the end of month eleven a deficit of £5.9m is reported which is ahead of plan. At the end of September the Trust agreed a five year long term financial plan (LTFP) as part of its revised strategic direction. The LTFP shows a surplus of £1.6m in 2014/15 and £3.1m in 2015/16. These remain the plan numbers for the purpose of this two year operational plan.

2. Introduction

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2.1 Background

Bolton NHS Foundation Trust provides hospital and community health services to the Bolton population and to a significant catchment area beyond Bolton.

In common with other NHS organisations, Bolton NHS Foundation Trust's outlook for the next two years and beyond is dominated by the twin challenges of improving quality and responding to changing demands on the service, while managing within a static or reducing budget.

Having been placed in significant breach of the Foundation Trust Terms of Authorisation in 2012, the Trust has seen steady improvement over the last twelve months:

- The Trust is on course to reduce its financial deficit from £14.4m in March 2013 to £7.8m in March 2014. The intention, set out in this plan, is to achieve £1.6m surplus by the end of 2014/15.
- Access time targets have been achieved and maintained, including performance on the four-hour Accident and Emergency access target which has been better than most other peers in Greater Manchester and beyond.
- Despite being above target for cases of C.Difficile in the current year, the incidence is markedly lower than last year as a result of systematic implementation of the Trust-wide improvement plan.
- Hospital mortality rates have shown a continued steady reduction.
- Improvements in medical patient pathways in particular, have resulted in lengths of stay which compare well with the best in the country.
- There have been pleasing improvements in objective measures of patient experience.

2.2 Challenges

As with other areas in the country, Greater Manchester, and the boroughs within it, are anticipating system-wide changes which will be needed to sustain affordable and effective health and care services over the coming years.

There are two significant factors that are relevant to Bolton NHS FT's plans:

- Firstly, plans to re-shape local health and care services, to provide much more prevention, early intervention and care in the community, keeping people out of hospital wherever that is possible.
- Secondly, the Manchester-wide review ('Healthier Together') which is developing new models of hospital care, for consultation later this year, aimed at securing financially and clinically sustainable services across the area.

These challenges will need to be met whilst meeting the needs of a population with a higher than average number of elderly people in a period where income is forecast to fall in real terms.

2.3 Aims

Central to our strategy is our view of the range of services we will be providing. The Trust is clear that it aims to:

- Build on the advantages of being an integrated provider of local hospital and community-based health services to deliver, with our partners, best care for patients throughout their healthcare journeys.
- Focus on prevention, early intervention and keeping people healthy, as well as to provide excellent care for people who need treatment.
- Remain a major provider of A&E, and medical and surgical emergency access services on the RBH site.
- Continue to develop as a centre of excellence for Women's and Children's Services.
- Retain and develop a range of planned diagnostic and treatment services (which are clinically and financially viable, and support the wider provision of services in the Trust).
- The Trust will act in partnership with other organisations to provide and sustain high quality care, when this is the most appropriate solution.

3. OPERATIONAL PLAN

3.1 The Short Term Challenge

We have worked with our local health economy partners, through the Health and Wellbeing Board, through Board to Board meetings with Bolton CCG and through regular executive meetings to define and agree how to address the challenges within the local health economy.

The key challenge for the Local Health Economy and the Trust is to ensure we improve outcomes for patients whilst maintaining national standards and targets within increasing financial constraints.

The following principles have emerged from discussions between partners involved in Bolton's Health and Well-being Board:

- Patients should receive high quality care which is centred around their needs rather than the needs of professionals and organisations.
- The clients/patient should be empowered to manage their own care and self-care
- Services should be local wherever possible
- Services should be centralised where necessary (to ensure clinical safety)
- Care should be integrated across health and social care in all settings
- Services should be accessible, convenient and responsive
- Information and communications should be centred around the client/patient not the organisation/professional
- High quality care should be accessible quickly regardless of the time or day of the week

3.2 Driving the integration agenda

It is crucial for the local economy to ensure the pace of change towards integration is maintained; to address increasing demand on hospital service models of care will be developed to divert patients from acute to ambulatory care.

Closer integration of health and social care has been a pervasive and recurrent theme of public policy. The national framework document, *Integrated Care and Support* clearly signals the Government's commitment to integrated care and the willingness of national organisations to work together to ensure that policy and regulatory levers support this approach.

