The BayWay
SHAPING A BETTER FUTURE

University Hospitals of Morecambe Bay NHS
NHS Foundation Trust

Operational Plan 2017/19

A great place to be cared for; a great place to work.

bettercare together

CONTENTS

Introduction

The Operational Plan for 2017/19 is set out to cover four key areas of focus and the approach we will take in the next 2 years. The focus will be on:

- Quality Planning
- Operational Delivery
- Workforce Planning
- Financial Planning

1. Approach to Quality Improvement

The Trust's Quality Improvement Strategy 2016-2019 brings together our improvement work, ensuring alignment between quality improvement priorities; actions for improvement following Care Quality Commission feedback; and proven improvement methodology. The Care Quality Commission (CQC) Hospital Improvement Plan forms part of the actions and outcomes of the Strategy to ensure the actions become embedded in practice. This approach also supports how we manage our top three clinical strategic risks through the robust Board Assurance Framework. The top 3 clinical risks identified are:

1. Robust Sustainable Safe Staffing Levels
2. Patient Flow
3. Provision and Access of Mental Health Services

The Executive lead for Quality is the Executive Chief Nurse who is closely supported by the Medical Director and the Director of Governance. The Quality Committee is accountable to the Board of Directors and it has the purpose of:

a) providing a focus for improving the quality of patient centred healthcare in accordance with the Trust objectives;
b) providing a focus on quality in clinical governance, with a particular emphasis on patient safety, effectiveness and patient experience issues;
c) providing detailed scrutiny of clinical and operational performance; in order to provide assurance and raise concerns (if appropriate) to the Board of Directors;
d) making recommendations, as appropriate, on quality in clinical governance and clinical and operational performance matters to the Board of Directors;
e) ensuring the organisation responds effectively to the clinical issues raised in national / local reports, patient surveys and complaints, serious untoward incidents, never events, duty of candour other clinical incidents and claims and inquests;
f) to assess and identify risks within the Quality portfolio, escalating this as appropriate;
g) to determine those matters delegated to the Committee in accordance with the Scheme of Delegation and Standing Financial Instructions as set out in the Trust's Code of Corporate Governance.

1.1 WESEE

WESEE triangulates and provides assurance reporting in the following distinct areas:

- Workforce
- Efficiency
- Safety
- Effectiveness

- Experience

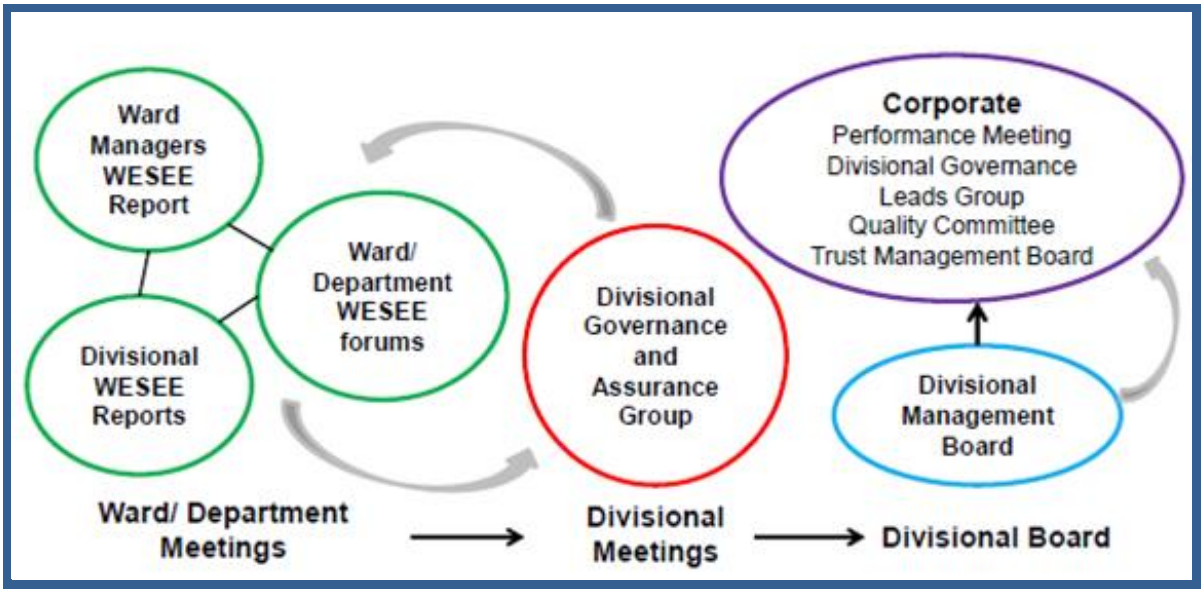
The Trust triangulates workforce, financial and quality, indicators using the WESEE reporting mechanism and reports through the Governance structure on a monthly basis.

WESEE is a simple and robust integrated reporting mechanism that begins with ward/area mangers and escalates to divisional governance and management meeting through the organisation via the Governance structures and any issues requiring escalation are reported through to Quality Committee. Information is cascaded back through to staff on the front line so that all staff know how they and their areas are performing in all aspects of NHS life.

Within the WESEE framework are a suite of key indicator metrics with agreed trajectories for achievement. This ensures all areas report and are measured against the same set of KPI's.

This process allows Divisions, Committees and the Board to use this information to improve the quality of care and enhance productivity. The following diagram shows the WESEE flowchart.

Diagram 1. Assurance Reporting Process



To support the delivery of 'quality improvements' and staff engagement overall, the Trust has commenced the 'Listening into Action' programme. The Staff Pulse Survey results show that staff are very positive about the improved staff engagement and the Listening into Action (LiA) programme.

The Listening into Action (LiA) methodology continues to be rolled out and embedded across the organisation enabling the teams to make significant improvements. Wave 7 of the LiA schemes will launch early in 2017. A review of several LIA Schemes and a summary of their impact is outlined within Appendix 1.

1.2 Summary of the Quality Improvement Strategy 2016 / 2019

The Strategy aims to provide staff, patients and the public with a clear description of our refreshed priorities for quality improvement, patient and staff experience, and how these will be measured.

We have learned a great deal over the last year, particularly around which areas to measure, ensuring they fit with our wider plans. These have been incorporated into the measures for 2017/18. The key areas covered in the Strategy include:

- Refresh of quality governance structures to incorporate the new Patient Safety Unit;
- Focus on the importance of recognising human factors;
- Focus on Listening into Action as a Trust methodology for engaging front line staff in leading improvement;
- Resetting quality goals to ensure focus is on those areas that are likely to deliver highest level of safety and quality improvement;
- Review of leadership roles and accountabilities;
- The importance of improving public engagement and staff experience;
- Measurement and assurance;
- Building capacity and capability; learning with and from other organisations through this system including our stakeholders and commissioners to help drive further improvements.

To ensure that the Trust meets the quality standards set out within the NHS Constitution and within the NHS Mandate the Trust publishes its Quality Goals in the Quality Account. Table 1 at Appendix 2 below sets out the Trusts Quality Goals for 2016/17. The Governors are consulted on the content and targets within the Quality Accounts. They monitor quality improvement initiatives through the Quality and Patient Experience Group and by attending meetings of the Quality Committee.

