Trust Board Paper V

To:	Trust Board
From:	Kate Shield
Date:	20 December 2013
CQC regulation:	All

Title:	**2014/16 OPERATIONAL PLAN – 1ST DRAFT**

Author/Responsible Director: Kate Shields/Helen Seth

Purpose of the Report:
The purpose of this paper is to:

i. Provide an overview of the national and local landscape within which we are developing our 2-year operational plans.
ii. Provide a high level overview of our 1st draft CMG plans.
iii. Outline next steps.

The Report is provided to the Board for:

Decision		Discussion	X
Assurance		Endorsement	

Summary / Key Points:
On the 4 November, NHS England, Monitor, National Trust Development Authority (NTDA) and the Local Government Authority (LGA) wrote to all CCG's, NHS and Foundation Trusts, Local Authorities and Social Care Services to outline draft strategic and operational planning guidance, focusing specifically on process and expectations. The guidance outlined 14 key objectives (Appendix 1) and emphasised the expectation that 5-year integrated transformation plans will be developed across the NHS and social care.

In the immediate term there is a clear expectation that 2-year operational plans will create headroom in 2014/15 for a stepped change in performance in 2015/16.

The report reflects the 1st cut of CMG initiatives. These are still under development and are presented to give a flavour of service plans to date. Please note they reflect work in progress.

Following discussion between executives and the CMG leads it is proposed that a one day workshop will be held in January to progress this work further with a view to a single framework for our business plan with clear trajectories for delivery.

Recommendations:
The Trust Board are asked to:
RECEIVE this report
NOTE the progress to date
PROVIDE comment as necessary

Previously considered at another corporate UHL Committee?

Strategic Risk Register:N/A	**Performance KPIs year to date:**N/A

Resource Implications (eg Financial, HR): Set out in the AOP 2013/14**.**

Assurance Implications:N/A
Patient and Public Involvement (PPI) Implications: Yes
Stakeholder Engagement Implications:
Equality Impact:
Information exempt from Disclosure:
Requirement for further review?

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: Trust Board

REPORT FROM: Kate Shields, Director of Strategy

AUTHOR: Helen Seth

RE: 1st Draft CMG Operational Plans 2014-2016

DATE: 20 December 2013

1. PURPOSE

The purpose of this paper is to:

i. Provide an overview of the national and local landscape within which we are developing our 2-year operational plans.

ii. Provide a high level overview of our 1st draft CMG plans.

iii. Outline next steps.

2. CONTEXT

The NHS and social care system face unprecedented levels of financial and service pressure. The size of the challenge calls for fundamental change which will only be achieved through joint working, the commitment to implement an integrated service between NHS and local government, seven day working and the risk appetite to push forward long-term transformation, pump primed as necessary through non-recurrent financial resources.

On the 4 November, NHS England, Monitor, National Trust Development Authority (NTDA) and the Local Government Authority (LGA) wrote to all CCG's, NHS and Foundation Trusts, Local Authorities and Social Care Services to outline draft strategic and operational planning guidance, focusing specifically on process and expectations. The guidance outlined 14 key objectives (Appendix 1) and emphasised the expectation that 5-year integrated transformation plans will be developed across the NHS and social care. The latter will ultimately need to show how local partners will jointly rise to the challenge, be accountable for delivery and secure clinical and financial sustainability.

In the immediate term there is a clear expectation that 2-year operational plans will create headroom in 2014/15 for a stepped change in performance in 2015/16.

The establishment of the CMG's in September has provided a timely opportunity to engage clinical services in the development of their service plans on the basis of 2 year's detail, within an evolving 5-year strategy framework.

3. FINANCIAL CONTEXT

The Trust's financial performance in 2013/2014, the first cut Financial Plan for 2014/15 and the Terms of Reference for the Health Economy External Review are covered by separate papers to Trust Board in December. They are not therefore replicated in this paper. Future iterations of our Service and Financial Plans will be presented for Trust Board consideration in a single integrated document as the

necessary level of detail becomes available. Final approval will be required in March, 2014.