UK and international evidence suggests that integrating care can deliver better outcomes, improve individual experience and support cost containment, and that significant improvements can be made through a dual focus on redesigning services and supporting people to self-care (building on the assets around them). System level integrated care addresses the fragmentation of care, shifts the focus away from individual organisations and can provide powerful incentives to focus on prevention, self-care and cost reduction at a neighbourhood level.

> We will work with our commissioners and other provider organisations to develop an Integrated Care model across the borough to help to keep people well and out of hospital and care homes wherever possible. We have committed to contribute to the delivery of an Integrated Health and Social Care system by 2015/16

Aims of the Integrated Care Model

The high level aims of the Bolton Integrated Care Model are to deliver integrated health and social care services for the people of Bolton which are centred around the needs of the individual and:

- Aim to keep patients well, independent and in their own homes
- Provide a good experience of care for patients and their families and result in better outcomes
- Meet the challenges of rising need for health and social care services within dwindling resources

Integrated care teams will:

- Be formed from primary care, social work and community health service providers working at the community level to ensure integrated care management. Social as well as medical concerns will be proactively addressed (debt, poor housing, isolation)
- Continue to manage patients during admission to hospital in partnership with the secondary care team. Discharge planning will begin prior to admission. The numbers of unplanned admissions to hospital will reduce.
- Community services such as district nursing, physiotherapy and podiatry are an essential part of an integrated and well-targeted system of care. Community health services are integrated with general practice and social work teams to support clients/patients to remain independent and safe for as long as appropriate.
- When patients do need urgent/unplanned care, there is a crisis team available (24/7) to meet patient's immediate needs without admission to hospital or to work with the hospital team to ensure early discharge and provide post-discharge care.
- Provide care every day of the week.
- Ensure that care management delivered by the integrated community team continues during any hospital stays supported by better use of information technologies.

- Ensure that care is dignified care. Undignified care is that which renders individuals invisible, depersonalises and objectifies people, is abusive or humiliating, narrowly focussed and disempowers the individual.

Specialised (secondary care) services will coordinate their work with integrated community teams to ensure specialist expertise is available, particularly in areas such as dementia care, geriatrics, diabetology and respiratory care.

The Bolton Integrated Care System will be centred around a multidisciplinary team to include: the GP, practice nurse, district nurse, physiotherapist, OT, pharmacist, social worker and mental health worker.

Patients/clients with multiple long term conditions and/or at high risk of hospital admission and the frail elderly will be designated a care coordinator who will be responsible for developing and coordinating the patient's/client's care plan.

Key individuals within the multi-disciplinary team will operate outside "normal working hours" with services available 7 days a week, 365 days a year. Routine assessment and care planning will be undertaken during the Monday to Friday working week; However, District Nursing is a 24/7 service as will be the step-up Intermediate Tier Services that will need to be able to respond in the event of a patient's Crisis Management Plan being in need of activation in the out of hours period.

The multidisciplinary team will be able to pull in specialist expertise from services including but not limited to – tissue viability; palliative care, microbiology, diabetology; cardiology, gastroenterology, dermatology, rheumatology, gynaecology, respiratory medicine, orthopaedics and therapy services,

- Falls and re-ablement services will also support the multidisciplinary teams.
- Geriatric medicine and Psychiatry will be particularly important.
- Consultant job plans will reflect these new ways of working.

By 2018/19 the health and social care system across Bolton will look and feel significantly different. The full implementation of the new Integrated Care model will see a major shift in care delivered to individuals within their own homes (or usual place of residence).

- Community premises will be fully utilised to provide one stop shop assessments, diagnosis and treatments for the majority of patients.
- Care will be delivered to patients at a time when they need it, over seven days per week.
- Patients and service users (together with carers) will be the heart of individual care planning, with one shared record for all health and social care professionals to work with. The care plan will provide a holistic package of care for the patient, with a comprehensive escalation plan for the patient and their providers of care to implement should the patient's condition deteriorate.
- The treatment of patients in their own home will allow the closure of approximately 50 inpatient beds.

Intermediate step up and step down care will provide a discharge service for complex care that operates seven days a week through an integrated health and social care team.

Further work is planned to understand the potential demand for step down Intermediate Tier support for people who fall outside of the remit of current provision and require a different form of intervention. This work will include support for those adults who may have complex needs due to complex lifestyle issues.

3.3 Healthier Together

The full implications of Healthier Together are currently unknown, however it is expected that this will lead to considerable service reconfiguration.

