

Luton and Dunstable University Hospital NHS Foundation Trust

Annual Plan

2013/14

Approved by the Board of Directors 22nd May 2013



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Forward

April 2013 saw one of the most significant changes to the management of the Health Service, with the creation of Clinical Commissioning Groups, abolition of Strategic Health Authorities and Primary Care Trusts and the establishment of the National Commissioning Board. The publication of the Francis Report two months earlier provided everybody working in the Health Service with a stark reminder of the importance of ensuring that very basic care needs to be embedded within organisations if they are to deliver the quality of care that patients deserve and expect. The report makes it clear that these priorities must form the cornerstones of effective and high performance hospitals and they need to be both strategic as well as operational priorities for all organisations.

2012/13 has been a year of sustained operational performance for L&D. Throughout the year we worked to deliver better clinical outcomes, safer care and improving patient experience.

I am pleased to report that through the hard work and commitment of our staff, we have consistently met all national quality and performance targets. Importantly the CQC also recognised the transformation that has taken place in the Trust, when they confirmed that we are delivering compliance against all essential standards.

Throughout the year our greatest focus has been on delivering our quality priorities. In particular, our work to improve clinical outcome in relation to fractured neck of femur has made real progress, however, we recognise that more needs to be done and this will remain a key clinical priority this year.

As in previous years, we have delivered our financial targets and in Quarter 4 achieved a financial risk rating of 3. We are however concerned about the significant financial challenges facing all Foundation Trusts and have therefore worked closely with our Clinical Divisions to develop a comprehensive programme of efficiency projects detailed in the plan.

Strategically, 2012/13 provided the Trust with the opportunity to work with internal staff and external stakeholders, partners and experts to clarify our likely future service portfolio and market share. This has enabled the Trust to develop a clinical services strategy 'Delivering the New L&D' which is presently being launched for wider discussion.

The redevelopment of the L&D site has been a key strategic objective for a number of years, the development of 'Delivering the New L&D' has enabled us to move ahead with a strategic outline case for the redevelopment entitled 'Building the New L&D' and later this year we will submit an outline business case to Monitor for the project.

The coming year will bring us real opportunities but considerable challenges, it will be important that we continue to work with our CCGs and other stakeholders if we are to continue to meet increasing demand and higher patient expectations with fewer resources.

Our work programme is relentless:

- We must continue to consistently deliver to meet all national quality and performance targets.
- We must not lose focus on delivering quality improvement, in particular, we must focus on the provision of 24/7 consultant care, making greater improvements in fractured neck of femur mortality and revolutionising how we manage and learn from patient feedback and complaints.
- We must work with our CCGs and other key partners to finalise our clinical services strategy and to provide a secure basis for our hospital redevelopment programme.
- We must use our energies to deliver our comprehensive programme of efficiency in order to provide the highest quality affordable care.
- We must not lose sight of the tremendous contribution of our staff and continue to build an organisation that will motivate and inspire them to give their best to every patient every time.

Delivering these priorities will allow us to look ahead with a real sense of optimism.

1. Summary of 2012/13 Performance

1.1 Performance against Corporate Objectives 2012/13

Objective 1: Deliver Excellent Clinical Outcomes

- ***Improve performance on overall hospital mortality and in particular for patients with fractured neck of femur***
 - For 2012/13, the Trust overall hospital mortality was consistently under 100 with the best performance of 91.7 in June 2012.
 - The poorer performing mortality HSMR was identified as fractured neck of femur patients and this has been the focus during the year.
 - A comprehensive plan was developed and implemented to improve fractured neck of femur mortality including:
 - The redesign of the fractured neck of femur integrated pathway.
 - The establishment of a dedicated fractured neck of femur ward with strong nursing leadership.
 - The appointment of a second consultant orthogeriatrician facilitating the reorganisation of orthogeriatric cover to the dedicated fracture neck of femur ward.
 - The development of a dedicated multi-disciplinary team which has allowed the delivery of improvements in peri-operative and post operative care.
 - The mortality rate decreased from a peak of 197.4 in September 2012 to its current level of 152 at the end of March 2013. Significant progress has also been made in delivering the best practice tariff during the year.
 - A significant reduction in the length of stay has been achieved for patients admitted with a fractured neck of femur. In May 2012 the average length of stay was 24.4 days and in March 2013 it had reduced to 9.7 days.
- ***Fully participate in national and local clinical audits***
 - During 2012/13, the Trust participated in the required National Audits set by the Department of Health, commissioners, regulatory bodies and local audits, within the current resources available and in accordance to the Clinical Audit and Effectiveness Forward Plans.
 - Awareness was raised and proactively measured and monitored the impact of implementing clinically effective & evidence based best practice.
 - External and expert support was provided to clinicians, managers and staff in the integration of best practice and improvement plans into the services provided.

- Representation of stakeholders at the Clinical Audit and Effectiveness Committee has ensured that the requirements set out in the Clinical Audit and Effectiveness Strategy have continued to be embedded across all service areas. During 2012/13 the Clinical Audit activities have influenced the quality of patient outcomes and led to improvements in services and enabled the delivery of the Trust's objectives. Further information regarding the Trust participation in clinical audit will also be published in the Quality Account.
- ***Improve performance on average length of stay (ALOS)***
 - In 2012 it was recognised that it was essential to reduce the average length of stay (ALOS) in order to maintain patient safety and meet key operational and performance targets.
 - Consequently a project was set up led by the Divisional Director for Medicine who, as part of the project, undertook a review of all patients in hospital over 14 days who were not medically fit for discharge. The objective was to prevent care and treatment delays and to promote discharges. This achieved a reduction in length of stay and reduced the overall percentage occupancy over an extended period. This was one of the actions that supported the achievement of the emergency care target.
 - Ongoing initiatives to reduce length of stay are:
 - A Length of Stay Programme Board has been set up, to achieve a coordinated robust management of projects with clear deliverables and timeframes across the Trust.
 - Work is ongoing with Community partners to establish the requirements to facilitate more timely discharge from secondary care.
 - An Ambulatory Care Unit and Hospital at Home service have been established to assist with admission avoidance.
 - Improved management of ward processes to expedite discharges is being secured through the implementation of daily Board Rounds where a daily multi-disciplinary team review of all patients takes place to establish and progress care, treatment and discharge plans.
 - A robust system is now in place to track and manage medically fit for discharge patients – in addition a medically fit for discharge ward will be operational from mid May enabling concentration of resources in one clinical area to promote more rapid discharge.
 - Performance data continued to be analysed to ensure the strategies deployed remain effective.
 - We have developed and written discharge pathways that involve multiple organisations.

Objective 2: Improve Patient Safety

- ***Reduce hospital acquired C Diff infection***
 - During the year we had 17 cases of C Diff against a threshold of 31, this was a significant achievement as during 2011/12, 34 cases were reported. We believe

the performance was a result of good hygiene, good isolation policies and antibiotic stewardship.

- ***Increase compliance with hand hygiene***

- A hand hygiene campaign was launched in January 2013, '*Hand Hygiene in Partnership*' with a key focus on improving staff and patient knowledge in understanding the right times to undertake hand hygiene.
- A core group explored various ways to communicate to patients and the public and came up with a novel initiative called the 'Virtual Assistant'. The 'Virtual Assistant' is a digital signage solution that brings messages to life regarding hand hygiene and will be in operation early in 2013. This will also support the Trust's priority to improve communication with patients.
- Compliance with hand hygiene is regularly monitored and published and training is targeted where compliance is not consistently high. Training compliance has improved by 12% throughout 2012/13.
- There is an increased vigilance in clinical areas to ensure that staff and visitors comply with hand washing and use of hand gel.

- ***Implement Safety Express throughout the organisation***

- Implementation of the safety express in 2012/13 focussed on staff training and data collection, establishing an accurate baseline. This has provided a snapshot of harm from pressure ulcers, falls, urinary infection in patients with catheters and treatment for VTE. 95% harm free care against these four harms has been delivered consistently.
- The Trust has participated in the East of England Stop the Pressure campaign and have reduced pressure ulcer incidence in numerous clinical areas.
- The Falls Care Bundle has been implemented across all elderly care wards and there has been a 17% reduction in all falls in 2012/13 compared to 2011/12. The focus for 2013/14 will be on further improvement on outcomes particularly for pressure ulcers and falls and the national CQUIN scheme will be undertaken.

- ***Increase consultant led care***

- 14 new consultants were appointed during 2012/13 allowing further progress in improving clinical outcome to be made.
- Consultant care is now provided on-site, 12 hours a day seven days a week in acute medicine.
- There is extended consultant cover across Paediatrics, NICU, obstetrics and gynaecology covering evenings and weekends. The development of 24 hour resident consultant cover in the neo-natal unit will also continue.

- The establishment of consultants in Emergency Medicine has increased with an aim to provide 24/7 consultant presence in the near future.
- ***Implementation of electronic nursing observations***
 - Implementation of the electronic nursing system has enabled easy and remote access to patient observations by nurses and doctors. This has facilitated more timely intervention, thus preventing cardiac arrests and reducing avoidable deaths.
 - Four wards are now completely paperless. A decision was made to delay the further roll out whilst the Trust implemented the necessary enhancements to facilitate the National Early Warning Score (NEWS) to ensure best practice was being followed in identifying deteriorating patients early and intervening. This upgraded version is now live on the four wards. Plans for 2013/14 will be for further roll out of the observation module across all adult surgical and medical wards by August 2013. The Trust will also commence maintaining an electronic fluid balance and integration of key nursing assessments.

Objective 3: Improve Patient Experience

- ***Transform the outpatient experience***
 - Significant progress was made with the programme to transform the outpatient experience:
 - Patient satisfaction is now measured in real time on an ongoing basis and feedback is positively acted upon to ensure continuous improvement.
 - A texting reminder service was implemented to remind patients about their appointment.
 - By changing the way in which patients are sent their first appointment details the Trust is now able to also send them more relevant information prior to their attendance at clinic.
 - Phase one of an outpatient refurbishment programme was completed in the main outpatient facility.
 - Consultant clinic utilisation data and clinic templates are being reviewed to improve productivity, efficiency and reduce over-runs. This work is linked very closely to the medical productivity work to ensure clinic capacity and consultant availability is aligned.
 - A consultant survey was carried out.
 - All clinics were MOT'd to identify which were the highest priority for improvement.

- All appropriate services are now available to patients via Choose and Book.
 - 85% of outpatient staff are undertaking NVQ training to improve customer care.
 - An in-house customer training programme has been run which has focused on multi-disciplinary staff development to encourage more effective team working.
 - Did Not Attend (DNA) rates for follow-up appointments have significantly reduced from 14% to 10% at Q3. This will reduce further with the introduction of an interactive appointment communication system.
 - Advice & Guidance rolled out throughout the Trust which is a service that enables GPs to seek specific advice from consultants rapidly.
 - The fracture clinic pathway has been redesigned to improve patient experience.
 - Significant audit work has taken place within Phlebotomy in order to improve the patient experience and investment in staffing, new ways of working, queue management systems and ensuring the chute system is reliable and fully functioning are in progress
- ***Deliver more clinical and diagnostic services during evenings and weekends***
 - A weekend therapy service has been established in orthopaedics.
 - Seven day imaging services have been extended to include CT and weekend ultrasound.
 - Imaging supports emergency services and additional waiting list initiatives at weekends.
 - Following consultation a shift system in imaging will be introduced during the first quarter of 2013/14 allowing a more robust foundation for a seven day service.
 - Laboratory services are available 24 hours a day 7 days a week.
 - The Pharmacy operates a weekend service, plus an on call pharmacist is available to provide urgent advice.
 - Weekend therapy pilots in Medicine and Emergency Assessment Unit have contributed to improved weekend discharges.
 - Some outpatient clinics are now being offered on Saturdays.
 - ***Review and re-design how we communicate with all patients (verbal and written) including those with learning disabilities and translation needs***
 - Staff from the Patient Experience Centre telephone all inpatients after discharge to ask them about their experience at the L&D.
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- Responses to key questions are analysed regarding communication, involvement in decisions about care, privacy and dignity and used to inform and guide a strategy for improvement.
- The information given to patients receiving elective surgery has been reviewed and greatly improved.
- The bedside information folders are currently being refreshed. The refreshed version will include written information in several languages to enable patients to understand their contents.
- The Quality of Interaction with Patients (QUIS) tool has started to be adopted to measure the quality of communication. This has been introduced to the corporate nursing team, matrons and wards sisters/charge nurses as a way to measure, monitor and educate staff about excellent communication while delivering care.
- Ward knowledge and use of the Language Line interpretation service has been assessed and initial steps taken to increase appropriate usage.
- ***Modernise non-clinical support services***
 - The findings of the cleaning review were fully implemented.
 - The cleanliness quality monitoring system (Maximiser) is now in place, the system is fully updated and accessible on the shared network.
 - A ward housekeeping service was established on all wards.
 - An independent review of catering was carried out which provided the basis to explore alternative ways to provide the service in the future in order to maximise the quality of services in the future.
 - A number of long running leadership issues within both Estates and Catering were dealt with through the year which had impacted upon the overall service provision.

Objective 4: Deliver National Quality and Performance Targets

- ***Deliver sustained compliance of all CQC outcome measures***
 - The nursing assurance programme continues to support all clinical areas in providing high quality care in a safe environment for patients. The process is based on the 16 essential care standards that most directly relate to quality and safety of care. Observation of patients and how staff care for them is undertaken. For example, nurses are watched in how patients are helped with feeding and how they interact and communicate with people. This programme includes self, peer and external assessments.

- ***Deliver nationally mandated waiting times for 18 Weeks, Cancer & A&E including A&E Indicators***

- During 2012/13 the emergency care 4 hour national target was consistently met despite experiencing both a high volume of Emergency Department attendances and an increase in admissions.
- National standards for patients not waiting more than 18 weeks for treatment from the point of referral in all quarters of the year were met or exceeded.
- The sub-specialisation of orthopaedic services which reduces flexibility in managing the waiting list has been a significant challenge, however, compliancy will be achieved by the second quarter of 2013/14 in respect of the orthopaedic contractual target which completes improvements.
- All Monitor Compliance targets throughout 2012/13 were achieved and forecast to be compliant through 2013/14.
- Performance on infection control has continued to be maintained with improvements in the number of hospital acquired Clostridium Difficile cases. Only two cases of MRSA Bacteraemia and 17 cases of Clostridium Difficile against a target of 31 were reported.

- ***Deliver reduced carbon emissions***

- Energy saving lighting was installed.
- Heating insulation was improved in a number of areas.
- An electric car charging point was installed in collaboration with Luton Borough Council.
- Variable speed drives were implemented.
- The amount of waste recycled was significantly increased.

- ***Achieve CQUIN targets***

- The CQUIN's for 2012/13 were achieved with some very minor exceptions. Achievement included:
 - Ensuring that providers have real-time systems in place to monitor patient experience.
 - Collection of data on patient harm using the NHS Safety Thermometer harm measurement instrument (developed as part of the QIPP Safe Care national workstream) to survey all relevant patients in all relevant NHS providers in England on a monthly basis

- National goal to reduce avoidable death, disability and chronic ill health from Venous Thromboembolism (VTE).
- National goal to improve responsiveness to the personal needs of patients.
- Reducing the amount of time that patients wait to be physically admitted to an actual Critical Care area (ITU, HDU, combined unit, or appropriate L3 or L2 facility (Intensive Care Society 2009 Levels of Care).
- Improving awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting
- Improving care for adults with learning disability

Objective 5: Progress Clinical and Strategic Developments

- ***Commence implementation of clinical services strategy***
 - A number of clinicians were actively engaged in the “Healthier Together” programme. The outputs from this work will form the foundations of the Trust’s Clinical Strategy which will be published in quarter one of 2013/14.
- ***Agree overall site re-development masterplan ‘Building the New L&D’***
 - A great deal of work was undertaken during the year to identify the priorities for the masterplan. This work has helped inform the most appropriate manner to proceed with the re-development given the current strategic and economic context.
- ***Commence phase 1 of ‘Building the New L&D’***
 - Many key enabling schemes commenced throughout the year including the expansion of the Endoscopy Unit, expansion of staff car parking, major lift upgrade programme, outpatient refurbishment and theatre refurbishment.
- ***Continue to participate in the Healthier Together Review***
 - Senior clinical staff from the L&D actively participated in the Healthier Together Review throughout the year.
- ***Deliver next stage of Electronic Patient Record***
 - A new modern data centre was completed and became live from March 2013.
 - Single Sign On and Clinical Context has been deployed to 1176 users, including all consultants. The roll-out to wards and trainee doctors has been completed in Paediatrics, Medicine and DME.

- By March 2013 there were 700 PCs enabled with the Clinical Context software. Clinical context is the ability to find a patient in one system, and to have it automatically searched for and presented across all applications. This is being deployed to all users, as it has been found to be extremely useful, saving time and reducing the risk of using multiple systems within a consultation. The project is now focussing on locum access processes. The project will be closed in May 2013 when the system will become business as usual as part of standard IT systems.
- Advance scanning of planned activity has been delayed by extended contractual negotiations. However, the contract is now signed and revised date for scanning to begin is 23rd September 2013. Preparatory work is proceeding on time, and full scan on demand for all activity will begin in February 2014.
- ***Develop robust arrangements to ensure joint working with Local Authorities, CCGs and all other stakeholders***
 - Throughout 2012/13 work to develop the foundations for good working relationships with the Clinical Commissioning Groups was undertaken. Divisional Directors of Medicine and Surgery represent the Trust at the CCG Board meetings.
 - The Trust CEO and relevant Directors now meet every six weeks with Clinical Commissioning Groups (CCG) to identify priorities for the future and to discuss operational challenges.
 - Quality Monitoring Boards with the Trust's commissioners and other CCG led Boards are attended.
 - The Trust CEO meets regularly with the Director of Social Care, Health and Housing for Central Bedfordshire Council and the Corporate Director, Housing and Community Living from Luton Borough Council.

Objective 6: Develop all Staff to Maximise Their Potential

- ***Complete the implementation of performance management of postgraduate medical education***
 - The process now in place was validated in the Deanery Performance and Quality Review 2013, and complimented as a model for other trusts to follow. There is now an accreditation and appraisal process for Educational Supervisors and college tutors, and the success of the performance management process with the clinical divisions was reflected in the trainees confirmation that they would recommend the Trust to colleagues for medical training.

- ***To extend the aspirations as a University Hospital beyond undergraduate training to all staff groups***
 - A new Division of Clinical Training and Research will start in shadow form from April 2013. The educational performance management process established in Medical Education will be extended, working with the clinical divisions, to all staff groups. The outcomes this process will focus on will derive from patient experience, safety and clinical outcomes. Collaboration with higher education organisations in research and development of all staff will be taken to a new and higher level, and is a key objective of the new division.
- ***Increase the number of staff appraisals to 80% (of staff available)***
 - The overall staff appraisal rate of 80% was not achieved. However, there has been a steady increase in appraisal completion rates since June 2012. The figures at the end of March 2013 are DTO – 77% (70%); Corporate – 81% (40%); W&C – 56% (50%); Surgery – 67% (56%) and Medicine – 68% (48%). The figures in brackets indicate performance in June 2012. Currently, overall Trust compliance is 69% which is an increase of 16% from June 2012.
 - Plans are being developed to move away from the rolling 12 month reporting cycle to bring appraisals in line with the financial year (April to March) and to develop this further to incorporate talent management and succession planning. The timescale to commence implementation of this approach is from April 2013.
- ***Increase compliance with mandatory training and increase the level of mandatory training available through e-learning***
 - There has been steady improvement in mandatory training indicated by the March 2013 figures (March 2012 figures in brackets, where available). Safe Moving: 74% (60%); Information Governance: 71% (56%); Fire: 73% (60%) and Infection Control: 73% (60%). Safeguarding Adults: 73% and Safeguarding Children: 68% are steadily increasing over time and are now reported to the Board having clearly established the appropriate level of training for different professionals.
 - Classroom-based sessions have been well-attended and the uptake of e-learning through supported sessions for individuals is encouraged.
 - Work is continuing to consider how the number of refresher e-learning modules could be increased so that staff can keep up their knowledge and skills. Plans for customised modules will be developed and investigating the cost of buying refresher modules that more closely meet the requirements as some of the national content is overly complex.
- ***Establish clinical leaders development programme***
 - A development programme has been designed and the first session took place in March 2013. The programme will include topics ranging from leadership to

understanding the new healthcare economy. The programme will be delivered by internal and external speakers.

- ***Establish a culture where all staff understand our values and quality objectives***
 - Trust Aims and Values have been agreed and the Trust's key quality priorities were launched in July 2012 at the 'Thank You' day.
 - A full review of communication has commenced with an initial mapping exercise which demonstrates an extensive number of initiatives throughout all parts of the Trust. This will inform the development of a strategy for communications which may have an external impact. A broader initiative will be considered focusing on the development of a cultural change programme to be established in 2013 in line with recommendations from the Francis Report.

Objective 7: Optimise our Financial Position

- ***Deliver our financial plan 2012/13***
 - A surplus for the 14th successive year was achieved.
 - The surplus was less than that anticipated in the Annual Plan for 2012/13 and reflects the challenging financial climate.
- ***Implement service line reporting and management***
 - Service line reporting was introduced in 2012/13 and financial reporting was in place for all months of the year. This development saw a significant increase in Divisional ownership of the financial position and clinical engagement in the financial agenda. The process of refinement and improvements with greater speciality detail continued throughout 2012/13 and significant improvements in the sophistication of financial reporting are expected in 2013/14.
- ***Increasing productivity (manpower & supplies)***
 - A significant workplan was launched in 2012/13 to improve workforce productivity. The key elements included tracking sickness absence through more robust reporting and management and improving medical productivity with new job planning arrangements and the roll-out of new performance reporting tools and arrangements. 2012/13 was the foundation for this work that will continue and accelerate in 2013/14.

1.2 Summary of Operational Performance

Key performance targets 2012/13

Operational performance is assessed against external national targets published by the Care Quality Commission (CQC) and Monitor Compliance Framework and other locally agreed contracts, with the support of external peer review and other external expertise.

Activity

During 2012/13 the ED 4 hour national target was met monthly, despite ongoing challenges in terms of the volume of ED attendances and admissions continuing to rise. As in previous years, the challenges in discharging patients into the community resulted in additional pressure and the Trust worked intensively with colleagues in the health economy to identify solutions. Concern remains about the availability of community services for some of the Trust's catchment population particularly following a reduction in the availability of nursing home beds in Luton. The opening of a new community intermediate care facility in Houghton Regis during 2012/13 has assisted the Trust in managing the challenge.

National standards for patients not waiting more than 18 weeks for treatment from the point of referral were met or exceeded. As with many acute providers the sub-specialisation of orthopaedic services which reduces flexibility in managing the waiting list has been a significant challenge. Following the implementation of an intensive recovery programme, the reduction in the backlog of patients waiting for treatment has been maintained.

All cancer targets in all quarters of 2012/13 were achieved and forecast to be compliant through 2013/14.

Performance on infection control has continued to be maintained with improvements in the number of hospital acquired Clostridium Difficile cases. Only two cases of MRSA Bacteraemia and 17 cases of Clostridium Difficile against a target of 31 were reported.

An increase in referrals following national screening campaigns was responded to by including additional clinical and diagnostic testing during evenings and weekends.

Earlier in 2012/13 the Trust struggled to meet the stroke target of ensuring that 90% of patients spend 80% of their time on a stroke ward due to bed pressures. However, this position greatly improved towards the end of the year and this will be maintained by the development of services to act as the hyper acute hub.

L&D performance against CQC and Monitor Targets

The table below summarises how the Trust operational performance described above is interpreted against the national objectives by CQC and Monitor.

L&D performance against CQC and Monitor Targets

	Threshold	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Total time in A&E - ≤4 hours (Whole site %)	95%	98.1%	95.3%	96.8%	96.5%
All cancers: 31-day wait for second or subsequent treatment (3), comprising either:					
Surgery	94%				
anti cancer drug treatments	98%				
radiotherapy	94%	N/A	N/A	N/A	N/A
Cancer: two week wait from referral to date first seen (7), comprising either:					
all cancers	93%				
for symptomatic breast patients (cancer not initially suspected)	93%				
All cancers: 31-day wait from diagnosis to first treatment (6)	96%				
All cancers: 62-day wait for first treatment (4), comprising either:					
from urgent GP referral to treatment	85%				
from consultant screening service referral	90%				
Referral to treatment waiting times – non-admitted	95%				
Referral to treatment waiting times – admitted	90%				
Referral to treatment waiting times – Incomplete pathways	92%				
Clostridium Difficile – meeting the Clostridium Difficile objective of no more than 31 cases/year	31				
MRSA – meeting the MRSA objective of no more than 1 cases/year	1				

Activity performance analysis

The table below identifies those areas where demand has changed by comparing the actual contracted activity to that planned.

Activity Type	Units	Actual*	Plan*	Forecast	Plan
		2011/12	2012/13	2012/13	2013/14
Admitted Patients					
Elective PbR	Spells	28,097	30,201	30,257	31,438
Elective Non PbR	Spells	130	61	61	52
Non Elective - General & Acute PbR	Spells	29,302	26,750	31,730	30,785
Non Elective - PA Unit	Spells	1,201	1,000	1,253	832
Non Elective - AA Unit	Spells	386	200	620	500
Non Elective Non PbR	Spells	510	400	544	498
Total Admitted Patients	Spells	59,626	58,612	64,465	64,105
Outpatients					
Outpatients - 1st (PbR)	Atts	82,774	74,922	79,756	74,396
Outpatients - Follow UP (PbR)	Atts	137,677	137,595	137,938	134,633
Outpatients - Procedures (PbR)	Atts	19,906	22,606	27,873	28,991
Outpatients - Pre Assessment (PbR)	Atts	10,153	10,423	8,853	10,004
Total Outpatients	Atts	250,510	245,546	254,420	248,024
A&E	Atts	71,792	70,740	78,379	70,210
Maternity Pathway					
Ante-Natal Pathway	Patients	6,336	6,200	6,207	6,207
Births	Births	5,312	5,200	5,260	5,264
Post-Natal Pathway	Patients	5,250	5,200	5,260	5,633
Total Maternity Pathway		16,898	16,600	16,727	17,104
Critical care					
Adult - Intensive Care	Bed Day	2,013	2,006	2,051	2,124
Adult - High Dependency Unit	Bed Day	2,450	2,248	2,301	2,350
Adult - Ward Based High Dependency	Bed Day	1,322	1,446	1,235	1,266
Neonatal - Intensive Care	Bed Day	2,640	3,065	2,772	3,169
Neonatal - High Dependency	Bed Day	2,575	2,644	2,307	2,552
Neonatal - Special Care Babies	Bed Day	5,550	5,952	5,113	5,567
Neonatal - Transitional Care	Bed Day	926	1,382	1,176	1,242
Paediatric - High Dependency	Bed Day	1,788	1,553	1,760	1,674
Total Critical Care	Bed Day	19,264	20,296	18,715	19,944
* Rebased to reflect Maternity Payment Pathway		PbR = Payment by Results			

In 2012/13 the Trust commissioners anticipated substantial QIPP reductions. Despite their endeavours, planned reductions on activity did not occur.

The hospital performed well to accommodate this unplanned activity without compromising a range of national target indicators. However, this activity could not be provided within existing employed staffing levels, consequently the hospital incurred substantial temporary staffing costs.

In 2013/14 commissioners once again plan a range of demand management initiatives designed to reduce pressure on the Hospital. The Hospital will need to carefully manage its own capacity and staffing levels to ensure that services are provided efficiently and effectively.

1.3 Summary of Financial Performance

Review of Financial Performance

A financial surplus for the fourteenth successive year was achieved with a 2012/13 surplus of £0.9m. This was behind the planned surplus of £2.4m forecast within the Trust Annual Plan and reflects the challenging operating environment.

Staff successfully handled a range of financial pressures and challenges throughout the year. This included delivering savings to accommodate efficiency targets inherent within the national tariff system, meeting the costs of pay reform from Agenda for Change, and activity related pressure caused by both the 4 hour emergency care target and the 18 week elective care targets. Furthermore the Hospital was significantly challenged by periods of Norovirus and a lack of community bed provision and increased demand for services that put pressures on staff and bed availability. The table below illustrates historic income and expenditure (I&E) performance since 2005/06.

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Turnover	143.6	153.2	169.1	189.3	204.9	211.6	220.8	230.6
Surplus	0.4	2.0	2.9	4.3	3.1	2.6	2.5	0.9
Cash	1.9	18.8	35.4	45.4	43.7	50.9	47.6	37.5

All figures £m

Cash balances continued to be managed closely, ending the year with a balance in excess of £37m. Given the level of cash accrued since achieving Foundation Trust status the working capital borrowing facilities remain unused.

The Trust stayed within the private patient income cap for the year.

£11m was invested in long-term investments. Significant projects included: the completion of the Cardiac Catheterisation Laboratory; additional car parking capacity; increased endoscopic capacity; over £2m on new medical equipment; and further sums on a range of IT and estate infrastructure projects.

The Board is now reviewing a new medium term financial strategy with the desire to undertake a major Hospital Development Project to support the Clinical Services Strategy.

Looking forward, it is expected that the new financial year will be significantly more challenging and it is vital that the Trust continues to exercise sound financial management as a period where the NHS faces tighter financial settlements is entered.

Going concern

After due consideration, the Directors have a reasonable expectation that adequate resources are in place to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the

annual accounts.

1.4 Summary of Ratings

1. A comparison of ratings between 2011/12 and 2012/13 is detailed in the tables below.

	Annual Plan 2011/12	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q4 2011/12
Financial risk rating *	3	3	4	3	3
Governance Risk Rating	Red	Red	Red	Amber Red	Amber Green

* Based on 2011/12 Monitor financial Risk Rating

	Annual Plan 2012/13	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13
Financial risk rating	3	3	3	3	3
Governance Risk Rating	Green	Green	Green	Green	Green* TBC

2. Trust performance against national targets

National Target	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13
CQC Action	No	No	No	No
Monitor override	No	No	No	No

No formal interventions occurred within the year.

1.5 Other Key Achievements

Strategic Developments 2012/13

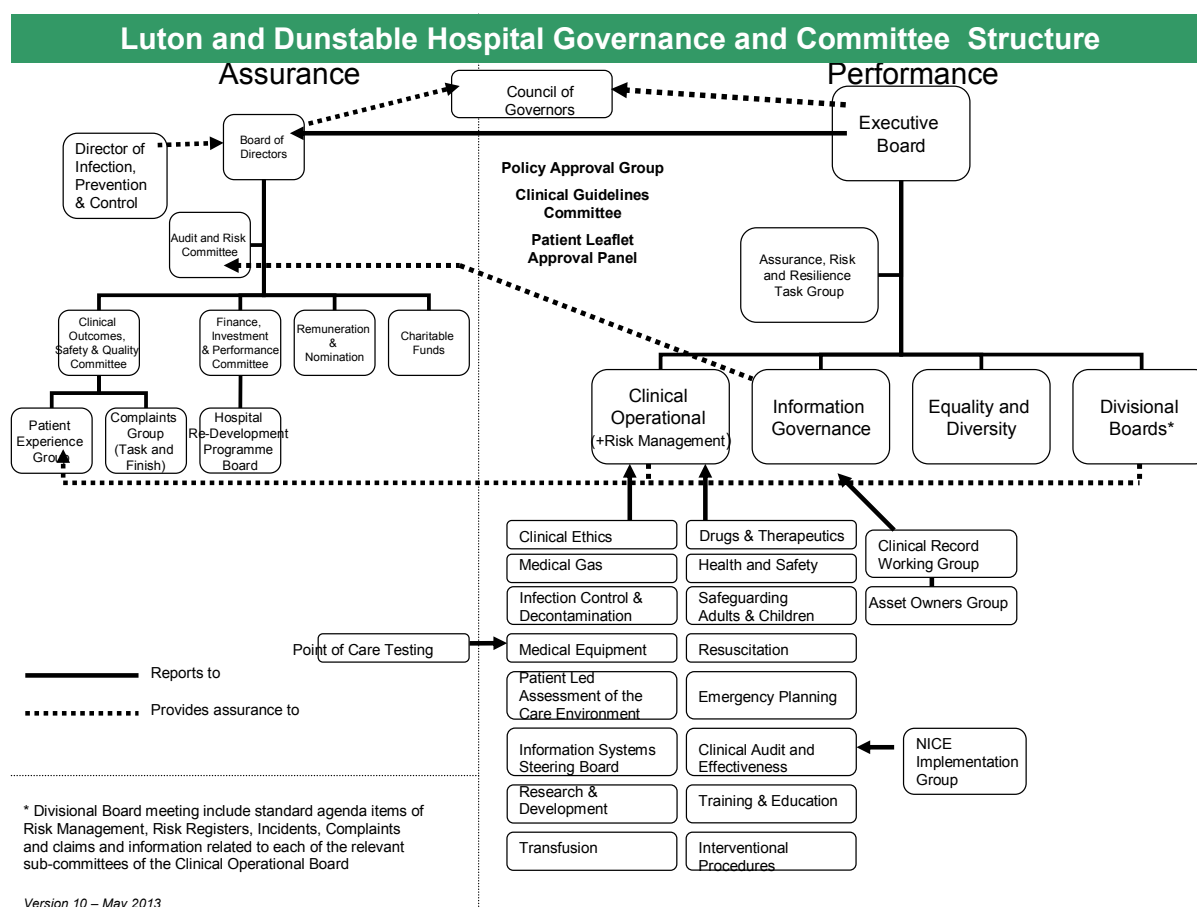
During 2012/13 a number of key developments supported the delivery of the Trust's Strategic Vision.

- The Trust became a designated Trauma Unit within the East of England Trauma Network. Work with other providers to ensure that the best care is delivered for patients arriving at the hospital with severe injury
- A 10 year contract was awarded to Xerox to transform the Health Records Service. This contract lays the foundations for changing the Trust paper service to a scanning service providing records into an electronic document and record management system (eDRMS). This will be implemented in 2013/14.
- Surgical spinal service was re-established with two consultants now in post.
- The formation of a specialist team in ophthalmology offering both corneal and medical retinal services means patients can have their treatment at the L&D rather than having to travel to larger centres.
- The Stroke Team have extended specialist hyper acute services, including 24/7 stroke thrombolysis and weekend rapid access TIA clinics to a wider catchment area. These services will be developed further with the development of a stroke HUB at the L&D.
- The new Cardiac Catheterisation laboratory (Cath Lab) facility became operational in June 2012. This allows coronary angiography and pace maker insertion to be performed at the L&D rather than transport patients to neighbouring Trusts for treatment. The Team wish to expand this service during 2013/14 to include Percutaneous Coronary Intervention (PCI), commonly known as angioplasty treatments.
- The Trust agreed to work in partnership with Bourne Hall, a leading fertility centre, to establish an IVF service here at the L&D. The new facility for the service is currently being built and the service will begin in June 2013.
- Occupational and Physiotherapy services have commenced weekend working pilots in Medical wards and EAU, and introduced weekend therapy services delivered in patients' homes following surgery, demonstrating patient benefit and improved weekend discharge rates as a result of expanded 7-day service provision.
- Opportunities to establish a satellite outpatient and treatment centre are being actively pursued enabling the site to be decongested as well as taking some of the L&D services into the community.

1.6 Governing to Ensure Quality and Safety

In 2010, the Board of Directors undertook a Board Evaluation process and amended the structures that were implemented in April 2011. The new governance structures were subject to Internal Audit review in November 2011 and assurance was received that robust processes were in place. During 2012/13 an assessment of the Trust Board governance was undertaken through the Institute of Directors. The Divisional management structure is now embedded throughout the organisation and supported by performance review, appraisal and personal development.

The committee structure is set out in the governance table below:



In addition to the formal committee structure, the Board of Directors and Executive Team participate in regular seminar and informal sessions. Throughout 2012/13 the Executive Team and Non-Executive Directors met regularly with individual clinical specialities to discuss strategic and operational issues.

2. Delivering Quality Priorities during 2012/13

2.1 Introduction

As discussed in the forward to the plan, 2012/13 was a year of sustained delivery for the L&D. Delivery was underpinned by a strong focus on improving and monitoring service quality.

Quality is managed through the Divisional Boards and the Clinical Operational Board which provides assurance to the Clinical Outcome, Safety and Quality Committee and Board of Directors. Divisions are represented by their Divisional Directors on the Clinical Operational Board. During 2012/13 the Executive Board commissioned a number of external experts and external reviews to support its work and to ensure the Trust was aware of best practice nationally and internationally. The reviews included:

- Fractured neck of femur;
- Services for the elderly;
- Colorectal surgery;
- Colposcopy;
- Clinical sustainability;
- Hospital development financial strategy; and
- Whole system financial modelling

2.2 CQC Performance

The Luton and Dunstable NHS Foundation Trust is fully registered with the CQC and its current registration is Registration Without Conditions. Based on their comprehensive assessment undertaken over two days in 2012, CQC were satisfied that the Trust was meeting all essential standards.

The Trust undertook a review as part of the targeted inspection programme to services that provide the regulated activity of terminations of pregnancy. The Trust was judged to be fully compliant.

During 2011/12 a robust CQC self assessment programme was developed in order that all wards and clinical areas are supported in delivering performance against all 16 standards and implement corrective action in a timely manner. This has been shared and is used in a number of acute trusts within the East of England.

The self assessment tool is completed on a quarterly basis and reviewed by the Trust Executive and the Clinical Outcomes, Safety and Quality committee monthly. It is also discussed by the Board of Directors. An example of the self assessment tool is shown below.

A demonstration of a self assessment (not L&D):

[illegible]

The assessment process is further enhanced by two other initiatives:

- Non-Executive Directors participating in a 3 x 3 initiative, the initiative requires them to spend 3 hours every 3 months in a clinical setting working with staff to review their performance against CQC standards.
- A newly introduced 'Ward Buddy' system, whereby all Executive Directors and General Managers buddy with a ward for three months (on a rotational basis) monitoring and supporting the ward in the delivery of its performance.

The NHS Litigation Authority Risk Management Standards Level 2 for the Trust was maintained and the Trust achieved Clinical Negligence Scheme for Trusts Standards for Maternity services at level 1 in September 2012.

2.3 Report on Priorities for Improvement in 2012/13

Last year three quality priorities were developed, the following report describes action taken and what was achieved as a consequence. All of these priorities continue to be relevant and will be further developed during 2013/14.

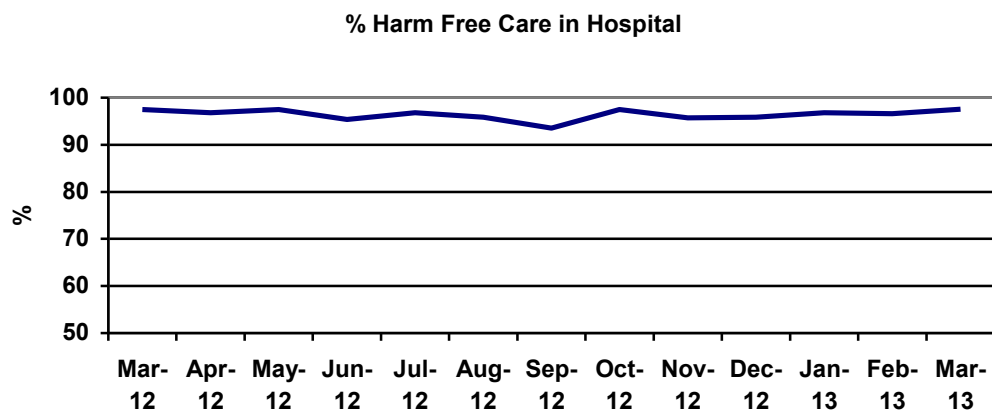
Priority 1: Patient Safety

To improve overall safe care for patients

Delivering the Safety Thermometer programme

During 2011/12 the Trust was a pilot site for Safety Express, and in 2012/13 the Harm Free Care programme was rolled out using the Safety Thermometer to all wards. Monthly information is collected about the proportion of patients treated who receive health care without experiencing any of the 4 harms (pressure ulcers, falls, Urinary Tract Infections associated with urinary catheters (CA-UTI) and venous thromboembolisms (VTE). This includes harm that may have occurred prior to admission to the hospital.

The graph indicates the percentage of harm free care within 2012/13. This data demonstrates a high level of harm free care that occurred whilst an in-patient and does not include harms that occurred prior to admission to hospital.



The safety thermometer targeted four key areas:

- 1) **Continuation of the implementation of care bundles to support the elimination of all avoidable hospital acquired grade 2, 3 and 4 pressure ulcers by the end of 2012.**

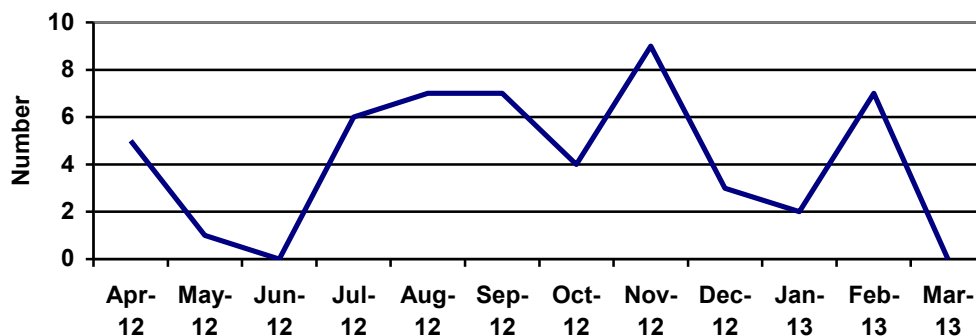
Action Taken

- Nurses continue to undertake essential care rounding in all wards delivering a number of interventions but with a particular focus on pressure care.
- The Trust participated in the regional Pressure Ulcer Collaborative within NHS Midlands and East and have implemented the SSKIN Bundle within the hospital. Wards 17 and 23 were pilot wards for the Collaborative within the hospital and this involved implementing a number of initiatives to raise awareness of tissue damage and intervention that were put in place to help avoid tissue damage. The roll out to all clinical areas will commence in May 2013.
- Mandatory training on pressure damage prevention continued.
- The root cause analysis tool used to investigate all pressure ulcers to improve the opportunity for learning and preventing future incidents was enhanced.
- Meetings are held with the ward teams and the Chief Nurse to review the RCA and scrutinise care to determine if pressure ulcers that develop are avoidable or unavoidable.
- Performance data has been made more accessible and relevant to clinical areas and matrons.
- Intensive support to areas with a higher incidence to support quality improvements has been implemented. This has resulted in an improved performance.

Achievements

- The number of avoidable grade 3 and 4 pressures ulcers that developed within 2012/13 was 51. It is not possible to compare this with 2011/12 as the criteria to determine whether a pressure ulcer was avoidable or unavoidable was not used.

Number of Avoidable Grade 3 and 4 Pressure Ulcers in 2012/13



- The majority of wards have been avoidable pressure ulcer free for at least 100 days. This is celebrated and recognition given to areas where this has been achieved.

2) Implementation of the falls care bundle in all wards leading to an overall reduction in the incidence of falls resulting in moderate or severe harm or death, by at least 25%.

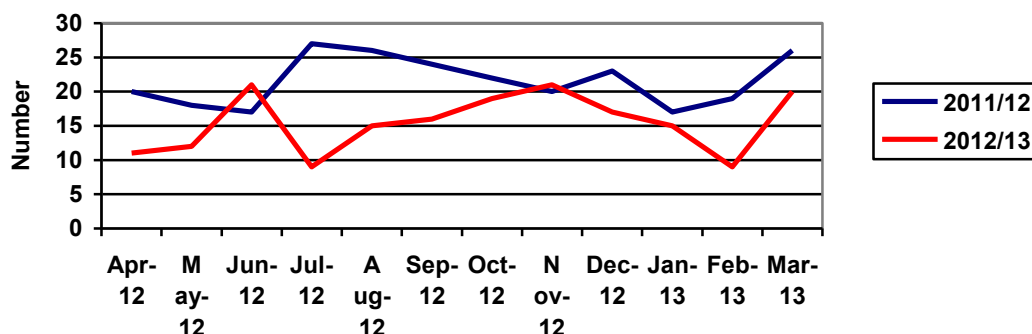
Action Taken

- A phased implementation of the falls care bundle within the hospital has continued.
- Bed and chair sensors have been introduced to alert staff to patients moving who have been identified as a high risk of falling.
- A trial of hip protectors for high risk patients on the Frail Elderly Unit has been undertaken.
- A business case has been agreed to purchase 20 low rise beds for patients that are at high risk of falling.

Achievements

- There has been a 28.6% reduction in falls that have resulted in moderate or severe harm or death as a result of patients falling whilst in hospital.

Number of falls resulting in moderate or severe harm or death



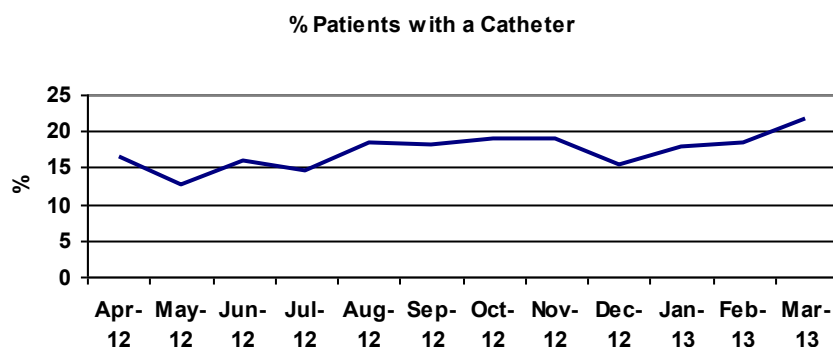
3) Implementation of best practice guidelines for insertion of urinary catheters

Action Taken

- The Hospital guideline for urinary catheterisation was updated and approved by the Clinical Guidelines Committee in June 2012.
- There is an extensive training programme within the hospital on urinary catheterisation.
- An audit programme was commenced to monitor compliance with the guideline.
- The Trust has invested in bladder scanners to improve assessment of patients prior to urinary catheterisation in order to avoid unnecessary catheterisation.

Achievements

- The Safety Thermometer (ST) data demonstrates the number of patients during the monitoring period each month that had a urinary catheter in place. The national average within Safety Thermometer (during 2012/13) is that 12 – 16% of patients have a urinary catheter in place. The data within the ST for this hospital indicates that the range of prevalence is 12.6% - 20.3% (median 18.1%). This suggests a higher incidence of use of catheters when compared with the national average.
- Local audit has been undertaken and established that only a third of patients had a bladder scan performed prior to urinary catheterisation.
- Half of the patients had had a formal review undertaken of the need for the catheter to remain in place.
- The local audit also determined that 29% of patients with a catheter in place were prescribed antibiotics for a urinary tract infection.



4) Venous Thromboembolism (VTE) – ensuring 95% compliance with VTE risk assessment and prophylaxis for all patients by the end of 2012.

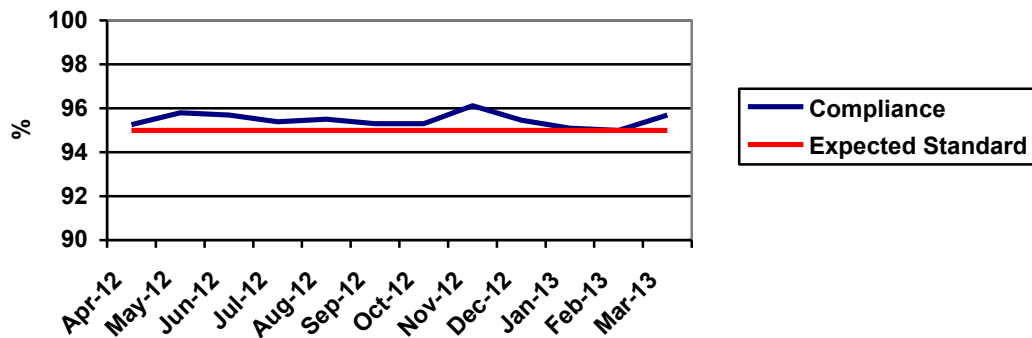
Action Taken

- The focus on the completion of VTE risk assessment has continued to identify patients at risk and enable appropriate treatment to be provided.

Achievements

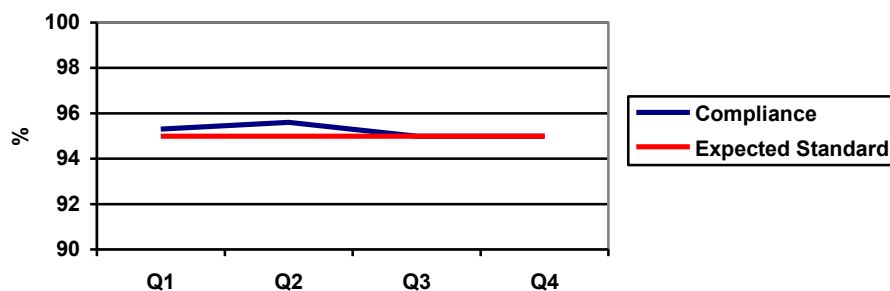
- The compliance with undertaking the VTE risk assessment exceeded the minimum standard of 95% each month in 2012/13.

VTE Risk Assessment Compliance 2012/13



- Quarterly monitoring was undertaken ensuring that appropriate prophylaxis was given to all patients assessed to be at high risk of developing a VTE and in each quarter the Trust exceeded 95% compliance.

VTE Prophylaxis Compliance 2012/13



Priority 2: Patient Experience

To improve patient experience

This priority targeted seven key areas:

- To provide additional information to patients with their appointment letter about what to expect during their outpatient appointment**

Action Taken

- Information within outpatient correspondence is now included explaining what patients should expect when attending their appointment, including:
 - detailing the checking in process;
 - car parking;
 - tests, checks and examinations that may be performed when attending outpatients;
 - information relating to consent;
 - GP correspondence and follow-up appointments; and
 - questions patients may wish to ask during their appointment with the clinician.

- A new service, currently being established, has been invested in that will enable patients to receive additional specialist information relating to their medical condition or procedure to be undertaken where this is clinically appropriate.

Achievements

- As from Q2 2012/13, all first outpatient appointment invitation letters have included this additional information.
- Patients have reported a high level of satisfaction with the verbal information they have been provided about their medications issued to them following their appointment.

Performance measure	Achieved	Not Achieved	Nov 12	Dec 12	Jan 13	Feb 13	March 13
% of patients given verbal information on medicines (outpatients at L&D dispensary)	>85%	<75%	72%	71%	63%	89%	90%
% of patients who know what to expect prior to attending	> 85%	< 75%	76%	73%	71%	68%	72%
% of staff treating / examining patients who introduced themselves	> 85%	< 75%	76%	76%	79%	76%	89%
% waiting > 30 minutes	< 15%	≥ 15%	29%	35%	56%	33%	35%
% welcomed at reception and privacy	> 85%	< 75%	86%	85%	58%	86%	83%
% Confidence / trust in the doctor	> 85%	< 75%	86%	88%	71%	80%	95%
% Confidence / trust in the Nurse	> 85%	< 75%	85%	88%	67%	81%	96%
% Rating service (good to excellent)	> 85%	< 75%	90%	89%	85%	97%	90%

2) To offer extended outpatient clinic opening times to include evenings or weekends

Action Taken

- Clinicians have been surveyed to obtain their feedback on weekend and evening opening times.
- Work with HR/medical workforce to progress out of hours working in to new consultants' contracts has been undertaken.

Achievements

- Some speciality areas are now providing regular weekend clinics e.g. Transient Ischaemic Attack TIA clinics, and others on a Saturday morning.
- Evening and weekend clinics are currently being provided on an ad hoc basis in order to support compliance with performance targets.

The table below demonstrates the number of additional clinics and where these have occurred outside the normal working hours.

The table below demonstrates the number of additional capacity clinics provided in 12/13. It is acknowledged that only a small proportion of these are provided out of hours (evenings and weekends), however the Trust is also keen to ensure capacity is

utilised as efficiently as possible during weekdays when clinicians, staff and supporting services are more readily available.

The Trust is committed to expanding clinic provision alongside expansion of 7 day support services and is currently consulting with Clinical Divisions about what services are needed out of hours to support both inpatient and outpatient activity affordably and sustainably.

