



Strategic Plan Document for 2013-14

Bolton NHS Foundation Trust

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

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

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Date	30 th May 2013

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

In signing below, the Trust is confirming that:

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

Approved on behalf of the Board of Directors by:

Name (<i>Chair</i>)	David Wakefield
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Signature



Approved on behalf of the Board of Directors by:

Name (<i>Chief Executive</i>)	Antony Sumara
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Signature



Approved on behalf of the Board of Directors by:

Name (<i>Finance Director</i>)	Simon Worthington
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Signature



1. Executive Summary

In common with other NHS Organisations, Bolton NHS Foundation Trust's outlook for the next three years is dominated by the twin challenges of improving quality and responding to changing demands on the service, while managing within reducing public expenditure. The Trust starts 2013/14 from a position of having failed historically to deliver a number of key access time and quality targets, and having a financial deficit in 2012/13 of £14.4m. By the end of 2012/13, however, there was also marked and sustained improvement in the Trust's performance on the A+E four-hour target standard, and other waiting time standards. The organisation, however, has remained above the target number of C.Difficile cases occurring in the Trust.

The plan set out in the following pages, therefore, covers both immediate objectives (2013/14) and the three-year view.

Underpinning our plans for 2013/14 are five aims:

- To improve care
- To be well governed
- To be financially viable
- To be a great place to work
- To be fit for the future

There is a detailed financial "turnaround" plan in place, which anticipates a cost reduction of 5.4% in 2013/14, achieved predominantly through changes in non-clinical staffing, procurement, nursing and medical staff deployment and efficiencies in clinical and non-clinical support services. The scale of saving in the subsequent two years, is projected to be 5.5% (£15m) in 2014/15, and 4.7% (12.4m) in 2015/16. In all workstreams, processes are in place to assess the potential impact of savings on quality, and to modify or remove plans where necessary. By the end of 2013/14, the deficit will have reduced to £7.8m, reducing further to a projected £2.0m in 2014/15, and removal of deficit by 2015/16.

The Trust's longer term service and financial plans are under review, in the context especially of the two major "drivers" which will shape services locally, and across Greater Manchester.

Locally, there is a shared intention between our Commissioners (Bolton Clinical Commissioning Group), the Bolton MBC, and ourselves to change the way services are provided, in order to manage patients' needs better and to care for more people outside hospital, through integrated systems of care, and across patient pathways. The detail of the phasing of this shift, and the financial, workforce, and service redesign changes needed to achieve this, are expected to be finalised jointly by October 2013.

At Greater Manchester level, a strategic review of health services, on behalf of the 10 local CCGs, is developing proposals for new models of provision, focussing acute hospital services on fewer sites and centralising more acute care, particularly higher risk or complex surgery. Proposals are expected to be formally consulted upon by the end of this year.

The Trust is undertaking its strategic review, to assess the impact of various potential service configurations, and against the clinical service standards emerging from the "Healthier Together" process, in partnership with other provider organisations in the North West sector of Manchester, local commissioners, staff and public. It is intended that this will form the basis for a more detailed service/financial plan to be set out by October this year.

The Board of the Trust has already set out its high level strategic direction, based on initial analysis:

- Bolton FT will build on the advantages of being an **integrated provider of local hospital and community-based health services to deliver**, with our partners, the very best care for Bolton patients throughout their healthcare journeys. We will focus on ensuring the best care for frail elderly people and people with long term conditions, outside hospital, through design and delivery of effective pathways of care.

- **Prevention, early intervention and keeping people healthy is central to why we are here**, as well as to provide excellent care for people who need treatment
- Royal Bolton Hospital will remain a **major provider of A&E and emergency access services**
- The Trust will **continue to develop as a centre of excellence for Women’s and Children’s services**, remaining one of Greater Manchester’s hubs for those services
- The Trust will **retain and develop a range of planned diagnostic and treatment services** which
 - Can sustain high standards, have critical mass and are clinically viable
 - Meet the needs and preferences of patients
 - Make a positive financial contribution and/or
 - Are essential to sustaining the wider service provision in the Trust
- The Trust will act in **partnership to provide and sustain high quality care** when this is the most appropriate solution

2. The Trust’s Strategic Position within the Local Health Economy

2.1 Overview – catchment/service profile

Bolton NHS Foundation Trust is a major provider of hospital and community health services in the North West Sector of Greater Manchester, delivering services from the Royal Bolton Hospital (RBH) site in Farnworth, in the South West of Bolton close to the boundaries of Salford, Wigan and Bury; and also providing a wide range of community services from locations within Bolton. The RBH site is close to the junction of the M60 and M61 motorways and, for non-elective services in particular, is estimated to have a catchment population of 310-320,000, compared with a resident Bolton population of 270,000. The majority of community services are provided to the Bolton population although there are some specific services provided to a wider catchment, such as Sexual Health Services.

In 2012/13 the majority of hospital activity was commissioned by NHS Bolton for its resident population but a significant proportion of work came from neighbouring areas:

Bolton Hospital NHS Foundation Trust

FFCEs split by CCG and Patient Type

Excluding well babies

Period: April 2012 - March 2013

Figure 1

	Elec IP and DC		Non-Elec		Obstetrics		Total
	Number	%	Number	%	Number	%	
NHS Bolton CCG	25,246	77.16%	26,138	75.12%	9,327	61.20%	60,711
NHS Bury CCG	1,118	3.42%	963	2.77%	1,887	12.38%	3,968
NHS Salford CCG	2,820	8.62%	2,224	6.39%	2,283	14.98%	7,327
NHS Wigan Borough CCG	2,767	8.46%	3,879	11.15%	1,430	9.38%	8,076
Other	770	2.35%	1,592	4.58%	314	2.06%	2,676
Total	32,721	100.00%	34,796	100.00%	15,241	100.00%	82,758

A&E Attendances				
PCT	2010/11	2011/12	2012/13	% Change
NHS Bolton CCG	82637	83888	86813	4.8%
NHS Wigan Borough CCG	11653	11247	12104	3.7%
NHS Salford CCG	8421	9518	9954	15.4%
NHS Bury CCG	1951	2230	3099	37.0%
Other	3749	3850	3950	5.1%
Total	108411	110733	115920	6.5%
Arrived by Ambulance Att's	28708	28874	30028	4.4%
% Arrived by ambulance	26.5%	26.1%	25.9%	

Data from the North West Ambulance Service shows that the RBH site receives approximately 20% more ambulance arrivals than other DGH sites in Manchester. 26% of all non-elective attendances arrive by ambulance.

Within Greater Manchester, the Trust has become a hub for the provision of Obstetric, Paediatric and Neonatal Services, since the reconfiguration of GM-wide service in 2011-2012. The Trust now delivers 6,500 babies per year and has a 39 cot Neonatal Unit, servicing Bolton and surrounding districts.

2.2 Positioning of Trust Services/Competition

The Trust's key hospital service competitors are predominantly other providers in the North West of Manchester, particularly the Wrightington, Wigan and Leigh Foundation Trust (WWLFT) and Salford Royal Hospital Foundation Trust (SRFT). The three Trusts' hospital services share catchment areas in their boundaries. In terms of DGH-level acute and elective services, these three Trusts provide a comparable range of services. SRFT is a GM-wide provider of some specialist/tertiary services, including Renal and Neurosciences and level-two Cancer services. Both WWL and BFT have areas of specific specialist provision. In Bolton FT this is predominantly Women, Children's and Neonatal services, and in WWL this includes Neurorehabilitation, Elective Orthopaedic and Cardiac Catheterisation services.

Section 10.5 of this document describes key comparative indicators of performance of the Trust and local peers.

2.3 Independent Sector

Through the AQP (Any Qualified Provider) process in 2013/13 independent sector providers are now in direct competition in some aspects of Trust services, including Audiology, Podiatry, Diagnostics and Ophthalmology. The impact is being monitored although it is too early to see significant change for the Trust. No further AQP proposals have been notified by local commissioners at this point.

Under a GM-wide contract, Care UK provide some elective referral services for initial consultation and minor treatment. Utilisation of the Care UK contract, which has been in place for three years, has risen from 43% in 2010/11 to 75% in 2012/13. Between April 2010 and March 2013 independent sector referrals overall rose from 7.6% to 12.6% (down from a peak of more than 16% in mid 2012). Around 9% of all Bolton CCG admissions are in the independent sector.

The Trust's strategy is based on maintaining improvements and developing capacity in key financially beneficial services in order to sustain and build market share where appropriate.

2.4 Market Share

During April 2012 to February 2013 the Trust received 75% of Bolton PCT's elective admissions and 93.8% of the non elective admissions attributable to Bolton PCT. This is an increase in market share for both elective and non elective admissions.

Specialties that have increased their market share for elective admissions are: General Surgery, Urology, Orthopaedics, Haematology, Paediatrics and Elderly Medicine.

In non elective admissions we had increase in the specialities of Obstetrics, Paediatrics, General Surgery and General Medicine.

Period	Market Share for Bolton PCT	
	Elective Admissions	Non Elective Admissions (excluding Well Babies)
Apr 10 to Mar 11	73.2%	92.5%
Apr 11 to Mar 12	72.8%	92.9%
Apr 12 to Feb 13	75.0%	93.8%

3.	What Factors Will Influence Our Future?
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POLITICAL	
NHS reforms	The NHS reforms launched in 2010 have led to significant reorganisation and change across the service, most notably in the commissioning arrangements which have placed local commissioning with GP-led Clinical Commissioning Groups, but also establishing a wider arrangement at conurbation and regional level under the auspices of the new National Commissioning Board which sets the framework for planning and priorities across the system. Monitor, as regulator of NHS providers, now has a role in overall market management. Public Health services and commissioning have, in part, moved into local authorities.
Increased patient choice/ competition	The 2010 reforms have brought about more extensive competition through the “Any Qualified Provider” process, requiring commissioners openly to tender for a wider range of services, and providing for NHS and non-NHS providers to bid to be recognised providers of services or part-services.
Increased focus on standards/compliance	With related penalties and incentives NHS standard contracts now require an increasing range of compliance measures, and regulation and scrutiny of the NHS have intensified. Monitor, the CQC and other external bodies, and the FT licencing régime are key cornerstones of a more public and rigorous system of inspection and performance management.