There are three strands to Greater Manchester's Healthier Together programme:

- primary care reform particularly with respect to access to urgent care;
- integrated care and
- Hospital reconfiguration.

The Trust's role in Integrated Care has been described previously above and there is widespread agreement across all key stakeholders in Greater Manchester that if, hospital reconfiguration is to be successful, plans for Integrated Care need to be fully implemented particularly where there may be changes to hospital urgent care provision.

The case for change across hospital provided services was recently highlighted by an independent service review undertaken by the National Clinical Advisory Team. Their findings were that not one provider in Greater Manchester could achieve all of the clinical standards in the four main workstreams; A&E/Acute Medicine; Emergency Surgery; Children's services and Women's services. Although the three main University Teaching Hospitals were best able to achieve the clinical standards, Bolton NHSFT certainly managed to compare favourably with the non-teaching provider Trusts. In many cases where the standards could not be achieved it was the medical workforce requirement that proved the main obstacle. Bolton NHSFT does not generally struggle with recruitment of medical staff but rather there is more of a national recruitment issue in some specialities, notably A&E and surgery and there is certainly a financial constraint across all provider organisations.

Bolton NHSFT has participated actively in all clinical discussions around Healthier Together since its inception and is currently expected to develop collaborative services across three sites Bolton, Wigan and Salford for four Clinical Commissioning Groups; Bolton, Wigan, Salford and Bury CCGs.

There are on-going discussions around the provision of emergency surgery and obstetric care in particular which should culminate in a proposal with which to go to public consultation in June 2014.

3.4 Medical workforce recruitment driving service reconfiguration

A progressive move to consultant provided as opposed to consultant led services that is explicit in the drive to 7 day services does create challenge for unplanned care. This is further exacerbated by the changes in training specifically for medical staff resulting in increased demand for consultant input to patient care throughout the patient pathway.

The inability to either recruit and/or fund increased consultant numbers has led to the need to collaborate with other providers on a wider geographical footprint to ensure safe access to urgent care. Nationally, the reorganisation of Vascular has been mandated and locally we have begun discussions with local providers for a shared emergency surgery service.

Commissioners originally agreed a framework for the reorganisation of Vascular surgery on a two site model based at Preston and Blackburn. However, recently discussions consideration has also been given to becoming part of a Greater Manchester Network. No final decision has been made and no final date has been set but it is expected that all moves would be completed by 2015/6 for whichever model is agreed.

4 Quality Plans

4.1 Quality Goals

We aim to rise to the challenge of delivering safe, effective and compassionate care.

To do this we must maintain and strengthen the focus on quality in the face of financial and organisational challenges. We must respond to the call from Francis, Keogh, Cavendish and Berwick to listen to and act upon the concerns of our patients, their carers, their families and our staff.

We will achieve this by putting patients at the heart of how we do things, actively seeking and demonstrating learning from their feedback We will work on a portfolio of projects that will lead to demonstrable improvements in outcomes, safety and patient experience. Each project workstream will involve patients and staff from across the organisation, working systematically, sharing best practice and using proven quality improvement tools to ensure consistent delivery of improved performance.

4.2 Key Ambitions

In 2013 in consultation with our stakeholders including governors, commissioners and patients we developed a new Quality Strategy. In this strategy we set out our quality ambitions for the next three years setting the key ambitions of reducing mortality, preventing infection and harm and improving patient experience. In order to support the achievement of these ambitions we have agreed an additional ambition to improve staff engagement and to make Bolton NHS Foundation Trust a great place to work.

Reduce Mortality

- Top 10 nationally – hospital mortality
- Top 10 nationally – perinatal mortality

Prevent Infection and Harm

- 50% year-on-year reduction in C.Difficile
- No ‘never events’
- Achieve ‘harm free care’ standards

Respond and Learn

- Improved complaints process
- Clinical incident reporting
- Strong patient voice

Improve Patient Experience

- Strengthen monitoring systems
- Shared best practice
- Aim for best results, nationally in the ‘Friends and Family’ test

Improve Staff Engagement

- Develop leadership
- Develop an inspirational culture
- Aim for best results nationally in the Staff Survey.

4.2.1 Reduce mortality

Over the last five years our crude mortality rates have fallen year on year. The work of the Mortality Reduction Group will continue to work towards the aim of no needless deaths in this organisation.