	No. of additional temporary clinics	Percentage of clinics in session
Evening	74	9%
Weekday AM	347	43%
Weekday PM	342	43%
Sat AM	16	2%
Sat PM	19	2%

3) Ensure clinics start on time and improve clinic efficiency

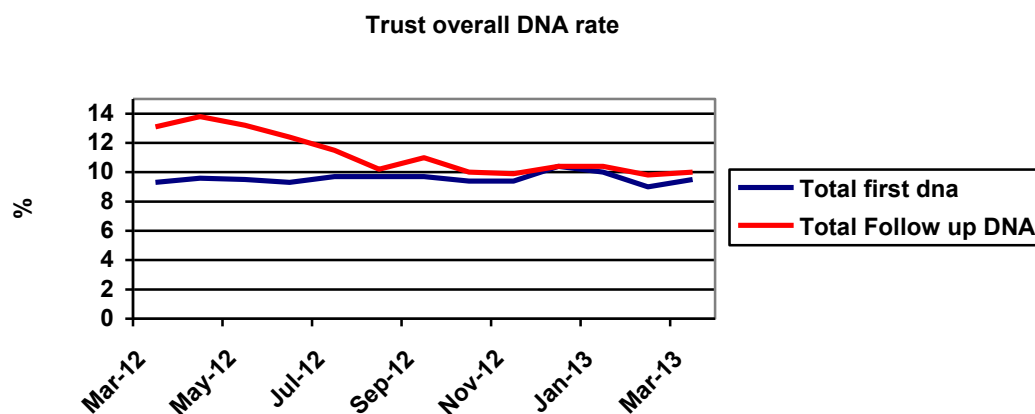
Action Taken

- Between June 2012 and October 2012 outpatient clinics were monitored in order to identify where clinics were starting later than their scheduled start time. This intelligence enabled the identification of bottle-necks and regular late starts.
- A regular cause for delays in start time concerned medical commitments outside outpatients (ward rounds) and conflicting meetings with clinic start times.
- At the same time the process also identified delays outside the control of the OP department such as delays due to traffic, IT system downtime, and unavailability of junior medical staff from clinics.
- The results will feed into work currently underway to review and improve medical productivity by identifying and then freeing up medical staff from competing priorities.
- A clinic capacity calculator was developed as a tool to assist in planning clinic templates and appointment scheduling.
- Key performance metrics were developed to demonstrate performance and drive improved efficiency.
- Close working alongside the Trust's medical productivity programme is in place to improve outpatient clinic efficiency.
- GP and patient access to all Outpatient clinics via Choose and Book is facilitated.

- Advice and Guidance throughout the Trust to assist GPs in gaining access to specialist advice prior to referral was introduced.
- Clinic start times against a 30 minute standard are being measured and provide management information to improve timeliness of clinic commencement.
- Ensuring patients are better informed and made aware of any delays whilst in clinic.

Achievements

- Appointments not attended (DNA) rates have reduced over the course of the last year and are anticipated to fall further this year with the introduction of interactive appointment communications. This will reduce wasted appointments, enhance clinical productivity and improve patient access.



- The analysis of clinic start times in April 2013 demonstrates 77% of Outpatient clinics started within 15 minutes of the scheduled start time. Data is being provided to Divisions by clinician to facilitate improvement where needed.

4) Reduce the number of clinics cancelled at short notice

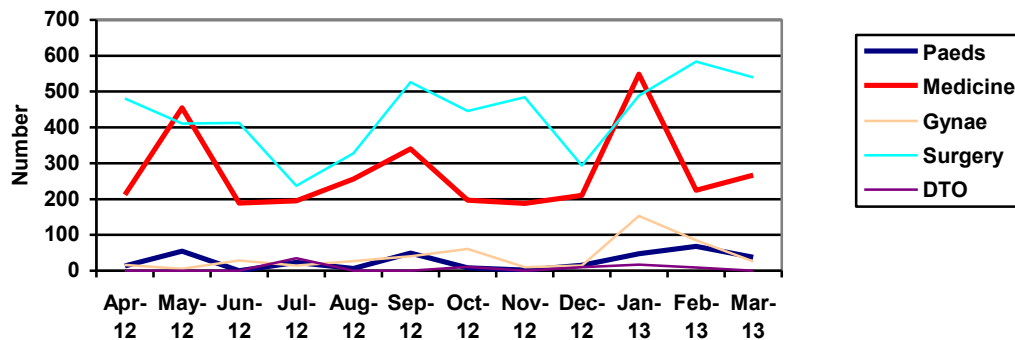
Action Taken

- Detailed information relating to the number of patients whose appointments have been cancelled by the hospital at short notice is provided to Divisional managers each month. Progress is being made, but needs to be sustained.
- Working in tandem with the medical productivity programme is in place to minimise short notice clinic cancellations to improve patient experience, efficiency and productivity.

Achievements

- Progress is variable on short notice cancellations and close working with the medical productivity programme and Divisional management is needed to drive this down.

Patients impacted by cancellations at short notice



- Alternative Outpatient booking systems, such as partial booking in pilot service areas, will be trialled during the course of 2013/2014 to help improve the patient experience and reduce hospital initiated cancellations.
- The proportion of rescheduled appointments compared to the total monthly volume of Outpatient appointments is 4%.

5) Commence a programme of outpatient refurbishment

Action Taken

- A survey of Outpatient accommodation was undertaken to prioritise a programme of refurbishment.

Achievements

- Zone C outpatient waiting area has been comprehensively refurbished and air conditioning installed to each of the consulting rooms.
- A programme to upgrade the consulting rooms has commenced this year.
- Patient feedback has been very positive, with comments received from patients on how the department is now much lighter, brighter and more comfortable.

6) Provide additional training to staff and support improved team working

Action Taken

- Outpatient clerical staff were provided with the opportunity to participate in an NVQ programme in customer care.
- Work with nursing and administration staff across Outpatient specialties is being undertaken to develop an Outpatient customer service commitment.

Achievements

- 85% of clerical staff have participated in the NVQ training programme.

7) Provide support, information and opportunity for patients to take responsibility for their health and management of long term conditions

Action Taken

- More community based clinics have been established for patients with long term conditions.
- Alternative support mechanisms are being made available to patients, including telephone clinics.
- A wider range of literature is being made available to patients in pre-appointment correspondence.
- An ambulatory care unit has been established to provide support and treatment to patients with a range of conditions to avoid hospital admission when appropriate.

Achievements

- The Trust is proactively seeking to provide more Outpatient facilities in the community to improve access and provide care and management of long term conditions closer to home.

Priority 3: Clinical Outcomes***To improve clinical outcome for fractured neck of femur***

Early in 2012/13 an overall improvement plan for improving clinical outcome for patients with fractured neck of femur was developed.

This priority targeted four key areas:

- 1) Establish a dedicated and ring-fenced unit for patients with a fractured neck of femur and other fragility fractures requiring hospitalisation.**

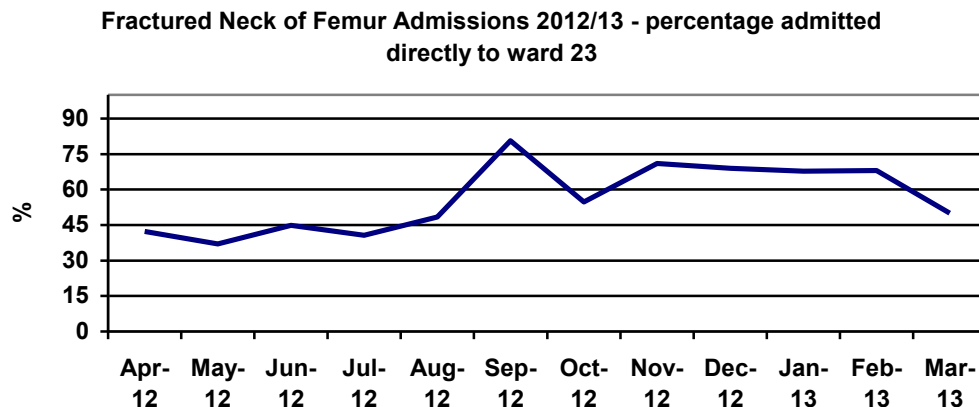
Action Taken

- A fractured neck of femur ward was established during 2012/13 and endeavours to cohort patients within this ward; this has been increasing through the year despite significant bed pressures during difficult periods.
- A second Consultant Orthogeriatrician was appointed, junior staff allocated to the Orthogeriatric service and a formal re-organisation of Orthogeriatric consultant cover to the fractured neck of femur ward completed. A monthly multi-disciplinary team meeting to review all fractured neck of femur cases that result in death is also being established.
- The number of nurses working on the fractured neck of femur ward has been increased.
- Significant progress has been made in achieving best practice over the past year that also strengthens the financial position.
- The fractured neck of femur integrated care pathway documentation has been completely re-written. This is for multidisciplinary use and is commenced on diagnosis of the fractured neck of femur whilst in the accident and emergency department.
- Meetings were held with high performing trusts within England to explore their management of fractured neck of femurs and endeavour to apply learning.

- An external review of the management of patients with fractured neck of femur by the British Orthopaedic Association was invited. This was undertaken in January 2013 and an improvement plan has been developed.

Achievements

- An improvement in the percentage of patients with a fractured neck of femur admitted directly to ward 23 has been achieved. The data includes patients who could not be admitted to the fractured neck of femur ward for clinical reasons, e.g. ITU etc.



- The Trust met the criteria for the repair of fractured neck of femur Best Practice Tariff for 65% of the patients seen in the year 2012/13. This represents a significant improvement as the Trust did not achieve Best Practice Tariff for this procedure in 2011/12.
- 2) The Orthopaedic and Anaesthetic Directorates should review the findings of the mortality review at a joint Clinical Governance Rolling Half Day session, following which both specialties should be asked to produce action plans to address the key issues raised.**

Action Taken

- In March 2013 the data from the National Hip Fracture Database report did confirm that the Trust is an outlier in terms of mortality rate for fractured neck of femur that was identified as part of annual planning in March 2012. Teleconference consultations have been undertaken with two high-performing organisations during the year to better understand how the Trust might improve systems, and commissioned a multi-disciplinary external review of the fractured neck of femur service from the British Orthopaedic Association.
- Fluid optimisation techniques have been introduced for patients with a fractured neck of femur. This is a technique used during the operation for those patients that have a general anaesthetic.

Achievements

- Following the outcome of the formal review in January 2013, the improvement plan has been updated.

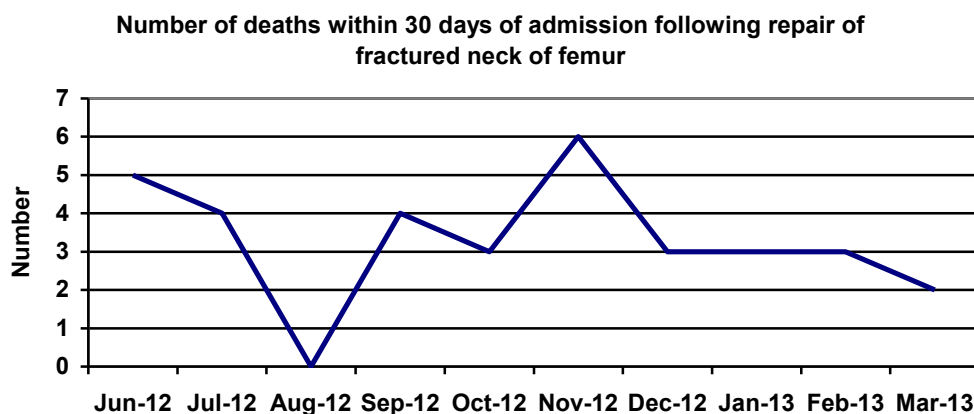
- 3) A multi-disciplinary group will be convened under the direction of the Divisional Director for Surgery, to review on a monthly basis, the data from Dr Foster, the National Hip Fracture database, any deaths that have occurred within 30 days of surgery for a fractured neck of femur, and to formulate and co-ordinate any appropriate audits deemed necessary by the group.

Action Taken

- A monthly multi-disciplinary team meeting has been introduced to review all fractured neck of femur cases that result in death.
- The case note review is undertaken by a Consultant Orthogeriatrician of every patient that dies following surgery to repair a fractured neck of femur.
- There is daily communication distributed widely within the hospital of information about patients with a fractured hip, including location of patients, numbers of patients awaiting surgery, number of patients that had been operated on within 36hrs of admission and number of deaths within 30 days of admission.

Achievements

- Significant improvements in peri-operative and post-operative care have been delivered, which have seen the mortality rate for repair of fractured neck of femurs decrease from a peak of 197.4 in September 2012 to 154.0 at the end of March 2013.
- The number of actual patients that died following repair of fractured neck of femur between June 2012 to March 2013, known as crude mortality, was 33.



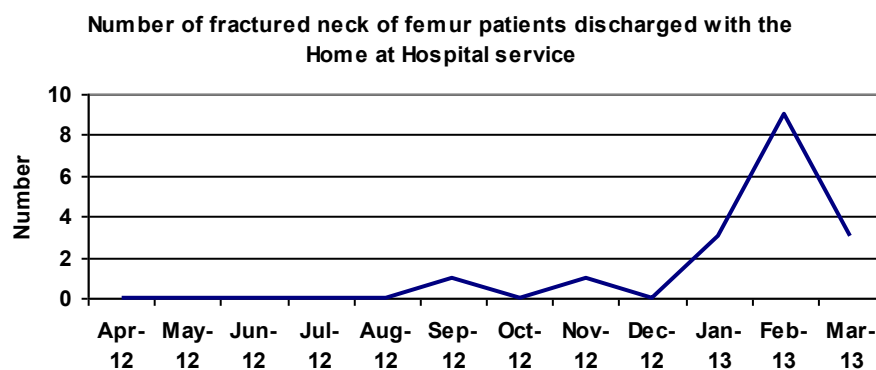
- 4) New strategies to reduce the average length of stay of these patients in secondary care, and enable earlier, appropriate discharges to community-based rehabilitation facilities for suitable patients will be explored. Discussions about the development of a Fracture Liaison Service would be initiated, aiming to reduce the incidence of fractured neck of femur in the population we serve by 10% in three years will be initiated.

Action Taken

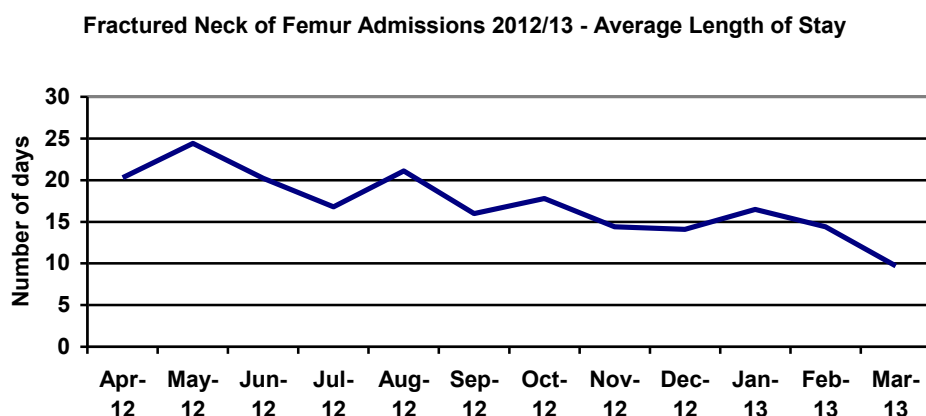
- A Hospital At Home (H@H) service has been introduced which enables some patients that have suffered a hip fracture to return home sooner with the support of the Hospital At Home team.
- Commissioners have agreed that they will commit to negotiations to establish a Fracture Liaison Service in quarter 3 of 2013/14.
- Screening using a nationally recognised risk assessment tool will be commenced for all patients over the age of 65 that attend the A&E department that present with falls and wrist fracture or fractured vertebral body. These patients may be at risk of future falls and subsequent fractured neck of femur.

Achievements

- There has been an increase in the number of patients that have had repair of fractured neck of femur that were discharged with the use of the H@H service in quarter 4.



- There has been a significant reduction in the length of stay of patients admitted with a fractured neck of femur. In May 2012 the average length of stay was 24.4 days and in March 2013 it had significantly reduced to 9.7 days.



3. Future Business Plans

3.1 Our Strategic Direction

Strategic Context

April 2013 saw one of the most significant changes to the management of the Health Service, with the creation of Clinical Commissioning Groups (CCGs), abolition of Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) and the establishment of the National Commissioning Board. During this period of uncertainty, the Trust has sought to provide both the 'corporate memory' of many of the issues facing the health economy and also to ensure the relationships with the emerging organisations are built on solid foundations which will cement partnership working in the future to ensure that the L&D is in the best possible position to meet the needs of present and future patients.

The new Health Act has not only created structural change within the health service but has also brought with it new powers for Foundation Trust Governors which the Trust will embrace during 2013/14 in order to optimise their role and the benefits they bring to the overall governance of the organisation and the essential link they make to the wider population served.

In addition to the national changes to the NHS, the Trust experienced significant strategic uncertainty during 2012/13 in relation to the proposed local strategic changes related to Milton Keynes and Bedford hospitals. As a consequence of this and the uncertainty over acute service rationalisation during the Healthier Together discussions, progress with the strategic intentions and decisions surrounding the site re-development were deferred during the year. However, the recent decision to change the focus of the Healthier Together project to enable hospitals to work closer with their CCGs and other stakeholders has meant that the L&D has a more certain platform from which to plan its future strategic direction and aspirations. In setting these aspirations the Trust will use much of the service configuration work undertaken during the Healthier Together programme to underpin the Trusts' Clinical Services Strategy.

Lastly, the publication of the Francis Report earlier in the year provided a stark reminder of the need to ensure the very basics of care need to be embedded within all organisations if they are to deliver the good quality health care that patients deserve and expect. The Francis Report makes it clear that these priorities are not 'nice to haves' but form the cornerstones of effective and high performing hospitals and they need to be both strategic as well as operational priorities for all organisations. The Trust has considered the recommendations and have and will continue to listen to the views of patients and staff to ensure that the Trust does not ever lose sight of the essence of high quality care.

Clinical Services Strategy (Delivering the New L&D)

In response to the challenges and context described earlier, the Trust has devised an overarching strategy, ***'Delivering the new L&D'***. This is illustrated below in figure 3.



'Delivering the new L&D' is based upon 5 key themes however it can be summarised as follows:

The Trust's Clinical Services Strategy is to invest and further develop the core clinical services to ensure long-term viability as an acute provider. This will include maintaining market share in some core services such as: ED; Acute Care of the Elderly; Acute Medicine sub-specialties for respiratory and diabetes; Colorectal surgery; Trauma & Orthopaedics; Obstetrics and Maternity; and Neonatal Care; whilst expanding market share for others by developing a range of specialist services such as Hyper Acute Stroke Care, Ophthalmology, Paediatrics and Gynaecology, which can complement the core services and add real value and profit rather than burden the Trust financially or operationally. Many of these service expansions are either repatriating work back to Bedfordshire to save patients having to travel and to save the Market Forces Factor or have the ability to draw activity from a wider catchment population and some will attract private patient income over and above that currently generated.

The need to redesign and modernise services to meet the needs of its patients and commissioners by offering services closer to patients' homes and in some cases in a patient's home has been acknowledged and services are being developed on that basis.

If the Trust is to deliver all the above to the highest quality possible it also needs to attract develop and retain high calibre staff. The Trust's University status will be an essential tool in this endeavour.

Lastly, in some cases the Trust will need to provide services in partnership with others, whether from the public or private sector in order to maximise the offering it can deliver to its patients.

The recent opportunity to bid for some aspects of the Community Services portfolio may offer the Trust an ideal opportunity to draw the demarcation line between acute and community care differently. This form of vertical integration may enable the Trust to control a greater proportion of the care pathway than is currently the case. The Trust is clear it is not a generic community care provider however, that more innovation approaches potentially with a partner organisation could deliver real benefits in terms of quality of care but also in terms of overall efficiency and patient safety. The Trust will actively explore the opportunities during the procurement process and will work with SEPT to ensure a comprehensive community service can be offered.

As stated above, the strategy is built around 5 key themes.

- L&D 'Closer to Home'
- High Quality Acute Care
- Specialist Service Provider
- Teaching and Research Excellence
- Working with Others

Each theme is described in more detail below and the workstreams for each theme can be found in appendix B of appendix 6.

L&D Closer to Home

The Trust continues to be fully committed to the principle of providing a range of appropriate services within the community in line with both national and local policy directives. However, services need to be developed in a co-ordinated and planned manner, in concert with the CCGs and the social care colleagues, to ensure the services transferred remain highly effective clinically and offer the optimal patient experience.

During 2013/14 L&D will continue to work the CCGs and respond to tenders to establish more services in the community to complement those already operated for Muscular Skeletal (MSK) conditions in Luton, Diabetes and COPD for Bedford patients in collaboration with Bedford Hospital and community ENT services in West Hertfordshire. It is anticipated that community Cardiology, Urology, and ENT services along with the larger Community Services will be opportunities in 2013/14.

An extended Home from Hospital Service pilot will commenced at the beginning of April 2013 enabling L&D staff to care for medical and elderly patients in their own home when it is safe to do so.

In addition the feasibility of establishing a clinical satellite facility to provide a wider range of medical and surgical outpatient appointments and treatments in the community is being actively pursued. This development will also help de-congest the hospital site, facilitate other departmental moves in order to improve the hospital's overall efficiency and assist in freeing up potential redevelopment space.

High Quality Local Acute Care Services

During 2012/13 all national and local performance targets were achieved. Over the coming years the Trust will build upon its success and reputation by further improving its clinical outcomes and mortality rates.

As an acute hospital, the Trust's prime role is to provide high quality secondary acute services therefore it is vital these services are managed in the most efficient manner possible given the numbers of patients using the services. To this end, reducing length of stay, improving efficiency and patient experience remain high priorities. Formal transformation programmes have already delivered tangible benefits in Theatres and Outpatients during 2012/13, however this work needs to be continued if real transformational change is to be embedded but with a greater emphasis on medical productivity during 2013/14. The Board of Directors remain very committed to this approach.

In addition to enhancing how A&E attendees, outpatients and in-patients are treated within the hospital more innovative models of care are being explored in order to avoiding admission to the hospital. Examples of this include the new Ambulatory Care and Clinical Decision Units. Both units will enable patients to be treated in the appropriate setting for their condition without the need for an in-patient admission. The Ambulatory Care Unit has been in place since April and the results so far have been encouraging. The Clinical Decisions Unit will be established adjacent to the ED by the late autumn. Evidence from elsewhere suggests that both these developments will have a very positive impact upon the number of acute admission and length of stay for a high number of patients.

Whilst many patients still need to be admitted for the acute phase of their care, there is significant evidence to suggest a patient's outcome is further improved if they are discharged in a timely fashion. In response to this the Trust is launching a new virtual ward which will enable more patients to leave hospital earlier whilst still assured they can receive responsive care should their condition deteriorate. All these new models of care will assist in reducing both admissions and lengths of stay. Tackling both of these issues will have a positive impact on patient care and the wider health community pressures.

The Trust is very keen to establish a 24/7 working culture in key services and departments and the findings of the Francis Report re-enforce the need for hospital care to be consistent 24/7. A new medical staffing model and extended weekend

working for clinical support services is being introduced in 2013/14 and these initiatives will be the first stages in establishing the true 24/7 hospital. More Consultant led care will deliver real quality and safety benefits to patients whilst enabling the Trust to operate more effectively and use its buildings and assets more intensively.

In response to the need to provide high quality nursing care to all patients in whatever clinical setting the Trust has embarked upon an innovative project known as **The Perfect Day**. This initiative is predicated on releasing qualified nursing staff from time-consuming activities which could easily be done by unqualified, trained support staff thereby segregating the clinical care from the hotel and patient administration aspects of the day-to-day ward work. This project will see nurses being able to spend more time with patients caring for them rather making beds, cleaning equipment and filling in paperwork. Job roles will change and trained support staff will gain a higher profile on the wards and will provide a wide range of support services. This model of ward management is very new in the UK and the pilot has been built around a more European model of nursing care. We intend rolling the pilot out to all wards during 2013/14. The patient and staff satisfaction feedback from the pilot wards has been excellent and provided confidence moving forward.

Specialist Service Provider

The Trust continues to provide a number of specialist services for a wider catchment population, for example, Bariatric services are provided for East of England, Thames Valley and Northamptonshire; and specialist stroke services are provided for Milton Keynes and West Hertfordshire, in addition to those in Bedfordshire. The Neonatal Unit is a level 3 Unit and therefore cares for babies from beyond the L&D catchment.

Through 2013/4 the Trust will continue to develop further specialist services, on a sub-regional basis by providing hyper acute services in collaboration with Specialist Tertiary centres. Examples of these developments include: Fertility services in collaboration with Bourn Hall in Cambridge, Paediatric step down services with Great Ormond Street Hospital and Trauma Services with St Mary's and Addenbrookes amongst others.

Ophthalmology services will continue to expand both in terms of the volume of patients seen and the range of services offered including tertiary corneal services which were until recently only available in Specialist Eye Hospitals such as Moorfields.

Building on the success of the Cardiac Catheter laboratory the service will be applying to become a recognised interventional cardiac centre enabling patient requiring Percutaneous Coronary Intervention (PCI) treatment to be treated locally.

The continued development of specialist services as part of the Trust's portfolio will enhance our ability to recruit the best clinical staff. The expansion of hyper acute services also contributes to the care closer to home agenda, as patients will be able to receive more of their care pathway locally in collaboration with the tertiary

providers rather than having to travel repeatedly from Bedfordshire into London or Cambridge.

Teaching and Research Excellence

2012 saw the Trust formally recognised as a University Hospital. This achievement recognises the quality of teaching at the Trust and the breadth of research undertaken. Clinical research opportunities will be actively pursued in order to improve the quality of patient care.

It is also acknowledged that the Trust's reputation for excellence in teaching and research greatly enables the Trust to attract high quality medical staff of all grades but especially consultant staff. This is even more important at a time when training numbers are down and therefore, the labour pool is reduced. Overall this will contribute to the Trust being able to improve the quality and safety of its services to patients.

Working with Others

The Trust has previously had a rather inward looking, hospital centric approach to delivering its services. However, things are changing and have already changed in certain areas.

The Trust is working collaboratively with Great Ormond Street Hospital to develop tertiary step down services to enable children who have had to be admitted to GOSH for specialist care to be discharged from GOSH earlier than previously into the care of the L&D service. This enables some of the sickest children to be in hospital closer to home rather than parents having to travel constantly to London. This is a great accolade for the team at L&D and acknowledges the quality of care they are now able to offer locally.

Another example of the Trust working with others is its recent collaboration with Bourn Hall for Fertility Services. Once again this collaboration with an internationally renowned centre of excellence enable the L&D to provide services locally which until recently patients had to travel to either Cambridgeshire or into London on a very regular basis for the duration of their treatment.

The Trust also developed its community COPD and Diabetes service in partnership with Bedford Hospital and this combined service is now provided throughout Bedfordshire.

The Trust is also in the early stages of exploring relationships with Circle in response to the Bedfordshire CCG MSK tender and with the South Essex Partnership Foundation NHS Trust (SEPT) in response to the Luton Community Service Tender.

The Trust also recognises the importance of working with organisations such as the McKinsey Hospital Institute and UCLP to develop learning about best practice which can be imported to the L&D.

In addition the Trust is part of the Mount Vernon Cancer Network and has a number of joint appointments with other centres such as Royal Free, Harefield, and Bedford etc.

Transforming Facilities and Systems

The need to re-develop and transform the hospital site and IT systems remain a very high priority. The Board of Directors has commissioned the preparation of a business case to redevelop the site focusing on a number of key priorities including:

Building the new L&D

- Building a new NICU
- Refurbishing the theatre suites including the delivery suite and the provision of clean room facilities
- Expanding the Emergency Department and associated Emergency care facilities to include a Clinical Decisions Unit
- Renewing the hospital infrastructure to improve site resilience
- Continuing the redecoration of the outpatient facility
- Further expanding the Endoscopy Suite including negative pressure facilities
- Creating a combined ITU and HDU facility
- Refurbishing of a number of the wards, including the provision of more side rooms
- Creating an off site surgical and medical treatment facility which is likely to contain Ophthalmology, Dermatology and Plastic services
- Relocating the fracture clinic into appropriate facilities
- Creating a new main entrance and improved public facilities
- Creating a bed store and equipment wash facility
- Building new parental accommodation to support NICU
- Increasing car parking and improving access and egress of the site
- Refurbishing the mortuary facilities

The schemes listed above will form an overarching Strategic Outline Case (SOC) which will set out the case to invest in the L&D estate over a period of four years. This will form the basis of a submission to the Foundation Trust Financing Facility (FTFF) for a loan to support this extensive investment in services for the patients and staff of L&D now and in the future.

IT Systems

A new IM&T Strategy was published in May 2013 and plans a clear road map for the next five years. The IM&T Strategy was developed in conjunction with this strategy.

There is already much work planned, with many months of procurement giving way to a year of implementation. Further capability has been built to deliver care safely and efficiently without the need to request paper notes – an electronic patient record. In order to deliver this, there are several key projects. In the previous year, the Trust signed a long-term strategic contract with Xerox to transform our existing Health Records Service into a modern state of the art scanning service. This contract

commenced on the 4th February, and this year will see large-scale transformation in many of the key processes where paper notes are vital to care. At the end of September 2013, the process of advanced scanning out book patients' notes will begin. By February 2014, all requests for paper notes will be fulfilled with an electronic scan into a new electronic document management system. This will improve the availability of the notes at the point of need, and make the access instantaneous from anywhere anytime to multiple staff as required.

The electronic observation system, already proven to assist in early identification of patients whose condition is deteriorating, has been deployed into Medicine in the past year, but will be rapidly deployed across all adult medical and surgical beds during 2013. The ability to be alerted to all deteriorating patients across the Trust from one system is a key improved capability in our push to improve patient safety further. Functionality to capture electronically fluid balances will also be extended along with ensuring that the patient inserted devices such as cannulae and catheters are managed safely and in adherence to best practice protocols.

The past year has been one of procurement with both an electronic system to support drug prescribing and administration, and a replacement for the Trust's telephony system. The prescribing system will be deployed initially in the Department of the Medicine for the Elderly in the late autumn of 2013, with wider rollout thereafter.

The replacement of the Trust's telephony system will take place mostly in 2014, although the preparatory work and initial deployments will begin in 2013. This will include plans to replace the current "bleep" system of paging staff, with a state of the art system for managing urgent messages and communication.

Behind the scenes, investment has already been made in a new data centre that has been built and will be fully populated with all the L&D systems early in the New Year. In addition, the data centre hardware: servers and storage will be refreshed with sufficient capacity to meet the next five years of growth. This will include much improved ability to run systems from offsite in case of any disasters affecting the onsite data centre. This greatly enhanced resilience means the reliance upon electronic systems can be safely increased.

In 2013/14, there will be a return on its investment in electronic systems with care safely able to occur without the need to recall a paper record. Access anywhere, anytime to the persistent patient record will create efficiencies and opportunities to work differently. For example, all clinical coding will be completed on screen, without need to seek the paper notes. At the same time a recently discharged patient may well, be in an Outpatient appointment the same record concurrently accessed.

Whilst not clinical services, the Trust also acknowledges the importance of improving and investing in the facilities and systems which all underpin the provision of high quality clinical care.

3.2 Our Vision and Aims

3.2.1 Our Vision & Aims

In January 2011 the Board of Directors engaged with the Council of Governors, external Stakeholders, Staff and Patients to agree a 3 year vision for the L&D.

Vision Statement

“The L&D is committed to delivering the best patient care, the best clinical knowledge and expertise and the best technology available and with kindness and understanding from all our staff “

Aims

- To put patients first, providing the best possible clinical outcome and the highest quality to the patient experience.
- In partnership with Cambridge University, University College London and others, to be nationally respected for the provision of education and development.
- To ensure value for money and using the freedoms of Foundation Trust status, to exploit our strengths and specialisms for the benefit of patient care and clinical outcomes.
- To ensure effective governance, accountability and leadership while maintaining staff engagement and involvement.
- To ensure a full appreciation throughout the organisation of the changing environment of commissioning, competition, risk, regulation, patient choice, sustainability, QIPP and our financial position.
- To develop and maintain productive relationships with external partners and maximise opportunities for communication and joint working.
- To retain and recruit the best staff.
- To market and promote effectively the services of the Trust.

Values

- To put the patient first, working to ensure they receive high quality safe care with dignity and respect.
- To value the contribution of staff, volunteers, members, governors and other partners and stakeholders, working collaboratively and professionally to deliver high quality clinical care.

- To focus on continuous improvement in the pursuit of excellence, maximising development opportunities.
- To manage our resources in a co-ordinated way, with an emphasis on productivity, value for money and quality.
- To see the diversity of our people as a strength, through our commitment to inclusion, equality and human rights.
- To accept responsibility for our actions, individually and collectively, to meet our obligations and deliver our commitments.

3.2.2 Maintaining our Performance

During the year ahead, we will spend a significant amount of time focussing on finalising our Clinical Services Strategy and implementing the Hospital Redevelopment Programme. It will therefore be important that we do not lose sight of internal and external challenges and ensure that our operational and financial performance continues to be maintained.

Maintain and Develop Key Clinical Specialties

- Maintain key specialties to secure our future in terms of clinical excellence, financial sustainability and reputation.
- Develop clear strategies for key specialties to mitigate the risks from the re-organisation of acute services to the north of the Trust with aspirations of other service providers.

Exploring Opportunities for Growth

- Explore the growth opportunities across the range of services offered as a consequence of the acute services review, either alone or in partnership.
- Actively engage other stakeholders including the CCGs and the local authorities in rethinking models of community care embedding L&D expertise services in the heart of the major localities.
- Increase the Trusts' market share in the services identified in the Clinical Services Strategy as offering greatest opportunity e.g. Trauma and Orthopaedics, Spinal Surgery, Women & Children, Bariatrics and Ophthalmology.
- Strengthen the relationship with tertiary hospitals to enhance and develop a range of hyper-acute services, in particular paediatrics, cancer, stroke and trauma.

Ensuring Sustainability

- Continue to improve the patient experience and safety, for example, through improving communication and the provision of information to patients and greater access to consultant-led care.
- Ensuring the maximum use of information to deliver safe and efficient care by using an electronic patient record, and decision support information systems at all levels of the organisation.

- Ensure that the delivery achieved during 2012/13 against national and local quality and performance targets is fully embedded, further improved and maintained.
- Maintain financial sustainability, delivering a comprehensive programme of efficiency projects.
- Implement 'The Perfect Day' to ensure nursing staffing establishments are able to improve the quality and safety of care provided to patients.
- Review and modernise non-clinical support services including catering, cleaning and portering to ensure they are responsive to patients' needs and support clinical care.
- Further develop and strengthen the Divisional Management Teams in order to benefit fully from the benefits of service line reporting and management.

3.3 Trust Corporate Objectives for 2013/14

In April 2012 the Board of Directors in consultation with relevant stakeholders determined a new 3 year plan. The plan was to be delivered via seven core objectives.

March 2013 saw the conclusion of the first year of this three year plan. The Trust now moves into the second phase (year) of achieving its core objectives.

During 2013-2014 the Trust will facilitate internal and external discussions to agree a new three year objective based on the Clinical Strategy 'Delivering a New L&D' and the hospital re-development programme 'Building a New L&D'.

The agreed three year objectives (2012-2015) are outlined below:

- 1. Deliver Excellent Clinical Outcomes**
 - Year on year reduction in HSMR in all diagnostic categories
- 2. Improve Patient Safety**
 - Year on year reduction in clinical error resulting in harm
 - Year on year reduction in HAI
- 3. Improve Patient Experience**
 - Year on year improvement in patient experience demonstrated through hospital and national patient survey, leading to upper quartile performance
- 4. Deliver National Quality & Performance Targets**
 - Deliver sustained performance with all CQC outcome measures
 - Deliver nationally mandated waiting times & other indicators
- 5. Progress Clinical and Strategic Developments**
 - Implementation of Clinical Services Strategy
 - Implementation of Site Re-development Plan '*Building a New L&D*'

6. Develop all staff to maximise their potential

- Deliver excellence in teaching and research as a University hospital
- Ensure a culture where all staff understand and promote the vision and values of the organisation
- Recruit and retain a highly motivated and competent workforce

7. Optimise our Financial Plan

- Deliver our financial plan 2012-2015

The table below outlines the detail underpinning the 2013/14 plan identifying the actions that will be taken to achieve the objective and the success criteria.

L&D Corporate Objectives 2013/14

Objective	Key Milestone 13/14	Action to deliver in 2013/14	Success Criteria
1. Deliver Excellent Clinical Outcomes	Key Quality Priority Improve performance by reducing average length of stay for older people	<ul style="list-style-type: none"> Establish a 'frail elderly unit'. This will allow for specialist nursing and concentrated effort from the multidisciplinary team to reduce the average length of stay for these patients. Work with colleagues in social services, local government and community providers to provide alternatives to hospital beds. 	<ul style="list-style-type: none"> Reduction in the average length of stay for elderly patients from 12.4 to 11.0 Reduction in the number of elderly patients placed in less appropriate wards Reduction in the number of patients medically fit for discharge but still in hospital
	Key Quality Priority Improve performance on overall hospital mortality across fractured neck of femur and all specialties	<ul style="list-style-type: none"> Complete the implementation of the new orthogeriatric model of care by August 2013 Implement revised orthopaedic theatre schedule to improve access to timely surgery for patients with fractured neck of femur by end of May 2013 Establish anaesthetic guidelines for fractured neck of femur by end of July 2013 	<ul style="list-style-type: none"> Significant reduction in fractured neck of femur HSMR Improve number of patients for which best practice tariff to 90% is achieved
	Reduce avoidable emergency re-admissions	<ul style="list-style-type: none"> Introduce an ambulatory care model Introduce Hospital at Home 	<ul style="list-style-type: none"> Reduction in unnecessary admissions Reduced length of stay
	Fully participate in national and local clinical audits	<p>To provide advice and support Divisions & their subspecialty teams on:</p> <ul style="list-style-type: none"> Programme of national audits planned for 2013-14 Project inclusion criteria Arrangements for data submission The dissemination of results from national audits that are made available to the principal clinical lead(s) 	<ul style="list-style-type: none"> Clinical speciality lead(s) register with the national project organisers All eligible patients are included & target sample achieved Data is submitted within the project timescales The Trust will participate in 100% of all national audits that it is eligible to participate in, according to the DoH

Objective	Key Milestone 13/14	Action to deliver in 2013/14	Success Criteria
2. Improve Patient Safety	Key Quality Priority Ensure that we have the appropriate level of clinical expertise available to deliver safe and effective care 24/7	<ul style="list-style-type: none"> Introduce a new medical model of care which will increase availability of a consultant led service Provide stronger senior decision making and support for junior medical staff 	<ul style="list-style-type: none"> Reduction in unnecessary and avoidable admissions Reduced length of stay for all patients
	Key Quality Priority Ongoing development of Safety Thermometer, exceeding performance year on year	<ul style="list-style-type: none"> Collect data on the four elements of the Safety Thermometer: Pressure ulcer prevalence; Harm from falls; Urinary tract infections in patients with a catheter; Proportion of patients with a VTE risk assessment, appropriate prophylaxis and clinical treatment Use the prevalence baseline data from the Safety Thermometer as an improvement tool to reduce the amount of harm patients experience 	<ul style="list-style-type: none"> Improve clinical outcome 50% reduction in the prevalence of hospital acquired, avoidable grade 2 and 3 pressure ulcers 10% reduction in the proportion of patients with harm from a fall 3% reduction in the proportion of patients with a urinary catheter 95% (minimum) patients to have had a VTE risk assessment on admission Root cause analysis (RCA) on all cases of hospital associated thrombosis
	Continue to reduce HCAI rates year on year	<ul style="list-style-type: none"> Increase the number of side rooms by leasing six infection control pods and refurbish existing side rooms in wards 10, 11, 12, 3 and 4 Contract external service to provide Hydrogen peroxide vapour decontamination as part of enhanced cleaning of wards and shared near patient equipment. Institute active surveillance of all patients with multi-resistant gram negative infections – report on isolation of all hospitalised patients with gram negative multidrug resistant organisms. Ensure the safety of water supply in the hospital – set up a Trust water safety management group, produce a gap analysis and ensure compliance with national guidance Re-convene Antibiotic Stewardship Group – Audit the prescription of antibiotics against Trust guidelines 	<ul style="list-style-type: none"> Infection rates below 2012/13 rates

Objective	Key Milestone 13/14	Action to deliver in 2013/14	Success Criteria
	Increase compliance with hand hygiene year on year	<ul style="list-style-type: none"> Reassess the hospital's status with regards to all components of hand hygiene improvement Develop revised, reliable and robust hand hygiene data reports featuring staff compliance, for wards and the hospital overall (from the new electronic monitoring system) – with a clear action plan for ongoing improvement going forward Have a greater and refreshed understanding of the importance of when hands should be cleansed, in identified staff Review overall of patient feedback on staff hand hygiene with the aim of understanding confidence levels by the end of 2013 	<ul style="list-style-type: none"> Identify a reliable baseline score for hand hygiene Improve on the baseline score by the end of the year
	Extend electronic nursing observations to include fluid management, weight and device management	<ul style="list-style-type: none"> Complete the implementation of electronic nursing observations on all clinical areas by October 2013 Complete the implementation of electronic fluid balance monitoring by March 2014 Commence the implementation of the device module by January 2014 	<ul style="list-style-type: none"> Improved response and completion of repeat observations following deterioration of patients Improved recording of observations at night 20% reduction in cardiac arrests 20% reduction in need for critical care
3. Improve Patient Experience	Key Quality Priority Revolutionise how we handle complaints	<ul style="list-style-type: none"> Create a sub committee of the Board to examine incoming complaints, how they are being managed, what issues they raise are learned from Take actions to change the culture over time so that clinicians and managers prioritise complaints as a rich source of information and learning 	<ul style="list-style-type: none"> Further increase in the quality of complaint responses as evidenced through complainants feedback and Ombudsmans review of responses Improvement in the timeliness of complaint responses without decreasing the quality of the response An increase in the use of local resolution meetings wherever appropriate Summary of learning from complaints published to the Trust website as recommended by the Francis report

Objective	Key Milestone 13/14	Action to deliver in 2013/14	Success Criteria
	Key Quality Priority Continue to implement the Outpatient Transformation programme	<ul style="list-style-type: none"> Develop operational sub committee to Transformation Board Develop Outpatient customer service training programme and OPD service commitment Establish OPD specific patient experience facility Embed OPD patient experience KPIs Deliver interactive appointment communications Deliver outsourced Outpatient mail Complete consulting room upgrades to Zone C Improve appointment scheduling Improve call centre functionality Improve divisional / specialty / clinician level Outpatient performance data 	<ul style="list-style-type: none"> Be amongst the most improved Trusts in the National Outpatient Experience Survey in the EoE Achieve further 2% reduction in DNA rates Expanded specialty specific pre-appointment patient information Achieve fit for purpose Outpatient facilities Reduced number of patients experiencing hospital initiated clinic cancellations Reduced delays in clinics and provide better intra-clinic patient communications Faster Outpatient call centre response times Alignment of Outpatient productivity to medical productivity to drive efficiency and transformation
	Improve patient experience by establishing a framework to take forward the key messages from the listening events and the recommendations from the Francis report	<ul style="list-style-type: none"> Embed a task and finish group with all key staff group members to identify key actions Determine and measure what matters to patients Understand and act on what matters to staff Develop a clear accountability framework Reduce bureaucratic burden 	<ul style="list-style-type: none"> Developed a 'ward health check' Developed a ward sister training and accreditation programme Developed a training and education strategy for Health Care Assistants (HCAs). Robust process in place to ensure that when problems are raised, they are heard, addressed and acted upon and used as vital information for improvement Revised clinical documentation

Objective	Key Milestone 13/14	Action to deliver in 2013/14	Success Criteria
	Improve the quality of professional communication with all patients and carers.	<ul style="list-style-type: none"> • Spread the use of the Quality of Interaction Schedule tool to both measure the quality of staff interaction with patients and families but also to educate professional staff and managers • Roll out the "Perfect Day" model of care across all inpatient wards to allow nursing staff to spend more time at the patient bedside. • Continue to provide positive and negative feedback from the calls made in the Patient Experience Call Centre to medical and nursing staff and their line managers • Continue to involve professional staff in making post discharge telephone calls to patients so that they hear direct feedback about the impact of their communication • Work to make sure that professional staff are well supported by other roles so that they can concentrate on the patient and family • Identify those staff who need further training in relation to breaking bad news and facilitate access to that training • Involve patients in junior doctor communication training • Build on the principles of the "Perfect Day" to improve patient involvement in decisions about them. The introduction of the reliable ward round tool will be used to facilitate this. 	<ul style="list-style-type: none"> • An increase in the number of patients who would rate communication from doctors as excellent (49% at Q4 2012/13) • An increase in the number of patients who would rate communication from nurses as excellent (61% at Q4 2012/13) • A reduction in complaints where communication is mentioned negatively • Reduction in complaints relating to poor communication between patients and clinical staff • Improve patient experience scores in relation to communication on the Meridian patient experience scores in those areas where the new model has been adopted.
	Work with patients, their families and stakeholders in Luton to redesign end of life care.	<ul style="list-style-type: none"> • Participate in CCG led workstream to improve access and support for end of life care. • Provide "Significant Conversation" training for senior clinical staff. 	<ul style="list-style-type: none"> • Single Point of Contact available to all end of life patients and clinicians. • Improved communication between patient and medical staff demonstrated in patient experience score

Objective	Key Milestone 13/14	Action to deliver in 2013/14	Success Criteria
	Establish an off site facility for ophthalmology, plastics and dermatology	<ul style="list-style-type: none"> Establish a project team – April Agree clinical model – April /May Conclude discussion on the purchase price for building - May Generate a business case – April to July Present business case to Trust Board - July Consult Staff – July –October Consult patient s- July to Sept Identify and procure appropriate site – April – August Refurbish facility – Sept – Dec Commission facility – Dec Jan Commence service Jan-Feb 	<ul style="list-style-type: none"> Facility delivered within budget and on time Services fully operational by Feb 2014 Patient and Staff satisfaction high
	Deliver additional clinical and diagnostic services during evenings and weekends	<ul style="list-style-type: none"> Implement Imaging shift system Determine expanded weekend service requirements for Imaging by modality Obtain Divisional support for business cases for expanded weekend pharmacy and therapy services Conduct staff consultation in pharmacy Determine demand for expanded and substantive evening and weekend Outpatient service provision 	<ul style="list-style-type: none"> Imaging shift system to commence June 2013 Improved patient access to a fuller range of Imaging services at weekends, facilitating reduced LOS and weekend discharges Improved patient access to specialist therapy support at weekends, facilitating reduced LOS and weekend discharges Improved patient access to out of hours Outpatient clinics where required, supported by Diagnostics and other co-dependant services
	Improve patient experience by implementing the 'Perfect Day'	<ul style="list-style-type: none"> Roll out the "Perfect Day" model of care across all inpatient wards to allow nursing staff to spend more time at the patient bedside. Reduce unnecessary nursing paperwork 	<ul style="list-style-type: none"> Improvement of 10% in the Meridian patient experience scores in those areas where the new model has been adopted. Improvement in national inpatient survey
	Formally explore alternative ways to deliver non-clinical support services in order to improve quality and contain cost.	<ul style="list-style-type: none"> Obtain approval to proceed with business case – April Establish project team – April Explore options and generate business case – April – August Present options to Trust Board - September Implement approved option – Oct onwards 	<ul style="list-style-type: none"> Clear plan in place by October regarding how Soft FM services will be operated in order to improve quality and maximise value for money

Objective	Key Milestone 13/14	Action to deliver in 2013/14	Success Criteria
4. Deliver National Quality and Performance Targets	Deliver sustained compliance of all CQC outcome measures	<ul style="list-style-type: none"> Continue to deliver the CQC nursing assurance programme 	<ul style="list-style-type: none"> Compliance with CQC outcomes reported to the board via COSQ Improved compliance with outcomes
	Deliver nationally mandated waiting times for 18 Weeks, Cancer and A&E including A&E Indicators	<ul style="list-style-type: none"> Ongoing performance forecasting of targets and corrective action to be taken in a timely manner. 	<ul style="list-style-type: none"> Full compliance with Monitor measures. Board and Sub-committees aware of any performance risks.
	Sustainability culture established across the organisation	<ul style="list-style-type: none"> Sustainability champions identified throughout Trust - September Energy saving campaign established - October 	<ul style="list-style-type: none"> A reduction in carbon and utility consumption from an agreed base line
	Achieve 40% of the Trust's Carbon Management Plan Target	<ul style="list-style-type: none"> Sustainability measures to form the central focus of all capital works as part of the site Masterplan. Building Management systems replace to enable remote monitoring Replacement Boilers installed for the Maternity block 	<ul style="list-style-type: none"> Target met against an agreed baseline.
	Deliver CQUIN targets year on year	<ul style="list-style-type: none"> All CQUIN initiatives implemented CQUIN monitoring Board established 	<ul style="list-style-type: none"> All CQUIN goals to be achieved Budgeting income secured
5. Progress Clinical & Strategic Developments	Clinical Strategy agreed and implemented	<ul style="list-style-type: none"> Clinical Services Strategy agreed by Board – Q1 Divisions to progress service developments following Board approval of overall strategy, subject to business case approvals Work locally with CCG's to implement the clinical services strategy 	<ul style="list-style-type: none"> Clinical Service Strategy approved by the Board Service developments implemented to plan

Objective	Key Milestone 13/14	Action to deliver in 2013/14	Success Criteria
	Agree detailed business cases for phases as laid out in Masterplan	<ul style="list-style-type: none"> Investment strategy prepared and agreed by the Board – July Loan submission to FFTF – Oct/Nov Business case developed – May-Oct Business case agreed by various stakeholders, Board of Directors, Council of Governors and Monitor - Nov Business cases generated throughout year as required to fulfil the Masterplan 	<ul style="list-style-type: none"> Investment Strategy and relevant business cases approved.
	Deliver masterplan enabling schemes and early phases	<ul style="list-style-type: none"> Agree design solutions for each discrete element of the Re-development Procure construction partner as required. Agree decant strategy Decant services 	<ul style="list-style-type: none"> Breast Screening Car Park extended Endoscopy scheme (phase2) completed Off –site facility operational ED expanded Fracture Clinic relocated into new facility
	Care can safely and efficiently take place, without need to request a paper record	<ul style="list-style-type: none"> Complete underpinning technical work and underlying application elements comprising - single sign-on, clinical context, and remote access Complete roll-out of planned systems – including e-observation, electronic document and record management system (eDRMS), ensure that the integration between elements works well so that end-to-end processes are efficiently supported. Provide read-only access to GP and community clinic data via System One Clinical Records Viewer (CRV) - . SystemOne is used for 50%+ of GP records, all community services including Child Health and Palliative Care, and also by other Urgent Care providers. Increase range of diagnostic investigations, interventions and activities that can be ordered and reported electronically Begin the implementation of electronic prescribing and medicines administration (ePMA) within DME 	<ul style="list-style-type: none"> New Data Centre fully live and populated. Offsite - Live Failover Data Centre live in Cambridgeshire. Key systems proven to run from both locations seamlessly to users. Reduced number of password challenges for most clinical users of electronic systems down to one single sign on. Reduced number of patient searches for most clinical users of electronic systems down to one single patient context select. 50% of patient admissions generating a check on CRV to review non-acute clinical record. Deployment of the eDRMS solution across the Trust, and launch of full scan on demand for all clinical activity. All notes requested for clinical activity will be delivered as electronic scanned documents rather than physical note retrieval. Integration of Neurophysiology to allow use of ICE for Requests/ Reports. ePMA live on at least one ward within DME replacing the electronic drug chart entirely. A robust plan ready to rapidly roll-out the successful configuration and deployment model across the entire Trust in 2014/2015.

