Trust Board Paper S

To:	**Trust Board**
From:	**Andrew Seddon – Director of Finance and Business Services**
Date:	**25 April 2013**
CQC regulation:	**All**

Title:	**2013/14 ANNUAL OPERATING PLAN (AOP)**

Author/Responsible Director: Andrew Seddon/Helen Seth

Purpose of the Report:
To present to Trust Board the 2013/14 AOP following submission to the National Trust Development Authority (NTDA) on the 5 March 2013 in line with nationally mandated timescales.

The Report is provided to the Board for:

Decision	X	Discussion	X
Assurance		Endorsement	X

Summary / Key Points:
The Annual Operating Plan represents the Trust's first steps on its FT trajectory which is currently subject to review. Some critical aspects of the strategic vision are still being finalised and so 2013/14 will see the start of initiatives which are valid irrespective of the final outcome of the UHL site reconfiguration – as well as work to finalise our strategy.

2012/13 has been a year of consistent operational pressure particularly in respect of the emergency process. This has been reflected in variable financial and clinical performance in key areas.

This together with the wide ranging changes expected across the NHS following the publication of the Francis Inquiry and more locally, as a result of the Leicester, Leicestershire and Rutland Better Care Together programme and the associated economic modelling, sets the scene for 2013/14.

The Trust has faced significant financial challenges throughout 2012/13 but expects to exceed its financial control total of £46k surplus. The Trust, prior to audit, is reporting a £90k surplus at year end. This is due in significant part to a favourable non-recurrent year end settlement with our local Commissioners.

The impact of the unsatisfactory performance in year, the fiscal drag caused by the sub-optimal configuration of hospital services and the residual impact of non-PbR tariff arrangements mean the Trust has an underlying deficit of c£12.5m (1.6% of turnover) as it exits 2012/13. The 2013/14 plan is set in this context and is designed to address short-term operational challenges whilst at the same time providing opportunity to develop a financial strategy to support progress against longer term strategic goals.

Reflecting on current performance and on the economic and service challenges ahead, there are four common themes that the Trust recognises that it must address in our short and medium term plans:

1. Safe, efficient and effective emergency care systems
2. Delivering quality
3. Financial sustainability
4. Reconfiguration

To support progress against the four key themes identified, the Trust will pursue a number of key priorities to support the delivery of safe and sustainable services, to quality standards within the financial envelope available. The actions being taken reflect the breadth of the Trust's portfolio and are outlined in appendix 1 of the executive summary.

Key elements of the AOP include:

Monitoring, reviewing and addressing mortality - The Trust has defined governance structures, processes and controls in place to promote safety and excellence in patient care; identify, prioritise and manage risk arising from clinical care; ensure the effective and efficient use of resources through evidence-based clinical practice; and to protect the health and safety of patients, public and Trust employees.

In the context of the Francis report and our vision of 'Caring at its best' it will come as no surprise to see that the first of our priorities for next year relates to our 'quality commitment' to save lives, avoid harm and provide patient centred care.

A key indicator of the quality and standard of care received in hospital is a hospital's mortality rate. The Summary Hospital Mortality Index (SHMI) is the national indicator used for measuring this. It reflects the ratio of the observed number of deaths to the expected number of deaths for a hospital over a defined 12 month period.

Independent detailed analysis of the Trust's SHMI identified two groups of patients that appeared to have the greatest impact on the '>100 SHMI' i.e. areas above the national average. These include patients admitted at weekends or 'out of hours' and patients with a respiratory diagnosis (specifically pneumonia). These have been identified as priorities by the 'Saving Lives' Quality Action Group and provide an example of those areas which offer the greatest opportunity to impact our quality targets within the next 12 months. Priorities have also been identified to help reduce harm and enhance patient centred care.

Finance – The Trust is planning to achieve a £3.7m surplus in 2013/14 which is approximately 0.5% of turnover. Whilst the plan is to deliver a year end surplus the underlying deficit as we exit 2012/13 is likely to adversely impact on our monthly run rate in Q1 2013/14. It is proposed that a proportion of the £10m contingency built into our planning assumptions will be used to manage this position non-recurrently. At the same time the Trust will consider the most appropriate financial strategy to simultaneously address short term imperatives, whilst accelerating the necessary strategic transformation to address sub-optimal service configuration. Discussions with key stakeholders have commenced in this regard and will continue in order to establish the best way forward.

Cost Improvement Plans and Quality Impact Assessment – A key element of the financial plan is the cost improvement programme and the need to ensure a financially sustainable position. The Trust set a 2013/14 CIP target of £40.4m (5.6% of the total revenue base) and has plans in place to achieve this value. The CIP plan places a strong focus on the delivery. As part of the Trust's governance for managing CIPs and in line with the National Quality Board's recommendations, there is a clearly defined

process for CIP sign-off to guard against negative impact on quality and patient safety.

All schemes have a project initiation document and have been signed off by the respective Division Director and Head of Nursing. Any schemes valued at over £100k and/or a risk score of 15 have been through a robust confirm, challenge and sign off process undertaken by the Chief Nurse/Deputy Chief Executive and the Medical Director. This has also been undertaken in collaboration with our Commissioners.

Cost Pressures and Service Developments - As part of the business planning process divisions and corporate directorates have submitted cost pressures and new service developments for due consideration. The schemes submitted far exceed the resource available. A robust confirm and challenge process is being undertaken to prioritise any unavoidable investments. The output of this process is subject to on-going confirm and challenge. It is anticipated that this will be completed by the Executive Team in the next few weeks.

Performance - The Trust faces significant clinical performance challenges particularly in respect of the ED target, 62 day cancer target in particular tumour sites and the Referral to Treatment Time (RTT) target in a small number of specialties. The Trust has plans in place to achieve sustainable improvement. It is important to note that ED trajectory has been revised to the 4 August. This differs from the previous trajectory discussed by Trust Board and is subject to CCG sign off. Achievement of the ED target continues to represent the most significant clinical performance risk facing the Trust and the Local Health Economy.

Quality– the Trust has agreed CQUIN schemes (national and local) as part of contractual discussions. Quality indicators are embedded within the clinical contract. This, together with the activities underpinning our quality commitment places quality at the centre of everything we do.

Workforce - The Trust has developed Workforce Plans for 2013-2018 which outline where we are currently, where we need to be in the future and options to help us get there. The AOP plans have been reconciled against contractual assumptions, CIP plans and Commissioner QIPP Plans. The workforce trajectory, as would be expected, illustrates a downward trend in both worked WTE's and pay bill.

FT Timeline - In developing our 2013/14 AOP, the Trust has reviewed our existing FT application timeline. A number of internal and external factors were taken into consideration including the implications of the Francis Inquiry, current ED performance and recent change in leadership. Following due consideration the Trust has requested NTDA approval to revise our FT timeline. The potential implications of this are outlined in appendix 1. This remains subject to formal approval.

Recommendations: The Trust Board are asked to:

- Approve the AOP for 2013/14 and ratify the associated NTDA assurance checklists which were circulated (on 9 April) to Board members following the Board's discussions on 5 April and subsequent submission to the NTDA that day in accordance with the NTDA deadline.

Previously considered at another corporate UHL Committee?
Finance and Performance
Trust Board

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: See below “Stakeholder engagement implications”.	
Stakeholder Engagement Implications: Prospective Board of Governors and our Patient Advisors have received an overview presentation on our prospective AOP for 2013/14	
Equality Impact: The AOP will be subject to the Trust’s equality impact processes.	
Information exempt from Disclosure: None	
Requirement for further review? Reports on implementation of the AOP 2013/14 will be submitted to the Board during 2013/14.	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: Trust Board

REPORT FROM: Andrew Seddon, Director of Finance and Business Services

AUTHOR: Helen Seth/Simon Sheppard

RE: Executive Summary - Annual Operational Plan 2013/14

DATE: 25th April 2013

1. PURPOSE

The purpose of this paper is to:

- Provide an Executive Summary of the Annual Operational Plan (AOP).
- Highlight the four key themes that have shaped the AOP and outline how making progress against these will secure progress in our Strategic Direction.
- Summarise the key improvement and development priorities for 2013/14 in support of our Strategic Direction and strategic objectives.
- Outline the financial plan for 2013/14 including an overview of our Cost Improvement Programme and Capital Programme.
- Outline the consequences on our Workforce Plan.
- Highlight key areas of risk and our approach to mitigating that risk.

2. PLANNING GUIDANCE FOR 2013/2014

2013/14 is the first year that the development of provider (i.e. trust) plans has been overseen by the NHS Trust Development Authority (NTDA). The NTDA officially took over the responsibility from the Strategic Health Authority (SHA) for provider development on 1 April 2013.

Subsequent to the Board's discussions at its private meeting on 5 April 20213,the Trust submitted the 2013/14 AOP to the NTDA that same day – the deadline for such submissions being 5 April. Development of the AOP has been an iterative process and has been informed by feedback received from stakeholder groups.

The Trust met with the NTDA on the 15 April to discuss their feedback. The NTDA are broadly supportive of the AOP but challenged the Trust's strategies for coping with variation in demand, in particular the risk of commissioner QIPP schemes not delivering in line with plan. The Trust is discussing the risk mitigation strategy for this possible scenario.

Copies of the AOP submissions made to the NTDA on 5 April 2013 were circulated to Board members on 9 April 2013 by Trust Administration, including the final versions of various planning checklists which were signed off by the Board on 5 April, evidencing the governance process underpinning the development and delivery of our plan.

3. STRATEGIC DIRECTION

In the next five years the Trust's vision is to become a successful Foundation Trust (FT), internationally recognised for placing quality, safety and innovation at the centre of service provision.

We will do this by building on our strengths in specialised services, research and teaching; offering faster access to high quality care, developing our staff and improving the patient experience. The Trust calls this "Caring at its best" and this strategy was captured in a public document in November 2012.

