Agenda Item Trust Board Paper C

TRUST BOARD – 2nd APRIL 2015

MONTHLY UPDATE REPORT – APRIL 2015

DIRECTOR:	CHIEF EXECUTIVE
AUTHOR:	DIRECTOR OF CORPORATE AND LEGAL AFFAIRS
DATE:	23rd MARCH 2015
PURPOSE:	1. To brief the Trust Board on key issues and identify changes or issues in the external environment. 2. To recommend the Trust Board to adopt the updated strategic objectives and proposed annual priorities for 2015/16 (attached).
PREVIOUSLY CONSIDERED BY:	N/A
Objective(s) to which issue relates *	√ 1. Safe, high quality, patient-centred healthcare √ 2. An effective, joined up emergency care system √ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) √ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☐ 5. Enhanced reputation in research, innovation and clinical education √ 6. Delivering services through a caring, professional, passionate and valued workforce √ 7. A clinically and financially sustainable NHS Foundation Trust ☐ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	N/A
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	N/A
Organisational Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☐ **Board Assurance Framework** √ **Not Featured**
ACTION REQUIRED *	For decision ☐ For assurance ☐ For information √

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

* tick applicable box

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **2 APRIL 2015**

REPORT BY: **CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – APRIL 2015**

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1. The Chief Executive submits a written report to each Board meeting detailing the key Trust issues and identifying important changes or issues in the external environment.

2. For this meeting, the key issues which the Chief Executive has identified and upon which he will report further, orally, at the Board meeting are as follows:-

(a) emergency care performance;

(b) the Trust's month 11 financial position;

(c) activity and capacity planning work (please see paper appended);

(d) Executive and Associate Director recruitment - progress;

(e) NHS Change Day 11th March 2015;

(f) the new national timetable for the approval and submission of the Trust's Annual Operational Plan 2015/16;

(g) Mutuals in Health – Pathfinder Programme;

(h) new care models – Vanguard sites;

(i) NHS England national review of maternity care.

3. Attached to this paper are updated strategic objectives and proposed annual priorities for 2015/16. These have been formulated in the light of discussions at the Trust Board 'thinking day' on 12th February 2015, and subsequent discussions at the Executive Strategy Board and Clinical Senate.These are submitted for formal approval.

4. The Trust Board is asked to consider the Chief Executive's report and, in line with good practice, consider the impact on the Trust's Strategic Direction and decide whether or not updates to the Trust's Board Assurance Framework are required.

John Adler
Chief Executive

26th March 2015

BETTER CARE TOGETHER PARTNERSHIP BOARD

19th MARCH 2015

ACTIVITY AND CAPACITY PLANNING

1. Introduction

As the Partnership Board is aware, the Better Care Together (BCT) programme involves very significant changes in the way that we deliver health and social care to local people, with a shift away from reliance on acute hospital care towards preventative and community-based strategies. As a result, it will be necessary to adjust the balance of capacity across the system, be that in terms of actual beds or "virtual" beds such as those provided by community support teams.

The above changes in capacity will be taking place against a backdrop of very high current pressure on capacity across the system. This backdrop has inevitably led to some questioning of the rationale underpinning the original planning assumptions in BCT e.g. reductions in acute bed numbers. It is therefore necessary to be very transparent as we move from the planning to the implementation phase of BCT about how the required capacity is to be calculated, and to ensure that those calculations are undertaken as rigorously as possible, so as to avoid unintended consequences or service failures.

2. Principles

There are three key principles which the Partnership Board is being asked to endorse:

1. Activity and bed capacity requirements will be calculated in accordance with recommended best practice. In the case of acute emergency bed capacity, this includes a target average occupancy of 85%, with a range of 90-95% being applied for elective capacity. The current contracted average occupancy rate for community beds is 93%; this is not in line with best practice and will require a review of best practice to inform the capacity model. Other types of capacity and more efficient provider processes will also need to be agreed and applied in the context of best practice benchmarks e.g. avoidable hospital admissions/ambulatory care pathways, length of stay and day case ratios.

