To:	**Trust Board**
From:	**Director of Strategy**
Date:	**26th April 2012**
CQC regulation:	**All Applicable**

Trust Board Paper D

Title:	**2012/13 Annual Plan**

Author/Responsible Director: Abi Tierney, Director of Strategy & Innovation

Purpose of the Report:
To present the updated and finalised Trust's 2012/13 Annual Plan

The Report is provided to the Board for:

Decision	X	Discussion	
Assurance		Endorsement	X

Summary / Key Points:
We presented an Annual Plan to our Trust Board on April 5th and it was approved subject to closing the financial gap of £5.8m and addressing a number of qualitative points as captured in the minutes of the meeting. This updated Annual Plan shows a planned 2012/13 surplus of £0.05m. This gap has been closed primarily by further work on Cost Improvement Programmes that at the time of presenting the previous plan were either RAG rated red or pending.

Key updates since 5th April:

(a) Section 7.1 has been extended to explain how the 5 critical safety actions will be monitored. Further detail will provided to the Trust Board following a meeting that is taking place on April 24th;
(b) We were asked to consider attaching the Emergency Care Network (ECN) plan to reduce emergency attendances, as this was a crucial element of UHL's own plans. This has not been attached as it is a detailed plan but can be provided separately;
(c) We have included more explicit reference to UHL's approach of actively encouraging patient complaints/concerns in section 3.5.1;
(d) We have included an explanation (in section 7) as to why the Trust's target for WHO checklist usage was 97% rather than 100% (mirroring the explanation provided to the March 2012 GRMC);
(e) We are working as a Board to re-energise UHL's OD plan and as part of a session planned for May 18th we will agree how the plan will be delivered, including measures to empower and engage staff in that delivery;
(f) We are also developing a communications plan, which will include a summarised version of the more detailed section;
(g) We have augmented the 'key risks' section to include mitigating actions.

Recommendations:
To approve the 2012/13 Annual Plan.

Previously considered at another corporate UHL Committee?

Presented to:

- March 28th Finance and Performance Committee.
- March 29th Governance and Risk Management Committee.
- March 30th Trust Board.
- April 25th Finance and Performance Committee.
- April 5th Trust Board.

Strategic Risk Register	**Performance KPIs year to date**
Yes.	Delivery will be monitored through the Quality and Performance (Q&P) Report and Provider Management Regime (PMR).

Resource Implications (eg Financial, HR)

The Financial and HR implications are summarised in Chapters 9 and 10 of the Plan.

Assurance Implications

Yes.

Patient and Public Involvement (PPI) Implications

Public and patient involvement in the development of the Annual Plan is summarised in the Executive Summary.

Equality Impact

An Equality Impact Assessment has been or will be completed for the 2012/13 service developments where appropriate.

Information exempt from Disclosure

None.

Requirement for further review?

We will review and monitor achievement against our Annual Plan through the following mechanisms:

- The Q&P Report.
- The PMR which will be reported to the Trust Board on a monthly basis, and tracks performance against national and contractual targets and standards.
- The Tripartite Formal Agreement which tracks Foundation Trust Application progress on a monthly basis and is reported to the SHA.
- The Transformation Board which will monitor and support the delivery of our transformation work streams.
- Individual programme boards will monitor the delivery of the key service developments.

University Hospitals of Leicester NHS
NHS Trust

Annual Plan

2012 - 2013

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1 Executive Summary

1.1 Review of 2011/12

Our performance and delivery in 2011/12 was dominated by two winters. Our recovery from winter 2010/11 was too slow, and we kept open extra capacity supported by premium staffing costs for too long. The 2011/12 bed closure programme was the right thing to do but we recognise that it was not supported by transformation in our processes. Therefore, when 2011/12 winter arrived and we experienced an increase in activity we have had to open up additional capacity for longer than we had anticipated. This time we have done this without increasing our agency costs but the knock on impact is that our staff have done more than it has been reasonable to expect in order to cope. This is reflected in deterioration of our staff survey results, weak cultural indicators and clinical engagement has been tested as a result.

1.2 Quality

Given the challenging year we have had, we are extremely aware of the potential impact on quality. We have therefore undertaken a review of quality indicators over the past winter. The findings are that mortality is within seasonal expectations and incidents of falls, pressure ulcers and infections are lower than previous years. However, we have found that patient complaints have increased even though the results of our patient polling are steady. We therefore believe that demand pressures over winter have had a negative effective on patient experience but no measurable effect on mortality or clinical outcomes.

1.3 Priorities for 2012/13

We are clear that in response to our performance in 2011/12 we most refocus on our core purpose to provide Caring at its Best. This purpose will drive our organisation over the coming year, and this will be underpinned by the following priorities:

- improve patient experience
- enhance clinical quality
- strengthen staff engagement
- transform the emergency care system
- build transformational capability
- develop a sustainable site and service reconfiguration
- deliver all operational targets
- achieve financial sustainability
- deliver a successful FT application

As a result of significant work with partners across Leicester, Leicestershire and Rutland (LLR) to develop a shared vision, 2012/13 will see us working with stakeholders to design and deliver a local health system which cares for people when and where they need it most. This means redressing the imbalance between care that is provided in hospital and care that is provided in the community. It means looking after people and especially older people in ways which prevent them having to go into hospital.

1.4 Financial Plan

Budgeted income for next year is £707.5m and our total costs are £707.45m, giving a nominal surplus of £50k.

Within the income and costs we have assumed that we will deliver on £27m of cost improvement schemes which our divisions have risk rated and cleared to go ahead this year.

In presenting this plan, we acknowledge that there are unavoidable cost pressures relating to maintaining a safe service in 2012/13. These arise particularly around our emergency care patient pathways which have been stetched in 2011/12. Based on our analysis, we are estimating that the incremental costs of these items and of increasing nursing ratios will be £8.3m. We have allowed for this critical investment in the plan.

Transformation schemes: The Trust is progressing a number of schemes which are designed to fundamentally change the way we work and in doing so both improve the service for patients and reduce the costs. The main ones are outpatients, theatres, readmissions and length of stay. Given the nature of these schemes it is more difficult to predict the quantum and timing of delivery. However, the plan currently assumes £5m delivery in year. We recognise clinical engagement is essential, and are therefore discussing support with our commissioners to ensure our clinical leaders have the capacity to lead transformation.

Overall, therefore, our financial plan assumes a CIP target of £32m, 4.5% of turnover.

1.5 Workforce

Reflecting on what has been an extremely difficult year, we genuinely believe that the work we do here in Leicester is a credit to the NHS and a credit to our staff. What we need to address is how we work together to create something which we can all, ultimately, be proud of.

We recognise that successful transformation relies on meaningful and effective staff engagement. Through our updated Organisational Development Plan (ODP), we will therefore do more to involve staff in decision-making and service improvement, ensure we consult and engage about changes impacting on their roles, provide regular constructive feedback, improve communication between senior managers and staff, and ensure everyone feels that their contribution is valued.

1.6 Patient and Public Engagement in the Development of the Annual Plan

The Trust engages with patients and the wider public in a number of ways to ensure that its annual plan reflects the needs of people using our services. Over the last year we have increased the numbers of patients completing our comprehensive inpatient survey and now survey well over a thousand patients every month. The survey provides a wealth of information on how people experience and rate our services and the treatment they received during their stay. This information not only provides a vital barometer for the quality of our services, it also ensures that patients' views are integral to the work of our Clinical Business Unit's (CBU) and divisional boards. As such, throughout the year we have been able to shape our planning around the experience and needs of our patients. Survey data is also shared each month with individual wards and departments which means that any areas for improvement can be quickly acted upon.

One of the cornerstones of our annual planning activity is the development of our Quality Account, which sets out our priorities for improving the quality of services over the coming year. To arrive at these priorities we have been actively seeking the input of members of the public. Early in 2012 our trust members, Local Involvement Network (LINk) members across the city, county and Rutland, our aspirant governors and our patient advisors were all invited to identify three quality priorities which they felt we should be focusing on in 2012/13. We were keen to include the perspective of people from our local Black and Minority Ethnic (BME) communities on this issue. As such we also approached participants in our recent programme of BME community symposia to contribute to the process. Responses gathered through this engagement have directly contributed to our priority setting and direction of travel. Indeed, two out of our three final priority areas were identified through our public engagement. The resulting Quality Account will be shared with our local Overview and Scrutiny Committees and LINk Boards for further comment in April 2012.

Throughout the development of the annual plan each CBU has taken its own approach to ensuring that its business planning is informed by patient views. This activity is captured in a dedicated section in the business planning template. Some have identified themes through our "Message to Matron" and "Postcards from Leicester" initiatives which offer patients, relatives and carers an opportunity to provide feedback on their experience. Some CBUs have based their planning on information from our inpatient surveys and consultation with patient representatives on CBU and divisional boards, while others, for example, cancer services, have drawn upon their engagement over the year with patient support groups.

Cancer services have also developed their own local patient surveys, as have our outpatients and orthopaedic teams. These “local” surveys provide an excellent source of patients’ views which can have a direct influence on our business planning, for example, when developing the plan for new operating theatres and the management of elective surgery our orthopaedic CBU sent questionnaires to patients to canvass their opinions. As a direct result of this patient feedback the CBU team took a decision to keep their outpatient clinics at Glenfield Hospital (GH) while concentrating surgery at the Leicester General Hospital (LGH) site as this was the preference of patients surveyed.

Our engagement throughout the year has proved invaluable in planning for the future. Our children’s cardiac service has recently benefited from an extensive programme of public engagement, which was particularly well supported by city and county LINks. The Trust has also assembled a Reconfiguration Board which oversees and coordinates much of the future planning of our services. This board includes the chair of our patient advisor group who not only provides a lay perspective but also advises on wider public involvement as we develop our services for the coming years.

Many of the boards and committees responsible for developing the annual plan benefit from the regular involvement of a patient advisor. Patient Advisors are members of the public who work within our CBUs to provide a lay / patient’s perspective in both strategic and operational groups. They are involved in gathering patients’ views and working with our staff to improve the experience of patients.

The views of Patient Advisors therefore help to shape the on-going development of our services and inevitably influence thinking around the annual plan.

2 Trust Profile

2.1 Key facts - Population Served, Range of Services Provided, Staff and Structure

We are one of the largest teaching hospitals in the country. We operate across three main sites and six satellite facilities.

We are the only acute trust serving the diverse local population of Leicester, Leicestershire and Rutland (LLR). This population is split as follows:

- Leicester City – population 304,722
- Leicestershire County and Rutland – population 685,100

We provide a wide range of services across our three sites, these are summarised in the following table:

Leicester Royal Infirmary	Leicester General Hospital	Glenfield Hospital
General Surgery	Elective Orthopaedics	Paediatric Cardiology
Gastroenterology	Urology	Cardiothoracic Surgery
Trauma	Nephrology	Respiratory Medicine
Obstetrics and Neonatal	Renal Transplantation	Breast Surgery
Well Babies	End Stage Renal Failure	Breast Screening
Emergency Gynaecology	Sports Medicine	Orthodontics
Rheumatology	Neurology	Restorative Dentistry
Diabetes and Endocrinology	Obstetrics	Adult Cardiology
Adult and Paediatric Accident and Emergency (A&E)	Elective gynaecology	Clinical Support Services
	Clinical Support Services	
Acute Medicine		
Paediatric Medicine & Surgery		
Oncology and Radiotherapy		
Ear, Nose & Throat (ENT)		
Ophthalmology		
Maxillofacial Surgery		
Vascular Surgery		
Plastic Surgery		
Clinical Haematology		
Dermatology		
Infectious Diseases		
Genetics		
Genito-Urinary Medicine		
Immunology		
Stroke Medicine		
Elderly Medicine		
Clinical Support Services		
Central location for Pathology		

Figure 1: Services available at the University Hospitals of Leicester main sites

During 2011/12, we delivered 10,795 babies, and treated 180,972 inpatients and 638,401 outpatients. In our operating theatres 33,481 elective and 2,479 emergency operations took place.[1] In January 2012 we had 1,779 beds open (167 of these were additional capacity beds). During 2012/13 we will use 43 Operating Theatres.

[1]These are YTD figures at month 10

We currently have 10,078 staff based in substantive whole time equivalent (WTE) posts. We have 1,075 active volunteers, volunteering across a range of services including the Women's Royal Voluntary Service (WRVS), Chaplaincy and other groups such as the Radio Fox team.

Site Name	Staff WTE	Volunteer Headcount
Leicester Royal Infirmary (LRI)	5119	432
Glenfield Hospital (GH)	2397	180
Leicester General Hospital (LGH)	2392	288
Family Planning St Peters Health Centre	1	-
Harborough Lodge Renal	24	-
Peterborough Renal Unit	20	-
Loughborough Renal Unit	26	1
St Marys Hospital	19	-
Lincoln Renal Unit	26	-
Gwendolen House	52	-
Staff not identified by site	-	174
Grand Total	**10076**	**1075**

Table 1: Total WTE Staff numbers for all UHL sites and satellite units

Our clinical management is structured into four divisions, with each division led by a senior consultant, called the divisional director. Our four divisions are:

- Acute Care
- Planned Care
- Women's and Children's
- Clinical Support

Each divisional director has a medical background and works in a clinical environment as well as providing overall leadership for the Division. Alongside the director the divisions each have a head of nursing and a divisional manager. Across the four divisions we have fourteen CBUs based on core service lines. Each of these is led by a clinician, senior nurse and manager.

The clinical management of the organisation is supported by the following corporate directorates:

- Communications and External Relations
- Corporate Medical
- Finance and Procurement
- Human Resources
- Operations and Nursing
- Research and Development
- Strategic Development including Facilities and Information Technology (IT)
- Corporate and Legal Affairs

In 2011/12 our planned operating income was £680.3m and our planned expenditure was £679m.

3 Commentary on the Previous Year and the Delivery of Plans

3.1 Background

The expectation is that patients using National Health Service (NHS) services benefit from safe quality care, treatment and support due to effective decision making and the management of risks to their health, welfare and safety. Assessing and monitoring the quality of service provision is one of the Care Quality Commission (CQC) requirements (Outcome 16 – Regulation 10).

Although quality may mean different things to different people Lord Darzi defined three key domains of quality, namely:

- Clinical effectiveness
- Safety
- Patient Experience

In UHL we are awash with data, but we recognise that the utility of data sets is sometimes limited, both for assessing our changing performance over time and for assessing our relative performance with that of our peers (benchmarking). In other words we struggle to translate the data into insight, and we sometimes use data inappropriately either to provide false assurance or to raise concerns. We will therefore be undertaking a thorough review of our measurement processes and strategies to ensure we are focusing on the important indicators for our patients in 2012/13. We will be engaging with our commissioners in this review to ensure we develop a common data set, which both parties will recognise as useful and a fair representation of our performance.

This review of 2011/12 presents an objective analysis of a small number of key performance metrics which meet the necessary criteria to assess the current quality of care provision within the UHL setting. The indicators have been chosen as representative of the three domains of quality outlined above. Additional data is called upon where appropriate to supplement the conclusions drawn.

3.2 Context

As mentioned in the executive summary, our performance and delivery in 2011/12 was dominated by two winters. Our recovery from winter 2010/11 was too slow, and we kept open extra capacity supported by premium staffing costs for too long. The 2011/12 bed closure programme was the right thing to do but we recognise that it was not supported by the equivalent transformation in our processes. Therefore, when 2011/12 winter arrived and we experienced an increase in activity we have had to open up additional capacity for longer than we had anticipated. This time we have done this without increasing our agency costs but the knock on impact is that our staff have done more than it has been reasonable to expect in order to cope. This is reflected in a deterioration in staff survey results, weak cultural indicators, and clinical engagement has been tested as a result. Given the challenging year we have had, we are extremely aware of the potential impact on quality and safety.

Since December 2011 it is clear that the emergency care system within LLR has been under relentless pressure. UHL has been providing extra capacity beds in order to meet the additional emergency activity, and we have called a number of internal incidents related to capacity to deal with the pressure.

At the same time a number of clinician concerns, incident forms and complaints relating to the quality and safety of care have been raised by our staff both internally and externally, particularly in relation to care provided on medical wards at both the LRI and GH sites.

As a result of these concerns the CQC, undertook an unannounced inspection on the Acute Medical Unit (AMU) at the LRI and found in their judgement that there were ‘major concerns’ in relation to the care and welfare of people who use the service. They will therefore be issuing a warning notice and we will be required to formally respond. These concerns relate to information to patients who may wait on a trolley; the appropriateness of some of the patients transferred to a chair or trolley, the monitoring of the length of time a patient stays on a chair or trolley and the privacy and dignity of patients during this time.

There were also comments by the CQC in terms of medication supplies, the suitability of the clinic room and also mechanisms for staff to receive feedback when concerns were raised.

A number of improvements are taking place including more robust monitoring of waiting times and building works to expand the clinical area to provide more treatment and assessment space and more privacy.

Although the pressures on the organisation have appeared greater this year than before, there is a well-known seasonal variation in patient outcomes. Thus to ensure objectivity in reviewing the quality of the care we have provided over the past twelve months, a review has been undertaken of key indicators spanning several years.

The key indicators which were reviewed include mortality (as a robust marker of clinical effectiveness), incidents (as a durable marker of safety) and complaints and patient polling (as a robust marker of patient experience). The methodology of data collection for these indicators has been consistent over time.

3.3 Effectiveness/Outcomes

3.3.1 Mortality

A hospital's crude mortality rate looks at the number of deaths that occur in a hospital in any given year and then compares that against the amount of people admitted for care in that hospital for the same time period. The crude mortality rate can then be set as the number of deaths for every 100 patients admitted. What it tells you is how a hospital or a trust's mortality rate changes over time. In the case of our hospitals, our crude mortality rate has demonstrated 'seasonal variation' for the past five years with an increase in crude mortality being seen in December to February each year (Fig 2). The peak crude mortality in 2011/12 remains lower than in other years, as does the trough to peak change in crude mortality.

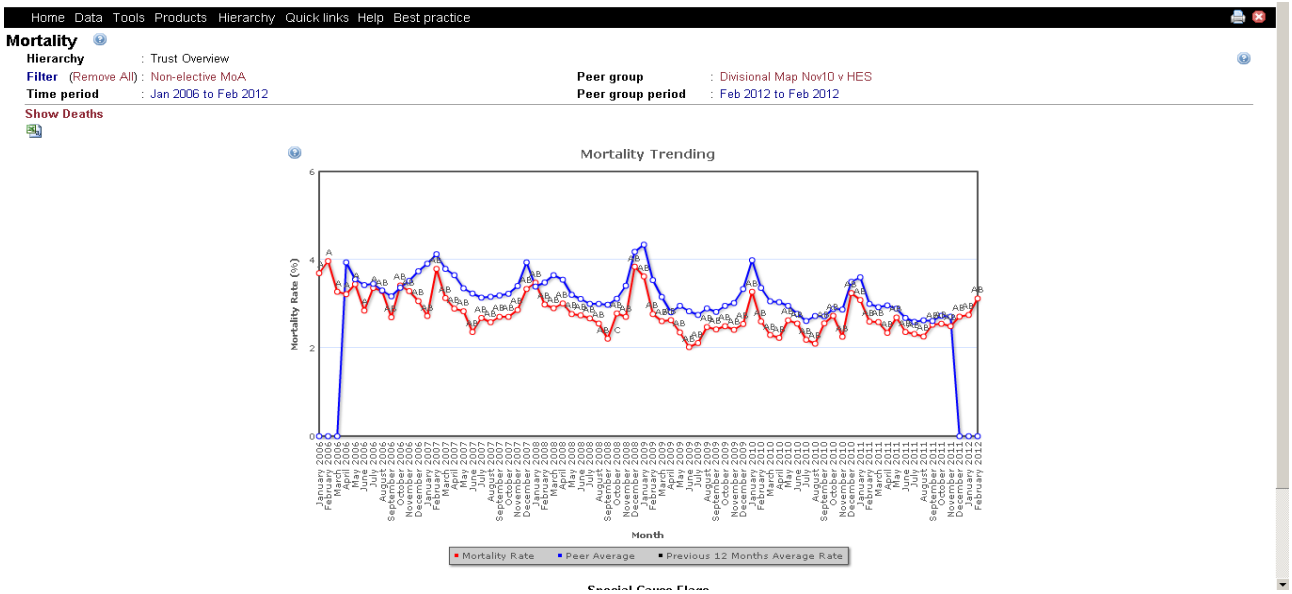

Figure 2: Non elective (emergency) crude mortality rates 2006-12

Our lowest crude mortality rate for emergency admissions was 2% in June 2009 and the highest was 3.9% in December 2008. In February 2012 the Trust's crude mortality for emergency admissions was 2.9%.

Over the 5 year period the trend in crude mortality is down. In addition we have a lower crude mortality rate than our peers.

The same pattern is observed when looking at our risk adjusted mortality rate, which compares our actual mortality rate to the mortality rate that would be expected given the characteristics of the patients that were treated.[2] The same pattern is also observed when benchmarking our risk adjusted mortality rate.

Our risk adjusted mortality index, using the Comparative Health Knowledge Systems (CHKS) methodology – Risk Adjusted Mortality Index (RAMI), has been 100 or below since February 2009. Our RAMI for February 2012 is 91.

The reasons for seasonal variation in crude mortality are complex but include a greater prevalence of life threatening illnesses (predominantly respiratory) in the winter months. In addition, patients aged over 85 year constitute an additional 1-2% of the emergency inpatient population each December/January.

Summary Hospital Mortality Index (SHMI) is the new hospital level indicator introduced in 2011. It uses a standard and transparent methodology for reporting mortality at hospital trust level across the NHS in England. Like all mortality indicators, the SHMI shows whether the number of deaths linked to a particular hospital is more or less than expected, and whether that difference is statistically significant.

UHL's SHMI for April 10 to March 11 was 106 which fell within an expected range when using the 95% control limits but was 'higher than expected' when using the more sensitive 99.8% control limits as displayed below. UHL's overall crude mortality rate is below other trusts with a much lower SHMI. This suggests that the complexity of patients' admission diagnosis and co-morbidities are not being adequately reflected in clinical coding and subsequent SHMI case mix adjustment. This theory has been supported by a case note review and therefore discussions have been held with the UHL coding manager about what can be done to support improvement of clinical coding.

In conclusion, mortality remains within control limits and we have not observed to date any variation outside that which might normally be expected seasonally. However this will remain the subject of intense scrutiny in 2012/13 through the clinical effectiveness committee.

3.4 Patient Safety

3.4.1 Incidents reported onto DATIX (Web Incident Reporting Tool)

There have been an increased number of incidents reported during 2011/12. However, the rate of incidents has remained fairly static for the 4 years. Despite this increased reporting of incidents, we have now moved from being in the top quartile of reporting trusts to just below the top, with our reported rate being 7.3 incidents per 100 admissions.[3] (The national median is 6.5 incidents).

This may in part be due to the increased scope of incident reporting. For example, to include hospital acquired pressure ulcers, confidential information breaches, and hospital acquired infections. It could also in part reflect the subsequent implementation of interventions to reduce such incidents.

Whilst the number/rate of incident reporting varies between quarters, there does not appear to be any pattern to the variation.

Although reporting for quarter 4 is not completed, there has been a marked increase in the number of Early Warning Signs (EWS) incidents reported from January to February (9 to 22). Several of the incidents refer to work load pressures affecting capacity to follow policy whilst others are about failure to recognise early signs of deterioration or to communicate observations that cause concern.

February data for incidents relating to inadequate staffing levels has also seen a significant increase from 74 in January to 134 in February.

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[2] Please note the dependence of risk adjustment on accurate coded clinical information within UHL, and also the dependence of comparative risk adjustment on Trusts using identical coding methodologies.

[3] National Patient Safety Agency report for 1 April 2011 to 30 September 2011.

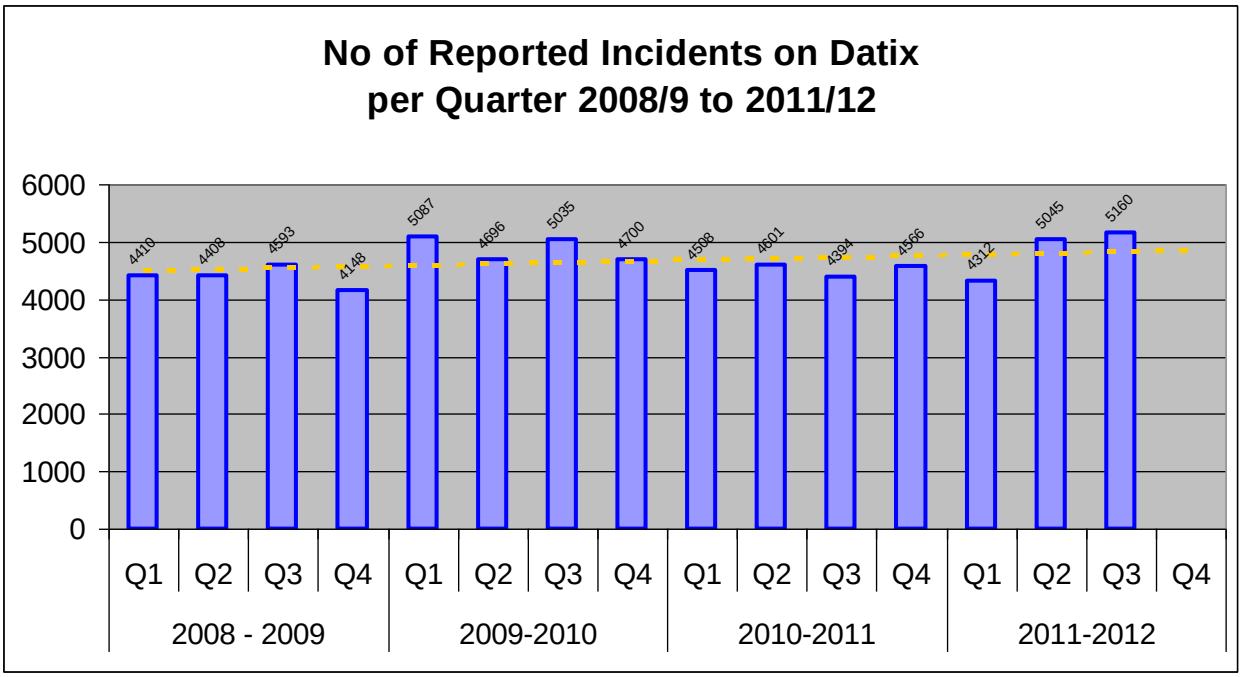


Figure 3: No of Reported Incidents on Datix per Quarter 2008/9 to 2011/12

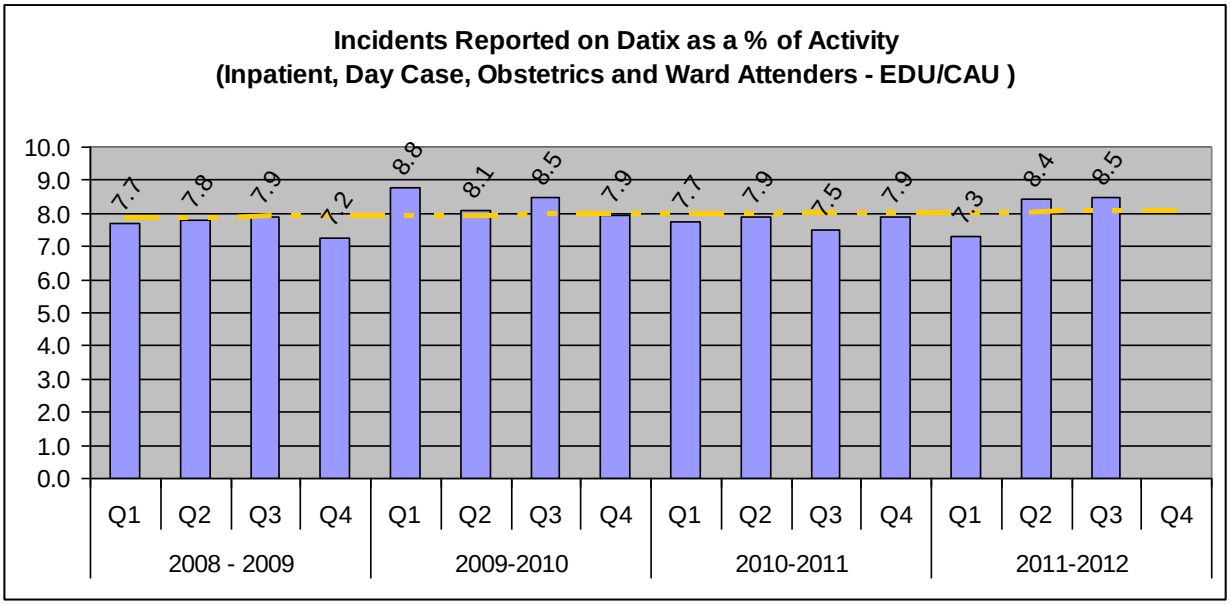


Figure 4: Incidents Reported on Datix as % of Activity

3.4.2 Serious Untoward Incidents (SUIs)

Whilst incidents and complaints do not appear to have a pattern of variation, it seems that the number and rate of SUIs follows a seasonal trend with an increase in both for quarter 3 and quarter 4. There has also been an overall increasing trend for both the numbers and rate of SUIs as shown in the figures below. The majority of SUIs relate to 10 x medication errors, suboptimal care of the deteriorating patient, not acting on EWS triggers or delayed diagnosis.

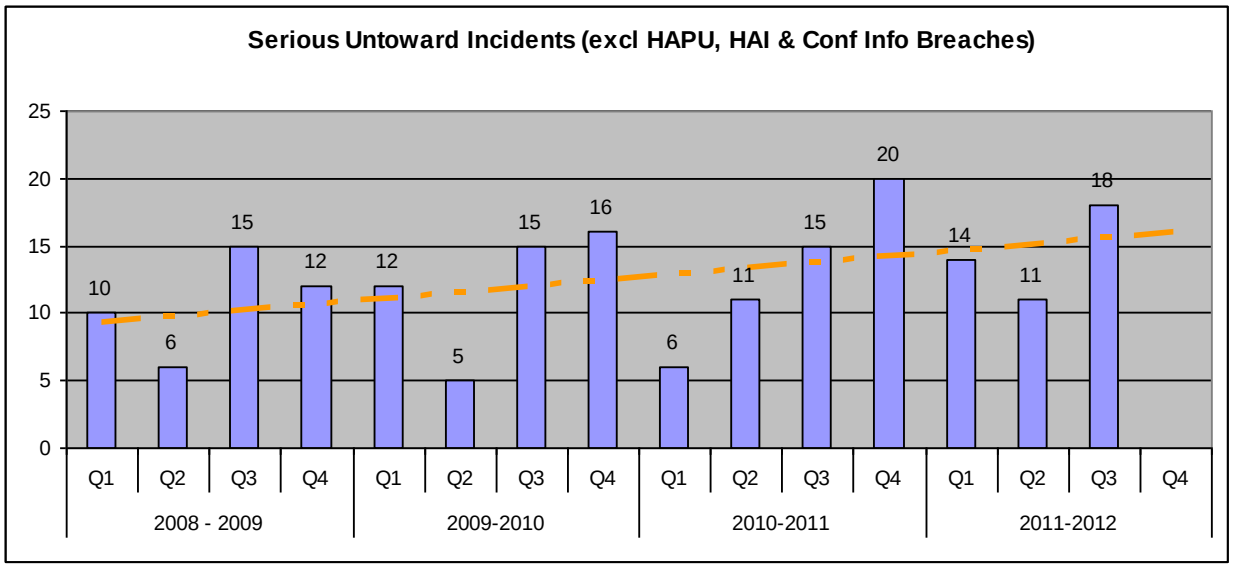


Figure 5: Serious Untoward Incidents

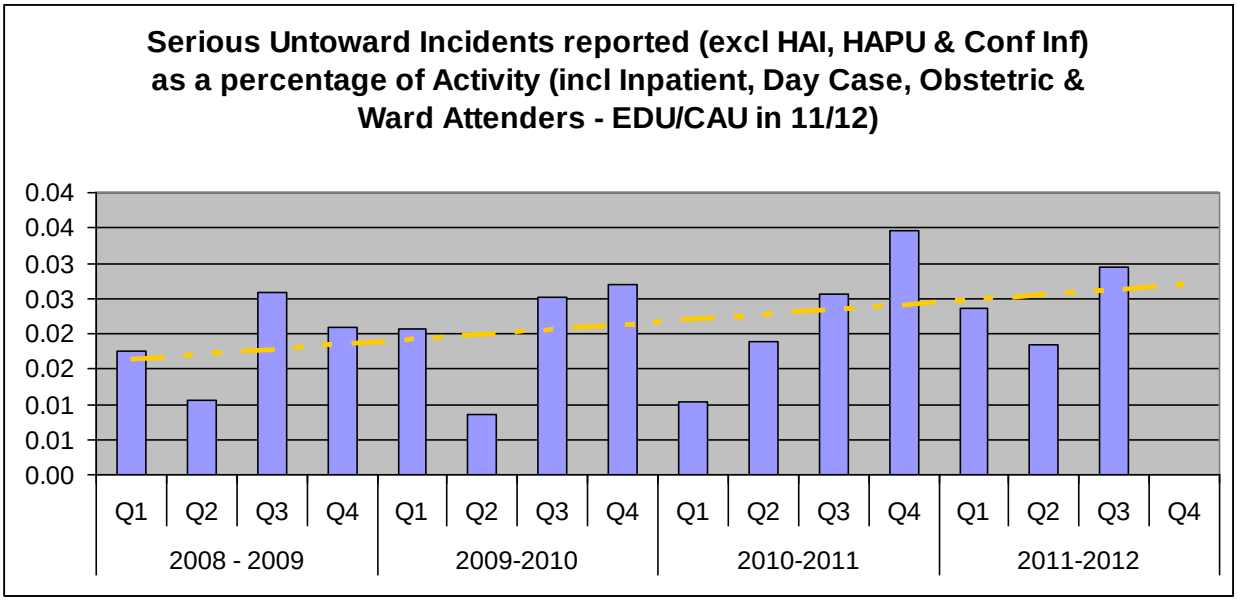


Figure 6: Serious Untoward Incidents reported as a % of Activity

3.4.3 Other Metrics

Other metrics which have been reviewed include pressure ulcers and in-hospital falls. However, it should be noted that the data collection does not go back beyond two years and these metrics have been subject to changes in definition, making meaningful comparison difficult.

