

Annual Planning Review submission for 2015/16 – operational plan redacted summary**1. Establishing strategic context****1.1. Strategic context**

Blackpool Teaching Hospitals NHS Foundation Trust operates within a regional health economy catchment area that spans Lancashire and South Cumbria, supporting a population of 1.6 million. The Trust provides specialist tertiary care for Cardiac and Haematology services across this region; a range of acute services to the 330,000 population of the Fylde Coast health economy and the estimated 11 million visitors that visit the seaside town of Blackpool each year; and a wide range of community health services to the 440,000 residents of Blackpool, Fylde, Wyre and North Lancashire.

1.2. Financial position at the end of 2014/15

The Trust faced an extremely challenging financial environment in 2014/15, downgrading its financial forecast in-year from a deficit of £1.3m to a draft deficit of £4.1m (before reporting exceptional items). However, the Trust delivered CIP of £20.3m (5.5%), achieved a CoS rating of 2 and ended the financial year with a cash balance of £25.1m. Key drivers contributing to this financial position are:

Workforce: Whilst progress has been made in increasing staffing levels, the Trust is currently unable to recruit to desired establishment levels, resulting in an over reliance on the use of contingent labour. This is an issue for medical staff and both qualified and unqualified nurses, caused by difficulties in recruitment into the Trust and long-term staff retention.

Increase in non-elective activity: The Trust achieved the A&E 4-hour standard across Q1 to Q3, although the Q4 standard was not achieved, with quarterly performance reported as 93.95%. The Trust experienced a growth of 6.7% in non-elective admissions between 2013/14 and 2014/15, predominantly in medical specialties, which has resulted in the utilisation of an increased number of temporary staff to meet the capacity requirements. Furthermore, the Trust has needed to utilise capacity in other organisations, such as care home and intermediate care beds, to meet this demand. A number of actions were implemented in 2014/15 and will continue into 2015/16, along with a further increase in medical staffing and the implementation of new models of care to support a reduction in A&E attendances and non-elective admissions.

Underperformance in elective activity: The RTT standards were not consistently achieved across 2014/15, with particular challenges faced in orthopaedics, cardiology, and gynaecology due to increased referral rates and restricted theatre and inpatient bed capacity. These pressures have been compounded across the winter period. Delivery of the RTT standards at specialty level during 2015/16 will be a challenge for gastroenterology in addition to the above specialties. Actions to address this include:

- Improved matching of demand and capacity through increased theatre utilisation, additional theatre sessions, increased day case rates / reduced LoS (e.g. using different surgical techniques, enhanced recovery pathways) and, where necessary, medical staff recruitment;
- Partnership working with other NHS providers;
- Use of independent sector providers where appropriate.

The cancer standards were not consistently achieved across 2014/15, due to peaks in referral rates (predominantly driven by national cancer campaigns and higher than average positive bowel cancer screening results) and increased case complexity, which are anticipated to continue into 2015/16. Actions to address this include:

- Improved matching of demand and capacity through proactive pathway management (including a review of all administrative processes), the introduction of new roles (e.g. Nurse Colonoscopist) and, where necessary, medical staff recruitment;
- Partnership working with other NHS providers, particularly regarding endoscopy services.

Quality: Whilst the Trust has achieved the trajectory for Clostridium difficile cases due to lapses in care, the number has been greater than desired and therefore the Trust commissioned an external review of its clinical processes during 2014/15. Although the target number of cases in 2015/16 has been set at 40 (due to lapses in case), the Trust considers this to be a priority area for improvement and has a number of actions planned and/or underway to improve C.diff rates in 2015/16:

- Bed area equipment replacement programme for high risk areas / areas of high prevalence;
- Optimisation of diarrhoea management;
- Rolling programme of deep cleaning, particularly in high risk areas / areas of high prevalence;
- Implementation of guidance regarding anti microbial practice ('Start Smart then Focus') and review of microbiologist capacity allocated to delivery of the HCAI;
- Re-launch of the Infection Prevention & Control programme with staff, patients and visitors;
- Expansion of cross organisational working with CCGs to review and embed joint working, and share best practise / lessons learned actions.

The resulting financial impact is an underlying deficit which, when added to the further investments required for patient safety / quality and the latest nationally mandated changes for 2015/16, means that it is unlikely that the Trust will return to a surplus in the one-year planning period even with delivery of above sector average CIP.

1.3. Commissioning and contracting for 2015/16

The Trust's strategy and key priorities are well aligned with its two main commissioners (NHS Blackpool CCG and NHS Fylde and Wyre CCG), with a clear focus on the need to reduce demand for non-elective secondary care services and transfer services away from acute settings into community-based settings wherever clinically possible.

