



Operational Plan Document for 2014-16

University Hospitals Bristol NHS Foundation Trust

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

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Date	2 nd April 2014

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)	John Savage
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Signature



Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Robert Woolley
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Signature



Approved on behalf of the Board of Directors by:

Name (Finance Director)	Paul Mapson
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Signature



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SECTION 1 - EXECUTIVE SUMMARY

This plan sets out the Trust's priorities and challenges over the period 2014 to 2016. Its focus is on our operational business and it has been developed for ourselves, our partners and our regulators to ensure that all of our key stakeholders understand and have the opportunity to shape the way we deliver our services, and the way we work with others, over the next two years. Alongside this Operational Plan, we are also working on our Five Year Strategic Plan which will set out how we intend to deliver sustainable services out to 2020 and beyond.

We have spent time in 2013/14 working with our staff to examine *our purpose*, the *business* we are in and how we want to be viewed by our patients and our partners. This work has resulted in a re-fresh of the Trust's mission, vision and strategy and these statements will be central to the way in which we communicate our priorities and evaluate our success going forward.

The Trust is entering the next two year period with mixed fortunes. Positively, the Trust retains financial headroom to support transition towards the challenges of 2015 and beyond, taking forward an underlying surplus of £14m and forecasting a surplus plan for 2014/15 in line with its current Long Term Financial Plan. However, in terms of operational performance and quality, there are significant challenges facing the Trust. We are forecasting failure of four Monitor indicators in Q4 of this year, most of which we believe have common root causes, linked to the Trust's operating model.

A central plank of the Trust's Operational Plan for 2014-16 is a fundamental revision of some key aspects of our Operating Model with the aim of addressing directly, and rapidly, some of the underlying causes of current poor performance. Many of these issues have their roots in either the nature (size, make up and occupancy) of the Trust's bed base or the operational and administrative processes that support service delivery and consistent performance. The key changes we plan to make are:

- The establishment of a protected bed model within the Trust. This will enable us to improve the consistency with which we deliver elective care and lead to a significant reduction in the cancellation of planned care (based on evidence from elsewhere), alongside the ability to deliver the contracted levels of activity and recover the elective income assumed in our financial plan.
- Implementation of the findings of a Trust wide review of the provision of critical care. This will allow us to further improve the consistency with which we deliver planned care and reduce cancellations of planned surgery arising from the unavailability of critical care beds.
- We have a range of initiatives focused on reducing the number of patients remaining in hospitals after the point at which they no longer require hospital care. These initiatives are probably the most fundamental to Trust performance in the next two years.
 - The establishment of an integrated discharge hub, co-locating professionals from acute services, social care and community providers, and re-designing discharge processes and practices to support rapid assessment and care planning for patients who no longer require acute care;
 - Rapid (during Q1 of FY 2014/15) commissioning of additional out of hospital transitional care beds to assist with the discharge of patients who no longer require hospital care but for whom discharge is delayed for whatever reason;
 - Establishment of an Early Supported Discharge (ESD) function to enable those patients who are "homeward bound" to be discharged earlier – this will replicate the model we already successfully operate for stroke patients;
 - Revision of our approach to weekend discharge with the aim of significantly increasing the proportion of patients with a predicted weekend discharge, who go on to be discharged on a Saturday or Sunday.
- Implementation of a rapid improvement methodology to achieve a "re-set" of the operating model

delivered through an initiative we are calling Breaking The Cycle Together – the Trust is learning from two Trusts which have already mobilised this approach and we will be supported by the national Intensive Support Team (IST) who have developed the “perfect week” methodology upon which we are basing our local response. Ambitiously, we are aiming for a system wide “re-set” of key parameters, and not just a within hospital approach, in early April 2014.

Taken together, and in addition to the existing elements of our Transforming Care Programme, the initiatives listed above are at the heart of our Operational Plan to continue to deliver a financial surplus for the next two years and create the conditions for the acute sector in Bristol to unlock the £14m disinvestment assumed in the current plans for the Better Care Fund. They will also allow us to make important improvements to patient experience and performance by addressing the issue of timely discharge and timely access to our beds.

By its nature, this work will require us to work very closely with others across the Local Health Economy (LHE). The last 12-18 months have been characterised by developing and improving relationships with new partners in the revised system architecture however, all would recognise that the pace, with which necessary change has been mobilised, has not been consistent with the need for more immediate change if the challenges that face the whole system are to be addressed ahead of 2015. We believe that the speed with which we (as a Trust) need to address some of the issues we face may demand that we act to make changes that, if the pressure were not so acute, we might otherwise look to change over a longer timescale and on the basis of more consultation with others in the LHE. In the longer term though, we remain committed to working with others across the LHE and we will set out our longer term plans in this regard in our Strategic Plan, which we aim to develop with those partners.

In summary, we are focusing now on the work that will allow us to navigate the next two years successfully, maintaining the quality of our services and dealing with the very challenging financial context within which we and others will have to operate.

SECTION 2 – OUR OPERATIONAL PLAN

2.1 Our Mission, Vision and Intent

2.1.1. Our Mission and Vision

Our Mission as a Trust is to improve the health of the people we serve by delivering exceptional care, teaching and research every day.

Our vision is for Bristol, and our hospitals, to be among the best and safest places in the country to receive care.

We want to be characterised by:

- High quality individual care, delivered with compassion.
- A safe, friendly and modern environment.
- Employing the best and helping all our staff fulfil their potential.
- Pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.
- Providing leadership to the networks we are part of, for the benefit of the region and people we serve.

2.1.2. Our Strategic Intent

After considerable engagement with our staff and notably our Senior (clinical) Leadership Team and Board, we have confirmed our forward strategy. This is expressed in a revised statement of strategic intent which sets our intention to provide excellent local, regional and tertiary services, exploiting the synergies that flow from this portfolio whilst addressing the resulting operational tensions that have the potential to impact upon the success of one or more areas.

Our focus for growth remains our specialist portfolio and we aim to expand this portfolio where we have the potential to deliver exceptional, affordable healthcare.

Delivering the benefits that flow from combining teaching, research and care delivery will remain our key advantage, along with recruiting, developing and retaining exceptionally talented and engaged staff.

We will do whatever it takes to deliver exceptional healthcare to the people we serve and this includes working in partnership where it supports delivery of our goals, divesting or out sourcing services that others are better placed to provide and delivering new services where patients will be better served. The Trust's role in community service provision will be focused upon supporting our partners to meet the needs of our patients in a timely way; however, where our patients' needs are not being met, the Trust will provide or directly commission such services.

Our patients – past, present and future - their families, and their representatives, will be central to the way we design, deliver and evaluate our services. The success of our vision to provide “High quality individual care, delivered with compassion” will be judged by them.

2.2 The short term challenge

There are a number of key challenges in the next two years that we have identified as part of our own planning and through our work with others across the Local Health Economy. Our Operational Plan is a response to these challenges, and they are the key factors that have shaped our planning in the short term.

- We are refreshing our focus on Quality as the underpinning requirement for the delivery of all our services and the key component of our reputation. The main mechanisms by which we plan to achieve this involve addressing a number of specific issues within our Operating Model, ensuring that we are compliant with the newly developed range of specifications for the provision of specialised services and restoring trust and confidence in our children's services whose reputation for excellence has been dented by recent issues within paediatric cardiac services. The Trust has welcomed the recently announced Independent Review of the service, to be led by Sir Ian Kennedy.
- Across the acute sector of Bristol, we are opening two major new facilities, which together have the potential to significantly improve the services available to our local and regional populations - but we face a collective challenge in terms of ensuring that the transition to new operational models across the city is achieved smoothly.
- The transition plans for both UH Bristol and North Bristol NHS Trust (for the Bristol Royal Infirmary and Southmead redevelopments respectively) rely on a reduction in admissions, reductions in Length of Stay and in reductions of excess bed days. If any of these changes is not achieved, the opening of these two new facilities will result in an increase in pressure on the acute sector (and on

our ability to deliver elective services) in the short term.

- Accordingly, it is crucial that, as a system rather than just as organisations, we find ways to take greater control of the urgent care pathway. There is much current work focused on this, and we are also making specific changes to our own Operating Model to help us address this issue. There is also a collective challenge to develop appropriate and sufficient capacity in social and community provision across our Local Health Economy. Generally, the evidence suggests that we have admission practices and a “front door” that is working well. For us, the main impact is in terms of our ability to discharge patients that no longer require hospital care and we are making a number of changes to our own Operating Model that directly address this issue.
- We must continue to deliver the efficiency improvements demanded by the 4% expected national deflation of the tariff available for our services. It is becoming increasingly difficult to find these savings from within our own organisation and therefore a significant proportion of the 4% efficiency savings required will need to be delivered through ‘system level’ initiatives. The interaction of the national tariff efficiency requirements and the use of the Better Care Fund will be key. Release of funds into the Better Care Fund can only be achieved when the acute sector delivers over and above the 4% already required; this needs to be through new and improved ways of working.
- There are a number of specific financial challenges associated with the development of the Better Care Fund. First, there is the challenge of releasing approximately £14m of savings from within the acute sector that are currently assumed. And second, there is the related challenge of avoiding double costing in the short term – a potential situation where costs continue to be incurred within the acute sector at the same time as the new costs of a service designed to either replace acute provision or reduce the requirement for acute services is also being borne. Double running costs may be impossible to avoid in all cases, and we plan to work with others via the Better Care Fund to minimize the impact of these cases – via (for example) clear risk sharing and accountability across the system with recognition of potential increase in system costs whilst new systems are put in place.
- In summary, the challenges of the next two financial years demand that we work more effectively across the LHE to address operational and financial challenges. We are already well focused on working with commissioners at both local and national level as their understanding of their own objectives is developing – but we are also conscious that we must broaden the scope of our collaboration in the next two years in particular, including with Local Authorities and others via the Better Care Fund.

2.3 Our Role in the Local Health Economy - Delivering the Right Care in the Right Setting

The Trust retains a central position within the local Bristol health community and the wider South West region. Our strategy remains aligned to our aim of providing excellent specialist services on a regional basis whilst providing high quality local secondary care services to the people of Central and South Bristol. As an organisation we are committed to supporting the provision of the right care for the patients in the right setting. Depending on the service, our reach is local, regional and national – and we base our approach to the development of specific services around this structure.