Although there have been large 'in month fluctuations' in patient falls over the past two years, since December there has been a decrease in the number of recorded falls, such that the value in February 2012 is similar to that seen in February 2010. The following graph shows the reduction in falls recorded since January 2011:

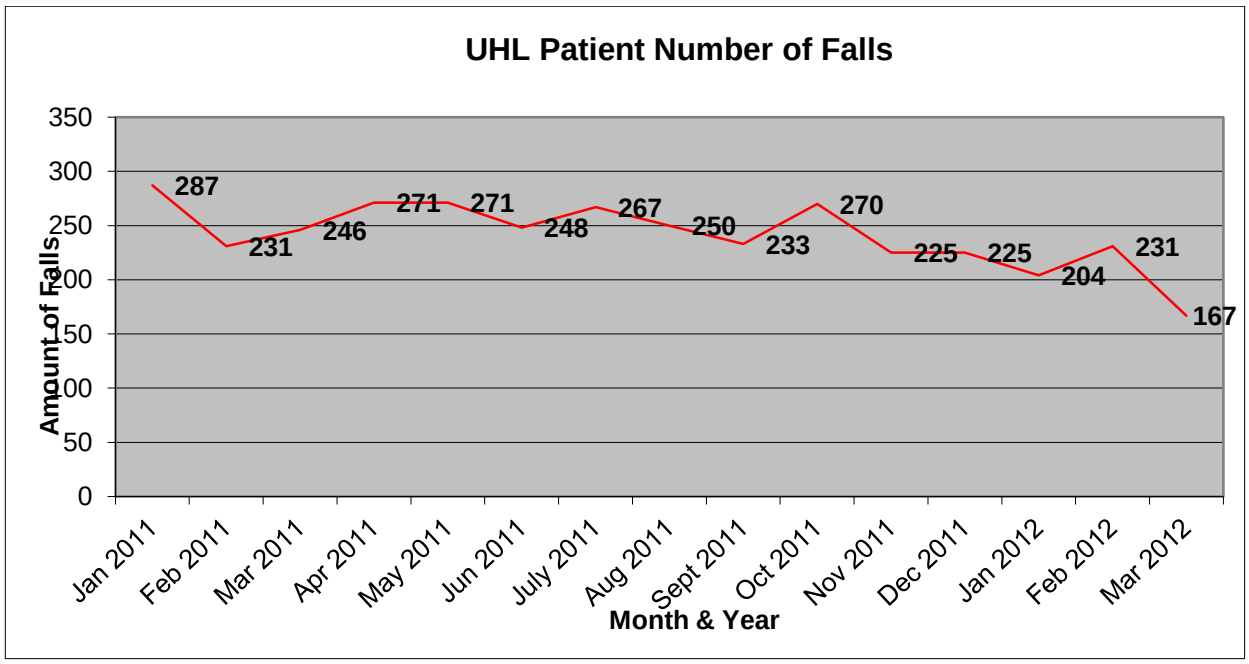


Figure 7: UHL Patient Number of Falls from Jan 11 - Feb 12 inclusive

Over the last 12 months we have made significant progress in reducing hospital acquired grade 3 and 4 pressure ulcers as illustrated in Figure 8 below. Between April 2011 and January 2012 we reduced the number of patients acquiring a pressure ulcer in hospital by 40%. Significant in month variation is also seen with respect to pressure ulcers, but overall the trend from 2010 to 2012 has been down.

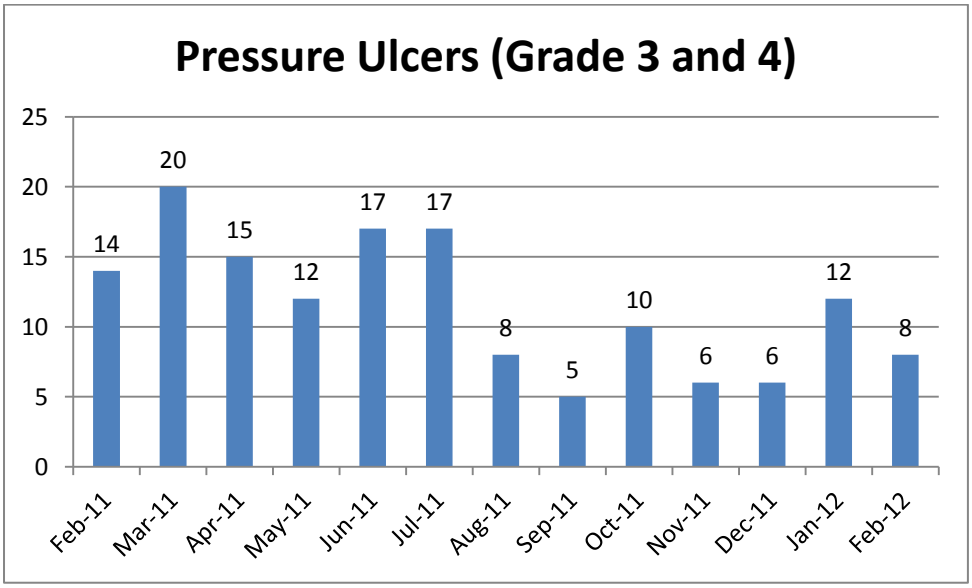


Figure 8: Pressure Ulcers (Grade 3 and 4)

MRSA and C.Diff rates have been subject to close scrutiny and have shown a significant and sustained reduction in rates over the past several years. The rate of decline of these markers has plateaued in the past year to be at an all-time record low level.

We have responded to the improvement target to get patients to theatre within 36 hours of their admission/diagnosis of fractured neck of femur. The monthly target is 70%, increasing to 75% by March 2012. During 2011/12, 65% of patients were operated on within 36 hours. The reasons for this shortfall have been analysed carefully and include:

- Insufficient theatre capacity to respond to peak demand, combined with inefficient use and preventable delays.

- Increase in admissions for fractured neck of femur by approximately 11%, coupled with increased emergency spinal activity which displaces fractured neck of femur patients.
- Some aspects of the agreed process are still not embedded into the clinical service.

In order to improve our position in 2012/13 we are considering increasing theatre capacity and establishing a dedicated ward for fractured neck of femur patients.

Many hospital patients are at risk from Venous Thromboembolism (VTE), where blood clots which form in the leg veins can break off and block blood vessels in the lungs. All acute trusts in England are required to assess 90% or more of their adult patients for their risk of VTE. We risk assess 93.9% of our adult patients and are one of twenty-two VTE exemplar sites in the UK. We have streamlined our pathways of care for patients who present with acute thrombosis by focussing on the safe use of anticoagulation therapy and attention to VTE prevention measures.

Quarter 1			Quarter 2			Quarter 3		
92.66%	93.55%	93.46%	94.51%	93.77%	93.83%	93.80%	94.47%	94.31%
	93.23%			94.04%			94.20%	

Table 2: Percentages of VTE Risk Assessments in 2011/12

To summarise our performance on patient safety, this analysis demonstrates that there has been an increase in the number of reported incidents and SUIs during quarter 3 and for January and February of quarter 4. For some incidents the numbers are lower than for the same time period in previous years (falls, pressure ulcers, infections) whilst for others there appears to be an increase (failure to act on high EWS scores). Activity pressures and staffing levels feature in several incidents for quarter 4 to date. As could be expected both of these issues are more prevalent in the Acute Division's emergency areas given the winter pressures.

3.5 Patient Experience

3.5.1 Complaints

There has been an increase in both the number and rate of formal complaints received since 2008/09. In previous years we have seen the rate fluctuating between 0.5 and 0.7, during 2011/12 the rate has remained at 0.7 for quarters 1-3.

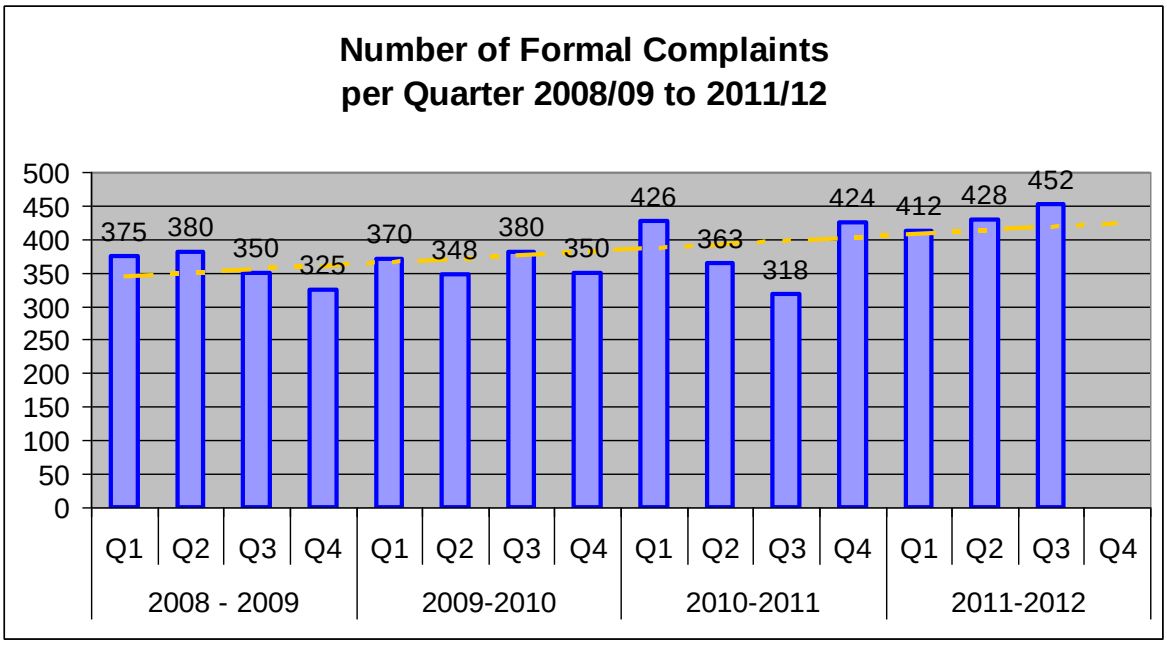


Figure 9: Number of Formal Complaints per Quarter 2008/09 to 2011/12

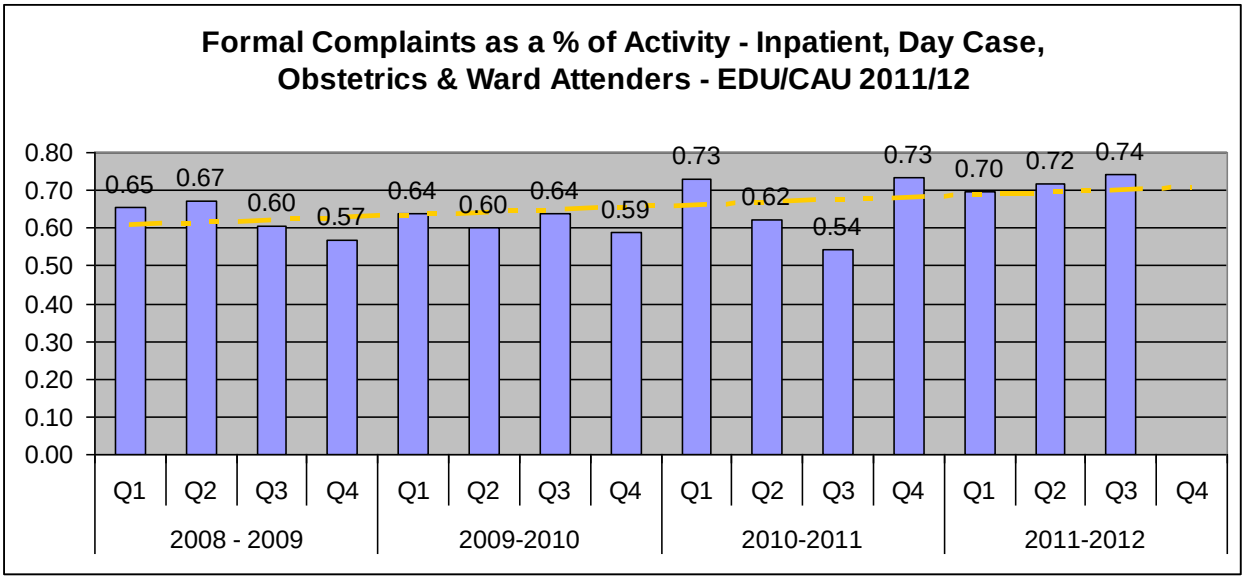


Figure 10: Formal Complaints as a % of Activity

The top 5 themes in complaints have not changed during the past 4 years and are as follows:

- medical care
- waiting times
- communication
- staff attitude
- nursing care

We have conducted a number of reviews of our complaints procedures in 2011/12 and new procedures to address complaints in a more efficient and timely manner are being introduced.

It is important to note that as a learning organisation we positively encourage the feedback and comments of patients and their relatives in relation to their experiences in our hospitals. We make contacting the Patient Information and Liaison Service (PILS) as easy as possible through the following mechanisms:-

- Calling the freephone number 08081 788337
- Email (pils.complaints.compliments@uhl-tr.nhs.uk
- Website (www.uhl-tr.nhs.uk/patients/support-and-advice/pils)
- In writing to the PILS or the Chief Executive

Information about PILS is also on the switch board link. This means that when anyone rings the hospital, whilst on hold they will hear about the service. Leaflets and posters are also displayed across all hospital sites, on wards and in clinics.

3.5.2 Patient Polling

Universal Patient polling only commenced in July 2010. It is therefore only possible to review this winter's results with those of last year. There does not however appear to have been a deterioration in patients' perception of 'overall care' or 'respect and dignity' during either winter periods. However, patient polling figures for Medicine suggest a reduction in satisfaction regarding patient experience, supported by an increase in complaints / concerns relating to medical wards.

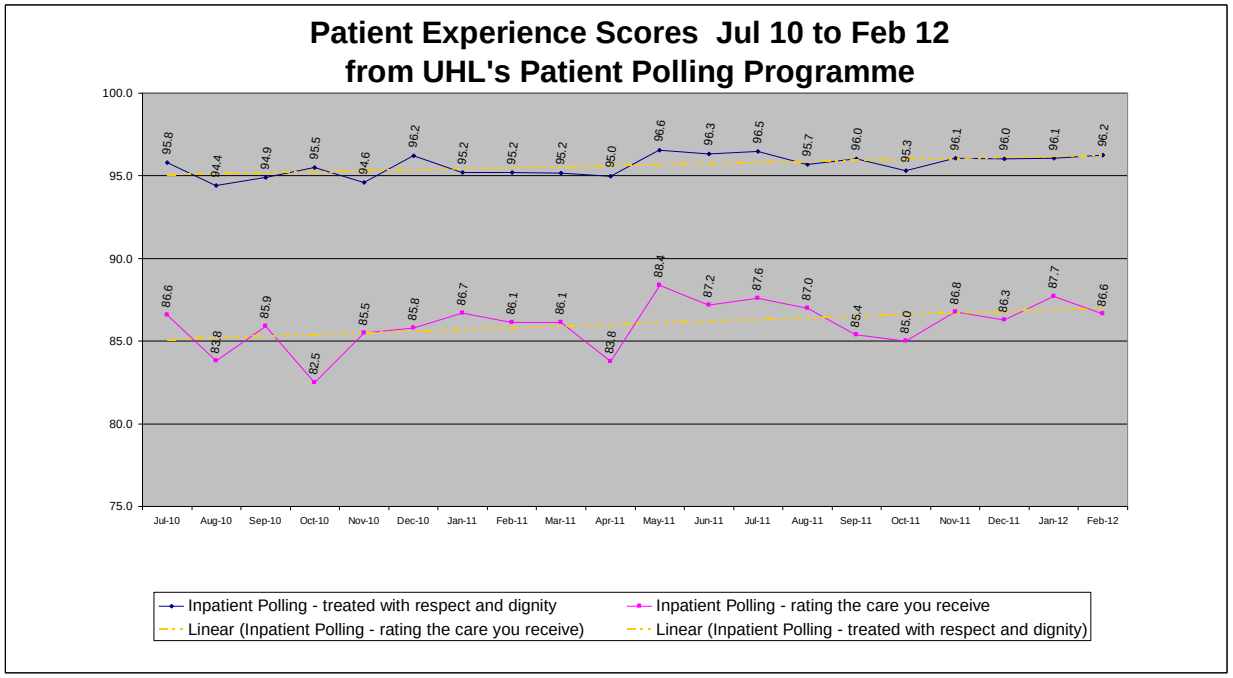


Figure 11: Patient Experience Scores Jul 10 to Feb 12

Based on this analysis, it is possible to conclude that whilst there has been a rise in complaints, the overall rate remains low. The complaints in medicine suggest a system under pressure with staff struggling to meet all the requirements of patient care. There is no evidence from in patient polling of a deterioration in the patient perception of the care provided at a UHL level. However, within Medicine, patient feedback is less positive.

3.6 Overall Conclusion

This review of key indicators of quality has demonstrated seasonal fluctuations in the outcome measure of mortality. Overall current performance for 2011/12 remains within confidence limits and is not out of line with previous experience.

There has been an increase in the number of incidents over 2012. Although this could represent an increase in vigilance and increased reporting with lower 'alert' thresholds having been applied internally, this trend is of concern and requires further urgent analysis.

Therefore, whilst review of the above data does not suggest an increased risk of death or serious harm for our patients, it may suggest certain areas of the system, particularly acute medicine, are not able to meet the Trusts' ambition of providing 'Caring at its Best.

It is anticipated that most of the concerns around staffing and activity pressures affecting quality of care will be resolved following closure of the extra capacity wards. However, it is recognised that there are likely to be similar pressures on the organisation this time next year and therefore it is imperative that there are robust winter plans in place before then. We also must make sure that we move from stabilisation to transformation, particularly with regard to the delivery of unscheduled care within UHL and across the health system.

In light of the CQC review and other data we have decided that we need urgent and rapid third party opinion on issues around quality and culture at UHL. As such we have invited a team coordinated by the Strategic Health Authority to visit the Trust and hold a mirror up to some of these issues. The team will be nursing and medically led.

In coming to the conclusion that we need a fresh pair of eyes on the important issues around quality and culture we are mindful that this will be both challenging and very public. Some might go as far as to advise that issues like this ought not to be aired in public. We disagree, rather than close our doors, batten down the hatches and address the feedback we've had from staff and other agencies in private, we think we have to be frank, open, and brave enough to meet this head on. Ultimately, this is about maintaining the confidence of our patients, our staff and the wider public.

3.7 Service Developments in 2011/12

3.7.1 Emergency Department (ED) Changes

We have recruited additional medical, clinical and support staff to work within the ED and to support the emergency flow. The changes included a combined pool of trainees and Consultants working flexibly to respond to fluctuations. The benefits of these changes include:

- increased quality and safety
- improved patient experience
- reduction in admissions and readmissions
- the development and implementation of ambulatory emergency pathways
- an expected activity reduction of 720 admissions per annum

We continue to work through the Emergency Care Network (ECN) to improve our pathways of care. This includes guiding our patients where the most appropriate place of care may be 'out of hours' and improving our discharge processes to ensure that patients get a fast and efficient service and are discharged as soon as is safely possible.

Given current performance in A&E as measured by the 4 hour target, improving our emergency flow will continue to be a priority in 2012/13.

3.7.2 Elderly Frailty Unit (EFU)

We have improved the quality of care to the growing frail and elderly population by establishing the Elderly Frailty Unit (EFU) within the Emergency Decisions Unit (EDU). Staffed by a dedicated team of geriatricians this unit enables the transfer of elderly patients to the most appropriate care pathway, either in the acute setting or community.

Working with the ED team, the unit will have avoided approximately 1,200 admissions through:

- implementing proper assessment and discharge processes
- ensuring appropriately skilled clinical teams for older people
- developing good working relationships with community partners

3.7.3 Move to a Two Site Emergency 'Medical' Take

We have streamed all medical emergency admissions to two hospital sites rather than three. In October and November 2011 the final two wards were relocated from the LGH to the LRI. The completion of this programme of changes has delivered several benefits including:

- improved patient experience by providing the right care in the right place
- enabled the concentration of medical staff on two hospital sites
- provided additional cardiology cover on at the GH site
- reduced length of stay in medicine from 7.7 days to 6.6 days which we have maintained over the winter months
- reduced the number of beds open for periods of time throughout the year which will be reviewed going forward

3.7.4 Single Site for Elective Orthopaedics

We have consolidated and streamlined the elective orthopaedic service to provide quality improvement for our patients. This has included four new laminar flow theatres which are spacious and contain air filters that reduce the risk of infection. A new patient waiting area near the theatres also helps patient flow. We have also increased the amount of patients who can be treated, and thereby shortened the waiting times for operations. It has also enabled the repatriation of all elective orthopaedic activity from the independent sector.

3.7.5 Partnership working with Lloyds Pharmacy

By partnering with Lloyds Pharmacy we have improved the dispensing service for out-patients, whilst also utilising the potential financial benefits from Value Added Tax (VAT) savings. This partnering approach provides the opportunity to further develop ward based clinical services by refocusing pharmacists' workload. This partnership was established as a 12 month pilot finishing in October 2012. At the end of the pilot we expect to see:

- a substantial reduction in out-patient waiting times for prescriptions
- improved patient pathways linking closely with community care services
- improved service to inpatients as staff able to concentrate on one service
- a more efficient service
- a reduction in the cost of the Home Healthcare service with corresponding reduction in drug costs

3.7.6 EMPATH Joint Venture

We have responded to the national pathology agenda as expressed in the Carter Report by establishing EMPATH. This joint venture with Nottingham University Hospitals (NUH) will improve service provision whilst streamlining the way services are provided and reducing costs. In 2011/12 we established a joint management structure and appointed a clinical and managerial lead to lead both services. We also developed a detailed business plan for the future of EMPATH, which was approved by both Trust Boards in March 2012.

The first bid for additional contracts under the new joint structure was won during the year. This is a three year Histopathology contract with a projected value of £30,000 per annum.

3.7.7 Electronic Prescribing

We have successfully begun the roll out of e-Prescribing across the Trust, which began with Cancer and Haematology Services in December. Electronic prescribing enables:

- greater patient safety through fewer drug errors occurring
- improved efficiency within the dispensing process
- improved patient throughput as a result of faster TTO (To Take Out) prescription preparation
- less staff time spent on error investigations as a result of fewer errors occurring

3.7.8 Healthcare at Home for Cancer Patients

We wanted to improve patient experience by providing treatment in the patient's own home rather than having to travel to hospital. We have worked in partnership with Healthcare at Home Ltd to provide all suitable patients with early or advanced breast cancer, and treated with Herceptin, the option to receive their treatment at home. This reduces pressure on capacity within the Chemotherapy Suite which helps to improve the experience for those patients who do have to attend hospital.

3.7.9 Macmillan Cancer Information and Support Centre

Our Cancer Information Centre was too small to deliver all the services our patients require. Together with Macmillan Cancer Support we are nearing the completion of a new centre attached to the Osborne building at the Leicester Royal Infirmary. The centre will have a drop-in area, a multi-purpose room, a quiet room and a beverage bay. The centre will also accommodate the Hair Loss Service, benefits clinics, complementary therapy sessions and support groups. This will help us provide improved services to anyone affected by or seeking information about cancer.

3.7.10 Theatre Arrivals Area

We needed a Theatre Arrivals Area (TAA) which would provide a streamlined single point of admission area for elective surgical patients. A temporary facility was created and opened in May 2011. This development means that where appropriate patients are admitted on the day of surgery rather than the night before. The TAA also reduces the time taken between the patients admission and beginning the operating session which means we can optimise the number of patients that can be treated per list.

3.7.11 Integrated Sexual Health Provision

In last year's plan we set out our objective to redesign Sexual Health services to provide integrated care across UHL and the community. We have made significant steps towards this goal with the introduction of a single point of access with online direct access booking. This is available through an integrated signposting site and has allowed us to increase the number of booked slots and reduce the amount of walk in clinics provided. Our new on site pharmacy support staff have improved the drug information given to our patients which has helped to increase compliance with medication regimes. Overall this project has reduced waiting times for patients and increased their choice of where their appointment will take place.

3.7.12 Clinical Genetics Service

We set out to consolidate and expand our Clinical Genetics provision within our regional network. We have done this through the recruitment of a locum consultant, with a further part time post to be recruited. This has increased our clinic capacity to meet increasing demand and has also enabled us to increase our research capacity, both of which contribute towards an improved external profile for the service. We will also be taking part in a ground breaking study, lasting four years, with the aim of uncovering the genetic changes that cause unexplained development disorders in children.

3.7.13 Midwifery Workforce

With the support of our commissioners we have invested in our midwifery workforce, recruiting a total of 10 WTE throughout the last year in order to bring our midwife to birth ratio from 1:35 to 1:33. This has allowed us to move towards the national standard of a 1:32 ratio and has increased capacity in the community to cope with increasing demand. The recruitment of more midwives has led to reduced transfers of activity between sites and reduced number of closures.

3.7.14 Paediatric Surgery and High Dependency Care Services

The aim of this development was to increase the capacity for Paediatric HDU (High Dependency Unit) and Paediatric Surgery in order to improve the flows between Neonates and Paediatric Surgery and reduce the number of refused retrievals from out of the county. To achieve this we have invested in extra HDU nurses and a Consultant Paediatric Surgeon in addition to opening four extra cots on the Special Care Baby Unit (SCBU). This has allowed us to increase our capacity and improve our patient flow.

3.7.15 Key Achievements for Research and Development

Our Biomedical Research Unit (BRU) 2011/12 applications were successful and we now have 3 BRUs. This is the largest number outside of the London, Cambridge and Oxford.

The Respiratory BRU aims to focus on the development of new and effective treatments for severe asthma and chronic obstructive pulmonary disease (COPD). The award included just over £2m for a new facility to be built on the Glenfield Hospital site over the spring and summer 2012.

The Nutrition, Diet and Lifestyle BRU is a collaboration with Loughborough and Leicester universities. It will focus on research in new areas of physical activity research including the potential benefits of short periods of exercise, particularly in patients with type II diabetes and chronic kidney disease. This BRU will build on the success of the Diabetes Centre of Excellence which the Trust has been developing.

We were also successful in securing funding for a further five years for the Cardiac BRU in partnership with the University of Leicester (UoL). The unit is an international leader on the genetics of cardiovascular disease and innovative interventions for its prevention and treatment. The continued funding will provide financial support for further studies and trials into better predicting those at risk of heart attack as well as trials to see if drugs can be developed to limit damage to the heart after a heart attack.

In January 2012, Health Secretary Andrew Lansley announced £10m funding for the East Midlands to develop one of three hubs for the Country's first ever National Sports and Exercise Centre of Excellence. The centre will help more people to be more active and treat injuries caused by exercise and conditions associated with lack of exercise. This will mean people who are injured return to physical health and work more quickly. It will also help people use the benefits of physical activity to cope with existing medical conditions, such as diabetes. The co-location of university researchers, clinicians and service delivery provides a new model in healthcare provision, allowing researchers to work in close contact with the people who ultimately benefit from their work. This new way of working will enable us to speed up the translation of pioneering academic research into clinical practice.

3.8 Delivering the Financial Plan

3.8.1 Summary of Financial Performance

	2011/12 Annual Plan £m	2011/12 FOT * £m	Variance	
			£m	% of Plan
Income				
Patient Income	595.7	615.1	19.3	3.2
Teaching, R&D	66.9	71.4	4.6	6.8
Other Operating Income	17.7	20.7	3.0	17.0
Total Income	**680.3**	**707.2**	**26.9**	**4.0**
Operating expenditure				
Pay	418.9	433.1	(14.1)	(3.4)
Non-pay	215.2	227.9	(12.7)	(5.9)
Total Operating Expenditure	**634.1**	**660.9**	**(26.8)**	**(4.2)**
EBITDA	**46.2**	**46.3**	**0.1**	**0.2**
Net Interest	(0.5)	(0.5)	(0.0)	8.3
Depreciation	(31.1)	(31.1)	(0.0)	0.1
PDC dividend payable	(13.4)	(13.4)	(0.0)	0.0
Net Surplus	**1.3**	**1.3**	**(0.0)**	**(0.0)**

*Based on month 10 actuals plus 2 months forecast

Table 3: Table to show income and expenditure summary for 2011 / 12 Annual Plan and for the FOT

3.8.2 Overall Financial Position

We are forecasting to deliver the planned year end surplus of £1.3m. However, there have been a number of challenges within the financial year as described in the following sections.

3.8.3 Income

There have been significant increases in income levels above the original plan in 2011/12, £26.9m (4%). Patient care income shows a £19.3m (3.2%) favourable position to the planned levels and reflects the following significant factors:

- Activity over performance against the plan;
  - Day Case £3.5m (6%)
  - Elective Inpatients £1.8m (3%)
  - Outpatients £3.3m (4%)
  - ED £0.8m (5%)
  - Critical Care £0.9m (2%)
- Activity under performance against plan;
  - Emergencies £2.2m (1%)
  - ECMO £1.6m (14%)
- An additional £8m of income received to 'reimburse' the Trust for the original penalty in the plan for re-admissions.

3.8.4 Expenditure

There has been an adverse position reported against both pay and non-pay when compared to the original plan.

These positions are a consequence of 2 main factors:

- Under delivery against the £38.2m cost improvement plan.
- Higher than planned expenditure particularly in the first four months of the year, reflecting increased activity and capacity levels and a failure to reduce the excess capacity once the activity levels began to fall. The following chart on premium pay expenditure illustrates this.