2. Where such reductions in acute or community beds are part of the plan, beds will only be removed once the admission reduction/efficiency scheme has been fully implemented and the impact assessed as clinically safe. Where bed reductions are planned through capacity replacement schemes, a double running phase will follow

scheme implementation to allow bedding in of the scheme, after which bed capacity will be mothballed until the scheme has been proven to work and consultation (where required) has taken place, when capacity will be removed from the system.

3. Although the interventions described in Principle 2 above will correlate to a reduction in acute and/or community beds, the actual implementation of such reductions will need to take account of the position against the target occupancy levels in the model, noting also the constraints (particularly in terms of phasing and system affordability) described in Section 4 below.

3. Planning capacity in practice

In practice, and applying the above principles, the overall process to arrive at the required capacity across the system will be:

1. Forecast required activity levels (before BCT interventions), taking account of demographic trends and activity levels required to meet performance targets (e.g. elective waiting times).
2. Apply calculated length of stay and target occupancy levels so as to calculate the baseline number of beds/other capacity required.
3. Apply the forecast impact (including in-year phasing) of the following:
    1. Improvements in internal provider processes/productivity (UHL and LPT)
    2. Implementation of Bed Reconfiguration workstream changes (i.e. shift to sub-acute care/care at home)
    3. BCT clinical workstream changes (e.g. Planned Care, Long Term Conditions)
    4. Better Care Fund schemes
    5. Commissioner QIPP schemes

The net result of these calculations will be the bed and other capacity required by different parts of the system in order to deliver services in a sustainable way whilst implementing the changes envisaged by the BCT Programme.

4. Issues and Constraints

It should be noted that there are a number of significant issues and constraints which become evident when applying the above process.

Firstly, whilst calculating the baseline capacity requirement may be relatively straightforward, it may be difficult to accurately forecast the impact of the various changes described in the previous section. It will however be important to do this as well as

possible, noting that service delivery risk will be mitigated by the application of principle 2 above.

Secondly, there will inevitably be double-running costs as new services are developed or non-acute capacity increased, given that acute capacity cannot be reduced until those new services are in place. The funding of these costs will need to be addressed. Given the current financial climate and lack of "headroom", this may be a significant constraint.

Thirdly, there may be physical constraints. For example, at least until the Emergency Floor development is completed, there are severe ward capacity constraints at the Leicester Royal Infirmary.

Fourthly, the overall staffing numbers required may not be available in the short term to reach the target occupancy level. It will also be important for UHL and LPT to work together to develop a workforce transition model so as to ensure that there are appropriate numbers of staff available with the right skills for the different settings of care.

Fifthly, there may be an absolute affordability issue in respect of achieving the target occupancy levels. This may necessitate a phased transition to the targets levels. Physical and workforce constraints as described above may necessitate a transitional approach in any event, but it will be important not to lose sight of the ultimate goal in such a process.

Sixthly, the model is not intended to incorporate social care at this stage. Nevertheless, the same principles of activity and capacity planning apply to social care so consideration should be given to extending the model to social care when feasible.

5. Implementation

Given the complexity of the modelling involved, it is important that this is co-ordinated in one place. It has been agreed that the BCT Programme Management Office will be the "owners" of the activity and capacity model, taking feeds from the partners and workstreams as appropriate. For example, the Bed Reconfiguration workstream is currently calculating the scale and pace of shift from acute to sub-acute care in 2015/16. Similarly, UHL is calculating the impact of greater use of ambulatory care. It will be important for the PMO to take a comprehensive approach to gathering the required information and turning it into the final product for 2015/16. It will be equally important for the partners and workstreams to provide the necessary inputs promptly and to a high quality standard.

6. Timescale

At the System Resilience Group on 2nd March, the Chief Officers made a commitment to bring the completed activity and capacity model back to the Group on 11th May. This reflects the importance that is attached to this exercise, given that it is key to the effective delivery of the BCT programme in 2015/16 and also to the improved delivery of emergency care. It is suggested that the model, and therefore capacity decisions for 2015/16, should first be signed off by the Better Care Together Delivery Board and Urgent Care Board.