Objective	Key Milestone 13/14	Action to deliver in 2013/14	Success Criteria
	To improve the ability of decision makers at all levels of the organisation to use information in order to improve service delivery, design, quality, efficiency and safety.	<ul style="list-style-type: none"> Support for the Medical Productivity work stream by providing dashboards for speciality analysis of activity. This will require iterative design and refinement during the course of the year. Clearer presentation of the analysis of service line performance by provision of appropriate dashboard. Greater levels of user involvement with the current data warehouse and reporting systems. Enhanced quality assurance with Clinical Coding, including an outreach programme to engage clinicians in discussions around correct recording and classification of activity. 	<ul style="list-style-type: none"> A quarterly individual consultant productivity dashboard. A quarterly service line dashboard. A specialty and consultant focus on accurate coding of activity. A monthly dashboard per service line (where relevant) of Outpatient utilisation. Automated quarterly allocation of cost and income to patient level. Interactive dashboards as well as scheduled reports via email (PDF/EXCEL)
	To increase levels of safety, efficiency, and flexibility delivered by transformational technology	<ul style="list-style-type: none"> Improve the resilience of the Voice and Emergency Messaging infrastructure by beginning the implementation of the a new Unified Communication platform. Enable remote, flexible working by increasing the number of staff with offsite access to critical systems. Build on the base telephony to design the most efficient means of communication via voice, messaging and data for key clinical and operational processes. 	<ul style="list-style-type: none"> A resilient deployment of 100 new VoIP phones across all critical areas to allow the Trust to operate effectively in case of analogue failure. All senior clinical staff having access to their critical applications from remote locations using their own hardware as appropriate. A clear roadmap for replacement of legacy bleep technology, and the new solution supporting the 24/7 (Hospital at Night Team) to co-ordinate activity.
	Work jointly with Local Authority, CCGs and other key stakeholders	<ul style="list-style-type: none"> Monthly meeting with CCG Chief Officer Attending Health and Social Care Programme Board Engagement with the Overview and Scrutiny Committees 	<ul style="list-style-type: none"> Support for key initiatives (e.g. PCI and Hyper Acute Stroke Unit) Support for Redevelopment Business Case

Objective	Key Milestone 13/14	Action to deliver in 2013/14	Success Criteria
6. Develop all staff to maximise their potential	Extend education and training performance management to all staff groups through the Divisional structure to go beyond regulator and training commissioner requirements to measurably enhance patient experience and safety globally through a radical development programme	<ul style="list-style-type: none"> Creation of the Division of Clinical Education and Research, with agreed governance framework, objectives, performance management framework and stakeholder support and financial resourcing by the Trust. Project management defined for new facilities and processes. Workforce and Training bureau operational by March 2014. 	<ul style="list-style-type: none"> Outcome measures and Divisional impact factor based of patient experience, outcomes and safety information from a wide range of sources, staff satisfaction survey.
	Develop and deliver joint accredited academic programmes with our partner Universities	<ul style="list-style-type: none"> Integrated pathways for Research and Training established with Bedfordshire and Hertfordshire Postgraduate Medical School. 	<ul style="list-style-type: none"> Increased collaborative working by 20% by 2014.
	Continue to increase the number of staff appraisals to 80%	<ul style="list-style-type: none"> Report departmental appraisal rates to all managers and the Board on a monthly basis Provide training for managers and staff briefings Review the appraisal cycle to bring it in line with objective setting and business planning. Pilot the incorporation of an agreed approach to talent management into the appraisal process and paperwork. 	<ul style="list-style-type: none"> 80% (of available staff) have an up-to-date appraisal Measure success through internal reports but also through the Staff Survey.
	Increase mandatory training compliance	<ul style="list-style-type: none"> Report to all managers and the Board on a monthly basis non- compliance Review the content of training and provide sufficient opportunities for updating completing the training. 	<ul style="list-style-type: none"> E-learning is easily accessed by all staff groups Mandatory training compliance has increased to 75%

Objective	Key Milestone 13/14	Action to deliver in 2013/14	Success Criteria
	Maintain clinical leadership development	<ul style="list-style-type: none"> Develop, deliver and evaluate a leadership programme that enables senior doctors to gain insights into best practice both nationally and internationally to drive improvements in patient care and quality of service delivery. 	<ul style="list-style-type: none"> Clinical leaders feel better equipped to manage and lead in their areas and in their corporate role Succession planning is improved for medical management roles Measure success through the Staff Survey
	Establish a culture where all staff feel able to sign up to our values and have knowledge of the Trusts Quality Priorities and staff fully aware of the Trust's vision, values and objectives	<ul style="list-style-type: none"> Continue to introduce the Trust's vision, values and objectives at Corporate Induction Incorporate key cultural messages into training and development Make links between culture change and behaviours at all levels in the organisation 	<ul style="list-style-type: none"> Staff can articulate and understand the Trust's vision and values. Patient experience is improved and this can be measured through the Patient Survey
7. Optimise our Financial position	Deliver our Financial Plan 2013/14	<ul style="list-style-type: none"> Achieve the financial plan 	<ul style="list-style-type: none"> Financial Plan achieved
	Finalise forward capital investment plans and agreed balance between borrowing and cash financing	<ul style="list-style-type: none"> Investment Strategy to be approved in summer 2013. Outline capital expenditure and financing plan contained in Section 6. Business Case required during 2013/14 to formalise development and substantiate case for external finance. 	<ul style="list-style-type: none"> Approved Investment Strategy Approved Business Case
	Develop service line management as the key tool to drive financial efficiency and increase clinical engagement	<ul style="list-style-type: none"> Service Line Reporting reported at service line level monthly to Divisions 	<ul style="list-style-type: none"> Evidence of clinically led financial management and control <p><i>Further detail of Service Line Reporting is in section 6.7.</i></p>

Objective	Key Milestone 13/14	Action to deliver in 2013/14	Success Criteria
	Increase productivity – Improved Theatre Productivity, improved outpatient productivity and establish ambulatory care model to reduce avoidable admissions and costs	<ul style="list-style-type: none">▪ Deliver work programmes for each individual transformation workstream:<ul style="list-style-type: none">▫ Workforce▫ Medical Productivity▫ Trauma and Orthopaedics▫ Length of Stay▫ Procurement	<ul style="list-style-type: none">▪ Delivery of the Divisional profit target <p><i>Further detail of this objective is in section 4.8 'The Trust approach to QIPP – Quality, Innovation, Productivity and Prevention.'</i></p>

4. Implementing the 2013/14 Plan

Our Annual Plan and Quality Account sets out our key quality priorities for 2013/14.

4.1 National & Local Context

This section of the Annual Plan sets out how the Trust intends to ensure that the organisation can meet national, regional and local strategies and challenges, implement its 2013/14 service and capital developments, deliver its contractual commitments and achieve the corporate objectives.

National – Operating Framework and Key Priorities

The Department of Health has published key pieces of guidance to assist health bodies in navigating their way in the new environment created by the new reforms. “Everyone Counts: Planning for Patients 2013/14” outlines the incentives and levers that will be used to improve services from April 2013, the first year of the new NHS, where improvement is driven by clinical commissioners.

The White Paper: Liberating the NHS outlined the Coalition Government’s intention to move the NHS away from focusing on process targets to measuring health outcomes. “The NHS Outcomes Framework” reflects the vision set out in the White Paper and contains a number of indicators selected to provide a balanced coverage of NHS activity. The framework was developed in December 2010, following public consultation, and was updated in December 2011.

Indicators in the NHS Outcomes Framework are grouped around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. For each domain, there are a small number of overarching indicators followed by a number of improvement areas. They focus on improving health and reducing health inequalities:

- Preventing people from dying prematurely;
- Enhancing quality of life for people with long-term conditions;
- Helping people to recover from episodes of ill health or following injury;
- Ensuring that people have a positive experience of care; and
- Treating and caring for people in a safe environment; and protecting them from avoidable harm.

Local Health Economy

2013/14 marks the creation of new local commissioning groups which take on full commissioning responsibility for the majority of services. The creation of an independent NHS Commissioning Board, and the new mandate to the Board from the Government means that Foundation Trusts will need to establish a set of new relationships within this context.

Both local CCGs have established their own plans which include their proposed actions to meet the local quality premium and establish the required three local priorities.

The local health economy has significant financial challenges. The challenge for the CCG is the difference between its anticipated resource growth and the pressures they face from pay and price pressures (i.e. increasing costs of drugs and devices), demand and quality pressures (growing and ageing population) and local underlying pressures arising from known differences between actual current expenditure and the allocation of resources through the exercise undertaken to establish CCG baselines less the benefit it receives from providers from the nationally agreed 1.3% reduction in tariff.

The Trust is fully engaged in working with the CCGs to meet these priorities and challenges and whilst these plans contain risks for the Trust, overall the commissioner objectives are aligned with the Trust ambitions. In particular the CCG's intentions to manage downwards the demand for urgent care is essential to allow the Trust to deliver its service portfolio within the available capacity.

Quantifying the Financial Challenge

The White Paper (Liberating the NHS) identified the requirement for NHS reforms against the backdrop of a very challenging financial position. In the Coalition Agreement, the Government said that the single greatest priority for the next Parliament will be to reduce the national deficit. The Paper identified that it is now even more pressing that the NHS increase productivity and efficiency.

The White Paper confirmed that NHS spending in real terms will increase in each year of this Parliament. Despite this, local NHS organisations will need to achieve unprecedented efficiency gains, if the NHS is to meet the costs of demographic and technological changes, and even more so if the NHS is to achieve improvements in quality and clinical outcomes.

Large cuts in administrative costs will provide an important but still modest contribution. In the next five years, the NHS will only be able to increase quality through implementing best practice and increasing productivity. This will be difficult work. Inevitably, as a result of the record debt, the NHS will employ fewer staff at the end of this Parliament; although rebalanced towards clinical staffing and front-line support rather than excessive administration.

The L&D approach to quantifying the financial challenge has been to use existing work, guidance by Monitor for aspirant Foundation Trusts, the work of an independent financial advisor and the work undertaken by Mckinsey as part of the Healthier Together Project.

This work identified the negative impact on FT finances that arise from tariff deflation, cost inflation (pay and non-pay) and additional cost pressures required to meet increased service standards. The FT has used 4.5% as an annual figure to model this financial challenge. This is marginally below the figure quoted by Monitor for

aspirant FTs but reflects the fact that the FT currently carries a level of contingency within its budget that could act as a buffer should the estimate be understated.

In addition to the 'status-quo' downside of delivering existing activity the FT is vulnerable to Commissioner QIPPs (i.e. reductions in income from demand management by local CCGs). The figure used to quantify this is derived from the McKinsey work that underpinned the Healthier Together Project albeit that any demand reductions can, in part, be offset by marginal cost reductions.

Further cost increases will be incurred as a result of the Hospital Re-Development Project. However, much of the cost consequence arising from the Development Project (in Income & Expenditure terms) will fall outside the period of this Annual Plan.

The Hospital Re-Development Project Business Case will robustly address issues of affordability arising both from the 'status quo' challenge but also from the cost change from the FT employing a higher asset base.

In order to mitigate the income and cost shortfall the Trust will seek to develop new services, increase market share and increase efficiency, effectiveness and economy via a Cost Improvement Programme. The approach to Cost Improvements is discussed in more detail at section 4.8.

Recruiting and Retaining High Quality Staff

Our vision is to be a recognised centre of excellence with high quality staff providing high quality services. Delivering this objective requires the Trust to maintain its ability to recruit high quality staff. The drive for ever more productive working, tightening resources, a national pay freeze, uncertainty over the future of the NHS occupational pension scheme and fears about job losses all contribute to a service wide employment relations environment that is the most challenging. Being able to engage effectively with staff at an individual and collective level to help improve performance has never been more important to the success of the Trust.

There are some key contextual issues which underpin the Trust's approach:

- the requirement for consistency of care and service over a seven day 24 hour period rather than more conventional working patterns is an essential prerequisite for the delivery of safe care. This will require fundamental changes to working patterns;
- the continued shortage of the ability to recruit junior and middle-grade medical staff will operate as a key driver for a consultant delivered service;
- achievement of sufficient critical mass to allow for the delivery of the required consultant numbers in key specialties will require consolidation of clinical services across hospital sites;
- the Trust's status in respect of teaching and research will continue to be a key enabler to recruit the staff of the right calibre.

Key Workforce Pressures

The key workforce pressures and the Trust's response are as follows:

- **Nursing** - The Trust has been relatively successful in its ability to recruit nursing staff although only a small number of vacancies remain. The decision to focus efforts on overseas recruitment has played a key part in this achievement. The development of the 'Perfect day' initiative is intended partly as a longer term solution, focussing nursing resource to the tasks which require qualified nurses and removing all other task to staff groups which present fewer recruitment issues. This will allow easing of pressure as the plan is rolled out but will also make the nursing roles that remain more attractive and aid retention rates.
- **Consultants** - The Trust has been pleased with its ongoing ability to recruit consultant staff, helped by the Trust's position of strength with respect to ongoing strategic viability compared to neighbouring Trusts. As the Trust seeks to ensure sufficient critical mass in each of its service areas it will look to make the most of its status as a university teaching hospital and centre of excellence for some key specialist services.
- **Midwives** - The Trust has bolstered its numbers in recent years through a number of recruitment initiatives including recruitment in Scotland in order to achieve a 1:30 ratio. As in many trusts, this will remain a difficult staff group for recruitment with additional pressure arising from the age profile of the existing workforce.

4.2 Deliver Excellent Clinical Outcomes

4.2.1 Key Clinical Outcome Priorities 2013/14

- **Improve performance by reducing average length of stay for older people (Corporate Objective 1)**

The 2012 Hospital Guide produced by Dr Foster includes 13 measures of efficiency for each Trust. An area in which the hospital did not perform well on was the length of stay for elderly patients, indicating that this is longer when compared to trusts in England. It is recognised that that staying in hospital for longer than clinically necessary can put patients at risk and frequently leads to increased dependence for older patients.

This objective will be delivered by:

- Expanding the pilot of the Frail Elderly Unit based on guidance within the 'Quality Care for Older People with Urgent & Emergency Care needs (Silver Book)'.
- Commissioning an external expert review to be undertaken within the Department of Medicine for the Elderly. This will be a full review of the way in which the Trust delivers DME services and ensuring that this is fit for the future. This will include the interface between primary and secondary care.

Key Success Criteria

- Reduction in the average length of stay for elderly patients from 12.4 to 11.0
- Reduction in the number of elderly patients placed in less appropriate wards
- Reduction in the number of patients medically fit for discharge but still in hospital
- **Improve performance on overall hospital mortality across fractured neck of femur and all specialties (Corporate Objective 1)**

The Trust HSMR for the calendar year 2012 was 97.2 compared to 94.6 for 2011. Whilst the HSMR continues to be excellent for some patient groups such as myocardial infarction (heart attack), and whilst there has been an improvement of HSMR for fractured neck of femur, it is recognised that there remain further improvements to be made.

In March 2013 the data from the National Hip Fracture Database report did confirm the Trust as an outlier in terms of mortality rate for fractured neck of femur. Mortality rate for repair of fractured neck of femurs decreased from a peak of 197.4 in September 2012 to 154.0 at the end of March 2013. Therefore a continued commitment to reduce the mortality rate amongst this group of patients remains a priority for the hospital in 2013/14.

An improvement plan is in place for care of patients with a fractured neck of femur following an invited external expert review which is expected to have an impact; these actions are set out in the following objectives.

- To improve clinical outcomes, aiming to keep the Trust HSMR to below 100 by the end of the 2013/14.
- To reduce and sustain the average length of stay of patients that have repair of fractured neck of femurs from its current level to a level that is below the national average, according to the National Hip Fracture Database, by the end of the financial year
- To put in place systems that will contribute to a reduction in the incidence of fragility fractures in the population served.
- To improve documentation throughout the fractured neck of femur clinical pathway.

These objectives will be delivered by:

- Implementing the use of fluid optimisation techniques for use with patients that have a general anaesthetic during the repair of the hip fracture.
- Commencing osteoporosis screening using a nationally recognised risk assessment tool for all patients over the age of 65 that attend the A&E department that present with falls and wrist fracture or fractured vertebral body. These patients may be at risk of future falls and subsequent fractured neck of femur.
- Continuing to undertake a case notes review of all patients that have died following hip fracture repair.

- Developing a pathway for patients with a fractured neck of femur that do not get admitted via the A&E department with the fracture.
- Continuing a multi-disciplinary group, under the direction of the Divisional Director for Surgery, to review on a monthly basis, the data from Dr Foster, the National Hip Fracture database, any deaths that have occurred within 30 days of surgery for a fractured neck of femur, and to formulate and co-ordinate any appropriate audits deemed necessary by the group.
- Continuing to explore new strategies, through the Consultant Orthogeriatrician, and Elderly Care Physician with a particular interest in fractured neck of femur and a role which spans primary and secondary care, and discussion with the Clinical Commissioning Groups, to help to reduce the average length of stay of these patients in secondary care, and enable earlier, appropriate discharges to community-based rehabilitation facilities for suitable patients.
- Initiating discussions about the development of a Fracture Liaison Service, aiming to reduce the incidence of fractured neck of femur in the population served by 10% in three years.

Key Success Criteria

- Significant reduction in fractured neck of femur HSMR
- Improve number of patients for which best practice tariff to 90% is achieved

Other Clinical Outcome Priorities 2013/14

These outcomes, including key success criteria, are detailed in Appendix 3.

• Reduce avoidable emergency re-admissions (Corporate Objective 1)

During 2013 two new schemes will be launched that will help to achieve the aim of reducing avoidable emergency re-admissions. The introduction of a new ambulatory care model will allow the treatment of patients with a range of conditions in an outpatient setting by offering short-notice, regular clinic appointments to patients who require a period of observation and treatment which would traditionally be managed as an inpatient. The Ambulatory Care Centre opened on 1st April 2013. Pathways have already been developed for patients presenting with cellulitis, DVTs and first seizures and these have proven successful in allowing patients to convalesce in the comfort of their own homes, whilst also ensuring they have the regular medical review that they require to treat their conditions. Throughout the year pathways will continue to be developed for other conditions that can be appropriately managed in this way. Currently the service is accessed by either referral from the Emergency Department or Emergency Assessment Unit and also by direct referral from GPs. As the service develops and the number of conditions treated increases the opening hours of the unit (currently 0900-1700) will be extended to ensure that as many patients as possible can be treated through the service. Ambulatory care's success will be determined, in part, by a reduction in emergency re-admissions as patients who require input from secondary care, but who do not require a stay in an acute bed, will be managed in an outpatient setting. The service will also reduce the Trust's length of stay for patients with those conditions that are treatable through the Ambulatory Care Centre.

In April 2013 a 'Hospital @ Home' pilot was also launched. This service aims to provide secondary care to patients in their own homes, rather than having them admitted to the hospital. These patients remain under the care of one of the hospital's consultants and are visited by acute nurses who are able to deliver various treatments, such as IV antibiotics, and observe patients who would benefit from being able to convalesce in their own homes. By taking acute care to patients the Trust will be able to avoid emergency re-admissions as patients who require further management once they are discharged from hospital will have regular support and observation allowing any developing issues to be dealt with in the community wherever possible. By supporting patients in this way after discharge, length of stay will also be reduced for patients who previously may have required further observation and treatment within an acute environment.

- **Fully participate in national and local clinical audits (Corporate Objective 1)**

Clinical Audit continues to be considered an essential part of developing, monitoring and improving high quality patient focused care. Robust arrangements are in place for taking forward Clinical Audit & Effectiveness activities across the organisation and stakeholder groups. During 2013/14, Clinical Audit activities will continue to influence the quality of patient outcomes and improvements made within the services provided.

The Clinical Audit & Effectiveness Strategy describes how clinical audit is well embedded within the Trust's vision and commitment to delivering services that are clinically effective, safe and put the needs of patients first.

The contributions of national and local clinical audit in achieving these needs will be achieved through the attainment of three key goals:

- Raising awareness of clinically effective and evidenced based best practice
- Support clinicians, managers and staff in the integration of best practice and improvement plans into the services provided by the Trust
- To proactively measure and monitor the impact of implementing evidence based best practices.

During 2013/14, priorities for national audit topics that are set by the Department of Health will continue to be integrated within the Trust's Clinical Audit & Effectiveness Forward Plans. Local clinical audits agreed by individual specialist services will continue to focus on local priorities for improving the quality of outcomes and to meet the governance needs of the Trust. Membership to the Clinical Audit & Effectiveness Committee will continue to be representative of the broad range of stakeholder groups within the Trust to ensure that the requirements set out in the Clinical Audit & Effectiveness Strategy are embedded across all service areas.

4.3 Improve Patient Safety

Key Patient Safety Priorities 2013/14

- **Ensure that we have the appropriate level of clinical expertise available to deliver safe and effective care 24/7 (Corporate Objective 2)**

There continues to be an increase in emergency demand nationally; therefore the optimum level of medical expertise is needed to provide safe and timely medical care.

During 2012/13 a new medical model will be implemented in medicine and further increase in the number of consultants. This new model will increase the availability of a consultant led service and provide stronger senior decision making and support for junior medical staff. The impact of this work will lead to a reduction in unnecessary and avoidable admissions and a reduced length of stay.

Key Success Criteria

- Reduction in unnecessary and avoidable admissions
- Reduce length of stay for all patients
- Improve clinical outcome
- **Ongoing development of Safety Thermometer, exceeding performance year on year (Corporate Objective 2)**

The NHS Safety Thermometer gives nurses a template to check basic levels of care, identify where things are going wrong and take action. It is used by frontline healthcare workers to measure and track the proportion of patients in their care with pressure ulcers, urinary tract infections, VTE and falls.

Implementation of the Safety Thermometer in 2012/13 focussed on data collection, staff training and establishing an accurate baseline. This has provided a snapshot of harm from pressure ulcers, falls, urinary infection in patients with catheters and treatment for VTE. The Trust has consistently delivered 95% harm free care against these four harms.

The Safety Thermometer objectives for 2013/14 will be to:

- ***Use the prevalence baseline data from the Safety Thermometer as an improvement tool to reduce the amount of harm patients experience***

To measure objectives, the data set from the Safety Thermometer tool will be collected, collated and reported. This will provide the Trust with a snapshot (prevalence) of the four key 'harms' described above, occurring on a particular day in the Trust. These data will then be used to drive improvements in practice and will be reviewed monthly as part of the nursing quality assurance framework. Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and reported to the Board.

- ***Deliver a 50% reduction in the prevalence of hospital acquired, avoidable grade 2 and 3 pressure ulcers.***

The East of England 'Stop the Pressure' project which reports to the Pressure Ulcer Project Board will continue to be rolled out. The effectiveness of this approach will be measured by the number of reported incidents of avoidable hospital acquired pressure ulcers.

- ***Deliver a 10% reduction in the proportion of patients with harm from a fall***

Whilst some falls are avoidable, reducing falls in an ageing and more frail population with complex health needs is challenging. Falls that result in injury through roll out of the 'falls care bundle' across all wards will be reduced.

- ***Deliver a 3% reduction in the proportion of patients with a urinary catheter***

The national Safety Thermometer data identifies the Trust as an outlier compared to the national average for the number of patients with a urinary catheter (national average 15% and L&D is 18%). A quality improvement plan that includes key interventions will be implemented.

- ***Ensure 95% (minimum) patients to have had a VTE risk assessment on admission***
- Undertake Root cause analysis (RCA) on all cases of hospital associated thrombosis.

Hospital acquired Venous Thromboembolism (VTE) is an important patient safety issue resulting in significant mortality, morbidity and healthcare resource expenditure. VTE manifests as either deep vein thrombosis (DVT) or pulmonary embolism (PE), and can be difficult to diagnose. All relevant patients will be risk assessed, prescribed and administered the appropriate preventative treatment. A root cause analysis (RCA) will be undertaken on all hospital associated thrombosis. Lessons learnt will be shared in practice.

Key Success Criteria

- Improve clinical outcome
- 50% reduction in the prevalence of hospital acquired avoidable grade 2 and 3 pressure ulcers
- 10% reduction in the proportion of patients with harm from a fall
- 3% reduction in the proportion of patients with a urinary catheter
- 95% (minimum) patients to have had a VTE risk assessment on admission

Other Patient Safety Priorities 2013/14

These outcomes including key success criteria are detailed in Appendix 3

- **Continue to reduce Healthcare Acquired Infection rates year on year (Corporate Objective 2)**

The Trust continues to be committed to reducing Healthcare Acquired Infections year on year and during 2013/14 will implement innovative ways to Increase capacity of side rooms by leasing six infection control pods which will increase side room capacity. This will enhance infection control measures. The side rooms will fit into existing ward areas and will support the campaign to reduce the impact of Norovirus.

The decontamination of equipment of ward based medical devices will continue to be enhanced though the use of Hydrogen Peroxide Vapour for the containment of infection outbreaks.

- **Increase compliance with hand hygiene year on year (Corporate Objective 2)**

The focus on hand hygiene in partnership will continue to be maintained as part of the overall infection control plan. The priority will be on improving the reliability of hand hygiene data through the introduction of a new electronic monitoring system and will then improve the baseline throughout the year. The hospital's status with regards to all components of hand hygiene improvement, refresh staff understanding of the importance of when hands should be cleansed and use overall patient feedback to demonstrate increased confidence from patients on hand hygiene will be reassessed.

- **Extend electronic nursing observations and include fluid management and device management (Corporate Objective 2)**

Standard Observations

It has long been recognised that management of the deteriorating patient is at times sub-optimal. This is due to the failure of clinicians to recognise and respond appropriately to a patient's deterioration in a timely way.

Objectives for 2013/14 will be to:

- Improve response and completion of repeat observations following deterioration of patients
- Improve recording of observations at night
- 20% reduction in cardiac arrests
- 20% reduction in need for critical care

These objectives will be delivered by completing the implementation of electronic nursing observations on all clinical areas by October 2013.

Fluid Balance

Maintenance of an adequate fluid balance is vital to health. Inadequate fluid intake or excessive fluid loss can lead to dehydration, which in turn can affect cardiac and renal function and electrolyte management. Attention to fluid intake and output, and careful completion of fluid balance charts, are important elements of nursing practice.

Objectives for 2013/14 will be to:

- Implement a system which will facilitate accurate completion of fluid charting throughout the 24hr period
- Enable accurate calculations of intake and output and summary fluid balance throughout the 24hr period for those patients that require it

These objectives will be delivered by:

- Completing the implementation of electronic fluid balance monitoring by March 2014

Device Management

Implementation of the 'Device management' Wardware module will enable effective tracking and surveillance of indwelling devices (urinary and vascular) during insertion and during the provision of ongoing care. This will enable the Trust to effectively monitor optimum standards attainment. This in turn should lead to a reduction in device related incidence of infection; for example Catheter Associated Urinary Tract Infection (CAUTI) and peripheral and central vascular related infections. This module will also support monitoring the duration of indwelling catheters and hence support removal of devices in a timely way.

Objectives for 2013/14 will be to:

- Set up and maintain a central record and individual ward based records of all indwelling devices in all patients across the Trust where Wardware is implemented.

This objective will be delivered by:

- Commencing the implementation of the device module by January 2014

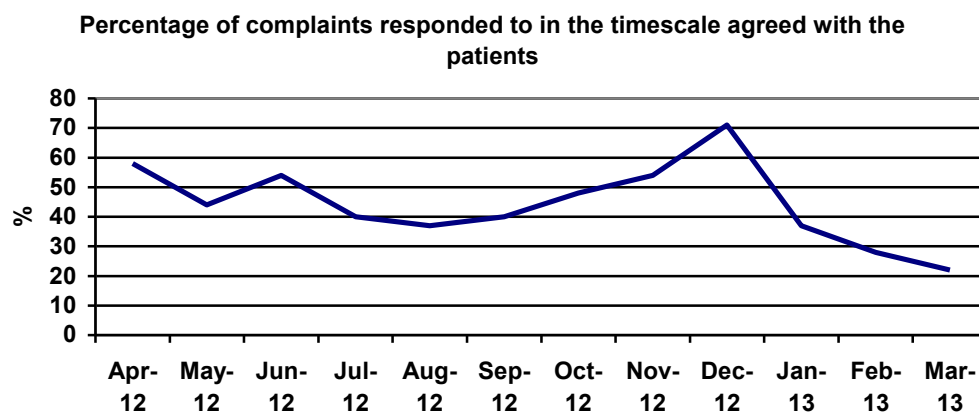
4.4 Improve Patient Experience

Key Patient Experience Priorities 2013/14

- **To revolutionise how we handle complaints (Corporate Objective 3)**

The fundamental purpose of the hospital is to deliver excellent patient experience and clinical excellence by constantly improving clinical outcome. Patient experience is of significant importance and the core values set out the determination of the organisation to put patients first and ensure that every patient has the highest quality experience.

During 2012/13 it was recognised that there are improvements needed in the process to ensure that complaints received from patients are managed and responded to in a more acceptable timeframe. Complaints are a valuable and vital source of patient feedback which allow the identification of areas of improvement that are needed. During the last year the Trust recognised that whilst the quality of responses to complaints was good, response times needed to be improved.



This objective will be delivered by:

- Improving the timeliness of response to complaints
- Improving learning from complaints
- Commencing a programme of using complaints and other metrics to establish an 'early warning' mechanism

Key Success Criteria

- Further increase in the quality of complaint responses as evidenced through Complainants' feedback and Ombudsman's review of responses
- Improvement in the timeliness of complaint responses without decreasing the quality of the response
- Increase in the use of local resolution meetings wherever appropriate
- Summary of learning from complaints published to the Trust website as recommended by the Francis Report

• Continue to implement the Outpatient Transformational programme (Corporate Objective 3)

The Outpatient Transformation programme will continue to build on its successes throughout 21013/14. During 2013 the foundations were established in terms the importance of delivering a high quality experience for patients with almost all outpatient staff completing their via the Customer Care NVQ qualifications. A number of outpatient facilities were also improved and a range of processes and systems were improved. However, there is still a lot to be done to totally transform the outpatient experience and the remit of the group will remain to improve the overall experience for patients.

A key focus for 2013/14 will be the need to align consultant availability to clinic capacity more effectively in order to minimise short notice cancellations and also to redesign the overall appointment pathway to reduce the time between an appointment being made and the actual appointment date.

This objective will be delivered by:

- Developing an operational sub-committee to the Transformation Board.

- Developing outpatient customer service training programme
- The achievement of a 2% reduction in the 'Did Not Attend' rates
- Reducing the number of patients experiencing hospital initiated clinic cancellations
- Reducing delays in clinics

Key Success Criteria

- Be amongst the most improved Trusts in the National Outpatient Experience Survey in the East of England
- Achieve further 2% reduction of those that Do Not Attend (DNA) their appointment rates
- Expanded specialty specific pre-appointment patient information
- Achieve fit for purpose Outpatient facilities
- Reduce number of patients experiencing hospital initiated clinic cancellations
- Reduced delays in clinics and provide better intra-clinic patient communications
- Faster Outpatient call centre response times
- Alignment of Outpatient productivity to medical productivity to drive efficiency and transformation

Other Patient Experience Priorities 2013/14

These outcomes including key success criteria are detailed in Appendix 3.

- **Improve patient experience by establishing a framework to take forward the key messages from the listening events and the recommendations from the Francis report (Corporate Objective 3)**

Following the publication of the Francis Report, the Trust set out its plan to brief and engage staff on the findings of the report. The approach taken was to hold a number of Trust wide listening events, the purpose of which was to engage and listen to as many staff as possible, identify key risks and early warning signs that the organisation face and agree and prioritise actions. The key message and aim was to create a common patient safety culture across the Trust where 'patients not numbers come first'.

In addition to the internal Trust projects, work is underway with University College of London Partners (UCLP) to accelerate improvement in light of the Francis report. Led by the Chief Nurses and Medical Directors across UCLP, a small number of carefully chosen initiatives have been prioritised;

- Understanding and measuring what matters to patients (developing a ward health check)
- Understanding what matters to patients (developing the UCLP Promise)
- Understanding and acting on what matters to staff
- Developing ward sister training and accreditation

This work can be accelerated and done more effectively by working in partnership, by sharing local work where helpful to peers in other organisations.

The Trust is committed to ensuring a consistent culture of compassionate care and following on from the listening and engaging events, the DH response and the UCLP programme, the Trust has identified many areas of action to consider. The Trust's next step is to complete a plan as to how to take the outcomes of these forward. It is essential that we build on the engagement and enthusiasm of our staff whilst also ensuring we respond to the DH recommendations as appropriate. To achieve this, the next stage will involve representation of staff from across the Trust.

- **Improve the quality of professional communication with all patients and carers (Corporate Objective 3)**

Communication with patients is a vital element of good patient experience. It is recognised that when communication is poor, this has an adverse effect on experience and is often a theme within patients' complaints.

This objective will be delivered by:

- Improving communication with patients by setting clear expectations of staff and provide training and support where required.
- Ensuring that patient feedback about staffs' communication, whether good or poor, this will be shared with staff to drive improvements in communication skills
- **Work with patients, their families and stakeholders in Luton to redesign end of life care (Corporate Objective 3)**

End of Life Care has been identified across Luton as an area for improvement. The Trust will work with a CCG led work stream to improve access and support for end of life care. This will result in a single point of contact to all end of life patients and clinicians. The Trust will also focus on the way in which the clinicians communicate with patients and their families at this stage of their care by providing "Significant Conversation" training for senior clinical staff that will result in improved communication between patients and staff. The impact of the training will be demonstrated in an improved patient experience score at ward and outpatient level.

- **Explore the possibility of an off-site facility for ophthalmology, plastics and dermatology (Corporate Objective 3)**

With very limited space on site and therefore to expand services it will be necessary to explore whether it is feasible to re-locate ophthalmology, plastics and dermatology to an off site facility close to the hospital site. In addition to de-congesting the site, this proposal would also move L&D services closer to people's home and away from the main site. This is one of the key themes within the clinical strategy. These three services have been identified as they can work independently from the main site and much of the accommodation can be shared ensuring the facilities are well utilised.

- **Deliver additional clinical and diagnostic services during evenings and weekends (Corporate Objective 3)**

Over 2012/13 a number of actions towards increasing the number of services able to be provided in the evening and weekends were implemented. During 2013/14 the

imaging shift system will be implemented allowing more x-rays and scans to be completed in a timely manner. This will be rolled out by determining the requirements for the Divisions. Further work will also be conducted to gain Divisional support for extended weekend pharmacy and therapy services that will also include a consultation process with the staff. Outpatient services will form part of the review programme to determine the demand for expanded and substantive evening and weekend service provision.

- **Improve patient experience by implementing the 'Perfect Day' (putting the nurse back at the bedside) project (Corporate Objective 3)**

At the L&D we believe it is important to put the nurse at the bedside providing the expert care and management that they are trained for. To achieve this we have developed a new approach to delivering care within our inpatient wards which will give nurses more time to care for patients. The model has been tested with significant improvement in patient experience outcomes. In the coming year we will roll out the "Perfect Day" model of care across Emergency Care, Medicine, DME and Surgery. This represents a significant change in the way nurses and support staff work. We will adopt the Human Factors principles to underpin the model, improve teamwork, communication and create a sense of value across our workforce.

- **Formally explore alternative ways to deliver non-clinical support services in order to improve quality and contain cost (Corporate Objective 3)**

In order to re-develop the site it is necessary to re-locate the current Kitchen and Restaurant facilities, therefore, rather than merely replacing the current systems the alternative solutions will be explored assuming that both quality and cost can be guaranteed. Therefore, the Board of Directors have formally commissioned a project to explore what alternative options exist to deliver all soft FM services. The output from this project will be a business case in the early autumn that clearly recommends a way forward for the Board of Directors to consider. Along with the recommendation will be a detailed implementation plan and timeline.

4.5 Deliver National Quality and Performance Targets

These outcomes, including key success criteria, are detailed in Appendix 3.

- **Deliver sustained compliance of all CQC outcome measures**

The Trust was declared compliant with all CQC outcome measures in 2012. Ensuring that the care patients receive meets the essential standards of quality and safety will be continued, and that patients' dignity is respected and their rights protected. In addition to the assurance about compliance with essential standards, any areas for improvement are addressed.

This is continuously monitored through the CQC nursing assurance programme which involves a three monthly cycle of audits and assessments. Compliance with outcomes is reported to the Board via COSQ.

- **Deliver nationally mandated waiting times for 18 Weeks, Cancer and A&E including A&E Indicators**

During 2012/13 the Emergency Department 4 hour national target was met each month. Plans are now in place to increase the capacity of our department and our bed base remains under review. It is forecast compliancy will be maintained throughout 2013/14. However, concern remains about the availability of community services for some of the catchment population particularly following a reduction in the availability of nursing home beds in Luton.

The national standards for patients not waiting more than 18 weeks for treatment from the point of referral for 2012/13 was met or exceeded and full compliance is forecast for 2013/14.

All cancer targets in all quarters of 2012/13 were met and extensive work is taking place to further refine cancer pathways and compliance is forecast for 2013/14. Our ongoing concern is related to patient choice.

Performance on infection control has continued to be maintained with improvements in the number of hospital acquired Clostridium Difficile cases. However, the target set for 2013/14 of 17 cases may prove challenging.

- **Sustainability culture established across the organisation**

A wide range of sustainability measures have been delivered over the last few years, however, in order to progress this agenda further it is vital a sustainability culture is established across the organisation. This means establishing a culture where people routinely turn lights off, re-cycle as much waste as possible, and turn off their PCs etc. We will achieve this change by creating a network of Sustainability Champions at ward and department level.

- **Achieve 40% of the Trust's Carbon Management Plan Target**

The Trust fully acknowledges the need to reduce its carbon foot print. A range of initiatives were implemented during 2013 and further schemes are being identified for 2013/4. These will include reducing the number of portacabins that rely on all electric heating, replacing old boiler plant, installing a Building Management System, changing street lighting to LED lamps and making alterations to the Steam Boiler plant. In addition, further work will take place to promote the need to save energy in order to reduce carbon.

- **Deliver Commissioning for Quality and Innovation (CQUIN) targets year on year**

The CQUIN framework was introduced in April 2009 as a national framework for locally agreed quality improvement schemes and it enables commissioners to reward excellence by linking a proportion of English healthcare providers income to the achievement of local quality improvement goals. The framework aims to embed quality within commissioner-provider discussions and to create a culture of continuous quality improvement, with stretching goals agreed in contracts on an

annual basis.

The goals in 2013/14 CQUIN, for all standard contracts, has been increased and for the L&D is approximately £4.8m.

A set of targets which form a key strand of the Trust's programme of quality improvement has been agreed. The delivery of the targets will be supported by the Trust CQUIN Monitoring Group which will report to the Executive Board.

CQUIN improvement goals

Goal no.	Description of goal	Indicator name
1.1	To improve the experience of patients in line with Domain 4 of the NHS Outcomes Framework	Friends and Family Test - Phased Expansion
1.2	To improve the experience of patients in line with Domain 4 of the NHS Outcomes Framework	Friends and Family Test – Increased Response Rate
1.3	To improve the experience of patients in line with Domain 4 of the NHS Outcomes Framework	Friends and Family Test - Improved Performance on the Staff Friends and Family Test
2.1	Reduction in the prevalence of pressure ulcers and falls	NHS Safety Thermometer – Improvement For further discussion
3.1	The proportion of patients aged 75 and over to whom case finding is applied following emergency admission, the proportion of those identified as potentially having dementia who are appropriately assessed, and the number referred on to specialist services	Dementia – Find, Assess, Investigate and Refer
3.2	Named lead clinician for dementia and appropriate training for staff	Dementia – Clinical Leadership
3.3	Ensuring carers feel supported	Dementia – Supporting Carers of People With Dementia
4.1	% of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool	VTE Risk Assessment
4.2	The number of root cause analysis carried out on cases of hospital associated thrombosis	VTE Root Cause Analyses
5.1	Fractured neck of femur	
6.1	Implementation of Enhanced Recovery Programme	
7.1	Respiratory	
8.1	Stroke	

4.6 Progress Clinical and Strategic Developments

These outcomes, including key success criteria, are detailed in Appendix 3.

- **Once agreed we will work locally with CCGs to implement the clinical services strategy**

Until now the strategic uncertainty regarding the wider acute provider landscape has made the development of the clinical strategy for L&D difficult.

The Trust is cognisant of the need to offer a solid foundation of core services in order to preserve its status as a District General Hospital capable of offering a wide range of secondary care services to its catchment population. The Trust recorded catchment population is around 320,000 however, it is known that this is extremely likely to be larger given the number of unregistered patients and extended family members who live in Luton. In order to make the organisation both clinically and financially viable in the future it is vital that the catchment is grown and services developed accordingly. To this end the clinical strategy is based upon developing specialist services where already well respected services such as Paediatrics, Cardiology and Stroke which can help expand the catchment population and critical mass, in parallel with developing the quality of core services both within and out with the hospital site. The Trust recent university status enables to attract high calibre staff.

The CCG and social care colleagues want the L&D to be a thriving acute provider and many opportunities exist to work more closely in order to develop more integrated solutions to the many demand challenges faced within the wider health economy.

- **Agree detailed business cases for phases as laid out in Masterplan**

During 2013/14, the business cases will be developed which will each address key schemes within the Masterplan. These business cases will demonstrate the clear clinical rationale for the investment as well as confirming that the scheme is affordable. In addition, the case will identify the key benefits to be realised as a consequence of the investment. The business case will be developed from the Strategic Outline Case (appendix 7). This will align with the Investment Strategy and comply with Monitor's Risk Evaluation for Investment Decisions by NHS Foundation Trusts (REID) assessment process

- **Deliver Masterplan enabling schemes and early phases**

Building upon the enabling schemes which were delivered in 2013, such as the car park extension, expansion of the Endoscopy Unit and theatre upgrade scheme, construction will commence on the next phases once the investment strategy and associated business cases have been approved by the Board of Directors. It is anticipated that the first enabling scheme will start on site in autumn 2013.

- **Care can safely and efficiently take place, without need to request a paper record**

This year will be a critical year for the Trust's move away from paper records. The agreed approach to implementation of a full Electronic Patient Record (ePR), as set out in the IM&T Strategy, is to implement 'best of breed' components which are integrated together to provide a comprehensive ePR. Considerable steps have been made in the last few years to put in place the main building blocks and work is on-going to implement or extend further elements. The following strategic principles set the key aspects of the approach necessary for the Trust to achieve a successful ePR.

The strategy needs to be evolutionary rather than revolutionary, taking incremental steps to minimise risks. Elements of the patient record where electronic processes can have the most impact upon patient safety will be prioritised.

Paper will not be entirely removed from care delivery processes, but paper must not be allowed to persist beyond the end of spell of treatment (clinic attendance or admission.) It must be rapidly scanned and made available electronically but not stored. The ergonomics of access to the electronic systems needs to be optimised to allow clinical workflows to flow unimpeded by accessing information on screens. This will mean adopting new touch screen interfaces and access technologies being developed for consumers at present (e.g. tablets). Future developments must build on existing systems wherever possible in order to minimise the complexity of supporting or using multiple systems to make decisions for patients. The number of password challenges and patient selections must be minimised by effective single sign on and clinical context. Business continuity arrangements must be assured as reliance upon electronic information will be critical to all clinical processes.

Electronic requesting and results, already in place for Radiology, Pathology, Endoscopy and Cardiology and will be rolled out across all diagnostic areas, including Respiratory Physiology, and Neurophysiology. This will allow electronic access to all diagnostic elements of the record.

The focus of our inpatient ePR will be on where maximum impact upon patient safety can be achieved. We have already locally evidenced impact of an electronic observation chart, and will therefore roll a system out across the Trust. This will include TPR, neurological observations including the Glasgow Coma scale, fluid balance and weight charts. This will also include the use of the system to manage patient inserted devices such as catheters and cannula. This gives an electronic record of the presence of these devices and allows timely reminders and monitoring of adherence to protocols.

An Electronic Prescribing and Medicines Administration (EPMA) system will begin to pilot in autumn 2013, which will make the Drug Chart electronic, with all the attendant safety and process benefits. Once piloted for 3 months it is envisaged that the roll-out of this system will take 9 months moving systematically through ward areas. This system will integrate with our Electronic Discharge system.

There is already considerable work underway to try to consolidate and control the proliferation of versions and copies of critical documentation. The Electronic Document Management project will aim to control the production of this paper work. Paper will be produced for a spell of care, and will be bar-coded and labelled for rapid scanning and electronic filing. This paper rationalisation, combined with electronic charting described above, enable the planned transformation in nursing working arrangements as defined in the “Perfect Day” strategy. Despite considerable effort currently being exerted in capturing the paper elements of the general medical record it is acknowledged that there are many complex processes within our services where we will need to allow paper to be used. The focus will be on producing intelligent paper, sometimes to be used as insert sheets, in order to allow rapid scanning and filling.

- **To improve the ability of decision makers at all levels of the organisation to use information in order to improve service delivery, design, quality, efficiency and safety**

Information needs to be delivered to decision makers in a timely, optimised, easily accessible fashion. The next stage of information development has been defined in the ‘Use of Info:Dashboards’ project. It seeks to deploy the information tools to maximum effect to support the organisation. The strategic initiatives that require direct support are in two key works streams: maximising our medical productivity; and the delegation of a hierarchy of quality/surplus targets to an identified hierarchy of division and service lines.

The key objective of the dashboard project is to provide a quarterly individual consultant level dashboard of productivity and quality metrics agreed with each of the service line specialties. It seeks to ensure that reliable streamlined data on the productivity within specialty and sub-specialty is available to support exchange of good practice and management of performance, much greater granularity of information is available to understand income recovery and allocation of direct costs at a patient level, and that the information required by all decision makers is available using the greatest automation achievable. Dashboards will also be widely used for income analysis, taking feeds from SUS extracts. There will be great focus on timely data capture and quality in this year. This will include an outreach programme for our Clinical Coders to ensure that the quality and accuracy of coding is assured by greater engagement with clinicians in a structured speciality by speciality approach.

- **To increase levels of safety, efficiency, and flexibility delivered by transformational technology**

Technology developments will support improvements or efficiencies in several aspects of clinical communications.

Modernising the underlying voice communication systems (e.g. introducing VOIP phones, ‘mobile’ phones, intelligent call routing, and bleep replacement) will provide support in a number of areas, e.g. radically improving different tiers of emergency messaging (e.g. cardiac arrest, trauma team contact, accessing porters, etc.). Improving hospital at night processes. General improvements in access to clinical staff (e.g. in support of new service models – community staff accessing hospital

based opinions) and enabling better management of clinical time (prioritising responses etc.).

Capturing and tracking all clinical correspondence as electronic documents, with all outbound documents to clinicians being sent electronically and incoming correspondence either received electronically or converted from paper soon after arrival. There will be workflow support for referral management to improve overall robustness and the efficiency and turn-around of clinical review.

Contact centre development, initially expanding as a transaction centre from the end of 2013, subsequently with potential to develop as a clinical support centre. The contact centre would support two main channels: Inbound communications primarily for patients; and GFPs Outbound communications primarily contacting patients, for example, booking and rescheduling appointments and potentially providing clinical contact such as support for clinical conditions triggered by remote monitoring. By the end of 2013/14 the software supporting the current outpatient rescheduling contact centre will have been replaced. When this is done the infrastructure will be able to take on more processes and more appointment areas. This should be linked with building a 'single number' strategy for patient calls (and for GP access), with a contact portal for internal staff use.

- **Work jointly with Local Authority, CCGs and other key stakeholders**

Close working with key stakeholders will continue to ensure collaborative working and that there is continued support for key initiatives, for example, PCI and hyper acute stroke unit. This is achieved by:

- Monthly meeting with CCG Chief Officer
- Attending Health and Social Care Programme Board
- Engagement with the Overview and Scrutiny Committees

4.7 Develop All Staff to Maximise Their Potential

These outcomes, including key success criteria, are detailed in Appendix 3.

- **Extend education and training performance management to all staff groups through the Divisional structure to go beyond regulator and training commissioner requirements to measurably enhance patient experience and safety globally through a radical development programme**

The delivery of teaching and training will be further expanded to enlarge the existing Division of Medical Education, to encompass the training and development of all staff, with specific programmes focused on patient experience, safety and clinical outcomes, making use of simulation and human factors methodology.

During 2013/14 action will be taken to create the Division of Clinical Education and Research. This will incorporate an agreed governance framework, objectives, performance management framework, stakeholder support and financial resourcing requirements.

These changes will ensure delivery of a number of the Trust Corporate Objectives for 2013/14, and will be measured by the impact on local and national patients, trainee and staff surveys.

- **Develop and deliver joint accredited academic programmes with our partner Universities**

The Trust achieved full University Hospital Status in November 2011 which is a formal recognition by the University of London that the Trust provides the very best training for medical students. The status as a full University Hospital will ensure the best medical staff are attracted, both through the medical students trained coming back to work as junior doctors, and in attracting consultants who are committed to teaching and research as part of their desire to ensure the best outcomes for patients. The status will also contribute to aspirations to enhance and widen research activity, and ensure the best treatments are available to patients, and provide more complex and specialist care locally as a result.

For 2013/14 plans are in place to develop integrated pathways for Research and Training established with Bedfordshire and Hertfordshire Post Graduate Medical School and increase collaborative working by 20% by 2014.

- **Continue to increase the number of staff appraisals to 80%**

Increased awareness, particularly where appraisal rates are below target, though a monthly report to all managers and the Board is provided. Poorer performing departments are also requested to report to the Clinical Outcome, Safety and Quality Committee to provide assurance of progress towards the achievement of the set target.

Further training will be provided to managers and briefings for all staff to ensure confidence and competence in completing appraisals to a high standard.

The appraisal cycle will also be reviewed to bring it in line with objective setting and business planning. This will also support an annualised approach to objective setting rather than a rolling 12 month monitoring programme. An agreed approach to talent management will be incorporated into the appraisal process as a pilot and paperwork to further enhance the quality of appraisal.

- **Increase mandatory training compliance**

Ensuring that staff are receiving the required mandatory training and made significant progress in 2012/13 remains a strong commitment. A report to all managers and the Board of Directors monthly to raise awareness of individuals who are non-compliant will be continued.

In order to support staff to complete the required training sufficient opportunities for updating knowledge, skills and attitudes through either tutor-led sessions or e-learning will be offered and review options for increasing the quality of refresher modules to ensure most effective use of staff time. Supported e-learning sessions

will continue to be supported and it will be explored how to increase access to computer-based learning for frontline staff who are not office based.

- **Maintain clinical leadership development**

The Clinical Leadership programme was initiated towards the end of 2012/13 and this will continue to be developed to deliver and evaluate a leadership programme based on an assessment of the interests and learning needs of senior doctors. The Trust will work in partnership with external providers as well as harnessing internal knowledge and skills to deliver the sessions. These leadership sessions will ensure that senior doctors are enabled to gain insights into best practice both nationally and internationally to drive improvements in patient care and quality of service delivery.

- **Establish a culture where all staff feel able to sign up to our values and have knowledge of the Trust's Quality Priorities and staff fully aware of the Trust's vision, values and objectives**

The organisation's vision, values and objectives will continue to be introduced at Corporate Induction to ensure that all new staff are given the opportunity to sign up to the values. These key cultural messages will be incorporated into training and development to ensure that all staff can discuss the implications of a positive culture focusing on high quality care for their roles.

Links between culture change and behaviours will be made at all levels in the organisation, promoting a coaching approach to performance management to build staff confidence and competence.

4.8 Optimise our Financial Position

- **Deliver our Financial Plan 2013/14**

The Trust has recorded 14 years of financial surplus. However this has been achieved in the context of significant growth in NHS Funding. It is clear that the challenges from 2013/14 will be significant.

From 2013/14 the Trust will be disadvantaged by the twin impact of reduced income (as a result of the tariff decreasing) and unavoidable inflationary cost pressures. These two factors working in tandem will require the organisation to improve efficiency by 4.5% per annum (£10m).

The challenge in financial year 2013/14 is made harder by a recurrent shortfall carried into 2013/14 of £3m (the FT only achieved financial balance in 2012/13 as a result of non-recurrent gains).

Furthermore aggregated commissioner QIPP plans sum to more than £6m. These, in part, can be seen to be ambitious. Commissioner schemes are multi-faceted and would require a step change in the control of patient demand for hospital services.

The Trust is placed in the unenviable position of second guessing whether schemes will be totally successful and then flexing capacity accordingly.

The Trust has developed a plan designed to deliver its Financial Strategy that includes the approach to QIPP. This contains more risk than has been evident in previous years and places significant emphasis on the abilities of Service Line Managers to deliver improved financial performance whilst maintaining operational targets.

A flexible contract has been negotiated for 2013/14 effectively removing any 'cap' or any material risk sharing agreement with commissioners. However, a risk sharing agreement for Outpatient Diagnostic Imaging Unbundling has been entered into.

Appropriate clinical outcomes, patient experience and safety remain the highest priorities and that this must be balanced with the requirement to achieve year-on-year efficiency savings.

- **Trust approach to Quality, Innovation, Productivity and Prevention (QIPP) / Cost Improvement Plans (CIP)**

The approach to QIPP (CIP) is fundamental to the ongoing viability of the organisation as it strives to meet the twin challenges of tariff efficiency and commissioner driven demand management initiatives, in addition to providing the basis to meet the affordability of the hospital redevelopment.

The overall approach will recognise a number of key factors:

- an acceptance that the scope for incremental cost reduction (e.g. identifying individual posts to remove across the hospital) is extremely limited;
- an assumption that income growth will be a factor;
- sufficient temporary pay costs currently exist in the system to allow for the financial challenge to be met without the requirement for major reductions to the substantive headcount;
- that current analysis suggest that the Trust's overall systems and processes are not fully functioning and that resolving these issues represents a key opportunity. In response to this the QIPP (CIP) plan therefore is seen as meeting the financial challenge by creating overall 'system' efficiency rather than delivering discrete cost reductions unconnected to the whole.

Key enablers

The foundation for delivery of the financial challenge will be built upon some key changes to the current internal systems which are in turn intended to drive changes in culture and system incentives. These changes are as follows:

- service line reporting – this allows the organisation to see the financial performance of different parts by comparing the cost of those individual parts with their income. SLR is allowing different parts of the organisation to be viewed as financial entities in their own right by harnessing the incentives which accrue from providing the different parts of the organisation with the freedoms, flexibilities and structures which are available to business enterprises;

- performance monitoring – with SLR in place, a richer and more rigorous performance system can be in place which looks at performance at service line level;
- IM&T strategy – the investment in the IM&T infrastructure and in particular the move to electronic systems with care safely able to occur without the need to recall a paper record will assist the Trust in driving out system inefficiency and significant costs associated with the current systems. This will be achieved through both reducing the administrative cost burden but also through facilitating a more effective and efficient patient journey and reductions in length of stay (e.g. via the electronic observations project).

These developments will not directly translate into ‘big bang’ savings but instead incremental efficiencies will occur and the changes will enable other efficiency programmes to come to fruition.

