Bradford Teaching Hospitals NHS
NHS Foundation Trust

Operational Plan Document for 2014-16

Bradford Teaching Hospitals NHS Foundation Trust

1.1 Operational Plan for y/e 31 March 2015 and 2016

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

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Date	**03.04.14**

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

Approved on behalf of the Board of Directors by:

Name *(Chair)*	**David Richardson**

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	**Bryan Millar**

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	**Matthew Horner**

Signature 

1.2 Executive Summary

Our vision for Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) is set out in our strategy for 2013-18 "Together, putting patients first". In this document we outline our ambitions and vision for the coming years. We have a clear mission to ensure that patients are at the centre of all that we do and that our services support the needs of our population. BTHFT is committed to the safe delivery of these services to the highest standard of quality at all times.

We understand that this vision and our ambitions will need to be delivered in the ever more challenging environment that is faced by the NHS both nationally and locally.

The NHS overall, faces an ageing population, an increase in long term conditions, rising costs and increased public expectations. Allied to this, there is also an unprecedented financial challenge with the NHS forecast to face a funding gap of £30bn by 2020/21.

Locally, the Bradford area faces a range of specific challenges. Amongst these is the fact that it sits within the 10% most deprived local authorities in the country. These higher levels of deprivation have a significant impact on the health needs of the population, with Bradford having higher levels of chronic disease than neighbouring areas. Areas of particular concern are cardiovascular disease, diabetes and respiratory disease. The local population also does not follow national trend with the majority of the population being younger, with a smaller proportion of older people.

BTHFT recognises these local factors and is also cognisant of the fact that, in line with the rest of the NHS, we will need to address these issues whilst faced with a significant financial challenge. The estimated funding deficit in the Bradford health and social care economy has been assessed by the Trust and its Local Health Economy (LHE) partners (including adult social care) as being in the region of £357m over the next 5 years. Indeed, the Trust's high level planning assumptions indicate that the Trust will need to identify £29m of efficiency improvements over the next two years.

We are also fully aware that whilst addressing the financial and social challenges outlined above we must also implement the lessons of the Francis, Keogh and Berwick reports and ensure that our focus on maintaining and improving the quality of our services does not waver.

BTHFT has recognised that in order to respond effectively to the unprecedented financial challenge and to maintain our ambitions in terms of quality and patient focussed services, current methods of service delivery will not be sufficient. As a result, it is vital that we work closely with our LHE partners to develop a range of transformational and integrated services.

Consequently, this plan sets out;

- the short term challenge facing BTHFT and its LHE partners and the approach being developed to respond to this challenge
- our quality plans
- our assessment of our operational requirements, workforce and physical capacity
- our proposed amendments to service delivery, including those aimed at transforming the way in which services are delivered
- financial projections and forecasts to support these plans

Delivery of this plan will ensure that patients receive the right, high quality treatment, in the right place at the right time.

1.3 Operational Plan

Short Term Challenge

As highlighted above the Trust understands that our services will need to be delivered in the ever more challenging environment faced by the NHS both nationally and locally and is also cognisant of the fact that, in line with the rest of the NHS, we will need to address these issues whilst faced with a significant financial challenge. The estimated funding deficit in the Bradford health and social care economy has been assessed by the Trust and its Local Health Economy (LHE) partners (including adult social care) as being in the region of £357m over the next 5 years.

BTHFT has recognised that in order to respond effectively to the unprecedented financial challenge and to maintain our ambitions in terms of quality and patient focussed services, current methods of service delivery will not be sufficient. As a result, it is vital that we work closely with our LHE partners to develop a range of transformational and integrated services.

Our Approach – Integration and Transformation

Integration

It is clear from our consultation with LHE partners that all parties are aware of the affordability gap affecting health and social care and the challenge of delivering patient focussed, high quality care whilst bridging this gap.

The transformation and integration of services and the appropriate use of the Better Care Fund are seen as key drivers in meeting this challenge. Indeed, BTHFT and its Local Health Economy (LHE) partners have been aware of the need to transform and integrate services for some time. Consequently, an established (since 2011) and robust Integrated Care Programme has been developed involving:

- Bradford Teaching Hospitals NHS Foundation Trust
- NHS Bradford Districts CCG
- NHS Bradford City CCG
- Bradford District Care Trust
- City of Bradford Metropolitan District Council
- Bradford Health and Wellbeing Board
- Airedale NHS Foundation Trust
- NHS Airedale, Wharfedale and Craven CCG

This Integrated Care Programme is underway and is overseen by the Bradford Integration and Change Board (ICB). The ICB liaises with the Health and Wellbeing Board and connects senior leadership from across the NHS with Local Authority Providers and Commissioners. There is also full engagement with local Healthwatch. Indeed, as a LHE community, we are working with Healthwatch and voluntary sector partners as a pilot site in the Building Health Partnerships programme.

BTHFT and its LHE partners have formally committed themselves, through the ICB, to a joint vision for transformation and integration. They have agreed that this joint programme of work must be evidence based and founded on sound data to demonstrate potential improvements in quality and value. Successful actions to date have included; work to develop the Virtual Ward, the development of the Urgent Care Programme and specific areas of service level integration such multidisciplinary teams in Motor Neurone Disease. Further detail on these areas of work is provided later in this section of the plan.

It is intended to implement the joint programme over the coming 5 year strategic planning period, with the majority of the integration work being delivered in the next two years. To this end, BTHFT and its LHE partners have established the Integrated Care Programme.

Integration - Key goals

Key goals of the programme are to use integration to provide better and joined up care at home and better coordinated intermediate care services. Particularly, BTHFT and its LHE partners are aiming to:

- create a sustainable health and care economy that supports people to be healthy, well and independent through 7 day, 24/7 integrated services
- create an increased community based capacity to prevent avoidable demand on the system including community access to diagnostics and assessment
- understand the population through the use of predictive risk stratification and embed self-care as core to service delivery
- become a digital health and care economy, implementing a connected digital care record across primary, secondary, community and social care services to achieve a seamless patient record, with the NHS number as the unique identifier
- expand intermediate care services maximising step-up capacity and capability, delivered through hybrid health and social care services in the community to meet the whole spectrum of an individual's needs
- establish deep engagement and co-production of services with service users and staff
- speed up access to clinical assessment using virtual ward approaches to avoid admit to assess and delayed discharges

It is recognised that this will result in changes to the configuration of services over the next five years which could include;

- changes to the provider landscape
- more people cared for at home
- workforce planning across agencies to meet the needs of local communities
- staff working in multi-professional and multi-agency teams
- reduction in the need for growth in acute beds
- staff working with managers and colleagues not within their own organisations
- staff working across services (e.g. geriatricians)
- changes to policy, systems and processes
- increased skill sharing across professional groups
- closer working between primary and secondary care
- increased delivery of care in the community
- the creation of a digital health economy

BTHFT will therefore work closely with LHE partners to ensure that it is at the heart of these developments and plays a full part in the creation of programmes of service delivery that ensure the provision of patient focused services within a sustainable business model.

It is intended that these programmes of service delivery will result in the following outcomes for patients:

- person-centred, co-ordinated care
- a rapid and timely response
- care provided at home or closer to home and reduced admissions
- reduced exacerbations of long-term conditions
- regaining and retaining health, wellbeing and independence for longer
- a reduction in premature admission to long-term care
- reduced dependence on NHS and social care services and support to self-care

BTHFT and its LHE partners have set key timeframes for the delivery of the integration process;

2014/15

- Stop further growth in unplanned demand
- demonstrable increased community-based capacity and capability in particular home based care
- development of commissioning activity to support integration including new payment models
- detailed economic modelling undertaken to fully understand the system and financial changes that are required to respond to the economic challenge of the next five years
- collective HR/workforce plan agreed across stakeholders for integrated teams
- work to begin to assess and develop a connected digital care record to enable better integrated working

2015/16

- procurement of integrated community and primary care services model with supporting payment models
- integrated community teams fully established with demonstrable increase in people cared for outside of hospitals
- community teams have delegated authority to deploy resources to meet health and care needs of the local population
- workforce planning undertaken across the health and care economy

It is clear that the integration process will have a definite impact on BTHFT, how we provide our services and the way in which we conduct our business. The Trust is cognisant of this fact and is working closely with the LHE through the ICB and specifically with its local CCG commissioners to ensure that it has full input into service development. This input will allow the Trust to both ensure that the quality of service to patients optimised and the early identification and mitigation of business risks.

Integration – Example initiatives

As mentioned earlier in this section of the plan; a number of initiatives and service developments are already in place and will continue to deliver benefits over the coming years. For example;

Virtual Ward – BTHFT, along with LHE partners has developed the virtual ward as a mechanism to deliver intermediate care and reduce inappropriate hospital admissions. The virtual ward provides the means to bridge the gap between hospital and home, offering vertical integration between community, intermediate and acute care services. In the virtual ward a patient can remain at home and be visited by the relevant staff from BTHFT and partner organisations such as the local authority and local care Trust. This provides a joined up, holistic approach to care and helps to reduce avoidable admissions to hospital. In the event that patients have had to be admitted, the virtual ward can also be used to get patients home as fast and as successfully as possible.

To date, the Trust has been particularly successful using the virtual ward to enable early supported discharge in care of the elderly. The Trust has used teams of Occupational Therapists, Physiotherapists and Therapy Assistants based in the acute care setting to develop pathways that enable patients to transfer from an in- patient setting to a primary care setting (in the majority of cases their own homes). Once in this setting the patient is able to continue a period of rehabilitation and enablement at a similar level of intensity, delivered by the same staff with the same level of expertise , as they would have received in the in- patient setting.

This has enabled accelerated discharge from acute care for patients with a variety of conditions, saving considerable bed days. Re-admission rates for patients on ESD have also reduced by half. All patients improved functionally and some patients had a decrease in their care package due to being more independent with activities of daily living. The Trust integrated with other health, social and voluntary services to ensure that the patient's holistic needs were met and that they received a package of support that would keep them safe and inclusive in their environment.

In addition the Trust has successfully developed ESD for Trauma & Orthopaedics and aims to expand this to stroke patients from April 2014.

Other examples of integration work include the Urgent Care Programme.

Urgent Care Programme - This programme links in closely with the Integrated Care Programme, with one of the key goals also being to prevent avoidable admissions to hospital and to treat people closer to home. This programme is considering ways in which LHE partners can work together to reduce attendances at A&E or assessment facilities. Often, A&E attendance is not the most appropriate way in which to meet patient needs from a quality, patient experience and financial point of view. BTHFT has a busy A&E department with more than 130,000 attendances each year and as a result, Urgent Care is seen as a key priority for transformation and integration.

