**Weston Area Health NHS Trust Business Operational Plan 2014 – 2016**

**March 2014 Final**

**CONTENTS**

|  |  |  |
| --- | --- | --- |
| **1** |  | **Page** |
| 1.1 | Context | 3 |
| 1.2 | Summary Business Plan | 4 |
| **2.** | **STRATEGIC CONTEXT** |  |
| 2.1 | Trust Profile | 5 |
| 2.2 | Socio-economic and demographic overview | 6 |
| 2.3 | Local NHS bodies and other providers | 9 |
| 2.4 | National Priorities | 10 |
| 2.5 | Local Priorities including key commissioning priorities and service improvement requirements | 10 |
| 2.6 | Implications of strategic context and market assessment | 13 |
| 2.7 | Outturn 2013/14 and implications for 2014/15 and 2015/16 | 16 |
| **3.** | **STRATEGY** |  |
| 3.1 | Vision and Values | 17 |
| 3.2 | Strategic and Corporate Objectives | 17 |
| **4.** | **DELIVERY PLANS 2014 - 2016** |  |
| 4.1 | Key operational delivery initiatives | 19 |
| 4.2 | Approach to improving quality and safety | 28 |
| 4.3 | Clinical strategy | 29 |
| 4.4 | Service capacity – Demand and Resource Analysis:   * Summary activity requirements * Summary workforce requirements * Summary bed requirements | 30 |
| 4.5 | Income and Expenditure and Capital Investment Plans | 32 |
| 4.6 | Savings Plans 2014 - 2016 | 32 |
| **5.** | **RISKS** |  |
| 5.1 | Key identified risks | 34 |

**1. Context**

1.1 Work undertaken by the Weston Area Health NHS Trust in partnership with NHS North Somerset over the last 4 years has demonstrated that Weston Area Health NHS Trust, as a standalone entity, is unable to satisfy the financial requirements required to achieve Foundation status.

1.2 Over the last 30+ years, the NHS has enjoyed continued year on year funding growth. The NHS is now operating in a “flat cash” environment. Between 2014/15 and 2015/16 the Trust is required to deliver efficiency savings of 4% in 2014/15 and 4.5% in2015/16.

1.3 Like all hospitals, Weston General Hospital has to be sustainable. In other words, it has to run:

* safe, high quality clinical services
* in suitable facilities; and
* in a way which achieves operational standards and financial balance.

1.4 The hospital has a strong history of providing excellent clinical services and working well with GPs, neighbouring hospitals and the local community. The hospital has worked hard to pay off a previous loan made to help the Trust ‘balances its books’. However, the financial challenges facing the Trust are such that it will require additional financial support in the future, support which is not available to the Trust.

1.5 The North Somerset health community has a long history of financial challenge, and these financial challenges will only get bigger in the future. The Health system is facing increasing financial pressure in addition to rising service demand as a consequence of technological innovation, increasingly complex and expensive treatments, clinical specialisation and the rising expectations of patients as to the availability of such innovation. The North Somerset Clinical Commissioning Group (CCG) remains circa 7% below average funding levels.

1.6 There is growing national recognition that it is better for patients if the most routine healthcare is delivered very locally - in GP surgeries or at home – and the most complex healthcare is delivered in large, regional specialist hospitals. While it is for health commissioners to determine what services they wish to commission from their local hospitals, generally speaking, district general hospitals like Weston will find some of their work migrating into the community or moving into the large regional specialist centres over the next few years.

1.7 Weston has explored all of the options to meet these challenges, ranging from achieving Foundation Trust status to developing an Integrated Care Organisation. Prior to its disestablishment, the Strategic Health Authority, together with the Trust concluded that, having exhausted all other possible options, the best solution to reduce the need for future financial support was to run a competition to find an innovative partner to help run services at the Trust more sustainably.

The National Trust Development Authority is leading this project.

1.8 This business plan is therefore set within this context and seeks to ensure the ongoing delivery of high quality, safe, effective and affordable health services during the transition period to a new organisational form over the next 12 months.

**1.2 Summary Business Plan**

**Our Quality Improvement Priorities are:**

Our Vision

***To put patients at the heart of what we do and be the local healthcare provider of choice by delivering the right care in the right place at the right time and with the right care team.***

**Patient Safety**

Reduce pressure ulcers

Reduce falls

Reduce Healthcare Acquired Infections

Improve VTE assessment

Reduce medication errors

Develop staff capability and leadership for patient safety

Our Values

**People and Partnership** – working together with colleagues, other organisations and agencies to achieve high care standards or specifically helping a service user, visitor or colleague (**C**are and **C**ommitment)

**Reputation** –actions which build and maintain the Trust’s good name in the community (**C**ommunication)

**Innovation** – demonstrating a fresh approach or finding new solutions to problems (**C**ourage)

**Dignity** – Contributing to the Trust’s Dignity in Care priorities (**C**ompassion)

**Excellence and equality** – demonstrating excellence in and equality of service provision (**C**ompetence)

Our Operational Objectives 2014 - 2016

Our Strategic Objectives are:

CQC/ NTDA themes:

Deliver clinically effective services which meet benchmarked best practice standards through implementation and audit of evidence based practice

**Clinical Effectiveness**

Reduce variation in clinical pathways

Mortality reviews

Quality improvement hub to improve practice

**Patient Experience**

Increase feedback and scores from friends and family test

Ensuring services are safe

Provide a safe environment for patients and reduce the incidence of avoidable harm , maintaining the level of harm free care above 93% as measured by the patient safety thermometer

Ensure that people have a positive experience of care, being treated in a safe environment that protects them from harm

Deliver dignified care that is responsive to patients’ personal needs, which ensures a positive experience of care and which meets CQUINs Family and Friend test standards

Ensuring services are caring

Embed clinical leadership providing clinicians sufficient time to lead together with clear, deliverable objectives

**Our Service improvement priorities:**

Improve the Health and Wellbeing of our staff

Provide a safe, effective and affordable workforce

Provide a flexible workforce with the capacity and capability to deliver high standards of patient care meeting the demands of service users, their carers and the health economy

Ensuring services are well led

**Implement evidence-based best practice across medical pathways, including introduction of the model ward and seven day working**

**Work in partnership with social care and partner organisations in the primary care setting to ensure effective and timely transfers of care**

**Reduce inappropriate hospital admissions, improve patient flow and reduce length of stay through utilisation of ambulatory care and Medical assessment unit**

**Realign capacity and workforce to commissioned activity;**

Invest in and develop our staff to continually deliver high standards

Improve and drive two way communication to increase staff engagement and build staff confidence and capability

Ensuring services are responsive

Provide responsive, flexible and consistent services, appropriate to the needs of the patient and in line with commissioner intentions

Meet and sustain local and national performance standards

Provide efficient and effective services, affordable and desirable to patients and referrers.

Deliver the savings plan for each year

Ensuring services are effective

Provide affordable services and demonstrate value for money

Deliver the financial plan for revenue income and expenditure, capital expenditure and cash

Deliver the Estates and IM&T plans to support safe, effective and efficient service delivery

**Our Financial Plan**

Secure a strategic partner(s) to manage the future delivery of clinically and financially sustainable and viable services

Deliver the Trust’s responsibilities within the procurement programme as defined in the Project Initiation Document

Our plan is to deliver the planned deficit or better for 2014/15 and achieve the national efficiency requirement of 4%, which will be a combination of service redesign, increased efficiencies, income generation, productivity and improved procurement.

**Infrastructure Development Priorities**

We expect to invest capital in our estate and infrastructure during each of 2014/15 and 2015/216 , focussed on a replacement Patient administration System, Implementation of Order Communications system and ward, radiology, critical care and theatre refurbishments. In addition, IT and medical equipment, and estate power generation.

**Summary Business Plan**

**2. Strategic Context**

**2.1 Trust Profile**

2.1.1 Weston Area Health NHS Trust was established in April 1991; the Trust comprises:

* Weston General Hospital – the main District General Hospital
* Children’s and Young Peoples Community Services including Child and Adolescent Mental Health Services

2.1.2 The Trust, situated in North Somerset, provides clinical services from three sites. The General Hospital is located in the main town of Weston super Mare and there are two children’s centres providing community children’s services located in Weston super Mare and Clevedon.

### 2.1.3 The Trust serves a resident population in North Somerset which, in 2011 was estimated to be 202,566 people (source: 2011 census), with over 70% of people living in the four main towns of Weston, Clevedon, Portishead and Nailsea. A further 3.3 million day trippers and 375,000 staying visitors increase this base population each year. The Trust also provides services to North Sedgemoor which has an estimated population (April 2012) of 47,825. The largest town is Bridgwater, followed by Burnham-on-Sea and Highbridge.

### Since 2001, the population of North Somerset is estimated to have increased by over 10%. By 2033, the total population of North Somerset is anticipated to increase by 40%, significantly higher than the national average growth rate of 18% (Mid 2011 JSNA).