The Trust has selected the Enhanced Tariff Option, which has been agreed with its two main commissioners. Furthermore, the Trust's preference is a move away from historic local contract terms and instead is seeking agreement to the implementation of national terms and conditions across all aspects of the contracts with its two main commissioners. Key areas for local agreement are the levels of investment that are required to achieve:

- RTT at specialty level;
- Appropriate management of an increase in demand for non-elective services (in secondary care and/or community settings, globally and/or for segmented patient groups), including the impact of the Better Care Fund, benefits delivered by new models of care, and the non-elective threshold baseline period;
- Increased demand for diagnostic services;
- Improvements in quality and safety, including a further reduction in mortality and infection rates.

1.4. Progress of strategic initiatives

The Trust (along with partners in the health and social care economy) has made significant progress with its Fylde Coast Out of Hospital strategy during 2014/15:

- All partners (commissioners and providers of physical and mental health, and social care) are committed to the implementation of New Models of Care;
- A New Models of Care Programme Board is well established, with executive representation from all partners, including associated governance structures and assurance processes;
- International models of care have been translated into a localised clinical blueprint and implementation plans, with two sites scheduled to begin assessing patients in Q1 of 2015/16;
- Local commissioners have identified investment for 2015/16 to support the Extensive Care Service that will be hosted by the Trust;
- Recruitment into new clinical and non-clinical roles is underway;
- The implementation of a shared electronic patient record is underway – all patient records in EMIS are available to view by clinicians in A&E, AMU, medical wards, urgent care and out of hours GP services – and the use of EMIS by community-based clinical teams has commenced.

This progress is reflected in the Fylde Coast health and social care economy being selected as an Integrated Pioneer site during 2014/15, and subsequently being selected as a Vanguard site for the implementation of a Multispecialty Community Provider approach to care provision. This Vanguard proposal includes the implementation of an Extensive Care Service hosted by the Trust and Enhanced Primary Care services provided by local GP practices, with alignment of Trust and local authority provided services into neighbourhood teams.

Similarly, in the Lancashire North region (where the Trust provides community services), the Trust is a key partner in the delivery of a new approach to out of hospital care through the Better Care Together

Programme. This region has also been selected as a Vanguard site for the implementation of an Integrated Primary and Acute Care System approach to care provision.

The Trust has been an active partner in two Better Care Fund submissions – Blackpool and Lancashire – and has approved these on the basis that the requirements will be largely delivered through the existing commitment to implementing new models of care, predominantly the Extensive Care Service, and therefore any financial risk of non-achievement sits with the CCGs.

Through the Better Care Now programme (which encompasses various service redesign / improvement schemes across in-hospital and community-based services), the Trust has continued to implement standardised clinical pathways, remove delays to diagnostics and/or treatment, and expand the types of service that are offered in non-acute settings.

1.5. Resilience and sustainability – strategic review

The Trust has undertaken an internal review of its position in relation to resilience and sustainability, assessing its performance against locally assumed definitions that are aligned with Monitor's descriptions.

Regarding resilience, the Trust has considered its performance during 2014/15 across a range of clinical, operational and financial indicators (e.g. Monitor Risk Assessment Framework, CQC Intelligent Monitoring Report, CQC inspection ratings, CoS Rating) and assessed the key areas of risk identified in its Board Assurance Framework. Although 2015/16 will be a challenging year, particularly if the increases in non-elective activity continue, the Trust considers that it will be resilient during this short-term planning period.

Regarding sustainability, the Trust has considered its performance during 2014/15, and identified key factors influencing this both within the Trust and across the wider local / regional health economy. These include the need to reduce the reliance on contingent labour, improved matching of capacity and demand for elective and non-elective services, improved integration and streamlining across the urgent / emergency care pathway, and an increased understanding of the financial position of each clinical service. Coupled with the need to making ongoing efficiencies, the Trust considers that in a 'base case' scenario, it would not be sustainable across the longer-term five year planning period.

Given this, along with the changes to the external environment that are likely to occur through the introduction of new models of care linked to the Five Year Forward View (and participation in two Vanguard sites) the Board of Directors has identified the need to refresh the current strategic plan. The Trust has committed to the use of internal and external resources in the completion of a detailed strategic review, using the approach outlined in Monitor's Strategy Development Toolkit. The first phases (diagnose and forecast) will be completed during April / May 2015, and will include engagement with clinical and operational teams.