Our strategy is to focus on tackling the health needs of our demographically and geographically diverse populations by delivering care closer to patients' homes where it is safe and economically sound to do so. At the same time, we intend to develop and strengthen our nationally recognised, specialist tertiary services.

As care moves closer to home, our hospitals will become smaller and more specialised. In order to optimise clinical outcomes and safety, services currently distributed across our three acute sites may need to be consolidated, ultimately leading to reconfigured hospital sites. A key task in 2013/14 is to set out in greater detail the future configuration of acute services in Leicester and the related transition path. This will require detailed planning and public consultation and needs to seen in the context of the health economy-wide Better Care Together programme.

In recognition of the scale of the necessary transformation of our services, and of the operational and financial issues that the trust has managed in 2012/13, the trust has proposed to the NTDA a deferral of its current FT trajectory. Our AOP for 2013/14 represents the first year of a rolling five year integrated plan.

4. OVERVIEW OF 2012/13

As we look forward to 2013/14 it is important to reflect on what has gone well and what could have gone better, over the last year. Illustrative examples include:

Action to provide safe, high quality, patient-centred healthcare – we reported 21% (11) fewer serious untoward incidents (SUIs) relating to the Critical Safety Actions (CSA) in Q1-Q3 compared to the same period in 2011/12. Of these, SUIs relating to Early Warning Scores (EWS) reduced by 25% (3). In contrast there have been 5 *Never Event* incidents during 2012/13. Root Cause Analysis (RCA) has been completed for each of these and improvements identified.

Professional, passionate and valued workforce – The comparison of annual Staff Surveys compiled by the Care Quality Commission shows significant progress by UHL in-year. The percentage of staff able to contribute towards improvements at work has improved by 7% and is now above the national average for acute trusts. In contrast, despite an improvement in our score from 3.24 to 3.46 for staff recommending the Trust as a place to work or receive treatment, the Trust's score remains below the national average.

Joined up emergency care - in 2012/13, demand for emergency care increased substantially in the Leicester, Leicestershire and Rutland (LLR) health economy. This placed severe pressure on the LLR emergency and urgent care system. Our results demonstrate that we have been unable to cope efficiently and effectively with the increase and the fluctuations in emergency demand. This resulted in sub-

standard performance against the national A&E 4-hour target and poor patient experience, despite expenditure levels well in excess of budget and what is sustainable.

On 18 February 2013 the Trust introduced new processes in the Emergency Department (ED) and related assessment units. The new way of working is designed to improve patient safety, patient experience and make sure, *inter alia*, that we see, treat and either admit or discharge patients within a maximum of 4-hours. The new process focuses on early assessment of emergency patients by a consultant or senior registrar at the point of entry into hospital. Whilst there has been encouraging early progress, thus far the process improvements have yet to be reflected in achievement of the 4-hour performance standard. The Trust and LLR partners recognise that this will not be an overnight fix; and accordingly our plans for 2013/14 need to reflect robust system-wide plans to turnaround this long-standing problem, as well as a realistic A&E target trajectory.

Sustainable high performing NHS Foundation Trust - Finance - The Trust has faced significant financial challenges throughout 2012/13 but expects to exceed its financial control total of £46k surplus. The Trust, prior to audit, is reporting a £90k surplus at year end. This is due in significant part to a favourable non-recurrent year end settlement with our local Commissioners.

Table 1 – 2012/13 Year End Income & Expenditure Position

	2012/13 Plan	2012/13 FOT	Variance	
	£000s	£000s	£000s	%
Revenue				
Revenue from Patient Care Activities	617,696	647,964	30,268	4.9
Other Operating Revenue	103,976	110,701	6,725	6.5
Employee Benefits	(440,635)	(455,210)	(14,575)	(3.3)
Operating Expenses	(267,826)	(290,404)	(22,578)	(8.4)
Operating Surplus / (Deficit)	13,211	13,051	(160)	(1.2)
Investment Revenue	65	77	12	18.5
Finance Costs	(595)	(655)	(60)	(10.1)
Surplus / (Deficit) for the Financial Year	12,681	12,473	(208)	(1.6)
PDC Dividend payable	(11,136)	(11,293)	(157)	(1.4)
Retained Surplus / (Deficit) for the Year	1,545	1,180	(365)	(23.6)
Adjustments in respect of donated/government grant asset reserve elimination	1,499	1,090	(409)	(27.3)
Retained Surplus / (Deficit) for the Year	46	90	44	

The year-end settlement reflects reimbursement over and above mandated levels for costs incurred in treating the significant increases in emergency activity (7% above Plan). It also reflects reinvestment by commissioners of mandated national fines relating to failure to achieve A&E and cancer 62 day targets which cumulatively amount to £6.5 million.

In reflecting on the 2012/13 draft results, is important to determine the estimated underlying position, stripping out non-recurrent sources of income and expenditure. This is inevitably a somewhat subjective process, and recognises both internal inefficiencies in trust processes and also operational pressures caused by substantial variations in patient demand.

The impact of the unsatisfactory performance in year, the fiscal drag caused by the sub-optimal configuration of hospital services and the residual impact of non-PbR tariff arrangements mean that the Trust has an underlying deficit of c£12.5m (1.6% of turnover) as it exits 2012/13. This analysis excludes the impact of any performance fines.

The 2013/14 plan is set in the context of the opening underlying deficit and is designed to address the short-term operational challenges whilst at the same time providing opportunity to develop a financial strategy to support progress against longer term strategic issues. Section 10 sets out a proposed handling strategy for the underlying deficit in 2013/14.

5. EXTERNAL CONTEXT

Francis Inquiry - In the wider NHS sadly, the defining moment was the Francis report (6 February 2013) following the events at Mid Staffordshire Hospitals. The UHL board along with our staff and stakeholders have spent some considerable time studying the report and considering its implications for all of us who work in and around the NHS. This has been described as *"the greatest leadership challenge the NHS has ever faced"*. In light of this it will come as no surprise to see that the first of our priorities for next year relates to our 'quality commitment'.

The Trust has completed a preliminary gap analysis against the large number of recommendations (considered by Trust Board on 28 March). Illustrative examples of early action being taken include:

Staff concerns – The re-launch the "3636 Concerns Hotline", an anonymous number for staff to report a quality or safety concern which they feel has not been addressed by the local leadership

Improving morale – The adoption of the evidence based ***Listening into Action*** Framework. This will seek to embed a fundamental shift in the way we engage and listen effectively to our staff about their frustrations, and how we ask them what they would want to do differently

Staff attitude – In signing up to our Quality Commitment, all staff have agreed to the goal to 'Treat all patients with dignity and respect' so as to achieve a recommendation (Net Promoter) score of at least 75.

Staff survey - Leadership and Management Standards have been developed in consultation with staff at all levels. These set out key actions and behaviours expected from all managers.

Care of older people – We will build on our successes in this area to become leaders in the field and will work with partners to secure better integration of services.

Public and Patient engagement – We will seek opportunities to improve the ways in which patients and the public can engage with the Trust and will create more visible, accessible opportunities to seek support and information.

Better Care Together (BCT) - Key amongst the changes to the structure of the NHS locally is the fact that clinicians, doctors and nurses, are working collaboratively to make decisions about how we provide quality, safe and affordable health services to our local population.

Our clinical leaders and service experts from CCGs and UHL are working together with stakeholders, including LINks and the BCT stakeholder group, to develop the best models of care in key areas such as the care of frail older people, non-emergency care and urgent / emergency care.

External advisors have helped LLR partners assess the scale of the financial challenge facing the health economy. Preliminary findings from this system-wide service and financial review are that the solution needs to include a transformation programme to modernise delivery of services across the local health economy. The Trust is fully engaged with the BCT programme to ensure that our Strategic Direction complements the plans of our LLR partners.

In setting our plans, we recognise previous difficulties and slow progress in delivering a long term plan spanning all partners in health economy. The emergency process reflects a case in point. With the new clinical leadership (with CCGs coming into being on 1 April 2013) and renewed vigour, we are confident that BCT will overcome that legacy, in part by expecting all those involved, clinicians and stakeholders alike, to maintain an open mind, ruling nothing in or out until we have a sound clinical rationale, underpinned by realistic costs and a clear view on the benefit to patients.

6. 2013/14 PLAN – KEY FEATURES

Thematic approach

Reflecting on our current performance and on the economic and service challenges ahead, there are four common themes that must be addressed in our short and medium term plans:

1. **Safe, efficient and effective emergency care systems**
    - clinically and financially sustainable
2. **Delivering quality**
    - Measured through patient experience, safety, clinical effectiveness and performance standards
3. **Financial sustainability** - short, medium and long term
4. **Reconfiguration** of acute services on a clinically sustainable basis.

The 2013/14 AOP marks the start of the journey to address the above.

FT Timeline

In developing our 2013/14 AOP, the Trust has reviewed our existing FT application timeline. In doing this, a number of internal and external factors were taken into consideration. These include:

- Our new Chief Executive joining the Trust in January 2013

- The importance of aligning our AOP and five year Integrated Business Plan (a key element of our FT application) with the development of BCT and other LLR plans
- The need to further refine our Strategic Direction and consult on our service development and improvement plans
- The importance of sustained operational performance, in particular the internal and system wide changes required to deliver the A&E 4 -hour target
- The impact of the Francis Inquiry recommendations, published in early February 2013.

Taking into consideration all of the above, the Trust has requested SHA / NTDA approval for a revised FT timeline. The implications of this are explained in more detail in appendix 1.