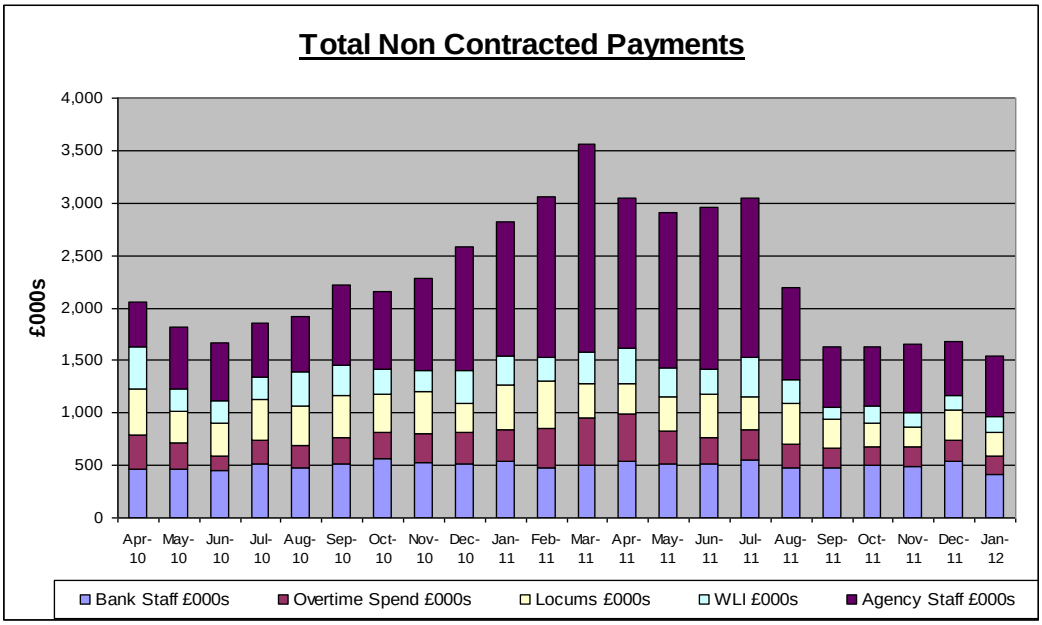


Table 4: Graph to show the total non-contracted payments from April 2010 through to January 2012

The monthly income and expenditure profile chart shows the 2011/12 monthly profile of both income and expenditure. This illustrates the deficit financial position in the April to August period which resulted in a £13m deficit up to 31 August 2011. In response to this financial position, we implemented the "Stabilisation & Transformation" financial recovery plan, which was agreed by the UHL Trust Board on 21st July 2011.

This plan resulted in a stabilisation of our costs, particularly premium pay costs (refer to the earlier chart), and a monthly breakeven position in September followed by monthly surpluses from November onwards.

The following graph shows the Trust achieving a breakeven monthly position for the first time in September, reflecting the stabilisation element of the financial recovery plan.

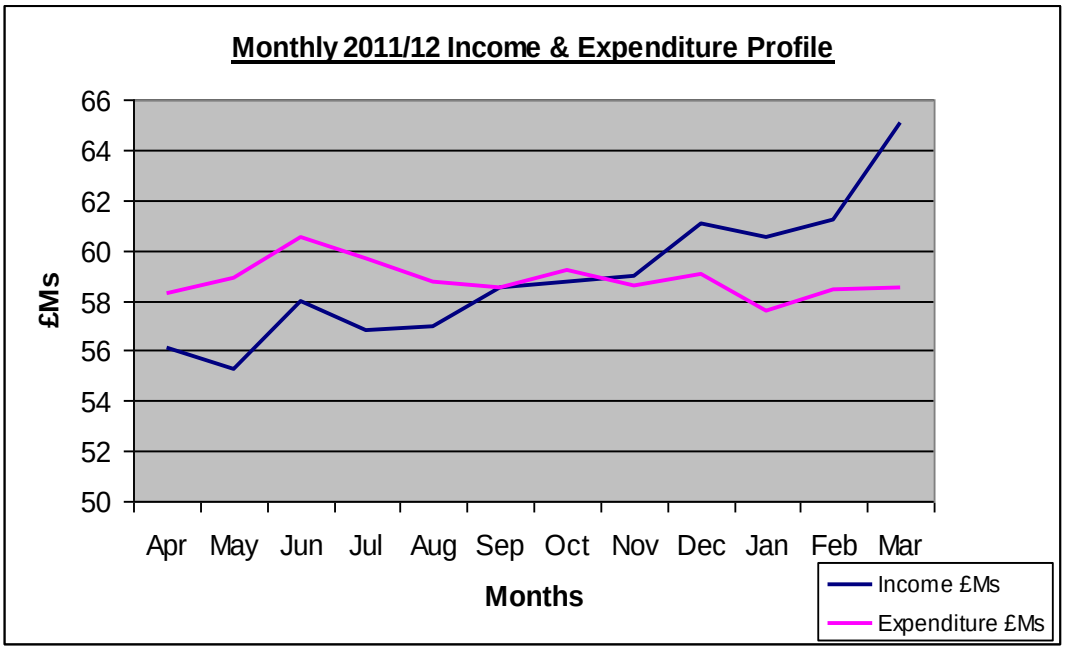


Table 5: Graph to show the monthly income and expenditure profile for 2011 / 12

3.8.5 Cost Improvement Plan (CIP) Delivery

The cost improvement target was £38.2m in 2011/12, 5.6% of total turnover. The cost improvement plans included improved efficiency within the divisions and corporate divisions, as well as Trust wide transformational schemes.

The year-end position is to deliver £25.2m, 66% of the target.

Category	Plan £m	Forecast * £m	Variance £m
Income	4.5	5.3	0.8
Non-Pay	11.0	7.0	(4.0)
Pay	22.8	12.8	(9.9)
Total	**38.2**	**25.2**	**(13.1)**
*Based on month 10 actuals plus 2 months forecast			

Table 6: Summary of income between plan and forecast 2010 / 11

The shortfall against the cost improvement schemes is across both pay and non-pay and is a consequence of delays in schemes starting in 2011/12 and some schemes being pushed back into 2012/13. The full year benefit of these schemes will be seen in 2012/13.

The delayed schemes resulted in £8.9m (35%) cost improvement schemes being delivered between April to September and £16.3m (65%) between October and March. Having successfully delivered 100% of CIPs in 2010/11, we felt we had the infrastructure and capacity in place to repeat this performance in 2011/12. In 2011/12 we learnt that during the previous year we had taken costs out but had not supported this with true transformation. Therefore, when activity increased over the winter, the costs escalated to deliver the activity through premium payments etc.

Of the £25.2m saved in 2011/12, £21.1m or 84% was recurrent.

3.8.6 Capital

	2011/12 Annual Plan £m	2011/12 Forecast Outurn (FOT) £m	2011/12 Variance £m
Funding			
Capital Resource Limit (CRL)	24.5	19.5	(5.0)
Disposals & Transfers		19.8	19.8
	24.5	**39.3**	**14.8**
Expenditure			
Backlog Maintenance	13.0	11.1	(1.9)
Land Swap	-	19.8	19.8
LGH Theatre and Ward Refurbishment	2.0	2.2	0.2
ED Reconfiguration	1.5	-	(1.5)
CDU Phase II	0.9	0.7	(0.2)
Other Developments	7.1	4.5	(2.6)
	24.6	**38.3**	**13.8**
Underspend	**-**	**1.0**	**1.0**
Gross Capital Expenditure	24.5	38.3	13.8
Disposals & Transfers	-	(19.8)	(19.8)
Grants and Donations	(0.8)	(0.8)	
Charge to the CRL	**23.7**	**17.7**	**(6.0)**
*Based on month 10 actuals plus 2 months forecast			

Table 7: Table to show the Capital Annual Plan and FOT for 2011 / 12

In 2011/12 we will have spent £38.3m of capital, the key areas being:

- Reduced from the overall programme, £5m to release cash and support the financial plan
- Cash neutral land swap with Leicester Partnership Trust completed 1st July 2011. Additions off set by matching disposals
- Theatre & ward refurbishment schemes completed on time allowing the reconfiguration of musculoskeletal & women's services
- Schemes within other developments re-profiled into 2012/13 to reflect changing Trust priorities during the year
- The IT & Medical equipment figures are included within the figure for backlog maintenance
- IT – plan was £2.5m (FOT £2.0m)

- Medical equipment – plan was £4.5m (FOT £4.0m)
- Facilities – plan was £6.0m (FOT £5.1m)
- For IT and Medical equipment, the lower FOT mainly reflects the reduction to the plan to aid Trust liquidity

3.8.7 Changes in Workforce

The following graph demonstrates both a reduction in worked and contracted WTE in 2011/12:

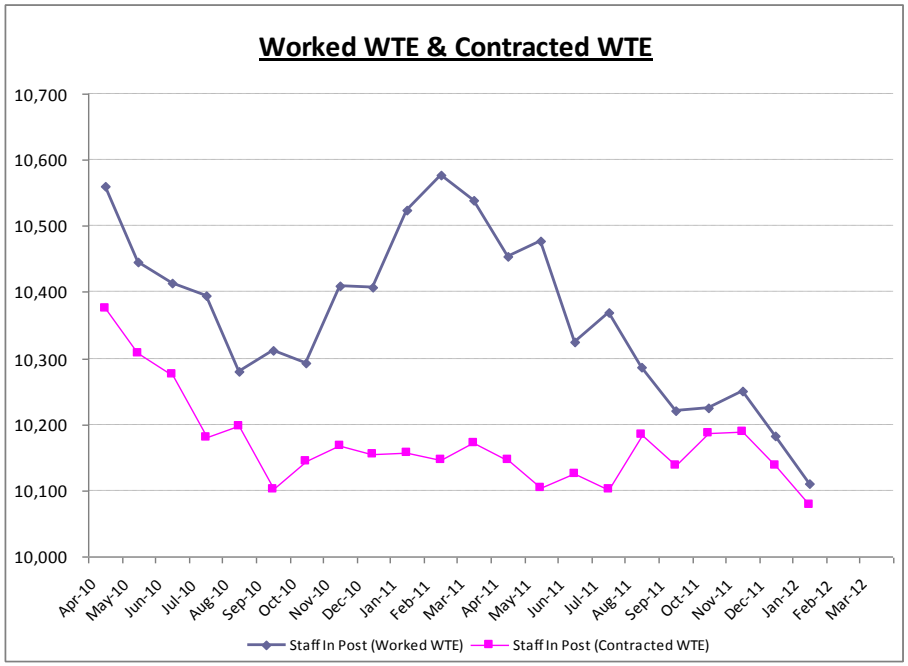


Figure 12: Graph to show worked WTE & Contracted WTE

3.9 Performance against key targets and standards

Performance Against Key Targets – final position will be available April / May			
	Target	**Actual**	**Additional Comments**
C.Diff in Patients (UHL – all ages)	165	**106**	
MRSA bacteraemia	9	**7**	Includes 1 appealed case & 1 to appeal
2 week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers	93%	**94.2%**	
2 week wait for symptomatic breast patients (cancer not initially suspected)	93%	**96.3%**	
31 day (Diagnostic To Treatment) wait for first treatment: all Cancers	96%	**97.5%**	
31 day wait for second or subsequent treatment: anti-cancer drug treatments	98%	**99.9%**	
31 day wait for second or subsequent treatment: surgery	94%	**95.4%**	
31 day wait for second or subsequent treatment: radiotherapy treatments	94%	99.0%	
62 day wait (urgent GP Referral to Treatment) for first treatment: all cancers	85%	83.4%	Delivered monthly from Qtr4
62 day wait for first treatment from consultant screening service referral	90%	93.4%	
62 day wait for first treatment from consultant upgrade	85%	85.7%	
RTT 18 week (admitted)	90%	84.6%	Planned backlog reduction
RTT 18 week (non-admitted)	95%	95.5%	
ED waits (2011/12 – Type 1 and 2) plus Urgent Care Centre (UCC)	95%	94.2%	

Table 8: Performance against key targets and standards

3.9.1 Further reduce health care associated infections

We continue to achieve a year on year reduction in our numbers of MRSA and C.Diff infection. Hospitals are given a target figure beyond which they are not expected to exceed. For MRSA bacteraemia this was 9 cases and for C.Diff this was 165 cases for 2011/12. During 2011/12 we delivered both targets. MRSA elective and non-elective screening has been achieved at 100% respectively.

3.9.2 Cancer Waits

We achieved eight of the nine cancer targets during 2011/12. In response, additional focus was given to the 62 day referral to treatment target where small patient numbers can disproportionately affect the breach position. Supported by a visit from the National Intensive Support Team, we undertook a review of the patient journey during 2011/12 in order to reduce waits and improve overall patient waiting times and performance. Additional clinics, theatre sessions and diagnostic activity were also introduced during the year to improve the position. As a result the 62 day target has been delivered each month since January 2012.

3.9.3 Referral to Treatment (RTT) – 18 weeks

The RTT (18 week wait) standards are that 90% of admitted and 95% of non-admitted patients should start consultant-led treatment within 18 weeks of referral.

Admitted pathways are those that end in an admission to hospital (either inpatient or day case) for treatment. There was a deliberate reduction in admitted performance as we agreed a plan with our commissioners to increase activity in quarter 3 and quarter 4 to reduce the number of patients on an 18 week backlog and 26 week backlog.

Progress in backlog reduction is shown in the following graphs:

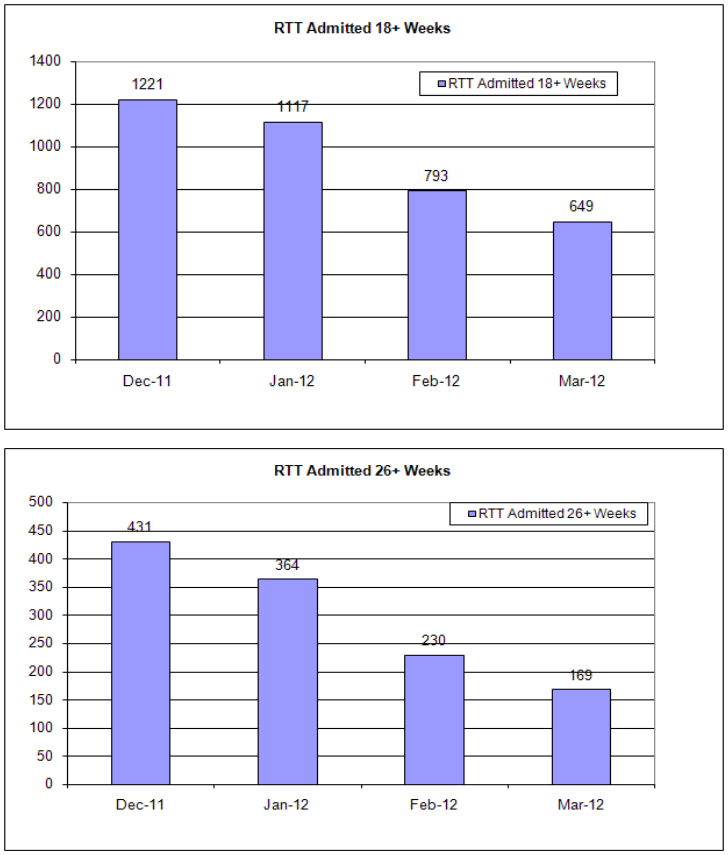
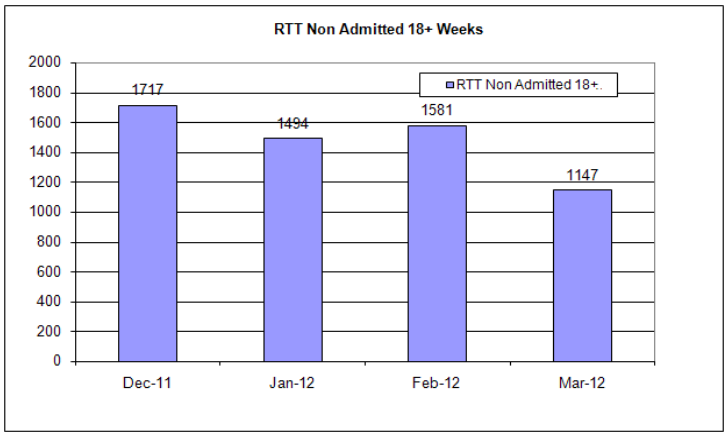


Figure 13: Graphs to show number of RTT Admitted 18+ Weeks and 26+ Weeks Backlog Reduction

Non-admitted pathways are those that end in treatment that did not require admission to hospital or where no treatment is required. Additional focus has been placed on validating patients that are waiting over 18+ and 26+ weeks. Progress is shown below:



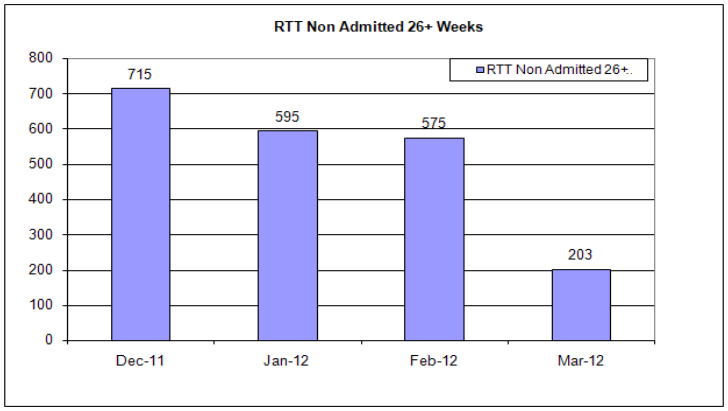


Figure 14: Graphs to show number of RTT Admitted 18+ Weeks and 26+ Weeks following validation

Following a full review and validation, the number of patients waiting on an incomplete pathway more than a year reduced from 166 at the end of October to 0 at the end of February.

3.9.4 A&E Performance

The final 2011/12 year to date figure for UHL including the UCC was 94.0%. In response to a consistent underachievement of the 4 hour target, new clinical roles have been introduced and a new pathway commenced in November 2011 called "Right Place, Right Time". This initially resulted in a considerable improvement in our emergency department performance. However, following a number of challenging weeks of activity (with ED attendances 5% higher and emergency admissions 7% higher this quarter compared to the same period last year) achievement of the 4 hour target has deteriorated. An action plan has been developed to strengthen internal processes in addition to external support.

3.9.5 Cancelled Operations

We are aware that cancelled operations can result in patient distress and are an inefficient use of resource. As a result we have redesigned our processes so that every possible effort is made to avoid the cancellation of operations at the last minute. The percentage of operations cancelled at short notice for non-clinical reasons in 2011/12 was 1.3% of all elective activity, which is similar to the previous year's performance. The main reasons for short notice cancellations include ward bed availability, ITU/HDU bed availability, admission of a high priority patient and theatre list over-runs. The target for 2012/13 is to reduce the cancellation rate on day of operation to 0.8%.

3.9.6 Stroke performance

Following the relocation of stroke services to concentrate them on the LRI, we have consistently achieved the target to ensure stroke patients spend 90% of their stay on a dedicated stroke unit. During 2011/12 86% of patients achieved this against a target of 80%.

3.9.7 Treatment of transient ischaemic attack (TIA)

The aim is for patients to be assessed and receive appropriate investigations, diagnosis and treatment, including referral for carotid intervention, in a single visit to the hospital seven days a week. The percentage of higher risk patients seen within 24 hours of first contact with a healthcare professional for 2011/12 was 66.4% against a national target of 60%. Nurses, healthcare assistants, clinic aides and vascular technicians are all integral to the delivery of the 7 day specialist service.

3.9.8 2011/12 Provider Management Regime

In December 2011 the NHS Midlands and East Provider Development Committee, a sub-committee of the SHA Cluster Board, agreed to adopt a Provider Management Regime (PMR) approach to over-sight of NHS Trusts across the cluster.

The approach is based on the Monitor Compliance Framework and puts the onus on Trust Boards to:

- demonstrate self-awareness in providing assurance
- submit accurate self-certification
- be clear on plans to address issues in a timely manner
- hold Trust Boards to account for the delivery of their commitments.

The Acute Governance Risk Ratings for 2011/12 are shown in the following table:

University Hospitals of Leicester ACUTE GOVERNANCE RISK RATINGS 2011/12					YES = (target met in month) NO = (not met in month) N/A (as appropriate)											
Area	Indicator	Sub Sections	Thresh-old	Weight-ing	April 2011	May 2011	Jun 2011	July 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012
Safety	Clostridium Difficile	Are you below the ceiling for your monthly trajectory	Contract with PCT	1.0	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	
Safety	MRSA	Are you below the ceiling for your monthly trajectory	Contract with PCT	1.0	NO	YES	YES	NO	YES	YES	YES	YES	YES	YES	YES	
Quality	All cancers: 31-day wait for second or subsequent treatment, comprising either:	Surgery	94%	1.0	YES	YES	YES	YES	YES	YES	YES	YES	NO	NO	YES	
		Anti cancer drug treatments	98%													
		Radiotherapy	94%													
Quality	All cancers: 62-day wait for first treatment, comprising either:	From urgent GP RTT	85%	1.0	YES	YES	NO	NO	NO	NO	NO	NO	NO	YES	YES	
		From consultant screening service referral	90%													
Patient Experience	RTT waiting times – admitted	95th percentile	23 wks	1.0	NO	NO	NO	YES	YES	YES	YES	NO	NO	NO	NO	
Patient Experience	RTT waiting times – non-admitted	95th percentile	18.3 wks	1.0	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	
Quality	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	
Quality	Cancer: 2 week wait from referral to date first seen, comprising either:	all cancers	93%	0.5	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	
		for symptomatic breast patients (cancer not initially suspected)	93%													
Quality	A&E: Total time in A&E	Total time in A&E (95%)	≤ 4 hrs	1.0	NO	NO	YES	YES	NO	NO	NO	NO	YES	YES	NO	
Quality	A&E:	Total time in A&E (95th percentile)	≤4 hrs	No weight-ing	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	
		Time to initial assessment (95th percentile)	≤15 mins													
		Time to treatment decision (median)	≤60 mins													
		Unplanned re-attendance rate	≤5%													
		Left without being seen	≤5%													
		TOTAL			3.0	2.0	2.0	2.0	2.0	2.0	2.0	3.0	3.0	2.0	2.0	0.0

Table 9: UHL's Acute Governance Ratings 2011 / 12

3.10 Commissioner relations and contract delivery

The financial year 2011/12 was a time of transition for commissioners. It was the final year where PCTs are solely responsible for commissioning acute services. Over the course of the year we have seen the PCTs amalgamate into a single cluster and 3 Clinical Commissioning Groups (CCGs) established:

- Leicester City CCG
- West Leicestershire CCG
- East Leicestershire and Rutland CCG

The financial year 2012/13 will be the final period of transition from PCT to CCG, with CCGs taking over full responsibility and accountability from 2013. To manage the transition, we are building on existing relationships with commissioners and creating new relationships through a range of engagement opportunities. The focus is on getting the right people in the room to discuss what really matters - patients. Some of the engagement we are undertaking to ensure a successful transition includes:

- alignment of UHL senior clinicians and executive directors to CCGs, meeting at least quarterly
- involvement of clinicians in contracting round to provide consistency and expertise
- joint working groups to develop key strategies i.e. Site Reconfiguration, Right Care
- adding UHL senior clinicians to the CCG board
- building clinician to clinician relationships through the LLR Collaborative clinical interface group and clinical working groups
- quarterly GP / Consultant forums which provide opportunities for clinicians to discuss services / pathways
- attendance of providers at the Collaborative Commissioning Board

As a health community we are working to get better at what we do, through working more effectively together. The strengthened relationships emerging are ensuring that the most effective pathways are commissioned and developed for patients.

During 2011/12 the majority of our services were commissioned on behalf of our local population by the PCT Cluster - £424m including associates. We also provide specialist care that is not available in all acute

hospital Trusts, and our primary commissioner for this activity in 2011/12 was East Midlands Specialised Commissioning Group (EMSCG) - £153m. UHL also provide specialised services on a national basis commissioned on behalf of the country by the National Commissioning Group - £12m.

Our primary Patient Care Contract is managed in line with the national framework, and there are regular monthly meetings including contract performance, technical and quality. This regular formal engagement, coupled with the informal activity above, has supported the development of working relationships with commissioner that allows for challenging discussion, issue resolution and ultimately supports the move to a more productive economy.

The contractual plan that was established for 2011/12 was based on a negotiation of the needs of the population and the plan was jointly established. This took account of the commissioners intended Quality, Innovation, Productivity and Prevention (QIPP) schemes. It also recognised that we had invested in new Theatre capacity so was better placed to meet the needs of the population. It was also agreed in 2011/12 that the contract would carry a threshold for over and under performance against that plan to limit both parties exposure to financial risk. This threshold has not been triggered, demonstrating that the plan was established at a realistic level.

The main Patient Care Contract for LLR was agreed and signed at the outset of the financial year. All other key contracts for 2011/12 were agreed and signed.

During 2011/12 there have been a number of formal challenges to our performance from commissioners. In February 2012 we were issued with a First Exception Notice relating to cancer 62 day performance. We have responded to this formal challenge in line with the terms of the contract and do not expect this First Exception Notice to translate in to a permanent withholding of funds.

3.11 Board Development

3.11.1 Trust Board Composition and Membership

Our Trust Board comprises thirteen members: a Chairman, seven Non-Executive Directors and five Executive Directors, one of whom is the Chief Executive. Our Board is supported in its work by the Director of Communications and External Relations, Director of Corporate and Legal Affairs and Director of Strategy.

There have been no changes to Board membership during 2011/12.

3.11.2 Performance Management Reporting Framework

To ensure that the Board is aware to a sufficient degree of granularity of what is happening in the hospitals, a comprehensive quality and performance report is reviewed at each monthly public Board meeting.

The monthly report:

- is structured across five domains: patient safety; patient experience; clinical outcomes; staff experience/workforce; and value for money
- includes a summary section, 'UHL at a Glance', which provides an overview of both in-month and year to date performance, and trends
- includes performance indicators rated red, amber or green
- includes data quality indicators, measured against five key data quality components to assist the Board in gaining assurance
- is complemented by commentaries from the Executive Directors identifying key issues to the Board and, where necessary, corrective actions to bring performance back on track

A divisional heat map, identifying individual divisional and CBU performance across all of the domains is also available to the Board.

This formal Board performance management reporting framework is accompanied by a series of measures to achieve a more interactive style of governance, moving beyond paper reporting. Examples include:

- Patient stories, which are presented in public at Board meetings every quarter. These shine a light on individual experiences of care provided by the Trust and act as a catalyst for improvement
- Board members undertake patient safety walkabouts regularly
- Four of the Non-Executive Directors are linked to the clinical divisions and attend divisional board meetings

These arrangements allow Board members to help model the Trust's values through direct engagement, as well as ensuring that Board members take back to the boardroom an enriched understanding of the lived reality for staff, public and patients.

3.11.3 Committee Structure

We have a well-established committee structure to strengthen our focus on finance and performance, governance and risk management and workforce and organisational development. The structure is designed to provide effective governance over, and challenge to, the Trust's patient care and other business activities. The committees therefore carry out detailed work of assurance on behalf of the Board. A diagram illustrating our Board committee structure is set out below.

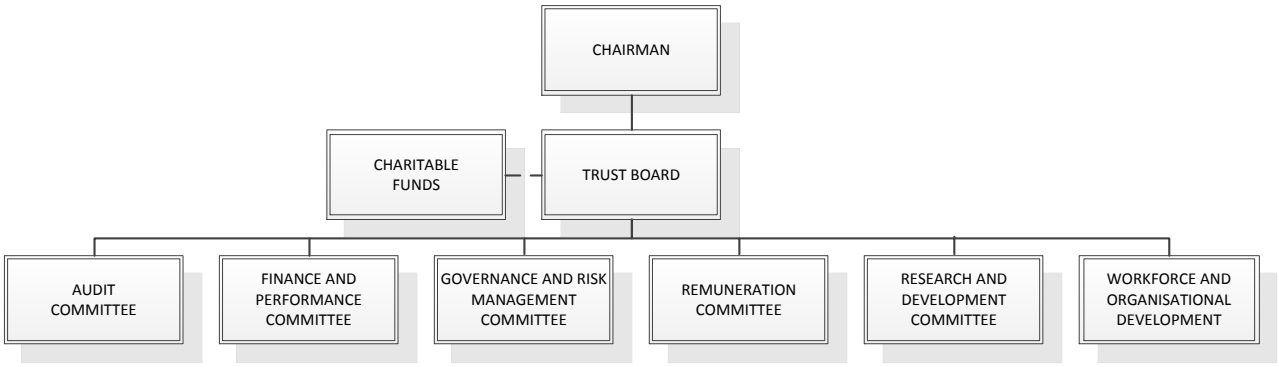


Figure 15: UHL's Board committee structure 2012

All of the Board committees are chaired by a Non-Executive Director and comprise a mixture of both Non-Executive and Executive Directors within their memberships. The exceptions to this are the Audit Committee and the Remuneration Committee, which comprise Non-Executive Directors exclusively.

3.11.4 Board Development

Board performance depends both upon leadership and the interaction of particular people and personalities. Recognising the importance of getting the right dynamics between Executive and Non-Executive Directors, and to strike the right balance between challenge and support to the Executive Team, each member of the Board has undertaken a 'Myers Briggs' assessment of their personality preferences. This has helped each Board member to become aware of their particular style and to better understand and appreciate the helpful ways that people differ from one another. It has also formed the basis of the development and Board agreement of the Code of Conduct for Directors.

The Board recognises the importance of effectively gauging its own performance so that it can draw conclusions about its strengths and weaknesses, and take steps to improve. The Board therefore undergoes regular assessment using third party external advisers to ensure that it is:

- operating at maximum efficiency and effectiveness
- adding value
- providing a yard stick by which it can both prioritise its activities for the future and measure itself

Outside of its formal meetings, the Board has held development sessions throughout 2011-12. Amongst the topics considered were risk management; winter planning; market assessment and the forthcoming establishment of Health Watch.

3.12 Progress with the FT Application

In early 2011, all NHS Trusts were required to sign up to a Tripartite Formal Agreement (TFA), outlining their trajectory for becoming a FT and identifying any issues that would need to be resolved to ensure a successful FT application.

UHL's TFA was signed off by the Trust and the SHA in March 2011 and by the Department of Health (DoH) in July 2011. Had we remained on the FT trajectory outlined in the TFA, our FT application to the DoH would have taken place in October 2011. However, not long after the agreement was signed, the Trust began to experience significant financial and performance issues, the details of which have been covered in earlier commentary on the delivery of our 2011/12 Annual Plan.

We subsequently launched a programme of turnaround and stabilisation with external support. As a result of this, our Trust Board took the decision to put our FT application on hold and consequently we have been reporting 'red' against the key milestones within our TFA. During this period we have continued to develop the capacity and capability within the Trust that is required to be authorised as an FT.

4 Strategy and Service Developments

4.1 Strategic Context – National

To improve services for patients, there are four key themes identified in the National Operating Framework that all organisations must focus on during 2012/13:

- putting patients at the centre of decision making in preparing for an outcomes approach to service delivery, whilst improving dignity and service to patients and meeting essential standards of care;
- completion of the last year of transition to the new system, building the capacity of emerging clinical commissioning groups (CCGs) and supporting the establishment of Health and Wellbeing Boards so that they become key drivers of improvement across the NHS;
- increasing the pace on delivery of the quality, innovation, productivity and prevention (QIPP) challenge; and
- maintaining a strong grip on service and financial performance, including ensuring that the NHS Constitution right to treatment within 18 weeks is met.

4.2 Strategic Context – Local

As well as ensuring the priorities listed above are delivered, we will also be supporting the achievement of the Midlands and East 'SHA Ambitions' in the following areas:

- eliminating avoidable pressure ulcers.
- making every contact count through our on-going efforts to use hospitalisation as an opportunity to encourage patients to stop smoking.
- improving quality and safety in primary care by supporting knowledge transfer between secondary and primary clinicians.
- strengthening partnership between NHS and local government by taking an active role in the LLR partnership arrangements and working closely with colleagues in the local authority to transform our urgent care system.
- support the patient revolution and ensure that the 'net promoter' question is asked in all patient surveys from April 2012/13 and that subsequent reports reflect a continuous improvement in score.

4.3 Strategic Context – Local

The NHS in LLR serves a population of just over 1 million people. It is one of the most diverse populations in the country not just because of the ethnic make-up of the city of Leicester but also in terms of age, wealth, education and health. Parts of the city and counties are very affluent, whilst other parts have some of the highest levels of poverty and deprivation in the country. Overall the city population is younger and much more ethnically diverse whereas the counties are relatively older and less diverse.

