Luton and Dunstable University Hospital NHS Foundation Trust

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

CLINICAL EXCELLENCE, QUALITY & SAFETY

Luton and Dunstable University Hospital NHS Foundation Trust

Operational Plan 2016/17

18th April 2016

Published

1. Overview

This document updates our 2014-2019 Strategic Plan and our 2014-2016 Operational Plan. It will also reference our 2015/16 Annual Report and later drafts should be read in conjunction with the same.

The Trust's Strategic and Operational Plans are underpinned by seven Corporate Objectives.

1. **Deliver Excellent Clinical Outcomes**
    - Year on year reduction in HSMR in all diagnostic categories

2. **Improve Patient Safety**
    - Year on year reduction in clinical error resulting in harm
    - Year on year reduction in Hospital Acquired Infection

3. **Improve Patient Experience**
    - Year on year improvement in patient experience demonstrated through hospital and national patient survey, leading to upper quartile performance

4. **Deliver National Quality & Performance Targets**
    - Deliver sustained performance with all CQC outcome measures
    - Deliver nationally mandated waiting times & other indicators

5. **Implement our New Strategic Plan**
    - Deliver new service models:
        - Emergency Hospital (collaborating on integrated care and including hospital at home care)
        - Women's & Children's Hospital
        - Elective Centre
        - Academic Unit
    - Implement preferred option for the re-development of the site.

6. **Secure and Develop a Workforce to meet the needs of our Patients**
    - Develop and monitor the delivery of a comprehensive recruitment programme for all staff groups. The programme will incorporate a work plan focussing on retention.
    - Ensure a culture where all staff understand the vision of the organisation and a highly motivated to deliver the best possible clinical outcomes.
    - Deliver excellent in teaching and research as a University Hospital. Ensure that all staff have access to appropriate education and facilities to maintain their competence.

7. **Optimise our Financial Plan**
    - Deliver our financial plan with particular focus on the implementation of re-engineering programmes

The updated plan sets out:

- How we will achieve further progress against our Strategic Plan in 2016/17
- Our key deliverables to ensure that we are able to maintain operational performance during the year
- How our plans are underpinned by our financial projections

1.1 The Sustainability & Transformation Plan

L&D is keen to play a leading role in restoring the clinical and financial sustainability of the local health and social care system. We are now centrally involved in planning and executing transformational change across a planning footprint covering the resident populations of Bedfordshire CCG, Luton CCG, and Milton Keynes CCG (BLMK patch).

Other key players who are central to transformation over this footprint include (but are not limited to) the three CCGs and the two other secondary care NHS providers, namely Bedford Hospitals NHS Trust and Milton Keynes University Hospital NHS Foundation Trust.

L&D is also looking forward to the close and active involvement from the four local authorities (Luton Borough Council, Central Bedfordshire Council, Bedford Borough Council and Milton Keynes Council) in the transformation planning and implementation process. Equally, given BLMK's distance currently from clinical and financial equilibrium, L&D expects NHS England and NHS Improvement to provide an active oversight and challenge role to ensure that planning and executing the necessary transformation in BLMK proceeds expeditiously.

In line with NHS England's planning guidance, a Sustainability and Transformation Plan (STP) is to be produced for BLMK by the end of June 2016 and Pauline Philip has been appointed STP lead.

Following an examination of the current disposition of health and social care need, demand and supply in and around BLMK, L&D expects the STP to make radical recommendations that lead to:

- Service reconfiguration of hospital and out-of-hospital care currently delivered in BLMK by the three secondary care Trusts, a number of mental health and community primary providers and GPs.
- The introduction of a "new models of care" (NMOC) approach to population health management across BLMK, leading to a recalibration of how risks are handled in the local health system, and a redrawing of the traditional boundaries between commissioning and provision, potentially via the introduction of some form of ACO vehicle.

L&D envisages a **four-stage** process, moving from planning through to mobilisation of new ways of working and execution of all associated transformation plans. The four stages can be summarised as follows:

i. **Stage 1** – examine the nature and "scale of benefits" that is within the reach of the local BLMK health system by better management of health needs and associated demand, and by reconfiguring services in BLMK (across primary, community (social) and secondary care). Go on then, to identify the key transformational activities needed, the associated steady-state costs of a post-transformational system in BLMK and the investment required to achieve that new equilibrium.
ii. **Stage 2** – complete the design and development work necessary to radically change how risks arising in the local health system are managed. The aim is to ensure that these risks are more closely aligned with the organisations that either control them, or can significantly influence them. This is expected to lead to the re-engineering of the traditional commissioner-supplier interface, with potentially a new delivery vehicle being introduced which possesses all the appropriate levers available to effectively manage the risks allocated to it.
iii. **Stage 3** – implement the new delivery models and, in so doing, restructure incumbent commissioners (CCGs) and providers (NHS Trusts) so that their organisational and commercial structures (and competences) are fit for purpose in the light of their radically revised functions. This is likely to demand workforce and service consultation exercises.
iv. **Stage 4** – deliver the transformation activities identified and achieve, over the agreed period (which will be measured in months and years), achieve a new and sustainable clinical and financial equilibrium in BLMK.

The STP has therefore embarked on a planning process designed to enable the BLMK health system to achieve **Stages 1** to **3** inclusive during 2016/17[1]. This process breaks down into a number of key activities namely:

i. Designing and initiating the BLMK STP programme superstructure, including programme governance, management and resourcing.
ii. Designing and developing the four stage work programme (see above) in outline, with immediate and detailed planning for **Stage 1**.

[1] **Stage 4** covers the totality of the transformation activities and therefore, is likely to span a number of years following planning and mobilising the new delivery model.

iii. Identifying, sourcing and mobilising programme delivery resources.
iv. Implementing **Stage 1** of the STP programme (whilst exercising programme governance and associated management controls).

A more detailed analysis of these activities, along with the issues and tasks that each activity surfaces, and which needs to be addressed, is available.

2. Delivering our 2016/17 Operational Plan

Our key deliverables and quality priorities underpin the delivery of our corporate objectives. As with our strategic objectives, the Executive Board is accountable for the management of delivery, performance is monitored by the Board of Directors and reported to the Council of Governors. Performance against 2015/16 deliverables will be reported in our Annual Report.

2.1 Key Deliverables 2016/17

The following key deliverables have been agreed for 2016/17:

2.1.1 Developing our Workforce

Workforce Planning

The Trust takes a robust approach to workforce planning with a real emphasis on clinical engagement. Through the process there is engagement with clinical leads to understand service and workforce needs so they are balanced with finances. Workforce planning is culturally an integral part of service development and the budget setting process. Comprehensive job planning and safe staffing reviews (safer nursing care tool based on the Shelford Group methodology) are used to balance the quality of care with financial resources and all workforce plans are approved within the Divisional Boards that are made up of clinical leaders with oversight from the Executive Board.