The Trust is increasingly focused on working with local Clinical Commissioning Groups (CCG) and others – mainly via the mechanism of the Better Care Fund - to identify opportunities for reducing reliance on

secondary care services in line with our joint strategic aspirations.

Whilst the Trust is both committed to, and planning for, this change in the emphasis of care, demand for its “district hospital” services remains strong. In addition to strong demand, there is evidence of increasing acuity and complexity of need in the patients presenting and a growth in the number of older patients requiring our services.

Last year we said that ‘changes to the commissioning landscape have created additional complexity in enabling us to bring about change at the scale and pace required’ – and whilst we have seen emerging clarity in terms of commissioner intentions, the general point about the changing at the scale and pace required is still one that is an issue for us and others within the Local Health Economy. Development of work on the Better Care Fund has helped to move toward more joint work across health and social care, but more ambitious system changes are still proving challenging.

2.3.1 Our commitment to the right care in the right setting

As part of the wider health economy plans to improve services for the patients of Bristol, we recognise that the need to develop new delivery models which will require significant changes to the current system, both in terms of where services are provided and the funding streams associated with this. The expectation is that a successful implementation of the LHE work programme will see an increase of care provided at home or in community settings and an associated reduction in the number of patients requiring hospital admission and if they do require acute care, their length of stay in an acute facility should be reduced.

Despite system wide investment, including intermediate, rehabilitative and re-ablement services, Bristol residents can expect to spend an average of 11 days longer in hospital than the best performing hospitals in the country. There is also a paradox that we have some of the highest number of delayed transfers of care in the country with some of the lowest social care delays. An additional impetus to change is provided by the rationalisation of both acute hospitals across the city reducing the number of acute beds by approximately 150 from 2014/15.

The basis of this LHE work is that services should be designed around clinical needs and outcomes and not by organisational boundaries. The focus of the LHE work stream during 2013/14 was around the rehabilitation and re-ablement agenda and a Project Board has progressed a number of ‘proofs of concept’ over the winter period including;

- Community discharge hub based at the acute site
- Additional community rehabilitation beds
- Community social care staff to support assessment out of hospital

These initiatives have been supported by all partner organisations; UH Bristol, Bristol CCG, Health and Social Care, Bristol Community Health and Intermediate Care. Governance is provided through the Out of Hospital Care Project, the Reablement and Rehabilitation Programme Board, and the Better Care Fund (BCF) Programme Board. Whilst there is strong evidence of the success of these initiatives, for example high occupancy and turnover through transitional beds, the number of patients whose discharge from acute care for social care reasons remains as high as it was a year ago.

2.3.2 The Better Care Fund

The Better Care Fund has great potential to address many of the Trust’s challenges and as such we are actively engaged in work to support its aims including membership of the LHE Better Care Programme Board. Locally the BCF aims to:

- Put people at the centre of services, giving more choice and control
- Explore opportunities for providing more integrated services e.g.
 - Single point of contact to access community services
 - Increased use of key workers who can operate across all agencies
 - Seamless transition from one service to another
 - 7 day working
- Shift more care closer to home
- Prevent inappropriate admissions and readmissions to hospital
- Appropriate length of stay in hospital with early planning of discharge back to the community, reducing excess bed days.

All of the above have been long-standing stated aims of successor bodies, however the financial levels that sit with the BCF do appear to provide new opportunities for moving forward some of these seemingly intransigent issues. This LHE vision links closely with our own plans to provide care out of a smaller bed base in line with planned changes to models of care and improved efficiency supported by the redevelopment of the Bristol Royal Infirmary.

The first phase of the Better Care Fund work will focus on the integration of services for people with long term conditions and older people, but the aspiration is that in future years (we will return to this in our Strategic Plan), this work will expand to include other areas in adult, children and family services where appropriate.

2.4 Managing Our Risks

The Trust undertook a review of its Risk Management Policy and procedures during 2013 and rollout and training were undertaken to support compliance with the revisions implemented.

Currently, the Trust Board is managing nine corporate risks through its register. Four of these pertain to poor patient experience and Monitor non-compliance, arising from our predicted failure of national standards for cancer 62 days, non-admitted Referral To Treatment Times (RTT), Clostridium Difficile national objective and the 4 Hour A&E standard. Looking forward, the Trust is declaring three Monitor indicators to be at risk for one or more quarters in 2014/15 as part of its compliance declaration against the Risk Assessment Framework (RAF); these are the 4 Hour A&E standard, non-admitted RTT and 62 day cancer standard. Clostridium Difficile has been de-escalated in response to revised arrangements for attribution and subsequent reporting of cases.

Two of the remaining risks are service related, the first describing the risk to high quality care for those patients who cannot be assessed in a timely way following presentation to A&E by ambulance and secondly the risk of sub-optimal care for babies cared for in, or requiring retrieval to, our neonatal intensive care unit (NICU).

The former service risk has recently been de-escalated following significant improvements in ambulance handover times though the risk remains at times of escalation and thus remains on the register.

The second risk pertains to the high occupancy and acuity of the our regional NICU unit; the Trust commissioned an external review of the safety and quality of the unit in 2013 and has subsequently developed a proposal to address the risks in large part – the proposal is currently with commissioners for their consideration and if supported would lead to the creation of a dedicated Neonatal Retrieval Service and investment in unit based staff. In the interim a range of mitigations are in place to ensure babies are

managed safely in the unit and during retrievals.

The remaining three risks are strategic in nature. The first pertaining to our failing to deliver all of the Trust's Corporate Objectives in 2013/14, the second the risk of not delivering all of the Cash Releasing Efficiency Savings set out in our plan – this has been fully mitigated through non-recurring measures and the third the risk to our reputation arising from the adverse media coverage on the Trust's paediatric cardiac service which the Trust is actively seeking to manage through its relationship with the media, the many parents who speak positively about the service and its full engagement with the proposed Independent Review of the service to be carried out in 2014.

2.5 Our Operational Plan

2.5.1 How we are planning for the future

As a Trust, we are working with our partners across the Local Health Economy (LHE) on two key areas of planning. The first is our Operational Plan (this document). We are also working on our Strategic Plan, which will set out how we intend to deliver sustainable services out to approximately 2020. In the last 12 months, we have conducted our own Strategic Review and have also - jointly with North Bristol NHS Trust – commissioned the Bristol Acute Services Review (BASR). These two key pieces of work have informed the development of the Strategic Plan that we will work on with partners between now and June this year.

Our strategic plan will set out a longer-term vision for the development of our services, and how we plan to work with others at local, regional and national level to deliver benefits for our patients. The focus of our operational plan is on the work we need to do, and the changes we need to make, in order to meet the specific challenges of the next two years, and set the conditions for the development of sustainable services over the next 3-5 years.

As highlighted above, there has been significant focus in 2013/14 on a review and refresh of the Trust's strategy – this has focused upon the key strategic choices that have the most to contribute to the challenge ahead which we have articulated through the strategic review as **maintaining and improving quality whilst managing our known risks within fewer resources**. The outputs of this work have fed into our Operational Plan but will be dealt with more directly through the subsequent submission of our Five Year Strategic Plan.

The Bristol Acute Services Review has also been an input to our own strategic considerations. It has highlighted that the greatest opportunities for improving the quality of local care in the context of declining resources, lie in the pursuit of more integrated services between acute, community and social care sectors. The pursuit of this agenda is playing out now, but at a pace that means that it is most appropriate to deal with our contribution to it in the context of our Strategic rather than Operational Plan.

Additionally – and crucially in terms of the next two years - the Review demonstrated very limited quality or financial benefit arising from reconfiguration of acute services between the two Trusts within the City. Accordingly, the output from the Review has not been a major influence on our Operational Plan.

In accordance with developing direction from both Monitor and NHS England we are beginning to adopt a 'unit of planning' approach to the development of strategic and business planning, acknowledging that the networks and organisations with whom we will have to deal (and plan) will change according to whether we are having a discussion with local, regional or (national) tertiary implications.

2.5.2 Our Operational Summary

The Trust is entering financial years 2014-16 with mixed fortunes. Positively, the Trust retains financial headroom to support transition towards the challenges of 2015 and beyond, taking forward an underlying surplus of £14m and forecasting a surplus plan for 2015 in line with its Long Term Financial Plan. However, in terms of operational performance and quality, there are significant challenges facing the Trust. We are forecasting failure of four Monitor indicators in Q4 of this year, most of which have common root causes linked to the Trust's operating model.

Our key priorities in the next two financial years are:

- The successful implementation of a revised operating model across the Trust including the introduction of protected beds and out of hospital care provision, in order to deliver the following benefits:
 - Enable the delivery of our elective activity plan, which is critical to delivering safe and timely care and to securing 2014/15 income;
 - Guaranteeing access to beds (ward and critical care) to eliminate a large number of cancer pathway delays and deliver planned activity
 - Addressing shortcomings in the quality of our care associated with the high numbers of patients whose discharge from acute care is delayed.
 - Restoring our A&E performance through delivery of reduced bed occupancy in the emergency care bed base thus supporting optimal flow from Emergency Department to assessment and ward environments
- Effective capacity planning to include robust assessment of required activity to meet projected demand and, importantly, activity required to address Referral To Treatment backlogs.
- Successful transfer of specialist paediatric and cleft services from North Bristol NHS Trust (NBT) to UH Bristol and timely transfer out of vascular services and breast screening to NBT.
- Successful commissioning and opening of the Bristol Royal Infirmary Redevelopment, including decommissioning of the then redundant estate.
- Delivery of 2014/15 cost improvement programmes and development of detailed plans to ensure delivery of 2015/16 opportunities that have been identified.
- Restoration of lost trust and confidence in paediatric cardiac services through engagement in the proposed Independent Review and effective reputation management alongside the need to ensure sustainability of the service model through effective support for staff and families currently working and cared for within the service.

2.5.3 Transforming Care

The Transforming Care (TC) programme will remain the means through which the Trust supports staff to innovate and challenge the way in which services are organised and delivered, using service improvement tools and techniques as the means through which we drive improvements in service quality and operational performance resulting in reductions in the cost of care. The TC programme is discussed in more detail later in this plan.

