Final 2016/17 Operational Plan submission – supporting narrative

1. Context for the Operational Plan

This plan is submitted to NHS Improvement on the 18th April 2016 as the final version, following the draft plan which was submitted on the 8th February 2016. The draft plan has been further developed with the plans for activity, capacity, workforce and quality now achieving a robust level which gives confidence in its delivery. The financial plan, however, is not in its final form due to delays in Service Level Agreement (SLAs) negotiations requiring estimates to be used based on the best information available.

The plan submission is a by-product of the Trust's Divisional Operating Plan process which requires:

- Final cut Operating Plans for each Division by 1st April 2016;
- Review by Governors during March and April;
- Approval by the Trust Board at an extra-ordinary meeting on the 5th April 2016;
- Agreement of SLAs with Commissioners during April;
- Submission to NHS Improvement on 18th April 2016; and
- Final submission ratified by Trust Board on 28th April 2016.

The financial plan has been further developed from the draft plan and presents a planned income and expenditure surplus of £14.2m (before donations and impairments). This compares with the draft plan surplus of £15.9m. This change is explained fully later in the document (section 4.7).

The financial plan is predicated on two key assumptions:

- Receipt of 80%-85% CQUIN income from Commissioners; and
- Receipt of Sustainability funding of £13.0m.

Both assumptions carry significant risk as they have not yet been formally agreed with NHS England and NHS Improvement respectively. Should these assumptions subsequently be proved incorrect a revised plan may need to be submitted.

Whilst the Trust reserves the right to revise its financial plan in the light of Commissioner SLAs that will be agreed in the post submission period, it remains confident in the delivery of an Operational Plan in 2016/17 that will:

- Deliver the agreed performance trajectories for Referral To Treatment (RTT), Cancer and the Accident and Emergency (A&E) four hour waiting standard;
- Continue with the necessary upgrading of the Estate along with medical equipment replacement;
- Continue to implement our Clinical Systems Implementation Programme (CSIP) along with system wide initiatives such as Connecting Care. This will include the necessary capital investment;
- Deliver a sustained improvement in quality from the programme described in this document (section 4.1); and
- Maintain sound financial control working to a surplus plan for the 14th year running, albeit caveated with significant remaining risks – both from Commissioner SLAs and internal pressures.

We will continue to develop the plan to both enhance the robustness of its delivery and to improve the financial plan through local and national negotiations with Commissioners, Health Education England and NHS Improvement.

2. Strategic Backdrop

2.1 Introduction

Our 2016/17 Operational Plan has been written in the context of the longer term direction set out in our existing five year strategic plan (2014-2019).

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

2.2 Our Strategy

As an organisation, our key challenge is to maintain and develop the quality of our services, whilst managing within the finite resources available. We are also clear that we operate as part of a wider health and care community and our strategic intent sets out our position with regard to the key choices that we and others face.

Our strategic intent is to provide excellent local, regional and tertiary services, and maximise the benefit to our patients that comes from providing this range of services.

We are committed to addressing the aspects of care that matter most to our patients and the sustainability of our key clinical service areas is crucial to delivering our strategic intent. **Our strategy outlines nine key clinical service areas:**

- Children's services;
- Accident and Emergency (and urgent care);
- Older people's care;
- Cancer services;
- Cardiac services;
- Maternity services;
- Planned care and long term conditions;
- Diagnostics and therapies; and
- Critical Care.

Our **Mission** is *to improve the health of the people we serve by delivering exceptional care, teaching and research, every day* and we are committed to the delivery of this tripartite focus. The clinical services strategy outlined above is also underpinned by our Teaching and Learning and Research and Innovation Strategies.

2.3 Strategic Priorities

Our 2014-19 five year Strategic Plan outlines seven strategic priorities, structured according to the characteristic of our Trust Vision outlined above. Our strategic priorities are:

- We will consistently deliver high quality individual care, delivered with compassion;
- We will ensure a safe, friendly and modern environment for our patients and our staff;
- We will strive to employ the best staff and help all our staff fulfil their individual potential;
- We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation;
- We will provide leadership to the networks we are part of, for the benefit of the region and people we serve;
- We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal; and
- We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.

Throughout 2015/16 we have reviewed our five year strategy, taking account of the changing context in which we operate. We are confident that our five year strategy is still relevant and sound in the evolving local and national environment and we will continue to refresh our delivery objectives to ensure our priorities remain correct. A full refresh of our strategy will be completed in Autumn 2016 to ensure that we are aligned to the system wide Sustainability and Transformation Plan (STP) currently in development and also that our approach to our key strategic choices positions us to be effective in progressing this agenda over the next five year period.

We have a clear governance route through which we measure progress against the delivery of our strategic priorities. Annual objectives are described and monitored through the Board Assurance Framework, and any emerging risks to delivery are subject to quarterly Board scrutiny. For 2016/17 we will also ensure that our in year objectives outline how we will deliver the priorities agreed as part of the system STP.

2.4 Progress with our Strategic Plan

In 2015/16 we have continued to make progress towards developing our specialist portfolio in the nine key clinical service areas outlined above. Our focus has been on driving the benefits to our patients from the major service transfers in previous years, including Head and Neck services, Cleft, and the centralisation of specialist paediatrics from North Bristol NHS Trust. It is our ambition to further evaluate opportunities to continue to develop this portfolio throughout 2016/17.

A key focus of our strategy is also to deliver excellence in care for our local patients, as well as regional and tertiary services and we consider the delivery of operational and financial sustainability key to this. Progress has been made throughout 2015/16 in the ongoing achievement of reductions in the total number of patients waiting over 18 weeks RTT. Although challenging, we have also delivered our improvement trajectory for 62 day GP RTT cancer standard for each month of quarter three, which is a notable improvement from performance at the start of the year.

Although we have made significant progress in 2015/16 towards the recovery of performance against national access standards, there continue to be specific risks relating to high levels of referrals for outpatient appointments and diagnostic tests and high levels of emergency admissions into the Trust in 2015/16 relative to the same period last year.

The level of delayed discharges also remained above plan and despite ongoing difficulties maintaining effective flow, and performance against the 4 hour Emergency Department (ED) standard, the focus remains on delivering high quality care in the right setting, with the number of days patients spent outlying for their specialty ward remaining within target levels.

Further progress needs to be made, but results like this give us confidence that we are moving in the right direction in operational terms. There will be significant challenges, but we are well placed to meet them in light of our track record of sound financial management and recent improvements in performance.

2.5 Progress with our Strategic Priorities

Significant progress has been made in 2015/16 against our strategic priorities to ensure a safe, friendly and modern environment for our patients and our staff. The new Bristol Royal Infirmary (BRI) ward block is now fully open, with new state of the art surgical, medical and paediatric wards, a new twenty bedded adult Critical Care Unit (CCU) and fully refurbished ED and Medical Assessment Units transforming the environment for our staff and patients.

Aligned to this new and modern estate, progress has been made towards our strategic priority to deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation. The new CCU contains a new state of the art Clinical Information System and we have also started the implementation of an Electronic Document Management (EDM) system, meaning that a number of our core clinical services now operate paperless documentation systems. Further priority will be placed in 2016/17 on the development of our technology and innovation functions to place the Trust at the forefront of these developments.

Although notable progress has been made in 2015/16, effective cross sector and patient flow remains a challenge due to external system wide factors. We are clear that fundamental improvements are required in this area for the year ahead, to be successful in delivering our strategic, quality, operational and financial objectives and expect these improvements to inform the system STP as a key priority to address.

2.6 Link to the emerging Sustainability and Transformation Plan (STP)

We are a clear that system leadership, partnership working and system sustainability is key to driving progress for the year ahead. Our 2016/17 Operational Plan is being developed in the context of delivering the Five Year Forward View. Critically, it will align with the system wide planning and is being developed in the context of the emerging priorities linked to the development of the system wide STP.

Agreement on the strategic planning footprint has been reached for Bristol, North Somerset and South Gloucestershire (BNSSG) and one of our key aims for 2016/17 will be to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability and transformation.

As a system we believe that a BNSSG STP will enable the development and implementation of another phase of a major transformation programme for the local health system, which has already delivered large change since 2004. For example, including a range of system and service-based initiatives which including the reorganisation of Breast, Head and Neck, Pathology, Urology and Vascular, Stroke and Children's services.

Notable progress has been made in the development of the BNSSG STP. The BNSSG System Leadership Group (SLG) is in place, bringing together chief officers from NHS organisations across BNSSG. There is also senior representation from each of the BNSSG Councils and Public Health. The South Western Ambulance Services NHS Foundation Trust will also be invited and a request for specialised commissioning involvement has been received. A sub-group of the SLG has been established, chaired by Robert Woolley, who is the BNSSG STP Senior Responsible Officer (SRO). This group is overseeing the development of the STP on behalf of SLG and is supported by a working group of strategic planning leads nominated by each organisation on the SLG. External support has been commissioned (in place from 4th April), with a remit to assist with the coordination of the STP

development phase and in particular supporting the decision-making process, challenging and testing developing plans and facilitating the difficult choices among the system leaders about the major changes needed to ensure a clinically and financially sustainable health and care economy for the long term. As a Trust we are taking an active role in the development of the STP and are clear that the objectives within our one year Operational Plan support progress towards individual organisational and system priorities.

The vision and priorities for the local health and care system's STP, as outlined by the SLG is as follows:

- Sustainable and efficient acute configuration, including the future of Weston Hospital;
- The transformation of community and primary care services, shifting care out of acute hospital settings;
- A step-change in the coordination of health and social care, supported by the roll out of the Connecting Care (interoperable patient records) programme;
- A shift in working practices and organisational culture to make prevention and self-care a priority in service delivery;
- Transformation in identified key disease areas to deliver value and improved outcomes. While not yet formally agreed, these are likely to include long term conditions, cancer, frailty, musculoskeletal (MSK) services and mental health pathways; and
- Workforce and Informatics to support required transformational change.

The scoping exercises undertaken to date have identified the high level proposed themes and workstreams for the emerging STP as follows:

- Out of hospital health and social care provision and pathways including urgent care flow, demand management systems, integrated model of community care across organisations, discharge models, sustainability of primary care and general practice;
- Self-care at scale and prevention;
- Developing overarching clinical models of care/clinical pathways engaging and involving clinicians across BNSSG to understand and deliver with ambition against the challenge of; efficiency; improved outcomes/value and safety/quality (including BNSSG Right Care opportunities) for example:
    - Acute service configuration, including Weston and specialised pathways, supporting diagnostics etc. including reviews of key pathways such as stroke;
    - Mental health including urgent mental health;
    - Dementia;
    - Long term conditions, multi morbidity and frailty models;
    - Cancer; and
    - Maternity services.
- Enabling workstreams for workforce planning, Information Technology, Estates;
- System financial model development and system capacity and demand model development;
- Continued public health modelling of the health and wellbeing gap and priority action areas; and
- Communications and engagement including Public and Patient Involvement (PPI).