Income

The Trust’s strategic position means that there is scope for income growth in key areas:

- (i) Specialist services – the Trust’s development in its specialist services portfolio will allow for income increases in stroke services with the development of hyper-acute services in 2014 onwards. The delivery of PCI represents the next stage of the Trust’s cardiac services and there is potential for further growth as pressure increases to consolidate cardiac services within the sector. The Trust’s bariatric services remain a long-term investment as obesity issues continue to grow within the overall population. The activity levels appear to be rising following a period of low demand and this represents a significant opportunity given the low volume, high cost nature of the work although it will continue to remain vulnerable as pressure on CCG budgets remain.
- (ii) Vertical integration – the market testing of local community services in Luton and Bedfordshire in 2014 represents an opportunity for the Trust to broaden its service portfolio. The Trust does not consider that this represents any significant gain in respect of EBITDA margin, although the sums involved are relatively large (£16m for Luton CCG). It is unlikely that the Trust would bid for the whole community service portfolio but is more likely to selectively bid for lots which would allow the Trust to unlock potential for efficiency within its hospital services.
- (iii) Core services – the scope for income growth within its core service remains relatively limited as the reduced tariff for emergency admissions means income increases lag behind activity demand. Whilst emergency activity has been flat in recent periods although the overall view remains that the long-term trend remains upwards and the level of acuity will increase as the population ages. This changing demographic means that opportunity also exists for growth within the elective portfolio, particularly as, for example, increased screening programmes (e.g. the commencement of flexible sigmoidoscopy screening in 2014 within the current bowel cancer screening programme) will drive up demand for diagnostics and potential surgery. This needs to be balanced with the

current pressure to reduce demand through greater restrictions on procedures by CCGs, an attempt by Bedfordshire CCG to pass the demand risk to providers through prime vendor contracting models, and the increase in competition through the choice agenda.

- (iv) acute hospital reconfiguration agenda – in line with the national picture neighbouring health economies to the L&D, including Buckinghamshire and Bedfordshire, are considering the reconfiguration of acute hospital services in order to ensure that hospitals have sufficient critical mass to deliver the required standard of care. Whilst the expected timeline for these changes is out with the timeframe of this plan, it may well be that some services which are currently experiencing pressure are subject to change in advance of more fundamental structural moves (e.g. paediatrics).

In summary the opportunity for growth is part of the current plan but the Trust is conservative in its assumptions. Over the period to 2015/16 income growth (before tariff deflator) of 4.8% is assumed with an assumption of a 50% incremental margin. This assumption excludes any income from changes to community services at this stage.

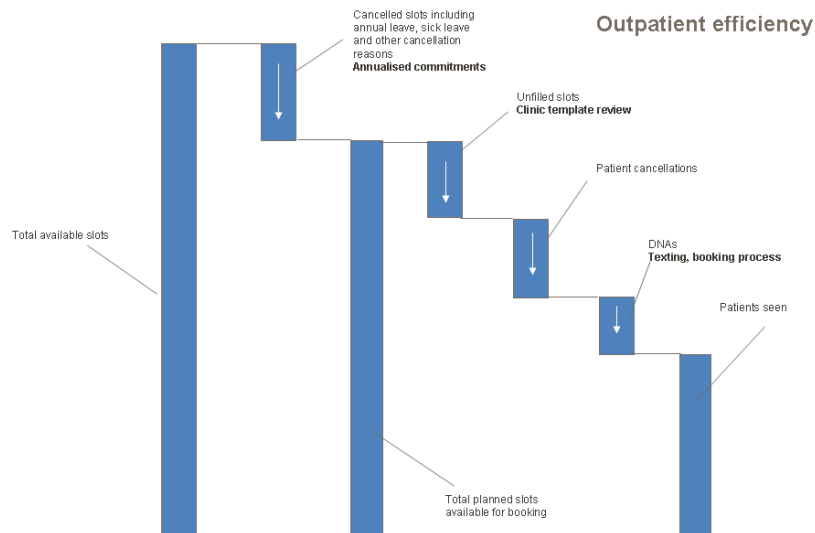
Efficiency

The efficiency gain required will be delivered through a series of projects and sub projects which are intended to continue through the three year corporate objective period. Between them they cover the major cost components of the Trust. These are set out below:

1. Outpatients

The largest cohort of patients visiting the hospital are outpatients and as high volume services (c.250,000 per annum) they have a major impact on the utilisation of medical resources. The work programme for this area consists of 12 separate projects designed to address all areas, particularly patient experience and efficiency). The efficiency element of the programme is designed to ensure that key questions are answered:

- are we getting the number of clinics we should?
- are an appropriate number of patients booked into clinics?
- are the clinics sufficiently generic to ensure that we do not get empty slots due to having a patient but not the right slot?
- are the slots of the appropriate length?
- are we giving the right job plan credit?



The programme identifies the 'loss' of capacity in each part of the system and attempts to tackle these component parts to deliver a marginal increase in the overall activity through the current system. The efficiency will manifest itself in a number of different ways:

- one-off increase in income as capacity rises and waiting list falls;
- increase in income as patients choose 'L&D' due to lower waiting times;
- pay saving due to reduction in clinical PAs allocated to outpatients time;
- pay saving due to reduction in extra clinics required;
- indirect benefits elsewhere as outpatient PAs are allocated to alternative clinical work;
- increase in income due to lower DNA and cancellation rate;
- pay saving in administration support.

2. Theatre efficiency

Theatres represent, outside critical care, the most expensive facilities the Trust operates with a corresponding impact on income. The approach has been piloted through T&O, which is the most financially challenged specialty within surgery. Like outpatients the approach has been to examine the component elements in order to reduce the capacity loss at each stage, and this programme has close linkages with the medical productivity workstream.

There are some key elements to this programme:

- examination of the anaesthetic model and consideration of alternatives;
- ensuring that the number of theatre lists expected within the job plan is delivered;
- performance management of the booking process;
- improvements in pre-assessment allowing for a pool of patients to substitute for cancellations;
- movement of specialties to different theatres to improve flexibility;
- removal of the Vanguard theatre.

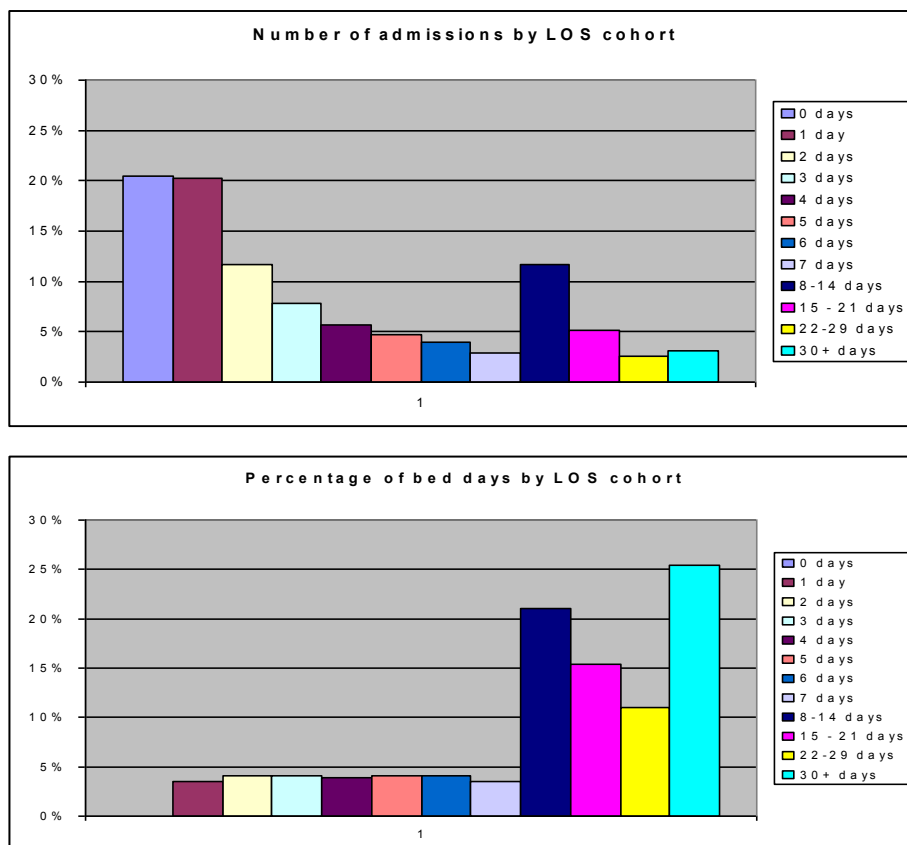
The efficiency will manifest itself in a number of different ways:

- one-off increase in income (with associated increase in cost) as capacity rises and waiting list falls;
- pay saving due to reduction in extra lists required;
- pay and non-pay savings when the Vanguard contract is terminated;
- increase in income due to lower cancellation rate.

3. Length of Stay

Length of stay is a key driver of resources given the number of beds the Trust operates. The variability in activity means that a fixed bed pool is not operated but seeks to flex its bed base up and down as appropriate. Length of stay varies due to internal factors such as availability of medical input and diagnostics, and also external factors such as access to rehabilitation. The length of stay programme seeks to establish an embedded and permanent approach to the systems which underpin and drive length of stay.

Whilst the programme, consisting of 17 projects, looks at all elements of the system, the graphs below show that the most significant impact will be achieved by addressing the long waiters who occupy a significantly disproportional complement of beds with 3% of patients occupying 26% of the bed days.



The key elements of the project are:

- development of an Ambulatory Care Unit;
- improve complex discharges;
- reconfiguration of bed stock and critical care;
- expansion of Hospital At Home;
- introduce new Medical Model;
- reengineer TTAs;
- introduce enhanced recovery;
- develop Elderly Frail Unit.

The efficiency will manifest itself in a number of different ways:

- reduction in pay and non-pay costs due to less use of escalation beds
- reduction in pay and non-pay costs due to less use of permanent beds;
- saving on decant costs for the redevelopment.

4. Medical productivity

In the past, the Trust has not monitored or performance managed medical productivity in any systematic or rigorous way. The movement towards such an approach represents a significant cultural shift which will only be achieved over time. However this initiative potentially represents the most beneficial element of the approach to QIPP. There are a number of different elements to the programme but the most important parts are:

- standardisation of the approach to job planning;
- introduction of annualised commitments for theatre and procedure lists and outpatient clinics;
- development of reporting tools to measure medical productivity on a consistent and ongoing basis.

The efficiency will manifest itself in a number of different ways:

- increase in income due to coding arising from improved consultant engagement;
- pay saving due to reduction in SPAs;
- pay saving due to reduction in extra clinics and theatre lists required;
- increase in income due to higher outpatient and theatre activity.

5. Workforce

The Trust's sickness absence rate is about 4% with 430 staff at any one time having a Bradford score above 200. The approach to tackling this issue is to ensure systematic and rigorous use of the policy which in the past has been inconsistently applied allowing a culture of acceptance and poor management of this issue.

The objective is to bring the sickness absence rate well below the benchmark for acute trusts and to reduce the number of staff with a high Bradford score to less than 200.

The Trust bank and agency rates have been between 12-15% of the total pay spend and therefore this project will see the overall temporary pay bill reduced.

A second part of the workforce programme is the introduction of e-rostering in order to tackle the issue of poor rostering which arises from the complexity of current rosters due to the proliferation of flexible working patterns which increase the number of constraints within a roster. It is difficult to evaluate the current cost of this problem but it is likely to represent 2-5% of costs within some rosters.

6. Procurement

The procurement workstream has, so far, concentrated on a series of individual projects (e.g. trauma prosthesis rationalisation) with an anticipated impact of £1m per annum which represents 2% of the overall non-pay budget. This work will continue with the Trust seeking to take advantage of opportunities as they arise. This work is being supplemented by another piece of work which is attempting to increase the proficiency with which support services are managed. These contracts are often managed by clinical staff who have insufficient commercial skills to navigate their way to achieve the required outcomes. The introduction of a new resource to oversee this work means that we will expect to see the outcomes from the procurement workstream increase to £1.5m or 3% per annum.

As this work and the medical productivity work is embedded the Trust will seek to identify new opportunities arising from a more consistent approach to clinical conditions and surgical procedures with a consequent impact on non-pay spend as well as other costs (e.g. open or laparoscopic hernias, cemented or uncemented hips etc). Currently, to a large degree this is primarily influenced by individual clinical practice whereas moving to an evidence based consistent Trust protocol would potentially allow for a much more significant impact on overall non-pay spend. At this stage no significant work has been carried out and therefore any savings are only likely to accrue in 2014/15 onwards.

The Trust is also considering a different approach to the provision of soft facilities services. Currently all services are provided in-house with exception of linen. Due to the difficulties in benchmarking services the potential opportunity is difficult to estimate but the relaxation of the requirement for Agenda for Change pay rates for contracted out services means that this is more likely to generate savings. At this stage no assumption has been included in the plan.

7. QIPP (CIP) Governance and Assurance

The Divisional QIPP (CIP) plans are delivered through divisional management structures as part of the ongoing embedded day to day work of the Division. These are small scale schemes which do not require significant project infrastructure. The corporate workstreams outlined above, however, all have appropriate project management and support to enable delivery to plan. Each project is different in its structure and set-up although all are subject to the same oversight and scrutiny by the Executive and Finance Committee.

In relation to the assurances required that quality is protected the nature of the programme and the integration with the corporate objectives and reliance on clinical leadership means that the programme actions have an embedded quality risk assessment. For example, the length of stay project is driven by a desire to drive efficiency but is underpinned by a recognition that a shorter length of stay will improve overall outcomes. Assessment of specific quality and safety risks (e.g. discharging patients too early) are built into the individual programmes.

Clinician engagement is crucial to the success of the programme and dedicated clinical time has been identified to lead the workstreams. However the key element of each scheme has been the identification of clinical champions to drive through this work. Governors are also involved in this work and as well as having a chance to direct the work they are part of the outpatient transformation group.

Summary

In summary the Trust has launched an approach to QIPP (CIP) which seeks to make fundamental changes in the way the organisation is managed, both from a performance and financial perspective, and to break down cultural barriers which in the past have inhibited major efficiency gains. This approach will continue over the course of the plan in order to provide the required 2.1% increase in income and to limit the growth in cost to 1.3% as follows:

CIPs (QIPPs)	Enabler	2013/14 £m	2014/15 £m	2015/16 £m
Outpatient Efficiency	Outpatient Project		0.50	0.50
Vanguard	Theatres Project		1.00	0.00
Staff Utilisation	Theatres Project		1.00	0.50
Ward	Length of Stay Project		1.25	0.00
Reduced Payments / Extra Income	Medical Productivity Project		0.25	0.20
Reduced Temporary Staff	Workforce Project		1.00	1.00
Buying Better / Cost Avoidance	Procurement Workplan		1.00	1.00
IT / Administration Costs	IM&T Projects		0.50	0.50
Corporate / Facilities	Zero Based Budgets		0.50	0.50
Efficiency linked to new builds	Hospital Development Project		0.35	1.00
Divisional Plans	Review of service lines	9.70	1.25	2.00
Totals		9.70	8.60	7.20

Scope exists for contingency within the plan arising from the conservative income assumptions which have been made and the fact that some major potential gains (e.g. contracting out facilities services) have not been included within current planning assumptions.

- **Finalise forward capital investment plans and agreed balance between borrowing and cash financing**

A new Investment Strategy will be agreed in quarter one.

Following on from the Investment a business case to support the proposed investment in the Hospital Re-Development will be progressed.

This business case will determine the definitive source and application of funds.

4.9 Clinical Divisional Development Plans

During 2012/13 significant progress was made in the development of Divisional management. Today, all clinical services are managed by Divisional Directors supported by General Managers and other key staff with business and financial expertise. Last year we set out the importance of decisions being made closer to the front line whilst ensuring robust governance was in place to support decision making. We believe that this has now been achieved and its implementation was greatly supported by the implementation of service line management and the establishing of a clinical leaders development programme.

The development plans for 2013/14 are the result of clinical expertise and inspiration combined with rigorous debate at Executive and Board level and strong dialogues with external stake holders.

4.9.1 Medicine Division

- *Further development of Cardiac Services* - The Cardiac Catheterisation laboratory (Cath Lab) facility became operational in June 2012. With the appointment of a second interventional cardiologist it is hoped that the Trust will gain BCIS accreditation to offer PCI (percutaneous coronary intervention) later in 2013.
- *Development of an integrated community cardiology service* – In collaboration with Bedford Hospital a proposal to provide an integrated community cardiology service for patients in North and South Bedfordshire will be presented.
- *Further development of stroke services* - A range of enhanced services for stroke patients will be developed including hyper-acute and acute stroke and transient ischaemic attack (TIA) services. The Trust has been authorised to become a specialist Hyper-Acute centre for stroke patients covering a wider catchment area including Milton Keynes.
- *Implementation of solutions to managing trauma patients* – Work will continue in conjunction with the East of England and appropriate London Trauma Networks to devise and implement appropriate local solutions for the management of major trauma patients in the Luton and Bedfordshire area.
- *Continuation of the Human Factors Teamwork Project* – Work across the Division will be undertaken to implement the learning from the project on the medical

wards and develop plans to increase communication of the Human Factors work across to other Divisions. Formal evaluations of the impact of the project in practice will be conducted.

- *Further expansion of endoscopy* - A further expansion of the endoscopy unit to include three procedure rooms with additional professional staff will enable the Trust to meet the increase in referrals resulting from the National Bowel Cancer Screening programme. This will also enable development of endoscopic ultrasound and endobronchial ultrasound procedures.
- *Development of an elderly frail unit* - The quality of care for older patients will be improved by the development of a frail elderly unit and an integrated model of care working across the interface between primary and secondary care.
- *Further improvement of respiratory services* - Respiratory services will continue to develop and it is anticipated that a Endobronchial Ultrasound (EBUS) will be started later in 2013. This will improve lung cancer pathways, prevent transferring patients to Harefield and reduce the need for surgical mediastoscopy (a surgical procedure to examine the inside of the upper chest). Developing on site cardiopulmonary exercise testing will improve and streamline diagnostic pathways and will help direct post-operative patients to the most appropriate recovery unit.
- *Implementation of a new model of acute medical care* - A new model of acute medical care will be implemented from May 2013. This will provide greater consultant delivered care for all patients admitted to the medical and Elderly wards. Fourteen hour on site consultant support will be delivered seven days a week enhancing better patient care at the point of admission.
- *Establishment of an ambulatory care unit* - The development of an ambulatory care unit, which will open in April 2013, will work alongside Hospital at Home nurses to avoid unnecessary hospital admissions and deliver care in the patient's home.
- *Employment of new consultants* - Linked to the new model of care four new consultants who will be dual accredited will enable the development of new services such as infectious disease. This offers an exciting opportunity to provide much needed new services for the local population with these specific needs.
- *Establishment of a Clinical Decisions Unit* - During 2013/14 the Emergency Department will be expanded with the addition of a Clinical Decisions Unit (CDU). This facility, which will be discreet from the existing areas within the department, will be used to care for patients who require a period of observation before a decision to admit into the hospital is made, or patients who need to wait a period of time after the onset of symptoms before diagnostic tests can be carried out. By managing patients in this way the number of admissions into the hospital will be reduced and improve the experience for patients for whom a full hospital admission would be inappropriate.

4.9.2 Surgical Division

- *Further development of Fractured Neck of Femur service* - In collaboration with colleagues in Medicine, a first-class fractured neck of femur service will continue to be developed building on the additional support implemented in 2012/13. The commitment to improve outcomes for fractured neck of femur patients will continue and ensure that patients receive surgery within 48 hours, and that patients have access to support from the full multidisciplinary team.
- *Further development of enhanced Recovery model* - During 2013/14 the Enhanced Recovery model for orthopaedic and colorectal surgery patients will continue to be rolled out to enable the reduction in hospital length of stay and improve patient's recovery from their surgical procedure.
- *Review of Admissions pathway* – Work will continue on the admissions pathway to ensure that patients are managed effectively within the 18 week referral to treatment time and that the admissions team overseeing all the linked processes including pre-assessment and arrivals are well organised and proactive.
- *Refurbishment of theatres* – A comprehensive refurbishment of theatres 1-6 will be completed in early 2013/14 to carry out maintenance to the Air Handling Unit (AHU), install new lighting, install safety devices to meet new regulations for the safe use of laser equipment in theatres, install new Nurse Call System, refurbish changing facilities, install new doors and dampers, wall protection and replace flooring and complete decorating.
- *Recruitment of another Head and Neck Consultant Surgeon* - The recruitment of a second Head and Neck Consultant Surgeon will enable the Trust to meet the workload in this area and ensure continued success in delivering against the cancer access targets for the local population
- *Development of Ophthalmology* - Ophthalmology services will be relocated to off-site premises to increase the space available to the service and improve access for patients.
- *Restructure of the operating timetable* - After successful implementation of the initial phases of the Trauma and Orthopaedic (T&O) transformation plan in 2012/13, the final stage which is the restructure of the operating timetable to increase the number of consultant led elective lists will be taken forward. This will ensure that the Trust is compliant with the 18 week waiting time target across all T&O subspecialties from Quarter 2 this year and improve the way theatre sessions are used to ensure theatre time is used as productively as possible.
- *Provision of electronic theatre booking forms* - This year the focus of the theatre utilisation programme is on streamlining booking processes, and by the summer the full roll out of the electronic booking forms will be completed and the implementation of pre-printed consent forms for the majority of procedures. Close work with consultants to implement check points for their operating lists is underway, and work is continuing to ensure that daycase lists are booked so that patients are only kept in overnight when clinically necessary. The good work

started last year on eradicating late starts for theatre lists will continue with further improvement anticipated this year.

- *Further expansion of bariatric surgery* - The specialist bariatric surgery service continues to go from strength to strength, and this year the Trust will work with new commissioning partners to ensure that the Trust is the first choice centre for patients in Anglia and West Midlands region, and continue to grow the business from South Central and other neighbouring regions.

4.9.3 Women's and Children's Division

- *A new fertility unit* - The gynaecology service will open its new fertility unit in May 2013. This will allow patients to access this busy service in a private and discreet setting away from the main hospital site. The new fertility unit will offer satellite IVF treatment for the first time, in collaboration with Bourne Hall, Cambridge, a prestigious fertility centre. The service will offer care for NHS patients and private patients.
- *Development of a dedicated ambulatory gynaecology service* - The gynaecology service will also open a dedicated ambulatory care suite in women's health. This facility will open in July 2013, allowing the current colposcopy service to grow in line with the introduction of the national HPV screening programme. The ambulatory suite will allow up to 80% of the hysteroscopy procedures currently carried out in the main operating theatres, to be offered to women in an ambulatory, clean room setting. This will enable more treatment to be delivered as a day case reducing the patients length of stay and recovery time. These procedures will be carried out in a new facility offering greater privacy, dignity and a more relaxed environment for women to be cared in. This is in line with national best practice. The ambulatory suite will also allow expansion within the urodynamic service, and will offer greater privacy for a variety of procedures.
- *Further development of community midwives access to IT* - April 2013 will see the team of 65 community midwives able to access information electronically and remotely. Over the last year the obstetric directorate have been working in close collaboration with IT, finance, information and private providers to work up an IT solution that will enable the community team to move from a paper based system to an electronic system of data input and information retrieval. Community midwives will be supplied with tablet PC's, they will be the first in the UK to use this technology. For example, the tablets will allow access to email, protocols and data systems, thus aiding timely communication. Information for antenatal and postnatal women for whom the midwives are caring will be entered in real time, and will be available to hospital based staff immediately. The midwives will be able to retrieve up to date information and manage their cases whilst in the community. They will have instant access to email communication, and will have less need to return to the hospital, improving their efficiency. Allowing immediate access to test results, thus eliminating duplication in processes and allowing a more streamlined service to be offered to pregnant women.
- *Improvement of the birthing environment* - Some minor works to improve the birthing environment for women and their partners will be initiated. This is a

charity funded project that aims to provide improved privacy and dignity for women birthing on the unit.

- *Development of a fetal medicine service* - A fetal medicine service will be offered within the obstetric directorate. This specialist service prevents the requirement to refer women into London for specialist diagnostics and/or treatment. In some cases however a tertiary referral is required and the fetal medicine service work in partnership with Great Ormond Street Hospital (GOSH) to offer a comprehensive service. This year a specialist paediatric cardiologist from GOSH will offer a clinic at the L&D, this will allow most women with fetal medicine concerns to be cared for locally, closer to home, and only where necessary will women be referred into London for further treatment.
- *Provision of enhanced antenatal service* - The midwifery team will offer an enhanced antenatal service to women and their partners, and will launch new aquanatal and hypnotherapy classes for women that wish to access enhanced services.
- *Further development of specialist paediatric services* - Specialist paediatric services will be further developed, including high dependency, endocrinology and gastroenterology care in collaboration with Great Ormond Street Hospital.
- *Improvement to parent's accommodation* - Support of charitable funds has been secured to develop parental accommodation utilising the Viridian accommodation enabling families with babies in Neonatal care stay close to the unit.
- *Development family centred pathways* - "Family centred" care nursery nurses will be developed that will improve the pathway of care on the neonatal unit.
- *Telemedicine for diabetes* - Using the experience of the pilot, telemedicine will be further developed for diabetes.
- *Provision of increased paediatric nurse training* - An extended nurse role will be developed through training advanced paediatric nurse practitioners to enhance acute paediatric care.
- *Implementation of a Children's rapid response service* – A children's rapid response service will be rolled out in partnership with Luton community services to provide a seamless integrated care pathway to safely reduce reliance on ED and hospital services.

4.9.4 Diagnostics, Therapeutics and Outpatients

- *Further development of CT services* – The introduction of CT Coronary Angiography (CTCA) services to the Trust over the course of this next year, will provide expanded specialist diagnostic services to cardiac patients.
- *Improvement of the CT scanners* - The enhanced specification of the CT scanner will provide additional benefits to patients with a range of conditions, e.g. stroke.

- *The storage of radiology images* – The Imaging's Picture Archive storage system will also be upgraded.
- *Development of links with networks* – The Imaging Services are also developing links to establish a regional Vascular Intervention Radiology Service network with other local Trusts.
- *Recruitment of further pharmacists and therapists* – The Trust will be providing expanded 7-day services with plans to substantively recruit to Pharmacy and Therapy services to deliver weekend services sustainably to meet patient and Divisional needs.
- *The Upgrade of equipment in the laboratories* - Pathology, as part of the transition to Consolidated Pathology Services (CPS) will be upgrading the clinical chemistry analysers in the Blood Science Laboratories.
- *Implementation of infection control point of care testing* - The Infection Control service will be developed with the implementation of Point of Care testing (POCT) for MRSA, C-difficile and Norovirus to improve the early diagnosis and management of patients with infections and to facilitate improved bed management and infection control within the Trust.
- *Increased specialist services* – Haematology will be working to expand specialist services at L&D and links with UCLH in the treatment of patients with haemoglobinopathies and thalassaemia.
- *Implementation of electronic systems for prescribing* - E-Prescribing will be implemented across the Trust.
- *Appointment of breast screening specialists* - The Breast Screening will be appointing and training additional Breast Associate Specialists in order to ensure continuity and future proofing of the service.
- *Implementation of a new system of outpatients appointments* – The Outpatients Department will be implementing new systems to improve patient appointment communications, information and attendance rates. Outpatients will be working closely with those involved in progressing improved Medical Productivity to help drive better efficiency and patient experience across the different Outpatient speciality areas.

5. Risk Analysis

5.1 Introduction

The governance arrangements in place have enabled the Trust to manage risk proactively, there is a clear line of governance from the ward to the Board. The Trust risk and control framework is described in detail in 5.3.

5.2 Financial Risk Rating

The Board of Directors proposes a risk rating of 3 for finance. The Trust's financial plan for 2013/14 to 2014/15 produces the following performance against Monitor's financial risk rating methodology as shown in the table below:

Financial Risk Rating (Based on 2013/14 Financial Risk Rating)

Metric	2011/12 Actual	2012/13 Actual	2013/14 Plan	2014/15 Plan	2015/16 Plan
EBITDA margin	3	3	3	3	3
EBITDA % achieved	4	4	4	4	4
Net Return after financing	4	3	3	3	3
I&E surplus margin	3	3	2	2	2
Liquidity rating	4	4	3	4	4
Weighted average	4	3	3	3	3

* Figures shown are the Monitor Score with 5 being the top score and 1 being the lowest score.

5.3 Governance Risk Rating

The Trust foresees minimal risk against the Governance Statements as defined in the Monitor Compliance framework.

Service Performance

It is forecast that the Trust will maintain compliancy throughout 2013/14 on all of the Monitor Compliance Framework performance requirements. However, concern about the availability of community services for some of the catchment population, particularly following a reduction in the availability of nursing home beds in Luton, linking to the Emergency Care Target and the low hospital acquired Clostridium Difficile threshold following excellent performance in 2012/13 remain.

Third Parties

- **Care Quality Commission Registration**

Luton and Dunstable Hospital NHS Foundation Trust is registered to provide the following regulated activities:

- (a) Treatment of disease, disorder or injury
- (b) Surgical procedures
- (c) Diagnostic and screening procedures
- (d) Maternity and midwifery services

- (e) Termination of pregnancies
- (f) Assessment or medical treatment for people detained under the Mental Health Act 1983
- (g) Management of supply of blood and blood derived products

The Luton and Dunstable NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration is 'Registration without Conditions'.

- **NHS Litigation Authority Clinical Negligence Scheme for Trusts (CNST)**

The Trust achieved NHS Litigation Assessment Risk Management Standards Level 2 in March 2011 and will maintain level 2 throughout 2013/14. Maternity Services achieved CNST level 1 in September 2012.

Commissioner Requested Services

The Trust operates in a financially challenged health economy and inevitably faces a degree of mandatory services risk. Whilst the policy of shifting work from the secondary to primary care sectors will impact upon the Trust's workload, it is envisaged that in the short term this will offset the trend of increasing demand rather than reduce overall activity. In addition, the work to develop 'community medical hubs' will enable the Trust mitigate the financial impact of this shift.

The Trust anticipates a green rating for mandatory services.

Other certification matters

- **Governance**

The Trust completed a one year contract with Primary Care Trusts on 31 March 2013. The FT is poised to sign two new one year contract legally binding contracts, one with local commissioners and the other with the newly formed National Commissioning Board (in May 2013). The main contract (£180m) will be signed by newly constituted commissioners (mainly CCGs). The co-ordinating commissioner will be NHS Luton CCG. The National Commissioning Board contract will be for £26.5m.

The FT undertook a five month exercise negotiating the new contracts with local commissioners. The term of the new contract is determined by changes in NHS Commissioning arrangements. The contract is a mandatory DoH contract.

- **Cooperation with NHS bodies and local authorities**

The Trust is seen as a stable performer in its local health economy and has taken the lead in many areas of service redesign. It has worked closely with NHS and Social Care partners and will continue to do so, particularly in building strong relationships with the forming CCGs, the Whole System QIPP Programme and in Business Continuity.

Furthermore the Trust is an active partner in the Acute Services Review, Healthier Together.

- **Information Governance**

The Trust's Information Governance (IG) position continues to strengthen with ownership and accountability firmly embedded into roles within the Trust. The Trust's Senior Information Risk Owner (SIRO) and Caldicott Guardian are supported by an Information Governance Manager & an IT Security Manager. This is in addition to several other roles across the Trust which incorporate responsibilities from the IG agenda, e.g. Registration Authority, Contracts, and Health Records.

5.4 Risk Review

Managing Risk

Risk is managed at all levels of the Trust and is co-ordinated through an integrated governance framework consisting of performance and assurance processes. The Executive Board and the Clinical Operational Board lead the review of risk through the Divisional, Information Governance, Equality and Diversity and Site Redevelopment sub Boards. The Board of Directors lead the review of Board level strategic risk seeking assurance from the Audit and Risk; Clinical Outcome, Safety and Quality; and Finance, Investment and Performance Committees.

Risk Management Strategy

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

There is a Risk Review process under the leadership of the Executive Directors, who meet weekly and approve any new risks that have been identified through the Divisions, Corporate Services or Committees and reported through the central risk register database (Datix). This group will agree whether the risk is a Strategic Board Level Risk that has implication to the achievement of the Trust Objectives, review the assessment score (risk appetite) and also allocate the risk to the relevant Sub-Committee for assurance and operational board for performance monitoring. The Risk Review Group also monitors the risks being closed by the Divisions to ensure the Executive Team is aware of risk amendments.

The assessment and subsequent management of risk is informed by its quantification using a risk grading matrix, which is set by the Board of Directors. Consequence and likelihood tables are outlined in the Risk Management Framework across a range of domains; the consequence tables grade each risk by reference to its expected impact. This, combined with the likelihood score, defines a measure of overall risk. The Trust risk tolerance is set by considering all risks through the Risk Review Group

and identifying those risks that have implications to the achievement of the Trust Objectives. Any of these Board Level Risks that are rated as a high risk are reported to the Board of Directors monthly. Actions and timescale for resolution are agreed and monitored. Through this process, the Board are informed of any risks that would require acceptance as being within the Trust's risk tolerance.

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

L&D Top 5 Risks

Risk Type	Risk description	Impact	Likelihood	Mitigating actions	Outcome Monitoring
Clinical Operational	Increased emergency pressures, ongoing lack of community provision, whole system working and patient experience in outpatients	High	High	Board approved action plans with Trust partners. Transformational programme for outpatients	Managed emergency activity, improved discharge process, improved patient outcomes for outpatients
Service Development	Trust site may not be consistent for optimum patient care	High	High	Board led service re-development strategy including a site redevelopment master plan	Implementation of clinical service re-development plan and hospital re-development plan
Business Continuity	The Trust needs to be able to function in the event of a major or catastrophic event.	High	Low	Ensure that the new Emergency and Business Continuity plans are communicated and understood by key staff.	New Business Continuity plan tested. Risk Assessment ongoing and relevant adaptation of plans.

Risk Type	Risk description	Impact	Likelihood	Mitigating actions	Outcome Monitoring
Legislation/ Target/ Regulation/ Patient Safety	Maintaining compliance against CQC outcomes, national and contractual targets and legalisation	High	Moderate	Board approved action plans in place	Regular monitoring / Assurance from Board Sub-Committees
Finance	Delivering the financial challenge in 2013/14 including Commissioner plans, agency spend, CQUIN and efficiency requirements	High	High	<p>Monthly review of key income & expenditure metrics.</p> <p>Monthly performance review meeting with Divisions led by Executive Directors.</p> <p>Assurance and oversight provided by FIP with monthly report to FT Board.</p>	<p>Monthly reports of cumulative financial performance.</p> <p>Trust to create a contingency budget to assist with risk mitigation</p> <p>Thereafter FT has planned surplus and cash reserve to buffer downside risk to going concern status.</p>

Incident reporting is actively promoted and encouraged across all directorates as part of the culture of the organisation. The Trust actively promotes a culture of 'fair blame' / 'just blame', to encourage staff to report incidents. Incidents that have a significant impact on the Trust, its business or an individual are immediately and thoroughly investigated and the lessons learnt are shared across the Divisions.

Risks to data security are managed through a security risk register and through incident reporting. Mitigating actions are reviewed through the Information Governance Steering Group and reports to the Executive Board.

Embedding Risk Management

Risk Management is an embedded activity of the organisation and can be demonstrated through a number of examples:

- Each Divisional Board reviews reported incidents on a quarterly basis and are required to report to the Clinical Operational Board a CLIP report (Complaints, Litigation, Incidents and Patient Affairs) to triangulate and reflect on the issues raised, develop any further controls to manage the principal risks and to minimise,

as far as reasonably practical, the incident occurring again. If there is a persistent risk issue identified from the incident, the issue is evaluated through the Risk Register and also subjected to independent scrutiny (for example: internal audit, NHS Litigation Authority Risk Management Standards)

- Risk management is integrated into core Trust business in relation to equality impact assessments. All policies and procedures when created or reviewed have to include an Equality Impact Assessment Form. If there are any negative impacts on a particular group of people/equality group following the completion of this form, the Trust will record any changes to the service and/or policy. Any actions will be integrated into existing service planning and performance management frameworks along with monitoring and review processes.
- Business cases include a risk analysis both financially and clinically. This is an improving process as the Trust moves to a more refined format of Service Line Management in 2013/14.

External Assurance

During 2012/2013 the Trust also embedded a culture of external review and the engagement of independent expertise to facilitate greater objectivity and learning.

- During the year in addition to using the services of internal and external audit, a number of specific reviews were commissioned including fractured neck of femur. This practice will continue in 2013/14.
- A number of consultants and turnaround experts were engaged to address concerns in relation to delivering the cancer, 18 weeks and outpatients targets, again, where appropriate this practice will continue.
- The value of benchmarking and learning from others has been greatly enhanced through membership of UCL Partners and the McKinsey Hospital Institute. This endeavour has been complemented by external reviews into orthopaedics, medical productivity and patient flow.

The Luton and Dunstable NHS Foundation Trust is fully registered with the CQC and its current registration is **Registration Without Conditions**.

The Trust promotes the involvement of patient representatives to ensure the quality of performance data and to triangulate feedback and reviews in many aspects of its activities. Patients are represented on the following committees:

- Equality, Diversity & Rights Committee
- Clinical Audit and Effectiveness Committee
- Patient Experience Group
- PEAT (Patient Environment Action Team)
- Research and Development Group
- Patient Information Working Group
- Ethics Committee

- Transforming Outpatients
- Catering Review

LINKs monitor the services provided by the Trust and report directly to the Chief Executive and these are then referred to appropriate Directorate for consideration and action. Representatives from Luton LINKs (now Healthwatch) are members of the Trust's Patient Experience Committee. The National Patient Survey action plan is also progressed and monitored through this group. LINKs have been involved in the development and assurance of the Quality Accounts.

Since becoming a Foundation Trust the organisation has extended the involvement of staff and the public by creating a Council of Governors. The Council of Governors is responsible for a wide range of duties including, but not exclusively, being consulted on health service changes, meeting with members in their constituency, appointing the Chair and Non-Executive Directors and attending Council of Governors' meetings. The Governors include representation from other key stakeholders such as the PCT's, Council and Universities.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. The Trust has reported about progress with carbon reduction within the Operational Performance section of this report.

Review of economy, efficiency and effectiveness of the use of resources

In addition to the financial review of resources within the quarterly monitoring returns to Monitor and the monthly financial information provided to all budget holders, the processes that have been applied to ensure resources are used economically, efficiently and effectively include the below departments and groups. The Trust has also strengthened governance arrangements for the Finance, Investment and Performance Committee during 2012/13 with Divisions presenting through to the committee on a range of financial and operational matters.

A Clinical Audit and Effectiveness Department is also maintained to:

- To oversee the implementation of National Institute of Clinical Effectiveness (NICE) guidance.
- To monitor the introduction of new techniques ensuring clinical and cost effectiveness of new treatments, as well as the appropriate training of clinicians.

- To support clinical audit work within the Trust, ensuring clinicians work in the most effective way, adopting good practice uniformly across the Trust through protocols and guidelines.

The use of Management groups charged with monitoring efficiency and effectiveness as part of their terms of reference:

- The Medical Equipment Group advises on the replacement and purchase of new medical equipment.
- The Medicines Management Group oversees the maintenance and development of the drug formulary to ensure clinically appropriate and cost effective use of medicines.

The Trust's efficiency is quantified annually through the national reference costs exercise. The latest published index for the Trust is 99 (based on 2011-12 accounts and activity) compared to a national average index of 100.

The Trust is also engaging in a range of benchmarking exercises to determine best practice and assess the means of implementing it at the Luton & Dunstable.

6. Financial Projections

6.1 Financial Strategy

The Board have determined three key financial operating metrics that will create the framework through which the Trust can demonstrate on-going financial viability and compliance with the 2006 Act. These are:

- The Trust shall maintain a cash reserve equivalent to 1/12th of operating expenditure
- The Trust shall at all times maintain a minimum financial risk rating of 3¹
- The Trust shall retain a contingency £3m in each financial year to avoid recording a financial deficit².

6.2 Financial Outlook

The Trust has recorded 14 years of financial surplus. However this has been achieved in the context of significant growth in NHS Funding. It is clear that the challenges from 2013/14 will be significant.

From 2013/14 the Trust will be disadvantaged by the twin impact of reduced income (as a result of the tariff decreasing) and unavoidable inflationary cost pressures. These two factors working in tandem will require the Trust to improve efficiency by 4.5% per annum (£10m).

The challenge in financial year 2013/14 is made harder by a recurrent shortfall carried into 2013/14 £3m (the FT only achieved financial balance in 2012/13 as a result of non-recurrent gains).

Furthermore aggregated commissioner QIPP plans sum to more than £6m. These, in part, can be seen to be ambitious. Commissioner schemes are multi-faceted and would require a step change in the control of patient demand for hospital services. The Trust is placed in the unenviable position of second guessing whether schemes will be totally successful and then flexing capacity accordingly.

The Trust has developed a plan designed to deliver its FT financial strategy. This contains more risk than has been evident in previous years and places significant emphasis on the abilities of Service Line Managers to deliver improved financial performance whilst maintaining operational targets.

The Trust has negotiated a flexible contract for 2013/14 effectively removing any 'cap' or any material risk sharing agreement with commissioners. However the FT has entered into a risk sharing agreement for Outpatient Diagnostic Imaging Unbundling.

¹ Based on existing Compliance Framework. Would need to amend in light of new Risk Assessment Framework

² The Contingency consists of an unallocated expenditure budget plus the planned surplus for the financial period

The Trust maintains the belief that appropriate clinical outcomes, patient experience and safety remain the highest priorities and that this must be balanced with the requirement to achieve year-on-year efficiency savings.

6.3 Contracts and Income

The Trust finished a one year contract with Primary Care Trusts on 31 March 2013. The Trust is poised to sign two new one year contract legally binding contracts, one with local commissioners and the other with the newly formed National Commissioning Board (in May 2013). The main contract (£180m) will be signed by newly constituted commissioners (mainly CCGs). The co-ordinating commissioner will be NHS Luton CCG. The National Commissioning Board contract will be for £26.5m.

The FT undertook a five month exercise negotiating the new contracts with local commissioners. The term of the new contract is determined by changes in NHS Commissioning arrangements. The contract is a mandatory DoH contract.

The table below summarises the major changes to the financial and activity schedule. Key aspects of the finance and activity plan are discussed in the commentary below the table.

Financial Impact of 2013/14 Contract

	Luton	Beds	Herts	Bucks*	LAT	Sub Total	Spec Comm	Other**	Overperf	Total
Contract Value 2012/13	104.0	57.9	20.4	3.7	0.0	186.0	11.0	2.7	3.5	203.2
Forecast Outturn	110.0	60.2	20.4	4.2	0.0	194.8	10.5	3.8	0.0	209.1
Tariff Changes	-0.5	-0.2	-0.1	0.0	0.0	-0.8	0.0	0.0	0.0	-0.8
Growth (Population)	2.4	0.8	0.2	0.0	0.0	3.4	0.1	0.0	0.0	3.5
Like for Like	0.1	0.1	0.0	0.0	0.0	0.3	0.0	0.0	0.0	0.3
Trust Plans	2.0	0.9	0.3	0.3	0.0	3.5	0.8	0.0	1.7	6.0
Commissioner Alignments	-11.6	-7.6	-5.3	-1.5	9.2	-16.8	16.5	1.2	0.0	0.9
Commissioner QIPP	-3.3	-1.5	0.0	0.0	0.0	-4.8	-1.5	0.0	2.4	-3.8
2013/14 Plan	99.1	52.8	15.4	3.0	9.2	179.6	26.5	5.2	4.1	215.3

* Includes Buckinghamshire, Milton Keynes, Nene & Corby

** Includes Local Authorities & NCAs

Forecast Outturn identifies the Trust establishing new activity levels driven from historic performance and developments initiated during 2012/13 (such as Breast Screening). The NHS Commissioning Board contract (formerly East of England Specialist Commissioning) reflects a change of contract away from the historic block contract to a payment by results type contract and the fact that more services are commissioned by the NHS Commissioning Board rather than local Commissioning Organisations.

Tariff Changes – reflect the headline 1.1% price reduction embedded with 2013/14 prices (as stipulated by DoH) together with a range of other changes to the 2013/14 (such as the Maternity Payments Pathway and Outpatient Diagnostic Imaging Unbundling).

Growth in contracts identifies the financial impact of demographic and technological change. CCGs have applied variable uplifts ranging between 0 and 2.8%.

Trust Plans contain the activity numbers required to deliver 18 week targets, new spinal activity, new Catheterisation Laboratory activity, new endoscopy activity, additional Bariatric activity and NICU activity.

Commissioner Alignments represents the fact that following the April 2013 reorganisation responsibility for commissioning certain services has moved from local commissioning group to the NHS Commissioning Board.

Commissioner QIPP shows significant ambition by commissioners to control and reduce demand for Hospital Services. NHS Luton & NHS Bedfordshire are seeking to reduce patient activity by £6m (mainly by reductions in elective and non-elective admitted patient numbers).

6.4 Activity Levels – 2012/13 & 2013/14

The table below identifies those areas where demand has changed by comparing the actual contracted activity to that planned.

Activity Type	Units	Actual*	Plan*	Forecast	Plan
		2011/12	2012/13	2012/13	2013/14
Admitted Patients					
Elective PbR	Spells	28,097	30,201	30,257	31,438
Elective Non PbR	Spells	130	61	61	52
Non Elective - General & Acute PbR	Spells	29,302	26,750	31,730	30,785
Non Elective - PA Unit	Spells	1,201	1,000	1,253	832
Non Elective - AA Unit	Spells	386	200	620	500
Non Elective Non PbR	Spells	510	400	544	498
Total Admitted Patients	Spells	59,626	58,612	64,465	64,105
Outpatients					
Outpatients - 1st (PbR)	Atts	82,774	74,922	79,756	74,396
Outpatients - Follow UP (PbR)	Atts	137,677	137,595	137,938	134,633
Outpatients - Procedures (PbR)	Atts	19,906	22,606	27,873	28,991
Outpatients - Pre Assessment (PbR)	Atts	10,153	10,423	8,853	10,004
Total Outpatients	Atts	250,510	245,546	254,420	248,024
A&E	Atts	71,792	70,740	78,379	70,210
Maternity Pathway					
Ante-Natal Pathway	Patients	6,336	6,200	6,207	6,207
Births	Births	5,312	5,200	5,260	5,264
Post-Natal Pathway	Patients	5,250	5,200	5,260	5,633
Total Maternity Pathway		16,898	16,600	16,727	17,104
Critical care					
Adult - Intensive Care	Bed Day	2,013	2,006	2,051	2,124
Adult - High Dependency Unit	Bed Day	2,450	2,248	2,301	2,350
Adult - Ward Based High Dependency	Bed Day	1,322	1,446	1,235	1,266
Neonatal - Intensive Care	Bed Day	2,640	3,065	2,772	3,169
Neonatal - High Dependency	Bed Day	2,575	2,644	2,307	2,552
Neonatal - Special Care Babies	Bed Day	5,550	5,952	5,113	5,567
Neonatal - Transitional Care	Bed Day	926	1,382	1,176	1,242
Paediatric - High Dependency	Bed Day	1,788	1,553	1,760	1,674
Total Critical Care	Bed Day	19,264	20,296	18,715	19,944
* Rebased to reflect Maternity Payment Pathway		PbR = Payment by Results			

In 2012-13 the Trust Commissioners anticipated substantial QIPP reductions. Despite their endeavours planned activity reductions did not occur.

The Hospital performed well to accommodate this unplanned activity without compromising a range of national target indicators. However, this activity could not be provided within existing employed staffing levels, consequently the Hospital incurred substantial temporary staffing costs.

In 2013-14 Commissioners once again plan a range of demand management initiatives designed to reduce pressure on the Hospital. The Hospital will need to carefully manage its own capacity and staffing levels to ensure that services are provided efficiently and effectively.

6.5 Capacity

Operating Theatre Requirements

To meet the year's likely requirements for elective admissions, it has been calculated that, an average of 143 operating sessions a week will be required for surgical specialties. Details by individual specialty are shown in the table below.

This assumes a 42-week operating year and also that there will be improvements in productivity in some specialties enabling a higher average number of cases per session. This year OMFS has been split into minor surgery and major surgery as the types of patients and numbers per operating list are very different.

Most patients having endoscopies do not go to the main theatres, this being the predominant reason for the low proportions in some specialties of elective admissions operated on in theatre.

						42 weeks
SPECIALTY	Required 2013/14 elective spells	% elective spells operated on in elective theatre session	2013/14 elective L&D theatre operations	Elective cases per session	2013/14 elective sessions needed	2013/14 SESSIONS NEEDED PER WEEK*
General Surgery	4,978	45	2,230	2.3	970	23.1
Bariatric Surgery	373	90	336	1.6	210	5.0
Urology	3,336	85	2,836	4.1	692	16.5
T & O Surgery	4,066	76	3,090	2.1	1,472	35.0
ENT	2,142	96	2,056	2.8	734	17.5
Ophthalmology	2,725	98	2,671	6.0	445	10.6
OMFS majors	838	100	838	2.3	364	8.7
OMFS minors	2,303	100	2,303	3.6	640	15.2
Gynaecology	1,869	72	1,346	3.0	449	10.7
Pain Relief	92	96	88	4.6	19	0.5
TOTAL	22,722		17,705		5,994	142.7

Bed Requirements

The hospital has increased its number of overnight beds from 657 to 670 over the last year mainly as a result of small changes in maternity and Cobham. The table below shows how bed numbers have changed in the last few years the current split between different specialty groups for mixed specialty wards.

The beds on what was ward 19 have now been converted to an Ambulatory Care Ward.

Available Inpatient Overnight Beds Breakdown by Specialty Group 2013/14

Overnight Beds

WARD	CURRENT SPECIALTY GROUP	BED NUMBERS					Elderly	Adult Medicine	Surgery	Paediatric Medicine	Neonatal Unit	Obstetrics	Total Available
		April 2009	April 2010	April 2011	April 2012	April 2013							
1	Closed	17	17										
2	SURGICAL	20	20	20	17	17			17				17
ACU	Closed	51	51										
EAU	MIXED SPECIALTIES			20	21	21	4.7	13.1	3.2				21
MSS	Closed			30									
3	MEDICINE			21	21	21		21					21
Respiratory Unit/4	MEDICINE	20	20	20	25	25		25					25
Respiratory HDU	MEDICINE	4	4	4	8	4		4					4
5	MIXED SPECIALTIES	18	18	18	16	18	9.3	7.1	1.6				18
6 (CCU)	MEDICINE	13	13	13	13	13							13
10 (Respiratory)	MEDICINE				23	27		27					27
11	MEDICINE	31	31	31	31	31		31					31
12	MEDICINE	30	30	30	30	30		30					30
14	MEDICINE FOR THE ELDERLY	28	28	28	29	29	29						29
15	MEDICINE FOR THE ELDERLY	28	28	28	29	29	29						29
16	MEDICINE FOR THE ELDERLY	28	28	28	28	28	28						28
17	MEDICINE FOR THE ELDERLY	28	28	28	28	28	28						28
18	MEDICINE FOR THE ELDERLY	29	29	29	29	29	29						29
19 (Ambulatory Care)	MIXED SPECIALTIES (11 beds)				0	0							0
20	SURGICAL	23	26	26	26	26			26				26
21	SURGICAL	22	17	18	30	30			30				30
22	SURGICAL	30	30	30	30	30			30				30
23	SURGICAL	30	30	30	30	30			30				30
24	CHILDREN	15	14	15	15	15			0.3	14.7			15
PHDU	CHILDREN	2	2	2	2	2				2			2
25	CHILDREN	17	16	17	17	17			5.9	11.1			17
26	CHILDREN												
26A	CHILDREN	5	5	5	5	5			0.7	4.3			5
32/32	WOMENS	55	53	53	55	57						57	57
34	WOMENS	25	19	19	20	20			20				20
I.C.U.	MIXED SPECIALTIES	7	7	7	7	7	0.5	4.0	2.5				7
H.D.U.	MIXED SPECIALTIES	7	7	7	7	7	0.6	1.9	4.5				7
Labour Ward/MLBU	WOMENS	13	13	22	22	26						26	26
N.I.C.U.	CHILDREN			11	11	11					11		11
S.C.B.U.	CHILDREN	36	35	16	16	16					16		16
N.H.D.U.	CHILDREN			8	8	8					8		8
Cobham	SURGICAL	*	*	7	8	13			13				13
	Total	632	619	641	657	670	158.1	177.1	184.7	32.1	35	83	670

*ward not open/applicable

Mixed/specialty wards have beds allocated on basis of actual usage in 2012/13

Modelling work has been done to assess the beds required to meet the planned elective and emergency activity for 2013/14. This is based on the current lengths of stay and day case rates using the planned contract numbers for 2013/14.

This capacity modelling shows the number of beds required to maintain realistic numbers of empty beds to cope with the normal variations in demand. Since admissions are not spread evenly throughout the year or evenly across the days of the week a calculation has been made of how many beds would be required to cope with the days when admissions peak. To cope with these variations in demand an assessment is commonly made that an additional 15% of beds are required in most adult specialties and an additional 30% in paediatrics and obstetrics which show greater volatility.

The model shows that overall an average of 653 beds would be required (to meet an average daily occupancy of 536 beds).

In fact the Trust currently has 670 beds giving a notional surplus of 17. When broken down by specialty group this surplus is shown to be split across the main specialty groups. Obstetrics, Paediatric Medicine and Surgical specialties all show small surplus numbers of available beds but the beds in these groups are not easily interchangeable so hard to consolidate into a viable number of beds in any one

area. Medical beds show a small deficit against an ideal occupancy rate of 85% although even in Medicine the modelling suggests that bed pressures are likely to be less than last year.