ECONOMIC	
Local community – deprivation	Indicators of deprivation show some areas of Bolton amongst the worst in the country. These are reflected in corresponding poor health status.

Local community – deprivation Cont:	<p>The impact of the recession can be seen in increasing rates of unemployment. Bolton Council’s Health and Wellbeing Strategy, which sets out the key health priorities for the Borough over the next three years says being out of work leads to poor health and has a “significant negative psychological impact”, and reveals 49,600 people in Bolton – 29.5% of the Borough’s working age population – are “economically inactive”.</p> <p>The overall figure is higher than both the North West and National averages.</p>
NHS funding pressures	<p>In response to the national economic position and pressure on public finances, the NHS is required to save £20billion by 2014/15 and further significant savings are expected to be needed for at least the following 4-5 years. Nationally, the QIPP programme is expected to underpin delivery of cost reduction while improving the quality of care and outcomes by reforming the way the service works to prevent ill health and deliver care.</p>
Local Authority funding pressures and changes in social care	<p>National policy on the organisation of adult social care services has, over recent years, seen an increasing shift away from the Social Services Department as a provider of services to being a commissioner of services. This is further emphasised in recent Government policy, in particular the development of “personalisation”, with allocated funds held and spent by individuals according to their own preferences of where, how and by whom their care needs are met. In common with other public services, social care is facing significantly reduced funding over the next two years (in Bolton, a minimum reduction of [40%] over this period), underlining the need for maximum value from integrated health and social care working to maintain and care for the population with least duplication and best outcomes.</p> <p>BMBC have set out a model for the client’s “journey”, describing a system of eligibility assessment, and re-shaped organisation of care – services or funding provided on the basis of “eligible need”</p> <p>It focuses strongly on improvement of information and advice available to individuals and on the wide coverage (aiming for 80%) of a short term multidisciplinary assessment that is designed to establish care needs and achieve significant reablement (eight weeks maximum), avoiding further deterioration and more complex demand on services, where this is possible.</p>

	<p>It is intended that many more people will access this service than do currently, instead of being referred directly for a service.</p> <p>For those with established longer term needs, it is expected that many more people will begin to take control of their package of care or “self-directed support”, enabled through “personalised” budgets, able to be used by a client to procure their preferred type of care.</p> <p>In response to the reduced funding available, people with needs classed as “moderate” do not now qualify for Council support, restricting this to those with “critical” or “substantial” needs.</p>
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Social	
Ageing population	<p>The number of older people in Bolton over 65 is projected to grow from 46,000 in 2013 to 51,900 by 2020.</p> <p>Bolton’s age structure is also predicted to change significantly in the next twenty-five years. The proportion of the population aged 65 and above is set to increase from 15.4% in 2008 to 22.0% in 2033. Bolton’s working age population (age 20-64) is expected to decrease in number by 2.9% by 2033, the proportion of working age people in the population as a whole will reduce from 58.4% in 2008 to 52.9% in 2033. The number of dependent children (age 0-19) is expected to increase by 2.7% by 2033.</p>
Public expectation	<p>National and local trends reflect growing public expectation both of the capability and availability of health services. Access to more intelligence and comparative information about health and health services has reinforced this trend, and underpinned an increasing willingness to exercise choice.</p>
Population health indicators	<p>Life expectancy is commonly used as an indicator to gauge and compare the health and well-being of a population. The most commonly used indicator is life expectancy at birth i.e. the number of years that a baby boy or girl can expect to live to.</p> <p>Life expectancy in Bolton remains lower than the national average and the gap continues to widen</p> <p>Large internal life expectancy inequalities exist within Bolton, particularly for women. The steep social gradient within Bolton plays a significant role within this inequality.</p>

	<p>The all age all cause mortality rates continue to fall within Bolton but not as fast as the England rate and the 2010 inequalities target is in danger of not being met</p> <p>The major causes of death in Bolton, circulatory disease (CVD), respiratory disease and cancers (mainly lung) contribute approximately half of the gap in life expectancy. Alcohol related digestive diseases are another significant contributor.</p> <p>Smoking in Bolton remains high, especially in the more deprived areas and this is a significant contributor to health inequalities in the borough</p> <p>The prevalence of obesity continues to increase both nationally and locally</p> <p>Inequalities related to deprivation persist within Bolton</p>
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TECHNOLOGICAL	
Potential of IT	Acceleration of the capacity and functionality of new technology, its familiarity and its increasingly dispersed access, based on wifi and broadband capability, has the potential to transform models of care in the health service. The NHS Informatics Strategy envisages technology as the platform for more locally-based services, greater patient empowerment through access to records and other information, and the development of single records across diverse providers, supporting more integrated care.
Development and spread of new diagnostic and treatment capabilities and technologies	The National QIPP Framework has highlighted the benefit of innovation and rapid adoption as a significant element in responding to the challenge to improve quality and reduce cost (“Innovation, Health and Wealth”). Academic Health Science Networks have been established across the country to accelerate the benefit of area-wide redesign and adoption of best practice, harnessing the collaboration of providers, commissioners, academics and industry.

4.	<i>Healthier Together</i> – GM-wide Review of Healthcare – A Major Influence on Our Future
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In 2012 NHS Greater Manchester launched a major review of health services across the conurbation. Models for future provision, based on work developed in clinical reference groups over the last year, were published in January, leading to a more formal consultation process, which will put forward proposals for change in the organisation and location of services, particularly the distribution of acute hospital services across Manchester, by November 2013.

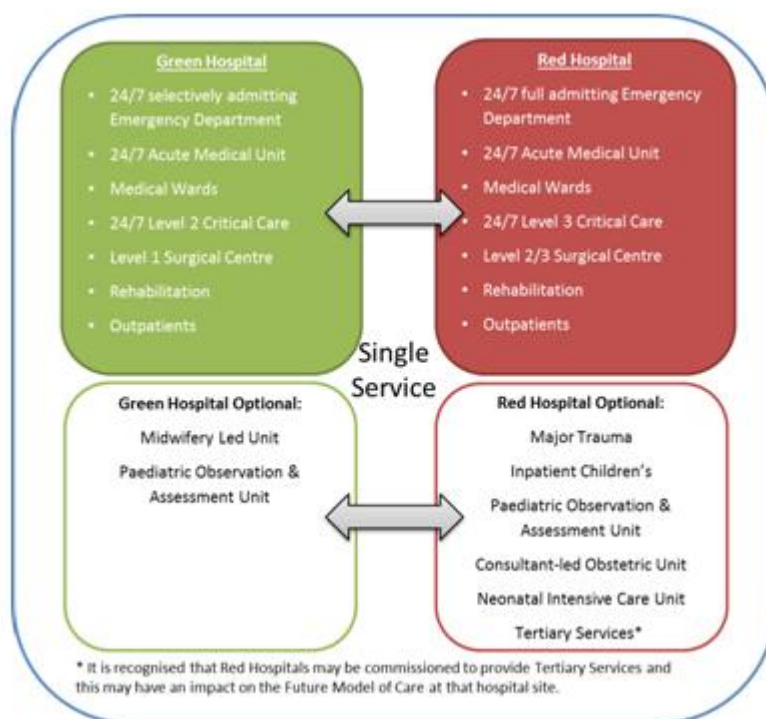
The high-level conclusions emerging from *Healthier Together* reflect the need for significant change in order to

meet the challenge of improving care and outcomes, while also addressing increasing demand and continuing reductions in public spending.

Emerging Headlines From <i>Healthier Together</i> About Future Models of Care:	
Primary Care	<ul style="list-style-type: none"> • Better access – 365/365 • Bigger groupings – “accountable care” organisations • Closer working with secondary care clinicians • Less variation
Frail Elderly/People with Long Term Conditions	<ul style="list-style-type: none"> • More geriatricians outside hospital • Acute and community response 24/7 • Patients able to make their own choices • Integrated acute access/rehab/supported discharge and pathways
Emergency Surgery (and Complex Elective Surgery)	<ul style="list-style-type: none"> • All high risk operations consultant-delivered • All patients on integrated pathways • Patient risk determining the seniority and urgency response • Centralise high risk/intermediate surgery at designated sites • Lower risk surgery at a limited number of other sites
Urgent/Emergency/Acute Medicine	<ul style="list-style-type: none"> • A single emergency service (sites/centres/ambulances) • Some hospitals to retain major emergency admitting services. Other linked hospitals operating less acute services, without acute surgery. • Linked “emergency floors” - at other identified sites • A virtual “corridor” takes patients to appropriate part of the system as soon as possible
Paediatrics	<ul style="list-style-type: none"> • Ethos of clinical excellence • Guaranteed standards • Staff freely transferable • Strong voice for health promotion • More services networked across hospital groups

The proposed *Healthier Together* Model of Hospital Services

The current proposals envisage two levels of hospital provision “red” and “green” (proposals only at this stage) described in the following diagram:



5. The Bolton Health Economy

Some facts and figures about the Bolton population:

- 21% of the adult population smoke
- 58% do not achieve the recommended levels of physical activity each week with 17% undertaking no physical activity at all
- 55% do not eat a healthy diet
- 54% are overweight or obese
- 24% drink more than the recommended units of alcohol
- 14% experience poor mental wellbeing
- **Over 21, 000 people aged 40 years and over have been identified at high risk of Cardio-vascular disease.** Across GP practices in Bolton 10,500 people are identified as having Coronary Heart Disease, 13,000 diagnosed with Chronic Kidney Disease, 16,440 with Diabetes, 2,300 with serious mental illness and 22,772 with depression.
- **Approximately 1350 new cases of cancer are diagnosed each year** (2007-09 average). The most commonly diagnosed cancers are lung, breast, bowel, and prostate. Skin cancer diagnosis is also rising. Almost 30% of all new cancers diagnosed during 2007-09 were skin cancer.