Our Goals

- Bolton to be within the top ten NHS hospitals for risk adjusted mortality
- Bolton to be a leading unit for low perinatal mortality

How

The Trust has a five point mortality plan, which is overseen by the Mortality Reduction Group, chaired by the Medical Director and which has representatives from clinical services across the Trust. The progress of the project is reported to the Board of Directors and the Quality Assurance Committee together with the most up to date trends in mortality.

The five work streams are:

1. The reduction of deaths associated with respiratory disease, especially chronic obstructive pulmonary disease.
2. The reduction of deaths due to heart failure.
3. The provision of better pathways of care for patients at the end of life, so that such patients do not spend their final days in hospital if this can be avoided.
4. The use of risk assessments in patients on elective and non-elective surgical pathways.
5. The management of the physiologically deteriorating patients, including those with sepsis, in all clinical areas in accordance with the Sepsis 6 Care Bundle

4.2.2 Prevent Infection and harm

We will focus on a range of infections including Clostridium Difficile (C.Difficile), hospital acquired pneumonia and surgical site infection. We will be vigilant in monitoring, and learning from critical analysis of cases, and using evidence-based prevention measures.

Key ambition

Bolton FT to be in the top 10% of NHS hospitals for C.difficile rates.

How

Deliver 50% year on year reduction in hospital acquired infections, including C.Difficile.

Our Goals

- Strengthen the infection control culture, with infection control champions in all clinical areas
- Deliver target reduction in other forms of healthcare acquired infection
- Ensure compliance with antibiotic policy across the Bolton healthcare community
- No “Never Events” (specific types of healthcare-related harm, or potential harm, that are judged to be “zero tolerance”)
- Achieve levels of quality care that ensure maximum reward from CQUINS funding, and year on year improvement in Harm Free • Care performance (relating to catheter care, prevention of falls,
- prevention of pressure ulcers, and assessing patients for the risk of blood clotting)

4.2.3 Responding to and Learning from Harm and Errors

- Ensure that the Trust's complaints process is fit for purpose
- Encourage the reporting of clinical incidents
- Develop an innovative system for sharing learning from harm and errors
- Ensure there is a strong patient and public voice in all aspects of learning from harm and errors

4.2.4 Improve patient experience

Providing a good quality patient experience requires actively seeking, responding to and learning from patient feedback. We will provide opportunities for feedback for all patients and carers.

Key ambition

Bolton FT to be in the top 10% of NHS organisations in patient experience surveys.

How

- Develop a matrix of patient experience scores across the organisation to give a clearer picture of variation in the way that patients experience our services
- Share best practice and develop action plans to address our weaker areas
- Continue to improve the coverage of the Friends and Family test and use the results to shape our improvements – aiming for the best scores in the country from our patients

4.3 External quality concerns and plans to address them

The Trust is licenced with the CQC without conditions.

The Trust is currently in breach of provider licence conditions for corporate governance and financial management. Many of the actions agreed with Monitor to address these concerns have been addressed. A recent review undertaken by PwC provided assurance that 80% of the actions identified to address governance failings have been completed. Work will continue to ensure the remaining actions are completed and embedded in early 2014/15.

4.4 Key quality risks and how these will be managed

The existing quality concerns for the Trust are around the key safety issues i.e. falls, pressure ulcers and infection control. In order to continue our absolute focus on safety we will build on our current strong foundations of good quality care and improvement methodology. The Board has approved, and we are now implementing, four key strategies; the Falls Strategy, The Pressure Ulcer Management Strategy, the Quality Strategy and the Patient Experience Strategy. We will deliver quality improvement by working with and empowering patients and staff across the organisation to implement these strategies.

We will continue to embed the core values of our Trust into all aspects of organisational life, as the foundation for the delivery high quality care. The Trust will also continue to build capacity and capability in our workforce to ensure that our staff have the skills to deliver high quality care, aiming for zero harm to patients, and looking for opportunities, every day, to improve what we do.

This is particularly relevant to our patient's experience as our surveys, complaints and external

feedback mechanisms tell us we have more work to do on staff attitude. An organisation's culture is derived from the behaviours and attitude of the workforce and leadership. A consistent theme that has emerged from our Big Conversation staff engagement events is the deep motivation of staff to do their best for the people who need their care. Not surprisingly therefore, the "turnaround" journey that the Trust has been on over the last 18 months, whilst successful in many ways, has been stressful for staff and this is reflected in the 2013 Staff Survey and overall sickness levels. There is now a concerted effort underway to enhance the visibility of the leadership teams and the communication channels to staff as well as overall sickness management.