We will also increase our focus on three key areas in 2017/18:-

- **Engagement with citizens and wider population**

  Participation, by the people who use and care about NHS services, enables us to understand and respond to their needs; including those people who have the poorest health. It allows us to see things through the eyes of those who use services and their families and to be innovative, leading to better use of taxpayers' money.

- **Wider Learning from Kirkup and the importance of remembrance**

  Carl Macrae (2016) * recently wrote that *'memory, and remembering the past, are fundamental to patient safety'*. One of the core objectives of safety improvement is to learn from the past in order to improve the future. The Trust aims to develop remembrance as an integral part of it safety improvement strategy by developing an annual remembrance event that demonstrates both the learning from when we get things wrong and to celebrate the way that keeping the memory alive helps us to improve.

- **Integration of physical and mental health care**

  The Five Year Forward View for mental health explains that one in four adults experiences at least one diagnosable mental health problem in any given year. People in all walks of life can be affected and at any point in their lives, including new mothers, children, teenagers, adults and older people. One of our key priorities this year is to reduce the inequalities that people with mental health needs face by

working as a health and care economy to integrate physical and mental care across Morecambe Bay.

*Macrae, Carl (2016) ***Remembering to Learn: the overlooked role of remembrance safety improvement***. BMJ: Quality & Safety on line.

1.3 Clinical Audit

The Trust has a prioritised annual clinical audit forward programme, which supports the provision of assurance against national standards including NICE, Royal college and CQC standards. The audit programme is informed by national priorities, trust priorities, audit projects requested by the commissioners, national best practice, and clinical interest and will be developed and agreed in quarter 4 of 2016/17 on line with the national timetable.

1.4 'Sign up to Safety'

Our other key areas of focus for Quality are included within the 'sign up to safety' priorities which are:

- Reducing the incidence of hospital acquired pressure ulcers;
- Reducing harm caused by patient falls;
- Reducing the harm caused by medication incidents;
- Reducing deaths from Stroke;

1.5 Mortality Review Programme

The existing mortality review programme has been extended to include all deaths in hospital and Mortality review groups for each Trust hospital have been formed, with an improved review process introduced in 2016/17. The reviewing team considers each and every case using Hogan's (2012) Mortality Retrospective Case Record Review scale and NCEPOD scoring system with a summary of the events. The cases where near harm or harm happened are escalated for Root Cause Analysis (RCA) and Rapid Review via the divisional governance team.
A monthly report for all patients is circulated to the divisions with lessons learned. This also features in the Trust's Lessons Learned Bulletin. Any cases where a clinical incident or Serious Untoward Incident (SUI) is issued are escalated to the governance team for discussion in the Patient Safety Summit, SUI panel and SIRI panel for further investigation and learning.

The Patient Safety Unit will develop an avoidable mortality strategy for the Trust. The overarching purpose of the Patient Safety Unit (PSU) is to promote a positive safety culture in the organisation and to work in partnership with Lancaster University to develop an evidence-based improvement programme in relation to patient safety with a focus on continuous improvement. Our main objective is to improve safety and quality of care through evaluation against current standards with the subsequent development of quality enhancement systems. We will engage the entire clinical workforce, and also our patients and stakeholders in the achievement of step-wise quality improvement trajectories.

1.6 Seven Day Services

The implementation and delivery of seven day services across the Trust and wider health economy poses significant challenges both operationally and financially. To mitigate these challenges, the Trust is developing clinical pathways with primary care
and CCGs through the community-wide Better Care Together strategy and part of this process is to ensure that more patients can be effectively and safely managed in the

community. This integrated care model will enhance the patient offer and improve the quality and efficiency of our care services. We will continue to benchmark our clinical contact time at weekends against other Trusts and we will undertake comprehensive job planning in 2016 to maximise the availability of consultants and other staff groups at weekends.

Whilst planning for 2016/17, the Trust has considered the recommendations in the Academy of Medical Royal Colleges' 2014 report; 'Guidance for taking responsibility: accountable clinicians and informed patients'. The Trust will ensure that effective management, good communication and continuity of care are delivered to every patient through the identification of accountable clinicians for each patient. Every patient admitted to one of the Trust's hospitals has a named consultant accountable for the care of the patient throughout their stay in the hospital. For each shift a named nurse is allocated to each patient. The accountable clinicians are recorded at the patient's bedside, in the clinical notes and on ward electronic whiteboards so that patients and families know which clinician is responsible for their care.

The Keogh Standards Project Steering Group continues to drive the work forward to address the identified gaps against the ten Keogh standards. The group meets monthly and has multi-organisational representation, allowing positive collaborative working. Particular focus is on working to achieve the four identified national 'priority' standards: (2) Time to First Consultant Review; (5) Diagnostics; (6) Intervention/Key Services; (8) Ongoing Review.

A recent audit of compliance against the four 'priority' standards showed a number of gaps. With regards to diagnostics and interventions, work is focussed on improving the provision of Interventional Radiology, GI bleed and MRI (non-cord compression) cover. In addition the Trust seeks to improve its performance against the two Keogh consultant review standards which specify that emergency admissions should be reviewed by a consultant within 14 hours of arrival at hospital, and that patients in high dependency areas are reviewed twice daily and then once daily when moved to non-high dependency areas.

1.7 CQC

The Trust had a CQC re-inspection in October 2016. The outcome is expected in early 2017. In advance of the CQC re-inspection the Trust had implemented a CQC Improvement Plan aimed at addressing all the must do and should do recommendations from the previous inception

1.8 Our Approach to Quality Improvement

The Listening into Action methodology continues to be rolled out and embedded across the organisation enabling the teams to make significant improvements. In 2017/19, the LIA programme will continue with a robust programme of improvement, following a sustainable track record of delivery in 2015/16 & 2016/17.

1.9. Quality Impact Assessment Process

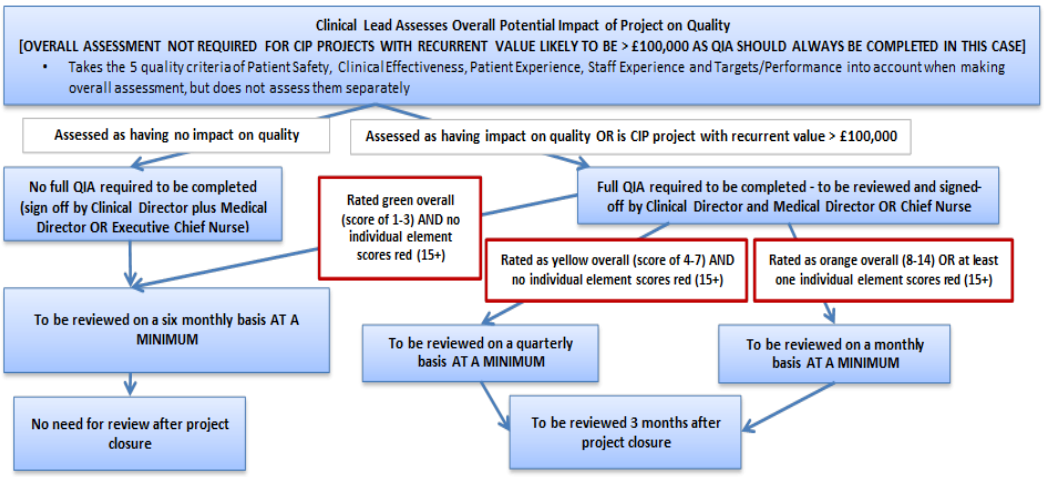
Clinical staff are fully engaged at all stages of scheme development, and the sign off for proposals to commence the planning stage includes a desktop assessment of any potential risks to quality, with clinical director sign off.