- **The governance process for Board approval of workforce plans**
  All workforce plans are aligned to the Trust Annual and Workforce Plans and are approved via the divisional management structure before review and approval from Director of HR, Chief Nurse, Director of Finance, Managing Director and Chief Executive.

- **Link to clinical strategy and local health and care system commissioning strategies**
  Workforce plans are predicated on the Trust's Clinical Services Strategy, Five Year Plan and annual plans. The Trust is a core member of the Health Education England (HEE) Bedford and Hertfordshire Workforce Planning Group (WPG). The Trust has a Recruitment Oversight Group (ROG) which uses a workforce forecast tool that takes into account vacancies, turnover, potential retirements, long term absences, workforce developments and staff working their notice to inform recruitment activity and future workforce needs.

- **Links with local workforce transformation programmes and productivity schemes, including impact on workforce by staff group**
  The Trust engages with local workforce transformation through the WPG Transformation Programme work streams.

The effective use of e-rostering and reduction in reliance on agency staffing

The Trust recognises that the delivery of high quality, compassionate care relies on having the right people, with the right skills, in the right place at the right time. The provision of a well-planned staff roster, based on the needs of our patients matched to the resources available is fundamental to ensure the delivery of safe effective care. The Trust has largely implemented eRostering across the bed base and Theatres and uses real-time data to ensure rosters maximise the effective use of resources and inform operational workforce needs. Rosters are developed based on service needs within budgeted establishment and data is used at quality and workforce meetings three times per day where resources are balanced across all ward areas to maintain the quality of care and minimise the use of agency.

The Trust has undertaken a number of pieces of work to reduce the reliance on agency workers including enhanced safe staffing escalation policy, skills mix redesign, overseas recruitment, bank recruitment and bank incentives. The Trust is working in partnership with Trusts across Bedfordshire and Hertfordshire to ensure there is a strong regional approach and parity for the implementation of the NHS Improvement agency rate caps and rules.

Alignment with Local Education and Training Board plans to ensure workforce supply needs are met

The Trust is committed to valuing our Band 1-4 staff and is particularly focusing on apprenticeships to up-skill existing and new staff and to provide career progression pathways. Individuals that are new to care and are in roles that involve direct patient/service user contact, are required to undertake the Care Certificate (a transferrable record of competence in fundamental care). Apprenticeships are available for staff in clinical and non-clinical roles and can be undertaken at various Qualifications Credit Framework (QCF) levels from 2 to 5. The Trust has introduced a band 4 Assistant Nurse Practitioner role that reduces reliance on agency workers and provides a bridge and clear career pathway for Nursing.

As a Local Education Provider (LEP) of Health Education England (HEE) the Trust works collaboratively with HEEEoE to fill medical and dental vacancies on a prospective basis at national and regional level.

Triangulation of quality and safety metrics with workforce indicators to identify areas of risk

The Trust uses a monthly Harm Free Care Dashboard to triangulate quality and safety metrics with workforce indicators which is reported to the Clinical Outcomes, Safety and Quality Committee (COSQ), a subcommittee of the Trust Board. The Divisional Boards monitor and review quality, safety and workforce data and a Safe staffing report is reported directly to the Trust Board.

Application and monitoring of quality impact assessments for all workforce CIPs

All CIPS are approved through the Divisional Boards which have appropriate clinical representation. The Divisional CIPs are then approved by the Finance, Investment and Performance Committee which includes the Medical Director with the specific remit to ensure quality is not impacted.

Balancing of agency rules with the achievement of appropriate staffing levels

The Trust holds workforce staffing meetings three times per day in the Control Room and uses a RAG rating tool to assess risk levels and take action to balance resources across the Trust. At this meeting all gaps are considered and the use of agency is considered to ensure achievement of safe staffing using the “break glass” procedure defined in the agency rules. The Trust is working in partnership with providers across Bedfordshire and Hertfordshire to ensure there is a strong regional approach and parity for the implementation of the NHS Improvement agency rate caps and rules.

Systems in place to regularly review and address workforce risk areas

The WPG collates regional information and uses this to inform key workforce development workstreams that address areas of risk. In addition, the following systems are in place to regularly review and address workforce risk areas: Safe Staffing reports to the Board, Divisional Boards, Recruitment Overview Group, Nursing and Midwifery Board and Matrons meetings (led by the Chief Nurse).

2.1.2 Staff Ownership and Engagement

At the heart of L&D is a culture of staff ownership and involvement. This culture is nurtured by a comprehensive range of communication and engagement activities. Particularly important are the large scale, trust wide ‘Good, Better, Best events’ where all staff come together to agree quality priorities and monitor progress in improving clinical outcome, patient safety and patient experience. These events will continue to take place twice a year.

2.1.3 Implementing Needs Based Care

Building on the scoping work undertaken in 2015/16 we will ;

- Redesign the inpatient medical specialty and elderly medicine wards to reflect a needs based approach to care delivery
- Provide a model that delivery improved continuity of care for all patients without restricting patient choice
- Roll out of Integrated Care for Complex needs patients
- Align all elderly care consultants to GP Clusters
- Introduce more “hot clinics” to improve Primary Care Access to same day or next day patient consultation for expert clinical advice
- Development of diagnostics at the time of need

2.1.4 Reduce the number of patients remaining in hospital who are medically fit for discharge

The Trust has developed an Integrated Discharge Team that facilitates cross system working, fostering good working relationships across health and social care . Further work is now in progress to reduce the number of patients remaining in hospital who are medically fit for discharge. This will be achieved by:

- Developing a Patient Tracking List approach to monitoring each patient delay.
- Setting up a weekly Senior Manager PTL to identify cause of delay
- Develop clear escalation processes with Health and Social Care partners and agree KPIs

2.1.5 Delivering Emergency Care

During 2016/17, L&D will work with partners and external stakeholders to deliver the vision set out in the NHS Urgent & Emergency Care Review. It is our intention to advance the delivery of an integrated access hub and to gain support for the development of an escalation ED as a fundamental component of the hospital provider response.

2.1.6 Delivering Diagnostics at the Time of Need

Our delivery of diagnostics is undergoing radical transformation with the increased capacity and expansion of operational services in both Imaging and Pathology. The Pathology diagnostic service, already 24/7 is being further transformed, new clinical bio-chemistry analysers are now in place, and the procurement of a replacement laboratory information management system (LIMS) and investment in Microbiology automation to drive improved on site diagnostic turn around times.