2.7 Organisational Strategy – 2016/17 Focus

Clear alignment can be drawn between the annual 2016/17 organisational objectives outlined in this plan and the emerging priorities within the developing STP. We are committed to continuing to lead and support the process of developing and implementing the plan to address the identified system gaps in Care and Quality, Health and Wellbeing and Finance and efficiency. Our Operational Plan forms year one of the five year plan and in this context, our 2016/17 organisational strategy and operational plans will continue to focus us on:

- **Operational and financial sustainability**, with a specific focus on aligning our workforce and clinical strategies towards reducing agency costs, maintaining service stability to continue to deliver excellent, patient centred high quality care, as well as continuing to improve performance against our core access standards. In addition to this our workforce strategy will look to innovate, with partners to developed new roles to meet the challenges for cross sector and pathway transformation. Through this focus, we will deliver four of the 2016/17 'must dos' outlined in the 2016/17 planning guidance which describes the requirement to achieve the core access standards and restore financial sustainability;
- **Our estates and capital strategy** for 2016/17 will closely align the modernisation and development of our estate to our evolving clinical services strategy, ensuring that opportunities are taken to transform our environment and innovate in the technological solutions we look to in improving the quality and timeliness of our services for patients;
- Development and delivery of a successful **system STP,** with an on-going focus on patient flow, evaluation of specific clinical services, with a focus on the **ongoing development of our specialist services portfolio** underpinned by effective **partnership working;**
- Development of our **innovation and technology strategy**; and

- Delivery of our annual quality objectives, including progress towards delivery of the four key **seven day services** standards by 2020.

In summary, in the specific context of a developing system wide strategic approach, our 2016/17 plan will remain focussed on our mission to *improve the health of the people we serve by delivering exceptional care, teaching and research every day.*

3. 2015/16 Performance

3.1 Non Financial

In the 2015/16 Operational Plan the Trust declared risks to five of the standards against Monitor's Risk Assessment Framework. The five standards (with the service performance score shown in brackets) not forecast to be achieved in one or more quarters were as follows:

- A&E 4-hour waiting standard (1.0);
- 62-day GP and 62-day Screening cancer standard (combined score of 1.0);
- RTT non-admitted pathways standard (1.0);
- RTT admitted pathways standard (1.0); and
- RTT incomplete/Ongoing pathways standard (no score - RTT standards failure capped at 2.0).

Table 1 below shows the planned performance against those standards not expected to be achieved in 2015/16, as declared in the 2015/16 Annual Plan, along with the actual reported performance for the quarter. Please note that the RTT admitted and RTT non-admitted pathway standards were removed from Monitor's Risk Assessment Framework during quarter one in 2015/16 and for this reason are not shown in the in reported position for any quarters.

Table 1 : Performance against access standards in 2015/16

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Standards not forecast to be met	RTT Non-admitted RTT Admitted RTT Incomplete 62-day GP cancer 62-day Screening cancer	RTT Non-admitted RTT Admitted RTT Incomplete 62-day GP cancer 62-day Screening cancer	RTT Non-admitted RTT Admitted 62-day GP cancer 62-day Screening cancer	RTT Admitted A&E 4-hours 62-day GP cancer 62-day Screening cancer
Forecast score	**3.0**	**3.0**	**3.0**	**3.0**
Standards not met in the quarter	RTT Incomplete A&E 4-hours 62-day GP cancer 62-day Screening cancer	RTT Incomplete A&E 4-hours 62-day GP cancer 62-day Screening cancer	RTT Incomplete A&E 4-hours 62-day GP cancer 62-day Screening cancer	A&E 4-hours 62-day GP cancer 62-day Screening cancer
Actual score	**3.0**	**3.0**	**3.0**	**2.0**
Governance Risk Rating	**GREEN**	**GREEN**	**GREEN**	**GREEN** **To be confirmed**

3.1.1 RTT Performance

As planned, the Trust made significant progress during 2015/16 in reducing the number of patients waiting over 18 weeks from RTT. In line with the agreed recovery trajectory, performance was restored to above the 92% national standard at the end of January 2016. At the start of the year 3,339 patients were waiting over 18 weeks for treatment. By the end of February 2016 the backlog of long waiters had dropped by 38% to 2,083. More than half of this reduction related to patients waiting for an elective procedure, with the number of patients waiting over 18 weeks on an admitted pathway reducing from 1,513 at the end of March 2015 to 861 at the end of February 2016. Demand for outpatient appointments was above plan in 2015/16 for several of the high volume RTT specialties, resulting in slower progress being made during the first half of the year in reducing the number of patients waiting over 18 weeks on non-admitted pathways.

3.1.2 Cancer Performance

The Trust continued to perform well against the majority of the national cancer waiting times standards, achieving the 2-week wait for GP referral for patients with a suspected cancer, the 31 day wait for first definitive treatment,

and the three 31-day standards for subsequent treatment (i.e. surgery, drug therapy and radiotherapy) in each quarter in 2015/16. The Trust failed to achieve the 62-day referral to treatment standard for patients referred by their GP with a suspected cancer. However, performance against the standard improved over the year, with the 85% standard being met in December 2015 for the first time since June 2014. At the time of writing, the Trust has achieved its monthly improvement trajectory, which was agreed as part of a national submission of 62-day GP cancer improvement plans in August 2015. The Trust failed to achieve the 62-day referral to treatment standard for patients referred by the national screening programmes in 2015/16.

In each quarter of 2015/16 the majority of the breaches of this standard were outside of the Trust's control, including patient choice, medical deferral and breaches at other providers following timely referral. Following the transfer-out of the Avon Breast Screening service, the majority of treatments the Trust reports under this standard are for bowel screening pathways, which nationally performs significantly below the 90% standard. This is largely due to high levels of patient choice to defer diagnostic tests, which continues to be the main cause of breaches of this standard for the Trust.

3.1.3 A&E Performance

System pressures continued to be evident in 2015/16 with levels of emergency demand at the Bristol Children's Hospital being significantly above plan for the majority of the year. During the first six months of 2015/16, levels of emergency admissions via the Bristol Children's Hospital Emergency Department were 15.2% above the same period in the previous year, reaching typical winter levels in some months. This increase in demand was a significant driver of the Trust's underperformance against the 4-hour standard during the year. Work with the Commissioners to understand the reason for the higher than expected levels of paediatric emergency demand continues.

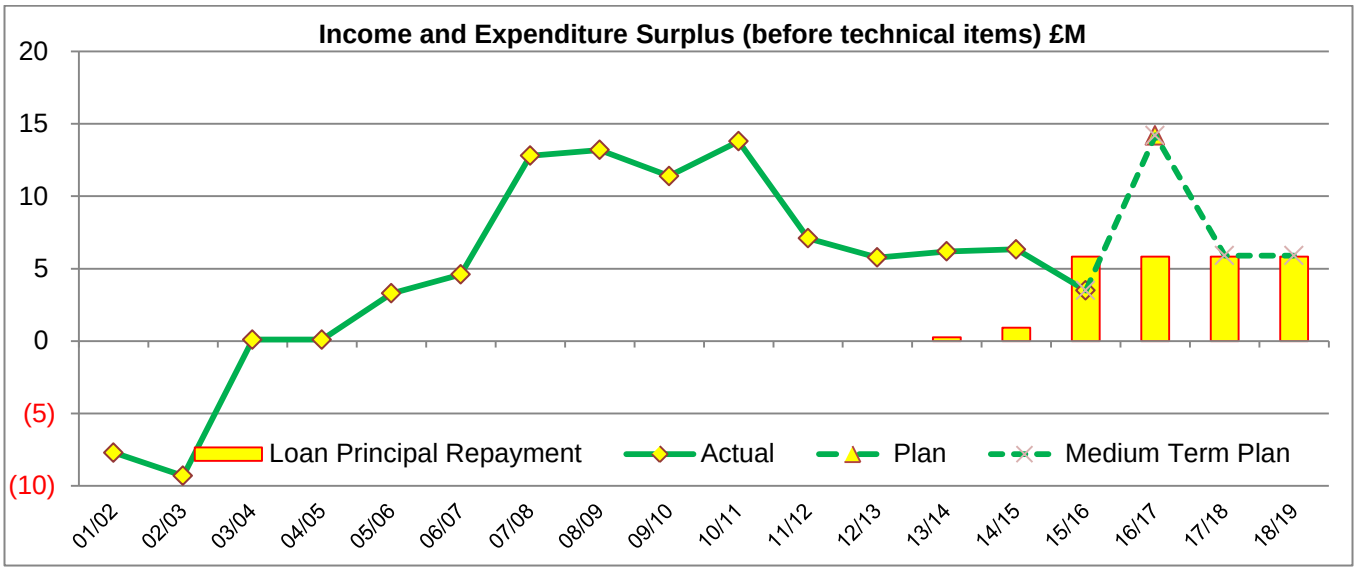
Following improvements early in 2015/16 the Trust experienced a significant increase during much of the year in the number of medically fit patients whose discharge from the BRI was delayed, with levels at their peak reaching more than double those seen at the start of the year. This was primarily due to a lack of sufficient domiciliary care packages as a result of providers taking time to reach their planned operating capacity, following the recommissioning of these services by Bristol City Council during quarter 2. An acute shortage of social workers also contributed to the increase in delayed discharges. Consistent with other parts of the country, the last quarter of the year has seen exceptional pressures on both the adult and paediatric Emergency Departments, with significant increases in emergency department attendances, emergency admissions and patient acuity leading to a significant deterioration in 4-hour performance. The combination of these system pressures on both the adult and paediatric emergency services led to the failure to achieve the 95% A&E 4-hour standard in each quarter of 2015/16.

3.2 Financial

3.2.1 Net surplus

The Trust is forecasting a 2015/16 net income & expenditure surplus of £3.5m before technical items against a revised plan of break-even. This translates to a surplus of £5.1m including donations but excluding impairments against a plan of £3.1m. This will be the Trust's thirteenth year of break-even or better. A summary of the Trust's financial position, including the historical performance, is provided below in figure 1.

Figure 1: Income and Expenditure Surplus



The Trust is one of only six Acute Trusts who are reporting both a year to date surplus at the end of February and a forecast outturn surplus. To achieve this, however, non-recurrent savings of £12.7m are being used to deliver this position. This makes the 2016/17 position more difficult to deliver as much of the non-recurrent savings cannot be repeated.

3.2.2 Savings

The Trust's 2015/16 savings requirement is £19.9m, net of £4.5m funded non-recurrently to support clinical services. Savings of £16.4m are forecast to be delivered by the year end. The forecast shortfall of £3.5m is due to unidentified schemes. The forecast shortfall of recurrent savings delivery in 2015/16 of £4.0m and the support provided in 2015/16 of £4.5m will be carried into 2016/17 as a requirement.

3.2.3 Capital expenditure

The Trust is forecasting capital expenditure of £24.9m for 2015/16 against a plan of £34.5m due to scheme slippage. It should also be noted that the generation of a capital receipt from the sale of the BRI Old Building at £13.0m has been brought forward into 2015/16. The Trust's carry forward commitments into 2016/17 are £20.0m.