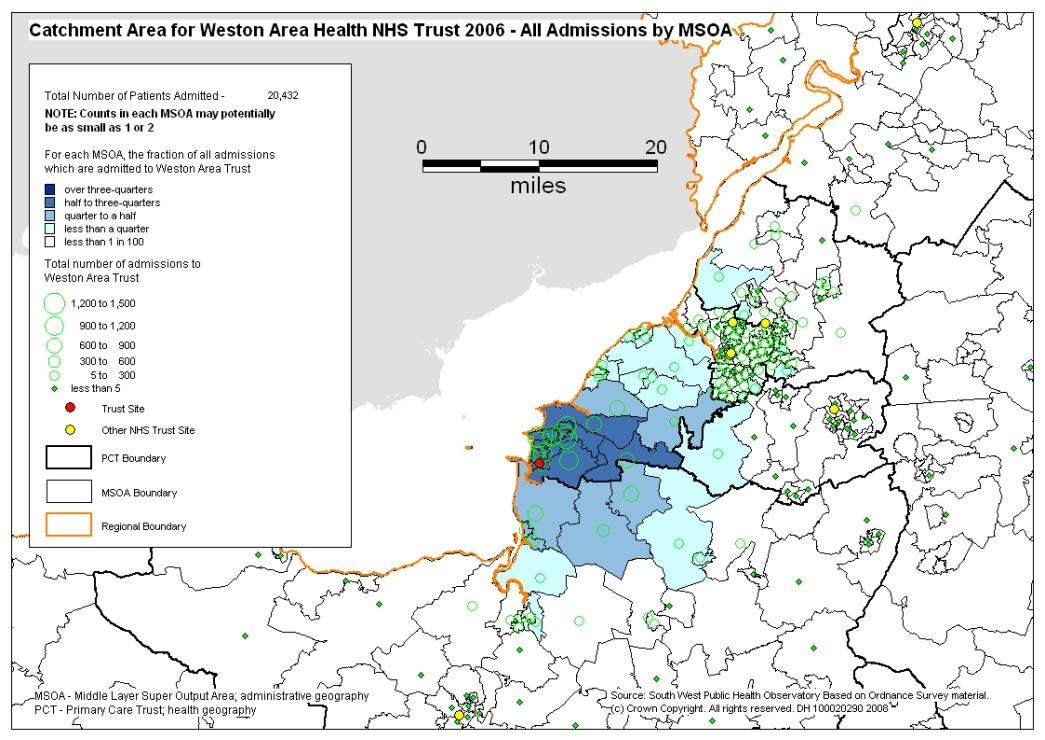
2.1.4 Specific points of note are:

* There are significant distances between major centres and a dispersed population elsewhere.
* The main town Weston-Super-Mare has good access to the M5. This combined with limited growth in local jobs, has led to a high level of commuting by car to and from the Bristol area.

2.1.5 The Trust provides circa 48% of acute health services to the population of North Somerset and works closely with other hospitals in Bristol as part of ‘clinical networks’ including, for example, cancer, pathology and cardiology.

2.1.6 Fig 1 shows the catchment population for all admissions Most people living in Weston and the surrounding area use the hospital, with fewer people doing so in the areas farther north or south. However, the catchment varies significantly between emergency and elective care.

**Figure 1**



2.1.7 The Trust is managed operationally on a Business Unit (BU) basis. Each BU is managed by a Divisional Director (Clinical), Divisional Manager (General Management) and Head of Nursing and all are accountable on a day-to-day basis through the Director of Operations to the Chief Executive for delivery of operational and financial performance. The range of services provided within each BU is set out in fig 2:

**Figure 2** **Service Delivery Unit – service provision**

|  |  |
| --- | --- |
| **Emergency Care**  Urgent Care (to include Emergency Department, ACC and CCT)  Emergency Wards  Patient Flow and Acute Care (MAU, Harptree East, Site Team and Discharge Planning)  Allied Health professionals (OT, physiotherapy, Cardiac physiology, Speech and Language therapy, Dietetics)  Pathology  Pharmacy  Seashore centre  Specialist Community Children’s services | **Planned Care**  Outpatients  Surgical Specialties (ophthalmology, ENT, general surgery, trauma and orthopaedics, urology, gynaecology)  Theatres  Surgical Wards  ITU and Anaesthetics  Private Patients  Access Team  Cancer  Maternity  Radiology  Sexual Health Services (WISH) |
| **Support Services**: Integrated Governance, Information Systems, Administration, Financial Management, Human Resources, Estates, Facilities and Hotel services | |

**2.2 Socio-economic and demographic overview**

2.2.1 Analysis has identified a number of demographic and socio-economic factors that underpin and affect demand for the services provided over the next 2 years to varying degrees. These are:

* Local and regional population projected growth.
* Local population’s gender and age structure.
* Levels of deprivation, health profile and health indicators for the local population.

Each of these factors have been analysed in detail. This section describes the conclusions drawn from this analysis and the implications of the market assessment on the Trust’s two-year plan.

**2.2.1 Demography**

|  |  |  |
| --- | --- | --- |
|  |  | |
|  | | **Figure 3 Predicted growth in long term conditions (adults)**    **Figure 4 Trends in hospital admissions by age**  cid:image002.png@01CF2F0B.FF7C0FA0  Services for older people are the largest area of spending for Adult Social Services and for the health service. Investments have been made in promoting early intervention and reablement services to reduce the reliance on costly forms of institutional care. |
|  | | 2% increase in population aged under 16 yrs 2001 - 2011  Anticipated 21% increase in 5 – 14 yrs old by 2021 |
|  | | The population of North Somerset is less ethnically diverse than England and Wales with 97% of people living in North Somerset classifying themselves as belonging to a white ethnic group, a decrease of one percentage point since 2001. Of those from a black or minority ethnic group 43% classified themselves as Asian and a further 37% classified themselves as mixed race.  **Fig 5 BME population 2011** |
|  | | North Somerset has 15 areas in the most deprived quartile in the country. All of these areas are in Weston-super-Mare. This includes areas within the most deprived 1% nationally, and the least deprived 1% nationally resulting in North Somerset having the 7th largest inequality gap in the county (calculated using the difference between the highest and lowest score in a unitary authority). |
|  | | The population of North Somerset and Weston-super-Mare in particular peaks during the summer months as a consequence of tourism. Latest available data from visitor interviews suggests:   * 75% of respondents were visiting the resort for the day - * The largest proportion of respondents visiting the resort were aged 65+, with little change in the age profile of visitors to the resort compared with previous survey years.   + The majority of visitors were from the UK. |

**2.3 Local NHS bodies and other providers**

2.3.1 NHS North Somerset Clinical Commissioning Group is the Trust’s main commissioner accounting for approximately £62m of healthcare income, with NHS Somerset accounting for £14m and other patient related income of £10m. In addition, there is approximately £8m of other non-patient related income including education and training monies.

2.3.2 The local health and social care economy includes one Local Authority – North Somerset Council.

2.3.3 Weston Area Health NHS Trust operates in a market in which there is increasing plurality of provision, with competition from a wide range of independent and other NHS providers.

2.3.4 United Hospital Bristol NHS Foundation Trust (UHB) and North Bristol NHS Trust (NBT) are both competitors for elective services and a hub for many of the clinical networks in the local health economy. This challenging competitive position is anticipated to increase with the introduction of “any qualified provider”. This competition has the potential to challenge the financial viability and sustainability of some services.

The Trust operates a number of joint clinical appointments and rotas with UHB to ensure sustainable delivery of local services.

2.3.5 Community services (excluding community-based Children’s services, maternity services and paediatrics provided by Weston Area Health NHS Trust) are provided by the North Somerset Community Partnership, a social enterprise. The Partnership currently represents the sole provider of 26 separate NHS community services in North Somerset, and is contracted under the standard community contract to provide them until March 2015.

2.3.6 Mental Health services for adults are provided by the Avon and Wiltshire Mental Health Partnership NHS Trust.

**2.4 National Priorities**

**Fig 6 Summary of national drivers for change** (For detail see appendix 1)

**2.5Local priorities**

2.5.1 Both North Somerset and Somerset CCGs have, In line with national strategy and frameworks, similar ambitions which are detailed below.

**Outcome ambitions**

5 domains – 7 outcome measures

+ reducing health inequalities

Parity of esteem between physical and mental health

**Delivering transformational service models**

* New approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care
* Wider primary care, provided at scale
* Modern model of integrated care
* Access to highest quality urgent and emergency care
* Step change in the productivity of all elective care
* Specialised services concentrated in centres of excellence

**Innovation**

Research and innovation

**Quality**

* Francis/Berwick./
* Winterbourne
* Patient safety
* Patient experience
* Compassion in practice
* Staff satisfaction
* Seven day services
* Safeguarding

