University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper F

TRUST BOARD – 8 January 2015

One Year Operational Plan 2015/2016

DIRECTOR:	Kate Shields, Director of Strategy
AUTHOR:	Helen Seth, Head of Partnerships (Local services and BCT Lead)
DATE:	8th January, 2015
PURPOSE:	To present the first draft of the Trust's Operational Plan for 2015/2016 prior to submission to the NHS Trust Development Authority (NTDA) on the 13th January, 2015. Development of the planning documentation is an iterative process and it is therefore to be expected that the documents will be subject to change prior to final submission. The initial plan will consist of: • Narrative plan • 1 year high level Financial Plan (2015/16 plus 2014/15 forecast outturn) • 5 year high-level Capital Plan • Aggregate Activity Plan (Outturn 2014/15 and 2015/16) • 1 year Workforce Plan • Planning Checklists The planning checklists and detailed technical financial and workforce plans are in development (guidance published on the 19th December and circulated within the Trust on the 24th December). . These will be approved formally and made available subsequently to Board members following submission to the NTDA on the 13th January, 2015. There will be opportunity to discuss the first draft further and consider the risks identified in the narrative plan and cover paper at the 'Thinking Day' on the 15th January, 2015. The Trust Board is asked to **RECEIVE** the first draft of the Operational Plan for 2015.
PREVIOUSLY CONSIDERED BY:	Executive Team, 6th January, 2015
Objective(s) to which issue relates *	[x] 1. Safe, high quality, patient-centred healthcare [x] 2. An effective, joined up emergency care system [x] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [x] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [x] 5. Enhanced reputation in research, innovation and clinical education [x] 6. Delivering services through a caring, professional, passionate and valued workforce [x] 7. A clinically and financially sustainable NHS Foundation Trust [x] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	Engagement with stakeholders has been under the auspices of Better Care Together . From September 2014 the Trust along with other NHS and social care organisations has been working closely with the 'BCT Patient, Public, Involvement Forum' (a lay body of local stakeholders from the likes of Healthwatch, Patient Public Groups, 3rd sector, media reps), to ensure appropriate involvement and engagement.

Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	Once the refreshed plan has been agreed an Equality Impact Assessment will be undertaken on the whole plan. In addition to this, an EIA is integral to each individual business case.
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

First draft - One Year Operational Plan 2015/2016

PURPOSE

1. To present the first draft Operational Plan for 2015/2016.

2. The planning checklists and detailed technical financial and workforce plans are in development (guidance published on the 19th December and circulated within the Trust on the 24th December). These will set the detailed figures and metrics underpinning our financial, investment strategy and workforce initiatives.

BACKGROUND

3. On the 19th December 2014 the National Trust Development Authority (NTDA) published the operational planning guidance for 2015/2016. It confirmed the need for NHS Trust's to submit first draft operational plans by 13th January 2015.

4. This represents year 2 of our 5 year delivery plan which was approved by Trust Board in June 2014 and was refreshed and presented to Trust Board in December 2014.

5. All content has previously been through the Executive Team meetings, the Finance and Performance Committee and previous Trust Board meetings.

6. The content in the Operational Plan represents a point in time in this year's planning round.

AREAS OF NOTE FOR TRUST BOARD

7. The first draft Annual Operating Plan reflects all Trust Board discussions to date and includes the refocusing of our plans following the Trust Board's 'Thinking Day' in October, 2015.

8. The planning checklists and detailed technical finance and workforce plans are in development. These will be approved formally and made available subsequently to Board members following submission to the NTDA on the 13th January, 2015.

9. There will be opportunity to discuss the first draft further and consider the risks identified in the narrative plan and cover paper at the Trust Board 'Thinking Day' on the 15th January 2015.

10. There are areas of risk in our 2015/2016 plan that will need consideration at the 'Thinking Day'. These are:

    a) A bed reduction of 130 during 2015/2016 as patients no longer requiring acute care are transferred to a suitable, lower acuity setting ideally their home. This project will be delivered in partnership with Leicester Partnership Trust and other partners and will require clear objectives that are agreed and monitored by the

Trust Board. The scale and pace of this change represents a material risk which will need to be reflected on the corporate risk register.

b) Workforce reductions will need to be aligned to our transformational work through the Cost Improvement Programme Management Office. The Trust delivered 2% workforce reduction last year.

c) The potential impact of new tariff guidance for 2015/16 on financial planning assumptions. For example, the proposal that providers will receive 50% of tariff for specialised activity over baseline.

d) The potential impact of the national contract for 2015/16 on financial planning assumptions. For example the potential for up to 18 month lead time, prior to counting and coding changes being actioned.