Over a third of the adult population in Bolton are living with Long Term Conditions, many of whom have multiple long term conditions. People with physical long term conditions are more likely to experience mental health problems than the general population leading to even poorer health outcomes and reduced quality of life. **People with long term conditions are the most frequent users of healthcare services and are also likely to have greater need for social care support, especially those with both physical and mental health problems.**

6. Local Commissioning Intentions – Bolton CCG’s Strategy

As the Trust’s predominant commissioner, and partner in the provision of services to the Bolton population, Bolton CCG’s plans to have a major influence on the Trust’s own plans. It is essential that these are therefore reflected in the Trust’s underlying assumptions about workload, income, service change and priorities. The following sections provide a summary of Bolton CCG’s strategy and specific changes which will affect the Trust and the wider system of health and social care in Bolton.

6.1 Bolton CCG Vision for Health and Care Services

The vision for Bolton is for the delivery of integrated care across health and social care with primary care at the centre of a remodelled service, which would see more services delivered in a primary care/community settings.

The aims are to improve early intervention in identifying and supporting vulnerable and elderly patients to remain independent, minimise their risk of reaching crisis and hospital admission and improve primary and secondary prevention of ill health across the population.

The following principles have emerged from discussions between partners involved in Bolton’s Health and Well-being Board:

- Patients should receive high quality care which is centred around their needs rather than the needs of professionals and organisations.
- The clients/patient should be empowered to manage their own care and self-care
- Services should be local wherever possible
- Services should be centralised where necessary (to ensure clinical safety)
- Care should be integrated across health and social care in all settings
- Services should be accessible, convenient and responsive
- Information and communications should be centred around the client/patient not the organisation/professional
- High quality care should be accessible quickly regardless of the time or day of the week

Key elements will be:

- Focussed on reducing avoidable admissions to acute care, and reduction in length of stay in acute care
- Identification of “at risk” individuals, and appropriate services at “front and back doors” of acute services.
- Changes and improvements to primary care, NHS Community Services and adult social care
- Changes to the funding model to move investment to out-of-hospital services

6.2 Bolton’s Integrated Care Model

- A multi-disciplinary health and social care team will be based in localities
- Patients with multiple long term conditions and/or at high risk of hospital admission and the frail elderly will be designated a care coordinator who will be responsible for developing and coordinating the patient’s/client’s care plan.
- The multi-disciplinary team will include adult community nurses, social workers, physiotherapists, occupational therapists, community psychiatric nurses and generic workers.
- Supported by community assets which enable people to remain independent, with greater confidence to manage their own care.

A high level plan across Bolton will be agreed by the end of June, and a detailed plan by October. This will help to inform the Trust's longer term service and financial planning.

6.3 QIPP (Quality, Innovation, Productivity, Prevention) and Demand Management

The CCG has recognised that the QIPP challenge of providing higher quality, affordable services in the context of local health need and demographic pressures, will require not only greater levels of efficiency in the services they commission but a "structural" change aimed at providing better alternatives to the hospital care, more prevention and early intervention, and stronger systems of demand management.

Current priority schemes described by the CCG include:

- **Improving referral management across the health economy** (including Consultant to Consultant referrals) and repatriation/the booking service previously transferred to the Trust.
- **Developing patient pathways** and monitoring **adherence to Effective use of Resources Policy** across the health economy.
- Developing **opportunities for patients to access pre-operative assessment in primary care.**
- **Reviewing out-patient follow-up care** to ensure that appropriate activity takes place at the most appropriate location.
- **Reviewing the MSK/Orthopaedics pathway** and making changes as necessary in line with best practice and eliminate the potential duplication of activity/charging inherent in the current pathway.
- **Improving efficiency in prescribing** and improve the system for **management of use of high cost drugs.**
- **Developing a process for reducing demands on A&E services** and streaming of "minors" patients.
- **Re-procurement of the GP out of Hours Service**, currently provided by the Trust.
- Developing an approach for **risk stratification of patients to enable early intervention** and reduce risk of non elective admissions
- **Redesigning community therapy, nursing and care services** to enable patients to be supported in their own homes or in step up/down facilities
- **Creation of integrated teams** supporting primary care
- Development of a **community geriatrician service**
- Supporting a programme to **improve quality of healthcare in care homes, and reducing A&E and emergency admission utilisation**
- **Development of Paediatric community nursing services** supported by acute community paediatricians, to assess and support GP referrals in the community

7.	Reflecting Commissioning Intentions in the Trust's Plans
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The 2013/14 plan has been fully reconciled and is consistent with Bolton CCG commissioning intentions. Beyond this the Trust has used its own estimate of the impact of the commissioners' stated intentions.

A significant shift of activity from the acute sector to community has been modelled. By 2015/16 acute activity is expected to reduce by £12m with an investment in community services of £9.6m to support this. This modelling is based on initial discussions with commissioners. A vision for health and social care in Bolton is currently being developed. This is expected to be completed by the end of June. Once this a granular deliver plan will be developed will full financial modelling to support. This information will support the next planning round.

The plan assumes that there will be no material changes to the Trust's income as a result of any qualified provider.

In line with Bolton CCG's commissioning intentions, the plan assumes that additional demand as a result of demographic change will be met by improved demand management rather than additional activity.

The impact of the Greater Manchester *Healthier Together* programme on the Trust is not yet clear. The plan assumes that the current mix of services will remain in place in Bolton. The impact of the *Healthier Together* Programme will inform future planning rounds.

The Trust is working with its commissioners on a comprehensive demand management programme. As noted above, this has been reflected in the plan by assuming that there will be no activity growth required in the acute setting over the period of the plan.

8.	Collaboration, Integration and Patient Choice
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Bolton

The Trust recognises that successful change will depend critically on strong partnership working with primary and social care services locally. The Trust is an active member of local Borough-wide joint planning arrangements, including membership of the Bolton Health & Wellbeing Board, and the Medical Director is taking the lead in establishing improved joint working arrangements between secondary and primary care clinicians.

Wigan/Salford

The Trust's strategic review is being undertaken in collaboration with Salford Royal FT and Wrightington, Wigan and Leigh FT, collaborating in appraisal of options for service change across the area. A bi-lateral planning group with WWL FT is currently designing a joint solution to sustaining viable General Surgical rotas through working together. Clinical leads from both Trusts have also developed outline proposals for closer working in Orthopaedics. BFT will start to use some operating capacity at Wrightington Hospital from September 2013.

There are also a number of non-clinical support services where joint delivery/contracting arrangements are being progressed with WWL, including catering, IT systems procurement and some Estates services.

Advice of regulators will be sought on any relevant proposals that may impact on competition rules, as they arise.

9.	Quality – Safety, Effectiveness, Patient Experience
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9.1 Current Concerns

There are no significant existing CQC concerns, but the Trust's major challenges in 2013/14 are to meet the annual Clostridium Difficile target of 28, to reduce the number of pressure ulcers acquired in our care to 4% prevalence, and to have no avoidable cases and to reduce the number of patients who fall in our care by 15% based on 2012/13 prevalence.

9.2 Managing the impact of Financial Turnaround

The Trust is in financial turnaround. There is a framework in place for regular review of Quality Impact Assessments (QIA's) including sharing these with stakeholders. A Quality Dashboard including all key quality KPI's derived from QIA's is in development, and to be established by June 2013.

9.3 Board Assurance

External reviews have raised some concerns during 2012/13 on quality governance and data quality, leading to two major reviews by Deloitte. It is planned to implement all recommendations by September 2013. The Trust has revised its quality governance structure in line with Monitor's Quality Governance Framework, and the establishment of Quality Assurance Committee in January 2013 provides the main mechanism of Board assurance on Quality and Patient Safety.

9.4 A Strategy for Quality

A Trust-wide review of the organisation's Quality Strategy is taking place. The aim is to build on foundations of quality care and a strong improvement methodology. Proposed priority work streams in the Quality Strategy include:

- Mortality
- Infection
- Complaints/Litigation/Investigations and Inquests
- Patient Experience and Harm-Free Care
- Informatics, Information and IT
- Staff Engagement and Training

9.5 Governors and Members

A key component of our membership work over the next three years will be to focus on ways to actively involve our members in the work of the Trust. We will look at improving what we know about our members including what their interests are and how they would like to be involved with the Trust. In this way we aim to improve the level and range of member engagement. We will also look to continue growing our membership but will ensure our focus is on individuals with a real interest in the Trust.

We recognise that at present we have six vacancies on our Council of Governors, the majority of these seats have become vacant in the last few months and will be included in our next round of elections which will start in July. In preparation for these elections we hold events for prospective governors which we will advertise in the local paper and through local area forums.

We recognise the changes to governor's duties in the Health and Social Care Act and will be providing training both internally and externally to ensure our governors are equipped with the skills required.

10.	Clinical Service Strategy
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10.1 Developing the Vision and Strategy for BFT

Now, more than ever, the Trust needs to articulate its view of, and aspirations for, the future. This provides the foundation for its decision-making; for communicating its values, priorities and plans to staff and to the wider group of people who have a stake in the future of this organisation, and the services that it provides. At the highest level, we firmly believe that this is what we aim to achieve:

The quality of care	Not accepting anything less than highest quality and professionalism in everything we do
The experience of patients	Having a strong reputation with our community based on patients' experience of a caring, competent and responsive organisation
Our role in serving the local population	Recognising our significant role in responding to the needs of the Bolton population in partnership with Primary Care and Social Care
The way we use resources	Continually seeking ways of doing things that drives out waste, reduces cost and improves quality Being a reliable steward of public monies
The way we care for and develop our workforce	Being an organisation where people want to come and work

Our Vision

To be an excellent integrated care provider within the district of Bolton and beyond, delivering patient-centred, efficient & safe services.