The drivers for this reduced requirement for beds are shorter lengths of stay in a number of specialties, a higher proportion of day cases and reduced activity volumes in some of the long stay specialties (such as orthopaedics which is no longer needing to catch up 18-week backlogs to the same extent as in 2012/13).

Projected bed requirements

Bed Requirements

	Planned			Planned			Calculated		Calculated		Calculated		
Specialty	Current LOS 2012/13 Elective IP LOS	2012/13 Emerg LOS	2013/14 Planned Elect IP/DC Spells	Current (2012/13) % Day cases	Plan for (2013/14) Elective IP Spells*	Emerg Spells	2013/14 Elective IP Occupied Bed Days	2013/14 Emerg Occupied Bed Days	2013/14 Total Occupied Bed Days	2013/14 Daily Occupied Beds	2013/14 Daily Beds Required* at Target%	2012/13 Daily Occupied Beds (Plan)	Change per day in plan for 2013/ Occ Bed
General Surgery	2.5	3.7	5,351	68.5	1,686	4,316	4,214	15,969	20,183	55.3	65	56.3	-1.0
Urology	2.2	5.2	3,336	73.9	871	255	1,916	1,326	3,242	8.9	10	7.1	1.8
T&O	3.1	7.4	4,066	54.0	1,870	1,874	5,798	13,868	19,666	53.9	63	60.6	-6.8
ENT	1.5	2.3	2,142	54.1	983	705	1,475	1,622	3,096	8.5	10	10.4	-1.9
Ophthalmology	0.3	1	2,725	98.3	68	17	20	17	37	0.1	0	0.1	0.0
Oral Surgery	1.3	0.9	3,141	81.4	584	772	759	695	1,454	4.0	5	5.4	-1.4
A&E	0	0.3	0	0.0	0	1,611	0	483	483	1.3	2	0.4	0.9
Pain Relief	1	0	92	97.8	2	0	2	0	2	0.0	0	0.0	0.0
Cardiology	3.6	7.5	629	87.8	77	202	276	1,515	1,791	4.9	6	1.6	3.4
Dermatology	0	2.4	23	88.5	3	2	0	5	5	0.0	0	0.0	0.0
Medical Oncology	0.2	2.2	2,976	97.9	62	57	12	125	138	0.4	0	0.0	0.4
Neurology	0.0	0.0	105	92.8	8	0	0	0	0	0.0	0	0.0	0.0
Paediatrics	2.1	1.1	876	70.2	261	6,723	548	7,395	7,944	21.8	31	19.5	2.2
General Medicine elective	0.7		5,955	73.9	1,554		1,088		1,088	3.0	4	2.7	0.3
Care of the Elderly elective	7.3		217	78.1	48		347		347	1.0	1	0.8	0.2
Combined DME/Gen Med emergency		6.9				15,179		104,735	104,735	286.9	338	318.7	-31.8
Obstetrics/midwives	1.3	1.4	6	14.3	5	13,030	7	18,242	18,249	50.0	71	47.6	2.4
Gynaecology	1.6	2.3	1,869	58.4	778	995	1,244	2,289	3,533	9.7	11	9.4	0.2
Other Pathology	0.0	0.0	9	54.5	4	0	0	0	0	0.0	0	0.0	0.0
Haematology	0.8	0.0	2,093	98.2	38	2	30	0	30	0.1	0	0.0	0.1
Total before Neonatal			35,611	74.8	8,901	45,740	17,737	168,286	186,022	509.7		540.8	-31.1
Averages per day							49	461	510		618		
Neonatal Unit										26	35	26	0.0
Total for whole hospital										535.7	653	566.8	-31.1
*Target % = 70% for paediatrics and obstetrics and 85% for all others													

6.6 Financial Plan

Historic Performance

The Trust has recorded 14 years of financial surplus. However this has been achieved in the context of significant growth in NHS Funding. The table below illustrates the Trust's historic income and expenditure (I&E) performance since 2005/6.

Historic I&E Performance

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Turnover	143.6	153.2	169.1	189.3	204.9	211.6	220.8	230.6
Surplus	0.4	2.0	2.9	4.3	3.1	2.6	2.5	0.9
Cash	1.9	18.8	35.4	45.4	43.7	50.9	47.6	37.5

All figures £m

Challenges during 2012/13 have been significant. In 2012/13 the Trust was disadvantaged by the twin impact of reduced income (as a result of the tariff decreasing) and unavoidable inflationary cost pressures. These two factors working in tandem required the Trust to improve efficiency by 4.5% per annum (£10m).

However, despite the challenges the Trust's income grew significantly. This was against a background of commissioner aspirations to curtail demand (and reduce payments) for hospital services. This growth in income enabled the Trust to deliver a surplus of nearly £1m. This was behind the planned surplus of £2.4m forecast within the Annual Plan for 2012/13 and reflects the challenging operating environment. The summarised results are shown below.

2012/13 Financial Results

	Plan £m	Actual £m
Income	221.3	230.6
Pay	146.3	150.0
Non-Pay	63.3	70.2
EBITDA	11.7	10.5
Interest, Depreciation etc	9.3	9.6
Surplus	2.4	0.9

The table below identifies the month trend for profitability over the year. The monthly surplus / deficit can be seen to fluctuate due to the number of working days in the month and other seasonal factors such as Christmas, Summer Holidays and Easter.

Monthly Profit



The results for 2012/13 were sufficient for the FT to earn a Financial Risk Rating Score of 3.

Financial Risk Rating

Metric	Performance	Rating
EBITDA Margin Rating	4.5%	2
EBITDA % of plan achieved	88.9%	4
Net Return after Financing	0.7%	3
IS Surplus Margin	0.4%	2
Liquidity	26.1 days	4
Weighted Average Rating		2.90
Financial Risk Rating		3

Future Plan

This section identifies how the Income & Expenditure budget for 2013/14 was created.

The construction of the annual budget is complex, especially given that the majority of income is now driven under a Payment by Results structure.

The approach identifies the five most significant steps that impact on the income and expenditure surplus/deficit.

The initial starting point of the 2013/14 budget is the 2012/13 Annual Plan. The approved Plan for 2012/13 was a planned surplus of £2.4m.

From 2013/14 the Trust will be disadvantaged by the twin impact of reduced income (as a result of the tariff changes) and unavoidable inflationary cost pressures (£10m), unavoidable Hospital related cost pressures (e.g. deep cleaning) and the impact of non recurrent benefits from supporting the 2012/13 not being available in 2013/14 (£3m).

During the 2013/14 budget round £1.4m of Service Developments were identified by Divisions to underpin the provision of services.

The £1.4m of Service Developments and changes are summarised below in the table below.

Service Developments by Division

Division	
Surgical Investments in fractured neck of femur services on Ward 23 (£0.1m), cancer service nurses (£0.1m) and £0.4m within Bariatric and General Surgery	£0.8m
Medical Investment in Medicine's medical staffing model comprising of 4 new physicians .	£0.3m
Women's and Children's Investments in additional uro-gynaecology and obstetric consultants (£0.2m) and a clean room for gynaecological services (£0.1m) which are offset by the gain in income from this year's contract changes (£1.1m)	(£1.1m)

Diagnostics, Therapies & Outpatients Outpatient interactive clinic attendance technology to improve on current DNA rates, reorganisation of management structure, and the creation of additional Associate Specialist for Breast Screening.	£0.4m
Corporate & Operational Services Additional staffing resource for the patient flow team (£0.2m), new Director of Transformation post (£0.1m), mainstream of patient experience call centre (£0.1m), and the provision of extra resource for deep cleaning (£0.3m)	£1.0m
Total	£1.4m

In order to deliver financial balance in 2013/14 the FT have identified a range of cost improvements and income gains (totalling £9.7m and £6.2m respectively).

Total Impact of Budget Setting

The table below demonstrates that the total impact of the 2013/14 budget setting

PLAN	£m	
Opening Plan 2012/13	2.4	
Tariff / Other Cost Pressures	-12.9	Impact of tariff/cost inflation/local cost pressures
Non Recurrent gains	-3.0	Reversal of non recurrent gains in 2012/13
Service Developments	-1.4	Developments designed to strengthen delivery
Cost CIP	9.7	2013/14 cost savings
Income Efficiency (CIP)	6.2	2013/14 income gains
Opening Plan 2013/14	1.0	

6.7 Service Line Management

This section reiterates the new governance arrangements which accompanied the changes to the performance regime from 1 April 2012. The key elements which underpin the new arrangements are:

- devolution of decision making to divisional level for the use of resources;
- a move to profit or loss as the key financial measure rather than cost.

The arrangements will operate to deliver this objective and cover (i) the decisions which will now be made at divisional level (ii) the approach to performance management based on profit and (iii) escalation processes in the event of failure.

Decision Making

The principle that acts as the foundation for governance arrangements is that the majority of decisions are best made closer to the front line as long as two conditions are in place, firstly that the correct incentives are in place to drive behaviour and secondly that appropriate rigorous governance is in place at divisional level to support good decision making.

The arrangements do not lessen the governance arrangements for committing resources but the governance takes place at a different level. The new

arrangements require rigorous Divisional decision making processes with the divisional executive becoming a key part of the governance process.

The principle adopted in respect of decision making is that all decisions regarding commitment of resources will be made by Divisions unless they are specifically excluded.

The decisions which are reserved for the Executive are as follows:

- capital spend;
- IM&T spend;
- establishment of new services;
- non-pay commitments for longer than 2 years (with the exception of maintenance contracts with a total value less than £30k);
- permanent Consultant appointments;
- any new posts in the senior management or nursing structure (i.e. 8a and above). This is because the Trust wishes to have a consistent senior management and nursing structure across Divisions;
- minor capital works will need to be in line with the Trust's accommodation policies, including the Site Masterplan, and be approved by Estates to ensure no compromising of the hospital infrastructure.

It is anticipated that major changes will be part of the business plan agreed with the executive and therefore the devolved decision making would be in the context of an agreed business plan presented to FIP by each division, providing assurance regarding the overall management arrangements.

Whilst non-consultant appointments are decided at divisional level, all appointments will need to be made in line with current HR policies regarding terms and conditions and payments to staff (e.g. expenses, additional payments, clinical excellence awards, maximum consultant PAs etc) will need to be in accordance with Trust policies and procedures.

Where the spend is likely to be incurred by one division but recharged under SLR to other divisions then new commitments will need to have the agreement of other directorates as appropriate. This will mean that the Executive meetings will be useful to agree expenditure increases or reductions of this nature but it will not be necessary for such decisions to be made by the executive where agreements are reached by divisions separately.

This arrangement however only applies to new services or commitments. For example if the imaging services needs to increase its staffing complement to meet demand from other divisions then no agreement is necessary from the divisions who will continue to pay a variable cost in line with their usage. If however the division is introducing a new test or new service then an agreement is necessary from divisions that they are happy to pay for it. This area is clearly open to interpretation and there is likely to be some ambiguity. It is the responsibility of divisions that they have a clear dialogue with finance regarding the process to be followed where there is uncertainty in order to avoid being unable to recharge expenditure.

Performance management based on profit

The key performance metric for the Division will be surplus. The Division's level of surplus or deficit is in large part due to the errors, inconsistencies and immaturity of the national tariff. Therefore it is not the level of surplus itself which is ultimately the performance measure used. Instead (i) surplus (or deficit) against budgeted surplus (or deficit) and (ii) movement in surplus quarter by quarter are more appropriate measures as they better reflect the actual performance of the team.

This is how the senior divisional team will be monitored and measured. Due to the fact that seasonality plays a part in affecting profit (i.e. elective income is lower in months with less working days), quarterly performance will be the key performance measure although monthly profit will be reported and monitored.

The difficulty in accurately setting a surplus budget (due to potential unforeseen changes in volumes, tariffs etc) means that quarterly improvement is ultimately the most important measure of a general manager's performance in respect of finance but surplus against budgeted surplus will also be a key scorecard measure.

Escalation and the failure regime

The intention of the changes outlined above is to better incentivise performance. One of the effects of the change will be to allow good and poor performance to be more transparent. This means that it is likely that there will be increased level of performance management in relation to individuals as it will be easier to separate high performing and low performing individuals. Of course this is in the context of a system which better incentivises higher performance.

Inevitably the judgement of performance will be guided by the performance dashboard but will remain subjective rather than formulaic. The reason for this is the interconnectedness of the divisions within a hospital. As an example the profitability of the surgical division could be affected by the cancellation of elective surgery in order to manage the emergency take. These factors are unavoidable and therefore the executive have to take a rounded view of performance, and importantly, view performance in the medium to long term rather than the short term.

The proposed system may be considered to be higher financial risk than the current one as the Trust is more exposed to poor decision making by the divisional management i.e. they are making more decisions. This is of course offset by lower clinical and operational risks because decisions are made much faster. In order to ensure that the risks are appropriately managed it is important that the financial reporting is rigorous and timely allowing intervention where necessary. The nature of this intervention would be dependent on the circumstances but might involve restricting decision making temporarily by the divisional team, providing a greater level of external support or in extremis changing the management team.

Service Line Reporting Budgets for Divisions

Divisions have provided budgets for 2013/14 which are in line with I&E targets set by the Board of Directors. This process represents a departure from the top down approach to budget setting.

The central QIPP programme consisting of five productivity work streams is designed to facilitate divisions driving to a more efficient, effective and economic business model. These productivity work streams are length of stay, outpatients, theatre productivity, workforce and facilities management.

6.8 Cash

Working Capital and Financing

A forward capital programme through to 2016 was approved by the FIP Committee (on behalf of the Board of Directors) in May 2013. This plan will be financed from internally generated resource (depreciation & retained Income & Expenditure surpluses) and will, for the first time, require the FT to seek external funding.

The FT has opened a positive dialogue with the Foundation Trust Financing Facility Team and would expect to submit the first loan application in the summer (for £5m).

In parallel with the work on the Business Case supporting the Hospital Development Project the FT will explore the creation of a subsidiary Property Facilities Management Company to test if the model is a more efficient, effective and economic mechanism through which high quality services can be delivered.

Reserve Policy

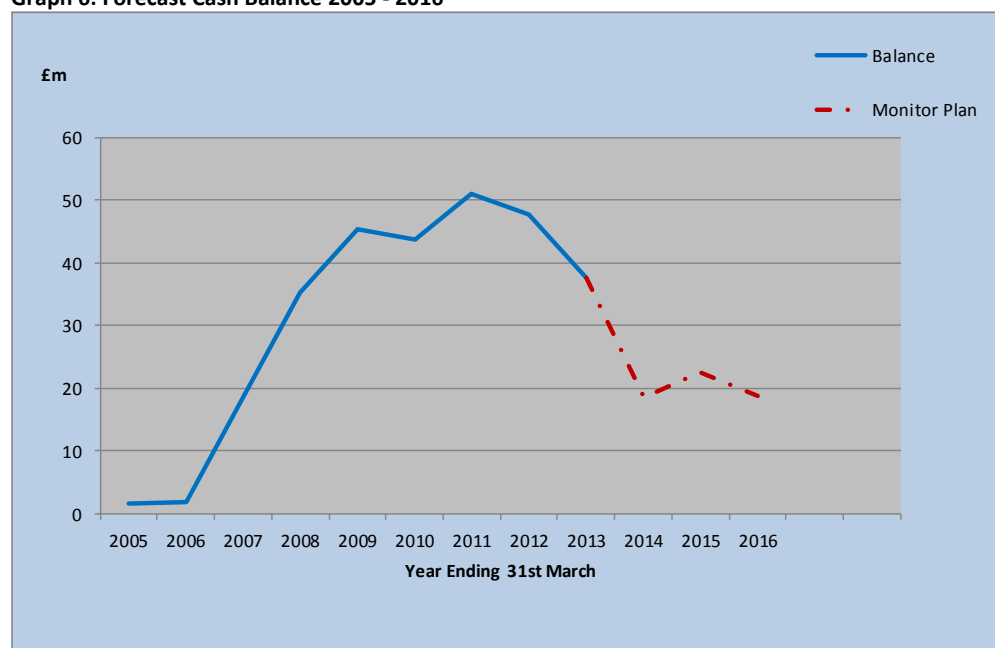
The Trust will earmark a cash balance to provide financial protection should trading performance slip. The Board of Directors has determined that an appropriate reserve would equate to 1/12th of annual operating expenditure.

The Trust has not retained a working capital facility with the Trust bankers with a maximum drawdown of £12m (in part due the prevailing cash balance and in part due to cost). The facility was in place at the time of the authorisation (August 2006 – for a period of one year) and was confirmed as part of the due diligence process as being a committed facility. Due to the level of anticipated capital expenditure, with the resultant effect on cash balances the Trust is expected to review the requirement for such a facility during 2013/14 and will review the need for a working capital facility annually going forward.

Forecast Cash Balance

Graph 6 below illustrates the Trust's forecast cash balance to 2016. The Cash position is dependant upon the FT securing external finance.

Graph 6: Forecast Cash Balance 2005 - 2016



6.9 Capital

Planned Capital Developments

Investment in buildings, equipment and other fixed assets is planned to meet the following objectives:

- Provision of sufficient capacity to deliver the projected activity of the Trust working to modern standards;
- Development of new service facilities in response to national standards and the emergence of new technologies;
- Enhancement of the physical assets of the Trust and in particular the reduction of backlog building maintenance and equipment replacement;
- The enhancements of service quality, including patients' privacy and dignity;
- Compliance with statutory requirements and the reduction of risk;
- The improvements of efficiency and income generation, including any growth of unregulated services;
- Modernisation of service delivery; and
- Support for national programmes.

The major expenditure line is the four-year Hospital Development Programme.

Having identified the total investment feasible the capital programme, the table below identifies the application of available funds.

Summary Capital Programme: 2012/13 to 2015/16

	2012/13	2013/14	2014/15	2015/16	Totals
Application of Capital Expenditure	£m	£m	£m	£m	£m
Hospital Development Programme	0.5	11.1	17.3	22.5	51.4
Business Cases	5.2	3.2	0.0	0.0	8.4
Estates	0.8	1.0	1.0	1.0	3.8
Medical Equipment (Multi-various)	2.3	5.8	2.2	2.2	12.5
IT Developments	2.5	5.7	2.4	0.9	11.5
Contingency	0.0	0.5	1.0	1.0	2.5
Total Capital Expenditure	11.3	27.3	23.9	27.6	90.1

Each Capital Scheme will be continually reviewed by the Finance, Investment & Performance Committee to ensure that it demonstrates value for money and achieves the objectives and compliments the overall Site Masterplan.

6.10 Staff Numbers

With over 70% of the Trust's expenditure being on pay, staff numbers are intrinsic to financial planning. Staff numbers are predicated on the Trust's planned level of expenditure for 2013/14. The table below shows the planned whole time equivalent levels through to March 2016.

Whole time equivalent staff numbers 2011 to 2016

Staff WTE	2011/12 Actual WTE	2012/13 Actual WTE	2013/14 Plan WTE	2014/15 Plan WTE	2015/16 Plan WTE
Total	3,396	3,597	3,580	3,488	3,435

A more detailed workforce plan will be developed consistent with the work outlined within the QIPP section and consistent with the whole system QIPP programme. This will mirror the document that supported the Service Development Strategy in August 2006.

6.11 Summary Annual Budget

Having applied the assumptions set out earlier to the Trust's 2012/13 financial position, the table below provides the agreed budget for 2013/14 and indicative plans for the next two financial years.

Agreed Budgets

	2011/12	2012/13	2013/14	2014/15	2015/16
	£m	£m	£m	£m	£m
INCOME					
Operating Income - Planned	203.7	212.4	217.4	217.4	217.4
Operating Income - Demand Growth				6.5	13.2
Operating Income - Commissioner QIPP				(4.0)	(8.0)
Operating Income - Tariff Deflator (-1.5%)				(3.3)	(6.5)
Operating Income - Coding Review				1.3	2.5
Operating Income - New Income				1.5	3.0
Non-contract income	16.9	18.3	16.6	17.0	17.4
Total income from activities	220.6	230.7	234.0	236.4	239.0
OPERATING EXPENDITURE					
Pay	(142.7)	(150.0)	(151.2)	(151.2)	(151.2)
Drugs	(16.4)	(17.9)	(17.8)	(17.8)	(17.8)
Clinical Support	(20.1)	(21.2)	(20.2)	(20.2)	(20.2)
Other Expenses	(30.2)	(31.1)	(30.5)	(30.5)	(30.5)
Contingency			(2.5)	(2.5)	(2.5)
NHS Activity Change (50%)				(1.3)	(2.6)
New Service Standards (0.5%)				(1.1)	(2.2)
Cost Inflation (2.5%)				(5.6)	(11.3)
New Income (50%)				(0.8)	(1.5)
CIPs				8.6	15.8
Sub-total OPEX	(209.4)	(220.2)	(222.2)	(222.3)	(224.0)
EBITDA	11.2	10.5	11.8	14.2	15.0
OTHER EXPENDITURE					
Depreciation (Historic)	(6.4)	(6.9)	(6.7)	(6.4)	(6.150)
Depreciation (Future)			(0.7)	(2.5)	(3.100)
Finance costs	(0.5)	(0.4)	(0.7)	(0.8)	(0.8)
New Interest Payable (2.2%)				(0.5)	(1.0)
Impairments					
PDC (Historic)	(1.8)	(2.3)	(2.3)	(2.3)	(2.3)
PDC (New)			(0.4)	(0.7)	(0.7)
Sub-total - Other expenditure	(8.7)	(9.6)	(10.8)	(13.2)	(14.1)
Retained annual surplus	2.5	0.9	1.0	1.0	1.0

The table below summaries the Trust's Balance sheet between 2011/12 – 2015/16

Balance Sheet

	£m	£m	£m	£m	£m
Non Current Assets	97.5	100.3	119.8	134.5	152.5
Current assets:					
Stocks	2.2	2.6	2.6	2.6	2.6
Debtors	9.8	11.9	11.9	11.8	11.9
Cash	47.6	37.7	19.1	23.1	19.7
Sub-total	59.6	52.2	33.6	37.5	34.1
Current liabilities					
Creditors	(9.7)	(9.5)	(9.3)	(9.3)	(9.5)
Accruals	(18.8)	(17.3)	(14.5)	(14.5)	(14.5)
Provisions	(6.7)	(4.7)	(2.7)	(0.7)	(0.7)
Other liabilities	(2.2)	(2.1)	(2.1)	(2.1)	(2.1)
Sub-total	(37.4)	(33.6)	(28.6)	(26.6)	(26.8)
Net current assets	22.2	18.6	5.0	10.9	7.3
PFI borrowings	(12.4)	(12.1)	(12.0)	(11.8)	(11.4)
Loan (assumed 25 years)	0.0	0.0	(5.0)	(25.0)	(39.0)
Loan Repayment	0.0	0.0	0.0	0.2	0.4
Trade and other payables	(0.2)	0.0	0.0	0.0	0.0
Provisions	(0.8)	(0.8)	(0.8)	(0.8)	(0.8)
Net assets	106.5	106.0	107.0	108.0	109.0
Represented by:					
Public dividend capital	60.1	60.1	60.1	60.1	60.1
Income and expenditure reserve	29.2	32.1	33.1	34.1	35.1
Revaluation reserve	17.2	13.8	13.8	13.8	13.8
Taxpayers equity	106.5	106.0	107.0	108.0	109.0

The table below provides a summary of the Trust's projected cash-flow for 2012/13 and beyond.

Cash Movement

Cash Movement (£m)	2011/12	2012/13	2013/14	2014/15	2015/16
Opening Cash		47.6	37.7	19.1	23.1
Surplus		0.9	1.0	1.0	1.0
Depreciation		6.9	7.4	8.9	9.3
Additions to fixed assets		(11.1)	(27.3)	(23.9)	(27.6)
New Loans			5.0	20.0	14.0
Other non-cash items			0.1	0.1	0.2
Loan Repayment			0.0	(0.2)	(0.2)
Total		(3.3)	(13.8)	5.9	(3.4)
Change in working capital		(6.6)	(4.8)	(1.9)	(0.1)
Closing Cash	47.6	37.7	19.1	23.1	19.7

6.12 Other Matters

Asset Valuations

The FT Annual Reporting Manual (ARM) requires specialised buildings to be valued on a depreciated replacement cost basis. Previously this value was determined on a like-for-like basis. This assumed that any replacement asset would be identical to the existing asset. In many cases this assumption is unrealistic as any replacement would in practice be a modern equivalent. For instance, a Victorian-built hospital constructed from stone and slate might be replaced by a modern building using glass and plastics.

This issue has been the subject of a review by the Treasury and as a result the RICS valuation standards have been adopted by Foundation Trusts. This methodology uses 'Modern Equivalent Asset' (MEA) valuation to identify the replacement cost. This is the cost of building a structure similar to the existing structure and having the equivalent productive capacity, which could be built using modern materials, techniques, and design. This cost is then depreciated to reflect the actual age and use of the asset.

The Trust's next formal property valuation is required as at 31 March 2015. An interim valuation took place at 31 March 2012 and work by the Trust's valuers is included in this plan.

Charitable Funds

The Foundation Trust is a corporate Trustee of the Luton & Dunstable Hospital NHS Foundation Trust Charitable Funds. Under International Accounting Standard 27 (revised) (IAS 27) the charitable funds are deemed to be a subsidiary which is required to be consolidated within the Foundation Trust Accounts. HM Treasury has deferred the requirement to adhere to IAS 27 (revised) in relation to the consolidation of NHS charitable funds until 2013/14.

7. Declarations and Self Certification

For quality, that:

1. The board is satisfied that, to the best of its knowledge and using its own processes and having assessed against Monitor's [Quality Governance Framework](#) (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), its NHS foundation trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of health care provided to its patients.
2. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.
3. The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.

For finance that:

4. The board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.
5. The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time

For governance that:

6. The board will ensure that the trust remains at all times compliant with its licence and has regard to the NHS Constitution.
7. All current key risks to compliance with the trust's licence have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner.
8. The board has considered all likely future risks to compliance with its licence and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.
9. The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.
10. An Annual Governance Statement is in place pursuant to the requirements of the [NHS Foundation Trust Annual Reporting Manual](#), and the trust is compliant with the risk management and assurance framework requirements

that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).

11. The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in **Appendix B**; and a commitment to comply with all known targets going forwards.
12. The board is satisfied that its NHS foundation trust can operate in an efficient, economic and effective manner.
13. The board will ensure that the trust will at all times operate effectively within its constitution. This includes: maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; that all board positions are filled, or plans are in place to fill any vacancies; and that all elections to the board of governors are held in accordance with the election rules.
14. The board is satisfied that all executive and non- executive directors have the appropriate qualifications, experience, training and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.
15. The board is satisfied that: the management team has the capacity, capability, training and experience necessary to deliver the annual plan; and the management structure in place is adequate to deliver the annual plan.
16. For an NHS foundation trust engaging in a major Joint Venture, or Academic Health Science Centre (AHSC), the board is satisfied that the trust has fulfilled, or continues to fulfil, the criteria in **Appendix C4**.
17. The board is satisfied that plans are in place to ensure that the trust will at all times comply with its statutory requirements.
18. The board is satisfied that during 2012/13 the Trust has provided the necessary training to its governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role
19. After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

Signature



Printed Name: Pauline Philip
In capacity as Chief Executive &
Accounting Officer

Signature



Printed Name: Spencer Colvin
In capacity as Chairman

Signed on behalf of the Board of Directors, and having regard to the views of the
Governors

8. Foundation Trust Governors and Membership

The Trust's Governors and Members continue to play a vital role in the Constitution as a Foundation Trust (FT). There are two broad categories of the membership constituency namely public and staff (including volunteers). The public constituency is further divided into three:

- i) Luton
- ii) Bedfordshire
- iii) Hertfordshire

As at 31 March 2013 there were 15188 registered FT members comprising 4228 staff (including volunteers) and 10960 public members. The FT public membership numbers showed an upward trend by 379 during 2012/13 which is a 3.5% increase as compared to corresponding period of the previous year. The staff member numbers showed an increase by 26% for year 2012/13 as compared to corresponding period of the previous year this is due to the inclusion of bank staff who have been registered to work for the Trust for one year or more in line with the Trust Constitution.

The Governors agreed a Membership Strategy through the Council of Governors in June 2012. The strategy outlined six objectives and progress on each is outlined below.

1) To increase the membership

The strategy outlined more focussed work on recruiting members in Bedfordshire with an engagement approach to the Luton and Hertfordshire membership. This has been achieved, but more recruitment in Bedfordshire is required.

2) To ensure membership diversity

A review of the diversity of the membership identified a need to increase the number of younger members. The aim to increase the membership by 30 in the 16-24 category has been achieved.

3) To develop the membership database

In order to increase communication, the aim to increase the number of recorded e-mails was set at 18-20%. For 2012/13, 30% was achieved. An annual review of those members that need to be removed was also conducted and the database updated.

4) To provide learning and development opportunities to the membership

The plan for 2012/13 was to hold two medical lectures and two further events within the year. This year, two medical lectures were held – one on Dementia and one on Ophthalmology held at the Barnfield West facility. This medical lecture proved to be the most popular so far with 250 members in attendance. A smaller lecture on Diabetes was also held at the Medici Medical Centre in Luton during Diabetes Week in June 2012 and there were four events held over the year that involved access for the membership to medical consultants, Chair and Governors. These were held in Toddington, Redbourn, Wheathampstead and Harpenden. Each proved a popular experience for the membership and provided excellent opportunity to learn about the services and speak to the medical team.

5) To communicate with the membership and encourage them to stand in elections

The strategy for this year involved continuing with the *Ambassador* newsletter. Two were issued in 2012/13 and there was a change in focus to inform the membership about the Governors and how they are involved in the hospital work. This has proved a worthwhile and effective means of communicating achievements and developments among members and local stakeholders. For 2012/13 an Annual Review was also produced that was issued to the membership at the Annual Members Meeting in September 2012. The strategy also committed to sending out more communications via the e-mail. This was achieved, but ensuring the correct e-mails and increasing the e-mails is an ongoing improvement plan. Opportunities to discuss elections and standing for Governors were held in 2012 and resulted in a number standing for election and indeed being elected.

6) Effective use of resources

The Council of Governors Membership and Communication Sub-Committee reviews the budget on behalf of the Governors. This year the Foundation Trust Department has performed well against the budget and been able to approve the membership of the Foundation Trust Governors Association (FTGA) that provides invaluable support to the Governors and also to hold events offsite to encourage more attendance.

Strategy for 2013/14

The strategy will be reviewed in May 2013 by the Membership and Communication Sub-Committee to identify the plans for 2013/14. The main objectives will remain the same and plans to:

- Forecast an increase of the membership to 15,788 for period ending 31 March 2014
- Further increase the membership and hold engagement events in Bedfordshire
- Target key membership groups to discuss becoming Governors
- Hold medical lectures at different sites across Bedfordshire and Hertfordshire
- Conduct more events with the younger membership

Elections for the Council of Governors will be held in June/July 2013 for nine seats (six public and three staff). Once again the services of the Electoral Reform Services Ltd will be engaged to assist with the electoral process as the independent scrutineer.

Membership size and movement:

Public constituency	2012/13 (Plan)	2012/13 (Actual)	2013/14 (Plan)
At year start (April 1)	10,581	10,581	10,960
New members	600	555	600
Members leaving	200	176	200
At year end (March 31)	10,981	10,960	11,360
Staff constituency			
At year start (April 1)	3335	3972	4228
New members	397	1070	1034

Members leaving	366	814	908
At year end (March 31)	3366	4228	4354
Total Members	14,347	15,188	15714
Patient constituency			
Not applicable			

Analysis of current membership:

Public Constituency	Number of members	Eligible membership
Age (years):		
0-16	5	338,319
17-21	126	94,471
22+	8,163	1,155,628
Unknown	2,666	-
Ethnicity:		
White	5,782	1,328,567
Mixed	69	20,921
Asian or Asian British	1,552	66,614
Black or Black British	465	24,747
Other	299	11,278
Unknown	2,793	-
Socio-economic groupings*:		
ABC1	5,832	678,020
C2	2,055	197,958
D	2,336	132,682
E	737	38,237
Gender analysis		
Male	4,607	786,448
Female	6,317	801,970
Unknown	36	-
Not applicable		

* Socio-economic data should be completed using profiling techniques (e.g.: postcode) or other recognised methods. To the extent socio-economic data is not already collected from members, it is not anticipated that NHS foundation trusts will make a direct approach to members to collect this information.

Notes:

TOTAL - Eligible members:

Age: 1,588,418
 Ethnicity: 1,452,127 **
 Socio-economic: 1,046,897 ***
 Gender: 1,588,418

The figures for Ethnicity and Socio-economic do not add up to 1,588,418.
The reasons provided by **Membership Engagement Services** are listed below:

** The overall **Ethnicity** figure for **Eligible members** is often lower than the other figures purely because it is based on a projection from the 2001 Census data so unable to provide a perfectly accurate representation.

*** The overall **Socio-economic** figure for **Eligible members** is lower due to the fact that it only takes into account those between the ages of 16-64 leaving out those outside of that range.

9. Conclusion

This Annual Plan is the working document that sets out how over the next 12 months we propose to meet the national, regional and local strategies and challenges, implement our 2013/14 service and strategic developments, deliver our contractual commitments and achieve our corporate objectives.

The Trust's progress on the delivery of this Plan will be delivered by the Divisional and Operational Boards, the performance will be monitored by the Board Sub Committees and reported to the Board of Directors.

Despite the challenges facing the NHS, growing demand, increasing patient expectations and fewer resources, the Trust remains confident that if primary care, social care and secondary care providers can work together patients will see a continuous improvement in the standard of care they receive.

Note: An Equality Impact Assessment has been undertaken in relation to this Annual Plan.
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APPENDICES

Appendix 1

CQC COMPLIANCE FRAMEWORK 2013/14

	Threshold	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Total time in A&E - ≤4 hours (Whole site %)	95%	95%	95%	95%	95%
All cancers: 31-day wait for second or subsequent treatment (3), comprising either:					
Surgery	94%	94%	94%	94%	94%
anti cancer drug treatments	98%	98%	98%	98%	98%
radiotherapy	94%	N/A	N/A	N/A	N/A
Cancer: two week wait from referral to date first seen (7), comprising either:					
all cancers	93%	93%	93%	93%	93%
for symptomatic breast patients (cancer not initially suspected)	93%	93%	93%	93%	93%
All cancers: 31-day wait from diagnosis to first treatment (6)	96%	96%	96%	96%	96%
All cancers: 62-day wait for first treatment (4), comprising either:					
from urgent GP referral to treatment	85%	85%	85%	85%	85%
from consultant screening service referral	90%	90%	90%	90%	90%
Referral to treatment waiting times – non-admitted	95%	95%	95%	95%	95%
Referral to treatment waiting times – admitted	90%	90%	90%	90%	90%
Referral to treatment waiting times – Incomplete pathways	92%	92%	92%	92%	92%
Clostridium Difficile – meeting the Clostridium Difficile objective of no more than 15 cases/year	15	4	4	4	3
MRSA – meeting the MRSA objective of no cases/year	0	0	0	0	0

Appendix 2

CQUIN**CQUIN Scheme 2013/14**

The Co-ordinating Commissioner	Luton CCG
The Associate Commissioners	As Described in Schedule 11, Part 5
Total financial value of Scheme	£4.8m

IMPLEMENTING THE PLAN MILESTONES

Appendix 3

Objective	Key Milestone 13/14 (Specific detail of action can be found in section 3.3)	Key Milestones 14/15	Key Milestones 15/16
Deliver Excellent Clinical Outcomes <ul style="list-style-type: none"> (Year on year reduction in HSMR in all diagnostic categories) 	Improve performance by reducing average length of stay for older people	Achieve upper quartile performance in terms of ALOS when compared to peers	Milestones for 2015/16 to be established through the next three year plan review at the end of 2013/14. This will cover 2016 - 2019
	Improve performance on overall hospital mortality across fractured neck of femur and all specialties	Improvement performance on overall hospital mortality across all specialties	
	Reduce avoidable emergency re-admissions	Sustain a low number of readmissions	
	Fully participate in national and local clinical audits	Fully participate in national and local clinical audits	
Improve Patient Safety <ul style="list-style-type: none"> (Year on year reduction in clinical error resulting in harm Year on year reduction in HCAI) 	Ensure that we have the appropriate level of clinical expertise available to deliver safe and effective care 24/7	Maintain appropriate level of clinical expertise available to deliver safe and effective care 24/7	
	Ongoing development of Safety Thermometer, exceeding performance year on year	Ongoing development of Safety Express, exceeding performance year on year	
	Continue to reduce HCAI rates year on year	Continue to reduce HCAI rates year on year	
	Increase compliance with hand hygiene year on year	Increase compliance with hand hygiene year on year	
	Extend electronic nursing observations to include fluid management, weight and device management	Completed	

Objective	Key Milestone 13/14 (Specific detail of action can be found in section 3.3)	Key Milestones 14/15	Key Milestones 15/16
Improve the Patient Experience <ul style="list-style-type: none"> (Year on year improvement in patient experience demonstrated through hospital and national patient surveys, leading to upper quartile performance) 	Improve the quality of professional communication with all patients and carers.	Sustain the improved quality of professional communication with all patients and carers.	
	Revolutionise how we handle complaints	Maintain agreed standards of responses to complaints and implement a process of Trust wide learning from complaints and other sources of intelligence	
		Maintain improved quality indicators at ward level and develop a health check for other clinical services i.e. speciality based.	
	Work with patients, their families and stakeholders in Luton to redesign end of life care	Implement the recommendations from the end of life care programme	
	Continue to implement the Outpatient Transformational programme	Achieve outpatient experience results in the upper quartile of the national outpatient survey Explore further satellite Outpatient Facilities	

Objective	Key Milestone 13/14 (Specific detail of action can be found in section 3.3)	Key Milestones 14/15	Key Milestones 15/16
	Be amongst the most improved Trust in the National Outpatient Experience Survey in the EoE	Achieve Outpatient experience results in the upper quartile of Outpatient & Inpatient Surveys in terms of environmental factors	
	Establish an off site facility for ophthalmology, plastics and dermatology	Relocate and implement the services from the off site facility	
	Deliver additional clinical and diagnostic services during evenings and weekends	Achieve comprehensive 24/7 service provision	
	Improve patient experience by implementing the 'Perfect Day'	Sustain improvements in patient experience through the Trust wide implementation of the 'Perfect Day' model	
	Formally explore alternative ways to deliver non-clinical support services in order to improve quality and contain cost.	Implement a new model for non-clinical support services	
Deliver National Quality and Performance Targets	Deliver sustained compliance of all CQC outcome measures	Deliver sustained compliance of all CQC outcome measures	
	Deliver nationally mandated waiting times for 18 Weeks, Cancer and A&E including A&E Indicators	Deliver nationally mandated waiting times for 18 Weeks, Cancer and A&E including A&E Indicators	
	Sustainability culture established across the organisation	Embed the sustainability culture across the organisation	
	Achieve 40% of the Trust's Carbon Management Plan Target	Exceed the reduced carbon emissions target set-out in the Trust's Carbon Management Plan of 60%	
	Deliver CQUIN targets year on year	Deliver CQUIN targets year on year	

Objective	Key Milestone 13/14 (Specific detail of action can be found in section 3.3)	Key Milestones 14/15	Key Milestones 15/16
Progress Clinical and Strategic Developments	Clinical Strategy agreed and implemented	Clinical Strategy embedded and reviewed	
	Agree detailed business cases for phases as laid out in Masterplan	Implement agreed business cases for phases as laid out in Masterplan	
	Deliver masterplan enabling schemes and early phases	Continue re-development of Hospital in Phases	
	Work locally with CCG's to implement the clinical services strategy	Work locally with CCG's to implement the clinical services strategy	
	Care can safely and efficiently take place, without need to request a paper record	Broader access to electronic care record to include patients and GPs	
	To improve the ability of decision makers at all levels of the organisation to use information in order to improve service delivery, design, quality, efficiency and safety	The production of a quarterly individual consultant level dashboard of productivity and quality metrics will be embedded within each of the service line specialties	
	To increase levels of safety, efficiency, and flexibility delivered by transformational technology	Capturing and tracking all clinical correspondence as electronic documents and modernised voice communication across the Trust.	
	Work jointly with LA, CCGs and other key stakeholders	Work jointly with LA, CCGs and other key stakeholders	
Develop all staff to maximise their potential	Extend education and training performance management to all staff groups through the Divisional structure to go beyond regulator and training commissioner requirements to measurably enhance patient experience and safety globally through a radical development programme	To extend the education and training agenda to establish international recognition, and attract training commissions from outside the Trust, and work with partner Universities to expand the educational infrastructure	

Objective	Key Milestone 13/14 (Specific detail of action can be found in section 3.3)	Key Milestones 14/15	Key Milestones 15/16
	Develop and deliver joint accredited academic programmes with our partner Universities	Develop and deliver joint Research programmes and training facilities with partner Universities, aiming for a joint investment of £5m	
	Continue to increase the number of staff appraisals to 80%	Maintain 100% appraisal rate (of staff available)	
	Increase mandatory training compliance	Aim for full compliance with Mandatory training	
	Maintain clinical leadership development	Effective clinical leadership embedded	
	Establish a culture where all staff feel able to sign up to our values and have knowledge of the Trusts Quality Priorities and staff fully aware of the Trust's vision, values and objectives	Staff fully aware of the Trust's vision, values and objectives	
Optimise our Financial position	Deliver our Financial Plan 2013/14	Achieve agreed income, expenditure and capital expenditure targets	
	Finalise forward capital investment plans and agreed balance between borrowing and cash financing	Implement the capital investment agreement	
	Develop service line management as the key tool to drive financial efficiency and increase clinical engagement	Use Service Level Management costing to drive out cash releasing efficiencies	
	Increase productivity – Improved Theatre Productivity, improved outpatient productivity and establish ambulatory care model to reduce avoidable admissions and costs	Deliver CIP / Income Generation Plans to Finance Capital Investment Plan	

QUALITY ACCOUNT – PRIORITIES – 2012 - 2015**Appendix 4**

In preparation for Quality Accounts in 2012/13 the Trust reviewed its progress to date and it's aspirations in terms of goals The Trust has set for the coming three years.

There are three over-all safety and quality priorities for the Trust:

Priority 1: Improve Patient Safety:

- Year on year reduction in clinical error
- Year on year reduction in HAI

Priority 2: Improve Patient Experience

- Year on year improvement in patient experience demonstrated through hospital and national patient survey, leading to upper quartile performance

Priority 3: Deliver Excellent Clinical Outcomes

- Year on year reduction in HSMR

These have been drawn from work through the Clinical Operational Board, its sub-committees and through discussions with the Board, Governors and Staff on the annual objectives. All safety and quality objectives has been shared with local commissioners with whom The Trust has agreed a set of Commissioning for Quality and Innovation goals in relation to patient safety, patient experience and clinical effectiveness.

DIVISIONAL PLANS

Appendix 5

Divisional Plan	Link to Corporate Objectives	Milestones
MEDICINE		
<i>Further develop Cardiac Services</i> - to gain BCIS accreditation to offer PCI (percutaneous coronary intervention) later in 2013	<ul style="list-style-type: none"> • Improve Patient Safety • Improve Patient Experience • Deliver Excellent Clinical Outcomes • Progress Clinical & Strategic Developments • Optimise our Financial position 	<ul style="list-style-type: none"> • CCG Support achieved March 2013 • BCIS accreditation by September 2013 • Staff recruited and trained by October 2013
<i>Develop an integrated community cardiology service</i> - work in collaboration with Bedford Hospital for patients in Bedfordshire	<ul style="list-style-type: none"> • Improve Patient Experience 	<ul style="list-style-type: none"> • Staff recruited and trained by March 2014
<i>Further develop stroke services</i> - develop and expand the range of enhanced services for stroke patients including hyper-acute treatments	<ul style="list-style-type: none"> • Improve Patient Experience • Deliver Excellent Clinical Outcomes • Progress Clinical & Strategic Developments • Optimise our Financial position • Deliver National Quality and Performance Targets 	<ul style="list-style-type: none"> • Staff recruited and trained by March 2014 • Equipment purchased by March 2014 • Increase number of consultants on rota by April 2014 • Agree financial structure by April 2014 • Achieve all national and local Stroke targets by July 2013
<i>Implement solutions to managing trauma patients</i> - work in conjunction with the East of England and appropriate London Trauma Networks will continue to devise and implement appropriate local solutions for the management of major trauma patients in the Luton and Bedfordshire area.	<ul style="list-style-type: none"> ▪ Deliver Excellent Clinical Outcomes ▪ Improve Patient Safety ▪ Progress Clinical & Strategic Developments 	<ul style="list-style-type: none"> ▪ Trauma designation achieved for East of England Trauma Network (March 2013). ▪ Complete TARN submission by end of Q3 2013/14
<i>Continue the Human Factors Teamwork Project</i> – work across the Division will implement the learning from the project on the medical wards and develop plans to increase communication of the Human Factors work across to other Divisions.	<ul style="list-style-type: none"> ▪ Improve Patient Safety ▪ Develop all staff to maximise their potential 	<ul style="list-style-type: none"> ▪ Complete Human Factors training for all staff in A&E Directorate in 2013/14. ▪ Roll training out to rest of division.
<i>Further expand endoscopy</i> - Further expand to three procedures to meet the increasing demand in referrals	<ul style="list-style-type: none"> • Improve Patient Experience • Deliver National Quality and Performance Targets • Progress Clinical & Strategic Developments • Optimise our Financial position 	<ul style="list-style-type: none"> • Completion of third room by August 2013 • Achieve JAG accreditation by April 2014
<i>Develop an elderly frail unit</i> - Develop an elderly frail unit to improve the quality of care for older patients	<ul style="list-style-type: none"> • Improve Patient Experience • Deliver Excellent Clinical Outcomes 	<ul style="list-style-type: none"> • Develop a pathway for these patients • Deliver specialist care
<i>Further improve respiratory services</i> □□□ Further improve respiratory services to cover Endo-bronchial	<ul style="list-style-type: none"> ▪ Improve Patient Experience ▪ Deliver Excellent Clinical Outcomes 	<ul style="list-style-type: none"> ▪ Additional Endoscopy procedure room by August 2013

Divisional Plan	Link to Corporate Objectives	Milestones
Ultrasound (EBUS); a procedure which will improve the lung cancer pathway.	<ul style="list-style-type: none"> Progress Clinical & Strategic Developments Optimise our Financial position 	<ul style="list-style-type: none"> Additional equipment by September 2013 Staff trained in procedure by September 2013 Agree financial recompense
<i>Implement model of acute medical care</i> - Implementation of a new model of acute medical care to provide consultant delivered care for all patients admitted.	<ul style="list-style-type: none"> Deliver Excellent Clinical Outcomes Improve Patient Safety Improve Patient Experience Develop all staff to maximise their potential 	<ul style="list-style-type: none"> Appointment of locum consultants by June 2013 Appointment of substantive consultants by December 2013 New consultant rota by June 2013
<i>Open an ambulatory care unit</i> - The development of an ambulatory care unit.	<ul style="list-style-type: none"> Improve Patient Experience Progress Clinical & Strategic Developments 	<ul style="list-style-type: none"> Extend opening hours to 0900 – 2100 Extend no. of conditions treated in ambulatory care environment
<i>Employ new consultants</i> - Employ four new medical consultants - Linked to the new model of care	<ul style="list-style-type: none"> Deliver Excellent Clinical Outcomes Improve Patient Safety Improve Patient Experience Develop all staff to maximise their potential 	<ul style="list-style-type: none"> Appointment of locum consultants by June 2013 Appointment of substantive consultants by December 2013 New consultant rota by June 2013
<i>Initiate a Clinical Decisions Unit</i> - During 2013/14 the Emergency Department will be expanded with the addition of a Clinical Decisions Unit (CDU).	<ul style="list-style-type: none"> Deliver Excellent Clinical Outcomes Improve Patient Safety Improve Patient Experience Progress Clinical & Strategic Developments Optimise our Financial position 	<ul style="list-style-type: none"> Establish viability of using Fracture Clinic as a Clinical Decisions Unit – determine maximum inpatient capacity.
SURGERY		
<i>Further develop Fractured Neck of Femur service</i> - Continue to improve outcomes for fractured neck of femur patients and reduce HSMR for these patients to less than 100	<ul style="list-style-type: none"> Deliver Excellent Clinical Outcomes Improve Patient Safety Improve Patient Experience Deliver National Quality and Performance Targets 	<ul style="list-style-type: none"> Finalising the implementation of the new orthogeriatric model of care by August 2013 Implement revised orthopaedic theatre schedule to improve access to timely surgery for patients with fractured neck of femur by end of May 2013 Establish anaesthetic guidelines for fractured neck of femur by end of July 2013 Reduction in fractured neck of femur HSMR to below 100 by month 8 Improve number of patients for which best practice tariff to 90% is achieved.
<i>Provide enhanced Recovery model</i> - full roll-out of the Enhanced Recovery model for orthopaedic and colorectal surgery patients	<ul style="list-style-type: none"> Deliver Excellent Clinical Outcomes Improve Patient Safety Improve Patient Experience 	<ul style="list-style-type: none"> Implementation lead recruited by end of June 2013 Agreement of fluid optimisation supplier and establishment of consumables supply by end Q1 2013

Divisional Plan	Link to Corporate Objectives	Milestones
		<ul style="list-style-type: none"> Pilot of initial pathways by end Q2 Full implementation for all appropriate colorectal and orthopaedic pathways by end Q3
<i>Review the Admissions pathway</i> - Work with elective admissions team and redesign all the linked processes including pre-assessment and arrivals to maximise theatre utilisation and improve patient experience.	<ul style="list-style-type: none"> Deliver Excellent Clinical Outcomes Improve Patient Safety Improve Patient Experience Deliver National Quality and Performance Targets Optimise our Financial position 	<ul style="list-style-type: none"> By the end of Q1 there will be an agreed the preferred operating model for pre-assessment Elective admissions team to have weekly booking targets and visible tracking information against this by end May 2013 Review location of daycase arrivals to minimise traffic across the hospital for patients pre-theatre by end August 2013
<i>Refurbish theatres</i> - comprehensive refurbishment of theatres 1-6 in early 2013/14	<ul style="list-style-type: none"> Deliver Excellent Clinical Outcomes Improve Patient Safety Improve Patient Experience 	<ul style="list-style-type: none"> Completion of first phase works by mid April 2013 Installation of final elements by July 2013 Forward plan for ongoing maintenance in place by end July 2013
<i>Recruit another Head and Neck Consultant Surgeon</i> – need to provide resilient services for head and neck cancer patients	<ul style="list-style-type: none"> Deliver Excellent Clinical Outcomes Improve Patient Safety Deliver National Quality and Performance Targets 	<ul style="list-style-type: none"> Interviews in July 2013 Start date September 2013
<i>Develop the Ophthalmology relocation proposal</i> - relocate Ophthalmology services to off-site premises to increase the space available to the service and improve access for patients.	<ul style="list-style-type: none"> Improve Patient Experience Deliver Excellent Clinical Outcomes Improve Patient Safety Deliver National Quality and Performance Targets Progress Clinical & Strategic Developments 	<ul style="list-style-type: none"> First draft business case complete July 2013 Operational off-site service by end of financial year
<i>Restructure the operating timetable</i> increase the number of consultant led elective lists to ensure that we are compliant with 18 week waiting time target across all T&O subspecialties from Quarter	<ul style="list-style-type: none"> Deliver Excellent Clinical Outcomes Improve Patient Safety Improve Patient Experience Deliver National Quality and Performance Targets Optimise our Financial position 	<ul style="list-style-type: none"> Phased implementation during May 2013 to ensure new timetable fully in place by end of Q1 2013
<i>Provide electronic theatre booking forms</i> - full roll out of the electronic booking forms and pre-printed consent forms for the majority of procedures.	<ul style="list-style-type: none"> Improve Patient Safety Improve Patient Experience Deliver National Quality and Performance Targets Optimise our Financial position 	<ul style="list-style-type: none"> Full use of e booking forms by July 2013 Launch of pre-populated consent forms in August 2013