Detailed Quality impact Assessments (QIAs) are undertaken by clinical leads as part of the detailed planning process and documented in the project workbook. Schemes are assessed for risk to five criteria: patient safety, clinical effectiveness, patient experience, staff experience and targets/performance. Where risks are identified, mitigating actions are required and a post-mitigation score also calculated.

All assessments are reviewed and signed off by divisional Clinical Directors, prior to the final review and sign-off by the Trust's Medical Director or Executive Chief Nurse. These assessments are live documents which are reviewed regularly through and after project implementation, with minimum review periods calculated according to the level of risk identified.

This approach was based on guidance published by the National Quality Board, and agreed by Quality Committee in November 2014. It is summarised through the flowchart below:

Diagram 2: QIA Sign off process



All projects running through the Programme Management Office (PMO)'s programmes should have a current Quality Impact Assessment (QIA) in place prior to commencing implementation, updated regularly in line with the review periods specified. This is monitored through QIA registers maintained within the PMO.

Additionally, as part of the enhanced governance arrangements put in place as part of setting up the Sustainability Programme during 2016-17, a Sustainability Dashboard has been developed. This includes monitoring of a range of quality/performance metrics including Staff Friends and Family Test feedback, bed occupancy, RTT performance, patient harms and mortality. This is reported monthly to Sustainability Programme Board to give an early indication if any of these measures of quality are deteriorating and allow for action to be taken.

1.10 Summary of the Quality Triangulation – Workforce/ Quality/ Finance

The Trust Board receives an Integrated Performance Report monthly which covers Workforce/ Quality/ Finance and includes an Executive Summary of overall performance. The Assurance Committees undertake detailed reviews of each Section and the Non-Executive Directors escalate any areas of concern to the Board

2. Approach to Operational Delivery

2.1. Activity and Capacity plans

2.1.2. Assessment of activity in 2017/18

The activity plans for 2017/18 are based upon robust demand and capacity modelling and lessons from the 16/17 resilience planning process. The approach has been jointly prepared and agreed with commissioners taking account of NHS Right Care data.

The activity returns are underpinned by the following agreed planning assumptions;

- All specialities have assumed growth as per CCG calculations (table 1).

Table 1: CCG Assumptions on Growth 2017/19

	A&E attendances (excluding Follow Ups)	**Outpatient First** (Consultant led) (Specific acute)	**Outpatient Follow Up** (Consultant led) (Specific acute)	**Elective admissions** (including Daycase) (Specific acute)	**Non-elective admissions** (including Daycase) (Specific acute)
2017/18	**0.93%**	**1.26%**	**1.40%**	**1.71%**	**1.49%**
2018/19	**0.98%**	**1.32%**	**1.47%**	**1.77%**	**1.54%**

Efficiency gains have been built into the activity plans;

- Activity forecasts have taken into account aligned Better Care Together work streams; including Patient Initiated Follow-up and the Advice and Guidance service for GPs;
- Ability of the wider health and care system to sustainably implement and deliver QIPP / Right Care Schemes;
- Reduction in the number of vacant Consultant, middle grade and nursing posts;
- Growth assessed for each service.

Table 2. Specific assumptions/ mitigations by Clinical Division include:

Division	**Assumptions/ Mitigations**
Women and Children's Division	○ 5% reduction aligned to Better Care Together (BCT) outpatient clinics for both Gynaecology & Paediatrics – Patient Initiated Follow Up (PIFU); ○ No activity increase required to achieve RTT 92% standard; ○ RTT – stretch target of 97% achievement set for the division to support the Trusts aggregate target; ○ Reduction in emergency bed days on implementation of Integrated community nursing team; ○ 5% reduction in emergency paediatric activity over 2 years; ○ Maternity demand to remain as at 2016/17 levels.
Division of Surgery and Critical Care	○ Trauma& Orthopaedics (T&O) and Ophthalmology teams have plans in place to improve performance and reduce the waiting list size; however, due to the large number of patients on waiting lists they will not achieve compliance against the 92% RTT standard during 2017/18; ○ Planned shift of 14,213 Follow Up (FU) contacts to Optometrists at lower unit cost (than Ophthalmologist FU's) although there is no planned reduction in activity overall. This scheme commenced in 2016/17. ○ The adverse impact of system pressures upon elective activity throughout the year in 2017/18 will be less than that experienced in 2016/17. ○ Planned reduction in FU contacts will enable a reduction in the number of patients treated through sub-contractor arrangements with Independent Sector providers from 16/17 position. ○ Clinical posts have now been approved which will support delivery of RTT standards. RTT improvement is dependent on having full access to surgical beds & theatre availability; ○ Improved use of 2 Week Wait Cancer referral templates and a move to E-

	referral will facilitate patient agreed timely appointments; ○ Integrated Muscular Skeletal (IMSK) scheme to remove 60-70 first outpatient T&O referrals from 2016/17 levels is currently in development, as yet this is not reflected in the 2017/19 plans. The impact upon conversion rate to surgery is to be understood. ○ Estimated impact of the adherence to the commissioning policies for Procedures of Limited Clinical Value for South Cumbria has been taken into account; ○ The plan reflects the estimated changes in pathways for the fracture clinic to a virtual setting in 2017/18.
Core Clinical Services Division	○ High percentage of Therapy Teams within 2016/17 on maternity leave which has been factored into 17/18 modelling ○ No more capacity available within therapy services unless workforce increases ○ Occupational Therapist capacity to improve in 2017/18. ○ Pathology – 1% increase ○ CT –7% increase ○ MRI – 16.2% increase ○ USS- 5% increase ○ Overall increase in radiology by 1% due to decreases in other radiology testing including plain film.
Division of Medicine	○ Emergency Department (ED) activity based on 2016/17 forecast figures; ○ Number of services identified as suitable for PIFU (Rheumatology, Dermatology, Gastroenterology & Diabetic medicine).Proposed reduction in FU contacts identified in plan which varies by speciality; ○ Assuming 1.49% demographic growth for emergency activity as per CCG assumptions ○ Assumed forecast outturn for elective and non-elective activity as a starting position ○ Continue to achieve a minimum of 98% Incomplete RTT performance for Medical specialties ○ Increased activity for Expansion of Bowel Scope programme

2.2. Operational Delivery for 2017/18

The clinical divisions have developed two year operational delivery plans for 2017/18 and 2018/19 in line with national guidance and the Trust's five year strategy. The Trust is required to meet all standards during 2017/18. The Divisions have taken this into account as part of the activity planning process. 2016/17 continues to be a challenging year operationally, but we maintain our ambition to turn around operational performance and we will make all reasonable efforts to achieve the national standards.