In terms of health there are also big differences between the health needs and the overall health of the various populations which make up our local area. In the city and the poorer areas of our market towns there is a higher proportion of people living with long term conditions like diabetes and cardiovascular disease and there are strong links between these diseases and people's lifestyles. In the older and more affluent counties people are living with diseases like hypertension and cancer, in part as a result of a greater proportion of the county populations who are elderly.

In response to the very different health challenges facing the City and County populations, we are working with our partners to develop a clinical strategy that is tailored to the diverse needs of the populations we serve (see Figure 17 below).

4.3.1 Health Characteristics of Leicester City

Life expectancy is lower than the national average and the gap is widening. Circulatory diseases, respiratory disease and cancers account for two thirds of all deaths in the city and for 65% of deaths under the age of 75 years (premature deaths). Circulatory disease is the principal cause of the life expectancy gap, with respiratory disease and infant mortality also important factors. The rate of smoking is above the national average at 26%. It is more of a problem in the white British population.

Due to the age structure of the population, the city will see only a modest increase in long-term conditions associated with old age in the next five years. However, the higher prevalence of both heart disease and diabetes at younger ages in the Asian population means that the prevalence of these conditions will grow.

4.3.2 Health Characteristics of Leicestershire County and Rutland

Overall the population of the two counties is older and less deprived than the England average. Life expectancy is better than the England average, but circulatory disease, respiratory disease and cancer are still the major causes of death. The rise in the percentage who will be over 65 years by 2020 will make a significant increase to the burden of long-term conditions, such as the number of people living with a diagnosis of coronary heart disease is predicted to rise by 27% by 2020.

A particular challenge is the care of those who are elderly and frail. Unnecessary hospital admission is expensive and not in the patients' best interests. A system to identify those patients most likely to run into difficulties and to intervene early to prevent a crisis needs to be established.

4.3.3 LLR Integrated Plan

Quality is the cornerstone of the LLR Integrated plan. It is the driving force behind our joint service redesign and reconfiguration priorities and is embedded in all work streams and contractual arrangements. The joint objectives of the cluster, local authorities, providers and CCGs are to continue to improve health outcomes, clinical quality, safety and patient experience. We acknowledge that whilst as providers we are being challenged to deliver substantial cash releasing efficiencies, it is critical there are processes and frameworks that monitor quality standards to ensure standards do not deteriorate.

The Cluster and CCGs aim to ensure quality through strategies to improve patient choice, responding effectively to patient feedback, developing patient safety mechanisms by maximising shared learning opportunities and ensuring the implementation of evidence based practice amongst providers. The Cluster aims to maintain this through effective implementation of quality impact assessments, risk monitoring and the implementation of early warning scores.

4.4 UHL's Response to LLR Context and Priorities

4.4.1 Our Core Purpose

Our core purpose at UHL is to provide 'Caring at its Best'.

Caring at its best:

- is about focusing on what matters most to patients, carers and those who work in healthcare
- takes the standard of care which each and every one of our patients should receive from us
- takes as a starting point that professionalism is everything
- seeks to build and in some cases remind us what caring really means

People who use our services rightly expect high-quality care and support. The importance of providing high-quality care and assessing that quality is central to the provision of services, and is therefore at the heart of this strategy.

4.4.2 Our Values

In the autumn of 2009, we engaged and consulted with staff and patients to identify a set of values that we will live by whilst delivering our strategy:

- We treat people how we would like to be treated
- We do what we say we are going to do
- We focus on what matters most
- We are one team and we are best when we work together
- We are passionate and creative in our approach to work

Staying true to these values will be even more critical as we continue to operate in one of the most turbulent and challenging periods the NHS and UHL have ever faced. Our People Strategy details the mechanisms the Trust has put in place to ensure that we continue to honour these values within the organisation.

4.4.3 Our Vision

UHL's vision is summarised in the following figure, which has become known as the 'Bull's-eye'. The purpose of this diagram is to demonstrate that as a University Teaching Hospital, UHL does not serve a homogenous market. We serve several markets each with different forces of demand and supply, different buyers and sellers, and different price, quantities and quality of services expected. It also demonstrates that the delivery of acute care is at the heart of our business. The current challenges we face in delivering this service in a sustainable way, is impacting on the successful delivery of all our other services. We therefore must continue to work with partners in primary and social care to improve emergency pathways and develop alternatives to the acute hospital setting.[4]

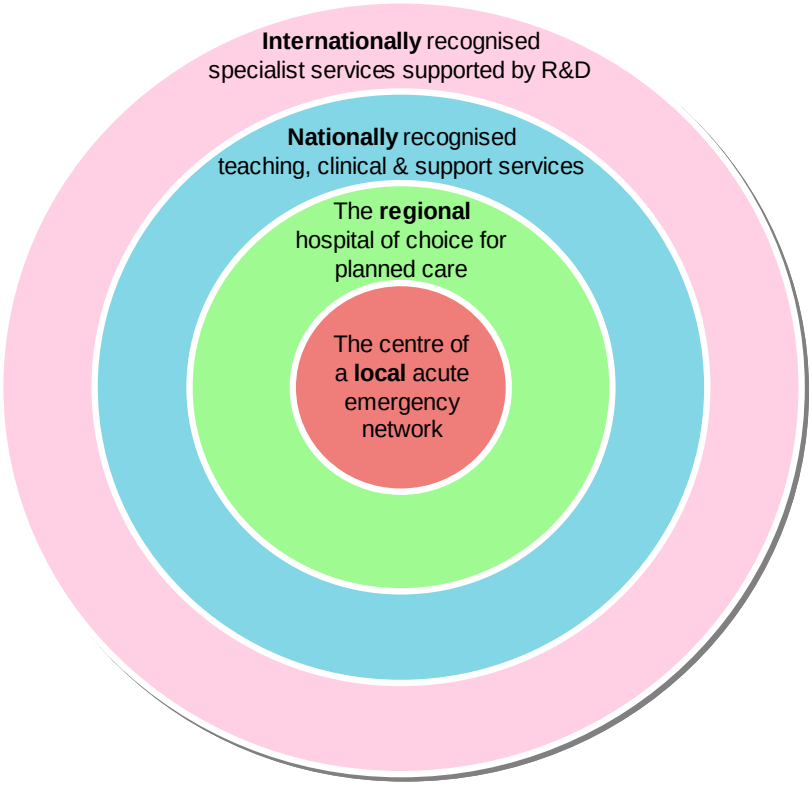


Figure 16: UHL's vision

4.4.4 The LLR Strategy

The NHS has, for nearly 60 years, operated on 'manufacturing' principles. In other words the people who invented the factory model to produce goods knew that by putting everything under one roof they could

[4]A successful example is the 'Frail and Elderly Model' which is being implemented by UHL's Acute Division, with support from PCTs, LPT, GPs and Local Authorities.

make their products more cheaply and cost effectively. Similarly the NHS has been built on the principle that it is easier, cheaper and more convenient (for the NHS) if as many services are offered under one roof as possible. The 'hospital model' has much in common with the factory model.

However when we talk to patients and patient groups what we hear most is 'Why do I always have to travel into the city or across the city to have treatment or see a specialist?' People rightly question why, when there are community hospitals, LIFT centres, health centres and other health facilities around the city and county, does everything seem centre on the three city hospitals? Just as importantly, when technology or just simple telephony exist, why is it always necessary to deliver health care, face to face, in clinics?

It's a fair question and the straight answer is that this is the way that the NHS has evolved over the years. It is not necessarily as the result of a long term plan but as a consequence of a series of independent actions taken over decades.

But this has created three problems:

- it may be convenient for the NHS but it's not convenient for patients
- in some groups of patients, particularly older people, the service is geared towards sorting out the crisis once it has occurred rather than helping to prevent and manage it before it happens
- it is enormously expensive

As an LLR Health System we want to address these issues. In fact in terms of 'expense' we have to address these issues because there simply isn't the money around to allow us to carry on with 'business as usual'.

Our strategy therefore is to create a local health system which cares for people when and where they need it most. This means redressing the imbalance between care that is provided in hospital and care that is provided in the community. It means looking after people and especially older people in ways which prevent them having to go into hospital.

We will achieve this in the following ways:

- There are services which are currently provided in hospital which could be provided either elsewhere or differently
- Then there are those services which would prevent the need for hospital admission, but are either not locally available or are too scarce to make a significant difference
- There are things we can do to prevent illness or intervene early enough so that illness does not become a way of life

We need to recognise that this does not mean we are calling for extra investment in services. The fact is that there is not the money available for 'extra'; instead by doing things differently or in different places we can do better with less.

Ultimately we think that this will lead to a local NHS where services are more evenly distributed across the LLR community. Smaller more specialist hospitals which concentrate on the acutely ill patients with complex needs and more of the less complex work delivered in different ways and different places.

These principles are reflected in the diagram below:

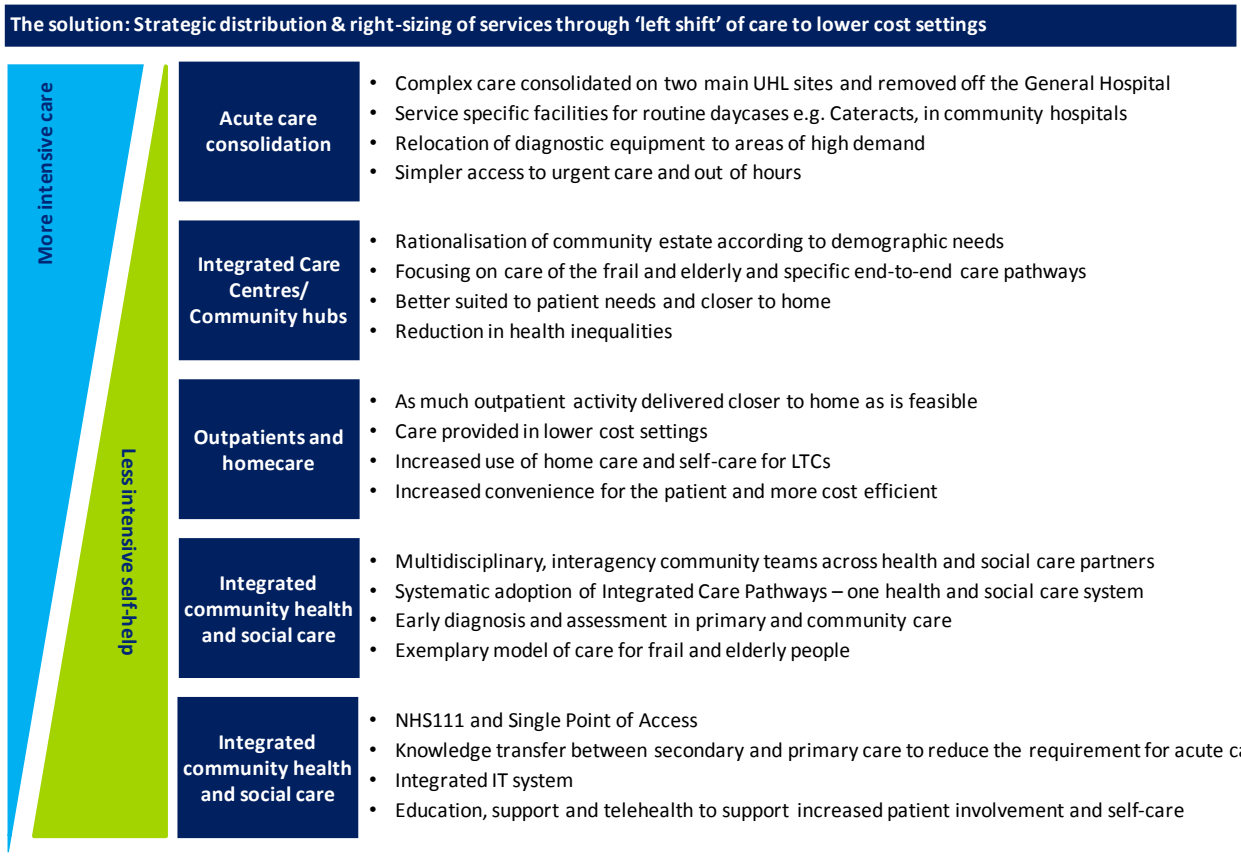


Figure 17: LLR's Vision

4.4.5 Strategic Objectives 2011/16

To support our vision and strategy we have agreed the following long term Strategic Objectives, which are known as the '6 Ps':

- Develop a culture where **people** who work for UHL are highly skilled, motivated, engaged, and take personal accountability for the services we deliver
- Improve **processes** so that the right services are delivered at the right place at the right time, whilst minimizing waste and fostering innovation
- Work with **partners** to create a modern and sustainable healthcare system ensuring better, local and faster access to health care
- Deliver high quality services (safe, clinically effective and excellent patient experience) to our **patients**

If we deliver the above objectives, we will:

- Consistently achieve national, regional and local **performance** targets leading to improved patient care
- Achieve financial sustainability and reinvest **profit** in delivering our vision

We recognise in our reflections on 2011/12 that we still have a long way to go to achieve the 6 'Ps' consistently across the organisation.

4.4.6 Corporate Objectives for 2012/13

Our shorter term key corporate priorities for 2012/13 are as follows:

- Improve Patient Experience
- Enhance Clinical Quality
- Transform the Emergency Care System
- Site and Service Reconfiguration

- Build Central Transformation Capability
- Deliver all Operational Targets
- Achieve Financial Sustainability
- Deliver a successful FT Application

4.4.7 Enabling Strategies

As part of our preparation for FT we completed the following enabling strategies in 2011/12 and they were approved by our Trust Board. These include:

- Estates Strategy
- IT Strategy
- Research & Development Strategy
- Workforce Strategy

However, in light of the challenges we have faced this year, some of these strategies are being reviewed. For example our Estates Strategy is being redeveloped as it is significantly impacted by the distributed service model described above and the site reconfiguration which we are proposing will take place sooner than in the previous strategy. Also, we have completed an in-depth analysis of our workforce, including trends, benchmarking and links to required capacity. The output will be used to refresh our workforce strategy and inform our workforce plan.

4.5 Key Service Developments

We have identified a number of key service developments for 2012/13 that will support the delivery of our strategy and our strategic objectives (refer to appendix A for more details).

4.5.1 Development of our emergency care services

The evidence of recent years is that incremental change to the delivery of emergency care in UHL does not produce sustainable improvements against a background where demand continues to grow both quantatively and qualitatively. While many of the challenges lie across the LLR health system some issues are particular to UHL/acute hospitals:

- the later presentation of demand across the working day and week
- the decreasing availability of trainees in emergency medicine and the consequences for both training and service delivery

In 2012/13 we will develop and implement a programme of major change within UHL:

- We will undertake a clinically-led external review focussing on the operation of the ED and the interface with acute specialties – by 31st May
- We will move to 24/7 consultant leadership – by 1st November
- We will complete an overhaul of ED systems and processes - by 30th June
- We will introduce an internal wait system in ED – from 1st July
- We will reduce the dependency on training grades by 31st July (thus improving the distribution and quality of training)
- We will implement an emergency floor concept – from 1st October
- We will implement a Right Time Right Place process for the AMU from 1st July

Given the degree of challenge to ED performance and the scale of change required it is unrealistic to predict consistent achievement of the 95% target for Type 1 and 2 attendance in Q1, though of course all operational efforts will be made.

It is also important to see the ED as part of the wider acute hospital. A number of changes to the entire acute pathway are in preparation, particularly for more effective 2012/13 winter planning.

4.5.2 Services for frail older people

In 2010, Leicester City PCT, Leicestershire Partnership Trust, Leicestershire County Council and Rutland PCT and UHL agreed to the implementation of a strategy for the care of older people across Leicester, Leicestershire and Rutland. The strategy incorporated various initiatives to improve the quality of care assessment and outcomes for frail older people who use secondary and community services. In 2012/13 we will improve the quality of care and reduce the time that the older person spends in our hospitals through increasing the number of older people who are cared for by our geriatric teams. We will extend our ward base for older patients, where appropriate, through the reconfiguration of existing facilities, which will be aligned to the varying demands placed on the service. In addition we will reshape our workforce to better respond to the complex needs of the older person and continuously develop the essential interfaces with community hospitals.

4.5.3 Managing Long term conditions

Many of the patients we admit to hospital are those with long term conditions. In order to reduce the number of times such patients are re-admitted to hospital we will continue to develop a number of ambulatory care pathways so that patients are managed safely and effectively within the community. Some examples of ambulatory care pathways we will be developing are:

- pleural effusion
- pulmonary embolus
- low risk chest pain
- asthma

Across the county, COPD has been highlighted as a priority by CCGs, therefore as part of our strategy we are focusing on this area. In 2012/13 we hope to be one of the first Trusts in the country to develop a care bundle for COPD. We will develop and implement an education and self-management manual to support patients with care planning and the management of their Chronic Obstructive Pulmonary Disease, (COPD). It empowers patients to manage their long term condition within their home environment, linking into healthcare professionals both in primary and secondary care.

We will also focus on a targeted approach at discharge in effective medicine management in the community in order to prevent inappropriate admissions and potentially reduce drug-related costs. We will use the PRICE intervention, an acronym for Pharmacist Readmission Intervention for COPD Exacerbations. This is a simple integrated care service with the aim to prevent hospitalisations caused by exacerbations in patients with COPD.

As a further focus for our work on managing long term conditions we are hoping to scope and commission an integrated diabetes pathway across LLR which incorporates the reconfiguration of Diabetes Services and development of a managed strategic clinical network and has a focus on targeted projects. These projects will be based on common core requirements for all organisations and the differing priorities of the CCGs, to address variations in need and care provision.

4.5.4 East Midlands Congenital Heart Centre ('Safe and Sustainable')

The recommendations coming out of national review of Children's Cardiac Surgery have been delayed and will now take place in 2012/13. We will therefore continue to work as a Trust to improve our service and respond to the opportunity provided by the National "Safe and Sustainable Review of Paediatric Cardiac Services".

4.5.5 EMPATH – Pathology joint venture with Nottingham University NHS Trust

In 2012/13 we will continue to develop EMPATH and establish it as the pre-eminent provider of pathology services in the UK. The aim is to deliver a cost effective service that provides significant economies of scale through the establishment of a single managed service. This will be underpinned by a defined commercial and new operating model for delivery.

4.5.6 LRI Aseptic Suite

We needed to build a new Aseptic suite for the production and storage of chemotherapy drugs to replace a rental unit which is failing to meet standards. Work has begun to build a new suite which is expected to be completed by early 2012/13. This will enable us to maintain current level of service with regards to provision of an intravenous chemotherapy service to adults and paediatric patients (and deal with any growth).

4.5.7 Community Elective Care Services

The CCGs within the County PCT cluster are committed to tendering Elective Care Services across the county. The tender process will seek to secure a suitably qualified provider to deliver Elective Care services across the community to meet the requirements of the local health economy. The services to be tendered include diagnostics, outpatients and day-case services. UHL will respond to the tender and provide detail on how through the development of innovative, integrated end to end pathways the vision for health care across the health economy could be delivered.

4.5.8 Teenage and Young Adults (TYA) Cancer Unit

In 2011 UHL launched the 'Our Space' appeal, an exciting project to create a world-class Children and Young Adults Cancer Unit. Working with the Teenage Cancer Trust and supported by the Robbie Anderson Cancer Trust, Leicester Hospitals Charity set about raising the required £1.4 million to transform the cancer unit on ward 27 at the LRI.

The new integrated unit will totally transform the environment in which children, teenagers and young adults are treated. The careful use of design, lighting and colour will turn an ordinary hospital ward into a space that children and young people will find stimulating, whatever their age, all contributing to an improved patient experience.

The support for this appeal has been fantastic with £1.1m raised as at February 2012, work is planned to begin in summer 2012, with designs being drawn up from early 2012.

4.5.9 Service and Site reconfiguration

As described in the LLR Strategy above, the current clinical service and capacity configuration across UHL and the wider LLR Health System is the product of fragmented, incremental development. Service configuration challenges for UHL include a 3 site emergency take; unsustainable Critical Care delivery across 3 sites; and an outmoded Emergency Department. Early priorities for service reconfiguration that impacts directly on UHL include:

- Relocation of outpatients and day cases from LRI into community settings
- Redesign of Emergency Floor
- Move to a two site emergency take

In addition to these three priorities individual service and site reconfigurations include:

- Centralisation of emergency gynaecology services at LRI and elective at the LGH
- Developing Hybrid theatres for Cardiology and Cardiac Surgery
- Converting non-clinical space to clinical, e.g. Ophthalmology, AMU areas

4.5.10 Capacity planning (right-sizing beds, theatres, and outpatients)

Linked to site and service reconfiguration is the need for UHL to reduce the amount of activity provided in the acute care setting, and in turn the amount of capacity used to deliver this activity. This includes the sustainable reduction in the number of beds, theatres and outpatient clinics. This will be achieved by a transformation programme that will support productivity improvement and service redesign to ensure any reduction is sustainable and improves patient care.

4.5.11 Developing Care Pathways

To support Site and Service Reconfiguration we will redesign patient pathways across the health economy to enable the shift of care from Acute to lower cost settings in the community and at the same time provide more efficient pathways within UHL. For 2012/13 this will include:

- Jaundice Care Pathway
- Lower GI and Urology Cancer Pathway
- Developing a comprehensive outpatient parenteral antimicrobial therapy service (OPAT)

4.5.12 FM shared services and total FM Procurement

Underpinning the LLR Reconfiguration Programme is the principle of 'one asset and one landlord'. To achieve this aim, UHL is part of the LLR Facilities Management Collaborative, which is procuring a seven year framework to provide core facilities services and support the transformation of assets across the health community. This transformational procurement will be completed in the summer of 2012, with a mobilisation date of October.

4.5.13 IT Transformation

Also key to a successful distributed service model, is a world class IT Infrastructure to support care delivery and knowledge transfer. UHL is therefore in the process of procuring an IT partner to support the delivery of core IT services and enable transformational change. This will ultimately lead to the implementation of an Electronic Patient Record. Priorities in 2012/13 include:

- clinical portal
- e-rostering
- electronic resource planning
- bed management
- unified communications
- transforming transcription together with the electronic transmission of outpatient letters to GP's
- outpatients self-check in

4.5.14 Transforming our Workforce

There are recruitment problems in some specialties which provide a challenge for our trainee medical staffing rotas. Through adoption of the Hospital at Night programme we will minimise and mitigate this impact by implementing an alternative way of working whilst improving patient outcome and experience. Initially we will concentrate this within the Acute Care Division.

The physiotherapy and occupational therapy services in UHL have traditionally been managed and operated within different managerial, clinical and operational systems. Although integration has occurred within some areas this has not been widespread. A review of the managerial, clinical and operational structures will lead to consolidation into integrated therapy teams with combined management and clinical structures. This will result in reducing duplication and improving efficiencies, both in staff time and finances and improving patient care by refining and integrating the therapy patient care pathway.

A proposal to transform the way we provide medical transcription in the Planned Care Division will be implemented during 2012/13. New service models have been developed jointly with clinicians and staff (through fortnightly medical secretary/audio typist engagement forums and CBU meetings). The new service models will improve quality, achieve turnaround standards and deliver recurrent efficiency savings. New roles have been developed which incorporate all existing duties with the typing element provided through a partner. These new roles align more closely to the delivery of the patient journey.

4.5.15 Building on the Trusts reputation for Research and Development

Research and development is a major strand of UHL's strategy. In collaboration with our academic partners, the Trust undertakes a wide portfolio of patient-centred research which includes almost every aspect of specialist medicine and surgery. Several of our research teams are recognised as international

leaders in their field; they include cardiovascular disease, respiratory disease, diabetes, cancer, renal and infection.

4.5.15.1 The 'Hope' Cancer Trials Unit

The development of the 'Hope' Cancer Clinical Trials unit, partly funded by The Hope Foundation, is critical to the renewal of UHL's Experimental Cancer Medicine Centre, (ECMC) status by Cancer Research UK (CRUK). The infrastructure provided by the Hope clinical trials unit will ensure that ECMC study activity continues to progress. The development of the unit and the opportunity to increase our trails portfolio is fundamental to the Trusts application to be a prestigious CRUK Cancer Centre and supports our ECMC grant renewal process.

4.5.15.2 Biomedical Research Units (BRUs)

Funds totalling more than £19m have been awarded in recognition of our excellence by the National Institute for Health Research to be spent on developing three BRUs which are described in more detail below.

In collaboration with the University of Leicester (UoL), the Respiratory BRU will focus on the development of new and effective treatments for severe asthma and chronic obstructive pulmonary disease (COPD). Over the spring and summer of 2012 we will see £2m invested in a new facility at the GH site for the respiratory BRU.

The collaboration with the UoL will continue through the development of the Cardiac BRU research portfolio in 2012/13. This will include further studies and trials into better predicting those at risk of heart attack as well as trials to see if drugs can be developed to limit damage to the heart after a heart attack.

The Nutrition, Diet and Lifestyle BRU will be sited within the Diabetes Centre of Excellence at the LGH and at facilities at Loughborough University. The focus of the research will be on new areas of physical activity research including the potential benefits of short periods of exercise, particularly in patients with type II diabetes and chronic kidney disease. Our diabetes research team is already one of the best in the country and leads the world in areas such as diabetes prevention and early detection. The integration of the BRU will serve to further enhance the Trust's reputation in this nationally important area of research.

4.5.15.3 National Centre for Sport and Exercise Medicine: East Midlands (NCSEM-EM)

A proposal for a national centre for sports and exercise medicine was accepted as part of the legacy bid for the 2012 London Olympics. The concept was to include research and education in addition to clinical services. Initially, it was conceived as a single centre to promote sports and exercise medicine for athletes and sports injuries. This has now broadened to become a network of three centres with slightly different configurations. The brief has also now been enlarged to include exercise as therapy in the context of chronic disease management.

The East Midlands consortium bid that includes UHL, UHN, NPT and Loughborough, Nottingham and Leicester Universities was accepted as one of the three centres along with London and Sheffield. UHL along with the other stakeholders contributed £10k towards the application development.

5 Alignment to commissioner plans

There is significant alignment between this plan and the LLR Integrated Plan. As a system we have co-created the strategy described above and all Trust Boards have agreed the corresponding priorities for 2012/13. The implementation of the plans and the monitoring of delivery will be taken forward by the LLR Reconfiguration Programme Board and overseen by the LLR Chief Executives. The Programme Board is chaired by the PCT Cluster Chief Executive and includes an Executive and Clinical lead from each partner organisation. It also includes representatives from LINks and Age UK to enable wide public and patient involvement in the development and implementation processes.

Planning for 2012/13 has been based on the forecast out turn position at specialty level for each category of service with the application of the following assumptions.

5.1.1 Baseline – Forecast Outturn

Baseline is based on April to November 2011 (Month 8 Year to Date) uplifted to full year. All providers are included in the model both LLR and Non LLR.

Activity is forecasted at the following level:

- Provider
- Management Type:
    - New Outpatients
    - Follow Up Outpatients
    - Outpatient Procedures
    - Ward Attenders
    - Day Cases
    - Elective Inpatients
    - Non-Elective Inpatients
    - Emergency Inpatients
- Treatment Function Specialty

5.1.2 Demographic Growth

2012/13 activity growth due to demographic population changes will then be applied to the Activity Forecast Outturn produced above. The growth rates applied have been provided by Public Health via our lead commissioner.

5.1.3 Adjustments

Adjustments for any additional considerations were discussed at confirm and challenge meeting during January where UHL and Commissioners engaged to drive a joint plan for 2012/13. This included the following:

- unmet demand for specialties with long waiting times or significant risks of breaching 18 week RTT targets
- outpatient procedures and ward attender growth in excess of recent trends
- CCG commissioning intentions
- Quality, Innovation, Productivity and Prevention (QIPP) initiatives:
- right care
- demand management
- national or local programmes and campaigns that may stimulate increased demand e.g. bowel cancer screening programmes and awareness campaigns
- contract variations or counting and coding changes that may affect how activity will be recorded or where it will appear
- birth rates – for specialties relating to obstetrics and maternity, rather than population growth rates, birth rate forecasts may be used to more accurately reflective growth in this area

The agreed activity plan for 2012/13 will form the basis of the contract for 2012/13. This will be costed and agreed and any contract terms then applied.

6 Key Risks

We operate a robust risk management process enabling the identification and control of risks at both a strategic and operational level.

A mechanism is in place to ensure these risks are captured and managed via the UHL Strategic Risk Register and Board Assurance Framework (SRR/BAF).

Key strategic risks are defined as those risks that are identified to/by the UHL Trust Board as being potentially damaging to the achievement of the Trust's principal objectives.

Each strategic risk is assigned an Executive Director as the risk owner and the UHL Executive Team and Trust Board review the SRR/BAF on a monthly basis to identify and review the Trust's principal objectives, clinical, financial, and generic. Key risks to the achievement of these objectives, controls in place and assurance sources along with any gaps in assurance are identified and reviewed.

This Annual Plan responds to and where possible addresses the strategic risks facing the Trust. However, once the Annual Plan has been approved, the Trust Board will review the current SRR and update it to reflect any additional risks in this plan.

6.1 Key Risks 2012/13

The Trust has identified a total of 19 key strategic risks across that may impact upon the achievement of its annual plan during 2012/13, and that the annual plan also aims to address. A brief outline of the key causes and consequences of each risk are outlined in the table below and a more detailed description can be found in the Trust Board's SRR.

Risk Domain	Risk Title	Causes	Consequences
Clinical Quality Risks	• Deteriorating patient experiences	• Cancelled / rescheduled operations • Increased waiting times • Poor communication • Overheating of emergency care system	• Patients not choosing UHL (reduced activity / income) • Contract penalties • Reduced CQUIN income • Increased complaints /reputational impact
	• Continued overheating of the emergency care system	• Behaviour of clinical commissioning groups • Delays in discharge • Lack of middle grade/senior decision makers	• Clinical risk/ inefficient, sub optimal care • Financial loss • Poor patient experience
Strategic / Local Health Economy	• New entrants to healthcare market	• TCS agenda • Financial climate	• Loss of market share, business, services and revenue • Increased competition
	• Failure to Develop and maintain relationships with clinical commissioning groups	• Weak relationship with GPs as a result of historical lack of engagement by UHL	• Lack of certainty/ continuity of commissioning during transition • Loss of revenue • Lack of GP support for UHL strategy
	• Failing to acquire and retain critical clinical services.	• National review of specialist services • Cost effectiveness	• Loss of key clinicians • Inability to attract best quality staff • Unable to achieve academic expectations • Loss of income
	• Non-delivery of operating framework targets	• Poor system management • Lack of clinician availability • Inefficient administrative procedures • Unplanned external factors	• Reduced choice- reduced activity • Reduced income stream • Poor patient experience • Failure to achieve FT status
Financial Risks	• Lack of appropriate	• Legacy of old contractual regime	• Service innovation constrained by

Risk Domain	Risk Title	Causes	Consequences
	Payment by Results (PbR) income	• Limited clinical engagement in clinical coding / contract negotiation • Failure to achieve key operational ratios • Penalties for readmission not based on clinical evidence	financial penalties • Potential for increased clinical risk through inappropriate cost reductions • Impact on delivery of statutory targets
	• Loss of liquidity	• Cumulative impact of non-standard contract	• Unable to invest in core services or develop new services • Failure to deliver EFL statutory target
	• Underperformance on CIP delivery	• Lack of management capacity/ capability • CIP delivery may stall if adversely impacting on quality	• Potential for increased clinical risk / compromised quality • Failure to achieve statutory targets • Delay / failure to achieve FT
	• No improvements in readmission rates		• Contract penalties • Reduced capacity • Risk of sub-optimal patient care
Organisational Development / Workforce Risks	• Skills shortages	• No development of a learning and development culture • No resource to invest in development opportunities • Inability to recruit and retain suitably skilled staff	• Lack of sustainability of some middle grade rotas • Increased clinical risk • Additional expenditure on locum staffing
	• Inadequate organisational development	• Lack of a specific development programme for change management • Low levels of staff engagement • Inadequate equipping of managers, leaders and staff for change	• Poor quality and efficiency of service • Poor Trust reputation • Low staff morale
Estates Risks	• Underutilisation and investment in Estates	• Lack of a clear Estate strategy	• Sub-optimum site configuration • Over-provision of assets across LLR • Significant backlog maintenance
IM&T	• Lack of organisational IT exploitation	• Insufficient capacity and capability • Failure of NPfIT • Lack of confidence in the delivery of benefits from IT systems	• Significant performance risk • Current systems will become obsolete/ unsupported by 2013/14 • Communications with partners is compromised
Governance and Leadership	• Ineffective clinical leadership	Inability to effectively implement organisational development strategy	Inability to responsively change service model to meet changing healthcare needs
	• Lack of management capability / capacity	• Lack of development opportunities • Lack of experience/ skills • Size of the challenge presented by the environment we are transitioning into	• Inability to support changes to service model • Lack of focus on key metrics and service delivery • Inadequate organisational development • Gaps in middle management leadership
	• Failure to develop a culture of innovation	• Innovation seen as optional 'if we have time to spare' • Too focussed on immediate operational issues	• Low staff morale • Out-dated models of delivery increasingly expensive and vulnerable
	• Inadequate data protection and confidentiality standards	• Inadequate recognition of minimum standards required to protect patient and key corporate information • Limited staff engagement and understanding • Inadequate development of	• Poor protection of sensitive personal / corporate data • Damage to reputation from data breaches

Risk Domain	Risk Title	Causes	Consequences
		managers, leaders and staff	
Business Continuity/Disaster Planning / Recovery	• Organisation may be overwhelmed by unplanned events	• Major disaster/ pandemic • Industrial action • Failure of business critical systems • Business continuity/ disaster recovery plans not robust	• Poor patient experience • Patient safety may be compromised • Loss of income • Failure to meet Civil Contingencies Act duties

Table 10: Risks taken from the UHL's Strategic Risk Register 2012

6.2 Financial Risk Rating (FRR)

There are four main financial risk areas for 2012/13:

- overall FRR
- cash and liquidity
- efficiency schemes
- patient care contract

6.3 Cash and Liquidity

We expect to deliver a FRR of 3 in 2012/13. This is predominately as a result of our cash and liquidity position. Whilst we will deliver the 2011/12 year end cash target of £18.2m, the changes in tariff and efficiency targets for 2012/13 will put pressure of the liquidity days. To mitigate against the risk in 2012/13 we are looking to maximise our working capital by reducing debtor days, managing creditors and maximising stock levels.

