University Hospitals Bristol NHS
NHS Foundation Trust

Strategic Plan Document for 2013-14

University Hospitals Bristol NHS Foundation Trust

Strategic Plan for y/e 31 March 2014 (and 2015, 2016)

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

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Date	31 May 2013

The attached Strategic Plan is intended to reflect the Trust's business plan over the next three years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

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

Approved on behalf of the Board of Directors by:

Name *(Chair)*	John Savage CBE

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Robert Woolley

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Paul Mapson

Signature 

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EXECUTIVE SUMMARY

This plan sets out the Trust's key priorities and challenges for the period 2013/14 through to 2016/17. In contrast to previous plans, significant detail has been developed over each of the three year plan reflecting the Trust's approach to the development of its first Medium Term Operating Plan; this plan is aligned to the key milestones associated with the redevelopment and rationalisation of the Trust's estate by 2016/17 and is presented alongside the resulting opportunities to transform the model of care for both urgent and elective services.

The plan presents a clear strategic vision for the delivery of high quality, secondary and tertiary services alongside an enviable track record of financial performance evidenced through delivery of a balanced financial plan for ten consecutive years.

The plan goes on to describe how the Trust is responding to the emerging commissioning intentions, from both local Clinical Commissioning Groups and NHS England, which provide opportunities for growth in specialist services whilst reflecting the system wide aspirations to reduce the flow of urgent care, notably for frail older people, into acute hospital settings. The Trust's plans take account of these intentions and assume significant improvements in whole system working with a resulting reduction in the number of patients for whom discharge is delayed and a significant increase in the number of patients managed in ambulatory care settings, rather than through traditional admitted care.

The Trust's clinical strategy will be refreshed during 2013/14 and be developed to take our strategic planning horizon out to 2020; this in recognition of the fact that whilst many aspects of the Trust's extant strategy *Rising To The Challenge* remain valid, the context within which the Trust is operating has changed significantly and the Trust must adapt accordingly. A key input to the refreshed strategy will be the outputs from the *Bristol Acute Services Review* which is considering the most sustainable model for acute services across the City; the work is being undertaken in partnership with North Bristol NHS Trust and is supported by external consultants, PwC UK.

Concerns raised by the Care Quality Commission (CQC) during 2012/13 have led to developments in the Trust's approach to governance - ward to Board. The lessons learnt from Mid Staffordshire have served only to underline the importance of listening to both staff and patients when concerns are voiced and a formal review of the applicable recommendations flowing from the Francis Report is in hand under the leadership of the Trust's Medical Director.

The specific service concerns raised by the Care Quality Commission during 2012/13 have been addressed in year and the CQC has subsequently re-inspected the services reviewed and confirmed compliance with the three outcomes in question. The wider lessons from these reviews have also been extended across the organisation including an external review of staffing levels in every ward of the Children's Hospital.

Reflecting the Trust's focus on quality, governance of our cost improvement plans (CIP) has been enhanced, including strengthened clinical oversight, with quality impact assessments being undertaken on all major CIPs. This internal focus has also been complimented by the Trust's lead Clinical Commissioning Group which has also reviewed and renewed its approach to commissioning oversight of the quality agenda which will contribute further to our collective approach to ensuring the quality of the services we provide.

The Trust's AMBER-RED Declaration of Compliance reflects both inherited and on-going risks for the current year. Firstly, the inherited Referral To Treatment Time (RTT) risk following the transfer in of Head and Neck services from a neighbouring trust and secondly the on-going risks to performance in Quarter 1, associated with unprecedented levels of activity in the Emergency Department during April which has jeopardised the achievement of the 4 Hour A&E standard for the first quarter of the year and the inherent risks arising from the approach to quarterly profiling of the C Difficile trajectory which doesn't reflect the well evidenced historic pattern of incidence.

Finally, in formulating this Annual Plan, the Trust has had due regard for the views of its governors who have been involved in the formulation of the plan through a programme of organised meetings and have expressed their support for the themes and priorities set out for the period ahead.

Section 1 - Our Mission and Vision

1.1 Strategic Intent

The Trust's mission remains unchanged from previous plans *we will provide patient care, education and research of the highest quality*. This mission is expressed in more detail through the Trust's vision statement which is summarised as *UH Bristol becoming the foremost provincial teaching hospital in England, recognised for the excellence of our clinical services and specifically our attention to the needs of individual patients, the international standing of our research and the quality of our teaching and learning.*

It is exploiting the synergies that exist across the Trust's three businesses of care delivery, research and teaching that will deliver our vision for the Trust.

Recognising the importance of communicating this vision widely to our staff, our patients, our governors and our external partners, the Trust has positioned this vision at the heart of its change programme known as *Transforming Care*. A description of how we wish to be viewed by ourselves and by others is captured below.

Expertise with compassion	• **High quality care** • **Sensitive to individual needs**
Welcoming and safe	• **Friendly and helpful** • **Safe from harm**
Where people want to work	• **Recruiting the best** • **Supporting staff to fulfil their potential**
Modern environment	• **Clean, bright, showing pride** • **Easy to navigate, easy to access**
Pioneering and efficient	• **Leading edge research for patient benefit** • **Constantly improving services**
Leading collaboratively	• **Giving leadership to clinical networks** • **Shaping the health system in partnership**

Figure 1 Transforming Care – End State Vision

The Trust's forward strategy reflects our focus on maintaining quality whilst addressing the requirement to reduce our costs in line with on-going national efficiency requirements. Quality, which the Trust defines as excellent clinical outcomes, optimal patient safety and a consistently positive patient experience, remains the organising principle for care throughout the organisation.

Concerns expressed by the Care Quality Commission in the past year, in relation to children's cardiac services, have been used positively to further strengthen the way in which the Trust governs its services from ward to Board; an examination of the lessons from Mid Staffordshire is underway and will undoubtedly shape the way in which the Trust develops and notably the ways in which it listens to, and learns from, its patients and staff.

The Transforming Care programme will remain the means through which the Trust supports staff to innovate and challenge the way in which services are organised and delivered, using service improvement tools and techniques as the means through which we drive reductions in the cost of care and improvements in service quality and operational performance. The recent appointment of a Director of Transformation will see a reinvigoration and re-launch of the Programme through 2013/14 in order to drive the next step change in the ways we organise and deliver best care and importantly to support the Trust to deliver the necessary improvements in operational performance. Outstanding levels of staff engagement, around a shared and common purpose, will be our primary focus for galvanising positive change.

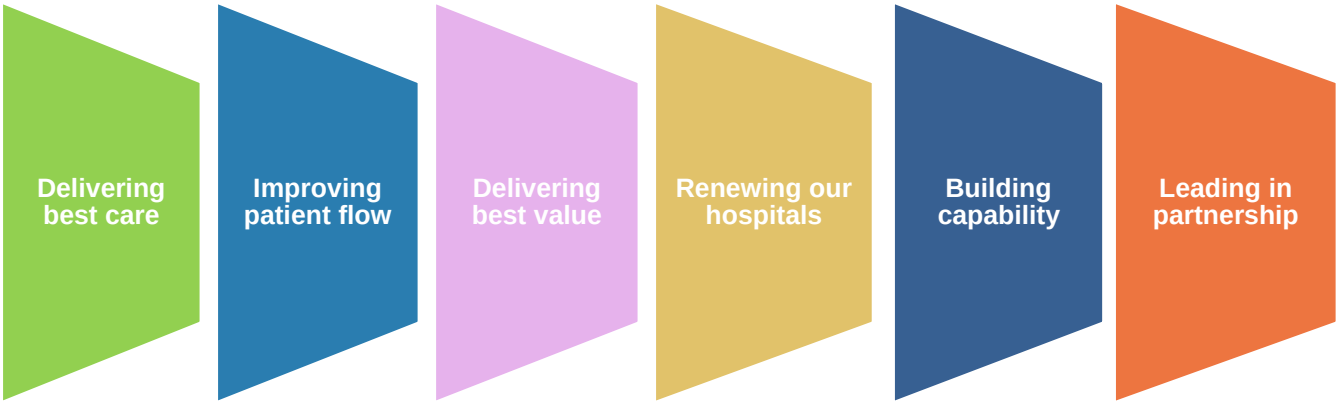

Figure 2 – The Pillars of Transforming Care

Section 2 - Strategic Context

2.1 Trust's Strategic Position and Direction

The Trust retains a central position within the health economies it serves – both in terms of the local Bristol health community and the wider South West region. Our strategy remains aligned to our aim of providing excellent specialist services on a regional basis whilst providing high quality local secondary care services to the people of Central and South Bristol.

Opportunities for growth remain predominantly within the specialist services portfolio arising from opportunities to repatriate care currently delivered to South West residents in London as well as in neighbouring regions together with the designation of UH Bristol as a provider of some of the most specialist services.

The Trust continues to work with local Clinical Commissioning Groups (CCG) to identify opportunities for reducing reliance on secondary care services in line with their strategic aspirations. Whilst the Trust is both committed to, and planning for, this change in the emphasis of care, demand for its "district hospital" services remains strong. In addition to strong demand, there is evidence of increasing acuity and complexity of need in the patients presenting and a growth in the number of older patients requiring our services. Strong whole system working is critical to our success and, whilst there is good evidence that all partners are committed to the common goal *of right care, right place, first time,* changes to the commissioning landscape has created additional complexity in enabling us to bring about change at the scale and pace required.

The Trust continues to compete on its reputation for high quality care and excellent clinical outcomes – its Hospital Standardised Mortality Ratio (HSMR) remains one of the most positive in the sector, the reputation of the calibre of Trust staff, alongside the Trust's strength in research, continues to grow. The Trust's most significant challenge over the coming years, in ensuring it remains attractive to potential referrers, is to ensure that it can maintain the equilibrium between demands for local urgent care and the ability for the Trust to guarantee access to its planned and specialist services all year round; cancellations of elective care have remained higher than planned and recent months have seen unprecedented periods of operational escalation when demand for beds has exceeded those routinely available.

In governance and performance terms the Trust had a very disappointing year in 2012/13. The Trust held an AMBER-RED governance risk rating during each quarter of the year, with a RED rating over-ride applied by Monitor from Quarter 3 due to the on-going failure to achieve the A&E 4-hour standard and a breach of the MRSA bacteraemia standard. The Trust recognises the importance of improving this performance landscape if it is going to compete effectively amongst the best healthcare providers in the region and this is one of the Trust's most significant priorities in 2013/14. That said, the Trust enters the year with risks to Monitor Compliance for quarter one already apparent which it is seeking to mitigate and address for future quarters.