2. Progress against delivery of the strategy

2.1. The Trust and LHE partners' response to the Five Year Forward View

The Fylde Coast health economy has been successful in its expression of interest to become a Vanguard site for 2015/16 in relation to the implementation of a Multispecialty Community Provider approach to care provision. The vision for the Fylde Coast is to create new models of care, wrapped around local populations, spanning across health and social care, to improve jointly the health and wellbeing of the Fylde Coast population, whilst maintaining financial stability. Initial analysis of the Fylde Coast population shows that a substantial proportion of the healthcare resources are spent on a relatively small proportion of patients, notably those with multiple long term conditions. Detailed review of successful international models has shown an opportunity to deliver different models of care. Principle changes will be the integration of community services, social care and appropriate secondary care resources with primary care. This integration will reduce hand-offs, enable effective sharing of information and reduce the reliance on unplanned, reactive care that is currently delivered in a fragmented way. This Vanguard proposal includes the implementation of an Extensive Care Service hosted by the Trust and Enhanced Primary Care services provided by local GP practices, with alignment of Trust and local authority provided services into neighbourhood teams.

In the Lancashire North region (where the Trust provides community services), the Trust is a key partner in the delivery of a new approach to out of hospital care through the Better Care Together Programme. This region has also been selected as a Vanguard site for the implementation of an Integrated Primary and Acute Care System approach to care provision. The CCGs are keen to develop new contracting models that more closely link providers to the same goals and outcomes. The first step is that for 2015/16 a joint CQUIN will be in place across acute, community and mental health providers.

2.2. Strategic initiatives

The key strategic initiatives that are reflected in the one-year plan are related to the introduction of an Extensive Care Service and the continued implementation of the Better Care Now programme (which encompasses various service redesign / improvement schemes across in-hospital and community-based services).

Extensive Care Service: The Trust's strength in implementing this innovative model of care is its provision of both acute and community healthcare services, affording the opportunity for integrated ways of working that facilitate an effective transition between community and secondary care. In addition, the local health economy has modern primary care centres located in the neighbourhoods that can readily be used to support the transition to community-centred care.

The Trust will work in partnership with its two local CCGs and Local Authorities to implement the service across the Fylde Coast, designed around the needs of local patient populations and aligned to neighbourhoods. The model will initially focus on patients that are aged over 60; who have two or more long term conditions from the following: heart failure, atrial fibrillation, congestive heart failure, COPD, diabetes and dementia; and who have a risk score of ≥ 20 . This risk score is calculated by considering the patient's number of long term conditions, other health / social risk factors, and their interaction with secondary care services in the past 12-months. The risk score is an indication of their likelihood of non-elective admission in the coming 12-months.

Future deployments will be tailored to each neighbourhood, with some focused on a frail, elderly (aged > 60) cohort of patients with multiple long term conditions, and others focused on a cohort with health needs caused by social and behavioural issues. All variations are underpinned by a multi-disciplinary care team, led by an extensivist (usually a generalist consultant physician), that has well-defined holistic responsibility for an individual's care – this includes overseeing care provision if a patient should require treatment in a hospital setting. Each extensivist will be responsible for managing a group of c.500 patients, coordinating disease specific care programmes and general intervention programmes (from existing service provision such as community heart failure services or End of Life care), with care taking place at locations that are matched to the needs to the individual and cohort of patients (e.g. domiciliary visits, primary care centres, care homes).

Better Care Now: The Better Care Now programme encompasses various service redesign / improvement schemes across in-hospital and community-based services, including the continued implementation of standardised clinical pathways, the removal of delays in accessing to diagnostics

and/or treatment (particularly therapy services), and an expansion in the types of service that are offered in non-acute settings, with a specific theme related to 'alternatives to hospital'.

2.3. Productivity, efficiency and CIP programmes

The Trust has planned to deliver cost savings of £20.6m in 2015/16. This figure is the minimum necessary in order to be confident of maintaining financial stability, with an acceptable level of liquidity. The target CIP figure of £20.6m has been derived from financial modelling of various scenarios, discussions with the Board of Directors and Divisional Management Teams, and a table top exercise to review those areas identified as having productivity and/or efficiency opportunities. The figure is considered to be a realistic albeit challenging target.