4. IMPROVEMENT AND DEVELOPMENT PRIORITIES

Our Annual Plan for 2013/14 was developed against a backdrop of numerous performance, economic and service challenges. Four material themes were identified. These reflect the "must do's" for our short, medium and long term plans. The themes are as follows:

i. The Emergency Department and emergency process

a. Discharge processes

b. Risk stratification – Care of the Elderly

c. Dementia Care

d. Seven day working

ii. Clinical and financial sustainability

a. Transformation in models of care

b. Medical model and productivity

c. Theatre productivity

d. Reducing premium spend

e. Commissioner Intentions

f. Seven day working

iii. Delivering quality

a. Delivering our quality commitment

b. Patient experience

c. Nursing establishment

d. Workforce planning

e. Seven day working

iv. Securing appropriate clinical configuration

a. Within the Trust

b. Across the local health community

c. Specialised services

d. Strategic Partnerships

Some progress has been made in 2013/14 however in other areas there has either been no change or indeed a worsening position. It is clear therefore that these themes remain key priorities for our forthcoming operational plans. These need to be

developed in line with our commitment to deliver cost control in 2014/15 and incremental deficit reduction. There will be limited opportunity to invest to save. 2014/16 will need to demonstrate the ability to save, in order to invest.

5. PROGRESS TO DATE

A workshop called "Delivering our Strategic Direction" was held with our newly established CMGs in November. It was hosted by the Director of Strategy and provided a timely opportunity to set the scene and define the context within which 2-year Operational Plans are to be developed.

Each CMG nominated a strategy lead to work in partnership with the Business and Strategy Support Team to define and develop the process by which our operational plans will be developed between now and consideration in detail by Trust Board at the end of March, 2014. A further workshop is planned for January 2014 with an extended invitation to heads of service and patient and public representatives.

6. HIGH LEVEL OVERVIEW – 1st DRAFT PLANS FOR 2014-2016

Key initiatives are still under development. They are summarised by CMG below and are presented to give a flavour of service plans the CMGs have developed to date. Please note they reflect work in progress.

Renal, Respiratory, Cardiac	Acute and Specialist Medicine	Cancer, Haematology, Urology and Gastroenterology and Surgery	Critical Care, Theatres, Anaesthesia, Pain and Sleep	Musculoskeletal and Specialist Surgery	Women's and Children's	Clinical Support and Imaging
Develop pathways with partners to decrease hospital admission and improve patient experience - For known patients develop direct access / crisis management / virtual ward so the patients can come straight to the service without needing to attend ED. Work with commissioners and contracting to set up telemedicine support to primary care to enable decision making in the community without sending patients onto UCC or ED Decrease 30 day emergency readmission rates (quality improvement and cost avoidance) Focus on top 3 HRGS per speciality to validate PLICS position and identify opportunities for cost improvement without detriment to quality	Transformation in Emergency Department model of care process and workforce design. Complete 43m capital investment programme - Emergency Floor Project Develop 7/7 services and the further development of care pathways with community partners supporting early and safe discharge Develop geriatric input to ensure that all areas caring for older people have access to a geriatrician. Implement focussed comprehensive geriatric assessment working in partnership with social care Implementation of the diabetes "super 7" Development of integrated acute and rehabilitation care pathways for stroke Ensure appropriate service requirement commissioned to achieve compliance with	Surgical Triage Emergency Pathways - Consultant led surgical triage ideally 7 days/wk. 11am – 7pm. Currently the project has agreement for Mon-Fri. This will require investment in Consultant posts but will ensure patients are triaged by a Consultant while the on-call Consultant is in theatre. Key benefits: Reduced LOS, efficient utilisation of beds which will impact positively on elective admissions Phase 2 of the surgical triage capital development project agreed for 2014/15. Business case to be submitted (SAU relocates to Ward 7 and has an access lift to ED replicating the AMU model) Review and reconfiguration of emergency admissions including the implementation of a Urology nursing outreach team; Chemotherapy - Aim to achieve more efficient throughput within the Chemotherapy Unit,	Deliver a planned maintenance programme - Expansion of emergency operating capacity Friday/ Monday. Short stay and ambulatory model of surgical care. Continue to provide theatre resources to meet the service and admitted pathway demands by removing suitable activity to a clean room setting and managing resources to greatest effect. Theatres - Workforce and retention planning. Roll out of LiA initiatives and programme of training Critical Care - LRI phase 1 build – 3 physical bed space expansion Critical Care - LRI/LGH change in consultant work plans to begin cross site on call rota Retain establishment of nursing staff to ensure critical care capacity is open – build increasing flexibility	Develop Trauma Services to include dedicated Spinal service and improved performance against BPT criteria for Fractured Neck of Femur Develop One Stop Screening Services for Breast Care patients thereby improving the patient experience and reducing multiple attendances Relocate Outpatient and Elective Services as part of the LLR Alliance Contract - moving care closer to home where it is safe and appropriate to do so Develop Full Business Case for Vascular Surgery (from LRI to GGH to facilitate co-location with cardio-vascular services Develop robust workforce models mapped to demand (specialties including Maxillofacial, Orthodontics and Restorative Dentistry)	Further strengthen Paediatric Acute Services working towards the delivery of single front door with Paediatric Emergency Department Develop East Midlands Congenital Heart Centre to ensure it meets the new Congenital Heart Review criteria Progress the development of Gynaecology services to include ambulatory Gynaecology, networking Gynae-Oncology, and working with community providers Create additional Maternity and Neonatal capacity through appropriate service modification, innovation and development Expand Children's and Neonatal surgery ensuring adequate intensive care and high dependency support	Consistently deliver ED turnaround time standards for imaging. **Further reduce imaging waiting times from request to report in all modalities.** **Consistently deliver cancer target turnaround time standards for imaging.** **Consolidation of imaging and therapy services with the community as part of the Alliance contract proposal.** **Support the Trust's BRUs from an imaging, pathology and medical physics perspective.** **Completed and implemented Management of Change in pharmacy and imaging giving us a flexible cross site 7 day /week workforce.**