**Value**

* Value for money
* Effectiveness
* Efficiently
* Procurement

**Access**

* Convenient for everyone
* NHS constitution
* NHS Operating Framework

2.5.2 **Key commissioning priorities for 2014/15** include:

|  |  |
| --- | --- |
| **Commissioning for Quality and Patient Safety** | * Embed VTE quality measures as “business as usual”. Measures for VTE risk assessments, appropriate prophylaxis and RCAs will be included within the contract; * Agree a common set of quality indicators across all Trusts in 2014/15; * Commissioning for outcomes using the Patient Report Outcome Measure for Knee Replacement Surgery as per the new best practice tariff for primary hip and knee replacement outcomes; * Greater involvement of the patient's GP in being notified of serious incidents and never events for their patient and involvement in sign off of RCAs; * Implement the recommendations from Severe Sepsis: rapid diagnosis and treatment saves lives; * Consistency in serious incident reporting and RCAs across all Trusts; * Trust to publicise staff to patient ratio on wards; * Trust reports on total hours worked for clinical staff each month; |
| **CQUINs** | * Develop system-wide vertically integrated CQUINs. This may include the local authority and primary care where appropriate; * To date CCG priority areas for North Somerset CCG relate to caring for patients with long term conditions. This should include best practice in management of improving end of life care for non-cancer patients; we also wish to further embed the work from the 2013/14 dementia CQUIN for Weston; * Explore a developmental CQUIN that sets new standards for discharge summaries/targeted case * Any patient flow CQUINs will be outcome focused i.e. contingent on achieving national targets; * CQUIN schemes individually and as a whole will need to demonstrate a tangible contribution to improved quality and safety as well as system transformation. |
| **Service Sustainability** | Review the commissioning and provision arrangements for the following:   * + Paediatric acute and community services   + Intensive Care Unit service   + Emergency Department service   + Emergency surgical services   + ENT services   + Neurology services   + Dermatology services   + Maternity services   + Any other services where service continuity is at risk or where the service is not cost effective.   Commissioners will work with the Trust to mitigate risk and maintain service continuity however, it may be necessary to make arrangements for these services to be delivered by another provider, from the 1 April 2014 or during 2014/15. Commissioners will also work with the Trust to review any additional services at risk and make alternative arrangements, in year if the Trust is unable to provide sufficient assurance regarding its ability to continue as provider. |

**Commissioner key service improvement requirements**

|  |  |
| --- | --- |
| **Service** | **Anticipated change** |
| **Urgent Care** | Maximise the proportion of urgent care delivered through self-care and primary care services, 7 days a week, closer to home;  Ensure that Ambulatory Emergency Care is the default service for patients attending hospital;  Ensure rapid movement and processing through ED with admission only if clinically needed and discharge back home or into community services as soon as possible;  Reduce length of stay for non-elective inpatients through development of multi-professional and multi-agency working and systems;  Reduce emergency attendances and admissions, especially for those from care homes or which are alcohol related;  Reduce over 14 day length of stay;  Fully utilise advanced care plans to support people in the community;  Support further community alternatives to ambulance conveyance to acute care;  Is financially sustainable. Providers will not be paid twice – if a patient on a hot clinic or ambulatory emergency care pathway are admitted as an emergency within 1 day of their initial presentation to the Trust, commissioners will only pay for the emergency admission and not for the hot clinic or AEC attendance.  Function as part of an integrated system. |
| **Stroke** | Improvement in performance against stroke and TIA targets ensuring patients can be admitted to a specialist bed as soon as diagnosis has been made and receive high quality rehabilitation in a timely manner. |
| **Rehabilitation and Reablement** | Implementation of a new model for 2014/15, it is expected that the Service specification will be included within Schedule 2 of the contract and the trust should adhere to all reporting and quality requirements |
| **TB Nurse led service** | Service specification will be included within Schedule 2 of the contract and the trust should adhere to all reporting and quality requirements. |
| **Mental health liaison** | Development of seven day mental health liaison services which should be age inclusive. |
| **Cancer** | Enhancement to the monitoring requirements and in some cases the performance requirements for cancer |
| **Somerset CCG Bridgwater Procurement** | Reductions in contracted activity from WGH in relation to inpatient, outpatient and day case activity |
| **Southmead New hospital development** | Planned reduction in emergency department attendances and consequent emergency admissions |

2.5.3 Significant financial challenges within North Somerset include:

* Notwithstanding a 2.14% (2014/15) and 1.7% (2015/16) minimum uplift and an additional 2% uplift for 2014/15, the North Somerset CCG forecast a financial deficit for 2013/14 together with a significant recurrent deficit requiring a recovery trajectory including repayment of the overspend. This will place significant new downward pressure on the spending of the CCG and its partner organisations;
* During the next two years, the acute Trust is required to deliver national efficiency savings of 4% in 2014/15 and 4.5% in 2015/16.
* The Health system is facing rising service demand as a consequence of technological innovation, increasingly complex and expensive treatments, clinical specialisation, the rising expectations of patients as to the availability of such innovation, a rapidly aging elderly population and a growing younger population.
* Funding and incentive systems nationally are not aligned and consequently, hospitals are incentivised to perform more, expensive activity whilst primary and community care have limited incentives to ensure that care is appropriately located and properly coordinated across all settings.

2.5.4 The CCG therefore has a significant recurrent QIPP savings requirement over the medium term in order to achieve recurrent financial balance and manage the impact of expected demographic growth.

NHS Somerset CCG’s QIPP and Commissioning plan describes planned reductions in acute service activity over the next 4 years in line with strategic intent to ensure delivery of care in settings outside of acute hospital facilities. This will lead to inpatient hospital care becoming much more focused on care for patients who are more complex and very unwell and the facilities and workforce will need to reflect this shift in case mix.

North Somerset’s commissioning intent describes planned activity reductions during 2014/15 and 2015/16 although specific detail concerning speciality-specific reductions is not yet available.

**2.6 Implications of strategic context and market Assessment**

2.6.1 Whilst opportunities to increase some income to the Trust through elective work are evident, increasing demands for emergency services are such that the Trust is not able to deliver, within a financially challenged health economy, the required financial risk rating and stability to satisfy Monitor’s requirements for Foundation Trusts.

2.6.2 In addition, clinical sustainability, safe service delivery and the continuity of an appropriate range of locally provided clinical services are put at risk as service reductions are realised. These challenges cannot be met under a standalone Trust option.

2.6.3 Whilst the Trust has demonstrated significant performance, clinical outcome and safety improvements over the last few years (sources: Dr Foster clinical efficiency measures and HSJ top improved Trust patient safety thermometer), strategic challenges relating to medical staffing (Junior Doctor reductions, availability of some specialist staff, requirements for 24/7 service provision) and increasing specialisation (Royal College Guidelines and innovation) are such that the sustainability of clinical services cannot be met under a standalone Trust option

2.6.4 Challenges posed by demographic challenges within an economically constrained environment are such that significant change is required if services are to remain clinically sustainable, of high quality and financially viable and relevant for service users in terms of choice.

2.6.5 Planned reductions in commissioned activity means that the Trust faces specific challenges in terms of critical mass and interdependencies between specialties, concerns regarding the domino effect of reduction in emergency capability, loss of core services and the need to retain sufficient complexity and volume of activity to support training, retention and recruitment. The acute services and wider health economy therefore needs to introduce new models of care and reduce reliance on traditional hospital buildings and beds to provide services. A whole-health economy solution is needed, in order to put the right services and the right capacity in place for the needs of the population. This will require all local providers to work together – through networks and pathways mapped out between providers to:

* ensure the clinical and financial sustainability of services within the hospital, as acute activity reduces with a consequent reduction in income and critical mass of staffing
* redesign care pathways that improve the experience of service users while at the same time being more cost effective and affordable within shrinking resources. This will include use of telemetry to reduce outpatient attendances at hospital, and utilisation of specialist hospital staff within the primary and community setting leading to an eventual shift in leadership of treatment and care for those with long term conditions and the elderly from the hospital to primary and community care practitioners.

2.6.6 It is within this context, and the sociological and demographic and market analysis that an assessment of the Trust’s strengths, weaknesses, opportunities and threats has been conducted. The outcome has served to shape the organisations strategic, governance and performance frameworks so that assurance can be given that strategic objectives and service development plans would be delivered and that the organisation would remain fit for purpose over time, able to respond to changing market requirements.

**Figure 7 SWOT analysis**

**2.7 Outturn 2013/14 and implications for 2014/15 and 2015/16**

The business plan is set within the context of strong service delivery and performance during 2013/14 and with a growing underlying financial deficit and the need to ensure the ongoing delivery of high quality, safe, effective and affordable health services during the transition period to a new organisational form. The plan and forecast outturn for 2013/14 is to deliver a £4.95m revenue deficit. The plan for 2014/15 is to hold the deficit at the same level as 2013/14 at £4.95m. The outline plan for 2015/16 is an initial deficit of circa £8m, which deteriorates due to the effect of prior year non-recurring savings schemes and additional investment in the recurring costs of new IM&T systems.

The Trust budget paper taken to the Trust Board on 1st April 2014 is attached at Appendix 2.

**3. Strategy**

**3.1 Vision**

The vision for the Trust is:

***To put patients at the heart of what we do and be the local healthcare provider of choice by delivering the right care in the right place at the right time and with the right care team***

This vision is supported by a series of local values which continue to guide actions, behaviours and decision making within the Trust and which are consistent with the NHS Constitution and National “6C” values. Trust’s values are:



**People and Partnership** – working together with colleagues, other organisations and agencies to achieve high care standards or specifically helping a service user, visitor or colleague (**C**are and **C**ommitment)

**Reputation** –actions which build and maintain the Trust’s good name in the community (**C**ommunication)

**Innovation** – demonstrating a fresh approach or finding new solutions to problems (**C**ourage)

**Dignity** – Contributing to the Trust’s Dignity in Care priorities (**C**ompassion)

**Excellence and equality** – demonstrating excellence in and equality of service provision (**C**ompetence)

**3.2 Strategic and Operational Objectives**

The Trust has 5 clear strategic objectives consistent with the Care Quality Commission and NHS Trust Development Authority key themes which help to drive appropriate behaviours and performance. These are supported by a number of corporate operational objectives.

