



## Strategic Plan Document for 2013-14

Heart of England NHS Foundation Trust



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## Strategic Plan for y/e 31 March 2014 (and 2015, 2016)

This document completed by (and Monitor queries to be directed to):

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Date	30 May 2013

The attached Strategic Plan is intended to reflect the Trust's business plan over the next three years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- The Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;
- The Strategic 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 Strategic 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;
- All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission.

Approved on behalf of the Board of Directors by:

Name (Chair)	Philip Hunt
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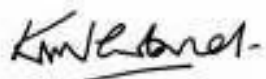
Signature



Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Mark Newbold
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Signature



Approved on behalf of the Board of Directors by:

Name (Finance Director)	Adrian Stokes
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Signature



## 1) Executive Summary

The NHS is going through an unprecedented period of change. The key factors driving the change are; growing demand for patient care, increasing expectation for continuous improvement in the quality of care and outcomes, and zero growth in resources. To continue as a leading health care provider, we are committed to transforming our organisation to meet this growing demand without growth in our resources. Our 4 areas of transformation are:

- Clinical Transformation – In delivering many acute services across 3 sites, we have the opportunity to plan as a system and to re-shape services across Heartlands, Good Hope and Solihull Hospitals to ensure we achieve the best balance between 'concentrating where necessary, and localising where possible'. By taking this approach, we can ensure our highly specialised services meet the highest quality and outcomes standards, while at the same time maintaining local access for general and high volume care. An important principle will be that each Hospital will remain an entry point into a system of urgent and emergency care provided by HEFT.
- Inpatient to home patient – We will change the way care is provided by putting greater emphasis on managing long term conditions out of Hospital and further developing community based services.
- Front door focus – With our recent experience of extreme pressure on our emergency pathway and findings of the Francis report, we will improve access to emergency acute care and take greater control and accountability for elements of the non-acute emergency pathway that we have not previously managed.
- Business Transformation - We will maximise the use of digital media to increase the speed and accuracy of all processes that support patient care and the management of our organisation.

As we are planning for tariff reductions to be £6m and inflation to be £17m each year, we have plans to deliver efficiencies of £23m and maintain an annual surplus of £6m over the next 3 years.

## 2) Strategic Context and Direction

### A. Trust vision and Current position

Our vision is to provide services that encourage confidence, trust, and pride within the communities we serve. The key priorities unpinning our corporate strategy of transformation are:

- Safe and Caring –To keep the safety message alive, we regularly promote safety programmes across the trust and published a new safety message every month. For example in 2012 we launched Recovery at Home service and held a 4-week Safety campaign in September.
- Locally Engaged – We will continue involving our local communities. In 2012 we organised the community fete at Good Hope and Solihull and Trust community health fair, celebrated anniversaries of Birmingham Chest Clinic and Sexual Health department building at Heartlands Hospital. Similar events are planned for the 2013/14 year. We are working with local GPs and developing specific services that link to the needs of our communities and our programme of early supported discharge.
- Efficient – As part of the overall Nicholson challenge we must deliver significant efficiency improvement each year. Alongside our Business Transformation we are working in

partnership with other organisations in our Health Economy to implement more efficient inter-organisation ways of working that will improve patient flow and efficiency.

- Innovative – We are striving to become a leading ‘open organisation’ to strengthen collaboration across all those who are directly and indirectly involved providing for our patients, and aiming to develop a number of beacon clinical services. Other newly implemented schemes will be rolled out across the Trust, such as rolling out VITAL (Virtual integrated teaching and learning) for nurses across all nursing groups, VITAL for doctors and will continue to build the recognition for our ‘HEFT Nurse’ brand.

The diagram below provides an illustration of the key priorities supporting our corporate strategy of transformation.



## B. External impacts on the Trust

In our plans we recognise the pressures of increasing demand for healthcare services, a restriction in resources and several trends that have emerged in NHS;

- ❖ The austerity and quality agenda are increasing pressure on lower volume services,
- ❖ The importance of developing integrated care,
- ❖ Funding uncertainty is driving benefits of broadening activities and building partnerships,
- ❖ Innovation is reducing the use of hospitals, and
- ❖ There is increasing competition for patients and talent.

Planning for efficiency and continually improving quality is covered in more depth in sections 3, 4 and 5.