3.2.4 Financial Sustainability Risk Rating

The Trust is forecasting a Financial Sustainability Risk Rating (FSRR) of 4. The Trust has strong liquidity with forecast net current assets of £30.2m and achieves 12.3 liquidity days and a liquidity metric of 4. The Trust's forecast EBITDA performance of £35.0m delivers capital service cover of 2.1 times and a metric of 3. The Trust's forecast net income and expenditure margin is 0.8% and achieves a metric of 3. The I&E margin variance is 0.3% and achieves a metric of 4. The position is summarised below.

Table 2 : FSRR Performance

	Metric	Rating
Liquidity	12.3	4
Capital servicing cover	2.1 times	3
Net I&E margin	0.8%	3
I&E margin variance	0.3%	4
Overall FSRR		**4**

Rating 4	Rating 3	Rating 2	Rating 1
0 days	-7 days	-14 days	<-14 days
2.5 times	1.75 times	1.25 times	<1.25 times
>1%	>0%	>-1%	<-1%
>0%	>-1%	>-2%	<-2%

4. The year ahead

4.1 Quality

4.1.1 Approach to quality planning

The Trust is committed to and expects to provide excellent health services that meet the needs of our patients and their families and provides the highest quality standards. The Board and Senior Leadership Team of UH Bristol have a critical role in leading a culture which promotes the delivery of high quality services. This requires both vision and action to ensure all efforts are focussed on creating an environment for change and continuous improvement. The Trust's annual quality delivery plans set out the actions we will take to ensure that this is achieved.

We have much to be proud of. The Trust's quality improvement programme has shown us what is possible when we have a relentless focus on quality improvement. Healthcare does not stand still. We need to continuously find new and better ways of enhancing value, whilst enabling a better patient experience and improved outcomes. Never has there been a greater need to ensure we get the best value from all that we do.

The focus of our strategy will continue to be on improving patient safety, patient experience and the effectiveness of care. It will be underpinned by our commitment to address the aspects of care that matter most to our patients in collaboration with our strategic partners. They also take into account national quality and commissioning priorities, our quality performance during 2015/16 and feedback from our public and staff consultations. Subject to final agreement and sign off, our objectives for 2016/17 are outlined below. Our priorities for 2016/17 can be themed into five key areas, which are:

- Objectives carried forward from 2015/16;
- Improving different aspects of communication;
- Improving responsiveness to patients' needs;
- Maintaining a strong focus on the fundamental need for patient safety; and
- Improving staff experience.

Our specific twelve quality objectives for 2016/17 are as follows:

- Reducing cancelled operations;
- Ensuring patients are treated in the right ward for their clinical condition;
- Improving management of sepsis;
- Improving timeliness of patient discharge;
- Reducing patient-reported in-clinic delays for outpatient appointments, and keeping patients informed about how long they can expect to wait;
- Reducing the number of complaints received where poor communication is identified as a root cause;
- Ensuring public-facing information displayed in our hospitals is relevant, up-to-date, standardised and accessible;
- Ensuring inpatients are kept informed about what the next stage in their treatment and care will be, and when they can expect this to happen;
- Fully implementing the Accessible Information Standard, ensuring that the individual needs of patients with disabilities are identified so that the care they receive is appropriately adjusted;
- Increasing the proportion of patients who tell us that, whilst they were in hospital, we asked them about the quality of care they were receiving;
- Reducing avoidable harm to patients; and
- Improving staff-reported ratings for engagement and satisfaction.

Our 'Sign Up To Safety' priorities for 2016/17 and the following year are:

- Early recognition and escalation of deteriorating patients to include early recognition and management of sepsis and acute kidney injury;
- Medicines safety at the point of transfer of care with cross system working with healthcare partners;
- Developing our safety culture to help us work towards, for example, zero tolerance of falls; and
- Reducing never events for invasive procedures.

We view quality, safety and efficiency as mutually beneficial. We will continue to use the following four questions to examine our approach to quality:

- Do we understand quality well enough in the Trust?
- How do we know that the services we provide are safe, effective, caring, responsive and well-led?
- What will it take to make all our services as good as they can be?
- How well do we understand the views of our staff and patients in relation to this agenda?

In the development of the priorities for 2016/17, we have also taken into consideration of national and local commissioning priorities and relevant national guidance. One of these key areas is delivering the Medical Royal Colleges 2014 "*Guidance for taking responsibility: Accountable clinicians and informed patients"*

The two priority objectives outlined in the guidance are:

"*A patient's entire stay in hospital should be coordinated and caring, effective and efficient with an individual named clinician – the Responsible Consultant/Clinician – taking overall responsibility for their care whilst retaining the principles of multidisciplinary team working"; and*

"*Ensuring that every patient knows who the Responsible Consultant/Clinician, with this overall responsibility for their care is and also who is directly available to provide information about their care – the Named Nurse".*

The Trust is focussing on progress towards the delivery of these two objectives with actions located in the Ward Processes work stream as part of the Trust's Transforming Care programme. These actions focus on the delivery of standardised ward processes to update Medway, the Trust's Electronic Patient Record (EPR) system within 15 minutes of admission to the, along with the roll out of electronic whiteboards to all wards, which will contain information relating to each patient, including the identified lead consultant.

Another National priority which forms an area of focus for 2016/17 is the participation in the annual publication of avoidable deaths. Through 2015/16 we have implemented an internal standardised process, whereby all deaths are flagged through Medway to the lead consultant for each patient, prompting a standard notes review. Patient deaths are also identified and escalated through the standard Trust incident reporting process if appropriate. These initiatives mean that the Trust is well placed to both participate in any required national reporting, but also to ensure that learning is taken into the clinical services wherever possible.

The Trust did not receive a Care Quality Commission (CQC) comprehensive inspection during 2015/16; our last major inspection was in September 2014. Key challenges around patient flow remain, and vital work continues with our partners in health and social care to make improvements in the areas identified as not meeting the required standards and will inform the development of the STP in addressing the system challenge in the area.

4.1.2 Approach to quality improvement

The Trust's objectives, values, quality and efficiency strategies provide a clear message to all staff that high quality services and excellent patient experience are the first priority for the Trust.

These priorities are reinforced through our five clinical Divisions having specific, measurable quality goals as part of the process of producing their annual Operating Plans. Progress against these plans is monitored by Divisional Boards and by the Executive Team through monthly Divisional Performance Review. The Trust's Clinical Quality Group monitors our compliance with CQC Fundamental Standards on an ongoing basis; our Board Quality and Outcomes Committee monitors performance against a range of performance standards.

Our governors engage with the quality agenda via their Strategy Focus Group and Quality Focus Group. Each quarter, the Board and its sub-committees receive the Board Assurance Framework and the Trust's risk register which report high level progress against each of the Trust's corporate objectives (including quality objectives) and any associated risks to their achievement. Additionally, the Board's Audit Committee works with the Trust's Clinical Audit and Effectiveness team to consider evidence that the Trust's comprehensive programme of clinical audit effectively supports improving clinical quality in alignment with the Trust's quality objectives.

Despite our quality strategy and work to improve our patient flow, we have identified ongoing risks in relation to access and patient flow. The top three risks to quality within the 2016/17 plan are within this theme of access and patient flow. Firstly, we have declared that we may not achieve the threshold of at least 95% of patients spending less than four hours in our A&E department during 2016/17, in the context of the rising paediatric and adult emergency admissions and increasing patient acuity which was particularly evident in quarter 4 of 2015/16. Our aim in 2016/17 is to try to mitigate these system pressures by reducing hospital emergency admissions and potentially reducing the lengths of stays in hospital for appropriate groups of patients that can be cared for in their own home. Secondly, associated with the risk described with managing urgent care flow and demand within the Trust, is the risk of the last minute cancellation of planned operations and the clear impact this has on the quality of care we provide to patients. This remains one of our core quality objectives for 2016/17 and plans to address this are associated with the improvement to urgent care flow within the Trust and across the system. We will also however, be focussing in 2016/17 on our planned care pathways to ensure the last minute cancellation of patients is avoided where possible. Thirdly, the treatment of patients diagnosed with cancer within 62 days of referral by their GP remains a challenge. Whilst improvements in the Trust's performance were seen during 2015/16, late referral by other providers remains a leading cause of breaches of the 62-day GP cancer standard. Further network-wide pathway improvement is planned, building on the work already undertaken during the latter half of 2015/16. This should complement the work on Ideal Timescale Pathways already undertaken within the Trust, and lead to further improvements in the timely treatment of cancer patients in 2016/17.

We continue to be an active member of the Strategic Resilience Group, one of the key aims of which is to provide a local whole system approach to addressing local emergency care and patient flow pressures. The challenges of improving patient flow across the health system in Bristol do pose risks to the quality of care that we can provide to our patients specifically in the areas of mental health and the frail elderly. The Trust is fully aware of these risks and has detailed plans in place to mitigate any impact on patients. It will also ensure that this gap in care and quality informs the emerging priorities in the STP.

In 2015/16, the Trust commissioned an independent review against Monitor's 'Well-led framework for governance.' This provided the Trust Board with assurance that systems and process were in place to ensure that the Board and Senior Leadership Team had good oversight of care quality, operations and finances. The Board recognises the importance of good governance in delivery of the Trust's objective to provide safe, sustainable high quality care for patients and is undertaking a number of actions to further improve the governance systems in the Trust as a result of the review.

4.1.3 Quality impact assessment process

The Trust has a robust approach to the assessment of the potential impact of cost reduction programmes on the quality of services. This includes a formal Quality Impact Assessment (QIA) for all Cost Improvement Plans (CIP) with a financial impact of greater than £50k and any scheme that eliminates a post involved in front line service delivery.

These QIAs are required to be reviewed through Divisional quality governance mechanisms to ensure robust clinical oversight of plans, from those service areas affected. In addition to this internal assurance of the impact of CIPs on quality, local commissioners also review plans, on a sample basis, to assure both the quality of approach and the impact of the most significant schemes (in financial terms). Finally, the Medical Director and Chief Nurse are responsible for assuring themselves and the Board that CIPs will not have an adverse impact on quality. Any QIA that has a risk to quality score over a set threshold, which the Trust wants to proceed with, is presented to the Quality and Outcomes Committee, our Non-Executive quality committee.

4.2 Seven Day Services

In 2013 NHS England's Seven Day Services Forum, established and led by Professor Sir Bruce Keogh, identified ten clinical standards that describe the standard of urgent and emergency care that patients should expect to receive seven days a week. Analysis commissioned by NHS England, in consultation with the Academy of Medical Royal Colleges, led them to advise that there are four standards that are most likely to help reduce weekend mortality: consultants being present to assess and regularly review patients and access to diagnostic tests and consultant-led interventions. University Hospitals Bristol has identified actions that could be taken to progress the seven day service model during 2016/17 in line with expectations for the four standards referred to below. These proposals have been outlined, with the associated resource implications to commissioners as part of the 2016/17 contracting round. The resources required to progress with these plans have not however, been supported through the 2016/17 contract and as the implementation of these schemes is dependent on funding, they will unfortunately not be progressing in 2016/17.

The sections below however, outline the current UH Bristol baseline against these standards and the schemes that have been scoped that would be considered possible to implement in year, should funding be available.