10.2 The Services We Aim to Provide in Future

Financial turnaround is an essential pre-requisite for the stability and strength of the Trust in future; but we recognise that our success will, essentially, be about the continuing improvement in quality of care and patient experience, and in the development and positioning of our services to do the job that our population and our patients need us to do, despite the financial challenges here, across the NHS, and in other local public services.

10.3 The Building Blocks of the Trust's Strategy

Over coming months, the Trust will be engaging widely in the debate on the vision and strategy for the organisation for the next three to five years. The Board has, however, recently set out a high-level view of what it believes should be key elements of that strategy, based on its current review of services.

These are the key elements which the Board believes should be the foundations of our strategy:

- Bolton FT will build on the advantages of being an **integrated provider of local hospital and community-based health services to deliver**, with our partners, the very best care for Bolton patients throughout their healthcare journeys. We will focus on ensuring the best care for frail elderly people and people with long term conditions, outside hospital, through design and delivery of effective pathways of care.

- **Prevention, early intervention and keeping people healthy is central to why we are here**, as well as to provide excellent care for people who need treatment
- Royal Bolton Hospital will remain a **major provider of A&E and emergency access services**
- The Trust will **continue to develop as a centre of excellence for Women’s and Children’s services**, remaining one of Greater Manchester’s hubs for those services
- The Trust will **retain and develop a range of planned diagnostic and treatment services** which
 - Can sustain high standards, have critical mass and are clinically viable
 - Meet the needs and preferences of patients
 - Make a positive financial contribution and/or
 - Are essential to sustaining the wider service provision in the Trust
- The Trust will act in **partnership to provide and sustain high quality care** when this is the most appropriate solution

10.4 Strategic Review – The Trust and its Services in the Context of the NW Sector of Manchester

The Trust has embarked on a strategic option appraisal to understand the possible impact of *Healthier Together* on the trust and its neighbours. The Trust is situated in the North West Sector alongside Salford Royal NHS Foundation Trust (SRFT) and Wrightington, Wigan and Leigh NHS Foundation Trust (WWL), although changes in Pennine Acute Hospitals NHS Trust’s activity will also have an impact on this Sector.

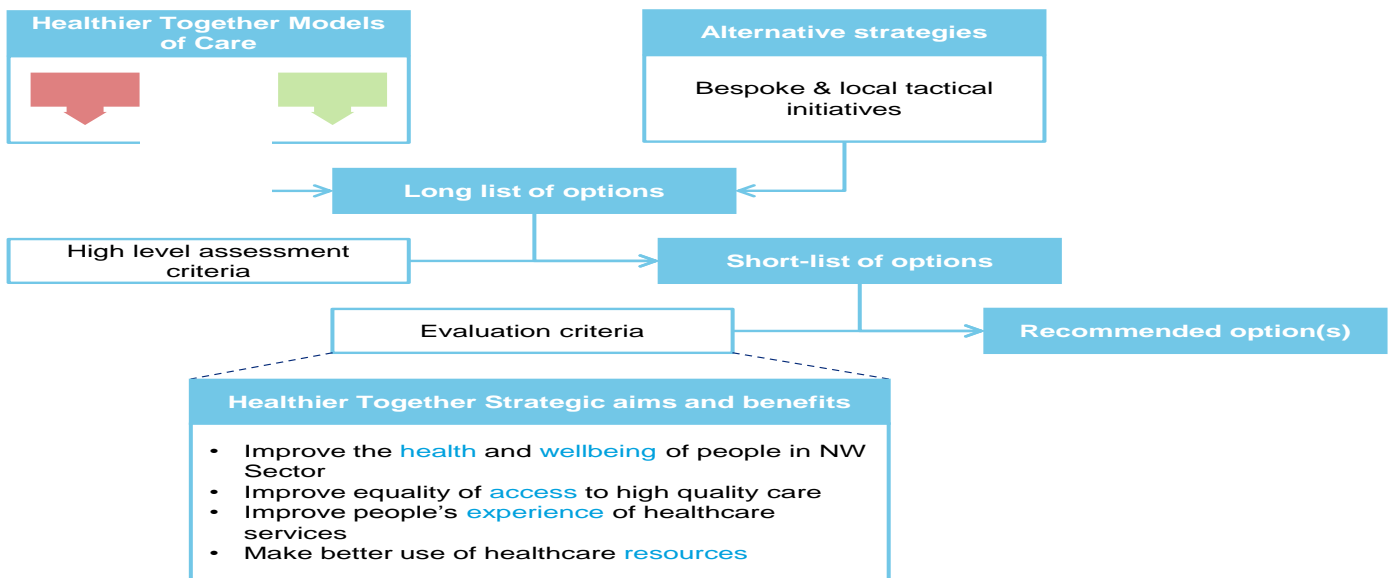
Figure 1.0 – Overview of trusts in the North West Sector



10.5 The Case for Change within the NW Sector

There are a number of factors which are driving the case for reconfiguration across the North West Sector. The first is demographics, with the rising elderly population driving an increase in demand for healthcare services across the sector.

In addition to the demographic case for change the North West Sector collectively reported a deficit of £25.5m in FY 11/12, emphasising the need for new clinical models to secure financial sustainability.



10.7 Approach to Specialty-Specific Evaluations

As well as understanding the impact of *Healthier Together* on the Trust, the Trust is also exploring collaborative ways of working on a specialty-specific basis. Early conversations have developed with WWL on General Surgery and Trauma & Orthopaedics, with proposed future models intended to relieve challenges related to safely sustaining clinical workforce rotas.

These bilateral discussions have started to develop options for long term models that could, for instance, redistribute elective and non-elective care. The Trusts are undertaking analyses to evaluate the impact of possible options.

11.	Clinical Workforce Strategy
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11.1 Overview

The clinical workforce strategy is entirely dependent on the Trust's clinical strategy, which has not yet been fully developed but will be aligned once completed. *Healthier Together* aims to reform Health and Care services across Greater Manchester (GM) with a shared ambition of delivering better outcomes for GM residents and patients within limited resources. The new models of care are designed to provide enhanced level of specialist, senior medical and nursing staff to increase more on site presence. Evidence demonstrates the positive impact on patient outcomes by having the most senior decision makers "at the front door". The GM-wide reconfiguration of services is likely to lead to a reduction in the range of specialties provided by each hospital across the health economy with critical mass addressed through *Healthier Together*.

Within the Trust, the current areas of greater risk are Accident and Emergency and Surgery. These specialties are experiencing workforce challenges at middle grade level in respect of the medical workforce and Surgery in particular, will require clinical collaboration at a consultant and middle grade level with neighbouring Trusts. We already collaborate in respect of on-call rotas in ENT and Vascular Surgery to maintain those services and provide safe out-of-hours on-call cover.

11.2 Key Workforce Pressures and Plans

Our **Accident and Emergency Department** continues to see high volumes of activity whilst maintaining performance against target. The requirements within A&E will depend ultimately on the outputs of *Healthier Together* and the level of services the RBH will provide. It is clear that A&E needs to move to full 24-hour shift work for consultants (thus requiring expansion of numbers on the rota) to address the clinical risks posed by the national middle grade shortages, and that the non-medical workforce would need to be significantly enhanced.

In addition, there is the potential to lose provision of **GP-led Out-of-Hours Services**, as commissioners put

them out for competitive tender this year. The Trust is a centre of excellence for Women's and Children's Services and it is felt that this will be maintained with potential expansion. Within the next 12 months there is the potential shrinkage in **stroke services** as all stroke admissions are to be centralised at hyperacute centres during this period, and local hospitals will provide step-down and rehabilitation care.

In relation to our **Elective services** we plan to build on the Trusts stronger services, which are currently part of a service line review, but include Orthopaedics, Ophthalmology, Endoscopy and Breast services. In respect of those services which are weaker in terms of income, outcomes or capacity, we are likely to agree that alternative collaborative models.

A collaborative provision of **Pathology** provision is likely in the medium to longer term. It is vital that we focus on improving current capacity within Microbiology to support infection control within the Trust.

There has been an external review of **Radiology** which suggests a limited number of productivity improvements. Any expansion needs to be linked with the delivery of seven day working, reduction in length of stay and reduced need to re-admit, ensuring that consultant-led diagnostics are available to support the other specialities required to deliver seven day services.

On a more local footprint, the intention to shift the delivery of the **care of older people and people with long term conditions** to the community rather than hospital. There will need to be "pump-priming" through a transitional period, and a redesigned workforce fitted to new roles and new locations of care.

There will be a **reduction in the number of the doctors in training** in most specialties over the next few years. This will have an impact where the Trust is reliant on middle grades to provide cover and may make some rotas less sustainable than under current working methods. This will give an impetus to look at non-medical roles (such as nurse practitioners) and more consultant cover.

As an **integrated care organisation**, we will take full advantage of having direct influence over what services are provided within the community setting for the benefit of our patient population. This necessitates **growing the skills and competencies to care for patients nearer home and in their own home**, including specialist workers, in particular the Allied Health Professionals and Nursing workforce.

Joint working between Health and Social Care in the Community, supported by joint education and training programmes will support a more integrated and efficient approach to care delivery. The increasing number of patients with complex co-morbidity and Dementia will require a workforce that is appropriately skilled and qualified to look after these patients.

The shift towards a more preventative model of care will require the whole workforce to be able to deliver public health interventions such as smoking cessation advice, alcohol screening and brief interventions and general lifestyle advice in relation to diet and exercise.

The Francis Report has highlighted the need for a real focus on Compassion and the development of the non-registered workforce in basic aspects of patient care.