2.3. Resilience planning in 2016/17

The goal for the 2016/17 Winter Plan was to deliver an 85% average medical bed occupancy through a combination of admission avoidance, reduction in length of stay and implementation of a number of initiatives designed to accelerate discharge to the right place or provide additional capacity.

To achieve this the strategy for each site was to:-

- Reduce the numbers of Medically fit For Discharge (MFFD) patients on each site through implementation of the Care Act and commencement of Home Instead;
- Pull back the outlier patients from the surgical bed base into the medical bed base;
- Implementation of a number of funded initiatives to support the Trust's staffing issues and accelerate the Delayed Transfer of Care (DTOC) work – focussing particularly on discharge for patients requiring long term care and in due course discharge to assess;
- Continued focus on delivery of the SAFER care bundle as recommended by the Emergency Care Intensive Support Team (ECIST).

In addition, the Trust continues to be part of the NHS Improvement Programmes on Reducing Delayed Discharges and Transfers of Care and A&E Improvement.

Looking forward – resilience planning in 2017/18:

The strategy of delivering and embedding 85% medical bed occupancy to support effective patient flow will be continued through 2017/18.

It is recognised that the 4-hour ED standard is a system wide measure. In 2017/18 focus will also be on a second phase of reducing MFFD numbers with focus on the development and implementation of a Discharge to Assess model across the system, building better clinical pathways for 24 hour care home patients, supporting the Integrated Care Communities (ICCs) across Morecambe Bay in admission avoidance and reducing lengths of hospital stay, together with development of intermediate care facilities in the Lancaster area.

In addition, the Trust intends to strengthen the hospital teams at night in terms of both clinical expertise and management of patient flow. This will improve the management of our patients through the night supporting the philosophy of right person right place first time.

2.4. Better CareTogether Clinical Strategy & Bay Health and Care Partners

The local health economy transformation programme Better Care Together (BCT), achieved Vanguard status and funding in 2015 and 2016 allowing the Trust and the Bay Health and Care Partners (BHCP) to progress towards the implementation of the improvements needed to secure population health improvement, clinical and financial sustainability across Morecambe Bay. As a Vanguard site the Better Care Together programme has submitted a value proposition for funding to continue these changes in 2017/18 and continue to build on progress to date. In 2017/18 our key milestones will support the delivery of the following activity reductions as outlined in the table below.

Table 4. 2017/18 BCT Delivery plan metrics

Activity Reductions	Year 2: 2017/18
Elective Bed Days	-1420
Non Elective Admissions	-2912
Non Elective Bed Days	-14395
Outpatients – first attendance	-1284
Outpatients – subsequent attendance	-31968

Beds	-24
Outpatient Clinics	-2517

2.5 Enabling operational delivery through IM&T

Informatics, Information and IT are increasingly critical to the way we work, both within the Trust and the wider community. The plans within the 8 themes of our current strategy are shown in Appendix 3 (I3 plan on a page 2017-19), with the main element for us being the completion of the Electronic Patient Record (EPR) with a view to being paperless at the point of care ahead of the national 2020 target. 2017/18 will see the implementation of a new theatres module which will help with resource utilisation and the scheduling of elective care and electronic prescribing which offers the ability to improve medicines management and patient safety. The second year of this plan will be more about ensuring that the benefits highlighted in EPR business case are fully realised.

The plans also see UHMB fully involved in wider plans for Bay Health and Care Partners to integrate the whole community and exploit technologies such as virtual consultation for better patient experience and reduced costs. UHMB also expects to be a leader in the developments in this area at the STP level; e.g. working on systems to support STP level developments in diagnostic services outlined within section 5.

3. Approach to Workforce Planning

3.1 Workforce & Organisational Development Strategy

The Trust is committed to creating a performance-driven culture focused on safety and quality, underpinned by strong and effective leadership, empowerment, involvement and continuous improvement. The Workforce Strategy is based on a Cycle of Excellence that leads to individualised employee-centric support for our staff that truly makes UHMBT 'a great place to work' and through an engaged and motivated workforce creates a 'great place to be cared for'.

3.2 Workforce Strategy – Cycle of Excellence

Diagram 3: UHMBFT Workforce Strategy - Cycle of Excellence

The Trust continues to develop an approach to work force planning across the Bay Health & Care Partners (BHCP) which allows us to plan the workforce requirements across the full system overview.

A key element of UHMB's workforce strategy over the last 3 years has been focused on **Recruitment & Retention**. Recognising the short-term challenges faced in respect of recruiting and retaining staff in a landscape of very limited workforce supply, the Trust has developed a long-term response through clinical service transformation and the development of a future workforce through the expansion in our healthcare apprentices with routes into professional training. The Trust also continues to implement e-Rostering for nursing and effective job planning for Doctors to maximise the current staffing efficiency, in addition making effective use of Bank and Contingent staffing solutions has supported us in reducing our Agency reliance (see Appendix 4 - Recruit & Retain).

There remains a large reliance on agency staff to support front-line service delivery whilst recruitment processes continue and the clinical service transformation programmes redesign pathways. There are severe national shortages in medical, nursing and midwifery staff groups, which have a disproportionate impact on UHMB due to its geographical isolation and challenges of providing acute health services across a dispersed, rural landscape from multiple centres. In addition, recent developments such as the Brexit vote, the changes to the nursing bursary and planned changes to Certificate of Sponsorships have impacted on our ability to attract, recruit and retain high quality staff. However, targeted recruitment campaigns across all shortage staff groups has resulted in significant improvements in our vacancy position, to support a reduction of agency spend, meet quality standards and ensure continuity of patient care. This continues to be an area of key focus for the coming two years (see Appendix 4 Recruit & Retain).

The Trust's approach to staff development **Grow & Develop** has focused on creating a culture of safety through the development of empowered leaders who have safety and quality as a core objective built into the Trust's Leadership Development. In addition, all Trust staff are enabled to take control of their own Learning & Development through the development of our 'My Learning & Development' platform. The Trust has seen marked improvements in our training rates over the past year which has supported our vision of creating a 'great place to be cared for; a great place to work'. Additionally, we have continued to develop our approach to developing and implementing Human Factors across the Trust which enables us to improve the synergy of our processes and improve our outcomes (see Appendix 3 Grow & Develop).

The Trust is committed to ensuring we have engaged and motivated staff who are informed and involved in the decisions which affect their working lives. The Trust's approach to working with staff **Engage & Involve** has focused on developing our Listening into Action improvement approach with our staff. This has empowered our staff to develop and lead service improvements across the Trust. The Respect Campaign focuses on embedding every element of our Behavioural Standards Framework to truly make it come alive. Our approach to Inclusion & Diversity will continue to develop over the coming 2-years with a greater focus on champion networks and improving education. The Trust Staff Survey Results, our LiA Pulse Surveys and our Staff Friends & Family Tests all show improvements in our staff engagement scores and feedback from each is used to plan future staff engagement and improvement campaigns (see Appendix 4 Engage & Involve).