### Developing integrated care

We are fully committed to developing integrated care. The Solihull site, which has an acute hospital and community services teams, is being used as an example of how integrated care should be approached. We have set up an Accountable care partnership with the local council and the clinical commissioning groups to deliver an end to end service for patients requiring access to care in the different forms. A similar arrangement is being developed with the partners involved in caring for patients who attend Good Hope hospital. We have started to develop a model of care to support the Supported Integrated Discharge process which could involve our staff providing care and support in a non-hospital environment to speed up the discharge process for those patients who are medically fit.

### Innovation reducing the use of hospitals

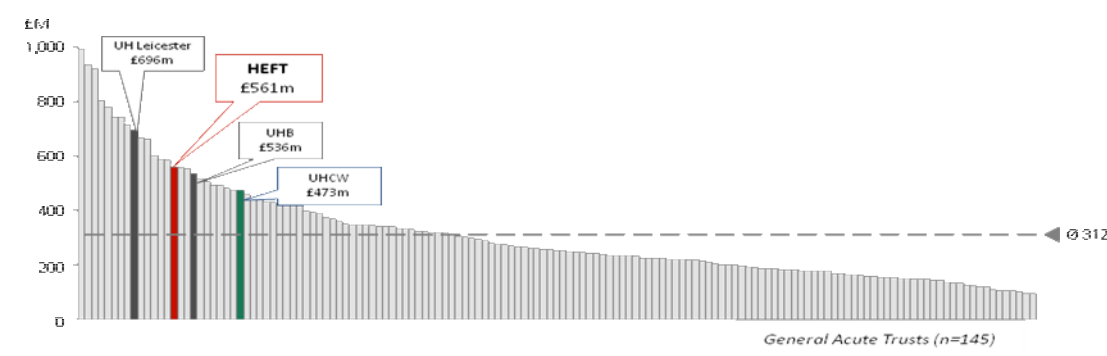
We are pursuing models of care that require less use of hospitals. This varies from running clinics in the community to working with commercial organisations and charities to have care provided outside of the hospital, such as the Healthcare at Home project.

We are continuing to increase the proportion of procedures performed as day cases instead of inpatient, and similarly increase the number of outpatient procedures instead of day cases. A new day case theatre suite at Good Hope hospital opened in March 2013 which has the facilities to use new technologies to perform shorter operations with improved recovery time. Although the need for a hospital visit is not eliminated by these advances it should reduce the amount of time spent in hospital.

In addition we have a partnership with local organisations to establish an Allied Health Sciences Network (AHSN) which will help to deliver additional innovations to improve healthcare and reduce need for hospital visits.

### Increasing competition for patients

We have assessed our size and capability against neighbouring Trusts and the diagram below shows the Trust is in the top quartile by size of acute Trust's in the country.



It is important that we identify the demographics of the catchment population we serve in order to ensure we understand the needs of its local population, providing efficient services in the 'right' place.

There is currently no set definition for a Hospital Catchment area, therefore the we have been gathering data and using analysis techniques to identify the best way of obtaining the demographics of the population. Our definition of the 'potential' catchment area is as follows;

'the Lower Super Output Areas (LSOA) which fall into an amalgamated 20 minute drive time around each of the three main sites: Heartlands Hospital, Solihull Hospital and Good Hope Hospital.'

The ONS (Office of national statistics) Mid 2010 Population estimates of these LSOAs have then been applied to identify a Trust Wide 'potential' catchment population of 1,161,628.

Further analysis shows that our catchment area overlays 12 boroughs. Demographic information by borough, available from the ONS, has been applied to the Mid 2010 populations of LSOAs within the Trust's catchment area to give a best estimate of the demographics of the population. This information has identified varying demographics within different regions of the catchment and therefore differing local populations for each of the sites it serves. It is also noted that the individual site catchment areas overlap with each other and other trusts.

Understanding the ethnicity of a population is important as ethnicity can have important effects in health and the uptake of Healthcare services. A knowledge and understanding of the different ethnic backgrounds of a population can help improve their healthcare. Our analysis shows that the central part of our catchment area is diverse in comparison to the North and South of the catchment. Over 61% of HEFTs potential catchment population is within the borough of Birmingham, within which Heartlands Hospital is located. The majority ethnic group of this borough is 'white' at 68% however this is almost 20% lower than the England average of 87%, with 20% identifying to Asian/Asian British and 12% other ethnic groups.