In relation to the **non-medical workforce**, the increased acuity and dependency of patients has led to an increased demand, particularly for nursing staff. The Trust has adopted a values-based assessment process, in order to recruit staff with the behaviours and competences that the Trust needs to meet this increased demand to ensure the quality and safety of patient care. In addition we are currently developing a **Medical Support Worker** role to support the work of the Hospital at Night team. This will free up skilled resource in the Hospital at Night team to focus on the improvement of response to the deteriorating patient.

Seven day-working will mean a redesign of clinical services and staffing rotas to ensure the correct skills are available through the longer working week. Good progress has already been made in key medical specialities.

The Trust has identified where the pressures on our workforce are largely predictable (winter pressures) and is planning its workforce more effectively. This is being undertaken through a blended approach to planning that incorporates a pool of staff employed on a contractual basis, bank staff and more forward

planning to take the opportunity to recruit newly qualified staff in a timely manner. Some staff are to be recruited on annualised hours contracts.

A more detailed extrapolation of workforce plans from service plans is a core part of the process of producing the full strategic statement, which is planned over the coming months.

11.3 Response to Financial Turnaround

The Trust is currently in **Turnaround** and has a number of workstreams aimed at reducing cost within the organisation. As the highest cost in any organisation is workforce, there are detailed plans aimed at reducing the size of the pay bill. The opportunities have been informed via benchmarking with like organisations in relation to staff groups to provide an indication as to where there may be opportunity for savings. There is a projected reduction in the workforce via redundancy of 218 wte, which is monitored via the Turnaround Board. The majority of redundancies to date have been via voluntary measures with a small number of compulsory. The reduction in workforce is mainly in non-clinical functions, thus safeguarding as far as possible front line services.

There is a **Quality Impact Assessment (QIA) for all workstreams**, initiatives and consultations which identifies potential impact on quality, the risks and how these can be mitigated and identifying the key performance measures that will be monitored. Where the impact on quality, during the course of the consultation has been found to be too great, alternative proposals have been developed. The QIA process is overseen by the Medical Director and Director of Nursing.

A key workforce priority is to **reduce the expenditure on bank and agency**, which is very high within the organisation currently, particularly in relation to the medical workforce where locums are being utilised to fill middle grade vacancies. The expenditure is scrutinised regularly to identify trends and how the expenditure on temporary staffing can be converted to recurrent expenditure, increasing permanent nurse-staffing levels, particularly on ward areas where the usage is high.

The Trust is undergoing significant change, which is challenging for everyone involved. The Trust will not only focus on the short-term, but also support the workforce in embracing change, and working with them on the strategic vision for the future of the Trust, instilling confidence and a direction of travel.

12.	Productivity and Efficiency/CIP (Cost Improvement Programme)
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The Trust has a comprehensive Turnaround programme in place in order to deliver the Cost Improvements planned for 2013/14 (£14.6m). The schemes to deliver these savings have been identified and are being implemented.

The governance of the Turnaround Programme is based on the following principles:

- No harm to patients.
- Quality and safety first and savings will follow.
- Deliver promises.
- Respect to staff.

Thirteen operational productivity and efficiency improvement workstreams are currently in the plan. The whole programme has a focus on production (process) and workforce efficiencies.

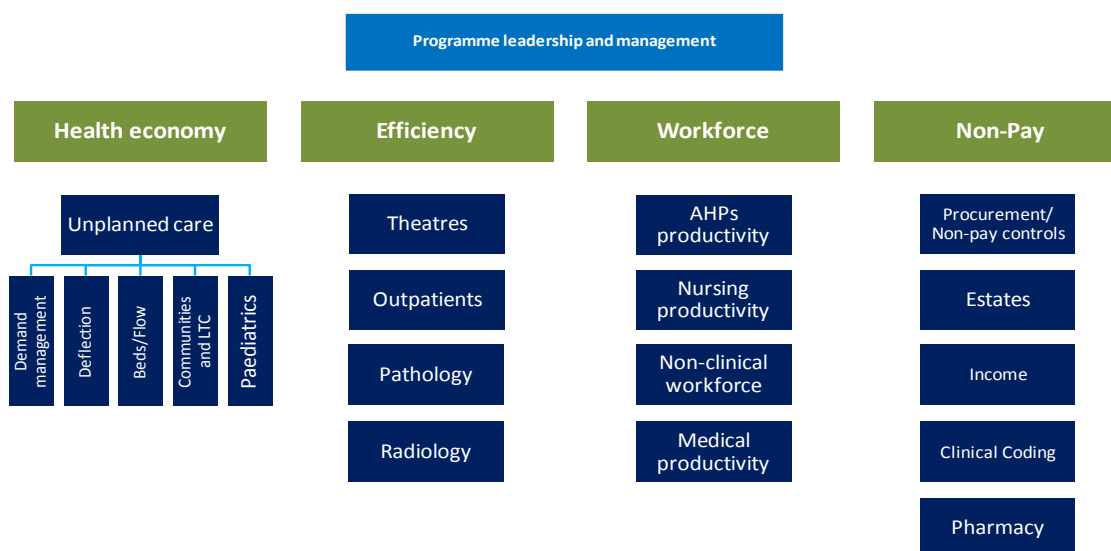
A summary of the planned savings from the Turnaround plan is as follows:

Table 3 - Turnaround Plan

	2013/14
	Value
	£,000
Workstreams	
Unplanned care	609
Theatres	1,517
Outpatients	1,380
Lab Medicine	415
Radiology	61
AHPs	517
Nursing	2,139
Medical	1,589
Non - Clinical	3,280
Procurement	1,668
Estates	924
Pharmacy	501
Total Cost Reduction	14,600
Income	1,575
Total Turnaround Plan	16,175

The scale of cost improvement required in the last two years of the plan have been identified (£15m in 2014/15 and £12.4m in 2015/16). A programme of work is planned to identify how these savings can be operationally realised. It is expected that this work will be completed by the end of September 2013.

The governance structure of the programme is as follows:



All Turnaround work streams have a full quality impact assessment (or QIA) undertaken as a part of our project and programme management methodology.

The QIA assesses all of the potential impacts (stressors) of any changes – including staff reductions – on the safety and quality of patient services.

If the QIA shows that the proposed productivity improvement, service change or reduction in staffing means we cannot maintain a quality and safe service, the change or staff reduction does not take place.

The triggers (or indicators) that might indicate that Turnaround is placing stress on the organisation’s safety and quality performance are numerous. Each work stream has developed bespoke indicators of impact under 6 risk areas:

- Clinical Effectiveness
- Patient Experience
- Patient Safety
- Staff Experience
- Inequalities
- Targets/Performance

These QIAs will be updated monthly.

There are three levels of oversight for the QIA process within the Turnaround Programme Governance – 1 - Work stream steering group are responsible for safe delivery of each work stream – 2 - Turnaround Delivery Group are responsible for safe delivery of all 12 operational work streams and 3 - Executive are ultimately accountable for safe delivery of the entire programme.

This QIA process is also included as a part of the Trust's Quality and Safety governance and relevant committees.

13.	Financial and Investment Strategy
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The Trust reported a deficit of £1.7m in 2011/12 and £14.3m (before exceptional items) in 2012/13. This position results from a general under delivery of cost improvements in the period in addition to the negative full year financial impact of the Transforming Community Services (TCS) and Making it Better (MiB) transactions undertaken by the Trust in 2011/12.

This financial plan shows how the Trust will eliminate its recurrent deficit and return to balance over the three year period of the plan to secure safe and sustainable acute and community services for the people of Bolton.

The Trust is also implementing a comprehensive financial improvement plan based on the following themes:

- Service and financial recovery
- Financial governance improvements
- Finance skills development

The financial improvement plan will secure the necessary improvements in finance processes.

The Trust has prioritised its capital expenditure based on available depreciation for 2013/14 on a risk based approach. Detailed plans for the two subsequent years are being developed. Spend of £5.9m is planned in 2013/14 with £5.3m in 2014/15 and 2015/16.

14.	Summary of the Trust Priorities and Objectives for 2013/14
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A summary of the immediate priorities and objectives for the Trust in 2013/14 given at Annex A. This provides the basis for objective-setting and performance monitoring throughout the Trust this year.

Aim to	2013/14 Objective	Priority Actions Include	Key Measures (Provisional)
Improve Care <ul style="list-style-type: none"> Improved clinical outcomes for our patients 	<ul style="list-style-type: none"> Achieve 7/7 working in all key specialties and services 	<ul style="list-style-type: none"> Increased number of weekend services Increased diagnostic provision at weekend – specifically radiology 	<ul style="list-style-type: none"> A&E, time to specialist opinion Weekend discharges LOS
	<ul style="list-style-type: none"> Improve response to deteriorating patients 	<ul style="list-style-type: none"> Redesign of Hospital@Night Team Embedding national EWS Extend 7-day working – senior medical opinion Increase ILS and ALS training in acute and ward areas 	<ul style="list-style-type: none"> Mortality rates Cardiac arrest audits NEWS compliance audits
	<ul style="list-style-type: none"> Improve the management of septicaemia, lung cancer, heart failure and COPD 	<ul style="list-style-type: none"> Reinforce septicaemia care bundle and Sepsis 6 awareness Implement a heart failure outreach team Joint review of lung cancer and COPD with CCG 	<ul style="list-style-type: none"> Sepsis audits AQ performance in HF Mortality rates in septicaemia, heart failure and COPD
	<ul style="list-style-type: none"> Achieve top five of GM performers in Advancing Quality 	<ul style="list-style-type: none"> Implement AQ compliance team Actively promote Stroke, Hip fracture, Pneumonia and Heart Failure Care Bundles 	<ul style="list-style-type: none"> AQ performance
	<ul style="list-style-type: none"> Improve surgical clinical outcomes 	<ul style="list-style-type: none"> Implement POSSUM Risk Assessment Score Consultant led high risk operations Implement measures to achieve 100% compliance with WHO Safety checklist Implement routine measurement of return-to-theatre metrics 	<ul style="list-style-type: none"> POSSUM compliance WHO Safety Checklist compliance Coded complications of surgery Return to theatre metrics Emergency surgery mortality rate % high risk operation Consultant led
Aim to	2013/14 Objective	Priority Actions Include	Key Measures (Provisional)
<ul style="list-style-type: none"> Improved patient experience 	<ul style="list-style-type: none"> Achieve and where possible exceed national waiting time standards 	<ul style="list-style-type: none"> 18-week plan Urgent care plan 	<ul style="list-style-type: none"> Access times: <ul style="list-style-type: none"> A&E Elective care Cancer Stroke
	<ul style="list-style-type: none"> Reduce cancellations 	<ul style="list-style-type: none"> Redesign booking programmes to reduce cancellations 	<ul style="list-style-type: none"> Cancellations – surgery and OP
	<ul style="list-style-type: none"> Introduce and roll-out the “Family & Friends” test and act on the results 	<ul style="list-style-type: none"> Agree policy/process Introduce in A&E and Inpatient areas – April Evaluate Extend to Obstetrics Agree further roll-out October Roll out F&FT throughout organisation 	<ul style="list-style-type: none"> Progress against roll out plan “100 Voices” – patient satisfaction