RECOMMENDATION

11. The Trust Board is asked to receive the first draft of the Operational Plan for 2015/16.

Annex A: Summary of One Year Operational Plan 2015/16 (First draft – will be subject to change)

University Hospitals of Leicester NHS Trust

Strategic context and direction **To include:** Outline of plan delivery in 2014/15 and narrative on the progress anticipated in 2015/16, within the context of the Trust's previously submitted five year plan to 2018/19. To include the impact of strategic commissioning intentions, service changes, local health economy factors, competitive position, strategic developments, transactions and organisational sustainability.	**PLAN DELIVERY IN 2014/2015** **1.**Our two year operational plan was approved in April, 2014. It identified three cross cutting issues that the Trust would focus on in securing progress against our strategic objectives. We said we would: •*Effectively lead and manage service provision in line with defined standards whilst delivering our financial plan and improving productivity;* •*Build effective strategic partnerships to support delivery of safe and sustainable core and specialised services;* •*Prepare strong foundations for forthcoming, large scale transformation – including improvement activities at scale and pace and early enabling capital schemes;* **2.**During 2014/2015 our primary focus has been predominantly on the first item. As we look to 2015/2016 it is important to reflect on what has gone well and not so well. **QUALITY IMPROVEMENT – ACTING ON THE CARE QUALITY COMMISSION (CQC) REPORT** **3.**The Trust was visited by the CQC in January, 2014 and received the draft report in March, 2014. The overall rating for the acute services provided by the Trust was "requires improvement". As anticipated it highlighted some areas for improvement many of which already feature in our plans. Key headlines include: ○**SAFE -** The CQC rated University Hospitals Leicester (UHL) as requiring improvement in this area. To date, there has been an improvement in safety-related Key Performance Indicators (KPIs), with 12 out of 16 being amber or green RAG rated. Particularly good progress has been made on compliance with SEPSIS6 Care Bundle and the incidence of pressure ulcers within the Trust.

- **CQUIN -** Performance against CQUIN's has been exemplary in 2014/2015 with only 1 out of 60 Commissioning for Quality and Innovation (CQUIN) indicators being RAG rated red. This was due to an isolated Methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia which was retrospectively confirmed as unavoidable.

- **CARING -** The CQC rated the care provided at UHL as good in January, 2014. To date, 11 out of 13 KPIs for the caring domain for which targets have been agreed are RAG rated green or amber. Performance continues to be monitored and action plans are in place to address low outpatient friends and family test scores and single sex accommodation breeches.

- **EFFECTIVE -** Rated as good by the CQC, UHL continues to strive to provide effective care. This was confirmed by KPIs at the end of 2013/14, where 13 out of 14 were RAG rated amber or green. Importantly, the trust's SHMI remains within the expected range. The number of fractured Neck of Femurs (NOF) operated on between 0-35 hours from admission was lower than target in 2013/14 and continues to be a challenge.

- **RESPONSIVE -** The CQC rated UHL as requiring improvement in this area and it continues to be a significant challenge. To date, 9/25 'responsive' KPIs are RAG rated amber or green despite increasing demand. Sustained improvement in and achievement of the Emergency Department (ED) 95% target remains the most significant challenge for UHL and partners in the local health system. Poor performance and care in the Emergency Department (ED) and Clinical Decisions Unit (CDU) is symptomatic of wider system failure which is being compounded by further increases in emergency hospital admissions. This pattern is being replicated nationally.

4. Overall ED performance continues to be below target; Performance from 1/12/ 2014 to the 11/12/14 was 85.1%. Demand for emergency admissions (adult) has continued to steadily rise (circa 10% higher than the same period in November 2013). Delayed transfers of care have risen recently and are at 5.7% (every 1% equates to a ward).

5. Performance against the two week wait target, the 31 day wait for treatment, 31 day wait for second treatment, 62 day wait for first treatment (GP referral) and 62 day wait for first treatment (screening referral) are all below target in-year having previously reflected good performance; demand on the 2 week wait pathway has increased by 18% without impact on the incidence of cancer diagnosis. UHL, together with primary care are taking steps to manage the on-going daily pressure being experienced due to increased demand.

6. Referral to Treatment (RTT) –Throughout 2014/2015 the Trust has achieved significant RTT backlog reductions. This represents a major achievement. Performance is in line with agreed performance trajectory. Despite this improvement, a number of RTT specialities have seen an increase in GP referrals which has impacted on the ability of the speciality to

deliver RTT performance on a sustainable basis. Illustrative examples include gastroenterology and general surgery**.**

7.WELL LED - UHL was considered to be well-led by the CQC in January, 2014. Related KPIs show this continues to be the case. All but one of the 2013/14 KPIs were RAG rated amber or green. In 2014/2015 performance has improved further in a number of areas. Friends and Family Test coverage has increased to target levels; statutory and mandatory training completion rates are at 87% (compared to year end in 2013/14 of 76%) and is on target to hit our improvement trajectory at the end of March, 2015 (95%); 98% of staff have attended a corporate induction (against a target of 95%).