2.5.4 Our Operating Model

A central plank of the Trust's Operational Plan for 2014-16 is a fundamental revision of some key aspects of our Operating Model with the aim of addressing directly, and rapidly, some of the underlying causes of current poor performance. Many of these issues have their roots in either the nature (size, make up and occupancy) of the Trust's bed base or the operational / administrative processes that support service

delivery and consistent performance. The key changes we plan to make are:

- The establishment of a protected bed model within the Trust. This will enable us to improve the consistency with which we deliver elective care and lead to a significant reduction in the cancellation of planned care based on practice elsewhere, alongside the ability to deliver the contracted levels of activity and recover the elective income assumed in our financial plan.
- Implementations of the findings of a trust wide review of the provision of critical care. This will allow us to further improve the consistency with which we deliver planned care and reduce cancellations of planned surgery because of the unavailability of critical care beds.
- We have a range of initiatives focused on reducing the number of patients remaining in hospitals after the point at which they no longer require hospital care. These initiatives are fundamental to Trust performance in the next two years.
 - The establishment of an integrated discharge hub, co-locating professionals from acute services, social care and community providers, and re-designing discharge processes and practices to support rapid assessment and care planning for patients who no longer require acute care;
 - Rapid (during Q1 of FY 2014/15) commissioning of additional out of hospital transitional care beds to assist with the discharge of patients who no longer require hospital care but for whom discharge is delayed for whatever reason;
 - Establishment of an Early Supported Discharge (ESD) function to enable those patients who are “homeward bound” to be discharged earlier – this will replicate the model we already operate for stroke patients;
 - Revision of our approach to weekend discharge with the aim of significantly increasing the proportion of patients with a predicted weekend discharge who go on to be discharged.
- Implementation of a rapid improvement methodology to achieve a “re-set” of the operating model delivered through an initiative we are calling Breaking The Cycle Together – the Trust is learning from two Trusts that have already mobilised this approach and will be supported by the national Intensive Support Team (IST) who have developed the “perfect week” methodology upon which we are developing our local response. Ambitiously, we are aiming for a system wide “re-set” of key parameters and not just a within hospital approach, in early April 2014.

2.5.5 Our Organisational Model

Our review of the our strategy and operating model has been accompanied by a revision to the Trust's leadership structures to ensure that they are fit for the forward challenge and aligned to the priorities that have emerged from these reviews. These changes have brought new leadership into each of the Trust's five clinical Divisions with emerging evidence that these changes are delivering benefit. Alongside this leadership review, is a recognition that we have further to go to deliver our vision of truly effective staff engagement; pleasingly our National Staff Survey results for staff engagement show small improvements on last year and we exceed the sector average but we recognise this as an area where our success rests upon us excelling in this domain; as such our new Director of Workforce and Organisational Development has signalled this as one of her early priorities.

2.6 Our Quality Plans

2.6.1 Our Approach to Quality

The Trust's quality strategy remains focused on patient safety, experience and effectiveness of care and our commitment to address the aspects of care that matter most to our patients which they describe as:

- keeping them safe;

- minimising how long they wait for hospital appointments;
- being treated as individuals by all who care for them;
- being fully involved in decisions about their care;
- being cared for in a clean and calm environment;
- receiving appetising and nutritional food;
- achieving the very best clinical outcomes possible for them.

The Trust has made significant progress in the last 12 months in addressing known quality concerns. Following challenges of previous years, the Trust has largely eliminated MRSA with no reported case since May 2013; the CQC concerns surrounding three outcomes in paediatric cardiac services have been addressed, the national Patient Safety Thermometer has given us comparative insights into how we perform across a number of the fundamentals of care and the most recent data demonstrates that we have exceeded the standard set by our commissioners for both Harm Events and New Harm Events. Finally, the Trust maintains a very positive hospital mortality rate confirming the safety and effectiveness of our services; this position on safety has been corroborated by the Care Quality Commission's Intelligent Monitoring Report which has placed the Trust in Band 6 (lowest risk) for each of the two quarters it has reported, for both its adult and children's services.

We continue to use the following four questions to examine our approach to quality and these lines of enquiry were central to developing our response to Francis.

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

Like all NHS organisations the events and subsequent learning from Mid-Staffordshire, the Berwick Report and Keogh Reviews have shaped our approach to quality and more specifically how we listen and engage with our staff and our patients. The Trust has presented its response to Francis to the Board and partners, which in summary demonstrated that many of the themes highlighted through the report were already understood within UH Bristol, with active programmes to underpin them such as our Living The Values training which more than 5,000 staff have undertaken. However, from this process was the emergence of a number of themes where the Trust might expect some benefit from further developmental work. These include addressing perceived variation in attitudes to openness and sharing across the Trust, listening and learning more effectively throughout the Trust following incidents and near misses and making the process of change easier, and more rapid, across the Trust.

2.6.2. Our Quality Objectives for the next two years

Looking forward, each year we consider national and local commissioning priorities related to provision of high quality services alongside available intelligence about the quality of all of our services (internal and external) and, with the involvement of our local stakeholders, patients and governors, agree a set of corporate quality objectives to reflect our agreed priorities. As a result of this approach, our quality objectives for the next two years will focus upon:

- Working with people to provide a positive experience of care;
- Treating and caring for people in a safe environment and protecting them from avoidable harm;
- Achieving clinical outcomes for our patients that are consistently in the upper quartile of comparable Trust's performance.

The Board of Directors recognises that the success of delivery of the Trust's Quality Strategy depends

significantly on the ability to engage staff at a time of increasing service and financial pressure. The primary focus of the Trust's transformation programme is on quality improvement, in the firm expectation that this is also the route to greater staff engagement, productivity and cost-efficiency.

2.6.3. Our Values

In addition to its robust governance and system of internal control and management, the Board has actively supported the development of the Trust's shared Values: *Respecting everyone, Embracing change, Recognising success, and Working together*. These Trust Values were developed by staff from across the Trust and have become increasingly embedded in the Trust since they were developed in 2009 with more than 5,000 staff having undertaken our *Living The Values* training programme which is now part of essential induction for all staff joining the organisation. Work will continue to embed these and make them a reality for staff and patients in 2014/16.

2.6.4. Listening to Our Patients and Staff

In addition, and as part of our developing our response to the Francis Report, in 2013 the Trust held a number of events to listen to the views of patients regarding their care in our Trust. These included:

- A joint meeting with North Bristol Trust and UH Bristol patient representatives
- Individual interviews with UH Bristol patients
- Face to face inpatient surveys in July and September 2013

The focus of these events, individual interviews and surveys was to explore what good hospital care looked like, as well as the actual experience of care patients had received. The key findings following the face to face interviews during July and September exploring the care patients received were:

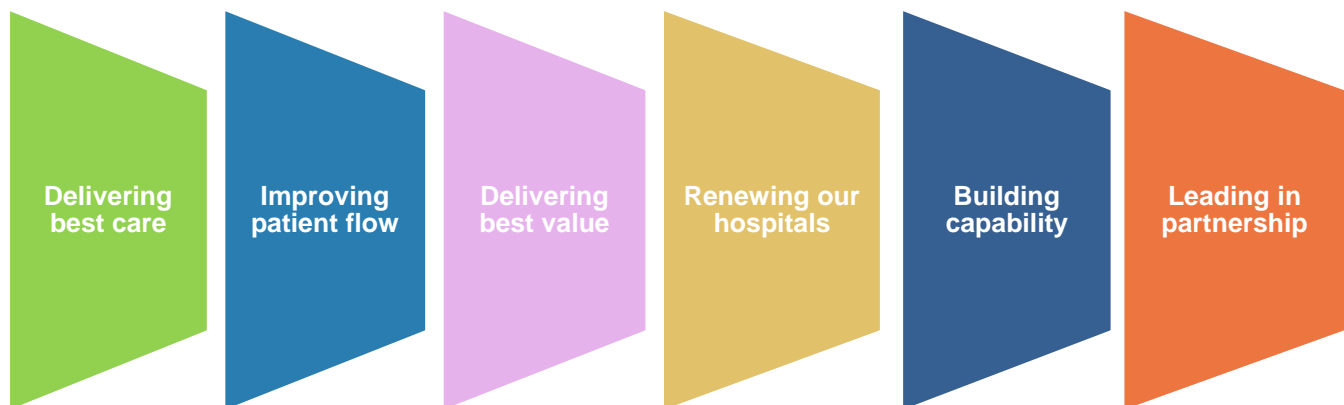
- Overall, the patients reported a good experience with a strong focus on the attitudes and actions of the staff involved in their care. The importance of the personal touch and individual care stood out for a number of the patients interviewed.
- Whilst the majority of patients felt they had sufficient time with the nursing staff some felt they needed to ask and at times felt they had received ambiguous messages about their care.
- The patients interviewed described the kindness and compassion they had received, reflecting the emphasis they placed on the interpersonal skills of the ward staff, especially when patients were at their most vulnerable.
- A lack of consistency regarding the ways patients were involved in decisions about their care was described, with some patients totally involved, others not and some not wanting to be at all.

In conclusion, many of the issues raised by our patients resonate with those of our staff, including; challenges with communication, processes both internal and external, variability and leadership. During the interviews with patients it was also encouraging to hear of examples of episodes where care was delivered effectively and efficiently by kind and caring staff. There is however, no room for complacency, this should and must be the experience for all our patients and their families whilst receiving care in the Trust.

The result of the Trust's listening exercise is that there are a number of initiatives, projects and programmes that are underway or in the final stages of planning for delivery in 2014/16. Board oversight of these initiatives will be secured through their regular review of our action plan falling out of our Francis response.

2.6.5. Quality and 'Transforming Care'

'Transforming care' is the unifying strategy for improvement. This is the overarching programme of transformational change designed to drive us towards our vision for the Trust. Transforming Care is both a set of projects and a structured approach to support the organisation in making change happen and to enable all our staff to improve the services which our patients receive.



The programme is structured under the 6 “pillars” above, which provide focus on the areas we need to address in order to achieve our vision.