<ul style="list-style-type: none"> Better integrated care for older people and people with long term conditions 	<ul style="list-style-type: none"> Review and strengthen complaints management and response processes 	<ul style="list-style-type: none"> Action recommendations of external review Implement quarterly thematic reviews report 	<ul style="list-style-type: none"> Turnaround times – complaints Escalation of complaints Proportion of complaints that lead to Divisional Review Early Warning Matrix
	<ul style="list-style-type: none"> Ensure staffing levels are consistent with recommendations from the Francis Review 	<ul style="list-style-type: none"> Introduce standardised measures of staffing levels 	<ul style="list-style-type: none"> Staffing ratios Early Warning Matrix
	<ul style="list-style-type: none"> Reduce unnecessary days spent in hospital, without increasing readmissions 	<ul style="list-style-type: none"> With primary and social care partners, establish integrated teams targeting known vulnerable patients in the community Increase access to Geriatricians and other specialists in the community Improve management of people with dementia Establish community-based model of “virtual wards” for identified groups of patients 	<ul style="list-style-type: none"> Avoidable readmissions/ admissions LoS for key conditions
	<ul style="list-style-type: none"> Improve end of life care in the community 	<ul style="list-style-type: none"> Review end of life provision in the community Consider Marie Curie Care provision to augment service 	<ul style="list-style-type: none"> Admissions of patient on EOL pathways Preferred place of death audits

Aim to	2013/14 Objective	Priority Actions Include	Key Measures (Provisional)
<ul style="list-style-type: none"> Safer care across patient pathways in hospital and community 	<ul style="list-style-type: none"> Achieve 100% compliance with Harm Free Care Standards(HFC) 	<ul style="list-style-type: none"> Introduce daily ward rounds – key indicator collection Intentional rounding Continue reviews of cases of harm via “HFC” panels 	<ul style="list-style-type: none"> Compliance, Harm Free Care Standards: <ul style="list-style-type: none"> –Falls –VTE –Catheter-related infections –Pressure ulcers Early Warning Matrix
	<ul style="list-style-type: none"> Improve overall infection control 	<ul style="list-style-type: none"> Implement fogging cleaning programme Improve hand hygiene compliance monitoring Enhance Infection Control Team and Microbiological support 	<ul style="list-style-type: none"> CDT targets MRSA targets MSSA targets E coli targets Hand hygiene compliance audits Early Warning Matrix

Be Financially Viable <ul style="list-style-type: none"> <i>Financial stability</i> 	<ul style="list-style-type: none"> Achieve 100% turnaround plan for 2013/14 in all workstreams 	<ul style="list-style-type: none"> Programme implementation Secure cash support pending recovery of the financial position 	<ul style="list-style-type: none"> Workstream progress v. plan
	<ul style="list-style-type: none"> Explore and take forward financially beneficial collaborative opportunities in all non-clinical departments 	<ul style="list-style-type: none"> Progress feasibility reviews with partners in the NW sector 	
	<ul style="list-style-type: none"> Avoid penalties and maximise income, from CQUINS and other incentive payments, and ensure income meets the costs of providing the service 	<ul style="list-style-type: none"> Programme to maximise CQUINS recovery programme Systems in place to ensure coding timeliness and completeness Close performance management of all activities which may attract financial penalties 	<ul style="list-style-type: none"> CQUINS recovery Penalty avoidance Coding coverage and timeliness
	<ul style="list-style-type: none"> Improve DNA rates 	<ul style="list-style-type: none"> Redesign OP booking pathways as part of Turnaround plan 	<ul style="list-style-type: none"> DNA rates

(* run-rate – the monthly difference between income and expenditure)

Aim to	2013/14 Objective	Priority Actions Include	Key Measures (Provisional)
Be Well Governed <ul style="list-style-type: none"> <i>Better governance</i> 	<ul style="list-style-type: none"> Ensure the Trust has robust internal and external assurance mechanisms and clear processes for escalation of risk 	<ul style="list-style-type: none"> Fully implement actions from external reviews: <ul style="list-style-type: none"> – KPMG – PWC – NHSLA 	
	<ul style="list-style-type: none"> Establish a clear well-embedded governance infrastructure 	<ul style="list-style-type: none"> Fully establish Board and Executive without the need for interim support 	
	<ul style="list-style-type: none"> Ensure that the Trust complies with the Duty of Candour requirement of NHS organisations 	<ul style="list-style-type: none"> Develop, communicate and monitor policy Increased visibility of managers in front line areas 	
Be a Great Place to Work <ul style="list-style-type: none"> <i>Bolton as the best place to work and train</i> 	<ul style="list-style-type: none"> Strengthen communication and engagement with staff throughout the organisation 	<ul style="list-style-type: none"> Improve availability and visibility of all managers/leaders. Programme of regular face-to-face staff meetings to brief and discuss current issues. Maximise other means of keeping staff informed, providing channels for staff comments and ideas Measure and track Staff Engagement levels on a quarterly basis in association with the Workforce Matrix 	<ul style="list-style-type: none"> Staff engagement score (score to be determined) Early Warning Matrix (tolerances to be determined) Staff Survey (response rates and key actions) LMSQ

	<ul style="list-style-type: none"> • Establish a firm investment and development plan for the use of technology to enable service change and efficiency 	<ul style="list-style-type: none"> • Business case review 	<ul style="list-style-type: none"> • Progress v. plan
	<ul style="list-style-type: none"> • Improve the Trust's marketing and reputation management 	<ul style="list-style-type: none"> • Service line analysis and planning • Strengthen GP communication • Build on capability of the new website • Anticipate AQP and other competitive tendering opportunities • Update GP and public surveys • Review and agree branding policy • Exploit more social media opportunities 	<ul style="list-style-type: none"> • Progress v. plan

Appendix 1 – Financial Commentary

A.1 Introduction

A.1.1 The Trust reported a deficit of £1.7m in 2011/12 and has incurred a deficit of £14.4m (before exceptional items) in 2012/13. This position results from a general under delivery of cost improvements in the period in addition to the negative full year financial impact of the Transforming Community Services (TCS) and Making it Better (MIB) transactions undertaken by the Trust in 2011/12.

A.1.2 This financial plan shows how the Trust will eliminate its recurrent deficit and return to balance over the three year period of the plan to secure safe and sustainable acute and community services for the people of Bolton.

A.2 Statement of comprehensive income (SoCI) 2013/14 to 2015/16 summary

A.2.1 The table below gives a high level overview of the planned income and expenditure position for the period.

	2012/13	2013/14	2014/15	2015/16
	Actual	Plan	Plan	Plan
	£m	£m	£m	£m
Total income	282.1	272.0	270.6	266.2
Total expenditure	-296.5	-279.8	-272.6	-266.1
Surplus/(deficit) - Before exceptional Items	-14.4	-7.8	-2.0	0.0
Redundancy provision	-9.3	0.0	0.0	0.0
Estate revaluation	-4.6	0.0	0.0	0.0
Surplus/(deficit) - After exceptional Items	-28.2	-7.8	-2.0	0.0
EBIDTA	-18.8	1.8	7.6	9.6
EBIDTA - Excluding non recurrent / exceptional	-0.2	1.6	7.6	9.6
EBIDTA %	-6.7%	0.7%	2.8%	3.6%
EBIDTA - Excluding non recurrent / exceptional %	-0.1%	0.6%	2.8%	3.6%
Recurrent cost reduction £m	8.6	14.6	15.0	12.4
Recurrent cost reduction %	3.1%	5.4%	5.5%	4.7%
Average over four year period				4.7%
Forecast Financial Risk Rating	1.0	1.0	1.0	2.0

A.2.2 It should be noted that the total cost improvements required over the period including the base year are £51.0m or 4.7% of income. This is within the tolerance of 5.4% over a four year period that international benchmarking research by McKinsey has identified as the maximum sustainable level.