7. IMPROVEMENT AND DEVELOPMENT PRIORITIES

For the coming year, the Trust has identified a range of priorities which are designed to take forward the key themes identified above and those of our Strategic Direction published last autumn. The actions reflect the breadth of the Trust's portfolio and are summarised below:

PRIORITY	WHICH MEANS	THEME	STRATEGIC OBJECTIVE
Delivering our Quality Commitment	Save more lives, reduce avoidable harm, improve patient experience	Quality and Performance	Action to provide safe, high quality, patient-centred healthcare
Improving the emergency care process including the Emergency Department (ED)	Consistently deliver timely, safe care and a good patient experience	Emergency Care	Provide joined up emergency care
Improving theatre productivity (clinical service transformation)	Fewer cancelled operations, fewer delays for patients.	Quality and performance standards	Earn the right to be the provider of choice
Improving outpatients (clinical service transformation)	Fewer cancellations, fewer patients who do not attend (DNAs)	Quality and performance standards	Earn the right to be the provider of choice
Improving the estate (estate improvement)	A series of schemes to bring immediate benefits as well as well as to take forward medium term reconfiguration	Financial sustainability and quality and performance standards	Sustainable high performing NHS Foundation Trust
Improving IM&T (support service transformation)	Priority schemes to support clinical service delivery	Reconfiguration; Financial sustainability; quality and performance standards	Sustainable high performing NHS Foundation Trust

PRIORITY	WHICH MEANS	THEME	STRATEGIC OBJECTIVE
Developing Listening into Action as part of our Organisational Development Plan	Better engagement with staff, leading to better support for colleagues and clear leadership standards.	Quality and performance standards	Professional passionate and valued workforce
Developing our specialised services	For example, vascular, adult cardiac, children's cardiac, renal	Quality and performance standards. Financial sustainability	Sustainable high performing NHS Foundation Trust. Provider of choice. Enhanced reputation in Research, Innovation and Education
Developing medical education	Clinical Education Centre improvements at The Royal, better engagement with trainees, considering the shape of future medical workforce	Quality and performance standards Financial sustainability	Sustainable high performing NHS Foundation Trust. Enhanced reputation in Research, Innovation and Education
Developing research and development	Strengthening our three Biomedical Research Units, playing a leading role in the creation of the Academic Health Sciences Network, and securing funding from the National Institute for Health Research. (NIHR)	Quality and performance standards Financial sustainability	Enhanced reputation in Research, Innovation and Education
Developing as a Foundation Trust	Strengthening our membership and making progress towards our Strategic Direction	Quality and performance standards Financial sustainability	Sustainable high performing NHS Foundation Trust

Details of the priorities are set out in appendix 1 to this executive summary.

8. MONITORING, REVIEWING AND ADDRESSING MORTALITY

The Trust has defined governance structures, processes and controls in place to promote safety and excellence in patient care; identify, prioritise and manage risk arising from clinical care; ensure the effective and efficient use of resources through evidence-based clinical practice; and protect the health and safety of patients, public and Trust employees.

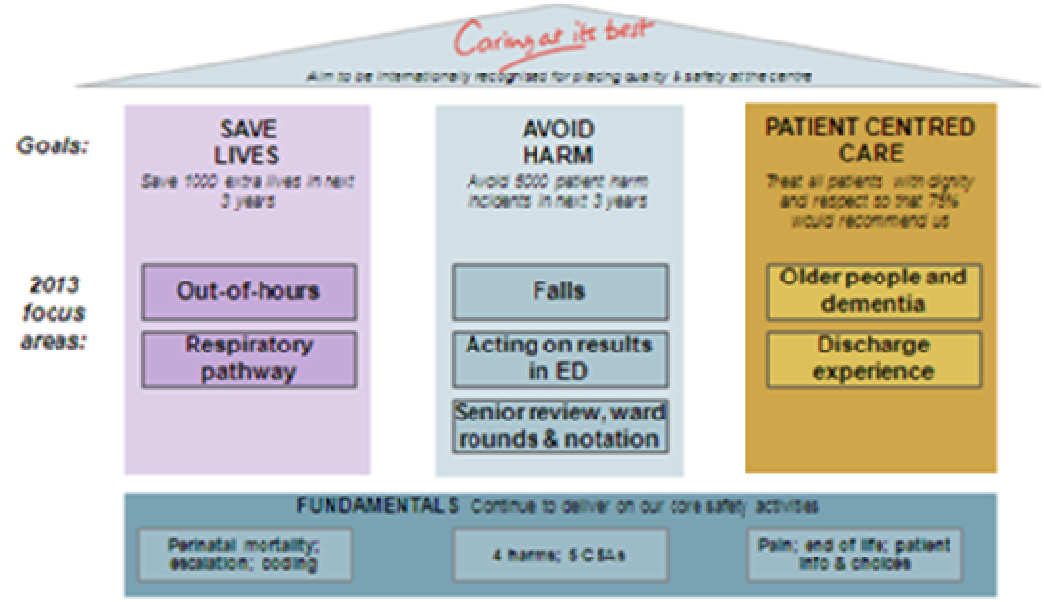
At an operational level the Divisions monitor and manage key indicators of quality and performance through their monthly Quality and Safety Boards informed by detailed data from validated sources including benchmarking tools.

The Division's Quality and Safety Board's report to the corporate Quality and Performance Management Group (QPMG) with membership including Divisional Directors, Divisional Managers, Heads of Nursing, Chief Nurse and Director of Operations. This group meets monthly and is chaired by the Medical Director.

The QPMG reports to the Quality Assurance Committee (QAC). QAC is established as a standing committee of the Trust Board and is accountable to the Trust Board. The purpose of QAC is to enable the Trust Board to obtain assurance that high standards of care are provided by the Trust. The Committee is appointed by the Trust Board with membership including four Non-Executive Directors, Chief Executive, Medical Director, Chief Nurse, a co-opted representative of the Leicester, Leicestershire and Rutland CCGs and a co-opted Patient Adviser representative. Other Executive or Corporate Directors and Senior Managers may be invited to attend meetings of the Committee as necessary. QAC is chaired by a Non-Executive Director.

The minutes of the QAC meetings are considered by Trust Board on a monthly basis. This is complemented by a monthly summary report of crude and risk adjusted mortality rates as part of the Quality & Performance Report.

Quality commitment - In the context of the Francis report and our vision of 'Caring at its best' it will come as no surprise to see that the first of our priorities for next year relates to our 'quality commitment'. Priorities have been brought together through three overarching strategic goals, each with a target to be delivered over the next three years. By 2015 we will aim to deliver a comprehensive programme of quality improvement.



A key indicator when considering standards of care is the Summary Hospital Mortality Index (SHMI), the national indicator used for measuring hospital mortality rates. The SHMI is updated on a quarterly basis and is reported as a '12 month rolling figure'. It reflects the ratio of the observed number of deaths to the expected number of deaths for a hospital.

Independent detailed analysis of the Trust's SHMI and other mortality data identified two groups of patients that appeared to have the greatest impact on the '>100 SHMI' i.e. above the national average:

- Patients admitted at weekends or 'out of hours'
- Patients with a respiratory diagnosis (specifically pneumonia)

These reflect the priorities to be taken forward by the 'Saving Lives' Quality Action Group in 2013/14 and provide an example of those areas which offer the greatest opportunity to impact our quality targets within the next 12 months.

Progress against this objective will be monitored and managed through the structure outlined above.

9. CONTRACTUAL ARRANGEMENTS 2013/14

The Trust agreed the Heads of Terms for the 2013/14 contract with our local CCGs (core clinical contract) and the National Commissioning Board (NCB Specialised Commissioning Group) on 28 March 2013. This represents an income envelope of £573.6m (£195.1 SCG and £378.5 CCG).

Core contract

Key elements of the contract agreed with local CCGs include:

- Counting and coding changes have been progressed in accordance with the agreed timeline
- The impact of the 2013/14 national tariff has been reflected and is in line with planning assumptions
- Activity plans reflect the impact of demographic growth, but will be largely mitigated by Commissioner QIPP plans (Emergency and Elective)
- Emergency Pathways – An agreement has been made for the Marginal Rate Emergency Tariff (MRET) and level of readmissions to be set at 12/13 outturn levels. This adjustment will be handled on a block basis is and excluded from the baseline. Commissioners have not agreed to an adjustment to the 2008/9 MRET baselines despite national guidance which permits this. Planned adjustments to the MRET baseline include CCG Emergency QIPP plans and the Trust's emergency care initiative. Any underperformance against the baseline (excluding the block arrangements) is subject to a 50:50 risk share. Any gain from this will be capped and based on the overall cumulative performance of the whole contract. For clarity, £4.2m of the £7.1m total CCG QIPP relates to emergency admissions.

Key risks associated with the core clinical contract include:

- Non delivery or either Commissioners QIPP or our Emergency Care Pathway plans which may impact on CIP and/or workforce plans
- Commissioner activity plans were only shared with the Trust on 28 March and therefore there has been limited opportunity for detailed review of the plans and assessment of any material delivery risks. A period of review and refinement will be necessary to allow reconciliation (by the end of April)
- Transformation Funding – A number of whole system clinical transformation projects were started in 2012/13 and were funded through a transformation fund held by commissioners. Some of these schemes will continue, by agreement, into 2013/14. The continuity of funding is to be confirmed.