4.2.1 Time to Consultant review

Baseline data analysis shows that the most pressing need to develop Consultant review within 14 hours is within general surgery, trauma & orthopaedics and gynaecology services. The Trust proposed plans to commissioners that would provide 8.75 direct clinical care programmed activities within Consultant job plans for this purpose. Implementation of these schemes would deliver incremental progress towards the delivery of this standard.

4.2.2 Access to diagnostics

Analysis shows that all diagnostic modalities are seven day available apart from Interventional Radiology (IR). University Hospitals Bristol does not have a vascular service and consequently has an interventional radiology capability limited to normal hours and an informal arrangement with North Bristol NHS Trust for emergency provision. Plans proposed for 2016/17 included the formalisation of IR arrangements with North Bristol NHS Trust and development of an in-house non-vascular IR service. These plans have been fully costed and were proposed to Commissioners as part of the 2016/17 contracting round. As implementation in 2016/17 is dependent on the agreement of funding there are no plans to progress with this development in 2016/17.

4.2.3 Access to Consultant delivered interventions

Analysis shows that the Trust has a seven day capability for this standard with the exception being for lower gastrointestinal endoscopy. Plans proposed to Commissioners for 2016/17 included the investment of two direct clinical care programmed activities to allow for the delivery of two additional weekend endoscopy lists, this would provide progress towards the full delivery of this standard, but will not be mobilised in 2016/17.

4.2.4 On-going review

Baseline analysis shows that all acute areas, with the exception of the Surgical Admissions Unit, currently meet this standard. This would be addressed however, by the plans to increase job planned programmed activities in surgery, as described under the Time to Consultant Review standard above. Most non-acute medical and surgical services also meet this standard, with the exception of colorectal surgery and cardiology. Colorectal weekend ward rounds currently take place on a fortnightly basis and could be increased to weekly with the investment of a single programmed activity. This is not in the Trusts 2016/17 plan but could be part of the 2017/18 plans. Meeting this standard within cardiology would require the investment of four programmed activities, which may be considered in the 2017/18 planning round. Plans to make progress towards the achievement of this standard, with associated resource implications in 2016/17 were outlined to Commissioners through the 2016/17 contract discussions, but as with the above standards will not be progressed in 2016/17 due to the funding position.

4.3 Capacity and performance

4.3.1 Approach to capacity planning

During quarter 3 of 2015/16, the Trust again undertook a detailed capacity and demand planning exercise, using the capacity planning tools provided in the previous year by the Interim Management and Support Team (IMAS). Each specialty used the IMAS capacity and demand models to estimate the level of capacity required to reduce waiting times for first outpatient appointment, diagnostic tests and elective admissions. The Trust modelled the capacity required to further reduce these treatment waits, where these were not already forecast to be met by the end of March 2016, in order to achieve 18-week compliant RTT pathways in 2016/17. This exercise has informed the amount of recurrent activity that the Trust needs to provide, subject to Commissioner agreement, to maintain 18-week waits once any residual backlogs have been addressed. The level of non-recurrent work needed to reduce backlogs of long waiting patients forecast to remain beyond March 2016, has also been assessed.

From these inputs the Trust has built-up a Service Level Agreement (SLA) proposal which adjusts the 2015/16 Forecast Outturn to meet recurrent demand, using the IMAS modelling, and has built-in the level of non-recurrent activity which is deliverable in 2016/17 to maintain Trust-level achievement of the 92% incomplete pathways standard and also achieve the required standard at a specialty level. The level of planned activity for 2016/17 also takes account of the impact of any planned service transfers, service developments, recurrent (demographic) growth and other known planned changes to activity levels. Whilst the SLA has not yet been finalised, Commissioners have confirmed their commitment to commission sufficient activity, both recurrent and non-recurrent to meet RTT. This requires significantly less non-recurrent activity than in 2015/16 and as such, the vast majority of activity will be delivered "in-house" with a small amount of outsourcing to maintain flexibility where activity is more volatile including ophthalmology, endoscopy and interventional cardiology. Additional in house capacity required to deliver activity increases is fully understood and plans are in place to mobilise this capacity. Any workforce and financial implications are built into this plan.

The Trust has planned for a level of demographic growth but should activity significantly exceed this, RTT delivery will be at risk. However, the Trust has proactive systems for identifying rising demand and in such scenarios additional waiting list initiative will be mobilised, as has been the case previously. Of note, discussions continue with Taunton and Somerset NHS Foundation Trust, with respect to the possible transfer of clinical genetic services to UH Bristol though this plan does not take account of that, pending further on-going discussions also involving Royal Devon & Exeter NHS Foundation Trust.

The schedule of planned day-case and inpatient activity for 2016/17 has been used to assess the number of beds required in the Trust in the coming year. The baseline bed requirements have been estimated from the forecast specialty and work-type level spell volumes and current length of stay. In doing so the increased demand for beds seen in 2015/16, through increases in paediatric emergency admissions and delayed discharges, has been factored-in. The bed requirements have then been apportioned across quarters according to historic seasonal variation. Planned bed-days savings from improvements in the delivery of planned and unplanned care have then been applied and the resulting modelled bed requirements have then been uplifted to an operational bed occupancy of 92.5%.

Of note, the Trust has just signed Heads of Terms with an independent provider *Orla Healthcare* to deliver a community based "virtual ward". This innovative model of care has been piloted for the last 18 months in Harlow, Essex and is targeted at those patients for whom a 'Decision To Admit' has been reached and who can be discharged back home and cared for by the Orla team. This is the not the traditional step up / step down care model. *Orla* can manage stable, acutely ill patients who would otherwise be admitted to the Trust's Acute Medical Unit (AMU). The service is expected to commence in July 2016 and be fully operational from January 2017 with capacity for 35 patients. This service will not only enable improvements in occupancy as it ramps up but will also provide Winter flex capacity in quarter 4 when it is typically most needed.

Children's services will continue to plan for an expanded bed base in quarter 3 and quarter 4 to respond to seasonal respiratory peaks and subject to commissioner non-recurrent funding will also open an additional Paediatric Intensive Care bed over the Winter months.

The table overleaf summarises key activity changes over 2015/16 plan and outturn. The Trust has plans to deliver this activity with limited risks compared to 2015/16.

Table 3: Activity Volumes and Contract Value

	2015/16 Plan	2015/16 Outturn	Growth over 2015/16 Plan	2016/17 Plan	Growth over 2015/16 Outturn	Growth over 2015/16 Plan
Accident & Emergency	120,799	123,654	2.4%	125,693	1.6%	4.1%
Bone Marrow Transplants	183	195	6.6%	198	1.5%	8.2%
Critical Care Beddays	50,805	51,977	2.3%	52,341	0.7%	3.0%
Day Cases	56,724	54,415	(4.1%)	57,003	4.8%	0.5%
Elective Inpatients	15,339	14,227	(7.2%)	14,237	0.1%	(7.2%)
Emergency Inpatients	39,185	40,283	2.8%	40,513	0.6%	3.4%
Excess Beddays	27,551	26,616	(3.4%)	26,357	(1.0%)	(4.3%)
Non-Elective Inpatients	14,214	13,823	(2.8%)	13,888	0.5%	(2.3%)
Outpatients	652,173	636,539	(2.4%)	674,168	5.9%	3.4%
Total	**976,973**	**961,729**	(1.6%)	**1,004,397**	4.4%	2.8%

4.3.2 Improvement trajectories for Non Financial Performance in 2016/17

The improvements in performance realised in 2015/16 will be built-upon in the coming year. The Trust achieved the RTT Incomplete pathways standard at the end of January 2016, with the standard forecast to continue to be achieved throughout 2016/17. The Trust also recovered performance against the 99% 6-week diagnostic waiting times standard during 2015/16, and expects to remain compliant in 2016/17.

The Trust is expecting to continue to make improvements against the 62-day GP cancer waiting times standard in 2016/17 through the ideal timescale pathways which were implemented in the latter half of 2015/16. The improvement trajectories set have been calculated from the expected reduction in pathway waiting times delivered through a combination of these ideal timescale pathways and planned increases in capacity in particular tumour sites. However, the established seasonal patterns of patient choice, which result in unavoidable pathway delays and breaches of the standard, have also been taken account of within the trajectory. Late referrals from other providers remains the leading cause of breaches of the 62-day standard, but for which improvements have needed to be assumed in the trajectory for quarters 3 and 4 on the basis of the work being undertaken network-wide to agree timescales for referral, and through agreement of a local Commissioning for Quality and Innovation (CQUIN) to encourage earlier referral amongst BNSSG Trusts. The trajectory delivers the 85% national standard in aggregate in quarter 3 and quarter 4. The regional ambition is to achieve the 85% national standard in September 2016, which the Trust cannot at this stage commit to without further assurances that a reduction in late referrals from other providers will be realised earlier than quarter 3. Due to the small number of treatments the Trust undertakes, and the high proportion of breaches of the standard that are outside of the control of the Trust, the Trust is not expecting to report compliance with the 62-day screening standard in 2016/17.

Quarter 4 of 2015/16 has proved to be a challenging period for emergency access, with levels of demand and patient acuity exceeding planning assumptions. This has re-set expectations for quarter 1 of 2016/17, which has traditionally been seen as one of the higher performing quarters in the year. An improvement trajectory has been developed using the established statistical relationship between bed occupancy and 4-hour performance, and the expected impact of the planned actions on bed occupancy during each month of 2016/17. This trajectory shows an improvement in 4-hour performance over quarter 1, relative to quarter 4 2015/16, with each subsequent quarter representing an improvement on the same period in the previous year. Whilst the regional ambition is to restore performance to 95% by March 2017, the Trust does not at present have sufficient confidence in the system-wide delivery plan to commit to achievement of the 95% standard at the end of 2016/17.

Unusually, the Trust is now also expecting to report a failure of the 31-day first definitive and 31-day subsequent surgery cancer waiting times standards in 2016/17. This is due to exceptional levels of demand on the adult Intensive Therapy Unit / High Dependency UnitT, in terms of both numbers and increasing patient acuity. Plans are being progressed to treat these patients as quickly as possible, with the expectation that the impact on performance will be limited to quarter 1 2016/17. Table 4 below reflects the predicted performance for 2016/17.

Table 4: Performance against access standards in 2016/17

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Standards not forecast to be met	A&E 4-hours 62-day GP cancer 62-day Screening cancer 31-day first definitive cancer 31-day subsequent surgery	A&E 4-hours 62-day GP cancer 62-day Screening cancer	A&E 4-hours 62-day Screening cancer	A&E 4-hours 62-day Screening cancer

4.4 Information Technology

UH Bristol has a mature, effective Informatics Service that has established a good track record of delivering transformative technology. Clinical Informatics at UH Bristol is driven through the Clinical System Implementation Plan (CSIP), now in its fifth year and well-positioned to take advantage of the emerging alignment of DoH, NHSE and HSCIC that will help make the digital future a reality for our health and care system.

UH Bristol is an active member of the national CIO Network and HSCIC's Digital Leaders Forum, helping us to drive digital best practice and innovation within the Trust whilst lobbying and contributing to the 'digital agenda' at a National level.