A.3 2013/14 to 2015/16 SoCI bridge analysis

A.3.1 The key movements in the position over the period can be understood from the following bridge analysis:

	12/13	13/14	14/15
	to 13/14	to 14/15	to 15/16
	£m	£m	£m
Starting (Deficit) / Surplus (exclude exceptional items)	-14.4	-7.8	-2.0
Non recurrent spending	5.3	0.0	0.0
Non recurrent surplus re 18 week wait activity	-0.4	0.0	0.0
Non recurrent surplus re winter pressure funding	-1.5	0.0	0.0
Non recurrent income to cover capital spending	-0.8	0.0	0.0
Non recurrent surplus re walk in centre closure	-0.6	0.0	0.0
Recurrent surplus / (deficit)	-12.4	-7.8	-2.0
Tariff reduction	-3.7	-3.5	-3.5
Pay awards / incremental drift	-4.7	-5.2	-4.9
Cost Pressures	-0.6	0.0	0.0
Non pay inflation	-2.6	-2.0	-2.0
Turnaround cost improvements	14.6	9.7	12.4
Turnaround cost improvements - balance to full year effect	0.0	5.3	0.0
Turnaround income improvements	1.6	1.5	0.0
Closing (Deficit) / Surplus	-7.8	-2.0	0.0
Cost pressures / tariff deflation as % income	4.2%	4.0%	3.9%
Cost improvements as % income	5.4%	5.5%	4.7%

A.4 Income Assumptions

A.4.1 The Trust is working closely with Bolton Clinical Commissioning Group (CCG) on the development of a financial framework that will support the Trust's turnaround whilst delivering the CCG's objectives in respect of QIPP. This framework is expected to be finalised by the end of April 2013. Key elements of the framework that are already agreed in principle are as follows:

- Open book working between the two organisations
- A standard national contract using standard PBR rules – this was a key turnaround objective for the Trust
- Joint governance of the QIPP programme
- The implementation of the QIPP programme to be designed so that there is no negative impact on the Trust's bottom line
- Non recurrent reinvestment of any QIPP savings in 2013/14
- A joint business case to be presented to the Greater Manchester Local Area Team (GM LAT) to access the 2% non-recurrent contingency reserve lodged with the GM LAT

A.4.2 There are on-going discussions with the CCG, in the context of the above, in respect of the impact of the TCS and MiB transactions on the Trust's financial position. The plan to resolve these issues will be a key element of the joint business case to the GM LAT to enable access to the 2% reserve lodged with the LAT. The Trust is committed to work with the CCG on a renewed service model for community services over the first quarter of 2013/14.

A.4.3 The contract value for 2013/14 is not finalised as the technical work that is required to finalise issues such as the impact of moving off the non-elective block contract and the new maternity tariff.

A.4.4 What is clear from the work described above is that Bolton CCG have the resources to pay the Trust the income identified as required in the plan. On the assumption that the business case to GM LAT is successful they will also have the resources to pay the income identified in the risks and opportunities section of the plan.

A.4.5 Over the longer term the Trust's income from Bolton CCG is planned to reduce due to the impact of the QIPP programme however the commitment to ensure that there is no negative impact on the Trust's bottom line means that income will not be withdrawn until costs have been taken out and also implies commitment to cover non recurrent implementation / double running costs. The impact of these changes is reflected in a detailed bridge analysis.

A.5 Cost Pressure Assumptions

A.5.1 The Trust's 2013/14 business planning process identified a range of cost pressures and risks that need to be managed. A Divisional Financial Management Framework has been agreed to manage these risks. This framework:

- Identifies clear expenditure control totals for the Divisions consistent with the delivery of the Turnaround plan
- Describes a clear accountability and performance management framework

A.5.2 This framework is the control that will mitigate the cost pressures and risks identified through the business planning process.

A.5.3 The plan is therefore predicated on tariff deflation and cost pressures being contained within the 4% assumption built into the tariff. For 2013/14 this has been validated within the Trust by direct calculation of:

- Pay award (1% of pay)
- Individual staff level incremental drift analysis (0.8% of pay)
- Non pay inflation based on the Health Service Cost Index (3.5% of non-pay)
- Specific cost pressures held in a risk reserve (0.3% of total costs)

A.6 Turnaround Assumptions

A.6.1 The Trust has an established Turnaround programme with a Programme Management Office (PMO) in place. The Turnaround process is being embedded into the mainstream financial management process through the Divisional Financial Management Framework.

A.6.2 The predicted impact of the Trust's Turnaround programme in 2013/14 is identified in the table below:

Table 3 - Turnaround Plan

	2013/14
	Value
Workstreams	£,000
Unplanned care	609
Theatres	1,517
Outpatients	1,380
Lab Medicine	415
Radiology	61
AHPs	517
Nursing	2,139
Medical	1,589
Non - Clinical	3,280
Procurement	1,668
Estates	924
Pharmacy	501
Total Cost Reduction	14,600
Income	1,575
Total Turnaround Plan	16,175

A.6.3 A more detailed analysis is available at appendix 1.6 which includes the plan phasing. It should be noted that of the £14.6m cost reduction target £5.6m is currently rated "Amber" for delivery risk and is therefore not certain. Work continues to strengthen these savings plans.

A.6.4 A key element of the implementation of the programme are the 37 consultations that are being concluded to implement new, reduced, staffing structures within the various areas in the Trust. These are at an advanced stage and are expected to yield £6.5m in recurrent savings from permanent staff. The Trust has £15m of variable pay costs in 2012/13 which is being addressed as part of the programme. This along with the ability to manage natural staff turnover and drive non pay savings demonstrate that the cost reduction target of £14.6m for 2013/14 is reasonable.

A.6.5 The Trust has engaged Deloitte to support the development of a service configuration strategy. It is expected that this work will identify a significant contribution to the required savings in year two and three of the plan. A key strand of this work is to plan for the potential impact of the GM LAT *Healthier Together* strategy on services in Bolton.

A.6.6 Further work is required to fully identify the other cost improvements required in years two and three of the plan.

A.7 2013/14 SoCI plan phasing assumptions

A.7.1 Summary phasing is shown below:

Table 4 - 2013/14 plan phasing

Month	Surplus/ (Deficit) £m
April	-1.8
May	-1.5
June	-2.0
July	0.0
August	-0.4
September	-0.7
October	0.2
November	-0.5
December	-0.5
January	0.2
February	-1.0
March	0.0
Total	-7.8

A.8 2013/14 SoCI risks and opportunities

A.8.1 The following table identifies the risks and opportunities inherent in the 2013/14 plan.

Table 5 - 2013/14 SoCI risk and opportunity range

	Worst £m	Plan £m	Best £m
1) Planned Deficit	-7.8	-7.8	-7.8
2) Bolton CCG income (including QIPP)	0.0	0.0	0.0
3) Other income	-1.4	0.0	1.4
4) Turnaround cost reduction	-5.6	0.0	0.0
5) Cost pressure management	-5.0	-2.2	0.0
6) Bolton FT risk reserve	2.2	2.2	2.2
Total risk and opportunity range	-17.6	-7.8	-4.2

A.8.2 As noted in section four the Trust is working with Bolton CCG to put in a joint business case to GM LAT. The Trust's assumption is that this will yield up to £6m of income that can be used to offset downside risk as well as pump priming change. There is potential for this to provide some upside on the plan in 2013/14.

A.8.3 The other items in the risk analysis are explained as:

1. Planned deficit of £7.8m is as per the base plan
2. No down side risk has been shown for the Bolton CCG QIPP plan because of the commitment to ensure that the QIPP does not negatively impact on the Trust's bottom line, with any in year savings being reinvested with the Trust.
3. A 1% downside or upside has been allowed for the other income within the plan
4. The "Amber" delivery risk Turnaround schemes have been identified as not delivering in the downside risk scenario
5. As noted in section five the Trust's business planning process identified a number of potential cost pressures and risks higher than the national tariff assumption. These are being managed through the Divisional Financial Management Framework. The downside risk scenario assumes that excess cost pressures of 2% are not managed. The base plan has an allowance of 0.8% (£2.2m) to cover off such issues.
6. The 0.8% budgeted risk reserve provides £2.2m of protection against downside risk or provides opportunity for upside if not required.

A.9 Capital Plan

A.9.1 The Trust has prioritised its capital expenditure based on available depreciation for 2013/14 on a risk based approach. Detailed plans for the two subsequent years are being developed.

Table 6 - Capital Plan

	2013/14	2014/15	2015/16
Schemes	£,000	£,000	£,000
Backlog Maintenance	2,516	0	0
New Facility Endoscopy (estimate)	850	0	0
Fees	40	0	0
Pre Commitments (RIS/PACS and CT)	350	0	0
Capitalisation of Salaries	130	0	0
Clinical Equipment	607	0	0
Information Technology	807	0	0
Schemes to be confirmed	0	5,300	5,300
Total before carry forward	5,300	5,300	5,300
Carry forward from previous year	600	0	0
Total spend	5,900	5,300	5,300

A.9.2 Two key capital risks remain unaddressed by the plan

- Backlog maintenance with a risk rating of over 16 - £2.5m
- Other backlog maintenance of £8.9m
- Community IT integration - £1.8m

A.9.3 The Trust is seeking a solution for these risks by negotiating with Bolton CCG in respect of the use of the patch risk reserve and seeking to secure additional PDC through the review of critical national infrastructure risk process.

A.9.4 In addition an estates strategy consistent with the proposed service configuration coming out of the work noted above needs to be developed. This strategy will look at the potential for cash receipts from disposals which can then be used to address backlog maintenance on other parts of the Trust's estate.

A.10 Cash Flow and Statement of Financial Position

A.10.1 The Trust has submitted a three year analysis of the planned statement of financial position and planned statement of cash flows along with a month by month phasing of the same for 2013/14.

A.10.2 The following table reconciles the cash position over the three years of the plan

Table 7 - Planned cash balance reconciliation

	2013/14	2014/15	2015/16
	£m	£m	£m
Cash balance b/f	0.3	0.4	0.4
Surplus / (Deficit)	-7.8	-2.0	0.0
Redundancy payments	-9.3		
Loan repayments	-1.4	-1.3	-1.3
Tax/NI Superannuation paid in 2012/13	2.7		
Capital b/f from 2012/13	-0.6		
Other working capital movements	-0.7	3.3	1.0
DH funding	17.2		
Cash balance c/f	0.4	0.4	0.1
Temporary PDC opening balance	9.0	26.2	26.2
Additional in year	17.2	0.0	0.0
Temporary PDC closing balance	26.2	26.2	26.2

A.10.3 As can be seen cash support of £17.2m is required in 2013/14 meaning that the balance of temporary Public Dividend Capital (PDC) will be £26.2m by the end of 2013/14. No further cash support is anticipated after 2013/14.