Enabling the delivery of highest quality care is at the heart of all our leadership programmes, including those for clinical and medical leaders. All our programmes evaluate the development of leadership skills throughout, tracking productivity and quality improvements made by each participant. We will continue to build and develop our coaching culture and will also provide additional support to help individuals and teams to realise their potential, working with staff to enable them directly to influence how things are improved in their areas of work.

Quality improvement is seen as essential to the financial sustainability of the Trust. We believe that high quality care need not cost more. Getting it right first time, and moving care out of hospital when appropriate, is less costly and the right thing to do for patients. Cost improvement programmes will only be implemented after a full quality impact assessment and the Board and Quality Assurance Committee monitor the associated key performance indicators that arise from the QIA's.

4.5 Quality Governance

In 2013, the Board commissioned a review of Quality Governance from Deloitte LLP; although this found many areas of good practice with regard to the governance of quality it also identified areas for improvement. The board reviewed the recommendations and agreed a programme of work to address them. A follow up review is currently underway and although the review has not yet been completed, we are assured that a significant number of the agreed actions have been completed. However, in our self-assessment we identified the need to further strengthen our clinical governance processes particularly with regard to risk and incident reporting. This work is well underway; a new risk management strategy was approved by the Board and a programme of training has been agreed to ensure all staff from ward to Board are aware of their role in risk management.

Engagement on Quality

In the second half of 2013/2014, in addition to the Quality Improvement Strategy, the Board also approved a Pressure Ulcer Strategy, a Falls Strategy and a Patient Experience Strategy. The development and launch of these new strategies, in association with staff and stakeholders, has provided an opportunity to engage with staff throughout the organisation to develop a quality culture. In 2014/15 we will:

- Continue to promote and embed these quality strategies with regular reports to provide assurance the Quality Assurance Committee.
- Develop an organisational culture of patient focus and quality improvement.
- ensure 100% compliance with mandatory training that includes quality improvement techniques
- develop a no-blame culture
- establish multi-disciplinary professional quality forums in each speciality to engage all levels of staff

Gaining insight and foresight into quality

To judge progress against the goals we have set ourselves in the Quality Improvement strategy we will monitor a range of relevant indicators. These will be included in the Trust's Integrated Performance Dashboard so that they can also be seen in the light of other aspects of organisational performance (such as workforce, operational delivery and finance).

Where a national or locally agreed target is in place we will aim to achieve or exceed this, where there are no such targets we will agree our own targets, supported where appropriate by trajectories for improvement

There is scope in the Integrated Performance Dashboard to add further measures as appropriate during the course of the year. The measures which are relevant to tracking improvements in the quality of care include:

- **High-level indicators** relating to the Trust's key priorities for clinical quality. These will be set on an annual basis and will form the basis of the Trust's Quality Account.
- **Commissioning for Quality and Innovation (CQUINs) targets** - These targets include national, regional and local CQUINs which are agreed with commissioners on an annual basis, as part of our service contracting negotiations. Achievement of relevant standards results in the payment of quality incentive monies.
- **Advancing Quality** - These are groups of indicators related to compliance with best practice (also called "care bundles"), relevant to the management of specific conditions.
- **Quality Schedule measures** - These are other measures of quality, agreed with our commissioners as part of the Trust's contractual commitments.
- **Trust clinical quality indicators** - Other Trust-specific indicators that are established at Trust, division and service level as part of our internal planning and performance systems.
- **Early Warning Matrix** - A report bringing together a group of location-specific indicators on workforce and the quality of care, which may identify potential "hot spots" for further action.

The Trust will also use a wide range of other evidence, observations, user-feedback, audits and external assessments, to assess the quality of its services.

Assurance and Escalation of Risks to Quality

All Board members have an understanding of their overall accountability for quality.

In 2014/15 we will:

- Continue to start each Board meeting with a patient story and ensure that each Board meeting spends a significant proportion of time focused on quality.
- Continue the development of our assurance and risk management processes to ensure that current and future risks to quality are assessed and addressed
- Continue our work to develop an overarching Assurance and Escalation Framework.
- Ensure that a significant proportion of our internal audit service is used proactively to provide clinical and quality assurance.

What the Quality Plans Mean for the Foundation Trust's Workforce

The workforce strategy sets out the Trusts vision, aims and objectives to develop a responsive and flexible workforce with the capacity and capability to deliver our quality strategy.