**Figure 8 Strategic and operational objectives**

|  |  |
| --- | --- |
| **CQC/TDA key themes** |  |
| **Strategic Objectives** |  |

| **CQC/TDA key themes** | **Operational objectives** | | | |
| --- | --- | --- | --- | --- |
| Ensuring services are safe and caring | Deliver clinically effective services which meet benchmarked best practice standards through implementation and audit of evidence based practice | Embed clinical leadership providing clinicians sufficient time to lead together with clear, deliverable, objectives | Deliver dignified care that is responsive to patients’ personal needs, ensures a positive experience of care and which meets CQUINs Family and Friend test standards | Provide a safe environment for patients and reduce the incidence of avoidable harm, maintaining the level of harm free care above 93% as measured by the patient safety thermometer |
| Ensuring services are well led | Provide a safe, effective and affordable workforce | Improve and drive two way communication to increase staff engagement and build staff confidence and capability | Invest in and develop our staff to continually deliver high standards | Improve the Health and Wellbeing of our staff |
| **Ensuring services are responsive** | Meet and sustain national performance standards | Provide responsive, flexible and consistent services, appropriate to the needs of the patient and in line with commissioner intentions |  |  |
| **Ensuring services are effective** | Deliver the financial plan for revenue income and expenditure, capital expenditure and cash. | Deliver the savings programme for each year. | Develop the Estates and IM&T plans to support safe, effective and efficient service delivery |  |
|  | Deliver the Trust’s responsibilities within the procurement programme as defined in the Project Initiation Document |  |  |  |

**4 Delivery Plans 2014 - 2016**

**4.1 Key Operational Delivery initiatives 2014/16**

|  |  |  |
| --- | --- | --- |
| Deliver clinically effective services which meet benchmarked best practice standards through implementation and audit of evidence based practice. | | |
| **Key work areas** | **Key actions/outcomes and benefits** | **Key measurable and timescales** |
| Implement a culture of continuous clinical improvement and audit through evidenced based assessment of outcomes.  Develop the Model Ward concept across all wards including a ward accreditation programme.  Access to service improvement through ED or RTT pathways.  Develop the use of International care pathways across the most common HRG/diagnostic codes.  Safety and Quality review of services for safe delivery of care 24/7 | Develop the functions and utilisation of the safety improvement hub.  Define the model ward concept which aims to embed best practice in patient care and pathways  Utilise the Ambulatory rapid assessment and CDU elements of ED to deliver appropriate access at point of entry.  Implement an audit and variation reduction approach to the key clinical pathways  Implement the Hospital at Night model. | Programme of improvement projects presented at Q&G committee to report outcomes and improvement plans to the Trust Board across the next 2 years.  First ward to be launched in April 2014 with rollout across the first half year.  Reduced inappropriate hospital admissions, reduced LOS, readmissions and mortality (Effectiveness, Quality and outcome ) achievement of 4 hr target and RTT (patient flow) measures to be reported through IPR to Board. Improved patient experience to be measured through patient survey  Quantitative measures including reduced inappropriate hospital admissions, reduced LOS, readmissions and mortality (Effectiveness, Quality and outcome ) achievement of 4 hr target and RTT (patient flow) across ED and access reported through the IPR and weekly performance reporting. Improved patient experience to be measured through patient survey  H@N launched April 2014. |
| Embed clinical leadership providing clinicians sufficient time to lead together with clear, deliverable, objectives | | |
| **Key work areas** | **Key actions/outcomes and benefits** | **Key measurable and timescales** |
| Organisational structure which defines the role of lead clinicians and puts clinical engagement at the centre of key decision making. | Clear job descriptions for Clinical leads  Refined Terms of Reference for the Clinical Advisory Group  Defined time in job plans with a focus on continued professional development and leadership of clinical services | New Job description, terms of reference and objective setting to be completed and in place by the end of Q1. |
| Deliver dignified care that is responsive to patients’ personal needs, ensures a positive experience of care and which meets CQUINs Family and Friend test standards | | |
| **Key work areas** | **Key actions/outcomes and benefits** | **Key measurable and timescales** |
| Delivery of the Patient Experience Improvement strategy aimed at delivering a caring and compassionate experience for all patients.  .  Effective and planned discharge to the community or social care settings utilising the green to go concept  Friends and Family participation and result improvements | Develop the CareMaker programme by increasing the number of CareMakers and achieving a programme of activities that will be determined by the CareMaker group.  Develop a Weston Accredited Older Person’s Nursing Award  Improvement programme which targets long stay patients and inherent delays in community and social care access.  Friends and Family test to be part of KPI for all wards and departments to drive improvement in outcomes from the monthly surveys. | Reporting of patient experience measures at Ward Wednesdays and through to the Quality and governance committee.  Develop the award and programme by end Q2  Reductions in LOS, inappropriate admissions and improved patient flow reported through IPR to Board. By end Q2  Reported through IPR to Board and to divisions/wards through performance assessment framework |
| Provide a safe environment for patients and reduce the incidence of avoidable harm, maintaining the level of harm free care above 93% as measured by the patient safety thermometer | | |
| **Key work areas** |  | **Key measurable and timescales** |
| Utilise Ward Wednesday to fully implement the Nursing Performance framework to establish harm free care across all patient areas.  Full compliance with NHS Safety Thermometer data entry.  Introduce the Medicines Safety Thermometer and re invigorate the Drugs and Therapeutic Committee to work through medicines management improvements. | Utilise the Patient Safety Thermometer to identify areas for improvement.  Infection Prevention and Control action plan to be fully implemented.  New lead for D&T committee with mandate from clinical body to drive improvement.  Pharmacy input into Model Ward action plan to reduce prescribing and medication errors.  New Anti Microbial prescribing action plan to reduce C Diff. Incidences caused by prescribing.  Reporting and measurement of effective and safe nurse staffing models, publicly available on a daily basis. | Reduce new pressure ulcer prevalence measured by the patient safety thermometer by 15%  Reduce total falls prevalence measured by the patient safety thermometer to less than 2% in line with national rate.  Maintain the level of harm free care above 93% as measured by the patient safety thermometer in line with national rate  New lead in place by end Q1  Reduce medication administration errors by 50%  Reduce medication errors with moderate or severe harm to zero.  Reduce C diff infections to below 2013/14 outturn numbers.  Ensure Registered Nurse shift compliance rate above 90%  Ensure Nurse Number shift compliance rate above 95%  Measures reported to Board through IPR |
| Provide a safe, effective and affordable workforce | | |
| **Key work areas** | **Key actions/outcomes and benefits** | **Key measurable and timescales** |
| Develop a workforce plan which matches capacity to demand and reduces the reliance on agency staff.  Develop a resourcing strategy and accompanying policies and procedures to attract and recruit high calibre candidates (home and overseas) to fulfil Trust vacancies for all staff position and improve induction and Trust support to retain staff when in post.  Define a strategic overview of the impact on 24/7 working in both safety and financial terms and to inform the board of the desired service model for 7 day access.  Enhance support and education of trainee medical staff  Deliver required undergraduate and postgraduate education programme curriculum  Deliver education and training for educational supervisors | Review medical staff establishment on a monthly basis to identify vacancies due to staff attrition and retirements to put in place early recruitment interventions, which will ensure posts remain vacant for the minimum time.  Review the existing appraisal/personal development processes and ensure that staff have clearly defined objectives that support the business plan and drive Trust performance. (Appraisal linked to AFC changes).  Ensure all recruiting managers have completed the safer recruitment programme  Publish monthly nurse staffing metrics and a six-monthly nurse staffing review  Work with universities and other training providers to improve recruitment amongst newly qualified staff and undertake activities that will promote WAHT as the employer of choice  Undertake a review of specialist nurses  Focus trainees on quality of patient care and treatment pathways whilst delivering curricular | Model and metrics to be developed in Quarter 1 with reviews to inform the board on a quarterly basis.  Implement the AFC changes from April 2014.  Review complete by end Q3  Staff costs reported to Board through IPR  End Quarter 4  April 2014 + monthly ongoing. Metrics reported to Board through IPR  End Q2. Recruitment metrics reported to Board through IPR  End Q2  Quality panels – annual  GMC survey - annual |
| Improve and drive two way communication to increase staff engagement and build staff confidence and capability | | |
| **Key work areas** | **Key actions/outcomes and benefits** | **Key measurable and timescales** |
| Produce a new comprehensive Trust-wide communications and engagement strategy to ensure, staff, patient and community involvement, engagement and communications  Utilising the results of the recent Staff Survey continue to drive engagement with staff to improve both response rates and outcomes  Maintain an effective and dynamic press office and media relations function that responds to reactive news stories generates proactive and positive coverage of the work across the Trust and procurement process  Replace the existing intranet with a brand new platform that is accessible, wired to individual and organisational needs and user friendly | Review governance and assurance structures to ensure appropriate involvement, engagement and outcome based meeting structure.  Complete the rebranding exercise of all Trust Publications.  Establish a dynamic social media and interaction approach to all levels of communication  Establish Listening In Action groups across the organisation  Continue to develop internal communications platforms to ensure all Staff are informed and able to participate in Trust communication.  Launch of regular staff e- Newsletter  Develop a plan of action for the new Staff Friends and Family Test to ensure maximum compliance and learning. | Review complete end Q3  Q2 complete strategy and rebranding  Ongoing increase in number of staff recommending the Trust as a place to work and to receive treatment  Q3  Q2 + ongoing  April 2014 and ongoing  Q1 and ongoing  April 2014 Plan in place and implemented  Increase in % positive media coverage  Q1 complete |
| Invest in and develop our staff to continually deliver high standards | | |
| **Key work areas** | **Key actions/outcomes and benefits** | **Key measurable and timescales** |
| Identify a talent pool of leaders of the future who can be developed for broader roles.  Work with the Leadership Academy to promote the leadership programmes available and ensure that effective support systems are in place in the Trust.  Develop training and e-learning programmes that assist staff to access and complete relevant statutory and mandatory training as required for their role | Develop and support all key clinical and Nurse leaders with targeted skills and development programme.  Continue to drive improving outcomes for appraisal and training compliance to ensure a skilled and focussed workforce | End Q1 and ongoing. Uptake and completion of training reported to Board through IPR  Ongoing. Uptake and completion of training reported to Board through IPR  Ongoing and achievement of compliance to Trust level of 90% by Q4 each year |
| **Improve the Health & Wellbeing of our staff** | | |
| **Key work areas** | **Key actions/outcomes and benefits** | **Key measurable and timescales** |
| Develop a Health & Wellbeing Strategy that includes the recommendations set out in the NICE public health guidance.  Ensure staff have access to appropriate health and wellbeing services, including on site Occupational Health Service, Employee Assistance Programme, Physiotherapy Service and Flu vaccination programme | Provide training for managers on early absence management to ensure staff are treated in a supportive and equitable manner and are encouraged to access appropriate health and wellbeing service to aid return to work  Promote the Green Travel Committee to help staff stay healthy and travel more sustainably. | Trust sickness absence (target 3%), reduced costs of absence and return to work time reported and performance managed at ward and divisional level and reported to Board in summary through IPR  Ongoing  Uptake of flu vaccination, utilisation of support services reported to Board through IPR |
| Meet and sustain local and national performance standards | | |
| **Key work areas** | **Key actions/outcomes and benefits** | **Key measurable and timescales** |
| Defined improvement programmes for both Planned and Emergency Care divisions, which deliver efficient and effective care pathways.  Continued focus on Performance Assurance Framework with a redefined priority aligned to Trust objectives for safe and quality care. | Reinforcing of the model of care established this Winter in ED with a focus on ambulatory care and rapid MAU/SAU assessment.  Model Ward programme aiming to deliver reduced length of stay, best practice medicine and reductions in readmissions.  Outpatient Improvement programme to deliver one stop service with predefined patient service outcomes.  Improve elective ward and theatre productivity –scheduling, leadership of wards, review of lists/processes more full day lists, reduction of late finishes – productive theatre philosophy  Implementation of a 7 day Physiotherapy/Occupational Therapy model to modernise and improve services. | Deliver the Emergency Access four hour standard consistently  Continue to deliver all RTT targets consistently.  Improved performance against Cancer access targets.  Reduction in inappropriate admissions, attendances, LOS and readmissions  Reduced complaint numbers and improved complaint response times  Improved Net Promoter score  All measures reported to Board through IPR |
| Provide responsive, flexible and consistent services, appropriate to the needs of the patient and in line with commissioner intentions | | |
| **Key work areas** | **Key actions/outcomes and benefits** | **Key measurable and timescales** |