6.4 Efficiency Schemes

We have established a Transformation Support Office (TSO) to help ensure that we apply consistency and rigour to the way we monitor, assure and report on our cost improvement and transformation schemes. Under the executive sponsorship of our Chief Executive our TSO provides intelligence to our Executive Team in three areas:

- CBU Financial performance
- Performance against our cost improvement schemes (focusing more heavily on schemes with a value greater than £65,000)
- The delivery of our transformation work streams

To support the logging and tracking of the delivery of our cost improvement schemes, we have introduced a number of processes and tools, including templates to capture and monitor our schemes and review and reporting structures including a Transformation Board.

Our TSO is responsible for reviewing our cost improvement schemes to ensure that:

- They are operationally deliverable and achievable
- The financial benefit and phasing of the benefit is based on reasonable assumptions
- Risks have been identified and appropriate mitigation strategies put in place and that these strategies have been signed off by the divisions and corporate directors.
- The cost improvement schemes deliver genuine savings
- Where schemes impact on other areas of our organisation this is discussed and agreed by those affected

All cost improvement schemes are risk assessed and 'RAG' rated Red, Amber or Green. This RAG is based on the TSO's confidence in a number of factors:

- If the majority of the risk assessment criteria score in the lower range i.e. 0 to 1, the scheme would be RAG'd as Red.

- If all of the criteria are assessed as 3 the scheme would be RAG'd as Green.
- If some of the criteria are assessed in the mid-range to high range, i.e. 2 to 3 the schemes would be RAG'd as Amber.

Criteria	Key Issues	0	1	2	3
Finance	Total financial value Basis for figures	No projected figures	High value but no confidence in the figure	Doubt over the figures, for any value	Full confidence in the figures, for any value
Project management and documentation	Plan, tracker, risk log exist Effectiveness of monitoring	Project planning not commenced. No agreed scope	Minimal documentation and monitoring	Documentation exists but variable quality	Effective and robust documentation and monitoring
Capacity and resources	Sufficient staff Correct skill mix	Absence of documentation and monitoring	Lack of capacity and the skills needed	Doubts over total capacity or the skills in the team	Sufficient staff with right skills mix to deliver
Track record	Project performance in previous year / YTD	No track record of delivery	Limited track record of delivery	Evidence of delivery with isolated incidences of	Consistent delivery over sustained period of time
Stakeholders	Support of stakeholders Availability of stakeholders	Stakeholders not identified; or stakeholders blocking CIP progress	Stakeholders unopposed to CIP but not involved	Stakeholders are supportive but not available	Stakeholders supportive, available and actively engaged
Deliverability	Dependencies Transactional versus transformational	Dictated by services / stakeholders outside of area of remit	Transformational; significant dependencies	Some dependencies	No dependencies; transactional

Table 11: Criteria used to RAG rate Cost Improvement Schemes

All of our cost improvement schemes are also risk assessed for impact on quality and signed off by the divisional or corporate director before being submitted to the TSO and entered onto the Trust's risk register as appropriate. This process is integral to our overarching risk management process.

Any scheme which has a negative impact on quality and /or poses a significant risk is withdrawn and not submitted to our TSO. Divisions and corporate directorates monitor and mitigate the on-going clinical and quality risks associated with their cost improvement schemes, stopping any scheme that has an adverse effect. As a requirement of the Operating Framework, all CIPs will also be signed off by our Medical Director and Chief Nurse, as well as by the Medical and Nursing Director within the PCT Cluster.

6.5 Patient Care Contract

A key component of the Trust's financial position is the patient care contract. Following extensive negotiation the 2012/13 Patient Care Contract has been agreed between Leicester, Leicestershire and Rutland PCT Cluster, on behalf of the three CCGs and UHL.

The contract will be based on the new 2012/13 NHS Standard Contract for Acute, Ambulance, Community and Mental Health and Learning Disabilities Services (Multilateral). The agreement is for one year in line with the operating framework guidance to allow for transition to CCGs as commissioners in 2013/14.

The contract is reflective of the needs of the local population and the requirements of the local health economy.

The value of the contract is an uplift of £20m from 2011/12 baseline. This recognises the increasing demand on services and the shift to a more PbR compliant contract than has been in place historically. The 2012-13 agreement undertakes to resolve a good proportion of the funding issues that have been perpetuated in past agreements. This will significantly support the underlying financial position and the cash and liquidity position.

7 Improving Quality and Safety

7.1 Priorities for 2012/13

Our Quality Account describes areas for improvement for 2012/13 covering patient experience, effectiveness and safety.

We have chosen to continue to focus on last year's priorities for improvement. This decision has been made following discussion with board members, divisions and our commissioners. These priorities are:

- to improve readmission rates
- to improve patient experience
- to improve mortality rates

In addition to these three main priorities for improvement we have also identified other specific areas including:

- Improving the use of the World Health Organisation, (WHO) checklist and team briefings in all our operating theatres by achieving 97% compliance with WHO checklist usage in patients having operations in our theatres[5]
- Reducing cancellations on the day of elective surgery by 50%. We will achieve this by ensuring that elective surgical patients receive their procedure on the intended date and working collaboratively across the organisation to improve theatre utilisation
- Provide high quality end of life care by improving advance care planning and staff training of staff
- Improving awareness and diagnosis of dementia using risk assessment

There is a comprehensive plan for patient safety to ensure our patients receive safe, high quality care. We are embarking upon a safety programme called "5 Critical Safety Actions". This seeks to embed safety processes to provide systematic, consistent and high quality care.

The 5 Critical Safety Actions are:-

1: improving clinical handover
2: relentless attention to EWS triggers and action
3: implement and embed mortality and morbidity standards
4: acting upon results
5: senior clinical review, ward rounds and notation

These Critical Safety Actions are supported by commissioners and will be subject to routine monitoring via agreed implementation plans and milestones. To support the monitoring, commissioners will undertake visits on a quarterly basis where they will expect to see evidence of the implementation in action.

For 2012/13, we have again identified improving patient experience as one of our top priorities. We want to increase the opportunity for patients, carers and the public to provide feedback on services and care provided through a range of media including establishing the question and baseline 'Net Promoter Score' for 10% of inpatient discharges for any given week at or within 48 hours of discharge.

The first month of reporting will be in April 2012, following which a trajectory for improvement will be agreed to ensure either a 10 point improvement in Net Promoter Score or achievement or maintenance of top quartile performance throughout 2012/13.

[5] Please not this target is 97% rather than 100% because whilst all elective and maternity theatres comply with the checklist, it is not always possible to complete the full checklist when operating on patients in an emergency due to time constraints. From April 2012, a monthly audit of the WHO checklist would be implemented in each theatre using ORMIS (theatre systems).

7.2 Monitoring Quality and Safety

We face another challenging year with a demanding cost improvement programme in 2012/13. By "focusing on what matters most" we will further strengthen the risk assessment process for CIPs.

All CIPs have been risk assessed and signed off by the division/corporate director before they are submitted to the Transformation Support Office and the RAG, (Red / Amber / Green) rate is included on the template. Schemes over £65k in value have completed a Risk Assessment form that is an integral to the Trust's risk management process and where appropriate are entered onto the Trust's risk register. Schemes which have a negative impact on quality and/or pose a significant risk have been withdrawn prior to submission to the TSO.

The Trusts' Director of Risk has reviewed the quality assurance process that divisions and corporate departments have gone through. These results have been reported to the Chief Operating Officer/Chief Nurse and Medical Director.

The Chief Operating Officer/Chief Nurse and the Medical Director have formally signed off the assurance process and reported the outcomes to the Governance and Risk Management Committee, (GRMC) in March 2011. The PCT Medical Director and Director of Nursing have also been provided with the risk assessments.

The GRMC will continue to review the quality and safety elements of CIP schemes by choosing to look in more detail at a selection of the schemes.

We will monitor the implementation of CIPs for the life of the scheme to ensure that safety and quality of care is not impacted. We will reverse any scheme that is having an adverse effect. Specific safety indicators will be monitored through the Quality and Performance report including:

- mortality data
- never Events
- SUIs relating to deteriorating patient
- death or serious harm following falls
- complaints relating to attitude of staff
- patient experience data
- open CAS alerts

External monitoring of quality and safety will continue monthly through the Quality Schedule and CQUIN scheme. Areas of non-compliance are escalated to the GRMC via exception reports. Any quality performance indicator which lies outside expected controls limits is fully investigated at the Clinical Effectiveness Committee with exception reports escalated to GRMC or Trust Executive.

Recognising the current challenges we face, we are augmenting the monitoring of safety, through the following arrangements:-

- executive/non-executive safety walkabout programme
- "3636" staff concerns reporting line
- monthly reporting on quality dashboards
- commissioner quality visits

Within 2012/13 our key safety aims will be to reduce preventable death and harm and to improve the quality of the patient experience. We have, therefore, set an ambitious target reduction of 10% of preventable patient safety incidents reported in 2012/13. This improvement trajectory will be monitored through STEIS SUI reporting and tracked monthly through the Provider Management Regime (PMR) dashboard as well as monthly reports to Quality and Performance Management Group (QPMG) and GRMC.

For 2012/13 we aim to reduce the number of formal complaints received and continue to reduce complaints related to staff attitude. Our target improvement will be 10% reduction in formal written complaints received with a parallel reduction in complaints regarding staff attitude.

7.2.1 Pressure Ulcers

Pressure ulcers are a recognisable proxy measure for the quality and safety care patients receive. The Midlands and East SHA have made the challenging commitment to eliminate avoidable grade 3 and 4 pressure ulcers, (3 & 4 ulcers are the most serious) by December 2012 as an 'ambition'. During 2012/13 the Trust will work to the SHA target, with the aim of reducing the number avoidable pressure ulcers to 0.

There is no confirmation at the present time as to whether improvement thresholds for Q1, 2 and 3 will be set by commissioners but it has been agreed that the monitoring of pressure ulcers will be undertaken using the NHS Safety Thermometer data collection (similar to a prevalence survey) and serious incident reporting for grade 3 and 4 ulcers.

7.2.2 Falls

Reduction targets for falls are being agreed with CBUs and where we still have a high incidence of reported falls we will be developing a further programme of actions for areas. Areas of focus will include patient environment and staff factors and ensuring that our fractures and head injuries are reported consistently across the organisation. We are also introducing the Patient Safety Thermometer to provide bench marking data during 2012/13.

7.2.3 Same Sex Accommodation Compliance

Quarterly same-sex accommodation estates walkabouts will continue to take place to:-

- Assess and promote the on-going culture of same sex accommodation
- Review toilet and bathroom signage and facilities to ensure they are available to patients close to their bed area
- Raise staff awareness around privacy and dignity and the importance of providing same sex accommodation and bathroom facilities for patients

During 2012/13 we will continue to monitor Same Sex Accommodation and will record any clinically justified and unjustified breaches using the Same Sex Accommodation Decision Matrix for the Trust. Same sex accommodation breaches will be reported in two ways:

- We will provide a monthly report to our commissioners identifying all breaches of sleeping accommodation as well as the mixing of toilet and bathroom facilities. The financial penalty will only apply to unjustified patient breaches
- All clinically unjustified breaches of sleeping accommodation only will be reported nationally via Unify

In addition to the Same Sex Accommodation Decision Matrix a flow chart has been developed to assist clinical teams with breach reporting. Currently the tool is under consultation with the aim that it will be available for clinical teams by March 2012.

We will produce a Same Sex Accommodation monitoring plan, relating to monitoring of estate (including bathroom facilities) and actions relating to non-compliance, to ensure the highest possible standards are maintained. Specific plans are in progress in the Acute Division to improve the facilities in the Brain Injury Unit and the Acute Medical Unit.

7.2.4 VTE Risk Assessment

During 2012/13 the priority for UHL will be to increase risk assessment for non-cohort patients. These are groups of patients where the risk of acquiring VTE is considered to be very low e.g.: patients attending for renal dialysis. Risk assessment for these patients is undertaken for the group as a whole. The aim will be to embed the 'root cause analysis' process established in 2011/12 which looks at the reason for patients developing a hospital acquired thrombosis in order to identify further preventative actions.

7.2.5 Readmissions

The readmissions project will continue next year with the aim of reducing readmissions by 10% across Leicester, Leicestershire and Rutland. This will be delivered by:-

- Working with clinicians, commissioners, and partners to undertake clinical reviews of readmissions to provide visibility on avoidable readmission groups
- Using risk stratification to allow the targeting of such groups for intervention on discharge
- Supporting senior medical assessment of potential readmissions
- Ensuring improved communication with patients on discharge, ensuring they have a contact point as they leave
- Working with partners and commissioners to ensure the effective targeting of resources in the community to support a reduction in readmissions

7.2.6 NHSLA

Following the achievement of compliance at level 1 in both the NHSLA Acute Risk Management Standards and CNST (Maternity) it is our intention to undertake assessment at level 2 during 2013/14. Assessment at this level requires us to demonstrate that the processes described within our policies and procedural documents have been implemented and embedded across the Trust. A strengthened accountability structure with regular progress reporting to senior Trust committees will place an increased emphasis on performance management to ensure this is achieved.

8 Delivering contractual and national targets and standards

8.1 Further reduce health care associated infections

Targets set for 2012/13 have been confirmed at no more than six MRSA cases and no more than 113 C.Diff cases.

The 2012/13 target for MRSA elective and non-elective screening is 100%.

8.2 Cancer Waits

The objective for 2012/13 is to meet and exceed all the 2 week wait, 31 day and 62 day cancer targets on a monthly basis.

8.3 Referral to Treatment – 18 weeks

The aim for 2012/13 is to achieve the operational standards of 90% for admitted and 95% for non-admitted waits in every specialty. We will ensure that 92% of patients on an incomplete pathway should have been waiting no more than 18 weeks.

Only those patients who choose to will wait longer than 26 weeks from referral to treatment. We also expect less than 1% of patients to wait longer than six weeks for a diagnostic test.

8.4 A&E Performance

The objective for 2012/13 is to consistently deliver the 4 hours target at 95+% and achieve each of the 5 A&E clinical quality indicators:-

Patient Impact	
	Target
Unplanned Re-attendance	<=5%
Left without being seen	<5%

Timeliness	
	Target
Time in department (Minutes) 95% Percentile	<=240
Time to Initial Assessment (Minutes) – 95th Percentile	<=15
Time to Treatment (Minutes) – Median	<=60

Table 12: The five A&E Clinical Quality Indicators

An inefficient ED footprint, 'traditional' pathways, lack of next day services and ambulatory models, poor linkage with the UCC and internal delays are all contributing to a continued overheating of the LLR emergency care system and poor performance against the 4 hour target. Sustainable delivery of the 4 hour target and associated A&E clinical quality indicators will be achieved when UHL actions (as described in Chapter 3, Section 3.4.1) have been addressed and the level of attendances have been reduced in line with the Emergency Care Network plan.

8.5 Contractual Standards and Targets

The 2012/13 contract sets out the Trust's performance requirements and the financial penalties, applied at the commissioners' discretion, if these are not met. These penalties are:

Issue	Penalty
Failure to agree remedial action plan and/or deliver its milestones	2% of total contract value for that month
Issuing of First Exception Notice	2% of total contract value to be withheld until resolved
Issuing of a Second Exception Notice	Withholding could become permanent

Table 13: UHL contractual penalties by issue

The PMR trajectory above, for example, would mean a total financial penalty of £2.9m for the first quarter, based upon the failure to meet ED targets for three consecutive months.

A maximum of 10% of the total contract value can be withheld per month, which equates to £4.8m. Therefore, the absolute worst case scenario would be that we incur the maximum monthly penalty (10%) for a full financial year, which would equate to a total £57.9m of funds being withheld.

The performance measures which pose the greatest risk for the Trust, with a possible monthly penalty of £3.8m, are:

- ED performance, including the 4 hour target
- Cancer waits, particularly the 62 day and 31 day targets
- MRSA and C. diff rates
- Number of operations cancelled on the day of admission

We have plans in place to deliver each of the requirements and reduce the risk of contractual penalties.

The 2012/13 contract also includes £14.1m for delivery of CQUIN and associated indicators, as outlined in the Quality Schedule this money can be withheld if the goals are not met.

Commissioner	Amount	Number of goals
City and County	£9.4m	11 (4 National)
LLR Specialised	£2.8m	12 (4 National)
All associated Specialised and Non-Specialised	£1.9m	-

Table 14: UHL CQUIN amounts by commissioner

We are held to account through monthly formal Contract Performance Monitoring and Clinical Quality Review Group meetings, both chaired by lead commissioners.

The Trust's internal performance management arrangements include:

- Monthly divisional confirm and challenge meetings
- A QPMG which includes all divisions
- Divisional escalation processes resulting where necessary in representation at Trust wide meetings such as the Finance and Performance Committee or the GRMC

For 2012/13, there are 11 Commissioning for Quality and Innovation (CQUIN) schemes for the LLR contract and 8 for the East Midlands Specialised Commissioning Group Contract.[6]

CQUIN Schemes and expected financial value are:

[6] The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of providers' income to the achievement of local quality improvement goals.

National, Regional and Local CQUIN Schemes	£9,617,093
VTE risk assessment within 24 hours	£96,171
Patient Experience – Responsiveness to patients' needs	£480,855
Dementia – screening, risk assessment and referral	£480,855
NHS Safety Thermometer – Pressure ulcers, Falls, Catheter related urinary tract infections and VTE prevention and development	£480,855
NET Promoter – would you refer this service to your family and friends question	£288,513
Urgent Care – Internal Professional Standards for ED, Assessment Units and Imaging	£1,731,077
Discharge Planning – TTOs 24 hours pre discharge, discharge before 11am/1pm and at weekends; definitive diagnosis and management plan on discharge	£1,634,906
End of Life Care – use of LCP, Advanced Care Planning and implementation of AMBER	£480,855
COPD – direct admission to Glenfield and 'COPD care bundle'	£1,442,564
Making Every Contact Count – Health promotion – advice and referral for smoking cessation, alcohol abuse, obesity and exercise	£961,709
5 Critical Safety Actions – M&M process, acting on abnormal results; responding to EWS triggers, clinical handover and ward round notation standards	£1,538,735
EMSCG CQUIN Schemes	£4,129,732
National CQUINs	£825,948
Implementation of Quality Dashboards	£412,973
Renal Dialysis - Home therapies	£412,973
Increased access to Intensity Modulated Radiotherapy	£412,973
Intravenous Chemotherapy and performance Status measurements	£412,973
Optimising HIV treatment	£412,973
Optimising Hepatitis C Treatment	£412,973
Neonatal CONS Infections	£412,973
Minimise the number of patients accidently extubated	£412,973

Table 15: National, Regional and Local CQUIN Schemes

Relevant clinical and managerial leads have been involved in the negotiation process for each of the CQUIN schemes and now the indicators scopes have been agreed, details are being communicated to all Division, CBU and Service leads for onward dissemination to relevant staff groups. Each CQUIN has an identified Lead Officer who will be responsible for the overview of performance in collaboration with Divisional/CBU leads as applicable.

Following the outcome of the Transformational Bids and confirmation of CQUIN monies, we will be reviewing the resource needs for each CQUIN scheme in order to prioritise accordingly.

Whilst CQUIN performance will be reported externally at Trust level, internal performance will be reported at Divisional and CBU level which highlights the financial implications where thresholds not met. Review of

performance will form part of the monthly confirm and challenge meetings (where monthly data is available) or on a quarterly basis.

Key to reducing the risk of financial penalties will be ensuring appropriate thresholds are agreed and that these are based on accurate baselines. One of the main aspects of the 12/13 negotiations has therefore been to ensure that any CQUIN indicators are appropriate and also the scope is realistic.

Meeting the thresholds for each of the CQUINs will be a challenge due to the fact most impact on the emergency pathway and therefore, will be at risk from activity pressures. Achieving the Discharge CQUIN will possibly be the most challenging due to the need for capacity within social services and community services in order to maintain the patient flow. Actions to mitigate will include close monitoring of reasons why patients are not discharged where this is outside of UHL's control.

8.6 2011/12 Provider Management Regime

In December 2011 the NHS Midlands and East Provider Development Committee, a sub-committee of the SHA Cluster Board, agreed to adopt a Provider Management Regime (PMR) approach to over-sight NHS Trusts across the cluster.

The approach is based on the Monitor Compliance Framework and puts the onus on Trust Boards to demonstrate:

- self-awareness in providing assurance
- to submit accurate self-certification
- to be clear on plans to address issues in a timely manner
- holds Trust Boards to account for the delivery of their commitments

8.6.1 2012/13 Predicted Governance Risk Ratings

University Hospitals of Leicester ACUTE GOVERNANCE RISK RATINGS 2012/13					YES = (target met in month) NO = (not met in month) N/A (as appropriate)											
Area	**Indicator**	**Sub Sections**	**Thresh-old**	**Weight-ing**	**April 2012**	**May 2012**	**Jun 2012**	**July 2012**	**Aug 2012**	**Sept 2012**	**Oct 2012**	**Nov 2012**	**Dec 2011**	**Jan 2013**	**Feb 2013**	**Mar 2013**
Safety	Clostridium Difficile	Are you below the ceiling for your monthly trajectory	Contract with PCT	1.0	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Safety	MRSA	Are you below the ceiling for your monthly trajectory	Contract with PCT	1.0	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Quality	All cancers: 31-day wait for second or subsequent treatment, comprising either:	Surgery Anti cancer drug treatments Radiotherapy	94% 98% 94%	1.0	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Quality	All cancers: 62-day wait for first treatment, comprising either:	From urgent GP RTT From consultant screening service referral	85% 90%	1.0	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Patient Experience	RTT waiting times – admitted	95th percentile	23 wks	1.0	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Patient Experience	RTT waiting times – non-admitted	95th percentile	18.3 wks	1.0	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Quality	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Quality	Cancer: 2 week wait from referral to date first seen, comprising either:	all cancers for symptomatic breast patients (cancer not initially suspected)	93% 93%	0.5	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Quality	A&E: Total time in A&E	Total time in A&E (95%)	≤ 4 hrs	1.0	NO	NO	NO	YES	YES	YES	YES	YES	YES	YES	YES	YES
Quality	A&E:	Total time in A&E (95th percentile) Time to initial assessment (95th percentile) Time to treatment decision (median) Unplanned re-attendance rate Left without being seen	≤4 hrs ≤15 mins ≤60 mins ≤5% ≤5%	No weighting	NO	NO	NO	YES	YES	YES	YES	YES	YES	YES	YES	YES
			TOTAL		1.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Table 16: Predicted Governance Risk Ratings 2012 / 13

9 Financial Plans

9.1 Financial Assumptions Underpinning the Plan

In this chapter, we describe the key assumptions underlying the Trust's 2012/13 operating plan and budget. The financial year 2011/12 has been very difficult for the Trust, with a well-publicised financial recovery plan implemented in July 2011. At the time of finalising this plan, delivery of the Trust's control total for 2011/12 is still at risk, and the underlying result, after adjusting for non-recurrent income sources, is a deficit.

A key feature of the 2012/13 budget is the successful negotiation of an additional £20m of contract income through the counting & coding change process. The growth of the cost base in 2012/13 will be carefully controlled with a realistic CIP programme through the year augmented by a pan-trust transformation programme, delivering during the second half of the year.

These features are described in greater detail in this chapter.

9.1.1 Activity/Income Assumptions

- 1.8% tariff reduction in each financial year, equates to £8.4m in 2012/13
- £4m recurrent reduction in the ECMO contract in 2012/13 as a result of change in national commissioning during late 2011/12
- £1.0m reduction as a result inflationary and volume changes to the Multi-Professional Education and Training (MPET) contract
- approximately £20m additional income via the contract:
  - £15m minimum relating to counting and coding changes, the size of the increase being due to the continued "unwinding" of the old contracting arrangements
  - £5m regarding readmission penalties

9.1.2 Expenditure Assumptions

- Pay and non-pay inflation, £10m. This includes:
  - a nil base pay increase for all but low paid workers
  - continued incremental drift
  - clinical excellence awards (fully funded) plus local discretionary points
  - non-pay inflation on drugs and clinical supplies
- Matched costs and income on NICE and other excluded drugs (estimate £4m increase)
- On our insurance premium costs as we migrate from CNST Level 2 to Level 1
- Inflationary increases in base CNST premia

These assumptions require a saving of approximately 4.5% of total operating cost base and up to 6% of the 'controllable' cost base to deliver a break even position.

9.2 Income

Income from Main Commissioners

Commissioner	2011/12		2012/13	
	£m	%	£m	%
Leicester City PCT	156.3	26%	159.2	26%
Leicester County PCT	230.4	38%	221.0	36%
EMSCG	156.9	26%	161.5	26%
Lincolnshire PCTs	7.0	1%	6.8	1%
Northamptonshire PCTs	7.6	1%	7.7	1%
National Commissioning Group	12.8	2%	8.1	1%
Others	37.7	6%	43.6	7%
Total Patient Related Income	**608.6**	**100%**	**607.9**	**100%**

Table 17: Table showing the income received from our main commissioners

Commissioner	2011/12	2012/13
	£m	£m
Non NHS Clinical Revenue	6.5	6.5
Education, Research & Training Income	71.4	67.7
Other Operating Income	20.8	25.4
Total Non-Patient Related Income	**98.6**	**99.6**

Table 18: Table showing the income received from other sources

The Trust receives the majority of its income from patient related activity - £608.6m, 86% of total income in 2011/12 and £607.9m, 86% in 2012/13.

The small change in this source of income in 2012/13 reflects the 1.8% tariff reduction, demographic growth of activity and approximately £15m of additional income to recognise the improved coding and counting of patient care activity.

Other income is forecast to increase by £1.0m or 1% from 2011/12 levels.

Patient Care Income by Point of Delivery

	2011/12		2012/13
Point of Delivery	**Plan £m**	**FOT £m**	**Plan £m**
Day Case	56.4	59.8	51.0
Elective Inpatient	68.0	69.7	71.1
Emergency	162.4	159.0	155.3
Maternity	29.7	28.3	26.8
Critical Care	42.8	43.7	47.0
Outpatient	82.7	86.0	86.3
Emergency Department	14.2	15.0	15.5
Other	133.1	147.0	155.0
Grand Total	**589.2**	**608.6**	**607.9**

Table 19: Patient Care Income by Point of Delivery

9.2.1 Patient Care Activity by Point of Delivery

	2011/12		2012/13
Point of Delivery	**Plan Activity**	**FOT Activity**	**Plan Activity**
Day Case	80,524	82,307	80,321
Elective Inpatient	23,190	22,342	23,239
Emergency	77,256	74,561	72,284
Maternity	41,301	39,677	39,376
Critical Care	39,550	39,583	45,183
Outpatient	751,698	768,173	781,790
Emergency Department	159,130	158,676	159,549
Other	6,520,293	6,562,725	6,729,303
Grand Total	**7,692,942**	**7,748,045**	**7,931,045**

Table 20: Patient Care Activity by Point of Delivery

9.2.2 Commentary on Income and Activity by Point of Delivery

The Trust has seen a mixture of increases and decreases in activity levels compared to the plan in 2011/12 across the various points of delivery. The key areas are:

- There has been a 2.2% increase in day case activity compared to plan (1,783 spells) with a reduction in elective inpatients of 3.7% (848 spells). This reflects a planned move of activity to a day case setting.
- Emergency activity is forecast to be 3.5% or 2,694 spells below plan. This is a consequence of a number of successful programmes to appropriately manage admissions into the Trust particularly through the ED.
- A significant proportion of the day case reduction in 2012/13 (c. £5.5m) is due to a national change in the payment mechanism for chemotherapy patients. This value is partially offset by a corresponding increase in "other" (c. +£3.6m). There is also national tariff inflation at -1.8% on average (or around a further £1m reduction).

- The "other" category includes ECMO, Bone Marrow Transplant, direct access, end stage renal care, NICE and high cost therapies, and transformation funding.

9.3 Expenditure

	2011/12				2012/13
Spend Category	**Plan £m**	**FOT £m**	**£m**	**%**	**Plan £m**
Medical and Dental	133.7	134.2	(0.5)	(0.3)	135.0
Nursing & Midwifery	158.3	160.2	(1.9)	(1.2)	160.9
Other Clinical	56.2	55.5	0.7	1.2	55.8
Agency	1.6	12.2	(10.6)	(668.4)	5.9
Non-Clinical	70.7	71.0	(0.3)	(0.4)	69.1
Pay Expenditure	**420.5**	**433.1**	**(12.6)**	**(3.0)**	**426.7**
Drugs	57.8	56.4	1.3	2.3	60.5
Clinical supplies and services	77.1	83.8	(6.7)	(8.7)	86.0
Other	82.1	87.7	(5.5)	(6.7)	90.8
Non-Pay Expenditure	**217.0**	**227.9**	**(10.9)**	**(5.0)**	**237.3**
Other Expenditure	**43.0**	**45.0**	**(2.0)**	**(4.6)**	**43.5**
Total Expenditure	**680.5**	**705.9**	**(25.4)**	**(3.7)**	**707.5**

Table 21: Table showing Expenditure for 2011/12 and plan for 2012/13

The 2012/13 expenditure plans reflect the key assumptions in section 8.1. This includes the impact of pay and non-pay inflation, and specific contractual settlements e.g. increased investment in NICE, and therefore in drug spend. They also account for the 2012/13 CIP plans.

