

# Liverpool Heart and Chest Hospital NHS Foundation Trust Operational Plan 2016-17



## Operational Plan for 2016 - 2017

This document completed by

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The attached Operational Plan is the final plan for 2016/17. The Trust can confirm that:

- The Operational Plan is an accurate reflection of the current shared vision of the Trust Board having had regard to the views of the Council of Governors and is underpinned by the strategic plan;
- The Operational Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;
- The Operational Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans; and
- All plans discussed and any numbers quoted in the Operational Plan directly relate to the Trust's financial template submission.

## 1. Overview – Strategic Context

## Strategic Context

### Background

Liverpool Heart and Chest Hospital Foundation Trust (LHCH) is a single site centre providing specialist services in cardiothoracic surgery, cardiology, respiratory medicine (including cystic fibrosis) and diagnostic imaging to a population of 2.8 million with a catchment spanning Merseyside, Cheshire, North Wales and the Isle of Man with an increasing rate of national referrals for highly specialised services such as aortic surgery.

### Introduction

The Trust's Operational Plan for 2016/17 has been prepared in accordance with Monitor's guidance issued on 22nd December 2015. It is set in the context of the emerging healthcare strategy and is aligned to the NHS Five Year Forward View, the plans of the Trust's main commissioners, and the local health economy's transformation and sustainability planning priorities. The plan caters for a small amount of growth discussed with commissioners as part of contracting round.

### Financial Assumptions and Sustainability and Transformation Fund

LHCH is facing an unprecedented challenge in 2016/17 in delivering an affordable and sustainable short term financial position. The risks arise from the delay of the introduction of the HRG4+Tariff and top up payments for highly specialised services. This has resulted in the Trust planning for an overall revised deficit plan of £4.3m, underpinned by a cost improvement plan (CIP) of £3.7m (3%). Consequently the Trust has been unable to sign up to receive its indicative share of the Sustainability and Transformation Fund (STF) given the inability to meet a control total of a £1.3m surplus outturn position for 2016/17. An overall net tariff loss of £2.6m, combined with quality investment of circa £2.7m (with anticipated slippage being incorporated into revised deficit position) to meet patient safety requirements, sustainably deliver waiting times and further extend seven day services, is material in driving this decision. The table below sets out the key issues and impact on the Trust's income and expenditure (I&E) position.

	<b>LHCH Impact £'m</b>
Inflation impact	(3.1)
Tariff impact	(2.6)
Efficiencies	3.7
Quality Investments/cost pressures	(2.2)
Total	(4.2)

These considerations have been used to set a financial plan to maintain a Financial Sustainability Risk Rating of a level 2 in 2016/17. The Trust is basing its strategic planning on the assumption that HRG4+ and specialist top ups will be implemented in 2017/18 as this will be critical to future sustainability. It is recognised through LHCH involvement with the Expert Working Groups (EWG) that there is a preference for HRG4+ phase 3 to be used to shape national prices for 2017/18 and to accurately reflect the complexity and co morbidity of services provided by LHCH. Current tariff design does not and LHCH was the sole provider with tariff loss in 2016/17.

LHCH recognises the challenges and opportunities and this plan is based on delivering a reasonable and realistic level of activity based on accurate demand modelling, the capacity required to meet this is based on 2015/16 outturn and it is underpinned by a robust and sustainable workforce plan to continue to deliver quality services to patients.

The Trust is actively pursuing a number of issues to support its submission and to mitigate risk in respect of reduced CQUIN allocation at 2.0% compared to an assumption used at 2.4% in the draft submission and to further seek to reduce the in-year deficit including;

- NHS England support for local pricing arrangements in respect of aortic surgery
- External audit approval of re-living exercise

### Trust Vision and Objectives

The Trust's vision is '**to be the best integrated cardiothoracic organisation**' underpinned by a mission to provide excellent, safe and compassionate care for patients every day.

The Trust has developed this plan with a focus on:

- Ensuring high quality, sustainable service delivery and improvements
- Meeting the requirements of the 2016/17 NHS England Mandate
- Delivering high quality services within a stretching financial efficiency plan
- Recognising and mitigating against the key strategic risks the Trust is facing

The Board of Directors have reaffirmed their five overarching strategic objectives encompassing Quality, Service and Innovation, Value, Workforce and Working Together and the KPIs for 2016/17 are being updated to ensure delivery.

### **1. Quality and Patient Experience**

LHCH will aim to further reduce avoidable harm through improving its mortality review process, alongside focussing on medication errors, anti-microbial resistance, human factors training, falls and pressure ulcers.

Effectiveness of care will improve through work on reliability, enhanced discharge processes and dementia case finding and referral. The delivery of compassionate care will continue through the care partner programme together with a focus on fasting and meeting the requirements of patients with special needs.

### **2. Service and Innovation**

The priority for 2016/17 is to ensure the Trust has resilient activity, capacity and workforce plans to deliver all key constitutional standards, ensure an excellent patient experience and meet the conditions of the licence.

The Trust has carried out a Strategic Options Appraisal underpinned by the development and delivery of Strategic Clinical Service Reviews at specialty level to set its long term, future strategic direction. Central to this is the ambition to become the network leader for cardiology in the region. Work is underway to implement a single cardiology service across the Liverpool City region working in partnership with Liverpool CCG and local acute providers.

Other service development priorities include community respiratory and the commitment to developing further seven day services.

### **3. Value**

The Trust will focus on delivering the activity plan, building a sustainable substantive workforce to reduce reliance and expenditure on bank, agency and premium sessions (and remain within the agency cap set), deliver the cost improvement plan seeking to reduce unwarranted variation in costs aligned to the Carter report recommendations.

### **4. Workforce**

In 2015/16 the Trust approved a comprehensive People Strategy with the aim of building an open, inclusive culture and embedding a new values and behaviour framework entitled PACT. In 2016/17 the Trust will focus further on delivering this strategy, which includes workforce resourcing, leadership development, education, staff engagement and wellbeing and equality and inclusion.

### **5. Working Together**

LHCH has developed a stakeholder service improvement plan to be delivered in 2016/17. Central to the plan is engaging and listening to stakeholders needs, reducing avoidable variation and inequity of access, and improving patient outcomes. Additionally, the Trust will play a key role in helping develop the health economy wide 2016-2021 sustainability and transformation plan.

## **Key Strategic Risks**

The Board Assurance Framework (BAF) has been developed as the tool for prioritising the Board's agenda and focusing on risks to delivering strategic objectives and regulatory compliance; it provides continuous and reliable assurance on organisational stewardship and the management of the major risks to delivery of organisational success. The operation of the BAF is supported by a written policy document that sets out the systems and processes underpinning the content and reporting such that the Board's agenda is driven by the BAF. These systems and processes include the relationship between the BAF, risk management processes; frequency of reporting to the Board; and the roles and responsibilities of the Board Assurance Committees, and how the work of these Committees informs the BAF.

The key strategic risks for the Trust in 2016/17 are:

- Finance - withdrawal of HRG4+ and specialist top ups mean that the Trust's planned deficit in 2016/17 will be £4.3m. Operational pressures in relation to increased acuity of patients, complexity of case mix, a higher proportion of urgent / non-elective workload and shortage of specialist workforce has meant continued reliance on agency staff. The Trust has reached a point where it needs to invest in additional capacity to be able to manage planned activity without the need to outsource less complex cases. New national guidelines for critical care medical staffing and loss of doctors in training from August 2016 will have significant impact on cost pressures, as will the increased CNST premium. The Trust has concluded a strategic options appraisal in partnership with KPMG to determine a long term solution to secure the sustainability of LHCH's clinical services. Work is also on-going to strengthen the PMO approach to CIP delivery in 2016/17.
- Workforce – the Trust is actively managing a recruitment strategy and has introduced comprehensive electronic rostering to minimise reliance on agency staff and to mitigate the reduction in trainee doctors. There is an added risk to Referral to Treatment (RTT) compliance in addition to the adverse impact on patient experience from shortages in key staffing areas.
- Access targets – for the reasons described above, the Board is mindful of risks to compliance with incomplete RTT target as well as being cognisant of the impact of single unforeseen events such as prolonged consultant absence or the admission of one or two very complex patients that require an extended length of stay in critical care. Divisions have led a robust capacity planning process this year, but investment will be required if the Trust is to provide the additional capacity required to support greater 7 day working and improve patient flow. Whilst the Trust is meeting the 62 day cancer target in accordance with the breach re-allocation policy for late tertiary referrals, it continues to work closely with partners across the health system to improve the patient pathway and minimise waiting times, this work will be further enhanced by the new national 38 day breach reallocation policy which will be implemented this year.

## 2. Approach to Activity Planning

Working within the new clinical leadership structure the Trust has developed a robust plan for 2016/17 based on extensive demand and capacity modelling working with the divisional leadership teams. Key to the delivery of this plan will be addressing the current workforce capacity constraints. Workforce plans have been developed to support this.

As part of the annual planning process for 2016/17 the Trust undertook a detailed review of its capacity and demand modelling using Monitor tools and guidance. This builds upon a comprehensive review carried out in 2015/16 which was subject to both internal and independent external review, working with commissioning colleagues.