8.Progress against the Organisational Development Plan in 2014/2015 is going well. Illustrative examples include the introduction of an 'Organisational Health Dashboard' for key HR indicators; the involvement of the UHL Clinical Senate in developing medical leadership and the introduction of value based recruitment processes.

9.The Trust continues to facilitate Listening into Action (LiA) 'Pass it on' events. LiA is becoming 'the way we do things at UHL'. 'Nursing into Action' for wards is progressing well with a focus on listening events to improve the quality of care and patient experience.

2014/2015 COST IMPROVEMENT PROGRAMME (CIP) DELIVERY

10. The CIP programme for 2014/2015 is £45m – reflecting 5.3% of the cost base. The Trust has had the benefit of the support from Ernst & Young to enhance governance and support delivery. This will continue as we move in to 2015/2016.

11.A clear CIP identification, planning and monitoring framework has been implemented. This has evidenced a step change in performance in CIP delivery with the total value of schemes on the Programme Management Tracking Tool (PMTT) reaching £48.05m (£45.86m risk adjusted). For month 7 the total forecast value has increased slightly to £48.18m and importantly the value of green RAG rated schemes totalling £45.14m meeting the value of the CIP target for the first time. This represents a major achievement.

12. Robust cost control has been central to delivery of the financial plan underpinned by feasible mitigations including enhanced non-pay control, strengthened vacancy management, filling post substantively (reducing premium pay).

ALIGNMENT AND GOVERNANCE	13.A Department of Health Gateway Zero review of UHL's reconfiguration and transformation programme was carried out in October, 2014. It received an amber/red assessment. The primary purpose of a Department of Health Gateway zero review is to review the outcomes and objectives for a programme and confirm that they make the necessary contribution to wider local government, NHS and/or organisational overall strategy. For UHL this would be the Leicester, Leicestershire and Rutland (LLR) Better Care Together (BCT) programme. 14.Plans to reduce activity and reconfigure clinical services across LLR require a significant amount of work to deliver the required change. Current variation in demand above plan highlights the size of the challenge. 15.For the Trust, delivery of our plan is critically interdependent with delivery of the LLR BCT programme and the Local Authority Better Care Fund programme. Whilst the LLR BCT programme has a series of workstreams established to drive system change, UHL did not have a similar governance structure to oversee and coordinate the required activities. 16.To that end, an internal programme of work has been established to deliver the Trust's transformation and reconfiguration plans and effectively contribute towards the BCT vision. The governance framework aligns CIP plans and BCT reconfiguration activities through a number of enabling cross cutting workstreams (*see Appendix 1) with the major productivity projects focused on beds, outpatients, theatres and workforce. This provides the framework within which the Trust, Clinical Management Groups (CMG's) and specialties are developing their plans (to agreed milestones). Governance arrangements have been put in place to monitor progress and mitigate risks to delivery with Executive input and oversight. A Delivery Board has been set up as the mechanism to carry out this function and to align with the wider health economy BCT Programme.
PROGRESS ANTICIPATED IN 2015/2016	17.For the Trust, the focus in 2015/2016 will continue to be on realising internal efficiencies as well as working with partners to move prioritised activity to lower acuity, community settings. To do this we will need to build effective strategic partnerships to support delivery of safe and sustainable core and specialised services and build strong foundations for forthcoming, large scale transformation. 18.The Trust's published a five year "directional" plan in June, 2014. It is aligned to the LLR BCT programme, national planning guidance and policy direction. No sooner had this been approved when a number of key drivers for change emerged. There is no alteration in the direction of travel described in the Trust's Strategic Direction (November, 2012): "In five years' time we expect to be delivering better care to fewer patients, we will be significantly smaller, more specialised, and financially sustainable". There are however revisions to our planning assumptions driven by: •Anticipated requirements of clinical standards

•Publication of NHS England's Five Year Forward View (November, 2014) and the Dalton Review (December, 2014)

•The challenge from the National Trust Development Authority (NTDA) to go "further, faster" to reconfiguration

•Actions required in response to external reports

•Service sustainability: The need to consolidate ITU services on grounds of clinical safety;

19.A number of these will have an impact in 2015/2016 including:

•Progress in the delivery of the new **Emergency Floor** development (currently at Full Business Case). Phase 1 development will be operational in 2016/2017 and Phase 2 (assessment beds) in 2017/2018. The **consolidation of vascular services** with the move of **vascular surgery** from the Leicester Royal Infirmary (LRI) to Glenfield Hospital (GH) (currently at OBC and will be operational in 2016/2017). * rephased capital plan see Appendix 2

•**Single Children's Hospital –** The work programme to establish a single Children's Hospital will be initiated in 2015/2016 starting with the development of an Outline Business Case (OBC). It is anticipated that the OBC will be approved in September 2015.