9.4 Financial Plan 2012/13

	2011/12 FOT* £m	2012/13 Annual Plan £m	Variance £m	Variance % of FOT
Income				
Patient Income	615.1	614.4	(0.6)	(0.1)
Teaching, R&D	71.4	67.7	(3.7)	(5.5)
Other Operating Income	20.7	25.4	4.7	18.5
Total Income	**707.2**	**707.5**	**0.3**	**0.0**
Operating expenditure				
Pay	433.1	426.7	6.4	1.5
Non-pay	227.9	237.3	(9.4)	(4.0)
Total Operating Expenditure	**660.9**	**664.0**	**(3.0)**	**(0.5)**
EBITDA	**46.3**	**43.5**	**(2.7)**	**(6.3)**
Net Interest	(0.5)	(0.5)	0.0	8.3
Depreciation	(31.1)	(31.0)	0.1	0.2
PDC dividend payable	(13.4)	(12.0)	1.3	10.9
Net Surplus / (deficit)	**1.3**	**0.0**	**(1.3)**	
	***Based on month 10 actuals plus 2 months forecast**			

Table 22: The Financial Plan for 2012/13

9.4.1 Movement from 2011/12 Forecast Out-turn

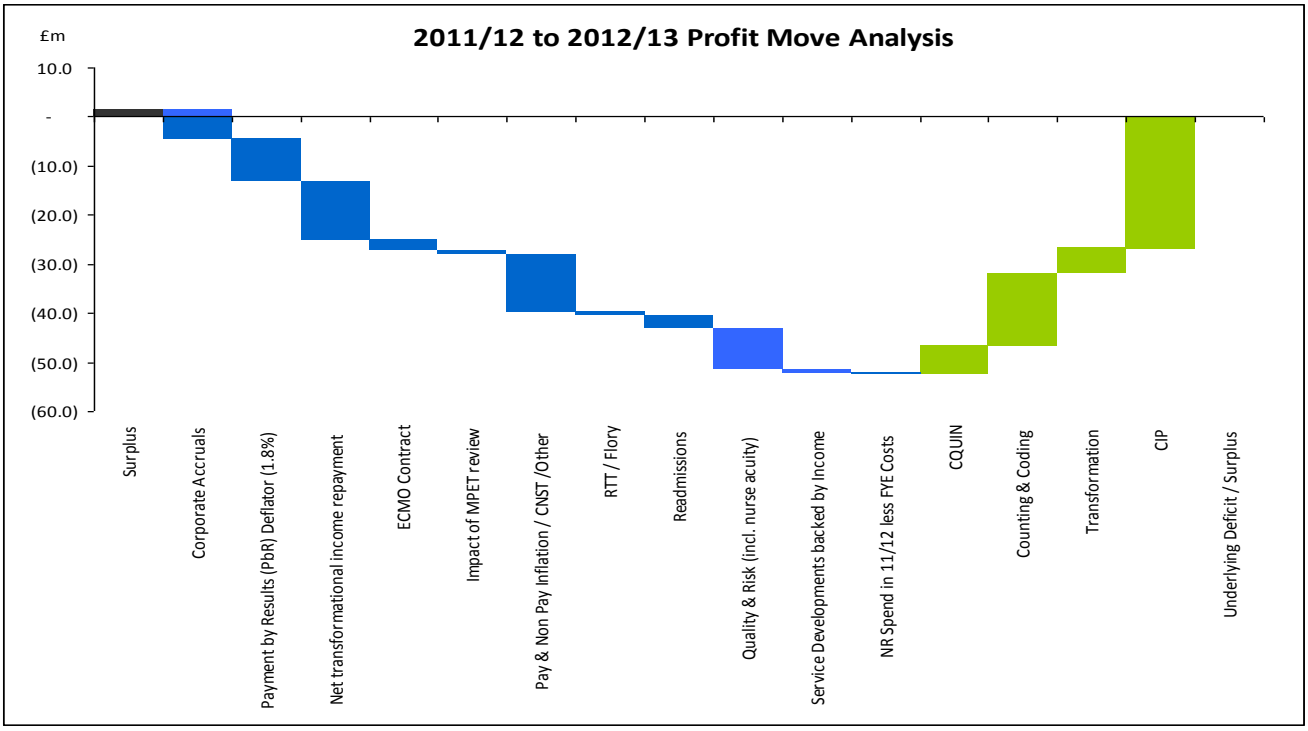


Table 23: Profit move analysis for 2011/12 to 2012/13 Profit Move Analysis

The Profit Move analysis graphically shows how the Trust moves from the 2011/12 forecast year end £1.3m surplus to the planned 2012/13 surplus of £0.05m.

The key movements from 2011/12 are those as described in the financial assumptions section, namely:

- impact of the national tariff
- net transformational repayment
- pay and non-pay inflation
- coding, counting and re-admission income secured in 2012/13
- required CIP of £32m, 4.5% of turnover (the CIP value is a combination of divisional CIPs and transformation schemes)

Note: Our latest expectation is that 2011/12 reported results will be a surplus of £0.1m.

9.5 Capital

Scheme	2012/13 £m	2013/14 £m
IM&T	4.0	4.0
Medical Equipment	4.6	4.0
Facilities	8.0	8.0
	16.6	**16.0**
ED Redevelopment[7]	1.0	0.5
MES Installation Costs	1.5	1.0
PICU / Ward 29 GH	1.0	0.0
Maternity & Gynae Reconfiguration	2.8	0.3
Theatres Arrivals Area (TAA)	1.3	2.3
Aseptic Suite	0.8	0.0
Brachytherapy	0.4	0.0
Re-provision of Management Offices	0.9	0.0
Feasibility Studies	0.1	0.1
Nutrition BRU Enabling	0.2	0.0
PPD Building	0.3	0.0
Individual Business Cases	1.3	5.7
	11.3	**10.0**
BRU Bids: Respiratory	2.2	0.0
BRU Bids: Nutrition, Diet & Lifestyle	1.4	0.0
	3.6	**0.0**
Heartlink	0.3	0.0
Donations	0.3	0.3
	0.6	**0.3**
TOTAL	**32.1**	**26.3**

Table 24: Capital Schemes for 2012/13 and 2013/14

[7] There is a total of £10m allocated to improving the Emergency Department. This will be allocated over the next 3 years now we have agreed with our Commissioners to develop an Emergency Floor. The capital in 2012/13 will cover interim improvements and design fees.

9.6 Financial Risk Rating (FRR)

Metric	Score	2012/13
EBITDA achieved (% of plan)	100.0%	5
EBITDA margin (%)	6.1%	3
Return on assets (%)	3.4%	3
I&E surplus (%)	0.0%	2
Liquidity ratio (days)	15	3
Overall Financial Risk Rating		**3**

5	4	3	2	1
100%	85%	70%	50%	<50%
11%	9%	5%	1%	<1%
6%	5%	3%	-2%	<-2%
3%	2%	1%	-2%	<-2%
60	25	15	10	<10

Table 25: Financial Risk Rating (FRR)

The planned FRR in 2012/13 is three.

9.7 Cost Improvement Plans

Category	2011/12 Plan £m	2011/12 Forecast* £m	2011/12 Variance £m	2012/13 Plan £m
Income	4.5	5.3	0.8	2.0
Non-pay	11.0	7.0	(4.0)	11.8
Pay	22.8	12.8	(9.9)	18.2
Total	**38.2**	**25.2**	**(13.1)**	**32.0**
*Based on month 10 actuals plus 2 months forecast				

Table 26: Table summarizing achievement against 11/12 Cost Improvement Programme

In 2011/12 we under achieved against our CIP target by £13.1m or 34%.The underperformance is across both pay and non-pay categories and is a consequence of planned schemes starting later in the financial year than originally planned or not starting at all. The delayed schemes resulted in £8.9m (35%)of CIPs being delivered between April - September and £16.3m (65%), between October -March.

The 2012/13 CIP target is £32m and will be monitored, assured and reported via the TSO as described in the risk chapter of this Annual Plan. The £32m CIP is a combination of divisional CIPs, which total £27m and a further £5m from the transformation schemes. Given the nature of these schemes it is more difficult to predict the quantum and timing of delivery.

The current progress in identifying and validating individual schemes against the Trust's 2012/13 CIP target is reflected in the following chart. This chart only reflects those CIPs identified by divisions and corporate directorates. It does not include any of the emerging cross-cutting Trust wide transformation schemes.

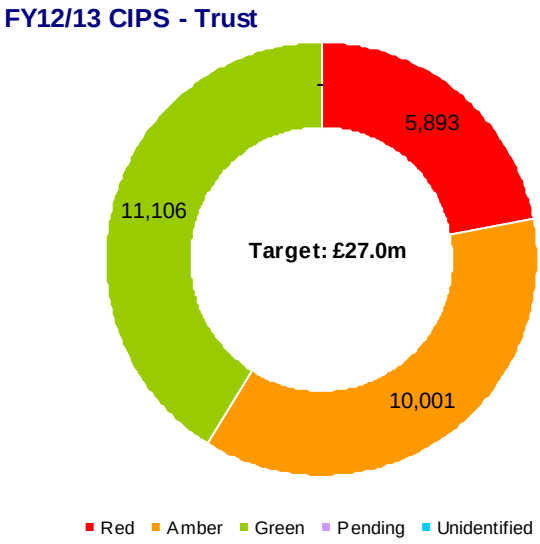


Table 27: FY12/13 CIPs

This financial plan is predicated upon maintaining the "stabilisation" measures implemented in 2011/12. This means that the current run rate of costs and income will be maintained. The impact of delivering this is shown graphically overleaf:

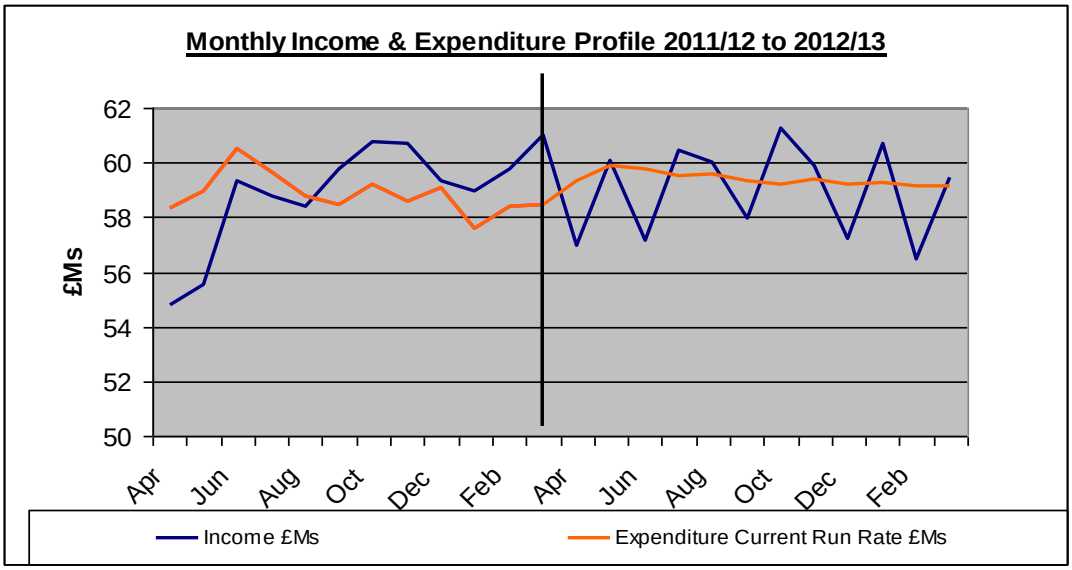


Table 28: Monthly Income & Expenditure Profile 2011/12 to 2012/13

The key assumptions underpinning this graph, in addition to those described elsewhere in this chapter, are:

Income:

- £7.5m transformation funding is secured and invested in resources to deliver transformation
- activity related Income profiled on working / calendar days and reflects seasonality

Costs - will continue at the current run rate with the following exceptions:

- non-pay costs will increase by £0.8m per month. This increase includes higher CNST premiums, NICE/ High Cost Therapy rebasing and general inflationary pressures
- pay costs continue at the current run rate of £35.7m, reduced by the delivery of the 2012/13 CIPs identified to date

In presenting this plan, we acknowledge that there are unavoidable cost pressures relating to maintaining a safe service in 2012/13. By pursuing this incremental planning approach, the Trust is aiming to de-risk the 2012/13 Plan, both clinically and operationally, and avoid the pursuit of unachievable CIP targets. Strict monitoring of leading clinical indicators will continue to ensure the clinical risk is monitored and managed. Attention will be focused, as described in a small number of major transformational schemes which realistically will begin to deliver fundamental changes in operations and greater efficiencies during the second half of 2012/13.

The details behind this are reflected in the table.

	Income			Pay			Non-pay			Total cost		Net surplus	
		Annual	Monthly		Annual	Monthly		Annual	Monthly	Annual	Monthly	Annual	Monthly
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Current income / spend		**707.8**	**59.0**		**433.7**	**36.1**		**274.0**	**22.8**	**707.7**	**59.0**	**0.0**	**0.0**
Less:													
Transformation	12.0			0.0			0.0						
Balance sheet & non recurrent	4.5			(2.0)			2.4						
Q1 premium pay costs				4.0									
Additional Winter capacity				1.0									
RTT / Flory / Other	5.0			2.5			0.5						
ECMO	4.0												
NR readmissions	7.5			0.0			0.0						
		(33.0)	(2.8)		(5.5)	(0.5)		(2.9)	(0.2)	(8.4)	(0.7)	(24.6)	(2.1)
Add:													
Tariff uplift (-1.8%)	(8.4)			1.5			4.6						
CQUIN	6.0			0.5			0.0						
Readmissions	5.0			0.0			0.0						
Transformation	7.5						7.5						
Transformation bid savings				(3.0)			(2.0)						
CNST							3.5						
CIP -11/12 FYE & 12/13	2.0			(15.2)			(9.8)						
FYE / Cost Pressures				4.1			1.2						
Quality / safety related priorities				5.8			0.5						
Nurse patient acuity				2.0			0.0						
Service Devlps backed by income	2.0			2.9			0.3						
Teaching	(1.0)												
NICE/HCT	3.8						3.8						
Counting & coding	14.9			0.0			0.0						
Demographics	8.7												
Other	(1.4)												
QIPP	(6.3)			0.0			0.0						
		32.8	2.7		(1.4)	(0.1)		9.6	0.8	8.2	0.7	24.6	2.1
		707.5	**59.0**		**426.8**	**35.6**		**280.7**	**23.4**	**707.5**	**59.0**	**0.1**	**0.0**

Table 29: Table to show the projected year end position

We will be undertaking further detailed work on the transformational work-streams to identify which programmes can deliver tangible benefits within 2012/13 and ensure these are resourced effectively to achieve this. These include (refer to appendix A for further details):-

- outpatients
- theatres
- length of stay
- readmissions
- coding
- e-prescribing (software implemented in Q3 2011/12)
- service and site reconfiguration
- procurement
- IT strategic partnership
- FM outsourcing – procurement process well underway

Each transformation scheme has a project manager and executive sponsor. Each scheme is in a different stage of development, with some already at the implementation phase (e.g. e-prescribing), whilst others are longer term and will have greater impacts in 2013/14 onwards (e.g. IT and reconfiguration). With the different timeframes in mind, each scheme is being thoroughly scrutinised and detailed project plans developed.

We recognise that the key to delivering safe and sustainable transformation will be clinical engagement and leadership. The divisional teams will therefore be taking more of a lead for transformation in 2012/13 and

are working together to address both the underlying and (including inter-divisional) causes of current suboptimal performance. They will be supported by the Transformation Director and the TSO. The TSO is the nerve centre for Transformation in the organisation, and will ensure the best use of scarce resources. This will include:

- facilitation of the process to identify and prioritise improvement projects
- identification and management of resources
- process expertise and identification of best practice
- guardian of the programme plans – management of interdependencies and major milestones
- streamline reporting around fundamental Key Performance Indicators (KPIs)

The immediate priority will be to identify a suite of deliverable projects from existing transformation work streams. We have also learnt in 2011/12 that we need to acknowledge the relationship between cultural/behavioural issues and project delivery outcomes. We need to understand how this impacts our ability to win hearts and minds and ensure we have the right capacity and capability to ensure transformation is part of what we do. We will apply a structured approach to all projects we decide to deliver. This will include a start-up phase which will identify the problem we want to solve; a current state assessment understanding how the process is currently delivered and whether we have sufficient data to inform the solution design; future state design which will include research of best practice from other Trusts and what implementation looks like; test and planning which will include testing the solution and developing implementation plans and then roll out where the solution will be delivered in a controlled way.

One of the focuses for 2012/13 will be to embed service improvement using process analysis tools such as Lean / Six Sigma. These techniques will focus on eliminating waste and clinical variation in our processes and patient pathways. They will enable us to release capacity through improved productivity and efficiency whilst improving patient care, and therefore deliver better service for less money. To achieve this transformation at the rate required based on the experience in 2011/12 we recognise we may need external help, particularly on the service improvement / Lean elements.

9.8 Implementation of SLR and PLICS

Within the 2011/12 financial year the Trust 'rolled out' PLICS throughout the organisation. The financial position is now reported one month in arrears in additional to the traditional budgetary reporting. The aim for the reporting team is to accelerate monthly PLICS reporting and to synchronise reporting cycles (general ledger and PLICS) in early 2012/13.

The Trust, as in 2011/12, set differential CIP targets to its services, by using the information from PLICS. The minimum 6% CIP target for all CBUs would be uplifted based on aggregated CBU margin performance as reported through SLR.

The four clinical divisions have now established 'local' PLICS steering groups to ensure the PLICS information is continually refined and embedded within their specialities.

UHL's Reference Cost Index (RCI) increased from 99.3 to 102.6 (2010/11 data), implying that UHL is deemed to be 2.6% more expensive than the national average for the casemix of activity.

Whilst the reduction in the RCI is disappointing (and surprising, given the success of the 2010/11 CIP programme) the 2010/11 submission does not reflect the better information we are obtaining via PLICS and the improvements over the last 12 months in data collection and understanding.

10 Workforce

10.1 Changes to our workforce

With pay amounting to approximately three quarters of our total controllable costs, reducing our pay bill will be critical to achieving and sustaining the level of efficiencies required over the next and future years.

We will achieve this through the continuation of our programme of stabilisation and the delivery of our service developments and transformation programme. This will include:-

- reducing contracted WTEs, through the implementation of our CIPs
- proactively managing vacancies to reduce the potential for redundancy
- reducing other staff costs, such as bank, agency usage, premium payments, sickness absence reductions, skill-mix changes and implementing a voluntary severance scheme.
- reducing sickness absence from 3.54% to 3% by April 2013
- developing a workforce model to inform workforce analysis and planning. This will include:
    - capturing recent trends in the workforce composition and key metrics (linked where possible to activity)
    - Internal and external 'bench-marking'
    - identifying potential efficiency gains to help to achieve the Trust's CIPs and highlighting opportunities for using the workforce differently
- working with and consulting with staff-side to ensure that staff are aware of the changes at the earliest opportunity
- ensuring that changes are handled appropriately with agreed management of change policies;
- risk and quality impact assessing all CIP schemes

Recognising the challenges relating to patient care described in Chapter 3, the Nursing Acuity review that concluded in 2011/12 is likely to lead to further investment in staff.

To support sustainable changes to our workforce, we also have a number of HR specific improvement programmes as follows:-

Project	Key Initiatives for 2012/13	Potential Financial/ Non-Financial Benefits
Medical and Locum Agency Project	Reduced usage to 3 nursing agencies and 5 medical agencies. Internal usage rates set. Regional contract to be finalised.	Reduced total agency spend in the last quarter (£1.6m) of 2011/12 to a third of the value of the first quarter of the financial year. As part of 12 /13 plans, divisions are looking to reduce premium payments.
Sickness Absence/Well Being	'At Work for Patients Group' (@W4P) leading on maximising attendance - this includes policy review, performance management of staff and managers and training. Comprehensive Well Being Programme funded by Staff Lottery money.	We have an average sickness absence rate in 2011 of 3.54% (lowest Acute Trust in East Midlands) this means an average of 421 staff off at any one time. Our target for 2012 is 3% which means an average of 357 staff off at any time.
Salary Sacrifice	Established a child care voucher scheme with circa 555 members - our aim is to increase this further. Launched our 'Park and Save' car parking permit scheme on 1st April 2012.	Estimated savings from the childcare voucher scheme are £200k per annum. Based on a 20% opt out for staff who have car parking permits estimated savings are £250k per annum.

	Plans to review Salary Sacrifice for staff accommodation.	
New Ways of Working	Introduced alternative and new roles to support clinical practice and patient care. Priorities for 2012/13 include roles to optimise the senior decision triage process within the Emergency Department, developing an Assistant Practitioner role in Theatres and a review of Specialist Nurses. LLR Workforce Steering Group in place to ensure sharing of practices, protocols and commissioning of education and training.	Provision of high quality patient care in the most effective and efficient manner. New roles fill skills gaps where there are recruitment shortages such as middle grade doctors in the Emergency Department.
Administrative and Clerical Review	We have systematically reviewed our secretarial workforce and are redesigning roles using partner organisations to maximise efficiency.	Benefits include a more cost effective administrative function, reductions in headcount, improved efficiency and timeliness of communication

Table 30: summary of HR Specific Programmes

10.2 Monitoring our workforce

The following HR KPIs are reported to the Trust Board on a monthly basis:-

- Achievement of CIPs – workforce reduction plan
- Headcount and salary bill – including total headcount and whole-time equivalent
- Use of agency staff, bank staff and overtime for each month
- Sickness divided into long and short term sickness
- Staff turnover and recruitment.
- Appraisals

Monthly "heat maps" are received by the four divisions and HR KPIs are discussed at monthly divisional confirm and challenge sessions.

The composition of the contracted WTE by staff category (as at January 2012) is as follows:

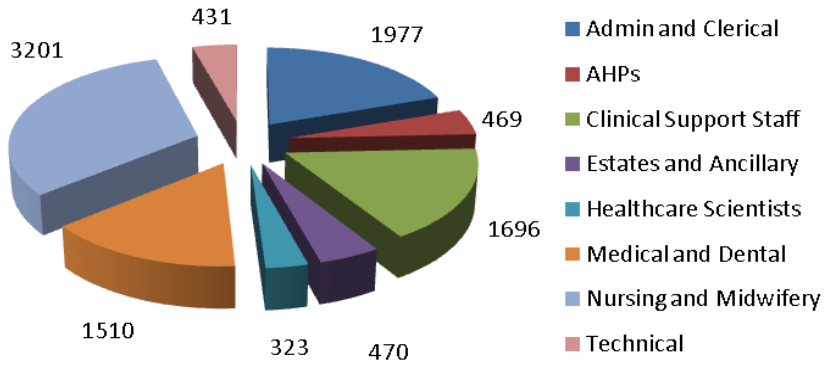


Figure 18: Pie-chart to show composition of contracted WTE staff by category

10.2.1 Bank and Agency Usage

A key element of our stabilisation plan is the tight control and monitoring of our non-contracted payments.

10.2.2 Vacancy rates and staff turnover

The turnover of staff across UHL equates to approximately 60/70 individuals per calendar month. A phased and coordinated approach to the implementation of our CIP schemes, in conjunction with proactive vacancy management will also help reduce the potential for redundancy. As CIP schemes take effect, we are redeploying staff into suitable alternative posts vacant through turnover.

10.2.3 Appraisal rates

As a result of targeted action over recent months, our appraisal performance has improved to 95% during December 2011. This is the highest rate since we started recording appraisal rates on our Electronic Staff Record (ESR) System. We have agreed the actions needed to sustain and continue to improve our appraisal rates in order to achieve our appraisal target of 100%.

10.2.4 Areas of difficulty in recruitment

The Trust has a strong record in attracting high quality candidates. There are however, some "hot spots" in more specialist areas, including:

- Emergency Medicine
- Children's intensive care nurses
- ITU nurses
- Neonatal nurses
- Some more specialised consultant areas including Maxillo-Facial, Cardio and Respiratory physiologists

During 2012/13 we will be working to ensure our approach to recruitment is proactively developed to address these 'hot spots'. Within specialist areas, such as Embryology and Cardio-Respiratory, where staff are not available nationally, we have developed ways to train our own staff. The development of new roles is also key to addressing these areas where recruitment is difficult.

During 2011/12 we have been developing our employer brand. This has included considering the results of our local staff polling and the national staff survey. We have also used feedback from:

- New recruits to the organisation over a period of six months
- Those candidates who choose to withdraw from a recruitment process
- Local professional Higher Education Institutes students who may become our employees of the future

We are also looking at how we market ourselves as an employer and we are developing both our internal and external websites in collaboration with our communications team.

10.3 Deanery and junior doctor arrangements

We employ over 900 trainee medical staff covering over 100 rotas across our three sites. Our rota templates are Working Time Directive and New Deal Compliant and we undertake monitoring twice yearly in line with contractual requirements. We work closely with the deanery and we are the lead recruiter for the Southern Deanery for most specialities. There are a number of immediate and medium-term factors/changes, which will impact on trainee medical staff numbers and rotas (e.g. a reduction in national training numbers). To aid the management of changes the Trust has set up a trust wide Workforce Group to share initiatives/good practice across the Trust and to generate and action ideas.

A recent deanery visit to UHL recognised that the very high clinical service load in some areas of UHL, particularly the emergency department and acute medical areas has resulted in an increased tension between service provision and training with a consequent detrimental effect on training. In other areas (ENT, haematology), the training was found to be of good quality.

Concern was expressed regarding loss of training opportunities in areas and a reduction in morale and engagement of trainers and trainees. There were also concerns raised regarding the impact of rotas on training, the administration of rotas and lack of clinical involvement in some areas.

A UHL Education Strategy has been developed and some aspects have been implemented following the appointment of a new Director of Clinical Education in July 2011. However, it is recognised that these measures will take some time to introduce and to effect the necessary changes. UHL is committed to finding solutions to restore quality training in the areas where problems have been identified and has agreed with the East Midlands Deanery, a specific targeted approach to address the issues identified in the acute medicine pathway (encompassing emergency medicine, acute and general internal medicine). This approach once established could be replicated in other areas as required.

10.4 What our staff tell us

We survey our staff to ask their views about working at UHL, in two ways:

- through the completion of Local Staff Polling was introduced in January 2011
- completion of the National Department of Health Staff Survey

We used the results from our local polling and the National Department of Heath Staff Survey to develop an Eight Point Staff Experience Action Plan. Launched in summer 2011, this summarises the key findings and actions for managers and staff to help bring about positive improvements across our Trust.

Between October and December 2011 we selected a random sample of staff from across the Trust to complete the National Department of Health Staff Survey questionnaire. A total number of 850 staff were selected to receive the survey and 388 were returned (3% of Trust employees), giving a response rate of 46%.

The results highlight that although statistically the results at UHL have largely experienced 'no change' there are significant areas for review and action in a number of Key Findings. (Questions are grouped nationally into key areas, known as 'key findings').

The four Key Findings for which the Trust compares most favourably with other trusts were:-

- KF12 – percentage of staff appraised in last 12 months
- KF14 – percentage of staff appraised with personal development plans in the last 12 months
- KF23 – percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months
- KF3 – percentage of staff feeling valued by their work colleagues

This reflects the on-going priority given to appraisals with staff which has resulted in a steady rise over recent months and the latest figure of 96% in February.

The four key findings for which the Trust compares least favourably are:-

- KF34 – staff recommendation of the Trust as a place to work or receive treatment
- KF30 – percentage of staff reporting good communication between senior management and staff
- KF1 – percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver
- KF27 – perceptions of effective action from employer towards violence and harassment

These are key areas of focus for review, discussion and action planning. It is essential that this review links to the patient survey work that is being undertaken.

Set in the context of an extremely challenging financial year, it is perhaps not surprising that there has been a significant reaction from staff. Overall, the survey responses indicate that there is still much work to be done to improve the way in which we work together to enhance the quality of care we provide to our patients. However, we do know that in many areas we are providing high quality patient care. We can clearly do more to involve staff in decision-making and suggesting new ideas for service improvement, consultation about changes, provision of feedback, communication between senior managers and staff and

making staff feel that their contribution is valued. Together with divisional management teams, we need to focus on a clear set of priorities building on the progress made during the last 12 months.

10.4.1 Responding to the feedback

The results from the staff survey are informing the refresh of the ODP. Our plan will be based on a framework that integrates the different facets of organisational development, summarised in the diagram below:

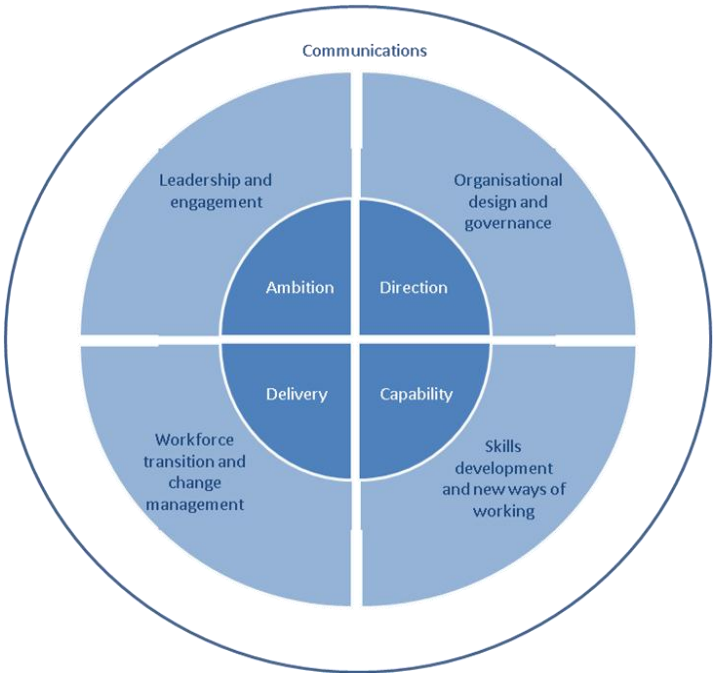


Table 31: Areas of focus for the Organisational Plan

The key areas of focus within the 2012/13 ODP include:

Behaviours:

- articulating the behaviours expected at all levels within the organisation to provide Caring at Its Best, how they will be rewarded and how they will be challenged
- based around mutual respect between individual and organisation
- unwillingness to accept people 'opting out'

Innovation:

- unlocking the untapped potential of all the good ideas that never make it into action
- creating an organisation that makes it easy for good ideas to happen by encouraging, nurturing and delivering on them
- establishing an innovation challenge/competition/process

Development:

- supporting people to understand and 'work' complex organisations
- helping people bridge gaps (both real and perceived) between clinicians and managers
- building core skills: particularly around finance, planning and people management

Broadening experiences and insight:

- encouraging movement of staff at all levels
- rotating middle managers (both internally and externally) to provide different experiences and insights
- embedding a culture of succession planning

Staff engagement and involvement in decision making is a key element of our ODP. Our Staff Engagement Strategy aims to shape and enable successful and measurable staff engagement. This work is led by our Staff Engagement Steering Group which includes staff side representation.

We have launched our new 'Caring at its Best Awards'. These awards are designed to recognise and reward inspirational staff that live our values and deserve recognition for their outstanding success and commitment. We will be moving to quarterly awards and an annual ceremony in September 2012.

10.5 Talent and Leadership Development

Our Engaging Leadership Excellence Strategy provides a framework for developing excellent leadership capability and capacity across the Trust. The strategy sets out the development provision for existing leaders and sets the direction of travel in relation to the ways in which we will develop our leaders for the future.

We have developed a Talent Plan for 2012-13 which includes a range of leadership programmes accredited by the Institute of Leadership and Management. We are also involved in regional and national schemes offered through the East Midlands Leadership Academy and NHS Institute for Innovation and Improvement including courses for aspiring directors and clinical leaders.

We have incorporated a talent management review into our appraisal process for non-medical staff and medical managers and are developing a 'Manager's Guide to Talent Management'. The guide will set out how to identify and develop individuals with high potential for future leadership roles. We are also putting in place processes to identify secondment opportunities and project roles which offer the scope for stretch opportunities.

10.6 Human Resources Strategies

We recognise that the commitment, experience and dedication of our workforce will be key to achieving our core purpose of 'Caring at its Best'. Strong leadership and cross organisational collaborative team working, supported by the right HR skills and professionalism will be vital to delivering the scale of organisational transformation required in 2012/13 and future years.

Our People Strategy describes the things that we are focusing on to develop our capacity and capability. The People Strategy which is supported by a number of other key strategies will be reviewed and refreshed as we develop our Integrated Business Plan (IBP) and WDP.

Figure 19: HR and Workforce Strategies

10.7 Equality and Diversity

UHL has been accepted as an early implementer of the Equality Delivery System (EDS). The EDS is a framework designed to support NHS commissioners and providers to deliver better outcomes for patients and communities and better working environments for staff, which are personal, fair and diverse.