2.2 Threats and Opportunities From Planned Commissioning Intentions

Our income in 2012/13 was £527.9m; we derived 61% of this from our three local Primary Care Trusts, 16% from specialist commissioners and the remainder from a combination of other sources[1]. In 2013/14 our overall income is set to increase by 4.34%[2] to £550.8m however, the proportion of income from specialist commissioning will rise to 30%, with the proportion of income derived from 'secondary' or local commissioning falling to 49% reflecting the change in commissioning responsibility for a number of service areas and notably cancer and cardiac care.

[1] Health Education England, research (gross), provider to provider, private patient income

[2] This drops to £537.4m following incorporation of the exceptional item adjustment relating to the transfer out of Skills For Health.

The Trust's 2013/14 contracts have been set broadly at 2012/13 out-turn levels, with the exception of a number of surgical specialties where it is considered 2012/13 activity levels have been particularly deflated; additional growth of £11.1m has been secured to address this. Non-recurrent activity, valued at c£1.73m, has been commissioned to ensure delivery of sustainable, specialty-level Referral to Treatment (RTT) standards and quality investments have been made to support the development of paediatric high dependency care of (£2m) and implementation of National Institute for Health and Care Excellence (NICE) recommended drugs (£6.3m). Historical activity trends are summarised below but it should be noted that significant changes in the coding and counting of activity, by work type, account for the majority of significant changes between years. However in summary, the trend is one of overall activity growth, most notably in outpatient based care reflecting both growth per se but also the re-classification of large amounts of day case activity into out-patient procedure care. Demand for accident and emergency services remains static at the target 2008/09 levels whilst demand for non-elective care is 8.6% higher than the baseline year and thus only attracts marginal rate funding at 30% of tariff. The growth in critical care reflects the changing case mix and acuity of patients the Trust is serving.

Type of Activity	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Day Cases (spells)	53,829	56574	59250	49,103	49,701	50,614
Elective Inpatients (spells)	16,047	17,131	15,814	14,464	14,730	15,111
Non Elective Inpatients (spells)	49,501	51,825	54,419	60,460	57,916	56,328
Outpatients (attendances)	448,832	483,629	529,792	498,109	513,929	552,934
Bed Days (Critical Care)	25,951	28,600	29,173	34,902	38,676	40,109
Accident & Emergency (attendances)	111,221	112,322	114,568	120,006	114,329	112,708
Excess Bed Days	43,238	35,710	33,121	35,650	25,875	28,183

Table 1 Recorded Activity Trends

2.3 Strategic Response to Known and Forecast Changes

In preparation for finalising its medium term operating plan in the lead up to completion of the Trust's major capital schemes, a full refresh of the Trust's original long-term capacity model (2009/10 to 2014/15) was undertaken in 2012/13. The refresh baseline has been updated from 2009/10 to the 2012 activity data-set. In addition the latest modelling uses the following key assumptions about changes in demand for services and peer group performance in respect of length of stay:

- Age and area specific ONS (Office for National Statistics) demographic growth rates, which average 1.02% per annum but rise significantly in the over 65 populations which is reflected at specialty level as appropriate. No further growth in activity beyond demographic or that associated with known service developments is assumed;
- Continued reductions in length of stay (LOS) are assumed but in light of both local experience and national trends these have been moderated. The impact of these assumptions is a reduction in the Trust's bed stock arising from LOS improvements of 103 beds from 2013/14 to 2016/17 (BRI redevelopment planning end state), equivalent to an annual reduction of 26 beds per annum;
- Static demand for urgent care services from the current catchment but assumed opportunities for specialist services growth;
- Changes in market share associated with a shift in the catchment for emergency activity following the closure of Frenchay Hospital, leading to an estimated increase in activity of around 500 spells per annum, equivalent to a requirement for 14 additional beds;
- Planned transfer of Specialist Children's Services from North Bristol NHS Trust (NBT) upon the closure of Frenchay Hospital leading to a requirement for an additional 20 paediatric beds.

- Transfer of Vascular Surgery Services to North Bristol NHS Trust equivalent to a reduction in 14 beds.

2.3.1 Growth Opportunities

Against the back drop of commissioner intentions to reduce demand for acute secondary hospital services the Trust has a number of opportunities it is pursuing to develop its specialist service base. These include pursuing designation as the West of England Regional Cystic Fibrosis Centre, the South West Regional Centre for Neuroendocrine disease, the South West Regional Centre for Intestinal Failure Services and the very significant opportunity to secure designation as the South West Surgical Centre for Adult Congenital Heart Disease. Designation for paediatric cardiac surgery centres remains on-going and the Trust continues to plan for centre status. Finally transfer of paediatric neurosurgical services from NBT in 2014 provides further opportunities for growth, notably in paediatric epilepsy surgery and developments in selective dorsal rhizotomy surgery (SDR).

Alongside these designation opportunities, in Quarter 3 of this year the Trust will establish the first Gamma Knife technology radiosurgery service outside of Sheffield and London which will serve the South West, South Wales and beyond and finally the Trust continues to actively pursue opportunities to repatriate work from other areas both within and outside the South West, most notably in the arena of cardiac services - building upon the growing reputation for excellence of the Bristol Heart Institute.

Known threats from new or existing providers are not considered to be high, though the development of a new hospital in the north of the City remains to a large extent an unknown entity with respect of impact on current patient flows. The Trust has, and continues to, work closely with its GP and secondary care referral base to build strong relationships with these key stakeholders and believes these positive relations, alongside the quality of our service offer, will support the continued position of UH Bristol as the provider of choice for our current referral base.

In addition, the Trust remains committed to working in partnership with its commissioners to ensure that all NHS commissioned capacity is fully utilised and as such will continue to work collaboratively with the Independent Sector Treatment Centre (ISTC) whilst noting the role of patient choice in determining where patients seek their care.

With regard to *Any Qualified Provider (AQP)* tenders, commissioner activity has been limited. However, audiology services were tendered under AQP in 2012/13 and new entrants will be established during the course of 2013/14. The Trust has a strong service offer in this specialty and continues to make further service improvement work to ensure that its waiting times are comparable to those which new entrants will offer but is also planning for a scenario whereby there may some reduction in activity from quarter 4 onwards.

The Trust ceased to provide breast and urology services from March 2013 following their transfer to North Bristol NHS Trust and these no longer form part of the Commissioner Requested Services. The Bristol Homeopathic Service, which now operates from the South Bristol Community Hospital continues to develop its feasibility study to explore the potential for it to be provided through a social enterprise under the *Right To Provide* legislation which if approved by the Department of Health, commissioners and the Trust Board would see the transfer out of this service; work on the appropriateness of this will continue through 2013/14.

2.4 Service Diversification

The Trust believes its success lies in being clear about its core purpose and exploiting those opportunities that underpin this strategy. In this context, the Trust will retain its focus on clinical service delivery, teaching and research with any further diversification aligning to these core strengths. A review of the potential for further growth and development in private patient services was undertaken in 2012/13 and actions are being progressed which are expected to deliver marginal growth in private patient income; opportunity for further growth is currently constrained by a lack of guaranteed access to dedicated bed and theatre capacity which cannot be addressed in the short term but it remains as a longer term goal.

We continue to grow and develop our research base and have a Joint Director of Research shared with North Bristol NHS Trust to strengthen our national standing as a major research city. We are a member of Bristol Health Partners (BHP), a research collaboration between four NHS Trust, two universities, three Clinical Commissioning Groups and the City Council. Via its sponsorship of a series of nascent health Integration Teams, Bristol Health Partners is focussed on generating significant health gain and improvements in service delivery in Bristol by integrating, promoting and developing Bristol's strengths in health services, research, innovation and education. The most significant opportunity for income generation in research is the Trust's recent application, with BHP partners, to secure authorisation and funding of around £9m to establish a Collaboration for Leadership in Applied Health Research and Care (CLAHRC). In addition the Trust is bidding to become one of the 15 national "super-hosts" for the National Institute of Health Research (NIHR) Local Research Network (LRN). Finally, we are committed and active members of the West of England Academic Health Science Network (AHSN) and it is in conjunction with the AHSN, that we are developing our approach to exploiting the intellectual property that will be generated from our research.

The future of Weston Area Health NHS Trust (WAHT) is now subject to market testing though has yet to formally come to market. The Trust Board is carefully considering how it will respond to this initiative. Many of the pathways delivered to North Somerset residents from WAHT are integrated with UH Bristol's services and significant clinical and operational interdependences exist between a number of services including maternity, paediatrics and cardiology. Given this context, the Trust is keen to explore both risks and benefits associated with the proposal and is also keen to examine whether partnerships with other providers may offer new opportunities to work differently for the benefit of patients and staff currently served and working for WAHT.

Finally, on a more commercial footing, the Trust has signed agreements with five major retailers who will occupy leased spaced in the Trust's new £5m Welcome Centre, which will open later this year. These agreements will not only secure valuable and much needed patient and staff amenities but will also enable the capital costs of the development to be covered in full whilst generating further revenue income streams to support additional patient services including an enhanced patient information service and a new outpatient booking bureau, both of which will be based in the Centre.

2.5 Reconfiguration Plans

Reconfiguration planning is on-going in both pathology and vascular services in response to both commissioner intentions and national policy direction. The former continues to explore the merits of establishing a single pathology provider for primary and secondary care customers in Bristol and Weston in response to Lord Carter's report of 2008. This proposal is currently subject to a Cooperation and Competition Panel Review and work between the three existing provider Trusts is on-going. There is no reconfiguration timeline for this possible service pending conclusion of the outstanding work.

Vascular services across Bath and Bristol are also the subject of review to explore how the service can best organise itself to respond to the national designation requirements for the aspects of this service which require the most complex care to be delivered from fewer, larger centres. This review may result in reconfiguration proposals but the review has yet to conclude.

In 2012/13 the Trust and its partners commenced a major review of the way in which acute care is delivered across the City; the Bristol Acute Services Review will develop a range of options for further work with the aim of ensuring we have high quality, sustainable and affordable hospital services for the future. This work which is on-going and is exploring the optimal models for service provision in eight high volume specialities where significant duplication of service exists within the City, is also looking more broadly at three pathways where more "radical" service options may deliver benefits for patients at lower cost; this work will inform further the Trust's plans for future service reconfiguration.