The plan for 2016/17 is based upon the outturn position for 2015/16 and the following information has been used to develop the demand plan:

- Capacity and resource planning tools.
- 5 year trend analysis by procedure.
- Referral growth and conversion rates.
- Clinical engagement on changes to clinical practice or guidance.
- Outsourced activity volumes in the current year.

The table below shows the forecast outturn for 2015/16 and the activity plan for 2016/17.

**Activity Plan 2016/2017:-The Trusts activity plan for the new financial year is as follows:**

	Planned Activity 2015/2016	Forecast Outturn 2015/2016	Plan 2016/2017
<i>In-Patient</i>	12,850	13,230	13,377
<i>Out-Patient</i>	77,715	84,492	87,143

The main activity planning assumptions for 2016/17 are:

1. Growth of 2% for Electro Physiology studies.

2. A decline in Angioplasty procedures of 5.8%.
3. Growth of 9.3% in Pacing and Devices driven by changes in NICE guidance.
4. An increase in demand for Urgent Surgery referrals of 4.6%
5. Growth in outpatient attendances of 3.1% against forecast outturn\*

\*Largely driven by increases in diagnostics (MRI, CT and echo to improve waiting times).

The Trust has made progress throughout 2015/16 in reducing the number of patients waiting over 18 weeks for cardiac surgery from 148 in early March 2015. The sustained reduction of the surgical backlog remains the key challenge to the sustainable delivery of RTT at Trust level and also for the delivery of service line compliance for the speciality. The closing backlog at the end of the financial year was 110 patients waiting over 18 weeks for cardiac surgery. The modelling shows a backlog of no greater than 36-38 patients is required to deliver speciality compliance in the cardiac surgery service line and the plan is to deliver additional activity during 2016/17 to reduce the backlog. It should be noted that the junior doctors strike action is having a negative impact on the backlog.

To support the delivery of RTT the Trust is working in partnership with United Hospitals North Midlands in Stoke and has outsourced some of the more routine cardiac cases, in agreement with patients whilst growth plans are implemented to deliver more in house capacity to repatriate these patients. This outsourcing option continues to provide a level of flexibility throughout 2016/17 as required. As part of the annual plan the Trust is aiming to increase capacity throughout the first six months of the 2016/17 financial year with the aim of repatriating the currently outsourced referrals to the University Hospital of North Midlands from October 2016.

The Trust is currently working as part of the Liverpool Partnership bid to deliver Congenital Heart Disease services as part of the NHS England national review. As the outcome of this review is still awaited this operational plan does not include any potential activity associated with this service development.

### **Capacity Planning**

To support the delivery of this year's annual plan the Trust has developed its capacity plan to cover the following key areas:

#### **Private Patients**

The Trust's private patient plan for 2016/17 is broadly set in line with the outturn for 2015/16 which includes a decline in thoracic surgery and catheter procedures as there has been a reduction in demand in these two areas. The Trust has ambitions to grow private work in future years and is currently developing a strategy to deliver this ambition.

#### **Beds**

The major capacity challenges faced during 2015/16 has been the on-going availability of critical care beds due to high patient acuity, enhanced critical care standards and staffing pressures both in critical care and on surgical wards.

A comprehensive review of the required bed stock using bed-modelling software has been undertaken. This highlights a need for additional critical care beds to improve patient flow through the Trust. Three critical care beds will be added, with one bed opening in Quarter 1 and a further two in Quarter 3.

To improve efficiency the Trust will be utilising benchmarking data provided by the National Cardiothoracic Benchmarking Collaborative (NCBC) to measure comparative length of stay and opportunities to remove unwarranted variation via improved utilisation of the bed base.

Catheter Laboratory and Theatre schedules have been reviewed based on activity assumptions with plans to begin routine operating at weekends during 2016/17. Additionally the Trust is extending the Acute Coronary Syndrome (ACS) service within cardiology at the weekends. This will support improved flow from local hospitals into LHCH and free up emergency capacity.

### **Performance Delivery**

LHCH has reviewed its current performance levels for RTT and diagnostics and capacity based on historical trends and predicated growth. The main risk regarding cancer targets stems from late secondary care referrals (post 42 days) into the Trust and work is underway with the cancer network, local CCG's and providers to introduce a new lung cancer pathway from March 2016. The Trust has developed a cancer action plan with referring Trusts and the Cancer network to ensure compliance with core standards.

#### Flexing Capacity

A key challenge facing the Trust regarding the sustainable delivery of RTT is managing the balance between urgent and elective capacity within cardiac surgery. At times of peak demand it is necessary to swap elective capacity to urgent to reduce waiting time for patients and free up capacity within the local referring hospitals. As part of the planning process the urgent referral demand has been mapped and the urgent/elective split of cases has been reviewed to optimise patient flow for both groups of patients.

#### Research and Innovation

The Trust has an excellent reputation for its research and has revised its strategy to include a stronger commitment to innovation. Areas of expansion include new areas of research – personalised medicine, regenerative medicine and digital health and increased collaboration with private sector partners as appropriate.

Priorities for 2016/7 include:

- Development and implementation of a genomics strategy including furthering LHCH work as a recruitment centre for the 100,000 genomes project
- Delivering targets for patient recruitment and time taken to open a new trial
- Acting as partners in a number of European innovation projects in collaboration with the Academic Health Science Network
- Developing innovation in clinical trials design and methodology through the creation of ICE CAP (Improving Clinical Effectiveness by the Continuous Assessment of Practice). This will be a new unit dedicated to integrating research and high quality evaluation into routine clinical practice
- Development of an integrated catheter laboratory software solution
- Development of a business case for robotic surgery

#### Key Risks and Mitigations

<b>Risks</b>	<b>Mitigation</b>
RTT Incomplete Compliance	<ul style="list-style-type: none"> <li>• Capacity and demand modeling used to develop monthly performance trajectories to meet the incomplete target.</li> <li>• Partnership arrangement allows us to flex capacity whilst in-house capacity is expanded.</li> </ul>
Delivery of the Diagnostic Target	<ul style="list-style-type: none"> <li>• Service improvement project will deliver additional capacity using extended days.</li> <li>• Partnership working across the health economy looking at options to have more integrated pathways.</li> </ul>
Delivery of National Cancer Targets	<ul style="list-style-type: none"> <li>• Delivery of the new Lung cancer pathway in March 2016.</li> <li>• Working with the cancer network and local partners to improve health economy cancer performance.</li> <li>• The introduction of the national 38 day cancer breach re-allocation policy should help to improve performance if Trust's can improve their referral times to LHCH.</li> </ul>

### **3. Approach to Quality Planning**

#### **Approach to Quality Improvement**

The Trust has a Quality Strategy setting out priorities for 2014-17 which includes patient and family experience, key quality and safety awareness improvements. The Trust has agreed four key quality priorities with the wider stakeholder group for the year. The Trust has already committed to the National "Sign up to Safety" campaign and has developed key objectives to support this. The National Programme aims to reduce avoidable harm by 50% and save 6,000 lives nationally by listening to patients, carers and staff, learning from what they say when things go wrong and taking action to improve patients' safety. The Trust has developed its key objectives to support this.

The Trust has been conducting mortality reviews for the past six years. LHCH is in a good position to respond positively to the directive issued by Sir Bruce Keogh asking all Trusts to undertake a self-assessment of avoidable mortality and publish avoidable deaths.

The Trust has two key approaches to quality improvement which are the 'Listening into Action' methodology and the "Plan Do Study Act" to understand the effectiveness of the change considered. The Trust signed up to the "Listening into Action" programme in 2015. This quality improvement methodology has led to improved staff engagement scores as well as key quality improvements such as improved timelines of discharge for patients from the "home for lunch programme".

**Commissioning for Quality and Innovation (Cquin):-** The table below summarises the position with all schemes commissioning teams have discussed with the Trust. The Trust is exempt from engaging in two schemes aligned to services the Trust provides as a consequence of either lack of return on investment or because the Trust is not included in the initial pilot cohort. Due to the size and complexity of the CQUIN programme together with the risk that the Trust's improvement resources will be spread too thinly, the Trust will not be advancing any CQUINS of its own design in 16/17. Also included are the service development and improvement schemes. These initiatives are not incentivised but represent important commitments for quality improvement by the Trust to the commissioners.

Also included are the Service Development & Improvement Plans the Trust is required by the Commissioners to work on in 16/17.