Key strategies for the LHE include:

- Providing better support for people to self-care
- Helping people with urgent care needs to get the right advice in the right place first time
- Providing highly responsive, simple to navigate, urgent care services to patients
- Ensuring those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery
- Connect all urgent and emergency care services together so the overall system becomes more than just the sum of its parts.

For BTHFT this means the opportunity to co-locate an Urgent Care Centre and develop the A&E to become a Major Emergency Care Centre (MECC). To prepare for this we have engaged the services of a team experienced in AED redesign to remodel the department in conjunction with the CCG with the added focus on Paediatric facilities reflecting the volume of paediatric attendances which are higher than some stand-alone Children's' Hospitals

Additionally the LHE has joined Cohort 5 of the Ambulatory Emergency Care Collaborative with the aim of significantly increasing the use of ambulatory pathways, reducing both assessment unit activity and overall acute admission rates.

Service Level Integration - There are further examples of integrated provision on a more specific service level. BTHFT and the Bradford CCGs hold a monthly Service Development Group meeting. The purpose of this group is to consider, and act as a conduit, for the further development of new service proposals. Increasingly this group is looking towards the transformation and integration of services. To this end, a range of multi-disciplinary teams (MDT) have been developed on a service level basis. These MDT arrangements reduce costs and greatly improve patient experience by providing services based around the needs of the patient often in a location that is more easily accessible. An example of this is the recently approved multi-disciplinary arrangement for Motor Neurone Disease (MND).

The neurological basis and complexity of MND means that it frequently affects a range of bodily functions and has a range of symptoms. As a result, patients often have to attend appointments with neurologists, gastroenterologists, respiratory specialists, physiotherapists, speech therapists, occupational therapists and palliative care teams. Prior to integration, patients had to travel to these appointments at different times to different locations and be dealt with by different providers. The creation of a MDT means that patients will now travel to one, more easily accessible, location once to receive care from a range of carers and care providers. This will greatly improve patient experience and increase quality as a more coherent and co-ordinated approach to treatment will be possible. It will also allow savings to be made in terms of clinical time and resources. The development of this service integration has involved input from BTHFT, the local care trust, the local authority and the charity sector.

Further work in 2014/15 is planned to include clinical transformation and integration programmes in relation to;

- Cardio vascular disease
- Diabetes
- Improving outcomes for older people
- Pain management
- Dermatology
- Gastroenterology
- Respiratory illness
- Musculoskeletal system complaints

Transformation

BTHFT is aware that it has a responsibility to internally review its services, assess the way in which they are provided, and look to transform delivery wherever possible. Consequently, it has developed a robust process to do this.

During 2013, BTHFT recognised that it would be appropriate to strengthen its resources with regard to service improvement and service development and appointed an experienced Head of Transformation. The Head of Transformation and the Trust's Transformation Team are charged with supporting teams to transform the way in which services are provided delivering improvements to the quality, safety and productivity by thinking and working differently. The Head of Transformation and the Service Improvement Team work closely with the BTHFT Planning department to ensure that opportunities to develop and transform services are identified at early stage. During the summer and autumn of 2013, the Trust developed and ran a series of strategy development days for each of its divisions. The purpose of these development days was to encourage clinicians, nurses and service management to identify and have input into the development of services based on key drivers and core principles. These service developments are to apply over the coming 2 year (operational) and 5 year (strategic) period.

The strategy development days were also attended by representatives of the local CCGs and patient. Broad commissioning intentions and the perceived health needs of the local community were discussed and factored into the service development process at each review day. The impending financial challenge and the subsequent need to deliver services in new transformational ways were highlighted as some of the key drivers to maintain operational and financial sustainability.

The output of this has been distilled into a series of Divisional planning templates and a range of both incremental and transformational service developments were identified.

The progress and delivery of these service developments will be overseen by the Trust's Programme Management Office (PMO). The PMO is responsible for monitoring and supporting the delivery of service developments. It assigns business partners to work with the relevant managers at the Trust and has the remit to focus sharply on outcomes and the delivery of benefits for patients. In this way it will ensure that proposed service transformations are delivered and are effective.

Transformation – Example service developments

The process described above has allowed the Trust to develop a range of service developments for the next two years aimed at transforming the way in which services are delivered. Examples include;

Seven day working – BTHFT is to ensure that 7 day working is introduced as we are committed to the principle of "equality of treatment or clinical outcome regardless of the day of the week." Seven day working will enable the Trust to provide increased access, improving patient experience and the quality of care.

The Trust has recognised the importance of 7 day working and throughout 2014/15 will assess service delivery models to find and provide the optimum delivery model for each appropriate service. We recognise that suitable 7 day working can be provided across a range of areas without necessarily providing all services at the same level. For example elective services will require different service delivery models than acute services as long as the overriding principle is that patients continue to flow through the system in a way that is effective to their needs and matches capacity to demand. The Trust

will develop 7 day working throughout 2014/15 and has agreed key outcomes as part of the CQUINs scheme. We have committed to ensure all emergency admissions are seen by a Consultant within 14 hours of admission by the end of Quarter 3 and it is also our intention to ensure that community therapy staff form part of integrated care clusters across Bradford. This will ensure that integrated care teams have access to therapists. We also have plans to develop a community based respiratory physiotherapy team which will allow patients to be managed at home and will reduce admissions.

Diabetes – in line with LHE aims to integrate and provide greater community based care, the Trust intends to establish consultant community clinics for diabetes during 2014/15. Diabetes education and treatment is a key priority area for our local commissioner partners. The creation of consultant community clinics will ensure that patients have increased access to services without having to travel into a centrally based hospital site thus providing improved patient experience.

Cardio-vascular – our work with our CCG partners will also help us achieve a number of service developments throughout 2014/15 in relation to cardio-vascular care (another key priority area for our commissioners). These developments are planned to include community based IV therapy, community based cardiology clinics, extended 7 days per week acute chest pain services and an expanded refractory angina clinic. Each of these developments will provide better access for our patients.

Elderly Care – as referred to above, the Trust will look to expand its virtual ward arrangements in 2014/15, particularly in relation to Elderly Care. Again, improving outcomes for older people is one of the key priorities for our local commissioner partners; consequently the Trust is planning build upon the success of our virtual ward initiative and expand its use to provide greater access to integrated step up/step down pathways. A virtual ward hub concept is also planned that will act as a central point for all referrals for intermediate care services, and will work with the referrer to determine the most appropriate care arrangement for the patient within the wider intermediate care infrastructure. This new hub arrangement will accept referrals 24 hours a day.

This expanded "hub" model will deliver a more streamlined, inclusive service which simplifies access to our service and extend the use of the virtual ward concept. This will ensure that optimum use is made of the model and that opportunities are taken to make best use of capacity through the prevention of unnecessary admissions or the optimisation of patient flow.

Continuing Care – The Trust plans to expand its Children's continuing care team by the summer of 2014. Improving outcomes for Children is another of our local commissioner partner's key priorities. The expansion of this team will allow the Trust to deliver care packages at home negating the need for children to be admitted to hospital away from their families. This will improve the care experience for the child and improve outcomes. It will also free operational capacity for the Trust, increasing productivity and efficiency.

Patient Flow & Urgent Care Pathways – Patient flow on urgent pathways can be improved to increase patient experience and provide service efficiencies. Through our work with the clinical teams supported by external expertise we have agreed a new model for Medicine which will introduce dedicated facilities for the management of patients on ambulatory pathways, fit for purpose assessment facilities and a new short stay medicine ward developed from the reconfiguration of all medical specialties. This will significantly improve the patient experience and deliver smooth flow across the Trust supporting sustainable good performance of the Emergency Care Standard.

Outpatient Facilities – the Trust is aware that it currently has a mixed economy of arrangements in relation to Outpatients. This includes;

- Inpatient wards delivering some Outpatient activity
- a significant number of speciality specific clinics with their own workforce often staffed from Inpatient wards
- the need to expand and improve some clinic environments
- high volumes of activity being undertaken on its Bradford Royal Infirmary (BRI) site. The BRI site holds the majority of the Trust's higher quality acute accommodation and it would be more appropriate to undertake acute work at BRI.

These factors do not contribute to good quality care from both an Outpatient and Inpatient point of view. They also mean that Outpatient services are not provided efficiently. Consequently, the Trust is to undertake a review to assess the most appropriate way of delivering outpatients services off the BRI site as we deliver a strategy of St Luke's being a cold site of outpatients, day case and diagnostics and BRI supporting acute work and inpatient activity.

In line with the Integration agenda, the Trust will also further explore the possibility of providing Outpatient clinics in the localities. Both of these steps will improve the quality of service provided to patients throughout the coming two to five year period.

Discharge – if BTHFT is to realise the potential benefits outlined by the Integrated Care Programme and the shift in the location of care provision it is essential that the Trust has effective discharge processes in place. As a result the Trust will be looking to transform the way in which it manages the discharge of patients. This will involve the mandating of Estimated date of discharge; maximisation of 7 day discharges and nurse led discharge; increasing the use of the Discharge Lounge with morning targets and extended opening times, early supported discharge schemes for the elderly making additional use of therapy services, orthopaedics and stroke and enhanced recovery for elective procedures.

Integration and Transformation - Improved use of technology and e-solutions

BTHFT is acutely aware that it will be necessary to make best use of IT via e-solutions if the integration and transformation challenge is to be met successfully. The Trust appointed a Director of Informatics in 2013 and tasked this officer with the development and delivery of a clear informatics strategy aimed at addressing the Trust's needs to support the provision of responsive, high quality and integrated care.

Consequently a Clinical Informatics Strategy Group has been formed and has embarked on a work programme to:

- fully consider the Trust's current IT provision
- assess the fitness for purpose of existing systems and processes
- define a comprehensive programme to enable the clinical agenda and
- identify priority areas for development and improvement

The Group has representation from clinicians and other staff responsible for the delivery of services. The strategy will identify and prioritise the Trust's information technology needs and develop a strategy to ensure that those are met. This planning work will be completed early in 2014/15. The clinical informatics strategy will define and focus the priorities for the next three to five years around an Electronic Patient Record (EPR). As the strategy is refined the Trust will continue to provide technology that makes care safer across all care settings and ensure our systems are current. The development of an information strategy will also support clinical areas in the achievement of their quality and performance plans.