The following actions have been identified to develop the workforce to support the quality plans:

- A programme of work to improve staff engagement with the ultimate aim of being the best place to work in the NHS.
- Ensure staffing levels are appropriate and take into account the dependency and acuity of patients, ensuring the right skills at the right time in the right place.
- Renewed focus on the development of the integrated organisation, working with teams across the community and hospital in developing streamlined care pathways focused on high quality patient experiences.
- Increased focus on the development of the unqualified workforce, including Healthcare Assistants and Practitioners.
- Continue to build and consolidate a high performing and inspirational culture; ensuring staff are clear what is expected of them in relation to performance delivery standards and improvement,
- Develop a performance assessment framework which links incremental progression to performance, recognising and rewarding accordingly.
- Review and improve the current provision of management, leadership development programmes and learning opportunities,

4.6 The Trust's response to Francis, Berwick and Keogh

Reflections on the reports produced as outcomes of the high profile reviews undertaken by Francis, Berwick and Keogh were presented to our Quality Assurance (QA) Committee and used to shape the new strategies developed in 2013. We have shared our Francis action plan with our commissioners and will continue to review performance against the agreed actions through our QA Committee.

In 2014/15 the actions planned to continue to embed these actions include

- The continuation of listening and learning events implemented by the Medical Director - these events are open to a wide range of staff from across the organisation to ensure that patient experience remains at the heart of what we do.
- Having reviewed and revised our governance processes we will continue to look for new ways to be open and honest ensuring that appropriate information is published in a way that is accessible and meaningful for our patients
- We will continue to develop and utilise our Ward to Board information. The "heatmap" provides detailed information per ward that enables triangulation of information. Quality indicators are clearly highlighted in the context of staffing levels and training within each area.
- We have developed a new Exemplar Star System of Accreditation (ESSA) framework which we will use this to ensure that wards and departments are continually improving their services to patients. When issues are identified a practice review process has been developed to support the areas to address any concerns.

- A performance framework, including revised KPI's have been developed for Ward Managers and Matrons to provide clarity in relation to roles and responsibility. A Leadership programme to further develop staff and identify talent is currently under development.
- One of the 2014/15 local CQUIN's that has been agreed with our Commissioners is the development of a learning cartel utilising the MAPSAF assessment of patient safety culture. This will enable the Trust to have a formal assessment of its attitude towards patient safety issues and learning.

We will continue to review our progress against these actions through the Quality Assurance Committee.

4.7 Contingency built into the plan

Our Quality strategy is underpinned by a number of workstreams which can be flexed if required to respond to operational pressures

5 Operational Requirements And Capacity

In our five year strategy published in September 2013 we reflected the anticipated service shift in terms of hospital services

Demand

- Demographic change – local population projections indicate an expected 12.6% increase in the over-75 population between 2013 and 2018.
- The health status of the Bolton population is generally worse than the national average, and, in some areas of the borough, amongst the worst in the country.
- Both of the above will drive continuing increases in demand. The underlying rate of demand growth assumed for planning purposes by commissioners and Providers is 5.4% for non-elective services and 4.5% for elective services.
- The Trust will be carrying out an in depth analysis of demand and capacity in order to be clear how it can respond to fluctuations in demand.

5.1 Key operational risks

Ward closures are a key component of the Trusts CIP plans. However there is considerable risk to delivering both quality and operational performance targets if the pace of change to clinical pathways does not lead to reductions in admissions and length of stay.

The key risks can be summarised as:

- Quality – pressure on beds following reductions leads occupancy levels above 85% at midnight leading to:
    - Increased risk of infection outbreaks
    - Delays in transfer to ward from points of admission (e.g. ED, OPD, GP etc)
    - Increased risk of admission to the wrong specialty ward leading to delays in appropriate care
- Operational performance- lack of availability of beds leads to
    - Delays in transfer from ED leads to failure of the 4 hour target
    - Increased patients outlying specialty leads to cancellation of elective activity resulting in failure of 18 week RTT.
- Financial – increased HAI and failure to meet national and local targets leads to loss of income due to:
    - Increased fines
    - Lost elective income
    - Increased inefficiencies such as under utilisation of theatres
- Enablers - two key enablers to bed closures are the pace of integration and IT support
    - Although a number of schemes for integration are being developed with local partners as yet they have not demonstrated a large scale benefit in admission avoidance. Failure to maintain the pace of change could jeopardise the ability to close beds.
    - The IT infrastructure both of the hospital and the community needs considerable upgrade to enable better use of telemedicine, decision support and improved communication and other efficiencies. Failure to support the Trust IT strategy may result in reduced opportunities to develop systems in their own home or reduce

length of stay.