|  |  |  |
| --- | --- | --- |
| Review of Community Paediatric services in light of Royal College review and Commissioner intentions regarding the strategic direction of the service.  Response to the Keogh Review of emergency departments  Active participation in CCG QIPP programme to ensure that demand management challenge is met. | Deliver action points leading to safe services for children in north Somerset.  Clear child protection governance and safeguarding measures to be put in place.  Training compliance in ED for dealing with paediatrics  RCEM review of ED in Q1 and action to ensure sustainability of the service  Develop a clinical pathway plan which actively seeks to divert patients back to the community. | Maintain adult safeguarding training compliance at 90%  Achieve 90% compliance to Mental Capacity Act and Deprivation of Liberties training  Achieve 90% compliance to Child Protection Training  Monitor compliance to adult and child safeguarding procedures through a planned audit programme  Q1 2014 and ongoing – measures reported through IPR to Board  Implement evidence-based best practice pathways Pneumonia, CCF, UTI, chest pain and syncope – fully operational Q3 2014  Deliver NICE guidelines – April 2014 and ongoing as published |

|  |  |  |  |
| --- | --- | --- | --- |
| Deliver the savings plan for the year | | | |
| **Key work areas** | **Key actions/outcomes and benefits** | | **Key measurable and timescales** |
| Discharge and Long stay patients work stream. Aimed at reducing delays in discharge for long stay patients who are medically fit and awaiting onward care through a different provider.  Integrated Best Practice care Pathways- delivery of best practice clinical care across unplanned care wards.  Programme to establish model wards with emphasis on high volume diagnosis and reductions in clinical variation  Reduce non-NICE pharmacy spend – improved reporting, use of formulary, stronger links to Bristol procurement, training for clinical staff  Secure additional NHS and commercial income: including eg. waterside, SSS radiology (Bristol Trusts), ophthalmology  Review current loss making services and provision arrangements  Outpatient and Theatre transformation project. The programme will focus on three areas- booking, Outpatient productivity and Theatre utilisation.  Achieve CQUINS targets working with health and social care partners in the delivery of vertical CQUINs  Corporate departments to achieve a 5% reduction in expenditure | New case management team with responsibility for managing patient onward dispositions.  New standards and process for areas which cause delay  Improved coordination and communication with community and social care.  Clear patient pathway process which focuses on diagnosis, care planning and EDD  MDT ward rounding daily  Clinical audit of outcomes and cross peer challenge to variation.  Improved reporting, use of formulary, stronger links to Bristol procurement, training for clinical staff  Increase income from PPU  Work through SSS to secure non local activity  Introduce an on site Ophthalmology service to provide full range of service for the local population  Simplify booking processes to enhance Choose and Book performance  All day listing for theatres and Outpatients  Reduce Day Case conversion rates  One-stop Outpatient process to include Pre op. | | Green to Go List being managed at below this years levels – currently averaging 36 patients  Reduction in escalation bed usage and reduced LOS  End Q2  Reduction in LOS leading to closure of medical beds to match activity.  Q2  Deliver of 80% of eligible best practice tariff’s from end Quarter 1  Deliver reduction in pathology requests from October 2014  Reduction in non NICE pharmacy spend from April 2014 and ongoing  Deliver target private patient income from Quarter 1.  Signed contract with SSS by April 2014.  Tender process (opthalomology) to commence April 2014.  Notice provided to commissioners on identified services by April 2014 and ongoing  Signed SLA’s with each host Trust by August 2014 which ensure operational provision within budgeted expenditure.  Measurable reduction in spend to under £5k per month (waiting list initiatives) from April 2014 as seen in budget statements.  Quarterly reports to EMG, leads to report on progress and trajectory to ensure compliance by required timescales.  Deliver phased savings on non pay from April 2014 as defined in the Trust SIP programme 2014/15. |
| Deliver the financial plan for revenue income and expenditure, capital expenditure and cash | | | |
| **Key work areas** | **Key actions/outcomes and benefits** | | **Key measurable and timescales** |
| Produce a financial plan that will achieve the Trust objectives with ownership by all budget holders to ensure successful delivery  High quality financial systems, controls and processes are maintained  Continue to explore income opportunities for the Trust and individual services | Budgets signed off by budget holders and approved by Trust Board  Medium term plan with clear planning assumptions    Revenue support (Public Dividend Capital) received to support cash requirements  Audit review and action plans  NHS and non NHS income maximised  Improved clinical counting and coding of activity  Further clinical and operational engagement in Patient level costing and Service Line reporting | | Initial approval and monthly monitoring of delivery  To inform future planning of services and overall Trust viability  Cash flow monthly and annually  Annual accounts, financial reporting and financial governance  Annual plans and monthly reporting  Business planning is fully informed of financial impacts to inform better decision making |
| Develop the Estates and IM&T plans to support safe, effective and efficient service delivery | | | |
| **Key work areas** | **Key actions/outcomes and benefits** | | **Key measurable and timescales** |
| Refresh the estate strategy that will deliver the fit for purpose patient environment which will support delivery of clinical out-comes  Provide safe and effective Trust wide informatics solutions and services  Provide the safe and effective information infrastructure required to facilitate clinical communications and business processes  Provide a health records framework that meets clinical and legal, primary and secondary requirements for the processing of clinical information  Facilitate the delivery of timely and accurate clinical, activity, commissioning and performance information; | | Meet obligations under the Disabilities Discriminations Act, mandatory fire safety requirements, statutory safety legislation, and other relevant legislation  Improve engineering infrastructure and resilience  Active replacement or refurbishment of existing infrastructure where required to offset the impact of economic obsolescence  Right size the estate and improve functionality wherever possible to include issues of utilisation and fitness for purpose  Procure and implement new systems including PAS and A&E and Order Communications which achieve operational and clinical benefits  Meet the highest standards of data quality and data collection to improve the quality of service provided while maximising service income  Demonstrating good clinical, financial and information governance to stakeholders  Providing information fit for planning, risk and market assessment | Ongoing compliance with legislation  Strategy refreshed by end Q2 to include an operational plan  New systems successfully implemented on time and to budget  Maintain high standards and reporting to key stakeholders- ongoing  Influence and inform the service delivery and quality improvements - ongoing |

**4.2 Approach to improve quality and Safety**

4.2.1 A main component of the Business Plan is to ensure that clinical quality standards are adhered to and that patient safety is managed as a high priority. The Trust will continue to work to ensure quality is maintained and patient safety is effectively managed.