This significant level of cost savings, coupled with the requirement to ensure continued improvement in the quality and safety of clinical services and the need to introduce new models of working in alignment with the Trust's strategic direction, means that the robust processes used to support the management of cost savings in 2014/15 will be continued during 2015/16. This will include the continued use of a Programme Management Office (PMO), led by a full time CIP Director, to ensure that governance and assurance processes are maintained from ideas generation through to benefits realisation. Each proposed CIP scheme (traditional or transformational) will require the completion of a Project Initiation Document and accompanying Risk and Quality Impact Assessments prior to submission to the PMO. The scheme will be assessed by a cross-functional team of Executive Directors and Deputy Directors for its impact on quality, safety, workforce, financial performance and strategic alignment, with the opportunity for veto if significant concerns are raised in any of these areas. Once approved, the tracking of planning, implementation and benefits realisation will be managed through an overview and scrutiny process that is led by the Chief Executive as chair of the CIP Programme Board

The key aims of the CIP process are to:

- Provide a means of holding to account those responsible for delivery of CIP.
- Manage the delivery of sustainable financial balance through the identification and implementation of CIP schemes.
- Provide assurance to the Executive Directors that work is being undertaken to deliver the key financial sustainability targets, within a context that does not compromise delivery of safe, high quality clinical care.
- Provide a robust but fair challenge to the planning and performance of the programme ensuring that all projects have clear objectives, performance indicators, key milestones, savings targets (including phasing), timescales and accountability.
- Provide summary reports that highlight areas of concern and resultant contingency plans that have been implemented to mitigate the risks associated with the delivery of planned savings.
- Receive
 - updated financial plans and associated workforce impact summary reports showing the overall progress of the savings programme through an agreed CIP Tracking Tool;
 - detailed exception reports from the lead directors/managers and divisional finance manager for each project that is indicating a red or amber RAG status for delivery
 - a summary of the Quality Impact Assessment of CIP plans
- Identify and resolve potential conflicts that may arise between projects and the overall strategy of the Trust to deliver financial balance by year end whilst maintaining commitments to quality and service delivery.
- Recommend that additional projects are added to the programme of work so that risks to the delivery of financial break-even are minimised.
- Assess the need for extra resource to be provided to projects that are underperforming but which are key to success.
- Communicate progress and news of the savings plan to the wider organisation.

An initial assessment of the areas of opportunity across the Trust has been completed, with a number of traditional and transformational CIP schemes identified. These include a range of cross-divisional (and in some cases LHE-wide) transformational schemes that in the majority of cases are clearly aligned with the strategic direction of the Trust:

- A reduction in unnecessary attendances (A&E and outpatients) and admissions (inpatients)
 - Introduction of 'alternatives to hospital' schemes
 - Introduction of new models of care (linked to Vanguard scheme)

- Review of outpatient processes
- Optimisation of length of stay
 - Review of care pathways (both in-hospital and out of hospital)
 - Introduction of 'alternatives to hospital' schemes
- Improvements in the productivity and efficiency of operating theatres (including pre-operative assessment)
- Improvements in the procurement of goods and services (including medicines management)
- A review of workforce opportunities
 - Increased substantive recruitment and an associated reduction in premium labour spend
 - Management structures
- Partnership working
 - Joint working with other provider for pathology services
- Income generation
 - Improved clinical coding
- Estates rationalisation

These are supplemented with smaller, divisionally led schemes and transactional CIP schemes.

2.4. Capital programme

The Trust has introduced a Capital Strategy Group, chaired by the Director of Finance and Performance and with representation from clinical and operational teams, which reports directly to the Finance Committee. The main objective of the group is to assess and prioritise all capital expenditure proposals and ensure that any investment is aligned with the strategic direction of the Trust. The group considers maintenance capital (routine replacement of existing equipment and reorganisation or rationalisation of existing building infrastructure) and development capital (investment into new build initiatives or equipment which will increase the underlying asset base and will therefore require separate financing. This will only be agreed through approval of a full business case).

The Capital Strategy Group requests the following subgroups to assess and prioritise relevant maintenance capital investment requirements:

- Strategic Development Group (estates and buildings);
- Medical Devices Steering Group (clinical equipment);
- Health Informatics Committee (information and communications technology)

3. Plan for short-term resilience

3.1. Quality priorities

3.1.1. Quality goals and priorities

The Trust's quality goals remain focused on the provision of safe, high quality care and have not changed from 2014/15: All patients and carers involved in decisions about their care; Zero inappropriate admissions; Zero harms; Zero delays; Compliance with standard pathways.

Its quality priorities for 2015/16 have been agreed following consultation with Trust staff and governors, local CCGs, Healthwatch, and local Health and Scrutiny Committees, and are aligned with the standards outlined in the NHS National Outcomes Framework:

| NHS Outcomes Framework Quality Domains (2015/16) | Trust priority indicators / actions for Quality Improvement (2015/16 and 2016/17) |
|---|---|
| Domain 1: Preventing people dying prematurely | <ul style="list-style-type: none"> • Reduce premature mortality from the major causes of death; • Improve compliance with pathways implemented during 2013/14 & 2014/15; • Implement clinical pathways for further high mortality conditions. |
| Domain 2: Enhancing the quality of life of people with long term conditions | <ul style="list-style-type: none"> • Enhance quality of life for people with dementia and improve outcomes by ensuring that 90% of patients aged 75 and over are screened on admission. |
| Domain 3: Helping people to recover from episodes of ill-health or following injury | <ul style="list-style-type: none"> • Improve Patient Reported Outcomes Measure (PROMs) scores • Reduce emergency readmissions to hospital within 28 days of discharge |
| Domain 4: Ensuring that people have a positive experience of care | <ul style="list-style-type: none"> • Improve the Trust's results in the CQC National Inpatient Survey across five key questions related to treatment. • Improve staff survey results regarding recommending the Trust to friends or family needing care. • Improve the experience of care for patients at end of life |
| Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm | <ul style="list-style-type: none"> • Achieve 95% Harm Free Care through the following scheme <ul style="list-style-type: none"> ○ Risk-assessment for VTE ○ Reduced incidences of Clostridium Difficile and MRSA ○ Increased reporting of, and acting upon, patient safety incidents (including falls, medication errors, and hospital / community acquired pressure ulcers) |

3.1.2. Existing quality concerns and plans to address these

Local Keogh review: In 2013/14 the Trust was selected to undergo an external review into the quality of care and treatment it provides as part of the Keogh review of Trusts with high levels of mortality. Key areas of focus identified during the review were the recruitment of clinical staff and the implementation of standardised clinical care pathways. Both of these have seen improvements during 2014/15, with a resultant reduction in mortality rates, and further actions are planned for 2015/16:

- Continued recruitment of clinical staff in alignment with NICE Safe Staffing Level guidance across inpatient wards and wider clinical services;
- Continued implementation of the Better Care Now programme, which draws together all quality and safety initiatives under one scheme with key strands focused on workforce, pathways and delays;
- Implementation of new standards for medical care and record keeping, coupled with further introduction of electronic ways of working (such as electronic prescribing and medicines administration);
- Continued use of Nursing and Medical Care Indicators (NCI / MCI) to assess and review clinical quality, with MCIs focusing on an in depth review of clinical teams. This is an innovative approach which will be used to contribute to appraisal, revalidation, training and development.

Care Quality Commission (CQC) inspection: The Trust received an inspection from the CQC in January 2014, with the outcome report received in March 2014. Its acute services received an overall rating of “requires improvement”. Key compliance actions that were identified, along with associated ongoing plans to address these, are:

- **Incident reporting and learning from incidents**
 - Review of incident reporting processes, and introduction of ‘you said – we did’ feedback;
 - Introduction of a revised training programme to increase competency in incident reporting;
 - Upgrading of IT desktop hardware to support improved access for incident reporting.
- **Quality of record keeping and access to information in patient records**
 - Quarterly audit to identify particular areas and/or professional groups where focus is required;
 - Implementation of an electronic document management system and electronic patient record.
- **Higher than expected rates of post partum haemorrhage / high rate of hysterectomy**
 - ROCG review undertaken and action plan implemented, including human factors training, team development and leadership training, and monthly multidisciplinary meetings to review performance and identify areas of focus;
- **Appropriate levels of clinical staffing**
 - Continued recruitment of clinical staff in alignment with NICE Safe Staffing Level guidance across inpatient wards and wider clinical services;
 - Improved links with the Higher Education establishments and Health Education North West to support staff recruitment and retention.

In addition, the Trust will continue its participation in the national Sign Up To Safety campaign, which aims to reduce avoidable harms in the coming three years, with a local focus on four key areas: falls, pressure ulcers, clinical pathways and care of the deteriorating patient.

3.1.3. Key quality risks

Mortality: The Trust has had high reported mortality levels (SHMI) for the past three years. Since 2012, a series of distinct workstreams has been developed to improve the provision of safe, harm-free care as well as ensuring that national mortality ratios accurately reflect the Trust’s position. Continued action in relation to this is described above.

Local demographics: The local population has considerable levels of deprivation and transience, is older than the national average, and has a low life expectancy. High rates of smoking, alcohol consumption and drug use contribute to increased prevalence of long term conditions. These factors result in a hard-to-reach population in relation to ill-health prevention, ownership of self-care, and education on appropriate places to receive care. Changes to models of care and partnership working with primary and social care providers, and the voluntary sector, are being progressed to support the local population.

Workforce: Whilst there has been progress in increasing staffing levels, the Trust is currently unable to recruit to desired establishment levels, resulting in an over reliance on the use of contingent labour. This is an issue for medical staff and both qualified and unqualified nurses, caused by difficulties in recruitment into the Trust and long-term staff retention.