Level	CQUIN	Detail	Value (£K)
National	Antimicrobial resistance and antimicrobial stewardship	Reduce antibiotic consumption and timely review of antibiotic prescriptions	38.4
	Staff health & wellbeing	5% improvement in commitment to health & wellbeing, stress and MSK plus changing way unhealthy food / drinks offered and achieve 75% flu vaccinations.	115.1
	Sepsis	Timely identification and treatment.	38.4
Specialised Commissioning	Clinical Utilisation Review	New software tool to assess appropriate bed utilisation. Integration with our clinical systems to be explored.	450.8
	Patient activation for patients with LTCs	Application of a quality of life tool in year 1 and deliver behavioural change therapy in year 2.	50
	Right device, right time	Standardisation of device price stratified by device functionality.	100
	Inter hospital transfer times	Time from angiography to surgery in coronary artery bypass patients referred urgently.	20
	Delayed discharges from critical care	% patients discharged within 4 hours of declared fitness for discharge to wards.	371.8
	Cystic Fibrosis patient activation	Excluded - scheme in pilot form, so will be invited next year.	
	Hand hygiene	Excluded - we are a low risk Trust for infection so no return on investment.	
CCG	Cancer survivorship	Holistic needs analysis and shared supportive care plan for each patient - use of national tool.	76.7



	Digital maturity	Full engagement with iLINKS, improve digital maturity, information sharing, interoperability with EMIS (Allscripts facilitating).	46
	Cancer 62 day waits	% treated within 62 days and review of patients waiting >=104 days.	38.4
	Learning disabilities	Equality of care.	30.7
	eReferrals	Increase utilisation to 80%.	0
Service Development and Improvement Plans	7 day service	Consultant review of all emergency admissions within 14h of admission. Central reporting twice yearly.	0
		7 day access to Diagnostics. Reported within 1 / 12 / 24 h.	0
		7 day access to Interventions.	0
		Twice daily consultant review of all patients in high dependency areas.	0
	Digital maturity - roadmap	Participate in the development of local digital roadmaps. Paper free at point of care by 2020.	0

### **Quality Priorities 2016-2017**

The quality priorities have been chosen to enhance patient and family experience, and identify the specific care requirements for frail and vulnerable patients whilst in hospital. These are listed below with actions taken to safe quality delivery of care.

#### **Priority One: Improve the experience in outpatient department for patients and families**

Some of LHCH patients have said they are waiting over 30 minutes to see a doctor and this has a negative impact on their experience within the outpatient department. The aim in monitoring this aspect of care provision is to improve the total of positive responses to Friends and Family test (FFT) "would you recommend our hospital" question and therefore to improve the care experience.

#### **Priority Two: Development of Care Pathways for patients with enhanced or complex needs**

We would like those patients identified as having complex care needs to have a care plan specific to them. Pathways will be developed to ensure all care required can be evidenced and all identified care needs received by our patients.

#### **Priority Three: All Patients identified as frail receive frailty assessments**

We want to ensure all our patients who are assessed as frail, receive a full assessment and referral to their GP for further management on discharge from hospital.

#### **Priority Four: Post discharge from hospital support**

Our patients who have undergone complex Aortic surgery would like a follow up care telephone call following discharge from hospital; this will enable them to feel further supported whilst at home.

Key quality priorities for 2016-17 are described below grouped under the Care Quality Commission's (CQC) five domains:

### **Safe**

Continue to develop a safety culture – Sign up to safety plan.

The Sign up to Safety Improvement Plan focused on two areas of action – improving the safety culture and improving communication and documentation.

The LHCH campaign priorities are:

- Develop a reliable care bundle to support the improvement of documentation of care by 50% by 2017
- Improve documentation and communication within the clinical setting.
- Ensure all senior clinical teams receive training on the advanced use of the EPR system.
- Improve the Safety Culture within the organisation and improve Incident reporting by 50% by 2017

LHCH has procured the Datix risk management software system to improve integration of incidents, complaints, claims and risk registers. Incident reporting will become electronic with feedback to the reporter once an incident is actioned and closed by the assigned manager. Incident reporting has seen a rolling average increase of 42% since the start of the campaign.

The information team have developed a Sign up to Safety dashboard allowing all managers to view progress with the campaign aims. Reported incidents can be viewed with learning and action taken, clearly displayed and accessible for staff.

The Chief Executive hosts a daily safety huddle each day for managers and staff to get together to discuss the previous days safety and any forthcoming issues likely to present that day.

An integral part of improving the safety culture is supporting staff to report incidents in confidence. LHCH has been involved in the Speak out Safely campaign since April 2014 seeing increased methods of reporting such as the concerns hotline, contacting the risk management team directly or reporting via the established incident reporting route. The Trust has appointed a Freedom to Speak up guardian and is developing a network of champions in 2016/17.

#### Maintain low infection rates

The Trust has maintained low infections rates over the last two years. The ambition is to maintain these low rates and seek to improve where possible.

### **Effective**

#### Dementia/Patients with enhanced care needs

Nursing documentation in the patient electronic record has been developed to capture information regarding patients with additional needs. Importantly it ensures any specific care needs are met. In the first part of 2016/17 a pathway of care for patients with dementia and other enhanced needs will be developed.

#### Care of the Older Person (Frailty)

The Trust wants to identify patients with frailty on admission and ensure they receive the best in quality, safe care in accordance with their needs. The target for 2016/17 is that 100% of all appropriate admissions will be assessed.

### **Caring**

#### Patient and Family Experience

LHCH is recognised for the delivery of excellent patient and family experience evidenced by the National Patient Survey results. The Trust will carry out four Trust wide listening events with patients and families in 2016/17.

#### Shadowing

In 2016-17 the programme of shadowing will continue. This allows staff to walk in the shoes of patients/carers to observe care from their perspective. The Trust has an in-house cardiothoracic BSC programme and all staff undertaking this will carry out a shadowing.

#### Care partner programme

On admission to hospital all patients are asked if they would like their family/carer to be involved as a “care partner” to work in partnership with the Trust. Patient’s families/carers can be involved in various aspects of care if the patient requests this.

## **Responsive**

### **Equality and Inclusion – Patients**

The Trust has a new Equality and Inclusion strategy setting out the commitment to embedding equality, diversity and human rights in everything. The two patient priorities for 2016/17 are to:

- Design services focused on improving health outcomes in communities served and take targeted action to reduce health inequalities for the most vulnerable and disadvantaged individuals and groups.
- Maintain continuous quality improvements around patient and family centred care and take proactive steps to ensure services meet their individual needs.

### **Developing an open and transparent culture**

The Trust has a major commitment to an open culture by:

- The Listening into Action programme
- Implementation of ‘Speak out Safely’
- Appointment of a Freedom to Speak Up Guardian
- Daily Trust wide safety huddle led by the Chief Executive
- Human factors awareness training and launch of the ‘Have Ask Let Tell’ (HALT) initiative to empower staff to speak out if they have a concern and stop the line if their concern is not heard.
- Executive/Non-Executive and Governor walk-rounds
- Promoting awareness of Duty of Candour

The intention for 2016-17 is to build on this work to further promote an open and honest culture within the Trust and become a learning organisation.

## **Well Led**

### **Organisational Learning**

The Trust has developed a new Organisational Learning Policy with a framework for how:

- the Divisions receive feedback about their services
- improvement needs are identified and delivered through the Divisional Governance process
- assurances about improvements and their implementation are reported into Operational Board
- improvements in one Division are shared widely, so the organisation learns from itself
- assurances are provided to the Board of Directors

The priority for 2016/17 in responding to the Mandate requirement to become a learning organisation will be to fully embed the practices of this policy into the Trust’s governance processes.

### **Mortality Review Process**

In line with national guidance LHCH updated its Mortality Review Policy and will review all deaths, report any avoidable deaths and ensure learning is shared and acted upon. Priorities for 2016/17 include:

- Introduce stronger KPIs to improve timeliness of mortality reviews
- Deliver mortality strategy training for Associate Medical Directors, Clinical Leads and the mortality improvement strategy leads
- Include in standard mortality reports information about how the mortality process is performing, and report avoidable deaths

- Definitively decide whether a death is avoidable or not. If deemed potentially avoidable, undertake a root cause analysis (RCA) to be certain, and ensure full learning is extracted and communicated, also ensuring compliance with the Duty of Candour.

### Governance and monitoring of Quality priorities

The Director of Nursing and Quality is the lead for quality, supported by the Medical Director. The quality priorities are agreed with the leadership teams after full engagement with patients and stakeholders. LHCH governance systems monitor the quality priorities with reporting through Divisional Governance meetings to the Quality Committee which is an Assurance Committee of the Board of Directors chaired by a Non-Executive Director. This committee reports to the Board of Directors.

### **Seven Day Services**

The Trust has developed an action plan against the 'Seven Days' baseline assessment and has been working towards improving seven day access to services for patients. In line with this action plan, consultant intensivist cover on critical care has been increased at weekends, the pain management service has also been increased to cover seven days and therapy services are currently being reorganised to provide a consistent seven day service for patients. There are further improvements planned for the coming year including ACS lists at weekends.

### **Quality Impact Assessment (QIA)**

The Quality Impact Assessment process has been developed to ensure that appropriate steps are in place to safeguard quality whilst delivering significant changes to service delivery. This process is used to assess the impact that any individual CIP, service development or improvement project may have on the quality of care provided to patients.

A full Quality Impact Assessment is to be considered when embarking on any CIP Scheme or Improvement Project valued at greater than £25k, or if the scheme is considered potential quality or safety risk. Each scheme is assessed and risk rated against the following themes using the 5x5 risk rating system: Patient Safety, Clinical Effectiveness, Patient Experience and Operational/Non-Clinical. This process is administrated by the Programme Management Office (PMO).

The Medical Director, Director of Nursing & Quality and Head of Nursing (Corporate) are all responsible for signing off the QIA document for all clinical schemes/projects. In doing so they are ratifying that the paperwork has been completed correctly and full consideration has been given to potential impacts on quality as well as how on-going monitoring will be managed within the clinical department.