Imaging services have expanded into evenings and weekends across all four main Imaging modalities, supporting improved timeliness of in-patient and out-patient scanning, expanded out of hours in-patient reporting capacity and investment in reporting radiographers with specialist skills in plain film reporting. The Imaging department is supporting the Trust's performance in meeting hyper-acute stroke and trauma network standards with new state of the art CT scanners in place in 2015/16, and working in collaboration with Cardiology, the new CT coronary angiography service which commenced in April 2015. This next year will see maternity ultrasound facilities being set up in the community and an MRI efficiency project to improve throughput.

2.1.7 Delivering our Re-Engineering Programme

Building on transformation of Theatre efficiency and patient records, re-engineering will continue to be an Executive focus. The programme will drive forward key priorities in the delivery of Needs Based Care, and the continued improvements being delivered by Outpatient Re-Engineering. The programme will also support the production of our Health System Sustainability and Transformation Plan.

2.1.8 Sustaining our Performance

The ability of the organisation to maintain operational performance whilst focussing on strategic planning is a tremendous strength. This will continue to be important as we engage with our regulators and partners in developing and implementing the STP. We will, as in previous years, continue to constantly review and evaluate the processes that we have in place to ensure effective delivery.

2.1.9 Delivering our Redevelopment Programme

In October 2015, the Trust Board completed the OBC for the redevelopment of the site and agreed to proceed with an option based on re-development of the existing site against a target cost of £150m. The proposed scheme includes a new clinical block which will provide critical care facilities, additional operating theatres, a Neonatal Intensive Care Unit, a new delivery suite and improvements to outpatient facilities. The existing Emergency Department will be substantially expanded and refurbished. Importantly, the programme will also ensure that patient experience is greatly improved by integrating all clinical blocks into a 'single hospital'. Maintenance issues in other buildings on the site will also be addressed. The Trust commenced the first phase of the programme in 2015/16 with the creation of a urology one-stop clinic, a new orthopaedic hub, two modular theatres, and new wards on the ground floor of the St Mary's PFI and the general upgrading of a number of wards and communal areas. A design team, led by AECOM, were appointed to deliver the next stage of the design for the clinical block. This work was completed in March 2016

In 2016/17, the Trust will continue the project with proposals for the development of an energy centre and the ongoing refurbishment of inpatient wards. Work on the development of the Full Business Case for the redevelopment scheme will resume when the outcome of the STP for the Bedfordshire, Luton and Milton Keynes area is known.

2.2 Improving Quality

2.2.1 Key Clinical Outcome Priorities

- **Improve the management of patients with Acute kidney injury (AKI)**

AKI is a sudden reduction in kidney function. As well as being common, AKI is harmful and often preventable, thus representing a major patient safety challenge for health care. It is a major factor in increasing patients' length of stay and can contribute to significantly increased mortality. This was a key priority for the Trust last year where we focused on implementing a Trust wide electronic system to improve detection, developed an AKI management care bundle and improved AKI diagnosis and treatment. Building on this work, there are three key priorities for this year. These will focus on:

- Working collaboratively with UCLP, (as part of our sign up to safety work), to devise optimum 'standards for recognition and treatment' of AKI.
- Improving the use of fluid balance charts to ensure an accurate record of fluid intake and output and an early escalation score.
- Providing a plan of care for the GP to monitor kidney function after discharge.

- **Improve the management of patients with severe sepsis**

Sepsis is a common and potentially life threatening condition where the body's immune system goes into overdrive in response to infection. Sepsis is recognised as a significant cause of mortality and morbidity in the NHS. Problems in achieving consistent recognition and rapid treatment of sepsis are currently thought to contribute to the number of preventable deaths from sepsis. Early detection and effective management of patients presenting with sepsis will reduce morbidity and mortality of patients presenting as an emergency admission with this condition. The Trust will build on the work commenced in emergency care in 2015 with a particular focus on:

- Embedding the timely delivery of the sepsis bundle to all patient groups presenting as an emergency

- Implementing the use of the sepsis screening tools for ward based patients who develop sepsis as an inpatient
- Commencing rollout of the sepsis care bundle to patients developing sepsis as an inpatient

- **Improve our approach to Mortality surveillance, identifying and reducing avoidable deaths**

The Trust's 12 month rolling HSMR is still statistically high, but the monthly trend has seen 5 consecutive months of improvement within expected ranges. It is likely that the 12 month HSMR will remain elevated until the particularly high values seen in January, April and May 2015 fall out of the indicator. This monitoring and reduction of our HSMR remains a critical priority in the year ahead. The Trust Mortality Board will oversee the delivery of:

- The refinement and embedding of our ongoing review of all mortality to identify avoidable deaths. This aligns with the national initiative by Sir Bruce Keogh, to which we will continue to report our findings.
- The Trust's ongoing data mining for significant trends and correlations within our clinical information. Using external benchmarks particularly the newly available SHMI by diagnosis type, we will review all areas of concern.
- Responding to the findings of the upcoming external quality assurance of our mortality surveillance processes, and our response to several months above expected range in early in 2015.

In this manner the Trust intends to improve our benchmarked mortality to the upper quartile of performance.

- **Reduce our antibiotic consumption**

Antimicrobial resistance (AMR) has risen over the last 40 years and inappropriate and overuse of antimicrobials is a key driver. The number of new classes of antimicrobials coming into the market as reduced in recent years and between 2010 and 2013, the total antibiotic prescribing has increased by 6%. This leaves the prospect of reduced treatment option when antimicrobials are life-saving and standard surgical procedures could become riskier with widespread antimicrobial resistance. Therefore, the Trust has an AMR CQUIN that:

- Aims to reduce total antibiotic consumption and also the reduction in the use of certain board-spectrum antibiotics.
- Focuses on antimicrobial stewardship and ensuring antibiotic review within 72 hours

2.2.2 Key Patient Safety Priorities

- **Ongoing development of Safety Thermometer, improving performance year on year**

The NHS Safety Thermometer continues to provide nurses with a point of care survey tool to check fundamental levels of care identify where things go wrong and take prompt action. It is used by nurses to measure and track the proportion of patients in our care with pressure ulcers, urinary tract infections, VTE and who have incurred a fall and sustained harm. In addition to collection of this prevalence data, the Trust will also continue to monitor and improve the incidence of these key harms.

