Agenda Item: Trust Board Paper F

TRUST BOARD

Thursday 7th May 2015

Draft Annual Operational Plan 2015/16

DIRECTOR:	Kate Shields, Director of Strategy
AUTHOR:	Gino DiStefano, Head of Strategic Development
DATE:	7th May 2015
PURPOSE:	**Context**: NHS Trusts require annual operational plans as set out in the planning guidelines published by the NHS Trust Development Authority (NTDA), 'Delivering in a Challenging Environment: Refreshed Plans for 2015/16' Our plan for 2015/16 sets out the objectives and priorities for the second year of our five year strategy. Enclosed is Annex A of our draft annual operational plan, which provides an overall narrative and summarises the plan's component parts (technical planning returns for activity, finance, workforce, and self-certification checklists). **Questions** (that this paper seeks to answer): 1. What are the key risks associated with the plan? 2. Is the plan completely finalised? 3. If not, what are the next steps? **Conclusions**: 1. The key risks (to successful delivery of our plan) include: • System and/or Trust failure to deliver improvement initiatives in line with plans, including new models of care / service reconfiguration • Increasing demand for acute care which may stretch beyond activity and capacity plans • Failure to enact change / new models underpinning our planning assumptions. • Failure to deliver CIP (in full) • Failure to secure capital investments needed to realise our plans • Lack of certainty around the cost of borrowing (capital) • Managing the pay bill - failure to reduce premium spend (through substantive recruitment) in line with plans 2. Our plan is well developed and close to completion. However, we are constantly receiving feedback from the NTDA which informs further changes and/or requires additional assurance. We have had the opportunity to review draft / high level feedback over recent days which highlights two areas that are likely to require further work / assurance, finance and performance. Formal and detailed feedback from the NTDA on our previous submission (dated 7th April) is expected week commencing the 4th May. On receipt, we will consider the feedback / actions in full and update our plan accordingly. 3. Next steps include: • Reviewing the formal NTDA feedback when it is received • Considering what changes, if any, are required to our plan and/or component parts, including the consequences of non-compliance • Providing additional levels of assurance to the NTDA where necessary • Submitting the final plan to the NTDA on the 14th May (subject to Trust Board approval – see input sought, below).

	Input Sought: The Trust Board is asked to: 1. Provide comments and feedback on the current draft plan, enclosed. 2. Delegate authority for the formal review and sign off of the annual operational plan (when finalised over the coming week) to Mr Karamjit Singh, Chairman, and Mr John Adler, Chief Executive Officer ahead of the formal submission to the NTDA on the 14th May.
PREVIOUSLY CONSIDERED BY:	Integrated Finance, Performance, Investment Committee, 30th April Executive Performance Board, 28th April Executive Strategy Board, 14th April Executive Strategy Board, 10th March Trust Board, 8th January
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 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:	As reported previously, engagement throughout the planning process has been via the Better Care Together Programme, which frames the system's strategic planning. In addition, our annual priorities were shaped with internal and external stakeholders, including the Clinical Senate. 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:	There is no formal requirement to conduct an Equality Impact Assessment (EIA) for the annual operational plan at a global level. However, EIA is integral to each individual business case / proposed service change described within the plan. Therefore, the plan will require several EIAs to be undertaken and some have already been concluded e.g. Emergency Floor.
Organisational Risk Register/ Board Assurance Framework *	[ ] **Organisational Risk Register** [X] **Board Assurance Framework** [ ] **Not Featured**
ACTION REQUIRED *	
For decision [ ] For assurance [X] 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

SUMMARY OF ONE YEAR OPERATIONAL PLAN 2015/16

University Hospitals of Leicester NHS Trust

1. Strategic context and direction

1.1. Introduction - Our purpose, values and 5 year strategy

University Hospitals of Leicester NHS Trust (UHL), a leading teaching hospital, is one of the ten largest trusts in the country and has a significant research portfolio. We provide acute and specialised services to the local population of Leicester, Leicestershire and Rutland (LLR) and, for some services, to people from a much wider catchment.

Our five-year plan - published in June 2014 - is ambitious, as is that of the wider health economy's Better Care Together (BCT) plan, which reflect the scale of the challenge ahead. It states:

> *"In five years' time, we expect to be delivering better care to fewer patients; we will be significantly smaller, more specialised, and financially sustainable".*

Our plan touches every part of the organisation and requires all services to transform in an incredibly tight timescale. Integral to this plan is an ambitious estate modernisation programme and the consolidation of acute services onto a smaller footprint (two sites instead of three) to deliver the clinical co-locations described in our clinical strategy. We will grow our specialised, teaching and research portfolio, only providing in hospital the acute care that cannot be provided in the community.