Our **Health & Wellbeing** approach has enabled us to support our staff to flourish at work. This has included a focused 12-month campaign to encourage and empower our staff to become more active, eat healthily, together with opportunities to consider mindfulness and how to maintain a healthy heart. The continued development of our Wellbeing service has allowed us to expand and maximise the support available to our staff. The Trust's approach to supporting staff through short, medium and long term interventions has enabled us to maintain our attendance rate at a level above the national average. The Department is on

target to achieve all CQUIN targets set for it in year and will continue to plan to meet the developing national CQUIN targets going forward (see Appendix 4 Health & Wellbeing).

3.3 Workforce Strategy – Transformational Change & Workforce Efficiency

The current community health system relies heavily on a small number of key roles, in particular those in the fields of nursing, social work and primary care particularly within medicine (GPs). The work across BH&CP organisations allows us to think differently about roles which are assigned to care needs to create a sustainable system. This will require a substantial shift in our current care pathways and will require us to work to understand our service user needs across all sectors. Their care needs can be aligned to current skills/ competencies across professions and once models have been designed for each pathway, we will equate current capacity and identify changes required in relation to service provision deficit.

These opportunities can be summarised as:

- The development of new roles that cross health and social care;
- Innovative skill mix solutions with appropriate competencies;
- Exploring advanced practice to overcome established workforce gaps;
- Aligning management and administration teams to the new model of care;
- Shared services.

In practice, each service transformation programme will identify the scope to improve the multidisciplinary function of acute and primary care, through a range of workforce development and education support initiatives. Our innovative approach to Workforce Planning allows us to think boldly about how service transformation can be supported through workforce developments, such as the development of new roles and different ways of working within remodelled pathways crossing traditional organisational boundaries. Each service transformation programme will feed into the development of a five-year workforce strategy to ensure that we, as a local health economy, deliver a safe, affordable and quality sustainable patient care service.

4. Approach to Financial Planning

4.1. Financial forecasts & Modelling Assumptions

The Trust control total for 2016/17 is a deficit of £17.0m. This deficit assumes a LPM of £35m, a CIP delivery of £12.5m and full receipt of the STF funding. The Trust is forecasting to achieve this control total.

In developing the financial plan for 2017/18 and 2018/9 the financial impact of the following have been assessed:-

- Net activity changes (Growth net of BCT and other demand reductions)
- Non recurrent CIPS and full year effect of 2016/17 schemes
- Uplifts and Tariff changes
- Pressures
- Level of CIP
- Local Price modification(LPM) / Sparsity Funding
- Access to the Sustainability & Transformation fund (STF)

The table below shows the Forecast activity by year for the period. This is based on an assessment at speciality level and looks at growth as well as BCT and other demand reduction schemes.

Table 5: Forecast Activity for 2016- 2019

POD Group	Activity Forecast 2016/17	Activity Plan 2017/18	Activity Plan 2018/19
Daycase & Elective	47,935	51,718	52,313
Non Elective	45,513	45,815	45,540
Outpatient Firsts	150,122	154,498	154,093
Outpatient Follow Ups	339,844	343,846	344,279
Accident & Emergency	90,156	90,598	90,181

4.2 Control totals

In the November plan submission, the Trust identified that the CIP profile required for the two years compared to what we could achieve meant that the Trust could not achieve the control totals in 2017/18, but, could achieve a position for 2018/19 which was an improvement on the 2017/18 control total. At this stage, the Local Price Modification (LPM) was included based on the 2016/17 assumption. In the November submission, the Trust highlighted the following concerns:

- Welcoming the movement of the control totals – but highlighting the pressures are still not reflected;
- Trust Board support for the principles of the 2 year planning approach and the financial improvement trajectory required;
- CIP profiling – the CIP required to achieve the trajectories as required could not be achieved in the proportion indicated; noting that a 4% recurrent CIP in each year is double the national contract requirement;
- UHMBT specific issues for which the Trust had yet to receive a response – LPM, CCG allocations and STF requirements.

In the interim the Trust has continued to develop its 2 year plans making good progress, particularly in identifying efficiency plans.

The Trust has now received an updated control total which adjusts for LPM outlined in table 6.

Table 6: Control totals for 2017/18 & 2018/19

	2017/18		**2018/19**	
	In STF	Excl STF	In STF	Excl STF
	£'000	£'000	£'000	£'000
Original control total	(16,881)	(16,881)	(13,242)	(13,242)
STF		(8,834)		(8,834)
Adjust for LPM	(22,000)	(22,000)	(22,000)	(22,000)
Control Total	**(38,881)**	**(47,715)**	**(35,242)**	**(44,076)**

The agreed plan for 2016/17 included an LPM of £35m therefore the adjustment of £22m leaves a balance of £13m to be resolved. Of this NHSI's view is that £7m should be covered from the CCG's sparsity allocation leaving a £6m pressure for the Trust. The Trust is therefore not in a position to agree the control totals for either year and therefore cannot access the STF. This means that the planned deficits for the Trust are £57,513k in 2017/18 and £53,615k in 2018/19.Table 7 below outlines the build up of these deficits.

Table 7: Bridge from 2017/18 to 2018/19

Bridge	Plan 2017/18	Plan 2018/19
	£m	£m
Forecast deficit previous year	**(17.0)**	**(57.5)**
LPM	(35.0)	0.0
STF	(10.2)	0.0
CIP Non rec & BFYE	(2.3)	0.0
Other non-recurrent	(1.2)	0.0
BFYE Investments	(1.6)	0.0
Underlying position from previous year	**(67.3)**	**(57.5)**
Inflation/uplifts	(7.7)	(5.6)
Net activity impact	0.0	0.0
Pressures	(2.0)	(2.7)
CIP	12.5	12.2
Subtotal	**(64.5)**	**(53.6)**
Sparsity	7.0	0.0
STF	0.0	0.0
Planned deficit for year before impairments	**(57.5)**	**(53.6)**

The Trust has requested to meet with NHSI urgently, at the earliest convenience to agree resolution to all the issues highlighted above.

4.3 Risks

The forecast deficit is dependent upon the management of the following major financial risks:-

- Agreement of planned deficits with NHS Improvement and cash support to cover these;
- Agreeing activity plans with CCG's;
- CCG's affordability of the plans;
- Emerging Morecambe Bay CCG – notification of allocations need to be agreed;
- Agreement by CCG to pay £7m sparsity funding;
- Delivering the £24m stretch CIP;
- Management of cost pressures in year;
- Access to distressed funding to support the Revised Estates Strategy.

In cash terms the Trust will require between £57.5m and £64.5m in 2017/18 in revenue loans depending on agreement to the Sparsity payment from the CCG's. For 2018/19 the figures are £53.6m to £60.6m. In addition, Capital loans of £22.1m are required to support the proposed capital plan. Details of the cash flow are shown in table 8 below.