Specialised commissioning

Key elements of the specialised commissioning contract include:

- There has been a material shift of commissioning responsibility from local to specialised commissioners in 2013/14. The NCB now accounts for 1/3 of our patient care income. Transition processes from CCGs to the NCB have been challenging.
- Activity plans reflect the impact of demographic growth
- Counting and coding proposals put forward by the Trust have largely been recognised (an illustrative example being a £200k increase for clinical genetics)

Key risks include:

- **Critical Care Expansion** (this cuts across non-specialised and specialised activity) - The agreed envelope excludes the request for £0.9m to support the expansion of critical care (9 beds). Funding for this will held in reserve pending a "Utilisation Review" audit to be undertaken by NCB. (Previous audits undertaken by the Trust have identified that there is inadequate ITU and HDU capacity resource). The NCB has agreed to fund non-recurrently 3 additional beds from Q2 while the audit is undertaken. This creates an immediate financial pressure for the Trust as we are compelled clinically to open 3 additional beds in Q1 2013/14.
- **Payment mechanism for CQUIN** – Commissioners have advised the Trust of their intention to make CQUIN payments at the end of each quarter. As significant investment is required to facilitate the delivery of CQUIN this is not acceptable to the Trust and has therefore been escalated for resolution
- **CQUIN on "pass-through" costs** - The NCB issued a late direction that the base contract value for determining the 2.5% CQUIN element should exclude "pass-through" payments for drugs and devices, with a further 0.1% top-sliced to fund operational networks. This late and unilateral imposition has been rejected by UHL and all specialist provider trusts. This equates to £1.2m for UHL. A risk share clause has been included in the Heads of Terms should this issue not be resolved nationally.
- **Cardiac ECMO** – The NCB has advised that cardiac ECMO (as distinct from respiratory ECMO) is not a commissioned service and so should not feature in any baseline agreement pending an urgent in year review. Any recommendations of the review would be enacted in year. This decision poses a clinical and financial risk to the Trust. Under *Safe and Sustainable* it is clear that cardiac surgery should not be performed unless cardiac ECMO is available post-surgery. The clinical risk associated with this position needs to be carefully assessed together with consideration of the attendant financial exposure.

CQUIN - Health, Wealth and Innovation

A pre-requisite for CQUIN payment in 2013/14 is compliance with the criteria relating to six *High Impact Innovations*. Five of these relate to the Trust. National guidance states that a Trust must comply with 50% of the relevant criteria in order to meet the pre-requisite standard.

Self-assessment of UHL's compliance with these criteria has been carried out as part of the Trust's Annual Plan return. Plans are in place to meet the pre-qualification criteria for three of the five innovations in 2013/14.

AREA OF INNOVATION	CRITERIA	CURRENT SITUATION
Intraoperative Fluid Management (IOFM)	Demonstrate to commissioners that 2013/14 trajectories for the technology are in place which are consistent with National Technology Assessment Centre (NTAC) guidance	A new 'tag box' has been built into the theatre computer system which automatically flag up if one of the NTAC OPCS codes are inputted. The system will then ask for the method of IOFM used or if this was clinically not indicated. The new tag commenced, 1st March in order to have a month's data for a baseline before April. The Trust will then agree a trajectory for achieving the 80% threshold by end of 13/14.
International & commercial activity (cross reference to development priority 4)	Demonstrate that clear plans are in place to exploit the value of commercial intellectual property – either standalone or in collaboration with Academic Health Science Network	UHL is responsible for a significant output of high-class clinical research activity all of which involves local patients and commerce. The Trust has developed robust Intellectual Property arrangements. The Trust is a leading, influential partner in the development of the East Midlands Academic Health and Science Network (AHSN) and is therefore fully engaged in this agenda
Carers for people with Dementia (cross reference to improvement priority 1)	Demonstrate that plans have been put in place to ensure that for every person who is admitted to hospital where there is a diagnosis of dementia their carer is sign-posted to relevant advice and receives relevant information to help and support them	Information leaflets are available for Carers which have the details of dementia diagnosis and the contact details of the Alzheimer Society. In addition the Frail Older Person Services give information to carers about memory advisors. Action to enhance current arrangements form part of the Quality Commitment 'Patient Experience' workstream

For the remaining two innovations (digital first, telehealth and telecare) discussions on how best to take these forward are on-going via the LLR IM&T Board (April 2013). This will inform subsequent priority actions.

Key Performance Targets

As part of the 2013/14 contractual discussions, the Trust has shared its plans and delivery trajectories to achieve key performance targets. Of particular concern is sustainable delivery of the A&E 4-hour access target and the 62 day cancer target. A summary of the actions being taken is outlined below:

ED performance – The Trust has implemented the Emergency Care Pathway programme with the aim of improving the quality of the patient experience and clinical outcomes by ensuring timely access to the appropriate emergency care. As explained earlier, the first phase of the programme has thus far not resulted in sustainable improvement in performance as the changes form part of a much bigger process. Phase two of the programme was launched on 26 March. This will focus on ward management, patient flow and bed configuration and will implement consistently applied consultant-led ward processes that enable optimal length of stay to be achieved for all patients based on their clinical need. The trajectory for improvement is attached at Appendix 2. Based on the plans in place the Trust anticipates sustainable compliance with the ED target in the week ending 4 August. This trajectory is subject to CCG sign off.

62 day wait from urgent GP referral to first definitive treatment for cancer (85% threshold) - The Trust has been unable to deliver sustainable performance against this target during 2012/13. In 2013-14 the Trust is implementing plans that aim to deliver improvements to the patient experience. These will focus in particular on reducing unnecessary delays in early diagnosis. Root cause analysis has identified a bottleneck in the diagnostic/ imaging stage of the pathway.

Work is underway to make sure that this is addressed and that the Trust delivers waiting time performance that is at least as good as the national average at tumour site level. Monthly sustainable delivery of threshold is expected from July 2013. This is a prudent assessment given the range of actions required by the tumour site teams however; every effort is being made to achieve sustainable improvement prior to that date.

Referral to Treatment Time (RTT) at specialty level – In 2013/14 the Trust will be required to achieve the admitted and non-admitted RTT targets at an aggregate and at an individual specialty level. The Trust has been unable to deliver sustainable performance against this target across all specialties during 2012/13. In 2013/14 the Trust is implementing plans that aim to deliver improvements to the patient experience. Illustrative actions include the need to:

- Optimise theatre productivity - increasing cases/list, reducing list overrun and cancellations
- Recruit additional Consultants in key specialties including General Surgery
- Increase critical care capacity at risk (in year utilisation review to be undertaken by the NCB with a commitment to non-recurrently fund 3 additional beds from Q2)
- Delivery of the ECP plans thereby releasing planned care bed capacity currently occupied by acute medical patients

10. FINANCIAL PLAN 2013/14

This section provides a brief overview of the key elements of the 2013/14 financial plan:

- Income & Expenditure Position
- Cost Improvement Programme
- Capital

Income & Expenditure Position

The Plan may be summarised:

Table 2 – 2013/14 Financial Plan

	2012/13 FOT £000s	2013/14 Plan £000s	Variance £000s	Variance %
Revenue				
Revenue from Patient Care Activities	647,964	640,973	(6,991)	(0.6)
Other Operating Revenue	110,701	101,358	(9,343)	(8.4)
Employee Benefits	(455,210)	(440,547)	14,663	3.2
Operating Expenses	(290,404)	(289,082)	1,322	0.5
Operating Surplus / (Deficit)	13,051	15,702	2,651	
Investment Revenue	77	82	5	6.5
Finance Costs	(655)	(846)	(191)	(29.2)
Surplus / (Deficit) for the Financial Year	12,473	14,938	2,465	
PDC Dividend payable	(11,293)	(11,232)	61	0.5
Retained Surplus / (Deficit) for the Year	1,180	3,706	2,526	
Adjustments in respect of donated/government grant asset reserve elimination	1,090	0	1,090	
Retained Surplus / (Deficit) for the Year	90	3,706	3,616	

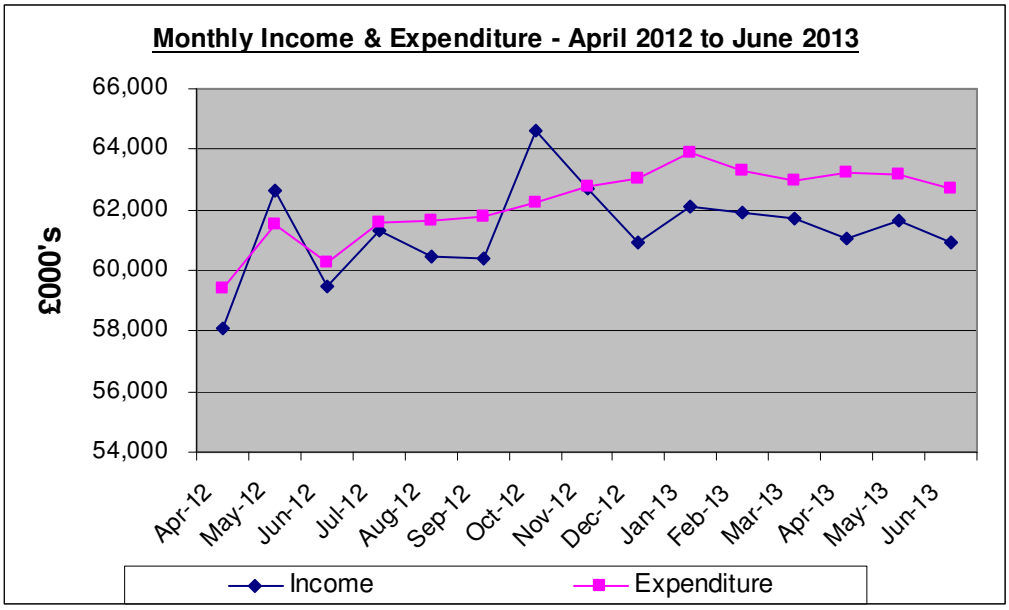
The Trust is planning to achieve a £3.7m surplus in 2013/14 which is approximately 0.5% of turnover. This is based on the following key assumptions;

- Tariff Deflator of 1.3%
- Reduced education and training income of c £3m from SIFT and MADEL.
- Demographic growth of 1.5% and associated costs to deliver the additional activity
- CCG QIPP plans of circa £8m
- Pay and non pay inflation of £13m
- Contingency of £10m
- Cost Improvement Plans of £40m
- Investment in NICE / High Cost Therapies of £6m
- Funding of unavoidable cost pressures
- Investment in prioritised service developments

Run rate and underlying deficit

Whilst the plan is to deliver a year end surplus of £3.7m, the underlying deficit as we exit 2012/13 is likely to adversely impact on our monthly run rate in Q1 2013/14. It is proposed that a proportion of the £10m contingency built into our planning assumptions will be used to manage this position non-recurrently. This is shown in the following chart;

Chart 1: Monthly income and expenditure April 2012 – June 2013



At the same time the Trust will consider the most appropriate financial strategy to address the simultaneous need to deliver on short term imperatives, whilst accelerating the necessary strategic transformation to address sub-optimal service configuration. In this context, it is important to recognise the time it will take for the changes envisaged in the Better Care Together programme to gain traction. Discussions with key stakeholders have commenced in this regard and will continue in order to establish the best way forward.