The CIP Steering Group is the final arbiter for all QIAs. QIA assurance is received by the Quality Committee, The on-going Programme Management Office (PMO) monitors the schemes through monthly highlight reports to provide assurance that there is no compromise to quality and safety.

### **High Level Quality Related Risks**

- There is a risk to patient safety caused by inadequate compliance with the sepsis bundle care leading to untimely delivery of antibiotics to patients with sepsis and the potential for premature mortality. Sepsis is a focus area for 2016.
- There is a risk to maintain safe staffing levels; a risk to the recruitment and retention of nurses due to a potential inability to recruit to key posts and an over reliance on agency. This is being managed through improved rostering, reduced sickness absence and turnover and a robust overseas recruitment campaign.
- Never event - the Trust has undertaken a full root cause analysis and developed an action plan in light of a never event in 2015/16. The Trust has undertaken extensive work on human factors, ensuring a heightened awareness of how these can impact on safety and launched a major safety campaign to support people to raise their concerns.

### **Triangulation of Performance Indicators Strategic and Operational**

A comprehensive dashboard of Key Performance Indicators is reviewed monthly by the Board of Directors to ensure delivery of the five strategic objectives. The dashboard triangulates information on activity delivery and capacity levels, workforce engagement, patient safety and experience and financial performance. This information is cascaded

throughout the organisation at Divisional level and through team brief. In addition the Board of Directors receives a monthly Board Assurance Framework (BAF) key issues report from each Assurance Committee regularly.

The Board Governance structure consists of three operational assurance committees plus Audit Committee chaired by Non-Executive Directors.

The Quality Committee reviews and monitors the systems and processes required to ensure the effectiveness of patient care, patient experience and clinical risks. The Integrated Performance Committee provides assurance to the Board in relation to the operational and financial performance of the Trust. A quarterly People Committee was introduced in 2015 to provide greater assurance to the Board that the Trust has the right culture, staffing and engagement levels to deliver services effectively and efficiently. The Audit Committee has overall responsibility for assuring the Board of Directors that financial and quality reporting and internal control systems are in place and are being applied effectively.

The Board annually undertakes a rigorous review of performance of its assurance sub committees which assure on the quality of care provided. The Board completed a self-assessment against Monitor's Well Led Framework during 2015/16.

Daily operational performance is managed through the Operational Board which meets monthly. This is chaired by the Chief Executive and comprises of the divisional senior clinical leadership teams and the executive team. Twice yearly in depth performance reviews are held with each division to review on going performance against plan and agree any remedial action.

## **4. Approach to Workforce Planning**

### **Staff Engagement and Survey Results 2015**

The Trust has implemented the Listening into Action Staff Engagement Methodology and this has had a very positive result in the National Staff Survey this year. The trust has improved significantly on 19 of the 60 questions asked in both 2014 and 2015, and has obtained scores significantly better than other NHS organisations on 64 of a total of 86 questions.

The trust scored particularly well on questions related to engagement, satisfaction, leadership and, raising concerns and safety reporting, which have put LHCH among the top 3 Trusts in the country.

The areas in which the Trust has received lower scores relate to appraisals and staff putting themselves under pressure to come to work when feeling unwell.

Work is being carried out with all areas and departments to identify the issues that matter most to staff with the intention to developing action plans for further improvement in these areas in 2016/17.

### **Workforce Planning and Governance**

The Trust recognises that a highly motivated and skilled workforce is the most essential component to delivering excellent patient services. In order to build on its high level engagement scores and its position as a top 100 NHS employer, LHCH has introduced the Listening into Action approach to involving frontline staff directly in identifying and removing barriers that cause frustration and get in the way of delivering outstanding patient care.

The Trust has implemented a People Committee of the Board which is chaired by a Non- Executive Director (NED). The new People Strategy for 2015 -2018 was approved in July 2015 by the Board of Directors and the People Committee monitors delivery of the strategy and workforce plan alongside a wide range of related KPIs. The Committee is also responsible for regularly reviewing and ensuring workforce related risks are addressed.

Workforce Plans are signed off by the monthly Operational Board, which is Chaired by the Chief Executive and attended by the divisional senior leadership teams and the executive directors. Each divisional workforce plan is subject to scrutiny and challenge at this forum. The Operational Board reports to the Board of Directors via the Chief Executive's written summary report and receipt of minutes.

### **Clinically Led Leadership Structure**

A robust approach to workforce planning and management has been implemented through the new divisional structure. Each of the clinical divisions has a HR Business Partner who works as part of the senior divisional team and supports the division on workforce related matters. The three divisions are led by an Associate Medical Director (AMD) whom, together with the Divisional Head of Operations and Head of Nursing, are responsible for ensuring the

workforce plan is developed alongside the activity and capacity modelling and that there is full alignment. The AMD is supported by a Clinical Lead and Matron/Ward Nurse for each service line.

Following the introduction of the new clinically led Divisional structure the Trust has introduced a new Leadership and Management development programme for the senior clinical and managerial leaders throughout the Trust. This includes a personalised leadership development plan together with the introduction of team and individual coaching. The new PACT appraisal process is also being used to identify and build talent and succession planning to develop a more resilient workforce and improve retention rates.

### **NHS England and Local Education and Training Board (LETB)**

The Trust is working closely with colleagues across the local health economy and NHS England as part of the wider regional workforce planning process to ensure that LHCH's plans are aligned with workforce supply.

This includes developing multidisciplinary roles to support the on-going reduction in trainee doctor posts, commitment to the development of Bands 1-4 staff through the use of apprenticeships, the Care Certificate and access to development pathways into multi-disciplinary professional roles. The Trust continues to access regional funding opportunities to maximise investment in workforce.

In 2016/17 the Trust will continue to strengthen external partnerships with local Higher Education Institutions, the North West Deanery and other local delivery partners.

### **Recruitment Plans for Safe Staffing and Increased Acuity Levels**

The Trust is looking at innovative ways to fill vacancies and retain staff and new ways of working to mitigate the gaps left by staff shortages. Each hotspot area has a bespoke recruitment plan covering local, national and international recruitment from outside the European Union. The level of vacant posts across the Trust has reduced significantly in the last six months following the appointment of a new Head of Resourcing post and retention levels are also improving.

Assurance on the levels of nurse staffing is presented to the Trust Board at six monthly intervals. The Trust continues to use the safer nursing validation tool as well as professional judgement to determine the daily staffing requirements for each area. Updates on compliance are presented to the Board at each meeting and published monthly in line with national requirements.

A key part of delivering the operational plan will be the successful recruitment of a number of additional clinical staff in order to ensure the Trust can sustainably deliver its key operational standards such as RTT, Incomplete Cancer Pathway and Diagnostics waiting times, as well as continuing to achieve recommended national safe staffing levels in the face of increasing patient acuity. The additional staff required are primarily qualified nurses in three areas of national shortage namely intensive care, theatres and the cardiac catheter laboratory.

### **Surgical Intensive Care Unit (SICU)**

The majority of the required nursing posts are in the Trust's surgical intensive care unit (ICU) where the number of patients requiring level 3 care has increased sharply in recent years. This has led to a high reliance on bank and agency staff to cover the difference in staffing from 14 budgeted level 3 beds to a daily average of 20.

The majority of vacancies in SICU have now been filled. However, there is a lengthy induction, training and supervision programme in place which means that nursing staff in the unit are classed as supernumerary or approximately four months. Therefore there is some reliance on agency staff; although this will reduce significantly in year and is working towards meeting the agency cap by the end of 2016/17.

Additionally, the Trust is planning to open a further three ICU beds in 2016 to meet high patient acuity levels as well as the repatriation of some outsourced surgical work. An additional 17 Band 5 nurses will be recruited on a phased basis to staff these additional beds.

Full recruitment to a number of specific additional clinical posts is key in order to ensure the Trust can sustainably deliver its key operational standards such as Referral to treatment (RTT), Incomplete Cancer and Diagnostics waiting times, as well as continue to achieve recommended national safe staffing levels in the face of increasing patient acuity.

### **Catheter Laboratory Nurse Staffing**

The Trust has five cardiac catheter laboratories which are running at high utilisation rates. The labs also provide a 24/7 Primary PCI service for emergency patients spanning Cheshire and Merseyside. This high work rate has resulted in a number of hard to recruit vacancies and a reliance on agency staff to cover gaps. In order to mitigate this, the Trust has a strategy to grow its own catheter laboratory trained nurses by offering educational skills and training places for staff from Coronary Care to develop their skills and rotate into the Catheter Laboratories.

### **Theatre Nurses**

Recruitment to theatre vacancies has proven difficult during 2015/16 although recruiting scrub staff has been more successful than operating department practitioners. In the short term there will be requirement to utilise some agency support to cover rota gaps for the first six months of 2016/17. Competition amongst the local health economy is high for theatre nurses and so these posts have been added to the international recruitment campaign as a medium to long term solution. The Trust is also working closely with local universities to attract and recruit student nurses to the profession earlier on in their training programme.

### **Ward Cover**

Some additional capacity is needed to extend the opening hours of the day-care ward to provide seven day cover together with filling nursing vacancies on the major surgical ward to ensure the additional four beds agreed in 2015/16 are able to remain open to assist patient flow, especially the step down of patients from ICU.