Finally, the Trust is very mindful of the complexity of service configuration in light of the influence of choice and competition issues on such matters. We are tracking the discussion on the application of competition law to the health system and the approach that the Office of Fair Trading (OFT) will take in this area. Having consulted the OFT, we are renewing our focus on the clear and rigorous demonstration of 'relevant customer benefits' whenever we consider new service developments or organisational changes.

Specifically, the Trust is currently working with the Cooperation and Competition Department, within Monitor, on its Phase 2 Review of the move of breast, urology and head and neck / ENT services within the City and is awaiting the outcome of its Phase 1 Review of the proposed changes to pathology services.

2.6 Collaboration, Integration and Patient Choice

Collaboration remains critical to the way in which the Trust does its business. Formal collaborations exist through our membership of a wide range of networks including the West Of England Academic Health Science Network, our membership of Bristol Health Partners described earlier, our active participation in the Local Education and Training Board and our membership of the developing Strategic Clinical Networks (SCN) and Operational Delivery Networks (ODN) – two of the latter which will be hosted by the Trust (adult critical care and neonatal services).

Like much of the NHS, our success increasingly relies upon fuller and more effective integration of our services with those delivered by partners in community based health and social care settings. A large proportion of the Trust's acute bed base continues to be occupied by patients who have completed their episode of acute care and are ready to return home or transfer to an alternative community setting. Determining and implementing the most effective means of working with these partners is a key strategic goal for 2013/14 and the Trust has established both internal and external forums to ensure that the gains for both patients and the wider system, associated with more joined up care, are progressed at greater pace and scale than has been the case to date. The Trust has enlisted the assistance of external consultants, KPMG, to assist with these work streams. The primary emphasis of our integration programme is to work with partners to ensure that only those patients who require acute care are admitted to hospital (with a particular emphasis on supporting older people to avoid admission) and that when patients have recovered sufficiently to return home, their partners are able to support their discharge in a safe and timely way. The system goal is to reduce the number of patients who are delayed in acute settings to no more than 20 at any time – currently these patients range in number from 60 to 80 at any one time.

The Trust's strategic intent is to be the provider of choice for the portfolio it delivers, to both patients and referrers. The Trust has undertaken work with its primary care referrers in 2012/13 to understand how the organisation and our individual services are viewed by these key stakeholders and is now progressing a number of initiatives to respond to their feedback. We have specific initiatives to promote our services to referrers further afield building upon the strategy of *local where possible* which enables patients from the South West to receive much of their care close to where they live, travelling to our centre only when necessary – this approach is enabling Bristol to be offered as a choice to more remote referrers who might otherwise rule out this possibility.

However, it is evident from the National Patient Survey results that we have more work to do with primary care to ensure that they are playing a full part in offering choice of provider at the time of referral given the small proportion of patients who recollect having been offered choice of provider and/or location of care by their GP, when they were subsequently surveyed.

Choice of place, time and type of treatment remain central to the way in which we are approaching choice for the patients who are referred to us. In 2013/14 we are rolling out a new approach to outpatient and in-patient booking which will support our goal of ensuring all patients are able to choose a time and location for their care that suits them – including offering South Bristol Community Hospital as a choice for outpatient and day-surgery. Choice of treatment remains an important factor for patients and is reflected in our approach to care; we continue to offer the choice of home, community or hospital based chemotherapy, surgical or radiotherapy approaches for cancer pathways where this is clinically appropriate such as for urological cancers and this year we will commence a pilot with commissioners to evaluate the benefits of using formal *Decision Aids* to support patients in making choices about surgical versus more conservative care options.

Section 3 Approach Taken to Quality

3.1 Quality Priorities and Risk Management

The Trust's quality strategy continues to reflect our focus on patient safety, experience and effectiveness of care and our commitment to address the aspects of care that matter most to our patients which they describe as keeping them safe, minimising how long they wait for hospital appointments, being treated as individuals by all who care for them, being fully involved in decisions about their care, being cared for in a clean and calm environment, receiving appetising and nutritional food and achieving the very best clinical outcomes possible for them.

Each year, we consider available intelligence about the quality of all of our services and, with the involvement of our governors, agree a set of corporate quality objectives to reflect our agreed priorities. Our individual quality objectives for 2013/14 are set out in Appendix 1 of this plan.

The means by which we develop and strengthen our understanding of patients' experiences and aspirations of care continues to develop. The Trust's core patient experience strategy ensures that we gather feedback from patients in a wide variety of ways which includes the use of comments cards made available on wards and in clinics; a monthly post-discharge inpatient survey; an annual outpatient survey and bi-monthly ward-based interviews. In addition, in 2012/13 the Trust undertook a further 80 bespoke patient surveys seeking to understand patients' experience of the quality of, and access, to services. Finally, we have successfully completed our piloting of the Friends and Family Test (FFT) and this is now routinely in place throughout the Trust and will provide additional insights into how patients perceive the services we offer, at individual service level.

Importantly, the Trust has learned from recent Care Quality Commission inspections. Staffing concerns, relating to Outcome 13, highlighted on Ward 32 of the Bristol Royal Hospital for Children have been addressed and compliance confirmed by a positive re-inspection in November 2012. We currently await feedback following recent re-inspection of Ward 32 to confirm the improvements we have made in respect of staff training and patient experience, CQC Outcomes 4 and 14. Developments to establish paediatric High Dependency Care beds in both cardiac and medical settings have been supported by commissioners and have been established from April this year, with the aim of all 11 additional HDU beds being in place by the early summer. Elsewhere, we are awaiting feedback following a CQC re-inspection of maternity services to confirm recent improvements in our midwife to patient staffing ratio.

The events surrounding the Children's Hospital prompted a wider review of nurse staffing levels in children's services which, whilst confirming the safety of nurse staffing levels, identified areas where the sustainability of current quality was at risk in the longer term and in response to this the Trust Board has committed to invest a further £700,000 in children's nursing and recruitment is already underway.

One of the Trust's on-going key priorities for improving the quality of care to patients in the coming year will be to further reduce the number of patients who experience *avoidable harm* whilst in our care; our focus will be on improving the fundamentals of basic nursing care skills and the compassion with which that care is delivered by all staff, to all patients. Our measures of success will be reductions in the incidence of pressures ulcers, falls, infections, medication errors, complaints and the overall number of clinical incidents leading to moderate or severe harm.

During 2013/14 we are embarking on a programme of work to systematically assess the safety culture of our Trust. This will involve the use of the Manchester Patient Safety Framework (MaPSaF) 2006, produced by the University of Manchester and endorsed by the National Patient Safety Agency. Its purpose is to facilitate front line clinical and management teams to better understand their patient safety culture and to enable them to identify actions to build a culture where managing patient safety is an integral part of everything they do.

Finally, the Francis report into the failings at Mid Staffordshire NHS Foundation Trust has provided salutary lessons for every NHS organisation. Work, led by the Trust Medical Director, has commenced to enable the organisation to identify and respond to both specific and general learning for the Trust; the work is being framed through a dialogue with our staff, governors and patients utilising the following approach.

Specifically, we are considering all the conclusions and recommendations in the report and have identified 74 that we believe apply to the Trust and we are using the following questions to frame this work:

- Are any of the failings that led to the problems in Mid Staffordshire NHS Trust ones that also might apply to us?
- Are any of the recommendations made in the report also ones that we should implement here?
- If the answer to either of the above is yes, then what do we need to do about this and by when?

More generally, we will use Francis as a catalyst to initiate a discussion using four questions to frame this more general work:

- Do we understand quality and patient experience well enough in the Trust?
- How do we know that the services we provide are safe?
- What will it take to make all our services as good as they can be?
- How well do we involve our staff and patients in this agenda?

This work is now underway and a report will be presented to the Board later this year and in advance of the proposed national timeline of December 2013.

3.2 The key quality risks inherent in the plan and how these will be managed

As evidenced by recent reviews of ward to Board governance, including a recent review by Monitor, the Trust has an increasingly robust approach to the identification, assessment, monitoring and mitigation of risk. An additional full time risk manager was appointed to the Trust in the latter half of 2012/13 with the aim of further enhancing the Board's approach to risk management. A root and branch review of our approach to risk from strategy, through policy, procedures and practice is underway; developing capability in all staff to effectively identify and manage risk will be the central tenant of our approach.

As would be expected, all risks are actively managed through the risk management practices described above through a devolved management structure. Each of the Trust's six divisions maintains a risk register which is managed through Divisional Board structures and is also monitored routinely by the Executive Risk Management Group which is chaired by the Chief Executive. In addition all high risks are reviewed by the Board, in detail, at its monthly public meetings. The Trust's key risks, their impacts and the key mitigations are described in Appendix 2 of this plan.

3.3 Overview of how the Board derives assurance on the quality of services and patient safety

The Trust's overall ambitions for Quality are set out in our *Quality Strategy 2011-2014*. The Trust's approach to quality governance remains the *Monitor Quality Governance Framework* and this framework continues to shape the way in which we govern the organisation.

The means through which Board derives its assurance on the quality of our services is comprehensive and the key steps, structures and processes are set out below.

Each year, our five clinical divisions develop specific, measurable quality goals as part of the process of producing their Annual Operating Plans. Progress against these Plans is monitored on a monthly basis by Divisional Boards and corporately by the Executive Team through the Divisional Performance Review process. Corporate quality ambitions are developed alongside the divisional objectives so that the two processes inform each other - corporate ambitions, for example derived from the NHS Outcomes Framework, may be passed down to Divisions and common patterns in Divisional objectives may be elevated to become corporate objectives. The choice of quality objectives is also influenced by our governors, by patients (for example through our robust monthly post-discharge survey) and this year with the newly established *HealthWatch*, formerly the Local Involvement Networks.

Alongside the tracking of high level objectives, the Board also receives an in-depth monthly quality report, which includes a detailed quality dashboard which monitors progress against corporate quality objectives and other key safety, experience and effectiveness measures. RAG-based performance thresholds are set and exception reports are presented if performance falls below expected levels. The exception reports explain why performance has been affected and what actions are being taken to address this. Every Board Quality Report is prefaced by a patient story – an honest account of a patient's personal experience of our services, usually derived from a complaint but on occasions from a compliment. The purpose is to underline the central importance of excellent patient experience, to demonstrate to the Board how the Trust has responded and learned when things have gone wrong (or well) and to share that learning across the organisation and in public.

