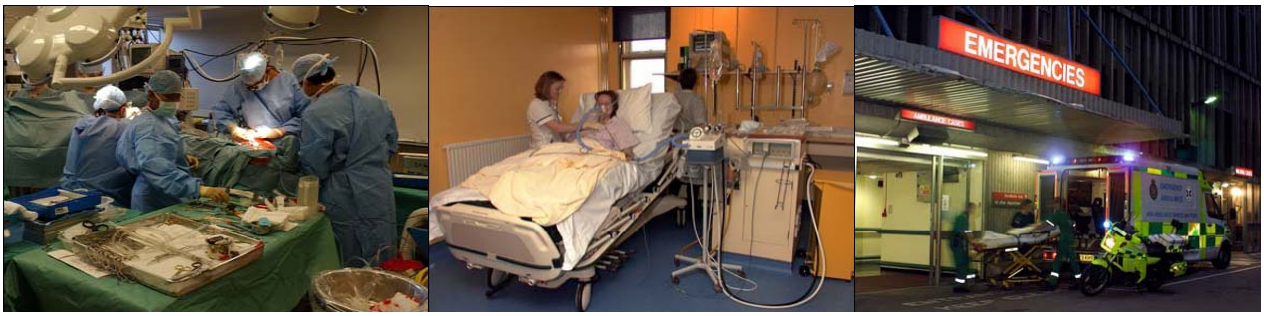
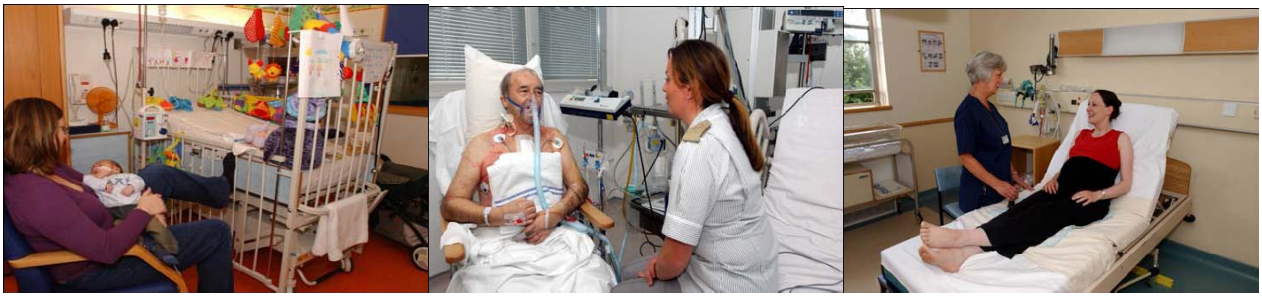
United Bristol Healthcare NHS
NHS Trust



INTEGRATED BUSINESS PLAN



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1. EXECUTIVE SUMMARY

1.1 PROFILE OF THE TRUST

United Bristol Healthcare NHS Trust is one of the largest acute NHS Trusts in the country and the major teaching and research centre for the South West of England.

We provide specialist and local acute healthcare services from eight hospitals in the centre of Bristol, including:

- the Bristol Royal Infirmary
- the Bristol Royal Hospital for Children
- the Bristol Haematology and Oncology Centre
- the Bristol Eye Hospital
- the Bristol Dental Hospital
- St Michael's Hospital
- the Bristol General Hospital
- the Bristol Homeopathic Hospital.

A further site, the Central Health Clinic, houses the Avon Breast Screening service and, from June 2008, will also accommodate the integrated Sexual Health Service.

We undertake research and teaching in partnership with the University of Bristol, the University of the West of England and other higher education institutions.

The Bristol Royal Infirmary has been providing care 'to benefit the poor sick' since 1737.

1.2 WHO WE SERVE

The Trust provides services to three distinct populations, as follows:

- Acute and emergency services to a local catchment population of around 300,000 in central and south Bristol.
- Specialist services to the wider acute network in Avon, Somerset and Wiltshire with a population of 2.4 million.
- Specialist regional and supra-regional services to the South West of England, South Wales and beyond, comprising a population of 5 million plus.

Table A shows the levels of commissioned activity by work-type for 2007/08.

	Day Cases	Elective Inpatients	Non Elective Inpatients	Non Elective Short Stay	Outpatients	A&E
Bristol PCT	30,213	6,856	23,624	8,990	254,557	82,141
South Gloucestershire PCT	8,649	2,051	3,624	648	57,566	10,905
North Somerset PCT	8,459	2,420	5,541	1,050	62,622	12,346
Other commissioners	6,724	5,396	3,960	910	58,815	2,928
Grand Total	**54,045**	**16,723**	**36,749**	**11,598**	**433,650**	**108,320**

Table A: Summary of 2007/08 Service Level Agreement activity plan

1.3 OUR MISSION AND STRATEGIC AIMS

The Trust's mission is to provide patient care, education and research of the highest quality.

In pursuit of this mission we abide by the following values:

- We put patients first
- We involve, develop and support staff
- We promote innovation and improvement
- We pursue excellence in everything
- We respect others and treat everyone as equals
- We work in partnership to improve the health and well-being of the community, within a sustainable environment
- We are accountable for our use of public resources.

Our strategic aims in the three core business areas of clinical services, research and teaching are shown in Table B, along with aims in key supporting areas.

Clinical Services	Research & Development	Teaching and Learning
• To provide efficient and effective services, affordable to commissioners and desirable to patients and referring clinicians • To be the major specialist service provider for the population of Bristol & the South West region • To provide additional services for the local population • To support the principle of local access wherever possible • To provide services which are quick and easy to access and provide an excellent patient experience • To deliver services to the highest standards	• To develop collaborative and consultative research partnerships with patients, carers and the public • To support research of national and international excellence and innovation • To develop the Trust's research portfolio in line with its service strategy • To develop a Clinical Research Imaging Centre in partnership with the University of Bristol • To develop research activities in partnership with academic and healthcare organisations • To further develop research governance	• To ensure staff are enabled to provide safe, effective and high quality patient care • To pursue teaching and learning partnerships with education providers and others • To embrace personal and organisational development • To encourage a culture of innovation and enterprise • To maximise recruitment and retention by meeting the development needs of current and prospective staff
Supporting aims		
• To achieve a sustainable financial surplus • To improve the environment for patients and staff, to improve ease of access for patients and visitors and to develop the Trust's estate to give the optimal configuration of services • To ensure that the Trust has the governance and information structures, systems and processes necessary to deliver its mission efficiently, effectively and with the highest standards of probity.		

Table B: Our strategic aims

1.4 WHY WE WANT TO BE A FOUNDATION TRUST

We believe that becoming an NHS Foundation Trust is the right thing for the organisation and its staff, for our local community and for users of our services for the following key reasons:

- it will drive genuine understanding between the Trust and its users, allowing us to respond to the issues that matter to those who have direct experience of our services and staff - this will be vital to the success of the Trust in an increasingly competitive market-place
- it will facilitate meaningful involvement of patients and the public in the Trust's planning processes, which we firmly believe will produce better decisions which have wider ownership
- it will be the basis for real engagement with the community of Bristol, reinforcing our rights and responsibilities as a major employer in the heart of the city
- it will give staff a voice in decision-making through their elected representatives on the Membership Council.

As a Foundation Trust, we will have the autonomy to prioritise spending in the areas we consider most appropriate, to make faster financial decisions, particularly about capital spending, and to plan for the long-term rather than in annual cycles. Together with this autonomy will come the responsibility to manage public resources in a sustainable way for the benefit of our users and our members.

1.5 MARKET ASSESSMENT

The Trust has a dominant (74%) share of its catchment in central and south Bristol. In the wider Avon, Somerset and Wiltshire market, it has a 25% share of adult services and 33% for children's services. It is also the main provider across the South West and parts of South Wales for certain specialist services, especially for bone marrow transplantation and a number of specialist services for children.

The Trust's strategy accounts for the implications of major reforms to the structure and organisation of the NHS, which we expect will create:

- greater volatility in activity levels for planned services as a result of patient choice and GP practice-based commissioning
- competition from neighbouring NHS and Foundation Trusts
- competition from independent sector providers of health care
- substitution of existing emergency and elective activity by new or expanded primary and community care services
- the need for increasing cost efficiency in order to cover costs under the national tariff.

The Trust has anticipated these new challenges through a deliberate programme to review and re-define its strategic direction over the last two years.

Our strategic planning has taken account of the changing health needs of the population we serve, both in terms of its growing numbers but also its changing age profile, with an increasing proportion of people over 65 years old, who are also living longer than previous generations.

At the same time, we have acknowledged the public's desire, reflected in government policy and the plans of our local commissioners, to have more care provided closer to their homes, or even at home, and to have greater choice of healthcare provider.

We have allowed for new developments, in hospital and community settings, by NHS or private providers, which will alter existing referral flows to the Trust. These include:

- new cardiology facilities in north Bristol in 2008
- a new oncology centre expected to open in Taunton in 2009/10
- a new independent sector treatment centre in South Gloucestershire in 2009/10
- new community facilities in south and east Bristol in 2009/10
- a new hospital for north Bristol and South Gloucestershire in Southmead in 2013/14

Most of these developments form part of the Bristol Health Services Plan, which is a co-ordinated programme of reconfiguration and investment across the health community.

1.5.1 How The Trust Will Address Competitive Factors

The Trust's strategy aligns closely to the objectives of the local health economy. It fully intends to retain its role as the main provider of local acute services for central and south Bristol and to maintain the infrastructure and services necessary to support a city centre Emergency Department.

It also intends to consolidate and, where appropriate, expand its role as the specialist provider for the Avon, Somerset and Wiltshire area, particularly in children's, cardiothoracic and cancer services (including cancer surgery), in line with the strategy of the local clinical networks.

The Trust is specifically working in close partnership with Bristol Primary Care Trust over the planned closure of the Bristol General Hospital and establishment of alternative rehabilitation services at the planned new South Bristol Community Hospital and in the community.

This partnership extends to the transfer of additional hospital activity (day surgery diagnostics, outpatients, dental and minor injuries services) to the South Bristol Community Hospital, where, subject to the agreement of contracts with the PCT, the Trust expects to be a major service provider.

We are also committed to improving the services we provide in the hospital setting and increasing the speed and efficiency with which patients receive their care. We know from recent pilot studies that we can reduce the number of steps in some of our care processes, which have developed incrementally over time, by substantial amounts, meaning fewer delays for patients and better value for the public purse.

Thus, our plans show how we will provide increasing levels of activity without unduly expanding our capacity. This means that we can prioritise our capital spending on improving the patient environment and replacing the oldest and least suitable parts of our estate.

Our site development plans include completion of the new cardiothoracic centre at the Bristol Royal Infirmary in 2009, the centralisation of specialist inpatient paediatric services in Bristol through conversion and expansion of the Bristol Royal Hospital for Children and redevelopment of the Bristol Royal Infirmary to provide the appropriate clinical capacity and configuration for the long-term.

1.6 PERFORMANCE OVERVIEW

1.6.1 Non-Financial Performance

The Trust achieved the highest rating of 'Excellent' for the quality of its services in the Healthcare Commission's 2006/2007 annual "Health Check". Only 16% of Trusts in England received this rating.

On key indicators of clinical quality, such as standardised mortality ratio, average length of inpatient stay, day-case rate and emergency readmission rates, the Trust performs well against local competitors.

1.6.2 Financial Performance

We are in good financial health. In each of the past four financial years, we have achieved break-even or better. As a result, the Trust is in recurring financial balance.

We have delivered and are forecasting a surplus in the current financial year, efficiency savings of between 3.6% and 4.3% of income from 2004/05 to 2006/07 while delivering increased clinical activity. Our reference cost index (a national measure of cost efficiency where 100 represents national average costs) has fallen over 5 years and now stands at 97.

We accumulated a cash deficit of £20.3 million up to 2005/06, primarily as a consequence of financial difficulties in 2001/02 and 2002/03. This was resolved by a long term loan repayable over 20 years taken out in March 2007. This ensured the Trust became financially secure enough to support operations without the need for further external support.

The Trust now intends to repay this loan in full by 2009/10 starting with a £12.8 million repayment in 2007/08. The historic income and expenditure deficit stands at £12.8 million at the end of 2006/07 thereby breaching the statutory duty to break even. However a forecast surplus of £12.8 million in 2007/08 clears the Trust from the statutory duty breach and provides cash to enable the planned loan repayment.

The Business Plan shows how we will achieve our strategic objectives while repaying this loan and remaining in sound financial health.

1.7 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

Over the last two years, we have examined our strengths and weaknesses as an organisation as objectively as possible, while we sought to understand the opportunities and threats that face us in the external environment. The headlines from this analysis are shown in Table C. Each of these factors is discussed in detail in the Business Plan.

Key strengths	**Key weaknesses**
Reputation for clinical excellence Established specialist services, many with market dominance Strong financial control Low reference costs in several specialties Strong hospital brands in city centre location National reputation for excellence and specialist expertise in research management Strong relationships with the Universities of Bristol and the West of England Strong portfolio of research particularly in priority areas for clinical service provision. Strong facilities and infrastructure to support provision of high quality education and training Detailed strategy and plans to support education and training in partnership with educational providers	City centre location restricting availability of parking and drop-off for patients and visitors Quality of customer service in some areas Sustainability of performance improvements Age, quality and infrastructure of some of the estate Capacity constraints e.g. BRI theatres and critical care, BEH outpatients. Ageing information management and technology infrastructure in some areas Lack of collaborative plan between all NHS and university partners in Bristol Need to build further internal capacity for mentoring, assessment and verification Placement capacity
Key opportunities	**Key threats**
Extend and deepen specialist service portfolio Spearhead service redesign Establish leading research programmes Redevelop or refurbish the Trust estate to improve the patient environment and clinical adjacencies Secure service provider role at the planned South Bristol Community Hospital Introduction of Electronic Staff Record Use existing partnerships to address key national developments such as the Leitch Review and the 14 – 19 agenda	Predation by competing providers, NHS or independent sector Loss of research and development support funding Cross-community service redesign fails to deliver expected benefits Bristol Health Services Plan does not proceed Current and potential changes in funding arrangements for National Vocational Qualifications and in higher education. Changing standards for Nursing and Midwifery pre-registration training Availability of training time for staff

Table C: Summary results of the strengths, weaknesses, opportunities and threats (SWOT) analysis

This “SWOT” analysis has informed our decisions about where to prioritise our efforts.

- We have developed a financial plan based upon the use of internally generated capital resources, meaning that we do not intend to use Private Finance Initiative funding to help us deliver our site development objectives. The plan is conservatively based and does not depend on borrowing. The historical deficit is eliminated in 2007/08 and the long-term loan fully repaid by 2009/10.

- We have prepared a service improvement plan focused on streamlining our core clinical and operational processes for the benefit of patients and staff.
- We have put in place a research and development plan to develop our research strengths and to mitigate potential loss of funding under the national research strategy.
- The Trust has successfully bid to become the host organisation for the Comprehensive Local Research Network and has also led on a combined Bristol bid for a "Collaboration for Leadership in Applied Health Research Centre" and a Cardiac Biomedical Research Unit.
- We have advanced site development plans, intended to give us the appropriate clinical infrastructure to meet long-term needs and improve the patient environment.
- Our detailed workforce and organisational development plans are designed to improve the skills of our staff, enhance recruitment and retention and improve customer service.
- Our programme of corporate social responsibility, 'UBHT in the Community', shows how we intend to expand the civic contribution of the organisation as the major employer in the centre of Bristol.
- We have prepared plans for our information management and technology which will support service delivery and clinical decision-making, as well as effective reporting and control.
- We have a patient environment programme and related initiatives in place which aim to enhance the condition of the care environment, improve patient privacy and dignity and address the accessibility of our services.
- We are engaged with the Bristol PCT and other healthcare partners in the plans to develop a new community hospital in south Bristol, aiming to bring services closer to where patients live by providing them at the new hospital where appropriate and affordable.

The Business Plan describes in detail the three service development plans which we see as the major vehicles for delivery of our strategic aims:

- Service Improvement Plan
- Research & Development Plan
- Site Development Plan.

1.8 FINANCIAL PLAN

The Financial Plan shows a financially sound position maintained throughout the planning period, taking account of the activity plan, desirable capital developments and workforce changes as well as likely inflation, national tariff changes and cost pressures. The plan demonstrates a normalised net surplus in each year ranging from £6.6 million in 2009/10 to £18.7 million in 2015/16.

Savings requirements have been calculated to cover the national expectation of annual efficiency improvements on service level agreement income and a variable level of anticipated cost pressures over the ten year period. The overall savings requirement is approximately 2.8% over the period, ranging from 3.9% in 2007/08 to 2.25% in 2012/13 (and later years). A five year cash-releasing efficiency savings plan is in place which requires a total £15.3 million saving in 2007/08 and annual savings thereafter in the order of £11-12 million.

The plan generates significant cash surpluses in the early years of the plan. The projected cash balance for March 2013 is £29.9m. Surpluses then increase rapidly due to the sale of the BRI Old Building, lower demand on the capital programme and significant I&E surpluses.

In terms of phasing, the confluence of reconfiguration changes in 2009/10 mean that special consideration has been given to managing the impact of a negative gross impact in that year of £7 million on strategic schemes.

1.9 KEY RISKS AND MITIGATION

We have assessed the key risks to our strategy and identified the actions we will take to mitigate them. These are shown in Table D.

Risk	Mitigating Actions
Delays or changes to reconfiguration and development initiatives under the Bristol Health Services Plan.	Implement model of care changes irrespective of capital developments, particularly in non-acute services e.g. in rehabilitation services. Apply robust operational management of discharge arrangements. Assist commissioners to maximise demand management impact. Maintain flexible options for use of capacity. Prioritise service redesign through Service Improvement Strategy based upon 'Lean' thinking. Prioritise Trust objectives for internal capital programme.
Uncertain impact of new national arrangements for research and development.	Implement research and development strategy. Bid for integrated programme grants in areas of specialist expertise. Align strategy with that of universities to build scale and credibility for applications. Develop Clinical Research Imaging Centre in 2009 in partnership with Bristol University. Host research and development networks in the region.
Higher loss of elective activity to independent sector competitors.	Develop those clinical services where there is less contestability. Improve customer care skills of staff. Improve the patient and public environment and physical access to the site. Maximise involvement of clinicians in leadership and management to speed up innovation and improvement. Introduce 'Lean' methodology to streamline processes and reduce the length and complexity of care pathways.
Risks to delivery of performance targets, affecting Healthcare Commission annual rating, achievement of efficiency savings and Trust reputation.	Manage bed-base proactively and flexibly to enable additional beds to be opened as needed. Continue to collaborate with PCTs to limit un-necessary admissions. Continue to manage performance against key patient access targets and activity plans robustly. Maintain active focus on delivery of efficiency savings through Divisional Financial Reviews. Prepare contingency plans for delivery of maximum referral to treatment time target. Agree schedule of support to be provided to Divisions by Innovation Team. Agree Resource Utilisation Management priorities with PCTs.
Insufficient progress with modernisation and service redesign, leading to capacity constraints.	Manage programme proactively through multi-disciplinary Innovation Board. Innovation Team to use gap analysis and process redesign to support NHS Care Records Service implementation. Priorities for efficiency gains managed through Trust Operational Group. Agreed schedule of support to be provided to the Divisions by Innovation Team, encompassing improvements for the whole patient journey.
Under or over-achievement of demand management plans affecting income and performance.	Monitor delivery of Resource Utilisation Management savings through Trust Operational Group. Collaborate with PCT in key strands of the Trust Resource Utilisation Management plan (e.g. reducing Follow-up demand). Maintain annual capacity/demand modelling as integral part of business planning process.
Unforeseen cost pressures exceeding the allowance in the Business Plan.	Use mitigation plans to offset non-recurring impacts. Adjust savings plans or re-prioritise commitments to compensate for recurring cost pressures.
Under-achievement of savings plans.	In the short term, employ more centralised control of vacancies and procurement. In the medium term, bring forward savings plans from future years. In the long term, take a more aggressive approach to improving operational efficiency including length of stay.

Risk	Mitigating Actions
Fundamental reduction in demand for acute services meaning that activity falls recurrently below plan.	Review service portfolio and rationalise estate to remove fixed costs.
Delays to National Programme for Information Technology mean that the existing Patient Administration System becomes obsolete.	Continue contract negotiations with existing supplier. Continue to work with regional implementation team to ensure transition to the new system is seamless.
National Programme for Information Technology is aborted locally for whatever reason.	Programme governance structure and plans are in place at Trust, local, regional and national levels to support the delivery of the system. Develop contingency plan to implement alternative electronic patient record and related systems.
National Programme for Information Technology delivers systems which do not meet Trust needs.	Deliver extensive change programme alongside the technical project to minimise disruption and maximise benefits. Develop contingency plans for worst case scenario.
Shortfall of suitably qualified and experienced candidates for specialist posts, compromising range/quality of services.	Undertake specialist recruitment campaigns, including permanent or short-term agency contracts. Utilise existing flexibilities in employment contracts. Redesign roles and review skill-mix to free up service capacity. Offer additional sessions to existing staff.
Ageing workforce leads to potential shortages, increasing bank and agency costs.	Prepare annual workforce plans which address age profile with detailed recruitment planning. Maintain close working with key agencies, schools, colleges and educational partners. Develop proactive and creative recruitment and retention strategies.

Table D: Key risks and mitigating actions.

1.9.1 Managing the down-side scenario

The section on sensitivity analysis in the document describes the factors included in the down-side scenario and shows that the financial impact is manageable over the period of the plan.

1.10 CONCLUSION

In conclusion, the organisation is well governed by an experienced and balanced board, supported by an effective divisional structure with strong clinical engagement. The systems for performance, finance, workforce and risk management are well proven. Membership recruitment is well advanced, with 8,500 patient and public members recruited at time of writing, and the draft constitution has been approved by the Board.

Over the last four years UBHT has improved its cost efficiency and achieved breakeven or surplus. The organisation has detailed plans to sustain and further improve upon its very sound financial standing.

The Integrated Business Plan shows in detail how the Trust, operating as a membership organisation, responsive and accountable to its patients, staff and local community, and led by an experienced team of executive and non-executive directors, intends to deliver its strategic aims in the new NHS environment.

2. PROFILE OF TRUST

2.1 OVERVIEW

United Bristol Healthcare NHS Trust was formed in April 1991 as a 'first wave' NHS Trust, from the former Bristol & District Health Authority. It is one of the largest acute NHS Trusts in the country and the major teaching and research centre for the South West of England.

The Trust provides general acute and emergency services to the local population of Central and South Bristol, and a broad range of specialist and regional/supra-regional specialist services across a region that extends from Cornwall to Gloucestershire, into South Wales and beyond.

As a specialist teaching Trust, we work in strong and dynamic partnership with the University of Bristol, the University of the West of England and several other higher education institutions in this country and abroad. We are a major provider of medical, nursing, midwifery and allied health professional education at pre and post-graduate levels. Staff throughout the Trust are involved in a thriving research portfolio, comprising around 450 varied, pioneering projects resulting in approximately 600 published papers each year. Much of the research at UBHT has changed the clinical care of patients worldwide, particularly in cancer, cardiac surgery and child health and has informed the National Institute for Health and Clinical Excellence (NICE) and other national guidelines. Research, teaching and learning are integral to our business and are a key element of our strategy for the future. We aim to produce a flexible, multi-professional workforce, through a focus on evidence-based learning with expert patient feedback.

Following the Kennedy Inquiry report into failings in the paediatric cardiac surgery service at the Bristol Royal Infirmary between 1984 and 1995, the Trust now has a strong culture of clinical governance and effective systems for assurance. It was among the first Trusts to publish mortality figures for cardiac surgery in both children and adults, where it continues to demonstrate outcomes significantly better than the national average.

Under the aegis of the Bristol Health Services Plan, UBHT has embarked on a substantial programme of major capital schemes designed to upgrade the estate and replace old accommodation that is not fit for purpose. A new extension to the Bristol Royal Hospital for Children opened in April 2007. Refurbishment and expansion of the Bristol Dental Hospital was completed in December 2007. Construction of a new cardiothoracic centre is in progress which will open in 2009. Outline business cases for a further expansion of the Children's Hospital and a £55 million redevelopment of the Bristol Royal Infirmary received Strategic Health Authority Board approval in October 2007.

2.1.1 Trust Key Details

Table 1 provides summary information about the Trust.

9 sites:		
Bristol Royal Infirmary	572 beds Provides general and acute medicine and surgery, critical care, trauma and orthopaedic care and emergency treatment. The BRI is the centre for cardiothoracic services for the northern part of the South West region.	
Bristol Eye Hospital	45 beds The region's leading ophthalmology centre.	
Bristol Royal Hospital for Children	185 beds The only dedicated children's hospital in the South West. It is the regional centre for a wide range of specialist paediatric services and is the base for the internationally renowned bone marrow transplant unit. The intensive care unit provides the highest level of specialist paediatric critical care.	
Bristol General Hospital	111 beds Cares for the elderly and is a centre for rehabilitation and intermediate care.	
Homeopathic Hospital	Outpatient facilities only. The only homeopathic hospital in the region.	
Bristol Haematology & Oncology Centre	76 beds Provides inpatient and day case chemotherapy and radiotherapy, inpatient oncology, a full range of haematology services, including adult stem cell transplantation and a comprehensive care centre for haemophiliacs, and is a base for the Trust's palliative care team.	
St Michael's Hospital	162 beds Provides obstetrics and gynaecology care and ear, nose and throat (ENT) surgery. The hospital is a regional referral unit for high-risk pregnancies and for foetal medicine.	
University of Bristol Dental Hospital	5 day case beds Provides routine and specialist clinical dental services for the South West, as well as research and undergraduate and postgraduate teaching.	
Central Health Clinic	Central Health Clinic provides the Avon Breast Screening Service and, from June 2008, the Integrated Health Sexual Service.	
Total beds (April 2007)	1,156	
Turnover (07/08 projected)	£412m	
Total Net Assets Employed	£351.5m	
Ref Cost Index (2006/07)	97	
Employees	7,424 headcount	
Activity (06/07 actuals)	Elective spells (inc. day case) Non-elective spells Outpatients (inc. follow ups) A&E attendances	64,016 48,311 419,416 107,631
Main Commissioners	Bristol, North Somerset South Gloucestershire PCTs	Comprise 76% non-elective income and 70% elective income
Performance History	2003/04 2004/05 2005/06 2006/07	Two stars One star Good (quality of services) Fair (use of resources) Excellent (quality of services) Fair (use of resources)

Table 1. Summary facts and figures

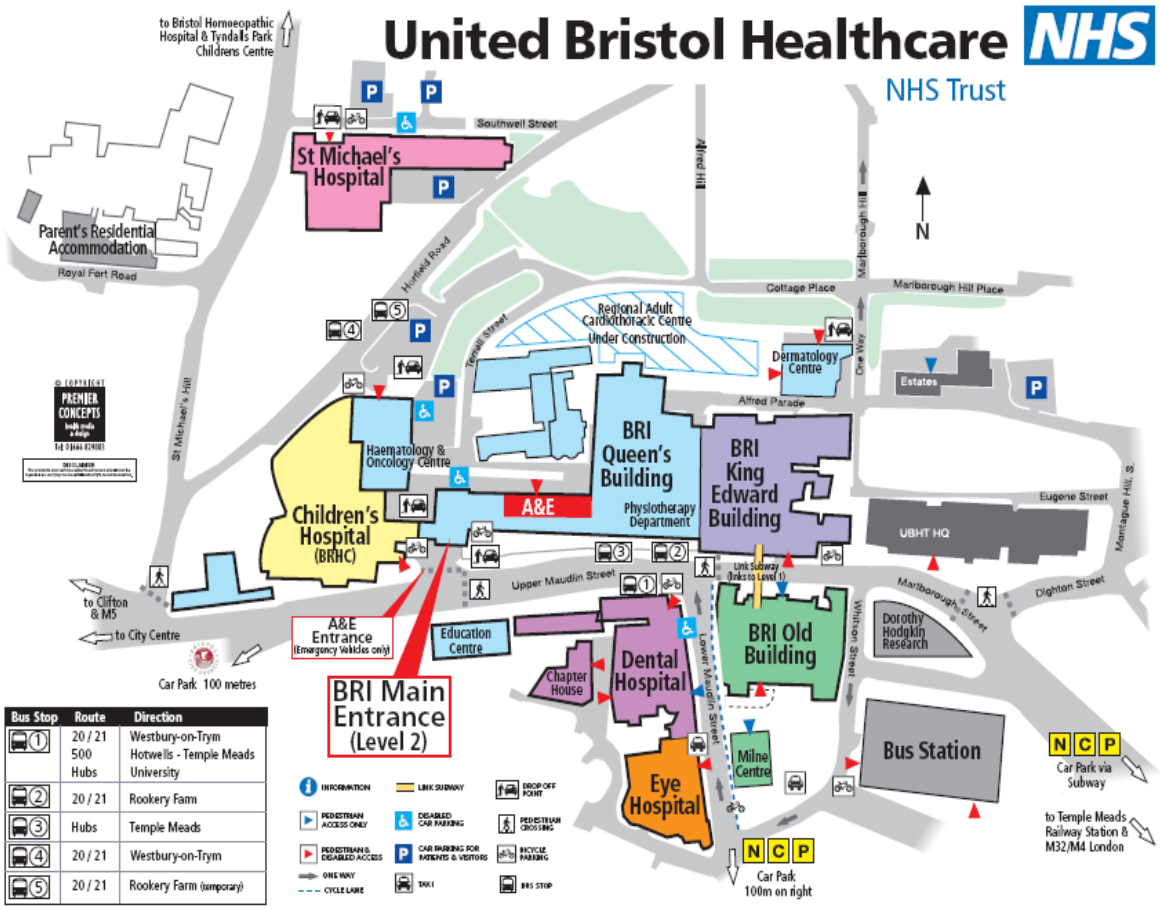


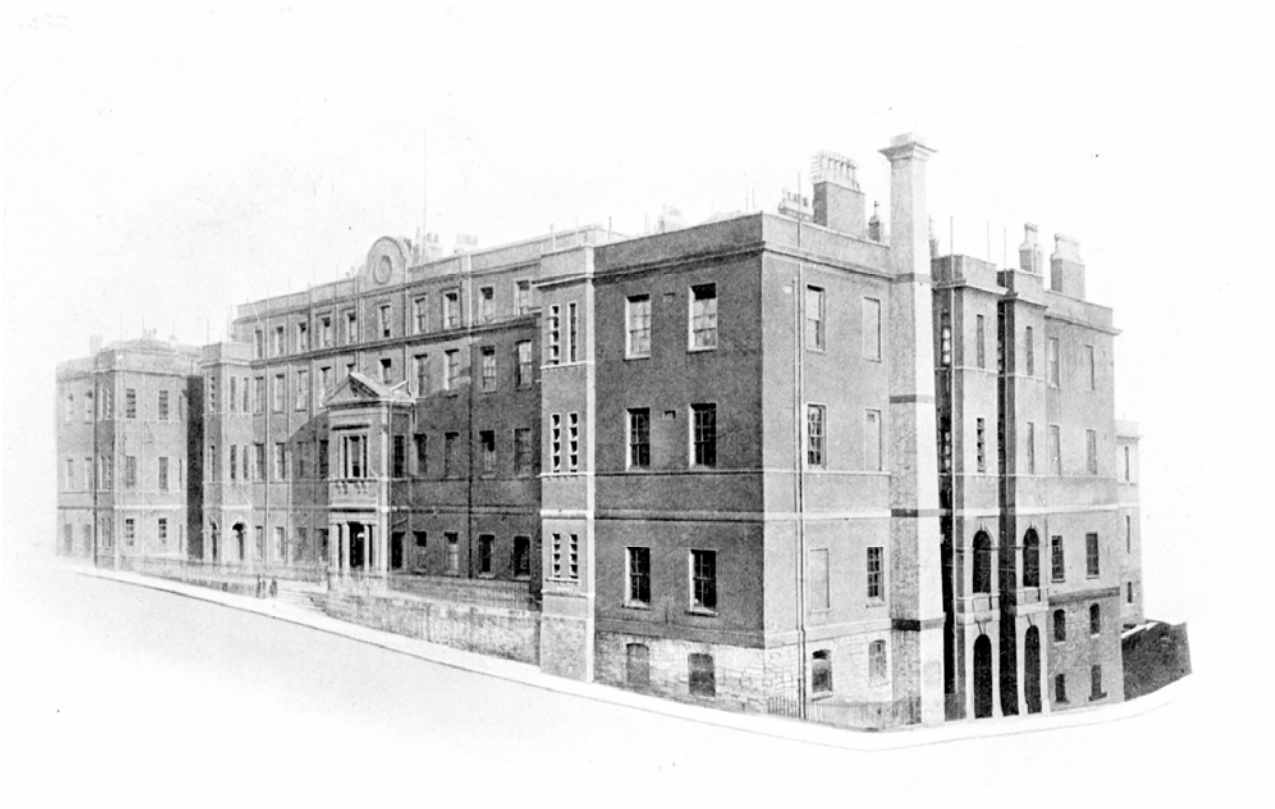
Figure 1: UBHT Campus Map

2.2 OUR HISTORY

2.2.1 Bristol Royal Infirmary

The oldest part of our estate, the Bristol Royal Infirmary Old Building, dates from 1737. The building houses a number of wards which are among the oldest clinical environments still in use in the country. The Infirmary was founded with the pledges of 78 Bristol citizens who each gave between two and six guineas, to be used 'to benefit the poor sick'.

From the day it opened its doors to outpatients on 20th May 1737, the Infirmary provided medical training – apprentices to the resident general practitioner, known as the Apothecary, shortly followed by surgical apprentices. Teaching remains one of our three core values today (along with care and research). Thirty-four outpatients were admitted, under the care of four physicians and two surgeons.



Sketch of the Bristol Royal Infirmary Old Building, which dates from 1737

The Infirmary received its royal title from Queen Victoria in 1850. As its use grew, the hospital needed more space by the turn of the 20th century. The Trustees at the time asked Sir George White, a prominent Bristolian and transport entrepreneur, to spear-head a public appeal. The money raised, boosted by a donation from Sir George himself, enabled the King Edward Building to open in June 1912. The Queen's Building, which houses the majority of wards, was opened by the present Queen in 1973. The Old Building will close in 2012/13 when new ward accommodation is completed adjacent to the Queen's Building.

2.2.2 Bristol Royal Hospital for Children

The origins of the Bristol Royal Hospital for Children can be traced to 1866 when a house in Royal Fort Road, Clifton, was set aside for "sick children and for the outdoor treatment of women". The hospital was established by Liberal politician Mark Whitwell, who laid down the principle that any child, no matter how poor, would be admitted provided there was room.

Within 20 years, the hospital was treating 900 women and 2,000 children annually. The hospital moved to a new site on St Michael's Hill in 1885, providing 88 beds and cots and seven beds for women. The hospital was granted its Royal status by Queen Victoria in 1897.

The hospital survived bomb damage during the Bristol Blitz to become incorporated into the newly-formed National Health Service in 1948. By the end of the last century, the building had become outdated, with advances in technology and rising demand for services. A major public fund-raising campaign was launched to build a purpose-built, exciting and child-friendly new building. The new hospital, adjacent to the BRI, was opened by HRH Prince Charles in 2001. A dynamic arts programme continues to enhance the environment and help young patients' recovery.

2.2.3 Bristol Eye Hospital

Dr William Henry Goldwyer founded what was to become Bristol Eye Hospital when he opened "The Institution for the Cure of Disease of the Eye Amongst the Poor" in a house in Lower Maudlin Street in 1808. In 1839, neighbouring properties were bought to allow expansion and by 1898 more adjoining buildings had been bought and demolished as the hospital continued to grow.

A new building was completed in 1935 at a cost of more than £47,000. That was in turn demolished in 1982 to make way for the present hospital, which opened four years later.

2.2.4 Bristol Homeopathic Hospital

The roots of the hospital can be traced back to 1852 when a Doctor Black began dispensing from premises on The Triangle, Clifton. The service developed during the next 69 years, culminating in the commissioning in 1921 of a new hospital in the grounds of Cotham House.

Bristol Homeopathic Hospital continued to provide a full range of services until 1986, when inpatient facilities were transferred to the Bristol Eye Hospital. A purpose-built hospital opened in 1994 next to Cotham House.

2.2.5 Bristol General Hospital

There has been a hospital in Guinea Street, Redcliffe, since 1832, but it was not until 26 years later that the General was to open on the site. The new hospital cost £28,000, with much of the funding coming from local workers, who gave a penny a week towards building and running costs. Their efforts provided 100 beds and 20 nurses. Two new wings were added in the 20 years before the First World War to provide medical and maternity wards and a dental department. They brought the number of beds to 150. The General joined with the Bristol Royal Infirmary in 1938 to become the Bristol Royal Hospital.

The Bristol General Hospital will close in 2009 when the planned South Bristol Community Hospital opens and the care of the elderly and rehabilitation services currently provided at the General transfer to the new hospital.

2.2.6 Bristol Haematology & Oncology Centre

The Oncology Centre, formerly the Radiotherapy Centre, opened in 1971. Haematology Services were centralised at the centre in the 1990s. Before the centre opened, the radiotherapy department was based at Bristol General Hospital. However, the advent of cobalt radiation treatment in the early 1960s and the resulting increase in patients highlighted the need for a purpose-built centre. The present site was chosen because of easy access to the Bristol Royal Infirmary and the Children's Hospital, then based on St Michael's Hill.

2.2.7 University of Bristol Dental Hospital

The University of Bristol Dental Hospital exists side by side with the University of Bristol Dental School, which has been training dental surgeons since 1906 and professionals complementary to dentistry since 1972.

A £18 million refurbishment and expansion programme at the Dental Hospital was completed in December 2007. The expansion has enabled the number of dental

undergraduates to grow from 50 to 75 and improved the hospital's main entrance to make it more accessible for those with disabilities.
A major revision of the undergraduate curriculum led to a new and innovative programme being introduced in October 2006. The aim is to introduce students to clinical practice in their second year and to deliver a modern teaching programme.

2.2.8 St Michael's Hospital

The origins of St Michael's Hospital can be traced to the purchase of a house in Alfred Place, Kingsdown in 1865 for "the rescue of young girls who have gone astray". The home, which was run by the Bristol Female Mission Society, moved to Southwell House in nearby Southwell Street six years later but it was not until 1894 that the "lying-in" hospital was opened there.

Bristol Maternity Hospital was opened on the site in 1914. In 1950, the hospital, which now consisted of Southwell House, neighbouring Carlton House and the Nurses' Home, moved to Queen Victoria House, Redland.

Maternity services relocated again when the current St Michael's building opened in 1972. In September 2003, a birthing suite, promoting as natural, positive and normal a labour as possible for low risk births, and the Lavender bereavement suite opened following major refurbishment.

2.3 DIVISIONAL STRUCTURE

In July 2005, the Trust reorganised its management structure, moving from thirteen clinical directorates to five clinical divisions. Changes to corporate governance arrangements were made in parallel, as described in Chapter 9.

The size and content of the clinical Divisions are shown in Table 2. A sixth Division, Trust Services, consists of all corporate services including Facilities and Estates, Information Management and Technology and the Trust headquarters function.

Women's & Children's Services	Medicine	Surgery, Head & Neck	Specialised Services	Diagnostics & Therapies
Budget: £77m	Budget: £44m	Budget: £68m	Budget: £50m	Budget: £37m
Children's Services Paediatric A&E Paediatric theatres Neonatology Obstetrics Gynaecology Reproductive Medicine Paediatric Anaesthesia Paediatric Intensive care	General Medicine Adult A&E Respiratory Endocrinology Neurology Dermatology Rheumatology Sexual Health Gastroenterology Care of the Elderly	General Surgery Breast Surgery Thoracic Surgery Urology Orthopaedics Maxillo-facial surgery Adult ENT Ophthalmology Dental BRI & St Michael's operating theatres CSSD Critical Care General & obstetric anaesthesia	Cardiac Surgery Cardiology Cardiac Anaesthesia Cardiac Intensive Care Clinical and Medical Oncology Clinical Haematology Homeopathy	Physiotherapy Occupational Therapy Orthotics Nutrition & Dietetics Adult Speech & Language Therapy Adult Audiology Laboratory Medicine Pharmacy Radiology Medical Physics & Bioengineering Medical Equipment Management

Table 2: 2007/08 budget and service range of the clinical Divisions

The Divisional structure and supporting governance arrangements deliver a number of significant benefits for the Trust:

- maximising clinical involvement in corporate decision-making
- placing accountability closer to the point of resource use
- devolving authority closer to the point of service delivery
- improving the speed of decision-making, simplifying internal communications and reducing bureaucracy.

The Divisions have been established in a way that fosters multidisciplinary team-working, organised around appropriate patient pathways rather than physical boundaries.

Each clinical Division is led by a Head of Division, drawn from a clinical background, supported by a Divisional Manager, Lead Doctor, Head of Nursing, Lead Allied Health Professional, Divisional Human Resources Manager and Divisional Finance Manager. Together with a University representative, lead manager for administrative and clerical functions and other representatives appropriate to Divisional circumstances, these individuals meet formally as the Divisional Board.

Divisions prepare strategic and annual plans which are co-ordinated centrally and reviewed corporately through performance management arrangements described in Chapter 9.

Alongside the Divisional structure, the Trust established designated care pathway leads in areas such as Emergency care, Elective care, Older People's services and Cancer services, to help ensure a focus on the entire patient pathway, particularly where these still cross divisional boundaries. A Clinical Reference Group was put in place to ensure that clinical views were debated and could feed into the different layers of decision-making within the Trust and Divisions.

2.4 POPULATION SERVED

The Trust provides services to three distinct populations, as follows:

Acute and emergency services to the local catchment population of around 300,000 in central and south Bristol.

Specialist services to the wider acute "network" (comprising Bristol, North Somerset and South Gloucestershire (BNSSG) PCTs, Bath and North East Somerset, Wiltshire and Somerset) with a 2.4 million population.

Specialist regional and supra-regional services to the South West region, South Wales and beyond to a population of 5 million plus.

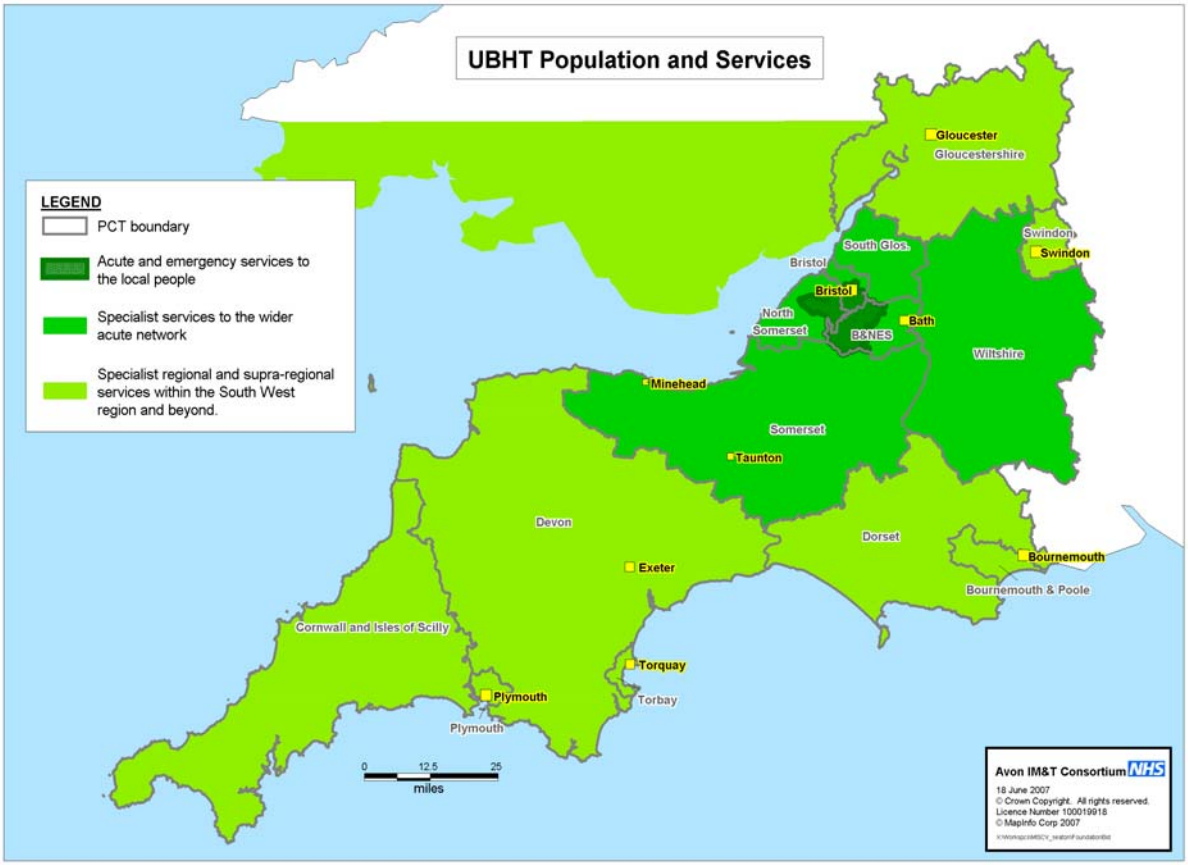


Figure 2: UBHT Population and Services

2.5 RANGE OF SERVICES

Table 3 shows those specialties provided by the Trust which have income values of over £3 million in 2007/08 Service Level Agreements, and the activity by key work type for those specialties.

The Trust provides a wide range of designated specialised services. The full list is provided at Appendix 1 and was agreed by the South West Specialist Commissioning Group on 4th July 2007.

The main future change to the Trust's service portfolio will be the transfer of inpatient paediatric neurosciences, burn care, orthopaedics and oral surgery to the Bristol Royal Hospital for Children from North Bristol Trust as part of the planned centralisation of specialist paediatrics in Bristol to be completed by 2012.

Other changes described in this plan affect activity levels in existing services but do not constitute changes to the range of services currently provided by the Trust.

Specialty	2007/08 Planned Activity by Key Worktype						2007/08 SLA Value £000
	Day Cases	Elective Inpatients	Non Elective Inpatients	Bed days	Outpatients	Other	
Accident & Emergency	0	2	5,181	0	0	108,320	11,183
Adult Cardiology	1,115	1,263	1,727	0	11,492	0	12,590
Adult Intensive Care	0	0	0	4,206	0	0	6,925
BMT (no activity plan)	0	0	0	0	0	0	7,016
Cardiac High Dependency	0	0	0	7,173	0	0	5,939
Cardiac Surgery	1	1,145	737	0	2,525	0	15,369
Clinical Haematology	3,814	224	142	0	6,619	0	3,185
Clinical Oncology	6,490	1,225	303	0	8,591	0	6,316
Elderly Care	1	2	696	0	2,701	0	3,360
ENT	991	1,676	644	0	17,849	0	5,470
General Medicine	818	388	9,503	0	16,514	0	22,676
General Paediatrics	2,111	470	6,582	0	9,552	46	10,219
General Surgery	6,109	2,562	3,936	0	20,926	0	20,582
Gynaecology	1,964	1,303	1,834	0	16,161	0	6,671
Medical Oncology	5,681	1,011	477	0	9,330	2,953	9,596
Neonatal Intensive Care	0	0	0	11,912	0	0	7,729
Nephrology	28	88	100	0	1,583	854	3,847
Obstetrics	4,959	154	9,971	0	7,235	0	12,091
Ophthalmology	9,433	1,506	1,084	0	93,228	3	14,642
Paediatric Cardiology	111	426	162	0	3,453	0	3,551
Paediatric Intensive Care	0	0	0	4,217	0	0	8,956
Paediatric Surgery	962	718	972	0	2,953	19	6,350
Radiotherapy	0	0	0	0	0	3,093	6,719
Rehabilitation	0	0	1,066	0	0	1	9,219
Trauma & Orthopaedics	1,691	727	2,364	0	27,840	4	13,077
Urology	2,716	680	86	0	8,533	0	3,567
Other*	5,050	1,153	780	0	161,475	252	127,216
Grand Total	**54,045**	**16,723**	**48,347**	**27,508**	**433,560**	**115,545**	**364,063**

*Other includes: Accident & Emergency attendances, Regular Attenders, Day Patients, Radiotherapy Courses (Excess bed days not included)

Table 3: Summary of specialties provided by the Trust with SLA income value over £3 million and activity by key work type

[Source: Long Term Financial Model Historic Income model]

2.6 ACTIVITY

Table 4 and Figure 3 below show total Trust activity by key work type from 2005/06 to 2007/08 (the latter being based on Service Level Agreement plans). The significant increase in levels of elective inpatient and day case and outpatient activity for 2007/08 reflect the increased capacity required to meet Referral to Treatment interim milestones. Non-elective activity plans for 2007/08 are broadly at 2005/06 levels as a result of anticipated PCT resource utilisation management plans for admission avoidance and early discharge schemes. Critical Care capacity (bed days) is planned to increase by 9.2% from 2005/06 levels as a result of agreed investment by PCTs for additional Adult ITU and Paediatric Intensive Care beds.

Type of Activity	Actual 2005/06	Actual 2006/07	SLA 2007/08	%Change 2005/06 to 2007/08
Day Cases (spells)	46,822	48,615	54,045	15.4%
Elective Inpatients (spells)	16,326	15,399	16,723	2.4%
Non Elective Inpatients (spells)	48,264	48,311	48,347	-0.1%
Outpatients (attendances)	407,687	419,416	433,560	6.3%
Bed days (Critical Care)	25,184	25,431	27,508	9.2%
Accident & Emergency (attendances)	105,454	107,631	108,320	2.7%
Excess Bed days	43,401	44,632	43,393	0.0%

Table 4: Activity trends 2005/06 to 2007/08

[Source: 05/06 & 06/07 FT LTFM Historic Income model; 07/08 FT LTFM Future Income model]

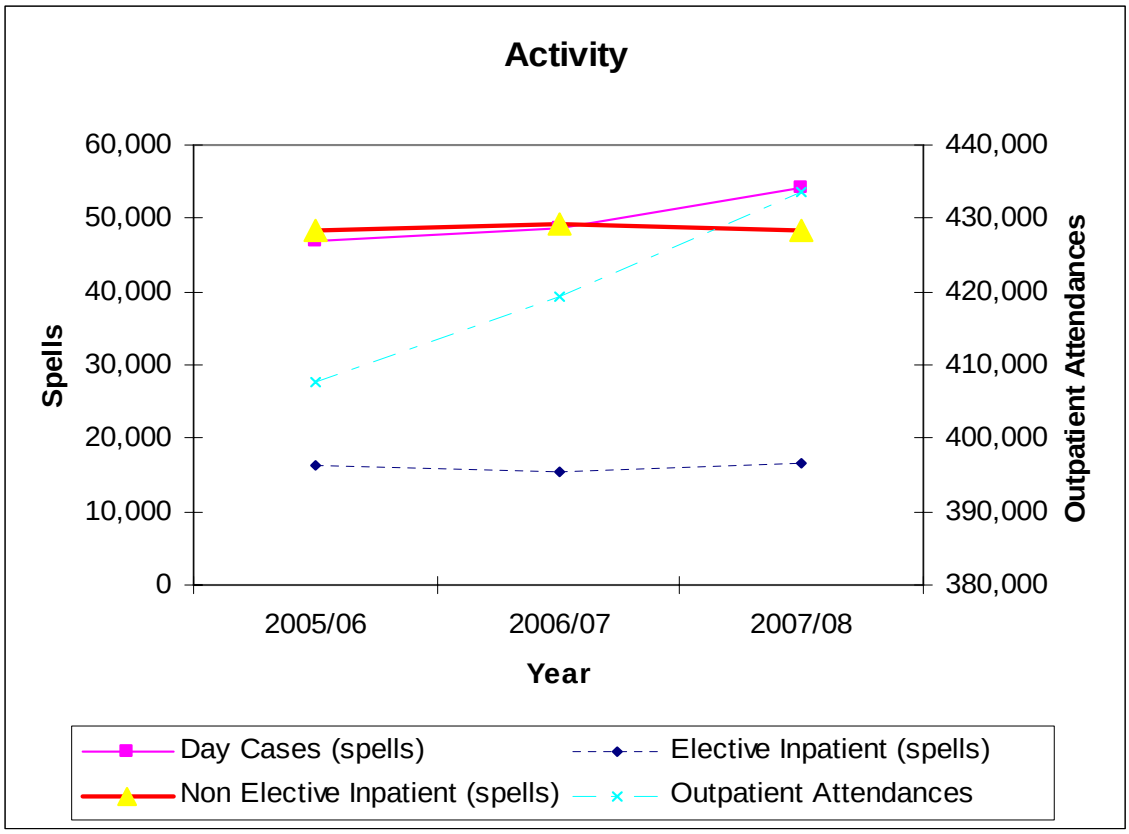


Figure 3: Activity trends 2005/06 to 2007/08

[Source: 05/06 & 06/07 FT LTFM Historic Income model; 07/08 FT LTFM Future Income model]

2.7 OUR STAFF

The Trust employs 7,285 staff members, (6,177whole time equivalents) and hosts a further 139 staff (134 whole time equivalents). Total staffing = 7,424 staff (6,311 whole time equivalents). Figure 4 below shows the wte across the staff groups. Further detail is shown in Section 8.7, Workforce Strategy.