The Trust has historically had a doctor-to-bed ratio that is lower than the national and North West average. During 2014/15 this has improved but remains below target.

3.1.4. Operational requirements

3.1.5. Non-elective services and waiting times in the Emergency Department (A&E)

The Trust achieved the A&E 4-hour standard across Q1 to Q3, although this was a significant challenge and will remain so into 2015/16. The Q4 standard was not achieved with performance reported as 93.95%. Plans to ensure that this standard can be maintained in 2015/16 include increased partnership working with local primary and social care providers, coupled with improved integration across acute and community services, to reduce the flow of patients into the hospital and ensure timely discharge for those who are admitted. This will include an extension in scope of the Primary Care Assessment Unit and continued implementation of the Better Care Now campaign to remove unnecessary delays. Staffing levels have been increased in the Emergency Department during the night, with the paediatric area now in use 24/7, and further staffing investment is planned. Patient flow through the acute wards will be improved through an increase in consultant medical input into the Acute Medical Unit (AMU) and increased registrar staffing during the night, the introduction of prescribing pharmacists, the development of a dedicated DGH cardiology service, continued focus on daily 'board rounds', and a restructuring of the bed management team.

Underlying growth in non-elective admissions associated with demographic and epidemiological changes means that the current service model for adults, particularly the frail elderly population, is not sustainable. The Trust experienced a growth of 6.7% in non-elective in 2014/15, predominantly in medical specialties. Medium-term plans to manage this across the LHE include an expansion of existing admission-avoidance schemes across a wider geographic area following successful pilots, for example development of multi-disciplinary care pathways for at-risk patients, in-reach support from community nursing and therapy teams to local care homes, an increase in IV therapy services in community settings (an increase in volume and type of treatments), and an increase in the geographic coverage of rapid response teams. Long term plans are linked to the Trust's strategic plan to transfer care from acute to community settings with the establishment of an holistic health and social care model to support frail elderly patients and those with multiple long term conditions. Supported by individual care plans and evidence-based care pathways, a reduction in A&E attendances and non-elective admissions is predicted.

Similar issues have been identified in children's services, with an increasing number of referrals to the Children's Assessment Unit. The Trust is working in partnership with the local CCGs, and other local secondary care providers, to implement standardised pathways of care for the management of children's health and social care that will support primary care professionals to make appropriate choices in urgent / emergency situations.

3.1.6. Elective services including Referral To Treatment (RTT) and cancelled operations

The Trust is committed to providing high quality, safe care in a timely manner and expects that all patients referred to the hospital will receive their first treatment within 18-weeks of referral. Referral To Treatment (RTT) for admitted and non-admitted care is used as a measure of clinical service capacity and delivery of high quality care. The RTT standards were not consistently achieved across 2014/15, with particular challenges faced in orthopaedics, cardiology, and gynaecology due to increased referral rates and restricted theatre and inpatient bed capacity. The Trust experienced significant pressure in achieving the waiting time standards for diagnostic cystoscopies. The increased pressure on the service compromised the performance measure of 99% of all patients waiting a maximum of six weeks for their diagnostic tests. The Trust did not achieve this standard in Q1 and Q2 of 2014/15, but has consistently met the standard from November 2014 onwards. Delivery of the RTT standards at specialty level during 2015/16 will be a particular challenge for gastroenterology in addition to the above specialties, and the Trust faces potential financial penalties if this is not achieved.

In order to achieve the 18-week RTT standard at specialty level, the Trust will need to continue to respond to changing patterns of demand. To mitigate risk and address capacity issues, a combination of actions will be taken including creation of additional internal capacity, and identifying opportunities to redesign pathways and create new ways of working. This will be achieved through increased theatre utilisation, additional theatre sessions, increased day case rates / reduced LoS (e.g. using different surgical techniques, enhanced recovery pathways) and, where necessary, medical staff recruitment. Key CIP schemes for 2015/16 will review the operational efficiencies of outpatient clinics and operating theatres which will improve the matching of demand and capacity. However, the Trust has performed consistently well in maintaining an annual average of less than 0.64% for the number of reportable cancellations compared to the total number of elective procedures undertaken.

The Trust has reviewed its access policy and re-launched the 18-week training guide, with over 400 members of staff now trained and plans in place for annual refresher training for all teams. The Scheduled Care Division will continue to utilise a tracking system that identifies current and forecasted performance levels across each of the three component parts of the RTT pathway and the activity and income performance of each speciality.