A.11 Safety and quality implications of the plan

A.11.1 Bolton NHS Foundation Trust is committed to providing safe quality services to patients in both the hospital

and community setting. To ensure that the financial turnaround of the Trust does not negatively impact on the quality of services the following safeguards are in place

- The Trust's overarching quality governance system is being strengthened
- Each work-stream in the Turnaround plan has had a meaningful quality impact assessment performed
- Under the Divisional Financial Management Framework each Division's plan will be subject to a meaningful quality impact assessment.

A.11.2 The financial plan is consistent with the maintenance of Care Quality Commission standards.

A.11.3 The plan allows for sufficient capacity to be in place to ensure that key access targets are consistently achieved.

A.12 Workforce

A description of workforce strategy, key challenge, priorities and plans is contained in section 12 of this plan.

A.13 Conclusion

A.13.1 The plan set out shows how the Trust can recover its financial position so that no further cash support is required after the close of the 2013/14 financial year.

A.13.2 As with all such plans there is a significant element of delivery risk which is set out in section eight.

A.13.3 Years two and three of the plan will be further strengthened by work that is on-going to identify

- Strategic Service Configuration Changes
- Estates strategy work
- Longer term CIP development

Glossary of Abbreviations	
• AHP	• Allied Health Professional
• AQ	• Advancing Quality
• BFT	• Bolton NHS Foundation Trust
• CCG	• Clinical Commissioning Group
• CQC	• Care Quality Commission
• CIP	• Cost Improvement Programme
• EOL	• End of life
• GM	• Greater Manchester
• GM LAT	• Greater Manchester Local Area Team (part of the National commissioning Board)
• LOS	• Length of stay
• MiB	• Making it Better (Women's and Children's Service reconfiguration)
• SRFT	• Salford Royal Foundation Trust
• SoCI	• Statement of Comprehensive Income
• TCS	• Transforming Community Services (Merger of Bolton's Hospital and community Health Services, 2011)
• VTE	• Venous Thromboembolism
• WWLFT	• Wrightington, Wigan & Leigh NHS Foundation Trust
• QIA	• Quality Impact Assessment
• QIPP	• Quality, Innovation, Productivity & Prevention
• PBR	• Payment by Results

Appendix 2: Cost Improvement Plans (CIPs) - Top 5 CIP Schemes (NOT FOR PUBLICATION)

Note: this schedule is to provide additional information regarding CIPs. Please refer to CIPs guidance on page 5.

Ref	Scheme	Scheme description including how scheme will reduce costs	Under-pinning IT / information or management systems	Total savings £m	Phasing over three-year period (£)			WTE Reduction	Has the scheme been subject to a quality impact assessment (Y/N)	Who is responsible for signing off on the quality impact assessment	Key measure of quality for plan	Scheme Lead
					Yr. 1	Yr. 2	Yr. 3					
1	Non – Clinical	Review admin & clerical staff, management structures and other non-clinical specialist services (including back office functions) to gain efficiencies, maximising the use of technology, streamlining processes and having right skill mix in place.	<p>Turnaround Programme Board & PMO.</p> <p>The TPB meets every 2 weeks, reviewing a programme dashboard compiled by the PMO.</p> <p>The dashboard has a matrix of key project principals reflecting the ‘health’ of each workstream (scheme).</p> <p>The dashboard is a performance summary of each scheme and highlights the key risks to be managed through the Programme governance framework.</p> <p>Bi-weekly all workstreams have to compile highlight reports with the risks and progress reviewed and scrutinised by the PMO.</p>	3.280	3.280			81.7	<p>Yes</p> <p>All schemes have a QIA at the outset and these are reviewed pro-actively on a bi-weekly cycle within the PMO risk assurance framework.</p> <p>On a monthly basis the QIAs are again reviewed & signed off by the Medical Director via the Programme Board</p>	Dr Jackie Bene-Medical Director	<p><u>Clinical effectiveness</u></p> <ul style="list-style-type: none"> - Turnaround times for clinic and discharge correspondence - Complaints relating to administrative processes <p><u>Patient Experience</u></p> <ul style="list-style-type: none"> - Complaints relating to administrative processes - Turnaround times for clinic and discharge correspondence <p><u>Patient Safety</u></p> <ul style="list-style-type: none"> - Turnaround times for clinic & discharge correspondence - Complaints relating to administrative processes 	Nicky Ingham-Director of Workforce & Organisational Development

			Weekly each workstream has a 'board' meeting with the core workstream team, including the exec sponsor and clinical lead, in order to maintain momentum and address any issues that threaten objectives.									
2	Nursing	Ensuring safe and sustainable levels of ward based nursing and reviewing the shift patterns to reduce handover times. Reviewing the role of CNSs, actively reducing bank and agency spend and re-launch e-rostering.	Turnaround Programme Board & PMO	2.139	2.139			50.85	Yes	Dr Jackie Bene Medical Director	<u>Clinical effectiveness</u> - Exemplar programme metrics - Advancing Quality metrics - Cancer Staging CQUIN - Public Health CQUINS - CQUIN and other indicators in Quality Schedule of Contract - Increase in patient-facing activity and decrease in duplication and waste <u>Patient Experience</u> - National Inpatient Survey - Local Patient Experience CQUIN - GM Cluster CQUINS - CQUINS for Harm Free Care, - Dementia, Patient	Trish Armstrong- Child – Director of Nursing

											<p>Experience etc.</p> <ul style="list-style-type: none"> - E-Rostering KPIs - Number of patient complaints - Ward Assurance Escalation Framework - PAF <p><u>Patient Safety</u></p> <ul style="list-style-type: none"> - CQC standards for Quality and Safety - NHSLA standards Clinical Incident Reporting-number of incidents and degree of harm - E-Rostering KPIs 	
3	Procurement	Short term controls on expenditure, reviewing major procurement areas to achieve c8% reduction in addressable non-pay spend	Turnaround Programme Board & PMO	1.668	1.668			None	Yes	Dr Jackie Bene-Medical Director	<p><u>Clinical Effectiveness</u></p> <ul style="list-style-type: none"> - Clinical incidents relating to changes to goods and services procured <p><u>Patient Experience</u></p> <ul style="list-style-type: none"> - Clinical incidents relating to changes to goods and services procured <p><u>Patient Safety</u></p> <ul style="list-style-type: none"> - Clinical incidents relating to changes to goods and services procured 	Simon Worthington – Director of Finance

4	Medical	Ensuring payments reflect agreed job plans, reviewing all consultant job plans and reducing locum spend	Turnaround Programme Board & PMO	1.589	1.589			None	Yes	Dr Jackie Bene-Medical Director	<p><u>Clinical Effectiveness</u></p> <ul style="list-style-type: none"> - Monitor reduction in audits completed, level of direct improvement activities such as BICS, impact on appraisal outcomes and revalidation status. <p><u>Patient Experience</u></p> <ul style="list-style-type: none"> - Temperature Check undertaken through usual Divisional processes. <p><u>Patient Safety</u></p> <ul style="list-style-type: none"> - Monitor any shifts not covered by locums due to the new controls and process. 	Dr Jackie Bene - Medical Director
5	Theatres	Improving theatre efficiency and productivity to remove the need for premium payments and to reduce resources and costs needed to deliver current activity.	Turnaround Programme Board & PMO	1.517	1.517			6	Yes	Dr Jackie Bene-Medical Director	<p><u>Clinical Effectiveness</u></p> <ul style="list-style-type: none"> - Cancellations on day due to lack of equipment <p><u>Patient Experience</u></p> <ul style="list-style-type: none"> - Cancellations on the day due to hospital non-clinical reasons <p><u>Patient Safety</u></p> <ul style="list-style-type: none"> - Inbrief - Time out - Wrong site surgery - Scrub related clinical incidents 	Jon Scott – Chief Operating Officer

Appendix 3: PFIs costs and utilisation (NOT FOR PUBLICATION)

If during the Strategic Plan period a Trust has or will have a PFI scheme, please detail:

- Where a PFI already exists, please summarise the assumptions underpinning the business case for the PFI at the time of entering into the PFI and the assumptions underpinning the business case for the PFI now, explaining the reason for and financial impact of any changes;
- Where a new PFI scheme is planned, please summarise the assumptions underpinning the business case for the PFI or investment; and an assessment of the financial sustainability of the investment;
- PFI Unitary payment as % of income and any plans to reduce the proportion; and
- Utilisation of PFI resources and any plans to maximise use.

This commentary should be consistent with the Trust's associated financial template.

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N/A

Appendix 4: Use of external assurance (including internal audit) (NOT FOR PUBLICATION)

Third party reports are a valuable tool for Trust Boards to gain assurance and to highlight areas of weakness within the Trust. Please indicate below the material assurance projects which the Trust has commissioned within the last 12 months, particularly in respect of the delivery of this plan and/or diagnosis of the issues it is trying to address, and any material issues or recommendations which were raised and proposed action plans to address them.

At the start of 2012/13 the Trust was found to be in significant breach of its Terms of Authorisation. In order to address the failings leading to this several pieces of external assurance have been commissioned during the year, some as a direct Monitor requirement and others at the instigation of the Board to identify mitigating actions.

- Review of Corporate Governance (KPMG)
- Review of Financial Governance (PWC)
- Review of Quality Governance (Deloitte)
- Report on C.Difficile (Kiernan)
- Review of Coding (Deloitte)
- Independent review of Sepsis (Doran)

Significant engagement has also take place with Intensive Support Teams for 18 weeks and Urgent Care.

Findings of reviews have informed the Trust's plans and priorities in 2013/14, and in particular the current review of governance and risk management processes. Action plans have been shared with Monitor. The Trust is currently on target to meet the compliance requirements and enforcement undertakings required by Monitor.

Appendix 5: Commercial or other confidential matters (NOT FOR PUBLICATION)

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