The EDS replaces what was the Single Equality Scheme. However our legal responsibilities remain unchanged and the Trust published its annual workforce profile in January 2012. By April 2012 we will have published one objective from each of the four EDS areas (see below) which will be based upon the workforce and patient data analysis. The objectives will be agreed and signed off by the Trust Board by April 2012:

- better health outcomes for all
- improved patient access and experience
- empowered, engaged, and included staff
- inclusive leadership at all levels

In addition to the above we will publish specific information on any analysis that is undertaken in year on the gender pay gap.

UHL has a well-developed approach to equality with work already being undertaken in all of the 4 EDS goals as part of our existing Single Equality Scheme. There are work streams identified for most of the outcomes but further refining is required as more guidance is made available.

Our two main workforce priorities based upon our last workforce report were to address BME and female representation at senior levels and ensure good representation at all levels across the workforce. Our achievements to date have been positive in terms of the activity in respect of workforce equality. In particular we have seen an increase of the BME representation across the organisation. However, this needs to be a much longer term objective for it to be both meaningful and sustainable. Internal monitoring will be via the Equality and Diversity Board, the Organisational Development and Workforce Committee

and the Equality Advisory Board. A six monthly equality update report will be provided for the GRMC. We apply due regard analysis to all of our policies and service developments.

11 Sustainability

Work to date to address the Sustainability agenda has reached the following milestones:-

- The Trust has undertaken EUETS (European Union Emissions Trading Scheme) and CRC (Carbon Reduction Commitment Scheme) compliance initiatives:
    - registered for CRC and accounted for CRC tax within Financial Year 2011/12
    - complied with energy performance of building regulations 2007
    - continued to identify our annual carbon footprint
    - approved a carbon management and implementation plan in conjunction with the Carbon Trust
- Achieved Building Research Establishment Environmental Assessment Method (BREEAM) – good rating for Neonatal (NNU) development
- Worked with UoL towards BREEAM Excellent rating for Cardiovascular Research Centre (CVRC) development
- Increased usage of the Hopper Bus Service from 7,000 journeys per week to 11,000 per week
- Enhanced cycle to work provisions
- Procured waste disposal contracts which have increased recycling to 95% for clinical waste and 73% for domestic waste
- Reduce energy consumption by 7%
- Completed annual Estates Return Information Collection (ERIC) and proactively utilised data

In the coming year the Trust will:-

- Through the LLR FM Review we will work with our FM provider and strategic partners, across LLR, to address the sustainability agenda
- Review and revitalise the UHL carbon management implementation plan
- Register with the Good Corporate Citizenship Assessment Model
- Carry out a self-assessment using the Good Corporate Citizenship Assessment Model
- Deliver sustainable capital developments and backlog investments
- Reduce energy costs through technical solutions, strategic partnerships and engaging the Trust's workforce
- Monitor and report on energy usage and carbon emissions
- Continue to and refine and test emergency preparedness plans in relation to environmental issues such as heat wave planning and flooding.
- UHL is full participant of the Carbon Reduction Commitment Energy Efficiency Scheme and will ensure full compliance with the regulations

11.1 Sustainability – Emergency Preparedness

The Trust will continue to be compliant with its obligations under the Civil Contingency Act 2004 for emergency preparedness. We will continue to work with the Local Resilience Forum to ensure that we have system wide plans to address any emergency as it arises.

Significant amounts of planning and preparation will go in to ensuring readiness for the Olympics, in light of Team Great Britain residing at Loughborough.

The financial year 2012/13 will have a particular focus on business continuity management to ensure that the Trust is capable of managing any business interruptions without causing significant impact to the running of the organisation.

12 Delivering a successful Foundation Trust Application

12.1 Progress over the last year

UHL remains committed to becoming a FT. Since putting our FT application on hold in the summer of 2011, we have:

- Progressed towards a PbR contract, supported by improved clinical education in clinical coding
- Implemented 'Right Time, Right Place' to improve delivery of the four hour A&E Target
- Further embedded service line management and patient level costing and improved clinical engagement in these processes
- Developed robust CBU Annual Plans underpinned by cost improvement programmes
- Subjected these plans and CIPs to confirm and challenge by both the Executive Team and the TSO
- Developed a robust Annual Plan for 2012-13 which lays the foundation for the development of our five year IBP
- Informed our 2012/13 business planning process through the completion of a market assessment (looking at population, prevalence and activity trends and what this could mean for the services we currently provide)
- Refreshed our Trust Strategy in light of the market assessment, to ensure we are meeting the needs of our patients
- Continued to evolve our Trust Strategy which focuses on a distributed service model and which has been adopted by the LLR Health Economy as the future vision for sustainable health care delivery in the region
- Developed our site reconfiguration programme which includes moving to a two site acute medical take and the establishment of an LLR programme to oversee the process
- Completed a market assessment (looking at population, prevalence and activity trends and what this could mean for the services UHL currently provides)
- Refreshed our strategy in light of the market assessment, to ensure we are meeting the needs of our patients

12.2 Milestones outlined in our Tripartite Formal Agreement

A revised TFA is being discussed with the SHA and the DoH. Key milestones include:

- consistently deliver 85% against the cancer 62 day target
- consistently deliver 95% against the A&E four hour wait target
- consistently deliver the 90% admitted and 95% non-admitted target for the 18 Week Wait RTT
- consistently achieve 92% of incomplete pathways less than 18 weeks
- LLR Trust Board approve the LLR Reconfiguration Programme project initiation document and project plan
- completing Quality Governance Framework and Board Governance Assurance Framework self-assessments
- holding a public consultation on the FT Application
- the third party review of self-assessment against the Quality Governance Framework and Board Governance Assurance Framework
- holding a readiness review meeting
- board observation & further iterations of key documents post readiness review
- completing the Historic Due Diligence - 2nd phase (HDD2) process
- final submission of key documents to inform SHA sign off of FT application
- SHA / Trust Board to Board
- application to the DoH

12.3 Key risks and mitigations

The Trust's TFA identifies four key risks to be addressed before we make our FT application. These are:

Risk	Mitigation
Potential failure to achieve an affordable and sustainable clinical service and capacity configuration across UHL and LLR.	We are working collaboratively with our LLR partners to review and tackle the issues of capacity and assets and to right size the health economy.
Potential inability to consistently achieve key performance targets.	Action plans to address all of the key performance targets where month on month achievement remains a challenge for UHL have been developed and achievement against these targets is reported on a monthly basis at both the QPMG and the Trust Board.
Potential inability to identify sufficient levels of cost reduction and deliver long term transformation.	We have established a transformation programme to support productivity improvement and service redesign and ensure any reduction in sustainable and improves patient care.
Potential inability to address the overheating within the LLR emergency care system.	An LLR ECN has been established with multi-agency representation to oversee the delivery of a multi-agency plan. Within this plan UHL's core actions include a review and reconfiguration of: • the ED footprint • Trust processes • discharge planning • the ED workforce

Table 32: Key risks identified in UHL's TFA

13 Declarations and Self Certifications

13.1 Clinical Quality

The Board is satisfied that, having used its own processes and having assessed against Monitor's Quality Governance Framework (supported by relevant information from the Trust and third parties such as the Care Quality Commission), it has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	✓
The Board is satisfied that plans in place are sufficient to ensure on-going compliance with the Care Quality Commission's registration requirements.	✓
The Board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the Trust have met the relevant registration and revalidation requirements.	✓
The Board is embedding patient experience into the service design, improvement and delivery cycle.	
For 2011/12, we set ourselves the target to be in the top 20% of Trusts nationally for positive patient feedback, according to local patient experience survey results and the national patient survey.	X

Based on the most recent national survey results, although we have not achieved the target we set ourselves, we are in the middle 60% of Trusts for patient experience in relation to privacy and dignity and patients rating their care as excellent.

For 2012/13, we have again identified improving patient experience as one of our top priorities. We want to increase the opportunity for patients, carers and the public to provide feedback on services and care provided through a range of media including establishing the question and baseline 'Net Promoter Score' for 10% of inpatient discharges for any given week at or within 48 hours of discharge.

The first month of reporting will be in April 2012, following which a trajectory for improvement will be agreed to ensure either a 10 point improvement in Net Promoter Score or achievement or maintenance of top quartile performance throughout 2012/13.

13.1.1 Service Improvement

The Board is satisfied that plans in place are sufficient to ensure on-going compliance with all existing targets (after the application of thresholds), and compliance with all targets due to come into effect during 2012/13.	X

The RTT (18 week wait) standards are that 90% of admitted and 95% of non-admitted patients should start Consultant-led treatment within 18 weeks of referral.

Admitted pathways are those that end in an admission to hospital (either inpatient or day case) for treatment. In 2011/12, there was a deliberate reduction in admitted performance as we agreed a plan with our Commissioners to increase activity in quarter 3 and quarter 4 to reduce the number of patients on an 18 week backlog and 26 week backlog.

The aim for 2012/13 is to achieve the RTT standards in every specialty. We will ensure that 92% of patients on an incomplete pathway should have been waiting no more than 18 weeks.

In respect of A&E performance, the final 2011/12 year to date figure (including the UCC) was 94%, against a 95% target.

The objective for 2012/13 is to consistently deliver the 4 hour target at 95+% and achieve each of the five A&E clinical quality indicators.

13.1.2 Risk Management

All current key risks to compliance with the Trust's Authorisation have been identified (raised either internally or by external audit and assessment bodies) and addressed in a timely manner. | N/A

The necessary planning, performance management and corporate and clinical risk management processes and mitigations plans are in place to deliver the annual plan, including that all Audit Committee recommendations are implemented satisfactorily to the Board. | X

The Board is satisfied that all Audit Committee recommendations are implemented satisfactorily. Nevertheless, once the Annual Plan has been approved, the Board will review the current Strategic Risk Register and update it to reflect any additional risks in this plan.

An Annual Governance Statement is in place pursuant to the requirements of the NHS Foundation Trust Annual Reporting Manual, and the Trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk). | ✓

The Trust has achieved a minimum of Level 2 performance against the key requirements of the DoH's Information Governance Toolkit. | X

At the time of preparing this Annual Plan, the Trust had yet to confirm formally that it had achieved Level 2 performance against the key requirements of the DoH's Information Governance Toolkit.

Having achieved Level 2, it is the aim of the Trust to sustain achievement during 2012/13.

13.1.3 NHS Constitution

The Board will ensure that the Trust remains at all times compliant with its terms of authorisation and has regard to the NHS Constitution. | N/A

13.1.4 Board Roles, Structures and Capacity

The Board will ensure that the Trust will at all times operate effectively within its constitution. This includes: maintaining its register of interests, ensuring that there are no material conflicts of interest in the Board of Directors; that all Board positions are filled, with plans in place to fill any vacancies; and that all elections to the Board of Governors are held in accordance with the election rules. | N/A

The Board is satisfied that all Executive and Non-Executive Directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability. | ✓

The Board is satisfied that the management team has the capability and experience necessary to deliver the annual plan; and the management structure in place is adequate to deliver the annual plan. | X

The Board has rated the Trust's management capability/stretch as 'high risk' as at March 2011. The Chief Executive, supported by the Chief Operating Officer / Chief Nurse continues to take action to address this key, strategic risk and progress is reviewed by the Trust Board monthly.

13.1.5 Finance

The Board anticipates that the Trust will continue to maintain a financial risk rating of at least 3 over next 12 months. | X

The planned Financial Risk Rating in 2012/13 is 2. This is largely as a consequence of the liquidity ratio and the planned I & E surplus of £1M, 0.1% of turnover.

The Board is satisfied that the Trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time. | ✓

13.1.6 Major Joint Venture or Academic Health Science Centre

The Board is satisfied it has or continues to:

N/A

- ensure that the partnership will not inhibit the Trust from remaining at all times compliant with its Authorisation
- have appropriate governance structures in place to maintain the decision making autonomy of the Trust
- conduct an appropriate level of due diligence relating to the partners when required
- consider implications of the partnership on the Trust's financial risk rating having taken full account of any contingent liabilities arising and reasonable downside sensitivities
- consider implications of the partnership on the Trust's governance risk rating having taken full account of the impact on the seven elements of governance identified in the Compliance Framework
- conduct appropriate inquiry about the nature of services provided by the partnership, especially clinical, research and education services, and consider reputational risk
- comply with any consultation requirements
- have in place the organisational and management capacity to deliver the benefits of the partnership
- involve senior clinicians at appropriate levels in the decision-making process and receive assurance from them that there are no material concerns in relation to the partnership, including consideration of any
- re-configuration of clinical, research or education services
- address any relevant legal and regulatory issues (including any relevant to staff, intellectual property and compliance of the partners with their own regulatory and legal framework)
- ensure appropriate commercial risks are reviewed
- ensure that the principles and rules of the Co-operation and Competition Panel (CCP) are considered and where appropriate the CCP is consulted
- maintain the register of interests and no residual material conflicts identified and
- engage the governors of the Trust in the development of plans and give them an opportunity to express a view on these plans

The Board has received external advice from independent professional advisers with appropriate experience and qualifications and have taken into account the best practice advice in Risk Evaluation for Investment Decisions by NHS Foundation Trusts or comment by exception where this is not the case.

N/A

14 Appendix A

A.1 Key Service Developments

A.1.1 Development of our Emergency Care Services

A.1.2 Services for Frail Older People

A.1.3 Managing Long Term Conditions

A.1.4 East Midlands Congenital Heart Centre (“Safe and Sustainable”)

A.1.5 EMPATH – Pathology Joint Venture with Nottingham University HNS Trust

A.1.6 LRI Aseptic Suite

A.1.7 Community Elective Care Services

A.1.8 Teenage and Young Adults (TYA) Cancer Unit

A.1.9 Service and Site reconfiguration

A.1.10 Capacity Planning (right-sizing beds, theatres and outpatients)

A.1.11 Developing Care Pathways

A.1.12 FM shared services and total FM Procurement

A.1.13 IT Transformation

A.1.14 Transforming our Workforce

A.1.15 ‘Hope’ Cancer Clinical Trials Unit

A.1.16 Biomedical Research Units (BRUs)

A.1.17 National Centre for Sport and Exercise Medicine: East Midlands (NCSEM-EM)

A.1.1 Development our Emergency Care Services

Primary Aims / Objectives

- To create a seamless emergency process in which demand is aligned with resources and capacity 24 hours a day 7 days a week.
- To shift from a complex emergency process where there are delays to a simplified process with minimal delays, ensuring timely safe and effective discharge.
- To develop an emergency floor and a single point of access:
- To improve our in emergency department processes order to achieve the required quality standards.

Strategic Drivers

- Compliance with national 95% 4 hour maximum waiting time target
- Compliance with nation quality indicators for A & E
- In December 2011 the NHS Midlands and East Provider Development Committee agreed to adopt a Provider Management Regime (PMR) approach for NHS Trusts across the cluster. The approach is based on the Monitor Compliance Framework, including assurance against achievement of the 95% A & E target.

Degree of Commissioner support

Proposals are fully endorsed by commissioners and the ECN Board

Timescales for Delivery

- Deliver short term initiatives – April 2012
- Fast track therapy discharge (CDU) – April 2012
- Review of bed base and processes for direct specialty admission – May 2012
- Multi-disciplinary review of the workforce to ensure alignment to demand – June 2012
- Placing Acute Physicians and more Geriatricians at the front door – June 2012
- Deliver improved discharge planning
- Complete winter planning to deal with seasonal demand – July 2012

Impact on Activity

Impact will be seen in reduced length of stay and efficient patient pathways. It is not anticipated that activity will increase. Changes will allow services to better manage increased dependency and acuity.

Impact on Finance

Improvement will be delivered within existing resources with the exception of improving discharge processes:

- £93,492 – Improving discharge processes
- £63,552 – Occupational Therapy Fast track discharge
- £10m is allocated to the development of the emergency floor within the Site and Service Reconfiguration proposals.

Impact on Workforce

The workforce will be reconfigured over time to better meet the demand and needs of our emergency patients

Non-Financial Benefits Assessment

Strategic fit:

- Consistent with the Trust's strategy to become the centre of a local acute emergency network
- Our shorter term key corporate priorities for 2012/13 are to Transform the Emergency Care System, improve patient experience and enhance clinical quality.
- Integral to QIPP plans
- Responds to SHA and other provider targets

Patient Outcomes and Safety:

- Reduced clinical and operation risk
- Achievement of CQUIN targets
- Clinical quality and patient safety enhanced through addressing current risks across the emergency process
- Improved performance, achieving clinical indicators and building on our success in reducing readmissions, reducing length of stay

Patient Experience:

- Patients are treated in the 'right place at the right time' first time
- Timely discharge or transfer to community settings
- Reduced requirement for patient to be moved between wards

Clinical Staff and Resources:

- Escalation and clarity of decision making

Key Risks

Significant cultural change is required to deliver sustainable improvement in our emergency processes. This will require continuous engagement with clinicians and clinical teams in UHL and across partner agencies.

A.1.2 Services for Frail Older People

Primary Aims / Objectives

In an acute setting to:

- Improve medical decision making with greater emphasis on integrated care and better holistic initial assessments.
- Improve the discharge rate of frail older people from ED/AMU
- Reduce length of stay for those admitted (acute) – 1 day per patient on average
- Reduce rate of readmissions – 5% from acute care and/or intermediate care settings
- Reduce institutionalisation – 10% for those frail older people in contact with acute care services
- Safely avoid admission of over 440 frail older people

In a community hospital setting to:

- Improve medical decision making, with greater emphasis on integrated care and better holistic on-going management
- Reduce length of stay within community hospitals by 2 days per patient on average
- Improve post-discharge follow-up with greater management and home support where existing community services have limited support.

Strategic Drivers

There are 158,400 individuals over the age of 65 within Leicestershire with around 10% admitted into hospital with acute medical concerns. This number will continue to grow therefore there is a need to plan for the surge in number of older people admitted to hospital.

Improving processes and the quality of discharge/transfer of care has one of the biggest potential impacts on patient outcomes and efficiency.

Timescales for Delivery

This development will consolidate existing practice evidenced by improved clinical outcomes and will expand upon existing services

Impact on Activity

Admission avoidance for approximately 440 frail older people

Impact on Finance

Recurrent funds have been requested to the value of £363,390. It is anticipated that these costs will be covered through the efficiencies across the health economy

Impact on Workforce

To invest in:

- 0.5 Consultant Psychogeriatrician
- 1.2 Community psychiatric nurse

Non-Financial Benefits Assessment

Strategic fit:

- The initiative is aligned with UHL's Strategy and underpinning principles to be the provider of emergency and acute care focussing on the 6P's underpinned by Caring at Its Best.
- The focus remains on developing and strengthening strong partnerships with community agencies.

Patient Outcomes and Safety:

- Reduction in length of stay of 1 day per patient on average UHL and 2 days community Hospitals
- 5% reduction in readmissions (UHL and intermediate care settings)
- 10% reduction in institutionalisation

Patient Experience:

- Admission avoidance for over 440 frail older people
- Dedicated personnel experienced in looking after the complex need of frail older people

Clinical Staff and Resources:

- Enhanced reputation, increase in kudos, which will attract highly motivated qualified staff who are experts in their field offer an integrated health and social care approach.
- Further development of our academic base in geriatric medicine.

A.1.3 Managing Long Term Conditions

Primary Aims / Objectives

To continue to sustain existing ambulatory care services and develop new models of care in respiratory medicine, cardiac services and medicine in order to:

- Manage emergency patients more effectively with increased focus on admission avoidance
- Reduce readmission rates for some chronic disease groups
- Reduce length of stay through early supported discharge and community follow up
- To build collaboration and strategic partnerships with community partners and GP's to manage patients with long term conditions in the most effective way

Strategic Drivers

- The Operating Framework for the NHS in England 2012/13 sets out a commitment to improved delivery of long term conditions with a clear focus on transforming care to deliver better quality and productivity.
- COPD has been highlighted as a priority by CCGs and is further stated in the DH report An Outcomes Strategy for COPD and Asthma in England
- Improving population health and outcomes is a key focus of the LLR integrated plan.
- The vision for acute care across LLR is to create an integrated system of urgent and emergency care.

Timescales for Delivery

- Commence emergency general medical clinics – March 2012
- Pilot low risk chest pain pathway – March 2012
- Sustain Pulmonary Embolus and Pleural Effusion services – April 2012
- Commencement of COPD care bundle – April 2012
- Develop COPD SPACE manual – April- June 2012
- Commence PRICE Pharmacy scheme for COPD patients – May 2012
- Develop other care pathways (14 identified in total) – throughout 2012

Impact on Activity

- Admission avoidance for circa 670 patients with pulmonary embolus or pleural effusion.
- Further impact on reduction in non-elective activity and the shift to ambulatory care activity to be quantified as pathways are implemented

Impact on Finance

Capital investment - £100K

Revenue investment - £ 1,237,000 (Ambulatory care pathways and emergency clinics)

£ 236,950 (COPD Care Bundle)

£ 42,400 (Pharmacy)

Impact on QIPP through community pharmacy savings. Further saving through reduced length of stay and reduced admission rates.

Impact on Workforce

- Consultants – 27 PA's
- Nursing – 15 WTE
- Administrative – 10 WTE
- Pharmacy – 1.10 WTE
- Physiotherapy – 1.0 WTE

Non-Financial Benefits Assessment

- Improved health outcomes and reduction in exacerbations of condition
- Opportunity to address variations in need and care provision
- Admission and readmission avoidance
- Patients empowered to manage their own condition at home
- Optimal pharmacy management and advice
- Improved post discharge support
- Enhanced capacity and capability in primary and secondary care professionals
- Improved communication and working relationships between primary and secondary care
- Opportunities for education , training and effective distribution of human resources

Key Risks

Lack of investment and resources to develop new pathways to the fullest extent.

A.1.4 East Midlands Congenital Heart Centre ("Safe and Sustainable")

Primary Aims / Objectives

To secure the future of paediatric cardiac services in Leicester in response to the National "Safe and Sustainable Review of Paediatric Cardiac Services"

To continue to implement plans in order to meet designation standards:

- Physical capacity to undertake 400 cases per annum
- 24/7 Intensive care consultant cover
- Co-location of interdependent specialist children's services
- Investment in support posts (clinical psychology and a transition nurse)

Strategic Drivers

Fewer, larger centres with the capacity and capability to deliver high quality, sustainable paediatric cardiac surgical services in the future.

Timescales for Delivery

- Outcome of Judicial review – awaited
- April 2012 - completion of the Adult Congenital Cardiac Services are undergoing a parallel national review. The recommended model and standards are due to be completed by, followed by a public consultation exercise.
- May 2012- A final decision on the centres to be designated.

Impact on Activity

- A projected increase of 180 paediatric cardiac surgical cases per year and associated cardiology in-patient and out-patient activity
- Assumptions are that the main growth in activity will follow 6-18 months after designation.
- A modest assumption of growth in 2012/13 of 30 additional surgical cases and related activity in cardiology and PICU. This relates to demographic growth and the strengthening of network arrangements to reduce referrals outside of the East Midlands

Degree of Commissioner support:

Full support from PCT, CCGs and EMSCG for designation

Impact on Finance

Capital:

- PICU expansion is due for completion in April 2012 and has been funded from 2011/2012 capital with a £300k charitable donation from Thomas Cook Children's Charity (TCCC)
- Expansion of the Ward base has been put on hold until a decision is forthcoming on designation
- £30k for the re-location of ENT out-patient services to the EMCHC facility, Glenfield Hospital

Revenue :

- £269K to provide sustainable 24/7 consultant intensive care cover
- £18k for dedicated Clinical Psychologist support
- £230k for 1 additional PICU bed

The costs above are in a detailed business case which has been approved by the Trust Board.
The additional activity will cover the investments required above.

Impact on Workforce

- The five year plan proposes a 90 wte increase in staffing for the department which includes all the supporting services.
- The 2012/13 increases relate to PICU nursing staff and a plan to recruit 2 full time consultant posts for PICU.

Non-Financial Benefits Assessment

Strategic fit:
One of UHL's top strategic priorities for 2012/13 is to secure designation as a Paediatric cardiac Surgical Centre given impact of losing the service would have on other services within the Trust. Particularly ECMO and Tertiary Children's Services.

Patient Outcomes and Safety:

- Provision of a safe and sustainable service designated service achieving the national standards for paediatric cardiac surgical services
- Consultant rotas able to sustain a split site PICU rota
- Detection of the majority of cardiac anomalies antenatally through roll out of the Fetal Anomaly Screening Programme (FASP)
- Cardiac screening protocol across the East Midlands network
- The production of increasingly sophisticated real time risk stratification for patients and surgeons.

Patient Experience:

- Continued provision of local services for children and their families
- Increased outreach provision with regional transition clinics enabling patients outside of Leicestershire to receive care closer to home.
- Dedicated clinical psychology support to aid children and their families to deal with complex psychological issues
- Improved facilities for adolescents

Clinical Staff and Resources:

The Business Case commits to invest in personnel and facilities in order to meet increased activity and achieve the recommended standards for designation. As a centre of excellence designation would motivate the workforce and make us an employer of choice

Key Risks:

Inability to secure designation of these services will impact significantly on a range of other clinical services including Paediatric, Cardiac and ECMO services. A loss of income will be associated with this risk.

A further financial risk is the charitable donation from Thomas Cook Children's Charity which is required to be paid back should the centre not achieve designation

A.1.5 EMPATH – Pathology Joint Venture with Nottingham University Hospitals NHS Trust

Primary Aims / Objectives

Empath has developed a detailed Business Plan approved by both NUH and UHL Trust Boards on the 1 March 2012.

The key principles underpinning the Empath are:

- Demonstrable benefits to patient care
- Adding value for the NHS
- An adaptable commercial structure that maximise participation across the wider health community

Strategic Drivers

The strategic pathology partnership with NUH is one of UHL's flagship alliances.

National and Regional Reports and programmes identify Pathology as a key support service and central to the delivery of patient care:

- Carter Report.
- National Pathology Programme.
- East Midlands QIPP programme.

Timescales for Delivery

April – June 2012

- Develop and approve the Joint Venture Agreement; Trust Scheme of Delegation; and Heads of Terms
- Launch Empath as a 'brand'

July – Sept 2012

- Identify and select the off-site hub location
- Establish the Empath governance arrangements with a fully 'appointed to' Empath management Board
- Commence the transition programme

Oct – December 2012

- Empath to work within the Scheme of delegation and board controls
- develop and agree the Empath three year business plan

Jan - Mar 2013

- Agree the merged Empath budget and business plan
- Sign the IT procurement and select a logistics provider

April – Dec 2013

- Undertake the formal staff consultation; fit out of the hub; and realise a fully operational hub by October 2013

Degree of Commissioner support

Support from commissioners for integrated model.

Impact on Activity

The project will deliver a radical step change improvement to overall service delivery to execute the most efficient and effective pathology service model; supporting quality, growth and innovation in service delivery.

Impact on Finance

The overall net savings on baseline costs before additional activity are projected at £10.5 m.

Impact on Workforce

- The new operating model for Empath will increase productivity by optimising staff skill mix; improved working processes; and the increased utilisation of automation.
- Overall the Empath Business Plan assumes a 12% reduction in WTE with an associated 15% reduction in cost.

Non-Financial Benefits Assessment

Strategic fit:

- The creation of innovative and technologically advanced Pathology Services in the East Midlands and beyond will result in greater local and National competitive advantage.
- Greater opportunities for translational research which will ultimately lead to reputation enhancement and subsequent income generation.

Patient Outcomes and Safety:

- Adoption of best practice for processes, systems and procedures resulting in improved quality of services.

Patient Experience:

- Localised access where appropriate, consolidated service where turnaround and consistency are critical.

Clinical Staff and Resources:

- For Commissioners – a single source of service provision across the health economy will facilitate speed of access; performance and enhanced delivery.
- Greater resilience and flexibility in staffing, leading to a more robust and reliable service able to respond to emerging needs.
- Leading centre that consolidates expertise and enhances opportunities for staff training and development.
- Recognition as a Regional Centre of Excellence for services, education and research, which will enhance the attractiveness of the service as an employer of choice.

Key Risks

The key risks associated with this project include:

- Failure to deliver at sufficient pace to realise the efficiency and cost reduction potential
- Scale of transformational change requires significant workforce transformation which will mean a 15% reduction in staff costs and a significant change in skill mix
- Maintaining and achieving enhanced income potential and maximizing competitor advantage
- Infrastructure requirements namely: Information technology capability and logistics

A.1.6 LRI Aseptic Suite

Primary Aims / Objectives

To establish a long term solution for aseptically prepared products - the current LRI aseptic unit was in use up until 2008 when it reached the end of its usable life. As a temporary measure of a refurbished rental unit was installed which runs until August 2012. The refurbished rental unit was failing to meet standards and long term solution became critical because:

- Intravenous chemotherapy and other agents must be prepared to standards that are compliant with MHRA criteria.
- An on-site facility for specific agents that cannot be outsourced easily is required

Strategic Drivers

- Increasing our joint venture relationships will ensure better planning for prescriptions, optimum working environments and better utilization of the drugs to ensure reduction in waste.
- The on-site Aseptic suite supports the Trust's vision to be recognized for premium research and innovation by the provision of aseptically prepared Investigative Medicinal Products (IMPs).
- It increases our relationship with Trusts within our SHA (e.g. Nottingham) to ensure maximum utilization of current aseptic facilities.

Degree of Commissioner support – there has been no adverse feedback from commissioners

Timescales for Delivery

To be completed by March 2013

Impact on Activity

- To maintain the current level of service with regards to provision of an intravenous chemotherapy service to adults and paediatric patients and deal with any growth; NB 50% of current workload (dose banded chemotherapy) is outsourced and there is no intention to bring this workload back into UHL. It is expected that we would continue to purchase this through our regional hub contract.

Total dispensed based on complexity:

- 09/10 Aseptically produced preparations – 40,600
- 10/11 Aseptically produced preparations – 44,174

Impact on Finance

- Cost avoidance of purchasing expensive commercial chemotherapy drugs
- Cost effective and continued supply of chemotherapy products for the Trust's patients
- Options 2 and 3 above (installation of new unit as opposed to refurbishment of current one) will ensure that expansion and increased demand from the Clinical trials unit will be managed and not result in unnecessary costly non-contract commercial preparations.

Non-Financial Benefits Assessment

Strategic fit:

- Supports the Trusts vision to be recognized for premium research and innovation by the provision of aseptically prepared Investigative Medicinal Products (IMPs).
- Increasing our relationship with Trusts within our SHA (e.g. Nottingham) to ensure maximum utilization of current aseptic facilities

Patient Outcomes and Safety:

- An on-site facility ensure that there are no disruptions to service provided to UHL patients

The new unit will also ensure safe dispensing of commercially produced products which need to be checked and dispensed in a 'clean' environment

Patient Experience:

- Production of high quality medicines to the patient in a timely manner
- The unit will be able to produce IMP's and other cytotoxic products that cannot be outsourced to a commercial supplier.
- The unit will meet all MHRA and NPSA standards ensuring that products prepared for UHL patients will be prepared to the highest standards.
- The new unit will be able to respond to new and existing research needs i.e. increased capacity for clinical trials and research needs
- Sufficient space to ensure correct storage, adequate preparation areas and safe and comfortable working environment.

Clinical Staff and Resources:

- The preferred option will ensure optimum working environments for the workforce
- There will be better utilisation of the drugs to ensure reduction in waste

Key Risks

- Breakdown of the rental modular aseptic suite (due to not meeting the current standards as laid out by the MHRA)
- Storage, receipts and dispensing facility for dose-banded chemotherapy and other outsourced items purchased. (currently done in the unused unit)

A.1.7 Community Elective Care Services

Primary Aims / Objectives

The Clinical Commissioning Groups within the County PCT cluster are committed to tendering Elective Care Services across the county. The tender process will seek to secure a suitably qualified provider to deliver Elective Care services across the community to meet the requirements of the local health economy. The services to be tendered include diagnostics, outpatients and day-case services. We will respond to the tender and provide detail on how through the development of innovative, integrated end to end pathways the vision for health care across the health economy will be delivered.

Strategic Drivers

- Supports and delivers the distributed healthcare model.
- The development of integrated pathways will deliver seamless care to the patient across organisations as stated in the Operating Framework 2012/13

Timescales for Delivery

The tender process is initially being led by the East CCG. With the West following a similar process sometime later.

For the East CCG:

- Request for expressions of interest – advert December 2011
- Bidder information day – 28th February 2012
- Invitation to Tender – June 2012
- Contract to commence – April 2013

Degree of Commissioner support

We are working with commissioners as part of the procurement process to secure their support.