Two of these pillars particularly support delivery of our response to the themes identified in the Trust’s listening exercise: “Delivering Best Care”, which is supported by initiatives focused on improving the quality and effectiveness of the care we provide, and “Building Capability”, which captures our work to develop our staff and enable them to contribute to their potential to the benefit of our patients. Some key Quality related elements – and ongoing - of our Transforming Care programme are:

Leadership development programme: The core of the Trust's leadership development programme is transformational leadership, focused on creating a culture of high performance, continuous improvement and organisational transformation. By using the national framework and ensuring people management training is evaluated regularly we can reduce the variability across the organisation, enabling accountability to be clear across the Trust.

Improving Staff Engagement: University Hospitals Bristol recognises that where organisations truly engage and inspire their employees, they produce the highest levels of innovation, productivity and performance. A comprehensive Staff Engagement Strategy is therefore being developed as part of the Transforming Care Programme.

Developing the right model of partnership with our patients and putting them at the heart of how we design, deliver and evaluate our services by learning from Patient Experience. This includes:

- Comment cards on wards and in outpatient clinics.
- Bi-monthly ward-based interviews with patients;
- Monthly post-discharge inpatient survey
- NHS Friends and Family Test

Through statistical analysis of patient feedback data, we have been able to **identify four ‘key drivers’** of overall patient satisfaction with our services:

- being involved in decisions about care and treatment;
- being treated with respect and dignity;
- doctors and nurses giving understandable answers to the patients’ questions;

- and ward cleanliness.

Delivering a patient focused complaints process, using learning/recommendations about complaints management contained in the Francis Report, the recent Parliamentary and Health Service Ombudsman's report Designing good together, and Ann Clwyd MP's report 'Putting patients back in the picture'.

Implementing the '15 Steps' approach: The 15 step challenge is a toolkit with a series of questions and prompts to help guide a team through their first impressions of a ward. The challenge helps staff to gain an understanding of how patients feel about the care they receive.

Developing 'Back to the floor' as business as usual: The back to the floor proposal aims to have all senior nurses/midwives, from the Chief Nurse down, out in clinical areas for a day a fortnight. The day is structured, and will include working alongside members of the ward team to gain an overview of patient care and team work in that area, focussing on one particular aspect of quality.

Implementation of Schwartz rounds: These provide a forum for staff across the hospital to come together once a month (or every other month) to explore together the challenging psychosocial and emotional aspects of caring for patients.

Developing the process of mortality review: The Trust is currently finalising arrangements for regular reviews of all adult deaths within the Trust. Currently, deaths are reviewed through a number of methods including Morbidity and Mortality meetings and Root Cause Analyses. However, learning from other centres suggests that even though 95% of such deaths are adjudged unavoidable, Trusts can learn important lessons regarding, for example, end of life care in particular, if a systematic review is performed.

Undertaking a Patient Safety Review : A Trust wide review of patient safety is to be conducted with the aim of ensuring that the structure and governance supporting patient safety is optimally organised across the Trust, so that reductions in avoidable harm to patients may continue to be achieved. This review will include the introduction of a systematic programme to measure patient safety culture within clinical teams using a recognised evidence-based tool.

2.6.6. More to do....

Although much is currently underway within the Trust regarding action anticipated to nurture the growth of a deeply embedded culture of care, compassion and candour, it would be complacent to consider the cumulative effect of the initiatives already described as sufficient in themselves to bring about systematic cultural development at the pace all would prefer. To this end a number of specific and quantifiable objectives have been identified for the next two years, the achievement of which could be considered indicative of a culture successfully demonstrating key aspirations of the Francis, Keogh and Berwick reports. These key objectives are:

- To ensure that every patient within the Trust always has a clearly identified Consultant responsible for their care.
- To ensure that mistakes in the delivery of care are not repeated
- Learning derived from system error in one area of the Trust must also be applied fully across the organisation.
- To ensure that every patient is appropriately aware of the treatments and care interventions being planned and why these have been chosen.
- The timely and straightforward communication of key elements of care plans to patients, relatives and carers, must be achieved consistently across the Trust's clinical services. All patients should be aware of the reasons for their continuing admission and the factors that will help affect their discharge.

- To ensure that all validated information relating to the quality of services is readily available to patients and the public by including a comprehensive set of appropriate performance indicators within the Trust's website.
- To implement the "expectations"/actions arising from How to ensure the right people, with the right skills, are in the right place at the right time (NHS England 2013) relating to nursing, midwifery and care staffing capacity and capability.

In common with many other Trusts, the potential for the exposition, via the Trust's website, of significant amounts of information derived from performance data has not yet been fully realised. Improved internal processes of data collection and validation, as well as increasing numbers of national audits, will facilitate the ways in which the Trust's performance and achievements can be made more accessible to the public.

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

All risks to delivery of the Trust's quality plans are actively managed through the Trust's risk management processes, through a devolved management structure. Each of the Trust's six divisions maintains a risk register which is managed through Divisional Board structures and is also monitored routinely by the Executive Risk Management Group which is chaired by the Chief Executive; in addition all high risks are reviewed by the Board, in detail at its public meetings. These risks have been described earlier in the plan.

Following a responsive review by the CQC to the operating department at the Bristol Royal Hospital for Children in Nov 2013 the Trust was found to not be meeting two standards. Cleanliness and infection control standards were not being consistently maintained and assessing and monitoring the quality of service provision risks to the safety of patients and staff within the operating department were not being effectively identified and managed in all areas. Compliance was noted to have been impacted by the major building works associated with the expansion of the BRHC and the Trust submitted an action plan to the CQC, all actions are complete and the Trust is waiting a re-inspection.

2.6.8. Governance

The Trust's approach to quality governance remains the Monitor Quality Governance Framework and this framework continues to shape the way in which we govern the organisation. The means through which the Board derives its assurance on the quality of our services is considered to be comprehensive when compared to Monitor's best practice guidelines set out in their Quality Governance Framework.

Each year, our five clinical divisions develop specific, measurable quality goals as part of the process of producing their Annual Operating Plans. Progress against these plans is monitored monthly by Divisional Boards and by the Executive Team through the Divisional Performance Review process. Corporate quality ambitions are developed alongside the divisional objectives so that the two processes inform each other - corporate ambitions, for example derived from the NHS Outcomes Framework, may be passed down to Divisions and common patterns in Divisional objectives may be elevated to become corporate objectives.

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

the organisation and in public.

The Board's responsibilities for quality are partly discharged via its formal sub-committee, the Quality & Outcomes Committee (QOC), comprising both executive and non-executive members. Finally, each quarter, the Board and its sub-committees receive the Board Assurance Framework which reports high level progress against each of the Trust's corporate objectives (including quality objectives) and any associated risks to their achievement.

2.6.9. Challenge and Assurance

HealthWatch, formerly the Local Involvement Networks. This provides a variety of views and challenge to views held by the Trust.

Alongside the tracking of high level objectives, the Board also receives an in-depth monthly quality report, which includes a detailed quality dashboard which monitors progress against corporate quality objectives and other key safety, experience and effectiveness measures. Performance thresholds are set and exception reports are presented if performance falls below expected levels. The exception reports explain why performance has been affected and what actions are being taken to address this.

The Board's responsibilities for governing quality are partly discharged by a Board committee established specifically for that purpose. The Quality and Outcomes Committee meets monthly to scrutinise in detail and, where appropriate, challenge the content of the Board Quality Report.

Additionally, the Board's Audit Committee has worked with the Trust's Clinical Audit and Effectiveness team over the past 18 months and has carefully considered evidence that the Trust's comprehensive programme of clinical audit effectively supports improving clinical quality in alignment with the Trust's quality objectives.

The Board has concluded that sufficient mechanisms can be shown to be in place to identify and address errors or failings in care in UH Bristol's services, but that this conclusion will be tested through the actions set out in the plan in this report. As already stated, the Trust can draw assurance from the actions it has taken and the assurances it receives, but it is essential that it is never complacent, continues to critically self-evaluate itself and take appropriate action where required.

2.7 Operational requirements and capacity

2.7.1. Approach to capacity planning

The long-term capacity model, that underpins the Trust's major capital schemes which will be completed in 2014/15, was refreshed in full in 2012/13. Additional elements of the model were updated again in 2013/14 as part of scenario testing service transfer volumes. The quarterly outputs of the model are the starting point for the more detailed annual planning of operational requirements for years 2014/15 and 2015/16, including detailed ward moves and closure plans. The long-term model uses the following key assumptions about changes in demand for services, and strategic aims relating to services delivery, including bed occupancy optimisation and length of stay improvements:

- Age and area specific ONS (Office for National Statistics) demographic growth rates, which average 1.02% per annum but rise significantly in the over 65 populations which is reflected at specialty level based upon the demographics of previous service users. No further growth in activity beyond demographic or that associated with known service developments is assumed;

- Continued reductions in length of stay (LOS) aiming to get 50% of the way towards upper quartile peer group performance by 2016/17 at a specialty/HRG level;
- Downward trajectory of bed occupancy levels in the Bristol Royal Infirmary (BRI) and Bristol Heart Institute (BHI), which currently operate at or above 95% during periods of high demand, with a plan to reduce occupancy down to 87.5% by 2016/17. All other sites will continue to operate below 90%.
- Static demand for urgent care services from the current catchment but assumed opportunities for specialist services growth.

2.7.2. Summary of key changes to physical capacity

The physical changes to capacity being made in 2014/15 include the baseline capacity requirements as predicted by the long-term capacity model, along with the impacts of planned service transfers. The impact of these service transfers have been separately modelled and scenario tested (further details of which are included in the Mitigation of Risks section below). Capacity planning assumptions for 2014/15 that underpin the changes being made to the physical estate and assumed activity levels include the following modelled changes in demand:

- Changes in market share associated with a shift in the catchment for emergency activity following the closure of North Bristol NHS Trust's Frenchay Hospital Emergency Department (ED) in quarter 1 2014/15, leading to an estimated increase in activity of around 500 emergency spells per annum, equivalent to a requirement for 14 additional beds within the Bristol Royal Infirmary;
- Planned transfer of Specialist Children's Services from North Bristol NHS Trust (NBT) upon the closure of Frenchay Hospital in quarter 1 2014/15, leading to a requirement for an additional 24 inpatient paediatric beds (16 neurology; 4 burns 4 general surgery), 5 day-case beds, 4 theatres and a further 4 High Dependency Unit (HDU) beds in the Bristol Royal Children's Hospital;
- Transfer of adult Vascular Surgery services to North Bristol NHS Trust (NBT) in the second half of 2014/15 (date to be confirmed), equivalent to a reduction in 14 inpatient beds within the Bristol Royal Infirmary (BRI);
- Increased demand for general adult Intensive Therapy Unit (ITU) beds, due to forecast spell growth in specialist work. The additional bed has been built-in to the plans for the new ITU in the BRI ward-block which will open in the latter half of 2014/15; please note that an additional ITU bed was opened in Q4 2013/14, due to increased demand for ITU beds already experienced in-year and in anticipation of increased demand associated with the closure of the Frenchay Emergency Department in Q1 2014/15.