- ***Pressure Ulcers.*** The Trust will continue to reduce the numbers of category 2&3 hospital acquired avoidable pressure ulcers. Having achieved a 65% reduction in incidence from hospital acquired grade 3 pressure ulcers over the last two years, the focus for 2016 will be further reducing grade 2 pressure ulcers. This will be achieved through supporting and educating nursing staff across the organisation on the early identification, prompt validation and subsequent management of skin breakdown and continually learning through the Root Cause Analysis (RCA) process. The Tissue Viability team will also continue to participate in the countywide pressure ulcer group to share learning to enable a further reduction of both community and hospital acquired pressure ulcers.
- ***Falls.*** Whilst some falls are avoidable, reducing falls in an ageing and more frail population with complex health needs, is very challenging. To date the Trust has been successful in

reducing the overall number of falls and the challenge for 2016 is to reduce the number of falls that result in severe harm. This will involve improved risk assessment and management of the frail elderly and working closely with the Falls and Dementia nurse specialist on this more vulnerable group of patients.

- ***Catheter Related Urinary Tract Infections.*** We will aim to reduce the number of patients who develop a urinary tract infection through use of a urinary catheter. The focus during the year will be targeting areas where high use is noted.
- ***VTE.*** Hospital acquired Venous Thromboembolism (VTE) is an important patient safety issue resulting in significant mortality, morbidity and healthcare resource expenditure. In addition to ensuring that all relevant patients will be risk assessed, prescribed and administered the appropriate preventative treatment, the sharing of lessons learnt from any hospital acquired thrombosis will be the key focus.

- **Improve the management of the deteriorating patient**

The recognition of acute illness is often delayed and its subsequent management can be inappropriate. This is because clinicians' may fail to monitor, document or act on physiological abnormalities in a timely way, commonly described as "Failure to Rescue". This in turn leads to further deterioration in the patient's clinical condition and potential death. Although the Trust's average cardiac arrest rate continues to be lower than the national average, analysis of the cardiac arrests for 2015 -16 has highlighted some areas for improvement. This includes earlier identification of the deteriorating patient by timely and appropriate observations and prompt medical action to prevent further deterioration. This has been a key Trust quality priority for two years and this year the focus will be on:

- Improving the identification of the deteriorating patient that is dying. This will be enabled by increasing and improving the setting of appropriate ceilings of care, the use of Personal Resuscitation Plans and where appropriate and timely DNAPR. To achieve this objective it has been identified that it is necessary to provide training and education to senior medical staff. The training provided will need to cover guidance in having difficult conversations, and the legal and ethical position regarding DNARCP. The Trust are working closely with UCLP to deliver this training.

- **Further development of stroke services**

Central to the Trust strategy to become a 'Hyper-Acute Emergency' hospital, is to deliver optimum stroke care through further investment in our 'Hyper-Acute' stroke Unit. Following an increase in therapies staffing and an additional two Stroke Physicians, 2016 will focus on the recruitment of additional speech and language staff and a senior Clinical Nurse Specialist to improve nurse leadership and ensure all performance targets are met. Data capture for SSNAP will be improved to ensure that all activity and key clinical interventions are accurately recorded. More ambitiously, the senior nursing team in conjunction with the new specialist nurse will design a revised educational programme to train nurses in key competencies. Multi-agency working will focus on further developing our repatriation policy to improve direct access to the unit.

An important factor in the successful implementation of evidence-based stroke care will be the emphasis on staff taking ownership of how to translate the goals of various policies into practice. For example, the physiotherapists will be encouraged to perform their own team goal-setting and to devise their strategies for meeting targets such as the 72-hour assessment. The speech and language therapy staff will be involved in adapting guidelines to their own specific practice. A commitment to multidisciplinary team working underpins all these initiatives.

2.2.3 Key Patient Experience Priorities

- **Improve the experience and care of patients at the end of life and the experience for their families**

Improving End of Life Care is a priority if we are to ensure the best possible quality of care to our patients and their families. The most sensitive and difficult decisions that clinicians have to make are around the starting and stopping of potentially life prolonging treatment. There is a need to

encourage a culture change across the organisation. We need to be open to and not fearful of discussion regarding death and dying. Once these decisions are made, it is crucial that our patients receive optimum end of life care. The last two years have seen improvements in communication with patients and families, improved symptom management and spiritual care, investment in training and education and reduction in inappropriate cardiac arrests through more timely decisions regarding DNACPR.

This year, the focus will be on working with our community colleagues and our commissioners to ensure patients achieve their choice of 'place to die' and that this is achieved in a timely manner.

- **Ensure there are processes in place to sustain improvement in timely assessment, diagnosis and support for people with Dementia and Delirium**

Patients with Dementia and Delirium can have complex care needs. These care needs often challenge the skills and capacity of carers and services. It is essential therefore that we identify these patients early in their in-patient stay, provide good quality patient care and experience whilst they are in hospital and plan effectively with primary care for their discharge. This has been a key quality priority for the Trust for some years with improvements in timely assessment, referral, treatment and support for carers. 2016 will focus on delivering the Trust dementia strategy through the following priorities:

- Working with the primary care services (our GPs) to improve the information they receive from our Consultants. This will enable the GPs to prioritise those patients who are more complex and require immediate support in the community
- Ensuring that appropriate dementia training is available to all staff and work with the commissioners to deliver a collaborative training programme across the local health and care economy
- The impact of the environment on the person with dementia will be recognised as a fundamental influence on the wellbeing and recovery of the patient. The redevelopment of the hospital site will embrace dementia friendly design where appropriate by promoting an enabling and safe environment.

- **Completing the Roll Out of Partial Booking across the Trust**

Outpatients have successfully completed the pilot of partial booking in several specialties in Medicine and Surgery over the course of 2015/16. The initiative that has worked well for clinicians, business managers and most importantly, our patients. Partial booking has brought substantial benefits in terms of improved waiting list management and service capacity planning, reducing the multiple rescheduling of patient appointments and reducing DNA rates in these specific specialty areas.

This next year will focus on the roll out of the programme across the whole of the Trust, providing increased momentum to enabling the Trust to further improve efficiency in appointment scheduling and reduce the volume of missed appointments to 8%.

3. Activity Plan

The Trust seeks to work in close collaboration with its local Commissioners to ensure activity plans are fully aligned and realistically based.

3.1 Baseline activity

The Trust's activity plans for 2016/17 are based on forecast outturn activity. The outturn is built up from a granular level based on the Trust's actual activity. The granular backing for the forecast outturn is essential, as for 2016/17 the Trust and Commissioners have agreed to plan at HRG level. This will underpin the demand and capacity modelling of both the Trust and the CCG.