In partnership with local CCGs, care pathways for high volume conditions and interventions of lower clinical value (ILCV) are in development, with agreed referral criteria from primary to secondary care and well-defined treatment plans across the pre-assessment, treatment, recovery and follow-up stages of the pathway. In support of this, some clinical specialties will see community based services acting as a central referral point (e.g. MSK service) whilst others will benefit from the introduction of prehabilitation services or improved surgical techniques. These schemes will introduce a level of demand management for elective services, promote 'readiness for surgery' being managed within primary care, ensure that treatment plans follow national best practice guidelines, and optimise length of stay in an acute setting.

In alignment with the Trust's strategy to provide increasing community-based care, outpatient activity associated with the management of long term conditions will be moved away from the acute setting wherever possible. Instead, this will be provided through an enhanced primary care model, or an holistic health and social care service that is centred on frail elderly and those patients with multiple long term conditions. In addition, minor procedures / treatments that are currently undertaken in an acute setting will be managed in an increasing number of ambulatory care settings.

3.1.7. Cancer services

The Trust continued to experience challenges in the delivery of the cancer standards in 2014/15, with standards not consistently achieved throughout the year. This is due to peaks in referral rates (predominantly driven by national cancer campaigns and higher than average positive bowel cancer screening results) and increased case complexity, which are anticipated to continue into 2015/16. Actions to address this include improved matching of demand and capacity through proactive pathway management (including a review of all administrative processes), the introduction of new roles (e.g. Nurse Colonoscopist) and, where necessary, medical staff recruitment. The Trust will continue its partnership working with other NHS providers, particularly regarding endoscopy services.

The Cancer Services Team will continue to work collaboratively with primary care clinicians and Cancer Network Teams to implement plans for 2015/16. The Trust is committed to developing the quality agenda around cancer treatment with the local CCGs, and key areas of focus include 'routes to diagnosis' to improve the quality of cancer 2-week wait referrals into the Trust, working with other providers within the LHE to improve the flow of referrals, ensuring that all patients referred to a tertiary centre are at day 42 in their pathway, and responsive capacity and demand reviews to ensure sufficient capacity is in the system to address increased demand as a result of national and local cancer campaigns.

3.1.8. Diagnostic services

The level of capacity across diagnostic services is a key factor in the delivery of operational standards relating to cancer services and RTT. The radiology department has experienced a further year of increasing demand in 2014/15, and this is forecast to continue in 2015/16. Particular capacity issues have been identified in MR imaging and in reporting times across plain-film imaging. To manage the levels of demand, 12-hour days in the MR imaging service have been introduced. The Trust has plans to recruit additional consultant radiologists during 2015/16, and these roles will be supported by advanced practitioner plain film reporting radiographers. This will provide an increased ability for radiologists to attend MDTs, and will continue to improve reporting timeframes.

The radiology department is undertaking a full review of processes across administrative tasks, direct patient contact and reporting with the anticipation that this will increase capacity across all modalities. Coupled with a workforce review which aims to redesign roles to allow staff such as reporting radiographers to be responsible for duties historically undertaken by radiologists, this will allow the department to manage the further increase in demand within existing resources. The transition to electronic ways of working, including requesting and protocolling, will enable enhanced demand management.

The pathology service also continues to experience an increase in demand, with difficulties in recruitment to a histopathologist role. Similarly, the pathology department will undertake a workforce review which aims to redesign roles to allow scientists, nurses and supporting technical staff to undertake enhanced roles.

3.1.9. Specialist services

The Trust is a provider of specialist tertiary care for Cardiac and Haematology services, which are commissioned by NHS England through Specialised Commissioning. The Trust is working with the Specialised Commissioning Team and other providers in shaping the future service provision across the region.

3.1.10. Key operational risks

Continued increase in demand for non-elective services and the ability to manage surges in demand: The Trust experienced a growth of 6.7% in non-elective admissions between 2013/14 and 2014/15, predominantly in medical specialties, which has resulted in the utilisation of an increased number of temporary staff to meet the increased capacity requirements. Should a similar increase be experienced in 2015/16, the Trust will experience significant difficulties in meeting required activity levels, particularly if driven by surges in demand.

A number of actions were implemented in 2014/15 and will continue into 2015/16, along with an increase in medical staffing and the implementation of new models of care to support a reduction in A&E attendances and non-elective admissions. The Trust is working in partnership with its local CCGs and GP practices in the development of its Out of Hospital Strategy for the Fylde Coast.