Cost improvement programme

CIPs are a key element of the financial plan in ensuring a financially sustainable position. The Trust set a 2013/14 CIP target of £40.4m (5.6% of the total revenue base).

The plan places a strong focus on the delivery of key CIP projects. These will be delivered through existing operational management frameworks and structures but will be programme managed by the head of CIP delivery and the Delivery Board.

Each Division is responsible for developing and delivering initiatives to support the delivery of their own CIP target and to work with the corporate transformation team to capitalise on identified opportunities e.g. outpatient transformation. There are clear lines of reporting and monitoring through the CIP Board, Delivery Board, CBU and Divisional Boards.

The CIP Programme Board (meets monthly, chaired by Chief Executive) provides clear visibility and assurance on Financial performance of CIPs and Transformation.

The CIP Delivery Board (meets fortnightly, chaired by Director of Service Improvement or Finance Director), together with fortnightly confirm and challenge meetings with Divisions, provides detailed challenge around individual schemes.

The table below shows that we have identified the £40.4m target.

Table 3 – 2013/14 CIPs

Category	Recurrent £'000	Non Recurrent £'000	Total £'000	Total %
Pay	19,303	251	19,554	48.4
Non Pay	15,932	194	16,125	39.9
Income	4,636	68	4,704	11.6
Total	39,871	512	40,383	100.0
Percentage	98.7	1.3	100.0	

Monitoring and reporting of CIPs is derived from the Performance Management Tracking Tool (PMTT) which is regularly updated by the CBUs. Reports are provided to the CIP Delivery Board, CIP Programme Board, the Executive Team and the Finance & Performance Committee. The Non-Executive Chair of the Finance & Performance Committee reports to Trust Board on a monthly basis.

As part of the Trust's governance for managing CIPs and in line with the National Quality Board's recommendations, there is a clearly defined process for CIP sign-off to guard against negative impact on quality and patient safety.

The majority of schemes identified are based on changes to process. No intentional negative impact on quality is anticipated and any schemes that were deemed to have a negative impact on quality have already been removed.

All Divisions have completed a project initiation document for each CIP scheme. This includes a risk, quality and safety impact assessment. The sign-off of all schemes by each Divisional Director and Head of Nursing prior to submission to the CIP Board has been confirmed by Divisions through the Confirm and Challenge meetings and for the Corporate Directorates, via the Executive Team. During April a physical signature check for all schemes is being undertaken with all signed PIDs to be stored on the Transformation site within Sharepoint.

The Chief Nurse/Deputy Chief Executive and Medical Director on behalf of the CIP Board have reviewed the detailed assessments of those schemes that have been given a 'high-risk' rating (over £100k and/or risk rating of 15). Thirty nine schemes fell into this category. These have been subject to a formal process of confirm and challenge by the Chief Nurse/Deputy Chief Executive and Medical Director. Those approved (thirty eight of the thirty nine) have been signed off for implementation by the Chief Nurse and Medical Director subject to Commissioner agreement.

The outcome of this process was presented and discussed with Commissioners on the 26 March. Commissioners asked for clarity on a number of points including how the Trust Board will gain assurance on areas of collective risk (schemes with multiple elements in different divisions).

In response, the Divisions, CIP Delivery Board and CIP Programme Board monitor performance and manage delivery of CIP schemes at a thematic and individual level. Thematic review allows a cumulative assessment of impact, progress, risk and benefit. An illustrative example is length of stay CIP plans and the associated phased bed capacity reduction. Delivery of these cross-Division plans is set in the context of sustained emergency pressure and an adverse impact on bed capacity.

Following discussion at the Executive Team it is agreed that the planned CIP projects to facilitate the reduction in length of stay will continue as planned however, taking into account the current pressure on beds, capacity (beds and workforce) will be reduced later than originally planned.

Commissioners also asked for clarity on how the Trust Board would monitor progress and how Commissioners could be kept suitably informed. In response it was confirmed that the minutes of the CIP Programme Board and Delivery Board would be made available to Trust Board and that there is a standing invite for members of the Joint Commissioning Body to attend the CIP Programme Board.

Cost Pressures and Service Developments

As part of the business planning process divisions and corporate directorates have submitted cost pressures (those associated with current service delivery) and new service developments for due consideration. Any schemes approved will need to be managed within the overall envelope of affordability outlined in Table 2.

Submissions received have far exceeded the resource available. In order to work within current constraints a thematic review and prioritisation process is being undertaken.

This has identified those pressures that are completely unavoidable. An illustrative example is the resource required to address the contractual requirements for CQUIN (Commissioning for Quality and Innovation) and where a contractual penalty would apply in cases of non-compliance.

The review has also identified those pressures and developments that have not yet started and/or where further scrutiny and/or business case development is required in-year.

The output of this process is subject to on-going confirm and challenge. It is anticipated that this will be completed by the Executive Team in the next few weeks.

Workforce Plan

The Trust is embedding a culture of workforce planning and development within divisions, aligned to our Strategic Direction and the Trust's Organisational Development Plan. The Trust has developed Workforce Plans for 2013-2018 which outline:-

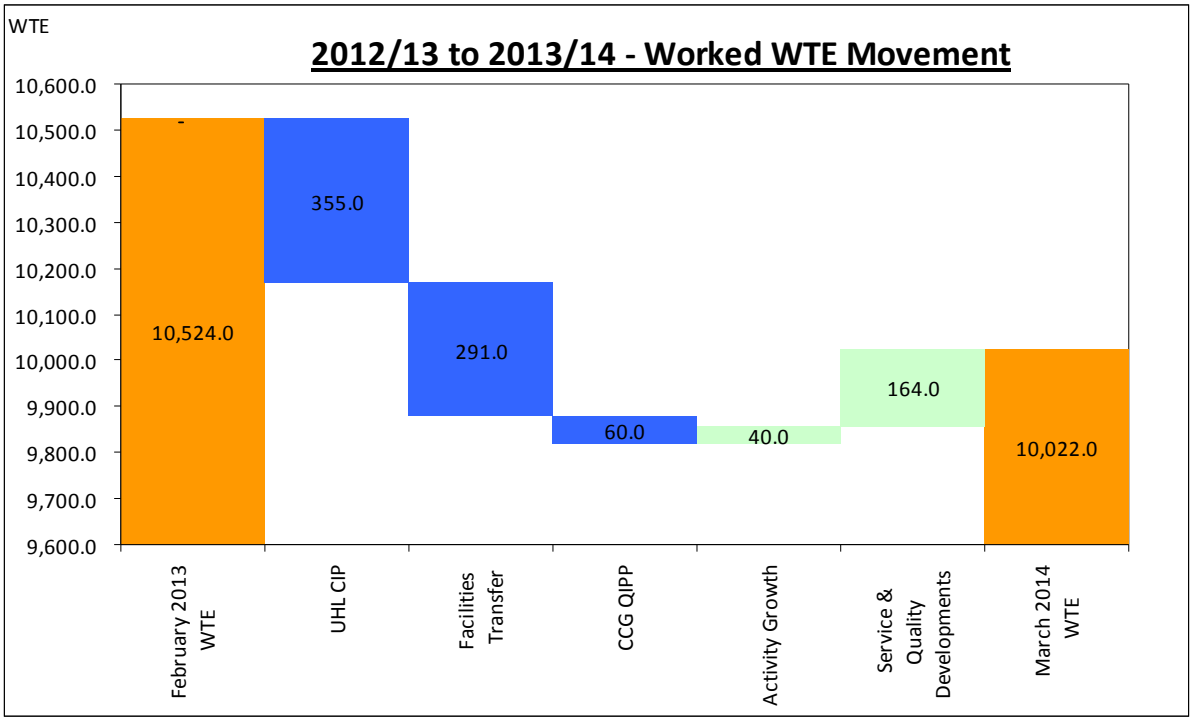
- Our current workforce profile
- Where we need to be in the future and the strategy to help us get there
- Divisional/Directorate Plans to manage the transition

This was approved by the Workforce & Organisational Development Committee in December 2012. In respect to the Workforce Plan for 2013/14 these have been built up by taking into account the worked whole time equivalent (WTE) and pay bill implications of:

- Forecast outturn position
- Full year effect of any part year developments
- Demographic growth

- Commissioner QIPP Activity Plan reductions
- Unavoidable cost pressures (subject to approval)
- Approved CIP Plans
- Risk adjusted Cost Improvement Plans (e.g. in the example given earlier the planned CIP projects to facilitate the reduction in length of stay will continue as planned however, taking into account the current pressure on beds, bed capacity and therefore workforce will be reduced later than originally planned i.e. workforce may stay the same or go up before it goes down

The net effect on the Workforce Plan, at an aggregate level, is summarised in the chart below. Overall it illustrates a downward trajectory for worked WTE and pay bill which is as to be expected given the impact of redesign and transformation activities.



Capital

To support the delivery of the financial plan we are planning for a capital spend of £37.8m, split between "business as usual" schemes, planned developments, and a small number of schemes brought forward from 2013/14.