3.2 Activity Changes

The key drives of activity in 2016/17 are

- Rising demand - to date A&E attendances have risen by a small percentage, however activity has led to a more significant rise in emergency admissions with each month in 15/16 higher than the corresponding month in the previous year and particularly areas in paediatrics, surgery and elderly medicine. The joint plans with the health authority and CCGs to deliver a reduced emergency demand through an integrated care model is at the early stages of implementation.

- Elective activity - the Trust is continuing to experience gradual but continuing upward trend in GP referrals and is ready to increase its capacity in development to meet the demand to ensure that access targets are maintained;

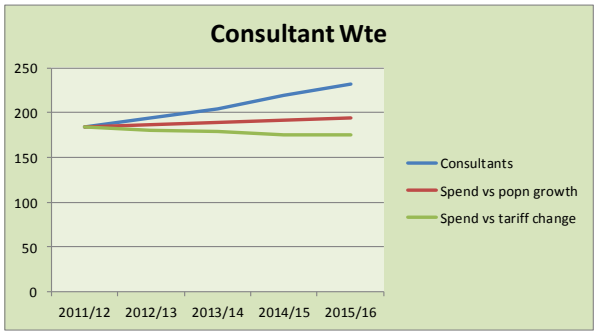
- Diagnostic working hours – the growth in demand for certain key modalities such as MRI is providing a challenge in ensuring that capacity can be maintained.

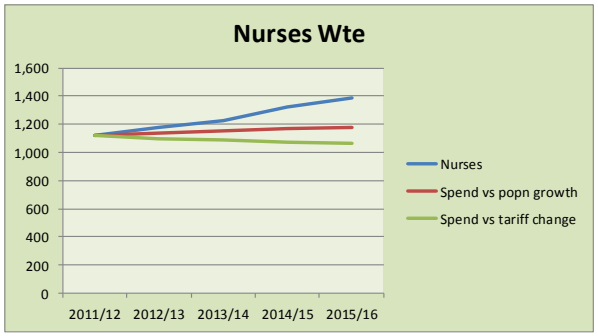
3.3 Capacity Planning

The Trust has a strong track record of delivery for all key operational standards without recourse to the independent sector and accordingly the Trust has submitted expenditure plans that allow the Trust to deliver the activity plans outlined in the Finance Planning section.

The most notable additions include an additional Theatre (on site from January 2016) and the creation of two new inpatient wards (the first completed in January 2016) to allow the Trust flexibility to meet anticipated activity levels.

Assessments of the likely workforce implications are also vital to ensure that all agreed plans can be delivered, and this is discussed in the workforce planning section. The Trust has however, already invested significantly in staffing to ensure that there is sufficient workforce to deal with activity growth, the growth in consultant and nursing numbers in the last five years are shown below.





The Trust is not planning to use the independent sector to deliver activity, although this does remain as a contingency option for the Trust. The Trust has hired a mobile MRI scanner in 2015/16 and will use this additional capacity periodically in 2016/17.

4. Financial Plan

4.1 Financial Outlook

4.1.1 Current Trading (FY15/16)

In our draft plan we identified an expectation that a financial surplus of £0.1m, in line with plan would be achieved. This would be the 17th successive year the FT has reported a surplus, and all against a backdrop of record levels of emergency attendances, limited community bed provision and an overall increase in demand for services. However, to achieve the plan the FT has had to rely on a number of non-cash non-recurrent accounting transactions, and £2m support from DH for winter / emergency pressures[2].

Our staff handled a range of financial pressures and challenges throughout the year. This included delivering savings to accommodate efficiency targets inherent within the national tariff system, meeting the costs of pay reform from Agenda for Change and activity related pressure caused by both the 4 hour emergency care target and the 18 week elective care targets.

The tables below illustrate our income and expenditure (I&E) performance since FY06/7:

Fig £m	2006/07	2007/08	2008/09	2009/10	2010/11
Turnover	153.2	169.1	189.3	204.9	211.6
Surplus	2.0	2.9	4.3	3.1	2.6
Cash	18.8	35.4	45.4	43.7	50.9

Fig £m	2011/12	2012/13	2013/14	2014/15	2015/16
Turnover	220.8	230.6	244.3	259.2	271.2
Surplus	2.5	0.9	0.4	0.1	0.1
Cash	47.6	37.5	24.8	11.7	9.1

In FY15/16 the Trust was disadvantaged by the twin impact of reduced income (as a result of the tariff decreasing) and unavoidable inflationary cost pressures. These two factors working in tandem required the Trust to improve efficiency by 4% per annum (£10m).

During FY15/16 the FT suffered from significant growth in emergency activity. One of the main drivers behind the growth in patients has been the failure of the local CCGs to appropriately invest marginal rate threshold (MRET) and readmission monies. This increase in patients has been contrary to CCG expectations and undermined CCG QIPP plans. The mismatch between CCG anticipated patient numbers and actual growth in patient activity in FY15/16 has given rise to substantial over-performance within the contract, and substantial Trust costs.

Whilst it is hoped that the CCGs will invest MRET and readmission monies more effectively in 2016/17, the FT is not yet sighted on the detailed CCG plans. The FT will welcome reductions in non-elective patient numbers as this will avoid reliance upon temporary staff. The FT will need to be resourced to ensure that capacity is responsive and flexible to both planned and unplanned demand.

Cash balances continued to be monitored closely, with the FT ending FY15/16 financial year with a balance of £9.1m (this was more than originally expected as capital expenditure was deferred and Luton CCG paid more cash to the FT than anticipated).

Given the diminishing cash balance largely because of investment on infrastructure and the re-development of the hospital site (from £50m in FY10/11) the FT will work with NHSI & DH to secure the equivalent of a working capital facility.

Latest projections suggest the FT will spend £20.6m on capital in FY15/16 to deliver modern NHS

[2] In FY15/16 the aggregate of non-recurrent measures is expected to be in the region of £9.0m. This will be the underlying deficit at the start of FY16/17

services. In FY15/16 the FT benefitted from a £19.9m ITFF / DH loan. The FT drew down £9.5m of this loan in FY15/16 for key schemes that are designed to increase capacity and mitigate winter pressures, with the remainder dedicated to schemes in FY16/17:

Scheme	Description	Link to NHS / Hospital Targets	Link to Site Development
Theatres	2 New Theatres to replace a single expensive temporary Theatre (rent £0.8m pa)	18 Week Target Demographic Growth	Provide Resilience for Aging Estate Remove Capacity constraint
Increase Emergency Department Capacity &Create Orthopaedic Centre	Move Fracture Clinic out of Emergency Department (ED) to a newly created Orthopaedic Centre & create expansion capacity within ED	Maintain Achievement of the 4 hr A&E Target Cover Demographic & Non Demographic Growth (attendances increased by 12% in 14/15 alone)	Remove Capacity constraint Create more Out-patient Capacity Relieve some car parking issues
Ward Capacity	Create a new dedicated 30 bedded ward to meet Winter Pressures and to provide decant facility. The full year effect of Escalation areas in 14-15 was £3m largely driven by utilising 5 sub scale clinical areas. This compares with the cost of a standard 30 bedded ward of £1.5m. Refurbish existing specialist medical wards to address shortfalls in standards.	Achieve 4 hr A&E Target by ensuring patient flow maintained Cover Demographic & Non Demographic Growth (attendances to A&E increased by 12% in 14/15 alone)	One of two new wards envisaged in the LDH masterplan

The FT have determined that to maximise available cash that priority be given to creating patient care facilities and that investment in the short term in an on-site office block be postponed.