Recognizing the challenges set in FYFV whilst focusing on the specific requirements of the National Information Board in *Personalized Health & Care 2020* and subsequent guidance, CSIP is delivering a comprehensive range of digital capabilities and systems to fulfil local digital strategy and meet the national objectives set for 2018 and 2020.

"Our vision ... is one in which every member of our staff will have access to the information they need, when they need it, without having to look for a piece of paper, wait to use a computer or ask the patient yet again...".

Our strategy is Board-led, clearly defined, fully funded and aligned to clinical and corporate objectives. Over the past few years we have delivered the foundations of our strategy and built upon this to provide a Trust-wide Electronic Patient Record (EPR) that supports our core patient activity recording and provides a range of clinically-relevant functions that are in routine use across the Trust. Operating within a secure, resilient technical infrastructure, these functions include:

- Fully integrated EPR modules covering inpatients, outpatients, ED, maternity and theatres, with clinical noting and ad hoc data collection suites;
- Digitized case notes in use across the first of our hospital sites;
- Order communications and results reporting for pathology, radiology and a wide range of other services;
- A range of services to deliver and share diagnostic images across the region;
- A sophisticated Intensive Care System in use across all four intensive care units;
- Widespread intra-operability between our core EPR and the wealth of specialist departmental systems to ensure authentication;
- A document sharing portal providing digital delivery of discharge summaries and other documents to GPs;
- Digital dictation and speech recognition; and
- Increasing use of 'right here, right now' real-time dashboards and reports.

Looking outside the Trust, UH Bristol is a founding member of Connecting Care, a digital shared care record service that boasts participation of all health and social care organisations across BNSSG and rich content. Connecting Care is not only a leading example of shared care technology, but also the focal point of effective cross-organisational collaboration under the guidance of BNSSG's System Leadership Group. The influence of Connecting Care on our digital roadmap cannot be overstated. The range of shared information and functions delivered by Connecting Care is extending all the time, with new content and collaboration tools as diverse as safeguarding, care-planning, document sharing and genomics featuring on our development roadmap.

During the coming year we will continue to deploy new digital capability throughout the Trust, further embedding and extending existing functions with particular emphasis on:

- Rolling out digital case notes across our other hospital sites together with the implementation of e-forms and workflow automation;
- Commencing delivery of a new nursing e-observations and replacement e-rostering systems;
- Going live across the Trust with electronic prescribing and medicines administration;
- Providing more convenient access to our systems and services through the wider use of mobile technology and telehealth techniques; and
- Delivering the objectives of the Clinical Utilisation Review (CUR) by using existing systems rather than purchasing duplicate systems which are not supported by Clinicians or the IT function.

As a part of this practical delivery of technology, we will work with our partners to:

- Make our digital systems work harder and more reliably, interoperating more intelligently to promote better information sharing inside and outside the Trust;
- Help our clinicians and staff become better equipped, more 'expert' users who understand the value of good information and are able to use it meaningfully; and
- Allow our patients and service users to benefit from cohesive cross-organizational pathways and smoother, more convenient encounters with our services.

4.5 Commissioning Position

4.5.1 Review of the Local and national commissioning landscape

The local commissioning landscape largely reflects the national landscape. The Trust's services are commissioned in the majority by the three local Clinical Commissioning Groups (CCG) Bristol, North Somerset and South Gloucestershire (BNSSG) and NHS England. The Trust has issued seven detailed contract proposals (activity and value) to Commissioners, and contract discussions are ongoing. CCG Commissioners' counter offers are currently under review and negotiation. However, NHS England are yet to make a comprehensive counter offer which can form the basis of detailed negotiation.

The Trust's contract proposals reflect the key sustainability and transformational priorities for both the Trust and the local health system with particular focus on:

- Ensuring sufficient capacity to meet local demand for emergency and planned care and manage RTT waiting times in line with agreed capacity;
- Service development proposals which ensure we maintain the Trust's ability to adhere to national specialised service specifications, as well as local developments to address key local priorities;
- Addressing the Trust's strategic intent to provide the right level of specialist and acute care to the local and regional population; and
- A neutral impact of coding and counting proposals.

4.5.2 NHS England South West – Specialised Services (contract value £224.5m)

The key aspects subject to negotiations are:

- Specialised Services now make up around 43% of our proposed contract income;
- The Trust will seek investment to embed hosted Operational Delivery Networks (ODNs), such as Paediatric Neurosciences and (subject to final designation) Congenital Heart Disease;
- UH Bristol continues to perform well against key requirements of national services specifications, but investment is being negotiated with NHS England to ensure continued compliance in a number of key areas. Service development proposals have been reduced to the absolute minimum value;
- NHS England's approach of linking CQUINs to Quality Innovation Productivity and Prevention (QIPP) in 2016/17 has been rejected in principle and presents a real challenge to the Trust, particularly where delivery is dependent on other providers and carries significant delivery costs;
- Very late in the contract negotiation process, NHS England has introduced a mandatory CQUIN for Hepatitis C ODN lead providers. This accounts for over 57% of the total value of the Specialised CQUIN scheme, and requires the ODN to manage resources within an indicative financial budget forecast, prioritising patients with highest clinical need despite National Institute for Health and Care Excellence (NICE) Technology Appraisal guidance having been published. The indicative financial budget is substantially understated and out of line with the rest of the country, hence a revised budget is required in order to be acceptable to UH Bristol. Non-delivery of the CQUIN would result in a loss of £2.7m CQUIN income;
- NHS England continues to seek the mandatory implementation of Clinical Utilisation Review (CUR) from a recognised CUR provider through a QIPP-related CQUIN. The potential effect of this initiative would have significant impact on the current delivery of key IM&T projects, and is not supported by the CIO or clinicians. It also requires the CQUIN income to be spent which is not affordable. The Trust has proposed that the aims of the CQUIN could be achieved through the use of its existing integrated systems;
- We are seeking to ensure CQUINs are earnable, as per national guidance, at circa 80-85% net earnable income. This currently remains a point of significant misalignment in relation to the national Hepatitis C ODN and CUR CQUINs and other QIPP-related CQUIN proposals, where in most cases NHS England is enabling a maximum 10% net earnability;
- NHS England's proposal includes circa £9m of Specialised QIPP, which the Trust believes is a balancing figure and too high to be deliverable. Significant QIPP is assigned to Payment by Results (PbR) excluded drugs (through compliance with NICE and commissioning policies). Further QIPP is expected to be released through the extension of Blueteq prior approval to a range of specialised procedures and devices (principally cardiac), coupled with the centralisation of device procurement. The extension of Blueteq for this purpose is being challenged. Very brief details of schemes have now been received and are being reviewed. The Trust will engage in those schemes which are considered realistic and clinically supported, but expects the inclusion of QIPP in contracts to be at Commissioner risk; and
- The issues relating to CQUINs and QIPP have been escalated to the National level where resolution must be achieved in order for a contract to be agreed. The negotiations are extremely challenging.

4.5.3 Local Commissioning (contract value £259.5m)

A key consideration this year continues to be the effect of programmes designed to divert services away from acute settings. CCGs aim to achieve this through levers such as the Better Care Bristol (an extension of the Better Care Fund (BCF)) and other QIPP proposals which have largely rolled over from 2015/16, moving urgent care into the community, reviewing pathways and integration. The Trust continues to be actively engaged in discussions around these initiatives in order to manage the demand being calculated through IMAS and other capacity modelling. However, pressure on acute services has not reduced and has, in fact, significantly increased in year bringing into question the impact of the programmes in 2015/16. The Trust will expect that QIPP included in the contract is at Commissioner risk.

Negotiations on CCG CQUIN proposals are progressing, and a CQUIN scheme has been agreed in draft, which addresses mutually agreed priorities and principles such as organisational responsibility and deliverability/ appropriate net earnability. The 2016/17 national CQUINs will be extremely challenging, in particular new CQUINs relating to Staff wellbeing (including unachievable flu vaccination targets and healthy food requirements which cannot be imposed on existing contracts with suppliers) and Antimicrobial resistance (where the Trust has improved markedly in recent years and further reductions in antibiotic prescribing will be difficult). These issues are also being escalated Nationally.

There is broad alignment with CCGs on activity in the contract. Negotiations on service development proposals are continuing, with CCGs unable to invest in 7-day services and therefore an expectation of derogation in this respect. CCGs are reconsidering their ability to fund Patient Transport Services and a small number of other proposals.

Re-procurement of sexual health services will commence in April 2016. The Trust has committed to maintaining its contract with the local authority for the duration of the procurement. The key challenge in 2016/17 is the Public Health funding allocations and the need for Councils to continue to seek service efficiencies, in the order of up to 10% across the board for public health services together with additional services required in the tender specification.

Following the procurement of an interim solution, CCGs have consulted on the re-procurement of the Children's community health contract. Procurement is ongoing. UH Bristol will be fully engaged as a key partner in both the interim and substantive community children's health services.

Commissioners and the Trust will seek to be aligned on activity and finance within the contract in order to move to contract signature by the end of April, subject to the satisfactory resolution at a National level of the CQUIN and QIPP issues noted above.

4.5.4 Education Commissioning

Health Education England (HEE) commissions education and training from the Trust including Undergraduate Medical (SIFT) and Dental (DSIFT) teaching, post-graduate Medical and Dental (MADEL) teaching and non-medical education and training (NMET). The baseline contract is £35.9m, but a loss of £2.5m is expected due to a 5% efficiency requirement and changes in student numbers plus transitional SIFT tariff being reduced. Formal communication has now been received confirming the Trust's assumption. The main outstanding item is the funding for the Junior Doctors proposed pay award.

4.6 Workforce

4.6.1 Background

Our Workforce and Organisational Development Strategy recognises that achieving financial and operational sustainability depends on robust workforce planning, including effective recruitment and retention plans to meet service needs within an agreed financial envelope. In addition, there is increasing recognition of the need for transformational change to release productivity savings, engaging staff in the process, as described in the Carter (February 2016) report.

One of the Five Year Forward View "must dos" is the completion of a system wide STP, and the associated workforce approach includes explicit consideration of cross sector, pathway development and how we need to change our staffing models and develop our staff to deliver new pathways. The work is also considering how to attract and retain key staff groups in the context of changes to the supply of traditional labour sources. Cross sector work is already underway using Health Education England South West funding to introduce 'Well-Being Partner Apprentices'. These new roles are supported by training programmes that will prepare staff to work across different care settings to meet patient need; whilst the new career pathway should help reduce turnover among nursing assistants across all organisations, public and private, in the local health economy.

The Five Year Forward View also highlights the importance of delivering seven day working, although the challenge is to do this in an affordable way. We have completed an audit led by our Medical Director to identify gaps in our delivery against the four key standards. Plans have been developed to address these gaps and demonstrate incremental progress towards the 2020 requirements. We are keen to build on the early successes with our therapy services: in 2014 we introduced 6-day working across all in-patient teams. We achieved this through the redistribution of resources; all staff continue to work only standard contractual hours over the 6-days, and no staff work more than 5 days consecutively.

4.6.2 Workforce Planning Approach – Operating Plans

The annual workforce planning process at UH Bristol forms an integral part of the annual Operational Plan cycle. Each Division is required to provide a detailed workforce plan aligned to finance, activity and quality plans.