17% of our catchment population covers the southern part of our catchment. This is in the borough of Solihull, in which Solihull Hospital is located. The majority ethnic group of 'white' is higher at 90% , with only 5% being Asian/Asian British and 5% being other ethnic groups.

Walsall, Lichfield and Tamworth are boroughs located North of the catchment in which Good Hope Hospital is located. The majority ethnic group of 'white' is again higher with over 90% of the combined boroughs, with only 5% being Asian/Asian British and 3% being other ethnic groups.

We have also analysed the age demographics of the catchment area. This is vital to aligning services in the correct place and ensuring community services are also available. The majority of our catchment population is age 20-64 at 58%, 27% are aged 0-19, 11% 65-79 and 4% aged 80+.

The largest proportion of the elderly population is located in the boroughs to the South of the catchment. Bromsgrove, Solihull and Stratford all have a population of >6% aged 80+. These boroughs along with North Warwickshire and Lichfield (in the north) also have the highest percentages of patients age 65-79 year olds at >14%.

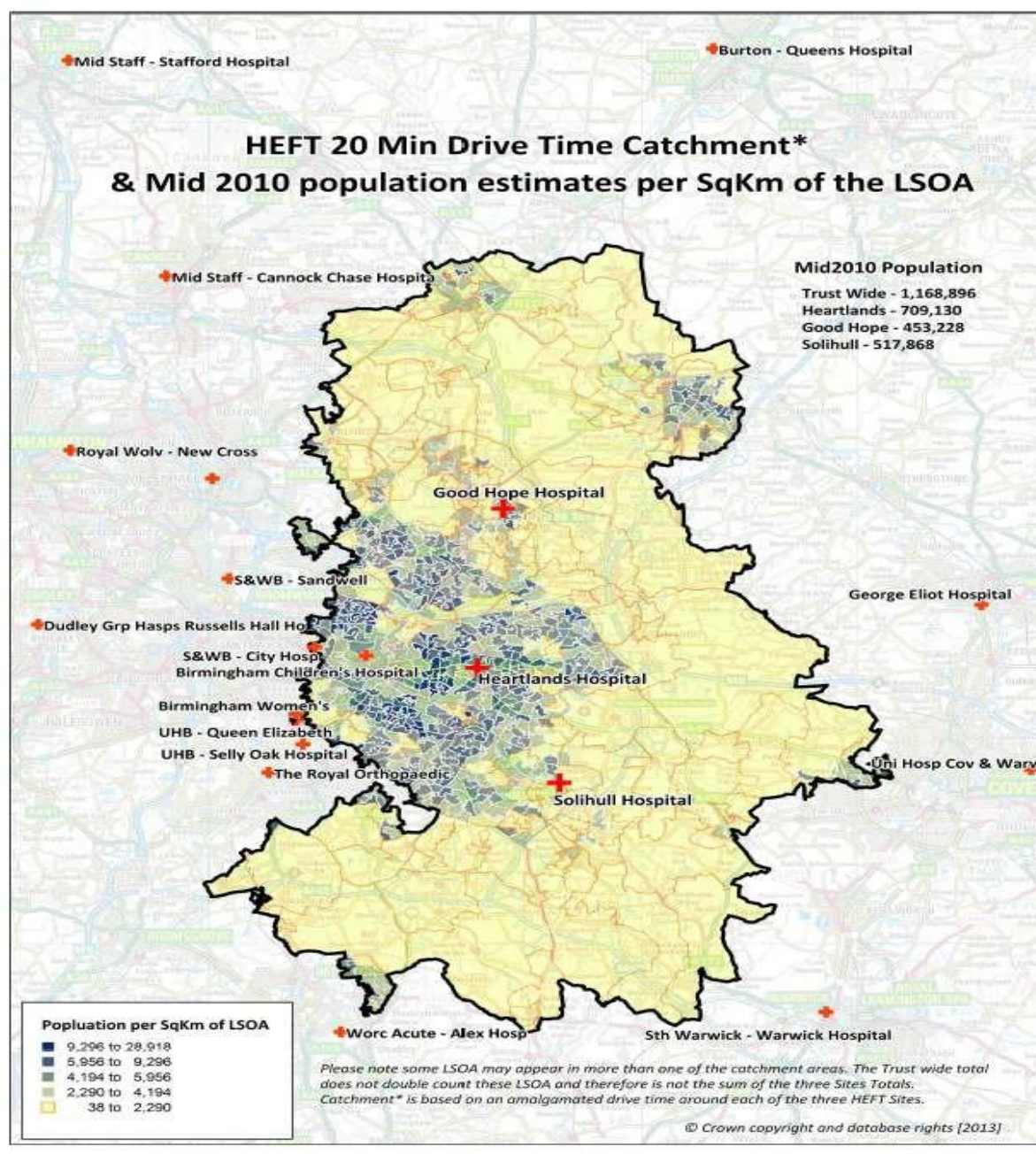
The borough of Birmingham, in the centre of the catchment, has a high 'Young' and 'working age' population with only 9% age 65-79 and 4% age 80+. Tamworth and Walsall, towards the North of the catchment have the highest percentages of the 'working age' population in there borough with 62% in each.