### **Knowsley Community COPD service**

The Trust successfully bid to provide a full community COPD service to the population of Knowsley with effect from April 2016. This service is being provided collaboratively by LHCH as lead provider, in partnership with the three local acute hospitals namely, the Royal Liverpool, Aintree and St Helens and Knowsley Trusts. Recruitment to an additional 17 posts required is underway. Services will be provided across seven days and a period of consultation is in progress with existing staff to introduce new working patterns when the extended service is implemented in April.

### **Junior Doctor Staffing Levels**

The Trust, in common with many other hospitals is experiencing a reduction in the number of core medical trainees due to changes in their training rotations to accommodate more placements in general practice and mental health. In addition, and more pressing, is the decision to remove the Foundation Year 2 doctors from the specialist hospital rotations from August 2016. In response the Trust has already embarked on a programme to introduce more Advanced Nurse Practitioner (ANP) roles and additional pharmacy staff to support the junior doctor staffing model and to build a multi-disciplinary team providing equivalent cover across the wards and out of hours. Satisfactory progress has been made and there are plans to further increase the numbers of ANPs, together with an additional prescribing pharmacist to mitigate this loss of junior doctor cover and ensure patients are safely cared for. Four additional surgical associate specialists will also be required to provide additional cover to compensate for the reduction in surgical core trainees.

In order to fully meet the Intensive Care Society standards and to cover the additional ICU beds a further 8 WTE tier 2 anaesthetists will need to be recruited. It is recognised however that these are hard to fill positions and this will need to be staggered across the year.

### **Consultant Staffing**

An additional two consultant anaesthetists are required to meet the increased demand and recruitment plans are underway looking at an overseas campaign. These posts, and the tier 2 anaesthetists, are forming part of an extensive overseas recruitment campaign to combat national occupational shortages. In the meantime safe staffing levels are being achieved through additional sessions being carried out by existing LHCH anaesthetic consultants. An additional radiologist consultant is also being recruited to help meet diagnostic waiting times.

An additional thoracic surgeon will also be appointed to provide additional capacity and cover to referring acute hospitals for thoracic MDTs and joint working, as well as the recruitment of an additional cardiac surgeon in the second half of 2016 to provide additional capacity to ensure all waiting time standards are being maintained.

### **Seven Day Services**

The Trust is introducing routine weekend working for ACS lists. Staff consultations about the proposed change in working patterns have commenced. Modest additional recruitment will be required to support this change. The surgical division is planning to consult with medical, theatre and perfusion staff to implement normal seven day services across cardiac surgery. At present, theatres operate over seven days but this additional activity is voluntary and attracts

premium rates for all staff. In order to support this, additional theatre staff will be required to work a seven day shift pattern.

In addition, imaging and therapy services are being extended across seven days to provide more effective and seamless service. The Trust has a Workforce Change programme for 2016/17 to ensure all staff affected by organisational change to enable the introduction of extended seven day cover and workforce skill mix changes are managed appropriately. Any potential impact on patient quality and safety arising from these workforce related efficiency or productivity schemes are assessed through the Quality Impact Assessment process detailed in the quality section of this plan.

### **Workforce Efficiencies and Productivity**

The Trust already has a number of outsourced support services and has commenced a review, working in partnership with the Royal Liverpool and Broadgreen Hospital Trust, to examine the potential for further rationalisation and shared services in 2016/17 in line with expected Carter recommendations.

### **Actions to Reduce Agency Reliance and Spend in 2016/17**

The Trust saw an unprecedented increase in Agency usage for nursing staff in 2015/16. This was primarily due to the following:

- Increase in the number of patients requiring Level 3 care in ICU due to comorbidities and increased age profile, in addition to an increase in demand for aortic surgical procedures. This has led to a need for additional nursing staff.
- A decision, following advice from CQC, not to allow 9.4 WTE Band 4 ICU Assistant posts to be counted in the required staffing numbers anymore. This led to a further 10 ICU Band 5 nurses being required to meet recommended staffing levels.
- High vacancy levels arising from the above points and difficulties replacing staff due to national shortages.

The Trust now has a robust plan in place to reduce reliance on agency staff in 2016/17 and has set a realistic trajectory to move towards a maximum of 3% of total nursing budget spend by the end of the financial year based on the following actions:

- Improved efficiency in how staff are rostered across all areas through the rollout of the Allocate Health-roster system to identify inefficiencies in rota management and improve effectiveness.
- Implementation of a new, tighter Roster Policy across all areas to improve efficiency.
- Targeted recruitment campaigns in specialist, hard to fill areas including SICU, Theatres and Cath Labs, including a campaign of outside EU overseas recruitment.
- Increased medicine divisions rotations and developing Trust staff to work in the Catheter Laboratories to reduce vacancies.
- Enhanced bank payment rates introduced in SICU, Coronary Care Unit, Theatres and several surgical wards to encourage staff to work more bank shifts for the Trust. This will be monitored throughout the year to ensure bank uptake is increasing.
- A focused recruitment campaign in local press to recruit 'Bank only' staff to cover Theatres and Critical Care.
- Introduction of a weekly payroll for all Bank shifts worked by LHCH staff from April 2016.
- Improved sickness absence target of 3.56% from 3.7% 2015/16 outturn.
- Initiatives to improve staff turnover from 10.3% at the start of 2015/16 to 7.2% by 2015/16 outturn. Target reduced from 9% to 8% overall in 2016/17.
- Collaboration with Cheshire and Merseyside Procurement Group to agree the list of approved agency suppliers. Working proactively with agencies on the framework to agree fills rates for the Trust.
- Escalation process in place with Executive and People Committee sign off to ensure 'off framework' agencies are only used in exceptional cases where patient's safety is at risk.

### **Sickness Absence reduction and Improved Staff Retention**

Plans are underway to further reduce sickness absence in 2016/17 to 3.56% by the end of the year and further reduce turnover to an average of 8% or less by the end of 2016/17 through increased staff engagement and improved retention incentives and health and wellbeing initiatives.

### **Consultant Job Planning**

The Trust has invested in the Allocate E-Job Plan system and this is now being implemented. A comprehensive round of job planning took place in the autumn and a number of changes to individuals' job plans have been implemented to



improve service delivery. All job plans are being entered on the new electronic system and will be reviewed in 2016/17 to ensure maximum value is being achieved.

### **High Level Workforce Related Risks**

The major risks to the delivery of the workforce plan are: -

- Inability to recruit to the positions affected by national shortages
- Failure to reduce reliance on the use of agency staff to meet the agency cap and to cover the gaps in certain key areas
- Failure to recruit sufficient ANPs and replace medical staff to mitigate the risk from the removal of Deanery funded junior doctor rotational posts.

## **5. Approach to Financial Planning**

### **Financial Forecasts and Modelling**

The Trust's financial plan has been developed in line with the annual planning timetable set out by Monitor. The final plan has been discussed by the Board of Directors at regular intervals; with Board approval at its January meeting with the final plan being agreed at its April strategy update meeting. The overarching financial strategy principles agreed by the Board of Directors is to create a long-term financially stable organisation with the:

- Ability to invest in patient care and facilities.
- Capacity to cope with short-term financial shocks.
- Ability to survive structural changes in the financial flows in the NHS and health economy (16/17 Tariff impact)
- Strength to be able to deliver efficiency savings on a longer basis.

In the short-term

- Maintain a FSRR of at least 2
- Balanced approach to delivering on the money, safety and quality in 2016/17
- Ensure sufficient cash balances.
- Seek opportunities for income growth through business development(e.g. Vanguard/hospital chains/acute care collaboration)