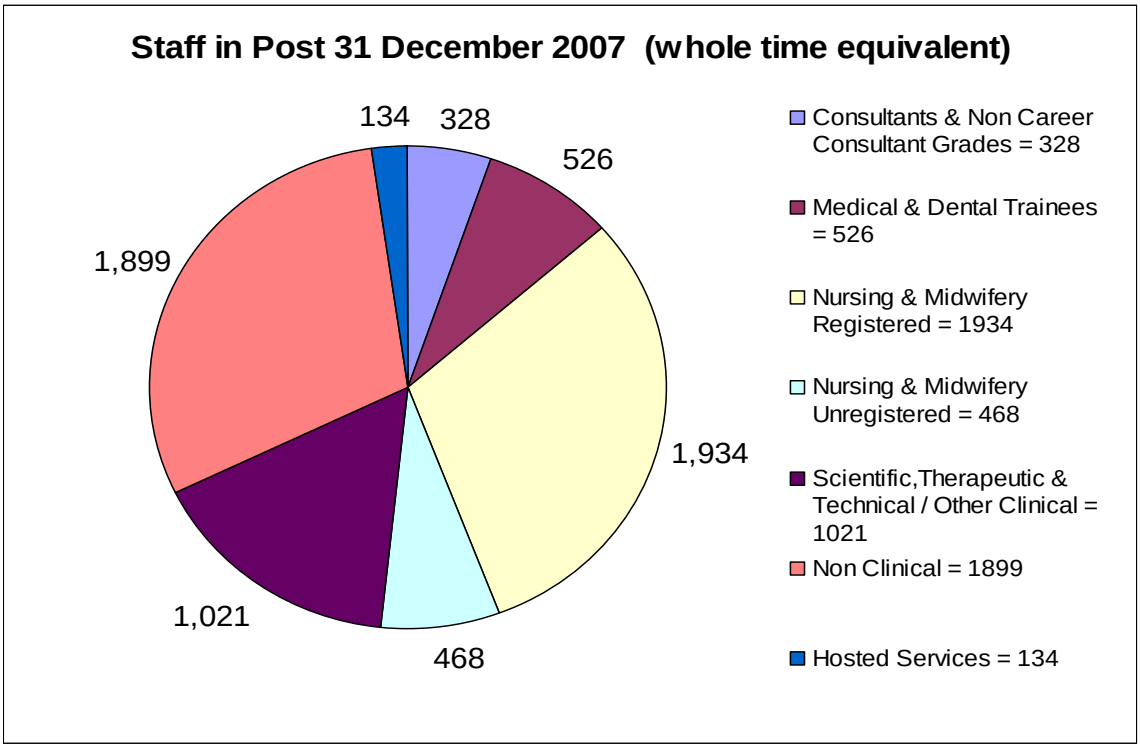


Figure 4: UBHT WTE Staff

2.8 PROTECTED ASSETS

Table 5 below details the Trust's protected and unprotected assets.

The Hospitals	
Bristol Royal Infirmary	Asset North of Upper Maudlin Street Protected BRI Old Building site not protected as strategy plans disposal 2013
Bristol Royal Hospital For Children	Protected
Bristol Haematology And Oncology Centre	Protected
Bristol Eye Hospital	Protected
Bristol Dental Hospital (Chapter House)	Protected – lease
St Michael's Hospital	Protected
Bristol General Hospital	Not protected as strategy shows disposal 2009
Treatment Centres: Non Hospital-Patient Facilities	
Central Health Clinic	Not Protected
Tyndalls Park Children's Centre	Not Protected
Homoeopathic Outpatients Department	Not protected – not core and for flexibility
Southwell House	Not Protected
36 & 38 Southwell Street, Bristol BS2 8EJ RA7RC	Not Protected
Parents' Hostel: Ronald McDonald House And	Not protected – not core and for flexibility
Parents' Hostel: Sam's House	Not protected – not core and for flexibility
Support Facilities: Non Hospital-Non Patient	
Education Centre	Protected – lease
Trust Headquarters	Not protected – not core and for flexibility
Multi Storey Car Park & Swimming Pool	Not protected – not core and for flexibility
Facilities & Estates Building	Not protected – not core and for flexibility
Radiopharmacy	Not Protected (could be redeveloped as per estate strategy)
King David Hotel Complex	Not Protected
The Honeypot	Not protected – not core and for flexibility - lease
Terrell Street Buildings	Not Protected (will be redeveloped as per estate strategy)
The Central Boiler House	Not Protected
The Grange	Not protected – not core and for flexibility
Greyfriars	Not protected – not core and for flexibility – lease
Whitefriars	Not protected – not core and for flexibility – lease
Goldsmiths House	Not protected – not core and for flexibility
Brislington House Pavilions	Not protected – not core and for flexibility
Brentry Laundry	Not protected – not core and for flexibility
Brentry Trust Quality Foods(TQF)	Not protected – not core and for flexibility
Kingsdown Fire/Health & Safety Office	Not protected – scheduled for disposal as per estate strategy
2 St Michael's Hill	Not protected – not core and for flexibility
Residential Properties	
Alfred Hill (27,29,33,35,37,41,42,43,44 And 56)	Not protected - residential
St. Michael's Hill (78,80,82,84,86,88,90,92,94,96,98 And 100)	Not protected – residential
Horfield Road (64,66,68,70,72,74 And 76)	Not protected – residential
10 & 10a Marlborough Hill Place	Not protected – residential
6 Kingsdown Parade	Not protected – residential
Rose Cottage	Not protected – residential
Eugene Street Flats	Not protected – residential - lease
Colston Fort	Not protected – residential

Table 5: UBHT Protected and Unprotected Assets

2.9 FINANCE

The Trust is forecasting a revenue surplus of £12.8m in 2007/08 from an expected turnover of £412m. This surplus will finance the £12.8m part repayment of the long-term loan of £20.3m taken out by the Trust in March 2007. The loan originally covered the Trust's cumulative deficit and other historical liquidity issues and created a sustainable balance sheet going forward.

The Trust's current financial stability has been achieved primarily from improving cost efficiency including the delivery of substantial savings programmes. A savings requirement of £15.3m for 2007/08 is a key challenge but is expected to be delivered in full.

The Trust will have gained £4.1m under Payment by Results by 2008/09 due to transitional arrangements in 2006/07 and 2007/08. The 2008/09 National Tariff provides a further estimated gain of £4.8m in 2008/09 due largely to an increase in specialist top ups. A further gross gain of £4.5m is anticipated upon the full rollout of Payment by Results in 2009/10 and 2010/11, however £2.2m is assumed to be reinvested in service quality leaving a net gain of £2.3m.

2.10 HISTORICAL PERFORMANCE

2.10.1 Financial Performance

UBHT experienced financial problems in the years 2001/02 and 2002/03 accumulating a deficit of £17m. However, over each of the past four financial years the Trust has achieved breakeven or better and, with the forecast surplus in 2007/08, will be in recurring financial balance. Table 6 shows both the reported Annual Accounts and normalised positions:

Surplus/(deficit)	2001/02 £m	2002/03 £m	2003/04 £m	2004/05 £m	2005/06 £m	2006/07 £m
I&E Position per Accounts	(7.7)	(9.3)	0.1	0.1	3.3	1.1
Normalised Position	(14.8)	(10.8)	(8.5)	(3.8)	6.7	5.7
Turnover	263.1	267.8	298.3	324.6	350.7	372.5

Table 6: Income and Expenditure position 2001/02 to 2006/07

The improvement in cost efficiency referred to in 2.9 above can be demonstrated by the National Reference Cost index for the Trust (where 100 represents national average costs) as set out in Table 7:

	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07
Reference Cost Index	116	108	104	96	94	97

Table 7: Cost Efficiency – Reference Cost Indices

2.10.2 Non-Financial Performance

In 2006/07 the Trust achieved the highest rating of 'Excellent' for its Quality of Services, and a rating of 'Fair' for Use of Resources in the Annual Health Check. Only 16% of trusts achieved a rating of 'Excellent' for the Quality of Services Element of the 2006/2007 Annual Health Check.

In 2005/2006, the Trust achieved a rating of 'Good' for its Quality of Services and a rating of 'Fair' for Use of Resources. Only 4% of Trusts achieved a higher rating (i.e. a rating of Excellent) for the Quality of Services Element of the 2005/2006 Annual Health Check.

Table 8 below gives a summary of performance over the last four years.

	2003/2004	2004/2005	2005/2006	2006/07
Target	**2 Stars**	**1 Star**	**'Good'**	**'Excellent'**
Key targets	Total number of targets: 9 • Achieved: 7 • Under-achieved: 2 • Failed: 0	Total number of targets: 8 • Achieved: 6 • Under-achieved: 1 • Failed: 1		
Balanced Scorecard Measures	• **Clinical focus**: Middle band of performance • **Patient Focus**: Top band of performance • **Capacity & capability**: Top band of performance	• **Clinical focus**: Top band of performance • **Patient Focus**: Middle band of performance • **Capacity & capability**: Top band of performance		
Existing Targets			**Almost Met** Total number of targets: 11 • Achieved: 6 • Under-achieved: 5 • Failed: 0	**Almost Met** Total number of targets: 11 • Achieved: 8 • Under-achieved: 3 • Failed: 0
New Targets			**Excellent** Total number of targets: 12 • Achieved: 11 • Under-achieved: 1 • Failed: 0	**Excellent** Total number of targets: 10 • Achieved: 9 • Under-achieved: 1 • Failed: 0
Core Standards			**Almost met** Compliant in 40 of the 42 standards	**Fully compliant in all the 42 standards by year end.**
Service Reviews			**Almost met** 4 Reviews • Good: 1 • Fair: 3	

Table 8: Summary of performance in the Healthcare Commission Annual Health Check and former Star Rating assessment.

2.11 SUMMARY OF CONTRACTUAL RELATIONSHIPS

The Trust is a teaching and research centre as well as being the main tertiary service centre for the South West. This is reflected in the analysis of income received by source. A full analysis is shown in Appendix 2, summarised below in Table 9. This shows that the Trust needs to plan in the context of not only the local health economy but also its regional specialised services and central budgets covering training, education, teaching and research.

2007/08 Service Level Agreement Income		
	£m	%
Local Health Economy (Bristol, North Somerset and South Gloucestershire)	224.2	62%
Market Forces Factor	24.2	7%
Non Local PCTs in NHS South West SHA	67.1	18%
Other PCTs outside NHS South West	10.8	3%
Training, Education, Teaching & Research	37.8	10%
Total	364.1	100%

Table 9: Summary of 2007/08 Service Level Agreement Income by Source

Table 10 below shows the Trust's income and expenditure contracts with a value of more than £1 million. All contracts have an expiry date of end-March 2008

	Purchaser	Service	2007/08 Contract Value
			£
Income	Bristol PCT	Patient Care SLA	150,718,149
	North Somerset PCT	Patient Care SLA	41,652,683
	South Gloucestershire PCT	Patient Care SLA	31,831,776
	Department of Health	Market Forces Factor	24,191,690
	Somerset PCT	Patient Care SLA	18,944,645
	Bath & North East Somerset PCT	Patient Care SLA	13,025,083
	NHS South West	MADEL	12,917,900
	Medical Sift	Medical Sift	12,706,100
	Gloucestershire PCT	Patient Care SLA	8,905,362
	Wiltshire PCT	Patient Care SLA	8,389,572
	Department of Health	R & D	6,129,600
	NHS South West	Dental Sift	6,081,300
	Health Commission Wales	Patient Care SLA	5,484,543
	Devon PCT	Patient Care SLA	4,469,743
	Bristol PCT	Clinical Excellence Awards	3,301,700
	Swindon PCT	Patient Care SLA	2,814,920
	Cornwall & Isles of Scilly PCT	Patient Care SLA	2,627,445
	Plymouth PCT	Patient Care SLA	1,080,316
	Torbay Care Trust	Patient Care SLA	1,013,376
	Department of Health	Transitional Charge PBR	-2,105,000
Expenditure			
	National Litigation Authority	Clinical Negligence Services	3,782,244
	National Blood Authority	Blood products	3,215,342
	Health Protection Agency	HPA pathology	1,876,958
	Great Western Ambulance Service	Patient Transport Services	1,335,744

Table 10: Contracts held by the Trust with a value of £1 million and over

[Source: Foundation Trust Long Term Financial Model Future Income model]

2.12 OVERVIEW OF OTHER PROCUREMENT ARRANGEMENTS

The Trust is a constituent member of the Bristol and Weston NHS Purchasing Consortium and a collaborative partner within the Avon, Gloucestershire and Wiltshire

Supply Management Confederation. It is also actively involved in the South West collaborative procurement hub project.

The Purchasing Consortium is a fully unified organisation hosted by North Bristol NHS Trust and has six constituent members from both acute and primary healthcare sectors. Its prime purpose is to provide high quality, cost-effective and independent procurement services to all constituent members.

Between 2004/05 and 2006/07 the Consortium has achieved cash releasing savings in excess of £6.5m, of which £1.8m was attributed to UBHT. A further £2.2 million savings have been projected by the Consortium for 2007/08.

2.13 JOINT VENTURES AND PARTNERSHIP ARRANGEMENTS

2.13.1 Section 31 Partnership Agreement

A Section 31 Partnership Agreement was concluded in January 2003 between the Trust, Bristol North PCT, Bristol South and West PCT, North Bristol Trust and Bristol City Council Social Services. The Agreement binds the parties to work to:

- set minimum acceptable thresholds for delayed transfers of care
- establish systems to monitor delayed transfers of care
- achieve a sustained reduction in delayed transfers of care
- promote investment in improved community care services aimed at reducing delayed transfers of care
- strengthen joint working between the parties to improve discharge planning, and encourage the timely provision of services that enable discharge from hospital.

The Agreement is reviewed annually by the partners, particularly to agree the budget for the new financial year and the reimbursement thresholds themselves.

The Trust has a reimbursement threshold of 2 acute delayed transfers of care with Social Services for 2007/08. The budget for Partnership Schemes in 2007/08 is £1,038k, supporting a range of schemes which are monitored through the Bristol Intermediate and Long Term Care Service Development Group.

2.13.2 Research and Development partnerships

Our research and development activity is pursued in collaboration with a large number of partners. These include academic, other NHS, government, charitable and commercial organisations as well as patients and the public. Our key academic partners are the University of Bristol and the University of the West of England but individuals and research groups collaborate with academic institutions throughout the UK and world-wide.

We work closely with NHS organisations locally in setting strategic direction as well as on individual projects and programmes of research. The Trust is viewed as a leader in research conduct, management and governance and provides support in these areas to Weston Area Health Trust and the University of Bristol. The Trust is a member of Cancer, Medicines for Children and Comprehensive Local Research Networks and NHS Innovations South West.

Best Research for Best Health emphasises the need for strong collaboration in development of an NHS research portfolio, and the Trust is developing joint strategies between both university and NHS partners to increase accessibility to the new

opportunities. Recent successes include a combined bid for regional programme monies in community based paediatric research and the successful appointment of new academic posts via Walport bids. This has provided new Academic Lecturer and Fellow posts within the Trust and within both local universities.

Joint UBHT - University of Bristol Clinical Research Imaging Centre

The Trust is hosting this joint development with the University of Bristol in St. Michaels Hospital which will provide a 3T MRI scanning facility and clinical research rooms for clinical research including first-in-man phase 1 Trials, which is due to open in 2009. The £6.5m capital investment by the University supports the strategic development of first class neuroscience research UBHT will contribute key NHS support staff in this partnership and provide estate and facilities support.

3. STRATEGIC OVERVIEW

3.1 OUR VISION AND AIMS

The Trust's mission is to provide patient care, education and research of the highest quality.

In pursuit of this mission we will abide by the following values:

- We put patients first
- We involve, develop and support staff
- We promote innovation and improvement
- We pursue excellence in everything
- We respect others and treat everyone as equals
- We work in partnership to improve the health and well-being of the community, within a sustainable environment
- We are accountable for our use of public resources.

3.2 CORE STRATEGY

Our strategic aims in the three core business areas (service, research and teaching) – plus key support areas – are shown in Table 11.

Clinical Services	Research & Development	Teaching and Learning
• To provide efficient and effective services, affordable to commissioners and desirable to patients and referring clinicians • To be the major specialist service provider for the population of Bristol & the South West region • To provide additional services for the local population • To support the principle of local access wherever possible • To provide services which are quick and easy to access and provide an excellent patient experience • To deliver services to the highest standards	• To develop collaborative and consultative research partnerships with patients, carers and the public • To support research of national and international excellence and innovation • To develop the Trust's research portfolio in line with its service strategy • To develop a Clinical Research Imaging Centre in partnership with the University of Bristol • To develop research activities in partnership with academic and healthcare organisations • To further develop research governance	• To ensure staff are enabled to provide safe, effective and high quality patient care • To pursue teaching and learning partnerships with education providers and others • To embrace personal and organisational development • To encourage a culture of innovation and enterprise • To maximise recruitment and retention by meeting the development needs of current and prospective staff
Supporting aims		
• To achieve a sustainable financial surplus • To improve the environment for patients and staff, to improve ease of access for patients and visitors and to develop the Trust's estate to give the optimal configuration of services • To ensure that the Trust has the governance and information structures, systems and processes necessary to deliver its mission efficiently, effectively and with the highest standards of probity.		

Table 11: Our strategic aims

The core business aims are drawn from a number of formal strategies, approved by the Trust Board over the last 2 years, including:

- Clinical Services Strategy
- Research & Development Strategy
- Teaching and Learning Strategy.

Supporting strategies have also been laid out and approved in the shape of the following:

- Financial Strategy
- Workforce Strategy
- Service Improvement Strategy
- Estates Strategy.

Plans are in place to deliver the stated aims, reflected in Divisional strategies and annual plans, directed through appropriate multi-disciplinary working groups and monitored through the corporate performance management framework.

Section 5 of this document highlights three key plans fundamental to the successful delivery of the Trust's strategic aims in the areas of service improvement, research and development and site development. Section 6 demonstrates how the financial strategy will be pursued, while Sections 8 and 9 describe the approach to workforce and organisational development and to overall corporate governance and assurance, respectively.

3.3 RATIONALE FOR FOUNDATION TRUST STATUS

We believe that becoming an NHS Foundation Trust is the right thing for the Trust, for our local community and users of our services for the following key reasons:

- it will drive genuine understanding between the Trust and its users, allowing us to respond to the issues that matter to those who have direct experience of our services and staff – this will be vital to the success of the Trust in an increasingly competitive market-place
- it will facilitate meaningful involvement of patients and the public in the Trust's planning processes, which we firmly believe will produce better decisions which have wider ownership
- it will be the basis for real engagement with the community of Bristol, reinforcing our rights and responsibilities as a major employer in the heart of the city
- it will give staff a voice in decision-making through their elected representatives on the Membership Council.

Foundation status will assist the Trust's ambition to become a world class provider of health care, teaching and research.

Representing the interests of the community

Foundation Trust status will ensure that the best interests of the local community, our patients and their carers, and our staff are taken into account when designing and providing services and planning for the future. We will be able to secure real benefits for them. We believe that people in these constituencies are the ones who have real insight into what is needed and the improvements which need to be made.

Foundation Trust status will allow us to be more representative by:

- Giving members of the public, people who use our services and our own staff a direct say in how we run things
- Allowing us to collect many more views and opinions than we do currently on how best to provide the healthcare people need
- Allowing anyone living locally, recent patients and our staff to become members of the Trust and express their views on what is needed
- Allowing our key partners and stakeholders in our services to have a say.

We believe that listening and responding to the opinions of people who use our services will help us to provide the right sort of healthcare to people in the right place and at the right time.

Greater accountability as an outward looking organisation

The United Bristol Healthcare NHS Trust has good relations with local communities through the Patient and Public Involvement Forum, patient support networks, extensive patient involvement, schools liaison work and corporate social responsibility activities. In addition close links with the business community exist through established groups such as the Business and Consumer Advisory Groups.

Local people, as members and Governors of the new NHS Foundation Trust, will have a real influence on how we take forward our future strategy through better engagement with local people and stakeholder organisations. This will ensure that our strategy meets their needs and that change can be achieved. We will utilise the membership to discuss and develop our strategy, ensuring consistency between the aspirations of our staff and the population we serve.

Greater financial freedom

The new financial basis from which NHS Foundation Trusts operate will allow us to invest our surpluses into specific service developments in response to the priorities of the membership. This, and the ability to borrow money as a public benefit corporation, will give us greater flexibility in how we use our financial resources.

3.3.1 How we will use freedoms as a Foundation Trust

A number of capital schemes are proposed over the next 10 years. As a Foundation Trust we will be able to make our own capital decisions without reference to the Strategic Health Authority and Department of Health. This should lead to faster capital development, for example; facilitating the re-provision of inpatient areas housed in the inadequate Bristol Royal Infirmary “Old Building”, which opened in 1737.

In addition, as a Foundation Trust we will have the ability to form a joint venture with, for example, Independent Sector providers or healthcare industry, in situations when this makes most sense. This may be important in allowing the Trust to make the most of its intellectual property.

The freedoms which come with Foundation status will allow us to plan and manage over a period of years rather than on an annual basis, for example: in 2009/10 several services are due to transfer out of the Trust and the financial regimen of Foundation status will ensure that we can plan effectively for this.

3.3.2 How we will use the Membership Council

The Membership Council has been designed to be as representative as possible of constituents and key stakeholders in order to embrace a range of view points and to use these to inform decisions regarding the future direction of the Trust. We will use all representatives on the Membership Council to engage with and energise the membership and to build on it by acting as ambassadors for membership in the wider community.

More specifically we will use the Membership Council as follows:

- Public Governors will provide a local perspective on service development plans and we will use them as links in to their constituencies to gather and put forward views from the membership, to assess local implications of proposals and to guide the Trust where further consideration is required through any contacts.
- Patient and Carer Governors, and their constituents, will bring their unique perspectives as service users, and are therefore best placed to inform the Trust of the potential impact of strategy and service development on the patient experience. We will use Patient and Carer governors and their links into patient groups to guide the Trust's thinking when this impact is potentially negative.
- Staff Governors will be used to help develop the culture of the organisation internally as a Foundation Trust and to further raise awareness of the importance of rising to the challenges of such things as the impact of patient choice and practice based commissioning on us as an independent NHS organisation. In addition, Staff Governors will be used to inform the development of working practices etc. to support evolving service developments.
- Appointed Governors will be drawn from stakeholders such as the local authority as health and social care partners, the business community, education and research establishments, community groups and other NHS organisations. They will be key partners in developing the future of the Trust and will be used to help ensure our strategy as an NHS Foundation Trust remains aligned with that of partnership organisations.
- In addition, we will have the potential to capitalise on joint benefits which result from joined up thinking and to use the leverage of Appointed Governors to progress partnership initiatives.

3.4 SUMMARY OF CONSULTATION PROCESS

An initial stakeholder analysis (Appendix 3) was used as a basis for reviewing current stakeholder relationships and informing our consultation strategy and plans. Approaches to each stakeholder were mapped (Appendix 4) to inform the consultation process.

3.4.1 Current stakeholder relations

The consultation process allowed us to build on our existing relationships with local communities and to develop new ones, in addition to strengthening those with key stakeholder organisations. Our good track record in patient and public involvement was also a sound basis for the consultation plan to be developed. We were conscious of a number of recent consultations across the city, including that on the Bristol Health Services Plan, and the need to build on existing patient and public involvement routes without overwhelming the community.

Our consultation strategy had three strands:

1. To ensure wide publicity of our plans to become a Foundation Trust throughout the local population, patients and carers and our staff.

2. To supplement this with a targeted approach to children and young people, hard to reach and seldom heard groups (including black and minority ethnic groups), and established community, patient and staff groups.

3. To facilitate adequate discussion on our foundation trust aspirations in bespoke meetings with staff and key stakeholder and partner organisations.

The consultation process began on 2nd April 2007 with the launch of our stand alone Foundation Trust website, press release and letters from our Chief Executive to our key stakeholder organisations.

This was followed by a series of 150 internal and external consultation events which ran until 25th June 2007. The full consultation schedule can be found in Appendix 5. Key consultation events are summarised below.

- A period of pre-consultation during February and March 2007 both internally, involving key staff groups and staff side representatives and externally, involving the Patient and Public Forum and Business Advisory Group, to help shape the initial membership strategy on which formal consultation was based.
- 5 public meetings across our local catchment area led by the Chief Executive or another executive director, supported by managers from across the Trust.
- 6 road-shows focussed in busy public areas across the city.
- High level communication with key stakeholders throughout the consultation process including offers of attendance at additional meetings upon request or invitation.
- Targeting consultation towards people who are already engaged in the health agenda, and who are likely to become active members of our Foundation Trust by building on established patient and public involvement relationships.
- Focussing consultation on children and young people, in the light of our proposal to set no lower age limit for membership.
- Focussing on hard to reach and seldom heard groups by negotiating invitations to meet with community groups, tailoring the approach and format accordingly.
- Production of a high quality summary consultation document which has been made widely available within hospitals and in community locations, and directly mailed to a range of groups such as schools, hard to reach and seldom heard groups, voluntary groups, black and minority ethnic groups and patient groups throughout the Trust's catchment area.
- Production of a high quality full consultation document for distribution to key stakeholders and partner organisations. Distribution of consultation documents is provided in Appendix 6.

3.4.2 Summary of consultation representation

Stakeholder groups consulted were as follows:

- Acute Trusts and PCTs
- Patient and Public Involvement forum
- Schools
- Children and Young Peoples groups
- Patient groups

- Faith groups
- Local Authorities
- Education and research establishments
- Staff groups
- Black and Minority Ethnic groups
- Senior Citizens groups
- Voluntary groups
- Disability groups
- Homeless and travellers
- Local Business groups.

The consultation process has enabled the local population to provide the Trust with feed back regarding its Foundation Trust aspirations as well as other local issues.

3.4.3 Summary of Consultation Outcomes

Key Stakeholders

All of the Trust's key stakeholder organisations were supportive of our decision to apply for Foundation Trust status and of our strategic aims and development plans, with the exception of the Patient and Public Involvement forum which was broadly neutral. This support is largely due to the close working relationship the Trust has with its key stakeholders and the considerable collaboration across the city which is evident in the implementation of the Bristol Health Services Plan, with which the Trust's plans are very much aligned.

Key stakeholders required some reassurances that:

- UBHT would continue to provide local hospital and emergency services for local people
- Issues of parking and access would be addressed
- UBHT would continue to work in partnership with stakeholder organisations.

Key stakeholders welcomed the proposed governance arrangements, including the proposal to set no lower age limit for membership, and suggested that:

- The Trust needed to consider whether there should be appointed governor representation from both a community and voluntary group
- The Trust needed to review the proportion of patient governor places for local and tertiary patients
- The Trust would need to ensure appropriate measures were in place to support the membership and governors, in particular for children governors, to ensure they could fully carry out their role.

Patients and the Public

The number of consultation responses from the patients and the public, including "hard to reach" groups and children and young people, was disappointing in relation to the efforts made to encourage people to give their views. Some parties felt they had already given their views on Foundation Trusts per se by responding to the consultation exercise carried out by neighbouring North Bristol NHS Trust as part of their Foundation Trust application in 2006, and were not inclined to comment again. For others, our Foundation Trust application was not a priority for them to consider within the consultation period.

The majority of patient and public respondents agreed that for UBHT to become a Foundation Trust, this would benefit local people, although some required reassurance that the new governance arrangements would really influence the Trust's developments and not just be a "talking shop" with no real power, and others were unconvinced of the true influence of the Membership Council.

Patients and the public were generally supportive of Foundation Trust status with respect to the financial freedoms which would allow any financial surplus to be reinvested locally into further service developments, although some respondents were concerned about the increased risk associated with getting into financial difficulties as a Foundation Trust.

A minority of respondents were not supportive of our application mainly due to:

- Concerns about diverting finances from direct patient care in order to cover the ongoing expense of servicing the membership and new governance arrangements, and
- Foundation Trusts were seen as breaking up the NHS.

Staff

The number of staff consultation responses was also low despite the number of internal briefings and communications. This may partly reflect the internal pre-consultation which was undertaken to develop the draft Membership Strategy, but also the lack of immediate impact foundation status has on individuals' employment.

Staff were generally either supportive or neutral regarding our Foundation Trust application. Staff, especially those involved with delivering children's services, were generally in agreement with the proposal for no lower age limit for membership, providing support was in place for younger governors.

The key theme arising from staff comments, particularly those whose jobs fell into the "Other clinical healthcare professionals" class of the staff constituency was in relation to the proposals for staff governors. Whilst the majority of staff were happy that the number of governor places on the Membership Council had been proposed in proportion to the workforce composition, some Allied Health Professionals and Healthcare Scientists had some concerns as to how representative one governor could be of a range of professions. However, these respondents also conceded that to have one governor for each profession would make the Membership Council too big.

A key theme from all respondents was the need to ensure that membership was representative in order to justify the new governance proposals.

Amendments to Foundation Trust proposals as a result of consultation

As a result of consultation, the Trust is making the following amendments to its proposed governance arrangements:

- For the two carer groups within the patient constituency, members will be able to choose whether to join the 'carers for patients under 16 years' class or the 'carers for patients 16 years and over' class according to which best suits their needs.
- The number of governor places for the tertiary patients will be reduced from 4 to 2, with a consequential increase in places for local patients from 4 to 6.
- The invited governor place for voluntary groups / community groups will be moved to two potential places. One will be allocated for voluntary organisations such as The Care Forum. Other local voluntary 'umbrella' organisations will be

consulted further regarding the process of selecting their representative organisation, and further work will be done with other local groups to determine if 'community groups' can also be represented via the second place.

- The Trust will appoint one of the non-executive directors as Senior Non-Executive Director for the Membership Council to approach in confidence if they have any issues they wish to be addressed which they do not feel appropriate to take directly to the Chair.

These amendments were approved by the Trust Board on 17th July 2007.

4. MARKET ASSESSMENT

4.1 DESCRIPTION OF THE LOCAL HEALTH ECONOMY

As a specialist teaching Trust, we provide services to the whole South West of England as well as to local markets. This section therefore describes the health services and health needs of the wider region as well as giving more detailed information about the local health economy in Bristol, North Somerset and South Gloucestershire.

4.1.1 The Wider Health Economy: South West region

The South West is the largest region in England, covering an area of 24,000 square kilometres, bounded by Dorset and Wiltshire in the east, Cornwall in the west and Gloucestershire in the north-east. Its 5 million[1] population, served by 14 PCTs, has the lowest population density of any English region (212 persons per sq. km.), and that density varies greatly from Bristol at one extreme (3,581 persons per sq. km.) to West Devon at the other (only 43 persons per sq. km.).

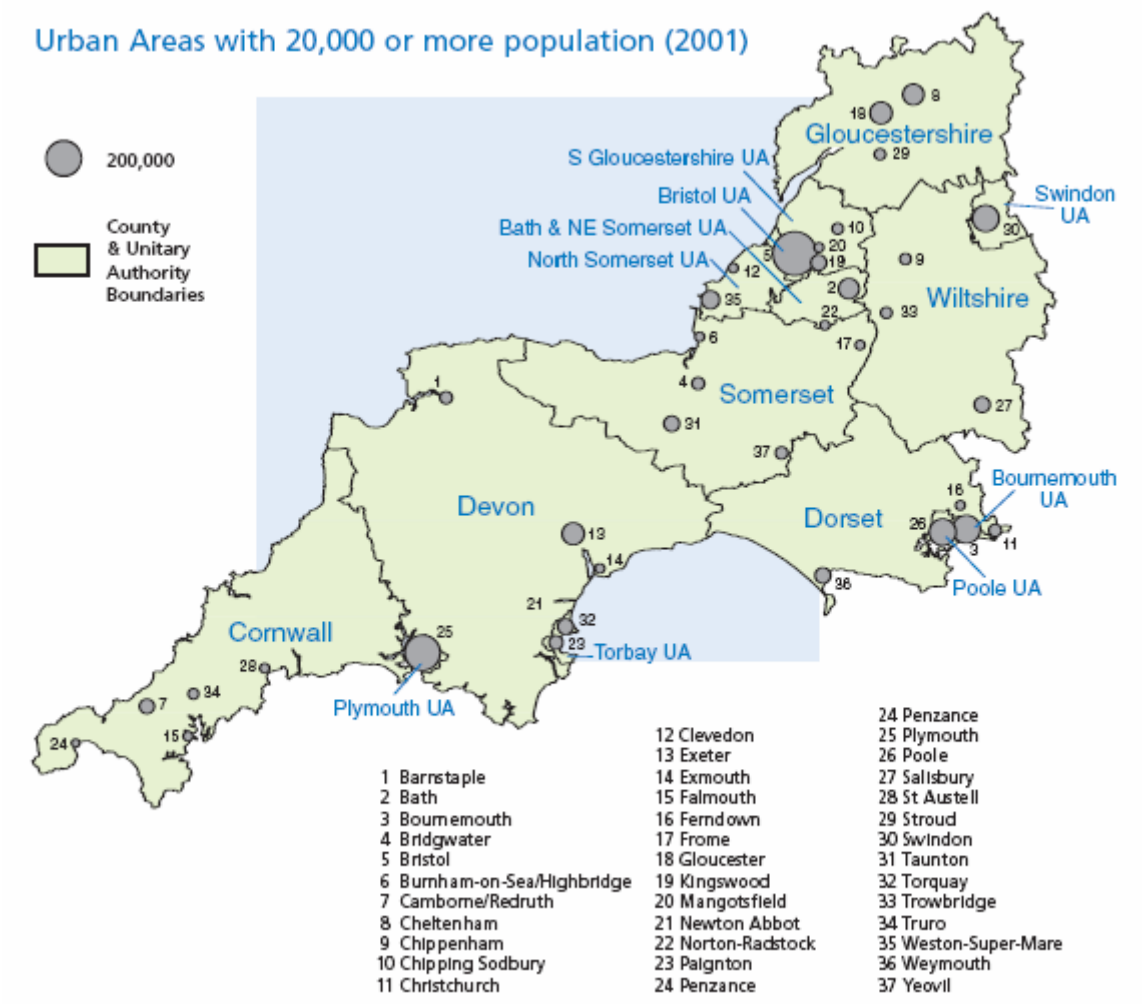


Figure 5: Urban Areas with 20,000 or more population (2001)

[1] ONS mid-2005 estimate

The South West has a higher proportion of its population in rural areas than any other English region. Despite this, nearly two thirds of the region's population live in towns of more than 10,000.[2]

The main conurbations are Bristol, Plymouth, Swindon, Exeter, Bournemouth, Poole, Gloucester, Cheltenham and Bath which together accommodate more than a third of the region's population. Figure 5 shows the main urban areas in the region[3]. Key characteristics of the South West include:

- An elderly and ageing population – there is a higher proportion of the population in all age groups over 50 than in the rest of England. The population is expected to grow by a further 10% between 2003 and 2026, with an increase in the numbers of people aged 65 and over from 19% to 25%.
- One of the smallest ethnic minority populations of all the English regions at less than 2% of the total (although this figure is believed to be rising at a faster rate than for England as a whole as a result of inward migration). The highest percentages are in Bristol, Gloucester and Swindon[4].
- The highest life expectancy in England, at 82 years for women and 77.8 years for men. In the 2001 Census, only 8.5% of the region's adult population reported that their general health was "not good" (England, 9.0%). At 92, no region has a lower standardized mortality rate than the South West.
- The highest incidence and mortality of malignant melanoma of any area in the UK[5].

These headlines, however, conceal significant variation across the region, and in particular within the Bristol, North Somerset and South Gloucestershire area, which are characterised by a mix of significant pockets of deprivation and areas of affluence.

4.1.2 The Local Health Economy: Bristol, North Somerset And South Gloucestershire

UBHT receives 70% (£224.2m) of its patient care service level agreement income from Bristol, North Somerset and South Gloucestershire PCTs, who commission services for a combined population of 849,000.

4.1.3 Bristol

Bristol is the largest city in the South West with a population of approximately 400,000 (2004 ONS estimates), with coterminous PCT and Local Authority boundaries. It is the tenth largest city in the UK with excellent road and rail links to the rest of the country and an international airport within 10 miles. However, the arterial nature of its transport services makes navigation around the periphery of the city difficult for non-car using residents.

Key characteristics of Bristol include[6]:

- population growth forecast at 5% over the next decade (2007-2017)[7]
- sharply drawn health inequalities: 27% of inhabitants live in the 20% of most deprived areas in England and 27% of children live in low income households

[2] *State of the South West 2007*, © SW Observatory, 2007
[3] *Information about the NHS in the South West*, NHS South West Strategic Health Authority, 2006
[4] *State of the South West 2007*, © SW Observatory, 2007
[5] ibid.
[6] *Health Profile for Bristol 2006*, Department of Health
[7] ONS Population Forecast dataset

- lower life expectancy for both men and women than the rest of England: 75.8 for males, 80.6 for women – rising, but more slowly than the national trend
- 5.7 years difference in life expectancy between the most and least healthy wards
- 8% of residents from black and minority ethnic communities, concentrated in wards around the city centre such as Lawrence Hill, Ashley and Easton but increasingly dispersed across the city
- a significant vulnerable population representing higher public health risk, including intravenous drug users, the homeless population, asylum seekers / refugees and commercial sex workers.

4.1.4 North Somerset

North Somerset PCT serves a very diverse population of 199,000 ranging from communities in the wealthy suburbs of Bristol to rural villages and the communities of the popular seaside towns. The PCT shares its boundaries with North Somerset Council and has a diversity of health care providers in its region including small, local hospitals as well as UBHT and North Bristol NHS Trust.

Particular features of the population profile in North Somerset include:

- population growth forecast at 8% over the next decade (2007-2017)[8]
- an older age distribution than for Avon as a whole; the difference is particularly marked in Weston-Super-Mare where 11.2% of the population is aged over 75 years compared with the Avon figure of 7.6%
- a life expectancy slightly higher than the England average, at 78 for males and 82 for females
- a high number of nursing and residential homes, particularly in the seaside areas of Clevedon, Portishead and Weston-Super-Mare
- a relatively small number of people from black and other minority ethnic populations at 1.4%[9]
- a large transient population in the seaside towns which have a significant impact on health and social services
- a difference of 13 years in life expectancy between the most and least deprived wards.

4.1.5 South Gloucestershire

South Gloucestershire PCT serves a population of nearly 250,000 people who enjoy, on average, better health than the rest of the UK. The population is served by a range of providers including North Bristol NHS Trust, UBHT and Gloucestershire Hospitals Foundation Trust, as well as a network of smaller community hospitals and health centres.
Particular features of the population profile in South Gloucestershire include:

- population growth forecast at 5% over the next decade (2007-2017)[10]
- life expectancy for males (79 years) and females (82.2 years) is rising and higher than England – over 85s are the fastest growing age group in the PCT
- no areas in the 20% most deprived areas in England, though 11% of children live in low income households

[8] ONS Population Forecast dataset
[9] 2001 Census
[10] ONS Population Forecast dataset

- a fairly low number of black and minority ethnic groups at 2.4%[11]
- a difference of 5.1 years in life expectancy between the most and least deprived wards.

4.2 KEY FACTORS DRIVING DEMAND IN BRISTOL, NORTH SOMERSET & SOUTH GLOUCESTERSHIRE

The key factors driving demand are summarised in Table 12 below. The differences between Bristol PCT and North Somerset/South Gloucestershire PCTs are immediately apparent.

	Bristol	North Somerset	South Gloucestershire
Premature deaths from heart disease and stroke	Falling but more slowly than England	Low and falling	Low and falling
Cancer rates	High and not falling	Lower than national average	Lower than national average
Long term illness	High proportions of people 65+ with a long term illness	Good health generally enjoyed, though low rate of people 65+ supported at home	Ageing but generally healthy population
Smoking	High: 34% of adults smoke, 660 people die each year from smoking related diseases	Low: 20% of adults smoke, though 360 people die each year from smoking related diseases	Low: 21% of adults smoke, though 350 people die each year from smoking related diseases
Violent crime	High	Low	Low
Teenage pregnancy	High	Low	Low
Alcohol usage	High levels of alcohol dependency, 1 in 5 binge drinking	Low levels of alcohol dependency	Low levels of alcohol dependency
Drugs	High rate of known drug misusers	Low levels of drug misuse	Low levels of drug misuse
HIV	Rates of infection increasing higher than national average	Low	Low

Table 12: Key factors driving demand

Health Poverty Index data (2003) demonstrate that there are apparent deficiencies in the resourcing and effectiveness of health and social care in Bristol. These deficiencies have informed the strategic objectives of the local health community, which are described later in this chapter, particularly towards increasing local access to services, improving public health and reducing inequalities.

[11] 2001 Census

Figure 6 demonstrates the extent of deprivation in Bristol, North Somerset and South Gloucestershire PCTs.

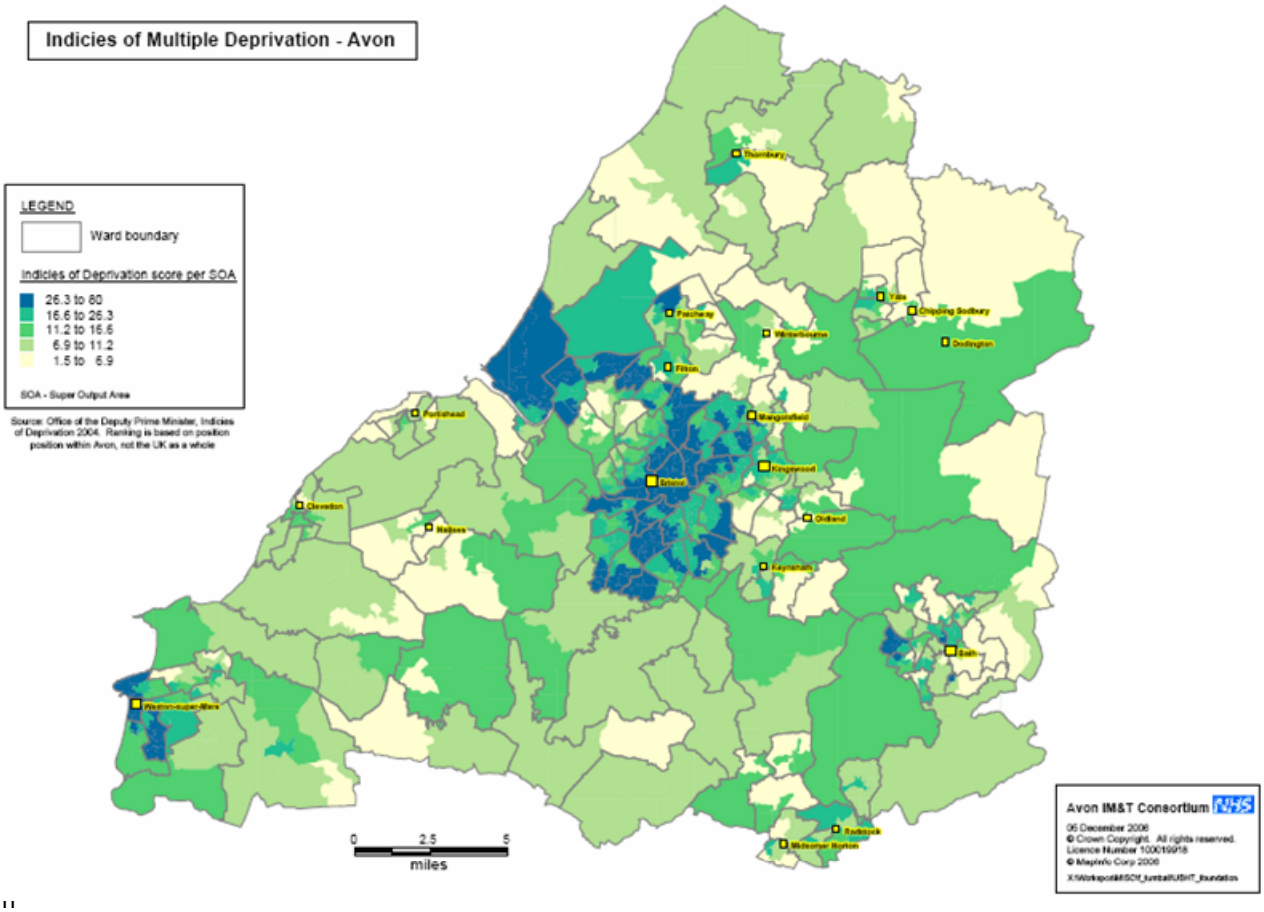


Figure 6: Relative deprivation in Avon. Source: Avon IM&T Consortium

Implications for the Trust

To determine the activity implications of the demographic trends described above, the Trust has applied population projections sourced from Office of National Statistics 2003 sub-national data, covering metropolitan and non-metropolitan districts and unitary authorities, by 5 year age-bands and gender, to 2005/06 out-turn activity.

Allowance has been made for additional growth in line with epidemiological trends only where there is reliable evidence to support an increase in intervention rates over and above demographic change. The three areas for which adjustment has been made are as follows:

- Coronary revascularisation, as reflected in the Trust's Department of Health-approved Full Business Case for development of the new cardiothoracic centre at the Bristol Royal Infirmary.
- Cancer, where the rising trend in standardised rates of both incidence and prevalence is predicted to continue for the foreseeable future and where South West Public Health Observatory data have been used to model growth in new cancer cases by Primary Care Trust, tumour site, age band and gender. The analysis demonstrates a growth in incidence of approximately 1% per annum, assumed to affect any admissions with a cancer diagnosis including surgery, and in prevalence of approximately 5% per annum, assumed to affect oncology and haematology specialties only.
- Colonoscopy activity, in response to the national bowel cancer screening programme introduced from April 2006, where an 80% response rate has been

assumed for the population aged 60 to 69 invited for screening once every two years with a requirement for colonoscopy in 2% of cases, applied to the Trust's current share of colonoscopy for Bristol, North Somerset and South Gloucestershire and Bath and North-East Somerset residents.

4.3 OBJECTIVES OF THE LOCAL HEALTH COMMUNITY

4.3.1 NHS South West

In June 2007, the NHS South West Strategic Health Authority published a draft strategic framework for improving health in the South West over the next 4 years.

The framework is intended to set the service improvement priorities for local health communities and to drive the agreement of ambitious local targets.

4.3.2 Bristol, North Somerset and South Gloucestershire

Local PCTs have developed a prospectus and more detailed strategic framework to set out their commissioning priorities and planned service developments, responding in particular to the recently published Framework for Commissioning Health and Well Being[12] and the draft NHS South West Framework. This lays out the key public health interventions that will close the gap between the best and worst off PCTs in the areas of smoking cessation, social care provision, and management of long term conditions in general and specific conditions such as hypertension, diabetes, respiratory problems and severe mental health conditions.

4.3.3 Bristol

Bristol PCT is in sound financial health, reporting a surplus of £6.3 million in 2006/07.

The PCT has improvement to public health, particularly health outcomes for the most disadvantaged, as its major strategic focus.

With regard to acute services, the PCT seeks to introduce new models of care which limit the need for hospital admission, in ways consistent with the overall Bristol Health Services Plan (see Section 4.3.6 below).

It particularly wishes to engage health and social care partners, including the acute sector, in service redesign programmes to develop new, effective clinical pathways that improve local access to services.

The PCT proposes to develop a community hospital in South Bristol by late 2009, procured through the Local Investment Finance Trust (LIFT). The hospital is intended to be the nucleus of a new model of care, supported by investment in enhanced community services, providing improved local access and reducing reliance on acute hospital services, not least through accommodating significant levels of existing Trust activity. The implications for the Trust of the South Bristol Community Hospital development are discussed further in section 4.5.

4.3.4 North Somerset PCT

North Somerset PCT faces significant financial pressures, with the PCT showing a deficit position (after repayment of prior year top-slice and provision for Strategic Development Reserve) of £20.742m, and there is an acknowledged tension between financial delivery

[12] Department of Health, 2007

and delivery of key Choosing Health targets in 2010. In order to redress financial deficits, there is a strong emphasis on demand management schemes, with Practice Based Commissioning and partnership working with the Local Authority through the Local Area Agreement viewed as key vehicles to deliver cost-effective service redesign. Continued development of community-based heart failure services, cancer services, including secondary care screening programmes, and palliative care are identified as key priorities. The Public Health Strategy outlines reducing alcohol-related harm, reducing smoking rates, improving services for those with mental health problems and tackling both the causes and the consequences of climate change as key strategic priorities.

4.3.5 South Gloucestershire PCT

South Gloucestershire PCT achieved breakeven in 2006/07, reporting a surplus of £30,000. The PCT's Commissioning Strategy emphasises prevention and earlier intervention, tackling inequalities and improving access to community services, and supporting people with long-term needs as its priorities, supported by the 2006 Local Area Agreement.

There is an explicit intention, in line with the Bristol Health Services Plan, to shift resources from the acute sector into prevention and to provide more care outside of hospitals and in the home, and, despite achieving break-even, a strong emphasis on demand management. Practice Based Commissioning is seen as the primary vehicle for locally-tailored, cost effective service redesign, with the PCT focussing on stroke, urgent care and diabetes in particular for increased primary care management. Community-based glaucoma follow-up and retinopathy screening has also been prioritised, which would assist the Bristol Eye Hospital to manage demand pressures.

4.3.6 Bristol Health Services Plan

All local NHS organisations, including the Trust, are partners in the Bristol Health Services Plan, a co-ordinated £600 million programme of capital investment in the Bristol, North Somerset and South Gloucestershire health community, which sets the local strategic context for service and capital development.