An assessment of the 'demand' for workforce is linked to commissioning plans reflecting service changes, developments, CQUINS, service transfers and cost improvement plans. The IMAS capacity planning tool is used to identify workforce requirements associated with capacity changes. We have agreed nurse to patient ratios which are reflected in the plans.

The planning process also considers workforce 'supply'; including an assessment of the age profile of our existing workforce, turnover, sickness absence and the impact these will have on vacancy levels and the need for temporary staff. Divisional plans are developed by appropriate service leads and clinicians, directed by the Clinical Chair and Divisional Director, and are subject to Executive Director Panel review prior to submission to Trust Board.

Throughout the course of the year, actual performance against the Operating Plan, including workforce numbers, costs and detailed workforce KPIs are reviewed through Quarterly Divisional Performance reviews held with the Executive team, chaired by the Chief Executive.

4.6.3 Workforce Planning Approach - Strategic Workforce Plans

We also undertake strategic workforce planning, taking a five year view of changing workforce needs. Strategic workforce planning workshops with Divisional teams, including clinicians, will take place in each Division between February and May 2016. This work is used to refresh our Organisational Development Strategy and supporting programmes of work and informs the Health Education England submission on which future education commissioning is based. Some of the emerging themes from the workshops include the following:

- **Apprenticeships**: the need to develop apprenticeships in a range of areas including radiography and other scientific and technical roles to address workforce shortfalls and attract new recruits into the workforce;
- **Development of new skills:** the complexity and acuity of our patients in the future, combined with increased technological interventions, will mean new skills are required. For example, more cardiological interventions and less cardio-thoracic surgery will change consultant specialty mix and require different types of technical staff, including more of the Band 4 technical roles we have developed to work flexibly across physiology and other technical areas;
- **Partnership working with academic providers**: removal of bursaries and changes in education commissioning will make educational partnerships even more important to ensure there are sufficient numbers of the right staff with the right skills in the future. We will need to build on work already underway with the Universities of Bristol and the West of England such as joint appointments to Clinical Academic posts, consideration of new roles and developing our existing workforce;
- **Pathway redesign and transformation:** linking with the Five Year Forward View, the need for pathway redesign and transformation across a range of services with roles which support a more integrated approach across the health and social care system;
- **Potential reductions in Junior doctors**: the need to develop clinical fellow and specialty doctor posts, with more roles which combine education, research and service elements to make them more attractive to potential recruits, combined with further exploration of physicians associates and increasing the range and number of our advanced nurse practitioner roles;
- **Specialist Nurses:** training and development of the specialist nursing workforce, including advanced nurse practitioners, and improving retention of nursing by increasing their skills and developing their roles in specialist areas to backfill junior doctors; and
- **Succession Planning:** we have a number of potential consultant and senior nurse retirements in hard to recruit areas, and succession planning at a Divisional and specialty level for these areas will be vital.

4.6.4 Achieving NHS Improvement's Locum and Agency expenditure ceiling

The following principles have been agreed by the Senior Leadership Team in relation to the implementation of the agency and locum ceiling:

- Maintaining patient safety is paramount;
- To adhere to the new rules and to only use agencies on approved frameworks whilst maintaining patient safety; and
- There is a clear clinical and business exception approval process for all staff groups which will be followed.

There are clear escalation arrangements for all staff groups, which have been tightened and standardised, especially in respect of the approval of agency staff costing more than the capped agency rates.

Improved rostering and job planning will ensure that there a fewer gaps, reducing the need for temporary staffing. Robust process and outcome KPIs are in place to evidence effective rostering, as outlined in the Carter report and re-procurement of an e-rostering system for nursing staff, to include acuity and dependency scoring, is underway. This will enable real time monitoring and reporting. However, recognising there is a place for a contingent workforce to provide flexibility to cover unavoidable absence and peaks in demand, we have been strengthening our Temporary Staffing Bureau (bank staff) through a range of initiatives and incentives.

Recruitment, retention and sickness absence management are also fundamental to the management of agency usage, which are described below. The scale of the challenge to achieve the agency and locum ceiling from a 2015/16 forecast outturn of £19.7m to £12.8m is well recognised, and is reflected in the scope and range of programmes which feed into the reduction plan.

The achievement of the ceiling is underpinned by the implementation and acceptance of the NHS Improvement capped rates by Approved Frameworks and associated agencies. Agencies that refuse to implement the 1st April 2016 rates will put the Trust at risk of not achieving the planned expenditure levels.

4.6.5 Workforce Numbers

The anticipated workforce plan, expressed in whole-time equivalents (wte) for 2016/17 and how this compares to the previous year is set out in the tables below.

Table 5 : Workforce Demand

	Funded Establishment 2015/16 Actual wte	Service Developments wte	Service Transfers wte	Savings Programme wte	Funded Establishment Mar-17 wte	Change wte
Medical and Dental	1,204	57	(3)	0	1,258	55
AHP/Clinical scientists	1,333	37	(17)	(3)	1,350	17
Nursing and midwifery	3,126	108	0	(4)	3,230	104
Ancillary	858	4	0	(7)	855	(3)
Admin and Clerical	1,680	36	(10)	(4)	1,702	22
Total	**8,200**	**242**	**(30)**	**(17)**	**8,395**	195

Table 6 : Workforce Supply

	2015/16 Actual Employed wte	2015/16 Actual Bank wte	2015/16 Actual Agency wte	2015/16 Total Staffing wte	Change in Planned Employed (Starters) wte	Change in Planned Employed (Leavers) wte	Change In Bank wte	Change in Agency wte	Total Changes wte	2016/17 Planned Employed wte	2016/17 Planned Bank wte	2016/17 Planned Agency wte	2016/17 Planned Total Staffing wte
Medical and Dental	1,153	0	52	1,205	390	(330)	0	(8)	53	1,214	0	44	1,258
AHP/Clinical scientists	1,296	7	3	1,306	267	(228)	5	0	44	1,335	12.1	3	1,350
Nursing and midwifery	2,933	207	76	3,216	577	(453)	(55)	(56)	14	3,058	152.3	20	3,230
Ancillary	787	44	14	845	145	(96)	(29)	(9)	10	835	14.7	5	855
Admin and Clerical	1,544	79	23	1,646	307	(246)	(6)	1	56	1,605	73.1	24	1,702
Total	**7,713.0**	**337**	**168**	**8,218**	**1,687**	**(1,353)**	**(85)**	**(72)**	**177**	**8,047**	**252**	**96**	**8,395**

The tables above includes planned cost savings, and transfers; for example, Histopathology to North Bristol NHS Trust, and aligns with the financial assumptions.

4.6.6 Safe Staffing Levels

The NHS national staffing return compares expected and actual staffing levels on the ward for each day and night. This information is triangulated with the Trust quality performance dashboard to assess whether the overall standard of patient care was of good quality (safety/clinically effective/patient experience). This forms part of the monthly report to a Trust Board Sub Group, the Quality and Outcomes Committee. Each ward receives its own RAG rated quality performance dashboard including workforce KPIs on a monthly basis. This enables the triangulation of workforce and quality data at a ward, divisional and trust wide level.

As actioned in the quality section of this plan a Quality Impact Assessment is completed for all cost improvement schemes which involve the removal of a patient facing post to identify and assess the quality and operational risk. These are reviewed monthly at the Savings Board and work stream accountability meetings which include both the Medical Director and Chief Nurse.

4.6.7 Transformation and productivity programmes

Our overarching Trust wide programme of work to deliver quality and efficiency improvements - Transforming Care – is overseen by the Trust Board and consists of six pillars. Within the "Deliver Best Value" pillar we have focussed savings work-streams which are delivering productivity initiatives focussed on each staff group. The key actions in respect of each are described below.

- **Nursing and Midwifery**
  - Improving efficiency through E-Rostering – our E-rostering system will be re-tendered in 2016/17.
  - Reducing turnover and sickness absence, especially for registered nurses in specialist areas (theatres, critical care) and for nursing assistants.
  - Exploring more cost effective ways of providing safe care to patients with mental health needs.

- **Medical Staff**
  - Review of consultant on-call payments.
  - Productivity based job plans.
  - Harmonisation of premium payments paid to substantive and locum medical staff.
  - Absence/leave management to ensure effective rota cover for medical staff.

- **Allied Health Professionals (AHP)**
  - Establishing integrated pathway teams across adult therapy services (physiotherapy, occupational therapy, speech and language and dietetics).
  - Development of shared support worker roles.
  - Improving efficiencies by Benchmarking workforce levels with other Trusts.
  - Expanding the newly developed role of independent pharmacist prescriber into other outpatient areas including urology (oncology) and myeloma clinics, and breast and lymphoma pre-assessment clinics.

- **Administrative and Clerical**
  - Focus on speed of recruitment, clear competency standards underpinned by training for all roles.
  - New standard operating plans to improve theatre booking procedures.
  - Implementation of a digital dictation and speech recognition system.
  - Mobile phone technology to enable clinicians to send dictation to secretaries in real-time and client side dictation during ward rounds.
  - Homeworking is being successfully piloted which will enable improve flexible working options.

4.6.8 Workforce Risks

Workforce risks are recorded at departmental, divisional and corporate level on Datix, our Risk Management System, and are managed and reviewed at an appropriate level, in line with Trust Policy. Our workforce risks are considered by the Workforce and Organisation Group and by the Trust's Risk Management Group on a quarterly basis. Our main workforce risks, identified in our 2015-2020 Workforce and Organisational Development Strategy, include the impact of higher than planned turnover, vacancies, and sickness absence on our ability to sustain safe services without recourse to agency usage. We also recognise the link between good staff engagement and motivation and high vacancies, turnover and sickness absence and have more work to do in this respect. Detailed plans are in place to mitigate these risks and the headlines are described below.

4.6.9 Workforce KPIs

Our workforce KPIs are set at a divisional and staff group level, taking account of historic performance and comparable benchmarks.

4.6.10 Workforce KPIs - Turnover

During 2016/17 turnover levels at UH Bristol have reduced against the background of other Teaching Trusts experiencing higher rates. Although this is encouraging, we started at a higher baseline than many and this is remains a key area of focus. We have set a target for 2016/17 reducing it from 13.6% to 12.1%, approximately 95 fewer leavers.

Our key areas of work in our retention and engagement plan include the following:

- **Visible leadership and improving two-way communication**: A number of staff experience and engagement workshops across different UH Bristol sites have taken place to agree how we improve communications between managers and teams;
- **Appraisal improvement project:** The embedding of role competency and career frameworks into a new appraisal process which will be fully implemented from September 2016;
- **Investment in staff development and team building:** This includes the provision of critical care modules and a theatre transformation programme including role development for band 6s. We also have also piloted the Aston team coaching model, with 20 coaches trained to work across the Trust;
- **Local Engagement Plans:** There are a range of activities tailored to the service and staff group context within divisions, including staff suggestion schemes, engagement events, ward away days, staff champions, newsletters, and the development of a "happy app" for staff to give feedback**;**
- **Health and Well-being programme:** The second year of the programme includes free on site health checks over the next 2 years with a target of reaching 2000 staff and the launch of "Step into Health" 12 week physical activity/lifestyle programme; and
- **Best Care Weeks:** designated weeks to strengthen team working and help all our staff focus on improving the quality of care, mobilising staff and leaders to help identify barriers to delivery of high quality care and escalating issues which local teams need help to resolve.