Table 8: Summary Cash flow 2017/18 to 2018/19

Summary Cashflow	2017/18	2018/19
	£m	£m
Net surplus/(deficit) before impairments	(57.5)	(53.6)
Capital Expenditure	(22.1)	(24.0)
Capital Loans - repayment	(0.3)	(0.9)
Less depreciation available	12.4	12.4
Change in capital creditors	(0.1)	0.5
Capital Loans -drawdown	10.1	12.0
Revenue Loan	57.5	53.6
Net Cashflow	**0.0**	**0.0**

4.4. Sustainability Programme for 2017/18 to 2018/19

The Trust engaged PriceWaterhouse Coopers (PWC) in 2016/17 to work with Trust staff to develop a three year Sustainability Programme. Through Phase 1 of this work the Trust has made substantial progress in:

- Establishing a clear programme governance structure to drive delivery including a Sustainability Programme Board (SPB) and Cost Control Board (CCB) that has tightened expenditure controls and brought down run rate;
- Undertaking a cultural assessment of the organisation's readiness for change and developing associated actions at Board/Senior leadership level;
- Investing in the Programme management Office (PMO) to enhance CIP delivery and assurance capability;

In Phase 2, PWC undertook Triple Aim Service Reviews in six specialties (Paediatrics, Gynaecology, General Surgery, Trauma and Orthopaedics, Radiology and Endoscopy). The objective of these reviews was to deliver exceptional patient experience and outcomes, while getting maximum value for money. These reviews resulted in action plans for each area which were handed over to the Trust for delivery.

PWC's Phase 3 review was undertaken to provide an analysis of where the Trust should focus attention in the remaining two years of the programme. This was delivered to the Trust in October 2016 and has been used to inform the development of the programme for 2017/18 and 2018/19 as outlined in table 9.

Table 9: PWC Phase Report Opportunity identified for 2017/19

Schemes	Plan 2017/19
	£m
EPR	2.3
PACS	0.4
Pharmacy	0.2
Patient flow	3
Outpatients	1.4
Theatres	2.2
Triple aim	0.9

Further triple aim	6.3
Other providers	5
Tactical	3
Totals	24.7

The divisions are now in the process of turning the opportunities identified in the PWC report into detailed plans. A series of Divisional Service Review meetings were held during October 2016, with the participation of a wide range of clinical and operational staff, to take forward the Triple Aim methodology by reviewing data packs for services and identifying where opportunities for efficiency improvements were greatest. Working with the new PMO divisional business partners, these initial ideas have been worked up into detailed proposal with high level milestones which have been assessed for risk and quality impact, and are ready for the development of detailed delivery plans.

Some of the recommendations resulting from the divisional service reviews; builds on the work already in train, i.e. reduction in agency spend, to support our continued progress to reduce inefficiencies.

Divisions have identified schemes worth £11.5m to date, of these £2.1m are non-recurrent. To meet the £12.5m recurrent target we need to identify a further £1m of savings in 2017/18 and increase the FYE of savings by £2.8m. For 2018/19, the plan is currently based on the balance of savings identified in the PWC phase three report of £12.2m.

4.5. Implementing the Carter recommendations

The work already in progress on implementing the Carter recommendations supports the opportunities identified by the Phase 3 work, and will help to build our plans for the next 2 years.

Carter milestones and deliverables have been incorporated into divisional and service line plans developed as part of this two year operational plan. Work groups and detailed plans have been agreed for specific elements of the implementation which do not have direct divisional responsibility, these are the areas of Agency spend, Pharmacy and Procurement.

Each UHMB oversight Group will ensure the Carter recommendations are implemented via the following agreed processes as outlined in the table below:

Table 10: Trust overview of the Carter recommendations & implementation

Tracking	Progress tracked against each Carter recommendation on a monthly basis. Timely submission of data to support the model hospital through the PMO, working with Finance and other directorates as required
Oversight	Preparation and implementation of UHMB detailed plans to achieve the Carter recommendations.
Reporting	Will take place monthly at the Finance Committee and the Sustainability Board
Escalation of Risks	Will take place through the Sustainability Board and PMO

Data submissions	Named lead responsible for the preparation of each national return

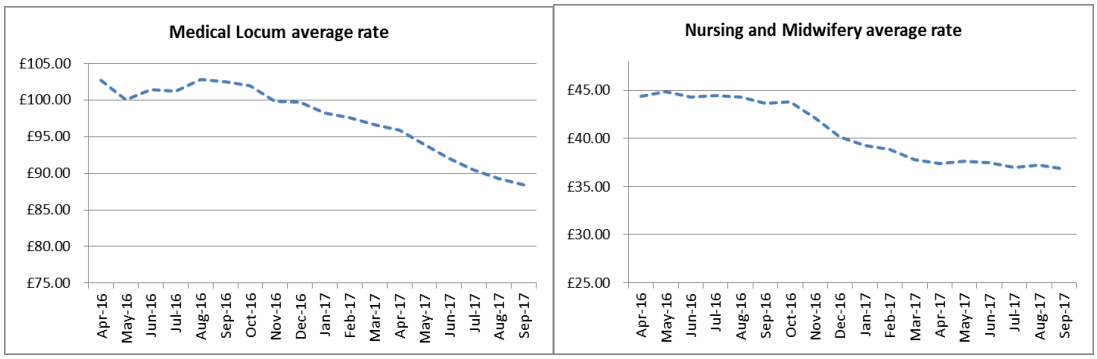
4.6. Effective use of the Agency Rules

Having a quality, sustainable and substantive workforce is at the core of UHMB planning, therefore, managing Agency spend is critical on UHMB journey to financial sustainability and providing the best care to our patients.

The Trust has been set a total expenditure ceiling for £20.9m for financial year 2016/17 by NHS Improvement. This ceiling will also be in place until the end of this operational plan. The Trust has made significant achievements within 2016/17 to date outlined within the appendices.

The two diagrams below outline the progress to date on hourly rates for nursing and locum agency spend. This trajectory and direction forms the basis for UHMB planning for the FY 17/18 & 18/19.

Diagram 4: Trajectory for medical locum and nursing spend 2017/18



4.6.1 Future Plans to make effective use Agency Rules

The Trust's plans are centred on the safe implementation of the NHS Improvement (NHSI) agency rules; and to strive for full compliance with the agency rules and to maximise the saving efficiencies which have been exclusively based on the detailed plans implemented within the full year (FY) 2016/17.

Going into FY 2017/18 & 2018/19, we plan to build upon these existing plans to continue to achieve the key objectives around agency spend:

- Recruitment of substantive staff;
- Compliance with NHSI agency capped hourly rate (medical, nursing & non-medical, non-clinical);
- Compliance with use of NHSI approved framework Agencies;
- Reduction of "break glass" shift rates.

In June 2016, we established an agency use Programme Board, chaired by the Director of Workforce, reporting into a newly established Cost Control Board, chaired by the Deputy Chief Executive and Director of Finance. Our plans are centred on the continued use of these two oversight groups to ensure delivery of the objectives.