•**Strategic Partnerships** -The Trust has carefully considered the best operational model that will help the service rise to the challenge of the forthcoming clinical standards for congenital heart services. Throughout 2015/2016 the Trust will explore the establishment of a strategic alliance with Birmingham Children's Hospital which could provide a collaborative model of delivery, governance, research and development and is in line with some of the opportunities outlined in the Dalton Review.

•**Maternity Business Case –** Due to the critical interdependency between Women's and Children's services the business case to consolidate maternity services will be brought forward and will be initiated in late 2014/2015. The OBC will be developed in 2015/2016.

•**Intensive Therapy Unity (ITU) Consolidation -** The Trust has established a discrete cross-cutting workstream to support the relocation of ITU (and interdependent services) from Leicester General Hospital by December, 2015. This will be supported by a two stage estate solution (interim and long term). In order to accommodate re-provision to the LRI, a significant estate footprint will need to be released. This will be facilitated by acceleration in the transfer of patients who no longer require acute care and bringing

	•**Treatment Centre -** The plans for this development have been brought forward with work starting in 2015/2016 (part new build/part refurbishment). Outline Business Case approval in forecast to be in August 2015 and FBC approval in February 2016. This together with an increase in planned activity delivered through the LLR Planned Care Alliance in Leicestershire community hospitals should have significant impact on the sustainable achievement of the Referral to Treatment Time (RTT) standard. •**Accelerated out of hospital community care** (for patients no longer requiring acute intervention)- As part of the Trust and BCT plan, LLR partners have agreed to work together to support the early transfer of patients who no longer require acute care, ideally back to their home. Based on the need to release estate footprint to relocate LGH ITU and the challenge to go "further, faster" the Trust is working with LPT to deliver this change over the next two years starting with a shift in 130 beds worth of activity to non-bedded alternatives in the community. This aligns to the planning assumptions underpinning the BCT programme and commissioning intentions to secure a step change in out of hospital care and improvements in the care of the frail older person. **COST IMPROVEMENT PROGRAMME (CIP) 2015/2016** 20.The Trust is planning to secure £41m in CIP savings for 2015/2016. 21.The CIP Programme is managed by the CIP Programme Management Office on behalf of the Trust with performance reported monthly to the Finance and Performance Committee and the executive team. 22.Four cross cutting workstreams are planned to coordinate activities in areas that affect more than one CMG. These will be: Beds Utilisation, Theatres, Outpatients and Workforce. 23.Currently £30.7m has been identified in total towards the £41m, equating to 75%. 44.21% of this is currently RAG rated amber/green. 24.Finalisation of CIP plans is incorporated into the business planning process with the expectation that plans will be in place for 80% of the CIP target (£32.8m) by 31 January, 2015 and 100% by 30 March, 2015.

Approach taken to improve quality and safety **To include:** The approach to quality improvement, the methodology used and the key improvements to be delivered over the next year across the five CQC domains of quality: safe, caring, effective, responsive and well-led. Consistent with information contained within the Trust's published Quality Account.	25. The Trust's 'Quality Commitment' aims to define UHL's approach to quality improvement and reflects the largely positive findings of the recent CQC inspection completed in January 2014. 26. The Trust has robust 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. 27. Each clinical service sets annual quality priorities aligned to 14 strategic quality goals agreed across UHL. The Board sets annual quality priorities for the Trust, drawing these from locally set priorities and incorporating national standards, CQUIN requirements, patient and stakeholder feedback, from contracts. The agreed priorities form a framework for CMG and service level quality priorities and reflect specific patient needs. These are developed through discussion with clinicians, including nursing and medical staff taking into account incidents, risks, complaints and feedback. **DELIVERING THE ACTIONS RESULTING FROM THE LLR QUALITY REVIEW AND THE STURGESS REPORT** - 28. Published in July 2014, the LLR Quality Review was jointly commissioned by UHL, LPT and the three local CCGs in response to a consistently high SHMI in 2012/13 and early 2013/14. The aim of the review was to identify areas where care quality delivered across the healthcare system could be improved. According to the reviewers 23.4% of cases received care of an unacceptable standard and 54.6% of cases received care where lessons could be learned. 29. Where lessons can be learned and issues are identified these have been integrated into the Trust's quality action plans for the current and forthcoming year. 30. One of the most significant issues identified was a lack of joined up healthcare provision locally. To overcome this, and with the aim of addressing historic cultural issues both within and between healthcare organisations in LLR, a Task Force has been established. The Task Force is chaired by the Chairman of West Leicestershire CCG, (also a practicing GP locally), and the group has constant executive-level representation from each healthcare organisation involved in the review. Meetings are also attended by Healthwatch and Local Medical Council. 31. In addition to the Quality Review, Dr Ian Sturgess, an expert in emergency care pathways, was commissioned by LLR partners to provide recommendations on how the emergency pathway can improve. His report published in November, 2014 found that the local system is 'relatively fragmented with barriers to effective integrated working'. 32. A recommendation was made to focus on the following issues:

	•**Admission avoidance** – ensuring people receive care in the setting best suited to their needs rather than the Emergency Department. This fits with the work programme of the Better Care Together programme more specifically the Urgent Care, Long Term Condition and Frail Older Person workstreams. •**Preventative care** – putting more emphasis on helping people to stay well with particular support to those with known long-term conditions or complex needs. This fits with the work programme of the Better Care Together programme and CCG specific proactive care strategies. •**Improving internal processes** within UHL •**Discharge processes** across whole system - ensuring there are simple discharge pathways with swift and efficient transfers of care. •The action plans that respond to both reviews and the governance structure to support change have now been integrate within the BCT programme structure, thereby placing quality at the centre of all we do.
Delivery of operational performance standards Including contractual and national targets and standards.	33.The Trust will continue to work with partners across LLR through the BCT to improve operational performance standards in the short, medium and long term. 34.UHL will continue to make improvements to its internal process through the service review process, the CIP programme and the four cross cutting workstreams. Examples include greater management and clinical input on wards at weekends, the opening of additional capacity on the LRI site and focussing on earlier ward rounds across all three sites. 35.LLR partners are putting a lot of effort into improving the discharge process with greater numbers of external partners in-reaching into UHL to support earlier transfer of care when patients no longer require acute care.
Workforce plans Including proposed changes, quality impact, staff engagement and support.	36.A workforce Plan for 2015/2016 is being completed by each CMG as part of the on-going business planning process which incorporates baseline establishment; growth schemes and cost improvement programmes. The output of this process will provide granular detail of the changing workforce. Key to delivery will be staff engagement and support through Listening in to Action (LiA); analysis of staff feedback (survey / friends & family) and consultation with staff / staff side.