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Work in partnership with neighbouring acute Trusts to lead the market for example: Burton - Short term to support a shortfall in staff and expertise and quality Kettering and Northampton General Hospital - Medium to long term pathway reconfiguration for cancer, respiratory and procedures. Attendance at MDT's to increase surgical referrals to LRI. Ireland - Waiting list initiatives Renal dialysis - Ensure robust delivery of renal dialysis in the community, maintain market share of delivery and thereby enable cost efficiency through procurement at scale Renal access - Increase Vascular access conversions compliance	specifications eg:HIV Maximising opportunities from the Alliance contract as part of core OP deliverable – OP redesign	Bone marrow patients often have an extremely long length of stay. The service plans to utilise an offsite facility where patients can go to after treatment rather than stay in a hospital bed (subject to appropriate safeguards) Nottingham Alliance - The CMG needs to understand the implications and ideas around partnership proposals with Nottingham for BMT and Haemophilia. Northampton Alliance - Discussions are underway to form an alliance with NGH and KGH to deliver sustainable Oncology The intention is to form a strong joint Cancer Centre. Elective General surgery and Urology day case work will move to suitable community hospitals allowing capacity to be utilised on the main sites	into workforce requirements to meeting daily changing demand HDU repatriation – Work with colleagues to improve patient flow, patient outcomes, SHMI and income to the Trust Critical Care - Approval for phase 2 physical build to meet future demand and consolidate capacity and expertise. Consolidate new anaesthetic roles. Separation of paediatric operating. Roll out LiA initiatives - Reduce same day cancellation rate. Improve efficiency through theatres Pain - Left shift to community setting – outpatients, acupuncture, day case treatments and Pain Management Programme		**Promote and develop specialist services as Regional and National** Centres of Excellence e.g. Clinical Genetics and Primary Ciliary Dyskinesia	