The Trust has also made successful funding bid applications to progress this work. These applications will allow the Trust to develop a Real Time ADT information system, further scanning of medical records, and extension of clinical documentation in community-based midwifery. The Trust's quality and efficiency agenda will also be served through initiatives to further integrate patient records across the Bradford area, the provision of a safer chemotherapy prescribing solution and a more efficient access to a patient's information via a portal,

The Trust is mid-way through implementing a system to allow it to more effectively manage Admissions, Discharges and Transfers (ADT). This system will ensure that the Trust makes the most effective use of its capacity by ensuring that bed management data is more readily accessible and can be acted upon more promptly. This will improve patient flow and provide a better care experience for patients.

The Trust continues to ensure that patient records are readily available when needed both across the Trust and in an integrated care setting. Work with local primary care providers to electronically and instantly share consultation reports and discharge summaries will continue to enable the integrated care goal with an integrated care record. The creation of an EPR will be essential if integration is to be successful in providing quality care.

One of the most important informatics opportunities is in the provision of electronic prescribing. BTHFT has begun work in this area for chemotherapy. This work will be a major step forward in the EPR journey as it enables not only efficiencies in patient care, but intelligently protects patients from harm. Alongside this, we will be improving the way in which clinicians access important clinical information from disparate systems through implementation of a clinical portal. This portal will help ensure clinicians have all the needed information in one place.

Each of these projects will be advanced throughout 2014/15 and 2015/16 as part of the Trust's Clinical Informatics Strategy.

QIPP

In addition to the work on transformation highlighted above, the Trust has also recognised that it requires further support to identify additional opportunities to transform services. As a result it has utilised the national Quality, Innovation, Productivity and Prevention (QIPP) initiative to run alongside the strategy development days and Annual Planning process. The Trust has also commissioned an external consultant, KM&T, to provide support in identifying QIPP schemes.

Detail regarding the QIPP process is provided in the Productivity, Efficiency and CIPs section of this plan document. In summary however, the QIPP programme has 8 main categories:

1. Workforce Productivity
2. Clinical Service Productivity
3. Diagnostic Services
4. Procurement
5. Divisional Specific
6. Estates
7. Back-Office & Support Functions
8. Other

A series of QIPP meetings have been held with each Division, corporate function and executive directors at the Trust. QIPP schemes have been discussed and worked up at these meetings. Steps to be taken to implement these schemes are being identified.

In line with the transformation agenda above, each QIPP programme will be managed through the PMO supported by a matrix team including appropriate representation from human resources, finance, IT and communications. Each programme will have an Executive Director lead that will have accountability for delivery and to ensure engagement of relevant clinical staff and operational managers.

QIPP Examples

Further detail regarding the QIPP workstreams is provided in the relevant section of the plan. However, some examples of areas currently being evaluated are:

Surgical flow including Theatre productivity and outpatients - these projects will be aimed at increasing productivity and efficiency. Theatres and outpatient clinics are a key business driver for the Trust and it is essential that they are utilised effectively. The projects will be aimed at ensuring that appropriate booking rules are in place for each theatre session and clinic optimising utilisation and that DNAs and cancellations are minimised. . Greater utilisation will ensure that the Trust receives a greater return on its most expensive assets. However, better management of theatres and clinics will also ensure fewer cancellations and late appointments, improving patient experience. Working with patients we will review patient information from appointment letters to consent processes

PACU - The Trust will assess the opportunities to develop a Post Anaesthetic Care Unit (PACU). This will help the Trust to ring fence beds for Surgical HDU purposes helping to reduce the number of cancellations relating to elective surgical work and following on from the issue above, help to plan theatre time more effectively.

Early Supported Discharge – as mentioned above, the Trust is looking to build on the success of its Virtual Ward work and expand its use to support admission avoidance and early supported discharge. A key area for development in 2014/15 is in the Stroke Service.

Productivity review of the Community Hospital base – the Trust will undertake a review during 2014/15 of the way in which it uses its community hospitals. Methods of utilising these important assets and ways in which productivity can be improved will be assessed.

Introduction of dedicated daycase facilities – these will include Haematology/Oncology; surgical and medical. These will deliver significant productivity and efficiency benefits as well as an enhanced patient experience.

Quality Plans

As stated elsewhere in this Operational Plan, BTHFT is fully aware that all services must be delivered to the highest standard of quality and that the lessons of the Francis report must be acted upon.

BTHFT is committed to ensuring that our focus on maintaining and improving the quality of our services does not waver. In our Corporate Strategy "Together, Putting Patients First" we outline our vision and commitment to ensuring that our healthcare is consistently of the highest quality and responsive to the needs of our patients, their families and carers.

National and Local Quality Priorities

BTHFT has considered the lessons of the Francis, Keogh and Berwick reports and has taken steps to ensure that it responds effectively to their recommendations and the government's response. Obviously, the Francis report and the national priority on quality also directs and focuses local priorities. BTHFT works closely with its LHE partners. Local priorities with regard to quality echo the national focus and BTHFT is cognisant that CCG partners have the same expectations of high quality, safe services for the population of Bradford.

BTHFT has digested the findings of the Francis, Keogh and Berwick reports and has devised the following response.

Common Values - We are determined to embrace the detail and spirit of the Francis report and have set out to apply the values of the NHS Constitution in all our dealings with patients and the public. A culture that puts patients at the centre of care will start with the Board and cascade out to each ward and department and to all staff. The Trust has taken steps to ensure that our values are understood and owned by our staff by developing and issuing our new Corporate Strategy "Together, Putting Patients First". In this document we outline our commitment to the quality of care, delivered in a patient focussed way by empowered, skilled and valued staff.

The Trust has also outlined its intentions to engage with staff through open forums and listening events to understand local needs and imperatives. However, we will also ensure that staff are aware of their own professional obligations and will hold them to account for their duty of care. Through our work on Organisational Development, we will also initiate a programme of teaching and learning for all staff groups to promote a culture of compassionate caring and honesty.

Openness, Transparency and Candour - BTHFT also ensures that it promotes honesty, openness and truthfulness in all dealings with patients and the public and for all staff working in the Trust. These principles also apply to the organisation when dealing with commissioners and outside regulators. Processes are in place to ensure that we adhere to a duty of candour to inform patients and family where moderate or severe harm may have occurred in the Trust. The Trust 'Being Open' policy and other relevant policies will also be reviewed in the coming year to ensure that they reflect the requirements and spirit of the Francis report. Work in this area has already started; in March 2013, the Trust reviewed and strengthened its Raising Concerns policy and reissued it to staff.

We will also continue to remind all staff of their obligation to report adverse events through the standard incident reporting mechanism. Through our approach we will encourage all staff to have the confidence to report concerns. Indeed a culture of reporting is now embedded at the Trust

We will develop a value based approach to recruitment and will ensure that our values are consistently linked with our appraisal and performance management systems.

Public and Patient Engagement and Partnership – BTHFT will continue to ask for feedback on the delivery and quality of our services and then listen carefully to what our patients are telling us. We will provide formal and informal vehicles for timely feedback. We will strive to ensure that the learning from local surveys, the annual inpatient survey, and the Friends and Family Test will be embedded into our practice. We intend to include patient representation in all important planning decisions around care in the Trust. We will use our local 'Patients First' campaign as a focus for our activities. There will be a regular emphasis on the powerful learning derived from patient stories, from the Board through to specialty level. We will re-invigorate the PALS office and co-operate fully with Local Healthwatch. BTHFT is in the fortunate position of having an active membership of over 50,000, all of whom care passionately about the quality of services that we provide. We will ensure that we continue to engage with our membership to obtain their feedback.

Caring, Compassionate and Considerate Nursing – BTHFT has charged its Chief Nurse with ensuring that we deliver on all relevant aspects of the Francis Report recommendations. The Trust has set out to achieve this challenge through a range of interconnected work streams. The National Nursing & Midwifery Strategy "Compassion in Practice" draws together and aligns all aspects of the Francis report that are pertinent to nursing and midwifery. This strategy is forming the backdrop for a number of key areas of work across the Trust.

Care of our Elderly Patients – BTHFT is committed to continuing its existing work with regard to elderly patients with a named consultant and daily ward round culture already in place. We are also delivering widespread training and awareness in the care of patients with dementia. A project has been instigated to assess how our geriatricians can have greater input into the care of elderly patients in the surgical specialties. We will promote a new therapeutic partnership in care with the patient and family. This will build upon our successful, and nationally recognised, work on Dementia. In December 2013, BTHFT became the first hospital in England to be recognised by the Dementia Action Alliance for the work that it has done to improve the environment and care provided to patients with dementia.

As referred to earlier in this plan, out new integrated care models will allow the development of timely and efficient communications with primary care and the community around discharge planning.

Leadership and accountability - the Board of Directors of BTHFT will ensure that there are robust governance arrangements in place to ensure that the actions outlined above are implemented to agreed timescales and that any quality/safety of care issues are escalated promptly. The Board of Directors has also signed up to the "Standards for Members of Boards" issued by the Professional Standards Authority. The requirement for Directors to be fit and proper persons is, of course, included in the Foundation Trust's licence and in its Constitution. The Trust has also ensured, through its Council of Governor meetings and governance process that its Governors are fully engaged and informed with regard to the processes and actions in place for implementing the Francis report recommendations.

Effective management of complaints – BTHFT has a robust a system for the management of complaints. A key feature of this system is that it is clear, fair and open. We ensure that patients have straightforward ways to register a concern or complaint without fear of adverse consequences and we will support the complainant through the process. The Trust is committed to using appropriate staff as investigators as well as arms-length independent investigation providers where advised. The process is Board led and we will develop innovative means for institutional learning from complaints. An example of work already underway is the thematic analysis and reporting of complaints. This allows the Trust to analyse complaints and identify common themes. Wider reaching corrective action can then be taken providing the Trust with assurance that improvements in quality are being made across each division.

A summary of complaints is to be published on the website quarterly. In line with "Review of the NHS Complaints System: Putting Patients Back in the Picture" we will review how complaints are managed.

Public availability of all aspects of quality and safety information about the Trust – BTHFT will provide, in an open and public way, information on performance including outcomes, incidents, complaints and investigations. We will, as always, ensure that we are compliant with any request for information.