7. Recommendations

The Partnership Board is recommended to:

- **Note the contents of this report**
- **Endorse the three key principles**
- **Endorse the 3-stage modelling process**
- **Note the key issues and constraints arising from this approach**
- **Agree that the BCT PMO should be the owner of the model**
- **Endorse the timescale and approval process for the completion of the 2015/16 model**

FINAL DRAFT REVISED STRATEGIC OBJECTIVES AND ANNUAL PRIORITIES 2015/16

[Strategic Objectives in bold, bullet points are 2015/16 Priorities]

Safe, high quality, patient centred healthcare

- Reduce UHL mortality rate (SHMI) to under 100 (Quality Commitment 1)
- Reduce patient harm events by 5% (Quality Commitment 2)
- Achieve a 97% Friends and Family test score (Quality Commitment 3)
- Achieve an overall "Good" rating following CQC inspection
- Develop a "UHL Way" of undertaking improvement programmes
- Implement the new PPI Strategy

An effective and integrated emergency care system

- Reduce emergency admissions through more comprehensive use of ambulatory care
- Improve the resilience of the Clinical Decisions Unit at Glenfield Hospital
- Improve the resilience of the Emergency Department in the evening and overnight
- Reduce emergency medicine length of stay through better clinical and operational processes
- Substantially reduce ED ambulance turnaround times

Services which consistently meet national access standards

- Deliver the three 18 week RTT access standards
- Deliver the three key Cancer access standards
- Deliver the diagnostics access standard
- Implement tools and processes that allow us to improve our overall responsiveness through tactical planning

Integrated care in partnership with others

- Deliver the Better Care Together year 2 programme of work
- Participate in BCT formal public consultation
- Develop and formalise partnerships with a range of providers including tertiary and local services (e.g. with Northamptonshire)
- Explore new models and partnerships to deliver integrated care

Enhanced delivery in research, innovation and clinical education

- Develop a robust quality assurance process for medical education
- Further develop relationships with academic partners
- Deliver the Genomic Medicine Centre project
- Comply with key NIHR and CRN metrics
- Prepare for Biomedical Research Unit re-bidding
- Develop a Commercial Strategy to encourage innovation within UHL

A caring, professional and engaged workforce

- Accelerate the roll out of Listening into Action
- Take Trust-wide action to remove "things that get in the way"
- Embed a stronger more engaged leadership culture
- Develop and implement a Medical Workforce Strategy
- Implement new actions to respond to the equality and diversity agenda including compliance with the new Race Equality Standard
- Ensure compliance with new national whistleblowing policies

A clinically sustainable configuration of services, operating from excellent facilities

- Deliver the actions required for year 2 of the 5 Year Plan:
  - Develop Site Development Control Plans for all 3 sites
  - Improve ITU capacity issues including transfer of Level 3 beds from LGH
  - Commence Phase 1 construction of the Emergency Floor
  - Complete vascular full business case
  - Deliver outline business cases for
    - Planned Treatment Centre
    - Maternity
    - Children's Hospital
    - Theatres
    - Beds
  - Develop a major charitable appeal to enhance the investment programme

  - Deliver key operational estates developments:
    - Construction of the multi-storey car park
    - infrastructure improvements at LRI at and GH
    - Phase 1 refurbishment of wards and theatres

A financially sustainable NHS organisation

- Deliver the agreed 2015/16 I&E control total - £36m deficit
- Fully achieve the Trust's £41m CIP target for 2015/16
- Revise and sign off by Trust Board and TDA of the Trust's 5 year financial strategy
- Continue the programme of service reviews to ensure their viability

Enabled by excellent IM&T

- Prepare for delivery of the Electronic Patient Record in 2016/17
- Ensure that we have a robust IM&T infrastructure to deliver the required enablement
- Review IBM support to ensure that we have the right resources in place to enable IM&T excellence

JA 26-03-15