Our Board Assurance Framework will be used to monitor the risks to our strategic objectives.

6 Income and Cost Improvements

6.1 Introduction

The Trust has a comprehensive programme in place to manage the delivery of the income and cost improvements required to deliver the financial plan. This programme focuses on ensuring the governance processes involved in the change are sound so that all proposed cost improvements are clinically safe.

6.2 Programme Governance

The Executive Team constitutes the programme board. The programme is organised in work streams as follows:

Work stream	Executive Lead	Key Deliverables
Estates	COO	Estates strategy
Community Integration	COO	Community Productivity Community integration impact
Corporate (priority based review / corporate pay)	CEO	Priority based review Reduce consultancy costs 6.5% efficiency in year one Long term efficiency plans
Procurement	DoF	Procurement strategy
Workforce (enabling pay reforms)	HR & OD	Policy – protection policy Policy – pay awards Policy – incremental progression Policy – grade mix review Policy – Medical Job Planning E Roster
Income	DoF	PBR Data Quality CQUINS Contractual Performance Improvements Community Income Improvements
Information Technology	COO	Information Technology strategy
Beds (modelling and reduction)	COO	Length of stay reduction Bed reduction
Acute Adult service lines	COO	Service line margin improvements and department initiatives
Elective service lines	COO	Service line margin improvements and department initiatives
Family Care service lines	COO	Service line margin improvements and department initiatives

A central programme management office (PMO) is in place to ensure programme governance operates effectively.

Standard documentation, templates and guidance have been reviewed and streamlined by the PMO. The PMO will continue to gather feedback to ensure the process does not become onerous. To manage a robust assurance process, and ensure centralised oversight by the PMO, all work streams will be required to complete a minimum of;

- Project Initiation Document (PID)

- Quality Impact Assessment (QIA)
- Milestone plan
- Risk Analysis
- Financial trajectory

All QIA's are produced by the clinical teams designing the change. These are then challenged and where appropriate signed off by the Head of Division and Chief Divisional Nurse before submission to the Trusts Medical Director and Director of Nursing for final sign off.

The Trust's financial management framework has a set of predetermined escalation points to manage delivery risk. This includes the potential for the appointment of a Turnaround Director to individual divisions if they are forecasting a failure to deliver their financial control total by more than 1% of their budget.

It should be noted that the community integration work stream is a transformational project.

6.3. <u>Forecast achievement of income and cost improvement targets</u>

The following achievement is forecast

- 2013/14 £18.3m
- 2014/15 £22.2m
- 2015/16 £15.5m

7. Supporting financial information

7.1 Introduction

The Trust incurred a deficit of £14.4m in 2012/13 (after adjusting for impairments and provisions). The plan for 2013/14 was to reduce the deficit to £7.8m. This is forecast to be achieved, at the end of month eleven a deficit of £5.9m is reported which is ahead of plan. At the end of September the Trust agreed a five year long term financial plan (LTFP) as part of its revised strategic direction. The LTFP shows a surplus of £1.6m in 2014/15 and £3.1m in 2015/16. These remain the plan numbers for the purpose of this two year operational plan.

7.2 Income

Bolton CCG wrote a letter of support for the income assumptions in the Trust's LTFP, although it noted that there might be some affordability issues in 2014/15.

As at the 17th March the contract for 2014/15 with Bolton CCG is not signed. The main issue still outstanding is agreement on the application of PBR rules in respect of contract terms and data quality issues. These issues are expected to be resolved by the 31st March with contract sign off on or before that date.

The income shown in the plan is as follows:

Forecast 2013/14 £281.1m

Planned income 2014/15 £279.2m

Planned Income 2015/16 £275.8m

Tariff deflation has been accounted for in the income estimates.

Income improvements of £3.5m in regard of contractual performance and CQUINs have been included in the 2014/15 numbers consistent with the long term financial plan. The CCG has confirmed that these estimates are within its affordability envelope.

Income assumed in 2014/15 to support community services (£3m in the LTFP) will now not be received. For planning purposes the same quantum of income has been included as the Trust has identified significantly greater data quality issues than the £0.8m identified in the LTFP. Potential downside on these numbers is addressed in the Trust's downside risk management plan.

Income for 2013/14 includes £1.6m winter funding from the DH via the CCG. Winter funding and costs have not been included in the 2014/15 or 2015/16 plan on the basis that it is not certain. This is consistent with the treatment in the LTFP and the Trust's 2013/14 operational plan.