1.2. Delivery of 2014/15 Plan

In terms of laying the strong foundations needed ahead of wide scale transformation, our two year operational plan (2014/15 to 2015/16) identified three cross cutting themes / priorities:

1. Effectively lead and manage service provision (and **performance**) in line with defined quality standards whilst delivering our financial plan and improving **productivity**;
2. Build **effective strategic partnerships** to support delivery of safe and sustainable core and specialised services; and,
3. Prepare for large scale change – including improvement activities at scale and pace and **early enabling capital schemes**.

During 2014/15, our primary focus has been on the first item, improving quality, financial resilience and operational performance.

1.2.1. Quality Standards

The Care Quality Commission (CQC) visited the Trust in January 2014. As anticipated, the CQC highlighted some areas for improvement, many of which already feature in our plans. The overall rating for our acute services was "requires improvement".

CQC Indicator (Jan 14 Rating)	Progress To Date
Safe (Requiring Improvement)	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. We have made particularly good progress on compliance with the SEPSIS6 Care Bundle and the incidence of pressure ulcers within our hospitals.
Caring (Good)	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 breaches.
Effective (Good)	In 2013/14, 13 of 14 KPIs for 'effective care' 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 (Requiring Improvement)	This 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 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.
Well Led (Yes)	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 our performance 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%).
CQUIN	Performance against Commissioning for Quality and Innovation (CQUIN) indicators has been exemplary in 2014/15 with only 1 out of 60 CQUIN indicators being RAG rated red. This was due to an isolated Methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia which was retrospectively confirmed as unavoidable.

1.2.2. Finance (including Cost Improvement)

Robust cost control has been central to delivery of our 2014/15 financial plan underpinned by feasible mitigations including enhanced non-pay control, strengthened vacancy management, filling post substantively (reducing premium pay).

Our cost improvement programme (CIP) for 2014/15 totalled £45m – reflecting 5.3% of our cost base and we will deliver £47.5m in year, a surplus of £2.5m. We have had the benefit of additional support from Ernst & Young which has helped to enhance governance and support delivery. This will continue into 2015/16.

1.2.3. Performance

The following table summarises our performance against national standards in 2014/15.

	Performance Indicator	Target	2014/15	Compared to 2013/14
Access to A&E	A&E - Total Time in A&E (4hr wait)	95%	89.1%	▲
Infection Control	MRSA (All)	0	6	▲
	Clostridium Difficile	81	73	▲
Referral to Treatment (RTT)	RTT - admitted patients (within 18 weeks of referral)	90%	84.4%	▲
	RTT - non-admitted patients	95%	95.5%	▲
	RTT - incomplete pathways	92%	96.7%	▲
	Diagnostic Test Waiting Times (99% within less than 6 weeks)	<1%	0.9%	▼
Access to Cancer Services (April 14 to Feb 14)	Cancer: 2 week wait from referral to date first seen - all cancers	93%	92.2%	▼
	Cancer: 2 week wait from referral to date first seen, for symptomatic breast patients	93%	94.0%	◀▶
	All Cancers: 31-day wait from diagnosis to first treatment	96%	94.4%	▼
	All cancers: 31-day for second or subsequent treatment - anti cancer drug treatments	98%	99.3%	▼
	All Cancers: 31-day wait for second or subsequent treatment - surgery	94%	89.1%	▼
	All Cancers: 31-day wait for second or subsequent cancer treatment - radiotherapy treatments	94%	95.8%	▼
	All Cancers:- 62-day wait for first treatment from urgent GP referral	85%	81.1%	▼
	All Cancers:- 62-day wait for first treatment from consultant screening service referral	90%	84.1%	▼

As the table shows, our overall 4 hour A&E (or ED) performance continues to be below target but we have seen an improvement despite increasing demand.

We are making good progress across all RTT standards and with backlogs (patients waiting over 18 weeks) in particular with improvements against every standard since 2014/15.

Our performance against the cancer two week wait target remains a significant challenge and, like ED, demand has increased. During 2015/16, cancer 2 week wait referrals increased by 18% without impact on the incidence of cancer diagnosis. We plan to deliver against the all cancer standards by July 2015.