4.2.2 The Trust uses a range of approaches and methodologies to continually monitor and improve the quality of services and healthcare provided for patients including the Single Operating Model (SOM) Oversight Regime (supported by Care Quality Commission information) and internally generated and benchmarked information on a range of quality and patient safety metrics including serious incidents, patterns of complaints, audit outcomes, mortality, patient feedback. The Trust is an active participant in the Safer Care South West local network and is adopting recognised improvement methodology of Plan, Do, Study, Act (PDSA) for its improvement projects. The Trust applies the duty of candour t incident management and reports on patient and staff incidents publicly.

4.2.3 The implementation of the workforce strategy underpins the delivery of quality and safety. The Trust has been an early adopter of the national nurse staffing guidance and will include AHP staffing metrics in future reporting.

4.2.4 Progress will continue to be reported regularly to the Trust Board, Commissioners, the Trust’s Patients Council and to the Health Overview and Scrutiny Committee. The Trust’s Quality and Governance Committee, a committee of the Trust Board, will also keep under review all aspects of clinical effectiveness and outcomes, patient safety, and the patient and staff experience.

4.2.5 Key improvements to be delivered over the next two years across the five CQC domains include:

* A continued focus on pressure ulcer, falls and HCAI reduction;
* Enhanced focus on medication errors and VTE prevention;
* Complaint prevention, resolution and response;
* Continued improvements in the emergency pathway;
* Further development of the national nursing 6c’s strategy implementation including strengthening the role of Caremakers;
* Continued leadership development for clinical, nursing and AHP leads
* The development of staff capability and leadership for patient safety
* Increasing feedback from the Friends and Family test
* Reducing variation in clinical pathways
* Mortality reviews
* Further development of the Quality Improvement hub to improve practice

4.2.6 These themes and approach are consistent with that described in the Trust’s Quality account.

4.2.7 Staff, patient and stakeholder engagement is already embedded as a key principle within the Trust with a range of processes in place to support this commitment. This will be strengthened by the production of a Board approved planned strategy on engagement.

4.2.8 The Trust will continue to develop existing communication and engagement processes, building on new and successful initiatives undertaken internally with staff and with patients during the last 12 months and during the procurement project with stakeholders. In particular, the Trust will continue to support the Patient’s Council and the work undertaken by them. Achieving high levels of engagement will be important as the organisation transitions to new structural arrangements.

4.2.9 The Trust has a well developed a Performance Assurance Framework (PAF) which is used at an operational level. The PAF links operational, quality, workforce and financial priorities with the framework providing the ability to monitor progress towards key objectives across all of these domains. Divisional progress against each of the domains are reviewed and evaluated by the Trust Executives on a monthly basis.

4.2.10 At Board level the delivery of the 2014-16 business plan will be performance managed through monthly Board scrutiny supported by the Integrated Performance Report (IPR) and the Board Assurance Framework (BAF).

**4.3 Clinical Strategy**

4.3.1 The acute service strategy is driven by:

* evidence demonstrating improved outcomes from critical mass and centralisation of some acute services;
* the requirement for Weston Hospital to work in partnership with other acute providers, social care and as part of wider clinical networks to maintain appropriate critical mass and staffing resilience in some services to assure high quality clinical outcomes;
* the need to focus on provision of those services appropriate for the identified population needs and to determine which services it should provide directly and those which should be provided in partnership or which, due to complexity or small numbers should no longer be provided locally;

4.3.2 The Trust already works closely with other hospitals in Bristol as part of ‘clinical networks’. These networks are essential to ensuring the delivery of safe and sustainable services on the Weston General Hospital Site. These networks include:

* hub and spoke models for: - breast surgery - Weston has a mini-hub status with strong, albeit informal links with UBHT (immediate reconstruction) and NBT (delayed reconstruction).
* clinical networks for: cancer, particularly upper GI, Lung and gynaecological cancers as well as haematology, cardiology, stroke (thrombolysis) paediatrics and obstetrics and major trauma
* Some joint consultant staff appointments with Bristol Hospitals including eg. Cardiology
* From the late Summer 2014 this will include Vascular in which Weston will be a spoke to the North Bristol Trust hub.

4.3.3. In addition, the Trust has service level agreements in place with each of the Bristol Hospitals for the on-site provision by visiting clinical staff of some specialist outpatient’s services.

4.3.4 Over the next 5 years, the Trust will continue to work with partners to determine the most appropriate clinical models that address both local health need and service sustainability issues. The Trust will need to introduce new clinical models of care and reduce reliance on traditional hospital buildings and beds to provide services, and work with other provider organisations to ensure that, through networks and pathways:

* All services remain sustainable and financially viable
* Service user experience is improved while at the same time achieving this in a way which delivers improvements in productivity and cost

**4.4 Service capacity - Demand and Resource Analysis 2014/16**

4.4.1 The Trust will continue to focus on working with a range of other health and social care professionals to develop integrated care pathways that span home, primary, community, and acute care settings and which ensure that the patient is treated in the acute phase by the right clinical staff in the right care setting, that unnecessary admissions to hospital and care homes are avoided and social problems do not inadvertently become medicalised.

4.4.2 On a service line basis, the Trust will have four key strategies:

* Focus on excellence and compete
* Collaborate with another provider to ensure service user safety and service resilience whilst maintaining local access
* Withdraw from the market – offer local hosted service
* Continue to offer local hosted service

4.4.3 The Trust will continue to deliver all contractual and national standards.  Elective access targets will be maintained, achieving all 18 week targets at speciality level.  Emergency access targets will be achieved supported through continued focus on reducing length of stay and readmissions.   All eight cancer targets will be achieved, working across pathways to ensure timely treatment of cancer patients.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **4.4.4      Summary Activity requirements 2014/16** | | | | | |
|  |  |  |  |  | |
|  |  |  | **Annual Activity Plan** | | **Annual Activity Plan** |
| **2014/15** | | **2015/16** |
| **Elective Day Cases** | |  | 13,391 | | 13,391 |
|  |  |  |  | |  |
| **Elective Inpatients** | |  | 1,605 | | 1,605 |
|  |  |  |  | |  |
| **Non-Elective Inpatients** | |  | 14,945 | | 14,945 |
|  |  |  |  | |  |
| **First Outpatients** | |  | 40,194 | | 40,194 |
|  |  |  |  | |  |
| **Follow Up Outpatients** | |  | 62,711 | | 62,711 |
|  |  |  |  | |  |
| **Emergency department attendances** | | | 50,871 | | 50,871 |

**4.4.5 Summary workforce requirements 2014/16**

4.4.5.1 Effective people management is embedded as a key component in leading and supporting change in the organisation. It is recognised that it is the people who deliver service who will be the most important factor in supporting service change and in the transition to a new organisation.

4.4.5.2 Particular emphasis will continue to be given to ensuring that sufficient and appropriate information is available for staff during the transition. The Trust will also focus on:

* Ensuring the workforce profile is updated regularly
* Proactive management of the existing workforce and addressing resource consequences
* Ensuring sufficient information is available to plan the learning and development needs of the workforce, so that appropriate use is made of available funding
* Risk assessments in terms of implications to service delivery arising from workforce supply difficulties
* Actively supporting programmes of service transformation and engaging with managers to produce service-driven workforce plans that review skill mix requirements and grow a more flexible workforce that can be reshaped over short timescales to support delivery of new models of care
* Ensuring all managers develop expertise in workforce planning skills
* Supporting service managers to develop a range of metrics that measure productivity for their particular service
* Benchmarking productivity scores with other organisations to identify areas for development and to promote successes.
* Continued development of leadership capability

| **Staff Group** | **1/4/14 Staff in post**  **WTE** | **1/4/15 Staff in post**  **WTE** | **1/4/16 Staff in post WTE** |
| --- | --- | --- | --- |
| **Scientific, Therapeutic and Technical** *Includes Pharmacy, Clinical Psychologists, Psychotherapists, Psychologists and Technicians* | 51.07 | 51.07 | 51.07 |
| **Support to Clinical Services** *Includes Untrained Nursing Staff, Medical Laboratory Assistants, AHP support staff, Phlebotomists, Admin support to Clinical areas (Ward Clerks, (medical Secretaries)* | 479.53 | 436.54 | 417.65 |
| **AHPs** | 91.65 | 89.65 | 89.65 |
| **NHS Infrastructure Support** *Includes, Housekeepers, Maintenance, HR, Finance, Managers* | 248.97 | 248.97 | 248.97 |
| **HCS** *(Biomedical Scientists)* | 32.47 | 32.47 | 32.47 |
| **Medical and Dental** | 179.39 | 181.69 | 180.69 |
| **Nursing & Midwifery** | 421.29 | 401.40 | 387.41 |
| **Total** | **1504.37** | **1441.79** | **1407.91** |

**4.4.3 Summary bed requirements 2014/16**

|  |  |  |  |
| --- | --- | --- | --- |
| ***Wards*** | ***No. of beds***  ***2013/14*** | ***No. of Beds***  ***2014/15*** | ***No. of Beds***  ***2015/16*** |
| **Acute beds** | 257 | 217 | 217 |
| **ITU** | 5 | 5 | 5 |
| **Maternity Unit** | 10 | 10 | 10 |
| **Private Unit** | 12 | 12 | 12 |
| **Total beds** | **284** | **244** | **244** |

**4.5 Income and Expenditure and Capital Investment Plans**

4.5.1 The Trust is operating with a revenue deficit in 2013/14 which is forecast to continue over the next two years. This has been a key consideration in the “procurement” of the Trust’s organisational form and the Outline Business case has modelled this impact in future years. The financial viability is driven by the clinical sustainability issues for the current services delivered by the Trust.