There are no additional services changes that impact on physical capacity during 2015/16. In addition to these physical planned changes to the estate and site operations, the associated work-force changes have been modelled. Workforce estimates have been based upon a work-programme which looked at what the model of care and associated skill mix needed to be to deliver new services (e.g. new paediatric specialties), and services set-up in a more optimal configuration (new BRI ward-block), rather than simply making proportional changes to staffing levels.

The new BRI ward-block has been configured to support patient flow and effective patient management, to capitalise upon the synergies created by medicine wards that work closely together being housed together. Similarly, the new configuration of wards will allow a separation of the elective and emergency surgical flows, which should allow elective work to be more effectively managed through the bed-base.

2.7.3. Mitigation of risks

Analysis of 2013/14 forecast out-turn suggests that actual spell volumes are growing at below that

predicted by ONS demographic growth rates. This analysis offers some assurance that sufficient capacity will be provided for the annual predicted level of demand. However, at particular times of the year significant levels of growth in emergency spells are seen in 75 year and over age bands, which outstrip that forecast by ONS. To mitigate the risk of in-year variation, 2014/15 and 2015/16 bed requirements have been planned on the basis of observed quarterly variation in the number of bed-days consumed.

There are a number of service transfers that are impacting in 2014/15. Each has been separately modelled and scenario tested to understand potential risks and likely scale of variation in demand if planning assumptions do not hold true. North Bristol Trust's spell data-set has been used to provide a forecast for the planned service transfer of specialist paediatric work. In 2013/14 a refresh of the modelling using the latest data-set showed that whilst there had been some shift in spell volumes for individual specialties, the overall modelled bed demand was consistent with the original modelling undertaken for the Full Business Case. Bed occupancy rates assumptions have been set at a low enough level to provide a good degree of flexibility in day-to-day operations, but also to allow for any under-estimates of the growth in demand to be covered.

The closure of Frenchay Hospital and its Emergency Department, and re-opening of Southmead Hospital as the site for type 1 ED activity, has been modelled by estimating the change in likely attendance patterns at type 1 EDs across the electoral wards. NBT's planning assumption is for no transfer of activity. Ambulance Trust intelligence has been sought to further inform the modelling of changes in catchment area, given that ambulance crews will be the likely determinants of the majority of the flow. However, the ambulance trust assessment is at this stage an estimate only rather than a statement of intention. A number of different scenarios have been run which has provided a range of estimates for demand for beds from emergency admissions, from 11 to 23. Provision within the BRI is being made for an additional 14 beds worth of demand, which is considered to be the most likely scenario. Additional mitigations to manage any increases in demand above that forecast include the use of substantive flexible bed capacity built-in to the BRI ward plans, and, in extremis, the use of a ward that is closed during the first two quarters of 2014/15, before any further improvements in length of stay can be realised.

A separate exercise has been conducted to plan for the likely increase in A&E attendances at the Bristol Children's Hospital following the Frenchay ED closure. This piece of work was led by the lead clinician for the Children's Hospital ED. This involved significant engagement with clinicians at NBT and other key stakeholders in order to understand likely changes to patient flows and resulting attendances and admissions.

2.7.4. Commissioner intentions, activity and revenue assumptions

Bristol, North Somerset, Somerset and South Gloucestershire CCGs are seeking to use the contract to lay the foundations for transformation in their own 2 and 5 year planning. To meet the financial challenges that commissioners have set out to us, CCGs have indicated that they would like to use the contract flexibly, including flexibility around the PbR tariff and contract duration – discussions are ongoing in relation to this. However, it is our intention that the 2014/15 contract will remain a PbR based contract.

The key financial messages from commissioners are:

- There will be a net reduction in PbR Tariff prices of 1.2% and non-PbR reduction of 1.5%
- Commissioners are seeking a cost neutral position on areas such as coding and counting changes
- CQUINs will remain at 2.5% locally – 0.1% being top-sliced to fund Operational Delivery Networks
- Activity will be commissioned at 2013/14 Month 8 Forecast Outturn levels, with additional non-recurrent activity to achieve RTT targets and other agreed adjustments to outturn levels.

CCG quality requirements aim to build on learning from Francis and Winterbourne View, agreeing

common indicators across all Trusts. This is in addition to the national contractual requirements around Francis and information schedules, which will apply directly to the way Trust staff work, but also in relation to the way we sub-contract for any work commissioned from UH Bristol.

To date CCG CQUIN priority areas have been identified as end of life care; Francis/information requirements; parity of physical and mental health; discharge summaries; cancer treatment summaries; deteriorating patient; and maternity - nutritional support for pregnant obese ladies. Discussions are ongoing regarding a small number of additional local non-specialised CQUINs. CCGs have indicated that they would like fewer CQUINs which are system wide and vertically integrated. We are in discussion with CCGs to understand the full implications of this, but there is agreement that UH Bristol should be able to control its own elements of any system wide CQUINs agreed.

In terms of Urgent care, there is a focus from commissioners on working towards 7 day services and improvements in the urgent care system, reducing the burden on ED and Trust capacity, including Ambulatory Care, GP Support Unit (moving to city wide) and full and effective utilisation of South Bristol Community Hospital. This will continue to impact on all areas of the Trust and the 7 day working board is looking into the detail of the CCGs' 7 day services action plan requirements. This will also impact on specific areas, such as Liaison Psychiatry, where commissioners want to see improved access to psychiatric support.

CCG intentions around service reconfigurations take account of work already well advanced, such as Centralisation of Specialised Paediatrics, Vascular Transfer, Acute service transfers (including the BRI redevelopment works) and pathology. North Somerset intends to relocate additional outpatient activity to Clevedon Hospital, a potential capacity of 1000 outpatients across UH Bristol and NBT.

CCGs have indicated that they are likely to invest in the liaison psychiatry service and the home enteral tube feeding service. A city-wide foot care review is planned, following which the model of care for the diabetic foot service will be confirmed.

NHS England intends to agree a separate contract. Nationally mandated NHSE Specialist Commissioning service specifications will be included within the 2014/15 contract together with any other specific requirements for NHS England directly commissioned services (principally dental and screening services). The financial key messages are consistent with BNSSSG CCGs. In relation to CQUINs, NHS England set out in October 2013 that its intention was to exclude PbR-excluded drugs and devices from the contract value to which CQUIN applies, which will impact significantly on the overall value of CQUINs available. Specialised CQUINs are likely to include highly specialised services; quality dashboards; clinical trials; neonatology/breastfeeding; and cardiac surgery inpatient waits.

NHS England's focus has been on compliance with national service specifications and it will be publishing the list of services UH Bristol is commissioned to provide, including those where compliance is derogated and actions required in 2014/15 to address non-compliance. NHS England is undertaking a review of a number of key service specifications which affect UH Bristol directly, and we shall respond to the consultation and assess the impact of any changes on our capacity to deliver those services effectively.

In terms of investment, and alongside its support for the Centralisation of Specialist Paediatrics, NHS England is focussing on the following in 2014/15:

- Neonatal Intensive Care/Paediatric Intensive Care (PIC) Retrieval, including investment and a review of arrangements across the South West and further discussions with Wales (for PIC)
- PICU (Paediatric Intensive Care Unit) Capacity – to increase capacity to meet current demand, in addition to increases to support the services transferring from NBT
- Paediatric Major Trauma – investment to meet designation standards

- Palliative Care – investment to achieve specification requirements
- Children's Epilepsy – drawing on central funding to improve this service and transfer from NBT
- Discussions are ongoing regarding further service developments, growth and adjustments to forecast outturn.

2.8 Transforming Care - Productivity, Efficiency and Cost Improvement Planning

In developing its savings programme, the Trust continues to focus on maintaining quality whilst addressing the requirement to reduce costs in line with national efficiency requirements.

The Trust sets Cost Improvement Plan (CIPs) targets in the light of:

- National efficiency requirements
- The Trust's own assessment of inflationary impacts it is facing, and
- An assessment of the requirement for investment to address risks or quality improvements it believes is necessary.

CIP targets are applied differentially across the Trust's six divisions reflecting their cost efficiency profile. The Trust has an established process for generating CIPs. Divisions maintain an 'ideas bank' through which Division teams assess the relative maturity of schemes based on a set of criteria. The ideas being transferred onto the Division's and Trust CIP plan only when they are sufficiently robust and fully mature. This process ensures that the divisions and Trust have a continuous pipeline of schemes coming through.

The Trust has a successful track record of delivering nationally required efficiency savings whilst continuing to maintain the quality of the services it provide. It has a strong track record of having delivered financial balance for 11 consecutive years; its reference cost index is 101.

2.8.1. CIP Governance

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

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

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

Specific attention is paid to assessing and monitoring the quality impact of plans. All schemes are supported by a dashboard which clearly identifies and assesses the quality and operational risk of each

scheme. This is completed by the responsible officer for the specific initiative and overviewed monthly by the Programme Steering Group and work stream accountability meetings which again include both medical and nursing director oversight.

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

2.8.2. Transformational 'CIPs'

As described earlier, the Trust operates an established programme of transformation - Transforming Care.

The key transformational work streams which support CIP are as follows:

Productive Outpatients aims to improve the service quality and productivity in our outpatients services.