1.2.4. Strategic Partnerships

We have agreed, with the support of NHS England and local commissioners in Northamptonshire, a strategic alliance for specialised services with Kettering General Hospital and Northampton General Hospital. The principles behind this collaboration focus on improving services and access to specialised services for patients, securing sustainable services into the future delivered locally wherever possible and sharing resources and clinical expertise between organisations. Early work has included successful joint appointments in cancer services to support the delivery of a single oncology service across Leicestershire, Northamptonshire and Rutland which, serving a population in excess of 1.5 million, will be one of the largest oncology services in England.

Clinicians from the children's hospitals at UHL and Nottingham University Hospitals, working with the strategic clinical network, are building on the success of the joint children's cancer treatment centre to look at other services where closer collaborations will result in better services for patients. A website containing a directory of children's services across both hospitals is currently under construction and when complete will form a valuable resource for clinicians, parents and carers.

1.2.5. Enabling large scale change

We have made good progress across our six major capital business cases, central to our estate modernisation programme. For example, the development of a new Emergency Floor (encompassing a new emergency department and medical assessment unit) is now at the full business case stage. The vascular services outline business case - to consolidate cardiovascular services onto one site - has been approved by the NHS Trust Development Authority (NTDA) and is now progressing to full business case. This will see the development of a hybrid theatre – this will provide patients with access to enhanced, inter-operative imaging improve clinical outcomes and reduce the need for travel to out of region quaternary centres.

In terms of wider enabling work, progress against our Organisational Development Plan is going well. Examples include the:

- introduction of an 'Organisational Health Dashboard' for key HR indicators;
- involvement of the UHL Clinical Senate in developing medical leadership; and,
- introduction of value based recruitment processes.

We continue 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.

1.3. Plan for 2015/16

We have revised our strategic objectives and plan for 2015/16 to reflect our commitment to the vision set out in the Five Year Forward View and NHS England's headline goals in its business plan for 2015/16.

We engaged internal and external stakeholders in shaping our objectives and annual priorities, including the clinical senate, which informed a number of key amendments.

Strategic Objectives	Annual Priorities for 2015/16
1. Safe, high quality, patient centred healthcare	• Reduce our 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 Patient and Public Involvement Strategy

2. 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 (GH) • Improve the resilience of the Emergency Department (ED) in the evening and overnight • Reduce emergency medicine length of stay through better clinical and operational processes • Substantially reduce ED ambulance turnaround times
3. 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
4. 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
5. 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
6. A caring, professional and engaged workforce	• Accelerate the roll out of LiA • 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

7. A clinically sustainable configuration of services, operating from excellent facilities	• Deliver the actions required for year two of the five year plan:
	  • Develop Site Development Control Plans for all 3 sites
	  • Improve Intensive Therapy Unit (ITU) capacity issues including transfer of Level three beds from Leicester General Hospital (LGH)
	  • Commence Phase one construction of the Emergency Floor
	  • Complete vascular full business case
	  • Commence enabling works indicated in the business cases
	  • Deliver outline business cases for
	    o Planned Treatment Centre
	    o Maternity
	    o Children's Hospital
	    o Theatres
	    o Beds
	  • Develop a major charitable appeal to enhance the investment programme
	  • Deliver key operational estates developments:
	    o Construction of the multi-storey car park
	    o Infrastructure improvements at Leicester Royal Infirmary (LRI) and GH
	    o Phase one refurbishment of wards and theatre

8. A financially sustainable NHS organisation	• Deliver the agreed 2015/16 Income & Expenditure (I&E) control total - £36m deficit • Fully achieve our CIP target for 2015/16 • Revise and sign off by Trust Board and NTDA of the Trust's five year financial strategy • Continue the programme of service reviews to ensure their viability
9. Enabled by excellent IM&T	• Prepare for delivery of the Electronic Patient Record (EPR) 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

1.3.1. System Alignment and Governance

The BCT programme brings together key partners across the local health and social care economy under one planning and delivery framework – this ensures transformational change is coordinated and well governed.

The BCT five year strategic plan is ambitious and provides a blueprint for the future configuration of services in LLR which will improve health and wellbeing outcome that matter to them our communities, enhance the quality of care and reducing cost across the public sector (to within allocated resources) by restructuring the provision of safe, high quality services into the most efficient and effective settings.

Our plan (to be smaller, more specialised) is critically interdependent to the delivery of the wider BCT plan, as well as the local authority Better Care Fund (BCF) programmes which seek to address increasing urgent care pressures.