The objectives of the Plan, agreed following formal public consultation in 2005, are:

- Provision of more and better care closer to people's homes
- Improved productivity and significant health gain derived from a more systematic and vertically integrated local care system that will enable patients to access primary and specialist care in an efficient and streamlined way
- A more systematic provision of secondary and tertiary hospital services
- Contestability for services with the independent sector
- Improved NHS estate with buildings that provide high quality environments for staff and patients.

The Primary Care Trusts in Bristol, North Somerset and South Gloucestershire have established financial parameters inside which the whole Bristol Health Services Plan can be afforded. The Trust has ensured that its own investment plans do not rely on future income from local Primary Care Trusts outside these parameters.
The healthcare schemes proposed in the Bristol Health Services Plan are as follows:

- New community facilities in South Gloucestershire (at Yate, Thornbury and Kingswood)
- New community facilities in Bristol (the South Bristol Community Hospital and Eastville health centre)

- New community facilities in North Somerset (at Clevedon, Portishead, Weston and in the rural communities)
- Development of the Bristol Royal Infirmary site, including the relocation of the Bristol Royal Infirmary Old Building services to the main site (UBHT scheme)
- New acute facilities for children, to enable inpatient children's services from across Bristol to be integrated at the Bristol Children's Hospital (UBHT scheme)
- A major new cardiothoracic centre at the Bristol Royal Infirmary (UBHT scheme) and expanded local cardiology services in North Bristol/South Gloucestershire
- A major new acute hospital for North Bristol and South Gloucestershire on the Southmead Hospital site (leading to the withdrawal of acute services from the existing Frenchay Hospital)
- New community facilities on the Frenchay and Southmead Hospital sites
- The rationalisation of some surgical specialties across the city
- Rationalisation of pathology services for the city of Bristol.

Implications for the Trust

It will be seen that the Trust has a number of major capital developments which are integral to the Bristol Health Services Plan, while the other developments proposed have significant implications for the Trust's future activity which are discussed further in section 4.5.

4.3.7 Clinical Networks

The geography of the South West has led to development of key regional networks for clinical services with which the Trust has a strong record of collaboration. At inception the South West Strategic Health Authority carried out a review of clinical networks and currently intends to maintain the regional models developed prior to re-organisation. The key networks for the Trust are Cancer (Avon Somerset and Wiltshire Cancer Services), Cardiac (Avon, Gloucestershire and Wiltshire), Intensive Care (Avon, Gloucestershire and Wiltshire), Neonatal Intensive Care (Avon, Gloucestershire and Wiltshire). The Trust also runs the Regional Paediatric Intensive Care Unit and Paediatric retrieval services.

The Cancer Network is one of the oldest in the country, established in 1996, and has a record for delivery of the NHS Cancer Plan. Improving Outcomes Guidance is being delivered with major service re-organisations in Upper Gastrointestinal, Gynaecological, Urological and Head and Neck cancers. The Trust is key to all these re-organisations providing the bulk of the tertiary-level surgical services and all the tertiary oncology services including Bone Marrow Transplants. The Trust's strategic cancer services review in 2005 demonstrated that 43% (from analysis of 2003/04 Hospital Episode Statistics data) of all cancer Finished Consultant Episodes in the Network were performed by the Trust. Board representation on the Network is through the Medical Director.

The Cardiac Network was established more recently and is chaired by the Chief Executive of Swindon and Marlborough Trust. United Bristol Healthcare NHS Trust is involved at many levels of the network, hosting the manager's offices within the Bristol Royal Infirmary. The network has focused its agenda on delivery of the National Strategic Framework, service improvement and delivery of access targets, including thrombolysis delivery times. The Trust provides all the tertiary and regional cardiac services, soon to be housed in the new Cardiac Centre. The Trust's cardiologists provide all retrieval stent interventions following failed coronary artery thrombolysis and

offer primary coronary intervention for the population of Bristol, in line with the development plans of the Cardiac Network.

Research for the Network is based in the Bristol Heart Institute which occupies much of level 7 in the Bristol Royal Infirmary and will be further facilitated by the development of the new cardiac centre. Bristol University is working in collaboration with the Bristol PCT's Public Health Department to assemble a comprehensive clinical database for the network. The Trust also provides all cardiac surgical services for the network and also specialises in Grown-up Congenital Heart disease and complex arrhythmia management. In line with the expanded national framework, the network is now placing increased modernisation and service re-design resource into the management of stroke. Trust representation at the Network board is through the Specialised Services Divisional Manager and Medical Director.

The other networks have fewer resources invested in their management but provide vital support for commissioners (local and specialist) in the development of specialist services. The Neonatal network focuses on retrieval services (based in St Michael's and Bristol Royal Children's Hospital), outcome benchmarking and planning service expansion. The adult intensive network is purely a clinical network focused on outcome benchmarking and improvement.

Implications for the Trust

In determining the impact of network plans on future activity, the Trust has only made adjustment in respect of specialist cancer surgery and the existing plans of the Cancer Network. Where Network plans for certain tumour sites are not yet developed the Trust has taken a view about the likely impact on future activity. A model has been commissioned which allows the Trust to test different activity scenarios and the related capacity consequences, using HES data at HRG level, subject to clinical appraisal to differentiate cancer and non-cancer cases.

The scenario adopted allows for limited expansion in those specialties where the Trust has already been designated the preferred provider by the Cancer Network, namely Gynaecology, Upper Gastrointestinal surgery and Thoracic surgery, and also tests the inclusion of Oral Maxillo-facial surgery, where commissioning plans have yet to be agreed. Consistent with Cancer Network plans, no expansion in Uro-oncology has been assumed.

4.3.8 Contribution to local health economy objectives

The Trust's strategy aligns closely to the objectives of the local health economy.

It fully intends to retain its role as the main provider of local acute services for central and south Bristol and to maintain the infrastructure and services necessary to support a city centre Emergency Department.

It also intends to consolidate and, where appropriate, expand its role as the specialist provider for the Avon, Somerset and Wiltshire area, particularly in cardiothoracic, children's and cancer services (including cancer surgery), in line with the strategy of the local clinical networks.

By prioritising service improvement as one of its key development plans, it is recognising the need to respond to the emerging SHA framework and the redesign objectives of local Primary Care Trusts.

It has formally committed to support the principle of improved local access to services (see strategic aims for clinical services in section 3.2). It is engaged with Primary Care

Trusts over the intended devolution of hospital activity to primary and community care, taking joint ownership of the £5.7 million resource utilisation management programme for Bristol, North Somerset and South Gloucestershire in 2007/08, and building the impact of demand management into its long range forecasts, as described in section 4.5. It also collaborates actively in cross-community service redesign initiatives through the established Bristol Health Services Plan structures.

The Bristol Health Services Plan provides a framework for collaboration with acute sector partners, especially North Bristol Trust, over agreed rationalisation plans and service reviews.

The Trust is specifically working in close partnership with Bristol Primary Care Trust over the planned closure of the Bristol General Hospital and establishment of alternative rehabilitation services at the planned new South Bristol Community Hospital and in the community.

This partnership extends to the transfer of additional hospital activity (day surgery diagnostics, outpatients, dental and minor injuries services) to the South Bristol Community Hospital, where the Trust is the PCT's designated provider for day surgery dental and diagnostic services.

Finally, the Trust's capital development plans are integral parts of the health community investment programme, the Bristol Health Services Plan. It has ensured that the activity projections underpinning its development plans are comfortably within the income growth parameters set down by local commissioners.

4.4 MAJOR CHANGES IN EXTERNAL ENVIRONMENT

4.4.1 Policy environment

The Trust's strategy accounts for the implications of major reforms to the structure and organisation of the NHS, which will create:

- greater volatility in activity levels for elective services as a result of patient choice and practice-based commissioning
- competition from neighbouring NHS and Foundation Trusts
- competition from the independent sector
- substitution of existing emergency and elective activity by new primary and community care schemes
- the need for increasing cost efficiency in order to maintain affordability within the national tariff, including improvements in patient throughput.

The Trust has anticipated these new challenges through a deliberate programme to review and re-define its strategic direction over the last two years. This section describes changes to the national policy environment affecting the Trust.

Patient choice

There has been negligible transfer of activity from the Trust to date under patient choice. As the initiative is rolled out, however, and the extent of competition for elective activity grows, it remains to be seen whether choice of provider will introduce significant volatility in traditional elective flows to the Trust or whether the Trust can positively influence patient choice through the regional status of many of its services.

The Trust's assessment of the risks to its activity and income from patient choice are described in section 4.5.2, Competitive Factors.

Patient access standards

The Standards for Health define the minimum standards for patient access to hospital care, monitored through the Healthcare Commission annual health-check. The Trust was rated as 'Excellent' for quality of services in 2006/07.

The Trust is committed to sustaining good performance against existing targets and delivering the new national targets, especially the maximum 18 week referral to treatment waiting time, through a comprehensive programme of service improvement, set out as one of our major strategic development plans in section 5.4.

To determine the activity implications of waiting time targets, modelling has been undertaken using inpatient and outpatient milestones towards the December 2008 target. In addition, an allowance has been made for increased demand as a result of shorter waiting times, based on econometric research which quantifies the elasticity of demand specifically for NHS waiting lists.[13]

Plurality and contestability

Increasing contestability of services has been driven through national procurement initiatives which will introduce new independent sector providers to the Trust's local market, both in diagnostics and elective surgery.

The Trust has accounted for potential market share loss to these providers in its demand assessment. The providers in question are discussed further in section 4.5.2.

Out of hospital care

The White Paper, *Our health, our care, our say: a new direction for community services* sets out proposals to address the expectations of the public for modern and convenient health and social care services, including:

- greater practice-based commissioning
- a shift of resources into prevention
- more care undertaken outside hospitals and in the home
- better integration of services at the local level
- encouragement of innovation
- allowing different providers to compete for services.

The NHS Next Stage Review

Professor Lord Ara Darzi is leading a wide-ranging review of the NHS to determine the direction of the next phase of reform. Lord Darzi published an interim report in October 2007, which has set the context for a nationwide consultation about the reforms necessary to improve the quality of care and the patient experience.

The consultation is currently in progress. Our understanding is that it is likely to support the direction of travel in the Bristol Health Services Plan, while bringing new focus to the redesign of pathways of care, particularly for stroke and coronary heart disease.

[13] 'Waiting times for elective surgery: a hospital-based approach', Centre for Health Economics, University of York, July 2003

The Government's commitment to improving care outside hospital will encourage greater substitution of new primary and community care led services for traditional secondary care. Increasingly, outpatient appointments, diagnostics and minor procedures will take place outside acute hospitals. The Trust will engage with PCTs and practice-based commissioners to manage this transition.

Education and training

The modernisation of national education and training**,** through key initiatives such as the Unified Training Grade and Modernising Nursing Careers, presents challenges for the Trust in effective local planning and education commissioning, including innovative use of Multi Professional Education and Training Funding, and working with key educational partners to design educational programmes and rotations which are focused on patients' and service needs, and are attractive to potential recruits.

Under *Modernising Medical Careers*, the Trust can expect to see greater numbers of less experienced staff graduating from medical training at the same time as the need for working hours to reduce to comply with the European Working Time Directive. The Trust's response to these changes is described in section 8.5 and 8.7.

4.4.2 Economic Environment

NHS investment

The Comprehensive Spending Review in October 2007 indicates higher than expected growth in NHS funding but still represents a reduction on recent levels of growth. The Trust has made conservative estimates of likely future growth in its financial plans.

Payment by Results

By setting tariffs around the national average cost of a procedure, the Payment by Results regime gives provider Trusts strong incentives to improve efficiency. However, as providers seek improved cost efficiency, national tariffs will deflate as average procedure costs fall, requiring continuous efficiency gain from the Trust. Failure to achieve relative cost efficiency will damage the viability of the services in question and, by extension, the overall viability of the Trust.

Success under this regime will therefore require:

- a clear understanding of the Trust's cost base and the position of individual services against projected tariff income
- the ability to deliver service improvement in an integrated way which maximises clinical and expenditure benefits across the Trust.

The Trust has developed five year savings plans (described in section 6.7.3), an approach to service level profitability analysis (section 6.8) and a comprehensive service improvement plan (section 5.4), in response to this major strategic driver.

Assumptions about national tariff deflation have been factored into the Trust's long term financial plan.

Capital funding regime

The new capital funding regime, by which Trusts raise capital through depreciation or cash surpluses or by prudential borrowing, will ensure that Trusts only take on the capital schemes they can afford to support. This has been an important factor in defining the Trust's long-term capital programme (see section 6.7.6).

Research & development

The national strategy, *Best Research for Best Health*, introduces changes to the funding of research & development, designed to establish a system in which the NHS supports leading-edge research, focused on the needs of patients and the public.

Existing NHS Research & Development support funding will be withdrawn and used to fund alternative streams of support funding allocated against competitive bids. In order to bid competitively for these funds the Trust will need to focus on research which:

- addresses NHS priorities
- is people-based
- is of national or international quality
- is cost-effective
- demonstrates strong collaborations
- will produce outcomes which can be implemented to improve patient care and the health of the population
- demonstrates the best standards in governance and delivery.

The Trust's strategic development plan for research is spelt out in Section 5.5.

Economic impact of climate change

It appears that global climate change will raise temperatures most markedly in the northern hemisphere. While the health effects of previous heat-waves in the UK (such as that in 2003) have been relatively small, there may well be economic risks for the Trust in energy prices and local food supply. Allowance has been made within the Trust's long term financial plan for unforeseen cost pressures of this sort.

As part of its programme of corporate social responsibility, "UBHT in the Community", the Trust is developing plans to reduce its carbon footprint.

Commissioning framework

PCT commissioning

Following the publication of *Commissioning a Patient-led NHS* and the reconfiguration in 2006 of primary care trusts and strategic health authorities, PCTs will focus on the development of strategic commissioning based on redesigned, accessible services demonstrating best value for money through contestability.

Use of demand management schemes and resource utilisation management plans is already a feature of the commissioning landscape in Bristol, North Somerset and South Gloucestershire, to which the Trust must continue to respond collaboratively.

There is likely to be increasing integration with Local Authorities both of commissioning and service delivery in community care.

Specialist commissioning

The national changes to the organisation of specialist commissioning will lead to more co-ordinated planning of specialised services, which is likely to work in the Trust's favour as a specialist provider but will require greater transparency and accountability over service developments. The Trust has made appropriate internal investment in resources to meet this challenge.

Practice-based commissioning

The introduction of practice-based commissioning provides the Trust with both opportunities and challenges: opportunities to work in partnership with local GPs to develop new ways of delivering care that are tailored to diverse local communities, challenges as clusters potentially look to commission increasing numbers of community and practice-based services, accelerated by the introduction of the 'any willing provider' model.

Thus far, local practices are concentrating on fully understanding practice and hospital activity and data at a practice and cluster level, focussing on demand management rather than significant service redesign and alternative provision. Increasingly, however, the Trust will need to be responsive to local decisions taken by a larger number of smaller organisations, which will provide cultural, clinical and operational challenges for a large acute teaching trust.

In 2007/08, the Trust's commitment to deliver half the local PCTs' Resource Utilisation Management Plan (a share worth £2.38m) is indicative of the increasingly shared agenda with local commissioners, and includes working in partnership with practice-based commissioning groups to reduce new and follow up outpatients; redesigning services to improve patient flow, for example, through one stop shop clinics and care pathways work; and improving the quality and timeliness of information to GPs and community-based health professionals through improved discharge reporting.

Table 13 describes the current status of practice-based commissioning in and around Bristol.

Bristol (population 400,000, 58 practices) Practices have formed five clusters, each incorporating between six and fourteen practices and covering between 60,000 – 120,000 registered patients. The clusters are at different stages of development. Some have pooled PBC incentive monies, either to fund clinical leadership or to enable project work, and are exploring moving to formal legal structures. Others are moving forward more cautiously. The two clusters in central and south Bristol (Bristol West and Bristol South) refer primarily into UBHT. The two consortia in the north of the city (6Go and G11) refer primarily into North Bristol Trust, with the remaining consortium, Inner City & East Bristol, referring into both Trusts. Areas of interest include minor surgery, urology, diabetes and endoscopy (mixture of commissioning and provision). The planned South Bristol Community Hospital and the Eastville Healthcare Park will impact on activity referred to UBHT from these clusters. The development of these two facilities does however provide UBHT with exciting partnership and business development opportunities, and there is real opportunity to further embed UBHT services in local communities.
North Somerset (population 199,000, 25 practices) North Somerset practices have formed two clusters of similar size, formalising already existing locality structures, with one standalone practice. Weston, the southern cluster, refers predominantly into Weston Area Healthcare Trust; Woodspring, the northern cluster, refers into United Bristol Health Trust and North Bristol Trust.
South Gloucestershire (population 250,000, 30 practices) South Gloucestershire practices have three Locality Service Development Groups of similar size. These forum leads on the commissioning of services in partnership with the PCT, whose management structure is aligned to the groups. The groups, Yate, Severnvale and Kingswood, refer into UBHT for 'acute network' specialist services. In addition, practices have formed smaller PBC clusters that cut across these localities. These clusters are primarily interested in provision of service, and are exploring moving to formal legal structures.
Bath & North East Somerset (B&NES) (Population 186,000, 27 practices) Within B&NES, practices have formed one PBC consortium executive consisting of five GPs, a nursing representative and an Allied Health Professional, funded through incentive monies. The executive makes all commissioning decisions on behalf of the practices, whom it meets with quarterly.
GP Care GP Care is a provider company formed by practices in Avon[14]. With 89 GP practice members, it aims to be the provider of choice for out of hospital care for patients in Avon. In conjunction with 6Go and G11 in Bristol, it has stated an interest in the provision of endoscopy services. At this time, there are no further service developments planned, but it remains to be seen what the partnership will deliver in the future.

Table 13: Local practice-based commissioning developments

[14] comprising Bristol, North Somerset and South Gloucestershire and Bath and North-East Somerset

4.4.3 Society

Demographic change

Predicted demographic changes in Bristol and the South West leading to an increasingly elderly population have been described in section 4.1.

Patient and public expectations

Consumer expectations for increasingly convenient, accessible and responsive services will force the Trust to respond by:

- Delivering excellent customer service
- Providing full and appropriate information to patients and the public
- Minimising delays for diagnosis or treatment
- Improving the hospital environment
- Improving accessibility to the hospital precinct
- Reducing rates of hospital-acquired infection to the minimum.

Labour market

The Trust's labour market will be affected by the same demographic changes as its patient base. This is already a very competitive market, both for clinical professionals and for administrative and ancillary workforce. The Trust's response is laid out in section 8.4.

4.4.4 Technological Environment

Major technological innovations will radically affect the delivery of care, particularly in the field of clinical genetics, where it will increasingly be possible to diagnose some conditions in the pre-symptomatic phase.

Other predictable developments are:

- Increasing use of laparoscopic and non-invasive interventional procedures which will reduce time spent in hospital
- Greater use of telemedicine to allow remote consultations and home monitoring
- Increased imaging accuracy giving improved diagnosis and potentially facilitating earlier or alternative forms of treatment
- Demand for greater functionality in and integration of clinical and supporting information systems.

4.4.5 Summary "PEST" analysis

Table 14 below summarises the preceding analysis of key factors in the external environment and their impact, and the steps which the Trust is taking to respond.

Political factors		
Factor	**Impact**	**Response**
Patient choice	Potential activity losses or gains	Service Improvement Plan Partnership with PCTs over service redesign 'Smarten Up' campaign, including BRI front entrance project Anticipated activity reduction incorporated into conservative activity plan. Other effects considered neutral Contingency plans to close capacity if required
Patient access standards	Further reduction in waiting times and streamlining of care pathways	Service Improvement Plan Aim to reduce waiting times below national standards
Plurality of providers	Potential activity and income loss	Provision of day surgery at planned new South Bristol Community Hospital Contingency plans to close capacity if required Anticipated activity reduction incorporated into conservative activity plan Abide by NHS Employers Human Resources framework for relationship between NHS and private business activities
Out of hospital care	Increasing devolution of services to primary and community care	Provision of services at South Bristol Community Hospital Partnership with PCTs and GPs over service redesign
Education and training	Modernising Medical Careers European Working Time Directive	Redesign of medical rota Hospital at Night plans and use of non-medical professionals Implementation of Workforce Strategy

Table 14: Summary Political Economic Societal and Technological (PEST) analysis: political factors

Economic factors		
Factor	**Impact**	**Response**
NHS financial regime	Declining growth after 2008 Financial deficits in parts of local health economy	Conservative growth estimates used for activity plan Implementation of Financial Strategy, especially creation of strategic financial reserve Cash-Releasing Efficiency Savings Plan
Payment by Results	Financial stability in the long term is dependent on providing services at or below the national tariff	Service Improvement Plan Cash-Releasing Efficiency Savings Plan
Capital funding regime	Affordability of capital plans depends on retained surplus or access to interest-bearing debt	Financial Plan (aim to achieve surpluses for re-investment) Conservative capital expenditure plans with no borrowing assumed
Climate change	Insecurity of energy prices	Develop plan to reduce the Trust's carbon footprint Green Travel Plan
Research & development	Loss of central research & development support funding	Research & Development Plan Partnership with Universities Development of Clinical Research Centre
New commissioning framework	Demand management and reduced acute sector growth Greater accountability for provision of specialised services to standards Substitution of Trust services by primary and community care	Service Improvement Plan Partnership with PCTs and GPs over service redesign Cash-Releasing Efficiency Savings Plan Effective communication networks with GPs

Table 14: Summary Political Economic Societal and Technological (PEST) analysis: economic factors

Societal factors		
Factor	**Impact**	**Response**
Demographic and epidemiological change	Population growth with changing age profile Incidence and prevalence of coronary heart disease and cancer Growing numbers living with chronic diseases	Realistic assumptions underpinning long term activity and capacity projections, taking account of demographic and epidemiological change Service Improvement Plan to redesign services according to patient need Collaborative redesign of services across care sector boundaries, especially care of the elderly/rehabilitation services/management of chronic diseases
Patient and public expectations	Requirement for enhanced customer service, full and appropriate patient information, reduced delays, improved patient environment, improved accessibility to the hospital precinct, reduced rates of hospital-acquired infection	Service Improvement Plan ("Six Ways to Reduce Delays") 'Smarten Up' campaign, including signage improvements and BRI front entrance project Redesign of public web-site Green Travel Plan and accessibility initiatives
Labour market	Competition for scarce professionals and for administrative and ancillary staff	Implement Electronic Staff Record Maintain high quality of education and training provision Continuing implementation of Workforce Strategy Continuing implementation of programme of corporate social responsibility, including work placements

Table 14: Summary Political Economic Societal and Technological (PEST) analysis: societal factors

Technological factors		
Factor	**Impact**	**Response**
Advances in medical technology	Changing diagnosis and treatment modalities, potentially reducing length of stay but requiring early adoption to stay ahead of the technology curve	Strategic review of imaging requirements Flexibility in capital programme to meet future investment needs
National Programme for Information Technology	Systems changes and consequential changes to working practices Business continuity implications	Trust IM&T strategy and implementation plans for order communications and Care Records Service Specify and order appropriate clinical sub-systems Develop wireless connectivity throughout the Trust Review and revise intranet Relocate IM&T server hub to assist business continuity planning

Table 14: Summary Political Economic Societal and Technological (PEST) analysis: technological factors

4.5 COMPETITIVE FACTORS

4.5.1 Market Position

Central and South Bristol

Trusts with local acute catchment areas overlapping that of the Trust are North Bristol Trust and, to a lesser extent, Weston Area Health Trust and Royal United Hospital Trust, Bath.

Table 15 shows that the Trust provides core services to this population, and holds a dominant 74% share of this market.

Provider	Inpatient/Day Case Spells	First Outpatient Attendances
UBHT	73%	74%
NBT	18%	15%
RUH	6%	8%
Weston	1%	1%
Other	2%	2%

Table 15: UBHT share of local market

Avon, Somerset and Wiltshire

The Trust provides a range of specialist services to this market including:

- Specialist cancer and blood disorder services, including haemophilia
- Cancer surgery (including Upper Gastrointestinal surgery, Maxillofacial surgery, Gynaecology Oncology and Uro-oncology)
- Specialist ophthalmology
- Oral surgery
- Cardio-thoracic surgery
- Clinical genetics
- Specialist respiratory medicine
- Homeopathy.

Relevant competitors in this market are:

- North Bristol NHS Trust
- Royal United Hospital Bath NHS Trust
- Swindon and Marlborough NHS Trust
- Taunton and Somerset NHS Trust.

The Trust has a 25% share of all admitted activity to these hospitals for patients aged 15 and over and 33% of all activity for under 15 year olds (Figure 7).

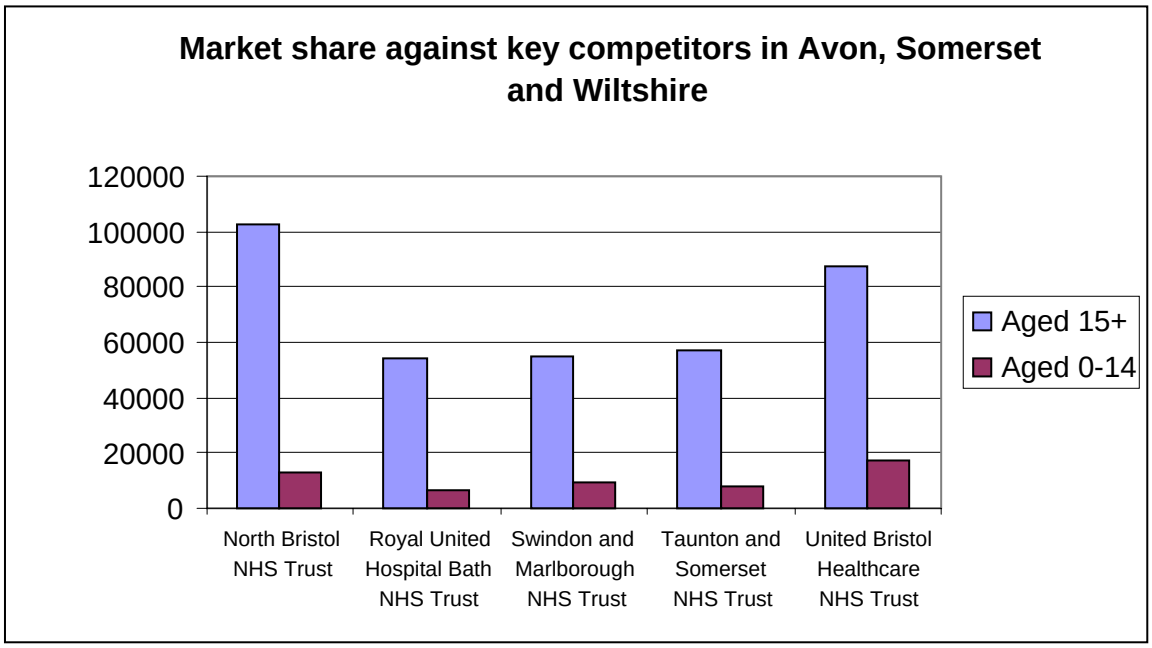


Figure 7: 2006/07 spells for selected Trusts. Source: Dr Foster.

Specialties in which the Trust is dominant in this market are:

- Upper Gastrointestinal surgery
- Clinical Haematology
- Medical Oncology
- Clinical Oncology
- Haemophilia
- Oral Maxillo-facial surgery
- Cardio-thoracic surgery
- Oral surgery
- Ophthalmology.

Specialist regional services

Figure 8 shows the Trust's market share by specialty of all admitted elective activity across providers in the South West region. It demonstrates that the Trust is the main or sole elective provider across the South West in a number of specialties, including:

- Bone Marrow Transplantation
- Grown-up Congenital Heart disease (in Cardiology/Cardiac surgery figures)
- Paediatric Cardiology
- Paediatric Dentistry
- Paediatric Neurology
- Paediatric Oncology
- Paediatric Surgery.

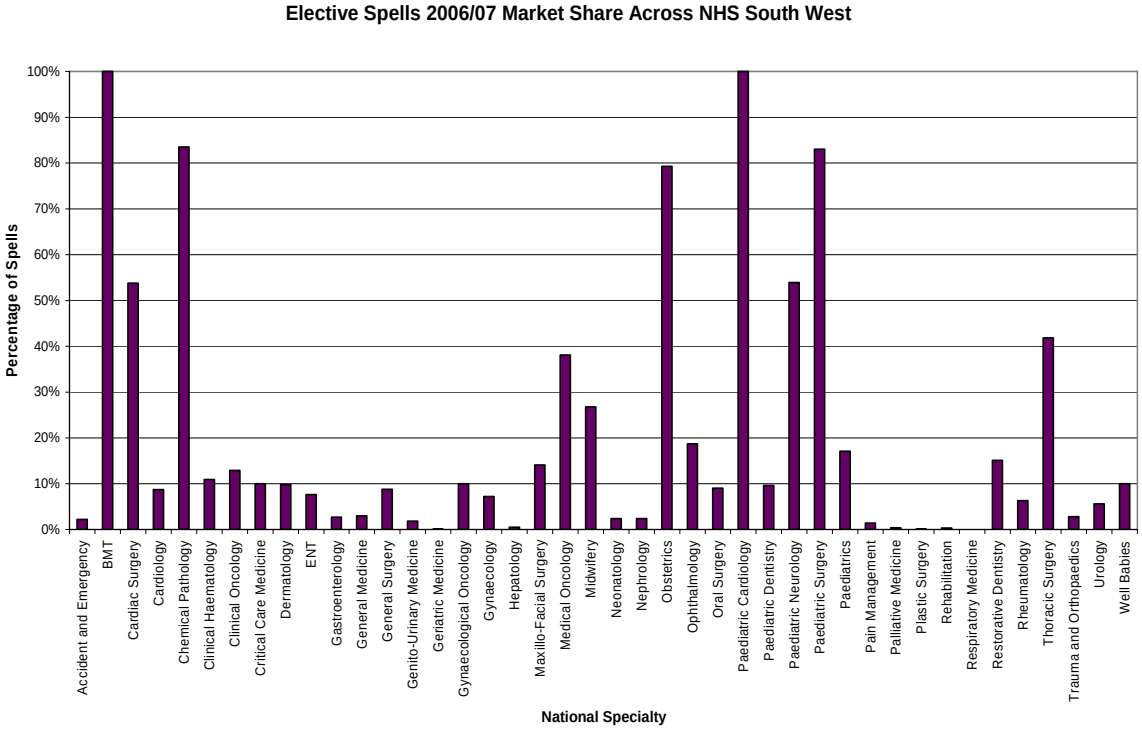


Figure 8: Trust market share of elective activity in South West region by specialty

[Source: Dr Foster Hospital Activity Tracker]

Note: 'Specialties' reflect the treatment specialty field in HES data

Outside the South West of England, there are also established referral flows to the Trust from South Wales, accounting for around 1.8% of the Trust's Service Level Agreement income (£5.5 million for Health Commission Wales (HCW) and £1 million in total for the Local Health Boards). These relate mainly to specialised tertiary referrals, the majority of which are commissioned by HCW. HCW is striving towards making Welsh paediatric services sustainable, and is therefore introducing a system of tertiary referral management whereby paediatric referrals must be authorised by a network of named Welsh specialists in order to be treated. Because of the specialist nature of the referrals, however, the impact of these changes is not expected to be significant.

The expectation, however, is that over time there will be a shift of elective general acute work to Welsh providers, coupled with some reduction in the lower end of specialist activity for both adult and paediatric services.

4.5.2 Competitive factors

Patient choice

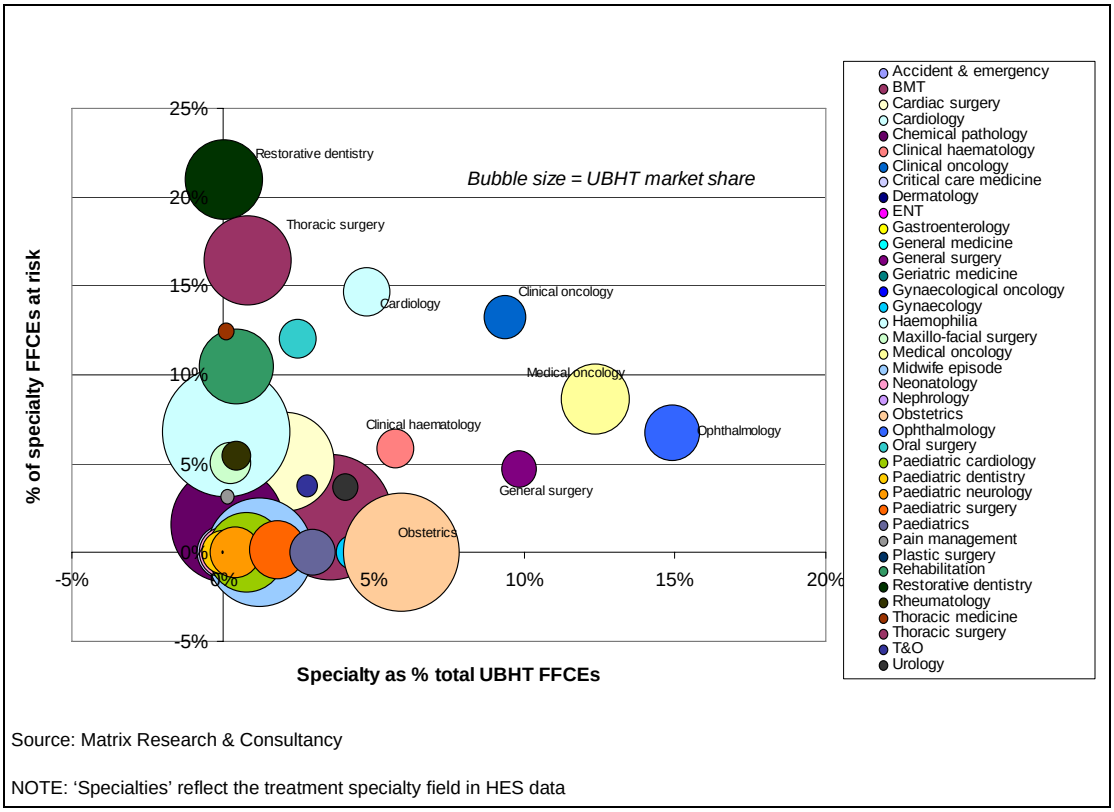
In order to help it understand the likely impact of patient choice on future demand for services, the Trust commissioned an independent analysis in December 2006. Drive-time data were used to rank the proximity of each provider in the South West to an electoral ward. The Trust's 2005/06 elective flows were re-mapped to the nearest appropriate provider to the patient's residence but the outputs were risk-adjusted to take account of provider characteristics which are known to influence choice[15], including:

- Clinical quality
- Provider reputation
- Facilities and cleanliness standards
- Access and convenience
- Waiting times.

Figure 9 shows the results of the choice analysis by specialty:

- The size of the specialty in terms of its percentage of UBHT's overall activity is shown by distance along the x-axis
- The proportion of the activity within a specialty that has been identified as being at risk is shown by distance along the y-axis, and
- The relative market share held by the Trust is reflected in the size of the bubbles.

[15] using the Report of the National Patient Choice Survey, July 2006, and publicly available information from www.nhs.uk



Source: Matrix Research & Consultancy

NOTE: 'Specialties' reflect the treatment specialty field in HES data

Figure 9: Risk of activity loss under choice by specialty.

The outputs from the market choice analysis suggest that the areas at risk of greatest activity loss in the Trust are high volume specialties where the Trust is not the dominant provider, particularly clinical oncology, medical oncology, cardiology and ophthalmology. Where the Trust holds a large market share, the lack of alternative providers indicates that choice risks are currently negligible.

The Trust has factored into its activity plans competitive developments in each of these specialty areas, which are described below:

- new oncology centre in Taunton
- new cardiology facilities in North Bristol
- new independent sector treatment centre in South Gloucestershire (providing significant levels of ophthalmology among other services).

These developments themselves account for the majority of the activity identified as vulnerable in the patient choice model. The risk of additional activity loss under choice is considered small.

The model also identified 1,500 first FCEs at other providers, which the Trust has potential to win under choice, particularly in oral surgery, general surgery and clinical haematology.

Overall, therefore, the Trust has concluded that further patient choice impacts, additional to the specific losses already factored into activity plans, are likely to be neutral overall.

Independent sector

Existing providers

Two private providers, Spire Healtcare (formerly BUPA) and Nuffield Hospitals, operate in Bristol, and another, BMI Healthcare, in Bath. The Trust has not developed plans to

compete with these providers for increased private patient activity but will wish to keep this opportunity under review.

Weston Area Health Trust has offered independently provided services since January 2003, to assist the delivery of shorter waiting times for orthopaedic procedures across Bristol, North Somerset and South Gloucestershire. However, UBHT is not a major provider of elective orthopaedics, meaning that the competitive impact on the Trust of the Weston treatment centre has been negligible.

An independent sector treatment centre opened at Shepton Mallet in July 2005, operated by UK Specialist Hospitals, providing a mix of orthopaedic, ophthalmology and general surgical cases, plus diagnostic services. The centre started to achieve its contracted levels of activity via its host commissioner, Mendip PCT, in 2006. The Trust has not experienced any material change in activity flows as a result.

New Entrants

Diagnostic services

Following a national procurement, a contract for provision of a limited range of diagnostic services in the South West was let to ATOS Origin, effective from April 2007. ATOS were intending to operate largely from mobile facilities until the South Bristol Community Hospital is opened, where it was supposed to operate the diagnostic imaging unit. However, the contract with ATOS was rescinded by the Department of Health in 2007. It is not yet clear whether a further national diagnostic procurement will take place but the South Bristol Community Hospital diagnostic service will now be provided by the Trust.

Given the scale of annual growth in demand for diagnostic examinations, particularly in GP direct access radiology, the Trust does not expect any reduction in its current levels of activity as a result of the development of the unit in South Bristol. Rather, it should help to reduce the pressure of growing primary care demand on Trust radiology services.

Elective surgery

The Department of Health has also awarded a contract to UK Specialist Hospitals, effective from August 2008, for elective surgical services in six centres across the South West.

UK Specialist Hospitals plan to construct a treatment centre at Emersons Green to the north-east of Bristol to provide inpatient, day case and minor procedures in general surgery, ear, nose and throat surgery, urology, orthopaedics and ophthalmology per annum.

The entry of a new elective surgical provider into the local market is clearly of major significance to all NHS providers in and around Bristol. There are two important factors, however, which mitigate the competitive threat to the Trust:

- The Trust is not a major provider of routine or intermediate elective surgery, except in ophthalmology, and
- A significant proportion of the Trust's existing day surgery activity is planned to transfer to the South Bristol Community Hospital when this opens in 2009.

The Trust has undertaken a detailed assessment of activity at risk of loss to the independent sector. Elective procedures vulnerable to competition (both day cases and inpatient procedures with less than 3 days average stay) were identified at OPCS

primary procedure code level by the relevant Trust clinical staff. Data for 2006 were then adjusted to reflect:

- Clinical advice about the proportion of activity in any procedure which would be suitable to be undertaken in the independent sector, with a minimum 25% retention of vulnerable activity by UBHT to reflect the Trust's central Bristol location, profile and status as extant provider of the services.
- Designation of a preferred location under patient choice based on estimated travelling times from the electoral ward of residence to central Bristol, Emerson's Green and, for day cases, Hengrove Park (the planned location for the South Bristol Community Hospital).

The outputs from the analysis have been factored into the long term activity plan.

NHS acute sector developments

The Trust has reviewed potential NHS provider developments in its key markets, of relevance to future demand.

A **new oncology centre** is planned to open in Taunton in 2008/09, housing 2 linear accelerators, outpatient clinics and inpatient beds for radiotherapy patients. This development will divert existing flows of Somerset patients from the Bristol Haematology and Oncology Centre. It is estimated that approximately 20% of existing activity will transfer to the new centre. This will be mitigated over a number of years by the increasing incidence and prevalence of cancer in the population generally.

The expansion of **local catheterisation facilities** has been a long-standing component of Cardiac Network plans, in line with the national strategy to address coronary heart disease. New or expanded facilities are already in operation in Bath and Swindon, helping to absorb expected growth in cardiology diagnosis and intervention rates. North Bristol Trust plan to open two catheterisation laboratories at Frenchay Hospital in 2008 which will divert cardiology flows to that Trust from North Bristol and South Gloucestershire. This activity loss has been factored into the demand projections for the new cardiothoracic centre currently in construction at the Bristol Royal Infirmary and set against the expected underlying increase in revascularisation rates agreed with local PCTs and the Cardiac Network.

The **centralisation of inpatient paediatric services** in Bristol is an agreed part of the Bristol Health Services Plan, the first phase of which was completed in April 2007. The Trust's plans to transfer the specialist paediatric services at Frenchay Hospital to the Bristol Royal Hospital for Children, are described in detail in an outline business case approved by the Strategic Health Authority in October 2007.

The development of a **new hospital for North Bristol and South Gloucestershire** at the Southmead Hospital site is planned to lead to the closure of all acute services at Frenchay Hospital by 2013. This will create changes to emergency flows across the city with a significant increase in demand at United Bristol Healthcare Trust.

A comprehensive analysis of baseline emergency flows across Bristol, North Somerset and South Gloucestershire by the Avon IM&T Consortium, with advice from local GPs and the Ambulance Trust, has provided the basis for assessing the net impact on the Trust. Baseline spells in general medicine, general surgery and orthopaedics deemed likely to transfer to the Bristol Royal Infirmary on closure of the Frenchay Hospital Accident and Emergency department have been identified and adjusted to account for the likely flow from the Bristol Royal Infirmary to Southmead Hospital once the new hospital there opens.

The net increase in emergency admissions to the Bristol Royal Infirmary, factored into the activity plan, is equivalent to 51 inpatient beds.

Rationalisation of certain surgical specialties, duplicated across the city, has previously been agreed under the Bristol Health Services Plan. However, plans to centralise inpatient breast surgery at St Michael's Hospital were halted in December 2007, following discussions with the Joint Overview and Scrutiny Commission for Bristol and South Gloucestershire. PCTs are currently setting up a wider review of the potential to centralise both screening and symptomatic breast services which is unlikely to conclude before December 2008. The linked centralisation of inpatient ear, nose and throat surgery at North Bristol Trust has also been put on hold until further notice. For the purposes of this business plan, therefore, no inward or outward transfer of activity has been assumed.

Bristol, North Somerset and South Gloucestershire commissioners continue to review the potential for further rationalisation. In particular, a major review of maternity and neonatal services is in progress, expected to conclude in 2008. This may ultimately lead to changes in the configuration of these services between North Bristol Trust and United Bristol Healthcare Trust. For the purposes of this business plan, however, no changes to current levels of service have been assumed. In addition, a procurement for provision of Child and Adolescent Mental Health and Community Child Health services has recently been started by Bristol PCT. The Trust currently provides services in both these areas and has expressed an interest in the wider role. The procurement is not expected to conclude until 2009, so no changes to current levels of service have been assumed.

NHS primary and community sector developments

Devolution of services to primary and community care

While the Trust is ideally positioned in the centre of Bristol's arterial transport system to be the provider of choice for much of the local population in central and south Bristol, it recognises that patients and GPs increasingly want care delivered locally from primary and community premises, in line with national policy and the Bristol Health Services Plan.

Changes in the location of care do not necessarily herald a change in provider. The Trust is keen to engage with practice-based commissioning groups to identify opportunities to work in partnership with local GPs to develop new services tailored to the needs of local communities and is exploring the establishment of a Clinical Forum to discuss of models of care and potential service improvements.

The Trust has accounted for commissioners' intentions to reduce emergency admissions to hospital by benchmarking the admission rates for Bristol, North Somerset, South Gloucestershire and Bath and North-East Somerset PCTs for those 19 conditions defined by the NHS Institute of Innovation and Improvement as 'ambulatory care sensitive', against the upper decile expected rates including:

- long-term conditions such as asthma, chronic obstructive pulmonary disease and diabetes
- headache and migraine
- urinary tract infections
- vaccine preventable diseases.

A corresponding reduction in emergency admissions to the Trust has been factored into the activity plan.

Community facilities

Under the Bristol Health Services Plan, local PCTs intend to develop new community facilities, which are expected to manage ambulatory patients who would otherwise be seen in an acute hospital. Facilities are planned for:

- South Gloucestershire (at Yate, Thornbury and Kingswood)
- South and East Bristol (the South Bristol Community Hospital and Eastville Health Centre)
- North Somerset (in Clevedon, Portishead, Weston and in rural communities)
- North Bristol (on the Frenchay and Southmead Hospital sites).

Of these developments, the most significant in terms of impact on the Trust's activity are the South Bristol Community Hospital and the Eastville Health Centre.

South Bristol Community Hospital

The proposed South Bristol Community Hospital has particular importance to the Trust. It is designed to facilitate the reprovision of inpatient rehabilitation services from the Bristol General Hospital. It is also a location from which alternative providers, including independent sector providers and primary and community care providers, may compete with the Trust. It therefore embodies the impact of many of the policy drivers described earlier in this chapter.

Bristol Primary Care Trust proposes to develop the South Bristol Community Hospital by 2009, procured through the Local Investment Finance Trust. The hospital is intended to be the nucleus of a new model of care, supported by investment in enhanced community services, providing improved local access and reducing reliance on acute hospital services, not least through accommodating significant levels of existing Trust activity.

The Community Hospital is intended to provide:

- inpatient rehabilitation beds
- outpatient clinics
- minor injuries service
- diagnostic imaging
- day surgery and endoscopy
- dental outreach services.

The Trust has committed to transfer the rehabilitation services at the Bristol General Hospital to the South Bristol Community Hospital and to close the Bristol General Hospital as a consequence. (A small amount of activity for acute stroke patients is expected to return to the Bristol Royal Infirmary at that time.)

There is agreement that the dental outreach services at the Community Hospital will be provided by the Bristol Dental Hospital (part of the Trust).

Minor injuries, outpatient and day surgery activity at South Bristol Community Hospital, however, is intended to be the product of a substantial transfer from the Trust, particularly from the Bristol Royal Infirmary. The Trust has made its own assessment of the minimum likely transfer of activity in these areas which has been factored into the long term activity and financial plan.

While this is broadly compatible with that assumed by Bristol Primary Care Trust in its Stage 1 business case for the Community Hospital, there are points of difference which continue to be openly discussed with the PCT.

A welcome development has been the advice from Bristol PCT in 2007 that it wishes to let a contract for the provision of day surgery, endoscopy, diagnostic services, and some outpatient clinics to the Trust. The plan therefore allows for retained income for these services but incorporates a cost penalty for split-site working.

The Trust's strategic response to the development itself is described in section 4.5.3 below.

Eastville Health Centre

A further transfer of UBHT activity to a planned new health centre in East Bristol has been taken into account in the activity projections. Again the Trust's analysis indicates some points of variance with PCT projections which are under open discussion.

The biggest impact on Trust capacity comes with the planned transfer of 11,500 outpatient attendances to the Eastville Health Centre, which are intended to be provided by the Trust on an outreach basis.

Summary of changes under the Bristol Health Services Plan

Figure 10 provides a “before and after” picture of the configuration of intended acute and community facilities, including independent sector developments, under the Bristol Health Services Plan.

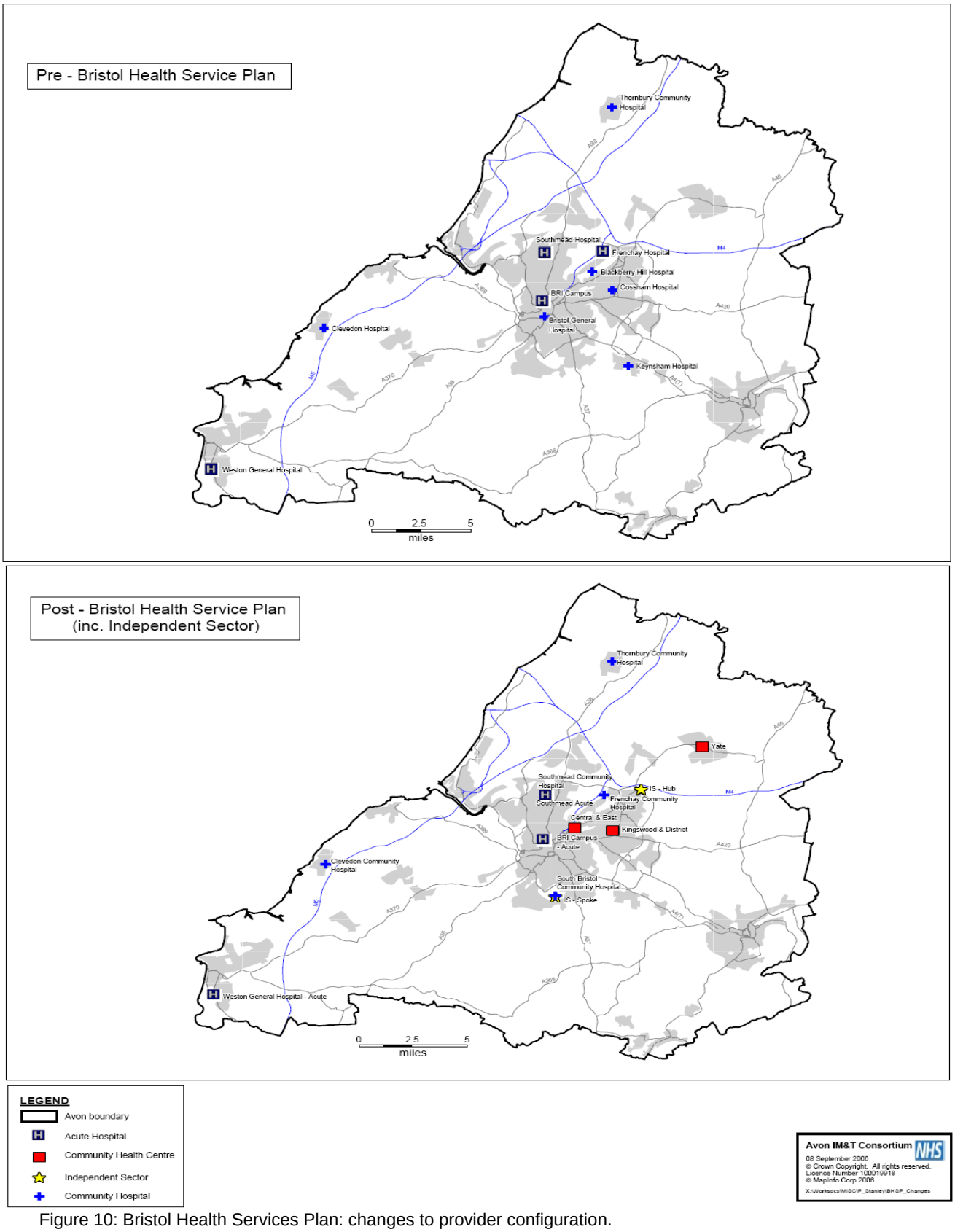


Figure 10: Bristol Health Services Plan: changes to provider configuration.

4.5.3 How the trust will address competitive factors

The direction of national policy, the plans of local providers and potential market developments indicate that the main focus of future competition for the Trust will be in local acute services.

Specialist regional services have higher barriers to market entry and have been subject to a process of rationalisation into geographic networks for some time which give stability to referral patterns while clinical outcomes remain acceptable.