Impact on Activity

The impact on activity from winning or losing the contract will be calculated in detail as part of the tendering process.

Impact on Finance

- The contract for Elective Care Services in the East CCG is circa £6 million
- The contract for Elective Care Services in the West CCG is circa £15 million

Impact on Workforce

- Responding to the tender process may require commercial support.
- The corresponding impact on staff from winning or losing the contract will be calculated as part of the tendering process

Non-Financial Benefits Assessment

Strategic fit: UHL's Strategy to deliver more care closer to home

Patient Outcomes and Safety: will improve as a result of the development of integrated care pathways

Patient Experience: will improve as a result of the provision of seamless care across organisations

Clinical Staff and Resources: there will be a significant impact on clinical staff resources dependent on the outcome of the tendering process

Key Risks

- Lack of dedicated resource to respond to the tender
- Lack of detailed information in the service specification
- Lack of commercial expertise in responding to large tendering requests
- Competition from external parties in the NHS and more widely
- Impact on service integration if we do not secure the service

A.1.8 Teenage and Young Adult (TYA) Cancer Unit
Primary Aims / Objectives • To provide dedicated medical and play facilities for children, including games and television. • To provide separate medical and recreational facilities for teenagers and young people aged 13 to 24, including games, television and access to the internet. • To provide a youth support coordinator to ensure that teenagers and young adults get the emotional, social and practical support that they need. • To avoid the need where possible to use the adult services through availability of dedicated outpatient and day case treatment areas within the children and young people's cancer unit • To provide an integrated team of specialist nurses, doctors and healthcare professionals from adult and children's medicine • To provide specially trained staff to assist with social activities, education and provide emotional support • To provide support for families with a child or young person on the unit
Strategic Drivers • Improving outcomes: a strategy for cancer • NICE guidelines : Children and Young People's Improving Outcomes Guidance • Teenage Cancer Trust • Liberating the NHS – patient centred services
Timescales for Delivery • Fundraising throughout 2011/12 – with £1.1m raised as at February 2012-03-21 • Designs to be drawn up from February 2012 • Building work to begin in Summer 2012
Impact on Activity This will ensure that wherever possible teenagers and young adults are treated in dedicated areas rather than having to interact with adult services which may be inappropriate
Impact on Finance The costs of the unit are being met through a Leicester Hospitals Charity appeal called 'Our Space' appeal in conjunction with the Teenage Cancer Trust and with support from the Robbie Anderson Cancer Trust
Non-Financial Benefits Assessment **Patient Outcomes and Safety:** • Studies have shown that teenagers with cancer have a much better chance if treated by teenage cancer experts, in an environment tailored to their needs • The youth support coordinators to ensure that patients are getting the emotional, social and practical support they need • An integrated team of specialist will be based within the unit to ensure high quality, age appropriate

care

Patient Experience:

- The unit will allow teenagers with cancer to be treated in a positive age appropriate environment, allowing for peer support and appropriate recreation, greatly improving the patient experience
- There will also be provision to support the families of the patients in the unit
- Specially trained staff will assist with social activities and education to ensure patients get the support they need

Clinical Staff and Resources:

- The unit will be staffed by people who are appropriately trained to deal with teenagers and young adults

A.1.9 Service and Site reconfiguration

Primary Aims / Objectives

To work with the LLR Reconfiguration Programme to develop and deliver a long term strategy for sustainable health care delivery across the region.

The primary aims and objectives of the Programme are:

- More care closer to home
- More integrated care for frail elderly
- Less requirement to attend UHL for routine outpatient appointments
- Better access to services
- Better take up of technology
- Faster communication
- Improvement in overall occupancy and savings in the cost of estates occupancy
- Reduction of backlog maintenance

Strategic Drivers

The current clinical service and capacity configuration across UHL and LLR is the product of fragmented, incremental development. Service configuration challenges at UHL include a 3 site emergency take; unsustainable Critical Care delivery across 3 sites; and an outmoded Emergency Department.

In the current economic climate the configuration is neither affordable nor sustainable. By working together, the Leicester, Leicestershire and Rutland (LLR) health and social care system will ensure that services are right-sized and delivered in lower-cost settings where it is safe and appropriate to do so.

Detailed analysis has shown significant opportunity for productivity improvements, low overall levels of occupancy and material estate backlog maintenance challenges. The LLR space occupancy review identified an opportunity to reduce operating costs by £12-£24m per annum if we improved our estate utilisation without the need for any activity reduction.

Timescales for Delivery

As part of the LLR Shared Clinical Vision key priorities have been identified for 2012/13:

- Where appropriate, relocation of outpatients and day cases from LRI into community settings
- Redesign of Emergency Floor
- Move to two site emergency take
- Centralisation of emergency gynaecology services at the LRI and elective at LGH
- Developing Hybrid theatres for Cardiology and Cardiac Surgery

Key Programme milestones are detailed below:

M1	Approve 2012 priorities.	February 2012
M2	Prioritise Transformation Bids. PID considered by LLR Trust Boards.	April 2012
M3	Pre-engagement	May 2012
M4	Confirm specific reconfiguration priorities over a 3 year time horizon. Develop business cases, timelines and costings. Scope consultation activities	July 2012
	Begin statutory consultation	September 2012
M5	Formal consultation – Closed	December 2012
M6	Enact prioritised reconfiguration plans - phased implementation.	January 2013
M7	Lessons Learned review – phase 1	January 2013

Impact on Activity

If successful this programme will see less activity delivered in the Acute setting and more activity delivered in the community setting and at home.

Impact on Finance

By increasing asset utilisation and delivering activity in lower cost settings, the overall cost of providing health care in LLR should reduce. The financial impact of this programme on the Capital Plan is significant, but each project will have a full business case which will go through the appropriate approval routes.

Impact on Workforce

This Programme will be underpinned by detailed consideration of working practices and workforce requirements. This could include:

- Delivery of services within the most appropriate clinical setting
- Patterns of working e.g. three session/extended days
- Non-clinical support functions delivered outside of the Acute setting

Strategic Fit:

Site and Service Reconfiguration is strategically aligned to local, regional and national priorities, including:

- Delivery of care close to home
- Providing sustainable and high quality care for frail and elderly population
- Improved access to services
- Use of integrated IT across health system

Key Risks:

MANAGING CONFLICTING PRIORITIES - we will need to balance the priorities of individual services with those of UHL and LLR overall.

ENGAGEMENT AND CONSULTATION – we will need to ensure robust and meaningful engagement and consultation with all stakeholders to ensure support and buy-in throughout the process.

LIMITED CAPITAL RESOURCE – we will need to make sure that capital is invested in those changes that deliver the greatest overall benefit.

INSUFICIENT PROJECT MANAGEMENT RESOURCE – a transformation bid has been approved to fund project managers to deliver the programme.

A.1.10 Capacity Planning (right-sizing beds, theatres and outpatients)

Primary Aims / Objectives

Readmissions, Outpatients and Theatres form part of the Trust's central transformation programme which aims to deliver improved quality of services, efficiency gains and cost reduction.

- The primary aim of the readmissions programme for 2012/13 is to reduce avoidable readmissions by 10% in line with the Emergency Care Network standard. An aim is also to ensure accuracy in the readmissions penalty for 2012/13.
- The outpatients transformation programme aims to deliver improvements in the management of support resources, pathway/service redesign, appropriate income in line with activity and appropriate metrics.
- Theatres programme aims to reduce the cost of surgical pathways and overall footprint to meet best practice utilisation rate of 86% and above. This includes the transfer of day case activity to clean rooms and community settings and the transformation of inpatient activity to day case.

Strategic Drivers

- In line with national and local drive to reduce readmissions and UHL to meet quality indicator relating to readmission.
- Achieving financial balance, value for money and efficiency gains.
- In line with national agenda to reduce avoidable surgical cancellations, which will in the future be counted as 'never events'.

Degree of Commissioner support: full support from commissioners to right size our capacity and deliver more care outside the acute setting.

Timescales for Delivery

- Capacity Model for UHL completed – March 2012
- 3 Year Capacity Assumptions for UHL agreed – April 2012
- Speciality Level Capacity Planning rolled out across Trust April-Dec 2012
- 10% reduction in readmissions by March 2013. Agreed readmission penalty position by the end of Q1 2012/13 identifying the proportion of avoidable readmissions.
- Key deliverables for the outpatients workstream in 2012/13 are as follows:
  - Reducing DNA
  - Clinic slot utilisation
  - Achieving agreed N:FU ratios
  - Reduced Hospital cancellations
  - Centralised clinic reception
  - Centralised clinic note preparation
  - Reducing admin burden through Order Communications
  - Improved outpatient coding
- A reduction in the overall theatre footprint by April 2014 by closing 4 theatres each year in a phased approach to allow for fluctuations in activity.

Impact on Activity

Theatres:

Potential reduction of 11 operating sessions in 12/13 (potential reduction 40 session if ophthalmology transfers alongside other day case activity to the community).

Readmissions:

There have been approximately 15,861 readmissions in 2011/12. At a high level a 10% reduction in readmissions would see a full year effect 1,586 less readmissions in 2013/14.

Outpatients:

Initiatives to reduce DNA activity and improve clinic utilisation are likely to result in approximately 2,300-3,500 new and 4,800-7,400 follow up appointments.

Impact on Finance

Theatres:

A reduction in theatre sessions releases consultant Programmed Activities (PA's) and theatre staffing costs. For one complete theatre closure the savings are £250k across the organisation.

Readmissions:

Should specialties who have a critical mass of avoidable readmissions achieve 10% reductions in readmissions, they should, where demand does not rise, be able to remove some bed capacity and therefore costs. At the 2011/12 LOS of 5.9 days, a successful 10% reduction would see a reduction in 9,357 bed days full year effect releasing 25 beds which amounts of cash savings in the region of £500K.

Outpatients:

£500K cost reduction and £800K-£1200K increase in income (excluding improvements in outpatient coding).

Impact on Workforce

Theatres:

The reduction of each theatre equates to 5 wte theatre staff the overall pay bill is reduced further due to the reduction in the use of agency and bank staff. Medical staff PA's can be reduced if sessions are reduced resulting in larger savings, for anaesthesia this would reduce the bounty payments as the PAs are used to support other uncovered sessions reducing the overall pay bill.

Readmissions:

Based on current nurse staffing levels across the Trust, a reduction of 25 beds would lead to a reduction in 25 posts.

Outpatients:

Expected reductions in A&C staff through centralisation of clinic reception and order communications implementation. As the number of clinics are reduced staff will be redeployed.

Non-Financial Benefits Assessment

Strategic fit:

- Care closer to home
- Rationalisation of resources and release of capacity to focus on more acutely ill patients.

Patient Outcomes and Safety:

- Providing appropriate surgical care in an environment that is prepared for these patients will reduce risk.

Patient Experience:

- Reduction in hospital cancellations and waiting times
- Fewer late running clinics.

A.1.11 Developing Care Pathways

Primary Aims / Objectives

- To support site reconfiguration
- To enable the shift from Acute to lower cost settings
- To support delivery of key quality performance targets

The key projects within this are:

Jaundice Care Pathway

The purchase of a number of bilirubin meters for use across UHL and the community with prevent unnecessary paediatric review in children's services and ensure appropriate and timely referral for those who need to be seen. This will also lead to consistency in values across the service helping to provide a more coherent service.

Lower GI and Urology Cancer Pathway

This project aims to align both clinical and administrative pathways to ensure delivery of quality and performance targets. The review of pathways and implementation of changes will lead to a more integrated service which delivers high quality care within mandated timescales through effective use of resources.

Developing a comprehensive outpatient parenteral antimicrobial therapy service (OPAT)

This scheme aims to provide parenteral antibiotics to patients in their own home or alternative community facilities. This will mean that care is provided closer to home for the patient and will result in a reduction in excess bed days, the length of stay and therefore the risk of healthcare associated infections. This development also improves patient choice of treatment.

Strategic Drivers

- National quality and performance targets
- NICE Jaundice Guidelines
- NHS Operating Framework – quality domains
- Liberating the NHS – providing a patient centred NHS

Timescales for Delivery

This will be an on-going programme of work with the initial projects beginning in 2012/13.

Impact on Activity

The overarching aim of this project is to move activity into the community where possible to enable patient's to experience care closer to home, this will enable admission avoidance through better preventative care. It also intends to make pathways more efficient which could have an impact on the amount of activity undertaken.

Impact on Finance

Through efficiency gains and probable workforce and pathway changes savings will be realised, although these are yet to be quantified. There may also be a change in patient related income due to a shift in care environment.

Impact on Workforce

This will vary for each individual project within the programme.

Non-Financial Benefits Assessment

- Our ultimate aim when ensuring we are providing efficient and preventative pathways is to improve patient outcomes and safety and this will be monitored on a project by project basis.
- Providing more care within a community setting and ensuring pathways are integrated throughout the health economy will mean a better experience for patients.
- Integrated pathways throughout the health economy will ensure that we have the correct staff and resources and are utilising them to their full potential.

A.1.12 FM shared services and total FM Procurement

Primary Aims / Objectives

To procure a seven year framework for provision of estate and facilities services and also estate transformation on a shared services basis for the health community.

Programme supports the Reconfiguration Programme by ensuring the framework delivers estate solutions that underpin the clinical vision of LLR.

Strategic Drivers

- Reduction in estate footprint of 20% (minimum scoped opportunity)
- Efficiency improvement in estate and facilities
- Left Shift in service provision to be matched by creation of a more flexible and efficient estate with all partner collaboration
- Creation of the LLR Facilities Management collaborative shared service hosted by UHL and the management vehicle with which to manage the framework private sector partner

Timescales for Delivery

- ISOS completed – select 2 bidders for ISDS end of February 2012
- ISDS and submission of detailed offer June 2012
- Appointment of preferred bidder July 2012
- Contract Award October 2012

Degree of Commissioner support:

Joint programme with PCTs, so has full support.

Impact on Activity

This programme does not have a direct impact on activity, but the FM contract must be flexible enough to respond to reductions in acute activity and increases in activity delivered in the community.

Impact on Finance

- Significant reduction in LLR Facilities costs (estimate commercially confidential)
- Improved space utilisation will reduce costs to LLR significantly

Impact on Workforce

- Block TUPE transfer of circa 2000 staff
- Transfers from three private sector providers and LLR partners
- Potential reductions in workforce numbers 20% to 30%.

Non-Financial Benefits Assessment

Strategic fit: Collaborative approach to LLR clinical service design and estate and service transformation. Congruent with UHL reconfiguration strategy.

Patient Outcomes and Safety: Secured

Patient Experience: Detailed specifications and safeguards for service quality

Clinical Staff and Resources: Resources for the LLR programme secured – match funding and transformation resourcing.

A.1.13 IT Transformation

Primary Aims / Objectives

- Stabilise our IT Services by introducing industry best processes and investing in our staff through training and development
- Centralise IT services to improve governance and control over IT services and future investments
- Secure a Managed Business Partner to deliver IT services and enable transformational change through IT
- Rationalise and optimise IT by reducing the variation of IT services and systems and ensuring the systems in place are fully utilised
- Improve the user experience of IT through being accessible, reliable, responsive and consistent to within 1 release.
- Implement an Electronic Patient Record

Strategic Drivers

Consolidate and rationalise the disparate set of IT systems and paper based processes currently supporting the delivery of care in UHL.
Meet the needs of:

- Clinicians: speed, convenience, individual care patterns,
- The hospital / health system: efficiency, effectiveness, safety, timeliness.
- Patients: patient-centred, equality coordinates multidisciplinary care, avoids errors.
- Reduce cost: standardises processes, reduces maintenance, and effectively uses resources.

Timescales for Delivery

- Award contract to a Managed Business IT Partner Summer 2012.
- Transition to MBP Autumn 2012 including stabilise IT services
- Develop transformational project business cases from Sept 2012
- Commence implementation of transformational projects subject to Trust approvals from 2012-2015
- Timing for EPR implementation to be confirmed once partner has been appointed

Degree of Commissioner support:

Full support from PCT and CCGs to provide a more integrated IT service.

Impact on Activity

Effective IT systems and processes will enable a higher volume of activity to be managed more efficiently.
Conversely, the implementation of the EPR may result in a fall in some diagnostic activity, as case studies have shown that supportive technology can significantly reduce the number of unnecessary test and process requests whilst end-to-end patient care is streamlined and becomes more patient and outcome focused.
We also anticipate an increased load on clinicians across the Trust, to be supported by backfill funding, to ensure that they are able to fully contribute to the design and implementation of the EPR.
It is anticipated that the EPR programme will build upon and support the developments and work of the UHL Lean programme.

Impact on Finance

An Enterprise Wide EPR will require an additional investment in IT revenue spend of some 20 – 25% per annum over 10 – 15 years, and up to £15m Capital funding for clinical engagement and backfill costs during the three year implementation programme.
In parallel, there will be a reduction of some £1.5m to £2m per annum on current IM&T capital

funding going forward, and the avoidance of some £30m- £35m of additional capital funding to fund urgent system replacements during the life of the EPR contract that would be avoided by the EPR being implemented.
Experience of similar major EPR implementations indicates that significant cash releasing and clinical benefits will be realised. Initial calculations indicate that the financial benefits accrued through clinical transformation and organisational redesign will be compelling, with the potential cost benefit of implementing an enterprise wide EPR over 15 years equating to some 4.4% per annum (Optimal Case) and 2.3% per annum (base case) of total Trust turnover.
Unified communications by quarter 4 2012/13 a saving of £400k
Voice recognition by quarter 4 2012/13 a saving of £1m

Impact on Workforce

Many of the individual IT projects planned for 2012/13 have identified potential to reduce workforce. However only one of these has been quantified. This is Electronic Document Management which identifies the opportunity to reduce medical records staff with a saving of £220k.

Non-Financial Benefits Assessment

Strategic Fit:
A single IT programme will enable UHL's journey from 'Good to Great' by helping to establish the Trust as a forward looking leader in the provision of high quality healthcare at a local, regional and national level. It will also support the Trust's aim to be recognised nationally and internationally for clinical research and development.

Patient Outcomes and Safety:
- Improved clinical outcomes and quality of care through decision support.
- Decreased patient complications and mortality rates.
- Real time recording of and access to patient information at a glance.
- Improved ED efficiency.
- Improved ability to perform data analytics on quality and safety.

Patient Experience:
- Improved patient experience following more efficient, end to end care.
- Reductions in MRSA infections and inpatient falls
- Reduction in delayed administration of medication.
- Reduction in ED waiting times

Clinical Staff and Resources:
- Improved data security.
- Improved effectiveness of pathology through interoperability with EPR.
- Optimisation of bed management through automation of bed management.
- Improved theatre utilisation.
- Increased efficiency in discharge summaries.
- Reduced medical records storage and management costs.
- Improved operational management through information.
- Improved staff attraction and retention centre that consolidates expertise and enhances opportunities for staff training and development.
- Recognition as a Regional Centre of Excellence for services, education and Research, which will enhance the attractiveness of the service as an employer of choice.

A.1.14 Transforming our Workforce

Primary Aims / Objectives

To ensure our workforce is aligned to patient pathways, through the implementation of cost effective and productive working processes which include:

- Outsourcing of medical transcription services
- A review of Occupational and Physiotherapy Services
- Implementation of Hospital at Night

Strategic Drivers

- To improve quality standards relating to clinical correspondence
- To deliver cost efficiency savings and improve productivity by reshaping our workforce
- To address significant recruitment problems at all training levels for junior medical staff

Timescales for Delivery

- Procure and implement outsourced transcription across the Planned Care Division – September 2012
- Review and restructure OT and PT workforce and redesign patient pathways – September 2012 – March 2013
- Implement productivity model in OT and PT – April 2012 – March 2013
- Review and development of therapy clinical outcomes, Action plan and roll out – June 2012
- Hospital at night has a fully developed project plan which will be implemented during 2012-2013

Impact on Activity

Will support the Trust in achieving activity plans through a cost effective multi-skilled workforce model

Impact on Finance

It is envisaged that recurrent savings of £1 million will be achieved from these specific projects.

Impact on Workforce

All staff affected have been or will be fully engaged with the redesign as the individual projects develop, ultimately delivering WTE reductions through a planned and considered process.

Non-Financial Benefits Assessment

Strategic fit: Fits with UHL Caring at its best strategy
Patient Outcomes and Safety: will improve as the workforce is aligned to patient pathways
Patient Experience: Will improve as the workforce is aligned to patient pathways
Clinical Staff and Resources: Clinical staff will benefit from the implementation of workforce models which enable service improvement and development

A.1.15 The 'Hope' Cancer Clinical Trials Unit

Primary Aims / Objectives

- To create a specific area for the treatment of cancer patients undergoing early phase clinical trials
- To provide the infrastructure to become the East Midlands CRUK Cancer Centre
- To amalgamate the two existing trials units

Strategic Drivers

- One of the key weaknesses identified in the Trust level SWOT analysis was that UHL has not yet fully embedded a culture of Research and Development within the Trust. The Cancer Clinical Trials facility will help to address this by building the UHL's R & D profile both internally and externally.
- The development of the Clinical Trials unit, partly funded by The Hope Foundation, is critical to the renewal of UHL's Experimental Cancer Medicine Centre, (ECMC) status by Cancer Research UK (CRUK)
- The infrastructure provided by The Hope clinical trials unit will ensure that ECMC study activity continues to progress.
- The development of the Unit and the opportunity to increase our trails portfolio is fundamental to the Trusts application to be a prestigious CRUK Cancer Centre and supports our ECMC grant renewal process.

Timescales for Delivery

The Unit is currently being built and will be operational from early 2012/2013

Impact on Activity

It is expected that the availability of a dedicated Cancer Trials unit will increase recruitment of patients by 10% per annum over the next 5 years a contributory factor to this will be the ability to attract patients beyond our boundaries. In line with the national agenda, the focus will be to engage with industry with a specific focus on randomised controlled trials and earlier phase studies designed through the National Cancer Research Network (NCRN) Alliances with Industry.

Impact on Finance

Capital Investment - £348,745 (£100,000 capital requirement from UHL)

Two trials units already exist with well-defined income streams therefore this development does not carry with it the risk of a new service development. The investment required has already been approved via three funding streams:

- £150,000 – External funding from The Hope Foundation
- £100,000- Internal funding from UHL Capital budget
- £100,0000-Internal funding from CBU Charitable funds

Revenue investment - £80,000

The investment required has already been approved via two funding streams:
Equipment/furniture revenue cost:

- £27,970 – External funding from CLRN to support furnishing the area
- £52,030 – Internal funding from Medical Equipment Charitable Fund

Impact on Workforce

As trials activity increases there will be a subsequent increase in medical and nursing staff which will be externally funded through the trails process.

There would also be opportunities to train more nurses to take part in clinical trial.

Non-Financial Benefits Assessment

Strategic fit:

The initiative is aligned with UHL's Strategy and underpinning principles:

- To provide internationally recognised specialist services supported by R & D: UHL will have the potential to become the largest centre for cancer prevention in Europe.
- Advancing medical science and knowledge – Evidenced by ECMC, phase 1 clinical trials, increase of 10% annually in recruitments and expansion of the trials portfolio.
- Developing strong partnerships: Working with the University, Commercial Organisations and The Hope Foundation (who have committed a significant sum of money to the project)
- CBU and Divisional Business plans reflect a vision of developing a culture of research and clinical trials.
- The development of The Hope Unit is supported by the Research and Development Board

Patient Outcomes and Safety:

- Centralised service in terms of nurses, notes storage etc.
- Closer observation of patients
- Greater regulation in terms of MHRA
- Patient outcomes improved when entered into trials. Therefore increase in patients recruited will improve outcomes overall

Patient Experience:

- The provision of an efficient dedicated clinical trials unit will improve comfort for the patients who will no longer be required to stay in the overcrowded Chemotherapy Unit.
- The development of and increased portfolio of clinical trials will offer a wider choice to patients particularly where there may be no other option via the NHS.

Clinical Staff and Resources:

- Leading centre for Phase 1 trails.
- Professors Steward and Dyer and Dr Anne Thomas all have international reputations within the research field.
- Leads on clinical study groups
- ECMC (Experimental Cancer Medicine Centre)
- Translation Studies, linked with the University
- Enhanced reputation, increase in kudos, and attracts highly motivated qualified staff who are experts in their field.

A.1.16 Biomedical Research Units (BRU's)

Primary Aims / Objectives

The primary aim of securing funding awards to develop the three Biomedical research units is to maintain and further increase the Trust's Research and Development portfolio, in the context of the strategic drivers below.

Strategic Drivers

- To support the Research and Development component of UHL's overall strategy.
- In collaboration with our academic partners, the Trust undertakes a wide portfolio of patient-centred research which includes almost every aspect of specialist medicine and surgery.
- Several of our research teams are recognised as international leaders in their field; they include cardiovascular disease, respiratory disease, diabetes, cancer, renal and infection.
- Our main academic partner is the University of Leicester; we have productive and growing partnerships with Loughborough University and other academic institutions throughout the UK and overseas.
- The specialist areas of research support the Department of Health current agendas for long term conditions, cancer and physical health/activity.

Timescales for Delivery

- Cardiac Biomedical Research Unit – funding approved to continue research already underway
- Respiratory Biomedical Research Unit – funding approved for a new clinical research facility at Glenfield Hospital. Building work will commence May 2012.
- The Nutrition, Diet and Lifestyle Biomedical Research Unit – operational Spring 2012

Impact on Activity

Raising our R&D profile will help to grow our market share and activity outside of LLR. One example is designation as a Children's Surgical Heart Centre.

Impact on Finance

£19m awarded from National Institute for Health Research for development of three Biomedical Research Units

Impact on Workforce

As R&D portfolio grows, so will our R&D workforce required to deliver the agreed strategy.

Non-Financial Benefits Assessment

Strategic fit: Maintaining and further developing UHL's national and international reputation for research

Patient Outcomes and Safety: Improved patient outcomes and safety as a consequence of the research projects and clinical trials undertaken

Patient Experience: Improved patient experience as a consequence of the research projects and clinical trials undertaken

Clinical Staff and Resources: Clinical staff from across the range of healthcare professions are already involved and will be recruited as required to undertake specific projects.

15 Glossary of Terms

A

A&E	Accident and Emergency
AMU	Acute Medical Unit

B

BME	Black and Minority Ethnic
BRU	Biomedical Research Unit
BREEAM	Building Research Establishment Environmental Assessment Method
CAS	Type of Alert
CBU	Clinical Business Unit
C.Diff	Clostridium Difficile – a species of bacteria that causes several diarrhoea and other intestinal disease when competing bacteria in the gut have been wiped out by antibiotics
CCG	Clinical Commissioning Groups
CCP	Co-Operation and Competition Panel
CDU	Clinical Decisions Unit
CHKS	Comparative Health Knowledge Systems – A system which supplies hospitals with information to help them compare their performance against their peers
CIP	Cost Improvement Programme
CNST	Clinical Negligence Scheme for Trusts
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission - the independent regulator of all health and social care services
CQUIN	Commissioning for Quality and Innovation Payment Framework - Enables commissioners to reward excellence by linking a proportion of provider's income to the achievement of local quality improvement goals
Crude Mortality Rate	A rate which looks at the number of deaths that occur in a hospital in any given year and then compares that against the amount of people admitted for care in that hospital for the same time period
CRC Scheme	Carbon Reduction Commitment Scheme
CRL	Capital Resource Limit
CRUK	Cancer Research UK
CVRC	Cardiovascular Research Centre

D

DATIX	Web-based patient safety software for healthcare risk management applications, used to record and analyse patient safety incidents
DoH	Department of Health

E

EBITDA	Earnings Before Interest, Taxes, Depreciation, and Amortization
ECMC	Experimental Cancer Medicine Centre

ECMO	Extracorporeal Membrane Oxygenation
ECN	Emergency Care Network
EDS	Equality Delivery System
EDU	Emergency Decisions Unit
EFL	External Finance Limit
EFU	Elderly Frailty Unit
EMPATH	Joint venture with UHN for providing pathology services
EMSCG	East Midlands Specialised Commissioning Group
ENT	Ear, Nose & Throat
EPR	Electronic Patient Record
ERIC	Estates Return Information Collection
ESR System	Electronic Staff Record System
EWS	Early Warning Signs
EUTES	European Union Emissions Trading Scheme

F

FASP	Fetal Anomaly Screening Programme
FM	Facilities Management
FT	Foundation Trust
FOT	Forecast Outrun
FRR	Financial Risk Rating
FY	Financial Year

G

GP	General Practitioner
GH	Glenfield Hospital
GRMC	Governance and Risk Management Committee

H

HAI	Healthcare Associated Infections
HAP	Hospital Acquired Pneumonia
HDD2	Historic Due Diligence (2nd Phase)
HDU	High Dependency Unit
HIV	Human Immunodeficiency Virus
HR	Human Resources

I

I&E	Income and Expenditure
IBP	Integrated Business Plan
IM&T	Information Management & Technology
ISDS	Invitation to Submit Detailed Solutions
IT	Information Technology
ITU	Intensive Therapy Unit

K

KPI's	Key Performance Indicators

L

LGH	Leicester General Hospital
LRI	Leicester Royal Infirmary
LLR	Leicester, Leicestershire & Rutland
LiNK	Local Involvement Network
LTCs	Long Term Conditions

M

MBP	Managed Business Partners
MES	Managed Equipment Services
MHRA	Medicines and Healthcare Products Regulatory Authority
MPET	Multi-Professional Education and Training
MRSA	Methicillin-resistant Staphylococcus aureaus – a bacterium responsible for several difficult to treat infections in humans.

N

NCRN	National Cancer Research Network
NCSEM-EM	National Centre for Sport and Exercise Medicine – East Midlands
NET Promoter	A Metric That Links to Growth Good and Bad Profits
NHS	National Health Service
NHSLA	National Health Service Litigation Authority
NICE	National Institute for Health and Clinical Excellence
NUH	Nottingham University Hospitals
NNU	Neonatal Unit

O

ODP	Organisation Development Plan
OPAT	Outpatient Parenteral Antimicrobial Therapy Service
OT	Overtime

P

PA's	Programmed Activities
PBR	Payment by Results
PCT	Primary Care Trust
PDC	Public Dividend Capital
PICU	Paediatric Intensive Care Unit
PLICS	Patient Level Information and Costing Systems
PMR	Provider Management Regime
PPD	Pharmaceutical Produce Development - a global contract research organization providing drug discovery, development and lifecycle management services.

	Pressure Ulcers	(Also known as bed sores or pressure sores) – type of injury that affects areas of the skin and underlying tissue. They are caused when the affected area of skin is placed under too much pressure.
	PRICE	Pharmacist Readmission Intervention for COPD Exacerbations
	PT	Part time
Q		
	QIPP	Quality, Innovation, Productivity and Prevention
	QPMG	Quality and Performance Management Group
R		
	R&D	Research & Development
	RAMI	Risk Adjusted Mortality Index
	RAG Rating	Red Amber Green Rating
	RCI	Reference Cost Index
	RTT	Referral to Treatment
S		
	SCBU	Special Care Baby Unit
	SHA	Strategic Health Authority
	SHMI	Summary Hospital Mortality Index
	SRR / BAF	Strategic Risk Register / Board Assurance Framework
	STEIS	Strategic Executive Information System
	SUI	Serious Untoward Incidents - something out of the ordinary or unexpected, with the potential to cause serious harm, and/or likely to attract public and media interest that occurs on NHS premises or in the provision of an NHS or a commissioned service.
	SWOT	Strengths, Weakness, Opportunity and Threats analysis
T		
	TAA	Theatre Arrivals (Assessment) Area
	TCS	Transforming Community Services
	TFA	Tripartite Formal Agreement
	TIA	Transient Ischaemic Attack
	TSO	Transformation Support Office
	TTO	To Take Out
	TYA Cancer Unit	Teenage and Young Adult Cancer Unit
U		
	UoL	University of Leicester
	UHL	University Hospitals of Leicester
V		
	VAT	Value Added Tax
	VTE	Venous Thromboembolism – blood clots which form in the leg veins can break off and block blood vessels in the lungs
W		

AW4P Group	At Work for Patients Group
WHO	World Health Organisation
WRVS	Women's Royal Voluntary Service
WTE	Whole Time Equivalent