Due to this interdependency, and following a Department of Health Gateway 0: Strategic Assessment[1], we have established an internal delivery programme (governance framework) to improve alignment between our internal transformation and reconfiguration activities and BCT / external activities. This governance framework also aligns CIP plans with BCT reconfiguration activities through a number of enabling cross cutting workstreams (see Appendix 1) with the major productivity projects - beds, outpatients, theatres and workforce.

This now provides the framework within which the Trust, Clinical Management Groups (CMG's) and specialties develop operational delivery plans. Governance arrangements have been put in place to monitor progress and mitigate risks to delivery with Executive input and oversight. We have also set up a Trust BCT Delivery Board as the mechanism to carry out this function and to align with the wider health economy BCT Programme.

Our focus in 2015/16 will continue to be on realising internal efficiencies and 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.

In light of more recent key drivers, we have made some revisions to the underpinning planning assumptions driven by:

1. Anticipated requirements of clinical standards
2. Publication of NHS England's Five Year Forward View (November 2014) and the Dalton Review (December 2014)
3. The challenge from the National Trust Development Authority (NTDA) to go "further, faster" to reconfiguration
4. Actions required in response to external reports
5. Service sustainability: The need to consolidate ITU services on grounds of clinical safety.

[1] The primary purposes of a Health Gateway Review 0: Strategic assessment, are to review the outcomes and objectives for a given programme of work (and the way they fit together) and confirm that they make the necessary contribution to government, departmental, NHS or organisational overall strategy.

1.3.2. Progress Anticipated in 2015/16

In delivering BCT and Trust objectives, we will progress a number of key schemes in 2015/16 including:

- **Emergency floor development** - the full business case is expected to be approved in May 2015 by the NTDA which will provide the funding to commence construction of the new emergency floor. This will be completed in two key phases:
  - Phase one (complete construction of new ED) will be operational in 2016/17.
  - Phase two (medical assessment units and complete construction) will be in place by 2017/18.
- **Consolidation of vascular services -** this involves the transfer of vascular surgery from the LRI to the GH. We will progress this at pace since it will vacate ward space at the LRI which will help facilitate the consolidation of ITU at the LRI, outlined below.
- **Consolidation of intensive therapy unit (ITU)** - the relocation of ITU (and associated clinical services that use ITU beds) from the LGH to the LRI and GH will take place by December 2015. The ITUs at the LRI and GH will be upgraded as part of the relocation and this will happen in two stages – an interim solution will be provided in 2015/16, followed by a long term upgrade. In order to accommodate the services (specialty bed requirement) that will also need to relocate from the LGH to the LRI, we will need to release a significant number of the existing wards at the LRI. This will be facilitated by the acceleration in the transfer of patients who no longer require acute care and can be managed in community settings (see accelerated out of hospital community care, below)
- **Single Children's Hospital**- an outline business case to provide a children's hospital with a single identity at the LRI will be developed in 2015/16.
- **Strategic partnerships** - we have 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 2015/16 we 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.
- **Ensuring a sustainable configuration of maternity services** – the model of care and preferred option will be subject to public consultation as part of the BCT programme in the autumn. We will then develop an outline business case.
- **Treatment centre** - our plans for the development of a treatment centre have been brought forward with work starting in 2015/16. Work will commence with the confirmation of which services will be provided in the treatment centre which will be located at the GH. This service development will be subject to public consultation as part of the BCT programme in the autumn following which the outline business case will then be developed in 2015/16. 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 RTT standard.
- **Accelerated out of hospital community care** (for patients no longer requiring acute intervention) is 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 Leicestershire Partnership NHS Trust (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.

2. Contract Arrangements 2015/16

We have agreed contracts for 2015/16 with local CCGs and with NHS England (for specialised services).

To support delivery of our plans, we have developed a collaborative contracting model / risk share framework with local CCGs, which includes tariff payments for elective activity, marginal payments for non-elective activity over the plan (no financial change if activity falls below the plan) and a block for other activity. This arrangement provides some stability and certainty over income and expenditure levels for each partner. This approach will encourage a focus on the necessary transformational change rather than the detailed transaction of contracting mechanisms.

For example, we have agreed four priority areas with LPT and LLR CCGs as part of the 2015/16 contracting round to ensure alignment of planning assumptions underpinning the BCT programme, commissioning intentions and organisational plans:

1. Bed movements to ensure more people are supported in the community and at home;
2. Urgent care models that support system sustainability by ensuring people are managed in the most appropriate clinical setting
3. Planned care delivered closer to people's homes; and,
4. Mental health access (including during crisis) and integration with physical health services.