The capital plan for 2013/14 may be summarised:

Table 4- 2013/14 Capital Plan

	2013/14 £'000
"Business As Usual"	
IM&T Sub Group Budget	3,375
Medical Equipment Executive Budget	4,187
Facilities Backlog Maintenance	6,000
Divisional Discretionary Capital	600
MES Installation Costs	1,750
Feasibility Studies	100
	16,012
Business Cases	
Emergency Flow	5,000
LRI Surgical Triage	1,000
Maternity Interim Development	2,800
Theatres Assessment Area (TAA)	1,549
Advanced Recovery LRI	625
Osbourne Ventilation	566
GGH Vascular Surgery	1,656
Hybrid Theatre (Vascular)	1,500
Daycase / OPD Hub	2,000
LRI Additional CEC	1,500
Endoscopy redesign	255
GH Imaging	1,500
Other Anticipated Developments	68
	20,019
Schemes 12/13	
Aseptic Suite (001052)	650
Diabetes BRU Development (001491)	600
Respiratory BRU - Third Floor (001703)	500
	1,750
Total Capital Plan	**37,781**
Funding	
Depreciation / CRL	32,481
Unspent capital cash from 2012/13	5,000
Donations	300
Total Source of Funds	**37,781**

It is important to note the alignment between the business cases and the reconfiguration and estate improvement priorities (Appendix 1 – Improvement priority 5). These reflect early progress towards our longer term Strategic Direction.

10. KEY RISKS

The Trust has a robust system and process to identify and manage risks to the achievement of the Trust's Strategic Direction and its strategic objectives.

Below is an excerpt from our Strategic Risk Register. It shows eleven strategic risks currently identified.

Earlier in the Executive Summary we considered performance to date and the challenges ahead. Four common themes were identified:

- Securing an efficient and effective emergency care system that is clinically sustainable
- Achieving short, medium and long term financial sustainability
- Delivering quality (patient experience, safety and clinical effectiveness) and performance standards
- Reconfiguration

The diagram below illustrates that our strategic risks can be aligned to the four themes identified. Our 2013/14 AOP marks the start of the journey to address the above and to support a reduction in the risks identified, ultimately securing progress against our strategic objectives and our Strategic Direction.

	RISK	RISK TITLE	CURRENT SCORE	TARGET SCORE
EMERGENCY CARE PROCESS	3	Failure to transform the emergency care system	20	12
	6	Failure to maintain productive relationships	15	10
	10	Patient experience/ satisfaction	12	6
FINANCIAL SUSTAINABILITY	11	Business continuity	9	6
	1	Failure to achieve financial sustainability	25	12
	5	Failure to achieve FT status	16	12
QUALITY AND PERFORMANCE	2	Inability to recruit, retain, develop and motivate staff	16	12
	4	Ineffective organisational transformation	16	12
	5	Failure to achieve FT status	16	12
	6	Failure to maintain productive relationships	15	10
	7	Failure to achieve and sustain operational targets	12	12
	9	Reducing avoidable harms	12	6
	10	Patient experience/ satisfaction	12	6
	11	Business continuity	9	6
RECONFIGURATION	8	inadequate reconfiguration of buildings and services	12	9
	5	Failure to achieve FT status	16	12
	10	Patient experience/ satisfaction	12	6
	11	Business continuity	9	6

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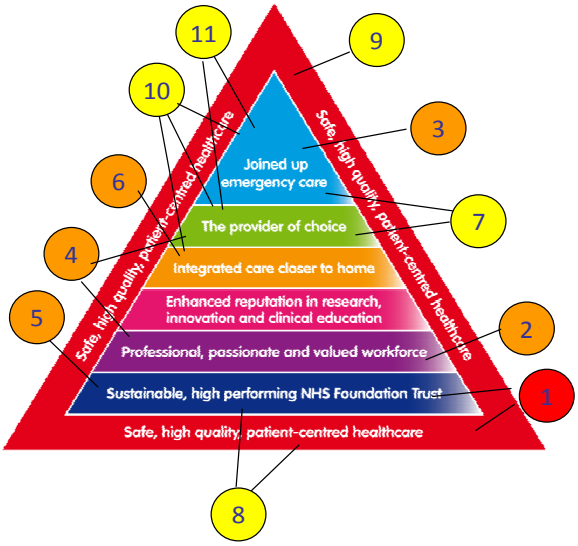

This provides a useful reference point as we move forward into 2013/14 and seek to review progress throughout the year.

APPENDIX 1 - Improvement and development priorities

High-level details of the improvement and development priorities are set out below.

IMPROVEMENT PRIORITY 1	THEME	STRATEGIC OBJECTIVE
QUALITY COMMITMENT	Quality and Performance	Action to provide safe, high quality, patient-centred healthcare

Priority actions for 2013/14 in support of this goal are as follows.

IMPROVEMENT GOAL	PRIORITY ACTION	TIMESCALE	MEASURE FOR IMPROVEMENT
Save Lives	**Reinforce Hospital 24/7 programme** Clinical notes audit Cultural changes - Identify key interventions to improve communications. **Respiratory Care Pathway** Pathway redirection - sending all respiratory pathway patients to Glenfield (either direct, or via LRI) Utilise findings from care bundle audit (January 2013) to reinforce best practice Cultural changes - Reinforce message that "minutes count". Co-ordinate with Right Place work	July 2013 September 2013 May 2013 May 2013	SHMI (6 month delay); OOH: cardiac arrests; Early warning signs response Time to transfer Publish consultant / ward level data on pathway redirection Percentage compliance to COST and COPD protocols

IMPROVEMENT GOAL	PRIORITY ACTION	TIMESCALE	MEASURE FOR IMPROVEMENT
Reduce Harm	**Falls -** Reinforce falls steering group recommendations (January 2013) Reinforce standards. Engage ward staff to follow standards. Engage key leaders and communicate message to wards Training - Develop dedicated training programme for nurses and HCAs. Roll-out programme Establish older people's team to coach under-performing wards **Acting on results in ED** - Agree standards for checking blood results and reporting imaging. Communicate standards and tracking approach to all ED staff (doctors, advanced nurse practitioners, physician assistants) outlining the case for change (use SUI examples) Baseline current performance and track improvement Produce league tables. Reward / Hold to account **Acting on results on admission and subsequent stay –** Senior review - Set standards for review (February 2013) Deliver on admission and daily review standards. Clear process to escalate delays; spot-checks to confirm Ward rounds - Pilot and audit two key approaches on selected wards. Review pilot and select most impactful approach for roll-out. Monitor compliance (including spot checks) Notation - Agree standard minimum for notes entry: Up-to-date differential / working diagnosis, Daily entry of patient status, and clear plan of care. Engage doctors through training & education using case studies	March 2013 April 2013 April 2013 April 2013	Number of patient harm incidents Adherence to standards for Root Cause Analysis (RCA) and actions Falls / admission >65 years Percentage of results authorised (through ICE) (100% target) before patient discharge / transfer Percentage of imaging examinations reported on within 24 hours SUI; Datix; Patient complaints At admission: % review within 12 hours Daily review: % compliance with specialty specific standards for senior review % of entries that meet standards
Patient centred care	**Older People and Dementia Care** - Education & training Roll-out older person and dementia multi-professional training. Particular focus on basic care delivered by Health Care Assistants (HCA's). Protected time for matrons to provide leadership on delivery of care. Focus roll-out on wards with greatest need (i.e. those with lowest net promoter scores and highest proportion of patients >65 yrs Multidisciplinary working - Offer opportunity for all to be Older People's Champions Set up resource centre. Facilitate stronger utilisation of carers, volunteers and charities Communicate effectively - Ensure completion of personal profile for all patients with dementia Utilise White board for communication with patients and carers). Increase patient / carer	March 2013 May 2013 July 2013	Net promoter score - Percentage of patients that recommend us Double number of champions over next year

IMPROVEMENT GOAL	PRIORITY ACTION	TIMESCALE	MEASURE FOR IMPROVEMENT
	involvement in care Track and hold to account - Agree metrics and track against them. Identify suitable method for increasing transparency (e.g. Ward Net Promoter Score). Ward visit from CEO for best improved / under-performers	July 2013 July 2013	 Patient survey
	Discharge experience - Discharge plan. Set specialty specific standards for discharge plan to be completed on admission. Deliver discharge plans standard - involve multi-disciplinary team and patient / carer. Spot-checks to monitor compliance Communication tools - Design and roll-out 'Ticket Home' tool including key information for every patient. Roll-out for every patient. Discharge co-ordinator - Increase dedicated resource for discharge-planning activities including multi-agency communication. Co-ordinate discharge plan and communicate with patient / carer. Implement across all priority wards Track and hold to account - Identify suitable method for increasing transparency. Ward visit from CEO for best improved / under-performers	March 2013 June – Sept 2013 June 2013	Net Promoter Score Key questions from patient survey

IMPROVEMENT PRIORITY 2	THEME	STRATEGIC OBJECTIVE
EMERGENCY CARE INCLUDING THE EMERGENCY DEPARTMENT (ED)	Emergency Care	Joined up emergency care

On 18 February the Trust introduced new processes in the Emergency Department (ED) and on the Acute Medical Unit (AMU). These are designed to improve patient safety, patient experience and make sure that we see, treat and either admit or discharge patients within a maximum of 4-hours. Thus far, the improvements made have yet to show up in consistent achievement of the 4-hour performance standard. On the 26 March the 2nd phase of this work was launched. This focuses on Ward Management and Patient Flow. It is likely to take some months to show results.