It is anticipated that the improvement in outpatient utilisation, resulting in a reduction in clinics and workforce requirements which will deliver financial savings in the first year of the plan of £0.4m with an estimated £1m more to be realised in year two of the programme.

Our **Theatre Productivity** transformation programme has been established to focus on improving theatre efficiency across the Trust. Additional objectives include reducing cancelled operations, reducing late start times to improve patient experience, reducing daily scheduling conflicts and better aligning capacity with demand in support of RTT targets.

The savings resulting from this work will arise from reductions in premium payments required to deliver theatre activity, and reductions in non-pay expenditure and are estimated to be £1.2m over the two year plan.

R3 (Right patient in the right bed at the right time) which is our patient flow programme is well established and provides a focus on improving patient flow from presentation to discharge with specific aims of supporting strong A&E 4 hour performance, reduced length of stay, reduced numbers of patients for whom discharge is delayed and a reduction in the rate of cancelled operations arising from a lack of available beds.

The benefits of this work will be realised by reductions in length of stay allowing us to operate consistently within our funded bed base and are estimated to be a further £1.5m in 2014/15 which will get us to our target bed base by March 2015.

The **Diagnostic Testing** project addresses the processes for delivering diagnostic testing across the Trust both for Pathology and Radiology in order to generate cross division opportunities to improve productivity, introduce common ways of working use benchmarking and detailed analysis to identify opportunities and scope changes. The work stream is also focussing on benchmarking with other trusts to identify further opportunities for efficiencies with an estimated benefit of £1.75m,

2.8.3. Summary of 'Traditional CIPs'

The Trust has established a further group of work streams dedicated to delivering 'transactional CIP's'. These are listed in the table at the end of this section which shows the savings identified in 2013/14 and planned for 2014/15 and 2015/16.

The ongoing areas of focus of the traditional CIP work streams are.

- Improving purchasing and efficient usage of non-pay including drugs and blood
- Reviewing staffing levels and staffing skill mix across all staff groups

- Consolidation of staff rostering tools. This is primarily focused on the nursing workforce, but during 2014/15 the tools and principles are to be expanded to other workforce groups.
- Reviewing and improving controls over expenditure through improvements to our training and expenditure review processes
- Job Planning and links to capacity and demand for the medical workforce. We are developing specific improvement projects working jointly with the Local Negotiating Committee to generate savings projects alongside the consultant job planning process.
- Reviewing and improving management structures including spans and layers reviews
- Ensuring best value in the use of the Trust's Estates and Facilities. This includes a review of the delivery of specific services, and further improvement in energy efficiencies
- Ensuring best value from all of our back office and corporate functions
- Ensuring best use of technology to improve efficiency, linking productivity improvement with the introduction of new tools in clinical records management and patient administration
- Addressing and reducing spend on premium payments including agency spend.

2.8.4. Summary of Planned Savings

Workstream	2013/14 Forecast delivery	2014/15 Planned delivery	2015/16 Planned delivery
	£'000	£'000	£'000
<u>Transformational "CIP's)</u>			
Out Patient Productivity	480	401	1,000
Theatre Productivity	-	219	1,000
R3 (Patient flow)	1,017	536	-
Diagnostic Testing	255	1,005	500
<u>Traditional "CIPs"</u>			
Medical staff productivity	970	897	978
Nursing Productivity	1,935	2,061	970
AHP Productivity	1,132	1,299	600
Medicines	1,309	1,101	1,000
Non Pay (Procurement /Usage)	2,891	4,504	3,000
Admin and Senior Managers including Use of Technology	427	283	978
Trust Services	1,080	1,011	1,371
Facilities and Estates	1,046	766	1,033
Income	1,503	-	-
Terms and Conditions	-	483	470
Corporate savings	2,885	6,297	3,000
Total	16,930	20,863	15,900

2.9 Workforce Plan

In a sector where more than 60% of the cost base is invested in staff, workforce deployment is a key component of responding to the significant financial challenges; in addition, 2014/15 brings the challenges of major workforce change associated with strategic schemes coming to fruition in year. These changes

include the movement of over 300 staff between North Bristol NHS Trust and UH Bristol as part of service transfers, and the reconfiguration of wards and opening of the new tower block as part of the Bristol Royal Infirmary (BRI) redevelopment which will impact on over 2000 staff.

Our workforce plans are designed to manage these challenges and to ensure that we have a workforce that is safe and affordable and aligns to capacity. Our work programmes are part of the 'Building Capability' pillar of our Transforming Care programme.

2.9.1. Workforce Plans

UH Bristol has a well-established annual operating plan cycle, which requires each Division to provide an integrated plan which aligns quality, finance, workforce and capacity. The Trust workforce plans which result from this process form the basis for the workforce targets which are monitored at Trust Board and at Divisional level in operating plan reviews and at Divisional Board meetings.

Whilst workforce planning follows an annual workforce planning cycle, ensuring that each area and ward has the right number of staff is an ongoing priority throughout the year. The Trust is developing a Safer Nursing Policy which involves an assessment tool to ensure that there are appropriate staffing numbers on every ward. Staffing levels are monitored on a monthly basis to ensure staff on the wards aligns with the planned numbers.

2.9.2. Changes in staff employed by WTE 2013/14 to 2015/16

The table below shows the planned changes in staff employed for 2014/15 to 2015/16:

	FOT 13/14 (WTE)	Change 13/14 to 14/15 (WTE)	FOT 14/15 (WTE)	Change 14/15 to 15/16 (WTE)	FOT 15/16 (WTE)
Budgeted Establishment	7495.2	194.5	7689.7	-69.4	7620.3
Savings Programme		-99.3			
Service Transfers		205.2			
Service Developments		83.6			
Other		5.0			

FOT = Forecast Outturn

2.9.3. Key factors in Workforce Plans 2014/16

Service Transfers and Developments

During 2014/15 there will be four key service transfers under TUPE (Transfer of Undertakings Protection of Employment) between UH Bristol and North Bristol NHS Trust (NBT).

The transfers from NBT to UH Bristol are as follows:

- Centralisation of Specialist Paediatrics, 229.8 WTE, transfer date May 2014
- Cleft, 15.6 WTE, transfer date August 2014

Transfers from UH Bristol to NBT include the following:

- Vascular transfer, staff numbers to be confirmed, October 2014
- Breast Screening, 40.7 WTE, transfer date August 2014

UH Bristol and NBT have developed a project methodology and a Memorandum of Understanding to ensure that we work following best practice in preparing for the transfers. This includes engaging and consulting with staff, planning the future workforce, exchange of information and undertaking due diligence. There is also a Human Resources Partnership Board to promote joint working between the two Trusts.

Other transfers with small numbers of staff affected include the transfer of dermatology services from Weston (2.6 WTE), Genetics staff from Taunton (4.5 WTE), and Cystic Fibrosis from Bath (4.2 WTE).

BRI Redevelopment

As a result of the BRI Redevelopment and the associated moves, ward sizes, specialties and locations will change, not just within the new ward block but across the Bristol Royal Infirmary estate, affecting approximately 2,450 staff. A phased preference, selection and consultation process, ending in December 2014, will ensure that nursing numbers match changed ward sizes, specialty and skill mixes.

In addition, changes in the model of care, the greater number of single rooms and ward configuration will require modified ways of working in some areas, and work is underway to prepare teams for the new environment. The first of the ward changes takes place in July 2014. There will also be a combined impact of the BRI Redevelopment and the Specialist Paediatric transfer resulting in an increased requirement of more than 50 more WTE ancillary staff.

7-day working

The Trust recognises the need and value of delivering comprehensive care seven days a week in order to deliver better clinical outcomes, improved flow, expanded capacity and patient convenience. In many areas, such as neonatal and paediatric care, this is existing practice.

In alignment with the CCG, in 2014/15 we are continuing to focus on changes to the way our staff support urgent and emergency care services, and their supporting diagnostic services, in order that agreed standards of care can be met at weekends and out of hours to promote active management and discharge, seven days a week.

A comprehensive review of other areas has been undertaken to establish what additional support, if any, will be required to deliver continuity of care, where appropriate, across the weekend.

Other Service Developments

There are a range of workforce developments which will result in increased workforce numbers, particularly in Women's and Children's Division, including PICU retrieval and support to prepare for Children's Major Trauma Designation.

Reducing workforce expenditure

The Trust has established a number of work streams dedicated to support the delivery of CIPs, described in section 2.8, which will result in reductions in some reductions in WTE.

Savings plans will result in a reduction of approximately 100 WTE in 2014/15. However, some savings will not have WTE reductions associated, but will reduce pay costs and increase productivity, including plans to change skill mix and reduce premium payments. Plans which will release pay costs through transformational change include the following:

- As part of the Medical Efficiencies workstream, partnership working with the Local Negotiating Committee has helped to take forward plans to reduce medical costs, including a comprehensive

review of job planning and the reduction of premium, medical agency and on call payments.

- The Theatre Efficiency workstream, work will impact on pay costs through transformational change to reduce capacity, including increased productivity of the Anaesthetic workforce.
- The Outpatients Efficiency workstream which will result in administrative workforce efficiencies.
- Work on patient flow is planned to reduce length of stay by changes in ward processes, ambulatory care and admission avoidance, and partnership working with social care, which will release nursing costs.
- As part of the Technology, Administrative and Senior Managers workstream, technological change will achieve reductions in numbers of staff, for example, through Electronic Data Management and digital dictation.

Plans for 2015/16 are still in the process of being developed, and the associated WTEs do not currently appear in the workforce plan.

2.9.4. Workforce Supply

Recruitment and Retention

Vacancy levels during 2013/14 increased, particularly for nursing, and this was exacerbated by increased budgeted establishments for the Children's Hospital and the plan to recruit to a higher percentage of the nursing budgeted establishment across the Trust. However, a successful recruitment campaign has resulted in the majority of vacancies across nursing and midwifery being filled. The focus for recruitment during 2014/16 will include continuation of a sustained recruitment programme to keep pace with turnover, and implementing the National Values Based recruitment programme. Recruitment to ancillary vacancies to recruit to the increased levels to support the BRI and Children's Services Developments will also be important during the coming year.