Workforce: As outlined above, the Trust is currently unable to recruit to desired establishment levels, resulting in an over reliance on the use of contingent labour. Key actions to address these issues in 2015/16 include:

- Review of recruitment materials / employment packages, and a continuation of the overseas recruitment campaign;
- Participation in a 'deep dive' project to research nursing retention;
- Establishment of a Great Place To Work (GP2W) Group, focusing on the cultural change required to improve staff experience and engagement at work;
- Continued development of a strategic partnership with a medical recruitment agency;
- The introduction of establishment control and vacancy trackers;
- The use of alternative roles such as Physician Associates and use of AHPs in roles traditionally undertaken by nurses, and increased usage of Trainee Assistant Practitioners, Trainee Advanced Practitioners, and Apprenticeships;
- Multidisciplinary student education placements in new services (e.g. Rapid Response Team, research and development, Care Home Support Team).

The Trust has assessed its current capabilities against the NHS England Seven days a week standards. The findings are being used to understand the requirements necessary to implement seven day services and the further developments that are required to ensure the organisation can deliver integrated, safe care, seven days a week and meet the national clinical standards by 2017.

3.2. Financial forecasts

3.2.1. 2014/15 Financial Performance

The Trust faced an extremely challenging financial environment in 2014/15, ending the financial year with a deficit of £4.1m (before reporting exceptional items) compared to a planned deficit of £1.3m. The Trust ended the year with a cash balance of £25.1m and a CoS rating of a 2.

3.2.2. Development of the 2015/16 Financial Plan

The Finance Committee and Board of Directors have been involved / informed throughout the planning process. The key steps have included:

- Detailed budget and planning presentations from Heads of Department and Divisional Directors (both of which are clinical leadership roles) during December 2014 and January 2015;
- Discussions at Finance Committee between December 2014 and March 2015 including an extraordinary meeting in February 2015 to discuss the overall position and the tariff options available to the Trust;
- Presentation and discussion at the Strategy and Assurance Committee in March 2015; and
- Trust Management Team discussions from January 2015 to March 2015.

3.2.3. 2015/16 Income & Expenditure Plan

The planned Income and Expenditure plan is projecting a deficit of £11.3m. The Trust is forecasting to end the year with a cash balance of £7.8m and CoS rating of a 1.

The key assumptions underpinning the 2015/16 income and expenditure plan are as follows:

Activity and Income

The 2015/16 activity and income plan includes:

- The 2014/15 forecast outturn activity as a foundation to adjust for known / predicted changes to activity and in turn ensure the Trust has the required levels of capacity to remain resilient throughout 2015/16;
- The Enhanced Tariff Option and the impact of this within the 2015/16 plan;
- The Trust has assumed that it will receive 70% of tariff for all non-elective activity above the threshold and has included the impact of this within its 2015/16 plan. Similarly, a marginal rate of 50% for over performance on specialist commissioned work has also been assumed;
- The operational and quality targets are fully met and no financial penalties stipulated in the contracts are applied.

Pay Expenditure

Over 65% of the Trust's operating costs relate to the workforce. The 2015/16 expenditure plan for pay includes:

- The impact of changes to the income plan, both activity and non-activity related including the introduction of a secondary care cardiology service to reduce length of stay and improve patient outcomes for patients with heart failure;
- Pay awards and incremental drift as outlined in the most recent guidance;
- Changes to pension commitments as outlined in the most recent guidance;
- Consultant contract commitments;
- Further investment in acute nursing following a Trust-wide establishment review;
- The required investment in community nursing.

Non-Pay Expenditure

The 2015/16 expenditure plan for non-pay includes:

- Budgets uplifted for known / assumed inflationary pressures;
- Calculated impact of NHSLA costs (following the national removal of the risk management discount);
- Further investment in quality and safety schemes, such as equipment replacement.

2015/16 Pressures & Service Developments

The Trust has set aside resources for 2015/16 pressures and service developments

CIP

The Trust is continuing to build upon the success of CIP delivery in 2014/15 (with delivery of £20.3m) and is targeting delivery of £20.6m in 2015/16. However, the Trust has included a figure of £19.2m in its assumptions. This allows for some in-built contingency / slippage within the plan.

Capital Expenditure

The Trust has introduced a Capital Strategy Group, chaired by the Director of Finance and Performance and with representation from clinical and operational teams, which reports directly to the Finance Committee.

The objectives of all capital investment schemes are to act as enablers to meet the Trust's strategic objectives associated with:

- Reducing avoidable admissions and readmissions by transferring more services into the community and linking clinical information systems;
- Ensuring all clinical equipment is reviewed to ensure quality and safety standards are met;
- Ensuring appropriate length of stay;
- Enabling a swifter move towards 7-day working across all professional groups.

This includes the need to:

- Develop a modern, efficient and right size acute hospital environment;
- Rationalise the community estate to ensure it enables, rather than hinders, the clinical objectives of placing more patient care in the community rather than hospital setting;
- Ensure the Trust leverages maximum value out of surplus land and buildings for the long term benefit of the Trust.