The commitments highlighted above provide a high level view of the Trust's response to Francis. To ensure that these commitments come to fruition, the Trust has created a formal Steering Group chaired by the Deputy Medical Director. This Steering Group has developed an action plan containing a series of detailed actions designed to ensure that the Trust's ambitions are met.

Each action has a clearly identified Executive Director lead and a named individual tasked with implementing the action. Implementation deadline dates are agreed and the required assurances needed to verify completion of each action are detailed. Progress against the action plan is monitored on a quarterly basis by the Medical Director's office. Risk rated progress reports will be provided to the Trust's Quality and Safety Committee (a committee of the Board of Directors) on a quarterly basis. It is also our intention to provide an annual report on the Trust's website to demonstrate to the public and our patients, the state of our compliance with the recommendations.

Quality Goals

In addition to our broader quality vision, ambitions and actions in relation to Francis, Keogh and Berwick, BTHFT also has a number of specific quality goals. These include aims to;

Improve engagement with patients and their families to improve patient experience

It is essential that the Trust reviews and improves its processes to obtain feedback from patients and carers in relation to quality and methods of service delivery, particularly with regard to the Friends and Family Test.

The Trust has put processes in place to ensure that it asks the Friends and Family question in all relevant cases. An external contractor has been appointed to manage the survey process.

The Friends and Family Test (FFT) has operated in all inpatient wards, maternity services and A&E since April 2013. Response rates across the Trust have steadily improved and the Trust has used innovative methods in areas such as A&E to do this. Specifically this has included giving A&E patients a token to post in a series of boxes each labelled with one of the defined FFT responses. Response rates are in excess of the national 20% target.

Results are reported on a quarterly basis to the Board of Directors. Net Promoter Score (NPS) targets have been set and wards are required to investigate if their NPS falls under the target (currently set at 60). Targets are being largely met. Patients are requested to add comments to their response. These comments are being used to make real improvements to services.

The Trust will continue, through 2014/15 and 2015/16, to canvass feedback from its patients using the Friends and Family test (as well as other sources of data) and act on their comments to improve quality. This includes the further roll out to outpatients and day cases.
The Trust also has a raft of other Patient Experience initiatives overseen by the Chief Nurse, these include:

- leaflets, communications and comments cards to be launched in 2014 under the "tell us what you think" banner. These are distributed across the Trust to patients, visitors and relatives and will replace existing PALS leaflets
- privacy and dignity surveys of the relatives of deceased patients to assess the perceived experience of the patient and the obtain the views of relatives, carers and friends of the patient
- information outreach services within selected outpatients sites
- pilots of extended and flexible visiting on a number of wards

- the development and implementation of a “patient stories” film project for presentation to clinicians. This will link in with the development of using patient stories at Board level and beyond to provide safety and improve patient experience and safety. This will ensure that those staff directly involved in delivering care receive feedback on their care experience from patients.

From April 2014, the Trust will roll out the FFT to all staff.

Continue to maintain and develop our clinical governance and risk management processes

It is vital, in times of significant change, that the Trust has robust processes in place to oversee the quality of care. The Trust undertakes to continue to review and develop its systems and processes of clinical governance at a specialty and divisional level. This will ensure that information is appropriately escalated through the governance structure so that effective remedial or improvement actions can be taken where necessary.

In addition the Trust has recently begun a review of its overall governance and risk management processes, appointing PwC to assist it in undertaking a review of our overarching governance structures. This work will help to ensure that the Board is sighted on all key quality indicators and risks and the effectiveness of any improvement actions taken.

Continually review and improve our standards of service

It is vital that the Trust continues to use its strategic planning and transformation/service development functions to facilitate the development and improvement of services. The latest planning round has identified a number of developments in relation to local commissioning priorities including*:*

- actions to improve Cardiology services through the improved use of community cardiology clinics, a second Cath lab and the use of telemedicine
- improvements to our diabetes service including the establishment of consultant community clinics for diabetes, a review of our diabetes unit including a reconfiguration of our estate and inpatient bed base and our roll out of the national “Think Glucose” campaign
- actions to improve the provision of respiratory beds to meet the needs of the local population. This will include 2 Respiratory assessment beds and dedicated Non-Invasive Ventilation (NIV) beds
- an increased pharmacist input to patients and clinicians on wards through increased pharmacist time with clinicians and enhanced support from ward based pharmacy technicians
- a commitment to review the Trust’s dietetic service with a view to the development of a next stage food and nutrition care strategy. Good nutrition has an enormous impact on the health and wellbeing of patients and is a crucial factor in their timely recovery. The Trust will also embark on work to ensure that appropriate nutrition pathways are developed with regard to virtual ward, early supported discharge and intermediate care beds
- the implementation of an extended gastroenterology service leading to a streamlined consultant lead service with flexible capacity to meet demand

Continued Commitment to Research

The Trust has an excellent reputation with regard to its research work and is keen to build upon the ongoing success of the Bradford Institute of Health Research (BIHR). The most significant enhancement in this area in the coming two year period will be the establishment of the AHSN Improvement Academy. This involves a significant capital build and investment in staff which will be funded by research grants and commercial trial income.

The development of the improvement academy will ensure that the Trust remains at the forefront of innovation and research aimed at improving outcomes and the quality of care.

Continue to develop the role of Advanced Clinical Practitioners

BTHFT has a long established process via its Advancing Practice Group to develop advanced practice skills across the Trust. As a result the Trust has been able to increase the use of Advanced Nurse Practitioners or Advanced Clinical Practitioners. In some areas these staff have been able to serve entire care pathways using their diagnostic and prescribing skills. The Trust therefore has a firm understanding and conviction of the benefits these staff bring to patient experience and clinical care.

The Trust has also recognised the need to further develop the roles of ANP/ACPs due to:

- national and local increases in urgent care referrals to secondary care
- changes in models of delivery such as the virtual ward and the reconfiguration of services to deliver services closer to home
- a greater appreciation of integrated ambulatory pathways and shared care delivery to allow a reduction in the hospital length of stay
- advantages relating to retention of staff and career development

As a result the Trust recently submitted a bid to Health Education Yorkshire and Humber and was awarded funding for an additional cohort of 10 Advanced Clinical Practitioners.

The Trust now intends to utilise these ACPs across the Trust to deliver care in more efficient and effective ways and to help deliver the integration and transformation agenda

Continue to meet the Quality Indicators in our contracts thus meeting the quality priorities of our commissioners

The Trust has an excellent record of meeting the quality indicator targets within our contracts especially in relation to national and local targets including;

National

- Emergency Care Standard
- Cancer Access targets
- HCAI targets

Local

- Stroke strategy targets
- Pregnant women seeing a midwife before 12 weeks and 6 days of pregnancy
- Elective care operation cancellation targets
- Safeguarding and mental capacity

We will ensure that we continue to robustly monitor our performance against these targets through our Performance Management framework and take effective remedial action wherever appropriate.

Share Best Practice

The Trust has close working relationships with other providers across West Yorkshire and beyond, attending a number of discipline specific regional groups. Consequently we are able to discuss new approaches to delivering healthcare and share best practice. Such groups include Regional Directors of Pharmacy, Yorkshire Cancer Network, Regional Neonatal Network and Regional Heads of Midwifery group. The Trust will continue to attend these groups throughout 2014/15 and 2015/16 to share best practice to assist in the continual improvement of services.

Continue to meet Quality Account and CQUIN targets

A number of our quality objectives will also be defined through the Quality Account and CQUIN process.

The Trust has robust processes to engage governors, patients, staff and the public in identifying appropriate improvement indicators for inclusion in the Quality Account. A range of membership/patient engagement activities have been undertaken in the first part of 2014. These exercises have been used to seek feedback and evidence of sustained improvements on existing indicators and to consult on the development of indicators of 2014/15. These have included mailing the Foundation Trust's membership and inclusion of a survey in the February edition of our membership magazine "Focus". Staff have been surveyed via the Trust's intranet; likewise the opinions of the general public have been obtained through a survey on the Trust's website.

The selection of indicators by the Governors is also based on an analytical review of themes and areas of concern arising from the past 12 months. Sources of information include:

- CQC inspection reports
- CQC intelligence monitoring reports
- the recommendations of the Francis report
- complaints and PALS reports
- incident reports
- national and local patient surveys
- HM Coroner's inquest reports
- Healthwatch reports
- staff surveys
- Patient Lead Assessment of the Care Environment (PLACE) reports

The indicators are developed so that clinical teams, staff in general, commissioners and the public can access performance information on quality and patient experience that is most relevant and useful to them.

Specific indicators for 2014/15 are:

- Management of Diabetes in the Acute environment.

  This indicator will be reviewed from a clinical effectiveness and patient safety point of view. Safe diabetes care is a Trust wide priority as part of our SAFE campaign. Diabetes is also a significant health issue in Bradford and a stated priority for our CCG partners. The Trust will seek to ensure that the way in which we manage diabetes in our patients minimises the risk of avoidable complications, that there is no avoidable harm resulting from inpatient stay and that patients have a positive experience.

- Meal time experience

  This is an issue that has links to the recent CQC report. Governors are concerned that there is a lack of consistency around the protection of meal times across the Trust and variability in patient experience as a result. It is essential that mealtimes are protected if patients are to receive proper nutrition and hydration to aid their prompt recovery. Indicators will therefore be aimed at ensuring that the mealtimes are protected

- Communication with patients for whom English is not their first language.

  This is an issue that has links to the recent CQC report. Communication is, of course, a key issue in terms of quality and patient experience, especially in Bradford where almost 30% of the population are of BME origin.

With regard to CQUINs, the Trust has agreed a number of national and local indicators. These include CQUINs on:

- Friends and Family Test
- Safety Thermometer
- Dementia and Delirium
- Ambulatory Care Services
- Seven Day working
- Integrated Care
- Electronic discharge information
- Liaison Psychiatry
- Diabetes

The Trust has robust arrangements in place through performance reporting and internal audit processes to manage compliance with these indicators and provides regular reports to CCG partners throughout the year. Robust internal processes are in place through the joint Contract Monitoring Board and Performance Group meetings held with commissioners.

Target continued investment into our Estate

The Trust will ensure that our accommodation is conducive to the efficient delivery of quality healthcare. Inadequate or inappropriate accommodation is recognised as a threat to quality by the Trust. Steps to address this risk are detailed in the risk section below.

Existing Quality Concerns

BTHFT is committed to the consistent delivery of safe, high quality services to all of our patients. Given this commitment, it was particularly disappointing to receive an adverse report from the Care Quality Commission (CQC) resulting in the receipt of a warning notice in December 2013.