4.1.2 Future Trading

NHS England published the CCG allocations for FY16/17 to FY20/21 on January 12th 2016. The first three years (2016/17 to 2018/19) are firm allocations, with the remaining two years being indicative at this stage.

All 5 of the L&D main commissioners have benefitted from both growth per capita and overall growth on their CCG allocations for 2016/17:

	CCG Allocations Per capita growth	**Overall growth**
Luton	6.2%	7.5%
Bedfordshire	8.4%	9.6%
Milton Keynes	4.6%	6.0%
E&N Herts	5.6%	6.6%
Herts Valley	5.5%	5.6%

Whilst the allocations settlement is good news both Luton & Bedfordshire CCGs have significant underlying deficits. These deficits have, in part, been caused by an acknowledged underfunding. The impact of CCG allocation realignment will, in time, increase the CCG allocation. Notwithstanding the ultimate benefit of 'fair shares' funding, the CCGs will, it is believed, continue to seek downward pressure on providers as they seeks to redress the short term funding challenge and to contribute to the Better Care Fund.

A plan designed to deliver our financial strategy has been developed. This contains more risk than has been evident in previous years and places emphasis on the abilities of the Trust's Management Team to deliver improved financial performance whilst maintaining operational targets.

As announced in the recent Spending Review, the government has committed to provide an additional £8.4 billion real-terms funding for the NHS by FY20/21. The increase in funding available for FY16/17 totals £3.8 billion in real terms, a £5.4 billion cash increase. This includes £1.8 billion for the Sustainability and Transformation Fund (S&T Fund) earmarked solely for the provider sector in FY16/17, to be targeted primarily at providers of emergency care.

NHS Improvement wrote to the FT on January 15th outlining a Control Target for FY16/17, and how much of the Sustainability and Transformation Fund would be available if certain conditions are met:

S&T funding and 2016/17 control total	
General element – S&T Fund Subject to provider eligibility and conditions	£9.1m
Targeted element – S&T Fund Subject to provider eligibility and conditions	To be confirmed
2016/17 Control total	£11.7m surplus

The Control Total was subsequently amended to £11.8m to account for the impact of donations to the FT.

The FT notified NHSI that as the FT has an underlying deficit in the region of £9m (impact of non-recurrent items underpinning the FY15/16 position) the full year effect of savings required to achieve the FY16/17 Control Total is c£18m (over 7%)[3]. This is clearly a considerable and unrealistic challenge without external assistance.

In developing the FT's FY16/17 plan the belief that appropriate clinical outcomes, patient experience and safety remain the highest priorities has continued to be maintained and that this must be balanced with the requirement to achieve year-on-year efficiency savings.

This plan reflects the changing ways in which the FT will be working, acknowledging influences and expectations such as the Better Care Fund, 7 day working and the delivery of truly integrated care. It will also be responsive to the means that will be adopted in rising to the associated financial challenges, abiding by the principles of economy, efficiency and effectiveness – all with the intention of protecting the resources that are available to ensure that the L&D continues to deliver the highest possible level of quality healthcare in the most appropriate environment.

Looking forward, it is expected that the new financial year will be significantly more challenging and it is vital that sound financial management continues to be exercised as the Trust enters a year in which the NHS faces a substantial resource challenge.

4.2 Summary Annual Budget FY16/17

The foundation for delivery of the FY16/17 budget, and future financial challenges, will be built upon the continued development of internal systems. These are in turn intended to drive changes in culture and system incentives:

[3] £18m derives from a projected £9.0m underlying deficit, £6.25m (2%) within the FY16/17 tariff change and £2.6m the 'new efficiency target' identified within the Control Total above

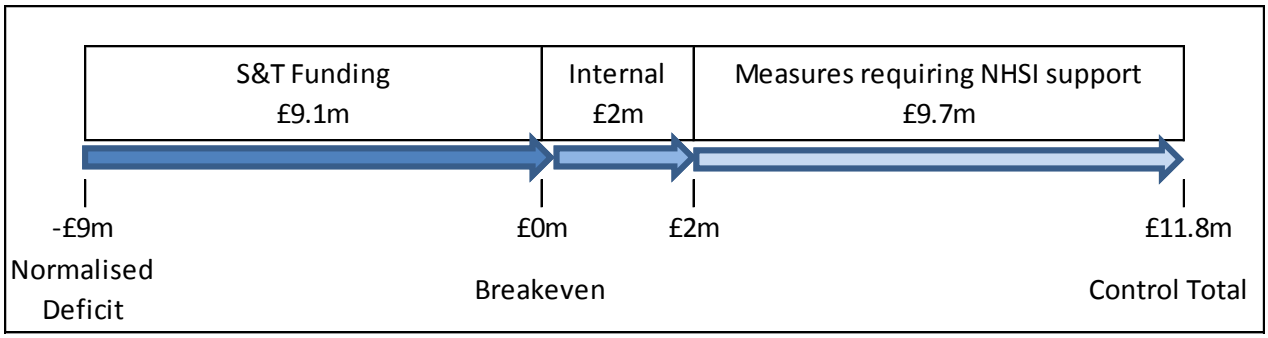
- **Service Line Reporting** (SLR) – this allows the organisation to see the financial performance of different parts by comparing the cost of those individual elements with their income. SLR allows different clinical and non-clinical functions to be viewed as financial entities in their own right by harnessing the incentives which accrue from providing the different parts of the organisation with the freedoms, flexibilities and structures which are available to business enterprises;

- **Performance Monitoring** – with SLR in place, a richer and more rigorous performance system can be in place which looks at performance at service line level;

- **IM&T strategy** – the investment in the IM&T infrastructure, and in particular the move to electronic systems will assist the Trust in driving out system inefficiency and significant costs associated with the current systems. This will be achieved through both reducing the administrative cost burden but also through facilitating a more effective and efficient patient journey, and reductions in length of stay (e.g. via the electronic observations project).