Divisional Plan	Link to Corporate Objectives	Milestones
<i>Expand bariatric surgery</i> - ensure that the Trust is the first choice centre for patients in Anglia and West Midlands region, and continue to grow the business from South Central and other neighbouring regions.	<ul style="list-style-type: none"> Progress Clinical & Strategic Developments Improve Patient Experience Deliver National Quality and Performance Targets Optimise our Financial position 	<ul style="list-style-type: none"> GP engagement event May 2013 Identify lead to develop marketing strategy for bariatric services and form link with GPs and commissioning leads Deliver plan of 370 cases this year
WOMEN'S AND CHILDREN'S		
<i>Open a new fertility unit</i> - The gynaecology service will open its new fertility unit in May 2013. This will allow patients to access this busy service in a private and discreet setting away from the main hospital site. The new fertility unit will offer satellite IVF treatment for the first time, in collaboration with Bourn Hall, Cambridge, a prestigious fertility centre. The service will offer care for NHS patients and private patients.	<ul style="list-style-type: none"> Improve Patient Experience Progress Clinical & Strategic Developments Optimise our Financial position 	<ul style="list-style-type: none"> Unit due to open 21/05/2013 and aims to offer IVF satellite treatment for up to 150 couples per annum.
<i>Develop a dedicated ambulatory gynaecology service</i> - The gynaecology service will open a dedicated ambulatory care suite in women's health.	<ul style="list-style-type: none"> Deliver Excellent Clinical Outcomes Improve Patient Safety Improve Patient Experience Progress Clinical & Strategic Developments Develop all staff to maximise their potential Optimise our Financial position 	<ul style="list-style-type: none"> Unit due to open July 2013. Monthly scorecard to manage performance in line with directorate plans for 2013/14
<i>Develop community midwives access to IT</i> - April 2013 will see the team of 65 community midwives able to access information electronically and remotely.	<ul style="list-style-type: none"> Deliver Excellent Clinical Outcomes Improve Patient Experience Optimise our Financial position 	<ul style="list-style-type: none"> Payment by Results financial targets being reached – 10/05/2013
<i>Improve the birthing environment</i> - some minor works to improve the birthing environment for women and their partners will be initiated. This is a charity funded project that aims to provide improved privacy and dignity for women birthing on the unit.	<ul style="list-style-type: none"> Improve Patient Safety Improve Patient Experience 	<ul style="list-style-type: none"> Estates costings – May 2013 Estates works – July-September 2013
<i>Enhance the current fetal medicine service</i> – A specialist fetal medicine service will be offered within the obstetric directorate.	<ul style="list-style-type: none"> Deliver Excellent Clinical Outcomes Improve Patient Safety Improve Patient Experience Progress Clinical & Strategic Developments 	<ul style="list-style-type: none"> August 2013 to initiate first clinic

Divisional Plan	Link to Corporate Objectives	Milestones
<i>Provide enhanced antenatal service</i> - The midwifery team will offer an enhanced antenatal service to women and their partners, and will launch new aquanatal and hypnotherapy classes for women that wish to access enhanced services.	<ul style="list-style-type: none"> • Improve patient experience 	<ul style="list-style-type: none"> • July 2013 to offer first private antenatal clinics
<i>Further develop specialist paediatric services</i> - Specialist paediatric services will be further developed, including high dependency, endocrinology and gastroenterology care in collaboration with Great Ormond Street Hospital.	<ul style="list-style-type: none"> • Deliver Excellent Clinical Outcomes • Improve Patient Experience • Progress Clinical & Strategic Developments • Develop all staff to maximise their potential • Optimise our Financial position 	<ul style="list-style-type: none"> • Clarification on current pathways – tertiary activity v's primary care demand. • Cost benefit analysis • Additional outreach clinic by Q3
<i>Improve parent's accommodation</i> - develop parental accommodation utilising the Viridian accommodation enabling families with babies in Neonatal care stay close to the unit.	<ul style="list-style-type: none"> • Improve Patient Experience • Progress Clinical & Strategic Developments 	<ul style="list-style-type: none"> • Monitor demand for facilities • Report on lost bed days where a delayed discharge has occurred if accommodation is not available
<i>Develop family centred pathways</i> - develop "Family centred" care nursery nurses that will improve the pathway of care on the neonatal unit.	<ul style="list-style-type: none"> • Deliver Excellent Clinical Outcomes • Improve Patient Experience • Progress Clinical & Strategic Developments • Develop all staff to maximise their potential 	<ul style="list-style-type: none"> • Improved breast feeding and mixed feeding rates. • Supported earlier discharge for tube fed babies • Evidence of improved family experience
<i>Enhance telemedicine for diabetes</i> - further develop telemedicine for diabetes.	<ul style="list-style-type: none"> • Deliver Excellent Clinical Outcomes • Improve Patient Experience • Deliver National Quality and Performance Targets • Progress Clinical & Strategic Developments • Optimise our Financial position 	<ul style="list-style-type: none"> • Client group identified • Role out of project • Report to CCG cost avoidance through admission prevention
<i>Provide more paediatric nurse training</i> - extended nurse roles through training advanced paediatric nurse practitioners to enhance acute paediatric care.	<ul style="list-style-type: none"> • Improve Patient Safety • Improve Patient Experience • Developments • Develop all staff to maximise their potential 	<ul style="list-style-type: none"> • Funding agreed for 2013/14 placements • Project funding from CCG for 2013/14 only through work force development and reduction in admissions for long term conditions and avoidable readmissions
<i>Implement a Children's rapid response service</i> - A children's rapid response service will be rolled out in partnership with Luton community services to provide a seamless integrated care pathway to safely reduce reliance on ED and hospital services.	<ul style="list-style-type: none"> • Deliver Excellent Clinical Outcomes • Improve Patient Safety • Improve Patient Experience • Deliver National Quality and Performance Targets • Progress Clinical & Strategic Developments 	<ul style="list-style-type: none"> • Quarterly activity and patient experience report. • Permanent recruitment into APNP role • Protected Paeds ED environment 24/7

Divisional Plan	Link to Corporate Objectives	Milestones
	<ul style="list-style-type: none"> Develop all staff to maximise their potential Optimise our Financial position 	
DIAGNOSTICS, THERAPEUTICS AND OUTPATIENTS		
<ul style="list-style-type: none"> <i>Further develop CT services</i> - Imaging Services are planning to introduce CT Coronary Angiography (CTCA) services to the Trust over the course of this next year, providing expanded specialist diagnostic services to cardiac patients. 	<ul style="list-style-type: none"> Deliver Excellent Clinical Outcomes Improve Patient Safety Improve Patient Experience Deliver National Quality and Performance Targets Progress Clinical & Strategic Developments Optimise our Financial position 	<ul style="list-style-type: none"> C1 capital form completion end of May 2013 Establish Project Board May 2013 Business case to FIP June 2013 Procurement process as from June 13 Staged replacement of CT scanners & turnkey works to ensure service continuity Q3 and Q4 Staff training programme Q4
<ul style="list-style-type: none"> <i>Improve the CT scanners</i> - The enhanced specification of the CT scanner will provide additional benefits to patients with a range of conditions, e.g. stroke. 	<ul style="list-style-type: none"> Deliver Excellent Clinical Outcomes Improve Patient Safety Improve Patient Experience Deliver National Quality and Performance Targets Progress Clinical & Strategic Developments 	<ul style="list-style-type: none"> C1 capital form completion end of May 2013 Establish Project Board May 2013 Business case to FIP June 2013 Procurement process as from June 13 Staged replacement of CT scanners & turnkey works to ensure service continuity Q3 and Q4
<ul style="list-style-type: none"> <i>Upgrade storage of radiology images</i> - Imaging's Picture Archive storage system will also be upgraded. 	<ul style="list-style-type: none"> Deliver Excellent Clinical Outcomes Improve Patient Safety Progress Clinical & Strategic Developments 	<ul style="list-style-type: none"> Appoint Project Manager Specification completion end of May 2013 Procurement August 13 Data migration Service migration June 2014 Phased implementation Sep 13 to Sep 2014
<ul style="list-style-type: none"> <i>Develop links with networks</i> - Imaging Services are also developing links to establish a regional Vascular Intervention Radiology Service network with other local Trusts. 	<ul style="list-style-type: none"> Deliver Excellent Clinical Outcomes Improve Patient Safety Improve Patient Experience Deliver National Quality and Performance Targets Progress Clinical & Strategic Developments 	<ul style="list-style-type: none"> Need to re- establish process
<ul style="list-style-type: none"> <i>Recruit more pharmacist and therapists</i> – The Trust will be providing expanded 7-day services with plans to substantively recruit to Pharmacy and Therapy services to deliver weekend 	<ul style="list-style-type: none"> Deliver Excellent Clinical Outcomes Improve Patient Safety Improve Patient Experience Deliver National Quality and Performance Targets 	<ul style="list-style-type: none"> Business case to Execs May 2013 Staff consultation to commence end of Q1 recruitment Implementation end of Q2

Divisional Plan	Link to Corporate Objectives	Milestones
services sustainably to meet patient and Divisional needs.	<ul style="list-style-type: none"> Progress Clinical & Strategic Developments Optimise our Financial position 	
<ul style="list-style-type: none"> <i>Upgrade equipment in the laboratories</i> - Pathology, as part of the transition to Consolidated Pathology Services (CPS) will be upgrading the clinical chemistry analysers in the Blood Science Laboratories. 	<ul style="list-style-type: none"> Deliver Excellent Clinical Outcomes Improve Patient Safety Deliver National Quality and Performance Targets Progress Clinical & Strategic Developments Optimise our Financial position 	<ul style="list-style-type: none"> End of June 2013 - Define process by which LDH as part of CPS will undertake equipment purchase. Mid August 2013 - Technical specification complete. September 2013 - commence procurement exercise.
<ul style="list-style-type: none"> <i>Implement infection control point of care testing</i> - The Infection Control service will be developed with the implementation of Point of Care testing (POCT) for MRSA, C-difficile and Norovirus to improve the early diagnosis and management of patients with infections and to facilitate improved bed management and infection control within the Trust. 	<ul style="list-style-type: none"> Deliver Excellent Clinical Outcomes Improve Patient Safety Improve Patient Experience Deliver National Quality and Performance Targets Progress Clinical & Strategic Developments Optimise our Financial position 	<ul style="list-style-type: none"> Business case finalisation and approval by FIP Company developing POCT for Norovirus and C-difficile testing to be available Q3 13
<ul style="list-style-type: none"> <i>Increase specialist services</i> - Haematology will be working to expand specialist services at L&D and links with UCLH in the treatment of patients with haemoglobinopathies and thalassaemia. 	<ul style="list-style-type: none"> Deliver Excellent Clinical Outcomes Improve Patient Experience Progress Clinical & Strategic Developments Optimise our Financial position 	<ul style="list-style-type: none"> Business case development Q2 with Commissioning support Establish SLA with UCLH Q3 Establish service Q4
<ul style="list-style-type: none"> <i>Implement electronic systems for prescribing</i> - Pharmacy will be implementing e-Prescribing across the Trust. 	<ul style="list-style-type: none"> Deliver Excellent Clinical Outcomes Improve Patient Safety Improve Patient Experience Deliver National Quality and Performance Targets Progress Clinical & Strategic Developments 	<ul style="list-style-type: none"> Phased implementation Go live DME Oct 2013 Completion Oct 2014
<ul style="list-style-type: none"> <i>Appoint breast screening specialists</i> - Breast Screening will be appointing and training additional Breast Associate Specialists in order to ensure continuity and future proofing of the service. 	<ul style="list-style-type: none"> Deliver Excellent Clinical Outcomes Deliver National Quality and Performance Targets Progress Clinical & Strategic Developments Optimise our Financial position 	<p>Recruitment in progress Commencement in Q2 2013</p>

Divisional Plan	Link to Corporate Objectives	Milestones
<ul style="list-style-type: none">• <i>Implement a new system of outpatients appointments</i> - Outpatients will be implementing new systems to improve patient appointment communications, information and attendance rates. Outpatients will be working closely with those involved in progressing improved Medical Productivity to help drive better efficiency and patient experience across the different Outpatient speciality areas.	<ul style="list-style-type: none">• Deliver Excellent Clinical Outcomes• Improve Patient Experience• Deliver National Quality and Performance Targets• Progress Clinical & Strategic Developments• Optimise our Financial position	<ul style="list-style-type: none">• Chronos interactive appointment system phased implementation as from Q2• Synertec outsourced OPD mail implementation Q2

Luton and Dunstable University Hospital NHS Foundation Trust

Clinical Services Strategy

‘Delivering the new L&D’

(DRAFT FOR DISCUSSION)

2013 -2016



Forward by the Medical Director

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Appendix A: PEST and SWOT Analyses**Appendix B: Clinical Strategy Workstreams**

Forward by the Medical Director

“The L&D is committed to delivering the best patient care, the best clinical knowledge and expertise and the best technology available, with kindness and understanding from all our staff “

In our clinical services strategy document we outline how we are going to develop our clinical services over the next three years. Many of the developments will strengthen our existing services ensuring that we can continue to deliver high quality acute care for our patients. Some will allow us to treat patients from much further afield increasing our ability to become a provider of specialist services. The new treatments and procedures that we plan will contribute to our high reputation as a centre for teaching and research.

Every year our hospital recruits new doctors, nurses, midwives and professionals allied to medicine. They strengthen our existing multidisciplinary teams and help them to deliver reliably good patient outcomes. These individuals also bring new ideas and techniques to improve our clinical outcomes. They introduce new procedures into the clinical care that we deliver and help us with our ambition to bring care closer to our patient’s homes. One of the recent examples of this is the opening of our new Fertility Centre. This means that patients no longer have to travel to Cambridge or London to receive care.

I look forward to seeing these clinical services expand within a redeveloped Luton & Dunstable Hospital site.

Dr Mark Patten

**Medical Director
Luton and Dunstable University Hospital Foundation NHS Trust**

1. Introduction

1.1. Purpose of Strategy

This document, known as **‘Delivering the new L&D’**, sets out the Clinical Services Strategy of the Luton and Dunstable University Hospital NHS Foundation Trust (L&D) from 2013 to 2016. In the current strategic climate, it is difficult to forecast beyond the next three years with any certainty and therefore rather than wait for the greater clarity the Trust has decided to focus on a shorter time horizon.

The document builds upon the Trust’s previous service development strategy “Fit for the 21st Century” and the Trust’s Monitor Annual Plan 2013/4. **‘Delivering a new L&D’** sets out how the organisation will achieve its vision: *to deliver the best patient care, the best clinical knowledge and expertise and the best technology available, with kindness and understanding from all our staff*. This strategy will describe the route map for the delivery of this vision against a backdrop of significant strategic and operational challenges.

‘Delivering a new L&D’ provides the basis of the Trust’s ambitious re-development programme – **‘Building the new L&D’**. Work has already begun on a number of the key enabling schemes to facilitate the changes necessary to the estate in order to ensure the facilities can compliment the high quality clinical services the Trust wants to deliver. A Strategic Outline Case (SOC) and the associated business cases will be developed throughout the half of 2013/14.

1.2. Background and profile of the Trust

L&D is a medium sized general hospital with approximately 640 inpatient beds. The Trust employs in excess of 3,000 staff and provides a comprehensive range of general medical and surgical acute services. In addition to the general acute services, the L&D has developed a number of specialist services including:

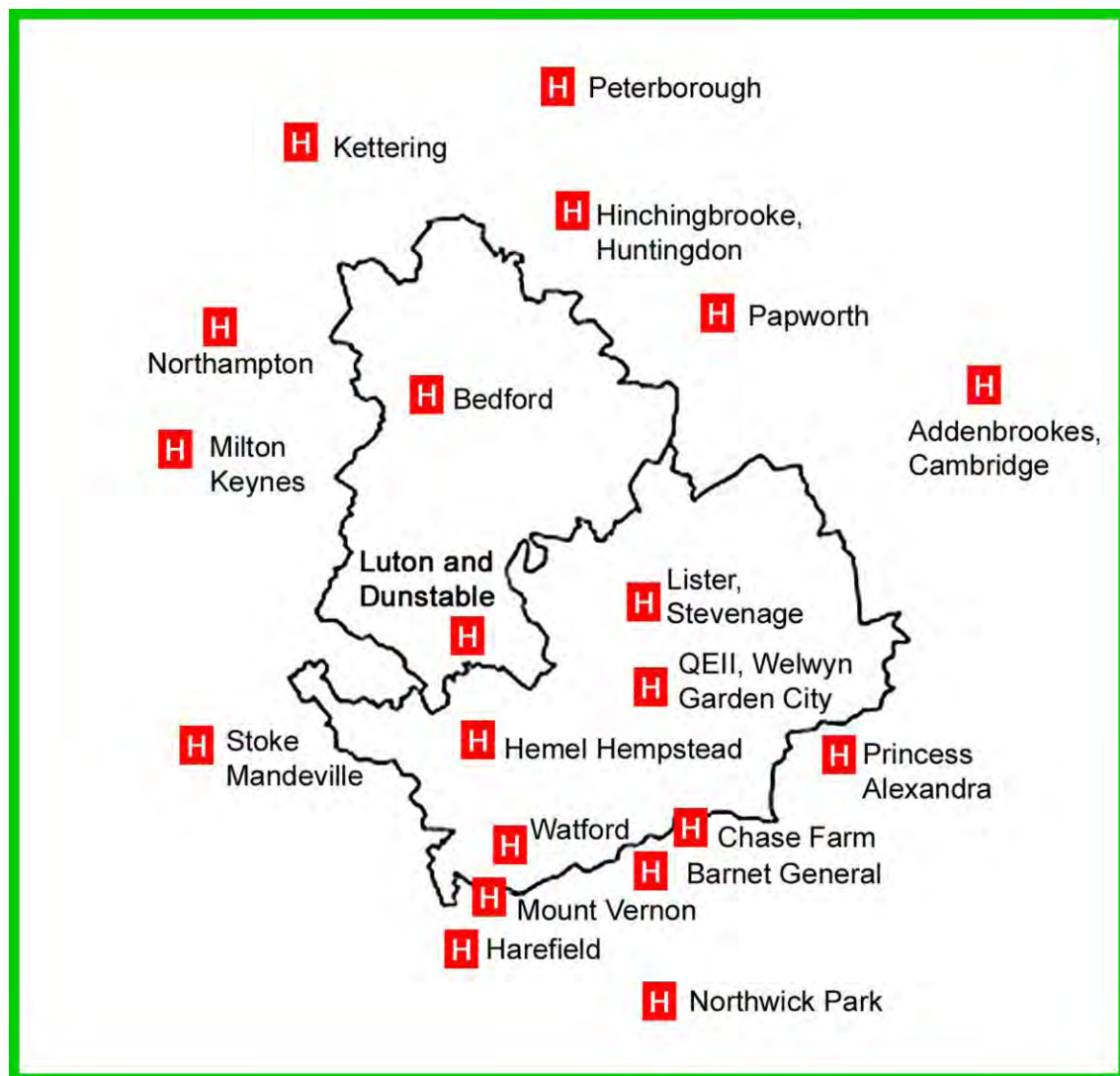
- Breast screening
- Bariatric services
- Level 3 Neonatal services
- Limb Fitting
- Oral Maxillofacial Surgery
- Hyper Acute Stroke Services

The Trust has also developed a number of services in partnership with others. For example, IVF services with Bourne Hall in Cambridge and Paediatric services with Great Ormond Street.

Over the last few years, the Trust has also taken L&D services into the community such as Muscular Skeletal Services (MSK), Chronic Obstructive Pulmonary Disease (COPD) and Diabetes.

The Trust has a registered catchment population of approximately 320,000 people, which is extremely diverse with 35% of Luton's population from different cultural and ethnic backgrounds including Pakistani, Bangladeshi, Indian, African - Caribbean and Eastern European. Some of its more specialist services serve a population of c. 1 million. The catchment population reside in parts of Bedfordshire, Hertfordshire and Buckinghamshire. The geography of the catchment is varied ranging from semi rural in the north of the patch, with centres of population located in Luton and Dunstable predominantly. The Trust is surrounded by other acute providers as illustrated in Figure 1.

Figure 1: L&D and neighbouring hospitals



On average, the Trust sees in excess of 300,000 outpatient and ED attendees per annum.

2. Strategic Context

2.1. National Position

The current context is extremely challenging. The NHS is facing un-precedented demand as the population ages and patient expectation increases. This will require acute trusts to change fundamentally how services are delivered to enable greater senior clinical decision making throughout a greater proportion of the 24-hour period 7 days per week. This transformational change has to take place in a period of significant financial constraint that requires savings in excess of £20billion to be made across the whole NHS.

In addition to the increasing demand for healthcare, there is a growing political desire to challenge the historic models of service delivery by subjecting service providers to more competition in an attempt to drive up quality whilst driving down costs and improving efficiency. All providers of health services are now expected to deliver better quality care for less. The tariff is reduced by 1% year on year and it is likely that this reduction will continue for a number of years, making the need for effective savings programmes vital if acute trusts are to survive and flourish.

2.1.1. Policy Change

Since its inception, the NHS has been subject to major change as it responds to the ever-changing environment within which it operates. 2013 sees one of the most significant transformations yet as the Health and Social Care Bill 2012 is implemented with the abolition of Primary Care Trusts (PCT) and Strategic Health Authorities (SHA). The Bill has been created in response to:

- putting patients at the centre of the NHS;
- coping with increasing demand and costs;
- an increasing focus on quality of care and outcome;
- and, lastly the state of the world's economy.

The key changes centre on clinically led commissioning with the formation of Clinical Commissioning Groups (CCGs) and the NHS Commissioning Board. With the latter being responsible for authorising CCGs, allocating resources and commissioning primary care. Ministers have set the objectives for the Commissioning Board through a mandate and commissioning outcomes framework. The mandate has five key areas as illustrated below in figure 2.



Figure 2: Commissioning Board Mandate priorities

The objectives of the mandate include:

- improving standards of care, especially for the elderly;
- better diagnosis, treatment and care for people with dementia;
- better care for women during pregnancy, including a named midwife;
- every patient will be able to give feedback on their care via the Friends and Family test by April 2013;
- by 2015 everyone will be able to book their GP appointment and order repeat prescriptions online;
- putting mental health on the same footing as physical health;
- preventing premature death from the biggest killers; and
- by 2015, people will be able to find out how good their local health services are performing with results published for all major services.

Other changes include regulation to support the development of innovative service models, a greater voice for patients, a changing role for public health with the creation of Health and Wellbeing Boards by Local Authorities, greater accountability locally and nationally and a streamlining of 'arms length bodies'.

Monitor's role will change to one of promoting the provision of efficient and economic services in order to maintain or improve service quality. In doing this Monitor will be responsible for licensing healthcare providers, setting prices,

enabling integrated care, preventing anti-competitive behaviour and supporting commissioners to maintain service quality.

Professional education and training will be overseen by Health Education England and the National Institute for Clinical Excellence will remain in-situ.

2.1.2. Francis Report

February 2013 saw the publication of the Mid Staffordshire NHS Foundation Trust Public Enquiry, chaired by Robert Francis QC. The quote below is an extract from Robert Francis' covering letter to the Secretary of State.

'the story it tells is first and foremost of appalling suffering of many patients. This was primarily caused by a serious failure on the part of a provider Trust Board. It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust's attention. Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care.'

The story would be bad enough if it ended there, but it did not. The NHS system includes many checks and balances which should have prevented serious systemic failure of this sort. There were and are a plethora of agencies, scrutiny groups, commissioners, regulators and professional bodies, all of whom might have been expected by patients and the public to detect and do something effective to remedy non-compliance with acceptable standards of care. For years that did not occur.....

Amongst other things, one key underlying message from the enquiry is that the basic compassionate care must be embedded into the DNA of every hospital. The DH response to Francis 'Patients First and Foremost' sets out an initial overarching response on behalf of the whole health system. It details key actions to ensure that patients are **'the first and foremost consideration of the system and everyone who works within it'** and to restore the NHS to its core humanitarian values. This is a call to action for every clinician and everyone working within health care. The DH sets out a 5-point plan:

- Preventing problems
- Detecting problems quickly
- Taking action promptly
- Ensuring robust accountability
- Ensuring staff are trained and motivated

Following the publication of the Francis report, the Trust set out its plan to brief and engage staff on the findings of the report. The approach taken was to hold a number of Trust wide listening events, the purpose of which was to engage and listen to as

many staff as possible, identify key risks and early warning signs that the organisation face and agree and prioritise actions. The key message and aim is to create a common patient safety culture across the Trust where 'patients not numbers come first'.

In addition to the internal Trust projects, work is underway with UCL Partners to accelerate improvement in light of the Francis report. Led by the Chief Nurses and Medical Directors across UCLP, a small number of carefully chosen initiatives have been prioritised;

- Understanding and measuring what matters to patients (developing a ward health check)
- Understanding what matters to patients (developing the UCLP Promise)
- Understanding and acting on what matters to staff
- Developing ward sister training and accreditation

This work can be accelerated and done more effectively by working in partnership, by sharing local work where helpful to peers in other organisations.

The Trust is committed to ensuring a consistent culture of compassionate care and following on from the listening and engaging events, the DH response and the UCLP programme, the Trust has identified many areas of action to consider. The Trust's next step is to complete a plan as to how to take the outcomes of these forward. It is essential that we build on the engagement and enthusiasm of our staff whilst also ensuring we respond to the DH recommendations as appropriate. To achieve this, the next stage will involve representation of staff from across the Trust.

2.2. Local Context

As previously, stated April 2013 saw some of the most significant changes to the management of the Health Service since its inception in 1948. Whilst the L&D has not been directly impacted by the changes in terms of re-structure the impact on those we work with on a day-to-day basis has been huge. Leading to a great deal of change both in terms of roles, responsibilities and personnel as new organisations have been developed from the old structures. During this period of uncertainty, the L&D has sought to provide both the 'corporate memory' of many of the issues facing our health economy and also to ensure the relationships with the emerging organisations are built on solid foundations. These foundations will cement partnership working in the future to ensure that the L&D is in the best possible position to meet the needs of present and future patients.

In addition to the national changes to the NHS, the L&D experienced significant strategic uncertainty locally during 2012/13 in relation to the proposed strategic changes related to Milton Keynes and Bedford Hospitals. As a consequence of this and the uncertainty over acute service rationalisation during the Healthier Together discussions, the L&D's progress with its strategic intentions and decisions surrounding the site re-development were deferred during the year. However,

2013/14 brings with it the knowledge that Bedford Hospital's preferred strategic intention is to be acquired by Milton Keynes FT. The 'Healthier Together' (HT) programme has been formally closed to enable commissioners and providers to work together locally to deliver the strategy for their communities. As a consequence the L&D has a more certain platform from which to plan its future strategic direction and clinical services strategy and has used much of the service configuration work undertaking during Healthier Together programme to underpin its development. A number of senior clinicians and managers were actively engaged in the Healthier Together Programme.

The Trust's other neighbours, West Hertfordshire Hospitals NHS Trust and East and North Hertfordshire NHS Trust have both declared their intentions to become Foundation Trust's. We understand that both Trusts are still in the FT pipeline.

The Trust predominately serves two main CCGs: Luton (46%) and Bedfordshire (24.5 %) however, an increasing number of services are also provided for Herts Valley and East and North Hertfordshire CCGs as well as a proportion for the services commissioned directly by the Commissioning Board (12.2%). The Trust has established excellent relationships with the new CCG organisations and has acted as the health economy memory as new individuals have taken on the senior roles within the new organisations. All the Trust's commissioners have expressed their support of the Trust and its strategic direction.

Key characteristics of the Luton CCG population

- Estimates for Luton population are of just over 200,000 with a comparatively younger population than that of the region or nationally although the proportion of older people is increasing, reflecting the national trend.
- Approximately, 32% of the population are from BME communities and 63% of children attending school in Luton are from non-white ethnic communities. In 2010, Luton had 18-22 Lower Super Output Areas (LSOAs) among the 10% most deprived in England with over a quarter of residents living in the worst national quintile of deprivation and over half in the worst two quintiles. Ethnic communities are more likely to live in these more deprived areas.
- Although life expectancy is increasing, for females, it has not increased as quickly as the national rate and inequalities between most-deprived and least-deprived areas have continued to widen for both males and females. Circulatory diseases are the main cause of death and a main contributor to inequalities.
- High migrant numbers also contribute to high levels of mental health problems, chronic diseases such as diabetes, and infectious diseases including TB and hepatitis B.
- The Health Profile 2012 shows:

- All age, all cause mortality and early deaths from heart disease and stroke to be higher than the national average;
 - High numbers of emergency admissions in mixed, Asian and black ethnic groups, possibly reflecting some patients not accessing or receiving the care most suited to managing their conditions;
 - Smoking in pregnancy, breast feeding initiation, physical activity and obesity significantly worse than the England average;
 - Significantly high rates of diabetes, TB, hospital stays for alcohol related harm and infant deaths; and
 - Cancer survival rates are poor compared to the England average.
- The quality of primary care in Luton is poor when compared nationally when taking account of access to GPs and Quality and Outcomes Framework (QOF) performance.
 - There is also wide variation in health outcomes by general practice in Luton that means that some patients in Luton do not have access to quality services and this can have a negative impact on their ability to live healthier and longer lives.
 - The JSNA focuses on the need to reduce the wide variation that is found within general practice in relation to access and diagnosing and managing health conditions.
 - Diabetes and chronic obstructive pulmonary disease (COPD) are two long-term conditions which make significant contribution to ill health and reduced life expectancy in Luton. They are also two conditions where the variation in outcome across general practice is evident.

Key characteristics of the Bedfordshire CCG population

- Central Bedfordshire has a growing and ageing population that is expected to increase to 290,000 by 2021 and 335,000 by 2031 due to increasing life expectancy, a rising birth rate and inward migration. The biggest increase - of around 30% - will be in the number of people aged 65 and over.
- The largest of these groups were: Asian (3.9%); White Other (3.5%); Black (1.9%); and White Irish (1.2%). The black and ethnic minority (BME) populations take up a higher proportion in younger age groups.
- Geographically there is a range of life expectancy within Central Bedfordshire; the gap between the most affluent and most deprived areas is on average 5.5 years for women and 7.4 years for men. People in the more deprived areas die earlier predominantly due to diseases of the circulatory system, especially coronary heart disease, cancers, especially lung cancer; diseases of the

respiratory system, especially bronchitis, emphysema and chronic obstructive lung diseases, and diseases of the digestive system.

- Overall, levels of deprivation in Central Bedfordshire are relatively low. However, when deprivation is assessed for the small areas known as Lower Super Output Areas (LSOAs), three LSOAs are in the most deprived 10-20% in England. These are within Dunstable, Parkside and Houghton Hall.
- Given the similarities of BCCG's population to the England population, it is not surprising to find that the health of the people in Bedfordshire is generally typical of the country as a whole, with a standardised mortality ratio of 97 (compared to an England SMR of 100). The estimated prevalence of long-term conditions, such as coronary heart disease, chronic obstructive pulmonary disease, hypertension and stroke, are comparable to those expected nationally.
- Bedfordshire's overall deprivation score is lower than that for England overall (14.6 vs. 21.5), although this hides pockets of deprivation in especially urban areas such as Bedford and Dunstable
- Population growth over the next 20 years is expected to be much higher than average, particularly around the north of the locality. This will be a residential led, mixed-use scheme of about 7,000 dwellings and 40 hectares of employment land together with its supporting infrastructure. This is known as Houghton Regis North'. The plans for primary and community NHS services in this area are currently being discussed.

2.3. Healthier Together Programme

The Trust actively participated in the recent Healthier Together (HT) programme, although the programme has now been closed to enable each Trust to work collaboratively with its neighbouring organisations. The final proposals made by the Clinical Senate, the cornerstone of the HT, will form the basis of clinical service planning across the locality moving forward.

The remit of the HT programme was to meet the health challenges of the 21st century and improve health services in the South East Midlands (SEM) to deliver improved patient outcomes in a safe, sustainable and affordable way. Led by GPs and hospital clinicians, the programme was a collaboration of twelve NHS partners across Bedfordshire, Luton, Milton Keynes and Northamptonshire.

The HT programme included all clinical services currently delivered on an acute hospital site. Mental health and dental services were outside the scope of the programme.

As stated previously, the Clinical Senate was at the centre of the programme and its remit was to develop clinically viable models for the population, based on the continued presence of five hospitals each continuing to deliver A&E and maternity

care. Reporting in to the Clinical Senate were six Clinical Working Groups (CWGs) made up of almost 200 clinicians from all specialties and partner organisations. The six CWGs were:

- Maternity
- Children
- Planned Care
- Cancer
- Emergency Care
- Long Term Conditions

The Clinical Senate was chaired by an acute Trust Medical Director and was made up of clinical representatives from all stakeholder organisations, the chairs of the six CWGs and patient and public representatives.

The proposed models for each of the CWGs were as follows:

Maternity

- The option of home births for low risk women
- Outpatient and day case (<23 hour) gynaecological services on all five sites supported by obstetricians and gynaecologists based in the obstetric units. The proposed model assumes that inpatient gynaecological services would be colocated with a consultant obstetric unit
- Three obstetric consultant-led units developing specialist services and increased consultant presence supported by acute and inpatient gynaecological services
- Three adjacent midwifery-led units and two stand alone midwifery-led units to increase choice and reduce medical interventions for low risk women. Each midwife led unit would share an overarching management and governance process with an obstetric unit.

Impact for L&D - given the L&D already operates a level 3 NICU the Trust would continue to have a consultant-led Obstetric Unit with an adjacent midwifery -led unit. The L&D would welcome the opportunity to expand its Obstetric activity and would have sufficient physical capacity to achieve this within the overall site Masterplan

Children's Services

Two broad models were proposed:

Three 24/7 sites with A&E, outpatients and inpatient beds, with three alternatives for the other two sites:

- A&E and outpatients on the other two sites
- A&E, outpatients and a short stay paediatric assessment unit on one other site and A&E and outpatients only on one other site
- A&E, outpatients and a short stay paediatric assessment unit on the other two sites

Four 24/7 sites with A&E, outpatients and inpatient beds, with A&E and outpatients on the other site.

Impact on the L&D – The L&D has developed its paediatric services significantly and is in the favourable position of being able to offer patients step down tertiary care in collaboration with GOSH. Therefore, the Trust would want to retain this specialist service and seek to grow the catchment further. As a result, the intention would be to provide a full 24/7 service offering both in and out patient care.

Planned Care

Across SEM core elective surgery would continue to be delivered on all five sites (except ophthalmology where fewer sites could be considered).

Day case and short stay surgery would be provided in dedicated short stay units, which offer the greatest flexibility in terms of case mix.

Complex surgery would be delivered on fewer sites as follows:

- One site for complex orthopaedic surgery
- One or two sites for complex breast, head and neck, gynaecology, plastics, colorectal and ophthalmology surgery
- Two sites for complex vascular surgery
- Outpatient and general diagnostic services would continue to be provided on all five sites or in the community where appropriate

Impact on L&D – Of all the HT proposals this causes the Trust greatest concern given the need to maintain viable surgical rotas, recruit and retain competent surgical staff along with the need for the Trust to have a combination of day case and inpatient surgical cases of a sufficient critical mass in order to drive productivity and efficiency gains. To this end the only model supported by the Trust would be for L&D to retain all current surgical activity, both inpatient and day case and would seek to be the location for complex surgery also given the nature of the specialist surgical services we already offer. Subject to a decision being made in the next 6 months for L&D to be an elective centre it would be possible for the Trust to accommodate more elective surgery, particularly day case activity. Scope exists to expand the new build to accommodate additional theatre and recovery space subject to a robust decision.

Cancer Services

A separate model of care has been developed for each tumour site. A summary of the themes of the potential models is as follows:

- Consolidation of some elective surgical specialties to improve outcomes
- Development of some specialist diagnostics
- Uniform co-ordination of screening services
- Provision of satellite radiotherapy to offer patients this service closer to home
- Ensuring reconfigured services continue to link with existing Cancer Networks
- Consideration of joint working for specialist cancer services across SEM to create volume and share expertise between sites
- Elective surgery of low complexity cancer could be on a non acute site but specialised high complexity cancer work e.g. head and neck should be on an acute site
- All hospitals with an A& E require an acute oncology service on site to meet cancer peer review.

The requirements of each tumour site, including co-dependencies will be different, but the CWG initially looked at the medical and surgical aspects of care for seven specific groups:

- Breast – complex breast surgery on 1 or 2 sites to improve access
- Urology – specialist cancer surgery on one site
- Gynaecology – specialist cancer surgery on one or two sites
- Head and neck – specialist cancer surgery on one or two sites
- Lung – local thoracic opinion on one or two sites
- Haematology – inpatients on one or two sites.
- Colorectal – specialist cancer surgery on two or three sites.

Overall there was a view that it would be better if all the very specialist cancer surgery were done in one or two centres. Further work would be required to look at the detail of this, which would also depend in part on the final configuration of inpatient elective services.

Specialist cancer consultants should work across SEM, for example by taking responsibility for one area with shared rotas to cover on-call. Specialist nurses and rehabilitation specialists would support this work.

Pathways for non-surgical oncology will depend on the final configuration of other services and pathways for each tumour site will need to be developed. Consultant oncologists will continue to be an integral part of the MDT directing patients' treatment by working with radiotherapy and chemotherapy services.

Impact on the L&D – L&D is part of a different cancer network, quality concerns about the current network exist and the future of the Cancer networks is currently unknown. Therefore the Trust is exploring how the Cancer services provided for its population are improved in collaboration with a tertiary provider.

Emergency Care

The CWG's preferred model was the retention of full A&E services on all five hospital sites. A list of specialties required to support an A&E department was also defined. However, further consideration needs to be given to whether all these services need to be on site or can be accessed easily from another site using clear, agreed protocols.

The CWG also recognised the concerns over the long-term viability of retaining five acute surgical rotas. Concentrating A&E and general surgeons onto fewer sites could improve sustainability, but there would still be a need to recruit further A&E consultants to provide consultant presence. The CWG therefore proposed an alternative model of four fully supported A&E sites with the fifth site being a 'warm' site managing and transferring some patients under clear protocols.

Consolidating emergency surgery onto four sites would improve the viability of the acute surgical rota. Strong commissioning of emergency and network services is also required. National evidence suggests that 10-30% of cases that attend A&E could be classed as primary care. To meet future acute healthcare needs, community and social services need to extend operational hours to incorporate nights and weekends. There is also a requirement for greater standardisation of service provision, skills and expertise to avoid varying responses.

In addition to A&E services, the CWG considered the number of sites for specialty service provision and proposed the following:

- Two sites for urology, acute stroke, ophthalmology, ENT, maxillofacial, complex gastroenterology and complex respiratory cases
- One or two sites for neurology
- One site for complex cardiology and specialist inpatient endocrinology

Impact on L&D – Given the geography, demography, levels of deprivation and ill health, quality of primary care and proximity to major transport links including an airport, it is inconceivable that the L&D would every lose its emergency care services. On this basis the Trust would support the retention of all key services and clinical support to enable the emergency service to flourish at L&D at these services are vital to ensure the Trust's ongoing viability as a DGH type provider. It is also important to ensure sufficient critical mass of workload across the specialities to ensure robust rotas to cover as much of the 24 hour day can be sustained.

Long Term Conditions

The first part of the proposals is to adopt the national generic, integrated framework for long term conditions, which is based on implementing three key service components:

- Risk profiling
- Patient self-management
- Shared decision making

The CWG also proposes a model for complex long term conditions which describes what should be provided at every GP practice and the support available from acute and community services, including social care.

In this model, groups of practices would work together to share expertise and resources in community multi-disciplinary teams covering a population of 50,000 to 100,000. Each community multi-disciplinary team would sit within an integrated care system and be supported by access to specialist services: consultant led community clinics, specialist telephone advice for GPs or input during an acute episode of care. Acute and community based health and social care services would support early discharge and community care.

Seamless pathways of care should be adopted for diabetes, chronic obstructive airways disease and heart failure with much of this pathway being provided in the community. Common aspects of care that could be managed in the community are: support for chronic conditions, improving access to psychological therapies (IAPT), mental health support, patient education and end of life care where appropriate. In acute care, the specialties of care of the elderly, imaging, pathology and ITU/HDU are identified as close or critical interdependencies for all three diseases. With medical advancement there are growing numbers of adolescents living with long term conditions and disability. Planning future services across SEM must include planning for their transition from paediatric to adult services.

Impact on L&D – The Trust would support these proposals and is very keen to see as much appropriate care possible in the community whether this is in order to avoid admissions or expedite discharge for this group of patients. The Trust is keen to work with colleagues in the CCG and Social Care to ensure the services are transferred seamlessly and where appropriate that L&D is given the opportunity to continue to provide services.

2.4. Commissioning intentions

2.4.1. Luton CCG

The key priorities for the Luton CCG as stated in their Commissioning Strategy – *a Healthier Luton* are as follows:

- **Ensuring a health start in life for children and young people**
 - Luton's Healthy Child Programme
 - Strengthening services for early intervention
 - Services for low income families
 - Services for families with complex needs (including Parenting Programme)
 - Services for families and young people with disabilities
 - Paediatric urgent care (including urgent care pathways and rapid response)
- **Primary and secondary prevention of disease**
 - Supporting people to quit smoking with a focus on pregnancy and pre-op patients
 - NHS Health checks programmes
 - Health checks for people with Learning Disabilities
- **Empowering people to live independently**
 - Telehealth and assisted technology linked to LBC telecare services
 - Self-help and patient education
 - Personalised Health Plans
 - Meet and Greet Programme
 - Counselling Services for Older People
 - Integrated Falls Prevention service
 - Enhancing LBC Reablement Team
- **Active management of long term conditions**
 - Implement the use of risk stratification in primary care
 - Community Heart Failure
 - The re-design and implementation of new models of care for diabetes and COPD – community integrated teams
 - Telehealth and Telecare programme
- **Improving medicines management**
 - Respiratory medicines
 - Medicine waste
 - Antipsychotics in dementia patients
 - Acute prescribing
- **Managing planned care and quality of referrals**
 - Towards excellence in primary care and targeted practice visit programme
 - Primary care investment scheme
 - Referral management
 - Out of hospital care
- **Improving urgent care**

- Maximising community support (single point of Access, Navigator Nurse, Care Home Matrons, Crisis Response)
- 111non-emmergency services
- Ensure delivery of ECIST recommendations
- Urgent Care Comms Strategy
- **Improving the management of people with Mental Health needs**
 - Promotion of mental wellbeing
 - Improving access to Psychological Therapies (IAPT)
 - Implementation of joint Dementia Strategy
 - Suicide prevention
- **Integration of health and social care**
 - Primary care led integration pilot
 - Integrated management information system
 - Integrated hospital discharge
 - Integrated Reablement strategy
- **Delivering high quality. Safe and value for money services**
 - Quality and Safety assurance – shared with Bedfordshire CCG
 - Patient and Public involvement strategy
 - Contract Management

2.4.2. Bedford CCG

The key priorities for the Bedfordshire CCG as stated in their Draft Commissioning Intentions document are as follows:

- **Care rightnow:urgent or unscheduled:**
 - Review all falls-related projects in conjunction with Public Health and Local Authorities
 - Review of the delivery of out of hours dressing's services and commission services to meet the needs of localities
 - Review of walk-in centre services
 - Review of scope of out of hours GP services
 - Review Of Maternity Services Liaison Committee (MSLC) arrangements to ensure arrangements are effective
 - Review of the Paediatric urgent care pathway
- **Care for my condition into the future:planned care and long term conditions:**
 - Review of new Integrated COPD and Diabetes Services
 - Procurement of new MSK System Model complete and service delivery starts
 - Procurement of new Dermatology System Model complete and service delivery starts
 - Commission Community Cardiology Services
 - Joint Commissioning of Vision services with Local Authorities
 - Review of Community Gynaecology Pilot
 - Review and re commission of Neurological Disorders model of care

- Implement recommendations of Stroke Pathway Review
- Commission Cancer Specific evidence-based pathways
- To review community mental health teams to ensure that mental health support is appropriate, accessible, responsive and recovery focused
- To develop a comprehensive primary care mental health model that promotes wellbeing and ensures that people are assessed and treated at the earliest point in their illness.
- Review of redesigned looked after children service
- **Care when it's just not that simple: addressing complex care needs**
 - Re-commission community beds configuration as a result of community beds review
 - Review the impact of the Sub Acute Programme South and (re)commission as appropriate
 - Commission a Community Geriatrician (older peoples consultant) model to support the primary health care team
 - Commission community nursing teams to align to GP practices within a 'GP attachment' model
 - Commission a 'Care Coordinator' model to support patients and carers to navigate the health and social care system
 - Review CHC processes and arrangements for Adults and Children in order to work with our Local authorities to review areas for integrated working and complete retrospective reviews in line with National frameworks and timelines
 - Review of Personalised Health Budget national recommendations

3. Strategic Analyses

3.1. PEST

In order to understand the external factors affecting the L&D clinical services and wider NHS a PEST analysis was undertaken. The results of which can be found in appendix A. The framework enabled the impact of political, economic, sociological, technological, legal and environmental issues to be analysed.

This analysis highlighted that the Trust is facing political challenges and change at a time of immense financial austerity. In addition, the population is living and working longer which creates more pressures for the health service. Technology provides real opportunities to change radically how services are delivered as well as enabling patients to become even more informed about their condition and their care.

3.2. SWOT Analysis

The Trust's management Executive carried out an analysis of the strengths, weaknesses, opportunities and threats facing the Trust's clinical services. The output from which can be found in appendix A.

The SWOT analysis indicates that the Trust has enjoyed a high degree of stability and autonomy for a number of years as an early wave FT. Our location is advantageous for a number of reasons including its proximity to major travel hubs such as the airport, motorway and the Midland mainline. In addition, the demographics of our catchment population are extremely varied and offer a wide variety of conditions making the medicine interesting to clinicians. Our ability to recruit from the local community is excellent which emphasises the hospital's reputation locally despite the poor fabric of the hospital estate. The hospital's University Teaching status plays an important role in attracting high calibre medical and senior clinicians. Our high quality teaching has helped the Trust train the clinicians of tomorrow, many of whom have chosen to return to L&D as Consultants.

On the negative side, the fabric and design of the facilities results in poor patient flow and experience. The Trust has tended to be very Hospital centric and has not previously embraced whole system working. The stability of the workforce has limited the amount of innovation. The emerging CCGs will initially be in a state of flux however, it is likely that some will outperform their PCT processors.

4. L&D's Clinical Services - Current Position

4.1. Operational performance

4.1.1. Key performance targets 2012/13

The Trust assess its operational performance against external national targets published by the Care Quality Commission (CQC) and Monitor Compliance Framework and other locally agreed contracts, with the support of external peer review and other external expertise.

4.1.2. Activity

During 2012/13, the Trust delivered the national A&E target monthly, despite ongoing challenges in terms of the volume of ED attendances and admissions continuing to rise. As in previous years, the challenges in discharging patients into the community resulted in additional pressure and we worked intensively with colleagues in the health economy to identify solutions. The Trust remains concerned about the availability of community services for some of our catchment population particularly in Luton. The opening of a new community intermediate care facility in Houghton Regis during 2012/13 did assist in managing the challenge.

National standards for patients not waiting more than 18 weeks for treatment from the point of referral were met or exceeded. As with many acute providers, the sub-specialisation of orthopaedic services reduces our flexibility in managing the waiting list. Following the implementation of an intensive recovery programme, the reduction in the backlog of patients waiting for treatment was maintained.

All cancer targets in all quarters of 2012/13 and forecast to be compliant through 2013/14 were achieved.

The Trust's performance on infection control has continued to be maintained with improvements in the number of hospital acquired Clostridium Difficile cases. Only two cases of MRSA Bacteraemia and 16 cases of Clostridium Difficile against a target of 31 were reported.

An increase in referrals following national screening campaigns by including additional clinical and diagnostic testing during evenings and weekend were managed effectively.

In 2012/13, the Trust struggled to meet the stroke target of ensuring that 90% of patients spending 80% of their time on a stroke ward due to bed pressures. However, this position greatly improved towards the end of the year and the intention is to maintain this as we develop its services to act as the hyper acute hub.

4.1.3. Activity Performance Analysis

Table 1 below identifies those areas where demand has changed by comparing the actual contracted activity to that planned.

Activity Type	Units	Actual*	Plan*	Forecast	Plan
		2011/12	2012/13	2012/13	2013/14
Admitted Patients					
Elective PbR	Spells	28,097	30,201	30,257	31,438
Elective Non PbR	Spells	130	61	61	52
Non Elective - General & Acute PbR	Spells	29,302	26,750	31,730	30,785
Non Elective - PA Unit	Spells	1,201	1,000	1,253	832
Non Elective - AA Unit	Spells	386	200	620	500
Non Elective Non PbR	Spells	510	400	544	498
Total Admitted Patients	Spells	59,626	58,612	64,465	64,105
Outpatients					
Outpatients - 1st (PbR)	Atts	82,774	74,922	79,756	74,396
Outpatients - Follow UP (PbR)	Atts	137,677	137,595	137,938	134,633
Outpatients - Procedures (PbR)	Atts	19,906	22,606	27,873	28,991
Outpatients - Pre Assessment (PbR)	Atts	10,153	10,423	8,853	10,004
Total Outpatients	Atts	250,510	245,546	254,420	248,024
A&E	Atts	71,792	70,740	78,379	70,210
Maternity Pathway					
Ante-Natal Pathway	Patients	6,336	6,200	6,207	6,207
Births	Births	5,312	5,200	5,260	5,264
Post-Natal Pathway	Patients	5,250	5,200	5,260	5,633
Total Maternity Pathway		16,898	16,600	16,727	17,104
Critical care					
Adult - Intensive Care	Bed Day	2,013	2,006	2,051	2,124
Adult - High Dependency Unit	Bed Day	2,450	2,248	2,301	2,350
Adult - Ward Based High Dependency	Bed Day	1,322	1,446	1,235	1,266
Neonatal - Intensive Care	Bed Day	2,640	3,065	2,772	3,169
Neonatal - High Dependency	Bed Day	2,575	2,644	2,307	2,552
Neonatal - Special Care Babies	Bed Day	5,550	5,952	5,113	5,567
Neonatal - Transitional Care	Bed Day	926	1,382	1,176	1,242
Paediatric - High Dependency	Bed Day	1,788	1,553	1,760	1,674
Total Critical Care	Bed Day	19,264	20,296	18,715	19,944
* Rebased to reflect Maternity Payment Pathway		PbR = Payment by Results			

Table 1: L&D Activity Analysis

In 2012/13 Commissioners anticipated substantial QIPP reductions. Despite their endeavours planned reductions on activity did not occur.

The Hospital performed well to accommodate this unplanned activity without compromising a range of national target indicators. However, this activity could not be provided within existing employed staffing levels, consequently the Hospital incurred substantial temporary staffing costs.

In 2013/14 Commissioners once again plan a range of demand management initiatives designed to reduce pressure on the Hospital. The Trust will need to manage its own capacity and staffing levels carefully to ensure that services are provided efficiently and effectively.

4.2. Recent Service Developments

The Trust has, over the last few years developed a range of services. A number of which are described below:

- **Catheter Laboratory** -The establishment of a Catheterisation Laboratory from which diagnostic angiograms are currently provided to the Trust's catchment population, however, it is anticipated that this service will be expanded within the next year to include PCI services. L&D patients currently have to travel to Bedford for this service.
- **Bariatric Services** - Highly regarded Bariatric Services, providing both medical and surgical treatment options for Bariatric patients across a wider catchment population have been developed.
- **Urgent Care** -The Emergency Department has been expanded and redesigned including the development of an Emergency Assessment Unit over the last few years. These changes have revolutionised the way in which urgent care is delivered at L&D and have enabled A&E performance at L&D to be amongst the best in the country against a backdrop of increasing demand and dependency.
- **Closer to Home** - A number of services have been developed in the community including Muscular Skeletal Services, Chronic Obstructive Pulmonary Disease and Diabetes.
- **Obstetrics** - A midwifery led birthing unit has been developed offering pregnant women more choice regarding the birth experience they can have.
- **Urogynaecology** – The L&D is now one of 5 hospitals in the country to have established a highly innovative approach to pelvic floor surgery.
- **Gastroenterology** - Endoscopy services have been significantly expanded with a significant refurbishment programme of the Department addressing many of the previous privacy and dignity issues as well as expanding the scoping capacity by a third. This has enabled the unit to run a bowel-screening programme.
- **Repatriation** - More patients can be seen at L&D for a variety of conditions as a number of services have been repatriated from major teaching centres as the level of clinician subspecialisation increases as the hospital's University teaching status begins to attract more sub-specialist consultants.
- **Orthopaedic Services** – In response to Commissioners' requests the Spinal Service has been re-established and the hospital has become a designated Trauma Unit.

- **Ambulatory Care Unit** – in response to the ever-increasing demands for urgent care the Trust has recently established an Ambulatory Care Unit to care for patient on a planned basis for a variety of treatments on an outpatient/day case basis. Previously these patients would have been admitted to a bed and would have received their treatment as an inpatient.

4.3. Continuing Viability of District General Hospitals

The need to concentrate services to enable hospitals to ensure the safe delivery of service is a real issue for the NHS as a whole. In order for acute care to be responsive, consistent, high quality and cost effective it is vital that services have a catchment population of sufficient scale to make it clinically viable. Whilst there is no definitive guidance regarding how large the catchment population needs to be there is evidence that the population should be between 300,000 – 500,000. Therefore, the L&D with its catchment population of approximately 320,000 is only just viable and needs to grow this catchment in order to optimise its future viability.

The Trust's ability to offer high quality emergency services 24/7 is at the centre of continuing viability. There are a number of key clinical services that make up the portfolio of services required to offer a robust emergency service. These include:

- A&E services
- Acute Medicine
- Emergency surgery
- Trauma and Orthopaedics
- Paediatrics
- Intensive Care; and
- Clinical support services including laboratory, imaging and theatres.