Whilst overall vacancy levels have improved there are still some hot spots where consultant posts are proving difficult to fill, for example histopathology, radiology and oncology. There have also been difficulties over the past year in recruiting to sufficient acute physicians resulting in changes in the Medical Assessment Unit Medical Model.

We also plan to reduce turnover over the next two years. Net turnover for 2013/14 (excluding bank, fixed term contracts and junior doctors) stands at 11.3%. The Trust targets for 2014/15 and 2015/16 are 10% and 9% respectively. These will be achieved through a range of changes which include improved data on reasons for leaving, increased focus on a standardised ward induction process, and a change in the way nursing assistants are recruited with an assessment centre approach to selection, combined with the work on staff engagement as part of the Building Capability programme.

Temporary Staff Usage

The workforce plan for UH Bristol assumes continued use of temporary staff to provide flexibility to reflect changes in demand and to cover absence. During 2014/15, we are aiming to reduce bank and agency usage from 4.9% of the WTE to 3.4% of the WTE, and to 3.2% by 2015/16. The focus will be on reducing agency, particularly premium rate; in 2013/14, 66% of total agency spend was for nursing. Reductions will be achieved through the following:

- Divisional controls to avoid the use of agency unless essential will continue and agency usage will continue to be closely monitored.
- The strategy implemented in 2014/15 of recruiting to a higher proportion of the budgeted establishment for nursing will be continued.
- Workforce models which include substantive staff are being developed to address fluctuating

demand for staff resulting from changes in capacity.

- Greater control of the use and payment of medical locums through alternative models in managing medical locums. After testing a number of models the Trust has recently appointed a preferred direct engagement model provider.

Sickness Absence

UH Bristol has set a target of 3.5% absence for 2014/15 and a stretch target of 3% for 2015/16 against a projected outturn of 4.1% for 2013/14. In 2013/14, 79.7% of days lost in UH Bristol were due to long term absence, with Stress-related and musculo-skeletal absence combined accounting for 31% of all days lost to sickness. Work to reduce absence over the next two years will build on existing programmes, and includes the following:

- Sustained and focused support from Employee Services to work with managers to reduce all sickness absence and review and implementation of a revised Supporting Attendance policy.
- Continued referral to Physio Direct for musculo skeletal injuries which provides fast track support for any staff who are affected by musculo skeletal pain or injury.
- The implementation of the work programme agreed with the Health and Well Being Board to progress a Trust wide Health and Well-Being plan.

We will also undertake a cost benefit analysis of Employee Assistance programmes, and implement if this proves favourable, along with scoping other programmes of work to support the reduction of sickness. It is anticipated that the achievement of the challenging targets will be supported by the increased focus on health and well-being as part of the Building Capability programme.

Role Redesign

As part of the Nursing Transformation Programme, there has been a focus on developing the role of the supervisory ward sister across the Trust. There has also been a review of the role of Clinical Nurse Specialist (CNS) to increase productivity and deliver more clinics. Advanced Nurse Practitioner (ANP) roles are being developed and extended. For example, the Emergency Nurse Practitioner model in Emergency Department will increase to provide a 24/7 service, and extended to treat 'majors'. There are also plans to introduce the ANP role to paediatric intensive care. There is also a key piece of work to develop the role of the unregistered workforce. There is already a clear induction programme for these staff, but in the future, we will be developing internship and trainee roles, ensuring there is a systematic recruitment and training pathway to ensure that they have the underpinning skills and values to deliver the best patient care.

Within Allied Health Professionals and Health Care Scientist roles, we are also reviewing the band 3 and 4 role to develop some further shared roles across pathways whilst developing their skills overall. This will allow us to release qualified staff time helping services to manage capacity pressures.

Education Commissioning

The new Education Commissioning body, Health Education South West has aggregated workforce plans from 2012/13 from health organisations including UH Bristol in the South West to inform Education Commissioning plans. UH Bristol has continued to work closely with Health Education South West to ensure that training places meet service demand. This has resulted in increased numbers of Operating Department Technician trainees reflecting the challenge that theatre recruitment presents at UH Bristol. HESW has also responded to the requirement to increase Nurse Training places, although there is a challenge to provide placements for the increased numbers of student nurses. UH Bristol Chief Executive

is now the Acute services representative from the West of England on the Governing Body.

The Trust has improved processes for managing changes to junior doctor posts. A Surgery Core Training post has been removed by the deanery from 2014/15, and two F1 posts have been transferred to psychiatry. There will also be changes in junior doctor numbers associated with the transfer of specialist paediatrics and vascular services.

Pay and Reward

Pay and Reward is an important area of work for the Trust and we continue to review and audit our policies and processes to ensure maximum productivity and efficiency. We value partnership working with our staff side representatives. The following programmes of work are examples of the Trust's planned Pay and Reward strategy for 2014/15.

- The Trust is phasing out the Cost of Living Allowance, previously paid to certain qualified Nursing and Midwifery and Allied Health Professional staff. Following a 50% reduction from 1st May 2014, the allowance will be completely withdrawn as at 31 March 2015.
- Mutually Agreed Redundancy Scheme/Extra Authorised Unpaid Leave/Hours Reduction schemes have been established for each of the last three years. It is likely that this will be an option the Trust will pursue again in Autumn 2014.
- The Trust will be implementing the nationally agreed changes for Agenda for Change staff linking pay progression with performance management with effect from 1st April 2014.
- The Trust is reviewing all Consultant job plans to focus on optimum use of consultant time and additional programmed activities are applied consistently.
- The Trust is also revising its processes for the payment of Consultant Pay Thresholds which will support the changes being made to non-medical staff in terms of linking pay progression with performance management.

Building Capability

Building capability is one of the six pillars that support the Transforming Care programme of work to transform our services to enable the delivery of high quality and safe care for all our patients. The Building Capability workstream will ensure that we recruit the best staff, create a culture of employee engagement and develop and support our staff so that they have the best skills to deliver excellent patient care and ensure our leaders know what is needed and can motivate people to achieve it, and can ensure that all staff know the part they play in delivering the Trust goals. Some of the elements of the workstream, such as 'recruiting the best' and 'health and well-being' have already been covered. In addition the following work is included with the Building Capability work:

Engagement

UH Bristol has an ongoing programme of work to engage staff in delivering the highest quality patient care and create a workplace where staff are motivated to work together, and this is reflected in the Trust's engagement score in the 2013 National Staff survey of 3.77 (out of 5) which compares with a national average of 3.74. An action plan has been developed to look at the opportunities to expand the engagement and staff experience agenda based on the six elements recognised in staff engagement and staff experience by Professor Michal West.

Leadership Development

During the next two years, we will continue to offer support in developing leadership skills, through both existing programmes; coaching and mentoring; and through the development of the E-Business skills

programme, as well as procuring the best possible programme for Divisional Directors and Clinical Chairs.

Essential Training

UH Bristol has made significant progress in updating the Essential Training matrix to ensure staff undertake the statutory and mandatory training that is essential to their role in a timely, effective and appropriate way, and has also transferred to a different Learning Management System provider. During 2014/15, the focus will be on implementing the agreed action plan to move to self-service, implement a robust plan for blended learning and ensure that compliance targets are achieved.

Clinical Skills

Investment has been made to support the use of simulation to ensure safe centralization of Children's services in Bristol. A programme has been designed to support staff transferring from North Bristol Trust using the Bristol Medical Simulation team at UH Bristol.

Compliance against the training plan to Improve Care for people with Dementia or mild cognitive impairment whilst in hospital is being achieved by the support of an additional teaching post for two years.

2.10 Financial plan

2.10.1. Introduction

The Financial Plan commentary describes the Trust's current assessment of the 2014/15 financial year and presents the 2015/16 position in outline. The 2014/15 financial year presents a significant financial challenge to the both the Trust and its Commissioners. It should be noted that it is likely that the current assessment of 2014/15 presented here will change considerably due to:

- The Trust identifying full savings plans necessary to achieve the 2014/15 saving requirement of £20.9m in full. The savings requirement is summarised below:

4% National requirement	£16.1m
Divisions underlying position	£10.8m
Less corporate support	<u>(£6.0m)</u>
2014/15 Savings requirement	<u>£20.9m</u>

- Ongoing Service Level Agreement (SLA) discussions with Commissioners. Heads of Terms are not expected to be signed until April 2014 and are likely to result in lower income from the current proposals due to Commissioner affordability. Therefore, a judgement has been made in determining the likely income position within this assessment.

Whilst it is anticipated that progress will be made on both issues, it may be necessary to update the 2014/15 plan in the second 30th June 2014 submission to Monitor. Planning for 2015/16 has not progressed to the same extent as 2014/15 and key components remain unresolved, in particular the identification of 2015/16 savings plans necessary to underpin the Trust's financial projections for 2015/16. However, work is in hand to develop these plans including external support to savings identification and delivery which commenced in early March this year. As SLA discussions and savings delivery plans firm up over the coming weeks, the Trust will give consideration to downside risks and mitigations as part of its strategic plan submission.

2.10.2. Income

The 2014/15 income plan is £575.7m, an increase of £28.3m compared with the 2013/14 forecast outturn income of £547.4m. It should be noted that the impact of the Better Care Fund is still being considered in the Health Economy and no estimate has been made at this point. The changes between the 2013/14 forecast outturn and 2014/15 Plan include:

2013/14 Forecast Outturn Income	£547.4m
Tariff deflation	(£5.7m)
Service Transfers / Transactions	£14.5m
Developments	£4.0m
Activity growth	£2.0m
Recording/Tariff changes	£2.7m
CQUINs reinstatement	£1.3m
Donation income	£8.6m
Other	£0.9m
2014/15 Proposed Income Plan	<u>£575.7m</u>

For 2015/16, income is estimated at £567.2m, a reduction of £8.5m compared with the 2014/15 plan. The reduction is primarily due to the impact of 2015/16 National Tariff deflation at 1.5% and a reduction in charitable donations.

2.10.3 Costs

The 2014/15 cost outlook for the Trust should be considered in the context of an increasingly challenging environment. Pressures on spending, savings plans and transformation initiatives are intensifying and firm control will be required to avoid the Trust's medium terms plans being undermined. The main assumptions and considerations included in the Trust's cost projections are:

- General pay award assumed at 0% *, drugs at 5%, clinical supplies 2% and capital charges at 8%;
- Multi Professional Education and Training (MPET) rebasing resulting in a funding loss of £1.3m;
- Savings requirement at £20.9m;
- Payment of loan interest at £3.2m; and
- The impact of the District Valuer (DV) full revaluation exercise carried out by the DV in February 2014.