4.6.11 Workforce KPIs - Vacancies

Recruiting to vacancies is an important element in our agency reduction plan, together with reducing turnover given the link with increased vacancies on staff motivation and work pressure. The UH Bristol vacancy rate (5.2% in February 2016 for all staff) continues to compare favourably with other Teaching Trusts. With a thriving local economy with a high employment rate, our highest vacancy rates are for administrative and clerical staff at 8.1% in February 2016. Vacancy rates are below 5% for nursing and midwifery, and 1.2% for medical staff. However, there are hotspots amongst these two groups, which have been the focus of specific campaigns, including overseas recruitment for hard to fill consultant posts such as radiology and targeted theatre nurse campaigns. We have implemented an assessment centre approach for nursing assistant recruitment and vacancies have reduced to 1.3% compared with 10.4% a year ago. Ancillary vacancies have also reduced by 28% in the last six months, due to the appointment of a Recruitment Lead to focus on this staff group. We have implemented a new recruitment IT system, TRAC, to improve workflow management, and intelligence of pipeline recruitment. There continues to be an ongoing plan of work in place to sustain our progress in reducing vacancies.

4.6.12 Workforce KPIs - Sickness Absence

Our 2015/16 sickness absence rate at 4.2% is similar to the average performance for other Teaching Trusts. We are aiming to significantly reduce absence in the longer term, with a target of 3.9% during 2016/17. Benchmarking has identified that our unregistered nursing and administrative and clerical sickness absence levels are above average and ancillary sickness absence rates are also a cause for concern, and targeted interventions are being actively pursued. We already have a robust sickness absence management framework and we continue to test how this might be improved.

We have put in place a comprehensive Health and Well-being Programme. Our main programmes of work target our top three reasons for absence which are as follows:

- **Stress related absence:** Although the staff survey indicates there has been a reduction in work related stress, suggesting that staff perceive a reduction in stress levels, this has not yet been shown in the sickness absence data. Support for staff includes an in house staff counselling service for all staff, a Resilience Building Programme providing self-help tools and techniques to prevent absence for psychological reasons and an Employee Assistance Programme for Women`s and Children`s Division.
- **Colds and flu:** Flu vaccine is offered to all staff throughout the annual flu campaign.
- **Musculo-skeletal/back problems:** Physio Direct continues to offer telephone advice and clinics by self or manager referral providing about 1,200 such interventions in the last year. In addition, there are around 1,400 site visits per year by the Manual Handling team including staff work place risk assessment for assessing musculo-skeletal health.

4.6.13 Staff Engagement

Our second all-staff annual survey was carried out in 2015. Our overall staff engagement score has improved from 3.69 in 2014 to 3.78 in 2015 compared with a National average score of 3.79. Our scores show a particular improvement in the following areas:

- Reporting good communication between senior management and staff;
- Staff satisfaction with level of responsibility and involvement;
- Support from immediate managers;
- Increase in staff motivation at work;
- Less staff suffering from work related stress in the last 12 months; and
- Less staff witnessing potentially harmful errors, near misses or incidents in the last month.

However, we retain a key focus on this agenda particularly as we aim to be in the top 20 teaching hospitals. Our work programme is multifaceted and the priority is to equip our leaders and managers at all levels to improve the following areas in the coming year:

- Effective Team working;
- Staff motivation at work;
- Percentage of staff satisfied with the opportunities for flexible working patterns;
- Staff satisfaction with the quality of work and patient care they are able to deliver; and
- Staff confidence around speaking up if they have concerns.

4.7 Financial Plan

4.7.1 Introduction

The financial plan narrative describes the Trust's current assessment and presents the 2016/17 position in outline. It should be noted that the current assessment of 2016/17 is based on SLA proposals to Commissioners and Health Education England which have not yet been concluded and hence carry potential upside benefits but more likely further downside risks. The plan is based on the following key drivers:

- The Trust's CIP target is set at 2.2% of recurring budgets plus the assessed underlying deficit carried forward from 2015/16 generating a target of £21.9m or 4.6% for 2016/17. However, the Trust's Board view is that 4.6% is too high and not deliverable therefore we have agreed not to plan on this basis (corporate support of 1% or £4.5m is provided) leaving a net CIP requirement of £17.4m (3.6%);

- The net favourable impact of 2016/17 national tariff guidance, specifically the removal of the specialised services marginal tariff at £2.4m offset by the adverse impacts of the Stereotactic Radiosurgery Service (SRS) tender at £0.6m plus the reversal of previous Monitor guidance on MDT services which reduces income by £0.8m;

- The loss of Health Education England (HEE) Service Increment for Teaching (SIFT) funding of £1.1m in addition to a 5% CIP requirement likely to be advised by HEE – so in total a £2.1m loss of funding on top of the £0.3m SIFT transition loss already planned for;

- Sustainability funding (general element) of £13.0m is assumed to be received. This has not yet been confirmed by NHS Improvement. It is anticipated that discussions about the build-up of the Control Total for UH Bristol will inform this. In particular the impact of Health Education England changes (£2.0m) and the baseline for the calculation (i.e. using the 2015/16 balanced plan rather than the Q2 £1.6m surplus) are issues which the Trust believes require consideration for adjustments to the Control Total on which the receipt of Sustainability funding is predicated;

- Service Level Agreement (SLA) proposals are at an advanced stage from the Trust with Version 7 of our offers having been sent to Commissioners. Whereas good progress has been made with local CCG contracts (the only significant issue is the National CQUINs being largely undeliverable), the NHS England (specialist and non-specialist) contracts are at an early stage with only one partial offer being received. The likely residual issues that could impact on the Trust's financial plan are largely for national resolution (CQUINS, QIPP and Pharmacy gain-share); and

- There is an expectation, however, that Heads of Terms could be signed by the end of April subject to the issue of CQUINs being resolved nationally. The Trust will consider using the dispute resolution process including Arbitration if the SLA issues cannot be resolved in April.

4.7.2 Financial Summary

The 2016/17 financial plan of a £14.2m surplus has changed from the draft plan submitted on the 8th February 2016 (a £15.9m surplus) in the following respects:

- The new guidance on MDT charging has reduced income by £0.8m;
- A residual level of non-core fines of £0.7m is included – originally the assumption was for no fines to be levied;
- Non-recurring measures are needed to be used to support the Divisional Operating Plans (mainly unadjusted CIP) instead of supporting the overall Trust position – this amounts to £2.2m;
- Other offsetting savings leave the net change at a £1.7m deterioration; and
- It should be noted that the donated income and depreciation is now excluded from the headline surplus quoted. Hence the £16.6m surplus at the draft plan stage becomes the £15.9m surplus referred to (i.e. net donations amounts to £0.7m).

4.7.3 Financial Plan

The Trust's 2016/17 financial plan is constructed as follows:

Table 7: Financial position

Surplus / (Deficit)	**Draft Plan 8th February**	**Final Plan 18th April**	
	£m	**£m**	
Underlying position brought forward	3.3	3.3	
Cost Pressures			
Capital Charges	(1.6)	(1.0)	Strategic schemes completion
BRI Old Building	0.9	0.9	Vacation in September 2016
Dental SIFT	(0.3)	(0.5)	Reduction in student numbers
Medical SIFT	(0.6)	(0.6)	Change in ratio WTE / weeks by HEE
Risk provision for cost pressures	(0.5)	(0.5)	Unavoidable recurrent costs only
Reduction in contingency	0.3	0.3	
Tariff – Capital Charges	1.0	1.0	Tariff inflator funds capital growth
Other	-	0.6	Various cost reductions
Sustainability Fund	13.0	13.0	Based on a revised control total of £14.2m.
SLA Contracting Issues			
Specialised Marginal Tariff	2.5	2.4	Per NHS Improvement guidance
Impact of Tariff			
SRS tender	(0.9)	(0.6)	Tender reduces the SLA price
MDT	-	(0.8)	Per Monitor Prices team correction
Other	-	0.6	Other tariff impacts
Non Recurrent			
Change costs / spend to save	(1.0)	(1.0)	To fund schemes that generate recurring savings
Risk provision for cost pressure	(0.5)	(0.5)	Unavoidable non-recurrent costs only
Transition costs for strategic schemes	(0.9)	(0.7)	
Clinical IT programme	(1.0)	(1.0)	Funds the IT Programme support costs
SLA fines charge	-	(0.7)	Residual fines
Other non-recurring measures	2.2	-	Now required to support Divisional plans
Net I&E Surplus / (Deficit) excluding technical items	**15.9**	**14.2**	
Donations	2.2	2.7	
Donated asset depreciation	(1.5)	(1.5)	
Net I&E Surplus / (Deficit) excluding impairments, including donations	**16.6**	**15.4**	
Net Impairments	(6.6)	(7.1)	
Net I&E Surplus / (Deficit)	**10.0**	**8.3**	

The final plan above requires c. £7m of non-recurring savings for delivery of Divisional Operating Plans in addition to the above Trust level changes, due to a combination of unidentified CIP (£5.0m) and nursing spend risks (£2.0m).

4.7.4 Income

The 2016/17 income plan is subject to further negotiation of SLAs with Commissioners and the resolution of the following key issues:

- Agreement of activity plans to deliver trajectories towards constitutional targets, allow for specialty specific growth, necessary service developments and NICE guidance;
- Agreement of CQUINs that can be earned to the baseline requirement of 80-85%;
- The non-payment of core fines as defined by the National Standard Contract plus non-reimbursement to Commissioners of re-admission penalties. The residual requirement for fines is £0.7m;
- Agreement of counting and coding changes; and
- Discussion of QIPP proposals from Commissioners including challenges raised.

Heads of Terms and SLAs are expected to be signed at the end of April 2016. The current 2016/17 income plan is £631.1m and includes the following key changes:

Table 8 : 2016/17 Income build up

		£m	£m
Rollover Income	Recurrent income from 2015/16		**592.1**
Tariff	Gross inflation including CNST	15.3	
	Efficiency	(10.1)	
			5.2
Impact on Guidance	Specialised Marginal Tariff Adjustment	2.5	
	Stereotactic Radiosurgery & Stereotactic Radiotherapy	(0.5)	
	MDTs	(0.8)	
	Other	0.5	
			1.7
Activity Changes	2015/16 forecast	(1.2)	
	Forecast outturn adjustment	4.8	
	RTT Recurrent	1.3	
	RTT Non-recurrent	4.5	
	Activity Growth	3.4	
			12.8
Other	Sustainability and Transformation funding	13.0	
	NICE Changes	4.1	
	Service Transfers	(0.9)	
	Service Developments	2.1	
	CQUINs	1.3	
	QIPP Savings	(0.5)	
	Fines	(0.7)	
	Dental SIFT	(0.5)	
	Medical SIFT	(0.9)	
	Other	(0.4)	
			16.6
	Total 2016/17 Income excluding donations		**628.4**
	Donations		2.7
	Total 2016/17 Income		**631.1**

4.7.5 Costs

The 2016/17 cost outlook for the Trust is challenging and should be considered in the context of operational pressures on spending, the full delivery of savings plans and transformation initiatives. Firm control will continue to be required to avoid the Trust's medium term plans being undermined beyond 2016/17. The main assumptions included in the Trust's cost projections are:

- Pay award at 1.0%, incremental drift at 0.5%, employer NI contributions at 1.6%;
- Controlling locum and agency costs to a maximum of £12.8m for the year;
- Drugs at 5.0%, clinical supplies 2.0%, CNST at 17.0%, and capital charges at 5.6%;
- Savings requirement of £17.4m;
- Payment of loan interest at £2.9m; and
- Depreciation of £21.6m.