These conclusions have informed the development of the Trust's clinical services strategy and especially the Trust's continued focus on its role as a regional provider of specialist services.

The impact of competition will nonetheless be significant. This section outlines how the Trust intends to address the competitive factors identified in the market assessment.

Central and South Bristol

In this market, the Trust will seek to maximise collaborative relationships with commissioners, both Primary Care Trusts and practice-based commissioning consortia, in order to ensure that the devolution of hospital activity to primary and community care is achieved in a managed way, without unplanned disruption to hospital services, and that new services are designed with optimal linkages to acute care.

The main grounds of engagement will be joint service redesign, through the Trust's Service Improvement Plan.

- The Trust has established liaison arrangements with the practice-based commissioning consortium in South Bristol in order to engage general practitioners in the service improvement agenda.
- A particular focus of engagement will be the South Bristol Community Hospital, where as described in the preceding section, Bristol PCT has advised that it wishes to nominate the Trust as a key provider at the Community Hospital.

Risk of greater losses of elective work under patient choice and from independent sector competition than currently planned will be addressed through the Service Improvement Plan, described in Section 5.4.

Opportunities for collaboration with the independent sector will be taken where there is identifiable benefit. The Trust has limited exposure to independent sector competition other than in ophthalmology.

Environmental quality, particularly for care of the elderly services, will be enhanced through the re-provision of inpatient wards from the Bristol Royal Infirmary Old Building, which does not meet modern healthcare standards, as part of the Site Development Plan, described in Section 5.6.

Avon, Somerset and Wiltshire

The appropriate response to competitive developments in this market is to concede the loss of local acute activity where this is predictable, particularly by effecting a managed transfer of:

- Clinical oncology, given expansion in Taunton
- Cardiology, given expansion at Frenchay Hospital.

The workforce implications of these transfers will also be carefully managed to ensure that costs are released appropriately while not impeding the ability to scale capacity upwards again as local demand increases in line with increased cancer incidence and increasing access rates for cardiology.

At the same time, the Trust will seek to consolidate its position as a specialist provider in these fields by:

- Developing new services with which general hospitals cannot currently compete, such as primary angioplasty in line with the plans of the Cardiac Network
- Expanding its role as a specialist provider of cancer surgery, in line with the recommendations of the Cancer Network, by providing appropriate clinical capacity for the future
- Enhancing the patient environment and the profile of the Trust's services through development of a new adult cardiothoracic centre at the Bristol Royal Infirmary and refurbishment of the Bristol Haematology and Oncology Centre
- Pursuing grants for innovative research programmes in cancer and coronary heart disease in collaboration with the University of Bristol.

A specific area of risk in this market is the provision of NHS homeopathy, which continues to benefit from public demand but which is increasingly seen as a low priority by PCT commissioners. A local marketing plan is in place to sustain referrals until the long-term prognosis for the service is clear.

Regional specialist services

The objective in this market will be to maintain or increase market share through:

- Partnerships with referring hospitals, particularly through shared care arrangements
- Effective engagement with the new South West Specialist Commissioning Group
- Development of appropriate facilities, such as the new cardiothoracic centre or expansion of the Bristol Royal Hospital for Children to accommodate specialist services transferring from Frenchay Hospital (see section 5.6)
- High profile research programmes in paediatric conditions, in addition to programmes in cancer and coronary heart disease.

4.5.4 Summary of how the Trust performs against local competitors

The Trust has analysed its relative performance against key local competitors on the following indicators:

- average length of stay
- day-case rate
- emergency readmission rate
- standardised mortality ratio.

Length of Stay

Table 16 shows the Trust's elective and non-elective length of stay for the period April to November 2007. It shows actual and expected length of stay compared to local competitors (adjusted for age, gender and case mix).

Elective

Peer	Inpatients	LoS	Expected LoS	Difference
Taunton and Somerset	6162	3.1	5.3	-2.2
Weston Area Health	1652	4	5.2	-1.2
Swindon and Marlborough	2227	3.7	4.5	-0.9
Gloucestershire Hospitals	10080	4.3	4.8	-0.5
North Bristol	11180	4.7	5.2	-0.5
Royal United Hospital Bath	4733	3.9	4.4	-0.5
United Bristol Healthcare	9666	4	4.1	-0.1

Non-Elective

Peer	Inpatients	LoS	Expected LoS	Difference
Taunton and Somerset	21450	4	6.1	-2.2
Weston Area Health	8778	5.5	6.7	-1.2
Royal United Hospital Bath	18117	6.7	7.6	-0.8
United Bristol Healthcare	28518	4.9	5.2	-0.3
Gloucestershire Hospitals	35894	5.4	5.6	-0.2
North Bristol	32516	6	6.1	-0.2
Swindon and Marlborough	8864	5.4	5.6	-0.2

Table 16: Elective and Non-Elective Length of Stay
[Source: Dr Foster Hospital Activity Tracker]

Day Case Rate

Table 17 compares the Trust's day case rate as a percentage of spells classified as day cases rather than inpatients[16] between April and November 2007 against other local providers.

Peer	Spells	Elective Inpatients	Day Cases	Day Case Rate %
United Bristol Healthcare	8777	1504	7273	82.9
Swindon and Marlborough	2653	488	2165	81.6
Royal United Hospital Bath	5174	957	4217	81.5
Gloucestershire Hospitals	9431	1826	7605	80.6
Taunton and Somerset	4948	1133	3815	77.1
Weston Area Health	1184	311	873	73.7
North Bristol	5760	1524	4236	73.5

Table 17: Day-case Rate
[Source: Dr Foster Hospital Activity Tracker]

[16] For procedures in Audit Commission 'Daycase Basket'

Emergency Readmissions

Table 18 compares the number of patients discharged from the Trust between April and October 2007 who were re-admitted as an emergency at any Trust in England within 28 days, against the results for other local providers.

Peer	Spells	Readmissions	Rate %
United Bristol Healthcare	69247	2719	5.5
Gloucestershire Hospitals	81348	3192	5.6
Taunton and Somerset	43509	1722	5.6
North Bristol	68734	2893	5.9
Swindon and Marlborough	15496	673	6.2
Weston Area Health	15231	842	6.7
Royal United Hospital Bath	36199	1859	7.3

Table 18: Emergency Readmissions
[Source: Dr Foster Hospital Activity Tracker]

Mortality

Table 19 shows actual deaths at the Trust against the expected number based on comparison with local competitors (adjusted for age, gender and case-mix) for the period April 2007 to November 2007, and gives the Hospital Standardised Mortality Ratio for the Trust within confidence intervals.

Peer	Spells	Deaths	Expected	Relative Risk	Lower Limit	Upper Limit
Weston Area Health	5504	263	348.6	75.4	66.6	85.1
Taunton and Somerset	13566	499	655.5	76.1	69.6	83.1
United Bristol Healthcare	21611	544	704	77.3	70.9	84
North Bristol	18438	884	1070.4	82.6	77.2	88.2
Royal United Hospital Bath	13093	737	857.5	85.9	79.8	92.4
Gloucestershire Hospitals	31674	1159	1323.4	87.6	82.6	92.8
Swindon and Marlborough	5618	282	277	101.8	90.3	114.4

Table 19: Mortality data
[Source: Dr Foster Real-Time Monitoring]

It will be seen that the Trust's performance on these indicators against key local competitors is good, particularly compared to its heartland competition in Bristol. For daycase rates and emergency readmissions, the Trust is actually the best in the sample. While there is room for improvement in the other areas, the Trust is not an outlier.

Challenging efficiency targets have been set for the future, as part of the ten year capacity plan, which have been benchmarked against upper decile performance in comparator Trusts and which underpin business cases for our major capital schemes. These are described in Section 5.8, Resource Implications of Activity Plans.

4.6 ACTIVITY IMPLICATIONS OF MARKET ANALYSIS

Table 20 shows the impact on projected activity of the environmental changes and competitive factors described above, between 2005/06 (the baseline year for capacity planning purposes) and 2016/17. These changes (adjusted for baseline differences) are incorporated into the long term financial plan.

Key Driver	***Impact on Activity***
Demography	7% overall growth in activity over the entire planning period (or 7,800 admissions).
Epidemiology	11,000 additional admissions for all specialties over the period (or 8% growth in total activity) - the majority of which are in oncology day cases and cardiology.
Reduced waiting times	Additional 2,700 elective admissions for all specialties over the period (or 4% of total surgical activity across the Trust).
Demand management	1700 total non-elective admissions avoided or 4% of total emergency activity, split between 1,350 non-elective admissions to medical specialties, 200 to surgical specialties and 100 to other specialties.
Market share	Reduction in inpatient and day-case surgical admissions by 2,250 as a consequence of independent sector competition. Loss of 1,700 admissions in clinical oncology as a result of service development in Taunton Additional 300 admissions in cancer surgery specialties over the planning period.
Service transfers – acute emergency flows	Net 3,200 additional spells as a result of changes to adult emergency flows in general medicine, general surgery and orthopaedics as a result of withdrawal of acute services from Frenchay Hospital.
Service transfers – cardiology	Loss of 1,000 admissions in cardiology as a result of service development in North Bristol Trust
Service transfers – community developments	Transfer of day surgery activity - 3,200 cases Transfer of outpatient activity - 38,500 attendances Transfer of minor injuries - 10,000 attendances
Service transfers – Bristol General Hospital	Loss of 1,150 spells under rehabilitation as a result of the development of community services at South Bristol. Additional 120 acute stroke admissions at the Bristol Royal Infirmary

Table 20: Impact on projected activity of the environmental changes and competitive factors

5. SERVICE DEVELOPMENT PLANS

5.1 INTERNAL CAPABILITY ASSESSMENT/ANALYSIS OF STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

Alongside the external environment review, described in the preceding chapter, the Trust has undertaken an internal analysis at corporate and at divisional level, which has informed its service development plans.

The summary results of this strengths, weaknesses, opportunities and threats (SWOT) analysis are shown in the following table.

Key strengths

Factor	Supporting evidence	Impact	Action
Reputation for clinical excellence	Healthcare Commission good rating for quality of clinical services Low mortality rate	Supports teaching hospital status and positive relations with local universities over teaching and research	Maintain/improve clinical outcomes Market good results and patient safety initiative
Established specialist services, many with market dominance	Regional referral base Specialist centres e.g. Oncology Centre, Regional Cardiac Centre, Children's Hospital	Supports tertiary centre status and linked research programmes Limited portfolio of local acute surgery vulnerable to competition	Consolidate/expand specialist services where business case exists Bid for major research programme grants
Strong financial control	Financial balance or better this year and the last 4 years	Supports delivery of efficiency savings and sound business planning	Link savings plans to service improvement strategy to leverage sustainable benefits
Low reference costs in several specialties	National reference cost report	Supports development of high cost services and support for priority research in early stages to enable national funding bids and help to build brand	Compete to maintain/increase share in low cost services
Strong hospital brands in city centre location	Dedicated hospital buildings/local geography	High profile under patient choice Secure local emergency catchment	Develop hospital brands inside corporate framework
National reputation for excellence and specialist expertise in research management	Well organised commercial research management Specialist knowledge of NHS research agenda among key staff Highly skilled and motivated research management team	Ensures excellent management and governance of research activity reducing risk to the Trust and supports funding bids	Maintain depth of expertise and proactively target funding bids
Strong relationships with the University of Bristol and the University of the West of England	Existing research and training partnerships Liaison arrangements Academic representation at Trust Executive Group	Increases opportunities to develop collaborative programmes leading to successful funding bids	Develop and implement collaborative synergistic research strategies

Factor	Supporting evidence	Impact	Action
Strong portfolio of research particularly in priority areas for clinical service provision	Majority of R&D programmes consistently rated as 'strong' by DH. Funding and publication record good	Supports recruitment of high calibre staff. Secures high reputation for Trust in attracting further research funding and contract research Adds value to brand	Improve dissemination of information about research activity. Target research support to areas of clinical and research excellence and to areas of service expansion
Strong facilities and infrastructure to support provision of high quality education and training	Modern, purpose built Education Centre with Learning Resource Centre, Simulation Centre and access 24/7, as well as specific provision in areas such as the Dental School Strong clinical skills infrastructure and wide range of pre-registration trainees	Supports teaching hospital status and positive relations with university and further education partners	Maintain and use facilities optimally to support education and training
Detailed strategy and plans to support education and training in partnership with educational providers	Teaching and Learning Strategy, steering group and annual plans Significant partnership working Organisational development strategic framework	Supports teaching hospital status and staff development Positive feedback on training and development opportunities in annual staff attitude surveys	Continue to improve and develop annual plans, and build constructive, productive partnerships

Key weaknesses

Factor	Supporting evidence	Impact	Action
City centre location restricting availability of parking and drop-off for patients and visitors	Patient and public feedback/complaints	Affects Trust reputation and attractiveness under patient choice	Implement Green Travel Plan Pursue accessibility improvement schemes Plan for expanded patient and visitor parking Plan to devolve services to satellite locations, especially the new South Bristol Community Hospital
Quality of customer service in some areas	Patient and public feedback/complaints	Affects Trust reputation and attractiveness under patient choice	Pursue staff education initiatives
Sustainability of performance improvements	Performance against Cancer 62 day wait target, 4 hour A&E wait target and GUM access target	Affects sustainable delivery of new targets at same or reduced cost	Develop comprehensive service improvement plan
Age, quality and infrastructure of some of the estate	Commission for Health Improvement report 2003 on Bristol Royal Infirmary Old Building	Affects patient dignity and Trust reputation and impedes infection control	Aim to re-locate inpatient facilities from BRI Old Building as soon as possible Plan for further refurbishment of BRI

Factor	Supporting evidence	Impact	Action
Historical deficit putting Trust in technical breach of statutory duty to break even	Auditors' Section 19 report	Affects assessment of Trust's financial standing	Clear historical deficit in 2007/08 to restore statutory break-even position
Capacity constraints e.g. BRI theatres and critical care, BEH outpatients	Cancelled operations Outpatient follow-up delays Lack of first 'in-man' trials facility	Affects patient experience and limits potential for market expansion Affects research capability	Plan to increase capacity in line with long-term demand assessment
Ageing information management and technology infrastructure in some areas	EDS patient administration system	Affects flexibility of reporting and communications	Work with national programme while maintaining contingency/business continuity plans
Lack of collaborative plan between all NHS and university partners in Bristol	Identified need for development of Heads of Terms agreement and strategy between key partners.	Expertise across partner organisations not used optimally. Results in partners competing with each other for funding. Mis-match of academic expertise and clinical research capacity.	Develop and implement collaborative synergistic research strategies proactively develop research programmes in partnership.
Need to build further internal capacity for mentoring, assessment and verification	Identified further need as part of strategy for National Vocational Qualifications and Foundation Degrees	Would need to utilise more external, expensive resources unless further internal development	Strategy group and training team identifying ways of building further capacity
Placement capacity	Identified need for greater strategic coordination of placements, due to high demand	Would need to limit level of further placements	Work with educational partners across all disciplines to manage future placement planning

Key opportunities

Factor	Validation	Action	Benefits
Extend and deepen specialist service portfolio	Market assessment	Consolidate relationships with referring hospitals Engage positively with new specialist commissioning arrangements Acquire or develop new services (e.g. specialist paediatrics from North Bristol Trust)	Enhanced security against market threats Enhanced reputation as tertiary provider Enhanced recruitment and retention of key staff

Factor	Validation	Action	Benefits
Spearhead service redesign	Addresses capacity constraints and sustainable delivery of referral to treatment waiting time targets	Complete 'lean' pilots and learning Establish comprehensive programme of service improvement activities Develop new or redesigned roles for e.g. allied health professionals, nurse specialists etc Engage with PCTs over cross-community models of care	Delivery of challenging patient access standards Improved patient and staff experience Sustainable efficiency gains allied to service improvement strategy
Establish leading research programmes	Best Research for Best Health Hub provider of many tertiary services in south west Focused Clinical Services Strategy provides clear priorities for research	Implement research & development strategy Bid for integrated programme grants in areas of specialist expertise Use strong south west clinical networks to build on already strong trials culture Use strengths of universities to develop focused research programmes	Secured research income Enhanced reputation Enhanced recruitment and retention of key staff
Redevelop or refurbish the Trust estate to improve the patient environment and clinical adjacencies	Capital strategy	Produce outline business case for redevelopment of the Bristol Royal Infirmary	Reduction in unsuitable patient accommodation Appropriate clinical capacity and service configuration for long-term Enhanced reputation
Secure service provider role at the planned South Bristol Community Hospital	Market assessment Partnership working with PCT/Bristol PCT Board decisions	Engage potential primary and community care provider partners Undertake due diligence of business model Establish appropriate governance arrangements	Flows from local catchment preserved and income loss mitigated Practice-based commissioners engaged in new models of care and partnerships developed to expand into other markets Routine work devolved to re-orient acute capacity to specialist services & reduce requirement for capital investment Reduced footfall at central hospitals & accessibility pressures alleviated

Factor	Validation	Action	Benefits
Introduction of Electronic Staff Record	System provides greater flexibility to develop computerised database of qualifications and training	Improved knowledge across all parts of the organisation about the knowledge, skills and competency of our workforce	Implement Oracle Learning Management module from point of go live in July 2007 and develop as an integral part of the system
Use existing partnerships to address key national developments such as the Leitch Review and the 14 – 19 agenda	Host employer for Skills for Health Close partnership with City of Bristol College Schools liaison officer in post	Trust can respond positively to the national and Bristol community requirements around education and training, as well as developing the skills of our own workforce	Work with schools, colleges and Skills for Health, to develop formal plans

Key threats

Factor	Validation	Action	Benefits
Predation by competing providers, NHS or independent sector	Market assessment (patient choice initiative & Independent sector procurement) Accessibility and customer service weaknesses	Base long term financial plan on conservative activity projections Invest in specialist services Pursue accessibility improvement schemes such as valet parking Plan for expanded patient and visitor parking Pursue service improvement plan Compete in contestable areas where appropriate e.g. Ophthalmology	Income risk minimised Long term financial plan secure against activity risk Service strategy based on areas of competitive strength consistent with Trust reputation
Loss of research and development support funding	Best Research for Best Health Reduction in own account research Domination of the 'Golden Triangle' academic units in competition for NHS research funding Reductions in Academic posts and staff willing to follow an academic career	Implement research & development strategy Bid for integrated programme grants in areas of specialist expertise Partner with relevant major academic units in receipt of NHS R&D funding for funding bids Improve support for academic training posts Develop strategy for supporting research without external funding	Secured research income Enhanced reputation Enhanced recruitment and retention of key staff Enhanced ability to develop research portfolio and compete as priorities change

Factor	Validation	Action	Benefits
Cross-community service redesign fails to deliver expected benefits	Historical delivery of demand management schemes	Engage with PCT over new models of care, especially rehabilitation Engage with practice-based commissioners to establish new services	Available capacity matched to demand
Bristol Health Services Plan does not proceed	Affordability reviews Financial problems affecting parts of the local health economy Public opposition	Ensure Trust developments are conservatively based and independent of other schemes as far as possible	Trust objectives not impeded
Current and potential changes in funding arrangements for National Vocational Qualifications and in higher education. Changing standards for Nursing and Midwifery pre-registration training	No longer in receipt of National Vocational Qualifications funding from Strategic Health Authority. Also reduction in funding for post-registration training for nurses, midwives, allied health professionals, allied to changing standards in nursing and midwifery pre-registration training which impact on capacity to deliver	Potential impact on number of National Vocational Qualifications which can be supported Potential further limitation on support for post-registration training, and limitations on ability to meet pre-registration contract, with consequent impact on recruitment	Identify continued overall funding to support National Vocational Qualifications, Foundation degrees and post registration training as part of annual service planning cycle, and as part of workforce plans to support skill mix changes. Strengthen in-house education facilitation and mentorship/assessment arrangements
Availability of training time for staff	Pressure of workloads on training time, particularly during peak periods of leave or at time of other major initiatives. Staff release becomes difficult without use of bank or agency cover, which has financial impact	Potential for non-attendance at key training or limited opportunities for further development	Major move to more usage of e-learning and blended learning to make the most productive use of staff time. Workload planning undertaken with full knowledge of key training requirements, to ensure release

Table 21: Summary results of this strengths, weaknesses, opportunities and threats (SWOT) analysis

5.2 COMMENTARY ON SWOT ANALYSIS

The comprehensive analysis of strengths, weaknesses, opportunities and threats summarised in the preceding tables has informed the Trust's strategic plans, in particular the prioritisation accorded to key initiatives.

It relates to Divisional level SWOT analyses which have been conducted as part of the Trust's annual strategic review for a number of years.

This section shows how the key initiatives being pursued by the Trust relate to the results of the SWOT analysis and the benefits which they are expected to deliver.

Financial plan (Chapter 6)

Exploits which strengths? *Addresses which weaknesses?*	Pursues which opportunities? *Defends against which threats?*	Expected benefits
Financial control Low reference costs in certain specialties *Statutory duty to break even*	Ability to retain and re-invest surpluses *Contestability* *Devolution of activity to primary and community care*	Prudential borrowing is last resort No Private Finance Initiative capital schemes Compliance with statutory duty restored

Service improvement plan (Section 5.4)

Exploits which strengths? *Addresses which weaknesses?*	Pursues which opportunities? *Defends against which threats?*	Expected benefits
Clinical leadership and Divisional engagement *Sustainability of performance improvements*	Potential for efficiency gain, particularly in reducing length of stay *Delay to or lack of benefit from Bristol Health Services Plan service reconfiguration/redesign*	Sustainable savings, linked to core clinical and operational processes Patient benefit Enhanced staff satisfaction Enhanced reputation

Research & development plan (Section 5.5)

Exploits which strengths? *Addresses which weaknesses?*	Pursues which opportunities? *Defends against which threats?*	Expected benefits
Strong University relationships Strong research portfolio *Trust sits outside "golden triangle" of research centres* *Lack of collaborative plan between all local partners*	Potential to establish leading research programmes Development of Clinical Research Centre Alignment of research to service strategy *Loss of R&D funding under national strategy*	Secure level of R&D income Enhanced recruitment and retention of key clinical staff Enhanced research capacity and capability Enhanced reputation and tertiary status

Site development plan (Section 5.6)

Exploits which strengths? *Addresses which weaknesses?*	Pursues which opportunities? *Defends against which threats?*	Expected benefits
Secure long-term future under Bristol Health Services Plan Flexible estate *Poor patient environment in some areas* *Clinical capacity constraints*	Development potential of estate National investment programmes (dental training, coronary heart disease) Optimal internal organisation of services *Loss of activity under patient choice*	Appropriate capacity for long-term Infrastructure to support service plans Enhanced patient environment Rationalised estate Enhanced reputation

Workforce and organisational development plans (Chapter 8)

Exploits which strengths? *Addresses which weaknesses?*	Pursues which opportunities? *Defends against which threats?*	Expected benefits
Excellent educational infrastructure Strong educational partnerships *Internal educational capacity* *Placement capacity* *Customer service issues*	Greater use of E-learning and blended learning *National education funding changes* *Staff training time (both trainers and trainees)*	Improved workforce skills Enhanced recruitment and retention Improved customer service

Corporate social responsibility programme - 'UBHT in the Community' (Chapter 8)

Exploits which strengths? *Addresses which weaknesses?*	Pursues which opportunities? *Defends against which threats?*	Expected benefits
Status as major city centre employer *Poor physical environment in some parts of the estate* *Poor accessibility and parking*	Potential for Joint working with local agencies on education, environment, crime, energy use and transport Staff goodwill for volunteering *Perceptions of isolationism affecting reputation*	Expanded role in city community Enhanced reputation Enhanced recruitment and retention

IM&T plans (Chapter 9)

Exploits which strengths? *Addresses which weaknesses?*	Pursues which opportunities? *Defends against which threats?*	Expected benefits
Proven ability to implement new systems (PACS, RIS, Pathology) Strong supplier partnerships *Legacy PAS* *Some ageing infrastructure*	National Programme for IT, especially NHS Care Records Service Electronic Staff Record	Enhanced support to service delivery and clinical decision-making Efficient flows of information Effective reporting and control

Patient Environment Programme (monitoring core Healthcare Commission standards) and related initiatives

Exploits which strengths? *Addresses which weaknesses?*	Pursues which opportunities? *Defends against which threats?*	Expected benefits
Staff enthusiasm *Poor public environment in some parts of the estate* *Accessibility and parking issues* *Culture of neglect of common areas*	Potential to gain activity under patient choice through improved environment and a professional image *Loss of activity under patient choice*	Enhanced patient and carer satisfaction Enhanced staff satisfaction Enhanced reputation

South Bristol Community Hospital provider role (Section 4.4.3)

Exploits which strengths? *Addresses which weaknesses?*	Pursues which opportunities? *Defends against which threats?*	Expected benefits
Strong partnership with host PCT *High admission rate in Bristol* *Accessibility to city centre location* *Perceptions of inertia on service redesign*	Vertical integration Development of productive GP relationships *Independent sector and NHS competition*	Maintained or enhanced share of core local market Patient and carer satisfaction Progressive relationship with practice-based commissioners Reduced footfall at city centre precinct

It will be seen from the summary above that there are important initiatives in progress in a range of areas and that the Trust is pursing objectives which do not necessarily require significant investment where there is potential to harness the goodwill of staff or of community partners.

Of all these initiatives, the Trust has chosen to highlight the central importance of its service improvement, research and development and site development plans to the delivery of its strategic aims, alongside the financial and workforce plans described later in this business plan.

5.3 SUMMARY OF FUTURE INITIATIVES

Taking account of the strengths, weaknesses, opportunities and threats analysis described above, the Trust has identified three service development plans as the major vehicles for delivery of its strategic aims:

- Service Improvement Plan
- Research & Development Plan
- Site Development Plan.

5.4 SERVICE IMPROVEMENT PLAN

5.4.1 Service Improvement Strategy

Key drivers for service improvement within any healthcare organisation are the need to support continuous improvement in the quality of healthcare provided, patient safety and patient experience. In addition, there are clearly internal and external drivers to the Trust to achieve ongoing efficiency and productivity gains through service improvement, which are recognised in our Savings Plan and underpin our long-term financial plan.

The Trust's Service Improvement Strategy therefore has three aims, namely to achieve:

- Continuous improvement in clinical outcomes for patients by focussing on quality and safety
- Excellence in patient experience so that the Trust is the provider of choice
- Robust financial performance through ongoing efficiency and productivity gains that enables delivery of performance targets in a sustainable way.

Strategic themes

Our strategy for service improvement is based on three strategic themes: a) developing capability, b) securing engagement and c) improving performance.

a) Developing capability

Focusing on developing the capability of our people drives delivery of improved service performance. Out strategy ensures we have staff and processes capable of realising our improvement objectives. It addresses workforce planning issues designed to ensure the availability of optimum skill levels/ mixes, across all staff groups, in line with our performance improvement objectives.

All improvement projects apply proven project management principles, demonstrating that it is possible to improve quality while reducing costs. The Trust now has a core group of around a 100 staff, across all disciplines and at all levels, who are improvement specialists which includes a corporate resource within the Innovation and Information Teams. Skills in leading teams through change are also being developed in clinical and managerial leaders.

b) Securing engagement

Securing engagement is about developing a culture that harnesses the skills and capabilities of our people, the expertise of chosen partners and inputs from our patients and the wider public.

In implementing our Service Improvement Strategy we aim to secure clinical leadership, where required, for all improvement efforts. The specific training and development needs of individual clinicians will be identified and addressed through the Trust's wider Organisation and Leadership Development Programme. The well established Trust-wide Clinical Reference Group is used for overall programme advice where appropriate. Also Care Pathway Leads are involved in service improvements within their portfolios.

We aim to learn from the best by always comparing ourselves to high performing organisations and to work in partnership across the health and social care economy, wider NHS and the NHS Institute for Innovation and Improvement (through our Practice Partner status). We aim to exploit these opportunities to raise the Trust's profile as a promoter of innovation and improvement.

We aim to involve Patient and Public Involvement colleagues in service improvement initiatives, to ensure patient involvement underpins our service improvement activities, ensuring that we put patients first. Once Foundation Trust status has been achieved, the membership will be consulted appropriately and patient experience used as one of the measures of improvement. The membership database will include specific areas of members' interests.

c) Improving performance

Improving performance focuses on ensuring that we realise benefits, tangible and intangible, from our service improvement activities. It includes specifying and measuring improvements in service, productivity and financial performance.

We ensure that service improvement is informed and guided by performance data/ information. From a productivity and financial perspective it requires our improvement objectives to be developed and defined on the basis of a detailed understanding of the Trust's cost structure. Only in this way is it possible to determine the scale of benefit to be derived and whether improvement activity is being focused on the most appropriate areas.

The theme also involves applying good practice methodologies, tools and techniques in improving the performance of our operational and clinical processes. For example, it includes improving our services through the application of *Lean Thinking* and its related principles and concepts.

Approach

The approach to implementing the Trust's Service Improvement Strategy is to shape a quality-focussed work programme primarily aimed at improving patient experience and the quality of their clinical outcomes, while demonstrating that this also delivers the productivity and efficiency gains that are essential. In order to embed continuous improvement within the culture is recognised that clinical leaders, frontline teams and patients are the experts in the services they provide and receive. Consequently, the emphasis is on supporting them to lead service improvement activities in order to deliver and sustain the benefits. Key elements supporting delivery of this strategy are outlined below.

a) Developing capability

We ensure that the organisation builds the skills and capabilities necessary to deliver our improvement ambitions; this includes improvement and project management skills and leading teams through change. Robust programme management is in place with corporate level co-ordination and support. A disciplined approach to project management has been applied and each project is taken through the key phases as outlined in Figure 11 below. This ensures the projects are well-defined, have clear deliverables and are more likely to sustain the improvements. In addition, each project is expected to demonstrate that it is possible to improve quality while reducing costs.

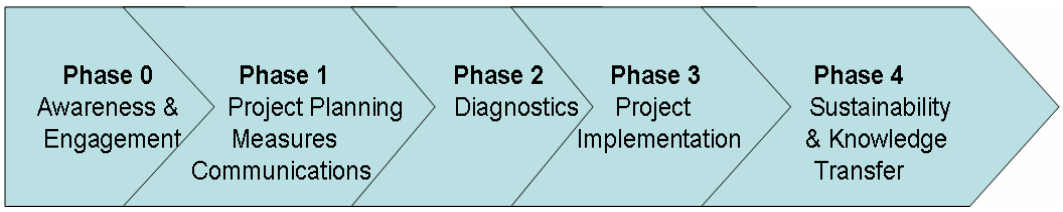


Figure 11: Structured project management

Each project is developed around improving patient pathways and has an identified clinical and managerial lead as well as a pathway team actively involved in developing and supporting this work with the emphasis on transferring project management skills. Alongside this, *Lean Thinking* philosophy and methodology is the preferred approach to identify and implement improvements as it focuses on defining clinical services based on what adds value for patients. Again, skills transfer is key. This approach complements and builds on some of the existing skills in improvement tools and techniques currently used in the Trust including process mapping, demand and capacity analysis as well as understanding and managing variation through the use of Statistical Process Control (SPC).

During 2008/09 each of the clinical divisions will have dedicated support for a number of improvement projects while we further build our internal capability. The aim is to develop improvement specialists in all service areas, across all staff groups. As teams grow in confidence and start to see the results of their efforts this support will decrease and will mainly be directed towards ensuring teams sustain the improvements while embedding the approach into their daily work practices.

To support this skills development, individual members of staff are encouraged to participate in projects in other service areas. It is anticipated that as these local experts develop, they will support on-going skills transfer by, for example, facilitating and/or contributing to pathway improvement projects in other clinical areas within their divisions or elsewhere in the Trust.

To complement the project management and improvement skills development the Innovation Team delivers training modules as part of the Trust's Training and Development Programme specifically aimed at leading teams through change covering topics such as conflict resolution, building resilience, managing stakeholders. Action Learning Sets will also be established to provide peer support.

b) Securing engagement

Finding and supporting the development of clinical leaders is vital for driving continuous improvement within our services. Participation in improvement projects requires time commitment from clinicians and it is essential that we make sure that this is part of the programme. The Trust has a strong record of engaging clinicians in management and this should be routine in service improvement.

It is acknowledged that securing senior medical consultant support is essential. However the engagement must span all professional groups and in particular identify and target emerging clinical leaders. The Clinical Reference Group will be used to advise on programmes and Care Pathway Leads and Nurse Consultants will be instrumental in certain areas.

Improving in-hospital services will be a major focus of the work programme over the next five years. However, it is recognised that we will work closely with colleagues across the health and social care economy where out-of-hospital services are deemed appropriate so that we optimise the use of public resources and provide care closer to patients' homes where necessary.

The NHS Institute for Innovation and Improvement has established a Practice Partner Network to support the transformation of the NHS by accelerating innovation and adopting best practice across the NHS. The Trust is part of this small network of receptive and highly motivated organisations across the NHS who can rapidly pilot new knowledge, processes, skills and tools to enable delivery on key service improvements for patients. This will afford us many benefits including the opportunity to work with forward thinking organisations from inside and outside the NHS as well as access to national and international improvement leaders and strategic partners.

We continue to strive to engage patients actively in service improvement efforts in a meaningful way and early on in the process. We will seek their feedback to identify areas for improvement opportunities and build ongoing feedback mechanisms through their involvement in redesign and service user groups. We aim to embed systematic use of tools such as discovery interviews, patient diaries, satisfaction surveys etc. into our improvement programme. The needs of different patient groups will inform service design in order to cater for equality and diversity requirements.

We ensure that we take the opportunity to celebrate and analyse the successes of our frontline teams in delivering service improvement. We recognise the challenges that lie ahead but also the importance of acknowledging and sharing the progress being made.

c) Improving performance

We will consider and act upon where appropriate, the products introduced by the NHS Institute for Innovation and Improvement particularly those aimed at improving productivity and will exploit our practice partner status with the Institute to secure on site support for implementation as required. This and other available benchmarking information will be used as a guide for identifying savings opportunities and where service improvement efforts need to be focused to support delivery of our Savings Plan. As part of Cash Releasing Efficiency Savings (CRES) planning, Divisions develop Critical Pathways of Outcomes (CPOs), which identify what needs to have been achieved or be in place to realise the planned benefits. Through the development of CPOs, service improvement support requirements are identified and built into the work programme for the following year.

Through strengthening our project management approach we have ensured that our improvement programme has realistic goals and objectives and key to this has been establishing baseline measures for individual projects against which we monitor progress. Consistent with our long-term financial plan we are aiming for upper decile performance for all major service indicators including average length of stay, outpatient efficiencies, theatre utilisation etc.

An integral part of the improvement programme is to agree with frontline teams key performance indicators for their areas so that they know how they are doing on a daily/weekly basis and how their performance contributes to the Trust's overall performance objectives. This approach is consistent with *Lean Thinking* principles and methodology that underpins the improvement work programme and helps promote a culture of innovation and improvement.

5.4.3 Improvement objectives

The Service Improvement Strategy represents an integrated approach to improvements in quality and efficiency which supports Divisional and corporate CRES delivery and achievement of the long term financial plan. It will be delivered through a co-ordinated programme of *Lean Thinking* implementation, and a range of corporate and divisionally-led projects. This section describes how the proposed approach will be applied to help deliver the aims outlined above and where the service improvement work will be focused.

The NHS Institute for Innovation and Improvement[17] recently identified a potential saving for the Trust of £7.6 million for improvements to overall length of stay, and a further £1.7 million by reducing pre-operative bed-days. Although these figures are known to be indicative only, they serve to highlight opportunities for productivity gain. In addition to these opportunities, there are other drivers of improvements to efficiency for 2008/09 and beyond, both internally and externally. External drivers include quality and efficiency improvements identified within the local PCTs' Resource Utilisation Management schemes, and performance indicators under the national contract. Key improvement areas highlighted by these external drivers include outpatient follow-up rates and planned procedures not carried-out (S22s). The internal drivers include the need to improve performance against certain existing national targets, such as last-minute cancelled operations and the 4-hour maximum wait for A&E, as well as the need to realise financial and efficiency savings.

When considering all these drivers and opportunities for improvement, a number of consistent priority areas can be identified which have been included within our

[17] Institute for Innovation & Improvement NHS Indicators Scorecard – Acute trusts Quarter 2 2007/08.

programme of service improvement for the next three years. The areas in which improvement will be focused are:

- Average Length of Stay
- Outpatients
- Theatres
- Imaging & Pathology

Objectives in each of these areas are described below, followed by an overview of a range of service improvement plans already underway to support improvements in patient care in other areas of operation. Whilst the description of the improvement objectives details the way in which savings will be realised, in accordance with our Service Improvement Strategy the focus will be on improving the quality of service provided, in terms of clinical outcomes, patient safety and patient experience, through which improvements in efficiency will be realised.

Average Length of stay (ALOS)

Reducing ALOS offers an improved patient experience and productivity benefits as it, in effect, provides additional bed capacity. This capacity release enables efficiency savings to be realised, bed occupancy rates to be optimised and waiting times to be reduced.

The Trust will aim to achieve upper decile performance, within its chosen peer group, for ALOS for elective and non-elective activity. This aim leads to an ALOS reduction profile for the five year period 2007/08 through 2011/12, as outlined below. In turn, this provides opportunities to reduce bed numbers and thereby realise workforce reductions and efficiency savings as indicated. As we define service performance improvement opportunities for the Trust (e.g. the ALOS reduction described in Table 22) we will as a matter of course address the workforce planning implications of the benefits/ improvements realised.

These bed reductions demonstrate the impact of reducing length of stay for current levels of activity. They do not reflect the underlying growth as a result of demography and epidemiology, which would increase both activity and resource requirements, or agreed service transfers into the Trust.

	2007/08	2008/09	2009/10	2010/11	2011/12
ALOS (days) Elective	4.4	4.3	4.2	4.1	4.0
ALOS (days) Non-elective	5.3	5.1	5.0	4.8	4.7
Bed reduction	25	43	22	21	19
WTE reduction	30	52	26	25	23
Recurring savings (£k)	840	1,445	739	706	638

Table 22: Planned Average Length of Stay reduction[17]

Length of stay reductions will be accelerated through our *Lean Thinking* programme. During 2008/09 part of the programme will focus on improvement work within the pharmacy service, to reduce delays for discharge medication. The programme will also focus efforts on improvements in the imaging and pathology services (see section below), to minimise delays for inpatient requests. This work will support the realisation of bed-related savings identified in the Trust's CRES plans.

[17] Note: different basis of calculation to Dr Foster benchmark in Table 16

Outpatients

The Trust aims to align its funded outpatient capacity with its booked activity levels eliminating the 'losses' in capacity due to reduced scheduling and utilisation of clinics. This will improve the waiting time for Outpatients appointments, and enable resource-reductions without reducing the level of service provision or affecting quality of service. Figure 12 illustrates the proposed approach to aligning capacity and demand and identifying the capacity losses which will be eradicated to reduce waiting lists and release resource, generating financial savings.

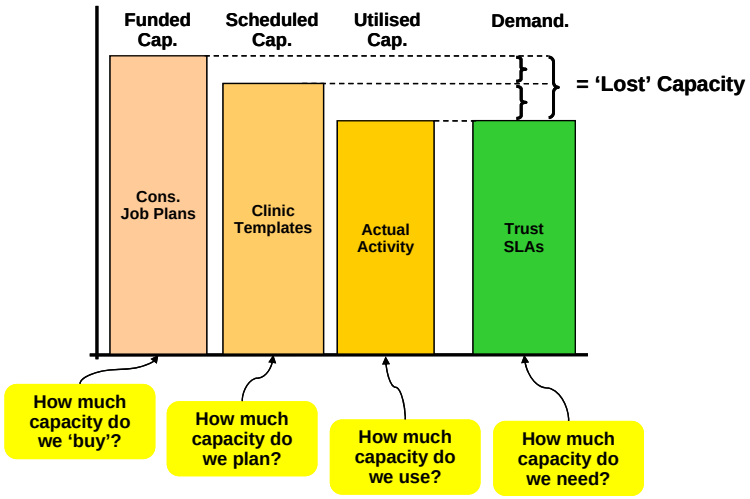
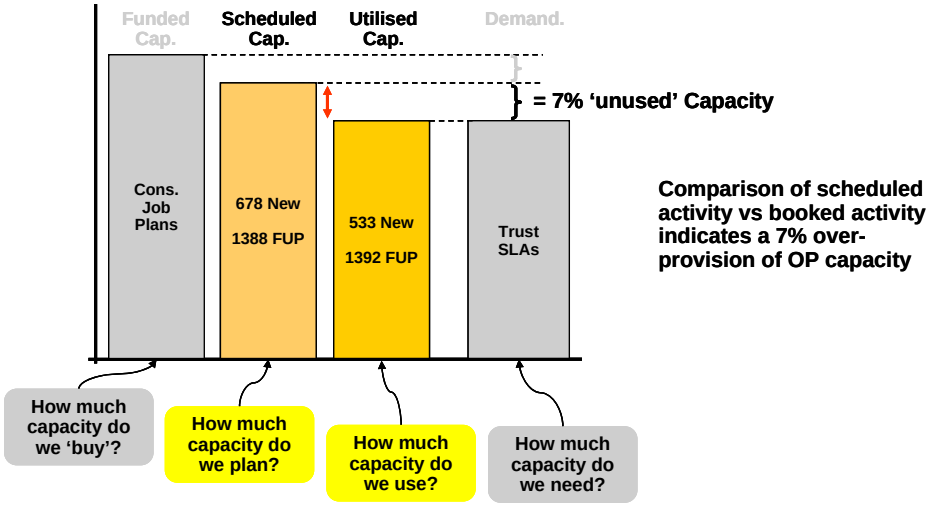


Figure 12: Proposed approach to capacity and demand alignment

Initial 'high-level' analysis completed in one pilot specialty, Dermatology, indicates considerable potential to reduce service delivery costs. A 7% opportunity to reduce capacity provision, based on the 'uptake' of scheduled capacity in May 2007 has been evidenced and is shown in Figure 13. The scale of this opportunity does not include any further available reductions through targeting the suspected imbalance between funded and scheduled capacity.



	New	FUP	Total
Scheduled Capacity	678	1388	2066
Booked Activity (inc. DNA's/Cancellations)	533	1392	1925
Over (under) capacity - slots	145	-4	141
Over (under) capacity %age	21%	0%	7%
Scheduled Clinics (May)			279
Pro-rata for year			3348
7% reduction			234
Approx no. of PA's (40 clinics/PA)			6
Saving (@£15k per PA - inc support costs)			~£90k
%age of Total Trust OP activity			4%
~Pro-rata Saving (targeting 25% of total)			~£560k

Figure 13: Opportunity to reduce capacity (Dermatology)

The Trust is planning to target the main Outpatient providing specialties (5 specialties contribute 25% of overall activity) over the next 2 years. Based on an extrapolation of the above Dermatology figures the Trust believes that there is the potential to release circa £550k of excess scheduled capacity (£300k in 2008/09 and £250k in 2009/10). These savings have been included in the Corporate Savings Plan (Appendix B). It is accepted that this figure needs to be substantiated by analysing the position for a wider range of specialties. The Trust expects to supplement these savings further by addressing any evidenced gap between funded clinic capacity and scheduled clinics. The value of this opportunity has still to be validated.

Table 23 shows efficiency gains expected to be made through improvements in our first to follow-up ratio and did not attend (DNA) rates. The Trust will aim to move towards a benchmarked target of 90th percentile for both.

	2008/09	2009/10	2010/11	2011/12
First to follow-up ratio	2.31	2.28	2.25	2.23
Estimated saving (£k)	78	74	70	67
% DNA rates	7.9	7.7	7.5	7.4
Estimated saving (£k)	45	41	38	35

Table 23: Efficiency gains expected

In a similar way to that outlined for the length of stay reduction targets, it should be possible to accelerate delivery of the five year DNA and first to follow-up ratios by two years. This would release circa £200k additional efficiency savings by the end of 2009/10. This has not been included in the Corporate Savings Plan, but represents a contingency plan in our corporate CRES. It is the Trust's intention to establish a corporate project to progress these improvements in outpatient services, as part of the overall service improvement programme.

Theatres

We will increase our theatre utilisation performance aiming to achieve levels in excess of 85%. The first step in this process, however, will be to confirm that we have a stringent definition and measure of theatre utilisation across the Trust, one that ensures we take account of all potential losses to our known capacity. Reducing process time lost in theatres and increasing cases per session based on an optimised case mix are examples of potential opportunities. Cost effective Theatres Operations Management is

highly dependent on patient turnaround time, clinical productivity and maximising list uptake across all specialities.

Implementation of strategies to improve theatre utilisation and consultant productivity has already commenced at UBHT, however, further improvement will aim to increase utilisation from an average utilisation of c. 79% to in excess of our 85% target. This objective together with the proposed approach is outlined in Figure 14 below.

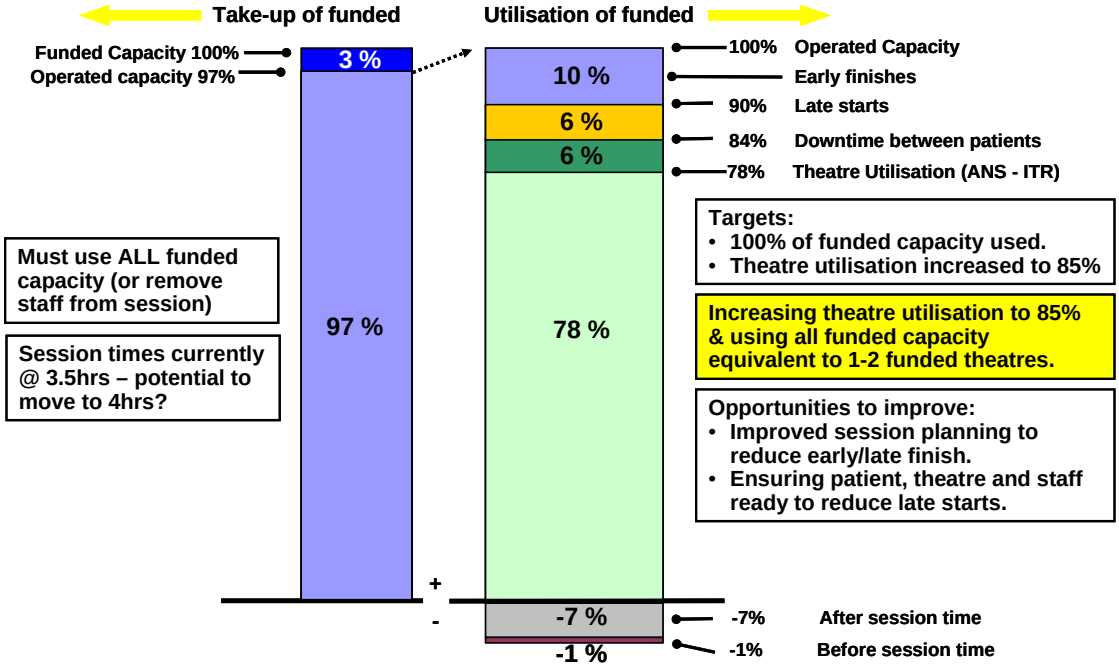


Figure 14: Theatres Productivity

It is anticipated that the majority of the savings will be realised from the top 10 specialities. A high level benefit calculation, as outlined in Table 24 below, suggests that improving theatre utilisation from 78% to 85% over a two year period has the potential to release recurring savings of circa £0.5 million over a two year period (i.e. £250k realisable in 2008/09 and in 2009/10), as outlined in Table 24 below. This is included in the Corporate Savings Plan (Appendix 8).

Benefit calculation		
Hours / session	4	
Target op time	85%	
Cost / session	£1,000	
	Top 10 specialties	All specs
Planned capacity (hrs)	31,668	39,516
Planned capacity (sessions)	7,917	9,879
85% target operating time	26,918	33,588
Difference from current (78%)	2,364	2,949
Sessions 'regained'	591	737
Estimated saving	£590,000	£737,000

Table 24: Theatre efficiency savings calculation

Imaging & Pathology

In imaging adjusting skill mix and improving facility configuration will reduce the time qualified staff spend on non-examination activity. For example, there are indications

that significant radiographer and radiologist time is spent on activities that could be either stopped or carried out by less qualified staff grades. In addition, the current situation requires that staff support multiple sites. A reduction in site coverage will reduce the cost of out of hours support, enabling staff scheduling benefits and reduced wasted time on travel between sites.

In Pathology redesigning processes to improve flow and mapping skill mix based on competencies will enable improved productivity and turnaround times. Employing strategies to increase 'on-ward' levels of education and improved referral monitoring to reduce the number of unnecessary tests requested by the Trust have the opportunity of reducing overall workload.

There are also opportunities to improve inpatient access to diagnostics/ imaging which would in turn support the length of stay and 18 weeks objectives. This focus on imaging and pathology services will support CRES schemes contingent upon bed closures and increasing income by increasing the through-put of elective admissions.

Other service improvement

In addition to the above areas of service improvement that support the Trust's Savings and long term business plan, there are a number of separate implementation plans have been created for key enabling projects that can be found in Appendix 9. These plans define the aims of each project/area, the specialties to which they apply and their associated benefits for 2007/08 and beyond. The projects/areas covered here include:

- A rolling programme of **patient pathway improvement projects** prioritised in the first instance in terms of those which pose the highest risks to delivering the 18 week challenge. Additional pathway work has been undertaken as **Lean pilot projects** in Ophthalmology, Gynaecology and other specialties, to test out the local application of the methodology in delivering productivity and efficiency gains. These initial pilots have proved highly successful.
- **Focus On Series** (NHS Institute for Innovation and Improvement) which identifies best practice in some areas including Acute Stroke, Fracture Neck of Femur aimed at improving productivity and efficiency, particularly relating to length of stay.
- A ward level initiative; **Productive Ward: Releasing Time to Care** (NHS Institute for Innovation and Improvement) will be implemented where the emphasis will be on increasing the time for direct patient care so that the ward team can create safe and reliable care systems. Four wardshave been identified; one within each of the clinical divisions and further roll-out is anticipated after evaluation of the pilot wards if increased time spent in direct patient care can be demonstrated.
- The pathway improvement projects and Productive Ward pilots will link closely to the Safer Patient Initiative underway in the Trust.
- An additional strand to the work programme relates to benefits realisation of the **NHS Care Records Service (NHS CRS).** Prior to implementation of the IT solution the Trust has identified opportunities for improvement through clearly defining and standardising some core processes to ensure we maximise the opportunities the new system will bring.

5.4.4 Review Processes & Governance

Delivery of the improvement programme is overseen by two established groups within the Trust; the Innovation Board and the Trust Operational Group, each with a different focus. The Innovation Board focuses primarily on the delivery of the individual projects that make up the improvement programme in terms of process/pathway redesign,

workforce redesign and changing working practices through the introduction of technology. The Innovation Board ensures that realistic and challenging objectives are set for the projects and oversees their delivery. It shapes the organisational development work required to embed continuous improvement within our culture and ensure clinical leaders and frontline teams are supported to lead improvement work in their areas thus, supporting delivery of two of the strategic aims; building capability and securing engagement.

The Trust Operational Group (TOG) oversees all operational aspects of the Trust's performance objectives. It will in 2008/09 and onwards focus on the high impact improvement objectives, such as the length of stay, outpatient and theatre projects, which underpin financial delivery of a significant proportion of the Corporate and Divisional Savings Plans (Appendix 8). TOG will support delivery of the third strategic aim; improving performance. Governance arrangements for delivery of the CRES plans themselves are outlined separately in the section 6.7.3 which addresses the Savings Plan.