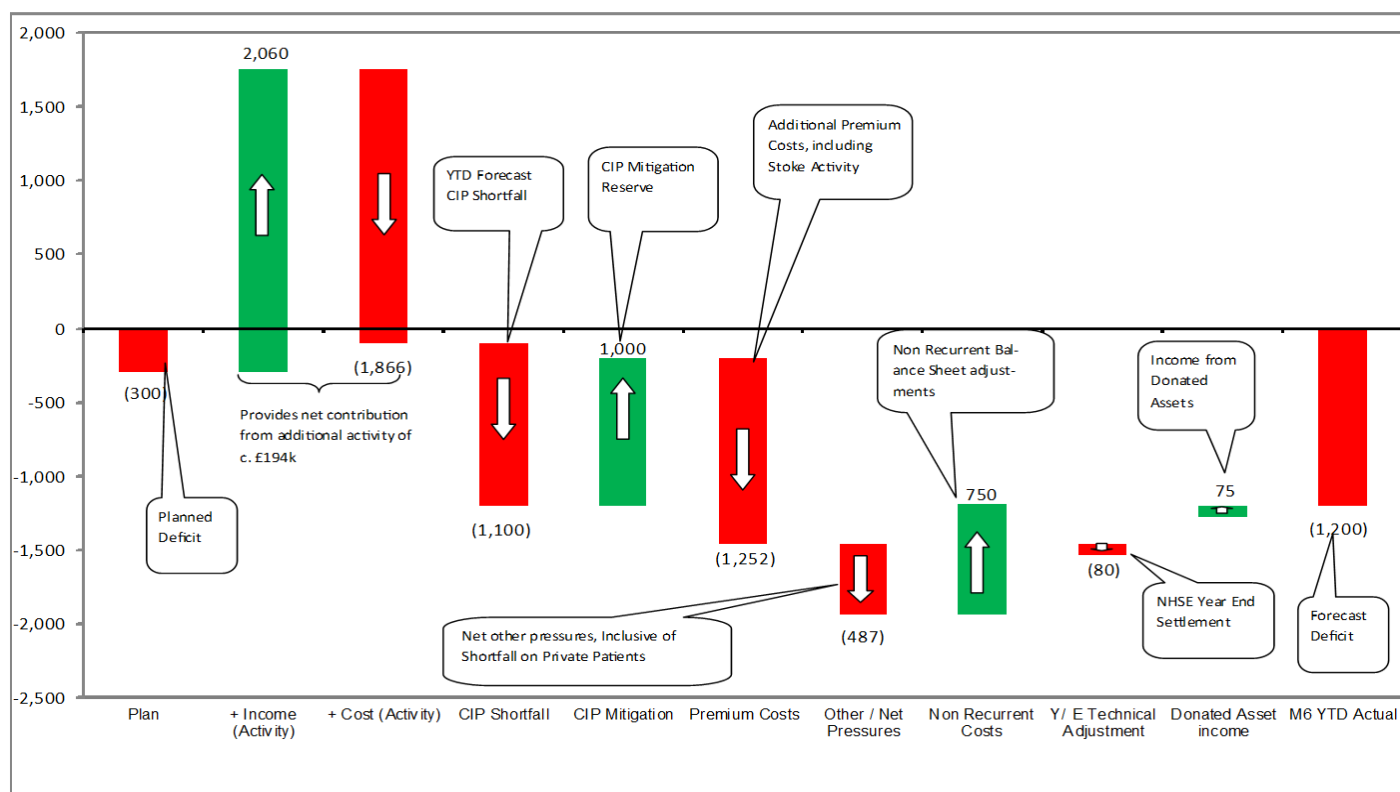
The Trust continues to recognise the challenges it is facing but sees opportunities to strengthen its position supporting the vision of becoming the premier integrated cardiothoracic healthcare organisation. The detail provided in this final operational plan supports the view that the Trust will continue to be successful and that commissioner focus on service quality and patient choice reflects and plays to the strengths of LHCH.

The plan has been formulated on the basis of;

- The application of Payment by Results (PbR).
- Financial planning and activity assumptions currently in the process of negotiation with commissioning colleagues. Broad principles around utilisation of forecast outturn activity at month 6 and refreshed for month 12 have been agreed. Dialogue continues with commissioning colleagues to ensure contract sign off by the 23<sup>rd</sup> April. The plan and financial assumptions and forecast ensure that LHCH clinical services delivers adherence to NICE guidance on access to specific treatments and ensuring patients are seen and treated to meet the NHS Constitution waiting targets.
- Detailed internal activity modelling and planning culminating in the production of internal divisional financial, service and performance contracts.

### **2015/16 Financial Plan Performance**

The bridge chart below summarise the key drivers behind the Trusts normalised outturn deficit of £1.2m compared to the deficit plan submitted at £0.3m.



The Trust in 2015/16 experienced some key workforce issues that adversely impacted on the delivery of the financial plan namely:

The inability to recruit and retain the critical care nursing workforce in line with original assumptions and activity growth and need to use agency with adverse impact on EBITDA and net deficit of circa £0.8m.

Temporary loss of key consultants resulting in the need to deliver backfill and activity requirements at premium rates of pay at a cost of £0.2m.

Overall workforce recruitment delays resulting in the need to use outsourcing to deliver activity plan with consequent adverse impact on EBITDA and net deficit of £0.3m.

Planned delivery of efficiency levels standing at £4.5m during 2015/16 has been challenging as the Trust entered the year with £1.0m of a combination of unidentified and opportunity status CIPS. Risk was mitigated by prudent financial planning with a £1.0m CIP contingency risk reserve and this reserve as detailed in the bridge chart has had to be deployed during 2015/16. Key schemes materially accounting for slippage centre around workforce transformation schemes in respect of consultant job planning, rostering, absence management.

### 2016/17 Key Inflationary working assumptions

As can be seen from the table overleaf the Trust has accounted for within its one year financial plan the impact assessment of inflation broadly set at national guidance levels with the exception of the impact of CNST costs upon its cost base where the actual increase in its premium above 2015/16 prices has been accounted for and drugs inflation. Pay inflation assumptions have been calculated to take account of the 1% pay award that has been made, in conjunction with the costs associated with incremental drift as per Agenda for Change and the increase in cost base associated with changes to pension costs.

Pay and Prices	National %	Trust %	Value £'000
Pay(inc changes in pension costs)	3.3	3.0	(2,035)
HCHS Drugs	4.5	0.3	(205)
Non-pay, non-drugs inflation	1.7	1.5	(861)
CNST(not allocated to HRG sub –chapters)	1.1	40.0	(282)

<b>Revenue cost of capital</b>	3.1	3.1	(236)
<b>Tariff Impact Assessment</b>	1.1	(1.8)	(2,646)
<b>CQUIN</b>	N/A	N/A	1,386
<b>Additional Costs/Quality Investments Recurrent</b>	N/A	N/A	(2,700)

The Trust has been materially disadvantaged in 2016/17 by the withdrawal of the implementation of both HRG4+ and specialist services top ups. The impact of this withdrawal cannot be over emphasised as past modelling of activity remunerated at HRG4+ indicated a significant upside to the LHCH clinical income base moving a significant number of loss making services lines (predominantly within cardiac surgery) to service lines that deliver good contribution levels.

After allowing for a transitional period of 4 years the withdrawal of specialist “top-ups” has adversely impacted on the LHCH expected clinical income base of circa £2.0m. The £7.7m impact set out below is consistent with past modelling work undertaken indicating through the full reflection of costs of delivering its complex activity base via use of HRG4 + the clinical income baseline growing by circa £8.0m.

This is further evidenced by the table below:

#### **Specialist Services Top Up Impact Assessment**

<b>Service Line</b>	<b>Plan Value £'000</b>	<b>Initial Top Up Guidance Proposal %</b>	<b>Value £'000</b>
<b>Cardiac Surgery</b>	19,588	25	4,897
<b>Complex thoracic</b>	5,454	38	2,073
<b>Inherited Heart Disorders</b>	541	16	87
<b>PPCI/Structural Heart Disease</b>	4,105	13	534
<b>Other Misc.</b>	N/A	N/A	143
<b>Total</b>			<b>7,734</b>

The Trust's financial strategy is to maintain a minimum level 2 Financial Sustainability risk rating (FSRR) throughout 2016/17 under the current risk assessment framework. In order to achieve this objective, the Trust recognises the need to continue the identification and delivery of increasingly challenging efficiency requirements, and has included plans for the delivery of a CIP of £3.7m (3%). Against this target the Trust has identified work streams to support the delivery of £3.7m (inc £0.3m revenue generation) of the overall requirement, fully developed schemes total £0.9m, schemes at a mature stage of progression at £1.5m with schemes under construct at £1.0m. The Trust has recently implemented a new electronic rostering system and following initial diagnostic reporting has built into its efficiency programme savings to flow from full roll out of an e-rostering system of some £350k. The Trust recognises from slippage experienced in 2015/16 this remains a key area of risk in delivering the financial plan. The Trust will continue to provide organisational focus, with the objective of mitigating the risk without recourse to contingency reserve by the end of quarter one.

Whilst specialist trusts are not formally included in the Carter review the Board of Directors fully support the principles and will be focusing on:

- A much tighter grasp on the use of resources overall, specifically around staffing costs and procurement opportunities
- The need for enhanced integrated reporting framework bringing together clinical quality and resource performance data
- Working as a system to ensure prompt discharge of patients to the most clinically appropriate care setting
- More focus on collaborative working particularly at a local health economy setting.

LHCH in its 2016/17 programme will maintain a focus on delivering efficiency across the following areas;

1. The introduction and full roll out of an e –rostering system. This will enable the delivery of more effective approval processes publishing rosters some 6 weeks in advance. The Trust is currently designing a formal process to tackle outlier areas within the hospital with clear escalation paths, action plans and improvement tracking methodology. In 2016/17 LHCH will continue to explore the greater use of collaborative working to deliver efficiencies in its corporate functions alongside continuing to explore optimal clinical workforce numbers and skill mix. Continued focus will be placed on improving absence management rates and reducing turnover.
2. Via the EPR system deliver savings e.g. within the pharmacy drug bill to eliminate unwarranted variation. The digital optimisation strategy underpins the delivery of the interface for electronic prescribing and administration system into EPR.
3. Through the Procurement Advisory Board and Operational Group oversee a procurement strategy and transformation plan sponsored by the Chief Finance Officer focussing on improved spend analytics capability, efficient electronic catalogue and inventory management systems (review Omnicell) and the reporting of high quality procurement information focusing on the measurement of key procurement metrics. In conjunction LHCH will explore the potential for greater collaborative working with key partner Trusts. The efficiency plan targets delivering procurement efficiencies of £0.9m with some £0.5m fully developed.
4. Through the strategic estates and facilities plan LHCH will continue to look to deliver efficiencies across hard and soft facilities management costs with a scheme fully developed at £0.1m.
5. Explore through collaborative working with key stakeholder partners the potential to deliver savings opportunities in corporate and administrative costs.