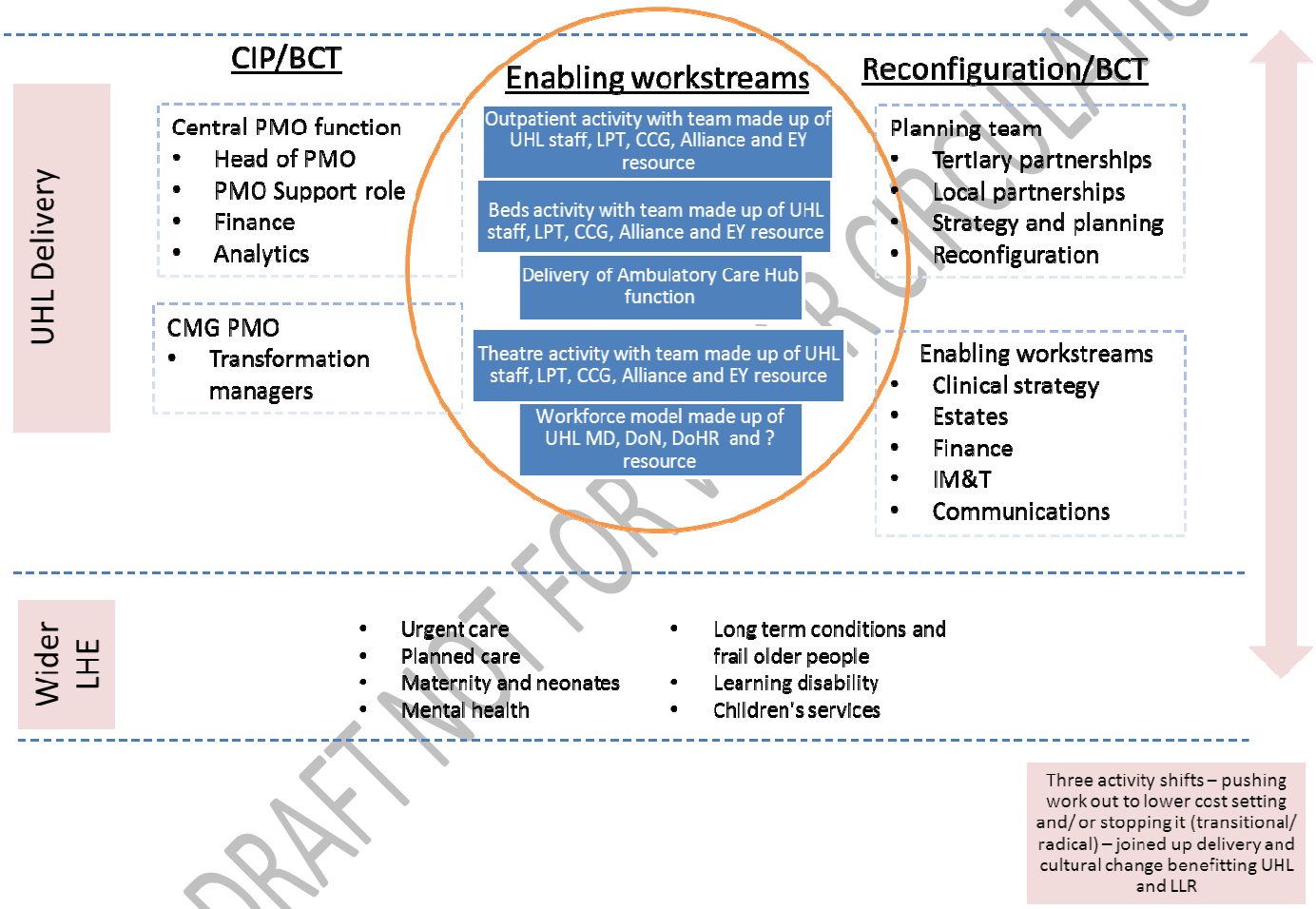
Financial and investment strategy **To include:** One year financial plan, financial sustainability, cost improvement programme, QIPP/BCF, capital and key risks and risk mitigation.	37. The Trust is currently working through an iterative planning process with CMGs and corporate directorates. As a result the initial financial and workforce plan submissions will reflect this current stage of planning and be subject to change prior to the final submission on 30th March 2014. 38. The Trust's financial plan for 2015/2016 is a planned deficit of £36.1m which is consistent with year 2 of our 5 year financial plan and assumes the following: •Tariff deflation and cost inflation are as per tariff guidance (1.9% each) •Increased capital charges and borrowing costs as a result of planned capital spend and loans to support the deficit and capital programme. •No assumed contractual benefits from contract terms or counting and coding agreements. 39. Further work is underway to validate each of these assumptions, with the impact of tariff being key. Discussions with CMGs and directorates have been taking place to support development of the income plan and develop a clear understanding of the minimum income required to service expenditure plans 40. The Trust has a robust strategy to deliver efficiency savings with the support of an expert external consultancy to help embed the governance and PMO processes. In 2015/2016 the programme will focus predominantly on 4 cross cutting work streams: bed utilisation, theatres, outpatients and workforce. The financial plan assumes the delivery of £41m in CIP savings and identification of these savings is on track within the iterative planning process described above.
Longer term financial sustainability, income, costs, activity, capital and risk mitigation.	41. The Trust's five year "directional" plan published in June 2014 included a Long Term Financial Model (LTFM) which reflected implied efficiency rates and realistic assumptions in respect of income, patient activity, inflation and staffing levels. This plan was in line with the BCT plan in the local health economy. 42. Since then the Trust has worked closely with BCT partners to ensure the growth, modernisation and transformation of services is consistent with the Trust's own strategy and reflected in the LTFM. As an active partner in the BCT programme, the Trust has contributed towards the development of a LLR Financial Model which is being adopted by all partners across the health economy. This reflects the planning assumptions within the Trust's LTFM.

Plans to improve efficiency and productivity through the more effective use of information and technology.	43.The Trust is investing in information technology at an operational and strategic level to support improvement in efficiency and productivity. 44.At a strategic level, the Trust has selected its preferred partner for an Electronic Patient Record (EPR). This will move in to implementation in 2015/2016. 45.At an operational level the Trust has purchased QlikSense which facilitates the monitoring, analysis and presentation of information to support:- Patient Outcomes & Safety, Patient Experience, Clinical Staff Resourcing, Quality Schedule and CQUIN indicators, Performance Management and Financial Management. It will empower UHL staff to make better and more efficient use of data and information across multiple domains. Benefits include the rapid development of Emergency Care Data Pack for immediate use and real time clinical coding to help drive improvements in capturing all co-morbidities. 46.The Trust also has access to a range of benchmarking tools including CHKS and Healthcare Evaluation Data (HED). Both are on-line tools which help the Trust identify clinical and productivity efficiencies comparing UHL performance with other NHS Trusts.
Organisational relationships and capability **To include:** Patient and public engagement, relationships with stakeholders and leadership development.	47.From the publication of our Strategic Direction in November 2012, which set out the case for smaller, more specialised hospitals and the transfer of more services to the community, engagement with key stakeholders has been constant and consistent. Clearly the UHL 5 year strategy is set within the wider context of the LLR BCT programme and logically therefore the engagement with stakeholders has been under the auspices of BCT. From September 2014 the Trust along with other NHS and social care organisations has been working closely with the 'BCT PPI Forum' (a lay body of local stakeholders from the likes of Healthwatch, Patient Public Groups, 3rd sector, media reps), to ensure that involvement and engagement is hardwired into the developing BCT plans and to co-create the approach to wider public engagement and consultation post the May election. The first drafts of these plans will be discussed by the BCT Partnership Board and the Patient and Public Involvement (PPI) Group in late January, 2015.
Development priorities and actions that the Trust is taking to meet its development needs.	48.The Trust has developed and submitted a detailed development plan to the TDA in November, 2014. The key headlines can be summarised as follows: **Priority 1: Trust Board development- embedding Board disciplines** **Action –** Secure resources for coaching and training to produce shorter reports, informed by analysis and identifying key issues to be addressed **Priority 2: Clinical leadership**