The Board's responsibilities for quality are partly discharged via its formal sub-committee, the Quality & Outcomes Committee (QOC), comprising non-executive members with executives in attendance. The QOC meets on a monthly basis with a primary role to scrutinise in detail and, where appropriate, challenge the content of the Board Quality Report; QOC has the authority to request more detailed information on particular topics where further assurance is required and to "deep dive" into any area of concern to it. The QOC reports the outcome of this detailed scrutiny directly to the public session of the monthly Board meeting.

Finally, each quarter, the Board and its sub-committees receive the Board Assurance Framework which reports high level progress against each of the Trust's corporate objectives (including quality objectives) and any associated risks to their achievement.

Section 4 - Clinical Strategy

4.1 Clinical Strategy

The Trust's current Clinical Strategy remains broadly unchanged from last year; our focus is on consistently delivering high quality care with a clear emphasis on safety first, positive patient experience and excellent clinical outcomes.

Rising To The Challenge remains our core strategy document and is the means by which we will deliver our vision of becoming the *foremost provincial teaching hospital*; the strategy frames our intentions around four themes: what we do, where we work, our service quality and finally our role, influence and reputation.

Underpinning these strategic ambitions are six key enabling strategies that will ensure we create an organisation capable of realising our ambitious goals. The six supporting work streams are: rationalising and improving our estate; increasing our productivity and efficiency; developing our workforce; improving information and business processes; strengthening organisational development and sustaining financial health. These remain enshrined in our quality improvement programme Transforming Care, described in Section 1 of this plan.

The Trust has also embraced the opportunities that the developing *Clinical Senates* afford us for working differently, and with other partners, to develop our clinical services. The Trust is an active participant of all the clinical networks relevant to our portfolio and has been appointed as host for two of the Operational Delivery Networks (ODN) for the South West in the areas of adult critical care and neonatal services.

Finally, the Trust recognises that it has a number of areas where it has the potential to be truly excellent and is considering ways in which it can support these clinical areas to further realise their potential and includes amongst others cardiac services, eye care and cancer services.

4.2 Service Line Strategy

Our service line strategy over the next three years will be informed by the initial conclusions of the Bristol Acute Services Review described in Section 2. This review has been jointly commissioned with North Bristol NHS Trust, and is the basis on which we develop our strategic planning out to 2020. Early work with stakeholders has recognised the value in broadening this review to consider the wider system context within which any acute service strategy will be located and local Clinical Commissioning Groups are now fully engaged in the work which has also been endorsed by the system wide strategic forum *Healthy Futures.*

As part of the review, we are focusing service line developments in eight specialities and across four pathways – these areas are those where we anticipate that there is most potential for performance and quality improvement, and operational and financial efficiencies both from an organisational and a wider system perspective.

The eight specialities that form the core of our service line strategy are:

- Musculoskeletal services
- General Surgery (to include acute GI Surgery)
- Maternity
- Cardiology
- Dermatology and plastic surgery
- Gynaecology
- Clinical Haematology
- Neonatal Intensive Care

The four pathways are:

- General medicine
- Geriatric medicine
- Urgent care including Accident and Emergency Services
- Stroke care

Detailed work, in close partnership with clinical leaders across the city, is now on-going within each of these areas and is on track to report to the Board at the end of June this year. It is not clear at this stage what the scale or scope of options recommended will be, but the findings will be considered, alongside North Bristol NHS Trust and our commissioners with the aim of agreeing the key priorities for action in 2013/14. The Trust will also use the conclusions of the Acute Services Review as the basis for a review and refresh of its own Clinical Strategy out to 2020. In practical terms, therefore, the next 3 years will be a combination of implementing our existing strategy (Rising to the Challenge), implementing the recommendations of the Acute Services Review and refreshing and restating our own Clinical Strategy for the period 2015-2020.

4.3 Key Priorities 2013/14

Mindful of the medium term nature of this strategy work, the Trust has clearly set out its priorities for 2013/14, each of which has a detailed delivery plan underpinning it. Whilst not a comprehensive list of all the Trust aims to accomplish next year it is intended to provide clarity to our staff and our partners about what we believe success will look like in the coming year and will support our engagement work with staff to secure their support for change through a shared and well understood common purpose.

<u>Quality Ambitions</u>

- Increase the proportion of patients who experience “harm-free care” through further reductions in the incidence of pressure ulcers, falls, VTE and medication errors;
- Further reduce the incidence of Health Care Acquired Infection with the aim of eliminating MRSA and achieving, at least, the required 35% reduction in C Difficile;
- Deliver a consistently positive patient experience reflected through strong performance in the Family and Friends Test – notably improving the experience of patients with dementia and disability;
- Reduce the number of clinical incidents resulting in moderate or significant harm to patients and successfully communicate our learning from such events to all our staff;
- Maintain our strong performance on clinical outcomes as evidence by our low Hospital Standardised Mortality Ratio (HSMR);
- Address deficits in minimum standards of performance and strive to exceed these standards:
  - Restore and sustain A&E 4 Hour Performance;
  - Significantly reduce ambulance handover delays;
  - Resolve inherited Head & Neck RTT issues and address speciality level RTT compliance, notably cardiology and rheumatology;
  - Strive for a maximum 40 week wait for admitted care as a key stretch target for 2013/14;
  - Deliver sustainable 62 day cancer standard performance
  - Restore 6 week diagnostic performance, notably endoscopy and sleep services;
  - Reduce scale of last minute cancellations and improve rate of re-booking within 28 day standard.

<u>Workforce Goals</u>

- Build upon our recent positive staff survey results and further develop our staff engagement and communication plans;
- Review and redefine our Essential Training requirements and ensure full compliance across all areas and workforce groups;
- Significantly reduce reliance on temporary nursing workforce through permanent recruitment to longstanding and newly established vacancies;
- Reduce staff sickness further through support for staff health and wellbeing and effective absence management;

- Develop our operational managers to support good performance management across all service areas in support of a high performing, motivated workforce;
- Identify core leadership and skills gaps, and deliver development programme to address these;
- Successfully implement national pay reforms and work with staff and their representatives to consider further opportunities for pay reform as a means of limiting the impact of pay cost reduction on the number of staff employed.

Operating Priorities

- Work effectively with partners to reduce the level of demand for acute services to former levels with the aim of achieving 2008/09 levels of emergency admissions;
- Deliver length of stay improvements commensurate with planned future capacity through successful implementation of *Flow* project targets at both "front and back door" initiatives ;
- Significantly reduce the number of patients whose discharge is delayed at any one time to 20 patients or less through improved system working and enhanced complex discharge practices;
- Successfully implement model of bed protection that enables planned levels of elective care to be delivered through the year;
- Strengthen operational practices and processes to ensure appropriate scheduling of planned care and optimal utilisation of available capacity including South Bristol Community Hospital;
- Identify and deliver opportunities for early adoption of the planned future model of care changes including increased ambulatory care, earlier elderly assessment and significantly enhanced contribution of the discharge lounge to flow.

Financial Strategy

- Deliver contracted levels of activity, without recourse to sub-contracting or similar ;
- Maintain strong expenditure controls across all departments;
- Avoid fines and penalties through consistent operational performance against key standards;
- Achieve quality targets to secure a minimum of 75% of quality payments (CQUIN);
- Deliver 100% of target Cost Improvement Plans (CIPs).

Communication and Partnerships

- Continue to build positive relationships with our key stakeholders through increasingly effective partnership working at all levels of the organisation
- Conclude and implement the re-structuring of the Trust's communication function to strengthen the Trust's approach to both internal and external communication and notably to ensure the Trust's approach to communication is centred in listening to, as well as informing staff and patients, about key issues
- Build upon the Trust's growing reputation, both locally and nationally, in areas of recognised excellence through proactive working with external stakeholders including local, regional and national media.

4.4 Clinical Workforce Strategy

The clinical workforce is key to our *Transforming Care* change programme and our staff are being supported to enable them to play their full part in ensuring the Trust is well placed to maintain and improve the quality of services whilst addressing the 4% cost reductions required of all acute hospital Trusts. Our over-arching strategic focus with regard to our workforce going forward is *engagement* – without staff ownership of, and involvement in, the challenges and opportunities facing the Trust, we will not succeed in delivering our ambitions.

2013/14 therefore will include a review of the ways in which we currently engage and listen to our staff, implementing the learning from Francis through initiating formal “listening opportunities” with staff right across the Trust. We are developing a series of regular communications that respond to questions staff raise through the regular Chief Executive briefings to ensure all staff have the opportunity to hear how we are responding to the challenges and concerns they express - we are working productively with our staff-side representatives on this initiative.

Other key Initiatives to support our wider workforce objectives include increasing individual productivity and efficiency through dedicated training and individual performance management, supporting staff to identify news ways of working through a tools and techniques based transformation approach, enabling opportunities for role re-design through seed funding and importantly re-focussing our staff development programmes to create a workforce with both the skills and appetite to innovate.

Finally, reflecting the challenging environment facing all staff working in the NHS at present, the Trust has a broad range of initiatives to promote staff health and wellbeing and to respond promptly to staff who experience ill health including identifying recurrent funding for our staff *Physio Direct* service aimed at supporting staff with musculoskeletal problems to recover quickly and avoid the development of chronic health problems as well as accessible counselling and support services for staff facing psychological ill health.

An overview of the key issues facing key staff groups is given below:

Medical Staff

The Trust employs 1,008 WTE medical staff (including locums) of whom 382.5 WTE are consultants. Teaching is an important part of our position and at any time we typically have between 100 and 150 under-graduate students learning within our services. Many of our medical staff are jointly appointed through our links to the Bristol University which not only brings benefits to patients through our research endeavours but enables us to attract and retain some of the very best medical professionals.

As a relatively small staff group contrasted to our overall workforce, our strategic aim is to recognise the cost and scarcity of this important resource and ensure our medical staff are deployed for maximum effect through a focus on effective job planning around service priorities and ensuring medical staff are aligned to work that only doctors can do.