Our contract with NHS England is the standard tariff contract.

3. Quality and Safety 2015/16

3.1. Quality Commitment

Our 'Quality Commitment' defines our approach to quality improvement and reflects the largely positive findings of the 2014 CQC inspection.

We have 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.

Each clinical service sets annual quality priorities aligned to 14 strategic quality goals agreed across the Trust. Our Trust Board sets annual quality priorities, drawing these from patient and stakeholder feedback, national standards, and local CQUIN and contract requirements. The agreed priorities then 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.

A key area of focus for 2015/16 is to make progress against five of the 7 day service standards. In 2015/16 the Trust we will focus its efforts on:

1. CS01 – patient experience
2. CS04 – handover
3. CS06 – intervention/key services
4. CS09 – transfer to community, primary and social care
5. CS10 – quality improvement

3.2. LLR Quality Review and the Sturgess Report

Following the publication of the LLR Quality Review, commissioned to identify areas where care quality delivered across the healthcare system could be improved, we have developed new quality action plans.

To ensure quality initiatives were fully aligned across the healthcare system, a multi-partner 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.

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.

Recommendations / priorities included:

- **Admission avoidance** – ensuring people receive care in the setting best suited to their needs rather than the ED. 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** – reducing waste, maximising efficiency, and improving flow
- **Discharge processes across whole system** - ensuring there are simple discharge pathways with swift and efficient transfers of care.

The quality action plans respond to both reviews and the new governance structure to support changes has been integrated within the wider BCT programme.

4. Delivery of operational performance standards 2015/16

We will continue to place high priority on delivery of operational performance standards.

In doing so, we will continue to work with partners across LLR through the BCT programme to improve operational performance standards in the short, medium and long term – this reflects the system wide effort needed to deliver NHS Constitution Standards. Improving discharge processes remains key, and greater numbers of external partners are in-reaching into the Trust to support earlier transfer of care when patients no longer require acute hospital care.

We will also continue to make improvements to our internal process through service reviews, the CIP programme and the four cross cutting workstreams (see appendix 1). 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.

Weekly delivery meetings between executive directors and CMG operational and clinical leads will continue throughout 2015/16 to ensure transparency, challenge and confirm and, where needed, development of recovery plans as part of the wider performance arrangements.

5. Workforce plans

Our workforce plan for 2015/16 reflects the immediate demand for Trust services (and the need to ensure adequate staffing is in place to deliver key performance standards such as the 4 hour ED target, RTT and cancer standards) and our CIP. Our plan shows that the closing position for worked whole time equivalents (WTE) for March 2015 was 11336. The closing position for the end of March 2016 is expected to be 11341 WTEs, which is an overall growth of 5 WTEs.

CIP schemes are included within this change in WTE with the principle initiatives relating to theatre and bed productivity efficiencies. We have also invested in our workforce across several areas to account for increased clinical acuity, ED Assessment Bays (to ensure improved patient flow) and investment to ensure a sustainable trauma service. Reconfiguration programmes linked to BCT are currently in progress and plans will be amended to reflect changes arising from these assumptions later in the year.

We are focused on reducing the dependency on agency staff and recruiting on a substantive basis with new roles (advanced practitioners, assistant practitioners and physician associates) where appropriate. This will enable us to reduce the average cost per WTE. There are robust performance management arrangements in place to ensure that local areas deliver against our agreed premium spend reduction trajectories.

In addition, a workforce cross cutting theme has been established to identify mechanisms which enable cross CMG processes and initiatives to improve workforce efficiency i.e. reduction in premium pay spend, improved efficiency of job planning and maximisation of electronic rostering implementation. This will ensure that robust processes are in place to identify further workforce CIP opportunities, proportionate to the size of our paybill.

Key to delivery of a successful workforce model will be the continued focus on staff engagement and support through Listening in to Action (LiA); our actions resulting from analysis of the staff feedback (survey / friends & family) and consultation with staff / staff side.

6. Financial and investment strategy (including Cost Improvement Programme)

6.1. Financial Plan for 2015/16

Our financial plan for 2015/16 is to deliver a planned deficit of £36.1m, which is consistent with year two of our five year financial plan and assumes the following:

- Tariff deflation and cost inflation are as per the Enhanced Tariff Option.
- 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.

Unfortunately, our financial plans for 2015/16 will not deliver statutory duties due to the planned deficit position.

We continue to monitor CMG and Directorate performance closely on an ongoing basis to ensure cost control.