The Trust does offer the full portfolio of services needed to maintain its status as a viable DGH however, a number of pressures impact on the Trust's ability to maintain this. These issues are common in many acute hospitals and include:

- the ability to maintain sufficient senior medical cover throughout the 24 period. Not only in relation to being able to attract sufficient numbers of staff but being able to afford the volume of high cost staff required;
- junior medical staff are becoming more difficult to recruit due to the changes to medical education, European working time directives and a reduction in training numbers;
- increasing demand for emergency services and managing increasing length of stay against a back drop of few out of hospital alternatives for some patients;

- increasing evidence that services need to be consistent services 24/7 not just during more traditional working hours. This puts even more pressure on scarce resource as the need of staff to work more anti-social hours will become the norm;
- as greater subspecialisation occurs within certain clinical services the quality of service should improve however; this means the need for more volume becomes vital as services require greater critical mass;
- hospitals are no longer judged on waiting times alone; now the quality of the patient's experience finally counts. Therefore, it is really important that hospitals consider what patients experience during their stay; whether it relates to the environment in which they were treated or the manner by which they were spoken to;
- and lastly, the ability to deliver all services at or below tariff in order to maintain competitive and enable surplus to be re-invested into the Trust.

4.4. Service Viability Review

Last year the Trust commissioned a review of its consultant staffing levels compared with current Royal College recommendations. The review was undertaken by external Consultants. This work identified that there were some specialties where the Trust's consultant establishment was light when compared against the Royal College recommendations. The Trust has considered these findings and each Division has responded with how they intend increasing consultant numbers accordingly. Some additional consultants are already in post and others appointments are in the pipeline.

In addition to reviewing the medical workforce against Royal College recommendations the review also assessed the financial viability of the services. This piece of work has proved helpful in flagging which services may be vulnerable to making a loss. However, it is felt at present that the immaturity of Service Line Management at the time of the review and the vagary of the national tariff make it difficult to use this information to withdraw from providing potentially non-profit making services. Given the high cost of exiting a service line activity, substantial evidence over a period of at least a couple of years is needed before withdrawing from a market. The Trust will continually review the situation using the information developed by the review as a starting point.

4.5. Service Portfolio Review (SPR)

In 2012 the Trust undertook a Service portfolio Review. This was a complex piece of work which looked at the market attractiveness and business strength of each of the divisions. Each of these headings had a number of elements within them,

and for each one the divisions were allocated a score, which resulted in an overall performance value on the display matrix.

In terms of business strength the market share of the speciality against expected share, the staff sustainability, the Consultant satisfaction, clinical quality and research ratings and clinical dependencies to other services were considered. For market attractiveness market size, potential for growth, local commissioning intentions, GP perceptions and support for the service and how many competitors existed in the market place for that specialty were considered.

The data used in many cases was gathered from questionnaires from key individuals, accessed from Trust data systems and interpreted by Trust teams, or gathered from Dr.Foster. In terms of sickness/absence measurements or financial data – this was based on the last financial year's data. It became evident that the same quality criteria for all of the specialties could not be used, for instance length of stay does not work as an indicator for Radiology, but does for Orthopaedics. Therefore some of the outputs had to be adapted to fit the specialty making them difficult to compare directly. The profitability of a service was a very useful tool for all, as long the overhead apportionment was correct, and the income was correctly split between specialties. This was an issue within Paediatric surgery. The refinement of patient level costing will hopefully make this less of an issue.

The key findings from the individual work streams were the lack of profitability within Orthopaedics in particular. In many Trusts this service is seen as a cash cow, but the Trust was failing to see the profits realised by others, and this led to a focussed piece of work on surgery looking at the specialty and other issues within surgery, for instance theatre utilisation, session planning & scheduling and synergy within lists. A lot of work has been undertaken to improve the position as shown in this work. Another key finding was the relatively high cost of agency and bank within the A&E department, driven by the rise in attendance in some part, but also due to the adhoc escalation of areas due to surges in attendances. The whole of the workforce budget for A&E was reprofiled by the management team and now agency is very rarely used, despite the surge, and the Medical staff are more contained within the overall spend due to the decision to recruit to a permanent structure.

The GP survey revealed some communication issues with certain services, which were rectified through this process. It was concluded that this was a good way to gauge the satisfaction of the GP's, and GP engagement events are now being held in an attempt to take this further. Services were also identified which are not dependent on a raft of others to provide services, and this has helped identify possible services which can co locate into an off site hub more easily than others. This analytical approach to services has been used to help inform the strategy with regard to the service portfolio, and the intelligence this exercise offered has been used to make targeted improvements to improve the service delivery and profitability.

5. Vision, Aims and Values

5.1. Our Vision

The vision for the Trust detailed below underpins both the wider organisational strategy and the Clinical Services Strategy. It clearly defines what the organisation is committed to.

Vision Statement

“The L&D is committed to delivering the best patient care, the best clinical knowledge and expertise and the best technology available, with kindness and understanding from all our staff “

5.2. Our Aims

Aims

- To put patients first, providing the best possible clinical outcome and the highest quality of the patient experience.
- In partnership with Cambridge University, University College London and others, to be nationally respected for the provision of education and development.
- To ensure value for money and using the freedoms of Foundation Trust status, to exploit our strengths and specialisms for the benefit of patient care and clinical outcomes.
- To ensure effective governance, accountability and leadership while maintaining staff engagement and involvement.
- To ensure a full appreciation throughout the organisation of the changing environment of commissioning, competition, risk, regulation, patient choice, sustainability, QIPP and our financial position.
- To develop and maintain productive relationships with external partners and maximise opportunities for communication and joint working.
- To retain and recruit the best staff.
- To market and promote effectively the services of the Trust.

5.3. Our Values

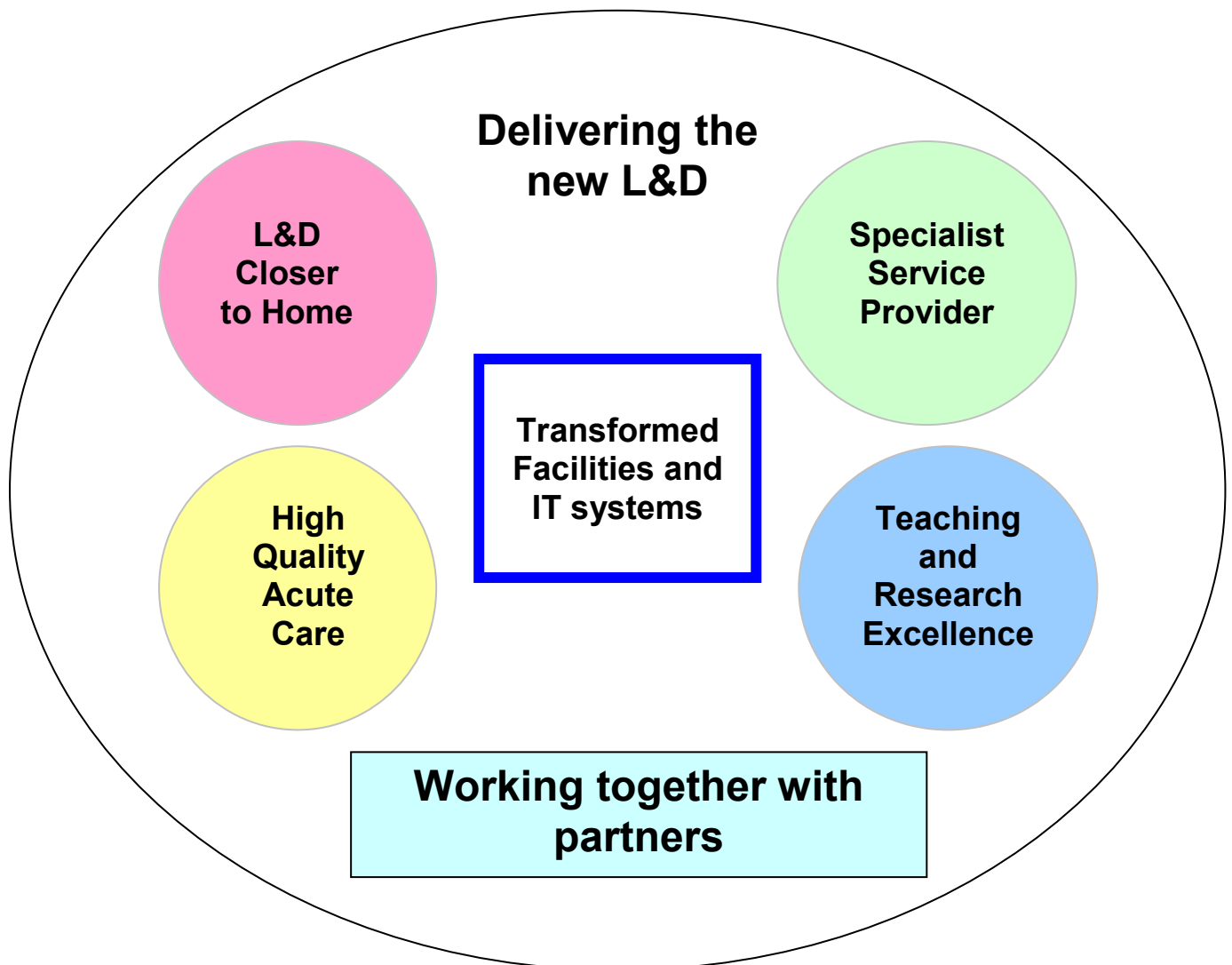
Values

- To put the patients first, working with them to ensure they receive high quality safe care with dignity and respect.
- To value the contribution of staff, volunteers, members, governors and other partners and stakeholders, working collaboratively and professionally to deliver high quality clinical care.
- To focus on continuous improvement in the pursuit of excellence, maximising development opportunities.
- To manage our resources in a co-ordinated way, with an emphasis on productivity, value for money and quality.

- To see the diversity of our people as a strength, through our commitment to inclusion, equality and human rights.
- To accept responsibility for our actions, individually and collectively, to meet our obligations and deliver our commitments.

6. The Clinical Service Strategy

In response to the challenges and context described earlier, the Trust has devised an overarching strategy, **'Delivering the new L&D'**. This is illustrated below in figure 3.



'Delivering the new L&D' is based upon 5 key themes however it can be summarised as follows:

The Trust's Clinical Services Strategy is to invest and further develop the core clinical services to ensure long-term viability as an acute provider. This will include maintaining market share in some core services such as: ED; Acute Care of the Elderly; Acute Medicine sub-specialties for respiratory and diabetes; Colorectal surgery; Trauma & Orthopaedics; Obstetrics and Maternity; and Neonatal Care; whilst expanding market share for others by developing a range of specialist services such as Hyper Acute Stroke Care, Ophthalmology, Paediatrics and Gynaecology, which can complement the core services and add real value and profit rather than

burden the Trust financially or operationally. Many of these service expansions are either repatriating work back to Bedfordshire to save patients having to travel and to save the Market Forces Factor or have the ability to draw activity from a wider catchment population and some will attract private patient income over and above that currently generated.

The need to redesign and modernise services to meet the needs of its patients and commissioners by offering services closer to patients' homes and in some cases in a patient's home has been acknowledged and services are being developed on that basis.

If the Trust is to deliver all the above to the highest quality possible it also needs to attract develop and retain high calibre staff. The Trust's University status will be an essential tool in this endeavour.

Lastly, in some cases the Trust will need to provide services in partnership with others, whether from the public or private sector in order to maximise the offering it can deliver to its patients.

The recent opportunity to bid for some aspects of the Community Services portfolio may offer the Trust an ideal opportunity to draw the demarcation line between acute and community care differently. This form of vertical integration may enable the Trust to control a greater proportion of the care pathway than is currently the case. The Trust is clear it is not a generic community care provider however, that more innovation approaches potentially with a partner organisation could deliver real benefits in terms of quality of care but also in terms of overall efficiency and patient safety. The Trust will actively explore the opportunities during the procurement process and will work with SEPT to ensure a comprehensive community service can be offered.

As stated above, the strategy is built around 5 key themes.

- L&D 'Closer to Home'
- High Quality Acute Care
- Specialist Service Provider
- Teaching and Research Excellence
- Working with Others

Each theme is described in more detail below and the workstreams for each theme can be found in appendix B.

L&D Closer to Home

The Trust continues to be fully committed to the principle of providing a range of appropriate services within the community in line with both national and local policy directives. However, services need to be developed in a co-ordinated and planned manner, in concert with the CCGs and the social care colleagues, to ensure the

services transferred remain highly effective clinically and offer the optimal patient experience.

During 2013/14 L&D will continue to work the CCGs and respond to tenders to establish more services in the community to complement those already operated for Muscular Skeletal (MSK) conditions in Luton, Diabetes and COPD for Bedford patients in collaboration with Bedford Hospital and community ENT services in West Hertfordshire. It is anticipated that community Cardiology, Urology, and ENT services along with the larger Community Services will be opportunities in 2013/14.

An extended Home from Hospital Service pilot will commenced at the beginning of April 2013 enabling L&D staff to care for medical and elderly patients in their own home when it is safe to do so.

In addition the feasibility of establishing a clinical satellite facility to provide a wider range of medical and surgical outpatient appointments and treatments in the community is being actively pursued. This development will also help de-congest the hospital site, facilitate other departmental moves in order to improve the hospital's overall efficiency and assist in freeing up potential redevelopment space.

High Quality Local Acute Care Services

During 2012/13 all national and local performance targets were achieved. Over the coming years the Trust will build upon its success and reputation by further improving its clinical outcomes and mortality rates.

As an acute hospital, the Trust's prime role is to provide high quality secondary acute services therefore it is vital these services are managed in the most efficient manner possible given the numbers of patients using the services. To this end, reducing length of stay, improving efficiency and patient experience remain high priorities. Formal transformation programmes have already delivered tangible benefits in Theatres and Outpatients during 2012/13, however this work needs to be continued if real transformational change is to be embedded but with a greater emphasis on medical productivity during 2013/14. The Board of Directors remain very committed to this approach.

In addition to enhancing how A&E attendees, outpatients and in-patients are treated within the hospital more innovative models of care are being explored in order to avoiding admission to the hospital. Examples of this include the new Ambulatory Care and Clinical Decision Units. Both units will enable patients to be treated in the appropriate setting for their condition without the need for an in-patient admission. The Ambulatory Care Unit has been in place since April and the results so far have been encouraging. The Clinical Decisions Unit will be established adjacent to the ED by the late autumn. Evidence from elsewhere suggests that both these developments will have a very positive impact upon the number of acute admission and length of stay for a high number of patients.

Whilst many patients still need to be admitted for the acute phase of their care, there is significant evidence to suggest a patient's outcome is further improved if they are discharged in a timely fashion. In response to this the Trust is launching a new virtual ward which will enable more patients to leave hospital earlier whilst still assured they can receive responsive care should their condition deteriorate. All these new models of care will assist in reducing both admissions and lengths of stay. Tackling both of these issues will have a positive impact on patient care and the wider health community pressures.

The Trust is very keen to establish a 24/7 working culture in key services and departments and the findings of the Francis Report re-enforce the need for hospital care to be consistent 24/7. A new medical staffing model and extended weekend working for clinical support services is being introduced in 2013/14 and these initiatives will be the first stages in establishing the true 24/7 hospital. More Consultant led care will deliver real quality and safety benefits to patients whilst enabling the Trust to operate more effectively and use its buildings and assets more intensively.

In response to the need to provide high quality nursing care to all patients in whatever clinical setting the Trust has embarked upon an innovative project known as **The Perfect Day**. This initiative is predicated on releasing qualified nursing staff from time-consuming activities which could easily be done by unqualified, trained support staff thereby segregating the clinical care from the hotel and patient administration aspects of the day-to-day ward work. This project will see nurses being able to spend more time with patients caring for them rather making beds, cleaning equipment and filling in paperwork. Job roles will change and trained support staff will gain a higher profile on the wards and will provide a wide range of support services. This model of ward management is very new in the UK and the pilot has been built around a more European model of nursing care. We intend rolling the pilot out to all wards during 2013/14. The patient and staff satisfaction feedback from the pilot wards has been excellent and provided confidence moving forward.

Specialist Service Provider

The Trust continues to provide a number of specialist services for a wider catchment population, for example, Bariatric services are provided for East of England, Thames Valley and Northamptonshire; and specialist stroke services are provided for Milton Keynes and West Hertfordshire, in addition to those in Bedfordshire. The Neonatal Unit is a level 3 Unit and therefore cares for babies from beyond the L&D catchment.

Through 2013/4 the Trust will continue to develop further specialist services, on a sub - regional basis by providing hyper acute services in collaboration with Specialist Tertiary centres. Examples of these developments include: Fertility services in collaboration with Bourn Hall in Cambridge, Paediatric step down services with Great

Ormond Street Hospital and Trauma Services with St Mary's and Addenbrookes amongst others.

Ophthalmology services will continue to expand both in terms of the volume of patients seen and the range of services offered including tertiary corneal services which were until recently only available in Specialist Eye Hospitals such as Moorfields.

Building on the success of the Cardiac Catheter laboratory the service will be applying to become a recognised interventional cardiac centre enabling patient requiring Percutaneous Coronary Intervention (PCI) treatment to be treated locally.

The continued development of specialist services as part of the Trust's portfolio will enhance our ability to recruit the best clinical staff. The expansion of hyper acute services also contributes to the care closer to home agenda, as patients will be able to receive more of their care pathway locally in collaboration with the tertiary providers rather than having to travel repeatedly from Bedfordshire into London or Cambridge.

Teaching and Research Excellence

2012 saw the Trust formally recognised as a University Hospital. This achievement recognises the quality of teaching at the Trust and the breadth of research undertaken. Clinical research opportunities will be actively pursued in order to improve the quality of patient care.

It is also acknowledged that the Trust's reputation for excellence in teaching and research greatly enables the Trust to attract high quality medical staff of all grades but especially consultant staff. This is even more important at a time when training numbers are down and therefore, the labour pool is reduced. Overall this will contribute to the Trust being able to improve the quality and safety of its services to patients.

Working with Others

The Trust has previously had a rather inward looking, hospital centric approach to delivering its services. However, things are changing and have already changed in certain areas.

The Trust is working very collaboratively with Great Ormond Street Hospital to develop tertiary step down services to enable children who have had to be admitted to GOSH for specialist care to be discharged from GOSH earlier than previously into the care of the L&D service. This enables some of the sickest children to be in hospital closer to home rather than parents having to travel constantly to London. This is a great accolade for the team at L&D and acknowledges the quality of care they are now able to offer locally.

Another example of the Trust working with others is its recent collaboration with Bourn Hall for Fertility Services. Once again this collaboration with an internationally renowned centre of excellence enable the L&D to provide services locally which until recently patients had to travel to either Cambridgeshire or into London on a very regular basis for the duration of their treatment.

The Trust also developed its community COPD and Diabetes service in partnership with Bedford Hospital and this combined service is now provided throughout Bedfordshire.

The Trust is also in the early stages of exploring relationships with Circle in response to the Bedfordshire CCG MSK tender and with the South Essex Partnership Foundation NHS Trust (SEPT) in response to the Luton Community Service Tender.

The Trust also recognises the importance of working with organisations such as the Mckinsey Hospital Institute and UCLP to develop learning about best practice which can be imported to the L&D.

In addition the Trust is part of the Mount Vernon Cancer Network and has a number of joint appointments with other centres such as Royal Free, Harefield, and Bedford etc.

Transforming Facilities and Systems

The need to re-develop and transform the hospital site and IT systems remain a very high priority. The Board of Directors has commissioned the preparation of a business case to redevelop the site focusing on a number of key priorities including:

Building the new L&D

- Building a new NICU
- Refurbishing the theatre suites including the delivery suite and the provision of clean room facilities
- Expanding the Emergency Department and associated Emergency care facilities to include a Clinical Decisions Unit
- Renewing the hospital infrastructure to improve site resilience
- Continuing the redecoration of the outpatient facility
- Further expanding the Endoscopy Suite including negative pressure facilities
- Creating a combined ITU and HDU facility
- Refurbishing of a number of the wards, including the provision of more side rooms
- Creating an off site surgical and medical treatment facility which is likely to contain Ophthalmology, Dermatology and Plastic services
- Relocating the fracture clinic into appropriate facilities
- Creating a new main entrance and improved public facilities
- Creating a bed store and equipment wash facility
- Building new parental accommodation to support NICU

- Increasing car parking and improving access and egress of the site
- Refurbishing the mortuary facilities

The schemes listed above will form an overarching Strategic Outline Case (SOC) which will set out the case to invest in the L&D estate over a period of four years. This will form the basis of a submission to the Foundation Trust Financing Facility (FTFF) for a loan to support this extensive investment in services for the patients and staff of L&D now and in the future.

IT Systems

A new IM&T Strategy was published in May 2013 and plans a clear road map for the next five years. The IM&T Strategy was developed in conjunction with this strategy.

There is already much work planned, with many months of procurement giving way to a year of implementation. Further capability has been built to deliver care safely and efficiently without the need to request paper notes – an electronic patient record. In order to deliver this, there are several key projects. In the previous year, the Trust signed a long-term strategic contract with Xerox to transform our existing Health Records Service into a modern state of the art scanning service. This contract commenced on the 4th February, and this year will see large-scale transformation in many of the key processes where paper notes are vital to care. At the end of September 2013, the process of advanced scanning out book patients' notes will begin. By February 2014, all requests for paper notes will be fulfilled with an electronic scan into a new electronic document management system. This will improve the availability of the notes at the point of need, and make the access instantaneous from anywhere anytime to multiple staff as required.

The electronic observation system, already proven to assist in early identification of patients whose condition is deteriorating, has been deployed into Medicine in the past year, but will be rapidly deployed across all adult medical and surgical beds during 2013. The ability to be alerted to all deteriorating patients across the Trust from one system is a key improved capability in our push to improve patient safety further. Functionality to capture electronically fluid balances will also be extended along with ensuring that the patient inserted devices such as cannulae and catheters are managed safely and in adherence to best practice protocols.

The past year has been one of procurement with both an electronic system to support drug prescribing and administration, and a replacement for the Trust's telephony system. The prescribing system will be deployed initially in the Department of the Medicine for the Elderly in the late autumn of 2013, with wider rollout thereafter.

The replacement of the Trust's telephony system will take place mostly in 2014, although the preparatory work and initial deployments will begin in 2013. This will include plans to replace the current "bleep" system of paging staff, with a state of the art system for managing urgent messages and communication.

Behind the scenes, investment has already been made in a new data centre that has been built and will be fully populated with all the L&D systems early in the New Year. In addition, the data centre hardware: servers and storage will be refreshed with sufficient capacity to meet the next five years of growth. This will include much improved ability to run systems from offsite in case of any disasters affecting the onsite data centre. This greatly enhanced resilience means the reliance upon electronic systems can be safely increased.

In 2013/14, there will be a return on its investment in electronic systems with care safely able to occur without the need to recall a paper record. Access anywhere, anytime to the persistent patient record will create efficiencies and opportunities to work differently. For example, all clinical coding will be completed on screen, without need to seek the paper notes. At the same time a recently discharged patient may well, be in an Outpatient appointment the same record concurrently accessed.

Whilst not clinical services, the Trust also acknowledges the importance of improving and investing in the facilities and systems which all underpin the provision of high quality clinical care.

7. Clinical Service Development Portfolio

In discharging '**Delivering a new L&D**' as described above the Trust will seek to develop or expand a number of clinical services and each Division will be generating the relevant business case over the next few years to gain approval to invest in these services as the opportunities arise.

L&D Clinical Service Development Portfolio		
Division	Service	Status
Medicine	Hyper Acute Stroke	Trust already offers the service and is seeking to obtain HASU status subject to tariff discussions
Medicine	Orthotic and Limb fitting	Trust already provides and will seek to expand catchment
Medicine	Cardiac PCI	Cath Lab now established. Intention to establish PCI from Q3 2013/14
Medicine	Hepatitis C liver Services	Currently a tertiary Service with scope to provide at L&D
Medicine	Capsule Endoscope	Service already provided at L&D but wish to expand catchment
Medicine	Neurology Specialist nursing for ME patients	Service already provided at L&D but wish to expand catchment
Medicine	Continuous subcutaneous insulin pump (CSII) therapy	Service already provided at L&D but wish to expand catchment
Medicine	Cutaneous Allergy	Service already provided at L&D but wish to expand catchment
Medicine	Cardio pulmonary Exercise testing	Service already provided at L&D but wish to expand catchment
Medicine	Full Polysomnography	Currently a tertiary Service with scope to provide at L&D
Medicine	Domiciliary non-invasive ventilation	Currently a tertiary Service with scope to provide at L&D

Medicine	Medical Thoracoscopy	Currently a tertiary Service with scope to provide at L&D
Medicine	UBUS (Endoscopic bronchial Ultrasound)	Currently a tertiary Service with scope to provide at L&D
Medicine	Bronchiectasis	Service already provided at L&D but wish to expand catchment
Medicine	Interstitial Lung Disease	Service already provided at L&D but wish to expand catchment
Women's and Children's	Level 3 NICU	Service already provided at L&D but wish to expand catchment
Women's and Children's	Urogynaecology	Service already provided at L&D but wish to expand catchment
Women's and Children's	Specialised Paediatrics in Collaboration with GOSH	Service already provided at L&D for L&D catchment but wish to provide a step down hub for patients from other health economies
Women's and Children's	Combined Urogynaecology and colo-rectal surgery	Service already provided at L&D but wish to expand
Women's and Children's	Maternity Diabetes care	Service already provided at L&D but wish to expand
Women's and Children's	Fetal Medicine	Service already provided at L&D but wish to expand
Women's and Children's	Children's Surgery	Service already provided at L&D but wish to expand. Specialist Anaesthetic and Surgical input required
Women's and Children's	Paediatric Haematology	Service already provided at L&D but wish to expand
Surgery	Bariatric Services	Service well established but keen to expand market beyond NHS due to the ability of Commissioners to ration

		services
Surgery	Max Fax Trauma	Service already provided at L&D but wish to expand
Surgery	Head and Neck Cancer	Service already provided at L&D but wish to expand but service under threat due to....
Surgery	Trauma Services	L&D recently awarded Designated Trauma Unit status and will continue to develop the services in collaboration with Cambridge
Surgery	Corneal Services	Was a tertiary service but expertise of L&D clinician has enabled the L&D to start establishing the service locally
Surgery	Medical Retina services	Service already provided at L&D but wish to expand. Specialist Anaesthetic and Surgical input required
Surgery	Spinal Services	Service already provided at L&D but service under threat due to tariff changes and affordability pressures
Surgery	Private Patients services	Trust wishes to develop but decision to be taken regarding whether bed and theatre capacity can be ring fenced in order to maximise opportunity.
Surgery	Neonatal retinopathy	Currently a tertiary Service with scope to provide at L&D
Therapeutics and Outpatients	CT Coronary Angiography	Innovative service which is currently only available in limited Tertiary Centres
Therapeutics and Outpatients	Regional Myoview service	Currently a tertiary Service with scope to provide at L&D
Therapeutics and	Specialised Blood Sciences	Currently a tertiary Service

Outpatients		with scope to provide at L&D
Therapeutics and Outpatients	Breast Screening	Service already provided at L&D but wish to expand
Therapeutics and Outpatients	Comprehensive Imaging service for primary care	Service already provided at L&D but wish to expand

8. Conclusion

Therefore, to conclude the Trust has a clear strategy for its clinical services that is based upon five key themes:

- Providing L&D Care Closer to Home
- Delivering High Quality Acute care
- Being a Specialist Service Provider
- Delivering Teaching and Research
- Working with Others

These themes are underpinned by the need for the Trust to transform its facilities and its IT infrastructure in order to compliment high quality service delivery and optimise patient experience.

Fundamentally, the Trust will implement this strategy in order to grow market share and therefore increase its critical mass in key specialities over the next three years. Whilst this strategy is predicated on growth of catchment population it is not ad – hoc growth but very specific and targeted growth with income gain based upon re-patriation or shift from other health economies. The need to improve efficiency and productivity throughout the organisation is fully understood along with the most important requirement to ensure patient receive the very best quality care.

Luton and Dunstable University Hospital
NHS Foundation Trust

Appendix A

PEST ANALYSIS
&
SWOT ANALYSIS

PEST ANALYSIS

<p>Political</p> <ul style="list-style-type: none"> • Positive relationship with GP's • Consolidation of Acute Services • FT & University Hospital Status • Good performance – benchmark well • Change in CCG team – opportunities • More multi-agency working – opportunities • Localism of disease <p>Changes that offer opportunities:</p> <ul style="list-style-type: none"> • Potential Personal Health budget • More Strategic oversight • Other Trusts performance • More informed patients • Government backed competition <p>Reactivity to Political changes</p>	<p>Economic</p> <ul style="list-style-type: none"> • Impact of austerity on patients health & wellbeing • Decrease in tariff • Cost debt • Government bailout for failed FT's • Labour Market changes <p>Changes that offer opportunities:</p> <ul style="list-style-type: none"> • Recruitment & retention benefits of downturn in economy • Opportunities to bid for other work • Opportunities to acquire other businesses 	<p>Social</p> <ul style="list-style-type: none"> • People working and living longer • Demographic and Immigration factors • Increase in the elderly population • Increase in dementia sufferers • Luton houses a highly deprived populous • Recorded population is much lower than actual due to the transient nature of the inhabitants • Demand increase year on year for secondary care due to the mismatch between primary care services and settings <p>24/7 services essential due to proximity to Airport/Motorway & clientele</p> <p>Changes that offer opportunities:</p> <ul style="list-style-type: none"> • Patient choice • Service redesign with other healthcare providers • Relatively dependent catchment population
<p>Technological</p> <ul style="list-style-type: none"> • Telehealth/telecare/telemedicine • Robotics to support care & operations • Paperless environment • Health data sharing across the economy • 2015 – direct access to diagnostic results • Genetic screening • Social Media • Expert patient • POCT in the home 	<p>Legal</p> <ul style="list-style-type: none"> • Duty of candour • Francis Report • Criminal & Legal capacity to manage legal issues • Competition Law • Opportunities for Partnerships – Governance arrangements 	<p>Environmental</p> <ul style="list-style-type: none"> • More use of technology for patient education and communication • Health care settings we choose to deliver care in – and the quality of those settings • Patient experience

Strengths <ul style="list-style-type: none"> • Advanced Clinical Leadership • FT status • Urban Population • Little competition at present • Single site • Geography/Airport/motorway/rail links • Good Recruitment & retention • Early adopters of technology & patient safety • Local loyal patients & staff • University Hospital • Strong Performance • Strong Leadership • Wide breadth of services • Outward looking • Interesting Medicine • Financially sound • Stable & good reputation 	Weaknesses <ul style="list-style-type: none"> • Ability to respond quickly – constraints of tariff • Estate is poor and little room for growth • Lack of a diverse work force • Imbalance in training of Drs v's Non-clinicians • Do not embed changes well • Do not always finish what we start • Inward perspective on performance and management style • Hospital centric – not part of the health community. • Our stability has led to a lack of new blood • Lack of systems – rely on individuals • Little succession planning/talent management • Reactive
Opportunities <ul style="list-style-type: none"> • Hospital Redevelopment • Ability to provide excellence • Selective services • Changing context of Health care • Freedom as FT • Using technology to monitor patients in other locations • Increasing 3rd party partnerships • Private Care • Access to better primary care information • New markets e.g. Nursing Homes <p>Potential to develop other services</p>	Threats <ul style="list-style-type: none"> • Independent Sector • Viability of an organisation the size of L&D • Our Image • Sufficient Senior junior staff • CCGs changing priorities • Improved commissioning • Local Authority funding changes • Greater emphasis on performance • Tariff changes • Centralised commissioning • Regulatory changes

SWOT Analysis

Luton and Dunstable University Hospital
NHS Foundation Trust

Appendix B

Clinical Strategy Workstreams

Theme 1	L&D Closer to Home
<i>Work stream</i>	<i>Benefit</i>
Establish an off site Surgical and Medical Treatment Unit <u>Target date Q4 2013/4</u>	<p>Ophthalmology, Dermatology and plastics services will be operated from satellite unit c.1 mile Services will be provided from good quality facilities in the community This work stream will:-</p> <ul style="list-style-type: none"> • significantly improve the quality of patient experience for patients • de-congest the hospital site; • provide additional space for clinics which are currently very cramped and operating beyond their physical capacity; • the development will incorporate surgical facilities enabling a range of day surgical cases to be undertaken; • and it will enable the re-development of the hospital site including the NICU and ED expansion, both of which are key strategic developments for the Trust.
Establish a Community Cardiology Service <u>Target date - Established</u>	<p>The Trust, in conjunction with Bedford Hospital, put together a joint bid to provide community based elements of the Acute services that are currently provided. The service was established last year, and is nearing completion of the first year of delivery. The hospital Consultants, in conjunction with specialist GP's and other team based healthcare professionals have remodelled the pathway to benefit the patient, whilst maintaining the quality and overview provided by the Hospital team.</p>
Continue to support the Community COPD and Diabetes Service <u>Target date - Ongoing</u>	<p>This service was also part of a joint bid with Bedford Acute Trust to bring together elements of the service that could be provided in a community setting, whilst maintaining the expert overview of the Consultant & clinical hospital teams.</p>

Continue to support the community MSK Service <u>Target date - Ongoing</u>	<p>The Luton community MSK service is now in its 2nd year of delivery, with hubs for the service based in Luton town centre. A number of refinements in the actual delivery model have occurred over time, with a less Consultant centric model currently being operated. There is now an opportunity to bid for the Bedford MSK service, as the CCG are looking to provide a similar but more bespoke service to its patients.</p>
Hospital at Home <u>Target date - Ongoing</u>	<p>Test the feasibility of providing 'inpatient' care at home, if successful implement an integrated medical and surgical Hospital At Home Team This work stream will:</p> <ul style="list-style-type: none"> • Use workforce development funding to test new ways of working • Demonstrate if there is a cost benefit to providing sub acute care in a patients own home • Demonstrate the impact on Patient Experience • Establish a business case for continued funding based on actual bed closures. • If the business case is proven – roll out Hospital At Home as a single team either Community or Acute led.
Virtual Ward <u>Target date - Ongoing</u>	<p>This work stream will:</p> <ul style="list-style-type: none"> • Ensure that systems are in place to observe trends in mortality • Reduce mortality in fractured neck of femur patients by delivering the agreed action plan (see annual plan)

Theme 2	Development of Specialist Services
<i>Work stream</i>	<i>Benefit</i>
Further expansion of NICU <u>Target date - 2015</u>	NICU cots will be increased from 16 to 20 once the new facility is completed. The fabric of the current NICU is poor, and the space between the cots is inadequate for access and infection control purposes. The plan is to provide a new NICU within the new block being proposed on the site of the Restaurant/Wendy House with connections into the existing Women's and Children's buildings.
Cancer <u>Target date - ongoing</u>	The Cancer services team have worked incredibly hard to remap pathways and redesign services in conjunction with the Divisions to greatly improve the cancer waiting times. The service is now robustly delivering excellent performance, supported by the Endoscopy redesign work stream, changes in surgical delivery pathways and clinic reprofiling. There has also been a major refurbishment of the Chemotherapy 7 Clinic area on level 1 in the surgical block, to enhance the patient experience.
Hyper Acute Stroke <u>Target date – Q3 2013</u>	The stroke services offered by the Trust have grown in catchment area for Thrombolytic services, with a robust pathway and approach to ensure all stroke patients are on the Stroke ward. The Trust now wishes to be recognised as a Regional HASU, and work is being undertaken to bid for that status.
IVF Services <u>Target date – June 2013</u>	A dedicated IVF centre will be created on Lewsey Road to expand our current excellent service, and allow us to offer, in conjunction with Bourn Hall, a service to patients from a much wider catchment area. The building works will be completed in June 2013 and we will then be open for business.

Neurology <u>Target date - Ongoing</u>	The need for a robust Neurology service as part of an Acute district general hospital has never been in doubt, and with the retirement of our lead Consultant, the service is planning to address its capacity and skill needs to ensure it is able to continue to support the other Divisions.
Cardiology (PCI) <u>Target date</u>	Following a successful year of offering diagnostic services in the newly opened Cardiac Unit, the Trust has now applied to be accredited to provide PCI services. Following a qualification process, it is envisaged the Trust will install its second piece of dedicated fluoroscopic equipment and start to provide the therapeutic procedures in Q3 of 2013.
Theme 3	High Quality Acute Care
<i>Work stream</i>	<i>Benefit</i>
Improve mortality rates <u>Target date - Ongoing</u>	<p>This work stream will:</p> <ul style="list-style-type: none"> • Ensure that systems are in place to observe trends in mortality • Reduce mortality in fractured neck of femur patients by delivering the agreed action plan (see annual plan)
Medical Productivity <u>Target date – Q1 2014</u>	A work stream has been established to benchmark our medical productivity against market leading health care providers, under the McKinsey umbrella, and to look at innovative ways of reprofiling our workforce and the programmed activities that are allocated to each speciality. This is being linked into job planning and overall service planning for the Divisions.
24/7 Hospital <u>Target date</u>	This work stream will:

	<ul style="list-style-type: none"> • Ensure that the resources available out of hours are utilised in the most effective way • Ensure that Patients receive the care that they require when they require it. • Improve communication systems to reduce interruptions
Clinical Decisions Unit <u>Target date – Oct/Nov 2013</u>	<p>With the increasing number of ambulances that are presenting at the A&E department – it is important to be able to allow the A&E Clinicians the opportunity to fully assess and work up patients within the A&E environment. Currently EAU has a defined bed pool that makes this process difficult to accommodate, but the need is still present. It is planned to relocate fracture clinic, with a permanent home being made available after Oakley Court becomes habited, and to create a Clinical Decisions Unit within the footprint of the old fracture clinic. This work stream is urgent, as winter; pressures will increase the flow through A&E, and may lead to ambulance off load fines, or misuse of other areas to accommodate the surge – which is not acceptable.</p>
New Medical Model <u>Target date – Q2 2013</u>	<p>The wish to have senior decision makers on the floor in the medical areas can only be achieved by significantly changing both the Consultant rotas, but also the junior cover to them to facilitate a team which can be present at all times. This requires the creation of additional posts, and the reworking of existing posts and contracts to facilitate this.</p>
Extending Hours of Clinical Support Services <u>Target date - Ongoing</u>	<p>It has been recognised that in order to provide a 24/7 hospital, it is important to be able to investigate patients in a timely manner, necessitating a more robust need for access to Radiology & Pathology as well as other diagnostic tests. Work has been ongoing within DTO to reprofile the service to meet these needs, with the development of a shift rota for Radiology, moving away from an on call system, which previously existed. Pathology have been exploring this as well, and joining blood sciences and Biochemistry on call, which requires a lot of training. The Consultants have increased their covering hours to provide 3 session days and more cover</p>

	at weekends. If 24/7 diagnostics is truly required there will be a significant cost implication, as currently out of hours cover is relatively cheap to the organisation. This is being investigated.
Co-location of Critical Care <u>Target date – Q2 2013</u>	<p>This work stream will:</p> <ul style="list-style-type: none"> • Test the feasibility of moving critical care to ward 3 • Manage the implications of the move to ensure that risks are mitigated. • Deliver the changes required
Expansion of EAU <u>Target date – Q3 2013</u>	The medical pathway of care can be severely compromised by the size of EAU, as it is stated in the planning notes for an assessment Unit that there should be a certain number of beds per 100 attendances. We fall very short of this, and the impact is bottlenecking, and the need to fully decant the facility 3 to 4 times a day. We do have medical short stay wards, but some of the patients would be served better by a more expansive EAU, which had the medical personnel and expertise to work them up efficiently whilst in EAU. A larger EAU coupled with a CDU run by A&E should greatly enhance the Medical pathway for patients who present in A&E, and help with triaging the GP heralded patients. We are currently undertaking an option appraisal as to where the best place is for the extension to EAU.
Improved Theatre Utilisation <u>Target date - Ongoing</u>	Linked to the McKinsey work on Consultant Productivity, there is also an ongoing study looking at theatre utilisation. This forms a QIPP work stream, and has been established for a few years. The refurbishment of theatres 1-6 and the implementation of the Vanguard have all been part of this overarching work stream. The desired output is to improve our utilisation so that we are in the top percentile for all procedures, that we develop clean room facilities, with the one in Gynae being the start, to ensure we achieve best practice tariff, and that we achieve all of our 18 week, emergency and cancer waits successfully, with the lowest cost per case possible.

Outpatient Transformation <u>Target date - Ongoing</u>	As one of the QIPP work streams – this has continued to be an important focus for the clinical delivery of the Trust. The Project group have informed and overseen a refurbishment programme of the area to improve the patient experience, and have looked at clinic utilisation data and targeted on pathways and support for those, such as Phlebotomy. The work is ongoing, with many good outcomes already realised.
Perfect Day <u>Target date</u>	This project has been set up to release the time from trained nurses to concentrate on caring and delivering high-end support to patients. It has reprofiled the nursing staff and support staff needed on each ward, and looked at ward manager roles, delivery roles and other functions carried out within the hospital to try to bring about a more streamlined approach.
Theme 4	Teaching and Research Excellence
<i>Work stream</i>	<i>Benefit</i>
Establishment of a Division of Education & Research <u>Target date - Ongoing</u>	This has been established, with the vision to enhance and improve our teaching and research facilities and grow as a provider of training and education, as well as be more prolific in terms of publications. We are now a University Hospital, as it is hoped to use this widely to increase our profile in this field. The benefits are reputation, which ultimately affects recruitment and retention, and our ability to attract grant monies.
Working with UCHP	We have been a member of UCH Partners for over a year now, and benefit from forums and information sharing to disseminate to our colleagues. The membership offers us challenge as well as support, and give us routes into other partner organisations to allow us to work with them when necessary, or to share our data and successes too. Educational lectures are organised, which we participate in.
Virtual Ashridge	This is an online service, whereby the Trust staff has access to learning material posted by the Ashridge Management Institute, and can access training environments from them, in a virtual

	form. There is also access to course material if needed, and information on formal courses that exist.
Clinical Leadership Development	The programme is ongoing and has been established to support and develop our Clinical
Theme 5	Working with Others
<i>Work stream</i>	<i>Benefit</i>
Reducing Length of Stay <u>Target date – Ongoing</u> First step reduction September 2013	<ul style="list-style-type: none"> • Ensure that a coherent and accountable programme board framework is delivered. • Work with partners to ensure that complex discharge pathways are timely, safe and patient care is proactively managed • Develop the Ambulatory Care Unit to it's full potential • Continue to improve ward processes to expedite discharges with a high degree of patient satisfaction as measured by the Patient Experience centre feedback system. • On-going re-design of the bed base to ensure that demand and capacity is matched and minimise outliers • Streamline the TTA process • Deliver a new Medical Model • Test the feasibility of 7 day and bank holiday working patterns.

End of Life Care <u>Target date - Ongoing</u>	There has been an end of life care group established within the region to try to improve the pathways of care for patients, and to get a multi-agency approach to address the pathways of care offered to patients, ideally trying to avoid going through the emergency care pathway to access the facilities.
Development of Paediatrics <u>Target date - ongoing</u>	A lot of work has been done looking at pathways of care for children inside the hospital and at home and within the community setting. The LOS within Paediatrics is short and this is achieved by good protocols and communications between all carers and stakeholders. The service is held in high regard, and there are opportunities to expand it by offering a wider range of services, and repatriating some services from other hospitals. This is being reviewed by the team, but the facilities are quite cramped, so expansion into the current area is limited.
Theme 6	Transformed Facilities and IT Systems
Re- building L&D <u>Target date - 2015</u>	The Hospital Redevelopment Board was established in 2012 to oversee the approach to improving the real estate and infrastructure that we currently deliver healthcare. A number of iterations have been developed, but the decision by the Board to agree the spend at £50 million has led to a new scheme being developed, focussing on the key priorities for the site, and the infrastructure requirements. This is currently being worked up into a programme, with a focus on A&E, Oakley Court and the bed store. The Infrastructure element is ongoing throughout the programme. Each individual scheme has a benefits realisation plan.
Key enabling schemes to Rebuilding the L&D	In order to progress any redevelopment of the site, there is a need to unlock key spaces. The first large scheme to allow this would be Oakley Court, where Ophthalmology, Dermatology & Plastics may be relocated to allow for expansion into their areas by other services that will be displaced as part of the Master plan. A number of other schemes are also reliant on decanting

	<p>to allow their changes to occur. Those are:</p> <ul style="list-style-type: none"> • CDU requires the Fracture clinic to be relocated. • The New Block requires the Restaurant & the Kitchen/Max Fax/Diabetes and offices to be relocated. • The Outsourcing project must deliver a different method of delivery for food to release the restaurant. • The New Front Entrance requires the COMET and pre-assessment to be relocated. • The Clean room on ward 21 requires the pre-assessment team to be relocated. • Ward refurbishment requires an empty decant ward. • The bed store or body store may require something to move to allow a new building to be put up.
Car Parking Farringdon – completed Breast screening – Q2/3 - 2013	<p>Following the Car Parking groups outputs, a business case was written to expand staff parking facilities on the site. Many options were considered, with the final option chosen employing a temporary deck on top of the Farringdon car park and a more permanent structure being erected on the site of the Breast screening car park.</p>
EDRMS 5 year programme	<p>The Trust is currently dependent on paper records, the only information currently accessible electronically is some clinical letters, and diagnostic results being requested, stored and results displayed on the ICE system. A Strategy has been developed and signed off by the Board to transition to an electronic document and records storage system, first starting with intelligent paper, which can be created, but then scanned into the patient's record, which will have been scanned in by the Xerox, a partner in the venture. The records management function has already transferred to the partner, as the 5 year transition plan is rolled out. The resultant system will integrate all clinical systems, either through direct links or through front-end system management, and many of the data created will eventually be captured electronically, gradually decreasing the amount of paper handled.</p>

E OBS

Trust-wide implementation of electronic observation system.

L&D is collaborating with Kings Hospital to design and implement an electronic observation system. There are 3 main modules Standard Observations, Fluid Module and devices module, each has specific functions and benefits:

Standard observation module:

- Implementation of the standard observation module will improve response and completion of repeat observations of vital signs following deterioration of patients, and improve recording of observations at night
- By improving the process of observations this will lead to a reduction in mortality, the number of cardiac arrests, and the need for critical care.

Fluid module:

- Implementation of the fluids module will facilitate more accurate completion of fluid charting throughout 24hr period, and enable accurate calculations of intake and output charting for those patients that need it
- This will assist in the prevention of inadequate fluid intake, excessive fluid loss, or over infusion of fluids. Appropriate attention to fluid intake and output, can prevent electrolyte, cardiac and renal dysfunction.

Device Management

- Implementation of the devices module will enable the set up and maintenance of a central and ward based records of all indwelling devices in all patients across the Trust.
- This will facilitate effective tracking and surveillance of indwelling devices both during insertion and during the provision of ongoing care. Which will enable the Trust to more effectively monitor whether we are meeting standards of High Impact Interventions and Actions, and facilitate feedback of concerns for improvements in practice where needed. Improved compliance with standards will lead to a reduction in device related incidence of infection, e.g. Catheter Associated Urinary Tract Infection (CAUTI) and peripheral and central vascular related infections.

Telephony <i>Target date – Q3 2013</i>	<p>The current telephone system is old and unreliable, and when issues occur, we do not have a suitable back up in terms of business continuity. Technology has moved on greatly, and the agreement by FIP to support new Cat 6 cabling to be installed within the Trust offers us the opportunity to use VOIP over the same cables. This will offer all sorts of benefits, more extensions, mobiles phones acting as extension on the move, easier paging and contact, and it will support hot desking. It will also be more robust and flexible, with a lot more functionality. This is currently being explored with different partners to come up with the best solution for the Trust.</p>

Luton and Dunstable University Hospital NHS Foundation Trust

Strategic Outline Case

‘Building the new L&D’

(DRAFT FOR DISCUSSION)



1 Executive Summary

1.1 Strategic Case

1.1.1 Purpose of this Strategic Outline Case (SOC)

This SOC makes the case for investment to re-develop or refurbish the key elements of the Luton and Dunstable University Hospital NHS Foundation Trust's (L&D) estate and infrastructure and seeks approval to proceed to the Outline Business Case (OBC) stage.

The redevelopment of the L&D site has been a key strategic objective of the Trust for two years; with the re-provision of other key services such as the Neonatal Unit pre-dating this.

A complete rebuild is unaffordable in the current and foreseeable economic climate, therefore key priority areas will be targeted for investment. A targeted site development plan has been generated with the need to enable future development in mind. This programme of works is known as '**Building the new L&D**' and it complements the Trust's clinical service strategy known as '**Delivering the new L&D**'.

In most parts the investment required is to enable the Hospital to maintain its current functionality; it is not based on major service change or expansion. The '**Building the new L&D**' programme is best described as an extensive 4 year capital programme.

1.1.2 Project Objectives

- To enhance the quality of patient and staff experience at the L&D Hospital significantly by improving the fabric and condition of the environment.
- To improve considerably the condition of the L&D estate in order to reduce backlog maintenance thereby reducing risk.
- To radically improve the resilience of the L&D site in order to reduce patient safety risk.
- To improve clinical adjacencies in order to improve efficiency and reduce patient and staff journeys by improving the overall estate master plan.
- To reduce the operating costs associated with the L&D estate because of its current condition.
- To deliver the re-provision of key elements of the L&D estate and its infrastructure through new build or refurbishment solutions and within agreed budgets and timescale.
- To ensure innovative solutions are identified to either drive down capital cost or attract an appropriate 3rd party to share risk.
- To ensure that the programme is delivered within the overall Trust strategic context in order to facilitate the delivery of the Trust's Clinical Service Strategy, '**Delivering the new L&D**'.

1.1.3 Structure of Document

This SOC has been prepared using the agreed standards and format for business cases, using the Five Case Model:

- the **strategic case**
- the **economic case**
- the **commercial case**
- the **financial case**
- the **management case**

1.1.4 Strategic Context

- **National Context**

The current context is extremely challenging. The NHS is facing un-precedented demand as the population ages and patient expectation increases. This will require acute trusts to fundamentally change how services are delivered to enable greater senior clinical decision making throughout a greater proportion of the 24 hour period 7 days per week. This transformational change has to be undertaken in a period of significant financial restraint.

The extensive findings of the recent Francis Report regarding the care at Staffordshire Hospital set out the case for fundamental good care and the need for criminal sanctions to ensure it is delivered in all hospitals.

- **Local Context**

The L&D experienced significant strategic uncertainty locally during 2012/13 because of a proposed strategic change related to Milton Keynes and Bedford Hospitals. Bedford Hospital has declared its strategic intention is to be acquired by Milton Keynes FT and it now seems inevitable this will happen. The other two local trusts (West Herts and East and North Herts) have both declared their intentions to become Foundation Trusts (FT) and are within the FT pipeline.

The Trust actively participated in the Healthier Together programme throughout 2012/3 and will now work with its Commissioners to implement any relevant outcomes.

The Trust predominately serves two main CCGs: Luton (46%) and Bedfordshire (24.5 %) however an increasing number of services are also provided for Herts Valley and East and North Hertfordshire CCGs as well as a proportion of services commissioned directly by the Commissioning Board (12.2%). Although the CCGs are in the early stages of formation relationships are good and are developing well.

- **Organisational overview**

L&D became a NHS Foundation Trust in 2006. The site is 10 acres and is bordered on all sides by residential housing which land locks the site. The hospital has grown in an ad-hoc manner over the years. As a result, many clinical adjacencies have been significantly compromised which makes the hospital difficult for patients to navigate and causes a number of operational inefficiencies.

L&D is a medium sized general hospital with 640 inpatient beds and employs over 3,000 staff. It provides a comprehensive range of general medical and surgical acute services. In addition to the general acute services, the L&D has developed a number of specialist services. A number of services are delivered in partnership with others. Over the last few years a number of services have been provided in the community.

The Trust has a catchment population of approximately 320,000, which is ethnically diverse.

Over the last two years the Trust has performed very well against all national targets. However, sustaining performance is extremely challenging and relies upon very tight management of processes, staff and facilities with very little room for failure.

- **The Clinical Strategy – ‘Delivering the new L&D’**

The Trust’s recently completed Clinical Services Strategy; known as ‘Delivering the new L&D’ is predicated on 5 key themes:

- *Providing care closer to patient’s homes*
- *Providing high quality acute care*
- *Providing specialist services*
- *Delivering excellence in Teaching and Research*
- *Working in Partnership*

The Trust is keen to expand its catchment population further in order to improve its clinical and financial viability moving forward. This will be achieved by repatriating specialist services for both the local and an expanded population base and by maintaining its current market share for its core services. The Trust will invest in these core services so that more operate 24/7 ensuring senior medical opinion is available at all times. However, for this strategy to be successful the facilities and IT systems have to be ‘fit for purpose’ and capable of complementing the high quality clinical services the Trust strives to deliver.

1.1.5 The Case for Change

- **Investment Objectives**

- to procure the most economically viable rebuild/refurbishment design solution that best meets the Trust's clinical requirements whilst improving patient experience significantly
- to minimise any financial risk to the Trust
- to deliver the '**Building the new L&D**' programme with minimum disruption to the organisation being very mindful of the need to protect patient safety at all times
- to ensure value for money throughout every element of the programme and drive down backlog maintenance and overhead costs
- to focus investment wisely, ensuring major risks are eliminated, and where not possible, that robust mitigation is put in place to significantly reduce the risk
- **Current Situation**

Over a number of years little investment has been made into maintaining and improving the L&D's estate and infrastructure as a consequence a sizable investment is now needed urgently to ensure the Hospital is 'fit for purpose' now so it can continue to provide services in the future.