Whilst the report received from the CQC did highlight many areas of good practice it did identify that action was needed against 4 of the 6 standards inspected. BTHFT senior management has taken the content of this report extremely seriously and has developed a robust action plan and assurance process to ensure that the concerns highlighted by the CQC are rectified as soon as possible. The Trust has also worked closely with CCG partners and local Health Watch to explain the issues raised by the CQC, the extent to which these may have impacted on care and provide detail on the proposed remedial actions and their timescales.

BTHFT quickly investigated and accepted the findings of the CQC and has acted promptly to resolve the issues raised. A summary of actions taken includes:

- triage in A&E is now undertaken in private rooms. The Trust's Estates department in conjunction with the AED clinical team is also reviewing the layout of A&E to provide greater privacy and flow
- the Trust is to reiterate and reinforce existing policies in relation to protected mealtimes and hand hygiene.
- a series of action plans and workstreams are underway to improve staff communication with patients for whom English is not their first language and to ensure that staff interact with patients more compassionately
- the Trust has launched a "Personal Responsibility Framework" for all staff across the Trust. There are also a number of "Compassion in Practice" workstreams ongoing to reinforce Trust values and culture. Performance against these standards is also to be included in staff appraisals.
- there have been formal interactions with staff at a personal and team level to reiterate the need to completely and correctly complete the relevant nursing documentation. Instruction on how to do this has also been provided.
- a project to review and where possible streamline nursing documentation to make it more user friendly has also begun.
- actions have been undertaken to improve, monitor and report nurse and medical staffing levels. In

addition to this the BTHFT will undertake a formal review of nurse staffing levels three times per year using the "Safer Nursing Care Toolkit". Board members were greatly concerned with the findings in relation to staffing and have put processes in place to ensure that in future any concerns regarding staffing levels are escalated to them quickly.

Addressing CQC Quality Concerns

The broad remedial actions to be taken by BTHFT in relation to the CQC report are detailed above.

However, BTHFT is acutely aware that robust governance processes will need to be in place to ensure that these actions are implemented and are effective. Consequently, the Trust has devised a programme of unannounced internal inspections to assess whether these actions are being implemented and have been effective. The results of these inspections will be monitored by the CQC Steering Group, chaired by the Chief Nurse. Regular reports on progress made will be provided to the Trust's Quality and Safety Committee and the Board of Directors. BTHFT will ensure that the actions required by CQC in their warning notice are taken and are effective.

BTHFT is committed to ensuring that improvements to quality are sustained and has developed robust quality governance processes as a result (see below). Allied to these governance processes is the development of a new Board Assurance Framework.

These actions have also been fed into the Trust's Annual planning process to ensure that the lessons learned from the CQC visit translate into each division's operational plans to ensure Trust wide application across each service.

Quality Governance and the Board Assurance Framework

As highlighted earlier in this document; quality and safety are key drivers in Trust strategy and form a major part of the Trust's strategy document "Together, putting patients first". As a result, the BTHFT Board has mechanisms in place to generate assurance regarding the quality of care provided. This process is in line with guidance on the Quality Governance Framework.

The quality governance process is overseen by the Trust's Quality and Safety Committee, a committee of the Board of Directors. The main purpose of this Committee is to provide detailed scrutiny of the Trust's arrangements for the management and development of quality and safety in order to provide assurance and, if necessary, raise concerns or make recommendations to the Board of Directors.

The Committee is chaired by a Non-Executive Director and has two other Non-Executive Directors as members. A number of Executive Directors including the Chief Executive, Medical Director, Chief Nurse and Chief Operating Officer are in attendance. Other attendees are the Deputy Chief Nurse, Director of HR, Director of Informatics, Director of Education and Director of Research.

The Committee meets on a monthly basis and members are required to attend at least 75% of meetings in any year. The number of members and attendees to ensure quoracy is 10; this is a relatively high figure and reflects the degree of focus and importance assigned to quality and safety.

The Quality and Safety Committee oversees the work of a range of reporting committees which have approved terms of reference, complete defined work-streams and provide regular reports. These reporting committees include the Clinical Effectiveness Committee, Risk Management Steering Group, Education Committee, Health Informatics Committee, Patient Experience Committee, Workforce Planning and the Research, Translation and Innovation Committee.

Through these committees, the Quality and Safety Committee reviews all aspects of quality and safety within the Foundation Trust through examination of:

- Serious Incidents
- Infection Prevention and Control reports
- Patient Experience reports

- Risk Management reports
- CQC Steering Group reports relating to surveillance and intelligence gathering
- National reviews and inquiries which involve systems failure.

The Committee also plays a lead role in:

- Developing a strategy for quality and safety in the Foundation Trust;
- Contributing to the development of the Foundation Trust's Quality Account; and
- Informing the development of the corporate objectives and priorities for inclusion in divisional annual plans

A key reporting committee to the Quality and Safety Committee is the Risk Management Steering Group. This Group meets regularly and is chaired by the Deputy Medical Director. It has representation from disciplines across the Trust and oversees work in relation to COSHH, Decontamination, Health and Safety, Medicines Management, Medical Devices, Health Records and Safeguarding.

It also receives reports from, and oversees the work of, Divisional risk management groups.

The Quality and Safety Committee also receives regular reports from the Trust's CQC Steering Group. The CQC Steering Group is charged with ensuring that the Trust continues to meet CQC requirements. It does this by monitoring and responding to the data used by the CQC to generate its intelligence reports and by overseeing a programme of mock CQC inspections.

The majority of the indicators considered by the CQC when compiling its surveillance and intelligence reports are generated from the Dr Foster database. The Trust also has access to this database and the CQC Steering Group has robust processes in place to review our own data as it is generated by Dr Foster. This allows the Steering Group to highlight potential quality and CQC compliance issues and develop action plans immediately. Consequently, the Trust is able to ensure that proactive corrective steps are in place prior to receiving any CQC intelligence or surveillance report. Issues raised and actions taken are reported to the Quality and Safety Group.

The CQC Steering Group also oversees a programme of mock CQC inspections. This programme is risk based and involves a rolling schedule of inspections across a range of Trust areas to assess compliance with CQC requirements. Inspections are carried out by senior nursing staff and the results reported to the areas inspected. The CQC oversees the delivery of the rolling programme. Given the recent CQC warning notice and report received by the Trust it has been necessary for the Trust to reconsider the robustness of this mock inspection process. The CQC Steering Group is therefore reviewing the mock inspection process and will look to improve the rigour of the inspections and the reporting process to ensure that potential issues are identified, disseminated appropriately and effectively dealt with.

The Quality Governance Framework in place at the Trust is designed to ensure that emerging risks are identified and appropriate remedial actions are taken. However, following the recent CQC report and warning notice, the Trust has taken prompt action to reconsider and, where appropriate, revise its governance arrangements. To this end, the Trust appointed PwC to undertake a review of our governance arrangements and suggest improvements. The Trust is also taking steps, and receiving advice from PwC, to develop a robust Board Assurance Framework (BAF). This BAF will be put in place in early 2014/15 and will provide additional assurance that the Board is sighted on all key risks and the effectiveness of the actions taken to mitigate those risks. In this way the Trust can continue to ensure that its patients are provided with treatment that is safe and is of the highest quality.

Risks to Quality

The Trust's governance processes with regard to quality are designed to highlight and deal with emerging risks.

CQC actions

One of the most immediate concerns at the Trust is to ensure that the lapses in quality highlighted by the

recent CQC inspection are addressed and that improvements are sustained. Consequently the Trust has identified a number of remedial work-streams and actions aimed at delivering improving working practices. A series of mock inspections is then to be undertaken across the Trust to ensure that these actions remain embedded and effective. The outcomes of inspections will be reported to the Trust's Quality and Safety Committee (a sub-committee of the Board).

Staffing

One of the key elements of the CQC report was staffing. Ensuring correct staffing levels and skill mix is obviously a fundamental to ensuring high quality care. As outlined above in response to the recent CQC report, the Trust is committed to ensuring that staffing levels are safe and that the skill mix is appropriate. Consequently, the Trust has taken steps to review staffing levels and, where appropriate, recruit additional nursing and clinical staff. It is the Trust's intention to regularly review staffing levels across its hospitals. With regard to nursing, the Trust will do this three times per year using the "safer nursing tool". Regular reviews will also take place with regard to clinicians.

Estate

The Trust is aware that it is essential that there are suitable premises and accommodation for clinical care. We have accepted that some our accommodation is no longer ideal for the provision of modern care. Consequently, we are in the process of developing an Estates Strategy. This strategy is being developed jointly with clinical managers and staff. By taking account of, and stratifying clinical priorities in each division, the estates strategy links in with the overall service development and planning process and the Trust's clinical strategy.

A major part of this strategy will be the delivery of a new ward block and accessible entrance. Planning permission for this ward block has been received and the final design phase is in the process of being signed off. It is the Trust's intention for the final business case to be put before the Board for approval and sign off in quarter 3 of 2014/15.

Facilities have been planned with local commissioners and the public of Bradford. The ward block will provide two new wards for Paediatrics and General Medicine. The accessible entrance will also provide a number of retail and catering facilities for patients and their families.

The de-cant space created by the new ward block will act as an enabler for wider reconfiguration and refurbishment plans across the Trust. Our ward refurbishment programme is wide ranging and will allow the Trust to provide modern, spacious patient care environments improving privacy, dignity and patient experience in general.

As part of our Estates strategy, we are also embarking on a process of moving all non-clinical activity out of clinical accommodation. This will mean that all back office functions will take place on the periphery of our main site, providing more space and flexibility for the delivery of clinical activity. To do this the Trust has been able to utilise and redevelop Daisy Bank; a building at the edge of the Bradford Royal Infirmary (BRI) site. A number of back office functions will de-cant to this site freeing more appropriate space for clinical activity. Likewise the Trust has embarked on a major project to centralise patient booking and administration processes on the St Luke's Hospital site, again freeing up space to be used for clinical accommodation at BRI.

Work will also be undertaken during 2014/15 to assess the way in which our wards and departments are configured and whether care pathways can be made more efficient and quality improved by co-locating certain departments and functions.

As mentioned above, in relation to the CQC report, work is to be undertaken to improve the layout of A&E to ensure greater privacy and dignity.