*A provision of £800k has been made for pay awards though it has not yet been possible to assess the reasonableness of this given the complexity of the recently announced award arrangements.

The 2014/15 position includes the following non-recurring costs:

- £1.0m change / invest to save costs;
- £0.5m transitional costs in support of the strategic schemes;
- £0.75m Clinical Systems Implementation Programme (CSIP);
- £0.5m risk reserve;
- £1.0m provision for SLA fines; and
- £23.0m impairment arising from the writing down of capital cost to depreciated replacement cost of the BRI Redevelopment Phase 3 following a forecast assessment by the District Valuer.

2.10.4 Strategic Developments

Bristol Royal Infirmary Redevelopment

Commissioning of Phase 3 begins in June 2014 and will be completed in January 2015 providing up to date and modern estate. Phase 3 will enable the delivery of new models of care through the Acute Medical Assessment Unit (AMAU) which will improve service efficiency, patient flow and quality of care. The full year effect net recurring revenue cost of Phase 3 in 2014/15 is £6.9m, the part year effect is £4.6m. The key action and key risk is the delivery of the planned length of stay reductions before the opening of Phase 3, and the delivery of length of stay savings post 2014/15. The bed closures are necessary to deliver the decant of patient services from the Trust's King Edward Building and the subsequent closure of the BRI Old Building in March 2016. The closure of the BRI Old Building delivers recurrent savings of £2.0m meaning the net recurring revenue cost of the scheme from 2016/17 is £4.9m.

Other Service Developments

It should be noted that the 2014/15 plan includes a number of service developments. However, these are not commented here because each of the developments has an impact of less than £0.4m and all are revenue neutral developments and fully funded by Commissioners.

2.10.5 Transactions

Breast Screening Transfer

The transfer of the Avon Breast Screening Service from UH Bristol to North Bristol NHS Trust (NBT) is planned to take place from 1st August 2014. The transfer will reduce the Trust's income by £1.50m and reduce the Trust's expenditure by £1.36m resulting in a net loss to the Trust of £0.14m.

Centralisation of Specialist Paediatrics

The project meets the long-term vision and strategy to centralise paediatric services delivering integrated paediatric services within the existing Bristol Royal Hospital for Children (BRHC). The recurring revenue impact is financially neutral with increases in both income and expenditure of £16.1m in 2014/15. The new service will begin treating patients from May 2014. As the project enters into the detailed commissioning phase, key to the delivery of the project and continuity of services for patients will be the successful transfer of approximately 150 staff from NBT and recruitment into the remaining workforce requirements.

Vascular Transfer

The transfer of Vascular services from UH Bristol to form a Major Arterial Centre at NBT is scheduled for 1st July 2014. The current financial assessment is the transfer will reduce UH Bristol's income by £2.4m and costs by £1.8m in 2014/15 resulting in a net loss to the Trust of £0.6m. The full year assessment is currently a net loss to the Trust of £0.8m.

2.10.6 Capital expenditure

The Trust has a significant capital expenditure programme investing £379.9m from April 2008 until March 2018 in the development of its services. In 2014/15, the Trust's planned capital expenditure totals £57.6m and 2015/16 totals £24.7m. This is summarised in the table below:

Source of funds	2013/14 Forecast £m	2014/15 Plan £m	2015/16 Plan £m	Application of funds	2013/14 Forecast £m	2014/15 Plan £m	2015/16 Plan £m
Public Dividend Capital	0.5	2.6	0.0	Strategic schemes	49.4	35.9	9.7
Depreciation	17.7	19.2	22.3	Backlog works	2.2	2.6	2.4
Loans	50.0	20.0	0.0	IM&T	2.9	6.8	1.3
Donations	1.1	8.6	3.0	Operational capital	7.2	11.4	6.3
Disposals	0.0	0.7	0.0	Medical equipment	6.2	6.8	2.5
Cash	(1.4)	6.5	(0.6)	Slippage	-	(5.9)	2.5
Totals	67.9	57.6	24.7	Totals	67.9	57.6	24.7

The Trust's major strategic schemes are:

BRI Redevelopment Phase 3 and Phase 4 £30.2m

The re-provision of clinical and non-clinical services from 18th century accommodation into a modern purpose built facility to:

- Eliminate all Nightingale wards and increase single rooms from 11% to 26% of the bed base;
- Enable delivery of new models of care which will improve service efficiency, improve patient flow, quality of care; and
- Improve patient experience through enhanced physical environment.

The Trust Board approved the Full Business Case (FBC) in April 2011 and the FBC refresh in January 2014. Phase 3 will be completed in January 2015 and Phase 4 completed by March 2016 which will allow for the closure of the BRI Old Building. The scheme spans seven financial years and will cost £115.7m upon completion. The scheme is being financed as follows: £46.5m long term loan; £10.7m asset disposals; £56.5m internal resources; £2.0m charitable donation.

Centralisation of Specialist Paediatrics £3.7m

The scheme received Trust Board approval in March 2011 and construction began in June 2011. The FBC refresh was approved by the Trust Board in November 2013. The scheme will be completed in May 2014 at a total cost of £31.6m. The scheme is being financed from: £23.5m long term loan; £5.8m charitable donations and £2.3m internal resources.

Bristol Haematology and Oncology Centre (BHOC) Redevelopment £2.0m

The redevelopment and expansion of the BHOC reached practical completion in February 2014 at a cost of £14.0m. The scheme created an integrated adult Haematology and Bone Marrow Transplant unit, a dedicated teenage and young adult unit and provision of two radiotherapy linear accelerator bunkers. The planned capital expenditure of £2.0m in 2014/15 is to purchase a replacement linear accelerator which is fully funded by a charitable donation.

2.10.7. Liquidity

The Trust's 2014/15 forecast year end cash balance is £46.6m and includes the drawdown of the Trust's third loan of £20.0m in quarter 1 of 2014/15. The Statement of Financial Position forecasts net current assets of £12.9m at the 31st March 2015 and £12.8m as at the 31st March 2016. The reduction in net

current assets from 31st March 2014 is primarily due to the Trust's loan principal repayments of £5.8m in 2015 being recognised as current liabilities as at 31st March 2015. The position is summarised below.

	2013/14 Forecast £m	2014/15 Plan £m	2015/16 Plan £m
Current Assets – Cash	43.2	46.6	46.5
Current Assets – Other	31.0	29.6	30.2
Current Liabilities	(52.4)	(63.3)	(63.9)
Net Current Assets	21.8	12.9	12.8

2.10.8. Continuity of Services Risk Rating

The Trust's forecast Continuity of Services Risk Rating (CoSRR) performance for 2014/15 is 4, the highest rating. The Trust's forecast liquidity days as at 31st March 2015 is 2.5 days giving a liquidity metric rating of 4. The Debt Service Cover metric performance is 2.7 times also giving a rating of 4. For 2015/16, the forecast CoSRR is 4 (rounded up from an actual CoSRR of 3.5). The Debt Service Cover metric performance reduces to 2.2 times in 2015/16 and a rating of 3. The reduction is due to the Trust making the first of the £70m loan principal repayments in 2015/16. Monitor's Risk Assessment Framework (RAF) defines a CoSRR of 4 as "no evident concerns." The components of the CoSRR are summarised below:

	2013/14 Forecast	2014/15 Plan	2015/16 Plan	Rating 4	Rating 3	Rating 2	Rating 1
Liquidity - days	8.4 days	2.5 days	2.4 days	0 days	-7 days	-14	<-14 days
Liquidity metric	4	4	4				
Debt service cover – times	2.9 times	2.7 times*	2.2 times*	2.5	1.75	1.25	<1.25
Debt service cover	4	4	3	times	times	times	times
Overall Rating – CoSRR (rounded up)	4	4	4				

* It should be noted that the debt service cover calculated in the submission template understates the Trust's debt service cover performance at 2.5 times in 2014/15 and 2.07 times in 2015/16. This is due to depreciation expense associated with the BRI Redevelopment at £2.8m in 2014/15 and £1.4m in 2015/16 being excluded from the calculation.

2.10.9. Key risks and mitigation

Key risks to delivery are:

- Commissioners are experiencing financial difficulties. The key risk is Commissioner affordability hence the 2014/15 SLA may be subject to protracted negotiations for 2014/15. This picture may not become clear until later in April 2014;
- Pressures of spending are intensifying and the identification of savings plans challenging. The Trust must identify savings plans to deliver the full savings target of £20.9m in 2014/15.

The key risks to delivery will be mitigated through:

- The engagement of external consultancy to assist with the full identification and delivery of the savings plans;

- The continuing work of the Financial Controls Assurance Plan;
- Monthly Operating and Financial reviews involving Executive Directors to ensure accountability for performance is maintained; and
- Establishing good working relationships with key CCG GP Leads and Chief Financial Officers and pro-active treasury management securing prompt payment should contain some uncertainty.

2.10.10. Summary Financial Results

The financial outlook for the Trust over the planning period is summarised below and remains one of strength relative to the sector with a forecast Continuity of Services Risk rating of 4 for each of the years of the operating plan submission and projected net surpluses of £5.8m and £5.4m excluding technical items.

This outlook continues the past decade of delivering net surpluses and forecasts:

- A normalised surplus in every year of the plan;
- A net surplus margin of 1%;
- A minimum CoSRR of 3; and
- A minimum cash balance of £20m.

	2013/14 Forecast £m	2014/15 Plan £m	2015/16 Plan £m
Income	547.4	575.7	567.2
Operating expenditure	(511.0)	(529.4)	(524.0)
EBITDA	36.4	46.3	43.2
Non-operating expenditure	(40.1)	(56.1)	(45.2)
Net surplus / (deficit)	(3.7)	(9.8)	(2.0)
Net surplus / (deficit) (excluding exceptional items)	5.9	5.8	5.4
Year-end cash	43.2	46.6	46.5
Risk Rating	4	4	4