Analysis by the ONS has identified that the UK population is projected to increase by an average annual rate of growth of 0.8% over the next 25 years. This is due to a natural increase of births



exceeding Deaths and an assumption that there will more immigrants than migrants. The Trust's overall catchment population is expected to have increased from the Mid 2010 Estimates by 10% in 2020, a further 4% in 2025, a further 4% in 2030 and a further 3% in 2035. This analysis identifies the strains that will put on the NHS in the following years with an ever increasing population, including an increase in births and an increasing elderly population.

We will continuously analyse the changing demographics of the potential catchment area as new data becomes available. This information will be shared with commissioners when activity plans are set every year.



The newly introduced Net Recommender Index (NRI) scores could be used as an indicator of HEFT's performance; this is a percentage of patients who are 'extremely likely' to recommend our hospital.

Our NRI scores are currently similar rate to the main acute competitors in Birmingham as well as in the West Midlands region. These will continue to be reviewed on a monthly basis and where the results suggest attention is required an action plan will be produced.

### C. Commissioning

We continue to have a good working relationships with our commissioner which allows us to have open and frank conversations in addressing commissioning issues jointly. Through the JMRA (Jointly Managed Risk Agreement) introduced in 2012/13, alongside our commissioners we have been able to increase our focus on the activities that are needed to improve patient pathways and drive more collaborative working on service developments and demand management

Our Reshaping HEFT project includes identifying where pathways or services need to change in line with national directives. For example we have recently undergone a review of the reconfiguration of stroke services to follow the clinically proven model implemented in London. Before this model of care can be implemented we will be having further detailed discussions with our commissioners to confirm the benefits for our patients.

We have also been working with committees set up by the commissioning organisations such as the Frailty Board, to put improved patient facilities in place that will have an impact across the whole health economy rather than each Healthcare organisation working in isolation.

### D. Reconfiguration Plans

Over the last 18 months we have been running the Reshaping HEFT programme, which has reviewed the way some of our key services at the Trust are provided. We have carried out extensive modelling of service configuration to inform our discussions with internal and external stakeholder in agreeing where any changes are required.

Alongside Reshaping HEFT, which focuses on clinical strategy redesign, a programme of Business Transformation was established in 2012/13. This is a three year programme looking at improving the digitisation of processes within our Trust and will involve automating processes such as electronic JONAH Boards (JONAH is a method used to make sure there are regular updates on patient status to improve discharge rates) . A full list of these projects can be seen in the financial appendix.

In April 2012 we performed a management realignment to a site based structure and this has operated for the whole of the 2012/13 and is expected to remain in place.



## E. Any Qualified Provider

We are aware that there may be increased competition in the future. Where the commissioners have indicated they are already planning to run competitive tenders for services we currently provide, our initial reviews of the services are underway with a view to decide whether we take part in the tender exercise. Where we are keen to compete, the necessary changes to these services are being put in place in the 2013/14 year, in preparation for the tender process. Currently these services include Audiology and Sexual Health.

## 3. Quality

Quality of care is our most important aim. We demonstrate this in our Quality Report and in having safe and caring as its key priority.