These developments will not directly translate into 'big bang' savings. Instead incremental efficiencies will occur and the changes will enable other efficiency programmes to come to fruition. In deriving the FY16/17 budget the FT has set individual profit / loss targets for Divisions and has utilised these empowered leaders to determine a budget for FY16/17:

NHSI has repeatedly stressed the requirement for the FT to submit a plan that is stretching but achievable. In order to deliver the £11.8m Control Total the FT has been forced to make a series of assumptions, which will need the support/intervention of NHSI, during contract arbitration, in order to deliver the required outcomes. This is summarised below.



The measures requiring NHSI support are detailed below:

MRET / Readmissions

NHS Improvement will need to support the FT in ensuring that MRET & readmission deductions (which have not been reinvested effectively by the CCGs) are reinvested into the FT in 2016/17. This has been modelled as income, but (subject to appropriate due diligence) could be reinvested to reduce costs.

Winter / Emergency Pressures

The FT has continued to deliver against all national performance standards and has consistently delivered against the ED target for a number of years. This has been achieved at significant cost to the Trust. During 2015/16 the Trust received only £0.5m of local winter monies, but was supported with a £2m from the DH. This adjustment assumes that the FT will receive an equivalent level of additional support in FY16/17.

Medically Fit Patients

The FT has invested significant time and resource into understanding the blockages within the wider health economy that contribute towards the issue with medically fit patients. A number of the

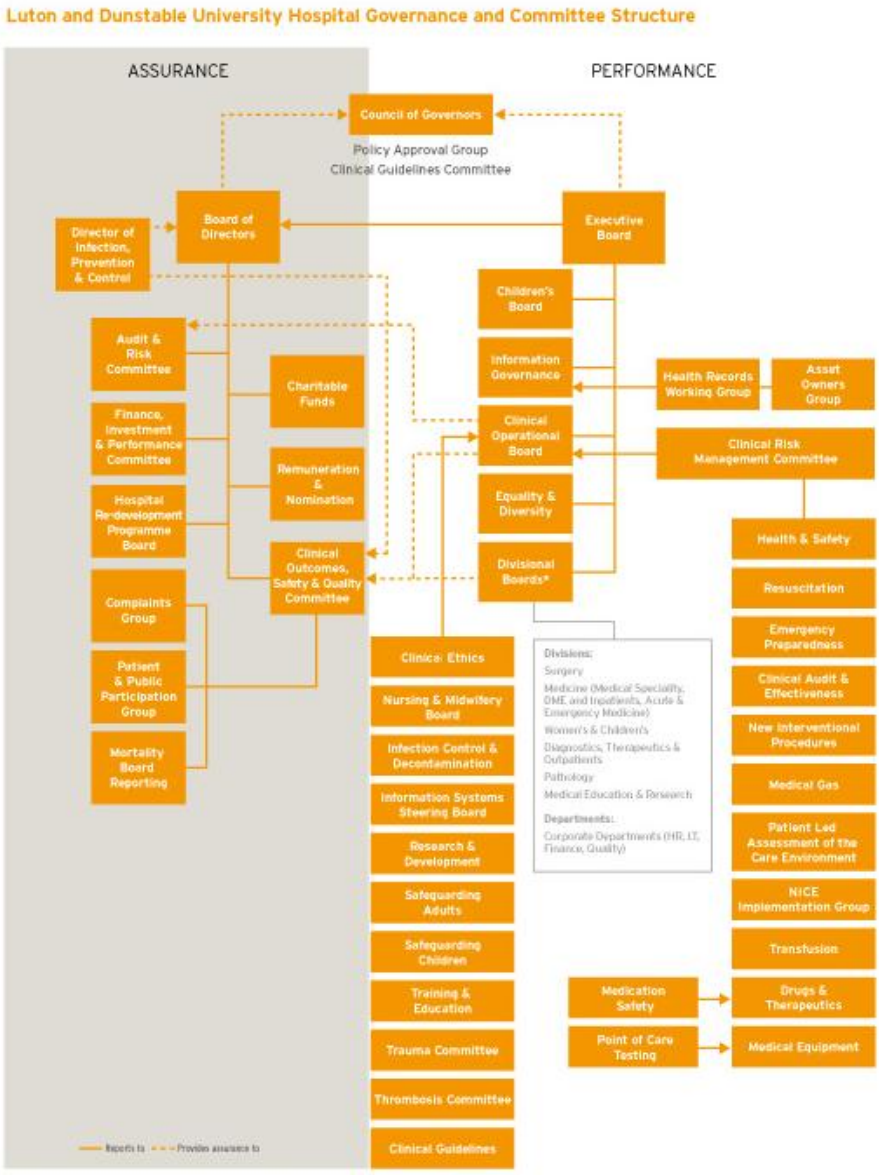
reasons behind this are not within the FT's direct control (e.g. Social Services capacity, availability of step-down beds and rehab facilities in some localities). Any unilateral action by the FT to mitigate system-wide pressures could lead to double running costs in the short-term, and this adjustment assumes support from NHS Improvement to deliver improvements outside of the FT that will enable the closure of one ward.

5. Improving our Governance

5.1 Governance and Committee Structure

During 2016/17 the Trust will commission an external Board level evaluation in line with previous reviews undertaken every 3 years.

Following a Clinical Governance review reported to COSQ in October and the start of the roll out of the new Divisional and Medical Director arrangements, it was agreed to review the committee structure to support reporting and assurance. The review led by the Chief Medical Advisor resulted in the introduction of the Clinical Risk Management Committee from December 2015 reporting to the Clinical Operational Board (COB). A revised structure is below:



* Divisional Board meeting include standard agenda items of Risk Management, Risk Registers, Incidents, Complaints and claims and information related to each of the relevant sub-committees of the Clinical Operational Board

5.2 Managing Risk

During 2016/2017, risk will continue to be managed at all levels of the Trust and is co-ordinated through an integrated governance framework consisting of performance and assurance processes. The Executive Boards and the Clinical Operational Board lead the review of risk together with the Information Governance and Equality and Diversity sub Boards. The Board of Directors lead the review of board level strategic risk seeking assurance from the Audit and Risk, Clinical Outcome, Safety and Quality; and Finance, Investment and Performance Committees.

The Risk Management Strategy continues to provide an integrated framework for the identification and management of risks of all kinds, whether clinical, organisational or financial and whether the impact is internal or external. This is supported by a Board Assurance Framework, which is used to record corporate objectives, risks to their achievement, key risk controls, sources of assurance and gaps in assurance to ensure effective risk management.