The 2016/17 position includes non-recurring costs of £3.2m as follows:

- £1.0m Change / invest to save costs;
- £0.7m Transitional costs relating the disposal of the BRI Old Building;
- £1.0m Clinical Systems Implementation Programme (CSIP); and
- £0.5m Risk reserve.

4.7.6 Cost Improvement Plans

The delivery of CIP is an essential element in the Trust delivering its 2016/17 financial plan, including the conversion of non-recurring schemes to recurring schemes. The Trust sets CIP targets for 2016/17 in the light of:

- National tariff efficiency requirements for Commissioners at 2.0% for 2016/17;
- The impact of HEE requirements at 5.0% (0.2% on Trust total); and
- Underlying deficits in divisions carried forward from the previous year (2.4%).

The Trust's CIP target is set at 2.2% of recurring budgets plus the assessed underlying deficit carried forward from 2015/16 generating a target of £21.9m for 2016/17. However, 1.0% or £4.5m will be dealt with recurrently corporately leaving a net recurring requirement of £17.4m. Currently, risk assessed plans exist for £12.4m. A reduction in nursing expenditure of £4.0m is required for the overall plan to be delivered.

The Trust has an established process for generating CIPs. It operates an established programme of transformation, called Transforming Care. The key transformational work streams which support CIP are as follows:

- Theatre Productivity transformation programme to focus on improving theatre efficiency;
- The Model of Care Programme which is our patient flow programme and focuses on reductions in length of stay along with improved productivity and reductions in cancellations;
- The Diagnostic Testing project addresses the processes for delivering efficient diagnostic testing across the Trust for Pathology and Radiology services; and
- Outpatient productivity which focusing on the efficient utilisation of outpatient capacity.

The challenge is to identify quantifiable savings from these transformation work streams.

The Trust has established a further group of work streams dedicated to delivering transactional CIPs, for example:

- Improving purchasing and efficient usage of non-pay including drugs and blood;
- 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;
- 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 improvements in energy efficiencies;
- Ensuring best use of technology to improve efficiency, linking productivity improvement with the introduction of new tools in clinical records management and patient administration; and
- Addressing and reducing expenditure on premium payments including agency spend.

The Trust's risk assessed CIP plan is summarised below. The total of unidentified savings is currently £5.0m.

Workstreams	**£m**
Allied Healthcare Professionals Productivity	0.5
Medical Staff Efficiencies Productivity	0.6
Nursing & Midwifery Productivity	0.3
Diagnostic testing	0.2
Technology / Admin & Senior Managers Productivity	0.2
Reducing and Controlling Non Pay	3.8
Medicines savings (Drugs)	1.4
Theatre productivity	0.3
Outpatients Productivity	0.1
Facilities & Estates	0.7
Trust Services	0.4
Corporate and other savings	3.9
To be identified	5.0
	17.4

4.7.7 Carter review

The final Carter Report has been published and the Trust is now actively developing an action plan to address the key issues within the report. The Trust has already been actively engaged with regards to Medicines / Pharmacy efficiencies and Estates and Facilities. The report also highlights the current local collaborative medicines procurement process as an example of good practice. Each of the trusts savings work streams will be tasked with establishing a clear action plan to take forward the recommendations in the Carter report particularly those concerned with developing efficiencies in relation to the use of staffing resources.

The Carter report introduces a number of new measures of efficiency relating to staffing which the Trust is keen to develop over the coming months as delivering savings from pay is recognised as one of the trusts biggest challenges in 2016/17 and beyond.

The Trust is keen to become involved with the 'Model Hospital' aspects of the Carter approach as the Trust recognises the considerable benefits this might bring in future. As yet this is relatively underdeveloped, however as this improves the Trust will actively use this as a further means of identifying opportunities for efficiency savings.

With regard to benchmarking the Trusts performance against peer Trusts which is a key element of the Carter approach, the Trust has in the past actively used Reference Costs to identify areas of potential efficiency improvement. Using the benchmarking portal released by the Carter team, the Trust will increase the benchmarking it carries out with a view to identifying examples of best practice in other Trusts. It should be noted however that it has been the experience of the Trust that identifying areas of inefficiency is relatively easy, transferring this knowledge into practical implementable cost reduction takes time and therefore improvements from this source will only become available later in 2016/17 at the earliest.

4.7.8 Capital expenditure

The Trust has a significant capital expenditure programme investing £452m from April 2008 until March 2021 in the development of its estate. In 2016/17, the Trust's planned gross capital expenditure totals £41.1m and incorporates slippage of £20.0m from 2015/16.

With the remaining uncertainty regarding SLA agreement, the capital programme has been retained at £41.1m but assumes up to £12.0m slippage into 2017/18. This will be reviewed mid-year when the position is firmed up. The net 2016/17 capital expenditure plan is therefore £29.1m and is summarised below:

Table 9 : Source and applications of capital

Source of funds	2016/17 Plan £m	Application of funds	2016/17 Plan £m
Cash	16.5	Carry forward schemes	20.0
Depreciation	21.6	Estates replacement	2.5
Disposals	0.0	IM&T	2.6
Donations	2.7	Medical equipment	6.5
Public Dividend Capital	0.3	Operational capital	4.6
		Strategic schemes	4.9
Subtotal	**41.1**	**Total**	**41.1**
Net cash retention	(12.0)	Net slippage	(12.0)
Total	**29.1**	**Total**	**29.1**

The allocation of the £12.0m reduction is yet to be agreed but is likely to be:

- Reduction in strategic schemes to that already committed by £3.6m; and
- Estimated slippage – this creates a first call on 2017/18 resources of £8.4m.

Once the position regarding Sustainability funding and Commissioners SLAs has been confirmed, along with the arrangements for the other conditions required, the position will be re-assessed with additional schemes being agreed if possible.

4.7.9 Financial Sustainability Risk Rating (FSRR)

The planned net surplus of £14.2m is the driver behind the Trust's overall FSRR of 4. The components of the FSRR are summarised below:

Table 10 : FSRR Performance

	Metric	**Score**
Liquidity	14.3 days	4
Capital service cover	2.7 times	4
Net I&E margin	2.4%	4
Margin variance	0.3%	4
Overall FSRR		**4**

Rating 4	Rating 3	Rating 2	Rating 1
0 days	-7 days	-14 days	<-14 days
2.5 times	1.75 times	1.25 times	<1.25
>1%	>0%	>-1%	<-1%
>0%	>-1%	>-2%	<-2%

4.7.10 Summary Statement of Comprehensive Income

The 2016/17 Statement of Comprehensive Income (SoCI) is summarised below.

Table 11: SoCI and closing cash balance

	2016/17 Plan £m
Income	628.4
Operating expenditure	(581.0)
EBITDA (excluding donation income)	47.4
Non-operating expenditure	(33.2)
Net surplus / (deficit) excluding technical items	**14.2**
Add net donations	1.2
Net surplus / (deficit) excluding net impairments, including net donations	**15.4**
Net impairments	(7.1)
Net surplus / (deficit) including technical items	**8.3**
Year-end cash	**70.8**

4.7.11 Financial Risks

The main risks to the delivery of the plan include:

- Sustainability funding is not yet confirmed;
- Commissioner SLAs are not yet agreed – it is likely that significant risks remain of insufficient funding being made available for activity, necessary developments and existing agreements that underpin the Trust's financial position. The level of risk is not quantifiable at this stage as Commissioner proposals have not yet been made in sufficient detail;
- The need to further develop the Trust's savings programme is high risk. The Trust will review its approach to the delivery of CIP to mitigate this risk; and
- The impact of emergency pressures not being sufficiently mitigated by system measures is significant and could result in the need for additional unfunded capacity (at premium agency cost) and/or the constraint of elective activity together with an associated increase in fines by Commissioners.

5. Membership and elections

5.1 Governor elections in the previous years and plans for the coming 12 months

The last governor elections held at the Trust were in 2014. This year we will hold elections in May 2016, which will include 15 governor seats, including Public, Patient and Staff governor roles. We are currently in the process of promoting the opportunity to stand for a governor role via our membership and wider network of contacts in health and social care. Once the election process is complete, newly elected (or re-elected) governors will start their term of office on 1st June 2016, and will be supported by a thorough induction process. There will be further elections in May 2017.

5.2 Governor recruitment, training and development

We promote the opportunity to become a governor when undertaking any wider membership promotion. We have increased the focus since October 2015, to support the governor elections being held this year.

We provide governors with a comprehensive programme of training and development that begins upon appointment with an induction. In additional to regular updates on Trust Strategy, Quality & Performance and Membership/ Constitution, we run four Governor Development Seminars each year, which for example have included training from NHS Providers/ Govern well and updates and training from leads within the organisation on topics such as Staff Health and Well Being. We use the governor development sessions and governor focus groups to ensure that the Council of Governors are sighted on the same issues as the Board. We are in the process of setting personal objectives with each governor, and from this will support them with an additional tailored personal development programme.

Engagement between governors and members is proactively encouraged, and governors support the facilitation of five member events held each year, Trust Patient and Public Involvement work and events organised by partners such as the University of Bristol.

5.3 Membership strategy

The Trust has a Membership Engagement and Governor Development Strategy that was refreshed in 2015 and approved by the Council of Governors. The strategy outlines the intended approach to membership is to grow member numbers and improve the frequency and quality of opportunities for engagement with members.

In addition to regular membership stands across the hospital sites and in the local community, the Trust holds five main member events a year, each with a focus on a particular health topic and with time for Q&A and feedback. In 2015 over 250 members from a broad demographic attended these events.

The Trust membership is under-represented in certain areas, such as 22-39 years age group, males and in some ethnic groups. Plans are in development for a 2016 summer membership recruitment and engagement drive that will incorporate additional focus in these areas. The 2016 member events are being developed to allow for increased learning from members' experience and feedback and we are working with colleagues from across the organisation on this agenda, for example leads from Palliative Care services.

6. Conclusion

This Operational Plan is the product of much hard work and has been built up from detailed Divisional Plans which makes it robust and hence has an excellent chance of being delivered.

The financial plan is still under review due to late engagement by Commissioners – especially NHS England – and a change in approach in the guidance re CQUINs. The issues outstanding are still under discussion at national level – the outcome will have a material impact on the final financial plan. We still, intend to deliver a surplus plan for the 14th year in row but significant changes need to be agreed nationally to make this a reality.

Paul Mapson
Director of Finance

Robert Woolley
Chief Executive

18th April 2016