### CQC visits

During 2012/13, the Trust has had four unannounced inspections from the Care Quality Commission: In November 2012, the CQC visited Solihull Hospital. The CQC assessed compliance with three outcomes – Outcome 1 (Respecting and involving people who use services); Outcome 4 (Care and Welfare of people using services) and Outcome 6 (Cooperating with other providers). We were found to be compliant with outcome 4 and 6, but non compliant with outcome 1. However, at a subsequent visit in March, we were found to be compliant with this outcome.

In February 2013, the CQC visited Good Hope Hospital. The CQC assessed compliance with three outcomes. We were found to be compliant with Outcome 7 (Safeguarding) and non compliant with Outcome 1 (Respecting and involving service users) and Outcome 17 (Complaints).

Although this has resulted in the Trust is not fully compliant with the registration requirements of the Care Quality Commission, we have taken immediate action to address any issues identified from the CQC visits and full action plans are in place for any outstanding actions. All action plans have been submitted to the CQC.

### Safety Management

Our Trust Board's focus on quality is set out and underpinned in the corporate priorities of; 'Safe and Caring, Locally Engaged, Innovative and Efficient'. To support delivery of these objectives, we have a robust corporate governance structure to facilitate the escalation of risk and issues associated with the delivery of safe and quality services. Strategic risks to the delivery of services and mitigation plans are reported quarterly to our Executive Management Board and our Trust Board.

Assurance is derived from a number of sources. Patient experience and nursing metrics are regularly reviewed by committees in our Trust and the Clinical Quality Performance Group reviews the quality dashboard monthly. In addition we self assesses each quarter against the Care Quality Commission core essential safety standards and compliance is reported to and monitored by our Clinical Quality Performance Group.

In addition, the head of internal audit provides an overall opinion of the arrangements for gaining assurance through the Board Assurance Framework and on the controls reviewed as part of the internal audit work. The following sources of information are regularly reported through our Trust committees:

- ◆ Monitor quarterly reporting;
- ◆ CQC essential standards of quality and safety;
- ◆ Health and Safety Executive;
- ◆ NHSLA;
- ◆ Patient experience metrics;
- ◆ Nursing metrics;
- ◆ Dr Foster information;
- ◆ Staff surveys;
- ◆ Internal audit;
- ◆ External audit;
- ◆ Peer reviews.

Each level of management, including Trust Board, reviews the risks and controls for which it is responsible. This is monitored through a reporting structure, to support our risk management strategy and Board Assurance Framework.

We also produce an annual quality account which provides a report to the public on the quality of the services we provide. This is independently reviewed by our key stakeholders, including the commissioners as well as our external auditors.

We will ensure that all relevant stakeholders, including staff are kept informed of, and where appropriate, consulted on the management of risks faced by the organisation. We engage our stakeholders through the following forum:

- ◆ Governors consultative Council
- ◆ Consultative Health Council
- ◆ Patient and public involvement forums
- ◆ Overview and scrutiny committees
- ◆ Patient surveys
- ◆ Patient focus groups
- ◆ Staff survey
- ◆ Foundation Trust membership
- ◆ Commissioners

These groups are regularly consulted to obtain assurance relating to the quality and safety of the services that we provides.

#### 4. Clinical Strategy

##### Clinical transformation

In delivering many acute services across 3 sites, we have the opportunity to rationalise services across Heartlands, Good Hope and Solihull to ensure each Hospital becomes more specialised in a fewer number of services, without reducing the overall services we provide as an organisation. We are planning for Solihull hospital to become a centre for elective care and where possible move

elective care from Heartlands and Good Hope to reduce the risk of elective cancellations as pressure for emergency beds increases. Our intensive care service at Solihull is also being reviewed to see whether it is better to move these beds to become part of the larger intensive care services at Heartlands or Good Hope.