5.5 RESEARCH AND DEVELOPMENT PLAN

Research is part of UBHT's core business. A robust portfolio is necessary to position the Trust well for future excellence in research and clinical delivery. It will:

- Make leading-edge treatments and services available to our patients
- Encourage the recruitment and retention of high calibre staff
- Enhance the Trust's reputation with commissioners, referring clinicians, patients and the public
- Allow our staff and patients the opportunity to take part in and contribute to clinical research
- Generate income.

As the premier secondary and tertiary acute teaching Trust in the South West the organisation is committed to providing high quality evidence based clinical care. The Trust supports, undertakes and collaborates in a wide range of research and development contributing to the global evidence base. The Trust implements relevant research findings to improve treatments and services for patients. The Trust's Clinical Effectiveness activity is also led by the Director of Research emphasising UBHT's commitment to both contributing and using up to date evidence in healthcare provision.

UBHT has a good reputation for conducting and disseminating high quality patient-focussed research addressing clinical priorities and our research has informed a number of NICE, and other national, guidelines as well as improving the quality and safety of patient care locally. For example we have the lowest in-hospital mortality for all cardiac procedures (including urgent cases and emergencies) of only 2.2% compared with the national average of 3.7%. This is due to the Cardiothoracic Unit of United Bristol Healthcare NHS Trust and the Bristol Heart Institute pursuing focused research themes over the last few years aimed at improving the safety and efficacy of cardiac surgery in a wide range of patient groups.

Key to the Trust's tripartite agenda is the maintenance of a strong research focus but the strategy outlined in *Best Research for Best Health* creates uncertainty about the future amount and mechanism of distribution of NHS R&D Support Funding to maintain the appropriate infrastructure. The Trust has planned for reduction of this support income as per the financial plan over the next three years, as shown below.

R & D Funding (at 2007/08 prices)	2007/08 £m	2008/09 £m	2009/10 £m	2010/11 £m
Baseline Income 2006/07	7.2	7.2	7.2	7.2
New Income	6.1	3.9	2.8	2.8
Net Loss of Income	1.1	3.3	4.4	4.4

The national strategy provides opportunities in that significantly more funding will be available for clinical patient-focussed research that addresses NHS needs. UBHT has consistently demonstrated a strong track-record in this activity. New research funding will be bid for in the NHS programmes with income allocated and accounted against those specific projects. Research funding from NHS sources as well as other Government departments, Research Councils and major charities will attract additional support funding through the U.K. Clinical Research Networks. Currently 72% of the £11m p.a. external research funding supported by UBHT is from funders that will attract this support. In future researchers will be expected to target grant applications to these funders where possible and the full economic cost of research will be sought from organisations that do not attract NHS Support costs. The mitigation of further financial risk is outlined below in four key areas:

- Improved collaboration between research partners
- Focus on clinical strengths and key strategic areas
- Commitment to NHS specialist and generic research trials networks
- Hosting the development of University of Bristol's Clinical Research Imaging Centre for trials facilities.

5.5.1 Research Partnership

Best Research for Best Health emphasises the need for strong collaboration in development of an NHS research portfolio. The Research Councils are increasingly focused on basic science and University academics will increasingly wish to use NHS research funding streams for clinically based programmes. Joint strategies will be developed with both university and NHS partners to increase accessibility to the new opportunities. The Trust has had an initial success with a combined bid for Research for Patient Benefit monies in community based paediatric research. A relatively new challenge for university academics is the priority now being given to user involvement in research bids at inception, planning and in delivery. Some research groups in UBHT have a strong track record in this and the Trust Research and Development Office provides expertise in this area and will engage all programme bidders in an educational programme to enhance the potential for success.

The Trust has successfully bid to become the host organisation for the Comprehensive Local Research Network. This will be accommodated in the new Research Management Office Suite of the joint UBHT and University of Bristol Education Centre. The Trust has also led on a combined Bristol bid for a "Collaboration for Leadership in Applied Health Research Centre" and a Cardiac Biomedical Research Unit.

Other recent successes have been the successful appointment of new academic posts via Walport bids providing new Academic Lecturer and Fellow posts within the Trust with both our main university partners. UBHT will optimise funding for research by

identifying all relevant funding opportunities and assisting appropriate investigators to bid for and strengthen appropriate grant applications. With our partners we will proactively identify cross-organisation combinations of expertise and skills that together can compete successfully for all available funding streams.

5.5.2 Clinical Strength and Key Strategic Areas

There will also be opportunities to take collaboration to further levels of engagement with the Trust hosting research planning meetings in its key themes identified in the clinical services strategy; Cancer, Cardiac, Children's and Emergency care. These themes are strengths within the Trust's and our key academic partners' current research portfolios. As the provider of main tertiary services in these clinical areas, the Trust will collaborate with the co-located university departments and neighbouring NHS partners.

The intention is for key priorities to be outlined between partners and shared collaborative bids to be developed for NHS programmes. Child Health, Rheumatology, Cardiac Surgery and Sexual Health are early examples which will be extended to cancer research where close links are already built in workforce development, clinical networks and clinical trials. We will continue to build on current work sharing research plans and aspirations with partners and develop a shared research strategy founded on current strengths.

5.5.3 Trials Networks

Since 2001 the Trust has provided the Hub for the South West's first NHS National Cancer Research Network, based in the Oncology Centre, providing leadership and central facilities for local, regional and national trials.

In 2006, it was successful in a bid to lead the South West Medicines for Children trials network and most recently in April 2007 was appointed host for the Comprehensive Local Research Network. These will be co-located in the Education Centre providing high profile offices in good estate close to the Trust's R&D office. It is anticipated that the management of these three key networks will ensure continued and expanded funding for national randomised clinical trials with an opportunity for the Trust to develop efficient management systems and preserve a significant proportion of NHS R&D support funding.

5.5.4 Joint UBHT & University of Bristol Clinical Research Imaging Centre

The Trust is partnering this development in St. Michaels Hospital which will provide a 3T MRI scanning facility and clinical research rooms for all phases of clinical trials including first 'in-man' phase 1 trials and facilities for sleep study which is one of our particular strengths. The £6.5m development is a key part of the University's development of first class neuroscience research. It is anticipated the centre will also host trials facilities for other academic and clinical departments which have previously dispersed clinical research throughout the Trust. The University is providing the capital funds and UBHT will fund key NHS support staff in this partnership and provide space and estate and facilities support. The centre is expected to open in 2009 and it is intended to seek further funding from a variety of sources, including charitable and commercial sources, to expand this core facility to embrace a broader range of opportunities.
The key to a successful implementation of the Trust's research strategy is consistent partnership working with focus on all the involved organisations' strengths. This will be achieved by setting common themes and through consistent communication.
Table 25 provides a summary of the joint Clinical Research Imaging Centre (CRIC) development.

Factor	Detail
The 'driver' (The link to environmental factors, strengths or weaknesses)	• Need for state-of-the-art MRI functional imaging for University and NHS neurosciences, children's and cardiac research • Planned closure of BGH requires reprovision of clinical sleep study facilities • Requirement of dedicated clinical research facilities to meet consumerism and governance needs
The high level benefits case	• Increased competitiveness of Bristol research groups • Co-location of adult and paediatric, clinical and research, sleep study facilities and expertise • Opportunity for income generation • Enhanced specialist reputation
Timescales	• Completion planned for 2009
Key risks and how they will be managed	• Researchers fail to obtain research income to enable optimal use of facility. Managed by detailed business plan identifying multiple funding streams.
High level operational, HR, governance and financial implications	• University of Bristol providing capital (£6.5M) and scientific staffing (~ 7 wte). UBHT providing some clinical staffing (~2 wte) and occupancy costs of 1100 sq.m. Joint management arrangements will ensure appropriate governance.
Link to more detailed plans	• CRIC Business Case (July 2007)

Table 25: Summary of joint Clinical Research Imaging Centre development

5.6 SITE DEVELOPMENT PLAN

The Trust's assessment of internal strengths and weaknesses and external opportunities and threats has highlighted the central importance of its site development plan to delivery of its mission.

This plan involves rationalisation of estate holdings to the most efficiently utilised central core and investment, firstly, to bring the core estate up to a condition suitable for modern clinical care and attractive to patients under choice and, secondly, to provide the appropriate capacity and configuration for the long-term.

The Trust provides services from eight main sites, the majority around a central precinct with a total floor area of 138,000 sq metres. The age profile reveals that 30% of the estate dates from before 1948, with only 31% being less than 30 years old.
The plans for site rationalisation and development described here will significantly improve the quality of the estate, by reducing the proportion of building stock that is over 30 years old. The proportion of buildings constructed after 2000 will increase from 16% to 32% of the estate as the percentage of those built before 1948 shrinks from 30% to 8%.

5.6.1 Site rationalisation

The Trust disposed of Keynsham Hospital during 2006, following a public consultation on the future of the hospital, and re-provided rehabilitation services for Bristol residents at the Bristol General Hospital.

The Bristol General Hospital itself will close once services have transferred to the new South Bristol Community Hospital in 2009.

The Bristol Royal Infirmary Old Building is one of the oldest operational medical facilities in the country. It is distant from essential clinical support services on the other side of Upper Maudlin Street and no longer provides an appropriate inpatient environment. It accounts for 25% of the Trust's current backlog maintenance requirement. The Trust plans to re-provide services from this building and dispose of the site in 2013.

The Trust will also dispose of a number of non-essential, off-site residential properties.

5.6.2 Investment Plans

The Trust's major capital investment plans are entirely consistent with the Bristol Health Services Plan described in Section 4 and have been shown to be affordable, through use of Trust capital, under the long term financial plan outlined in Section 6.

Current investment plans are driven by the requirements of national service frameworks and locally by the Bristol Health Services Plan.

An £18 million expansion and refurbishment of the Bristol Dental Hospital was completed in December 2007, jointly with the University of Bristol, as part of the national expansion in dental student numbers.

A £64 million new build cardiothoracic centre is currently under construction as part of the national programme. This important scheme, known as the Bristol Heart Institute is described further in the next section.

5.6.3 Bristol Heart Institute

The scheme, due for completion in 2009, involves the building of a modern purpose-designed cardiothoracic facility on a site immediately adjacent to the north aspect of the Queen's building of the Bristol Royal Infirmary. The building occupies four main floors, with accommodation surrounding a central atrium. Additional floors will be used for plant. The facility will link directly to the existing cardiac intensive unit and theatre area to provide a seamless continuation from existing facilities to the new centre. The integrated design includes a full range of outpatient and diagnostic facilities, cardiac catheterisation laboratories, cardiac theatres, coronary care unit, day bays and three large ward areas. The total floor area of the centre will be 11,900 square metres. The exterior of the building will be landscaped into the wooded area close to the BRI.

Table 26 provides a summary of the development.

Factor	Detail
The 'driver' (the link to environmental factors, strengths or weaknesses)	• Service strategy and focus on regional provider role in cardiothoracic services • National strategy for Coronary Heart Disease and increased revascularisation • Avon, Gloucestershire and Wiltshire cardiac network strategy • Commissioner strategy under Bristol Health Services Plan
The high level benefits case	• Capacity to deliver the NHS Plan and the Coronary Heart Disease National Service Framework • Delivery of improved access rates with equality across local health economy • Improved efficiency, reducing length of inpatient stay and reducing patient delays • Improved quality of service and clinical adjacencies • Increased research opportunities • Enhanced specialist reputation
Timescales	• Completion planned for 2009
Key risks and how they will be managed	• Flexibility designed in to accommodate changing treatment and imaging modalities • Joint review mechanisms in place with PCTs to monitor changes in demand or epidemiology
High level operational, HR, governance and financial implications	• 30 wte reduction in staff through natural wastage • Outpatient and diagnostic facilities, cardiac catheterisation laboratories, operating theatres and coronary care unit, as well as day and inpatient wards. • £64 million capital
Link to more detailed plans	• Full Business Case (February 2006)

Table 26: Bristol Heart Institute

5.6.4 Centralisation of Specialist Paediatrics in Bristol

The first phase of the centralisation of all acute inpatient paediatrics was completed in April 2007 with the transfer of general paediatrics from Southmead Hospital to a new extension at the Bristol Royal Hospital for Children.

The aim of the second phase is to transfer specialist children's inpatient and day-case services from Frenchay Hospital to the Children's Hospital.

The scheme proposed is a refurbishment of the Children's Hospital to provide a neurosciences service comprising Paediatric Neurosurgery and burns inpatient beds, an expansion of intensive care and theatre facilities coupled with dedicated diagnostic imaging. Other services including plastics, orthopaedics and scoliosis will also transfer, completing the full integration of hospital services for children in Bristol on to one site.

Table 27 provides a summary of the specialist paediatrics development.

Factor	Detail
The 'driver' (the link to environmental factors, strengths or weaknesses)	• Service strategy and focus on regional provider role in children's services • National strategy for centralisation of inpatient paediatrics (inpatient paediatrics currently split in Bristol) • Commissioner strategy under Bristol Health Services Plan • Planned closure of Frenchay Hospital
The high level benefits case	• Sustainable clinical governance through co-location with dedicated paediatric intensive care (avoiding cross-site transfers) • Increased research opportunities • Enhanced specialist reputation for the Trust
Timescales	• Completion planned for 2011/12
Key risks and how they will be managed	• Affordability under national tariff is a major risk to be managed through commitment to additional revenue support from PCTs (through South West Specialist Commissioning Group) plus additional internal subsidy of £228k, shown to be affordable under long term financial plan.
High level operational, HR, governance and financial implications	• Transfer of existing staff numbers with new medical posts required as a result of dis-aggregation of adult and paediatric workforce at Frenchay Hospital • 22 new inpatient beds, 3 theatres, day beds, CT scanner, MR scanner plus other imaging. • Allocation of existing adult day theatres in the Bristol Royal Infirmary to paediatric use. • £21 million capital
Link to more detailed plans	• Outline Business Case (June 2007, approved by SHA Board October 2007)

Table 27: Centralisation of Specialist Paediatrics in Bristol

5.6.5 Redevelopment of the Bristol Royal Infirmary

This project aims to improve adult inpatient facilities at the Bristol Royal Infirmary and facilitate the provision of additional capacity at UBHT to meet increased adult emergency workload as a result of the planned closure of the Frenchay Accident & Emergency department.

The improvement to inpatient facilities will be delivered through two phases, the first phase taking advantage of vacated inpatient bed space created by the completion of the Bristol Heart Institute, described earlier.

The second phase will deliver a new build providing replacement and additional adult inpatient wards to consumerism standards, an expanded intensive care unit and additional theatres to meet projected demand for surgery.

Some non-clinical facilities will be re-provided as part of the new build development. Completion of the second phase will achieve the total closure of the Bristol Royal Infirmary Old Building.

Table 28 provides a summary of the BRI redevelopment.

Factor	Detail
The 'driver' (the link to environmental factors, strengths or weaknesses)	• Quality of patient environment in Bristol Royal Infirmary • Commission for Health Improvement recommendation about BRI Old Building in 2003 • Consumerism standards • Commissioner strategy under Bristol Health Services Plan • Planned closure of Frenchay Hospital and changes to acute emergency flows
The high level benefits case	• Replace unsuitable inpatient accommodation • Provide appropriate capacity for long term • Introduce new models of care and improve clinical adjacencies in both medicine and surgery • Enhanced environmental attractiveness
Timescales	• Completion planned for 2012/13
Key risks and how they will be managed	• Delivery of efficiency improvements (essential to ensure that planned capacity meets future demand) will be managed through the Service Improvement Plan. • Enabling works (critical to programme) are already in progress.
High level operational, HR, governance and financial implications	• £55 million capital • Closure and disposal of BRI Old Building • Construction of new ward block extension to BRI Queen's Building • Extensive refurbishment of BRI Queen's Building • New models of care for management of medical and surgical urgent and emergency patients • Re-balancing of clinical staff and skill-mix to emergency "front-end" of hospital, with creation of acute physician role and enhanced assessment nursing.
Link to more detailed plans	• Outline Business Case (July 2007, approved by SHA Board October 2007)

Table 28: Redevelopment of the Bristol Royal Infirmary

5.7 SUMMARY OF ACTIVITY PROJECTION

Table 29 shows the baseline and future activity projections underpinning the long term financial plan, which take account of the environmental changes and competitive factors described in the Market Assessment, including:

- demographic and epidemiological drivers
- waiting time targets
- PCT demand management initiatives
- anticipated market share changes, including planned service transfers, both between local acute providers and to new community development.

Work type	2007/08 Activity	2016/17 Projected Activity
Accident & Emergency	112,894	108403
Elective Inpatients	16,407	18,784
Day Cases	53,702	55,774
Non-Elective Inpatients	38,888	44,169
Non-Elective Short Stay Inpatients	10,494	11,449
New Outpatients	138,716	139,732
Follow up Outpatients	312,639	295,244
Critical Care	25,365	30,359
Excess Bed days	46,792	41,130
Day Care	3,498	776
Radiotherapy Courses	3,254	3,443
Regular Attendances	5,984	6,259

Table 29: Baseline and Future Spells by Type of Activity

5.8 RESOURCE IMPLICATIONS OF ACTIVITY PLANS

To determine the implications of the activity plan on future requirements for clinical facilities, the Trust has developed a range of performance assumptions for day-case rates, average length of inpatient stay, and outpatient utilisation. These have been benchmarked against the 90th percentile (upper decile) peer performance in 3 groups of peer providers, according to the specialties concerned. These are shown in Appendix 10.

Table 30 shows the resulting bed capacity requirements by bed-pool (aggregated from the relevant specialties). The Trust currently has a maximum capacity of 1156 available beds, including the Bristol General Hospital. It will be seen therefore that a reduction by 60 beds, or 5% of the current bed-base, is a major resource implication of the activity plan. This reduction has been factored into the Trust's business cases for major capital development.

Bed Pool	Day Case	Inpatient	Critical Care	Total
A&E Observation	0	6	0	6
Cardiothoracic	3	92	22	117
ENT	1	18	0	19
Gynaecology	4	29	0	33
Maternity	3	65	0	68
Medical	4	240	13	257
Oncology/Haematology	32	65	0	97
Ophthalmology	21	16	0	37
Oral Surgery	4	0	0	4
Paediatric ICU	0	0	16	16
Paediatric Medical	19	83	1	103
Paediatric Surgical	10	69	1	80
Rehabilitation (stroke)	0	10	0	10
SCBU/NICU	0	0	40	40
Surgical	20	168	8	196
Grand Total	122	861	101	1,084

Table 30 projected bed requirements in 2016/17.

The impact on numbers in key workforce groups over the period is shown in section 8.7.1.

Planned changes to the Trust's estate will require major capital investment, as described in the Site Development Plan earlier and incorporated into the Financial Plan. The capital costs of the planned major schemes are itemised in Section 6.7.6.

6. FINANCIAL PLAN

6.1 INTRODUCTION

This section describes the key factors determining the Trust's financial performance over the period 2007/08 to 2016/17. The following areas are covered:

- Historical financial performance
- Current financial performance
- Base case projections including income and expenditure, balance sheet, cash and risk ratings
- Sensitivity scenarios.

6.2 FINANCIAL STRATEGY

The Financial Plan has been generated using the approach set out in the Trust's Financial Strategy (approved December 2006). The Strategy includes the following key principles:

- Key Strategic schemes will be afforded by the creation of a Strategic Reserve which will grow from the use of tariff funds for capital growth plus 25% of new activity tariff income. The Strategic Reserve then funds the infrastructure costs of strategic developments.
- Surpluses generated by positive balances in the Strategic Reserve will only be used for non-recurring purposes including improving liquidity, supplementing the capital programme, funding work in progress charges and repayment of loan balances.
- Savings requirements will be set between 0.25% and 0.5% above the level of national tariff efficiency savings. From this balance non-nationally funded cost pressures will be met. These may include the loss of Research and Development funding, local cost pressures, under-funded National initiatives etc.
- The decisions on which cost pressures will be funded are from a prioritisation programme with unfunded proposals subject to risk mitigation assessments.
- Non-recurring measures required to achieve break-even in any year must be below 1% of turnover as a proxy for recurring balance.

6.3 HISTORICAL FINANCIAL PERFORMANCE

Income and Expenditure

UBHT has achieved four financial years of breakeven or better following two years where significant deficits were experienced. The Trust achieved a normalised surplus in 2005/06 and has continued to deliver a normalised surplus in 2006/07 and 2007/08 (forecast).

Whilst recovering from a deficit position non-recurring measures were legitimately used (including some that were not cash backed) but the Trust is now in recurring balance and has a strict policy of only using non-recurring measures to compensate for slippage in recurring savings schemes or to offset in year non-recurring costs.

Table 31 shows the income and expenditure position over the past six years:

Surplus/(Deficit)	2001/02 £m	2002/03 £m	2003/04 £m	2004/05 £m	2005/06 £m	2006/07 £m
I&E position re Accounts	**(7.7)**	**(9.3)**	**0.1**	**0.1**	**3.3**	**1.1**
Less						
RAB Carry Forward					(0.1)	(3.5)
I&E NHS Bank Support Received	(6.0)	(1.3)	(3.8)			
Technical I&E Changes			(1.0)	(1.5)	(0.4)	
Non-recurring savings			(3.4)			(2.0)
Hosting services surpluses				(1.7)	(2.0)	(1.5)
Profit on sale of fixed assets	(1.1)			(0.2)	(0.4)	
Revenue to Capital transfers		(0.4)	(0.4)	(0.5)	(1.6)	(1.1)
Add						
Payment by Results clawback					5.7	4.1
Non-recurring funding reductions						4.4
PCT Income Adjustment						2.0
Hosting services reinstatement					1.7	2.2
Loss on sale of fixed assets		0.2				
Non-recurring costs					0.5	
Normalised Net Surplus/(Deficit)	**(14.8)**	**(10.8)**	**(8.5)**	**(3.8)**	**6.7**	**5.7**
Add						
Depreciation (net of donated)	6.8	8.7	10.2	11.4	10.6	12.0
PDC Dividend	10.0	10.5	6.9	7.1	7.3	8.1
Other costs below Operating Surplus	0.0	0.7	0.7	0.6	0.7	0.6
Less						
Other income below Operating Surplus	(1.0)	(0.2)	(0.3)	(0.5)	(0.5)	(0.5)
Normalised EBITDA	**1.0**	**8.9**	**9.0**	**14.8**	**24.8**	**25.9**
Normalised EBITDA Margin %	**0.4**	**3.3**	**3.0**	**4.6**	**7.1**	**7.0**

Table 31: Historical Income and Expenditure Performance

This analysis shows a steadily improving financial position and a normalised net surplus from 2005/06.

The 2006/07 position included a Central Budgets reduction in year of £4.5m. This was initially assumed to be non-recurring but was subsequently confirmed as a recurring reduction of £3.0m. The normalised net surplus of £5.7m is therefore after only £1.5m of the Central Budgets reduction is categorised as non-recurring (shown as part of the non-recurring funding reduction figure of £4.4m which is also includes a £2.9m AGW Trust top-slice).

Savings

The level of savings achieved since 2004/05 has been significant and is summarised in Table 32.

	Savings Achieved £m	% of Income
2004/05	13.9	4.3%
2005/06	14.0	4.0%
2006/07	13.4	3.6%
2007/08 forecast	16.1	3.9%

Table 32: Savings Achieved 2004/05 to 2007/08

The savings achieved in 2004/05 to 2006/07 are analysed by category in Appendix 11. Appendix 15 sets out the forecast achievement for 2007/08.

Productivity

The Trust has significantly improved its cost efficiency in line with its parallel improvement in the income and expenditure position. This has been achieved by a combination of cost savings and increased clinical activity. This efficiency improvement is measured by the NHS Reference Cost Indices (RCI) which show costs per unit of activity (expressed as Healthcare Resource Groups) for the whole country. This is shown in Table 33.

The Trust believes that its RCI would be significantly lower if the impact of Specialist Paediatric services was more accurately reflected in the national figures. This is likely to be addressed by the Department of Health in future years as it is accepted as a real issue with suitable uplifts to Specialised Services being introduced in the 2008/09 Payment by Results tariffs.

100 = National Average	Reference Costs Index
2001/02	116
2002/03	108
2003/04	104
2004/05	96
2005/06	94
2006/07	97

Table 33: Cost Efficiency – Reference Cost Indices 2001/02 to 2006/07

ALE Scores

The Audit Commission, as part of the Annual Health Check, uses a system known as ALE (Auditor's Local Evaluation) as an indicator to measure the organisation's "Use of Resources". The component scores for UBHT are shown in Table 34.

	2005/06	2006/07
	Score	Score
Financial Management	2	3
Internal Control	2	3
Value for Money	3	3
Financial Reporting	3	3
Financial Standing	2	2
Overall Score	**2**	**2**

Table 34: Auditor's Local Evaluation Scores

The financial standing assessment is subject to a review of the rules determining the statutory duty to breakeven. At present deficits from five years ago still count in deeming the Trust to fail the statutory duty to breakeven. The Trust's cumulative I&E deficit stands at £12.8m for 2006/07. The planned surplus in 2007/08 clears the cumulative deficit and would enable the Financial Standing rating to be scored as 3 leading to an overall score of 3 (assuming other scores remain the same) which is classified as 'Good' in the use or resources assessment in the Annual Health check.

Cash

The Trust has operated for the past three years with an underlying cash deficit of £20.3m. This resulted from a combination of issues as shown in Table 35 below:-

	£m	
Cumulative I&E deficit	12.8	From 2001/02 to 2006/07
RAB Carry Forwards	3.6	Net in I&E Deficit but not cash backed
Non-cash backed I&E actions	3.1	Including accountable stock extensions
Other cash shortfalls	0.8	Including NHS Debtors
Total	**20.3**	

Table 35 Cash Deficit to 2006/07

In March 2007 in accordance with national policy the Trust took out a long term loan of £20.3m repayable over 20 years. This effectively restores the liquidity position to a level which supports operations without the need for further external support. The IBP sets out plans for the early repayment of the loan (£12.8m 2007/08, £5m 2008/09, £2.5m 2009/10) following discussions with the Strategic Health Authority and the Department of Health. It has now been confirmed by the SHA that the early repayment penalty charges will be waived.

LTFM Outputs

The outputs from the Monitor Long Term Financial Model are included as Appendices:

- Appendix 12 Income Expenditure Performance 2004/05 to 2016/17
- Appendix 12a Income and Expenditure Changes Commentary
- Appendix 13 Balance Sheet Performance 2004/05 to 2016/17
- Appendix 13a Balance Sheet Assumptions
- Appendix 13b Balance Sheet Changes Commentary
- Appendix 14 Cashflow Performance 2005/06 to 2016/17
- Appendix 14a Cashflow changes Commentary.

6.4 CURRENT FINANCIAL PERFORMANCE

The financial plan for 2007/08 can be summarised as follows:

- An original £4m planned surplus – the cash generated to be partly used to pay the first instalment of the Long Term loan repayment.
- Savings of £16.3m were required, subsequently reduced to £15.3m with a forecast achievement of £16.1m. The initial target comprised £3.4m in respect of underlying Divisional overspendings and £12.9m of new savings. A detailed analysis of the 2007/08 Savings Programme is shown in Appendix 15.
- The Central Budget reduction of £4.5m in 2006/07 has been reduced to a £3m recurring reduction following agreement with the NHS South West SHA.
- Research and Development funding has been reduced by £1.4m as part of the phased implementation of the National Research and Development Strategy.
- Significant other challenges include the implementation of Modernising Medical Careers, the delivery of 18 weeks target within tariff, non-recurring work in progress capital charges for the Cardiac and Dental Student Expansion schemes (£0.9m) and other cost pressures.
- The plan for 2007/08 was revised at Month 6 following a detailed review of the financial position. The revised plan is now a £12.8m surplus. Continuing strong financial performance to 31st January confirms the Trust remains on target to

deliver the revised financial plan. This position is founded on CRES achievement, strong cost control and good income performance.

- The Trust will therefore clear its cumulative I&E deficit at the end of 2007/08. This will facilitate the early repayment of the long term loan as described in section 6.3 above.
- The Trust has a recurring surplus of £4.5m at the end of 2007/08. This is consistent with the Financial Strategy where the Strategic Reserve is not used for recurring purposes unless the scheme is part of the Service Development Strategy.

6.5 THE APPROACH TO PREPARING THE LONG TERM FINANCIAL PLAN

The assumptions used and the approach to preparing the Long Term Financial Plan are key to both understanding the plan and also evaluating its robustness. It is important that the Integrated Business Plan describes to both healthcare professionals and the public how the Trust intends to proceed over the next ten years or so in respect of:

- Clinical Services Development / Strategy
- Capital / Estates planning
- Workforce changes
- Implementation of the NHS Plan.

The Financial Plan needs to ensure a financially sound position is maintained throughout the period of the Business Plan. If financial plans are breached and the Trust is at risk of moving into recurring deficit, the service and clinical plans will automatically be put at risk and funding instead of being used to improve / develop services will instead need to be used to cover deficits.

Holding a recurring Strategic Reserve and making surpluses is necessary. Without this financial discipline the service and clinical plans in the following years cannot be implemented. Before the Trust can commit to and contract for its major capital schemes it must have robust plans that generate the savings required to finance those schemes. The purpose of the Financial Plan, therefore, is to provide a framework from which realistic and deliverable annual financial plans can be generated.

It is fully recognised that the projections in the ten year Financial Plan may be subject to changes from the plan for a variety of reasons – clinical change, political change and economic issues. This does not, however, undermine the Financial Plan but enables planned adjustments to be made in the future years to respond to actual changes in the early years. This ensures service plans are not compromised.

Cash Releasing Efficiency Savings need to be delivered by recurring schemes. Non-recurring CRES is not recognised other than in delivering non-recurring savings to compensate for slippage in implementing recurring schemes. Recurring CRES not delivered in one year will be added to the following years CRES target and performance managed to delivery.

The Plan needs to include sufficient flexibility to cope with potential downside scenarios. The importance of prompt managerial correction of adverse trends (mitigation) cannot be overemphasised. The Trust has a good track record in recent years of delivering financial surpluses despite pressures on the cost of services from non-financial performance targets.

Table 36 sets out the key changes included in the Financial Plan both to describe the plan but also to show the recurring and non-recurring impact of each change.

		Financial Impact of Each Change 2008/09 – 2016/17					
		Recurring				Non – Recurring	
		Start Date	Income £m	Expend. £m	Surplus/ (deficit) £m	WIP Charges £m	Bank Support £m
A	**Service and Clinical Changes**						
	Dental Student Expansion	Apr 2009	2.0	1.9	0.1		
	Bristol Heart Institute opens	Apr 2009		4.7	(4.7)	(2.6)	4.5
	NCRS Implemented (savings realised)	Apr 2009		(1.1)	1.1		
	Transfer of Somerset oncology service to Taunton	Apr 2009	(2.3)	(2.1)	(0.2)		
	Transfer of Old Building Wards to former Cardiac Unit	Apr 2009		0.4	(0.4)		
	Closure of Bristol General –re South Bristol Hospital	Oct 2009	(9.5)	(8.9)	(0.6)		
	Transfer of Minor A&E to South Bristol	Oct 2009	(0.6)	(0.4)	(0.2)		
	Transfer of out-patient activity to:						
	- South Bristol Hospital	Oct 2009		0.8	(0.8)		
	- Eastville Health Park			0.3	(0.3)		
	Transfer of elective activity to:						
	- ISTC	Oct 2009	(1.9)	(1.4)	(0.5)		
	- South Bristol Hospital			0.5	(0.5)		
	Specialist paediatric transfer from Frenchay	Apr 2012	11.4	11.7	(0.3)	(0.8)	
	BRI Redevelopment scheme completed (including Old Building closure and transfer of acute activity from Frenchay)	Apr 2013	11.0	10.8	0.2	(1.9)	
	Total		**10.1**	**17.2**	**(7.1)**	**(5.3)**	**+4.5**
B	**Other Changes**						
	R&D - loss of Income		(3.3)		(3.3)		
	- from internal cost pressures			(2.0)	2.0		
	Payment by Results						
	- New PbR gain		11.5	2.3	9.2		
	General activity projections		19.7	16.6	3.1		
	Tariff contribution re new Capital funding		2.8		2.8		
	Depreciation to fund major schemes		2.8		2.8		
	Interest receivable		3.8		3.8		
	Total		**37.3**	**16.9**	**20.4**		
C	**Start Recurring Surplus 2007/08**				**+4.5**		
D	**End Recurring Surplus 2016/17**				**+17.8**		
	Note – Impairments are excluded from the above analysis						

Table 36: Key Clinical/Service Changes included in the Plan

Whilst the I&E normalised surplus is maintained at between 2.3% and 3.4% of turnover it can be seen that service transfers out and new commitments, particularly in 2009/10, present a significant financial challenge. Changes which include the Cardiac Centre, South Bristol Hospital, Eastville Health Park, Independent Sector and Taunton Oncology present a challenge which amounts to a bottom line recurring negative impact of £7.0m over 2009/10 and 2010/11. These are effectively financed from gains in Payment by Results, contributions from net activity growth, NCRS savings and accumulated funding held in the Strategic Reserve.

The recurring position does however strengthen considerably in the subsequent years creating a strong underlying income and expenditure surplus which grows to £17.8m by 2016/17.

6.6 KEY ASSUMPTIONS IN THE FINANCIAL PLAN – BASE CASE

In addition to the service/clinical changes a number of key financial assumptions are made. These are the Base Case assumptions and are subject to sensitivity analysis later in this document.

6.6.1 Activity Assumptions

Activity changes not associated with the individual service changes listed in the previous section have been estimated using a combination of demographic and epidemiological growth, demand management and a number of factors related to individual specialties. This is described in Section 5.7 in more detail.

The overall rate of increases used is well below the 1.25% pa assumed by Local Health Economy PCTs in the Bristol Health Services Plan affordability assessment. These are summarised in Table 37.

	Change 07/08 to 16/17 %	**Change Per Annum %**
In-Patient – Elective and Day Cases	7.00	0.76
In-Patient – Emergency and Non-Elective	8.00	0.85
Out-Patients – New attendances	(0.60)	(0.07)
– Follow up attendances	(10.80)	(1.26)
Bed Day SLAs (including Excess Bed Days)	6.60	0.71
Accident & Emergency	2.70	0.30
Radiotherapy	46.20	4.31
Total Weighted Change	**6.00%**	**0.64%**

Table 37: Activity Changes – assumptions used 2007/08 to 2016/17

Information covering the general activity changes and individual service changes showing both planned income and activity levels over the period of the plan are included in the Appendices as follows:

- Appendix 16 SLA Activity projection by Type of Activity
- Appendix 17 SLA Income projection by Type of Activity
- Appendix 18 SLA Activity projection by Type of Activity and Specialty
- Appendix 19 SLA Income projection by Specialty
- Appendix 20 SLA Activity projection by Division, Type of Activity and Specialty
- Appendix 21 SLA Income Projection by Division, Type of Activity and Specialty.

6.6.2 Inflation Assumptions

The assumptions used in the model are set out below in Table 38.

	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Derived from:										
a. Clinical Income inflation										
• Pay inflation	2.50%	2.75%	2.40%	1.90%	1.80%	1.80%	1.80%	1.80%	1.80%	1.80%
• Non-pay inflation	0.60%	0.59%	0.60%	0.60%	0.60%	0.60%	0.60%	0.60%	0.60%	0.60%
• Clinical Negligence	0.20%	0.35%	0.20%	0.20%	0.20%	0.20%	0.20%	0.20%	0.20%	0.20%
• Drugs	0.70%	0.37%	0.70%	0.70%	0.70%	0.70%	0.70%	0.70%	0.70%	0.70%
• NICE	0.30%	0.30%	0.30%	0.30%	0.30%	0.30%	0.30%	0.30%	0.30%	0.30%
• Capital indexation	0.40%	0.27%	0.40%	0.40%	0.40%	0.40%	0.40%	0.40%	0.40%	0.40%
• Capital Growth	0.20%	0.08%	0.20%	0.20%	0.20%	-	-	-	-	-
• Quality and Reform	-	0.59%	-	-	-	-	-	-	-	-
• Connecting for Health	0.10%	-	-	-	-	-	-	-	-	-
• Efficiency	(2.50)%	(3.00)%	(3.00)%	(3.00)%	(2.50)%	(2.00)%	(2.00)%	(2.00)%	(2.00)%	(2.00)%
Total Tariff Uplift	2.50%	2.30%	1.80%	1.30%	1.70%	2.00%	2.00%	2.00%	2.00%	2.00%
Cost Inflation:										
• Pay	2.70%	4.50%	2.75%	2.75%	2.75%	2.75%	2.75%	2.75%	2.75%	2.75%
• Incremental Drift	0.90%		0.85%	0.45%	-	-	-	-	-	-
• Drugs (inc NICE)	10.00%	9.00%	10.00%	9.00%	9.00%	8.50%	8.00%	8.00%	8.00%	8.00%
• Capital Charges	6.00%	6.40%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%
• Other Non-Pay	2.70%	3.90%	2.70%	2.70%	2.70%	2.70%	2.70%	2.70%	2.70%	2.70%

Table 38: Tariff uplift and cost inflation assumptions 2007/08 – 2016/17

Notes:

- Increased non pay inflation in 2008/09 relates to establishment expenses resulting from reform and quality investment within the tariff uplift,
- Investment in new capital – as per tariff uplift (assumed to contribute towards the Strategic Reserve each year up to 2011/12),
- Clinical Negligence – as per tariff uplift (assumed at 0.2% of tariff each year from 2009/10 onwards),
- Efficiency – as per tariff uplift (assumed at 3% of tariff 2008/09 to 2010/11, 2.5% of tariff for 2011/12, and 2.0% 2012/13 onwards).

6.6.3 Saving Requirements/Cost Pressures

Annual savings requirements have been calculated to ensure the following items are covered:

• Service Level Agreement efficiency requirement	3.0% in 2008/09 to 2010/11 2.5% pa – 2011/12 2.0% pa 2012/13 onwards
• Cost pressures not covered by income inflation	0.5% pa to 2009/10 0.25% pa 2010/11 onwards

The overall impact of these items on the Trust's total turnover is approximately 2.8% pa over the ten year period, ranging from 2.25% in 2012/13 (and later years) to 3.9% in 2007/08.

The cost pressures not covered by income inflation are not specified individually as an annual assessment is necessary and recent experience has shown predicting specific cost pressures is unreliable as some arise in-year (e.g. energy prices), others cannot be accurately quantified in advance and lastly the national tariff uplift may make only partial allowance for certain cost pressures. Items that are expected to be covered by the 0.5% allowance include R&D losses (part), workforce re-structuring costs and other local cost pressures. The allowance of 0.5% has proved in practice to be a reasonable

estimate in recent years. The reduction to 0.25% from 2010/11 is due to lower levels of service change which is likely to lead to a lower level of local cost pressures.

The Financial Plan is prepared on the basis that the income and expenditure impact of income inflation, cost inflation, savings plans and internal cost pressures taken together are neutral. This is demonstrated in Table 39 below:

	2008/09 £'000	2009/10 £'000	2010/11 £'000	2011/12 £'000	2012/13 £'000	2013/14 £'000	2014/15 £'000	2015/16 £'000	2016/17 £'000
Income Inflation	18,720	18,736	16,895	16,793	16,561	17,446	18,359	18,854	19,373
Cost inflation	(18,404)	(18,130)	(16,559)	(16,315)	(16,781)	(17,765)	(18,572)	(19,217)	(19,911)
Tariff CRES	(10,597)	(11,230)	(11,367)	(9,499)	(7,764)	(8,184)	(8,618)	(8,843)	(9,078)
Capital growth from tariff	(747)	(720)	(653)	(640)	-	-	-	-	-
Internal Cost Pressures:									
• R&D	(1,000)	(1,000)	-	-	-	-	-	-	-
• Other	(411)	(837)	(662)	(867)	(720)	(670)	(825)	(696)	(544)
Savings Plan	12,439	12,172	11,275	10,528	8,704	9,173	9,656	9,902	10,160
Sub Totals	**-**	**(1,009)**	**(1,071)**	**-**	**-**	**-**	**-**	**-**	**-**
Transfer from I&E account re lower savings plan	**-**	**1,009**	**1,071**	**-**	**-**	**-**	**-**	**-**	**-**
Totals	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Table 39 Tariff inflation and Cost Pressures reconciliation

6.6.4 Payment by Results

To date the Trust has achieved a real recurring net gain of £4.1m on the current Payment by Results tariff. This is fully realised in 2008/09 when the clawback arrangement ends. The following issues are considered material for the Trust:

- There is expected to be a general deflation of the current national tariff due to coding improvements – we are assuming the level of general coding improvement in UBHT is in line with this national adjustment. Therefore the impact is neutral.

- This excludes corrective coding in certain specialities where the operation of the HRG Grouper Software has created the need for changes to restore the correct position. This occurs particularly in Specialised/Tertiary services.

- Specialised Services tariffs are well known to be inadequate and significantly under-fund services such as Specialist Paediatrics, Cancer Surgery and other high cost procedures. UBHT has a very substantial base of Specialised Services including a Regional Children's Hospital. This issue has been recognised nationally and the Payment by Results tariff has been substantially revised to reflect this position in 2008/09. The new tariff generates a £4.8m gain for the Trust.

- The full extension of Payment by Results has been deferred from 2008/09 and will now happen in 2009/10. After taking into account rehabilitation services which will largely transfer out of the Trust to the South Bristol Community Hospital in 2009/10 the Trust has a Reference Cost Index (based on 2006/07 figures) of only 93 for current non-PbR services. After allowing for a 50% investment in the gaining specialities and tariff being set at below RCI of 100 the assumed net gain for the extension of Payment by Results is £2.3m per year from 2009/10 (based on tariff being set at RCI of 98).

6.6.5 Research and Development Funding

Research and Development funding is being withdrawn over the period to 2009/10. Whilst an accurate assessment is problematic due to details of how funds will be bid back being only partially worked up by the National Research and Development Programme, a realistic assessment has been made of the likely impact. This can be summarised in Table 40 below:

R&D Funding (at 2007/08 prices)	2007/08 £m	2008/09 £m	2009/10 £m	2010/11 £m
Baseline Income 2006/07	7.2	7.2	7.2	7.2
New Income	6.1	3.9	2.8	2.8
Net Loss of Income	**1.1**	**3.3**	**4.4**	**4.4**

Table 40: Expected Research & Development funding

It is assumed, therefore, that a total loss of £4.4m is experienced which is 61% of 2006/07 baseline R&D funding.

6.6.6 NCRS

The National Care Records System (NCRS) has been budgeted for in 2007/08 but it is not now expected to be implemented until 2009/10. This funding will be used to create non-recurring flexibility in 2007/08 and 2008/09, primarily to cover any slippage in achieving savings programmes and investment in IM&T infrastructure. It is anticipated that savings will be realised in 2010/11.

6.7 THE FINANCIAL PLAN BASE CASE

This section describes the Base Case i.e. the most likely set of events impacting on the financial position over the period of the Financial Plan. The following key components of the Financial Plan are below:

- Income and Expenditure Projections
- Savings Plans
- Balance Sheet Projections
- Cashflow Projections
- Financial Ratings

6.7.1 Income and Expenditure Projections

The I&E plan shows a normalised surplus with each year having a surplus in excess of 2% of turnover. The 2009/10 position is the most challenging with a number of key strategic schemes impacting negatively on the financial position. Despite this, the projected normalised surplus remains strong and continues above 2% of turnover from 2008/09 onwards.

The continued strong income and expenditure position is generated by a combination of:

- Achievement of CRES
- Effective cost control
- Tariff gains from Payment by Results
- Contribution of activity growth to the I&E surplus
- Use of internal depreciation to fund major capital schemes therefore reducing capital charges on existing assets.
- Interest receivable on cash balances.

The income and expenditure forecasts show downturns in 2009/10 and 2013/14 due to the technical charge (i.e. below the EBITDA line) for the one-off impairment of assets prior to disposal in respect of the Bristol General Hospital and BRI Old Building, respectively.

The position is shown in Figure 15 where the income and expenditure surplus over the plan period is plotted both on an actual basis (including impairments) and on a normalised basis.

The line showing 2% of turnover sets the benchmark for each year. This value has been used as it is one of the 5 factors used to calculate a Foundation Trust's financial risk rating. An income and expenditure surplus between 2% and 3% attracts a weighting of 20% and is the 'norm' for a Trust with a FRR of 4.

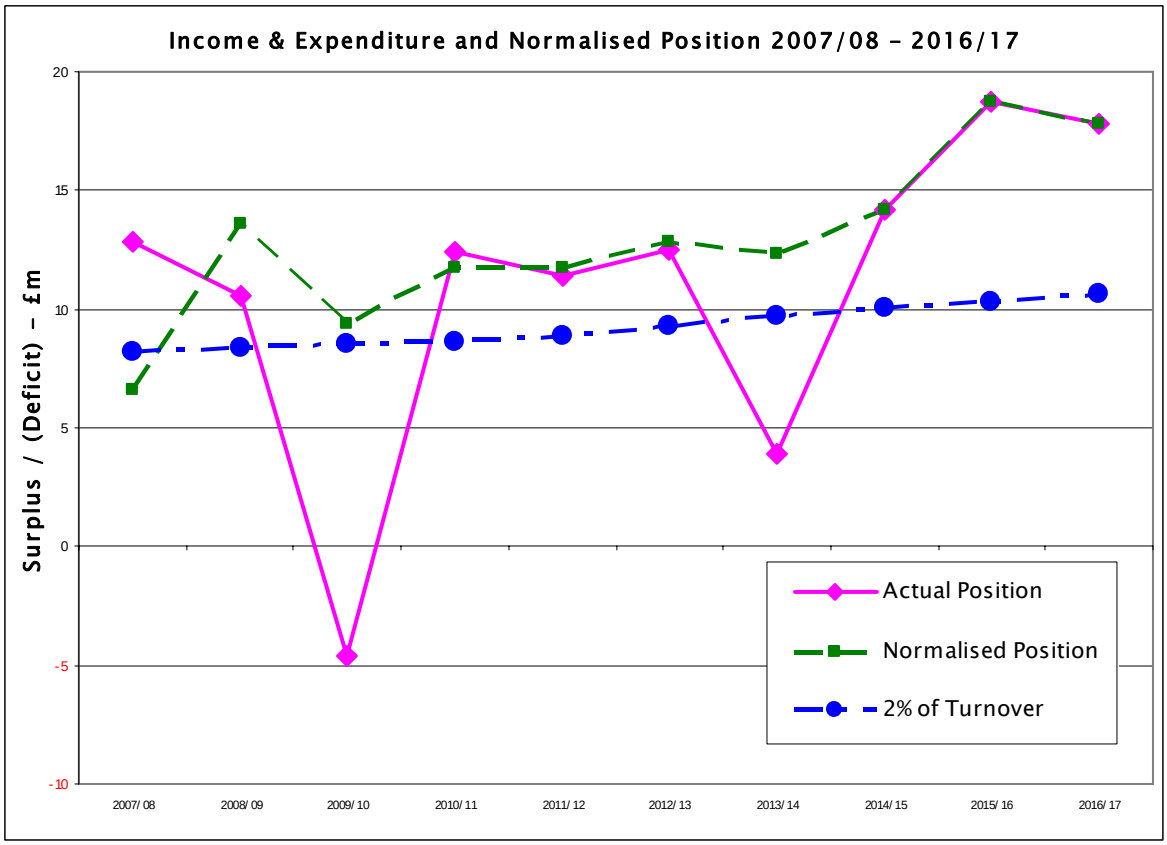


Figure 15: illustration of the base case Income and Expenditure projection (including impairments) and normalised position 2007/08 to 2016/17.

The income and expenditure projection along with the items that create the normalised position for the period 2007/08 to 2016/17 is shown in Table 41.

	2007/08 £m	2008/09 £m	2009/10 £m	2010/11 £m	2011/12 £m	2012/13 £m	2013/14 £m	2014/15 £m	2015/16 £m	2016/17 £m
Total Income	412.1	418.9	426.8	431.5	441.8	464.6	487.9	501.1	515.3	530.3
Total Costs	(373.7)	(381.2)	(383.8)	(387.4)	(395.4)	(415.5)	(434.3)	(445.3)	(456.8)	(469.0)
EBITDA	38.4	37.7	43.0	44.1	46.4	49.1	53.6	55.8	58.5	61.3
EBITDA Margin	9.3%	9.0%	10.1%	10.2%	10.5%	10.6%	11.0%	11.1%	11.4%	11.6%
Financing Costs Profit / loss on asset disposals	0.1	1.8	-	-	-	-	-	-	-	-
Fixed Asset Impairments	(2.1)	-	(15.1)	-	-	-	(8.7)	-	-	-
Total Depreciation and Amortisation	(14.6)	(17.7)	(20.6)	(20.6)	(22.8)	(23.4)	(27.5)	(28.1)	(26.6)	(29.1)
Total Interest receivable	1.5	0.7	1.0	1.4	1.4	1.5	2.1	3.0	3.8	4.5
Loan / Finance lease Interest	(1.6)	(0.8)	(0.6)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.3)	(0.3)
PDC Dividend	(8.9)	(11.1)	(12.3)	(12.1)	(13.2)	(14.3)	(15.2)	(16.1)	(16.7)	(18.6)
Net Surplus/Deficit	**12.8**	**10.6**	**(4.6)**	**12.4**	**11.4**	**12.5**	**3.9**	**14.2**	**18.7**	**17.8**
Less										
PCT Income adjustment	(2.0)	-	-	-	-	-	-	-	-	-
Profit/loss on asset disposals	(0.1)	(1.8)	-	-	-	-	-	-	-	-
Fixed asset impairment income	(2.1)	-	-	-	-	-	-	-	-	-
Non-recurring savings	(9.1)	-	-	-	-	-	-	-	-	-
Revenue to capital transfer	(0.4)	-	-	-	-	-	-	-	-	-
CNST Rebate	-	(0.7)	-	-	-	-	-	-	-	-
Cardiac scheme support	-	-	(1.5)	(1.2)	(0.9)	(0.6)	(0.3)	-	-	-
Hosting Service	-	(1.5)	-	-	-	-	-	-	-	-
Add										
Hosting Service	1.5	1.5	-	-	-	-	-	-	-	-
PbR Clawback	2.1	-	-	-	-	-	-	-	-	-
Work in progress charges	0.9	1.9	-	-	-	-	-	-	-	-
Fixed Assets Impairments	2.1	-	15.1	-	-	-	8.7	-	-	-
Non Recurring Costs	0.9	-	-	-	-	-	-	-	-	-
Risk Reserve (fines etc)	-	1.0	-	-	-	-	-	-	-	-
ICP Non Recurring	-	0.9	-	-	-	-	-	-	-	-
SfH Residual Liability	-	0.2	-	-	-	-	-	-	-	-
LDP Slippage Rebate	-	0.7	-	-	-	-	-	-	-	-
Tfr to Capital / Non Recur.	-	0.8	-	-	-	-	-	-	-	-
Cardiac FM costs	-	-	0.3	-	-	-	-	-	-	-
BRI transitional charges	-	-	0.1	0.3	0.6	0.9	-	-	-	-
Specialist paediatrics transitional charges	-	-	-	0.2	0.6	-	-	-	-	-
Normalised Net Surplus/(Deficit)	**6.6**	**13.6**	**9.4**	**11.7**	**11.7**	**12.8**	**12.3**	**14.2**	**18.7**	**17.8**
Depreciation (net of donated assets)	13.4	16.5	19.4	19.3	21.7	22.5	26.9	27.5	26.1	28.5
PDC Dividend	8.9	11.1	12.3	12.1	13.2	14.3	15.2	16.1	16.7	18.6
Net Interest	0.1	0.1	(0.4)	(1.0)	(1.0)	(1.1)	(1.7)	(2.6)	(3.5)	(4.2)
Normalised EBITDA	**29.0**	**41.3**	**40.7**	**42.1**	**45.6**	**48.5**	**52.7**	**55.2**	**58.0**	**60.7**
Normalised EBITDA Margin%	**7.0%**	**9.9%**	**9.5%**	**9.8%**	**10.3%**	**10.4%**	**10.8%**	**11.0%**	**11.3%**	**11.4%**

Table 41: Illustration of the base case Income and Expenditure projection and normalised position 2007/08 to 2016/17

The years from 2014/15 to 2016/17 need to be seen as largely indicative due to the difficulties of projecting this far ahead. Delivery of the IBP to 2013/14 provides an opportunity, given the subsequent projected increases in cash balances, to make further improvements in clinical services and the estate in the latter period of the plan. The Plan up to 2013/14 therefore needs to be regarded as the key period for assessment. The main service changes largely being completed by 2013/14.