4.5.2 The main CCG is also financially challenged due to its historic underfunding and also the current activity and costs of acute service delivery for its population provided from two Bristol providers and Weston.

4.5.3 The revenue plans are to maintain current services and safe staffing levels which deliver high quality care within a challenging local and national funding context. The strategy includes annual revenue PDC support to enable the liabilities to be fully discharged each year.

4.5.4 The Trust is planning to achieve the national efficiency targets for the two years but with an expectation that only 50% will be recurrent. This is due to the difficulties with continuously finding cash releasing efficiencies from pay and non pay expenditure which have been achieved in earlier years.

4.5.5 The capital plans reflect the essential needs for the Trust and in addition, the need to replace the Cerner Millennium systems from 2015 that will result in substantial capital and revenue resource requirements as detailed in the Outline Business Case.

**4.6 Savings plans (SIP) Plans 2014 - 2016**

4.6.1 The Trust is required as a minimum to deliver a 4% Service Improvement Programme (SIP) in 2014/15. The programme individual schemes are fully identified for the year 2014/15 and with risks to achievement graded for all schemes. Development of the programme has been informed by opportunities identified and evidenced through benchmarking, such as length of stay and implementation of international best practice.

4.6.2 The Nurse Director and Medical Director sign off quality improvement assessments for savings plans with the impact on quality being monitored monthly by the Executive Management Group.

**Savings plans (SIP) Plans 2014 – 2016**



**5. Key Identified Risks**

|  | **Risk Description** | **Impact**  **1-5** | **Likelihood**  **1-5** | **Rating** | **Impact + Implications** | **Risk Mitigation** |
| --- | --- | --- | --- | --- | --- | --- |
| **Ensuring services are safe, effective and caring** | | | | | | |
|  | Patient safety compromised by lack of medical staff  **Cause:** **1.** National shortage of some Consultant posts including Acute Physicians, Care of the Elderly and Emergency Department Consultants and Middle Grade . **2.** Deanery withdrawal of the some registrar and training posts  3. Difficulty in creating attractive job plans due to non-complex service portfolio | **5** | **4** | **20** | **Poor patient experience/outcome**  **Breach of CQC registration** | Active participation in BNSSG wide Urgent Care Groups in relation to demand management and health community wide management of emergency flow.  Joint posts with neighbouring Trusts being pursued.. Successfully recruited 2/3 Consultants (with education and training qualifications) in Care of the Elderly and reinstatement of registrars expected.  Review of how particular services can be delivered locally. |
|  | Paediatric care through ED compromised  **Cause:**Failure to appreciate how ED paediatric care should be configured  and lack of staff training, and poor clinical pathways | **5** | **4** | **20** | **Poor patient experience/outcome**  **Breach of CQC registration** | Extension of the opening hours of the Seashore Centre remains a further mitigating action, but will not be actively pursued at the present unless further concerns surrounding the safe management of paediatric cases emerge.  Additional middle grades recruitment required to provide resilience to the rota  Recruitment to ensure that a Paediatric trained nurse is present on each shift  Regular training opportunities in paediatric emergency care to be established to provide thorough year training (micro training sessions)  Work to establish a BNSSG wide protocol for the management of paediatric emergencies so that WAHT is part of a networked service which will include the new Southmead ED and BCH. |
|  | Trust would be unaware of failures to comply with Regulatory and Statutory requirements relating to medicines management and of any resulting patient safety issues that arise.  **Cause:** 1. An ineffective medicines Governance structure  2. Lack of clinical representation from the divisions at the DTC 3. Failure to receive critical data relating to medicines incidents | **4** | **5** | **16** | **Poor patient experience/outcome**  **Breach of CQC registration** | Divisions to be tasked with ensuring consultant representation on the D&T ARE committee through use of SPAs and job planning Better collation between Datix reports/complaints in which drugs and therapeutics are the major issue and the committee.  Action required to identify the most frequent types of medication errors and what can be done to reduce them.  Strategy to guide the development of medicines optimisation is required. Metrics for monitoring the costs and quality of medicines used need to be established 6. Duty of candour needs to be developed in relation to harm arising from medicine (score changed from 12 to 9) |
|  | Failure to follow guidelines when issuing a do not attempt CPR order (DNACPR)  **Cause:** Lack of education and understanding relating to DNACPR orders | **4** | **4** | **16** | **Poor patient and family experience/outcome**  **Breach of CQC registration** | Establish regular training sessions in end of life care DMA CPR and DoLs as part of the medical induction programme and stat/man training programme for Consultants |
|  | Safeguarding Risk that the identity of adopted children's new name and contact details could be revealed. This risk affects all vulnerable patients and is therefore wider than adoption. **Causes:** Millennium could be accessed easily by a staff member for their own advantage or on behalf of someone else. No known way to 'shield' records or limit who can access. Thereby possible for birth parents to find children and do possible harm. | **3** | **5** | **15** | **Poor patient experience/outcome**  **Breach of CQC registration** | In the short term find a way to shield or limit access to the system that meets the satisfaction of the adoption team in NS. In the mid term procure replacement Patient Admin and A&E systems and successfully implement by Mid 2015. (Trust Board has approved an Outline Business case.) |
| **Ensuring services are safe and well led** |  |  |  |  |  |  |
|  | Risk to patient safety if staff do not attend essential training (statutory and mandatory training).  **Causes:**  Staff may not have the necessary knowledge and skills to deal appropriately with: 1. Infection control 2. Fire safety 3. Child protection 4. Resuscitation 5. Health & Safety 6. Manual handling  Potentially putting themselves, patients and the organisation at risk. | 4 | 4 | **16** | Poor patient experience | * Detailed training compliance report (by ward and department) generated and shared on monthly basis with managers to allow targeted discussions with relevant staff. * E-learning options have been introduced, face to face training sessions have been reduced in time wherever possible and non-clinical staff can now complete all core essential update training via e-learning |
|  | Increasing number of vacancies within the medical workforce as a result of skills shortages in the UK, (medicine), which results in an increased use in temporary workers.  **Causes:** Difficulty recruiting into some hard to recruit posts | 4 | 5 | **20** | Poor patient experience  Increased turnover in staffing due to unstable workforce and pressures on staff | * Working with recruitment agencies to identify high calibre candidates in the UK and overseas who are able to join the Trust on a long term NHS Locum or substantive basis to stabilise the work teams and reduce short term placements of locums. * Increased national advertising to give the Trust more exposure and working with other Trusts to deliver services through shared consultant workforce. |
|  | Increasing numbers of ED middle grades due to shortage of this grade of staff in the UK  **Causes:**  This is a national shortage and recruitment from overseas takes time and induction / orientation process will be longer and more costly. | 5 | 5 | **25** | Poor patient experience  Increased turnover in staffing due to unstable workforce and pressures on staff | * Recruited ED Staff Grades from overseas who are due to commence employment in the Trust in August 2014. * Agreed methods of working with ED Consultants to ensure a safe and reliable service is provided via ED at all times. * Use of long term locums to stabilise work team |
| **Ensuring services are effective and responsive** |  |  |  |  |  |  |
|  | Failure to deliver required level of savings.  **Causes: 1.** Inability to deliver a major savings programme and to maintain high quality patient care and achieve all key performance targets.  **2.** Expenditure exceeding Budgeted level. | **4** | **5** | **20** | **Expenditure exceeding Budgeted level** | Work programme against detailed project plans for each of the transformation workstreams together with schedule of realisation of savings for each project. Outpatient project to be scoped commence Sept- 13 Schemes currently forecasting zero or minimal savings to be reviewed critically and reinvigorated (drugs, non pay)  Continued review of variances with budget holders and Divisional Managers to devise mitigating actions to offset slippage.  Additional finance support to Divisions as required to ensure savings realised in line with plans and budgets are not exceeded. Benchmarking against peers to scope areas of efficiency opportunities. |
|  | **Risk:**  Failure to achieve CQUIN schemes resulting in financial penalty and reduction in the quality of care   **Causes:**  Inability to deliver CQUIN schemes whilst maintaining high quality patient care. | **3** | **5** | **15** | **Failure to deliver financial plan** | Establish systems to ensure capture of baseline data and evidence for each quarter .  Appoint Lead Monthly report established including forward assessment of achievement. Identify and progress areas requiring investment to deliver  Continue reporting to EMG and Quality and Governance Committee. |
|  | Failure to achieve key performance indicators in relation to ED 4 hour performance, Cancer and Referral to Treatment Targets. **Causes:** Demand exceeding current capacity. | **5** | **4** | **20** | **Poor patient experience/outcome**  **Breach of CQC registration**  **Breach of NHS Constitution** | Active participation in BNSSG wide Urgent Care Groups in relation to demand management and health community wide management of emergency flow. Monthly contract meetings with commissioners to escalate demand issues in relation to electives Locums to be sought to cover periods of sickness and leave to maintain capacity |
|  | Wrong clinical guidance accessed.   Cause Review of Trust intranet reveals two different pages of clinical guidance - neither of which are up-to-date.  Lack of process/ownership of clinical guidelines. | **3** | **3** | **9** |  | Lead identified Review of current IT system and process Project plan improvement Trustwide approval for approach |
|  | Failure to identify strategic partner with whom the Trust can work to manage the future delivery  of clinical services at Weston General Hospital.Increasing financial and clinical sustainability challenges during the transition**Cause:**Failure at approvals processes, lack of capacity to undertake procurement process, insufficient market interest in proposals, dealy in procurement timeline (approvals processes) creating staff recruitment challenges. Increasingly challenging commissioning position 2014.15 | **4** | **4** | **16** | **Ongoing viability clinically and financially of Trust** | Establish programme and project infrastructure  Establish clear programme and project deliverables  Establish engagement programme  Ensure wide stakeholder involvement in programme  Ensure staff and lay user engagement on project board  Secure additional support from SHA to ensure appropriate capacity and expertise  Ensure ongoing delivery of targets to make Trust attractive proposition |
|  | Lack of policies to support best practice in Estates and Facilities Management.  **Cause** Lack of progress with planned review and update | **3** | **3** | **9** |  | Lead identified Review of current IT system and process Project plan improvement  Trustwide approval for approach |
|  | Failure to maintain overview of and therefore compliance with standards of clinical effectiveness **Cause:**  CEAC, Clinical Audit Plan and system for monitoring the Trust’s position against NICE quality standards not embedded. | **4** | **4** | **16** | **Poor patient experience/outcome**  **Breach of CQC registration** | Strengthen attendance at CAEC Clinical Audit Plan developed and approved System for monitoring and reporting NICE quality standards compliance in place Priorities for audit plan to be properly integrated with Trust priorities and areas of risk Improve monitoring and reporting  Demonstrate impact of improvement hub. Review of medical committees agreed with CEO April/May 2014. Trust Secretary to Lead. |
|  | Breach of the Data Protection Act and fine from the Information Commissioners Office and overspend of medical records budget.   **Cause:** Retention and **s**torage of medical records longer than NHS retention and disposal schedule periods. | **4** | **4** | **16** | **Poor patient experience**  **Breach of CQC registration**  **Financial and reputational liability** | Scoping work to be delivered.  Process & procedure for the destruction of records to be developed by the Medical Records Manager & sanctioned by IG Committee.  New contract, SLA and T&C's to be agreed and in place with Offsite Storage supplier.  Funding required to deliver programme to be agreed / allocated to HIS budget. |
|  | Loss of security of Trust network.  **Cause:** Inability to complete windows 7 rollout to April 14 timescale owing to Telepath system. | **5** | **4** | **20** | **Poor patient experience/outcome** | Upgrade Telepath or provide an alternative Pathology results reporting system.  Recommence windows 7 rollout programme.  Ensure sufficient resourcing to deliver the Windows 7 rollout to April 2014 timescales. |
|  | Patient safety; effective hospital management and achievement of Trust-wide efficiencies programmes compromised.  **Cause:**  The operational management of clinical and administration staff has not achieved the desired Millennium real time &/or data quality so duplication of efforts and focus to support two information systems - Millennium and legacy, manual information systems exists across clinical operational areas of the Trust. | **4** | **4** | **16** | **Poor patient experience/outcome**  **Failure to deliver Trust patient quality, safety and financial plans** | Appoint Chief Clinical Information Officer and appoint operational lead for leadership and monitoring.  Monitor delivery of the Millennium Improvement Plan (MIP) via the HIC and operations led meetings.  HIS to facilitate Millennium training and data quality reports to operations Managers.  HIS to support business case / review work of administration staff.  Operations to generate the required utilisation of the system to achieve real time and quality data for Trust management purposes . |