The Trust recognises the challenges it is facing but sees opportunities to strengthen its position through extending integrated models of care and taking a lead role in an integrated Cardiology single pathway across Liverpool. The detail provided in the operational plan will ensure that the Trust continues as a going concern in the medium to long term supported by commissioner focus on service quality.

The financial strategy includes clinical income based on forecast at month 6 2015/16 at 2016/17 draft prices(refreshed for month 12) but also references activity trends across service lines and point of delivery (POD) over a longer term five year period in conjunction with the need to deliver activity quantum's that will see waiting times specifically but the NHS constitution in general being delivered. Activity levels in 2015/16 were below plan predominantly within cardiac surgery on CABG (3%), CABG and valve (22%) and valves (12%), but specific significant over performance on some service lines e.g. pacing including devices, driven by NICE guidance on device implantation thresholds at 5% above plan, catheters and cardiac disorders some 23% above plan. The need to continue to deliver additional activity and capacity to return to sustainable RTT compliance in 2016/17 has been factored into the plan. Whilst the Trust will plan to deliver a sustainable RTT, in the first half of the year this will still require some outsourcing of work which has been profiled accordingly to reflect the workforce challenge in recruiting to some key posts.

Performance is under plan regarding the delivery of private patient income in 2015/16 with a revised plan downwards at some £3.5m compared to the 2015/16 plan at £4.0m (2015/16 outturn £3.3m). This is due to two main factors outside of the Trust's control which are a 50% reduction in thoracic private patient referrals and reduced catheter activity in cardiology due to changes in diagnostic pathways and insurance companies have changed their policy rules for these procedures.

Expenditure is expected to increase in 2016/17 as a result of inflationary pressures within the tariff consultation guidance, impact of changes to employers' national insurance contributions, the 2016/17 pay award and activity/quality related investments(2.3% overall). The financial strategy as detailed above caters for inflation of 0.3% for drugs and other non-pay inflation at 1.5%.

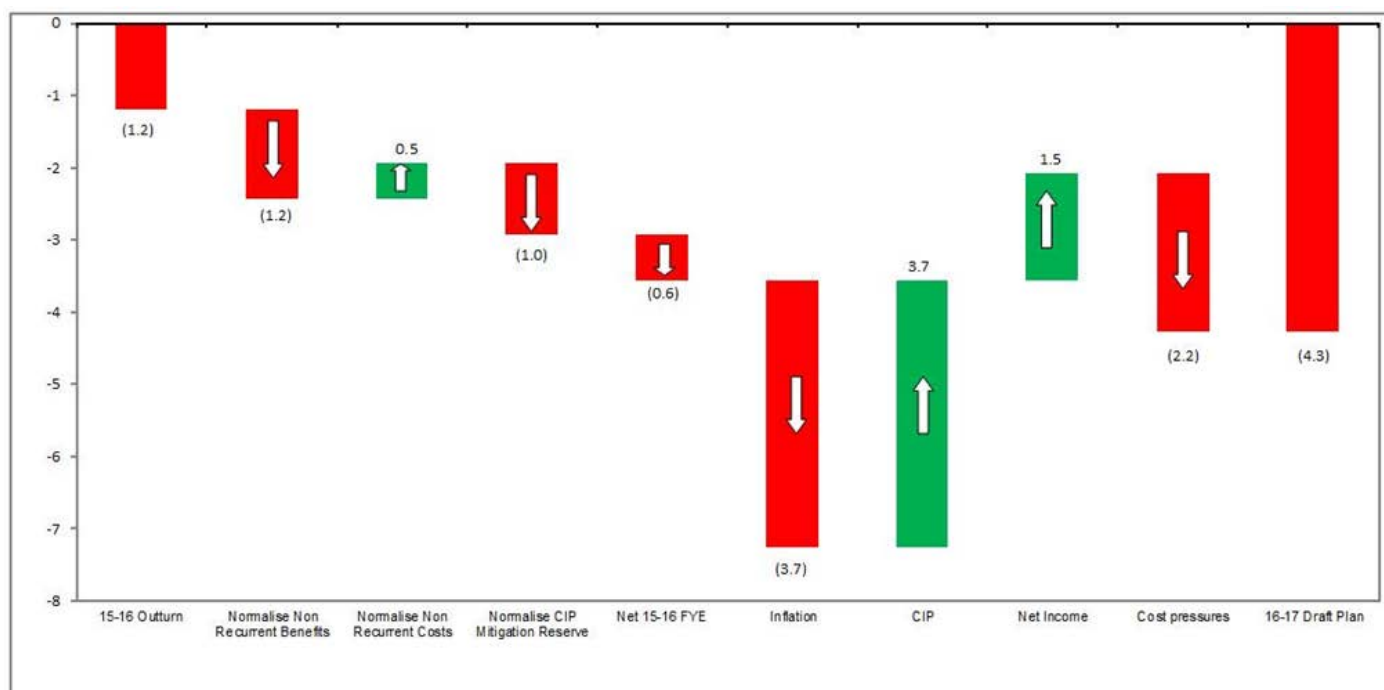
The summary income and expenditure position is detailed below:

	2015/16 Plan £'m	2015/16 Forecast £'m	2016/17 Projected £'m
Income	121.07	122.7	125.8

Expenditure	113.84	116.8	122.9
EBITDA	7.2	5.9	2.9
Normalised Net Surplus/(Deficit)	(0.3)	(1.2)	(4.3)
EBITDA Margin%	6.0%	4.8%	2.3%
Financial Sustainability Risk Rating	3	3	2

The 2016/17 plan shows a slight increase of circa £3.1m from the 2015/16 planned position (£122.7m out turn) with the constituent elements including general growth of £2.9m (2.4%) based on 2015/16 outturn.

**2015-16 Forecast Outturn to 2016-17 plan Bridge:** The detailed bridge set out below identifies the key drivers in reconciling the forecast deficit outturn for LHCH in 2015/16 at £1.2m to the deficit position contained within this draft operational, plan submission standing at £4.3m.



The deficit position included within the plan reflects the overall challenge the Trust faces in delivering efficiencies of £3.7m, whilst also incorporating unavoidable cost pressures, investment in quality and marginal / stepped costs in the delivery of planned increases to activity whilst at the same time working within the confines of a tariff system based on HRG4 which is acknowledged as being deficient in recognising the true costs of delivering activity within the Cardiac EA chapter.

The Trust will deliver a £1.2m deficit in 2015/16 with the key drivers noted in the bridge chart in the 2015/16 financial plan performance section. Using this as the revised starting point for 2016/17 the financial plan then caters for the non-recurrent impact of 2015/16 issues. As detailed previously LHCH has allowed for the impact of inflation (on both pay and prices) broadly in line with national guidance with the exception of CNST cost where the actual increase has been factored in and drugs inflation. Good progress has been made in the construct of a 2016/17 efficiency programme. Investments in quality and service made part way through the previous financial year have had the full year effect appropriately accounted for in 2016/17.

The Trust's long term financial strategy underpinned by this one year operational plan remains focused on the following areas to ensure delivery of the financial plan within it:

- Recognition of the complexity of the clinical services provided at LHCH and consequent cost base through the introduction of HRG4+in 2017/18.LHCH Board of Directors believe this to be integral to the on-going clinical and financial sustainability of the Trust.
- A continual, rigorous focus on the robust control of costs through strong internal controls underpinned by extensive communication and engagement within the organisation of the financial challenges and ideas for CIP schemes. Embedded new governance structures including a new clinical leadership model will enhance both the clinical and administrative management "grip" on the use of resources at LHCH.

- Embedded revised CIP governance processes and structures including the development of a structured process for the delivery of efficiencies, coordinated through the project management office (PMO) supported by a CIP Steering group.
- The maintenance of the LHCH clinical income base (managing the adverse impact of 2016/17 draft tariff prices) in conjunction with seeking opportunities for growth aligned with both patient requirements for specialist care and the Trusts vision to become the best integrated cardiothoracic organisation in the country. Growth in nationally based aortic referrals is one example.
- Through the new clinical leads structure a refreshed clinical engagement plan enabling iterative development and increased use of service line and patient level costing Information systems to drive increased efficiency and reduce costs e.g. to remove clinical variation
- A tight control of the liquidity position and building upon improved treasury management processes instigated during the latter part of 2015/16.

## Key Financial Risks and Mitigations

The key risks to the delivery of the financial strategy are:

- Delivery of another year of challenging 3% CIP target given historically strong performance but with latter two years seeing non-delivery in full and recurrently.
- The withdrawal of HRG4+ in 2016/17 in conjunction with the removal of anticipated specialist services top ups in 2016/17. LHCH Board of Directors will continue to lobby for the introduction of HRG4+ in 2017/18 to enable sustainable clinical services to be delivered in the longer term.
- The potential for loss making cardiac surgery activity including aortics to continue to increase over and above 2016/17 planned levels and the associated loss incurred on these procedures recognised by commissioners.
- Inability to recruit resulting in higher than planned bank and agency costs. The financial plan caters for premium costs in respect of locum and agency staffing at some £1.8m.
- The inability to reach contractual agreement with commissioners. Financial plan is predicated on the following;

Commissioner	Plan Value £'m
NHS England	75.36
CCGS	16.05
Wales	14.6
Isle of Man	3.5

At the time of submission contracts have been agreed with secondary commissioners with minimal risk in respect of Wales and Isle of Man. Contractual discussions continue with NHS England and expectation is that contracts will be signed by 25<sup>th</sup> April. Risk mitigated by over performance is paid in full at PbR rates.