Managing Agency spend is a critical element of the Trust's plans and it is vital that the rigorous processes established are continued. UHMB plans do not deal with Agency spend as a single stand-alone issue and our detailed plans are co-ordinated with the Trusts wider Workforce plans and are outlined in appendix 5.

4.7. Procurement

Our procurement strategy is a vital enabler in allowing the Trust to optimise its non-pay expenditure, by providing the highest quality goods and services for patient's at the most competitive price available.

The key focus for the delivery of maximising efficacy and CIP are based on:

- A developed procurement transformation plan, which is collaborative in nature;
- Adoption of Procurement as a strategic tool & function;
- Health system approach to Procurement;
- Contributing to a transformational approach to clinical & non-clinical services
- Embedding and delivering the concepts & opportunities with the national "model hospital";
- Use of Purchasing Price Index Benchmarking tool (PPIB);
- Implementation of Global Standards (GS1) for tracking (bar coding) of patient supplies and therefore improve the quality and robustness of patient care. To support the GS1 implementation, the Trust will strive to work to the Pan European Public Procurement (PEPPOL) standards to ensure that we are in line with all providers to deliver the same standards and specifications nationally for patients.
- Increased use of managed service and outsourcing during the next two financial years. Each strategic procurement which is either a managed service or outsourcing contract, will be have to be approved by the Trust Board before the start of any procurement.
- The use of Procurement, as an enabler, to act as the catalysis for different approach to clinical procedures.

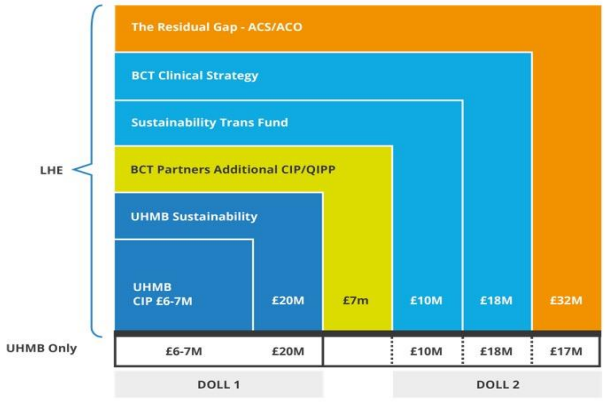
The procurement schemes identified so far for 2017/18 are outlined within Appendix 6.

4.8. Supporting the Local Health Economy to deliver Efficiency Savings for 2017/18 to 2018/19

At the heart of the planned efficiency savings for financial years 2017/18 and 2018/19 are the Trust strategies around delivery of a different model of care via the BetterCareTogether (BCT) strategy evolving into a shadow Accountable Care System (ACS), with the creation in the future of an Accountable Care Organisation.

Efficiency saving for UHMB need to be also viewed via the lens of a local health economy (LHE) and the efficiencies planned by adopting a system wide solution, the following diagram gives an overview of the planned efficiency savings as a Trust and the contribution from a health economy perspective as well:

Diagram 5: Efficiency savings model for UHMB & BCT



UHMB plans for delivery of the efficiency savings are focused on the 3 key headings: operational efficiency, Agency Spend and Procurement.

4.9. Capital Planning

The Trust has a 10-year forward horizon for capital spend within which a 5-year plan has been developed. It is important to note, that without access to distressed funding, the Trust will not be able to deliver the Capital Plan, solely within its own capital resources. This addresses identified risks and business-as-usual expenditure, and the 2-year Operational Plan comprises some specific schemes totalling £18m which includes:

- Completion of new maternity unit at FGH, to meet recommendations of the Kirkup Report;
- Improvement of the resuscitation unit at FGH, to meet a CQC recommendation;
- Improvement of the neonatal unit at RLI, to meet revised standards of care;
- Creation of space for a larger multi-disciplinary team for patient discharge and community support, to meet Better Care Together plans;
- Replacement of the Day Theatre Unit at RLI, to meet modern standards and allow capacity for a rolling programme of closure and upgrade of other theatres;
- Expansion of the Acute Medical Unit at FGH, to resolve a clinical vulnerability;
- Relocation of the Ambulatory Care Unit at FGH, to improve patient flow.

These schemes were all part of the original Trust's Estates *Strategy 2015-25*, which aimed to address clinical vulnerabilities and operational inefficiencies. The strategy required a high level of central Department of Health (DH) support over the period, and although some extra support was given as loan finance in late 2015-16 the DH indicated in summer 2016 that the Trust should re-assess its ambitions. Three smaller options were assessed against quality criteria by a team including senior clinicians, and a *Revised Estates Strategy 2016-26* has been adopted by the Trust. In broad terms, the capital schemes which meet clinical vulnerabilities have been secured into the new document, whilst many of the capital schemes that would improve efficiencies and improve patient experience cannot now be justified as outlined in table 11.

Table 11: Strategic Capital Schemes for 2017/19

Strategic schemes by clinical division during the Plan period 2017/ 19	
Core Clinical	
Acute & Elective Medicine	Offices at FGH for the discharge team Medical Assessment Unit at FGH Ambulatory Care at FGH Resuscitation unit at FGH
Surgery & Critical Care	Day surgery unit at RLI
Women's & Children's	Maternity unit at FGH Neonatal improvement at RLI

The Trust also has many schemes of backlog building and infrastructure work totalling £6m each year, which have been identified as high and significant risks on the Trust's Risk Register. We also have a rolling programme at £4m a year of backlog replacement of medical equipment that is well past its normal lifespan, which is managed to allow for immediate purchases when something fails in use as outlined in table 12.

Table 12: Capital budgets for 2017/19

Capital budget headings	**2017-8** **£m**	**2018-9** **£m**
***Revised Estates Strategy* schemes**	8.1	10
Clinical Improvement schemes	2	2
Backlog building schemes	6	6
Information Technology schemes	2	2
Medical equipment purchases	4	4
TOTAL SPEND	22.1	24
***Less* own resource including donations**	-12	-12
NET SPEND requiring DH support	**10.1**	**12**

Business as usual schemes include clinical improvements that respond to immediate needs as they emerge, and are an important part of the way the Capital Plan supports clinical divisions at £2m each year. Expenditure on Information Technology (IT) is also an essential component of the Plan, with the rolling programme for the upgrade of systems and hardware, plus innovatory work to improve efficiencies of both clinical and support functions.

The Trust manages capital spend through monthly meetings of a Capital Plan Group which all clinical divisions attend. Recognising that costs depend on detailed design and that conditions in the contracting market are not known when budgets are set, the group is empowered to manage schemes within the total allocations approved by Finance Committee and Board under the 5 headings of Strategic, Clinical Improvements, Backlog, Medical Equipment and IT. The procurement process is used to give the best result, including the use of P21+ management contracts for major schemes.