There are some key service changes in the next three years which will impact on the medical workforce and these are summarised below:

- The BRI Redevelopment, with the associated new model of care, opens in 2014/15 and in line with Royal College recommendations consultant cover will be provided across 7 days. The role of the acute physician is already established in the existing Medical Assessment Unit (MAU), and this will be extended further into the new development. Our primary goal in the new model of care is to establish key clinical adjacencies, deliver 24/7 comprehensive assessment for all emergency patients and achieve earlier senior review given the evidence for its impact on the speed of diagnosis, agreement of management plan and timely discharge. We aim to recruit additional acute physicians but as these are often difficult to recruit alternative models for senior review, including reviewing the role that elderly care physicians play in acute assessment, are being developed;

- The transfer of services from North Bristol NHS Trust, including head and neck services at the start of 2013/14, and the centralisation of specialist paediatrics (CSP) during 2014/15, mean transfers of medical staff between Trusts. A robust approach to job planning has been in place and will continue so as to ensure that the services are transferred safely and the vision for the delivery of the associated, additional benefits arising from the consolidation of services is achieved. Five Advanced Paediatric Nurse Practitioners will form part of the CSP transfer group from North Bristol NHS Trust, a

group who fulfil the majority of duties that junior doctors traditionally carry out for this group of patients - the Trust aims to look at how this model can be built upon within other areas of the Trust services following transfer;

- The Bristol Acute services review has highlighted workforce as a key theme to be considered as part of the review of city-wide service provision, including skill mix, retraining requirements, minimum staffing levels, recruitment, vacancies, shift cover, workforce productivity and generalist versus specialist skills;

- Increasingly the Trust recognises the need and value of delivering comprehensive care seven days a week. In areas such as neonatal and paediatric care this is existing practice. In 2013/14 we are focussing on changes to the way consultant staff support acute assessment and discharge at weekends and how the availability of imaging (and reporting) can be strengthened at weekends and out of hours to promote active management and discharge, seven days a week;

- During the last two years, the Trust has done significant work to support medical productivity through robust job planning. Benchmarking demonstrates further opportunities which are being explored through visits to other Trusts with lower medical workforce costs. A significant transformation project *Productive Outpatients* is expected to be a key contributor to releasing medical sessions for either reinvestment, or workforce reduction, as deemed appropriate;

- Investments made by commissioners in the last two years have addressed the main area where the Trust had a single handed consultant (Paediatric Inherited Metabolic Disease). This service has been significantly strengthened in the last year through investment in a second medical consultant alongside additional nursing and dietetic appointments. These developments have now fully mitigated the risks described in last year's plan;

- Our local deanery has signalled continued stability in junior doctor placements through next year and 2014/15 which will enable the Trust to retain compliant rotas across all of its services. Discussion regarding possible shifts in registrars from hospital to GP training places is being keenly followed by the Trust and underlines the important of the work the Trust is leading around role re-design to support medical duties being undertaken by appropriately skilled non-medical staff.

Nursing Staff

Nursing is the largest single staff group in the organisation and as such has a significant role to play in the success of the Trust; nurses' contribution to positive patient experience is without question and our strategic focus reflects this. The Trust employs 2,536 WTE nurses of whom 1, 961 WTE are registered nurses. The Trust has embraced the national policy direction regarding compassionate care and has a strong focus on developing a nursing workforce that is both competent and compassionate using the Chief Nursing Officer's *Compassion In Practice* strategy and her six "Cs" as our framework. The Trust introduced Supervisory Ward Sisters more than a year ago and roll out to all areas is almost complete. Their role is to provide effective leadership in the clinical, operational and staffing aspects of their ward with a focus of ensuring an excellent patient experience for each and every individual and their family; their impact is assessed through a set of quality measures and there is growing evidence of the success of this initiative.

The Trust undertook a major review of nurse staffing two years ago which led to both changes in nursing workforce numbers and shift patterns across the Trust. The Trust has a model for annually reviewing the continued appropriateness of staffing in light of changing demand and acuity of patients and in this context commissioned an external review of paediatric staffing levels this year, following concerns raised by the Care Quality Commission into the adequacy of staffing in one of the Children's wards in September 2012. As a result of this review the Trust will invest an additional £700,000 to recruit an additional 24.9 WTE posts to service areas where patient acuity now exceeds historical levels.

Other key changes in nursing workforce in the coming year include:

- Establishment of two paediatric High Dependency Units (HDU) in cardiac and medical specialities with associated requirement for recruitment of 32 additional nurses;

- Reducing bank and agency usage by recruiting higher levels of substantive staff, which has included successful recruitment from Ireland and Scotland, and a review of the nursing assistant training and recruitment pathway to promote pace of recruitment in this key group where turnover is high. These measures are expected to have a positive impact on both the quality and the cost effectiveness of the nursing workforce;

- A review of Clinical Nurse Specialists across the Trust is on-going and will conclude this year with the aim of ensuring this highly skilled workforce is utilised to best effect and supports the key priorities of the Trust;

- Nursing will also be impacted by the service changes which were described in relation to medical staffing, with changes resulting from ward configuration and developments in the model of care arising from the BRI redevelopment and the centralisation of specialist paediatrics. The latter will require approximately 120 additional nursing staff, some of whom will transfer from North Bristol NHS Trust and others who will be recruited (particularly theatre and HDU nursing staff) for whom recruitment and training plans are well advanced.

Scientific, Technical and Allied Health Professionals Workforce

The Trust employs 1,124 WTE scientific, technical and allied health professionals (AHP).

In 2012/13 the Trust completed a review of its AHP Services and the review recommendations have now been successfully implemented. Sickness levels in this workforce group are the lowest in the Trust and one of our priorities is to retain this whilst learning what practices have contributed to such low levels of sickness and turnover.

Given our specialist service portfolio, scientific and technical staff play an important part in the delivery of Trust services and the Trust works very closely with the University of the West England to support both under and post-graduate training of this workforce.

Since 2010 the Trust has been engaged in a city wide review of pathology services, exploring the creation of a single consolidated pathology service operated by North Bristol NHS Trust. This proposal has created a significant amount of uncertainty for scientific and technical staff working in pathology services and the Trust continues to support this group to handle this uncertainty. A formal decision regarding the service model for pathology, and associated implications for our staff, is now delayed pending the Cooperation and Competition Panel's (CCP) review of the proposed service reconfiguration.

Looking forward to 2013/14, the focus for therapy and pharmacy staff will be to consider how they can most effectively support seven day working across the Trust and promote timely discharge through working different with medical and nursing colleagues – length of stay reductions with the primary outcome measure of success for this initiative. Workforce and skill mix reviews will continue to take place across all of the professions to respond to the strategic changes ahead, such as the new model of care associated with the opportunities delivered through the BRI capital development.

Support Staff

In addition to its clinical workforce the Trust's success relies upon a stable and high functioning non-clinical workforce. The Trust employs 2,189 WTE non-clinical staff ranging from band 1 ancillary staff through to the Executive Board members. Achieving and maintaining the engagement of this group of staff around the Trust's priorities for the future is fundamental – in 2012/13 the Trust launched its first formal Recognising Success Awards where many staff from ancillary and administrative areas were celebrated for their

outstanding contribution to positive patient experiences and the smooth running of the Trust's clinical services.

Finally, the Trust is fortunate in the strength of its volunteer workforce and this group of staff continue to be a valued source of support to patients and Trust employed staff through the work they undertake.

Section 5 - Productivity and Efficiency

5.1 Productivity and Efficiency Overview

The Trust sets its Cost Improvement Plan (CIP) in light of the national financial efficiency requirements, the Trusts own assessment of the inflationary impacts it is facing and an assessment of the requirement for investment to address risks or quality improvements it believes are necessary. CIP targets are applied differentially across the Trust's six divisions reflecting their cost efficiency profile. CIP targets for 2013/15 have been set at 4.5% on average.

The Trust has a successful track record of delivering the nationally required efficiency savings whilst continuing to maintain the quality of the services it provides. It has a strong financial track record having delivered financial balance for 10 consecutive years; its Reference Cost Index is 99.

In 2013/14 the Trust's Cost Improvement Plan requirement is £21m and to date 86% of this has been identified and risk assessed as appropriate to proceed to implementation. Work is on-going to identify the balance of savings.

The Trust's focus on driving down its cost base, whilst maintaining quality, is delivered through its *Transforming Care* programme, described earlier in this plan and this will continue to be the focus of our approach alongside further diagnostic work to understand where our greatest opportunities for further cost reduction may lie coupled with our approach to working alongside comparable, lower cost Trusts to benchmark (in detail) our service models and expenditure with the aim of adopting and deploying the best practice found in other areas.

One of the Trusts major programmes addressing productivity is the Patient Flow initiative which is being supported by KPMG and is focussed on improving the flow through and experience of patients from presentation to discharge with specific aims of supporting strong A&E 4 hour performance, reduced length of stay, reduced numbers of patients for whom discharge is delayed and a significant reduction in the rate of cancelled operations arising from a lack of available beds. In line with the Trust's strategic capital development plans, the Trust aims to reduce the bed base of the Bristol Royal Infirmary by 24 beds in 2013/14 (6 %) requiring a reduction in current length of stay from 6.1 days to 5.5. Currently two of the three clinical Divisions within the BRI are on track to achieve this with the aim that the KPMG project will address the further improvements required in the Medicine Division during 2013/14 to ensure we remain on track. Savings currently attributed to this work stream are £0.85m for 2013/14 but are expected to increase significantly as the project develops and is scaled and rolled out across the Trust.

The Trust's second major work stream *Productive Outpatients* is dedicated to improving outpatient efficiency through improvements in session utilisation, reductions in patients that do not attend (DNA) for planned appointments and reductions in unnecessary follow up through improved working with primary care on this agenda. Key work streams within the programme include an enhanced use of technology including e-reminders and delivery of non-face to face care through digital means alongside the mapping and assessing of capacity requirements against planned demand. It is anticipated that the improvement in outpatient utilisation, resulting in a reduction in clinics and workforce requirements which it is anticipated will deliver financial savings in the first year of the plan of £1.0m with more to be realised in year two of the programme.

Spend on bank and agency staff is being addressed through a programme of recruitment to ensure staffing

levels are up to establishment and the Trust is also moving to a model of recruiting above establishment (but within budgets) to limit the need for bank and agency to cover planned leave, sickness and to minimise the impact of inherent turnover when staff leave and recruitment is delayed.

The key enablers to the Trust's CIP programme is the *Transforming Care Programme* including its Programme Management Office (PMO) function and its team of service improvement experts who are able to work alongside front line staff in supporting service improvement and CIP initiatives as well as leading Trust wide change programmes such as the previously mentioned *Production Outpatients* programme.

Finally, the Trust has embraced the opportunities presented through the national *Digital First* initiative and has established a programme of work to identify and implement digital solutions ranging from remote patient consultation using teleconferencing facilities, digital image transfer to support clinical advice to satellite providers and email and text communication to patients to support timely and high quality outpatient care.