- Anticipated new cost and quality investment requirements in 2016/17 are in line with those catered for in plan at some £2.7m recurrently with anticipated slippage non recurrent slippage of £0.5m.

These risks will be actively managed. The financial plan for 2016/17 caters for £0.8m in respect of risk mitigation. In order to achieve its short term financial strategy the Trust will continue to ensure that it has a firm control of the financial consequences of all its decisions (reinforced by revised governance structures) ensuring that robust control of costs is maintained at all times. The Trust will actively review all options to deliver financial improvements as set out in recent guidance. A revaluation of the Trust's estate is underway and the final impact will be introduced in the April submission. A relifing exercise has been undertaken and is reflected in the final submission.

**Capital Investment:** - The capital plan for 2016/17 broadly remains set within the context of the five year plan submitted in 2013/14 but refreshed where new known risks are expected. In terms of the capital programme, approximately £5.3m will be invested in 2016/17 including:

- Estate redevelopment £2.2m: The Trust will continue its modernisation programme of its wards and other patient facilities to ensure its facilities remain state of the art and offer the highest quality experience to patients and families. This includes £1.0m for the completion of a new main entrance, £0.3m for the final element of reconfiguration of outpatients to improve patient flow, £0.5m for the expansion of critical care beds to enable improved patient flow internally but to facilitate both faster referral acceptance from DGHs and the repatriation of outsourced activity in 2015/16.
- Medical equipment replacement programme of £1.5m. The replacement investment in equipment will enable the Trust to continue to deliver efficient and clinically safe services; investment includes £0.5m for bedside monitoring in critical care, investment in diagnostic equipment to facilitate 6 weeks diagnostics at £0.15m and £0.22m investment in echo machines.
- Estates infrastructure/maintenance of £0.5m.
- IT Investment £0.7m.
- Procurement £0.1m investment to support procurement alignment to Carter objectives including spend on analytics capability and the procurement of an electronic catalogue.
- Capital contingency £0.25m

**Liquidity:-** Cash balances over the life of the plan reduce materially resulting in forecast closing cash balances standing at £2.7m (2015/16 forecast closing cash balances at £7.9m). Working capital for Financial Sustainability Risk Rating liquidity standing at -£8.2m with consequent impact on liquidity days at circa -24 days.

In line with best practice LHCH will continue to prepare short term cash flow forecast on a 13 week basis. This will be shared with operational managers and clinical leads (via Operational Board) as key cash influencers to give greater visibility over the cash position to aid and influence decision making impacting on cash. Reports will also be incorporated within formal reports to LHCH assurance committees.

The Trust will continue to maximise options to improve the working capital management and further develop cash preservation initiatives during 2016/17.

## 6. Link to the Emerging Sustainability and Transformation Plan (STP)

The Clinical Commissioning Groups (CCGs) across Cheshire and Merseyside have established a formal Committee in Common (the Liverpool City region CCG Alliance) in order to take forward joint working to develop the Sustainability and Transformation Plan for the region and linking in with the plan for the Lancashire region. In order to ensure that all providers and commissioners are effectively involved in its production and delivery a PMO is being set up to coordinate delivery.

Liverpool Heart and Chest Hospital is playing a key role in the formation and delivery of this plan, building on some key initiatives it is already involved with.

### Healthy Liverpool Programme and Strategic Options Appraisal

The Healthy Liverpool Programme blueprint, led by the Mayor's commission, was published in September 2015 setting out the vision for an integrated health and social care system for the City of Liverpool. One of the key work-streams is for hospital care to be based around a centralised university teaching hospital campus with single service city-wide delivery, delivered through centres of academic, clinical and service excellence. In response to this LHCH has undertaken a formal options appraisal to examine the future direction of services and long term (5-10 years) options. This appraisal considered clinical and organisational strategy and the clinical links and interdependencies between services. It has also given consideration to the key opportunities, risks and the critical success factors that each option presents including financial and clinical viability. The work has focused on:

- Comparing the quality, access, productivity and cost of current care and modelling forecast demographic changes and future demand.
- Using a 'do nothing' model as a baseline.
- Articulating a case for change based on future scenarios and gaps in current arrangements.
- Describing and quantifying how the Trust will deliver its vision 'to be the best'.
- Develop a number of strategic options at specialty level then aggregating these at Trust level.
- Prioritise strategic options based on the productivity of delivery.

A final report, detailing the process and the findings, will be presented to the Board of Directors in April for a decision on the Trust's long term strategic direction and how this fits with the wider ST Plan.

### **Vanguard Cardio Vascular Disease (CVD) Single Service**

Liverpool Heart and Chest Hospital is playing a leading role, working closely with other local providers to create a single service, unified, city-wide delivery model for cardio vascular disease. The programme will develop care models for cardiology to improve equality of access and deliver the optimum health outcomes for the population of Liverpool with cardio vascular disease.

An Integrated Steering Group has been established, with representatives from Liverpool Heart and Chest, the two acute trusts, local GPs and Liverpool CCG. Five clinically led work streams, based upon clinical priorities have been agreed: -

- Palpitations and Syncopy
- Breathlessness
- Chest Pain (including ACS)
- Imaging and diagnostics
- Rehabilitation

The priority for the five groups is to work together to agree 'quick wins' to improve the services, the ideal model of care and where this is best delivered, and an implementation plan.

## **7. Membership and Elections**

### **Governor Elections**

In Summer 2015, elections were held for 8 public governor seats and 4 staff governor seats in accordance with the election rules set out in the Trust's constitution. In these elections 5 public governor seats and 2 staff governor seats were contested and the turnout was an average of 26.8% for public elections and 22.6% for staff elections. The Trust also introduced the option for online voting for the first time, and this change made voting more accessible to all members by offering the option of on line or paper ballot.

The Trust is currently reviewing the composition of the Council of Governors and the outcome of this will be concluded in March 2016. The next rounds of planned elections will be in summer 2017 and summer 2018. In order to manage the transition and ensure effective succession, the initial terms of half the elected governors were for two rather than three years. This will ensure that the cohort of new elected Governors will be split over a two year period.

### **Governor Recruitment, Training and Development**

The Trust ran a successful recruitment campaign for governors for the summer 2015 election which is evidenced by more than half the seats resulting in contested elections. 5 new governors were also recruited and commenced their terms of office on 1st October 2015 following the Annual Members' Meeting, along with re-elected Governors.

All new governors are well inducted receiving local induction with the Chairman and Associate Director of Corporate Affairs including provision of essential and useful induction documentation. All new governors attend an annual induction event hosted onsite by an external facilitator. This is provided annually in collaboration with other local Trusts and a number of experienced Governors attend to provide support and share their experiences. The Trust also encourages governors to access regional and national development opportunities throughout the year. These include the North West Governors Forum, Mersey Internal Audit Agency Governor Learning Series and Govern Well workshops. This is in addition to planned internal events including an annual joint Council of Governors and Board of Directors Development Day, executive director led interest groups (quarterly); Chairman's lunch meetings (quarterly); annual planning workshops, scheduled walkabouts to wards and departments, regular update presentations from service leads and membership of governor sub committees and task and finish groups.

An annual calendar of events is organised to give governors the opportunity to engage with members and the public. This includes an annual Members Health Day/Open Day; regular 'Medicine for Members' events as well as the Annual Members' Meeting. Governors are also invited to attend patient and family listening events as this is an invaluable way of engaging with patients and families.

Governors participate in an annual evaluation of the training and development provided by the Trust and contribute to a governor skills audit to inform the development programme.

### **Membership Strategy**

The Council of Governors' Membership and Communications Sub Committee, chaired by a public governor is



responsible for the review, delivery and implementation of the Trust's membership strategy. The Trust maintains a target of 10,100 for public membership (10,349 at 22/1/16). All new permanent employees and those who have worked for the Trust for 12 months or more automatically become a staff member (but may 'opt out'). The Trust's membership strategy is focused on retention and engagement of membership and active recruitment to manage the small turnover rate of members whilst striving to increase representation in relation to age profile, ethnicity, gender and demographics across the patient and public population.

A membership engagement, recruitment and communication plan is delivered across the catchment areas – Merseyside, North Wales, Cheshire and Rest of England and Wales. Members are invited to attend a series of health events on a wide range of topics. These are held out in the community to make this accessible to all. Views are also sought from members via the bi annual members' survey and an annual focus group which helps to shape the Trust's quality priorities.

The membership strategy will be reviewed by the Membership and Communications Sub Committee in 2016/17, along with the communications, recruitment and engagement plan which will incorporate a calendar of events.

## **Conclusion**

Overall the Trust believes that it has a robust operational plan to meet the challenges and opportunities facing it in particular the financial plan and constraints, quality priorities, delivery of activity levels and building a sustainable workforce.