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		This will provide a sustainable solution for RTT and cancer delivery. By 2015/2016 100% of patients suitable for radical radiotherapy are to have IMRT (50% in 2014/2015). To support delivery there will be a requirement for the 4th linear accelerator bunker to be replaced. At the same time a business case will be developed and submitted to NHS England identifying the need for a 5th bunker (decant). This is CQUIN target. Gastroenterology Bowel Screening – UHL Bowel Screening Centre established (split from Kettering). Screeners appointed and screening running from March 2014. Gastroenterology - JAG Accreditation GGH. The endoscopy unit requires building works to achieve JAG accreditation.	Pain - Investment in inpatient pain consultant sessions, supporting earlier **discharge for surgical and medical patients thereby reducing occupied bed days** **Pain - Become centre of choice for East Midlands – Specialist Commissioning (partnership working opportunity)** **Pain - First full year of Paediatric Pain Management Programme – strengthen out of LLR referral patterns for all MPT services** **Sleep - Left shift to community setting – annual device checks and home sleep study set up in the 2014/16 period with a longer term view to left shift for the county OSA service**			

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		Bowel Scope - An application has been submitted for the second wave of bowel scope (flexi-sigmoidoscopy screening programme). This is a national mandatory programme to be **implemented from December 2014. It will require extra capacity of 17 endoscopy lists per week. Opportunities to work in partnership and utilise capacity at Loughborough Hospital are being explored. This would require investment to get the JAG accreditation. This is an opportunity identified as part of the Elective Care Alliance Contract submission.** **Gastroenterology - Working with ethnic minority communities on health promotion in relation to all GI diseases.**	Sleep - Investment in Sleep Disorder services footprint to support left shift change in Service delivery model – conversion of outpatient space into complex sleep study areas matching OSA shift into community and increased demand for neurology complex sleep disorders Sleep - Development of system to capture OSA patient base as part of British Sleep Society accreditation criteria supporting bid to become centre of choice and facilitating accurate clinical outcome data and **performance measures**			

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		Urology Transformation - A major part of 2014/15 will focus on the Urology service. Potential removal of the bladder reconstruction service circa 15 patients per year – insufficient critical mass, not clinically sustainable. Palliative Care - End of life planning is a major focus. The Amber advanced care planning process will be rolled out and a business case will be submitted to the CCGs for consideration				

7. NEXT STEPS

Following an initial review of the first cut strategic plans, the publication of the 7 day working standards and the imminent financial recovery plan it is clear that we need to understand and address our 'drivers of deficit' in more detail.

Following discussion between executives and the CMG leads it is proposed that a one day workshop will be held in January to consider the next steps including:

i. Service based visions

ii. 2 – 5 year strategic intentions

iii. Delivering site reconfiguration

iv. Single framework for our business plan with clear trajectories.

v. CMG contribution to 7 day working (medical modernisation and ED)

vi. Cost control

vii. Theatre productivity

viii. Service model modernisation (workforce initiatives)

ix. Growing business – opportunities and stretch.

8. RECOMMENDATIONS

The Trust Board are asked to:

RECEIVE this report

NOTE the progress to date

PROVIDE comment as necessary

APPENDIX 1 – NATIONAL PLANNING GUIDANCE (NOVEMBER 2013)

NHS England, Monitor, National Trust Development Authority (NTDA) and the Local Government Authority (LGA) confirmed 14 key objectives that need to be considered as part of the strategic and operational planning processes:

i. Improving outcomes (informed by detailed patient and public participation)

ii. Delivering quality, meeting expectations and securing sustainability

iii. Consistent assumptions (e.g. demographic growth rates)

iv. Strengthening tariff guidance (including confirmation that when a Trust is reimbursed at less than 100% of national tariff, both commissioner and provider will be jointly engaged in the reinvestment decision and that there will be transparency in the re-investment scheme. This will include non-payment for readmissions, marginal rate for emergency tariff

v. Confirmed allocations (to be published week commencing 16 December)

vi. Efficiency assumptions (4% 2014/15 subject to consultation)

vii. Weighted average cost inflation (2.1% 2014/15 subject to consultation)

viii. Tariff deflator (1.9% 2014/15 subject to consultation – excludes impact of CSNT on specific HRG groups)

ix. CQUIN (Scheme to be revised. Guidance will be published in December,2 013)

x. Integration Transformation Fund (Further guidance in December, 2013)

xi. Joint working

xii. Unit of planning (support to commissioners)

xiii. Support

xiv. Assurance/ Challenge process – the processes used in 2013/14 will be enhanced including an additional step to reconciled commissioners and provider plans