### Front door focus

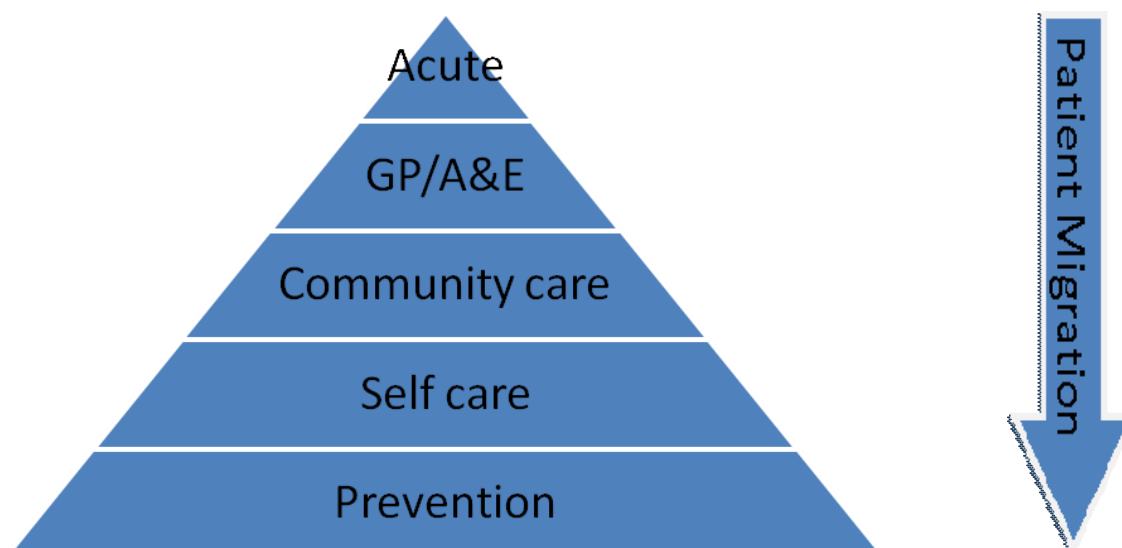
With our recent experience of extreme pressure on our emergency pathway and findings of the Francis report, we will improve access to emergency acute care and take greater control and accountability for elements of the non-acute emergency pathway that we have not previously managed. To ensure more beds are available for emergency patients arriving in A&E, we are extending our 'Heft at Home' programme that allows patients to leave the hospital setting as soon as they are fit to do so but remain under the care of the ward in their home until fully discharged. We are introducing Acute Medical Centres in each Hospital to diagnose and treat emergency patients where possible without the need to be admitted to a base ward. The schedule below shows work streams that are already underway to improve the emergency pathway across our hospitals:

E-Jonah (managing patient care on ward)	Good Hope AMU Changes to improve patient flow	Section 2/5 process (social care agreements with local authorities)
Winter staffing	Introduce Supervisory Ward Sisters	
18/7 Restructure (More senior nurses on wards for longer)	Wider implementation of HEFT@Home	Ambulance Turnaround

### Inpatient to home patient

We are changing the way care is provided by putting greater emphasis on managing long term conditions out of Hospital and further developing community based services. In leading the Accountable Care Partnership which oversees the community services in Solihull we aim to integrate acute services more with community services to increase the number of patients with long term care packages and reduce the risk of a need for an inpatient stay. The diagram below shows how a greater focus on managing long term conditions aims to move an increasing number of patients from each level of care into a more self-managed care setting.

This diagram is based on 'The Bubble Gum model for multiple LTC management', Dr Rahul Mukerjee.



## Service Line Management

We understand the importance Monitor places on Service Line Management and is currently running a project to further develop service line reporting;

Phase one (current phase) is to move from the current process of quarterly spread sheet driven information to an automated system with integrated dashboard reporting. The current focus is on the production of financial information. The next step is to have an integrated dashboard incorporating clinical outputs such as performance, quality and safety. The dashboard system will give accessibility and transparency to all relevant clinical and operational staff. This phase incorporates the introduction of performance measurers to monitor “Directorate Contribution” and the formation of an SLM Project Board to further inform decision making relating to investment and divestment of services. The Board will include both clinical and operational staff. The long-term aim is to formulate an “Organisational Framework” to enable the creation of “Foundation Directorates”.

Phase Two – June 2013 – March 2014 is the production of the “Organisational Framework”. This will be alongside the introduction of Patient Level Data into the Service Line Reporting Information. Initially efforts will be placed on Theatres, Drugs, Radiology, Pathology and implants. The method of reporting will also be further refined to incorporate the new patient level data and include the links with the quality, safety and performance data. This information is key to the full implementation of Service Line Management and forms the foundations of the “Organisation Framework”.

Phase Three – April 2014 Onwards will see the full implementation of an Organisational Framework and Service Line Management reviews as well as the Implementation of a full Patient Level Information and Costing System, reported monthly.