IMPROVEMENT THEME	PRIORITY ACTION	TIMESCALE	MEASURE FOR IMPROVEMENT
Emergency Care including ED	**Full implementation of Phase 1 of Emergency Care Pathway (ECP) redesign** - ED and assessment process	March 2013- onwards	Based on the plans in place the Trust anticipates sustainable compliance with the ED target week ending 4 August, subject to CCG approval
	Implementation of ECP Phase 2 – Redesign of ward processes and bed reconfiguration	Launch 26 March March-June 2013	
	Ambulance turnarounds times within contracted agreement Current performance 19mins		Within contracted agreement (15mins for clinical handover time) Reduction in contractual penalties

IMPROVEMENT PRIORITY 3	THEME	STRATEGIC OBJECTIVE
CLINICAL SERVICE TRANSFORMATION	Quality and performance standards	Provider of choice

The Trust is supporting a great deal of transformational or improvement activity under various banners (Cost Improvement Programmes, Quality Commitment, Better Care Together, Right Care, site reconfiguration) and it is important how these initiatives are coordinated and aligned to support achievement of our Strategic Direction. Accordingly, the trust is developing the concept of an "Improvement Framework" to link improvement initiatives to trust values and existing structures.
It is proposed that the Improvement Framework will encompass: *"major projects to improve the way the Trust works, in order to deliver high quality, cost effective care".*

Illustrative examples of projects that may fall within the Improvement Framework and are reflected in our AOP for 2013/14 are **theatre productivity** and **outpatient process improvement**. The high levels plans for improvement are reflected below:

IMPROVEMENT THEME	PRIORITY ACTION	TIMESCALE	MEASURE FOR IMPROVEMENT
Quality and performance standards Theatre Productivity	**Capacity and Demand and theatre info -** Review current capacity / demand; Define Future state; Develop Key Performance indicators and implementation plan ; Explore viability of further use of patient bar coding for real time information **Scheduling** - Define processes for scheduling; Review use of IT systems for theatre information and scheduling; Model patient selection for optimum use of theatre lists **Workforce Review** - Ensure Job planning matches scheduling and theatre list allocation; Review skill mix required for future state		Eliminate regular waiting list initiatives Cancellations < 0.8% Increased No. of cases per list (to be defined by specialty) Improve Staff morale Sickness Absence < 3% Reduce surgical

IMPROVEMENT THEME	PRIORITY ACTION	TIMESCALE	MEASURE FOR IMPROVEMENT
	Pre-operative assessment - Standardise processes and systems; IT solution to record pre- operative assessment and booking of appointments; Review workforce and capabilities; **Implement Theatre arrivals** (all sites) and advanced recovery (LGH)		readmissions within 7 days Fewer but more productive theatre sessions
Quality and performance standards	**Improve clinic slot booking utilisation** - Detailed analysis of top 25 specialties that result in 80% of outpatient income to identify opportunities for improvement		Target 95% utilisation
Outpatient Transformation	**Reduce DNA rate -** SMS text message reminders. Pilot commenced January 2013 in 4 specialties to call top 10% of patients identified as high risk of DNA utilising bespoke software – "patient call optimiser". On-going pilot. **Outpatient Clinic Template and Slot Management Policy** – to support consistent clinic administration and enable robust and accurate metrics. Roll out as part specialty analysis. **Clinic observation -** develop methodology with view to improve patient experience and validate assumptions around capacity. **Outpatient Improvement Team** – Establish team to ensure common approach and sharing of best practice	March 2013-2014 March 2013 March 2013-2014	SMS - Target 80% of patients by end of 2013/14

IMPROVEMENT PRIORITY 4	THEME	STRATEGIC OBJECTIVE
SUPPORT SERVICE TRANSFORMATION	Financial sustainability and quality and performance standards	Sustainable high performing NHS Foundation Trust

The main costs incurred by the Trust are people, treatment and the estate. In safeguarding clinical services, the Trust has looked at creative solutions to the transformation of support service functions. Two key developments, implemented in 2012/13, will begin to generate real improvements in 2013/14:

ESTATES & FACILITIES MANAGEMENT (FM) - Over the last two and a half years the Leicester, Leicestershire and Rutland (LLR) Health Community has worked together to better understand the collective capacity and estate challenge. Informed by jointly commissioned analysis, the local health community committed to a strategy to simplify, standardise and share the delivery of core Estates/FM services in partnership with a single, private sector partner.

A joint procurement strategy was pursued and the appointment of a single outsourced provider made. Our private sector partner for Estates and FM is Interserve.

Responsibility for the day to day management and delivery of core FM services transferred to Interserve on 1 March. In parallel Interserve is also working with the Trust to progress the early stages of the Estates Transformation Plan in 2013/14.

In working with private sector partners it is essential that their style and approach reflects the values and culture of the Trust. The relationship and partnering values will be managed by Interserve and the Health partners forming a joint board to drive the values and direction of the framework and services provided under it. This body is called the LLR FMC. It has specific terms of reference and has at its core, clear objectives to ensure the centrality of the patient experience and the transformation of the healthcare estate. The Trust's interests will be served by an intelligent client management team – who will manage the performance of the private sector partner and uphold the interests of the health partners.

INFORMATION, MANAGEMENT AND TECHNOLOGY (IM&T) - Effective IM&T is critical to the success of our Clinical Strategy and the transformation of clinical, R&D and Education and Training.

It is recognised that historical service provision has not been able to meet expectations and operate as efficiently and effectively as required by front line clinical services operating on a 24/7 basis. As such a critical enabler, maintaining the status quo was not an option.

The consensus was that the Trust should concentrate its resource and energy on delivering core NHS business. Where the business case stacked up, the strategic decision was taken to contract in IM&T services through the establishment of a Managed Business Partner.

Following a procurement exercise a preferred Managed Business Partner has been selected: IBM. The Trust is working with IBM to progress the early stages of the Trust's IM&T Transformation Plan throughout 2013/14. The Trust is a member of the Leicester, Leicestershire & Rutland (LLR) IM&T Community Delivery Board. This Board provides direction and management of community-wide IM&T plans and is currently considering plans to progress telehealth and telecare. This is in the context of the national commitment to improve the lives of 3 million people living with long term conditions through the appropriate use of information technology.

The aim of the Board is to ensure that all NHS organisations, working in conjunction with partner agencies, implement IM&T best practice and associated information initiatives in line with Commissioner and Provider Planning Guidance.

In 2013/14 the Trusts in partnership with IBM will deliver the following:

IMPROVEMENT THEME	PRIORITY ACTION	TIMESCALE	MEASURE FOR IMPROVEMENT
Financial sustainability Quality and performance	Remote working - Pilot to test the benefit of digital pens for Community Midwives - increasing timeliness and reducing admin time Remote interaction - Roll out of SMS Out Patient appointment reminders. Pilot online pre-operative screening. Communication of negative results		Improved productivity Reduce face to face iteration where technology can

IMPROVEMENT THEME	PRIORITY ACTION	TIMESCALE	MEASURE FOR IMPROVEMENT
	(phased. GU. Pilot remote follow-up using Skype or similar Simplify, Standardise, Share - Roll out of electronic OP letters. Order Communications in Out Patients. Unified Communications. Electronic Document and Records Management System. Digital dictation. Clinical Portal – providing access to real-time and historic patient record		provide same or better quality outcome

IMPROVEMENT PRIORITY 5	THEME	STRATEGIC OBJECTIVE
RECONFIGURATION AND ESTATE IMPROVEMENT	Reconfiguration; Financial sustainability; quality and performance standards	Sustainable high performing NHS Foundation Trust

The quality and fitness for purpose of the NHS Estate is integral to the delivery of high quality, safe and efficient care. The Trust has a mixed estate with facilities dating from 1771 to date. Not all of this is fit for purpose.

As care moves closer to home our hospitals will become smaller and more specialised. In order to optimise clinical outcomes and safety, services currently distributed across 3 acute sites will need to be consolidated, ultimately leading to reconfigured hospital sites.

Our 2013/14 AOP reflects the start of that journey during which time the following clinical configuration and estate improvement schemes will be progressed.

IMPROVEMENT THEME	PRIORITY ACTION	TIMESCALE	MEASURE FOR IMPROVEMENT
Reconfiguration Financial sustainability Quality and performance	Day Case / Outpatient Hub – A feasibility study will be completed prior to the development of an Outline Business Case for a dedicated Day Case and Outpatient Hub. This would support the segmentation of ambulatory planned care flows from planned and unplanned inpatient hospital care Emergency model of care – early feasibility studies (informed by Right Place programme outputs) Theatres Arrival Area and Advanced Recovery at the LRI – Completion of construction Maternity - Construction of additional delivery rooms at the LGH and LRI to safely accommodate the increase in births Enhance minimally invasive vascular and renal Interventional Radiology GGH - Supporting the shift from inpatient to daycase and/or inpatient length of stay Relocation of Vascular Services from the LRI to the GGH to consolidate cardio-vascular services on one site. Project Board established. Service model currently under development. Following agreement		Reduced cancellations Improved theatre productivity. Improved ratio between income per m2 and occupancy per m2 Reducing theatre delays (to be defined). Reducing stock (to be defined). Reducing idle capacity (cost) Increased utilisation of lower cost facilities without detriment to clinical quality

IMPROVEMENT THEME	PRIORITY ACTION	TIMESCALE	MEASURE FOR IMPROVEMENT
	on the service model the scheme will progress to feasibility and Outline Business Case. This scheme will include the development of a hybrid theatre Relocation of Renal & Transplant Services from the LGH to the GGH. Approval given to complete a feasibility study		
	Welcome Centre LRI – new main entrance located in the Windsor Building. Approved to progress to detailed design and delivery of an Outline Business Case Interim improvements to LRI entrances - Works to include vinyl flooring, way finding, signage, ceilings, lighting, finishes, wall protection and receptions. Approved given to progress to detailed design and tender. Contract award subject to future ET approval Balmoral Access for the Emergency Department – To include a review of highways, traffic plans, pedestrian access, car parking, levels, gradients and Blue Light access. Approval given develop detailed designs and tender		Improved patient experience particularly in respect to way finding
Financial sustainability Quality and performance	Refurbishment of Poppies Nursery – A feasibility report has been presented to refurbish Poppies into office accommodation for 42 hot desks. Approval has been given to proceed to detailed design and tender. Contract award subject to future review by Executive Team. Developments of a Clinical Education Centre at the LRI - Initial designs for conversion of Odames Ward into a CEC have been reviewed. Approval has been given to develop an OBC Energy Centre - Removal of existing life expired combined heat and power units (CHP) at LRI and GH. Installation of new gas CHP units on all 3 acute sites. Lighting and building energy management upgrades across UHL		30% reduction in carbon emissions. £350,000 cost improvement 2013/14. Reduction in energy spend of £1m saving in yr. 2 onwards Reduction in backlog of £3m

DEVELOPMENT PRIORITIES

To complement the Trust's Improvement Priorities, we have identified a small number of development priorities. These can be summarised as follows:

DEVELOPMENT PRIORITY 1	THEME	STRATEGIC OBJECTIVE
IMPLEMENTING OUR ORGANSATIONAL DEVELOPMENT PLAN	Quality and performance standards	Professional passionate and valued workforce

At the centre of every patient's experience is an encounter with the culture of the organisation. This culture, by which we mean the attitudes, assumptions, behaviours and values of the Trust and its many professional groups, influences the patient's journey and thus the quality and safety of care we provide.