Appendix 3 describes the Trusts three year CIP programme focusing on the top five schemes, the 2013/14 anticipated savings are summarised below by work stream.

Work Stream	Identified Savings 2013-14 £'000
Medical Staff Productivity	1,043
Nursing Productivity	3,570
AHP Productivity	1,173
Admin & Clerical staff Productivity	0,564
Medicines Procurement and Usage	0,891
Reducing and Controlling Non Pay	2,508
Optimising Facilities and Estates	1,079
Trust Services efficiencies	1,091
Total	11,919

Table 2 CIP Savings By Work Stream (2013/14)

5.2 Governance of Cost Improvement Planning

The Board, through its governance structures, has developed a robust means of ensuring cost improvement plans (CIP) are developed robustly to ensure both delivery and adequate mitigation of any risks associated with cost reductions. In recognition of the potential risks to service quality arising from cost reduction initiatives, clinical involvement and sign off of all plans is central to our approach.

Overall responsibility for the delivery of the CIP programme sits with the Trust's Transformation Board which is chaired by the Chief Executive. This Board delegates the day to day responsibility for CIP delivery and governance to the executive-led Programme Steering Group, which is chaired by the Trust's Chief Operating Officer. This group meets monthly to review progress by Division and work streams and reviews both quality impacts, operational risks and delivery of expected financial savings.

Divisions and work stream groups are held to account each month at both divisional and work stream CIP Reviews. These are led by the Director of Transformation with support from the Head of Financial Management. Monthly Divisional Operating and Financial Reviews are chaired by the Chief Operating Officer

and include both Director of Finance and Chief Nurse attendance.

The Trust operates a robust method of risk assessing cost improvement plans. The first level of risk assessment involves divisions making their own assessment of the likely delivery of plans against a set risk criteria around scheme start dates and the level of planning having taken place. Further risk assessments are carried out by the Programme Management Office finance staff working with, and challenging, proposals put forward. This is an on-going process and risk assessment is a key agenda item on the monthly Divisional CIP reviews as well as overall review by the Programme Steering Group.

Specific attention is paid to assessing and monitoring the quality impact of plans. All schemes are supported by a dashboard which clearly identifies and assesses the quality and operational risk of each scheme. This is completed by the responsible officer for the specific initiative and overviewed monthly by the Programme Steering Group and Work Stream Accountability meetings which again include both medical and nursing director oversight. The Trust is in the course of reviewing and building upon this process which will include aligning CIP risk assessment with the Trust standard risk assessment processes. Measures used to assess quality vary dependent on the project or scheme and details of these measures are provided in Appendix 2 and are reported to the Board via the monthly Quality Dashboard.

Finally, CIP delivery against plan is reported monthly to the Board and is subject to detailed scrutiny by the Trust's Finance Committee, a non-executive sub-committee of the Trust Board.

Delivery of CIP plans against targets for the previous 3 years is shown below; alongside the status of plans at the end of April 2013 noting the Trust has achieved or exceeded its planned surplus in each of these years.

Year	Planned Target	Actual Delivery Recurring	Actual Delivery Non-Recurring	Actual Delivery Total	Percentage Delivery
	£'000	£'000	£'000	£'000	%
2010/11	22,822	16,287	2,574	18,860	83%
2011/12	26,636	16,271	5,291	21,562	81%
2012/13	27,622	19,526	3,055	22,581	82%

Table 3 Historical CIP Achievement

Section 6 - Financial & Investment Strategy

6.1 An Assessment of the Trust's Current Financial Position

In common with the acute provider sector, the Trust is facing a challenging financial context characterised by a continued requirement to develop quality and services, whilst delivering significant efficiencies. The financial vision for the Trust is to maintain our position of strength, relative to the sector, continue to deliver a revenue surplus to support the Trust's ambition to improve its built environment and maintain a reference cost reflective of better than average efficiency.

The Trust's Financial Strategy includes the following principles:

- Key strategic schemes will be afforded by the creation of a strategic reserve;
- The strategic reserve will only be used for non-recurring purposes prior to the funding of key strategic schemes;
- The Trust's overall savings requirements will be set at the level of national tariff efficiency savings,

with differential targets applied to divisions which take account of their relative cost efficiency and profitability;
- Non recurring measures required to achieve break-even in any year must be below 1% of turnover as a proxy for recurring balance.

In the context of this vision and principles the key parameters for the forthcoming period are:

- EBITDA margin above 7% in all years;
- Income and expenditure net surplus margin greater than 1% in all years;
- A minimum cash balance of £20 million over the planning period;
- A financial risk rating of at least 3 in each year.

6.2 Service Priorities and Financial Investments

The Trust's clinical strategy and service priorities are described fully in earlier sections of this plan however the Trust's over-riding goal for financial investments in 2013/14 was that they addressed the concerns expressed by the CQC in their recent reviews of Trust services and that all of the high risks captured in the Trust's Risk Register, that required investment for their mitigation, were funded; the Trust's investment strategy for 2013/14 has addressed these goals.

The Trust is investing significant capital in the period of this plan to advance the quality of accommodation from which it delivers patient based services. This includes the Trust's four major capital schemes totalling in excess of £130m alongside more modest investments in the Trust's existing estate to address immediate operational priorities such as the creation of a Midwife-led Birthing Unit and an upgrade to the patient facing areas of the Trust's main Imaging Department.

In revenue terms the Trust created a reserve of £1.7m to address corporate risks that could not be mitigated without investment and which were unable to be funded within individual Divisional Operating plans. These investments included increased paediatric nurse staffing, enhancements to MRSA practice, increased midwifery and medical staffing to ensure CQC compliance standards, investment in training to increase compliance with essential training requirements and investment in cancer services management to further reduce delays in cancer pathways for all patients and notably lung cancer.

Alongside internal investment, the Trust secured significant additional external investment through its contract settlement with commissioners. These investments include more than £2m in the establishment of two Paediatric High Dependency Units within the Bristol Royal Hospital for Children and £8.6m investment in implementation of new or anticipated NICE guidance and other non-nice high cost drugs, notably Ivacaftor for the treatment of cystic fibrosis.

6.3 Key risks to achieving the financial strategy and mitigations.

Key risks to delivery of the Trusts financial plan are summarised as:

- Commissioned levels of activity are not delivered and income projections are not met – this risk materialised in 2012/13 and significant mitigations have been put in place to manage this risk in 2013/14 which includes operational capacity planning to speciality and sub-speciality level, service level recovery plans where 2012/13 activity was below plan and the introduction of *protected beds* for elective, planned care to ensure at times of peak demand for urgent care, planned activity is maintained;
- CIP delivery is not realised in line with the plan or delivery results in quality impacts that cannot be

mitigated – the mitigations to this risk are comprehensively described in Section 4, CIP Governance, of this plan;

- The Trust incurs contractual penalties and fines in excess of those assumed within the financial plan – this risk is largely mitigated through the nature of the contract settlement with commissioners but the Trust's over-riding priority is to deliver operational performance to a standard where financial sanctions are not in play;
- Expenditure exceeds planned levels – the Trust has invested significantly in staff development for every staff member who has budgetary responsibility and has a strong track record of good cost control. Strong governance of Divisional expenditure ensures any expenditure risk is picked up early and recovery actions agreed including enhanced oversight of all spending decisions by senior teams where evidence of controls is lacking;
- Commissioned activity exceeds that contracted and planned for with risk of non-payment from commissioners in light of their financial constraints – key mitigation is robustly negotiated in activity volumes, contract clauses to guard against occasions when non-payment could be justified and robust in year review of activity against planned levels with associated remedial action planning to restore to plan, wherever possible.

Section 7 Governors

7.1 Governors

In formulating the Annual Plan, the Trust has due regard for the views of the Trust's governors who have been involved in the formulation of the plan through a series of formal engagement meetings. Governors reflect the needs and priorities of the constituencies which elected or appointed them. These constituencies include a Foundation Trust membership base of 21,040 members. The Trust maintains this representative membership of people from eligible constituencies in keeping with the NHS Foundation Trust governance model of local accountability through members and governors. We continue to work to ensure that our membership remains representative of our catchment communities and that members have suitable opportunities to be engaged with the Trust and the work of the Council of Governors.

APPENDIX 1 - 2013/14 QUALITY OBJECTIVES

Quality Goal	Measures of Progress	Key Actions	Delivery Risk
Patient Safety			
To increase harm-free care (reductions in VTE, patient falls, hospital-acquired pressure ulcers and urinary infection in patients with catheters)	Measured via the NHS Safety Thermometer. National CQUIN target to be advised.	Improvement CQUIN for 2013/14 to be agreed with commissioners.	To be confirmed once 2013/14 CQUIN agreed.
To improve recognition of the deteriorating patient and escalation to a more senior clinician for review	Progress will be measured by monthly audits using the Safety Thermometer sample. Observations completed and early warning scores calculated correctly in 95% of adult patients measured in Q4 2013/14, and 95% of adult patients in the audit sample who triggered escalation were escalated according to the protocol in the Bristol Observation Chart using the SBAR structured communication tool.	We will continue to participate in the NHS South West Quality and Patient Safety Improvement Programme, with year-on-year improvements in the spread and penetration of all key changes relating to the programme	There is a risk that we will not achieve the necessary engagement from the breadth of staff required to fully deliver our patient safety and quality improvements within the planned timescales and therefore not achieve the planned reductions in harm to patients in the period.
Reduce medication errors	CQUIN target to be agreed. Pharmacists will sample inpatient prescription charts across all wards (minimum 500 sets per month) and will record omitted doses for those medicines defined by the National Patient Safety Agency or Trust as critical.	The Medicines Governance Group reviews all medication related incidents and disseminates learning. On-going trust wide performance in respect of omitted or delayed doses is being closely monitored at ward level to enable targeted improvement actions where required.	The main risk is associated with admission wards in situations where patients bring no medication into hospital.
Reduce healthcare acquired infections	We will achieve national targets for MRSA and C Difficile.	Weekly operational performance meetings; trust-wide review of infection control policies and training; specific focus on IV line care.	The inherent risk of not achieving very challenging year-on-year reductions in national infection control targets.