6.2. CIP 2015/16

Our CIP target for 2015/16 is £41m plus a further £2.3m to fund cost pressures.

Our Chief Nurse and Medical Director review CIP schemes to ensure there is no impact on patient safety or quality of care or that mitigating actions are sufficient (and in place) to reduce any detrimental effects to front line services.

Building upon the success of the cross cutting workstreams in 2014/15, we will focus on four high impact areas in 2015/16:

1. Beds;
2. Outpatients;
3. Theatres; and,
4. Workforce.

The combined contribution of these Trust wide workstreams will deliver circa 30% of the overall savings target. Each workstream is led by an Executive Director.

Our financial plan assumes the full delivery of £41m CIP savings, plus the £2.3m of cost pressures.

7. Longer term financial sustainability, income, costs, activity, capital and risk mitigation

Our LTFM, developed to reflect our five year plan, shows a 2014/15 planned (and delivered) deficit of £40.7m reducing to c£30m by 2018/19, primarily as a result of increasing productivity and efficiency. The final £30m is associated with the estates modernisation and the consolidation of acute services onto two sites (from three) to deliver the benefits described in our clinical strategy and release revenue costs.

This is a hugely ambitious plan within the context of national planning assumptions but one which all local health economy partners are signed up to (including the timeframe) through BCT.

Our financial plan for 2015/16 is in line with our original trajectory, at a bottom line level, in that the five year plan had a deficit of £36.1m in 2015/16 and that is what is now planned for the year ahead.

In addition, as an active partner in the BCT programme, we have 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 our LTFM.

8. Plans to improve efficiency and productivity through the more effective use of information and technology

We are investing in information technology at an operational and strategic level to support improvement in efficiency and productivity.

At a strategic level, we have selected our preferred partner for an Electronic Patient Record (EPR). This will move in to implementation in 2015/16.

At an operational level, we have purchased QlikSense which facilitates the monitoring, analysis and presentation of information to support:

- Patient outcomes and safety;
- Patient experience;
- Clinical staff resourcing;
- Quality schedule and CQUIN indicators; and,
- Performance management and financial management.

This will empower 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.

We also have access to a range of benchmarking tools including CHKS and Healthcare Evaluation Data (HED). Both are on-line tools which help identify clinical and productivity opportunities by comparing our performance with that of other NHS Trusts.

9. Organisational relationships and capability

As stated previously, our five year plan is set within the wider context of the LLR BCT programme – therefore, engagement with stakeholders has primarily been under the auspices of BCT.

Along with other NHS and social care organisations, we have 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.

10. Development priorities and actions that the Trust is taking to meet its development needs

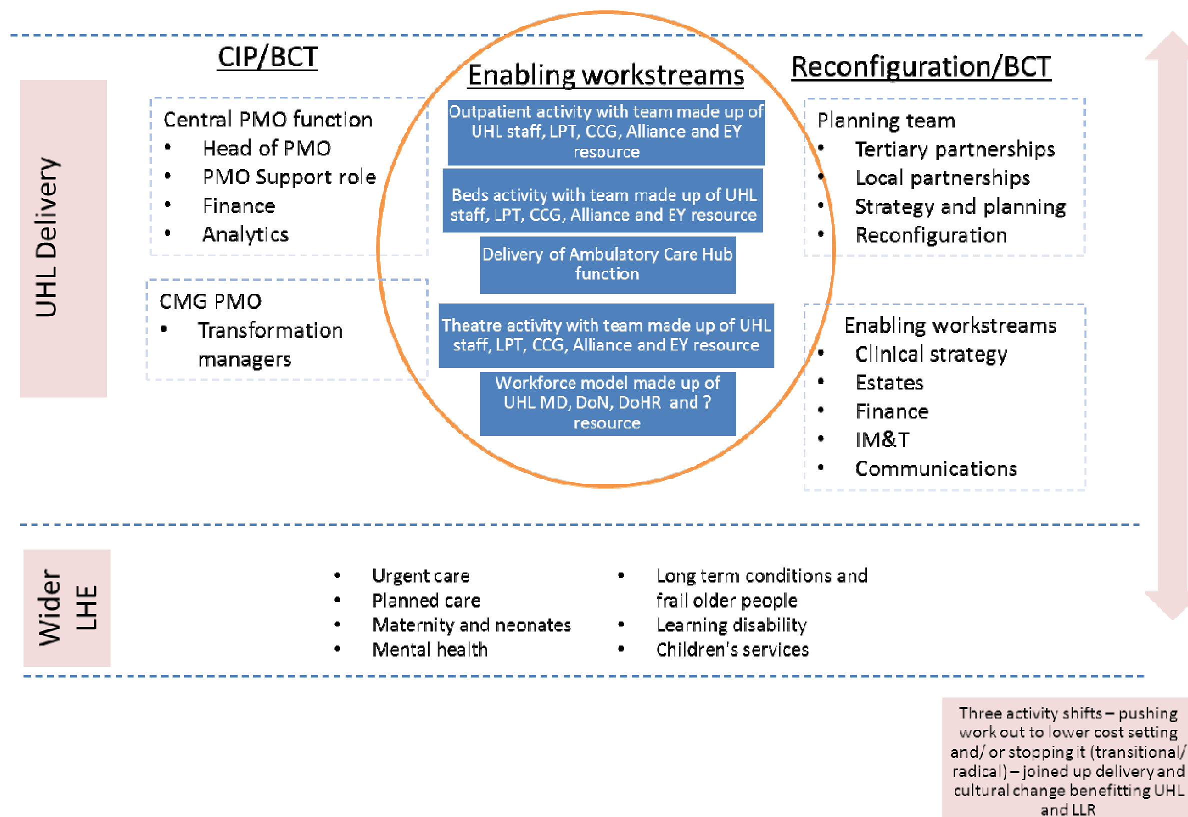
The key headlines can be summarised as follows:

Development Priority	Planned Action
1. Trust Board development- embedding Board disciplines	Secure resources for coaching and training to produce shorter reports, informed by analysis and identifying key issues to be addressed
2. Clinical leadership	Work with NHS Improving Quality (NHS IQ) and the Leadership Academy in developing structures and process for 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
3. Culture and behaviours in teams	Develop a programme brief that describes the scope of change planned, the anticipated benefits and outcomes of the five-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
4. Patient & Public involvement	Consider ways to ensure more time and resource is available to (or within) CMGs as part of our reconfiguration process to free up staff time to engagement activities (within the Trust and across the wider community); seek support and guidance from NHS England in further developing our 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.
5. Financial sustainability	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
6. Improvement & Innovation methodology	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 five year plan Consider participation (via application process) in the NTDA's development programme for quality improvement.

END

Appendix 1



Appendix 2

UHL Major Business Cases

Major Business Cases	2015/16 £k	2016/17 £k	2017/18 £k	2018/19 £k	2019/20 £k	Total £k	OBC Internal start	OBC Internal Approval	OBC Sent to TDA	OBC Approved by TDA	FBC Internal Approval	FBC Sent to TDA	FBC Approved by TDA	Construction Start	Construction Complete
Emergency Floor	17,698	18,341	353	-	-	**36,392**				Mar-15	Apr-15	Apr-15	May-15	Jun-15	Dec-16
ICU interim solution & Vascular Hybrid Theatre	9,778	2,322	-	-	-	**12,100**		tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc
Treatment Centre	5,000	7,000	25,000	16,000	5,000	**58,000**	Mar-15	Jan-16	Jan-16	Mar-16	Jul-16	Jul-16	Sep-16	Oct-16	Jul-19
ITU LRI	-	-	14,000	2,000	-	**16,000**	Oct-15	Mar-16	Apr-16	Jun-16	Dec-16	Jan-17	Mar-17	tbc	tbc
Women's services	1,000	26,200	26,600	12,100	-	**65,900**	Mar-15	Mar-16	Mar-16	May-16	Dec-16	Dec-16	Feb-17	Mar-17	Mar-19
Multi Storey Car Park LRI	4,229	-	-	-	-	**4,229**					May-15	N/A	N/A	Jun-15	Dec-15
Childrens' Hospital	400	3,600	4,000	9,000	-	**17,000**	Jan-15	Jun-15	Jul-15	Sep-15	Mar-16	Apr-16	Jun-16	tbc	tbc
Interim EMCH	3,500	-	-	-	-	**3,500**	tbc	tbc	N/A	N/A	tbc	N/A	N/A	tbc	tbc
Theatres LRI	1,650	4,000	7,000	-	-	**12,650**	Jan-15	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc
Entrance LRI	-	-	2,000	10,000	-	**12,000**	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc
Wards/Beds LRI	2,000	8,000	10,000	2,000	-	**22,000**	Jan-15	Jun-15	Jul-15	Aug-15	Jan-16	Feb-16	Mar-16	tbc	tbc
Wards/Beds GH	6,000	9,000	15,000	-	-	**30,000**	Jan-15	Jun-15	Jul-15	Aug-15	Jan-16	Feb-16	Mar-16	tbc	tbc
Identified reconfiguration projects	**51,255**	**78,463**	**103,953**	**51,100**	**5,000**	**289,771**									
Imaging GH	3,000	3,000	-	-	-	**6,000**	tbc	tbc	N/A	N/A	tbc	N/A	N/A	tbc	tbc
Outpatients LRI	-	-	3,000	2,000	-	**5,000**	tbc	tbc	N/A	N/A	tbc	N/A	N/A	tbc	tbc
Pathology GH	-	-	3,000	-	-	**3,000**	tbc	tbc	N/A	N/A	tbc	N/A	N/A	tbc	tbc
Supporting infrastructure	-	4,000	4,000	-	-	**8,000**	tbc	tbc	N/A	N/A	tbc	N/A	N/A	tbc	tbc
Other reconfiguration projects	**3,000**	**7,000**	**10,000**	**2,000**	**-**	**22,000**									
EPR Programme	33,511	22,091	463	-	-	**56,065**		N/A	N/A	N/A	Nov-14	Dec-14	Jun-15	N/A	N/A
Other major business case capital expenditure	**33,511**	**22,091**	**463**	**-**	**-**	**56,065**									
TOTAL MAJOR BUSINESS CASE CAPITAL	**87,766**	**107,554**	**114,416**	**53,100**	**5,000**	**367,836**									