The work on the estates strategy also identified a number of other specific projects that will be considered as immediate priorities in the next two years. These include;

- Daycase facilities
- remodelling our estate in relation to A&E/urgent care including the development of a dedicated paediatric facility
- Completion of the Endoscopy project
- Acute Medicine Model including ambulatory care facilities
- Improving and expanding macular facilities in ophthalmology
- Development of a Hybrid Theatre to support Vascular centralisation
- reconfiguring our surgical assessment facility to improve patient flow

Each of the priorities above will enhance the quality of the services we provide, improve patient experience and allow services to be provided more efficiently.

Informatics

BTHFT recognises that, in some areas, our use of information technology to enhance patient care could be improved. The Trust appointed a Director of Informatics in 2013 and tasked her with the development and delivery of a clear clinical information strategy aimed at addressing the Trust's needs to support the provision of responsive, high quality and integrated care. The Trust's Clinical Informatics Strategic Planning Project commenced in March 2014. The project has representation from clinicians and other staff responsible for the delivery of services. The project will identify and prioritise the Trust's clinical information technology needs and develop a strategy to ensure that those are met. As part of this strategy the Trust has a number of developments in train. Each of these will improve quality and are detailed earlier in this plan. They include;

- Real Time Admission, Discharge and Transfer - to allow the Trust to more effectively manage Admissions, Discharges and Transfers. Through this system, the Trust will make the most effective use of its capacity
- Electronic records – ensure that patient records are readily available when needed both across the Trust and in an integrated care setting
- Antenatal electronic documentation – extension of online documentation to community-based midwives to ensure clinical information is availability immediately anytime, anywhere
- Integrated Digital Care Record – working with our local health and social services partners to develop one record across the region.
- ePrescribing for chemotherapy – to take advantage of technology intelligence to for safer prescribing
- Clinical Portal – to create a view to more easily see a patient's information from disparate systems.

Finance

Clearly, the need to find ever increasing efficiencies in models of care can present a risk to quality. However, the Trust is determined that this will not be the case and will address this risk in two ways.

As highlighted earlier in this document, the Trust is committed to the Integrated Care Programme developed with its LHE partners. One of the key drivers of this programme is quality, its purpose is to improve patient focus and improve the ways in which care is provided. Delivery of the Integrated Care Programme will therefore ensure the delivery of patient focused, quality care whilst providing value to the Trust and its commissioners.

Internally, the Trust has robust risk assessment processes in place to review and consider any service transformation, improvement or change as part of its CIP programme. As part of these processes each proposed CIP or service improvement must be subject to a formal quality impact risk assessment and signed off by the Medical Director and Chief Nurse. Failure to gain sign off by either the Medical Director or Chief Nurse means that the proposed change to the service cannot go ahead in its proposed format.

Workforce

Ensuring correct staffing levels and skill mix is obviously a fundamental to ensuring high quality care. Workforce planning is therefore integral to the Trust's planning process which requires divisions and departments to identify potential changes in workforce needs as a result of proposed service developments, age profiles and service specifications. This is particularly important given the fundamental changes to be brought about by transformation and integration. To this end the Trust has made changes to the management of its recruitment processes. The Trust is now adopting a less devolved and more corporate or centralised approach to recruitment. This will enable the Trust to more readily see the wider picture regarding its workforce planning and corporate recruitment needs.

Indeed, the Trust is fully aware that it must ensure that retention and recruitment strategies are in place for key roles and that these must be allied to robust succession planning to ensure that the Trust is adequately staffed to ensure high quality service delivery. In particular the Trust has identified a range of "difficult to recruit to" posts and has put in place a range of actions to meet this staffing shortfall including looking to recruit internationally.

Other examples of staffing issues identified during the latest planning round include;

- the need to reassess staffing requirements and workforce configuration as a result of the proposed move to 7 day working for example
    - an increased need for Therapists and assistants in Therapy Services
    - a need to reconsider and rationalise the roles and structure of the pharmacy department in relation to the provision of ward based pharmacy technicians and 7 day operation

- a requirement to consider and reconfigure the roles of dieticians to ensure that appropriate nutrition pathways are developed for patients and an integrated care environment
- a need to develop a 5 year workforce plan in A&E alongside an innovative and comprehensive recruitment strategy. This will ensure that A&E is adequately staffed at all levels and at all times of the day.
- a review of staffing provision in cardiology with a view to funding a third interventional cardiologist and a second imaging cardiologist.

As detailed above, in response to the CQC report, the Trust also undertakes to continually review nurse and medical staffing levels across the Trust on a regular basis, taking remedial action wherever necessary.

The Trust will also undertake to continue to improve staff skills and standards of care through Organisation Development

Organisation Development (OD) can be described as the practice of planned intervention in order to bring about significant improvements in organisational effectiveness. It is a whole system approach aimed at enabling an organisation to continually improve and mature. The Trust recognises that it needs to continually reflect, learn and improve in order to adapt to its challenges and has recently undertaken an organisation development (OD) diagnostic to review what it needs to do in order to help facilitate change in culture, staff values and behaviour.

The OD work to be delivered will be wide ranging and will cover the need to;

- revisit the Trust's corporate strategy to ensure that there is clarity on corporate strategic aims and corporate objectives
- develop a performance development framework to translate organisational performance requirements into individual performance reviews
- build on, and further develop, values in action and work ongoing on core behaviours and the 6Cs work on compassionate care
- through the personal responsibility framework ensure that staff sign up to living the values
- review communication and staff involvement

This OD priorities will be implemented throughout 2014/15 along with the development of a longer term plan.

Quality and Safety Investment Fund

As stated earlier in this plan; BTHFT is committed to ensuring that our focus on maintaining and improving the quality of our services does not waver. Our quality goals and the perceived risks to quality are set out in this document. We have also outlined our robust processes to ensure that the Board has assurance that risks to quality are being identified and mitigated. Whilst the Trust is confident is these processes it is prudent to set aside a quality and safety reserve.

The level of financial efficiency required in the annual financial plan has allowed for the creation of a £1m quality and safety reserve. It is likely that this will be invested mostly in additional nursing and medical posts in 2014/15.

Operational Requirements and Capacity

Assessing Demand and Capacity

The Trust has taken robust steps to assess activity and demand pressures and ensure that there is adequate capacity to meet those pressures. These steps include;

Service Level Planning

The Trust has undertaken a great deal of work in relation to service level planning. As a result of this work, the Trust has introduced a series of systems and processes to allow it to assess whether services are effective and efficient. Consequently the Trust is able to assess whether individual services are utilising their capacity effectively and make adjustments to service delivery to provide those services more efficiently. This work will continue to be refined and used as a key management tool throughout 2014/15.

Capacity and Bed modelling – commissioned work

As well as undertaking our own internal analysis of capacity and predicted activity levels through a review of our past performance and current contracting negotiations we have also commissioned work from NHS IMAS. NHS IMAS are currently assisting the Trust in rolling out a standardised approach to demand and capacity modelling for elective services across its main sites.

This model has been developed by the Trust in conjunction with NHS IMAS and is designed to assist the Trust in understanding;

- our demand
- variations in demand in each specialty and where possible sub specialty
- the core capacity that we genuinely have available to treat patients
- the ad hoc/flexible capacity that we access and the degree of reliance placed upon it
- the capacity that we need to meet demand and sustainably deliver nationally and locally agreed waiting time standards

This modelling exercise was undertaken across each division and each specialty. It involved Clinical Directors, Lead Consultants, Divisional General Managers, Service Managers, Booking/Admin staff and the Trust's informatics department.

The modelling exercise was undertaken throughout the period November to February. Full and final results are still being developed. The results of this exercise will be used to inform the Trust's longer term strategic plans.

Capacity and Bed modelling – internal processes

In addition to the external project highlighted above, the Trust has undertaken its own work to model demand and capacity and react accordingly.

The Trust has reviewed activity levels over the past two years and compared these to the forecasted outturn for 2014/15. Alongside this, the Trust has also worked very closely with its CCG and LHE partners to review and assess forthcoming commissioning intentions. Contract negotiations for 2014/15 in particular have been very useful in this process. The outcome of this work has ensured that the Trust has a clear picture of the demand for its services for 2014/15, although the integration agenda makes this less certain for 2015/16.

Owing to our work and close relationship with our CCG and LHE partners we have been able to identify and define the inputs required to meet the demand for our services. For example we have assessed:

Physical Capacity

Following on from the work highlighted above, as well ongoing processes throughout the year to review and assess the quality of our services; the Trust has taken steps to ensure that we have adequate physical capacity to meet the needs of our patients and commissioners. For example the Trust is initiating a programme, which will come to fruition in 2014/15 and 2015/16, to increase clinical accommodation. The programme is designed to identify and remove all administrative or "office" accommodation from clinical areas and move it to the periphery of the site.

The Trust also recognises that in order to meet the needs of its patients and commissioners and meet the increasing financial challenge it will need to make the best use of its physical capacity and estate going forward. As a result we are in the process of developing a new 5 year Estates Strategy.

The development process for this strategy follows on from the process to develop divisional clinical strategies described earlier in this plan. As a result the Trust is ensuring that physical capacity and estate provision are aligned to divisional service delivery requirements.

The strategy is also aimed at improving the efficiency and quality of services and will make the most of our physical capacity by ensuring optimum ward configuration and appropriate service and departmental co-location. To support this we have commissioned a comprehensive bed modelling tool.

Workforce Requirements

The Trust has recognised that workforce planning is integral to its annual planning process. This process requires that divisions and departments, working alongside the Planning function, the Chief Operating Officer's office, Finance and Human Resources, identifying staffing requirements to meet the identified demand for services. The need to meet this demand efficiently and safely is also factored into this assessment.

Consequently, a workforce plan has been developed that includes and addresses workforce implications resulting from planned service changes and developments. The impact of efficiencies resulting from the work to improve physical capacity is also considered.

Key areas of change include:

- increase of consultants in A&E
- reduction in administrative staff due to the centralisation of appointment booking
- the need to reassess staffing requirements and workforce configuration as a result of the proposed move to 7 day working
- significant improvements the effectiveness of staffing due to the continued development and use of e-rostering

Additional Inputs

The Trusts internal processes have highlighted a number of instances where the need to increase or amend capacity has engendered a number of other work-streams and developments. The Trust is acting promptly on these needs and is developing expanded services. Examples of which are provided below:

Virtual Ward

In order to ease demand on capacity by preventing admissions and, where admissions were unavoidable, improving patient throughput; the Trust is putting considerable effort into continuing to develop the virtual ward.