There is a Risk Review process under the leadership of the Executive Directors, who are consulted to approve any new risks that have been identified through the Divisions, Corporate Services or Committees and reported through the central risk register database (Datix). The relevant Executive Director agrees whether the risk is a Strategic Board Level Risk that has implication to the achievement of the Trust Objectives, review the assessment score and also allocate the risk to the relevant Sub-Committee for assurance and operational board for performance monitoring. The closed risks are also monitored to ensure the Executive Team is aware of risk amendments. The Trust has in place a weekly Senior Staff Committee that overseas operational risk.

The assessment and subsequent management of risk is informed by its quantification using a risk grading matrix, which is set by the Board of Directors. Consequence and likelihood tables are outlined in the Risk Management Framework across a range of domains; the consequence tables grade each risk by reference to its expected impact. This, combined with the likelihood score, defines a measure of overall risk. The Trust risk tolerance is set by considering all risks through the Risk Review Group and identifying those risks that have implications to the achievement of the Trust Objectives. Any of these Board Level Risks that are rated as a high risk are reported to the Board of Directors every two months. Actions and timescale for resolution are agreed by the risk leads and monitored by the Board of Directors and relevant sub-committee. Through this process, the Board are informed of any risks that would require acceptance as being within the Trust's risk tolerance.

The organisations major risks are detailed on the Trust Risk Register and Assurance Framework. Through the annual planning, the risks are formulated into five elements and the risks linked to those and their mitigating action are documented below. The Risk Register is reviewed by the Board of Directors, Audit and Risk Committee, Clinical Outcome, Safety and Quality Committee, FIP, and Executive Board, it contains in year and future risks.

5.3 Membership and Elections

There are two broad categories of membership constituency and staff (including volunteers). The public constituency is further divided into three; Luton, Bedfordshire and Hertfordshire.

- **Governor Elections**

The Trust has in place 38 governors. 22 public (12 Luton, 7 Bedfordshire and 3 Hertfordshire), 9 staff and 7 appointed. There are on average 6 vacancies a year for the public membership and 3 staff.

The Trust annual elections to the Council of Governors are held during May – July and the elected candidates initiate their terms from September. The average turnout is around 20%.

In 2016/17 there are nine vacancies; 6 Public Governors (5 Luton, 1 Bedfordshire) and 3 Staff Governors (1 Admin, Clerical & Management, 1 Ancillary & Maintenance, 1 Nursing and Midwifery). During 2015/16, the Trust reviewed the voting profile of the membership and identified a diversity issue with the voting in the Luton Constituency. For the elections in 2016, an active programme to encourage voting will be put in place with our independent election provider.

● Governor Recruitment, Training and Development

The Trust continues to have in place a number of engagement activities to facilitate engagement between Governors, Members and the Public:

- Medical Lectures – the Trust hold two lectures annually on key topics identified by the Governors. Trust clinical staff present to 150 or more members at each session.
- Engagement Events – around five engagement events are held across the Trust constituencies every year to support the Governors and Trust staff to engage with the public.
- Membership recruitment – all Governors are involved with recruiting members. This ranges from visiting GP practices, attending events such as at the Chamber of Commerce and linking with local groups like the Women's Institute. A sub-committee of the Governors oversee this programme to ensure there is diversity of approach.
- Annual Members Meeting – the Trust usually has over 150 people at the Annual Members Meeting in September each year and it is considered an excellent event by those that attend.
- Ambassador Magazine – The Trust issues a 20 page magazine twice a year that is the opportunity for the Governors to report back to the members about Trust progress, Governor involvement and how the Governors are holding the Non-Executive Directors to account.
- Being a Governor awareness sessions – The Trust offers awareness sessions for those interested in becoming a governor. These are held twice a year in April and October and also on a 1:1 basis as required.
- Governor training – Training is accessible to all Governor through NHS Providers GovernWell programmes. Additionally, during 2015, the Trust held a bespoke joint training programme with Milton Keynes Governors provided by GovernWell. This was an excellent opportunity for the L&D Governors to network and share ideas. The Trust plans to continue this programme for 2016/17. The Trust offers a half day induction for all new Governors that includes meeting the Chair and current governors to share experience and learn about the Trust.

● Foundation Trust Membership

The Trust currently has 16,508 members (12,073 public and 4435 staff). The FT public membership numbers increase around 3% each year and the Governors set a target of 600 new members annually. The Governors agree a Membership Strategy through the Council of Governors and follows six key objectives:

1) To increase the membership - The strategy outlines more focussed work on recruiting members in Bedfordshire with an engagement approach to the Luton and Hertfordshire membership.

2) To ensure membership diversity - A review of the diversity of the membership identified that an increase the number of younger members was required. The Trust has made links with the Youth Parliament and Apprenticeship schemes.

3) To develop the membership database - In order to increase communication, the aim to maintain the number of recorded e-mails at 30%. The Trust has also initiated an email use group to expedite communications.

4) To provide learning and development opportunities to the membership - Two medical lectures were held for 2015/16 (End of Life Care and Sepsis/Infection Control) and two more are planned for 2016/17. Engagement events are also supported across the catchment area for the public and membership that provide opportunity to learn about the L&D services and speak to the medical team.

5) To communicate with the membership and encourage them to stand in elections - This has been part of the strategy for two years following an uncontested election of the Luton constituency. The Governors are key to ensuring that when members are recruited, they are also informed about being a Governor. At each of the L&D events, there is a stand to encourage members to stand for election and the Ambassador includes communication from present governors to also provide clarity on the role and how they can be involved.

6) Effective use of resources - The Council of Governors Membership and Communication Sub-Committee reviews the budget on behalf of the Governors.

6. Conclusion

Luton & Dunstable University Hospital NHS Foundation Trust is now fully engaged with 15 other partners and a wider range of stakeholders in the development of an STP to achieve transformational change across a planning footprint covering the resident population of Bedfordshire, Luton and Milton Keynes CCGs. Luton & Dunstable believe that the STP will lead to the introduction of a 'new models of care approach' to population health management across the patch and to the reconfiguration of clinical services.

This operational plan focuses on how L&D will continue to deliver against national and local quality and performance standards during 2016-2017 and highlights the financial challenges facing the organisation. In particular, it highlights the series of assumptions that the Trust has had to make in order to deliver the £18.5m control total and the need for NHSI support/intervention to enable delivery of the required outcomes. The operational plan and supporting financial information makes it clear that if these assumptions cannot be realised, then the Trust will need to re-submit a financial plan to NHSI during 2016-2017.