The Trust is not able to raise capital from sales and therefore looks for other opportunities to reduce pressure on the capital budget. The Trust intends to sign an operational lease with an energy-saving company during 2016-17, giving a saving in excess of £1m a year on energy costs before lease payments and a net present value to the Trust for the contract of £9m at current prices. For the same reason of seeking alternative funding structures where possible, the Trust intends to sign a concession with a carpark operator for a design-build-finance-operate scheme that will improve staff and patient parking at the RLI, once planning permission has been granted.

The length of individual asset lives is reviewed each year across the Trust's portfolio by its external valuation consultant, in the light of asset condition. This allows some beneficial changes to impairment costs each year.

5. Alignment to the Sustainability and Transformation Plan

The Healthier Lancashire and South Cumbria (HLSC) Sustainability and Transformation (STP) footprint comprises nine Clinical Commissioning Groups (CCGs), more than 200 GP practices, five acute NHS hospital trusts, a health and wellbeing trust and a single specialty learning disability trust. Social care is provided by Lancashire County Council and Cumbria County Council and the two unitary authorities of Blackburn with Darwen and Blackpool. Additionally, there is an active third sector supporting health and social care.

UHMBFT has been significantly engaged in supporting and contributing to the development of the STP. The STP programme of work reflects the ambitions of the Better Care Together Strategy: to deliver an appropriately resourced population health programme aimed at significantly reducing demand and improving health outcomes and quality of care through primary secondary and tertiary prevention; alongside a population based integrated out of hospital delivery model, including primary care, mental health, and social care. The combined impacts of these will enable a consolidated and reduced acute footprint.

The Trust's plans to develop an Accountable Care Organisation, through Bay Health & Care Partners, have a number of work streams which are directly aligned to delivering against the STP aims, below. The vision of Bay Health & Care Partners underpins the STP submission: to create a system that will take responsibility for the whole health and social care needs of the population within a single budget. The model will be to have a smaller, more productive hospital service working with integrated out of hospital services. This will ensure a focus on keeping individuals, families and communities healthy, developing capacity in general practice and community services. The benefits of the BHACP ACS development align to those of the STP, namely:

- Patients spending less time in hospital
- Shorter waiting times for hospital treatment
- People with ongoing conditions having more control over their lives
- Better communication between different parts of the NHS.

Our Local Delivery Plan (LDP) 2017/18 priorities will directly support the STP aims through a number of direct areas of focus:

- Sustainability is key to enabling the transformation plans. The LDP's reflects the need to return the system to aggregate financial balance (via an ACO control total management), with a stretching cost improvement programme. This includes the Trust delivering efficiency savings through actively engaging
  with the Lord Carter Provider Productivity work programme and complying with the maximum total agency spend.
- STP plans seek to ensure sustainability is achieved through support of implementation of standardised RightCare approach, which are being implemented by Bay partners in every locality.
- Effective out-of-hospital management of Ambulatory Care conditions and minimal PLCV activity will be directly supported by our focus on Out of Hospital developments. This includes development of integrated urgent care; Community Specialist Services; Self-care and Community Engagement; the Millom partnership.

- Our development of 12 Integrated Care Communities directly underpins the system ambitions to establish integrated care models in each LDP to effectively manage in the community the anticipated growth in demand for secondary care.
- The LDP Planned Care (in-hospital and community based) work streams such as referral and pathway support (advice & guidance, virtual clinics, PIFU, referral support) and integrated planned care pathways redesign support the STP implementation of short term high-impact secondary care measures to reduce demand on services.
- The LDP and the STP are both focussing on consolidation of acute physical and mental health services to ensure specialties will need to be delivered at the clinically correct scale within the necessary co-dependencies of related disciplines. A key part of the LDP focus is to develop plans to address the delivery of the most fragile clinical services, including review of wider service consolidation intentions.
- Active development of the Bay-system ACO has direct ambitions to introduce population health model at scale across the footprint. This will align with the STP plans to develop prevention strategies, comprehensive health promotion & well-being programme to support to people to co-produce health gains.

Although core elements, above, of the BCT Strategy form the basis of our contribution to the STP and underpin system change, there are a number of transformational programmes set out in the STP which are anticipated to have an impact on our local delivery plan. The most potentially significant of these are:

- **Acute and specialised work stream: -** The STP has set out a review of acute services resources to map interdependencies and agree priorities. This is detailed modelling work to review the options for optimal configuration of acute services, focusing initially on those services where a different delivery model will significantly improve clinical outcomes, those where workforce issues make it difficult or impossible to offer a robust service from multiple locations, and those services where rota consolidation may offer significant financial efficiencies. This will align with our own commitment to addressing the delivery of the most fragile clinical services.
- **Pathology: -** We are reviewing working with STP partners including consolidation options for pathology services. Quality improvements opportunities include sustainable staffing structures and the ability to develop pathology services to meet the future agenda, especially in relation to new technology deployments.
- **Back office:** - Our LDP aims to provide a common infrastructure to allow the sustainable delivery of clinical services to the population of Morecambe Bay. Development of these common platforms is a key work stream of the development of Bay Health & Care Partners. Detailed plans are being developed for areas such as procurement, IM&T and workforce, with high level opportunities potentially available in estates, finance, governance, communications and programme management office functions. These are
  likely to find areas of alignment with plans to develop back office efficiencies and opportunities across the STP.
- **Quality Priorities** - The STP sets out the wider system response to address the 9 national must do's described in the NHSE/NHSI planning guidance. The implementation of our local quality priorities directly aligns to system implementation plans in the following areas relating to achieving the access standards for: A&E; 18 weeks Referral to Treatment and the 31/ 62 day Cancer pathways.

6. Membership & Elections

When the Trust received its authorisation as a Foundation Trust the initial terms of office of the Public Governors were between 1 and 3 years. This was to ensure continuity of membership but also help with succession planning.

Public elections are held annually together with any Staff Governor vacancies that occur. The Trust has developed a candidates briefing pack supported by several briefing sessions for prospective candidates. At the briefing sessions there is an opportunity to meet existing Governors and the Company Secretary to learn about the role of a Governor. Expressions of interest in standing as a Public Governor remain strong and all recent vacancies have been contested.

The Trust has undertaken a market testing exercise for a new electoral provider. The exercise has been weighted to secure a provider who can provide additional particular support with the recruitment and nomination process and can help encourage voter turnout and support the delivery of the Membership Strategy.

The Membership Strategy was last updated and agreed in January 2015 and a review is underway. The Membership Strategy was the subject of wide consultation with the membership.

NHS Providers have supported the Governors in undertaking a review of their effectiveness that included a work stream on how governors could improve who they engaged with members and the public. Several membership engagement events have taken place over the last 12 months including Membership Talks on hospital services. Governors are actively involved in Membership recruitment and most recently Governors are undertaking presentation in the community and in particular meeting voluntary and 3rd sector groups.

The format of this year's Annual members meeting was revised to provide greater opportunity for the public and members of the trust to meet both the Board and Governors of the Trust and learn more about our plans for the future.
Through the Membership Strategy 2016/18 will see efforts made to recruit a membership which is more representative of the population served by the Trust including recruitment in more rural areas.

The BayWay
SHAPING A BETTER FUTURE

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bettercare together