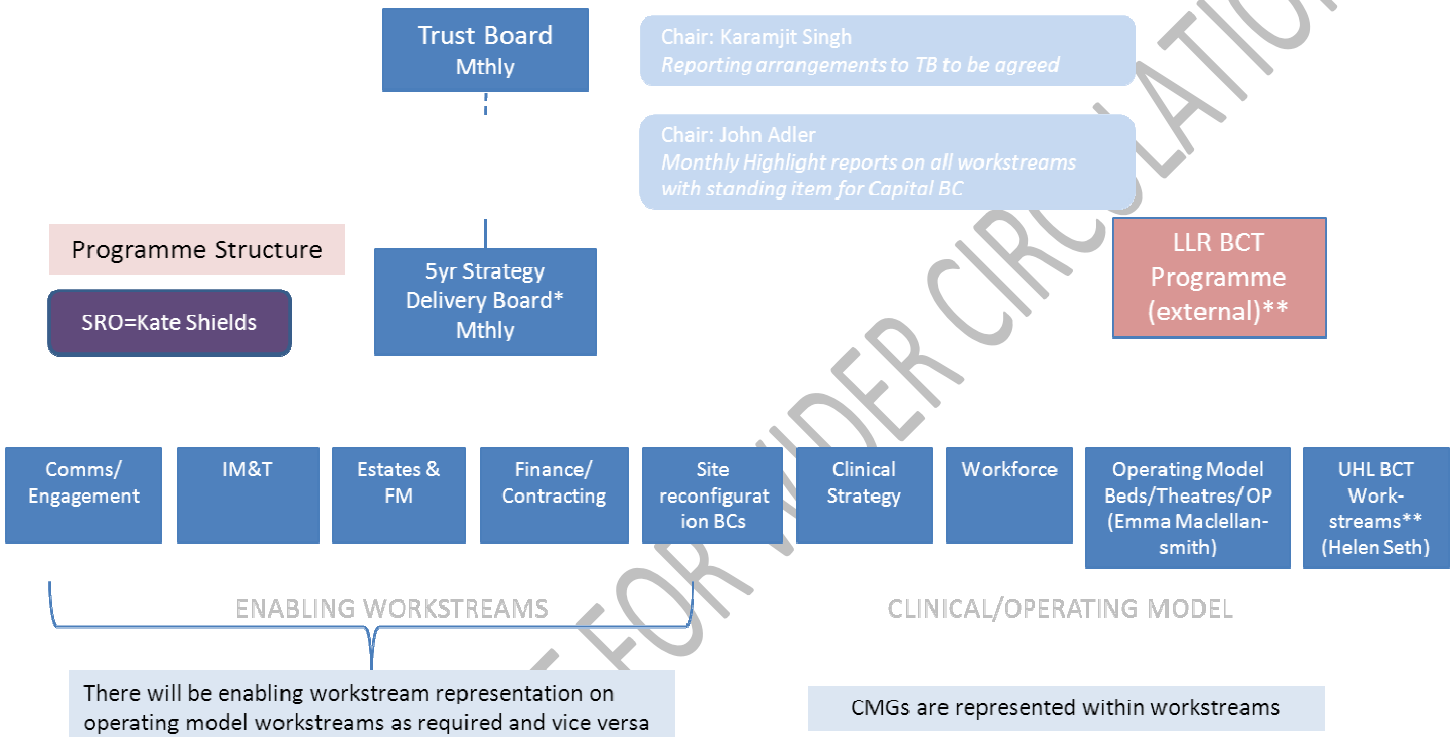
	Action - Work with NHS Improving Quality (NHS IQ) and the Leadership academy to systematically develop structures and processes for developing and garnering clinical leadership; set out clear expectations and sanctions as part of job planning and annual appraisal; train appraisers; clinical senate established; establish a similar model for nursing and midwifery **Priority 3: Culture and behaviours in teams** **Action -** Develop a programme brief that describes the scope of change planned, the anticipated benefits and outcomes of the 5-year plan and aligns this to the strategic priorities and values of the organisation; thorough engagement with staff to establish ownership of the plan; use the LiA methodology to provide clarity of roles and responsibilities (for all staff) to deliver the 5 year plan; coaching and development of the Executive Team and continue Practice Crucial Conversation Sessions (across CMG) in partnership with Momentum; building on-the ground change capacity with the support of NHS IQ Support **Priority 4: Patient & Public involvement** Action - More time and resource invested in to CMGs to free up staff time to engage within the Trust and in the wider community; seek support and guidance from NHS England, in developing a PPI strategy that will seek to strengthen our PPI within the Trust as well as linking into the wider community; Link into the Patient and Public Voice Team at NHS England; access to medical leaders in other health economies who are prepared to coach/enthuse support our CMG leadership teams. **Priority 5: Financial sustainability** **Action -** Enabling resource has been implemented for CIP which includes CMG specific support and also a number of cross cutting themes, each led by an Executive Director. This will be further refined in 15/16 to focus on four main areas (Beds, Outpatients, theatres and workforce) ; a five year internal CIP plan has been drafted and is currently in consultation with senior leader; external work-streams via BCT to support financial sustainability, service and pathway change. Requirement to provide an umbrella view and hold the interdependent areas (including organisations) to account to deliver the whole; externally the BCT programme SOC will outline the system requirement for transitional funding and capital and cash resources to successfully deliver system and organisational reconfiguration **Priority 6: Improvement & Innovation methodology** **Action -** Agree a methodology and agree the deployment across UHL; develop communications plan that aligns improvement and innovation with the overall programme management arrangements for delivering the 5-year plan