The current Virtual Ward team consists of a Consultant, Advanced Nurse Practitioners (ANPs), qualified and unqualified nursing and care support, and Therapists. The service provides home-based Multidisciplinary care. The service at present is centred on the following pathways:

- Frail Elderly
- COPD
- OHPAT
- DVT

The Trust also currently has a Therapy Elderly Early Supported Discharge (ESD) Service; this operates as a 'step down' focussed service. The purpose of the ESD service is to provide patients with a level and intensity of rehabilitation, by the same Therapists and staff, in their own home comparable to that they would have received in hospital. This enables safe earlier discharge from hospital environments, and helps to prevent readmissions by facilitating effective discharges and ensuring patients are supported adequately at home. Thus freeing up capacity and reducing acute demand.

The Trust has recognised an opportunity to improve and expand this service by creating a virtual ward hub. Currently the service for the virtual ward, ESD and wider intermediate care services in Bradford is fragmented and it is recognised that use of the concept is not optimised.

The virtual ward hub will act as a central point for all referrals for intermediate care services, and will work with the referrer to determine the most appropriate care arrangement for the patient within the wider intermediate care infrastructure. The new hub arrangements will accept referrals 24 hours per day.

The virtual ward team will continue to consist of medical, nursing, therapy, social care and support staff, and will be supported by access to diagnostic test facilities. It will still function as a single team delivering multidisciplinary care to patients with complex health and social care needs. However, the "hub" model will deliver a more streamlined, inclusive service which is simplifies access to intermediate tier services in Bradford and extend the use of the virtual ward concept. This will ensure that optimum use is made of the model and that opportunities are taken to make best use of capacity through the prevention of unnecessary admissions or the optimisation of patient flow.

As mentioned earlier in this document, the Trust and its LHE partners will look to use and expand the virtual ward initiative through more pathways in 2014/15 in:

- Elderly Care
- Oncology
- Haematology
- Palliative Care
- Stroke

Cardiac Catheterisation Laboratory (Cath Lab) & Expansion of MRI/CT Capacity

It was apparent to the Trust that current facilities and equipment in the Catheterisation Laboratory (Cath Lab) were restricting capacity and hindering the Trust's ability to meet demand.

The Cath Lab is a multidisciplinary facility run by medical staff, nurses, radiographers and cardiac technicians. It is currently located in the radiology department of the Bradford Royal Infirmary and is an operating theatre type room with an x-ray camera where cardiac catheterisation is mainly performed. This procedure is a way of obtaining detailed cardiac information by inserting small catheters into arteries or veins.

It was apparent from our review of capacity that the Trust was losing ground in its ability to meet demand. Further investigation identified that this was as a result of failing equipment and facilities that did not provide enough room to manage the efficient throughput of patients.

Consequently, the Trust is to embark in a project, to be delivered throughout 2014/15, to build a new Cath Lab. This build will be co-located to the relevant ward at the Trust and will also incorporate a day-case unit to improve efficiency and patient flow.

This facility will ensure that the Trust has adequate capacity to meet existing and projected demand. It will also allow the Trust to generate additional income through the repatriation of activity from neighbouring Trusts.

In addition to this, the Trust also has plans to facilitate improved performance against access targets and earlier appropriate discharge. The Trust has plans to invest £1.2m in increased imaging capacity including increased availability at weekends.

Diabetic Retinopathy Imaging Virtual Evaluation (DRIVE)

Diabetic Retinopathy (DR) is one of the most common causes of blindness in the UK. Bradford has a unique social economic and ethnic mix of population that leads to a higher incidence of diabetes and sight threatening retinopathy than other areas of the UK. Indeed, the local district has a diabetic population of around 32,000 patients all of whom are at risk of developing DR.

Given the prevalence of diabetes in Bradford its effective treatment is also a key commissioning objective of our CCG partners.

The Trust, though its work to model capacity and demand, identified a significant capacity gap within its Ophthalmology department in relation to DR and is therefore taking steps to address this imbalance.

Whilst the Trust has appointed an additional consultant we have also looked to innovate and create new ways of working through the development and use of DRIVE clinics. In a DRIVE clinic, data and retinal images are captured electronically by technicians and are reviewed in a separate 'linked' session by a trained clinician and the results conveyed to the patient and GP. This is a much more efficient way of working.

The Trust is therefore putting in place 4 DRIVE clinics (and associated "link" clinics per week) providing additional capacity of over 5,200 patients per year. The use of DRIVE clinics will also free up consultant time to follow up other patients.

Neo Natal Unit Expansion

The Trust has recognised that its Neo Natal Unit does not have sufficient capacity to meet the needs of the local population. This has meant that many neo natal intensive care cases cannot be treated by the Trust and have to be transferred to other locations.

Whilst this represents lost income for the Trust, more importantly it has also meant a sub-optimal experience for families as they do not receive care close to home.

Consequently the Trust has identified the need to expand the unit to become a full Network Neo Natal Intensive Care Unit. Previously, the unit comprised of 5 intensive care cots, 5 high dependency cots and 17 low dependency (or special care) cots.

A project is being undertaken to expand the unit to provide additional capacity. This work has involved the building of an expanded unit and the addition of 2 intensive care cots and associated staffing. The Trust is also appointing an additional consultant and more outpatient clinics as a result.

Phase 2 of this expansion is to open a further 2 intensive care cots. Consequently, the Trust is taking effective action to redress and identified capacity need and more babies born to Bradford families can now be treated closer to home in Bradford.

In addition to the above, the annual financial plan includes £950k of further investment in medical and nursing posts to NHS England's derogation requirements in relation to neo natal care.

Gastroenterology/Endoscopy Unit

The Trust's work to review capacity and demand had also identified that its Gastroenterology/Endoscopy unit was unable to meet demand in activity and had been reliant upon other providers to assist in the delivery of the contract. The Trust also forecasted considerable growth in endoscopy over the next 5 years.

As a result the Trust has recognised that a significant increase in endoscopy capacity is needed to meet service demand going forward. The Trust will therefore undertake an ambitious capital project over the next two years to expand its Gastroenterology facilities. This will involve the conversion and expansion of an existing ward to create an expanded Gastroenterology suite providing almost double the existing procedure rooms.

This will provide additional capacity to meet existing demand, as well as providing the ability to flex capacity and provide a considerable degree of future proofing. Indeed, the Trust has applied and been accepted to be in the next wave of the expansion of the national bowel cancer screening programme. This service will begin in the final quarter of 2014/15 and will expand from that point. The Trust is confident that the new gastroenterology unit will provide sufficient capacity for this expansion over the next 5 years.

In addition to this new unit, the Trust also plans significant capital investment in new state of the art endoscopy decontamination facilities.

Viral Hepatitis C

Hepatitis C is a serious liver disease that almost invariably causes liver cirrhosis which in turn leads to liver failure and liver cancer. It is a curable disease but treatment lasts between 6-12 months and has serious side effects therefore requiring specialist nursing time.

Hepatitis C is particularly prevalent in Bradford due to the fact that its population has a higher than average proportion of people from areas where the disease is endemic.

Our analysis of capacity has shown that we are only able to treat 70 patients per year. Our demand analysis has found that we need to be able to treat 150-170 patients in the same period. The treatment of Hepatitis C is labour intensive and capacity is very dependent on the availability of specialist nursing care.

Our analysis of our specialist nursing capacity has indicated that we need to provide an additional 2 specialist viral hepatitis nurses. This will provide an additional 5 clinics per week.

The Trust is therefore taking steps to appoint two additional specialist viral hepatitis nurses.

Rheumatoid Arthritis

A Trust demand and capacity review of the Rheumatoid Arthritis service identified a shortfall in capacity. The Trust took steps to provide additional consultant and clinic capacity to treat new patients promptly.

This, of course, had a knock on effect on review patient clinics as the demand for follow up increases as a direct consequence of seeing more new patients. As a consequence the Trust provided additional dedicated weekly clinics and additional clinician time. This provided an additional 572 appointment slots per year.

Paediatric and Uro-gynaecology Capacity

As a result of its internal demand and capacity modelling processes, the Trust has worked with commissioner partners to increase the elective contracts for 2014/15 in a number of specialties, most notably Paediatrics and Uro-gynaecology to ensure that 18 week access targets can be met. The relevant additional capacity has been identified in the annual financial plan.

Capacity/Demand Risks

Uncertain Commissioner Intentions and the Integration/Transformation Agenda

The Trust can view its demand projections for 2014/15 with some certainty. However, the integration and transformation agenda highlighted elsewhere in this document does engender some doubt as to service configuration going forward.

The unprecedented financial challenge, the development and uncertainty surrounding the use of the Better Care Fund and the need to redesign services all represent risks to the Trust in relation to the demand for our services and our business model.

However, as highlighted in the earlier parts of this Operational Plan, the Trust is highly engaged with LHE partners and playing a full part in the development of new services and service configuration. Work undertaken via the Bradford Integration and Change Board (ICB) will ensure that the Trust can identify risks at an early stage and position our services to mitigate them and take full advantage of the opportunities that they present.

There are also instances where there will be some derogation of services or instances where services will be offered to a wider range of providers via the Any Qualified Provider initiative. Once again, the Trust is aware that these situations represent a risk to demand. As above, the Trust works closely with NHS England and with CCG partners to ensure it is aware of proposed service changes and is in a position to react accordingly.

Overcapacity

Leading on from the point above, the Trust is very aware that it must also guard against situations where it has an excess of capacity over demand.

Consequently, the Trust is developing a formal marketing strategy. Work will then be undertaken to market Trust services. Some work in this area has already begun with Planning department staff visiting GP practices across the Bradford district to inform them of our services and to ask for feedback on what we do.

As a result of this work the Trust has developed, and will put into practice during 2014/15, a monthly GP bulletin. This bulletin was specifically requested by GPs and is one method that the Trust will use to keep them informed of new developments and successes at the Trust.

The visits to GP practices have also highlighted the need for the Trust to update its Service Directory. This is so that GP practices and the public can more easily obtain information on the services that we provide and gain access to those services.

Workforce Risks

Our work to assess our workforce requirements is highlighted at the start of this section. The Trust clearly recognises that correct staffing levels and skill mix are fundamental to being able to meet demand. As mentioned above, workforce planning is therefore integral to the Trust's planning process which requires divisions and departments to identify potential changes in workforce needs as a result of proposed service developments.