A more detailed analysis is shown in Appendix 12. In addition a commentary on the changes between years is provided in Appendix 12a.

6.7.2 Bridge Analysis

Bridge analyses are used to show the contributions to the income and expenditure position of a defined set of factors over a given period (in this case the plan period 2007/08 to 2016/17). A bridge analysis is provided in Appendix 22 with supporting commentary given at Appendix 22a.

6.7.3 Savings Plan

A four year Cash Releasing Efficiency Savings (CRES) plan has been developed by Divisions and Corporate Services. The savings targets have been determined in order to meet anticipated service level agreement efficiency requirements (3% in 2008/09 to 2010/11; 2.5% for 2011/12 and 2% thereafter) together with cost pressures not covered by income inflation.

The development of both divisional and corporate plans is informed by the Trust's improvement objectives (section 5.4.3), as the intention is to ensure that schemes, wherever possible, release recurring savings based on operational efficiency and productivity improvements. However, schemes also include opportunities to reduce costs from external suppliers via negotiated price reductions, revised material / product specifications and reduced order quantities. All opportunities and ideas to eliminate waste and improve efficiency are welcomed and CRES plans are not constrained, or limited, by the Trust's Service Improvement Strategy.

A proportion of the savings in the corporate CRES schemes will be realised through the operational efficiency savings which are outlined in the Service Improvement Plan given in section 5.4. Whilst these Trust-wide schemes are corporately managed, they are delivered within the Divisions.

The corporate schemes also include futher savings identified from other sources, such as the energy savings identified in the NHS Opportunities Assessment Report.

For 2007/08, the plan includes details of the type of scheme, the person responsible, the expected timeline and the expected impact on numbers of staff in post. The 2007/08 plan can be found in Appendix 15. Similar detail has been provided for CRES schemes, in accordance with a standardised format, for years 2008/ 09 to 2011/ 12. A summary of CRES proposals by theme / work stream is provided at Appendix 8. An overall summary of the forecast CRES savings for the five years is presented in Table 42 below, while details of the divisional and corporate CRES plans are provided at Appendix 8a.

In developing CRES plans for 2008/09 and onwards, the Trust has this year refined its approach. To ensure the requirements for successful CRES delivery have been identified, Critical Pathway of Outcomes (CPOs) have been produced for the CRES themes / work streams (e.g. Workforce, Non-pay, Income). The development of these CPOs has allowed the Trust to identify dependencies and interdependencies which are critical to the realisation of CRES. Through workshops facilitated by a management consultancy team, CPOs have been used to provide a structured format for peer review of Divisional and Corporate CRES plans, which in previous years have been reviewed via the Trust Operational Group (TOG). These sessions have also enabled the corporate structure required to support the realisation of Divisional CRES plans to be revisited, including the priorities for the Lean programme in 2008/09, and a more

integrated future approach to CRES, capacity, business and service improvement planning to be developed.

Analysis of Savings Programme 2007/08 to 2011/12

	2007/08	2008/09	2009/10	2010/11	2011/12
	£'000	£'000	£'000	£'000	£'000
Consultants	962	451	875	1,041	858
Junior doctors	811	460	394	132	64
Nursing	3,821	3,032	1,877	1,616	1,816
Non clinical staff	643	526	751	781	751
Other clinical staff	110	877	595	491	474
Scientific and technical staff	778	313	405	284	225
Blood	381	230	193	190	190
Drugs	444	998	654	608	615
Clinical supplies and services	1,662	1,263	1,380	1,568	1,291
General supplies and services	-	126	264	276	256
Premises and fixed plant	-	292	242	261	262
Review of external contracts	491	-	-	-	-
Establishment expenses	-	178	99	65	50
Capital charges	-	336	-	-	-
Out patient capacity improvements	-	300	250	-	-
Theatre utilisation	-	250	250	-	-
CNST savings	-	250	-	-	-
Early retirement savings		250	-	-	-
CESP contribution to overhead	300	-	-	-	-
Income from commercial activities	262	283	116	68	151
Income from private patients	109	349	56	6	6
Income generation	948	-	-	-	-
Income generation - research	-	-	214	265	265
Service agreement income – coding corrections	-	-	784	372	432
Service agreement income - other	-	1,015	535	488	493
Other	4,383	381	1,754	2,176	1,614
Total at 2007/08 prices	**16,105**	**12,160**	**11,688**	**10,688**	**9,813**
Inflation	**-**	**279**	**484**	**587**	**715**
Totals at Outturn prices for Year	**16,105**	**12,439**	**12,172**	**11,275**	**10,528**

Table 42: UBHT CRES programme summary – 2007/ 08 to 2011/ 12

Progress with delivery against CRES plans is reviewed within Divisions at Divisional Board meetings, and also at a corporate level via monthly financial performance review meetings between the Chief Operating Officer, Finance Director and Divisions. In January 2008 the Finance Committee was established, as a sub-committee to the Board. This committee is responsible for providing assurance to the Board that the Trust's financial objectives will be achieved, including the planned savings targets. A monthly report on the level of CRES realised by each Division against the target profile is presented to the Trust Finance Committee by the Director of Finance. The minutes of the Finance Committee are presented to the Board at monthly meetings by the Non-Executive chair, to supplement the Finance Report submitted by the Director of Finance.

There was full achievement of savings plans in 2006/07. Similarly, full achievement is expected in 2007/08. Future CRES plans have been risk assessed and contingency

plans are either in place or in the process of being developed in the event of a shortfall, both at divisional and corporate level.

6.7.4 Balance Sheet Projections

A summary Balance Sheet projection is shown below in Table 43:

	2007/08 £m	2008/09 £m	2009/10 £m	2010/11 £m	2011/12 £m	2012/13 £m	2013/14 £m	2014/15 £m	2015/16 £m	2016/17 £m
Fixed Assets	358.4	381.5	346.8	354.7	408.7	413.6	431.9	431.0	432.4	511.2
Current Assets										
Cash	0.6	9.6	23.4	28.2	26.2	29.9	52.5	67.2	83.8	98.5
Other	22.1	20.7	21.6	22.2	22.9	23.5	24.0	24.7	25.3	26.1
Current Liabilities	(21.6)	(28.8)	(27.0)	(29.7)	(30.9)	(31.6)	(32.1)	(33.2)	(34.1)	(35.2)
Net Current Assets/(Liabilities)	1.1	1.5	18.0	20.7	18.2	21.8	44.4	58.7	75.0	89.4
Long Term Debtors	0.6	0.6	0.6	0.6	0.6	0.6	0.7	0.7	0.7	0.7
Long Term Creditors	(8.6)	(8.6)	(8.5)	(8.5)	(8.3)	(8.2)	(8.2)	(8.0)	(7.7)	(7.5)
Total Assets Employed	**351.5**	**375.0**	**356.9**	**367.5**	**419.2**	**427.8**	**468.8**	**482.4**	**500.4**	**593.8**
Loans	7.5	2.5	-	-	-	-	-	-	-	-
Taxpayers Equity	344.0	372.5	356.9	367.5	419.2	427.8	468.8	482.4	500.4	593.8
Total Funds Employed	**351.5**	**375.0**	**356.9**	**367.5**	**419.2**	**427.8**	**468.8**	**482.4**	**500.4**	**593.8**

Table 43: Summary Balance Sheet Projection 2007/08 to 2016/17

The key features include:

- Fixed assets increase from £358m in 2007/08 to £511m in 2016/17 i.e. a 43% increase after allowing for the disposal of the Bristol General Hospital and BRI Old Building.
- The asset utilisation ratio (fixed assets as a percentage of turnover) increases from 87% in 2007/08 to 96% in 2016/17. This is caused by the major investment programme and the higher inflation assumed for asset values than overall tariff.
- The increase in current assets is due primarily to an increase in cash balances from £0.6m in 2007/08 to £98.5m in 2016/17. The cash balance increases to £23.4m by 2010/11, remains relatively stable over the following three years before rising significantly each year from 2013/14 onwards.
- There is no requirement to access Prudential Borrowing for the period of the plan.
- The Trust plans will repay in full the Department of Health Loan of £20.3m. In 2007/08 the repayment of £12.8m will be made from the projected income and expenditure surplus so that the Trust will meet its statutory breakeven duty. A further £5m will be repaid in 2008/09 and the balance of £2.5m will be paid in 2009/10.
- The net current assets / liabilities (excluding cash) balance changes little over the period from 2008/09 with changes in short-term debtors being offset by similar changes in creditors. Stock balances are forecast to reduce by £1m (c15%) over the final 5 years of the plan.

Appendix 13 sets out the detailed Balance Sheet projections for the period of the plan. A summary of the assumptions used to derive the Balance Sheet is outlined in Appendix 13a. In addition, Appendix 13b provides a commentary on the changes between years.

6.7.5 Cash Flow Projections

A summary Cashflow projection is shown in Table 44.

	07/08 £m	08/09 £m	09/10 £m	10/11 £m	11/12 £m	12/13 £m	13/14 £m	14/15 £m	15/16 £m	16/17 £m
EBITDA	38.4	37.7	43.0	44.1	46.4	49.1	53.6	55.8	58.5	61.3
Non Cash I&E Items	(1.2)	(1.2)	(1.2)	(1.3)	(1.1)	(0.9)	(0.6)	(0.6)	(0.5)	(0.6)
Movement in Working Capital	1.4	8.8	(1.2)	1.7	0.1	0.5	0.4	0.3	0.2	0.3
Cashflow from Operations	**38.6**	**45.3**	**40.6**	**44.5**	**45.4**	**48.7**	**53.4**	**55.5**	**58.2**	**61.0**
Capital Expenditure	(47.5)	(40.5)	(12.2)	(28.3)	(35.0)	(31.4)	(17.0)	(27.1)	(28.0)	(31.6)
Cashflow from Before Financing	**(8.9)**	**4.8**	**28.4**	**16.2**	**10.4**	**17.3**	**36.4**	**28.4**	**30.2**	**29.4**
Net Change in Loans	(12.8)	(5.0)	(2.5)	-	-	-	-	-	-	-
Change in PDC	29.9	20.6	-	-	-	-	-	-	-	-
PDC Dividends Paid	(8.9)	(11.1)	(12.2)	(12.1)	(13.2)	(14.3)	(15.2)	(16.1)	(16.7)	(18.6)
Other Financing	0.7	(0.3)	0.1	0.7	0.8	0.7	1.4	2.4	3.1	3.9
Net Cash inflow/(outflow)	**-**	**9.0**	**13.8**	**4.8**	**(2.0)**	**3.7**	**22.6**	**14.7**	**16.6**	**14.7**
Opening Cash Balance	**0.6**	**0.6**	**9.6**	**23.4**	**28.2**	**26.2**	**29.9**	**52.5**	**67.2**	**83.8**
Closing Cash Balance	**0.6**	**9.6**	**23.4**	**28.2**	**26.2**	**29.9**	**52.5**	**67.2**	**83.8**	**98.5**

Table 44: Summary Cashflow Projection 2006/07 to 2016/17

The cash position is absolutely key and the following assumptions regarding managing the cash position have been used: We will seek a working capital facility of 30 days (£31.766m at 2008/09 prices), although as illustrated in the table above, this would not be required on planned figures.

- Surplus cash balances, after providing for the early repayment of the loan, have been assumed to be invested on a short/medium term basis. This is due to the need to use cash to supplement the capital programme particularly in the years 2010/11 to 2012.
- The long term loan is fully repaid by 2009/10.
- The plan generates significant cash surpluses in the early years of the plan. The projected cash balance for March 2013 is £29.9m. Cash balances then increase rapidly due to the sale of the BRI Old Building, lower demands on the capital programme and significant I&E surpluses.
- The planned reinstatement of the creditor position in respect of tax, NI and superannuation payments is the principal reason for the improvement in the cash balance in 2008/09.

Appendix 14 shows the detailed cash flow projections over the period of the plan. A commentary on the changes between years is provided in Appendix 14a.

Table 45 below summaries the main contributory factors to the cashflow balance over the period of the plan.

	07/08 £m	08/09 £m	09/10 £m	10/11 £m	11/12 £m	12/13 £m	13/14 £m	14/15 £m	15/16 £m	16/17 £m	Total £m
Capital Programme – see table 46	1.1	(1.2)	8.6	(9.5)	(13.6)	(8.7)	10.2	0.3	(2.0)	(3.2)	(18.0)
I&E Account (excluding impairments)	12.8	10.6	10.5	12.4	11.4	12.5	12.6	14.2	18.7	17.8	133.5
Impairment Income	2.1	-	-	-	-	-	-	-	-	-	2.1
Loan Repayment	(12.8)	(5.0)	(2.5)	-	-	-	-	-	-	-	(20.3)
PDC Repaid	(2.5)	(2.1)	-	-	-	-	-	-	-	-	(4.6)
Working Capital changes & other finance changes	(0.7)	6.7	(2.8)	1.9	0.2	(0.1)	(0.2)	0.2	(0.1)	0.0	5.1
Changes in Cash Balance	**-**	**9.0**	**13.8**	**4.8**	**(2.0)**	**3.7**	**22.6**	**14.7**	**16.6**	**14.7**	**97.9**

Table 45: Contributing factors to change in cash balances

This shows that loan repayment and supplementary funding for the capital programme are financed primarily from income and expenditure account surpluses along with improvements in working capital.

6.7.6 Capital Programme

The capital programme is the key enabler for the strategic service changes planned by the Trust. The capital programme is managed through a Capital Review Group and monthly reports to the Finance Committee. The key features of the capital element of the Plan are:

- Schemes are funded primarily by internally generated cash (from depreciation) and property sales. Public Dividend Capital is already agreed with the Department of Health for both the Cardiac Centre and the Dental Student Expansion scheme in 2007/08 and 2008/09 to supplement internal resources.
- Continued rationalisation of the estate is a key priority. Following the closure and sale of Keynsham Hospital in 2006/07, the disposal and sale of both the Bristol General Hospital (£9.5m sale value) and the BRI Old Building (£8m sale value) are planned. In addition, residential accommodation is being rationalised within the precinct.
- Cash generated from income and expenditure surpluses and changes in working capital are used to supplement capital expenditure by £18.0m over the plan period.
- There is no need to utilise Prudential Borrowing through the period of the plan. Should other assumptions differ in practice from those planned utilising Prudential Borrowing is the contingency plan. The Trust's current PBL is £40.2m in 2007/08. The criteria applied will be that any scheme requiring Prudential Borrowing must be affordable in revenue terms and not compromise achieving strategic priorities.
- The Trust has a risk assessed Backlog Maintenance Programme and is compliant under the Healthcare Standards for this item. A Works Replacement allocation of £1.5m pa in 2007/08 rising to £2.0m by 2016/17 funds backlog maintenance expenditure.

The Programme is summarised in Table 46.

	07/08 £m	08/09 £m	09/10 £m	10/11 £m	11/12 £m	12/13 £m	13/14 £m	14/15 £m	15/16 £m	16/17 £m
Source of Funds										
Public Dividend Capital	36.2	22.7	-	-	-	-	-	-	-	-
Depreciation (Purchased)	13.4	16.5	19.4	19.3	21.7	22.5	26.9	27.5	26.1	28.5
Donations	0.1	-	4.0	-	-	-	-	-	-	-
Sale of Assets	0.6	3.0	9.5	-	-	-	8.0	-	-	-
Cash Balances from revenue sources	(1.1)	1.2	(8.6)	9.5	13.6	8.7	(10.2)	(0.3)	2.0	3.2
Total Sources	**49.2**	**43.4**	**24.3**	**28.8**	**35.3**	**31.2**	**24.7**	**27.2**	**28.1**	**31.7**
Application of Funds										
Cardiac Centre	22.6	21.1	-	-	-	-	-	-	-	-
Dental Student Expansion	7.8	1.4	-	-	-	-	-	-	-	-
Electrical Supply Infrastructure	0.9	1.1	-	-	-	-	-	-	-	-
BHOC Upgrade	-	-	3.0	-	-	-	-	-	-	-
Medical Equipment	5.0	4.3	3.3	3.4	3.6	3.7	3.7	3.9	3.9	4.0
Works Replacement	1.2	1.7	1.5	1.7	1.7	1.7	1.9	1.9	1.9	2.0
Specialist Paediatrics Transfer from NBT	0.3	0.5	0.5	11.0	8.7	-	-	-	-	-
IM&T	3.0	7.6	0.9	1.1	1.6	1.6	1.1	1.2	1.5	1.3
Air Ambulance	-	1.0	2.0	-	-	-	-	-	-	-
BRI Redevelopment	0.4	0.5	4.5	10.0	17.0	20.0	4.6	-	-	-
Other	8.0	4.2	8.6	1.6	2.7	4.2	13.4	20.2	20.8	24.4
Total Applications	**49.2**	**43.4**	**24.3**	**28.8**	**35.3**	**31.2**	**24.7**	**27.2**	**28.1**	**31.7**

Table 46: Summary Capital Programme 2007/08 – 2016/17

The Capital Financing Plan set out above is intended to avoid the need for Private Finance Initiatives (PFI) funding for the schemes identified. The use of Prudential Borrowing is also not assumed although this source of cash can be accessed if any of the current assumptions deviate from plan.

The detailed Capital Programme is shown in Appendix 23.

6.7.7 Financial Rating

The overall rating for each year of the plan is shown in Table 47.

	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Overall Risk Rating	-	4	4	5	5	5	5	5	5	5
* Prudential Borrowing Limit	£40.2m	£103m	£98m	£162m	£183m	£187m	£203m	£209m	£216m	£254m

Table 47: Financial Risk Rating 2007/08 to 2016/17

* The PBL value shown for 2007/08 is the confirmed figure. Later years are the estimated values based on the LTFM outputs.

This is an acceptable position with all years showing a minimum rating of 4. The Prudential Borrowing Limit is derived from the financial risk rating related to total assets.

The Financial Rating calculation for each year of the plan is shown in Appendix 24

6.7.8 Private Patients

Private Patient income is shown in Table 48.

	2002/03 £m	2006/07 £m	2007/08 £m	2008/09 £m
Private Patient Income	2.3	3.0	2.5	3.1
Total Patient Related Income	209.0	289.6	326.3	335.2
%	1.12%	1.03%	0.76%	0.92%

Table 48: Private Patients Income

Projected income for the treatment of private patients in the Financial Plan does not exceed 0.96% of total patient related income in any year from 2007/08 onwards. This complies with the Private Patient Cap requirement (which is based on the 2002/03 position).

6.8 SERVICE LEVEL PROFITABILITY AND PATIENT LEVEL COSTING

UBHT is committed to improving the quality of financial information for use in supporting operational service review and Strategic Planning. It plans to achieve this by:

Patient Level Costing

Improving costing at Healthcare Resource Group (HRG) level by matching costs to individual patients and grouping to episodes of patient care. This will be a mixture of internal development and external best practice.

Service Level Profitability

Allocating income and costs to defined services or groups of services (mainly specialities) to understanding their contribution to the financial performance of the Trust in terms of profitability. This will be done in a way which:

- Uses a tariff which can be relied upon to be sustainable over the medium term.
- Ensures those who manage resources are still responsible for their control.
- Can be operationally implemented in a timely and efficient manner.

Profitability statements have already been produced for 2005/06 and 2006/07. However, currently only 58% of SLA income is covered by National Tariff. The remaining 42% is primarily based on 2004/05 actual costs uplifted for inflation and subsequent service developments / savings. For these services effectively costs equal income pending the introduction of a comprehensive National Tariff in 2009/10. Therefore, with major changes to tariffs both in 2008/09 and 2009/10 great care must be taken in using such information to inform decision making.

The plan proposed by UBHT is to develop Patient Level Costing during 2008/09 to provide a sound information base for the full introduction of Service Line Reporting in 2009/10 when a sustainable comprehensive tariff will be in place.

The principles and systems required by Service Line Reporting will also be developed during 2008/09.

6.9 SENSITIVITY ANALYSIS

6.9.1 The Three Scenarios

The Financial Plan includes projections for the most likely set of assumptions. The assumptions used are set out in Section 6.7. The purpose of sensitivity is to assess the impact of alternative scenarios on the income and expenditure and cash positions over the period of the plan. The three scenarios used are:

- Base Case - using most likely assumptions
- Upside Case - using plausible optimistic assumptions
- Downside Case - using plausible pessimistic assumptions

The likelihood of having to deal with a downside scenario is considered to be low given the conservative approach taken on the main issues by the Trust within the IBP, particularly in respect of activity growth and R&D.

6.9.2 Commentary on Sensitivities

The areas subject to the upside and downside sensitivity analyses are as follows:

General Activity Growth - The base case assumption is considered very conservative at an average growth rate of 0.64% per annum (net of demand management). The alternative assumptions are as follows:

- Upside – 100% higher overall activity growth per year (net recurring gain of £1.078m in 2009/10, £1.931m for 2010/11 rising to £3.978m by 2016/17)
- Downside – 25% lower activity growth per year (net loss of £270k in 2009/10 rising to £483k in 2010/11 and potentially reaching £0.995m in 2016/17.)

The Bristol Health Service Plan affordability review allows for a 1.25% net annual growth in activity. Therefore the upside assumption is broadly in line with the PCT agreed parameters. The downside assumption is only 25% below the base case due to the conservative base case assumption.

Payment by Results – the base case includes a new net gain of £7.1m (after allowing £2.3m re-investment) from the full rollout of Payment by Results. This is derived from the 2008/09 revised tariff (£4.8m) and the creation of National Tariffs for current non PbR services (£2.3m). The latter compares the current overall RCI 93 for non PbR services with an estimated National Tariff equating to RCI 98.

Alternative assumptions show the following:

- Upside 1 – Non PBR Tariff equates to RCI 99 (recurring gain of £434k)
- Downside 1 – Non PBR Tariff equates to RCI 97 (recurring loss of £434k).
- Downside 2 – Tariff gain in 2008/09 is reduced by tariff revisions in later years i.e. 2009/10 onwards recurringly by £1.520m (at 2009/10 prices).

Although the methodology for the full rollout of PbR is not confirmed the assumptions used are relatively prudent, particularly in light of the 2008/09 tariff which generates a PBR gain of £4.8m in 2008/09.

Independent Sector Transfer – Due to the limited exposure of UBHT to the loss of non-complex elective activity the impact of higher or lower loss of activity to the Independent Sector is less than other Trusts. The alternative assumptions are as follows:

- Upside – 25% lower loss of activity (net gain of £48k in 2009/10; 93k in 2010/11 reducing to 71k by 2016/17)
- Downside – 25% higher loss of activity (net loss of £48k in 2009/10; 93k in 2010/11 reducing to 71k by 2016/17)

In this area it is considered that the base case assumption is the most likely scenario.

Research and Development – The impact of the new national arrangements for research and development funding are difficult to assess. The base case makes a pragmatic assessment of the likely position; the alternative scenarios can only be estimated as follows:

- Upside – net loss of income is 50% lower (recurring gain of £1.115m in 2008/09, rising to £1.695 in 2009/10)
- Downside – net loss of income is 50% higher (recurring loss of £1.115m in 2008/09, rising to £1.928m in 2009/10)

It should be noted that the base case assumes a 61% net loss of R&D income already so the downside scenario would represent a pessimistic assessment.

Savings Plan – The importance of delivering the required savings plans is emphasized by the scale of the impact. A 20% under-achievement will result in a c. £1.859m - £2.39m shortfall per annum. The alternative scenarios used are:

- Upside – no scenario is included
- Downside – under-achievement by 20% for 3 years (loss of £6.364m over plan period) with recovery of the position in the subsequent year.

Tariff Reduction – Changes to the tariff uplift are an important factor in the financial plan, as a reduction in the uplift could lead to a significant loss of income. A scenario has been tested showing the impact of a 0.5% reduction in tariff for 2009/10 and 2010/11 of the plan. The alternative scenarios tested are:

- Upside – no scenario is included
- Downside – income tariff reduction of 0.5% for years 2 and 3, (net loss of £2.080m in 2009/10, £4.210m in 2010/11 rising to £5.20m by 2016/17).

Appendix 25 sets out the impact of each area of sensitivity.

6.9.3 Analysis of Sensitivities

The summary impact of each scenario is shown in Table 49 a-c below

Base Case	2008/09 £m	2009/10 £m	2010/11 £m	2011/12 £m	2012/13 £m	2013/14 £m	2014/15 £m	2015/16 £m	2016/17 £m
EBITDA	37.7	43.0	44.1	46.4	49.1	53.6	55.8	58.5	61.3
I&E position	10.6	(4.6)	12.4	11.4	12.5	3.9	14.2	18.7	17.8
Normalised position	13.6	9.4	11.7	11.7	12.8	12.3	14.2	18.7	17.8
Year end cash balance	9.6	23.4	28.2	26.2	29.9	52.5	67.2	83.8	98.5
Risk Rating	4	4	5	5	5	5	5	5	5

Table 49a: Summary Impact of Base Case Scenario 2008/09 to 2016/17

The **Base Case** has been compiled using most likely / conservative assumptions. The Trust achieves a financial risk rating of 4 in 2008/09 and 2009/10 rising to 5 from 2010/11 onwards. There is no need to make use of Working Capital or Prudential Borrowing facilities.

Upside Case	2008/09 £m	2009/10 £m	2010/11 £m	2011/12 £m	2012/13 £m	2013/14 £m	2014/15 £m	2015/16 £m	2016/17 £m
EBITDA	38.8	46.3	48.4	51.1	54.3	59.1	61.8	64.9	68.1
I&E position	11.6	(1.3)	16.9	16.5	18.4	10.5	21.6	26.8	26.8
Normalised position	14.6	12.6	16.1	16.8	18.7	18.9	21.6	26.8	26.8
Year end cash balance	10.7	27.9	36.9	40.1	49.7	79.0	101.1	125.9	149.5
Risk Rating	4	5	5	5	5	5	5	5	5

Table 49b: Summary Impact of Upside Scenario 2008/09 to 2016/17

The **Upside Case** adds £51.0m to the cash balance over the plan period and increases income and expenditure surpluses throughout the plan such that a risk rating of 5 is achieved from 2009/10 onwards.

	2008/09 £m	2009/10 £m	2010/11 £m	2011/12 £m	2012/13 £m	2013/14 £m	2014/15 £m	2015/16 £m	2016/17 £m
Downside Case									
EBITDA	34.4	34.4	33.7	37.7	40.0	44.1	46.0	48.4	51.0
I&E position	7.2	(13.3)	0.9	1.1	2.0	(7.6)	1.4	4.9	3.1
Normalised position	7.5	1.0	0.5	1.5	2.2	0.7	1.4	4.9	3.1
Year end cash balance	6.3	11.5	5.3	(6.8)	(13.5)	(2.3)	(0.4)	2.5	3.0
Risk Rating	4	3	3	3	3	3	3	4	3
Downside Case with Mitigation									
EBITDA	38.1	41.2	42.8	46.2	48.8	53.1	55.3	57.9	60.7
I&E position	10.9	(6.5)	10.8	10.9	11.9	3.2	13.4	17.7	16.9
Normalised position	14.2	7.8	10.3	11.2	12.2	11.6	13.4	17.7	16.9
Year end cash balance	10.0	22.0	25.4	22.9	26.2	48.2	62.1	77.9	91.7
Risk Rating	4	4	5	5	5	5	5	5	5

Table 49c: Summary Impact of Downside Scenario 2008/09 to 2016/17

The **Downside Case** probably does have an element of duplication in that it includes a potential loss of recurring income for a downward adjustment to the 2008/09 PbR tariff gain in later years as well as an allowance for the risk of tariff deflation. However, the Trust has considered the remedial action to address any or all of the downside issues

The downside case results in a reduction in cash over the plan period of £95.5m compared with the base case. A cash shortfall is identified at the end of 2011/12 to 2014/15. The temporary shortfall arises despite the Trust achieving income and expenditure surpluses for those years because of the significant cash additions planned by the Trust to supplement the capital programme. The interim solution to this short-term cash shortage would be to review working capital balances and / or make use of the Prudential Borrowing facility to finance capital spending before cash balances begin to rise from 2015/16 onwards. The capital programme would be subject to review as a matter of course. A normalised surplus is maintained in each year.

Risk ratings of 3 or above are still maintained throughout the period.

6.9.4 Mitigation / Plan for Managing the Downside Case

The Downside Case would create challenges for the Trust but there is substantial scope for mitigating the impact to ensure a sustainable financial position is maintained. In any year the Trust would monitor the position and take early corrective action to ensure financial issues are limited in their impact.

In particular the following mitigations are relevant:

- The Base Case assumption in respect of activity growth and Payment by Results is more likely to be pessimistic and therefore the trading position will improve.

- The assumption around CRES in the base case is only at between 0.25% and 0.5% above the level of national tariff efficiency. This is therefore assuming almost the minimum level of CRES that any NHS organisation is required to achieve. There is scope for delivering higher levels of CRES to offset any downside scenario. If the Trust had for example, a base case CRES requirement well in excess of the National Tariff efficiency target this scope may not exist e.g. due to a significant PFI scheme or recovery plan.

- Achievement of savings plans is a core management responsibility and therefore alternative savings will be identified and delivered to recover the position within the year. Non-recurring savings may be required to compensate for slippage in delivering recurring savings. These can be relatively easily achieved by deferring developments or holding posts etc.

- More structural shortfalls may require a more robust review of costs and / or efficiencies along with a review of future commitments including either deferral or cancellation.

- The level of managerial effectiveness and track record of delivery is important in dealing with any downside case. The performance in the past few years on delivering CRES and financial surpluses is relevant and can provide significant assurance

The remedial action for managing the full effect of the downside comprises making non recurring savings in each of 2008/09 to 2010/11 to cover the risk of a 20% underachievement in those years. In addition, the Trust would secure additional recurring savings of 0.5% each year for the 3 years 2009/10 to 2011/12 inclusive. This action is considered to be achievable because the IBP currently includes a CRES plan which is only set at 0.5% above the National Tariff requirement (0.25% above from 2010/11). This is eminently achievable and is exactly what we already planning to do in 2008/09 in response to the expected increase in tariff CRES to 3%. The CRES levels are, therefore, driven primarily by the National Tariff and do not include other structural savings such as recurring deficit or an impending PFI scheme. The recent track record of CRES delivery supports this approach.

This action restores satisfactory FRR scores for the IBP period. Satisfactory cash balances are maintained throughout the plan period and after taking account of the proposed working capital facility, cash ‘headroom’ of over £40m is provided. Should it be required there is scope to defer items of capital expenditure to address any short-term liquidity issues or make use of Prudential Borrowing.

The Trust will also continually review service capacity and service level agreement activity in order to identify at an early stage any scope to reduce fixed costs if necessary.

In practice there would be a number of areas where cost reduction would be targeted - but CRES would inevitably be the main area to mitigate any downside scenario.

6.10 MONITOR TEST OF FINANCIAL VIABILITY

The Monitor test of financial viability requires the Trust to demonstrate, with a high likelihood that it can generate a sustainable net income surplus by year 3 of the business plan and maintain a reasonable cash position.

The Financial Plan shows the following:

- A normalised surplus in each year of the base case plan above 2% of turnover
- A normalised surplus in each year of the plan against the downside case.
- A base case cash position that maintains a significant balance in each year without recourse to Prudential Borrowing. The lowest year has a cash balance of £9.6m in 2008/09. Against the Downside Case temporary borrowing is required over the period 2011 – 15 of up to £13.5m with the position being restored from 2015/16.
- Risk ratings in the Base Case are 4 or above in all the plan years

7. KEY BUSINESS RISKS – HOW WE WILL MANAGE THEM

7.1 STRATEGIC RISKS

Risk Ref	Risk Area and lead Director	Description of risk	Impact 1-5	Likelihood 1-5	Risk Rating	Existing controls	Residual Risk	Mitigating Actions
S1	Reconfiguration under the Bristol Health Services Plan Director of Corporate Development	Community developments in Bristol Health Services Plan may be delayed or altered as a result of affordability concerns, or PCT demand management plans are ineffective, limiting Trust's ability to divest non-acute activity, inhibiting timely discharge and affecting capacity to deliver high quality specialist and/or elective services. Failure to achieve required changes in service provision/ delivery to achieve Bristol Health Services Plan (BHSP) results in reduced efficiency and loss of activity/income.	3	3	9	Medium	Moderate	Implement model of care changes irrespective of capital developments, particularly in non-acute services e.g. in rehabilitation services. Apply robust operational management of discharge arrangements in conjunction with community partners and monitor through weekly capacity management reports. Assist commissioners to maximise demand management impact in appropriate areas. UBHT is owner of some demand management plans in place for 2007/08. Maintain flexible options for use of capacity including the delay or resizing of capital schemes as necessary. Prioritise service redesign. Annual

Risk Ref	Risk Area and lead Director	Description of risk	Impact 1-5	Likelihood 1-5	Risk Rating	Existing controls	Residual Risk	Mitigating Actions
								performance priorities included in Trust Annual Plan (e.g. Six Ways to Reduce Delays). Service Improvement Strategy based upon Lean thinking, to maximise operational efficiency. Prioritise Trust objectives for internal capital programme. UBHT plays active part in Bristol Health Services Plan discussions.
S2	Research and Development Medical Director	The impact of the new national arrangements are hard to predict and the results of programme and other bids are not known.	2	3	6	Low	Moderate	Implement research and development (R&D) strategy. Bid for integrated programme grants in areas of specialist expertise. Align R&D strategy with that of the universities to build scale and credibility for applications. Development of Clinical Research Centre to open in 2009 in partnership with Bristol University. Host research and development networks

Risk Ref	Risk Area and lead Director	Description of risk	Impact 1-5	Likelihood 1-5	Risk Rating	Existing controls	Residual Risk	Mitigating Actions
								to underline the role of the Trust as central to R&D in the region.
S3	Independent sector transfer Director of Corporate Development	Higher loss of elective activity than assumed in the long term financial plan.	2	3	6	Medium	Low	The clinical services strategy focuses on areas where there is less contestability – children, radiotherapy, cardiac and complex cancer surgery. The Treating People Well initiative is designed to improve customer care skills. The smarten up initiative and the green travel plan are designed to improve the environment and physical access to the site. Involvement of clinicians in the leadership and management of the Trust to speed up innovation and improvement. Introduction of “Lean” methodology to streamline processes and reduce care pathway complexity and time.

7.2 OPERATIONAL RISKS

Risk Ref	Risk Area and Lead Director	Description of risk	Impact 1-5	Likelihood 1-5	Risk Rating	Existing controls	Residual Risk	Mitigating Actions
OP1	Performance Chief Operating Officer	Maintenance of performance against existing targets such as cancer and A&E, and ability to make progress toward 18 week may be compromised by financial constraints and reduced PCT investment. Risk to market share after 2008 if competitors improve faster. Risk to Healthcare Commission annual performance rating and reputation. Bed closures which form significant part of CRES may reduce the availability of beds to meet the demand created by emergency admissions, resulting in a failure to meet the 4-hour A&E target. Impact on Healthcare Commission annual performance rating and/or achievement of CRES.	3	3	9	Medium	Moderate	Flexible management of bed-base to enable additional beds to be opened-up and closed promptly as needed. Daily bed management meetings and escalation process to free-up beds. Ongoing collaborative work with the PCT to limit un-necessary admissions as part of Resource Utilisation Management Plans. Performance management framework to monitor performance against 4-hour target. Ongoing review of progress with CRES through Divisional Financial Reviews. Monthly performance management of activity at a specialty level against profiled trajectory. Contingency plans to be produced when forecast slippage on required activity, with

Risk Ref	Risk Area and Lead Director	Description of risk	Impact 1-5	Likelihood 1-5	Risk Rating	Existing controls	Residual Risk	Mitigating Actions
								options for alternative capacity provision (e.g. out-sourcing to private sector, hiring of mobile facilities, locum staffing, demand management). Agreed schedule of support to be provided to Divisions by Innovation Team, developed from Divisional 18-week plans. Resource Utilisation Management priorities agreed with the PCTs.
OP2	Modernisation and Service Redesign Chief Operating Officer	Insufficient progress to achieve efficiency savings result in length of stay and bed requirements exceeding assumptions in business/capital plans, driving- up costs of buildings and reference costs.	3	3	9	Medium	Moderate	A monthly multi-disciplinary Innovation Board has been established linking NPfIT, workforce and business process redesign. Innovation Team managing gap analysis and process redesign to support NHS Care Records Service (NHS CRS) implementation, to maximise efficiency gains of processes. Priorities for efficiency savings identified in Annual Plan and managed monthly through Trust

Risk Ref	Risk Area and Lead Director	Description of risk	Impact 1-5	Likelihood 1-5	Risk Rating	Existing controls	Residual Risk	Mitigating Actions
								Operational Group (TOG). Agreed schedule of support to be provided to the Divisions by Innovation Team, encompassing improvements for the whole patient journey.
OP3	Demand Management/ Income/ Performance Chief Operating Officer	Failure by PCT or Trust to achieve Resource Utilisation Management (RUM) Plan savings results in cost pressures and/or reduced ability to meet national waiting times targets. Risk to Healthcare Commission annual performance ratings. Demand management may reduce activity beyond that planned in the long-term financial plan, resulting in a loss of income and inability to develop services as planned.	3	4	12	Medium	High	Monitoring system established to keep track of Resource Utilisation Management (RUM) savings. Monthly reporting to Trust Operational Group (TOG) on progress with RUM savings and other efficiency plans. PCT involvement with key strands of the Trust RUM savings plan (e.g. reducing Follow-up demand). Annual capacity/demand modelling fully integrated into Trust business planning process.

7.3 FINANCIAL RISKS

Risk Ref	Risk Area	Description of Risk	Impact 1-5	Likelihood 1-5	Rating	Existing Controls	Residual Risk	Mitigating Actions
F1	Cost pressures Director of Finance	Unforeseen cost pressures i.e. over and above the 0.5% allowance in the Long Term Financial Plan. The impact could be local to UBHT or could be substantial and identified too late to mitigate its impact. Major items would normally be included in the LTFM. There have been no such issues in recent years.	3	3	9	High	Low	Where the impact is non-recurring alternative measures can be taken to offset the impact – this could cover for example a legal case not subject to insurance arrangement. Where a recurring cost pressure the scale can be mitigated by taking actions – the residual impact may need an increase in savings plans or a re-prioritisation of Strategic commitments to compensate. Cost pressure control has been effective over the past four years in UBHT.

Risk Ref	Risk Area	Description of Risk	Impact 1-5	Likelihood 1-5	Rating	Existing Controls	Residual Risk	Mitigating Actions
F2	Annual Savings i.e. under-achievement of savings by the Trust Chief Operating Officer	Slippage in savings plans is identified early in the monthly financial reviews and impact minimised by mitigating actions such as identifying alternative savings schemes.	4	3	12	High	Moderate	Short term, more centralised control of vacancies and procurement. Medium term, bring forward savings plans from future years. Long term, more aggressive approach to improving operational efficiency including length of stay. More rapid trust wide adoption of lean practices.
F3	Demand for Acute Activity drops below plan Chief Operating Officer	The activity variation could be temporary and therefore capable of being reversed through Clinical engagement/marketing etc. A long term change may be offset by increases in other specialities. A structural loss of activity may lead to services becoming uneconomic leading to major strategic decisions regarding service provision.	3	2	6	Medium	Low	Where lost activity is material decisions regarding cessation of service are possible – more likely estate rationalisation is necessary to remove fixed costs. Ward closures would be expedited and would be led by divisional teams, and coordinated by the Trust Operational Group. A review of Strategic commitments will also be necessary in these circumstances.

7.4 IT RISKS

Risk Ref	Risk Area and lead Director	Description of risk	Impact 1-5	Likelihood 1-5	Risk Rating	Existing controls	Residual Risk	Mitigating Actions
IT1	Existing Patient Administration System becomes Obsolete as NPfIT delayed Director of Finance	Contract to support existing EDS PAS expires before new system is implemented, resulting in Trust being unable to supply data for billing to manage the operational administrative function. Continuation of the EDS contract may cost more if other trusts discontinue using it.	4	3	12	Medium	Moderate	Contract negotiations with EDS continue and the current contract has been extended. Ongoing discussions within AGW and Southern Cluster to ensure transition from EDS to the new system is seamless. National and regional risks to timing of the programme are difficult to mitigate.
IT2	NPfIT Medical Director	UBHT does not implement NPfIT as a result of a local or non-local decision. The Trust or another party decide not to proceed with NPfIT at UBHT, resulting in the project ending without delivering a new system or any benefits.	4	2	8	Low	Moderate	Programme governance structure and plans are in place at Trust, local, regional and national levels to support the delivery of the system at UBHT. If necessary, the Trust would develop plans to commission an alternative electronic patient record.

Risk Ref	Risk Area and lead Director	Description of risk	Impact 1-5	Likelihood 1-5	Risk Rating	Existing controls	Residual Risk	Mitigating Actions
IT3	NPfIT Medical Director	The system delivered by NPfIT is implemented but is found to be 'not fit for purpose'. The system: • Costs more • Takes longer • Causes greater disruption to the organisation and/or • Delivers fewer benefits than planned • unacceptable clinical or financial risks.	4	4	16	High	Moderate	Extensive change programme running along side the technical project to minimise disruption and maximise benefits. Programme governance structure and plans are in place at Trust, local, regional and national levels. Monthly NPfIT board monitors progress against plan. Monthly innovation board tracks benefits. Clinical leads and change facilitators for identified for each division. High level of awareness of Care Record System deployment. Sign off processes in place to ensure quality criteria are met.

7.5 Workforce risks

Risk Ref	Risk Area and lead Director	Description of risk	Impact 1-5	Likelihood 1-5	Risk Rating	Existing controls	Residual Risk	Mitigating Actions
WF1	Staffing/service provision Director of Workforce & Organisational Development	Shortfall of suitably qualified and experienced candidates for small number of specialist posts may compromise range/quality of services and therefore lead to a reduced market share or income	2	2	4	Medium	Low	Specialist recruitment campaigns, including permanent or short-term agency contracts. Utilise existing flexibilities in employment contracts. Redesign of roles and skill mix reviews to free up service capacity. Offer additional sessions to existing staff.
WF2	Workforce planning Director of Workforce & Organisational Development	Ageing workforce particularly in estates and administrative roles, leading to potential shortfalls. Risk of attracting sufficient numbers of staff to non-registered posts in a city centre location.	2	2	4	High	Low	Annual workforce plans which address age profile with detailed recruitment planning. Close working with key agencies, schools, colleges and educational partners. Proactive and creative recruitment and retention strategies.

8. LEADERSHIP AND WORKFORCE

8.1 MANAGEMENT ARRANGEMENTS

The proposed Board structure of United Bristol Healthcare NHS Trust on authorisation as a Foundation Trust will consist of seven Non-Executive and seven Executive Directors, as well as a Non-Executive Chair.

Current Board members are:

Chair:
Dr John Savage

Non Executive Directors:
Ms Patsy Hudson – Vice Chair
Ms Emma Woollett
Mr Iain Fairbairn
Ms Lisa Gardner
Prof. Selby Knox
Two further appointments on authorisation

Executive Directors:
Dr Graham Rich – Chief Executive
Mr Paul Mapson – Finance Director
Dr Jonathan Sheffield – Medical Director
Ms Lindsey Scott – Chief Nurse and Director of Governance
Ms Anne Coutts – Director of Workforce and Organisational Development
Mr Robert Woolley – Director of Corporate Development (Non-voting until authorisation)
Ms Irene Scott-Chief Operating Officer commencing in post March 2008 (Non-voting until authorisation)

The Chair of the Hospital Medical Committee, Dr James Catterall, attends all Board meetings, as does the associate member, Mr Paul May.

Brief portraits of the current Board members are provided at Appendix 26.

8.1.1 Board Capacity

The Board is led by a Chair with extensive experience in commercial and public sector organisations, as well as a leading role in terms of the South West Development Agency. The Non-Executive Directors' knowledge and skills include in-depth experience in commercial, marketing, legal, public and voluntary sectors.

The Chief Executive has an extensive background in the NHS at local, regional and national level as well as healthcare reform experience in the USA. In his previous role as Chief Operating Officer at UBHT, he has made a significant contribution to the Trust's success over the past three years. He is supported by a highly experienced team of Executive Directors and they have an established track record of achievement and delivery in challenging environments.

8.1.2 Board Development

The combined experience of Executive and Non-Executive Directors ensures that the Board is fit to lead a Foundation Trust. In order to support this challenge, a development

programme has been established for all Board members. The development programme has been formed as a result of the diagnostic phase, which identified a number of areas where the Board members wished to develop their skills and knowledge to a higher level; at the same time the diagnostic phase identified that the Board as a whole met the necessary requirements. The programme has taken the form of a number of workshops, seminars and briefings on specific topics including governance arrangements, finance and risk management. Speakers have been invited to attend from established Foundation Trusts and members of the Board have also visited Foundation Trusts and attended conferences to look at topics in more depth. The Trust has joined the Foundation Trust Network and individual Board members have benefited from the events run by the network.

The Board will be using expert facilitation support to ensure that the Board members are focussing on the opportunities and risks which Foundation status will bring, with particular emphasis on driving continuing performance improvement, ensuring a strong marketing focus and aligning individual service improvement programmes to ensure maximum organisational gain.

As part of the Foundation Trust diagnostic, the Board recognised that further experience in finance was required amongst Non-Executive Directors. The extensive business background of the Chair has helped decrease this requirement but the Trust also advertised and appointed to a recent Non-Executive Director vacancy with a specific focus on business and financial skills. This Non-Executive Director is a qualified accountant who is a member of the Audit and Assurance Committee and now chairs the Trust Finance Committee. The role of Company Secretary is taken by the Chief Nurse and Director of Governance who is supported in this by an Assistant Director – Governance and the Trust Solicitor. This arrangement will be kept closely under review as the Trust moves to Foundation Trust status.

Further advice is provided to the Board through the Business Advisory Group and the Consumer Advisory Group which have been established for the past two years, but will be discontinued once Foundation Trust status is achieved, due to the establishment of the Membership Council.

8.1.3 Organisational Structure

In 2005, the Trust moved from a Directorate structure with 13 different Directorates, to a Divisional Structure based on five clinical Divisions and one corporate Division. Each of the clinical Divisions is headed by a clinical Head of Division, supported by a Divisional Board. The core membership of the Divisional boards includes:

- Divisional Manager
- Lead Doctor
- Head of Nursing and Midwifery
- Lead Allied Health Professional/Healthcare Scientist
- Finance Manager
- Human Resources Manager
- A representative of the University.

The corporate Division has a slightly different structure, as individual components are headed by the relevant Executive Directors, but there is a Trust Services Board once a month, supplemented by a Trust Services forum of all staff second in line to Executive Directors. As part of the implementation of this structure, a very significant organisational development programme was put in place, which is detailed further in this section.

8.2 WORKFORCE KEY PERFORMANCE INDICATORS

8.2.1 Reporting

The Trust Board receives monthly Workforce Performance Reports as part of its Integrated Performance Report, providing exception reporting against Key Performance Indicators. These reports are discussed at Trust Operational Group and with Staff Side at the regular monthly meetings.

Benchmarks are used and will be enhanced through membership of the Foundation Trust Network as well as the Association of University Teaching Hospitals group. The Trust is currently leading on benchmarking of administrative and clerical staffing for the Association of University Teaching Hospitals.

Divisional Boards receive a similar performance report on workforce on a monthly basis with additional localised information. More detailed discussion of workforce issues takes place regularly through Trust Executive Group (Executive Directors meeting with Heads of Division on a fortnightly basis), Trust Operational Group (monthly) and the two staff side meetings, one of which is monthly and the other being bimonthly.

Table 50 shows a range of demographic data about the current workforce and the following sections give details on some of the key performance indicators for the Trust. It should be noted that the bank and agency spend is for a projected period to 31st March 2008.

	Cons-ultant & non Cons Career grade	Medical & Dental Trainees	Nursing & Midwifery Registered	Nursing & Midwifery Un-registered	Scientific Therapeutic & Technical	Non Clinical staff	**Sub Totals**	Hosted Services	**Total / average**
Budgeted (WTE)	366.9	500.4	2,049.3	575.0	1,054.4	2,088.2	**6,634.2**	173.0	**6,807.2**
Staff in Post (WTE)	328.1	526.0	1,934.3	468.2	1,021.3	1,899.3	**6,177.2**	134.2	**6,311.4**
Staff in Post Head-count	390	535	2,239	612	1,289	2,220	**7,285**	139	**7,424**
Bank total cost £000[4]	£403 [1]		£4,507	£2,171	£209	£1,920	**£9,209**		**£9,209**
wte[4]	52 [1]		1,260	1,003	172	1,152	**3,639**		**3,639**
Agency total cost £000[4]	[1]		£289	£0	£105	£1,672	**£2,067**	£149	**£2,216**
wte[4]	[1]		59	0	16	820	**896**	32	**928**
Bank / Agency average monthly cost £000[4]	£34		£400	£181	£26	£299	**£940**	£12	**£952**
average monthly wte[4]	4.3		109.9	83.6	15.7	164.3	**377.9**	2.7	**380.6**
Sickness %	1.1%	0.5%	5.2%	9.0%	2.8%	4.7%	**4.3%**	3.1%	**4.3%**
Black & Minority Ethnic [2]	10%	25%	19%	11%	5%	11%	**14%**	8%	**13%**
Male / Female	57:43	50:50	7:93	11:89	23:77	28:72	**22:78**	23:77	**22:78**
Vacancies %	10.6%	-5.2%	5.6%	18.6%	3.1%	9.4%	**7.0%**	22.4%	**7.4%**
Turnover [3]	16.9%		9.2%	16.1%	12.1%	13.9%	**12.9%**	9.4%	**12.4%**

[1.] Medical Bank and Agency is a combined total.