Quality Goal	Measures of Progress	Key Actions	Delivery Risk
Extend medicines reconciliation	CQUIN target to be agreed Pharmacists will assess completion of medicines reconciliation (as defined by NICE and the NPSA) through sampling five patients per week in selected wards identified as admission areas.	NICE and the NPSA have identified medicines reconciliation ('getting the medicines right') as an evidence-based approach to improve patient safety. Spread of the medicines reconciliation process throughout the Trust is therefore an important medicines safety theme. Monitoring of performance in the selected wards encourages this spread and provides assurance of improvement and safe patient care.	The medicines reconciliation service is heavily reliant upon the Pharmacy workforce so the main risk relates to the available staffing resource.
Improve levels of nutritional screening and 72 hour nutritional review	Measured via the ward-based *Quality in Care* audits (the frequency of these audits is determined by levels of performance – wards achieving 'gold' standard are audited every six months; any wards achieving 'bronze' would be audited every two months. Local CQUIN target to be agreed.	We will continue to measure nursing care and practice, with year on year improvement.	No material risks identified.
Patient Experience			
Ensure patients are treated with kindness and understanding	CQUIN target to be agreed. Measured by improvements in scores in national and local patient experience surveys.	Our goal for 2013/14 is to sustain our strong performance in 2012/13.	The on-going challenge for staff is to continue to deliver compassionate care in the face of inevitable service pressures. Performance is closely monitored by the Trust's Patient Experience Group.
Implement the NHS Friends and Family Test (FFT)	Measured by national CQUIN. Minimum 15% response rate in Q1 and improved response rate by Q4.	The FFT was implemented at UH Bristol in March 2013 and went 'live' nationally on 1 April 2013.	The risks are that busy ward staff will not remember to ask patients to complete the survey; that patients will choose not to complete the survey; that wards will not return completed questionnaires within the required timeframe. The risk is mitigated by monitoring the corporate Patient Experience & Involvement Team and Divisional Heads of Nursing.

Quality Goal	Measures of Progress	Key Actions	Delivery Risk
Improve explanation of medication side effects to inpatients upon discharge	CQUIN target to be agreed. Measured by improvements in scores in national and local patient experience surveys.	Implementation of new adult discharge checklist (part of the updated Discharge Policy) - there is a section of the checklist developed with pharmacy where staff can record their discussions about discharge medications and side effects (we currently have no auditable evidence that these conversations take place, as the existing record of the conversation is given to the patients on discharge). The new checklist has a tear-off portion for the patient and a separate record that will be filed with the medical notes and can potentially be included in the new admission nursing documentation as a complete record of admission, inpatient stay and discharge.	We know from National Inpatient Survey data that this is an area that most non-specialist trusts struggle with. UH Bristol's performance in absolute terms is disappointing, but in relative terms is better than average. The risk is that achieving this objective requires a behavioural change from busy front-line staff.
Improve the experience of maternity patients (pre-commitment in 2012-15 Patient Experience & Involvement Strategy)	Improvements in patient-reported experience in maternity services, as measured using local survey and Friends and Family Test.	Introduction of midwifery-led unit; commence major reconfiguration of wards and staffing at St Michael's Hospital enabling greater 1 to 1 care for induction of labour; roll-out of enhanced recovery; co-design patient experience project involving women telling their stories about their experience of induction.	The key risk is if midwifery vacancies are not filled and the extra capacity and ward reconfiguration becomes difficult to staff. There is also an inherent risk that birth numbers may continue to rise, putting additional pressure on staff as they seek to deliver compassionate care.

Quality Goal	Measures of Progress	Key Actions	Delivery Risk
Clinical Effectiveness			
Ensure the identification of patients with dementia and other causes of cognitive impairment alongside their other medical conditions, leading to prompt appropriate referral and follow up after they leave hospital; also to ensure that we deliver high quality care to people with dementia and support their carers	Progress will be measured by implementation of the South West Dementia Partnership Standards in the Trust. Standards 2, 4 and 8 were implemented in 2011/12, and standards 5 and 6 in 2012/13. Focus in 2013/14 will be on standards 1 (ensuring that patients with dementia are treated with dignity and respect) and 7 (ensuring quality of care at end of life). This work is supported by a national dementia CQUIN and is also monitored through an annual local audit of dementia care and participation in the annual National Audit of Dementia (Royal College of Psychiatrists).	Continue to implement and monitor progress against the eight South West Dementia Standards incorporating findings from National and local audits and peer review visits. On-going actions relating to Older People's Care Strategy. The Trust has carried out a self-assessment against the recommendations made in the Delivering Dignity – Securing Dignity in Care for Older people in Hospitals and Care Homes report.	The key delivery risks are the challenge of enabling all appropriate staff to receive dementia training, and ensuring that the implementation of the standards happens across the whole Trust and is not confined just to Care of the Elderly wards. Risk is mitigated by the operational leadership of the Dementia Implementation Group and the appointment of a lead Nurse for Dementia in July 2012 to drive improvements and sustain momentum.
Ensure that patients with identified needs (such as a learning disability) have a risk assessment and patient-centred care plan in place.	At least 85% of patients with a known learning disability will be risk assessed within 48 hours of admission. A new CQUIN will be introduced for 2013/14 related to making and recording reasonable adjustments for adults with learning disabilities (a recommendation from CIPOLD – see key actions)	Staff will continue to receive training to ensure they are able to identify the needs of people with learning disabilities as early as possible and plan care according to the identified needs. The training matrix includes: Learning Disabilities Awareness, Autism, the Equality Act (2010), the Mental Capacity Act (2005) and the Confidential Inquiry into the Premature Deaths of People with Learning Disabilities (2010). Current paperwork will also be amended to focus on the core concept of reasonable adjustment.	There are more than 40 link nurses across the Trust who are keen to continue to raise awareness within their clinical areas and to support and implement local improvements. The risks relate to being able to release staff to share best practice and attend training/learning events. The risk is mitigated by the Learning Disabilities Steering group sharing best practice with Divisions.
Extend the use of enhanced recovery in surgical areas	The following CQUINs have been agreed in principle for 2013/14: • 85% thoracic surgical patients on a	Identify patient cohorts most appropriate for enhanced recovery; provide appropriate	The key delivery risks are: • Failure to reduce length of stay leading to patients having to spend longer in hospital

Quality Goal	Measures of Progress	Key Actions	Delivery Risk
	cancer pathway being cared for on a ER pathway; • 60% of lower GI patients on a cancer pathway cared for on a ER pathway; • Roll out of ER pathways into Vascular and Maxillary Facial surgery.	patient information; deliver practical ward support, OT and physiotherapy input, etc. Overall enhance the patient experience – through adherence to patient safety initiatives.	than required, reducing capacity for other patients. Risk is mitigated by operational leadership from within each specialty; • Effective bed management impacting bed availability and scheduled surgery. This is being addressed through a reorganisation of theatre availability per specialty and a separate programme of work designed to improve patient flow positively impacting bed management; • Increased re-admission rates of patients undergoing ER procedures. Risk is mitigated through operational leadership within each specialty and nationally recognised guidance. Mitigation is supported by improved flow of management information for 2013/14.
Ensure patients with diabetes have access to specialist diabetic support	By the second half of 2013/14: Increase percentage of inpatients with diabetes receiving specialist diabetic nurse input whilst in hospital (compared to 2012/13 baseline)	Continuation of Inpatient Diabetes Nurse post which has previously been supported through short-term CQUIN pre-commitment funding in the Division of Surgery Head & Neck. Post will now operate across SH&N and Specialised Services Divisions ensuring equity of care for patients with diabetes presenting to UH Bristol (an existing post already supports diabetic care in the Division of Medicine).	No material risks identified.
Achieve best practice tariff for hip fractures	By the second half of 2013/14: • 90% of patients will receive surgery within 36 hours of admission; • 90% of patients will be reviewed by an ortho-geriatrician within 72 hours.	Daily trauma operating lists will commence from 26th March 2013 following centralisation of Head and Neck services at UH Bristol. Recruitment of full-time	The key delivery risk is associated with being able to make appropriate and timely appointments.

Quality Goal	Measures of Progress	Key Actions	Delivery Risk
		Orthogeriatric Clinical Fellow and additional Consultant OG sessions. Discussions are in progress between Division of Medicine and Division of Surgery Head & Neck to appoint joint Ortho-geriatric and Care of the Elderly Physicians.	
Conduct a baseline review of available clinical outcome and PROM data	Evidence of comprehensive baseline review of availability of outcomes/PROMs data across all Divisions.	Review led by Clinical Audit & Effectiveness Team.	The risk is that this project requires co-operation from all clinical areas to discuss existing outcome/PROM measures and those which are most relevant to their particular services.
We will ensure that at least 90% of patients are treated for at least 90% of the time on a dedicated stroke ward.	At least 90% of patients will be treated for at least 90% of the time on a dedicated stroke ward. This measure forms part of the Board's monthly quality tracker.	We will focus on identifying potential stroke patients earlier in their pathway of care, enabling rapid admission of the stroke unit.	The key delivery risk is the operational challenge of protecting dedicated stroke beds at a time of high demand for beds. Contingency plans are in place to mitigate risk.

APPENDIX 2 - KEY QUALITY RISKS INHERENT IN THE PLAN AND HOW THESE WILL BE MANAGED

Type	Risk description	Current risk	Existing Controls	Key Actions in 2013/14	Residual risk Through Effective Controls and Mitigations
Quality	Failing to listen and act on the concerns of our patients and / or staff in order to improve our services	Moderate	• Patient Experience Group; • Patient Support and Complaints Team; • Complaints policy; • Patient Experience and Involvement Strategy; • Monthly inpatient survey and annual outpatient survey; ○ Divisional Patient Experience Action Plans in response to patient feedback through local and national surveys • Annual staff attitude surveys. • Whisteblowing policy and procedures.	1. Implement the NHS Friends and Family Test (FFT). 2. Actions to improve experience of maternity patients (in accordance with second year of strategy). 3. New quarterly patient experience report to Quality and Outcomes Committee. 4. Staff survey Corporate and Divisional action plans. 5. Staff engagement programme. 6. Implementation of formal CEO led *staff listening* events	Low
Safety	Failing to meet the challenge of the increasing number, acuity and complexity of patients requiring acute care from our local population.	High	• Escalation process in place; • Agreement in place with ambulance trust;	1. KPMG review of patient flow 2. Whole system review being overseen by Healthy Futures Programme 3. Continue to improve working relationships with Community care Partners and Social Services 4. Development of the Older Peoples Care Strategy	Moderate
Quality	Not maintaining the highest quality patient care, education and research whilst meeting challenging Cash Releasing Efficiency Savings (CRES) targets	Moderate	• Monthly oversight of both finance and quality indicators at Board, sub-committee and executive Level • CRES driven through service transformation with emphasis on quality improvement	1. CRES savings plans all subject to robust clinical risk assessment. 2. Quality metrics for all CRES schemes monitored monthly 3. Transforming Care Programme re-launch	Low