**Appendix 1 National Drivers for change**

| **National Policy/Drivers for change** | **Policy intent** |
| --- | --- |
| Securing Sustainability. Planning Guidance for NHS Trust Boards 2014/15 to 2018/19 | Establishes a 5 year planning framework, aligning assurance requirements with the CQCs five themes of safe, effective, caring responsive and well led. |
| Government Mandate to NHS England 2014-15 | Sets out the objectives for the NHS and highlights the areas of health and care where the Government expects to see improvements including   * improving standards of care and not just treatment, especially for the elderly * better diagnosis, treatment and care for people with dementia * better care for women during pregnancy, including a named midwife responsible for ensuring personalised, one-to-one care throughout pregnancy, childbirth and the postnatal period * every patient will be able to give feedback on the quality of their care through the Friends and Family Test so patients will be able to tell which wards, A&E departments, maternity units and hospitals are providing the best care * by 2015 everyone will be able to book their GP appointments online, order a repeat prescription online and talk to their GP online * putting mental health on an equal footing with physical health – this means everyone who needs mental health services having timely access to the best available treatment * preventing premature deaths from the biggest killers * by 2015, everyone should be able to find out how well their local NHS is providing the care they need, with the publication of the results it achieves for all major services. |
| Francis report and Government response to the Francis Report/Berwick review | These reports identify actions required by local health services and introduces new requirements including the introduction of a new hospital inspection regime and legislation for a duty of candour on NHS organisations. Actions on safety and openness include:   * transparent, monthly reporting of ward-by-ward staffing levels and other safety measures * quarterly reporting of complaints data and lessons learned by trusts along with better reporting of safety incidents * a statutory duty of candour on providers, and professional duty of candour on individuals, through changes to professional codes * a new national patient safety programme across England to spread best practice and build safety skills across the country. 5,000 patient safety fellows will be trained and appointed in 5 yrs * trusts to be liable if they have not been open with a patient * a dedicated hospital safety website to be developed for the public   Other actions include:   * a new criminal offence for wilful neglect, with a government intention to legislate so that those responsible for the worst failures in care are held accountable * a new fit and proper person test, to act as a barring scheme for senior managers * every hospital patient to have the names of a responsible consultant and nurse above their bed * a named accountable clinician for out-of-hospital care for all vulnerable older people. * more time to care as all arm’s length bodies and the Department of Health have signed a protocol in order to minimise bureaucratic burdens on trusts * a new care certificate to ensure that healthcare assistants and social care support workers have the right fundamental training and skills * a new fast-track leadership programme to recruit clinicians and external talent to the top jobs in the NHS in England |
| Equity and Excellence: Liberating the NHS | requires health services to focus on design of more responsive, patient-focussed services in which patients have a choice of consultant and on reducing management costs so that as much resource as possible supports frontline services. |
| Economic environment and Quality, innovation, Productivity and Prevention | Within a “flat cash” operating environment for the NHS, the Government has reaffirmed the need to place quality of care at the heart of the NHS by focusing on outcomes, giving real power to patients and devolving power and accountability to the frontline.  The NHS needs to continue to deliver efficiency savings through a focus on quality, innovation, productivity and prevention. |
| Provision of integrated services | There is now a significant body of national and international evidence which supports the potential that integrating health and social care services offers in addressing challenges created by demographic and fiscal challenges. Government policy intends to:   * deliver a properly integrated urgent care system that turns the NHS into a 24/7 service; * organise care around the needs of the individual service user rather than the needs of a particular provider * support the integration of care to ensure good outcomes; * Make this integrated health and social care approach explicit in the duties of the regulators, and the responsibilities of the NHS Commissioning Board, health and wellbeing boards and clinical commissioning groups. |
| NHS Constitution | Sets out the principles and values of the NHS in England and the rights to which patients, public and staff are entitled and pledges, which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another. All NHS bodies, private and third sector providers supplying NHS services are required by law to take account of the NHS Constitution in their decisions and actions. |
| Other key strategic drivers | * Personalisation - promoting choice and control over services and delivering better outcomes. * Prevention – improving access to advice information and community support to improve quality of life and reducing care home/hospital admissions. * Safeguarding – ensuring greater public awareness and improved standards of safety and dignity across all services especially health and social care. * Shared national priority for Health and Social care to work in partnership with carers to develop services which support their vital role. * Royal College focus on specialisation and sub-specialisation in acute services to ensure safe, quality assured complex care, placing the future sustainability of services at risk without disproportionate investment to maintain rotas. * Higher volumes of patient throughput required to maintain institutional and individual competence and ensure improved outcomes in acute services. * GPs having greater responsibility for managing the flow of patients into and out from hospital and for commissioning services. * Changes to clinical accreditation and revalidation making critical mass of services and experiences more important. * Difficulties of recruiting to some specialist clinical posts – particularly if jobs appear unattractive due to lack of professional opportunity and challenge. * The ageing population increases the number of patients living with dementia, together with the health and emotional impact on dementia carers. |