The Trust believes it essential to explore the prevailing culture of the organisation, to understand its strengths and weaknesses and based on this, consider how it may need to develop and change to further improve the patient experience.

The purpose of the Organisational Development Plan (2013/15) is to focus effort on specific projects that will have an optimum impact on staff and patient experience. To reach consensus, the Trust has consulted with key internal and external stakeholders to identify key priorities. Positive feedback has been received from commissioners and external reference groups on the approach adopted. Central to this will be the introduction of the "Listening into Action" approach to staff and patient engagement.

In an approach that mirrors that adopted in developing the Quality Commitment, six priority workstreams have been identified, each with priority actions for 2013/14.

Key actions include:

IMPROVEMENT THEME	PRIORITY ACTION	TIMESCALE	MEASURE FOR IMPROVEMENT
Quality and performance standards Live our values	Establish "Caring at its best" (C@b)Support Team Fundamentals – Embed organisational values with HR processes, Estate Improvement Projects and during 'formalised meetings		Reduced complaints Increase in compliments
Improve two way engagement	Driving accelerated improvement through the adoption of **Listening into Action (LiA)** Improve and build our model employer approach by implementing medical engagement priorities identified through the Medical Engagement Strategy (2013/14)	Launched March 2013	
Strengthen Leadership	Implement Leadership and Management Standards - linked to objective setting and 360 appraisals Agree Board, Executive and Senior Leadership Development plans Agree skills development in Finance and Business Acumen		
Enhance Workplace Learning	Enhance Statutory and Mandatory Training – with a focus on Health & Safety Training Implement Workforce Plans		
Improve External Relationships and Workplace Partnerships	Develop Patient and Public Involvement Strategy - Production of key guidance/toolkits		
Encourage Creativity and Innovation	Skills development to drive forward transformation change linked to the new Improvement Framework.		

DEVELOPMENT PRIORITY 2	THEME	STRATEGIC OBJECTIVE
SPECIALISED SERVICES	Quality and performance standards. Financial sustainability	Sustainable high performing NHS Foundation Trust. Provider of choice. Enhanced reputation in Research, Innovation and Education

The Trust is recognised nationally and internationally for the provision of a small number of highly specialised services. These are commissioned on a regional or national basis and play an important role in the delivery of our Clinical Strategy and in our capacity as a teaching organisation. These services are characterised by their high value (in terms of income and cost). In the fiscal climate this creates its own challenges as we seek to ensure that our services remain safe and sustainable (clinically and financially) and continue to be recognised as the Centres of Excellence that they represent. Priority actions in 2013/13 include:

IMPROVEMENT THEME	PRIORITY ACTION
Quality and performance standards. Financial sustainability Enhanced reputation in Research, Innovation and Education	Vascular Surgery - Plans are to be progressed to relocate Vascular Surgery from the LRI to the GGH thereby consolidating Cardio-Vascular Services onto one site. Co-location of highly specialised expertise is known to improve clinical outcomes. A Project Board has been established and the service model is currently under development. Following agreement on the service model the scheme will progress to feasibility and Outline Business Case during 2013/14. This business case will include a hybrid theatre to be part of the development
	Adult Cardiac Surgery - Review of Adult Cardiac Surgery, the Trust is engaging in early discussions with Nottingham University Hospitals (NUH) to explore the benefits of an East Midlands network approach towards adult cardiac surgery allowing opportunity to share and benefit from, best practice.
	Children's Cardiac Services - The outcome of the national Safe and Sustainable Review into Children's Cardiac Surgery was referred by the Secretary of State for Health to the Independent Reconfiguration Review Panel following challenge from various sources including our own local Health Overview and Scrutiny Committee. The outcome of the panel consideration will be known shortly. The Trust (with commissioner support) will implement the action required in response. A more detailed project plan will be developed when the outcome is known.
	Renal Services - Patients with renal disease often have concurrent cardio-vascular disease. There is therefore a case, in order to optimise outcome, for the co-location of Renal and Cardio Vascular Services. This would require the move of Renal and Transplant Services from the LGH to the GGH (with associated consultation). There is the possibility of a charitable donation to support this move (in part). An estates feasibility study has been commissioned. The case for change will be reviewed further upon completion

DEVELOPMENT PRIORITY 3	THEME	STRATEGIC OBJECTIVE
MEDICAL EDUCATION	Quality and performance standards. Financial sustainability	Sustainable high performing NHS Foundation Trust. Enhanced reputation in Research, Innovation and Education

As well as the more specialist areas, the Trust aims to always provide an excellent level of core clinical services. Clinical Education and Practice Development is key to providing and maintaining such skills. In this context our focus for 2013/14 will be:

IMPROVEMENT THEME	PRIORITY ACTION
Quality and performance standards	Improved infrastructure for clinical education at LRI - This includes converting Odames Ward to a library/learning centre and exploring solutions to resolve lack of education and training space generally across LRI. Initial designs for conversion of Odames Ward into a Clinical Education Centre have been reviewed and approval given to develop an Outline Business Case for delivery in 2013/14
Financial sustainability	Increase accountability for education and training resources and map resources to quality of education and training delivery
	Develop a funded (SPA) CBU/Departmental Educational Lead role to improve links between clinical service and training, to deliver quality measures, respond to challenges and increase accountability for education funding
Enhanced reputation in Research, Innovation and Education	Agree the shape of the future medical workforce in UHL and the associated training implications
	Enhance trainee experience and engagement with UHL through processes including Listening into Action (LiA). Ensure the Trust can meet the requirements set by GMC for recognition of trainers

DEVELOPMENT PRIORITY 4	THEME	STRATEGIC OBJECTIVE
RESEARCH AND DEVELOPMENT	Quality and performance standards. Financial sustainability	Enhanced reputation in Research, Innovation and Education

The Trust collaborates with a number of academic partners to deliver on our research and innovation agenda. It is recognised as one of the best NHS Trusts with respect to new national R&D approval and delivery metrics.

Working in partnership with University of Leicester, is host to 3 Biomedical Research Units (BRU) located at the Glenfield Hospital - the largest number outside London, Cambridge and Oxford.

Key areas of action for 2013/14 include:

IMPROVEMENT THEME	PRIORITY ACTION
Quality and performance standards	Ensuring the BRUs operate efficiently, effectively and are delivering on their objectives for example, developing new and effective treatments for severe asthma and chronic obstructive pulmonary disease (COPD) (LLR have a high incidence of COPD)
	Improving UHL's engagement with NIHR portfolio studies, thereby making significant progression towards every service taking part in this activity
Financial sustainability	Being a leading, influential partner in the development of the East Midlands Academic Health and Science Network (AHSN)
	Developing and delivering a comprehensive communication strategy for R&D within the Trust

DEVELOPMENT PRIORITY 5	THEME	STRATEGIC OBJECTIVE
FOUNDATION TRUST STATUS	Quality and performance standards. Financial sustainability	Sustainable high performing NHS Foundation Trust

As outlined in Section 6 of this summary, a number of internal and external factors have led the Trust to proactively reconsider and review our Foundation Trust (FT) application timeline.

The Trust has requested SHA approval for a revised FT timeline which subject to approvals would see us aiming to be an authorised foundation trust on 1st April 2015. The key milestones for 2013/14 in respect of the FT critical path include:

- Development of Better Care Together (BCT) case for change and potential scenarios
- Cost, prioritise and plan implementation of Strategic Direction reconfiguration in the context of the Trust's improvement framework (March 2013-December 2013)
- Capital Funding Strategy (March-December 2013)
- 5 Year CIP Plans (March -December 2013)
- BCT Public Consultation
- 2nd Quality Governance Framework Independent Review (October-December 2013)
- Iterative refresh IBP/LTFM (March 2013- June 2014)
- FT public consultation (January-March 2014)
- UHL Strategic Direction Consultation (January-March 2014)
- HDD2 Review (March 2014)
- 2nd Board Governance Memorandum Independent Review (January –March 2014)

IMPROVEMENT THEME	PRIORITY ACTION
Quality and Performance Standards	Develop and implement an Integrated Development Plan incorporating required developments in Quality Governance, Board Governance and Development and responding to external assurance processes
Financial sustainability	Develop a Service Line Management programme incorporating the key elements of business strategy, performance management, information and organisational structure
	Further develop the Trust's Strategic Direction so that there is clarity about site configuration and annual priorities for the organisation in pursuit of that Direction.

APPENDIX 2 - ED IMPROVEMENT TRAJECTORY