Type	Risk description	Current risk	Existing Controls	Key Actions in 2013/14	Residual risk Through Effective Controls and Mitigations
Safety	Risk of harm to patients from falling	High	• Falls Management Policy; • Falls Steering Group; • Falls investigation; • FallSafe project: pilot and evaluation • Falling Star magnets in place to identify patients at risk of falling on patient at a glance boards, to alert all staff to patients at risk and generate multi-disciplinary discussion on Board Rounds • Falls prevention when designing new buildings • Rental agreement for ultralow beds.	1. Implementation of the Royal College of Physicians FallSafe Project across the Trust. 2. Monthly review of falls data and investigations to identify areas of good practice, improve practice and ensure organizational learning. 3. Dementia Clinical leads actively involved in the design of the new build to ensure it meets the needs of patients with a cognitive impairment and at risk of falling. Audit of falls resulting in a fracture, with improvement plan where indicated.	Moderate
Safety	Risk of harm to patients from pressure ulcers	High	• Policy for pressure ulcer prevention; • Pressure relieving equipment purchased; • Root cause analysis investigation for pressure ulcers Grade 2 and above • Meetings held with Deputy or Chief Nurse to review all root cause analyses for grade 3 and above hospital acquired pressure ulcers to identify themes and ensure organisational learning from these reviews occurs. • Visit other Trusts to bring back and embed examples of good practice.	1. Action plan in place in response to external review from August 2012. 2. Roll out of a competency based Virtual Patient training programme across the Trust. 3. Monitor impact of upgraded Mattress Store and Band 2 Coordinator role. 4. Finalize Trust wide Equipment Library business case 5. Close monitoring of pressure ulcers through use of Patient Safety Thermometer and weekly senior nurse meetings.	Moderate
Safety	Failing to reduce the incidence of healthcare-acquired infections, specifically MRSA and C.Difficile.	High	• Infection control policy framework; • Infection control team; • Infection control training for all staff; • Saving Lives/High impact intervention programme; • MRSA screening; • Monthly Infection Control meetings	1. Comprehensive action plan in place to reduce hospital-acquired infections. 2. Appointment of a band 7 IV Access Nurse. 3. Monthly audits to monitor practice	Moderate

Type	Risk description	Current risk	Existing Controls	Key Actions in 2013/14	Residual risk Through Effective Controls and Mitigations
			chaired by the Deputy Chief Nurse; • Trust Infection Control Committee chaired by the Chief Nurse; • New testing processes for C Difficile in place; • External visit to review practice within the Trust, with advice built into the action plan.		
Quality	Suboptimal care of patients if there are delays in discharging or transferring to community-based services	High	• Closer working with social and community care partners; • Daily review of all delayed patients; • Discharge liaison team in place; • Ward based, named social workers.	1. Review of patient flow in partnership with KPMG 2. Whole system review being overseen by Healthy Futures Programme 3. Continue to improve working relationships with Community care Partners and Social Services	Moderate
Quality	Failing to meet the expectations of our patients, commissioners and regulators on important clinical indicators such as cancer waiting times and 4-hour Emergency Department waits. AMBER-RED Declaration 2013/14	High	• Performance Review at all key Trust meetings; • Pathway redesign; • Analysis of reasons for breaches and recovery plans as required; • Weekly notification of performance status to all key Trust staff.	1. 62-day cancer action plan in place developed and being implemented 2. External review of patient flow in partnership with KPMG 3. Investments in infection control practice	Moderate
Workforce	Not maintaining a fully competent and capable workforce If we fail to ensure that our staff attend all required mandatory training	Moderate	• Corporate Induction; • Essential training matrix; • Training Needs Analysis; • Mandatory Training policy	1. Essential training revalidation; 2. Procurement of a new learning database 3. Investment in additional staff to support training delivery and training administration	Low

Type	Risk description	Current risk	Existing Controls	Key Actions in 2013/14	Residual risk Through Effective Controls and Mitigations
Strategic	Delays and cost overruns if we fail to manage our major capital investments on time and in budget	High	• Robust programme management and governance; • Structure mirrors OGC best practice; • External OGC Gateway Review; • Deputy Chief Executive is responsible officer.	1. Undertake income and expenditure re-fresh of all major capital developments 2. Confirm commissioning plan for 12 month period leading up to opening of new developments	Moderate

APPENDIX 3 - CIP Focus - Top 5 CIP Schemes

Ref	Scheme	Scheme description including how Forward Plan will reduce costs	Under-pinning IT / information or management systems	Total savings £m	Phasing over three year period (%)			WTE Reduction	Has the Forward Plan been subject to a quality impact assessment (Y/N)	Who is responsible for signing off on the quality impact assessment	Key measure of quality for plan	Scheme Lead
					Yr. 1	Yr. 2	Yr. 3					
1	Nursing Productivity- Workforce Review	This scheme covers all nursing and midwifery staff in the Trust. Scheme includes a full review of nursing staffing levels on wards. This is an on-going project that initially involved all Heads of Nursing and an external consultant specialist. The review used benchmarking data to identify current staffing levels against peers and recommended changes. An integral part of the exercise has been a review of nursing rosters across 24 hour areas. The scheme will also review all Clinical Nurse specialist posts and all other nursing and midwifery posts. The scheme will reduce costs by changing rota patterns for wards, amend skill mixes on wards and introduce improved controls over sickness and absence. The review of Clinical Nurse Specialists will improve delivery of service as well as potentially	RosterPro Central E-rostering system. Electronic Staff Record. Safeguard Risk Management System. Pandora Clinical Nurse Specialist System. Management Accountants General Ledger. Safety Thermometer programme. Quality in Care Tool. Monthly Programme Steering Group work stream reporting mechanism. Monthly Divisional CRES reporting system.	**11.0**	**33**	**34**	**33**	**121**	**Y**	Chief Nurse	Tracking the key indicators of staff sickness levels and patient quality indicators: 1) Falls 2) Pressure sore rates 3) Medicines mis-administration events. 4) Venous Thromboembolism prophylaxis and assessments markers 5) Urinary Tract Infection Rates These are established best practice markers for quality. In addition there will be a full Key Performance Indicator programme to support the new Supervisory Ward	Chief Nurse

Ref	Scheme	Scheme description including how Forward Plan will reduce costs	Under-pinning IT / information or management systems	Total savings £m	Phasing over three year period (%)			WTE Reduction	Has the Forward Plan been subject to a quality impact assessment (Y/N)	Who is responsible for signing off on the quality impact assessment	Key measure of quality for plan	Scheme Lead
					Yr. 1	Yr. 2	Yr. 3					
		reduce headcount.									Sister role	
2	Reducing and controlling Non Pay	Continued full review of all procurement and usage of non-pay including clinical supplies and services across the Trust. All areas of non-pay are included except drugs and blood which are subject to review within other work streams. Savings will be delivered through product substitution standardisation; price of products used and reduced usage.	Management Accountants General Ledger. Trust internal tracker used for modelling and measuring planned and actual delivery. Trust electronic requisitioning and ordering system (EROS) Monthly Programme Steering Group work stream reporting mechanism Monthly Divisional CRES reporting system	**6.2**	**40**	**31**	**29**	**0**	**Y**	Director of Finance	Number of untoward clinical incidents relating to product substitution. Number of exceptions reported in relation to product substitution.	Director of Finance

Ref	Scheme	Scheme description including how Forward Plan will reduce costs	Under-pinning IT / information or management systems	Total savings £m	Phasing over three year period (%)			WTE Reduction	Has the Forward Plan been subject to a quality impact assessment (Y/N)	Who is responsible for signing off on the quality impact assessment	Key measure of quality for plan	Scheme Lead
					Yr. 1	Yr. 2	Yr. 3					
3	Medical Staff Productivity	Scheme includes a full review of all consultant job plans in order to ensure that job plans match the capacity requirements of the Trust in delivering contracted workload. Savings will be achieved by reducing the number of contracted PA's Other medical staff posts are also being reviewed including all rotas for junior medical staff.	Management Accountants General Ledger. Electronic Staff Record System. Trust Internal model reconciling Consultant PA's to capacity requirements. Monthly Programme Steering Group work stream reporting mechanism. Monthly Divisional CRES reporting system.	**5.2**	**20**	**41**	**39**	**N/A**	**Y**	Medical Director	Measures of % staff sickness. Hospital Standard Mortality Ratio (HSMR)	Director of Transformation
4	Medicines Procurement and usage	Full review of all drugs used in the Trust including procurement practices and usage. Efficiencies will be made as a result of improved purchasing as well as by ensuring prescribing is as efficient as possible, this will include benchmarking of prescribing against other organisations. Full use of gain sharing for savings made on non	Management Accountants General Ledger. Trusts Pharmacy system. Monthly Programme Steering Group work stream reporting	**3.7**	**24**	**38**	**38**	**0**	**Y**	Director of Pharmacy	Number of medication errors reported. % of patients with admission medicines reconciliation (Currently one ward only) % of TTA's dispensed within 2 hours.	Director of Pharmacy

Ref	Scheme	Scheme description including how Forward Plan will reduce costs	Under-pinning IT / information or management systems	Total savings £m	Phasing over three year period (%)			WTE Reduction	Has the Forward Plan been subject to a quality impact assessment (Y/N)	Who is responsible for signing off on the quality impact assessment	Key measure of quality for plan	Scheme Lead
					Yr. 1	Yr. 2	Yr. 3					
		PBR drugs and healthcare at home will be agreed with purchasers. The Trust is planning to procure an out sourced dispensing service with a third party to generate further savings from year two onwards.	mechanism. Monthly Divisional CRES reporting system									
5	Allied Healthcare Professionals and Clinical Scientist productivity	All Allied Healthcare Professionals and Clinical Scientist staff groups are being reviewed and staffing levels being benchmarked against peer trusts. This includes reviews of skill mix management structures and methods of working to support service delivery. Savings will come from reduced headcount and skill mix savings.	Management Accountants General Ledger Electronic Staff Record Monthly Programme Steering Group work stream reporting mechanism Monthly Divisional CRES reporting system	**4.0**	**29**	**36**	**35**	**22**	**Y**	Chief Nurse	% of Outpatients seen within waiting time target. Number of patient complaints actioned within timeframe. % of staff sickness.	Chief Operating Officer