APPENDIX 1

CIP and BCT Alignment



Governance structure for delivering the UHL five year strategy



All workstreams will have their own governance structure with PIDs, regular implementation meetings, and fortnightly highlights reports

***Delivery Board run by the Strategy PMO:**
SRO – Kate Shields
Clinical Lead - Deputy Medical/Nursing Directors
Finance Lead – Paul Traynor/ Paul Gowdridge
Programme Director – Ellie Wilkes
Programme Manager – Serina Koral

BCT Workstreams**

- Urgent care
- Planned care
- Maternity and neonates
- Mental health
- End of Life
- Children's services
- Long term conditions and frail older people
- Learning disability

APPENDIX 2

Estates Strategy 5 Year Phasing - "Further Faster" Dec 2014 Ver1.1

	2014/15 £k	2015/16 £k	2016/17 £k	2017/18 £k	2018/19 £k	TOTAL £k	*Total Dec-14*	OBC Start	OBC Internal	OBC Submission	OBC Approved	FBC Internal	FBC Submission	FBC Approved
Emergency floor LRI	13,000	25,000	10,000	-	-	48,000			Jul-14	Aug-14	Dec-14	Jan-15	Jan-15	Mar-15
Vascular GH	2,500	8,000	2,000	-	-	12,500			Jul-14	Aug-14	Jan-15	May-15	May-15	Jun-15
OPDC hub	3,000	20,000	32,000	3,000	-	58,000		Jan-15	Jun-15	Jul-15	Aug-15	Nov-15	Dec-15	Feb-16
Imaging GH	-	3,000	3,000	-	-	6,000								
Multi-story Car Park LRI	-	4,000	-	-	-	4,000								
Childrens' cardiac	-	3,500	-	-	-	3,500								
Childrens' IP/OP LRI	-	-	3,000	4,000	9,000	16,000		Jan-15	Jun-15	Jul-15	Sep-15	Mar-16	Apr-16	Jun-16
Outpatients LRI	-	-	-	3,000	2,000	5,000								
Inpatients LRI	1,500	2,000	8,000	10,000	2,000	23,500								
Theatres LRI	3,000	4,000	4,000	4,000	-	15,000								
Pathology GH	-	-	-	3,000	-	3,000								
Inpatients GH	-	6,000	9,000	15,000	-	30,000								
ITU LRI	500	-	-	14,000	2,000	16,500		Oct-15	Mar-16	Apr-16	Jun-16	Dec-16	Jan-17	Mar-17
Maternity LRI	400	7,500	27,000	31,000	-	65,900		Jan-15	Apr-15	Jul-15	Aug-14	Jan-16	Feb-16	Mar-16
LGH	1,000	-	4,000	4,000	-	9,000								
Entrance LRI	-	-	-	2,000	10,000	12,000								
Capital reconfiguration projects	24,900	83,000	102,000	93,000	25,000	327,900								

	14/15	15/16	16/17	17/18	
Maternity LRI	Feasibility and business case	Business case and Enabling works and demolition	New Build	New Build and refurb	Note uplift for out of sequence and possible disfunctional use