[2.] Black and Minority Ethnic Bristol City benchmark = 8.2%

[3.] Turnover excludes Medical & Dental Trainees

[4.] Bank / Agency figures projected 01 April 07 - 31 Mar 08

WTE = Whole Time Equivalent

Table 50: Key workforce indicators as at 31 December 2007

The age profile of Trust staff is shown in Table 51. The Trust is aware of the relative proportions of the estates and administrative and clerical workforce reaching retirement age. Although not all of these groups are difficult to recruit, this factor will be taken carefully into account in annual workforce planning and will be mitigated through imaginative recruitment campaigns, strong links with schools and colleges, and strong retention measures.

Staff group (by headcount)	Age under 25	25-44	45-55	Over 55	Totals
Consultants & Non-Consultant Career Grade	0	185	158	47	390
Medical & Dental Trainees	22	495	16	2	535
Managers and Senior Managers	1	69	56	20	146
Administrative and Clerical	85	536	398	284	1303
Ancillary and Maintenance	59	273	226	213	771
Nursing & Midwifery registered	126	1451	546	116	2239
Nursing & Midwifery unregistered	99	282	148	83	612
Allied Health Professionals	44	279	76	26	425
Healthcare Scientists	11	128	55	23	217
Scientific, Therapeutic & Technical	33	263	119	45	460
Additional Clinical Services	30	81	53	23	187
Total	510	4023	1851	882	7285

Table 51: Age Profile of UBHT Staff as at 31 December 2007

8.2.2 Improving Working Lives

The Trust was one of the first 10 Trusts in the country to achieve Improving Working Lives Practice Plus and continues to maintain that accreditation. In 2005 UBHT was ranked in the top ten of acute trusts for staff feedback in the national staff survey. Our latest staff survey feedback for 2007 has continued to emphasise positive messages.

The Trust scored in the top 20% of acute trusts nationally on:

- Percentage of staff using flexible working options (to support work life balance)
- Percentage of staff appraised in the previous 12 months
- Percentage of staff having well structured appraisal reviews
- Percentage of staff with personal development plans in the previous 12 months
- Percentage of staff receiving job-relevant training, learning or development in the previous 12 months
- Quality of job design
- Support from immediate managers
- Staff job satisfaction.

In addition, the Trust scored above average on:

- Quality of work life balance
- Extent of positive feeling
- Fairness and effectiveness of procedures for reporting errors, incidents etc.
- Perceptions of effective action from Trust towards violence and harassment
- Staff intention to leave jobs.

The areas where the Trust scored slightly less well than average (mostly very marginal) were in:

- Working of extra hours due to pressure and demands of job
- Percentage of staff working in well structured teams
- Percentage of staff suffering work related injury, suffering work related stress, experiencing harassment, bullying or abuse or witness harmful errors, near misses or incidents
- Availability of hand washing materials, although this finding was time specific and would be much improved if re-tested at the present time.

The Trust has strong results from staff from ethnic minority backgrounds, particularly around access to training and well structured appraisals. This finding has been consistent for the past three years.

Detailed action programmes are in place to support the results of the Staff Survey and ensure that staff are involved in taking ideas forward which will continue to improve in all areas of working practice.

8.2.3 Sickness Rates

The graph at Figure 16 shows the sickness absence rates to 31st December 2007. Although the November and December 2007 figures were relatively high, this is largely the result of cyclic variation associated with the winter months.

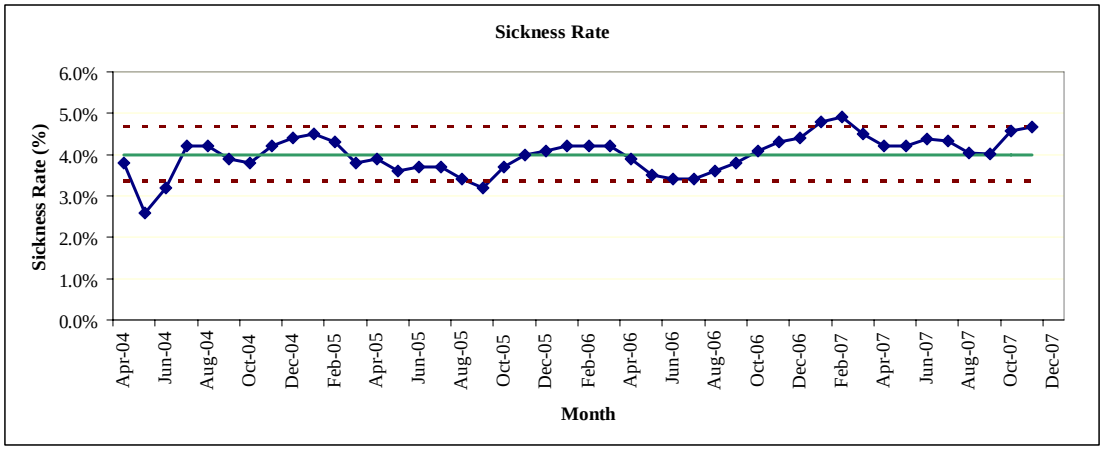


Figure 16: Sickness rates April 2004 to December 2007

UBHT has a robust sickness absence management policy which supports the effective management of absence, including personal reporting of absence to manager, return to work interviews and regular review of sickness patterns.

The average figure for April 2007 projected to March 2008 is 4.3% compared with an average for the health sector as a whole of 5.5% (Chartered Institute of Personnel and Development Annual Survey Report 2007). The average reported by the respondents in the survey undertaken by the Association of University Hospitals United Kingdom is 4.2%. There has been a slight upward trend in recent months in sickness rate but this is being addressed proactively. The Trust is very conscious of the potential contribution of sickness to productivity loss and has embarked on a significant trust-wide programme to improve attendance, focusing in particular on areas with higher than average figures.

8.2.4 Funded Posts, Vacancies, In-Post Figures

Figures 17 and 18 indicate the in-post and funded post position for the financial year 2006/07, month by month and the vacancy rate for the 3 years to December 2007. The increase in planned numbers is the result of a mixture of factors, for example, increases associated with the Local Delivery Plan for 2007/8, funded posts to support 18 weeks, Strategic Health Authority funded posts, and service changes such as the transfer of general paediatrics from North Bristol Trust, leading to the opening of Ward 38 at the Bristol Children's Hospital.

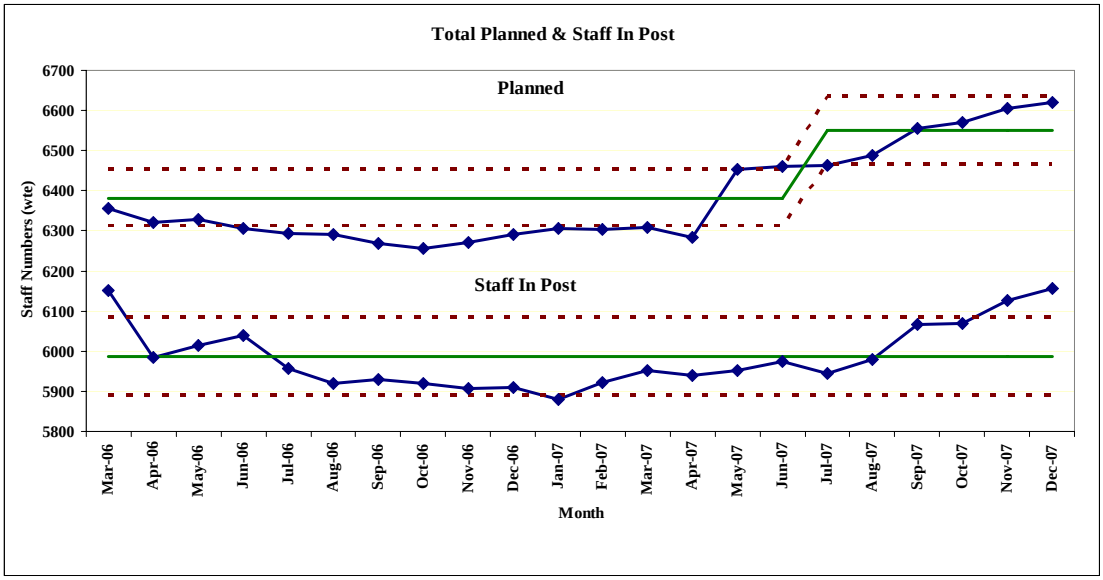


Figure 17: Total Funded Posts March 2006 to December 2007

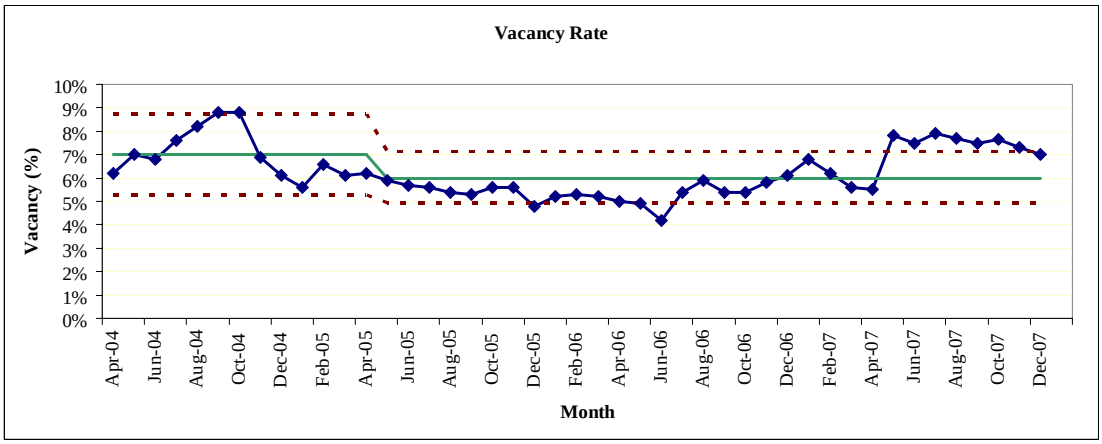


Figure 18: Vacancy Rate April 2004 to December 2007

Vacancy levels are monitored very closely, including all changes in establishment which may affect vacancy levels. Vacancy levels have been reducing since July 2007 from a figure of 7.9%. By December 2007, this figure was 7.0%, as a result of a range of targeted recruitment campaigns.

8.2.5 Turnover

Cumulative turnover at December 2007 was 13%. This figure excludes trainee doctors with known end of contract dates. The Trust turnover compares with an average for the health sector of 17.2% (Chartered Institute of Personnel and Development Annual Survey, 2007), and 12% for the Association of United Kingdom University Hospitals, (AUKUH). However, the range amongst the AUKUH members varies from 8% to 16.9%. The UBHT level of turnover is considered positive for a Trust in a major city, where turnover rates are normally higher than the average. It provides sufficient stability, whilst at the same time supporting workforce flexibility and facilitating further workforce redesign when vacant posts are filled.

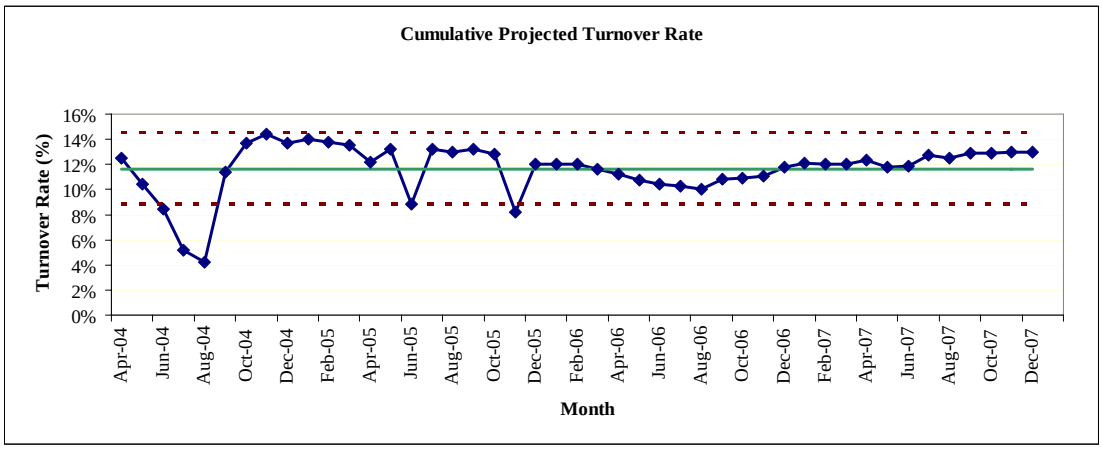


Figure 19: Cumulative Projected Turnover Rate April 2004 to December 2007, (note: projected annual turnover from December 2004; actuals prior to this date)

8.2.6 Bank/Agency Arrangements

The Trust operates a Bank arrangement which is open seven days a week, for the booking of all internal bank and agency staff. Preferred supplier arrangements are in place with relevant agencies through Purchasing and Supply Agency agreements, to ensure value for money and set quality standards. There is an electronic booking system in place which is important for ensuring that all claims and invoices can be verified against a confirmed booking. In 2006/7 the agency spend was £2.16 million, a reduction of 18.8% over the previous 3 years. In nursing and midwifery, which is naturally the highest user of temporary staffing, 97% of shifts were filled last year with bank staff rather than agency.

Graphs showing the agency and bank rates for nursing and midwifery for April 2004 to December 2007 are shown in Figures 20 and 21.

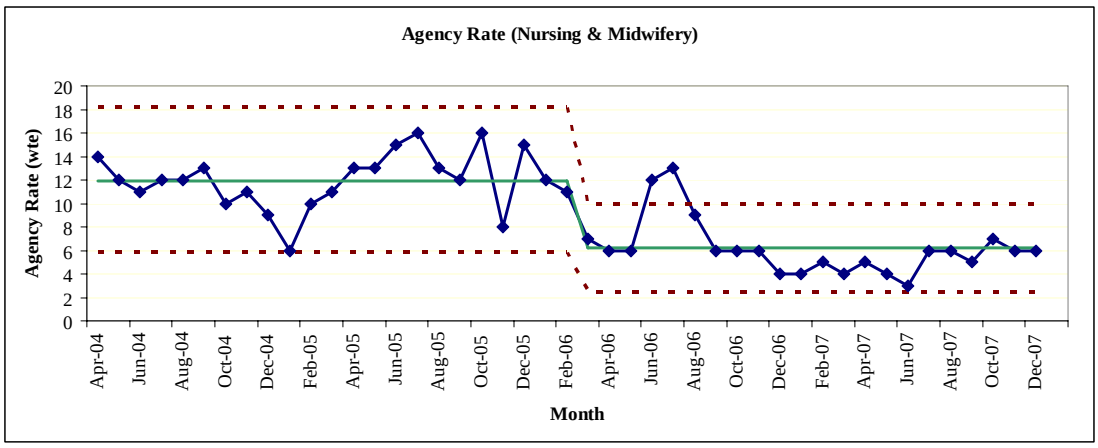


Figure 20: Agency Rate (Nursing & Midwifery) April 2004 to December 2007

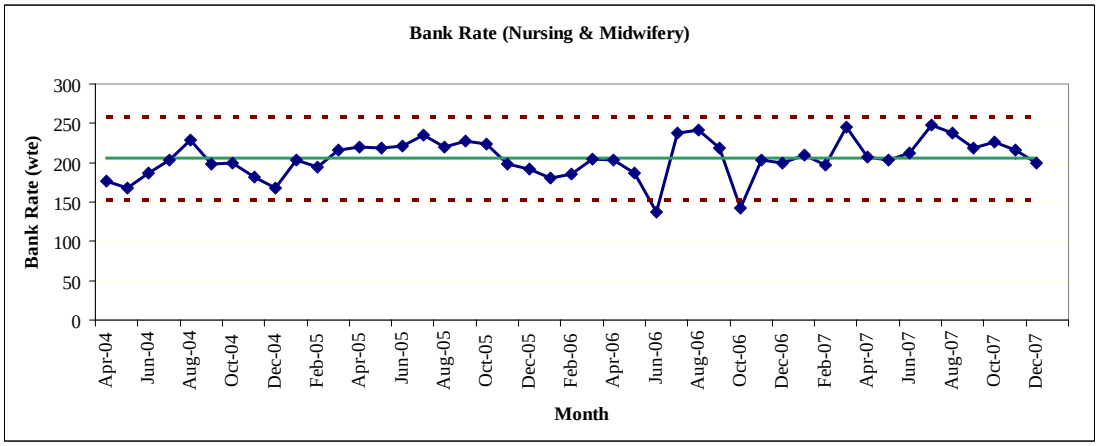


Figure 21: Bank Rate (Nursing & Midwifery) April 2004 to December 2007

8.3 AGENCY AND RECRUITMENT ARRANGEMENTS

The Trust has a centralised recruitment function, Jobs@UBHT, which deals with recruitment of all high volume posts, such as newly qualified nurses, ancillary and administrative and clerical staff. Each Division has a dedicated Divisional HR team and these teams deal with recruitment of more senior and specialised posts, working within the Trust systems and standards of good practice. A detailed recruitment toolkit is available on line for all managers.

UBHT has a record of strong and imaginative recruitment advertising and has won awards for its work in this area. The recruitment team also work closely with Job Centre Plus around employment for local people in Bristol.
Agency staff are recruited, as indicated above, through a centralised Bank office.

8.4 RECRUITMENT ISSUES AND ACTIONS

UBHT has a strong track record in terms of attracting high quality staff, both locally and nationally. We continue to be able to attract and recruit high calibre senior medical staff to most specialties, as a result of the Trust's excellent combined reputation for clinical services, research and teaching. Medical trainees are also attracted to UBHT for geographical reasons, and because of the appeal of a busy inner city teaching trust.

The report following the last visit from the Southwest Deanery in November 2006 to review medical education and training provision identified the following strengths:

- UBHT offers excellent experience to trainees and provides outstanding postgraduate facilities.
- Consultants, as well as Clinical Tutors and Foundation programme Directors have committed time and energy to supporting trainees.
- The Postgraduate Medical Education training programme has been well received.
- The Trust was congratulated on its preparation for the August 2007 induction programme.

The report identified the need to appoint a Director of Medical Education, who was subsequently appointed in September 2007. The report also highlighted the need to re-organise the education of surgical trainees. The new College Tutor for Surgery and his deputy are currently redesigning the surgical teaching programme in line with the Modernising Medical Career changes to medical education and training for junior doctors.

The Trust is able to recruit and retain registered nurses, nursing assistants and most grades of allied health professionals and healthcare scientists and technicians. There are some shortfalls in Band 5 nurses in adult general wards at the present time, but this is perceived to be a short term issue, which is currently being resolved through targeted recruitment campaigns. Nevertheless, the Trust has similar risks to many other acute trusts in attracting sufficient numbers of specialist staff in certain professions, particularly where there are national shortages, and has to remain continually focused on recruitment and retention.

The current risks are in the following specialist roles:

- Perfusionists
- Specialist estates staff
- Occupational Health consultants and nurses
- Paediatric Pathologists
- Ultrasonographers
- Some specialist Allied Health Professional staff and Theatre staff
- Neonatal intensive care nurses

These risks are being managed proactively through a variety of tactics, including different styles of advertising campaign, including open days, use of recruitment agencies, close working with Job Centres and potential use of local recruitment and retention premia. Considerable emphasis is placed on marketing the very high quality of education and training provided by the Trust, which is confirmed by the results in the Staff Attitude Survey.

High volume responses are received for administrative and clerical posts in the main, although more concerted marketing is occasionally needed for medical secretarial posts. Ancillary vacancies, particularly cleaning posts, are not particularly easy to fill in a city centre location, but increased flexibility of hours and the availability of National Vocational Qualifications are improving the situation.

8.4.1 Retention

Overall, the Trust has a high percentage of part-time posts (40%) and a considerable range of flexible working arrangements. It has also invested in both a Childcare Coordinator and a holiday play scheme for staff. UBHT has close linkages with local schools and colleges and employs a Schools/Colleges Coordinator to work closely with them on work experience schemes and taster days, as well as development sessions for teachers and careers staff on the health sector.

This is a significant area of development and forms part of 'UBHT in the Community', our programme of corporate social responsibility. During 2006/7 the Trust provided over 400 work experience opportunities.

In order to maintain our attractiveness as an employer, we plan to continue with a range of actions, including:

- Ensuring that the new Electronic Staff Record system is used to improve the quality of recruitment administration processes even further
- Providing a 'keep in touch' scheme with leavers – we will examine ways in which this can be linked to the membership scheme
- Ensuring that our recruitment brand – Treating People Well – remains appropriate for purpose
- Providing good quality induction
- Raising awareness of NHS careers and job opportunities from primary school age onwards
- Acting as a responsible, ethical employer in relation to overseas recruitment
- Emphasising retention, including initiatives such as carer support, flexible working, good quality appraisal, security for staff, training and development and accommodation

8.5 ORGANISATIONAL DEVELOPMENT

8.5.1 Pay reform

Agenda for Change

Agenda for Change has been fully implemented across the Trust, with virtually 100% transfer of staff to Agenda for Change terms and conditions. The Trust has invested £7.5 million in implementing the new pay system and improving staff rewards**.** It is vital to implement workforce strategies which will deliver a return on the substantial investment, in terms of quality of care to patients, increased productivity and retention.

Local flexibilities afforded by Agenda for Change have been used where there are recruitment and retention hotspots. Some key specialist clinical staff have been successfully appointed, helping us to achieve critical waiting list targets in areas such as the glaucoma service. Flexibility is equally important for non-clinical posts, such as in Estates and Finance, where a recruitment and retention premia is being used to attract staff in the context of a tight labour market.

The Trust will continue to use the Agenda for Change pay system for the foreseeable future but reserves the right to introduce local terms and conditions as the service needs determine, in partnership with Staff Side representatives. The Trust will be alert to

potential staff concerns about any changes in terms of conditions and respond sensitively and appropriately.

Career development is critical to ensuring staff satisfaction and high quality patient care. As well as implementing the national Knowledge and Skills framework, the Trust has taken the opportunity to introduce linked band progression, to recognise acquisition of new skills. For example, Pharmacy has developed a linked progression for pharmacy technicians on completion of the South West Accredited Technician Checking Scheme. In Payroll, a linked progression scheme enables the Finance Department to recruit more junior staff and develop them into experienced and specialist roles.

Productivity

Agenda for Change has supported opportunities to review services and increase productivity. For example, the Facilities department was able to implement the reduction in working hours from 39 to 37.5 without additional staffing, through redesign of rotas and working processes. In addition, porters are transporting medical devices in place of technical staff, which allows improved turnaround times for equipment. In Pharmacy, a review of working arrangements led to the introduction of a robotic dispenser, allowing staff additional opportunities to enhance their skills and development whilst maintaining productivity levels, despite the reduction in hours for some groups of staff. The dispensary opening hours were also extended to support discharge arrangements. Whilst reviewing working hours for the implementation of Agenda for Change, the Paediatric Intensive Care Unit adopted flexible patterns which enabled them to meet particular peaks in demand without using additional staff or necessitating the transfer of children to other units in the region.

The Trust is currently reviewing patterns of working for theatre staff providing out of hours cover, as part of the Trust's theatre modernisation strategy. In addition, the Trust's Lean Thinking programme is focusing on a number of key departments and services over the next year, such as Pharmacy and Radiology, in order to deliver improvements in productivity, the quality and timeliness of patient care, patient experience and staff satisfaction.

New and Extended Roles

The Trust has made significant progress in developing new and extended roles in many areas over a number of years, pre-dating Agenda for Change, but this has also given the Trust an opportunity in particular to develop Clinical Nurse Specialist roles to support high quality clinical care, out of hours working and reduce the pressure on trainee doctor rotas. These include roles in areas as varied as:

- Specialist nurses in Paediatric Oncology, Endoscopy
- Midwifery for drug and alcohol abuse
- Emergency Nurse Practitioners in Adult and Paediatric services
- Nurse led care in the Pregnancy Advisory Service, providing dating scans and preparing women for potential termination of pregnancy
- Learning Difficulties Liaison Nurse
- Nurse led telephone follow up in Outpatients
- Extended scope Practitioner in Orthopaedics
- Nurse Endoscopist
- Senior Assistant Technical Officers undertaking chemotherapy preparation instead of Pharmacy Technicians
- Assistant Clinical Technologists, trained in-house

- Therapy Radiographer led thyroid clinics
- Assistant Practitioners in Radiotherapy
- Shared care Optometrists
- Orthoptist/Optometrist led paediatric clinics for children with squints or amblyopia
- Physiotherapy and Dietetic Assistants
- Occupational Therapy Technicians
- Anaesthetic Practitioners
- Ward Housekeepers
- Ward clerk/Healthcare Assistant hybrid roles.

Consultant Contract

98% of Consultants, including clinical academics, have transferred to the new Consultant Contract.

The contract gives the opportunity for far closer alignment between service, research and teaching requirements, and the construction of individual and team based job plans, than has existed previously. Annualised hours have been introduced in specialities such as cardiac surgery, where there are significant variations in workflow, and in anaesthesia where programmed activities can be varied to meet the needs of theatre staffing.

Intensive care has successfully implemented shift systems of working in order to provide greater flexibility of programmed activities. Improved cover arrangements for cardiology have been achieved by developing a coronary artery rota. Job planning also enables more flexible working arrangements such as job sharing to be introduced, which in turn improves work life balance for Consultant staff and assists with recruitment and retention.

UBHT is part of the national Large Scale Workforce Project on consultant job planning and is undertaking a detailed project on using job planning to support service improvement in ophthalmology outpatients.

The Trust Board and Divisional Boards set out the annual objectives which identify the priorities for service development. These priorities form the basis of the job planning discussions, reviewing both service delivery achievements over the previous year and service requirements for the coming year. Dedicated time for teaching and research time is identified clearly in job plans and there is close linkage with the University on development of job plans for clinical academic staff. The requirement to complete mandatory and statutory training is allocated within the support programmed activities. Current plans include the introduction of electronic job planning software in 2008 with a view to streamlining the management of consultant timetables and enabling more proactive linkage between activity data and timetables.

The new pay arrangements for both Consultant and non-Consultant staff are mutually supportive. Agenda for Change supports our on-going role re-design and development work, enabling Consultant time to be released and utilised more effectively, for example through nurse prescribing and further nurse led clinics. In Radiology, there are plans to reduce the number of hours worked by trainee doctors but extend the role of Radiographers reporting directly to Consultants. The clinical site team support the Trust`s Out of Hours programme and Junior Doctor development.

Plurality of Provision

In relation to increasing plurality of provision, the Trust will abide by the NHS Employers Human Resources Framework regarding the relationship between NHS work and private professional/business activities. The Trust has arrangements in place to ensure that clear standards are in place for managing the relationship between consultants` NHS work and private, professional and business activities. Both the Department of Health's "A.Code of Conduct for Private Practice – Guidance for NHS Medical Staff" and the Terms and Conditions for Consultants (England) 2003 address the standards expected of NHS Medical Practitioners in relation to private practice, and these are summarised in the UBHT protocol, "Fee Paying Work and Private Practice". Consultants are advised of their obligations and must notify the Trust if they propose to undertake any activities which could potentially affect the basis of their contractual arrangement with UBHT.

8.5.2 European Working Time Directive

All doctors in training work to rotas which are compliant with current European Working Time Directive targets for August 2007. The Trust has achieved compliance in all rotas, except Maxillofacial Surgery, and continues to work closely with other Trusts involved in that rota to achieve compliance.
At present 61% of doctors in training are working on rotas which would be European Working Time Directive compliant in August 2009, which is similar to the South West benchmark of 63%. It is anticipated that the redesign of rotas to achieve compliance in August 2009 will reduce the banding supplement, thereby producing savings of about £500,000 between 2008/9 and 2010/11, as protection arrangements are phased out. However, an investment of a similar sum will be required to replace non-compliant rotas, which will mainly be invested in Trust grade doctors with some specialist nurse support. The Trust is currently reviewing all rotas to ensure that as many as possible can be brought in line with the 2009 targets in the 2008/9 financial year, ahead of target.

There is an Out of Hours group for UBHT and progress on rotas is monitored quarterly at Board level.

In relation to other staff groups, audits of compliance are carried out by the Health and Safety team to supplement managerial overview of compliance.

8.5.3 Organisational development

First Stage of Development

The Trust has an organisational development framework for 2006 – 2009. An important element of this is the development programme which has been carried out over the past two years in partnership with Keele University, to support the development of the five Clinical Divisions and one corporate Division. A modular programme extending over a six month period was run for all members of clinical Divisional Boards between June 2005 and January 2006. This included theoretical inputs, speakers from outside the Trust and considerable time devoted to development of the new senior teams.

Themes covered financial planning and management, innovation, strategic planning and marketing and managing people. The momentum from the programme is carried forward through continued sessions from external speakers on leadership themes, ranging from Professor Helen Bevan to Michael Vaughan, as part of a Trust Leadership Forum. When the corporate services Division was formed, a similar 'start up' programme was run for the second in line staff to Directors within the Division, and on-going events now blend clinical and corporate divisions together.

Second Stage of Development

As a second stage, a programme has also been run for senior staff reporting to Divisional Board members, which covered just under 90 staff across the Trust. This was delivered through a mixture of internal and external facilitation under the guidance of Keele University working with the Director of Workforce and Organisational Development. The programme has been written up for publication in the latest book by John Edmonstone on clinical leadership.

A third programme for Ward Sisters commenced in 2007, delivered by a facilitator from the University of the West of England, but explicitly linking into the themes and materials used by the previous programmes in order to ensure continuity of cultural message. A range of e-learning materials on leadership skills have been commissioned and will form part of the dedicated e-learning zone on the new intranet in 2008. We fully intend to continue this whole organisational approach to development, whilst at the same time supporting specific individual development. Latest work has included development of knowledge and skills for Divisional Board members entering Foundation Trust status.

Information and Knowledge

A new external website was launched in early 2008, with good quality information for external audiences and potential applicants to the trust. The new Intranet is now being developed and the HR web section has already gone live, with roadshows being run prior to the launch date for nearly 400 staff with managerial roles. This has received universally positive feedback, representing a one stop shop for information and policies/procedures on all aspects of people management. Further plans include Staff Map, a site for staff who are new to the trust or need early access to a wide range of cross-functional information.

Customer Focus

The Trust ethos of 'Treating People well' is underpinned by the commitment to the delivery of a strong customer-focused culture, both in terms of quality of care and in terms of investing in an assured financial future. A day course entitled 'Treating People Well' is run for staff within the trust, which aims to provide a customer perspective on the Trust, and improve staff interactions and service level for the benefit of the patients. Feedback from participants on their service areas is used to agree positive measures for improvement.

Particular attention is being addressed in the current year to customer care skills amongst front line reception staff and ancillary staff. Almost 100 frontline staff have attended the session to date. There is a continued roll-out plan in place for the coming year in order to encompass wider groups of staff and continue to strive for improved service across the Trust.

8.6 EMPLOYMENT RELATIONS

8.6.1 Partnership working and employee relations

Infrastructure

The Trust has a strong history of working collaboratively with Staff Side organisations which has been strengthened further through partnership working with the implementation of Agenda for Change. There are two regular meetings with Staff Side organisations: a

monthly Industrial Relations Group which concentrates on operational and performance issues, and bi-monthly Trust Consultative Committee, which concentrates on more strategic issues. The former is chaired by the Head of Human Resources and attended by the Chief Operating Officer as a member of the Executive team. The latter is chaired by the Director of Workforce and Organisational Development and attended by the Chief Executive, as well as regular inputs or presentations from other members of the Executive team. Agreement of employment policies is achieved through a sub-group of the Industrial Relations Group.

The Trust involves individual representatives of Staff Side on key committees and groups to enhance the involvement in important projects and programmes. Some examples include membership of the Redevelopment Board, the Innovation Board and the Electronic Staff Record project.

The Local Negotiating Committee specifically addresses issues affecting medical and dental staff and is attended by the Medical Director, the Chief Operating Officer and Director of Workforce and Development. The chair of the group, who is a local British Medical Association representative, also attends Trust Consultative Council.

There are arrangements for facilities and central financial support to staff side colleagues who hold positions of office, and this is captured in a formal policy to underpin the Trust's commitment to working in partnership.

Staff Involvement

The Staff Involvement Policy reflects the Trust's aim for all staff to feel valued by being involved, supported and given appropriate development in the work environment. The three core statements within the policy are that all staff should be:

- Involved in the planning and work of the Trust, and in decisions which affect staff
- Supported in the workplace, and also supported in maintaining a work-life balance
- Developed in their current role, and in continuing development for future roles.

Staff involvement is supported through a range of Divisional meetings and mechanisms, including involvement in business planning, in service redesign and improvement, and in change management. At Trust level, the Chief Executive holds a quarterly forum which any member of staff can attend, to talk about current issues and take questions. This is very well attended and will be further strengthened through greater use of the redesigned Intranet to provide areas of particular interest for staff groups and a way of posting important information and answers to frequently asked questions.

The key principles of the Staff Involvement Policy are that:

- UBHT will invest in developing leadership and team working skills across the Trust, which will support development of open, participative working styles and greater empowerment of teams
- UBHT will foster good partnership working with staff and trade unions
- UBHT will show commitment to sharing and learning about staff involvement and partnership, from both inside and outside the NHS
- UBHT will constantly work to improve communication systems and to provide a culture of openness within the Trust
- UBHT will regularly monitor and evaluate its progress in terms of partnership working and staff involvement.

Communications

As a result of previous years' surveys, the Trust has developed an ancillary forum and an administrative and clerical forum. There is a black and ethnic minority workers forum and a forum for staff with physical and sensory impairments. Ward sisters have their own self-directed forum. The Junior Doctors Committee is made up of all grades of doctors representing all specialties across the Trust.

A very positive development as part of the implementation of the Divisional structure was the establishment of the Clinical Reference Group. This cross-cutting group provides clinical advice on a wide range of issues to both Trust Executive Group and Trust Operational Group. A similar mechanism has now been established on matters affecting administrative and clerical staff. Projects such as the Patient Safety Initiative, in which United Bristol Healthcare Trust is partnered with North Bristol Trust, will enhance staff involvement in the coming months.

Communications at Trust level include a weekly bulletin called Newsbeat, which is circulated through the Trust through both electronic and paper based methods, and a bi-monthly publication called Pulse, which is in magazine style. A team briefing cascade system is in place.
Staff involvement will take a further significant step forward through the governance arrangements for Foundation Trust, which will include staff members of the Council of Governors. It is the Trust's intention to embrace the opportunities which this provides and is already working with Staff Side organisations to look at the way in which staff council members and staff side representatives will be able to work effectively to increase the voice of staff within UBHT. Staff side colleagues are making contact with other Foundation Trusts to consider issues about communications and involvement.

External Focus

As well as involvement internally, the Trust is committed to being focused externally, particularly in the local community. UBHT is a member of groups such as the Bristol Race Equality Health Partnership, Avon and West Wiltshire Mental Health Partnership Mental Health Steering and Operational Groups, Bristol Intermediate and Long Term Care Service Development Group and Bristol Safeguarding Children Board. There are proactive links with networks such as the Cancer Network and Change for Children, incorporating multi-organisational links.

The 'UBHT in the Community' programme is our commitment to corporate social responsibility and there are very close links with schools, colleges, Job Centre Plus and Connexions. A copy of the 2006/07 report is attached at Appendix 27. Whilst there is a well established volunteer programme in place within the Trust, we have recently commenced an arrangement whereby staff can offer some time within the community on certain projects.

One of the first projects undertaken was the planting of a garden at Monks Park School, which is also being opened to the community. This scheme is in its infancy but will be developed further over the course of the next year. The opportunities which Foundation Trust status offers to link in further with community groups and develop programmes which enhance the city of Bristol in general, are considerable.

The programme also involves staff in programmes which are international, including the partnership with Mbarara University Hospital in Uganda, whereby members of staff recently visited to offer clinical and technical expertise, whilst at the same time learning from their experiences overseas. An exchange scheme with two major health

organisations in Canada and Australia, for both clinical and managerial staff, has been put in place this year.

8.7 WORKFORCE STRATEGY

8.7.1 Overall Strategy

The overall purpose of the Workforce Strategy is to ensure that the Trust has sufficient numbers of staff with the appropriate capabilities to deliver high quality services over the period 2007 – 2012. A copy of the strategy is attached at Appendix 28. The Workforce Strategy is intended to:

- support the achievement of service modernisation and productivity gain
- enable the delivery of capital developments
- ensure that the Trust is a highly attractive choice for people seeking work in
- both the local community and nationally
- enable good retention of employees and robust succession planning
- provide the skills training and infrastructure to give managers the ability
- to plan workforce requirements effectively

All Human Resource Managers, ward managers and Allied Health Professional leads have received training in workforce planning. There has also been guidance issued and lunchtime drop-in sessions provided on workforce planning to support 18 weeks. A continuing programme is in place to provide training for other key managers. The Workforce Strategy and Clinical Services Strategy are integral components of the Trust's future development. Workforce modelling will be an essential part of the model of care development as it informs the scoping of available options for models of care, as well as supporting the models once they are developed.

The Workforce Strategy incorporates the Recruitment and Retention Strategy for the Trust and also supports the drive for healthy working practice within UBHT. There is a significant amount of current work on visioning the healthcare workforce for UBHT over the next ten years, including skill mix, role extension and new roles.

Over the next ten years we expect our workforce to reduce in numbers (see Table 54 below), but the workforce will also be more cost-effective as a result of the skill mix changes described in the following sections. Consequently, the fit between the overall financial envelope and the workforce profile is achieved through a combination of reduction in numbers and alteration in the skill mix.. It should also be noted that the reductions are not evenly spread throughout the period, due to a number of capital developments and service changes which cause both decreases and increases in staffing levels. Details of the major changes in workforce numbers (WTE) are contained in Table 52. We would plan to manage changes, which do not involve staff transfers, through natural wastage and extensive service redesign.

Integrated Business Plan (IBP) 2007 - 2017				
Start	Finish	Years	Scheme	Whole Time Equivalent
2009 - 2010	2010 - 2011	2	Dental Hospital Student Expansion (in)	26.03
2008 - 2009	2008 - 2009	1	Medium-term Plan for Non-surgical Oncology	8.00
2008 - 2009	2008 - 2009	1	Stroke Service	5.76
2008 - 2009	2008 - 2009	1	Breast Cancer Screening	7.60
2008 - 2009	2008 - 2009	1	Sexual Assault Referral Centre (Year 1)	6.50
2008 - 2009	2008 - 2009	1	Respiratory Services / Lung Cancer	2.10
2008 - 2009	2008 - 2009	1	Increase in Special Care and Neonatal Unit	9.50
2008 - 2009	2008 - 2009	1	Increase in Neonatal Unit	8.50
2008 - 2009	2008 - 2009	1	Community Midwifery Staffing	6.00
2008 - 2009	2008 - 2009	1	Non-invasive Ventilation Services	1.00
2008 - 2009	2008 - 2009	1	Pre-Operative Assessments	2.60
2008 - 2009	2008 - 2009	1	Inherited Metabolic Disorders	4.00
2008 - 2009	2008 - 2009	1	Cystic Fibrosis	3.50
2008 - 2009	2008 - 2009	1	Working Time Directive (9 rota groups)	11.00
2009 - 2010	2009 - 2010	1	Cardiac Centre (out)	-30.46
2009 - 2010	2009 - 2010	1	Taunton Oncology (out)	-36.00
2009 - 2010	2009 - 2010	1	Assumed Bristol General Hospital transfer (out)	-225.64
2009 - 2010	2009 - 2010	2	Assumed A&E loss to South Bristol Community Hospital (out)	-5.12
2009 - 2010	2009 - 2010	2	Independent Sector Treatment Centre (out)	-23.43
2012 - 2013	2012 - 2013	1	Specialist Paediatric work (in)	145.28
2013 - 2014	2013 - 2014	1	Frenchay Acute transfer (in)	130.19
			Total of Schemes	56.92
2007 - 2008	2016 - 2017	10	CRES	-623.64
2009 - 2010	2016 - 2017	8	Growth & Demand Management	280.67
Grand Total (difference between 31 December 2007 and 2016/17)				-286.06

Table 52: Staff changes 2007/08 – 2016/2017

There are detailed CRES plans for the first four years (Appendix 8), with extrapolation into the later years, as shown in Table 53.

CRES (WTE Related)	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	TOTALS
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Consultants	-0.50	-0.75	-1.92	-0.83	-0.69	-0.71	-0.73	-0.74	-0.74	-7.60
Junior medical	-0.20	-1.67	-1.00	0.00	-0.30	-0.31	-0.32	-0.32	-0.32	-4.42
Nursing	-88.96	-36.96	-31.98	-34.48	-34.47	-35.61	-36.77	-36.96	-37.17	-373.37
Other Clinical staff	-18.73	-13.50	-8.50	-8.00	-11.46	-11.84	-12.23	-12.29	-12.36	-108.91
Non Clinical staff	-9.10	-18.85	-19.35	-22.35	-11.37	-11.74	-12.13	-12.19	-12.26	-129.33
	-117.49	-71.73	-62.75	-65.66	-58.28	-60.21	-62.18	-62.49	-62.85	-623.64

Table 53: Effect of CRES on Staff Numbers (WTE) 2008/9-2016/17

52% of CRES derived from pay for the first four years will result in a reduction in Whole Time Equivalents. The remainder is associated with savings in pay which do not reduce numbers of staff, for example, reductions in Programmed Activities of individual Consultants, changes in nursing skill mix, and savings derived from reduced absenteeism. This percentage is also reflected in the extrapolation into the last five years. Table 53a shows the distribution across occupational groups of Whole Time Equivalent related CRES, and these distributions have been assumed for the extrapolation into the later period.

Occupation Group	4 Year Cumulative CRES Pay Related	4 Year Cumulative CRES WTE Related		Percentage CRES Pay Related by Occupation Group
	£000	WTE	£000	%
Consultants	3235	6.8	473	5%
Junior Doctors	1131	2.9	145	1%
Nursing	8250	189.6	5979	60%
Scientific & Technical	1226	32.1	1068	11%
Other Clinical	2398	16.6	591	6%
Non-Clinical	2848	69.7	1639	17%
Total	19088	317.6	9895	

Table 53a Distribution of WTE related CRES across occupational groups, 2008/9-2011/12

The workforce projections for the period (Table 54) take account of the service changes shown in Table 52 including growth, demand management and CRES plans in tables 53 and 53a. The net effect over the ten year period is a reduction of 312.74 Whole Time Equivalent.

Workforce Projections 2007/08 - 2016/17											
Planned Workforce (Whole Time Equivalent)	31 December 2007	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
TOTAL STAFFING	6807.22	6833.90	6805.77	6484.09	6447.06	6399.33	6510.00	6608.76	6578.80	6547.80	6521.16
Medical & Dental	867.33	875.22	888.39	889.15	889.76	891.34	929.81	949.96	953.31	956.58	960.50
Nursing & Midwifery	2631.26	2636.66	2592.24	2432.24	2408.84	2381.34	2430.43	2503.31	2479.12	2454.40	2431.24
Scientific,Therapeutic & Technical	1067.87	1076.77	1085.04	998.55	997.29	995.11	999.51	1009.58	1008.01	1006.30	1005.25
Other Clinical	666.76	664.48	660.48	608.20	607.82	606.25	614.81	611.59	608.74	605.84	603.40
Non Clinical	1574.00	1580.77	1579.62	1555.95	1543.34	1525.30	1535.44	1534.32	1529.62	1524.68	1520.77

Table 54: Planned Workforce 2007/8-2016/17

8.7.2 Medical Workforce

Amongst the medical workforce, there will be an increasing shift in workload to the community, supported by models such as polyclinics with Consultant supervision and one-stop shops. The priority for medicine will continue to be the acute medical take providing secondary care for the local population. In order to provide the correct level of care, and in the light of changing experience at trainee doctor level under Modernising Medical Careers, the Trust will shift towards the appointment of Acute Physicians. It will need to have 24 hour a day/7 day a week consultant cover on the Medical Admissions ward, which will require progressive appointment of Acute Physicians as vacancies are released through retirement. Recruitment to Acute Physician roles will include a commitment to special interest clinics for future career development. Skill mix in emergency care will increasingly be "front-loaded", to ensure that an expert opinion is obtained at the earliest possible stage. Throughout the Trust, there will be a move away from a waiting list culture by ensuring diagnosis is made early in the patient pathway.

In line with the Royal College of Physicians' report, *(Careers for Consultant Physicians: Focus on Flexibility, 2002,)* there will be a commitment to phase the Consultant role better over the span of the practitioner's career. In the earlier part of the career the job planning process should ensure that time is provided to support acute care and to develop a special interest. Towards the latter part of their career, Consultants should be enabled to focus more closely on their areas of special interest, with a reduced commitment to the acute physician rota. The increasing participation of women in the medical workforce will also be supported by flexible working approaches.

Consultant workforce planning in the Trust should recognise likely changes in disease patterns and trends in disease management in the next five years. For example, there is likely to be a significant rise in alcoholic liver disease and cirrhosis, diabetes and obesity in the next five years, combined with further support for an aging population and increased care in the community or self-care. Technology trends in surgical interventions will lead to shorter lengths of stay, increased day cases and overall reduction in open operations. Management of children will increasingly be community based. Within cardiac surgery, it is the intention to introduce surgical practitioners to replace clinical fellow roles.

In line with the *Medical Workforce Strategy*, issued by NHS Employers in 2007, the Trust`s own Medical Workforce Strategy will include balancing the formal education

needs of trainee doctors against the need to ensure that they make an effective contribution to service delivery.

8.7.3 Nursing and Midwifery Workforce

The nursing the workforce plan assumes that general wards will move from a current ratio of 65:35 registered to unregistered to 60:40 by 2010/11 and 50:50 by 2012/13. The ratio in nursing and midwifery overall will consequently move from a ratio of 78:22 in 2007/08 to 74:26 in 2010/11 and 68:32 in 2012/13. .

The unregistered proportion of the nursing workforce will be significantly changed to a combination of support workers, (who currently comprise virtually all unregistered workforce), and associate nurses (assistant practitioners). There will be a significant rise in the number of associate nurses from none in 2006 to 10% of the nursing workforce by 2013. The main emphasis across all nursing bands will be on expansion of roles, either vertically or horizontally, although there will continue to be some development of new roles. Development of nurse consultant staffing, which is currently at the level of 6 posts within the Trust, will be driven by changes in disease pattern disease management and application of new technologies.

The University Teaching Trust tool for measuring acuity will be added to the existing tool used for dependency measurement, to inform both rostering and longer term workforce planning. Within midwifery, a much richer skill mix will continue in the delivery suite, but senior support workers will lead on breast feeding rather than midwives. Obstetric wards will have a more balanced skill mix and ratios will decrease further in community midwifery teams.

There is likely to be a more centralised pool of newly registered nurses, supported through preceptorship and transition to Band 6, and accompanied by an increase in the number of rotational posts. The Trust will be considering a model which could be team led, with a matron for a defined area or service, supported in their leadership role by a nurse consultant.

The bank and agency ratio is likely to remain similar to present in a rough proportion of 95% bank to 5% agency, but with further development of a specialist bank.

8.7.4 Allied Health Professions/Health Care Scientists and Technicians

AHPs, healthcare scientists, and scientific and technical staff cover a wide range of different professions, and across each there are different skill mixes. For healthcare scientists as a group, the skill mix ratio of qualified to unqualified is currently 57:43, and amongst scientific and therapeutic staff it is 74:26. During 2008, there will be a programme of work to map ideal skill mix for each profession. In some cases, such as radiography, the career ladder may need to be lengthened, to introduce consultant and specialist roles, as well as an increase in support roles. There is potential to change the skill mix within professions such as occupational therapy, cardiac physiology and therapeutic radiography. However, across other professions this approach may be counter-productive and have a negative impact on length of stay. Across “bedded” services, there is potential for a role of generic support worker, and this will be explored in the mapping project. This may not mean major change in terms of high level skill mix figures, but the review will ensure that each profession works to their optimum skill mix.

8.7.5 Administrative and Clerical/Ancillary Staff

Within administrative and clerical groups, improved technology such as voice recognition software and digital dictation capacity will enable fewer numbers of higher banded medical secretaries to exercise greater administrative skills overall, whilst increasing the need for more routine work to be undertaken by support typists and clerical staff. As the National Programme for Information Technology is implemented, this will bring the need for changes in roles and a potential reduction in overall clerical requirements Ward Clerk roles have potential for development, undertaking administrative work currently completed by nurses and technicians. The Trust will ensure that the skills of existing administrative and clerical staff are developed to meet the changing needs of the organisation.

Within ancillary functions, technology will be a key driver in ensuring better utilisation of staff, higher productivity and increased efficiency. These technologies include electronic despatch, use of communications technology and electronic ordering, particularly amongst functions such as portering.

8.8 TEACHING AND LEARNING STRATEGY

The partner strategy to the Workforce Strategy is the Teaching and Learning Strategy 2007 - 2012 which aims to:

- Ensure that staff providing direct clinical care services within the Trust are able to provide safe, effective and high quality patient care, upholding the core values of the NHS, and that staff working in support services are able to provide efficient, customer focussed services to the same high standards of quality and governance.
- Develop existing partnerships with education providers and partner organisations, ensuring that curricula are fit for purpose and that students receive an excellent teaching and learning experience, both in the formal learning environment and during placement.
- Foster a climate in which staff of all disciplines embrace personal and organisational development, are committed to working and learning in multi-disciplinary teams, are given real opportunities to progress.
- Encourage innovation and a ‘can do, will do’ culture across the organisation
- Support the Trust in being an employer of choice for people seeking work in both the local community and nationally.

The Teaching and Learning Strategy will work in synergy with the development of the Clinical Services Strategy, Research and Development Strategy and Workforce Strategy, so that the four strategies are mutually exclusive. The Teaching and Learning and Workforce Strategies should enable the Trust to achieve internal and external quality and accreditation standards for service, teaching and research, as well as providing the skill levels required in our workforce, both now and in the future. A copy of the strategy is attached at Appendix 30.

8.8.1 Training and Development Provision and Plans

The Trust has a very strong reputation in the area of training and development and has a very wide portfolio of programmes offered internally, either at corporate or divisional level, as well as accessing a wide range of external opportunities through neighbouring academic institutions and external training providers. There are particularly close working relationships with the University of Bristol, the University of West of England and the City

of Bristol College. The Trust has an excellent purpose-built Education Centre, opened in 2001, which houses a range of facilities, including lecture theatres, tutorial rooms, an interview/observation suite, a clinical skills centre, the Bristol Medical Simulation Centre, a large Learning Resource Centre complete with library and computer facilities, plus two computer aided learning rooms.

The Trust is also the host employer for Skills for Health, which covers all four countries of the United Kingdom. The Director of Workforce and Organisational Development represents the Trust on the Skills for Health Management Board. UBHT has a strong track record in terms of hosting General Management, Finance and Human Resources trainees and is committed to maintain this role in the future.

Foundation Trust status will provide an opportunity to work more closely with our local community on issues such as the Leitch Review (published December 2005), which aims to ensure that the UK should become a world leader in skills by 2020, with significant increases in functional literacy and numeracy, higher levels of core skills and a shift upwards in intermediate and advanced skills. Within Bristol there is considerable disparity in skills development, reflecting both the high student population in higher education and the secondary school performance, which is below the national average.

The level of educational attainment at National Vocational Qualification level 2 and above within South Bristol, in particular, is low compared to national levels. The trust has signed the voluntary “Leitch” pledge for 90% of staff to have level 2 learning by 2010. As one of the major employers in the community, UBHT is committed to supporting the intentions in the Leitch review as well as continuing to develop the very highest levels of skills attainment to ensure that we invest in providing the experts of the future. Work with partner organisations such as Ablaze at Whitefields School in Bristol is one example of this developing role. The trust has a 100 strong School Ambassador network amongst its staff. There is a particular focus with the schools on increasing skills in science and on working with pupils from ethnic minority backgrounds as part of the Trust`s commitment to equality and diversity.