Note: timelines based on understanding of NTDA timescales, further clarification of DH/Treasury approvals process needs to be factored in.

Operational Capital Business Cases	2015/16 £k	2016/17 £k	2017/18 £k	2018/19 £k	2019/20 £k	Total £k
Facilities Sub-Group	5,355	6,000	6,000	6,000	6,000	**29,355**
MES Installation Costs	1,500	1,500	1,500	1,500	1,500	**7,500**
Aseptic Suite	440	-	-	-	-	**440**
Lloyds Pharmacy Extension	126	-	-	-	-	**126**
Theatre Recovery LRI	2,750	-	-	-	-	**2,750**
Life Studies Centre	850	-	-	-	-	**850**
IM&T Sub-Group	4,000	5,570	8,000	6,000	6,000	**29,570**
Managed Print	1,323	-	-	-	-	**1,323**
EDRM	3,000	-	-	-	-	**3,000**
Safecare Software System	58	-	-	-	-	**58**
Electronic Blood Tracking System	996	-	-	-	-	**996**
Medical Equipment Executive Budget	5,500	6,000	6,000	6,000	6,000	**29,500**
Linear Accelerators	3,000	1,775	-	500	1,750	**7,025**
Relocation of ICU level 3	3,000	-	-	-	-	**3,000**
Donations	300	300	300	300	300	**1,500**
LiA Schemes	250	250	250	250	250	**1,250**
Contingency	1,671	3,905	250	9,750	10,500	**26,076**
TOTAL OPERATIONAL CAPITAL	**34,119**	**25,300**	**22,300**	**30,300**	**32,300**	**144,319**
TOTAL CAPITAL EXPENDITURE	**121,885**	**132,854**	**136,716**	**83,400**	**37,300**	**512,155**
Funded by:						
CRL operational capital	33,819	25,000	22,000	30,000	32,000	**142,819**
CRL contribution to reconfiguration	-	7,000	10,000	2,000	-	**19,000**
Capital receipts	-	-	-	-	28,350	**28,350**
Internal capital resource	**33,819**	**32,000**	**32,000**	**32,000**	**60,350**	**190,169**
Donations	300	300	300	300	300	**1,500**
External borrowing	87,766	100,554	104,416	51,100	(23,350)	**320,486**
External capital resource	**88,066**	**100,854**	**104,716**	**51,400**	**(23,050)**	**321,986**
TOTAL CAPITAL FUNDING	**121,885**	**132,854**	**136,716**	**83,400**	**37,300**	**512,155**
	-	-	-	-	-	-

Other outstanding issues

Beds reduction profile/plan
Support accomodation
Medical equipment
Internally generated funding likely to increase as result of capital expenditure increase - not included in the plan
Affordability of contribution from CRL
Measure of total level of borrowing possible
Financial benefits of above programme need to be more clearly linked to business cases
- backlog maintenance
- contribution to efficiency improvements
- link to key capacity metrics - i.e. number of beds, theatres and consulting rooms