The Trust is fully aware that it must ensure that retention and recruitment strategies are in place for key roles and that these must be allied to robust succession planning to ensure that the Trust is adequately staffed to ensure high quality service delivery. In addition, the Trust has identified a range of "difficult to recruit to" posts and has put in place a range of actions to meet this staffing shortfall including looking to recruit internationally.

As highlighted throughout this plan, the Trust is cognisant of the fact that it will need to development different models of care if it is to utilise the integration agenda to meet the coming financial challenge whilst providing high quality care. These different models of care will require different staffing models.

Our workforce risk assessment is closely linked to both our forecasts of demand and our Clinical and Estates strategies and therefore takes account of the different staffing levels, skill mixes and working patterns required by different models of care. Examples in relation to the need to reassess staffing requirements and workforce configuration as a result of the proposed move to 7 day working in Therapy Services are provided earlier in this plan.

As part of the Annual Planning round, the Trust has identified the need to develop its cohort of Advance Nurse Practitioners to help it meet the integration and transformation challenge. This is especially the case in;

- Emergency and Acute Medicine
- Elderly medicine (especially as an integral part of the virtual ward)
- General paediatrics
- Neo natal care
- Intensive Care
- Acute surgical

Physical Capacity

The Trust is also cognisant of the fact that our estate has to be fit for purpose and provide enough clinical accommodation and space to provide the capacity to meet demand.

As highlighted at the start of this section of the plan; the Trust has taken steps to ensure that we have adequate physical capacity to meet the needs of our patients and commissioners through the development of the Estates Strategy.

Productivity, Efficiency & CIP's

Overview

The Trust has a strong record of successful delivery of cost improvement targets, through a combination of divisional schemes as well as corporately sponsored initiatives.

The Trust will be required to deliver cost improvements of around £29m in the next 2 financial years. In order to meet this increasingly difficult financial challenge, the Trust is building on its previous successes by creating a Programme Management Office to deliver the productivity agenda but also to safeguard the

quality of patient care.

The Trust is planning to deliver this agenda through a collaborative approach with local health providers and stakeholders and by emphasizing a holistic Quality, Innovation, Productivity & Prevention (QIPP) agenda.

QIPP Profile

The Trust's QIPP plans can be summarised into a number of categories:

9. Workforce Productivity
10. Clinical Service Productivity
11. Diagnostic Services
12. Procurement
13. Estates
14. Back-Office & Support Functions
15. Divisional Specific

Each QIPP programme will be managed through the PMO supported by a matrix team including appropriate representation from human resources, finance, IT and communications etc. Each programme will have an Executive Director lead that will have accountability for delivery and to ensure engagement of relevant clinical staff and operational managers. An external specialist consultancy firm is assisting the Trust in the identification and implementation of efficiency opportunities.

Workforce Productivity

There are a number of work-streams within this category:

i) Staff Rostering
ii) Consultant Job Planning
iii) Agency & Bank Staffing
iv) Terms & Conditions / Sickness Management
v) Non-Clinical Staffing organisation

Clinical Service Productivity

This category includes a large number of initiatives that will either generate real cost reductions and/or capacity to increase activity volumes to meet access targets/increase market share. The major work-streams within this category are as follows:

i) Operating theatre efficiency and productivity
ii) Reduction in premium rate activity (in-house & external)
iii) Gastro Unit sessional efficiency and productivity
iv) Out-Patient sessional efficiency and productivity
v) In-Patient Bed configuration & length of stay
vi) Intermediate Care Services

Diagnostic Services

This category includes a combination of demand management initiatives and efficiency programmes at the point of delivery.

Procurement

The Trust will continue to undertake value for money and tendering initiatives on drug and other clinical & non-clinical products and services through a combination of the Trust's procurement team and through collaboration with regional and national hubs including the North of England Commercial Procurement Collaborative.

Estates

The Trust will continue to review the premises that it owns to ensure they are being used as efficiently as possible, and to dispose of any that are no longer required. Energy efficiency initiatives are also a key component of this programme in terms of minimising energy usage and managing utility costs. The Trust is also reviewing the use of community facilities in conjunction with other local health providers and the local authority to support integrated care planning.

Back-Office & Support Functions

The Trust will continue to evaluate the efficiency of all back office and support functions, through benchmarking reviews and evaluation of outsourcing opportunities. There are also a wide range of IT based solutions linked to other QIPP programmes that will support the re-design of services and providing quality improvements as well as efficiency savings, for example:

- Real Time Admission, Discharge & Transfer
- Electronic Medical Record
- Electronic Requesting & Reporting (Diagnostics)
- Electronic Prescribing

Divisional Specific

A large number of smaller initiatives will continue be taken forward by individual Divisions including LEAN reviews and general housekeeping schemes to ensure all activities and elements of the cost base are continually reviewed and challenged.

Quality Impact

The Trust has an established Quality Impact & Assessment Group (QIAG) that risk assesses all cost improvement schemes prior to implementation and monitors these on an on-going basis to ensure there is no impact on the quality of healthcare or unintended consequences on safety to both patients and staff. The composition of the QIAG includes the Medical Director, Chief Nurse & Chief Operating Officer.

Financial Plan

Overview

The Trust is forecasting full delivery of its financial targets in 2013/14 with a predicted surplus of £3.4m. Over the next 2 financial years, the Trust will continue to plan for a 1% Income and Expenditure surplus to provide additional capital flexibility for investment in clinical infrastructure and also in schemes that will facilitate productivity and efficiency gains. In relation to the Risk Assessment Framework, the Trust is planning to maintain the Continuity of Services Risk Rating of 4.

High level financial planning assumptions indicate the Trust will need to identify £29m of efficiency improvements over the next 2 years which is one of the key risks to the delivery of the financial plan. The following table summarises the financial plans over the next 2 financial years:

	2013/14 Plan £m	2013/14 Forecast Outturn £m	2014/15 Plan £m	2015/16 Plan £m
Operating Revenue				
Clinical Activities	308.0	322.7	319.7	321.4
Non-Clinical Activities	36.5	40.1	34.2	34.2
Total Operating Revenue	**344.5**	**362.9**	**353.9**	**355.6**
Operating Expenses				
Staffing	-221.9	-227.2	-222.3	-224.3
Non-Pay	-106.2	-120.0	-115.2	-113.8
Total Operating Expenses	**-328.1**	**-347.2**	**-337.5**	**-338.2**
EBITDA	**16.5**	**15.6**	**16.4**	**17.4**
Non-Operating Items	-13.1	-12.2	-12.9	-13.9
Net Surplus/(Deficit)	**3.4**	**3.4**	**3.5**	**3.5**
Net Surplus/(Deficit) %	*1%*	*1%*	*1%*	*1%*

Key Financial Planning Assumptions

The key financial planning assumptions include:

- Activity levels broadly at 2013/14 outturn levels, with adjustments to reflect commissioning intentions, agreed service developments and activity required to meet patient access targets.
- An assessment of inflationary and regulatory cost pressures,
- Planned investment in quality initiatives and resources to meet access targets
- Efficiency requirement of £14.5m per annum
- Capital programme of £21.6m in 2014/15 and £15.1m in 2015/16

Income

Clinical revenue plans are based on activity & financial contract values agreed with all the Trusts main commissioners.

The income plans assume a number of agreed developments that include:

- Additional cardiac angioplasty associated with cardiac catheter/day-case unit development
- Growth in gastroenterology activity
- DRIVE ophthalmology service expansion
- Additional 2 neo-natal ICU cots
- Hosting of the Improvement Academy work-stream of the local Academic Health Science Network
- Expansion of the virtual ward, offsetting reductions in acute hospital admissions
- Early supported discharge for therapy services

The Trust aims to minimise contract penalty liabilities through re-designing patient pathways and processes as part of the QIPP process. Conversely, the Trust aims to maximise commissioning for quality & innovation (CQUIN) payments with these targets forming a key component of the clinical strategy.

Expenditure

Expenditure plans reflect the cost estimates of delivering the activity, quality and access targets agreed with commissioners. The plans also reflect the known and estimated impacts of inflation and other cost pressures across the range of cost categories.

A Quality & Safety reserve of £1.4m has been provided for within the expenditure plans, and will be used for the targeted investment in measures to address any issues arising from the Trust's review of the Francis & Berwick report recommendations, in addition to local quality assessments.

The Trust commenced planning for the delivery of £29m efficiency gains in autumn 2013. It became clear that traditional CIP's delivered by operating divisions would be insufficient, and therefore significant emphasis is now being placed on developing transformational schemes in conjunction with other local providers and commissioners. The establishment of a PMO and associated governance structures will be key to ensuring safe and effective delivery of these CIP's. The PMO in conjunction with external consultancy support, have undertaken an opportunity search which has identified in excess of £30m of potential productivity gains. The Trust is confident that a significant proportion of these opportunities will be deliverable, and work is underway to translate these opportunities into detailed project implementation plans by the end of June 2014.

At this stage the level of CIP plans at the draft outline or unidentified stage is £1.9m in 2014/15, and around £7m for 2015/16.

Capital Plans

The Trust plans to invest £36.7m in the next 2 years on capital investment priorities, which are summarised into the following categories:

- Maintenance of buildings and estate infrastructure
- Medical equipment replacement
- IT schemes
- Improvements to patient facilities
- Planned service developments

Some the highlights of the clinical infrastructure plans include:

- Cardiac catheter laboratory and day-case unit
- Intensive Care & High Dependency Unit
- Expanded endoscopy unit & new decontamination unit
- Expansion to the existing neo-natal intensive care unit
- Replacement picture archiving and communication system

Liquidity & Risk Ratings

The Trust aims to protect its current strong liquidity and debt servicing capacity position by maintaining a 1% income and expenditure surplus. The Trust is forecasting an overall Continuity of Services Risk rating of 4 for 2013/14, which it plans to maintain going forward.

Risk & Sensitivity Analysis

The Trust has undertaken an assessment of the risks to the delivery of the financial plan, the major risks being:

- The delivery of QIPP efficiency targets
- Maintaining activity/income targets
- Controlling expenditure run rates and inflationary pressures
- Impact of potential changes to the NHS VAT regime
- Contract penalties in service contracts

- Impact of Any Qualified Provider agenda

In recognition of these risks to the financial plan, the Trust has also identified mitigations that could be used to offset the impact on the EBITDA position and financial metrics, which include:

- Contingency reserve
- Deploy surplus headroom
- Additional QIPP targets & plans
- Expenditure controls
- Use of other non-recurring measures