A careers support system has recently been established for staff, in conjunction with the Learning Resources Centre, with a range of resources and signposting to key individuals and networks.

8.9 RELATED WORKFORCE STRATEGIES

In addition, the Trust has a Valuing Diversity Strategy (covering both patient care and employment issues), a Succession Planning Framework for 2006 – 2009 and an Organisational Development Framework for 2006 – 2009.

9. GOVERNANCE ARRANGEMENTS

9.1 HOW STAKEHOLDER INTERESTS WILL BE REPRESENTED/MEMBERSHIP

As a tertiary teaching hospital and Public Benefit Corporation we will develop a membership community from the populations we serve, patients and carers, staff and from local partner organisations involved in health and social care services. These are the stakeholders in the organisation. The Membership Development Strategy (Appendix 30) defines our membership community and the Trust's objectives for engaging with its membership.

The membership will provide a guardianship function in the Trust, ensuring that our strategic vision reflects the needs and expectations of the people served by the Trust. The benefits of the membership community are also likely to be improved communication between the Trust and its stakeholders and more opportunities for us to engage people in identifying and implementing service developments, which are relevant to the stakeholders and consistent with the values of the Trust.

The Trust will actively support the membership to ensure that it is effective in supporting the achievement of the Trust's aims and objectives. This will also assist in developing a culture of 'loyalty and ownership' to the organisation. This will be achieved through a structured engagement and communication programme, which will build on and integrate with existing patient and public involvement, and staff involvement programmes.

9.1.1 Membership Constituencies

The Membership Development Strategy (Appendix 30) and the Governance Rationale (Appendix 31) informed the establishment of the Constitution (Appendix 32). This defines our membership community as drawing members from the following constituencies:

- Public
- Patient and Carers
- Staff.

9.1.2 The public constituencies

There are three public constituencies drawn from the populations in the three main local government areas and commissioning localities:

- Bristol
- South Gloucestershire
- North Somerset.

The rationale for this is that these areas cover the majority (85%) of the Trust's activity and the three areas are coterminous with both the local government electoral area and the commissioning locality for that area.

Within the constituencies we have identified the 'seldom heard' groups and children and young people, as groups with whom we plan to engage with effectively to ensure that they are engaged with the development of the Trust.

These constituencies will be recruited using an opt-in approach. Restrictions on membership are defined in the Membership Development Strategy (Appendix 30).

9.1.3 The patient and carer constituency

This constituency comprises patients and the carers of those patients, who within the three years preceding authorisation have been a patient of the Trust.

Whilst Foundation Trusts are not required to have patient constituencies, the Trust is clear that patients and carers have a unique and valuable perspective about our services. The decision to identify this constituency was a very clear one and reflects the commitment of the Trust to patient involvement.

An additional rationale for the patient constituency is that the Trust is a tertiary and specialist centre, providing services to patients from a wide geographical area. It would not be practical or an effective use of resources to include these tertiary patients in the public constituencies, nonetheless their views are welcome and needed. The existence of a patient constituency will allow these patients to become members of the Trust.

The patient constituency is sub-divided into four groups:

- Patients from the three local public constituency areas
- Patients from the rest of England and Wales
- Carers of patients under 16 years of age
- Carers of patients 16 years and over.

The rationale for this sub-division is:

- It ensures that there is a focus on obtaining membership from the tertiary areas
- The carers of children and young people, and adults have very different perspectives and needs.

These constituencies will be recruited using an opt-in approach. Restrictions on membership are defined in the Membership Development Strategy (Appendix 30).
As of February 2008 the Trust has over 8,500 patient and public members.

9.1.4 The staff constituency

This will be drawn from staff within the following groups:

- Nursing and Midwifery
- Medical and Dental
- Other clinical healthcare staff
- Non-clinical healthcare staff.

The staff membership will also include staff who have academic roles, hold honorary contracts, and are volunteers or work for an external contractor in a role in which a significant part is just for the Trust. This reflects the teaching status of the Trust and the value the Trust places on the contribution of volunteers.

There will be an opt-out approach to this constituency. As of February 2008 only two members of staff have formally opted out of membership.

9.1.5 Membership Council

A Membership Council of governors will be established, which will strengthen stakeholder engagement. Elected governors will be drawn from the public, patient and carer, and staff constituencies. Appointed governors will be drawn from the Trust's main commissioning organisations, Bristol Local Authority and other partner organisations.

The composition of the Membership Council is summarised in Table 55.

Public Governors	**Number 9**
Bristol	5
North Somerset	2
South Gloucestershire	2
Patient and Public Governors	**Number 12**
Carers of 16 years and over	2
Carers of under 16 years	2
Patients local areas	6
Patients tertiary areas	2
Staff Governors	**Number 6**
Nursing and Midwifery	2
Medical and Dental	1
Other clinical healthcare staff	1
Non-clinical healthcare staff	2
Appointed Governors	**Number 6**
University of West of England	1
University of Bristol	1
Bristol Primary Care Trust	1
North Somerset Primary Care Trust	1
South Gloucestershire Primary Care Trust	1
Bristol City Council	1
Appointed Governors – Invited	**Number 5**
Great Western Ambulance Trust	1
Avon Wiltshire Mental Health Trust	1
Joint Union Committee	1
Voluntary Sector	1
Community Organisation / Group	1
Total	**38**

Table 55: Membership Council Composition

The number of governors is commensurate with the size of the constituency from which they are elected or appointed. Over 50% of the governors are from the patient and public constituencies.

Elections to the Membership Council will be managed by an external and independent organisation on behalf of the Trust.

The Membership Development Strategy defines how the ongoing engagement and relationship with the stakeholders will be managed. In November 2007, the current membership was profiled to identify areas of under-representation and, following consultation and debate by the Trust Board, a membership plan has been developed for 2008/09 to include recruiting members from under-represented groups.

The executive responsibility for the Membership Development Strategy rests with the Director of Governance and management responsibility is devolved to the Membership

Manager. The latter two individuals, plus the Assistant Director for Governance, will support the Board of Directors and the Membership Council.

Governor elections

Having secured the support of the Secretary of State for our foundation trust application, the governor election process, managed on our behalf by Electoral Reform Services, commenced on 24th January 2008. The Trust has received 203 governor nominations and all elected seats on the Membership Council will be contested. The election results will be known on 25th March 2008.

Names of appointed governor representatives have also been requested from stakeholder organisations.

9.2 CORPORATE GOVERNANCE AND MANAGEMENT

The corporate and integrated governance framework will support governance at three levels:

- Members
- Board of Directors
- Membership Council.

Our future governance arrangements as a Foundation Trust will ensure that the following objectives are met:

- There will be clear and comprehensive organisational structure, which is documented and supports all current functions
- The structure will be supported by clearly defined accountabilities and responsibilities for each function in the Trust
- There will be clear reporting lines from each function to the Trust's Board of Directors
- There will be a clear and documented relationship between the members, the Board of Directors and the Membership Council.

As part of the Trust's application process the Trust participated in a Foundation Trust Diagnostic Self-Assessment from which an action plan was agreed in which there were some specific governance arrangements. Upon completion of this action plan and when a formal application process was entered, a governance action plan was established (Appendix 33).

9.2.1 Membership Council

The Membership Council will be responsible for representing the interests of the stakeholder communities in strategic planning and in the guardianship of the Trust, and for maintaining good communication with the members.

The Membership Council represents the membership communities in the following roles:

- **Advisory** to advise the Board of Directors on decisions about the strategic direction of the Trust
- **Strategic** to inform the development of the future strategy of the Trust
- **Guardianship** to act as guardian of the Trust for the stakeholder communities.

The Membership Council will have the following statutory responsibilities as defined in the legislation for Foundation Trusts:

- Involvement in approving the appointment, removal and the terms of office including the remuneration of the Chair and non-executive directors of the Trust's Board of Directors
- Approving the appointment of the Chief Executive
- Appointing or removing the Trust's auditors
- Reviewing the annual accounts, auditors report and annual report at the Annual General Meeting of the Membership Council
- Expressing a view on the Board of Directors' forward plans.

The Membership Council will not be responsible for the day-to-day management of the Trust. This is the responsibility of the Board of Directors. Although the Membership Council has a duty to give its views on the Directors' forward plans, there is no reciprocal requirement for the Board of Directors to seek the approval of the Membership Council for major developments affecting the interests of members. The Membership Council has no effective power of veto over the decisions of the Board of Directors.

The duties and expectations of the Membership Council are set out in the Constitution (Appendix 32) and the Code of Conduct for governors (Appendix 34). Effective engagement of the Membership Council will be achieved through a range of mechanisms including; focus groups, development events and reciprocal attendance at meetings between the Board of Directors and the Membership Council.

9.2.2 Board of Directors

The Board of Directors is legally accountable for the overall performance of the Trust. It is led by the Chair, John Savage, and is responsible for setting and realising the vision of the Trust. Board members are responsible for the overall future of the Trust and the services it provides. They agree strategy and direction, oversee performance in all functions and ensure that the services provided give value for money.

The Board ensures that services are evidence-based, safe, underpinned by quality and are delivered in a cost effective way, in order that they meet the needs of patients, carers and the wider community and partner organisation. In doing so the Board of Directors will ensure that the Trust complies with the Terms of Authorisation and all statutory obligations.

Section 8.1 of the plan describes the Board capacity and development. This development plan is being implemented to ensure that the directors make the transition from operating as a Board within an NHS Trust to the corporate Board of a Foundation Trust, with the full weight of fiduciary responsibility. Non-executive directors will be supported to adapt to the new responsibilities. Their traditional role of guardianship of the community interest will be transferred to the Membership Council.

The Trust committee structure has been revised to provide clear lines of accountability, with emphasis being placed upon the assurances and reporting requirements for Executive Directors as their portfolios comprise the key functions of the Trust. The committee structure is described in section 9.2.3.

9.2.3 Committee Structure – Sub-Board Level

The Trust Board governance and management sub-committee structure is illustrated in Figure 22 below.

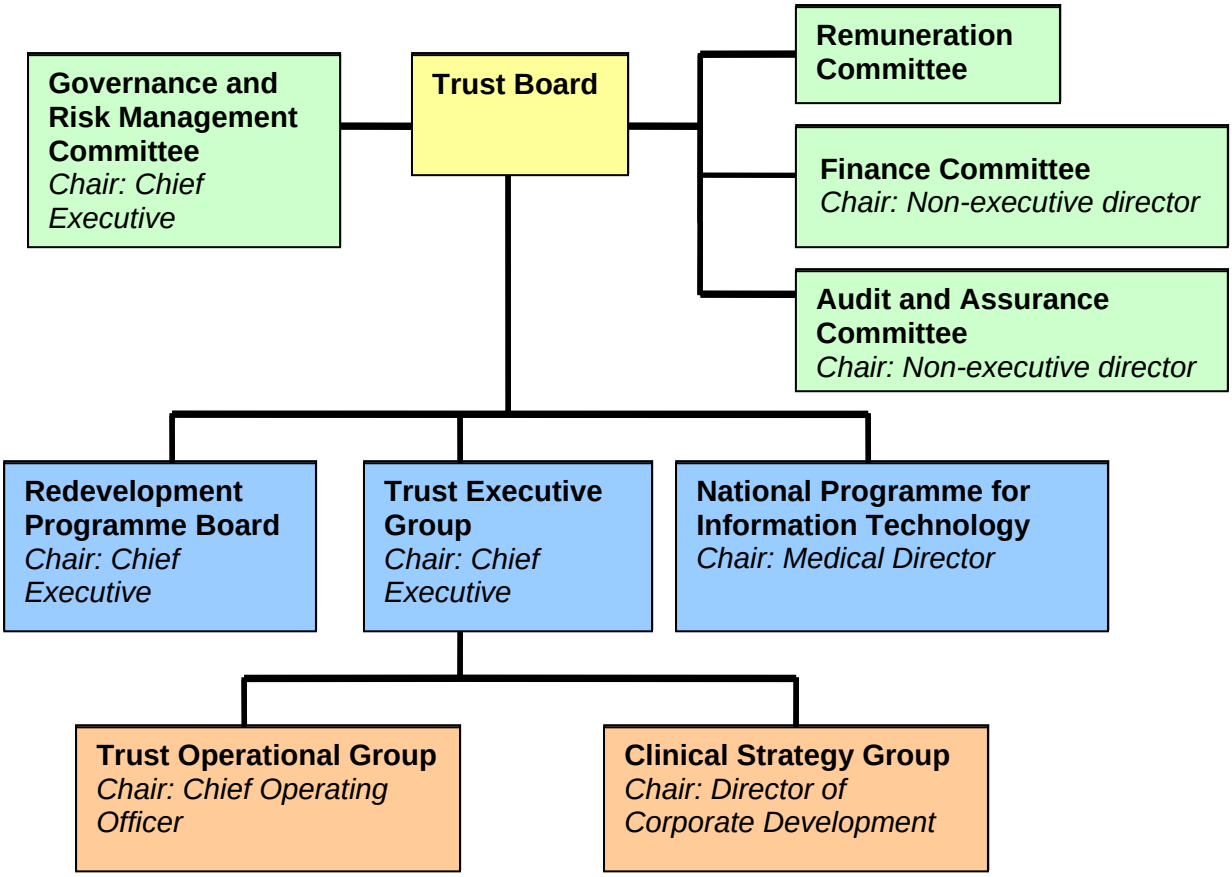


Figure 22: Trust Board governance and management sub-committee structure

All of the main sub-committees are chaired by a director. The Trust Board sub-committees are the Audit and Assurance Committee, the Governance and Risk Management Committee, the Finance Committee and the Remuneration Committee. The Trust Board has regularly reviewed these arrangements and, in particular, it has considered the need for a Finance Committee, which has been introduced from January 2008.

The Trust Executive Group and the Trust Operational Group oversee the strategic and operational management of the Trust on a day-to-day basis. They are complemented by the Redevelopment Programme Board, the Clinical Strategy Group and the National Programme for Information Technology Group.

This committee infrastructure is supported by:

- A governance and risk management system of committees and groups, including the clinical governance committees and the Health and Safety Committee. These are shown at Appendix 35
- A range of advisory mechanisms
- A range of partnership groups.

The advisory groups include:

- The Business and Consumer Advisory Groups directly advising the Trust Board (put in place to support the Trust in preparing for foundation status)
- The Clinical Reference Group
- The Nursing and Midwifery Committee
- The Allied Healthcare Professionals and Healthcare Scientists Advisory Group
- The Clinical Ethics Group.

The partnership groups include the University of Bristol and United Bristol Healthcare NHS Trust Joint Strategic Committee and the Occupational Health Partnership Board.

9.2.4 Board Reports

The Trust Board structures the reports it receives according to the best practice recommended in the Intelligent Board Report and reconstructed the agenda in this format from 2006. The monthly board agenda has a standard format of the following headings:

- Strategy
- Performance Management
- Assurance and Governance
- Any other business.

The agenda format is reviewed annually to ensure it is fit for purpose.

Board papers are available publicly on the internet.

The Board has an annual programme of activity which is reviewed each year and then implemented, in tandem with the reporting to the Audit and Assurance Committee and, the Governance and Risk Management Committee (Appendix 36).

The Governance Action Plan for 2007/08 (Appendix 33) was developed taking into account the draft Constitution and Governance Rationale, which were subsequently agreed by the Trust Board at the July 2007 meeting.

The Trust has reviewed Monitor's Compliance Framework (April 2007). Proposed changes to Board reporting, consistent with the requirements in the Compliance Framework, were agreed by the Trust Executive Group in July 2007.

The format of the Finance Board Report has been reviewed and refined to reflect the requirements of a Foundation Trust, with the new format being introduced in October 2007.

9.2.5 Audit Arrangements

The oversight of the audit arrangements is the responsibility of the Audit and Assurance Committee (Terms of Reference at Appendix 37). This Committee invites attendance at all its meetings from both internal and external audit representatives. The Committee meets with auditors at least once per annum on a confidential basis without executive directors or managers of the Trust being present.

9.2.6 Internal Audit

The Committee considers on a planned basis, within its annual programme:

- The annual report of the internal audit service and its effectiveness / value for money. This includes consideration of the resourcing of internal audit and ensuring that it has appropriate standing within the Trust
- The internal audit programme for each year, the major findings of internal audit investigations and management's response, and the full detail of any report which has adverse audit findings
- The coordination of both internal and external audit activity.

The Head of Internal Audit has right of access to the Chair of the Committee or, if this were not appropriate, to any other member of the Committee. Such access is only exercised in exceptional circumstances. The Head of Internal Audit Opinion for 2006/07 is at Appendix 38.

9.2.7 External Audit

The Committee considers on a planned basis, within its annual programme:

- The appointment of the external auditor as far as the Audit Commission's rules permit
- A discussion on the programme for external audit for each year
- The coordination of both internal and external audit activity
- Review of external audit reports including value for money reports, the Auditors Local Evaluation (ALE), annual audit letters and management's response.

The management letters to the Trust for 2005/06 and 2006/07 are attached at Appendix 39 and 40. External Auditors gave an unqualified opinion on the accounts for 2005/06 and 2006/07. There were no significant issues raised with regards to the financial position in these years.

The Use of Resources assessment which relies on ALE scores was overall 'Fair' in 2005/06 and 2006/07. This resulted from an ALE score of 2 generated primarily by the Financial Standing score of 2 which is dominant in the composite score. The breakdown of ALE scores for 2006/07 in Table 34 in section 6.3 demonstrates that the Trust scored 3 in all categories but one, Financial Standing.

9.3 ASSURANCE FRAMEWORK AND AUDIT

9.3.1 Audit and Assurance Committee

The Audit and Assurance Committee is a sub-committee of the Board and is responsible for ensuring that the Assurance Framework achieves its purpose in managing the principal risks to the Trust. Its terms of reference are at Appendix 37.

It meets quarterly with the Internal and External Auditors, and with the Director of Finance and Director of Governance in attendance. The Committee is chaired by a non-executive director of the Trust and, from June 2007, has included a non-executive director with financial qualifications. The Committee has a right to meet with the auditors without officers present and does so at least once a year. The terms of reference are reviewed regularly, performance evaluated and a report submitted to the Board.

9.3.2 Assurance Framework

The Assurance Framework provides the Board with a comprehensive approach for providing effective and focused management on the main risks related to meeting the Trust's principal objectives. It also provides a structure for the evidence to support the annual declaration on compliance with the core standards for health and the annual Statement on Internal Control. The framework is developed through the following steps:

- Establishing the principal objectives of the Trust, through the business planning cycle as well as the core and continual objectives related to the core standards for health, finance and national targets
- Identifying principal risks that may threaten the achievement of these objectives
- Identifying and evaluating the key controls, which may be systems and controls or assurances, intended to manage these principal risks and therefore secure delivery of the objectives
- Identifying arrangements for obtaining assurances on the effectiveness of key controls across all objectives
- Evaluating assurances obtained to demonstrate that the Trust is reasonably managing the risks and identify where there are gaps in controls
- Identifying where there are gaps in assurances.

The Board of Directors is fully involved with and consulted on these steps and formally ratifies the Assurance Framework on a quarterly basis. The Non Executive Director lead for the Assurance Framework and Risk is the Chair of the Audit and Assurance Committee. Additional steps to ensure that there is effective on-going management of the risks identified through the Assurance Framework include:

- All objectives in the Assurance Framework, including all of the core standards for health, have a named executive director who is accountable for that element of the framework
- A reporting schedule to the Governance and Risk Management Committee, the Audit and Assurance Committee, and the Board of Directors, which includes positive assurances, gaps in controls and assurances, and potential significant lapses related to the core standards for health
- A focused review of key risks and objectives through the annual programmes for internal and external audit, as well as the Audit and Assurance Committee's in-depth quarterly review of one or two core standards, as determined by them
- The maintenance of dynamic and robust risks registers corporately, within Divisions and for trust-wide issues which do not warrant entry on to the corporate risk register.

The Statement on Internal Control 2006/07 is at Appendix 41.

9.4 COMPLIANCE FRAMEWORK

Currently the Board of Directors is required to sign a statement of declaration on compliance with the Standards for Better Health. This requirement has influenced the development of an approach to securing Board assurance in which there is a requirement for each standard to have an executive accountable lead. For 2006/07 the Board declared compliance with all standards except 11b [mandatory and statutory training] and 21 (environment). These two were declared as not met for the full year, but met as of 31 March 2007. The 2006/07 Declaration on Core Standards is at Appendix 42.

On behalf of the Board of Directors, the Trust Executive Group and the Audit and Assurance Committee receive assurance through regular monitoring of progress in relation to:

- National Targets
- Finance
- Standards for Better Health
- Staffing
- Clinical Quality
- Partnership
- Constitutional requirements.

There is a monthly integrated performance report to the Board of Directors, and the Trust Executive Group ensures regular review of delivery systems across all areas of service performance to ensure they remain robust, resourced and are carried out in a way that meets the needs of the Trust.

The Clinical Governance Structure (Appendix 35) works to provide assurance on relevant core standards. There is a Clinical Governance Action Plan 2007/08 (Appendix 43).

The Medical Director is in the process of further developing clinical performance indicators and benchmarking activity and this work will contribute in the future to the development of Trust metrics to support compliance statements.

The Trust has a formal partnership framework which is used to monitor the health of key relationships. The framework has been revised following an external audit (which commended the Trust's approach), and is subject to quarterly monitoring at the Trust Executive Group.

The Trust has considered guidance in relation to the requirements for authorisation as a Foundation Trust and Monitor's Compliance Framework. During 2007 the Board of Directors has approved changes in some areas of governance, and strengthening in others, namely:

- Legality of the Constitution
- Representative Membership
- Board roles and structures
- Co-operation and Partnership
- Risk and Performance Management.

9.4.1 Performance Monitoring and Management Framework

Non-financial performance is monitored through a number of established procedures. A performance dashboard approach has been adopted for the management of key targets, which is being extended to the management of the key efficiency indicators. There are defined processes for assuring the management of performance for a number of other areas of non-financial performance, which are detailed in the following sections.

Appendix 44 identifies the portfolio responsibilities of Executive Directors of the Board. A Non Executive Director will be identified as the lead for performance management. A review of any changes required to the reporting procedures in view of the Foundation Trust application has taken place. The performance report has been amended and,

since February 2008, includes a dashboard showing performance against elements of the Monitor Compliance Framework and national targets.

Healthcare Commission New and Existing National Targets

UBHT uses a performance dashboard called the Target Tracker, to monitor progress against key targets. This was developed in-house and introduced in the first quarter of 2006/2007. The tracker is updated monthly and is published on the PiNet section of the Trust's intranet, which is accessible to anyone within the organisation that has access to a networked computer. The tracker shows monthly and year-to-date performance against the key performance indicators included by the Healthcare Commission in the annual assessment of Quality of Services. A traffic-light system is used to highlight areas of underachievement, using the thresholds for achievement of the required standard where these have been published by the Healthcare Commission.

The Target Tracker is used in the monthly reviews of performance of the clinical divisions. Reviews are carried-out by the Head of Performance Improvement and involve Assistant Divisional Managers from each clinical division. Divisions prepare an exception report in advance of the review, which covers its contribution to those targets for which the Trust is currently under-achieving the required standard, as well as any targets for which the Division considers future performance to be at risk. Any corrective action needing to be undertaken is agreed and documented together with the name of the operational lead and timescale for completion.

The performance reviews are used to prepare a monthly Performance Report, again based upon exception reporting, which is considered at the Trust Operational Group. Any additional action needing to be taken to address performance variances is decided and monitored at subsequent meetings of the group. The agreed actions are minuted and published on the intranet. Any outstanding issues are escalated to the Trust Executive Group where the monthly exception report is considered and action required is noted. The exception report which is presented at Trust Operational Group and then Trust Executive Group forms part of the integrated performance report which goes to the Board each month.

The integrated performance report also includes the exception reports and trend graphs using statistical process control, for the key national targets and other areas of corporate performance, such as workforce and quality indicators. The Trust Board performance report in this form was introduced in January 2007. The integrated performance report, is made publicly available via the Trust website and now contains a dashboard showing performance against elements of the Monitor Compliance Framework and national targets.

Healthcare Commission Core Standards for Better Health and Developmental Standards

The Trust reviews its compliance against the core and developmental standards every three months. Action plans to ensure compliance are developed by the relevant executive director and then considered by the executive-led Governance and Risk Management Committee, and then if necessary by the Audit and Assurance Committee of the Board. Minutes of the Governance and Risk Management Committee are received by the Board quarterly.

A separate meeting of the Governance and Risk Management Committee is held annually to consider the Trust's position regarding compliance with the Core Standards for Better Health. The recommendations of this committee are reviewed by the Board ahead of making the declaration of compliance. This system has been in place for two years.

Clinical risk

The Trust's performance regarding exposure to clinical risk is managed via reporting to the Governance & Risk Management Committee and then on to the Trust Board. Clinical risks are monitored via two routes: a) clinical incidents and b) risks which are logged on the Trust Risk Register. All incidents where the clinical care of patients was considered to have been, or could have been, put at risk are reported via clinical incident forms. All clinical incidents are logged onto a central database, Ulysses, which is also used to manage and report patient complaints and litigation. This database was introduced more than five years ago.

Those incidents rated as high risk using the Trust's standard risk assessment protocol, are reported to an executive within 24 hours of the incident having been identified and any action necessary to mitigate the risk is taken. The outcome of investigations into high risk clinical incidents are reported to the Clinical Risk and Assurance Committee on a monthly basis, the minutes of which are sent to the quarterly Governance and Risk Management Committee, which was established at the beginning of the second quarter of 2005/2006.

A wider report covering the level and types of clinical incidents reported in the period is presented to the Clinical Risk & Assurance Committee each quarter. All identified clinical and non-clinical risks are logged on the Trust Risk Register. Excerpts of the register relating to clinical risks are sent to Clinical Risk and Assurance Committee and on to the Governance and Risk Management Committee via the minutes. The Trust Board receives the minutes of the Governance & Risk Management Committee on a quarterly basis.

Corporate objectives, quality and efficiency

The Trust Board reviews progress against the corporate annual plan on a quarterly basis. Progress made against divisional annual plans is reviewed six monthly at Divisional reviews. At the Divisional reviews all aspects of divisional performance are considered and there is an opportunity to address issues of concern in more detail. Executive directors and divisional teams attend. Where necessary, action plans are drawn up and proactively managed by Trust Executive Group.

A similar approach to the management of Healthcare Commission targets has been adopted for tracking progress in improving efficiency and measures of quality. The indicator set used includes those indicators which relate to the trust's own performance priorities. In 2007/2008 these included reductions in length of stay, cancelled operations, as well as Resource Utilisation Management savings agreed with the PCT. A monthly progress report is produced by Divisions. This is used to develop a monthly exception report reviewed by the Trust Operational Group.

The Trust Operational Group also reviews benchmark data derived from the Hospital Activity Tracker provided by Dr Foster's and the quarterly NHS Institute Acute Trust productivity indicators to review the Trust progress against indicators of efficiency. As for the key national targets, any action needing to be taken to address variance from plan is agreed and minuted. It is the intention that in the future the monthly efficiency report will be sent via the Trust Executive Group to the Board on a quarterly basis.

A number of quality indicators are already included in the integrated performance report presented to the Board each month. The Board has been debating how it can consider a more robust suite of metrics relating to patient safety, patient experience and outcomes. This work is being collated by the Medical Director and Chief Nurse and Director of Governance so that Board reports in 2008 can match more clinical and quality metrics.

Other areas of non-financial performance

All reports arising from external reviews, inspections and audit have a designated executive lead and are monitored by a named group appropriate to the subject matter. Progress against action plans developed to address the recommendations of such reviews is monitored via quarterly exception reports to the Audit and Assurance Committee.

The Chief Executive and Chief Operating Officer review the individual performance of the Heads of Division who have objectives that reflect the financial and non financial performance agenda, and these are reviewed at least annually. The Heads of Division, in turn, appraise the Divisional Managers with the Chief Operating Officer present providing advice. This system has been in place since the establishment of the Divisional structure in 2005.

Financial Controls and Reporting

Since January 2008 the Trust has operated with a Finance Committee which reports to the Trust Board. Detailed financial information is provided to the Finance Committee with a more summarised version presented to the main Board.

9.5 INFORMATION TECHNOLOGY SYSTEMS

9.5.1 Vision

UBHT plans to become a modern 21st century centre of excellence for the provision of healthcare and for the Information Communication and Technology (ICT) services that support it. ICT will increasingly underpin service delivery and UBHT's success as a Foundation Trust. It will therefore provide fast, accessible and reliable services to make the capture, processing and display of information as relevant, quick and easy as possible for users. Building on existing strengths, it will be responsive to changing service and user needs, and will promote the delivery of leading-edge technology delivered to a high standard.

Priorities for 2007/08 include:

- Continuing to deliver the National Programme for IT (Connecting for Health) and working closely with the Local Service Provider (LSP) Fujitsu
- Supporting UBHT's progress towards a modern healthcare environment, including a modern Information Technology (IT) infrastructure that is resilient, secure and reliable and building on this to meet future business needs
- Supporting the implementation of the Bristol Health Services Plan, including new-build
- Providing information to support financial data flows, service redesign, monitoring of performance targets and benchmarking
- Ensuring that all staff have the necessary IT skills ahead of National Programme for Information Technology (NPfIT)
- Ensuring that all financial targets are met and appropriate controls are in place
- Ensuring that all areas of IM&T support UBHT as a Foundation Trust.

9.5.2 Background

The Trust has delivered a range of information technology services to support improvements in healthcare delivery and management. Key items include:

- Connecting for Health Picture Archiving and Communications System (General Electric PACS) and Radiology Information System (HSS 'CRIS') went live successfully in November 2006, and the benefits are now being realised in the form of improved reporting coverage and turnaround, reduction in repeat x-rays, and significantly reduced film and chemical costs
- A new Pathology Laboratory System (GE Ultra) went live in March 2006, replacing an aging in-house legacy system. Benefits include improved turnaround times, better access to results and improved data management. It also supports the Bristol Health Services Plan by providing access to results irrespective of where the test was processed, as neighbouring Trusts in the local health community use the same system
- Enabling of direct booking to the existing Patient Administration System (PAS) to support the Choose & Book programme
- A generic Document Management System which is also provided to other Trusts
- A Clinical Document Service which stores clinic and inpatient discharge letters
- Centralisation within Information Management and Technology (IM&T) of Clinical Coding, IT Training and Information Analysis
- Upgrading of current Information Communication Technology (ICT) infrastructure, including new higher capacity and more resilient network, wireless capability and new and replacement PCs, to support PACS, Care Records Service and other initiatives
- Partnerships with the major private sector suppliers e.g. EMC case studies re our use of data storage; a Microsoft reference site for unified communications; a Cisco world reference site for our wireless network; an Air Defence reference site for our wireless protection systems
- Enabling secure access to Trust systems by staff from home
- An integrated, centralised and robust voice system (managed within the IM&T department), and reduction in costs.

9.5.3 The future

Implementation of the NHS Care Records Service (NHS CRS) at UBHT is expected to take place in the next 1-2 years. Work is continuing with this project, and plans are in place to integrate existing systems to NHS CRS when it comes on line. Solutions are being planned, developed and implemented with NHS CRS and associated new ways of working in mind, but which are also able to deliver tangible benefits now, and have the capability to serve as a platform for alternative future developments independent of NPfIT should the need ever arise.

Initiatives in development or planned to start this year:

- Procurement and implementation of systems for Order Communications, Maternity and Pharmacy
- Interfacing of existing clinical systems with the NHS CRS
- Development of a local data warehouse for patient-based information and reporting
- Supply information necessary for capacity planning and the modelling to support the 18 week waiting time target and Local Delivery Plans

- Preparation for Data Migration to NHS CRS
- Upgrading the Helpdesk to meet Connecting for Health standards for first-line operation (ongoing)
- Providing prerequisite IT skills training to staff ahead of NHS CRS implementation (ongoing)
- Prepare and plan for the delivery of Super User & End User training for the NHS Care Records Service
- The concept of 'Virtual Machines' will be explored to allow for less servers contributing to cutting the Trusts energy consumption
- The piloting of a Radio Frequency Identification system which will help cut equipment and staff costs by identifying the location of expensive medical equipment whilst assisting with maintenance schedules and usage statistics
- The installation of a dedicated secure high-speed internet connection will enable appropriate N3 resources to be devoted to national applications
- Pilot communications architecture with partners to integrate email, telephone, and pager systems to allow the location of staff to be easily visible in the case of an emergency or pandemic
- Development of web-based products to support discharge planning and improving the patient experience
- Close working with clinicians to provide solutions which enable information to be made quickly and easily available to staff
- Exploration with the Divisions of better clinical use of communication facilities, particularly at the bedside
- Changes to Medical Records practice and procedures which may be required ahead of the implementation of the new system, in particular to address the issues of centralisation of registration and numbering of records.

9.5.4 ICT Hardware, Systems and Services

ICT systems and services are key enablers for successful performance today and continuing organisational development in the years ahead. The Trust aims to have a fit-for-purpose and well-supported ICT portfolio and infrastructure backed by a fully-resourced and professional department with the appropriate skills and experience to manage current services and undertake new developments.

9.5.5 Hardware

ICT hardware 5 years old or less has a gross asset value of £9.7m, which includes the NPfIT PACS project (Nov 2006) and the ongoing major upgrade of the IT network. The personal computers (PCs) base has been growing and improving steadily over recent years, with 98% of machines now running on Windows 2000 or Windows XP, and plans for more PCs, and also printers, to be rolled out in preparation for NHS CRS implementation. Technology refresh funding is available as part of the NHS CRS business case.

By entering into strategic partnerships with suppliers (Cisco, Dell, Air Defence, Microsoft and others) the Trust benefits from more competitive prices and better levels of support. UBHT has standardised on Cisco as our preferred manufacturer of network equipment. Network connections are supported to other sites used by the Trust, other local NHS organisations, and N3 links. The Trust has recently substantially upgraded the network topology providing resilience and diversity.

The servers support a wide range of clinical and non-clinical systems. The supplier is Dell. The vast majority of servers use Windows 2003. The existing EDS PAS system is run on Alpha hardware using the VMS operating system in a business continuity configuration. The servers are located in two geographically separate computer rooms with network triangulation to improve resilience.

It is planned to move the IM&T department, including Computer Room 1, to a purpose-built facility at St Michaels Hospital in 2009, with the benefits of improved business continuity and disaster recovery, greater capacity to expand, and provision of a more professional service.

The Trust has standardised on Dell as PC supplier. Brother and Kyocera are preferred printer suppliers. Plans are being developed to rationalise printing to reduce costs, and in particular to reduce the number of inkjet local printers.

We are installing wireless connectivity throughout the Trust which will allow us to maximise return with applications such as Radio Frequency Identification tagging, Vocera (voice activated pagers) and making use of dual-band telephones.

The key challenge for 2007/08 and beyond will be to ensure that the ICT infrastructure will support the successful implementation of the Care Records Service, expected to go live in the next 1-2 years. With each new release of software the clinical functionality will increase, resulting in greater demand for access in clinical areas, and requiring more networked IT devices (PCs, printers etc). The wireless network currently being rolled out will also support more efficient and effective working practices, as has already been demonstrated at UBHT through the PACS implementation.

9.5.6 Software - Current Systems, and plans in relation to NHS CRS

Current software systems are in place as follows:

- Integrated Healthcare System/PAS system (including Pharmacy, Maternity, Theatres, A&E and Medical Data Index)
- Business case in development for the replacement of the Pharmacy system (not part of NHS CRS release1)
- IHCS/PAS to be replaced by NHS CRS in 2008 or 2009
- Following gap analysis an options appraisal is in progress for a Maternity system (needs not met by NHS CRS release 1)
- Options appraisal to be developed for the replacement of MDI (needs not met by NHS CRS release 1)
- PAD (EDS Patient Activity Database) information analysis and reporting system - business case in development for new data warehouse (needs not met by NHS CRS release 1)
- ICS system for AHP and community staff - options appraisal in progress (needs not met by NHS CRS release 1)
- GE Ultra Pathology system – implemented in 2006; no plans for change, but will be enabled to work with NHS CRS
- PACS & RIS (Radiology) systems – implemented in 2006; no plans for change, but will be integrated with NHS CRS
- Order Communications System – not yet in place; business case in preparation; GP requesting will be interfaced with NHS CRS (a decision has yet to be made by

the Trust regarding the fitness for purpose of the Order Communications functionality in NHS CRS)

- Other Clinical sub-systems – where currently interfaced with EDS PAS, will be interfaced to NHS CRS.

Current plans assume the successful implementation of NCRS (National Care Records System). If this national programme was cancelled or delayed indefinitely the Trust would require a replacement plan for the provision of the modern fit-for-purpose information systems. The approach that would be taken by the Trust would be as follows:

- Identify the possibility of forming a consortium with similarly affected Trusts (probably within the SHA)
- Instigate a procurement of the required systems
- Negotiate an extension of arrangements of current systems supplier (mainly EDS) possibly with rights to continued use of software
- Create an accelerated implementation plan

9.5.7 Services

The Information Management and Technology (IM&T) department runs the following services:

- Helpdesk
- PC and printer support
- Network and server support
- Systems support
- IT systems training
- Information and Performance
- Information Governance
- Clinical Coding
- Systems Development
- National Programme for IT
- Medical Records (BRI only).

9.6 RISK MANAGEMENT

Effective risk management arrangements are essential to ensure that all types of risk are addressed in a manner that ensures effective risk management is integrated into the business of everyone in the Trust and all of its processes.

We are committed to providing patient care, education and research of the highest quality. This will be in an environment that promotes the safety, wellbeing and satisfaction of patients, carers, visitors and staff, whilst safeguarding the continuity of services, the assets and the reputation of the Trust.

The established Risk Management Strategy is being further developed to emphasise a comprehensive vision for risk management, underpinned by a culture that ensures that risk management is embedded in and a fundamental part of all we do, in an environment where individual and organisational learning flourishes.

The Trust's approach to risk management is central to good governance and provides the framework for internal control for:

- Risks focused on the Trust's objectives and other significant internal and external risk factors.
- A comprehensive and integrated approach to risk management across all risk areas:
- Employment (recruitment, training, health & safety)
- Clinical (clinical quality and safety for patients)
- Environmental (property, plant and equipment)
- Financial (income, budgetary control)
- Service (business planning, performance, delivery)
- Strategic (external confidence and Trust reputation, statutory duties)
- Information (collection, storage and use of data)
- Corporate (legal and statutory governance duties).
- The integration of risk management into decision making, policy decisions and planning, explicitly considering risk assessments and management strategies relating to risk exposure associated with all major policy and business development decision.
- Developing a clear understanding of the roles of all staff with regard to their responsibilities within the risk management framework.
- Utilising internal and external audit, and other internal and external assurances and assessments to provide assurance that our risks are being effectively managed.
- Continuing to improve the processes for capturing information about and learning from adverse events, complaints, claims and other incidents.

The objective of the Trust's strategy for risk management is to take a pro-active approach, which is on-going and involves staff at all levels and in all areas of the organisation and:

- addresses the risks of all the activities of the Trust
- identifies the risks that exist
- assesses those risks for potential frequency and severity
- eliminates the risks that can be eliminated
- reduces the effect of those that cannot be eliminated
- maintains contingency plans for the risks that remain
- makes provision for the financial consequences of the risks that remain
- provides for continual monitoring and review of those risks.

The Chief Executive chairs the Governance and Risk Management Committee, the terms of reference of which are at Appendix 45.

9.6.1 Risk Registers

All risks in the risk registers are logged according to the principle objectives of the Trust, assigned to either a core standard for health, finance, targets etc. A list of the categories for logging risks is at Appendix 46.

This allows all risks to be related directly to the Assurance Framework and for all corporate leads to obtain information on any risks logged in the Trust relating to a specific

area. For example, the Safeguarding Children Steering Group will receive a quarterly report on all risks logged in any risk register relating to Core Standard 2, Child Protection.

Risk registers are valuable tools in assisting the Trust in assessing compliance with the NHS Litigation Authority Risk Management Standards and the core standards for health. In addition, their continued development is invaluable in assisting the Trust in:

- Maintaining a comprehensive database of recognised risks which have the potential to harm patients, staff or the public, and / or threaten the achievement of the Trust's objectives and reputation
- Prioritising, monitoring and reviewing all significant risks
- Producing an annual business plan which accurately reflects priorities and risks
- Contributing to the Local Delivery Plan
- Identifying and addressing significant development requirements
- Identifying and addressing processes and systems that require review.

The Trust maintains nine high level risk registers as follows:

- Corporate Risk Register
- Trust-wide Risk Register
- Clinical Divisions' Risk Registers (five)
- Support functions' Risk Registers, (IM&T and, Estates and Facilities).

9.6.2 Corporate Risk Register

The Corporate Risk Register is owned by the Board of Directors and, as such, each risk has an assigned Executive Director who is accountable for the risk assessment, updating the risk entry in the corporate risk register and defining the mitigating action plan. For example, a risk relating to the achievement of waiting list targets is assigned to the Chief Operating Officer.

All board members undergo regular risk training and awareness raising. Everyone is encouraged to contribute to the Register's maintenance and to identify a risk if they believe it is significant, for entry onto the Corporate Risk Register. The Director of Governance is accountable for ensuring that the Corporate Risk Register is available at all Board meetings and at the sub-committees, so that risks can be entered or updated continually.

The Trust Board receives a quarterly formal report on the Corporate Risk Register.

9.6.3 Trust-wide Risk Register

This register has been introduced to fill the gap between the corporate risk register, which is Board led, and the local divisional registers. Risks on this register are logged if they are applicable to more than one division but are not corporate i.e. are not significant enough to be reported at the Board level.

Each logged risk category, is owned by a corporate group, for example risks relating to core standard 4a and infection control are owned by the Infection Control Committee. In reviewing risks quarterly a corporate group will not only look at the relevant risks on the Trust-wide risk register, but also review all related risks in local divisional registers. This allows Trust-wide risks to be identified and their management coordinated.

9.6.4 Local Divisional Risk Registers

There are seven registers which are locally owned:

- Clinical Divisions' Risk Registers (five)
- Support functions' Risk Registers (IM&T and Estates & Facilities).

The Divisional Boards or Management Boards for each area review their register regularly and have designated accountable officers who are trained in the maintenance of the risk registers.

The Governance and Risk Management Committee receives a quarterly report on all risks in the local registers that:

- Are new entries onto the Risk Register, or
- Are in the high residual risk category.

In addition, the Governance and Risk Management Committee reviews a local register in depth with the Head of Division being expected to attend the Committee to present a report on their Risk Register.

9.6.5 Risk Identification and Assessment

The Trust identifies, assesses, prioritises and records all risks through a variety of mechanisms and processes.

Proactive Identification and Management of Risk

This is governed by the risk assessment process defined in both the Health and Safety Risk Assessment Policy and the Clinical Risk Policy. Whilst the approach to risk assessment is the same in both policies, there is an intention to streamline and simplify this into one single risk assessment policy. This will then be consistent with the single incident reporting system.

The existing systems both use descriptive scales to determine the magnitude of the potential consequences of an identified hazard or risk and the likelihood that those consequences would occur. There is also a standard approach to assessing the effectiveness of any mitigating actions identified for that hazard or risk, resulting in a residual risk category.

Business Planning

For a number of years the Trust has required the divisions to risk assess all proposed developments for the annual Local Delivery Planning discussions and the Annual Plan is based on this work. Consequently all planning can be directly related to the risks the Trust is facing and, in doing so, allows prioritisation to take place.

Safety Alert Broadcast System

The Trust has an effective system in place for the management of the Safety Alert Broadcast System, for cascading the information to the relevant people and ensuring that any necessary action is taken. This is a key tool in ensuring that there is a consistent way of communicating to nominated leads and staff, important safety and device alerts.

Complaints, Claims and the Patient Advice and Liaison Service (PALS)

The Trust has established processes and protocols to support the handing of complaints and claims. We will continue to use information highlighted by the processes to identify risks, learn, develop and hopefully put in place preventative or remedial action to prevent a reoccurrence.

Incident Reporting

The Trust has a robust single incident reporting system and policy, for both adverse incidents and near misses. This allows all incidents to be graded using the nationally recognised 5x5 matrix and for trends to be identified and reported upon.

An integral part of this is the Serious Untoward Clinical Incidents Policy, whereby all commonly classified serious 'red' incidents are copied within 24hours to the Chief Nurse and Director of Governance or the Medical Director.

A more comprehensive approach to all serious untoward incidents is being established in 2007, in response to the requirement of the new Strategic Health Authority to report such incidents in a different way. All these incidents will be in future be monitored and reported to the Governance and Risk Management Committee, which is chaired by the Chief Executive. This group will have the oversight of the progress being made to implement recommendations made following a serious untoward incident.

Since February 2007, all MRSA bacteraemias have been reported to the Bristol Primary Care Trust and Strategic Health Authority within 12 hours of identification and a Root Cause Analysis completed within 5 days.

The Trust was one of the first trusts to report all patient safety incidents to the National Patient Safety Agency as part of the National Reporting and Learning System. We will continue to do this.

9.6.6 Training

As part of the corporate mandatory induction programme, all staff are provided with information regarding the management of risk. In addition, there is a specific training available for nominated staff in relation to risk assessment and management. This training is also given on an annual basis to the Trust Board members. An annual risk management training plan is produced, allowing specific needs to be met in any one year.

Nominated leads in each division are specifically trained in the risk assessment process and use of the risk register in their division.

9.6.7 Organisational Learning and Feedback

The Trust has a number of processes in place to facilitate learning and feedback as a result of incidents, complaints and serious untoward incidents as well as learning from external reports. These include:

- The use of action plans where appropriate following complaints resolution
- Feedback from complaints and Patient Advisory Liaison service to divisions and corporate groups on issues of relevance and trends, on a quarterly basis
- Serious Incident Reports copied to relevant corporate groups e.g. an incident involving a breach of the Mental Health Act Section requirements would be copied to the Mental Health Steering Group

- Health and Safety Committee, and Clinical Risk Assurance Committee regular reports and reviews of incidents and root cause analyses
- Quarterly reports of the above two committees to Governance and Risk Management Committee
- Establishment of new Serious Untoward Incident Policy and Procedures in 2007, in response to the new reporting requirements and system in the NHS South West
- Use of the reports of the Patient Safety Observatory, for both benchmarking and learning
- A system for monitoring compliance with National Confidential Enquiries
- A system of monitoring external accreditation visits and implementation of recommendations made during those visits e.g. from the Royal Colleges.

9.6.8 Major Incident Planning and Business Continuity

The Trust has a tried and tested Major Incident Policy, which follows national guidelines and has been agreed by our partner organisations. Other major incident plans are in place and have also been tested, for example the Pandemic Flu Plan.
In an organisation as complex as the NHS and in a large Trust like this, there will be occasions where the failure of a service or the occurrence of an individual incident leads to the widespread disruption of our services, for example the failure of an information system or a power supply failure. Such incidents may disrupt the flow of patients and potentially impact on our ability to meet financial and other targets. Above all, the biggest potential risk is to patients.

To maintain the highest possible standard of care and continuity of care during any disruption the Trust has a duty to ensure that all employees and support services understand the business continuity arrangements and continuity planning arrangements.

To limit the impact and risk of any disruption the Trust has established a Business Continuity Group, which is led by the senior manager for Business Continuity, a joint appointment with North Bristol Trust.

The overall performance and risks associated with business continuity and major incident are continually monitored through the assurance framework and core standard 24, which was declared as compliant in 2006/07.

9.6.9 Compliance with External Requirements

The Trust participates in the assessment process for the NHS Litigation Authority Risk Management Standards, formally the Clinical Negligence Scheme for Trusts and the Risk Pooling Scheme for Trusts. The Trust has achieved level 3 for the Maternity Standards and Level 1 for the General Standards. Work is underway for assessment on the latter in 2007/08 to level 2.

The Trust also is part of an annual assessment by the External Auditors in relation to the Auditors Local Evaluation and Key Lines of Enquiry in relation to internal control. The quality control process for the first phase of ALE, covering financial management, internal control and value for money, has been completed for 2006/07 and Trust has achieved a score of 3 in each of these areas.

The Trust makes an annual declaration on compliance with the core standards for better health, including those relating to the Patient Safety Domain and clinical risk. A compliant statement was made for the Patient Safety Domain standards for 2006/07.

9.6.10 Roles and Responsibilities within Risk Management

Responsibility of the Board

The Board is responsible for reviewing the effectiveness of internal controls in order to meet its statutory obligations on financial management, the quality of healthcare and on health and safety. The Board is required to make a statement of assurance that it is doing its reasonable best to manage the Trust's affairs efficiently and effectively through the implementation of internal controls to manage risks.

The Board demonstrates its commitment to risk management through the way it conducts its business and, in particular, through the endorsement of the risk management processes.

The Board delegates responsibilities within this to both the Audit and Assurance Committee, and the Governance and Risk Management Committee.

Responsibility of the Chief Executive

The Chief Executive has responsibility for risk management as part of his overall responsibilities and statutory duties for running the Trust. Specifically his role is to:

- Ensure that the responsibilities for the management and coordination of risk are clear
- Ensure that major risk management policies and procedures are ratified through the appropriate structure
- Identify and allocate the required resources from within available funds to implement risk management activities
- Ensure communication with stakeholders and other interested partners on problems of mutual concern
- Chair the Governance and Risk Management Committee.

Responsibilities of Directors

Whilst the Chief Executive retains overall accountability, he designates aspects of risk management as shown in Table 54 below, to the relevant Executive Director. The overall responsibilities of these directors are set out in the Risk Management Strategy (Appendix 47) and reflected in their objectives.

Risk Management Area	Responsible Director
Clinical Governance	Chief Nurse and Director of Governance Medical Director
Patient Safety	Medical Director
Patient and Public Involvement	Chief Nurse and Director of Governance
Clinical Audit	Medical Director
Education, Training and Development	Director of Human Resources and Organisational Development
Environmental	Chief Operating Officer
Finance	Director of Finance
Governance and Assurance	Chief Nurse and Director of Governance
Health and Safety	Director of Human Resources and Organisational Development
Information and IM&T	Director of Finance Medical Director
Major Incident Planning	Chief Operating Officer
Performance Standards	Chief Operating Officer
Research and Effectiveness	Medical Director
Staffing and Staff Management	Director of Human Resources and Organisational Development

Table 56: Risk Management Responsibilities – Executive Directors

The core standards for health are also designated to an executive director for overall management of risks and ensuring that there is compliance (Appendix 48).

Director of Governance

The Director of Governance has the management responsibility for delivering the Governance, Assurance and Risk Management agenda.

She does this with the direct support of specialist and senior managers, listed below:

- Lead Personal Assistant Governance and Assurance
- Assistant Director Audit and Assurance
- Trust Solicitor and medico-legal team
- Assistant Director Governance and Risk Management
- Senior Nurse Clinical Informatics
- Health and Safety Advisor.

There are a number of specialist advisors also in the Trust for specific issues, e.g. Radiation Protection, Infection Control.

Responsibility of other managers and employees

The responsibilities of these staff are set out in the Risk Management Strategy (Appendix 47) and reflected in their objectives.