The proposals for the implementation of SLM have been developed by visiting other NHS Organisations and comparing the systems and processes currently adopted by them. A limited number of organisations have a working Service Line Management model. The aim of this project is to take the best models, adapt them and hopefully enhance relevant aspects of them to implement a solution within the resources available.

Once phase 3 has been completed these tools will be used to provide more detailed information to further assist decision making and identify opportunities to invest in services or reduce services

## Clinical Workforce Strategy

Our Board has agreed 4 workforce transformation projects and these are being run by the HR department. These project focus on improving staff satisfaction, training, attendance levels and reduce vacancy levels.

Some of the key projects being worked on include;

- ! Doctor revalidation and job planning,
- ! Delivering VITAL (and training and competency tool) for all groups of nurses and doctors,
- ! Developing a workforce model that enables the hospitals to run more effectively more of the time once a decision has been made as to the time model we are working to (eg, 24/7,18/7). This work is being led by an external expert.
- ! Maximising the benefits from effective rostering across all services and all sites,
- ! Reviewing nursing models of care,
- ! Identifying improved ways of recruiting, and
- ! Identifying improved training options.

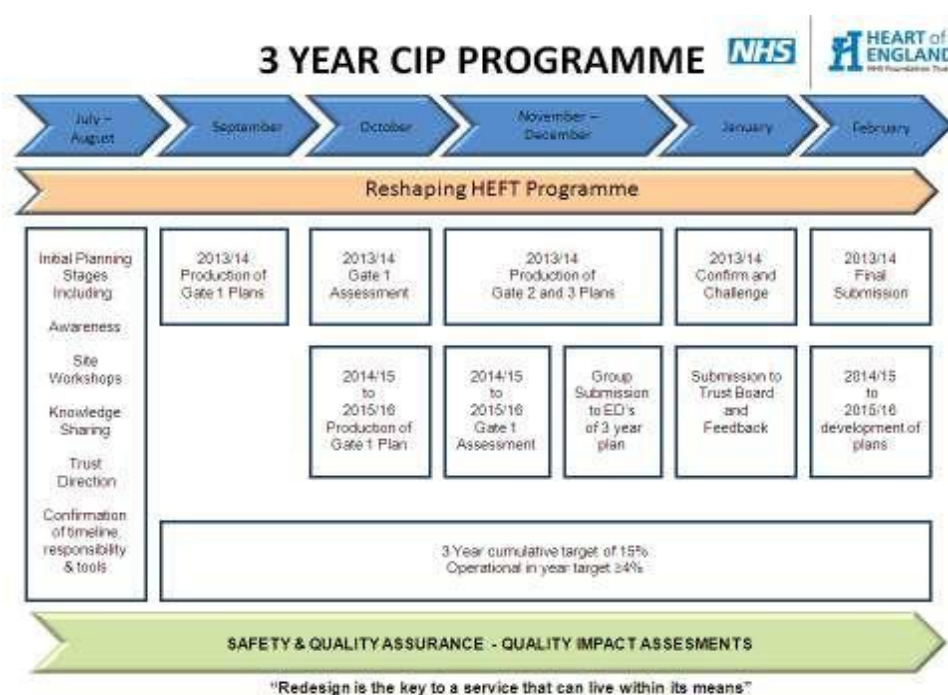
Our Medical Director, Nursing Director and HR Director are all working together to deliver these projects.

## 5. ProductivityandEfficiency

Innovation and efficiency are also key priorities for us. We have embedded a process for identifying schemes that will contribute to the cost improvement programme for the forthcoming year. We expect £23m cost reduction per year. Initially each division is given a target of circa 5% per year and this is reviewed when the proposed efficiency schemes have been considered. Our Operations Committee has taken a more overarching approach to delivering schemes that go across more than one division or site. All of our efficiency schemes undergo a quality impact assessment.

Our approach for planning, identifying and monitoring delivery is shown below.

### PlanningCycle



### Monthly monitoring

Each month, progress against the schemes is reported and challenged. If a scheme is not delivering then a rectification plan is required, so that closer scrutiny of the scheme's delivery can be carried out.

Owing to the importance of delivering efficiencies we carry out internal audits of our processes that support CIP delivery. In the last 2 years internal audit reports have given the CIP process significant assurance.