Income in respect of health and social care integration which was estimated in the LTFP has not been included, any such income will be dealt with as an in year contract variation.

Demand growth estimated by the Trust is assumed to be met by commissioner QIPP.

7.3 Costs

Cost pressures are included as follows

Item	2014/15 £m	2014/15 % of income	2015/16 £m	2015/16 % of income
Pay award 1%	1.9	0.7%	1.9	0.7%
Incremental drift + other pay pressures including quality investment	2.2	0.8%	3.2	1.2%
Non pay inflation – generic	2.1	0.8%	2.2	0.8%
CNST	0.3	0.1%	0.3	0.1%
Developments – Estates strategy	0.9	0.3%	0.8	0.3%
Developments – IT strategy	1.5	0.5%	1.7	0.6%
Total	8.9	3.2%	10.1	3.7%

Once the tariff deflation of 1.6% is taken into account the overall cost pressure is higher than the 4% included in the tariff due to the need to invest in the Trust's estates and IT infrastructure. The impact of this higher than tariff cost pressure on the Trust's financial position has been dealt with by increasing the Trust's income and cost improvement target.

It should be noted that the recent announcement in regard of the NHS pay award has not been incorporated into the above estimates. The impact of this will be dealt with as an in year, non-recurrent cost improvement.

In 2015/16 tariff deflation is assumed at 1.3% taking this plus pay wards, incremental drift and non pay inflation into account gives the national efficiency requirement of 4%. The incremental drift may be slightly less however the overall efficiency requirement is expected to remain at the 4% (excluding developments).

7.4 Income and expenditure risk range

Having reviewed the inherent risks in delivering plan and the availability of downside risk management schemes the following income and expenditure risk range has been calculated.

	Surplus / (Deficit) £m		
Financial Year	Worst Case	Most Likely	Best Case
2014/15	(7.8)	1.6	5.3
2015/16	(6.3)	3.1	5.3

7.5 Capital Plans

The Trust allocates its capital on a risk scoring basis, the financial plan allows for issues with a risk score of higher than 12 to be addressed. The Trust Board is assured that the residual risk is manageable.

A key element of the Trust's long term financial plan is securing capital , either through a non-commercial loan or through public dividend capital, to finance the Trust's IT and Estates strategies. The Trust is preparing the full business cases for these two developments. It is anticipated they will be submitted to Monitor in quarter one of 2014/15.

At the present time therefore there is uncertainty over the level of capital expenditure that the Trust will incur in 2014/15 and 2015/16 as it is not clear whether funding (PDC or Loan) will be received from the Department of Health to finance the Estates and IT Strategies. The Trust Board has agreed to continue to plan on the basis that this funding will be received but to restrict expenditure to that which can be financed from internal resources until funding is confirmed re the IT and Estates strategies (apart from £1.6m of IT spend in 2014/15)

	2014/15 *£'000*	*2015/16* *£'000*
Operational Capital	5,665	7,100
Operational Capital 2013/14 slippage	435	
Sub Total Operational Capital	6,100	7,100
IT Strategy Business Continuity	1,600	
Definitive Spend	7,700	7,100
Estates Strategy	5,636	9,009
IT Strategy	4,200	5,796
Planned Spend	17,536	21,905

The £7.3m definitive spend in 2014/15 is more than the £6.1m that can be financed through our internally generated resources. A request for PDC to support the £1.6m of the IT strategy that needs to be spent in 2014/15 to maintain business continuity has been submitted to Monitor. If this funding is not received elements of the Trust's cash downside risk management plan will be triggered to enable the expenditure.

7.7 Liquidity

The Trust has been in receipt of direct cash support from the DoH in order to maintain its on-going operations in 2012/13 and 2013/14. No such support is planned for going forward.

The forecast cash balance at the year-end is as follows:

2013/14 £0.4m

2014/15 £1.0m

2015/16 £1.6m

The Trust has modelled the impact of downside financial risk on its cash position and has a cash

downside risk management plan in place. The Trust could cope with a deficit of £5m in 2014/15 without needing to apply to the DH for distress funding.

7.8 Continuity of service risk rating

The Trust's risk rating is forecast to be as follows:

Quarter	2013/14	2014/15	2015/16
One	1	1	2
Two	1	2	2
Three	1	2	2
Four	1	2	2
Average	1	2	2