- **Capacity**

The Hospital's estate is now beyond its capacity in many areas.

Many departments are too cramped and the ability to provide good quality safe care is compromised. It is not only the buildings that are dysfunctional but also the car parking is insufficient to meet the demand.

- **Estate Condition**

A six facet survey was carried out in 2011 which identified:

'The estimated total investment to bring the Trust Estate up to a satisfactory condition is estimated at £24m. The current agreed programme (2011/12) allocates £9.6m of funds, which is deemed to present a significant risk to business continuity.'

Much of the estate has been developed in a very ad-hoc manner with many poor quality modular or temporary type structures having been used to provide interim solutions.

Effective cleaning and suitable infection control is extremely challenging. Despite the best efforts of FM staff the site looks shabby and untidy as a result the patient

experience is extremely poor and the overall working environment is not conducive to the delivery of high quality care that the Trust strives to provide for its patients.

- **Infrastructure Failures**

The Hospital regularly experiences infrastructure and /or general estate failures which costs a great deal to remedy and can also have far reaching effect on patient care and at times patient safety along with staff morale and overall operational efficiency.

- **Functionality**

Many of the departments fail to comply with Health Building note guidance with regards to the size of rooms relative to the function carried out within them, making areas cramped and potentially unsafe. The design of much of the current estate is extremely poor and therefore compromises are often made by staff as they develop 'workarounds' in order to deliver the best care they can.

- **Risk**

A number of the risks on the corporate risk register relate back in some way to the deficiencies of estate. These include:-

- Age and condition of engineering systems for Theatres A-D
- Aging electrical infrastructure and capacity issues of existing standby power systems to support critical care areas
- Aging heating systems vulnerable to failure and with poor resilience
- New defunct centralised controls and monitoring for essential environmental systems impacting on site overhead operational costs

- **Other Strategic Drivers**

The recent Francis Report emphasises inter alia the importance of providing good quality care. This statement accords with the Trust's Mission Statement: ***"The L&D is committed to delivering the best patient care, the best clinical knowledge and expertise and the best technology available, with kindness and understanding from all our staff"***. Whilst the Trust will deliver this mission via its staff their endeavours will be severely hampered if they are working in premises which are not 'fit for purpose', unreliable or poorly designed for the activity undertaken.

Two key strategic drivers across the NHS are to turn estate related liabilities into assets and to reduce the carbon emissions generated by the NHS significantly. Both of these are currently very difficult to achieve at the L&D without investment.

1.1.6 Future Service Model

This SOC addresses the need to invest in existing services therefore the service portfolio will not change as a consequence of the investment. However, if it is possible to stimulate changes to practice in order to improve quality and/or drive down cost as a consequence of the investment this will be actively encouraged.

1.1.7 Resource and Asset Management Implications

- **Scope of 'Building the new L&D' programme**

The criteria used to generate the priorities for the programme were:

- Patient Safety
- Patient Experience
- Site resilience
- Capacity pressures
- Performance requirements
- Control of Infection

Therefore, having considered all the various pressures across the site the priority areas that will receive investment are detailed below:

'Building the New L&D' Programme

- **New Neonatal Intensive Care Unit**
- **Replacement of the modular theatres, refurbishment of the Surgical Block and Delivery Suite theatres and development of clean room capacity**
- **Creation of a Clinical Decision Unit (CDU) adjacent to the ED to expand urgent care capacity**
- **Expansion of the Endoscopy Unit**
- **Co-location of the HDU and ICU in purpose built facilities**
- **Creation of an off site surgical treatment and outpatient hub for Ophthalmology, Dermatology and Plastics**
- **Ward refurbishment programme (c 3 -4 wards) to not only improve the environment but also increase side room capacity across the Trust**
- **Creation of a new Fracture Clinic and ongoing upgrade work to OPD areas**
- **An infrastructure upgrade programme to significantly improve site resilience and deliver a reduction in carbon emissions.**
- **A new main entrance and improvement to the public realm in order to connect the building together more effectively and improve patient experience**
- **Increased car parking**
- **A number of ancillary facilities including the Body Store, a bed store and bed wash**

The Trust will establish an appeal to fund the building of a house to provide en-suite over night accommodation for parents whose babies are on the NICU.

- What has been achieved so far – key enabling schemes

‘Building the new L&D’ Programme – Key Enabling Schemes

- Phase 1 & 2 of the Endoscopy scheme have been delivered, the final phase will complete in September 2013.
- Phase 1 of the car parking expansion has been completed (a new deck above the staff car park on Farringdon Fields), the final phase (Breast Screening car park) will complete by the autumn (subject to planning permission issues).
- Phase 1 of the theatre refurbishment has taken place in Main Theatres.
- Phases 1 and 2 of the Outpatient scheme are now complete; phase 3 will complete during the summer 2013.
- In order to resolve the capacity pressure in the Ophthalmology Department, Theatres and Outpatients, a project is underway to establish an off site surgical treatment centre for Ophthalmology, Dermatology and Plastics services. This development will also help decant and congest the site in order to facilitate the new build that will be necessary to accommodate some the re-development priorities. Given the timescale pressures a separate business case is under development for this key enabling scheme.

- **Approach to Site Master planning**

An overall site masterplan is being developed. This will incorporate the entire key priorities list above. In addition, future expansion or re-development cannot be constrained. This work is being carried out by a team of experienced health planners and architects.

- **Impact on Existing Estate**

The Surgical Block and Women’s Block remain virtually untouched by the programme, with the exception of the theatre suites in both blocks. The PFI wing, St Mary’s will also remain reasonably untouched unless the ground floor accommodation is used as decant space.

1.1.8 Land transaction and planning constraints

The only land transactions necessary to fulfil the programme is the acquisition of the off site facility as part of the enabling scheme. This transaction is addressed in a separate business case.

The Planners have previously stated that further planning permissions will be withheld until additional car parking is provided. This is addressed in the programme therefore will resolve the issue. The Planners have been informally consulted regarding **‘Building the new L&D’** and they appear content with the proposals. A formal planning permission proposal has yet to be submitted.

- **FM strategies**

A separate but linked project is underway to explore what alternative solutions exist in order to improve the quality of the soft FM services.

- **Workforce implications**

The workforce implications arising from the programme are minor as the investment mostly relates to enhancements to the physical estate.

1.2 ECONOMIC CASE

1.2.1 Purpose of the Economic case

The purpose of the Economic case is to outline the options that have been considered and the approach and methodology taken to generate the shortlist which will be further considered at the OBC stage.

1.2.2 Options appraisal

Given the nature of this proposal the generation of options has been extremely difficult. In essence the only feasible options to consider are the '**Building the new L&D**' programme (Option 1), 'do nothing' (Option 2) or the 'do minimum' (Option 3).

The do nothing option is not feasible because the Trust has an obligation to provide safe patient care and a legal duty to insure its staff are safe from harm under the Health and Safety at Work Act. Therefore, option 2 was discounted because the site would simply decay if no investment were made making it impossible for the Trust to discharge its legal obligations over time.

The option to progress the '**Delivering a new L&D**' along with the do minimum option will be taken through the stage to enable the preferred option to be compared against another.

The do minimum option consist of:

- Expand car parking (without this the planners will not approve further development)
- Re-building NICU on the boiler house car park
- Re-furbishing the existing modular and Delivery Suite theatre theatres (the Vanguard theatre would need to be retained)
- Refurbish delivery theatres
- Infrastructure resilience work
- Convert Fracture Clinic to CDU
- Convert ward 18 into Ophthalmology outpatients
- Convert Ophthalmology Unit into Fracture Clinic

The cost of the do minimum option is likely to be in the region of £25m. In addition, few if any operating costs would be reduced.

1.3 FINANCIAL CASE

1.3.1 Purpose of the Financial Case

The purpose of the Financial Case is to set out the indicative financial implications of the programme. Please note that detailed analysis of the financial case including affordability takes place at OBC stage.

1.3.2 Background

In January 2013 under Gateway 18624 the DOH required that all NHS Provider Organisations should be able to clearly evidence that they are:

- Delivering on the NHS Constitution Pledge to ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice,
- Operating efficient, safe and fit for purpose premises that support the delivery of high quality healthcare services and as required by the quality accounts agenda.

The issuing of the NHS Premises Assurance Model focusing on five key domains of Safety, Effectiveness, Patient Experience, Board Governance and Finance / Value for Money aligned with the FT view that in order that the Board could demonstrate assurance of essential statutory undertaking and quality that a programme of improving premises was required.

1.3.3 Finance Approach

The Board of Directors have acknowledged that current performance through a relative modest asset base is strong with the FT generating over £230m against a Non Current Asset value of £100m. This return per £ of Non Current Assets employed is at the higher end of that achieved by medium sized acute trusts.

The Board of Director determined that this level of return was unsustainable and commissioned PwC to identify an optimum level of investment that both delivered the key strategic investment objective but also enabled the FT to retain financial sustainability. The work of the Hospital and PwC was triangulated with further modelling work undertaken by McKinsey as part of the Healthier Together Programme.

- **Findings**

PwC identified that the investment would best be served by utilising a mixture of internally generated cash and access to external funds (loans) from the NHS Financing Facility (FTFF). In determining affordability PwC advised that the FTFF would place reliance on Monitor Metrics for long term borrowing. To that end the FT is advised that it should be able to secure loans of around £39m.

The overall investment in the three year annual plan period (from April 2013) identified planned capital expenditure of nearly £79m. Planned investments include a £51m contribution to the Hospital Development Plan. Further funds are used to fund routine Medical Equipment, embrace Information Technology opportunities and maintain the existing site.

The Board of Directors have identified that the financing gap between the application and source of funds shall be secured from existing cash resource plus internally generated cash from our trading activities.

The final phase of the 'BUILDING THE NEW L&D' will require a further expenditure of £9m in 2016/17 (making a total investment of £60m).

1.3.4 Revenue Affordability

The Board of Directors have determined three key financial operating metrics that will create the framework through which the Trust can demonstrate on-going financial viability and compliance with the Health Care Act. These are:

- The FT shall maintain a cash reserve equivalent to 1/12th of operating expenditure
- The FT shall at all times maintain a minimum financial risk rating of 3 (*based on existing Compliance Framework*)
- The FT shall retain a contingency budget of £3m in each financial year

The Trust has recorded 14 years of financial surplus. However this has been achieved in the context of significant growth in NHS Funding. It is clear that the challenges from 2013/14 will be significant. For the foreseeable future it is envisaged that the Trust will be disadvantaged by the impact of the tariff decreasing and inflation which will require the Trust to improve efficiency by 4.5% per annum (£10m). This challenge is made harder by a recurrent shortfall carried into 2013/14 £3m. The Commissioners QIPP plans and the interest and loan repayments represent further cost that the FT will need to accommodate.

The Trust has developed a plan designed to deliver its FT financial strategy.

1.3.5 Expenditure

The 2013/14 Annual Plan articulates productivity and efficiency gains built into plans, including financial impact of projected gains. Further work will be progressed in conjunction with the development of the OBC to drive further clarify on medium and long term cost improvement schemes.

1.4 COMMERCIAL CASE

1.4.1 Purpose of the Commercial Case

The purpose of the Commercial Case is to describe how the preferred option will be procured. During the development of the Outline and Full Business Case (OBC), the commercial case will summarise the outcome of dialogue with potential partners in relation to third party investment.

1.4.2 Current assumptions regarding the Commercial Case

It is intended that the overall programme is broken into discrete construction elements. The precise procurement solution will be explored further during the development of the OBC however; a range of options will be explored including the possible use of Procure 21+ in addition to more traditional standard OJEU and contract procurement approaches.

It is anticipated that the Trust will procure for third party providers to deliver the main entrance and the retail offering and the energy centre.

The Trust will also explore the potential benefit of establishing a 100% wholly owned subsidiary – Prop Co. If deemed appropriate the Trust does have the legal freedom to establish such an entity and could run discrete elements of the estate or the whole estate through it. The most obvious advantage of such a subsidiary is a potential VAT saving. Other opportunities, such as the establishment of a more commercial approach to the provision of property and facilities services are also an attractive proposition.

1.5 MANAGEMENT CASE

1.5.1 Project Management

- **Overview**

The CEO is the Senior Reporting Officer (SRO) for the programme and a Non-Executive Director will Chair the Hospital Redevelopment Programme Board (HRPB).

A small redevelopment team has been established led by the ‘**Building the new L&D**’ Programme Director who will report into the SRO and will be supported by the Director of Strategic Projects and a Programme Manager. The Director of Estates and Facilities will assume the role of Project Director for the Infrastructure Project and will report into the overarching programme in relation to the infrastructure project. The team will expand as the workload requires. A Project Office will be set up on site.

- **Governance**

The Hospital Redevelopment Project Board (HRPB) will oversee the programme. The HRPB is accountable to the Finance, Investment and Performance (FIP) Committee a formal sub-committee of the Board.

Prince 2 project management methodologies will be applied where relevant. The project management approach aims to be open, transparent, fair and equitable and will explore the range of options available in the most efficient way possible without incurring undo cost for both the Trust and potential partners.

The programme will be delivered in a phased approach, with a number of bespoke work streams, which will include a Clinical Chair, a dedicated project manager, and a member of the finance team, a General Manager or nominated lead and key team members. They will meet on a regular, at least fortnightly basis, and will present progress reports into the Hospital Redevelopment Programme Board.

A high profile communications plan will be implemented over the next month in order to inform patients, staff, visitors and other key stakeholders about the re-development programme – its scope and anticipated timescale.

- **Advisors**

PwC have been appointed as the Trust's financial and commercial advisors and they will assist the Trust with the development of an Investment Strategy as well as providing financial and commercial support with the OBC and the development of a funding strategy and loan application. PwC will also assist the Trust in undertaking the Risk Evaluation for Investment Decisions (REID).

Balfour Beatty, the Trust's P21+ partner have been re-engaged with the clear remit to develop the design solution for the new build elements of the programme. The refurbishment elements will be developed by the in house capital team supported by more local design expertise which will be procured competitively as required.

Bevan Brittan will provide legal advice regarding the creation or not of a Prop-co.

- **Approval Process**

The OBC and then the final Full Business Case will be presented for approval to the HRPB and then to the FIP Committee and finally to the Board of Directors and Board of Governors for approval.

Once the OBC and then FBC have been agreed, delegated authority will be given to the HRPB to sign off each individual elements of the business case against set criteria. If there is a deviation from the agreed project allocation by more than 10%, then an exception report will be written and passed to FIP for final approval. The overall scheme will then be re-profiled to allow for the deviation in funds.

1.6 Project Plan

Below are the key milestones relating to the programme are shown below:

Approval of OBC by HRPB/FIP/Board	November 2013
Approval of FBC by FIP	February 2014
Approval of FBC by Board	March 2013
Individual Business cases approved by	Throughout programme – linked to year

HRPB – delegated Authority	of deliver for funding pull down
Oakley Court Delivered	Q4 2012/3
Building a new L&D completed	Q2 2016/7

1.7 Key risks to delivery and measures to mitigate and manage these risks.

A number of key risks have been identified, along with the probability and impact assessed. The management and/or mitigation of each of these risks has been defined.

2 Strategic Case

2.1 Purpose of a Strategic Outline Case (SOC)

The main purpose of a Strategic Outline Case (SOC) is to establish the need for investment; to appraise the main options for service delivery; and to recommend a preferred way forward for further analysis.

The SOC sets out:

- the strategic context for the proposed change;
- establishes in broad terms the health service need that is to be addressed by the proposed change;
- considers the options for change;
- considers the affordability of the proposed change;
- sets out the headline timescales and delivery mechanisms; and lastly
- confirms that robust project management arrangements are in place.

This allows the Board of Directors and other decision making groups to be fully appraised prior to approval for proceeding to the work of the detailed Outline Business Case (OBC). Approval of the SOC by the Board of Directors is the trigger for the development of a more detailed OBC.

2.2 Purpose of this SOC

This SOC makes the case for investment to re-develop or refurbish the key elements of the Luton and Dunstable University Hospital NHS Foundation Trust's (L&D) estate and infrastructure and is seeking approval to proceed to the Outline Business Case (OBC) stage.

The redevelopment of the L&D site has been a key strategic objective of the Trust for two years; with the re-provision of other key services such as the Neonatal Unit pre-dating this.

A complete or even significant partial new build of the estate is unaffordable in the current and foreseeable future given the economic climate. As a consequence the Board of Directors have decided that any site investment programme has to be targeted at the highest priority areas, therefore a site refurbishment masterplan has been developed which consists of a number of key elements. In developing the site masterplan the need to enable future development has been considered wherever possible. This programme of works is known as '**Building the new L&D.**'

In most parts the investment required is to enable the Hospital to maintain its current functionality, it is not based on major service change or expansion. Where ever possible the investment will be used to facilitate service change however, the Trust acknowledges that in essence the programme is about creating an estate which is 'it for purpose'. Therefore, whilst any cash savings will be used to offset the

cost this is not the only driver for the investment. The **'Building the new L&D'** programme is best described as an extensive 4 year capital programme.

Given the need for the Trust to borrow to fund the investment it would be prudent for the Trust to agree this SOC by the end of May 2013 so that the design solution, and where relevant service models the can be developed further; along with the investment and funding strategies, including a loan application without delay. The outputs of which will be the basis of the OBC which will be submitted to the Board of Directors in November 2013. The current favourable interest rates being offered by the Foundation Trust Funding Facility (FTTF) make securing before the end of the year essential.

2.3 Project Objectives

The objectives for the **'Building a new L&D'** programme are:

- To significantly enhance the quality of patient and staff experience at the L&D Hospital by improving the fabric and condition of the environment.
- To improve considerably the condition of the L&D estate in order to reduce backlog maintenance thereby reducing risk.
- To radically improve the resilience of the L&D site in order reduce patient safety risk.
- To improve clinical adjacencies in order to improve efficiency and reduce patient and staff journeys by improving the overall site master plan.
- To reduce the operating costs associated with the L&D estate and infrastructure because of its current condition.
- To deliver the re-provision of key elements of the L&D estate and its infrastructure through new build or refurbishment solutions and within agreed budgets and timescale.
- To ensure innovative solutions are identified to either drive down capital cost or attract an appropriate 3rd party to share risk.
- To ensure that the programme is delivered within the overall Trust strategic context in order to facilitate the delivery of the Trust's Clinical Service Strategy, **'Delivering a new L&D'**.

2.4 Structure of Document

This SOC has been prepared using the agreed standards and format for business cases, using the Five Case Model, which comprises the following key components:

- the **strategic case** section. This sets out the strategic context and the case for change, together with the supporting investment objectives for the scheme
- the **economic case** section. This demonstrates that the organisation has selected a preferred way forward, which best meets the existing and future needs of the service and is likely to optimise value for money (VFM)

- the **commercial case** section. This outlines what any potential deal with any third parties or innovative funding solutions might look like.
- the **financial case** section. This highlights likely funding and affordability issues and the potential balance sheet treatment of the scheme
- the **management case** section. This demonstrates that the scheme is achievable and can be delivered successfully in accordance with accepted best practice.

2.5 Strategic Context

2.5.1 National Context

The current context is extremely challenging. The NHS is facing un-precedented demand as the population ages and patient expectation increases. This will require acute trusts to fundamentally change how services are delivered to enable greater senior clinical decision making throughout a greater proportion of the 24 hour period, 7 days per week. This transformational change has to be undertaken in a period of significant financial constraint which requires savings in excess of £20billion to be made across the whole NHS.

In addition to the increasing demand for healthcare, there is a growing political desire to challenge the historic models of service delivery by subjecting service providers to more competition in an attempt to drive up quality whilst driving down costs and improve efficiency. All providers of health services are now expected to deliver better quality care for less. The tariff is reduced by 1% year on year. It is likely that this reduction will continue for a number of years, making the need for effective savings programmes vital if acute trusts are to survive.

2.5.2 Policy Change

Since its inception the NHS has been subject to major change as it responds to the ever changing environment within which it operates. 2013 sees one of the most significant transformations yet as the Health and Social Care Bill 2012 is implemented with the abolition of Primary Care Trusts (PCT) and Strategic Health Authorities (SHA). The Bill has been created in response to:

- putting patients at the centre of the NHS;
- coping with increasing demand and costs;
- an increasing focus on quality of care and outcome;
- and, lastly the state of the world's economy.

The key changes centre on clinically led commissioning with the formation of Clinical Commissioning Groups (CCGs) and the NHS Commissioning Board. With the latter being responsible for authorising CCGs, allocating resources and commissioning primary care. Ministers will set the objectives for the Commissioning Board through a mandate and commissioning outcomes framework. The mandate has five key areas as illustrated below in figure 1 below.



Figure 1: Commissioning Board Mandate priorities

Other changes include regulation to support the development of innovative service models, a greater voice for patients, a changing role for public health with the creation of Health and Wellbeing Boards by Local Authorities, greater accountability locally and nationally and a streamlining of 'arms length bodies'.

The extensive findings of the recent Francis Report regarding the care at Mid-Staffordshire NHS Trust has re-emphasised the importance of hospitals providing high quality care in all aspects of a patient's episode of treatment. The findings from the enquiry will have far reaching consequences on the NHS and the care hospitals provide.

2.5.3 Local Context

In addition to the national changes to the NHS; the L&D experienced significant strategic uncertainty locally during 2012/13 in relation to the proposed strategic changes related to Milton Keynes and Bedford Hospitals. As a consequence of this and the uncertainty over acute service rationalisation during the Healthier Together discussions, the L&D's progress with its strategic intentions and decisions surrounding the site re-development were deferred during the year. However, 2013/14 brings with it a little more certainty as Bedford Hospital have now declared their strategic intention to be acquired by Milton Keynes FT, which now seems inevitable.

Despite Milton Keynes acquisition plans for Bedford Hospital, the Paediatric services and therefore Maternity services there are under immense threat due to medical

staffing issues. This may result in the withdrawal of trainees and therefore, Bedford Hospital may become unable to offer paediatric services and only midwifery led Obstetric care. Therefore, the L&D may be in a position to expand its catchment for both services. There are no definitive plans and therefore nothing concrete exists on which the L&D can currently plan its service but the Trust will clearly monitor the situation very closely.

Throughout 2012/3, senior clinicians and managers from the L&D actively participated in the Healthier Together programme. The programme has been formally closed to enable commissioners and providers to work together locally to deliver the strategy for their communities. As a consequence the L&D has a more certain platform from which to plan its future strategic direction and clinical services strategy. The Trust's Clinical Services Strategy known as **'Delivering a new L&D'** has used much of the service configuration work undertaking during Healthier Together programme to underpin its development.

The Trust's neighbouring trusts, West Herts and East and North Herts, have declared their intentions to become Foundation Trusts and both are currently in the FT pipeline.

The Trust predominately serves two main CCGs: Luton (46%) and Bedfordshire (24.5 %) however an increasing number of services are also provided for Herts Valley and East and North Hertfordshire CCGs as well as a proportion for the services commissioned directly by the Commissioning Board (12.2%).

2.5.4 Organisational overview

L&D became a NHS Foundation Trust in 2006.

The Trust has been a single entity since its inception originally situated in the Town Centre at the Bute Hospital. The Hospital moved out of town in 1936 to its current location. The site is 10 acres and is bordered on all sides by housing which in essence has land locked the site. The hospital has grown in an ad-hoc manner over the years, which has led to many clinical adjacencies being significantly compromised. This has made the hospital difficult for patients to navigate and leads to a number of operational inefficiencies.

L&D is now a medium sized general hospital with approximately 640 inpatient beds. It employs in excess of 3,000 staff and provides a comprehensive range of general medical and surgical acute services. In addition to the general acute services, the L&D has developed a number of specialist services including Breast screening, Bariatric services, Level 3 Neonatal services and Limb Fitting.

The Trust has also developed a number of services in partnership with others. For example, Fertility services with Bourn Hall in Cambridge and Paediatric services with Great Ormond Street Hospital (GOSH).

Over the last few years, the Trust has also taken L&D services into the community such as Muscular Skeletal Services (MSK), COPD and Diabetes.

The Trust has a registered catchment population of approximately 320,000 people. The population is extremely diverse with 35% of Luton's population from different cultural and ethnic backgrounds including Pakistani, Bangladeshi, Indian, African - Caribbean and Eastern European. Some of its more specialist services serve a population of c. 1 million. The catchment population reside in parts of Bedfordshire, Hertfordshire and Buckinghamshire. The geography of the catchment is varied ranging from semi rural in the north of the patch, with centres of population located in Luton and Dunstable predominantly.

Over the last two years the Trust's performance against all national targets has improved significantly. A particularly area of note include its A&E performance especially given the ever growing demand for the service. However, sustaining this performance is extremely challenging and relies upon very tight management of processes, staff and facilities with very little room for failure.

2.5.5 Corporate Objectives

The Trust's agreed three-year objectives (2012-2015) are outlined below:

1. Deliver Excellent Clinical Outcomes

- Year on year reduction in HSMR in all diagnostic categories

2. Improve Patient Safety

- Year on year reduction in clinical error resulting in harm
- Year on year reduction in HAI

3. Improve Patient Experience

- Year on year improvement in patient experience demonstrated through hospital and national patient survey, leading to upper quartile performance

4. Deliver National Quality & Performance Targets

- Deliver sustained performance with all CQC outcome measures
- Deliver nationally mandated waiting times & other indicators

5. Progress Clinical and Strategic Developments

- Implementation of Clinical Services strategy
- Implementation of Site Re-development Plan 'Building a New L&D'

6. Develop all staff to maximise their potential

- Deliver excellence in teaching and research as a University hospital
- Ensure a culture where all staff understand and promote the vision and values of the organisation
- Recruit and retain a highly motivated and competent workforce

7. Optimise our Financial Plan

- Deliver our financial plan 2012/2015

2.5.6 Trust Vision, Aims and Values

The vision for the Trust detailed below underpins both the wider organisational strategy and the clinical services strategy. It clearly defines what the organisation is committed to.

Vision Statement

“The L&D is committed to delivering the best patient care, the best clinical knowledge and expertise and the best technology available, with kindness and understanding from all our staff “

Our Aims

Aims

- To put patients first, providing the best possible clinical outcome and the highest quality of the patient experience.
- In partnership with Cambridge University, University College London and others, to be nationally respected for the provision of education and development.
- To ensure value for money and using the freedoms of Foundation Trust status, to exploit our strengths and specialisms for the benefit of patient care and clinical outcomes.
- To ensure effective governance, accountability and leadership while maintaining staff engagement and involvement.
- To ensure a full appreciation throughout the organisation of the changing environment of commissioning, competition, risk, regulation, patient choice, sustainability, QIPP and our financial position.
- To develop and maintain productive relationships with external partners and maximise opportunities for communication and joint working.
- To retain and recruit the best staff.
- To market and promote effectively the services of the Trust.

Our Values

Values

- To put the patients first, working with them to ensure they receive high quality safe care with dignity and respect.
- To value the contribution of staff, volunteers, members, governors and other partners and stakeholders, working collaboratively and professionally to deliver high quality clinical care.
- To focus on continuous improvement in the pursuit of excellence, maximising development opportunities.

- To manage our resources in a co-ordinated way, with an emphasis on productivity, value for money and quality.
- To see the diversity of our people as a strength, through our commitment to inclusion, equality and human rights.
- To accept responsibility for our actions, individually and collectively, to meet our obligations and deliver our commitments.

2.5.7 The Clinical Strategy – ‘Delivering the new L&D’

The Trust has recently completed its clinical services strategy, known as ‘Delivering the new L&D’. The strategy is currently being discussed with key stakeholders before its formal publication in June. The strategy is predicated upon 5 key themes:

- ***Providing care closer to patient’s homes*** – in response to not only making services more convenient for patients but also in order to reduce the need to invest in buildings rather than services.
- ***Providing high quality acute care***- this recognises that the Trust’s core business is the provision of care for acutely ill patients. Most of this care can only be provided from within a hospital as patients may need the backup of a number of different services to ensure the very best clinical outcome. The Trust will continue to modernise how these services are offered to ensure they are provided in the most clinically effective and efficient manner. To this end the Trust is exploring a number of initiatives to drive down length of stay or reduce admissions completely as well as how to make services more productive and improve patient outcome.
- ***Providing specialist services*** - having created the infrastructure in terms of staff, equipment and premises to deliver acute care it is beneficial for the Trust to utilise these resources and the expertise of the staff more by developing specialist services. This is good for the patients as it improves their local access to specialist services saving them having to travel for their treatment. Whilst the Trust is selective regarding which services to develop beyond those usually delivered in a secondary setting. The Commissioners welcome the development of local specialist services as it enables them to save the Market Forces Factor premium.
- ***Delivering excellence in Teaching and Research*** – the quality of the Trust is teaching and research has been recognised in the recent award of University status. This, along with the Trust’s appetite to develop Specialist Services enables the Trust to attract and retain high calibre clinical staff.
- ***Working in Partnership*** – for many years the L&D has been a rather inward looking organisation, however the organisation now acknowledges that working in partnership with a number of varied organisations, public and private can be extremely helpful and ensures the very best outcome for the patient.

The Trust has a relatively small catchment population for a District General Hospital (DGH) and therefore is keen to expand its population further, in order to improve its clinical and financial viability moving forward. However, given the economic climate this expansion needs to be achieved by repatriation of specialist services for both the local and an expanded population base. The Trust is also very keen to maintain its current market share for its core services. To achieve this the Trust will invest in these core services so that more services operate 24/7 and so that appropriate senior medical opinion is available throughout the 24/7 period.

However, the clinical strategy cannot be fully implemented unless the facilities and IT systems are fit for purpose and are able to complement the high quality services the Trust strive to deliver.

2.6 The Case for Change

2.6.1 Investment Objectives

The investment objective is to proceed with the development of an OBC so that the organisation can make an informed decision based on the following investment objectives:

- **Investment Objective 1:** to procure the most economically viable rebuild/refurbishment design solution that best meets the Trust Clinical requirements whilst improving patient experience significantly.
- **Investment Objective 2:** to minimise any financial risk to the Trust.
- **Investment Objective 3:** to deliver the *'Building the new L&D'* programme with minimum disruption to the organisation, being very mindful of the need to protect patient safety at all times.
- **Investment Objective 4:** to ensure value for money is delivered throughout every element of the programme and to drive down backlog maintenance and overhead costs.
- **Investment Objective 5:** to focus investment wisely by re-configuring the site so that the greatest risks are eliminated or robust mitigation is put in place to significantly reduce risk and backlog maintenance.

2.6.2 Main Benefits Criteria

Satisfying the potential scope for this investment will deliver the following high level strategic and operational benefits. By investment objectives these are as follows:

Investment Objectives	Main Benefits Criteria
Investment Objective 1: to procure the most economically viable rebuild/refurbishment design solution that best meets the Trust Clinical requirements whilst improving patient experience	Provide a safe environment which complements and enables the high quality clinical care the Trust seeks to provide.
Investment Objective 2: to minimise any financial risk to the Trust.	Minimise any financial risk to the Trust and ensure the investment stimulates changes to practice which help the organisation realise its cost improvement programmes.
Investment Objective 3: to deliver the 'Building the new L&D' programme with minimum disruption to the organisation being very mindful of the need to protect patient safety at all times.	Minimise disruption and maximise patient safety at all times both throughout the build programme and beyond.
Investment Objective 4: to ensure value for money throughout every element of the programme and drive down backlog maintenance and overhead costs.	Deliver Value for Money so that resources can be invested into clinical services.
Investment Objective 5: to focus investment wisely by re-configuring the site so that the greatest risks are irradiated or robust mitigation is in place to significantly reduce risk and backlog maintenance.	Reduce risk or enhance mitigation for the organisation as a whole.

2.6.3 Current Situation

Over a number of years little investment has been made into maintaining and improving the estate and infrastructure as a consequence a sizable investment is now needed urgently to ensure the Hospital is "fit for purpose" now and so that it can continue to provide services in the future.

- **Capacity**

The L&D is an extremely busy acute Hospital which strives to offer the very best clinical care to its patients. The demand for the services offered by the Hospital has grown significantly over the years. Whilst services have been re-designed in an attempt to reduce the number of patients actually attending the Hospital to receive their care, a significant number still need the services only found within an acute hospital facility. As a consequence the Hospital's estate is now beyond its capacity in many areas.

The Ophthalmology Unit is a good example of a department having exceeded its physical capacity. Amongst other operational pressures the service has no option at present but to carry out three separate patient interventions simultaneously in one reasonably large room. Clearly this is not acceptable on the grounds of patient privacy and dignity. However, the demand for the service means without combining the activities in this one room patients would have to travel further for their treatment or would have to wait longer.

It is not only the buildings that have become cramped and dysfunctional but also the quantity of car parking is now insufficient to cope with the current level of demand. The number of staff spaces has recently been increased which has released some additional patient and visitor spaces however; additional spaces are still required for patients and visitors. The lack of parking on site leads to many staff parking off site in the local side streets outside people's houses. This creates significant disquiet amongst the Trust and its neighbours.

- ***Estate Condition***

A six facet survey was carried out in 2011 which identified:

The estimated total investment to bring the Trust estate up to a satisfactory condition as per NHS Estatecode is £24 million.

The original hospital was built in 1938. Subsequent developments over a number of years have not always adhered to an overall master plan.

In many instances, key aspects of the estate have not received life cycle investment to optimise performance. Significant investment is required in the areas of:-

- External building fabric
- Existing water distribution systems to protect against Legionella
- Electrical resilience
- Poor ventilation
- Compliance with statutory recommendations in respect of key building services

The overall quality across the existing estate is compromised by:-

- Lack of storage provision

- Old floor coverings
- Poor signage (way finding)
- Inadequate and poor control of aging heating and ventilation systems
- Decoration

The site overhead running costs are sub optimal due to:-

- Aging heating and ventilation systems with poor controls
- Use of local portable heaters and mobile air conditioning unit
- Poor wall / roof insulation
- Single glazing
- Inefficient lighting

Much of the estate has been developed in a very ad-hoc manner with poor quality modular or temporary type structures having been used. Four operating theatres were constructed 25 years ago using a modular construction which at the time had an expected life of five years. These theatres are still used today albeit no longer for Orthopaedics due to ventilation constraints.

In addition, the condition of many of the buildings makes effective cleaning and the delivery of suitable infection control measures extremely challenging. Despite the best efforts of FM staff the site looks shabby and untidy. As a result the patient experience is extremely poor and the overall working environment is not conducive to the delivery of high quality care that the Trust strives to provide for its patients. The negative effect of the estate on the patients overall feeling of well being is often commented upon by patient groups and Governors as well as being identified more formally within national patient surveys and will no doubt continue to be raised as PEAT inspections are replaced with PLACE inspections.

The quality of the environment throughout the Hospital is poor in many areas, with departments which have recently been refurbished such as the Cath Lab or phase 1 of the Endoscopy scheme 'standing out' like mini oases. This has the unfortunate effect of making other areas look even worse.

- ***Infrastructure Failures***

The Hospital regularly experiences infrastructure and /or general estate failures. Over the last few years these incidents have included a loss of mains power for 2 days, a loss of heating to half the wards and department for a week during mid-winter, and a number of other major failures. Such as major drain and sewage problems, leaking roofs, ventilation plant failures etc to name a few examples.

Not only do such failures cost a great deal to remedy, but they also have far reaching effects on patient care and at times patient safety along with staff morale and operational efficiency.

- ***Functionality***

Many of the departments fail to comply with Health Building note (HBN) guidance with regards to the size of rooms relative to the function carried out within them, making area cramped and potentially unsafe. Whilst HBN guidance is not mandatory, they have been developed by expert health, planners and designers based upon the specific task to be undertaking within a specific room. It is acceptable to derogate from HBN guidance but the scale of derogation is massive at the L&D and not related to local practice just down to poor design many years ago.

The Neonatal Intensive Care Unit is a very good example of this, where the space between cots is highly inadequate, increasing the spread of any infection, and also allowing little space for x-ray machines and manoeuvring equipment around the cot. The lack of space makes it difficult for parents to sit nearby, and this has led to a problem with bonding with the infant for some parents.

The design of much of the current estate is extremely poor and therefore compromises are often made by staff as they develop 'workarounds' in order to deliver the best care they can. An example, of this would be that during extremely busy periods in ED, the Paediatric Emergency Department has been used as an ad-hoc Clinical Decisions Unit. The creation of the new Clinical Decisions Unit adjacent to the ED will stop this practice.

- **Risk**

A number of the risks on the corporate risk register relate back in some way to the deficiencies of estate.

These include:-

- Age and condition of engineering systems for Theatres A-D
- Aging electrical infrastructure and capacity issues of existing standby power systems to support critical care areas
- Aging heating systems vulnerable to failure and with poor resilience
- New defunct centralised controls and monitoring for essential environmental systems impacting on site overhead operational costs

- **Other Strategic Drivers**

The recent Francis Report emphasises, inter alia the importance, of providing good quality care. This statement accords with the Trust's Mission Statement: ***"The L&D is committed to delivering the best patient care, the best clinical knowledge and expertise and the best technology available, with kindness and understanding from all our staff"***

Whilst the Trust will deliver this mission via its staff their endeavours will be severely hampered if they are working in premises which are not 'fit for purpose', unreliable or poorly designed for the activity undertaken.

A key strategic driver across the NHS is to turn healthcare estate from liabilities into assets. In many trusts this can be achieved by site reconfigurations which often

release capital to re-invest. Sadly that is not an option for the L&D owing to its single site status and that almost every building is already at or beyond its capacity. Some scope does exist to streamline the use of portacabins and temporary facilities such as the Modular Theatre Suite (Vanguard) which is currently on hire. Not only does this save on the rental per annum, releases badly needed car parking spaces, but also reduces the amount of estate heated by solely by electricity...

The NHS as a whole is extremely aware of the volume of carbon emissions it generates from its activities. Therefore, all NHS organisations have been mandated to develop Sustainability Strategies to reduce carbon emissions years on year in order for the Government to meet its overall target to reduce green house gases. The L&D takes sustainability very seriously and as a consequence has introduced many measures to save energy, recycle waste etc. However, for more to be achieved the Trust has to replace boiler plant and heating systems, upgrade windows, utilise more energy efficient lighting, reduce the number of electrically heated portacabins and improve insulation etc.

The lack of any major investment in the infrastructure of the Hospital is a specific concern and is identified as a key risk on the corporate risk register. The Trust has previously experienced significant operational pressures when it experienced a major electrical failure. Whilst a number of interim solutions were implemented many were only short term in light of the Trust's aspiration to reconfigure the site.

2.7 Future Service Model

As discussed previously this SOC addresses the need to invest in existing services and therefore, the Trust's service portfolio will not change as a consequence of the investment.

The service model of each clinical department impacted by the **'Building the new L&D'** programme will be subjected to detailed scrutiny to ensure that the facility design enables new, more efficient ways of working rather than merely replicating traditional service models. The NICU team have already had their proposals challenged by an external expert to ensure the most up to date model of care has been specified in the brief.

2.8 Resource and Asset Management Implications

2.8.1 Scope of 'Building the new L&D' programme

A list of key priorities for re-provision has been developed. The criteria used to generate the priorities were as follows:

- Patient Safety
- Patient Experience
- Site resilience
- Capacity pressures
- Performance requirements

- Control of Infection risks

Therefore, having considered all the various pressures across the site the priority areas that will receive investment are detailed below:

‘Building the new L&D’ Programme

- **New Neonatal Intensive Care Unit**
- **Ward refurbishment programme (c 3 -4 wards) to not only improve the environment but also increase side room capacity across the Trust**
- **Replacement of the modular theatres, refurbishment of the Surgical Block and Delivery Suite theatres and development of clean room capacity**
- **Creation of a Clinical Decision Unit (CDU) adjacent to the ED to expand urgent care capacity**
- **Expansion of the Endoscopy Unit**
- **Co-location of the HDU and ICU in purpose built facilities**
- **Creation of an off site surgical treatment and outpatient hub for Ophthalmology, Dermatology and Plastics**
- **Creation of a new Fracture Clinic and ongoing upgrade work to OPD areas**
- **Infrastructure upgrade programme to significantly improve site resilience and deliver a reduction in carbon emissions.**
- **New main entrance and improvement to the public realm in order to connect the building together more effectively and improve patient experience**
- **Increased car parking**
- **Number of ancillary facilities including the Body Store, a bed store and bed wash**

Should the position regarding the Paediatric and Obstetric services current provided by Bedford Hospital change in the near future it will be feasible to flex the design solution to accommodate the additional workload within the scope of the programme assuming capital funds were made available. However, if additional capital not be available then the Hospital Re-development Programme Board would make recommendation to the Board of Directors regarding how best to flex the scope of the programme.

Please note that whilst not linked directly to the **‘Building the new L&D’** programme the Trust will establish an appeal to fund the building of a house on the site’s perimeter to provide en-suite over night accommodation for parents whose babies are on the NICU. This project will still be managed under the auspices of the **‘Building the new L&D’**.

2.8.2 What has been achieved so far – key enabling schemes

During the last year a number of the schemes associated with the list of priorities above have begun and some early works have even been completed:

'Building the new L&D' Programme – Key Enabling Schemes

- **Phase 1 & 2 of the Endoscopy scheme have been delivered, the final phase will complete in September 2013.**
- **Phase 1 of the car parking expansion has been completed (a new deck above the staff car park on Farringdon Fields), the final phase (Breast Screening car park) will complete by the autumn (subject to planning permission issues).**
- **Phase 1 of the theatre refurbishment has taken place in Main Theatres.**
- **Phases 1 and 2 of the Outpatient scheme are now complete; phase 3 will complete during the summer 2013.**
- **In order to resolve the capacity pressure in Ophthalmology, theatres and outpatients, a project is underway to establish an off site surgical treatment centre for Ophthalmology, Dermatology and Plastics services. This development will also help decant and congest the site in order to facilitate the new build that will be necessary to accommodate some the re-development areas. Given the timescale pressures a separate business case is under development for this key enabling scheme.**

2.8.3 Approach to Site Master planning

The redevelopment of site has experienced a number of false starts as the amount of funding available changed dramatically due to the deterioration in the Trust's trading position and a significant change in the key priorities. However, the previous work has helped to shape the current proposed master plan.

The previous masterplan was generated by John Cooper Associates, a renowned Healthcare Architect and Master planner. Elements of that work have been retained and have evolved further to accommodate the necessary change to the priorities.

The revised site masterplan is still in development however it seeks to provide the Trust with a new main entrance and public realm which moves the entrance to the South of the site. To achieve this it will be necessary to re-locate the COMET building. This will either be achieved within a stand alone new build at the edge of the site or by re-modelling a Nightingale Ward. This re-orientation of the main entrance enables the A&E entrance, which is currently very cramped, to be re-modelled and extended.

Difficulty finding a suitable location on which to develop a new standalone NICU has hampered its construction for the last five years; however, this scheme provides the opportunity to combine a new NICU with a replacement theatre complex and combined adult Critical Care facility. Clearly, the adjacency of the NICU and the Delivery Suite and Post Natal wards is essential and this will be achieved by building a new block adjacent to the existing Women's block. A link corridor will connect the

new theatre suite with the existing Surgical Block. To enable the new building it is necessary to relocate the ENT Department and Diabetes Centre. The future location of those services is still under discussion. The catering production kitchen, restaurant and linen store will also require relocation in order to release the land necessary to build the new block. The linen store will be re-located with the bed wash and bed store in a low specification building elsewhere on the site and the alternative options for the catering solution are being explored by a separate soft FM project.

The Fracture Clinic will be re-located into the vacated Ophthalmology Department providing more space. The vacated fracture clinic will become a Clinical Decisions Unit (CDU) which will provide a much needed expansion valve for the ED and will assist the Trust in continuing to meet its A&E performance targets and deliver high quality urgent care.

The ward re-furbishment programme will be led by the Director of Operations once it becomes possible to close a ward to enable Ward 18 to be used as a decant facility. Wards 10, 11 and 12 are likely to be the first wards refurbished.

2.8.4 Impact on Existing Estate

As stated previously, complete re-build of the hospital is unaffordable. The existing St Mary's block was built as a PFI and will continue to operate as such and will not be affected by the changes unless the ground floor is remodelled as part of the decant strategy.

The Women's and Surgical blocks will receive little refurbishment other than the Delivery Suite and Main Theatre upgrades that are a feature of the '**Building the new L&D**' programme. However, the Main Theatres have very recently undergone a major upgrade which has significantly improved the quality of the overall fabric and ventilation systems. The ventilation systems are now operating appropriately and achieving the number of air changes expected in modern theatre.

2.8.5 Land transaction and planning constraints

No land transactions are necessary to fulfil the programme on the actual L&D site but the Trust does have to acquire the off site location which will be used to re-provide Ophthalmology, Dermatology and Plastics. As stated previously this is subject to a separate business case that will be submitted to the Board of Directors in July 2013.

With regards to planning consents, the Planners have previously stated that unless the Trust meets its obligations in relation to a previous planning application to increase the number of car parking spaces that it will withhold any further development on the site. This condition will fall away with the completion of the Breast Screening car park. The Planners have been informally consulted regarding the L&D's wider plans and they appear content with the proposals. A formal planning permission proposal has yet to be submitted.

2.8.6 Impact on sustainability/environment strategies

As previously stated the Trust's ability to deliver its Sustainable Development Management Plan (SDMP) is constrained by the condition of the site. Whilst the investment will fail to address all the requirements it will assist in making the SDMP more achievable. It should be noted that the new block will, given the nature of the services it will accommodate, be highly engineered. It will therefore consume more energy, which will affect carbon emissions however, it is hoped that other benefits, because of new building techniques, etc, will help mitigate this, along with the opportunity to rationalise and remove much of the temporary portacabin type accommodation

2.8.7 IM&T Strategies

Full cognisance of was taken of the revised site masterplan when the recent IM&T strategy was prepared therefore, it complements the plan.

2.8.8 FM strategies

Given that the most obvious location for the new block is the current location of the production kitchen and restaurant and alternative catering strategy will be required. A parallel working group is currently exploring the options available to the Trust. The remit of the group is not constrained to catering but has been expanded to include all soft FM services. The output for the project will be a business case to the Board of Directors that will recommend a way forward for the provision of high quality soft FM services. Having considered the options available to the Trust, the Board of Directors will be asked to approve the most appropriate option so work can begin on implementing the option.

2.8.9 Workforce implications

The workforce implications arising from the 'Building the new L&D' are minor as the investment mostly relates to enhancements to the physical estate.

3 ECONOMIC CASE

3.1 Purpose of the Economic case

The purpose of the Economic case is to outline the options that have been considered and the approach and methodology taken to generate the shortlist which will be further considered at the Outline Business Case stage (OBC).

3.2 Options appraisal

Given the nature of this proposal the generation of options has been extremely difficult. In essence the only feasible options to consider are the **'Building the new L&D'** programme (Option 1), 'do nothing' (Option 2) or the 'do minimum' (Option 3)

On the basis that the do nothing option is not feasible because the Trust has an obligation to provide safe patient care and a legal duty to insure its staff are safe from harm under the Health and Safety at Work Act. Therefore, option 2 was discounted, as the site would decay further if no investment were made making it impossible for the Trust to fulfil its obligations over time.

The option to progress the **'Delivering a new L&D'** strategy along with the do minimum option will be taken through the Outline Business case stage to enable the preferred option to be compared against another option.

The do minimum option consist of:

- Car Parking expansion
- Re-building NICU on the boiler house car park
- Re-furbishing the existing modular and Delivery Suite theatre theatres (the Vanguard theatre would need to be retained)
- Refurbish delivery theatres
- Infrastructure resilience work
- Convert Fracture Clinic to CDU
- Convert ward 18 into Ophthalmology outpatients
- Convert Ophthalmology Unit into Fracture Clinic

The cost of the do minimum option is likely to be in the region of £25m and will not enable the revenue savings to be generated that are associated with **'building the new L&D'**.

3.3 Benefits Realisation

Benefits realised from Option 1 'Building the new L&D'	Benefits realised form Option 3 Do Minimum
Patient experience will be improved in 16 discrete areas of the hospital (ED, CDU, Fracture Clinic, Ophthalmology,	Patient experience will be improved in 6 discrete areas of the hospital (ED, CDU, Fracture Clinic, Ophthalmology, Modular

Dermatology, Plastics Clinic, Out patients, Theatres, 3 wards, main entrance, clean rooms, Audiology and Endoscopy)	Theatres and Delivery Suite Theatres)
The NICU will be provided in new purpose built accommodation which will be fit for purpose and meets current technical requirements.	The NICU will be provided in new purpose built accommodation which will be fit for purpose and meets current requirements – albeit adjacency with Delivery suite will be severely compromised
50% of the Trust's operating theatre capacity will be purpose built and designed to modern technical specifications. 50% will be re-furbished.	100% of the Trust's operating theatre capacity will be re-furbished and improved but will not necessarily meet designed to modern specifications
c. 3 Ward areas will be re-furbished creating more side room capacity and drastically improving patient experience	
The Trust will be able to reduce its carbon emissions	
The new main entrance and refurbished communication spaces will improve first impressions, provide improved patient, staff and visitor amenities and help patients navigate their way around the Hospital.	
Staff morale will be improved as a consequence of improved environment in at least 15 separate areas of the hospital	Staff morale will be improved as a consequence of improve environment in at least 6 separate areas of the hospital
The site's infrastructure will be both more robust and resilient, easier to maintain and less costly to operate	The site's infrastructure will be both more robust and resilient, easier to maintain and less costly to operate
The mobile operating theatre pod will no longer be required saving approximately £1.2m per annum.	
More car parking spaces will be available for patients, staff and visitors	
Car Park income will increase as a consequence of the increase in the number of spaces	
Cleaning will be more effective in new and re-furbished areas and control of infection challenges will be significantly reduced	
Fracture clinic will have sufficient space to enable the new pathways of care to	Fracture clinic will have sufficient space to enable the new pathways of care to

be delivered effectively which will improve patient experience	be delivered effectively which will improve patient experience
The ED will be able to function more effectively with the opening of an adjacent Clinical Decisions Unit which will enable the A&E performance target to be achieved	The ED will be able to function more effectively with the opening of an adjacent Clinical Decisions Unit which will enable the A&E performance target to be achieved
Ophthalmology, Dermatology and Plastics will no longer be so cramped and will be operating in good quality condition accommodation which delivers patient safety, privacy and dignity	
Theatre capacity will be utilised more effectively once the Clean Rooms are commissioned and best practice tariff will be achieved	
Outpatient accommodation will be refreshed and the patient experience enhanced	
The Body store will be fit for purpose	
Beds and other larger items of patient equipment will be able to be deep cleaned and decontaminated prior to use by another patient	
Bed frames will no longer clutter corridors and will be maintained in an appropriate location	

As can be seen from the above list option 3 - do minimum option delivers fewer than 50% of the benefits associated with Option 1, as fewer areas would be affected.

4 FINANCIAL CASE

4.1 Purpose of the Financial Case

The purpose of the Financial Case is to set out the indicative financial implications of the programme. This section will be developed further in the OBC to address how the Trust will afford the scheme and how it will be funded. Please note that detailed analysis of the financial case including affordability takes place at OBC stage.

Both an Investment and a Funding Strategy are currently being developed. The intention is that these two documents along with the Trust's Cost Improvement Programme (CIP) will heavily influence the content of the financial section of the OBC.

4.2 Background

The Board of Directors have determined that the site redevelopment is a key strategic objective of the Trust.

In January 2013 under Gateway 18624 the DOH required that all NHS Provider Organisations should be able to clearly evidence that they are:

- Delivering on the NHS Constitution Pledge to ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice,
- Operating efficient, safe and fit for purpose premises that support the delivery of high quality healthcare services and as required by the quality accounts agenda.

The issuing of the NHS Premises Assurance Model focusing on five key domains of Safety, Effectiveness, Patient Experience, Board Governance and Finance / Value for Money aligned with the FT view that in order that the Board could demonstrate assurance of essential statutory undertaking and quality that a programme of improving premises was required.

4.3 Finance Approach

The Board of Directors have acknowledged that current performance through a relative modest asset base is strong with the FT generating over £230m against a Non Current Asset value of £100m. This return per £ of Non Current Assets employed is at the higher end of that achieved by medium sized acute trusts.

The Board of Directors determined that this level of return was unsustainable and commissioned some work with PwC to identify an optimum level of investment that both delivered the key strategic investment objective but also enabled the FT to retain financial sustainability.

The work of the Hospital and PwC was triangulated with further modelling work undertaken by McKinsey as part of the Healthier Together Programme.

- **Findings**

The PwC work identified that the investment would best be served by utilising a mixture of internally generated cash and access to external funds (loans) from the Foundation Trust Financing Facility (FTFF).

In determining affordability PwC advised that the FTFF would place reliance on Monitor Metrics for long term borrowing. To that end the FT is advised that it should be able to secure loans of around £39m.

The overall investment in the three year annual plan period (from April 2013) identified planned capital expenditure of nearly £79m. Planned investments include a £51m contribution to the Hospital Development Plan. Further funds are used to fund routine Medical Equipment, embrace Information Technology opportunities and maintain the existing site.

The Board of Directors identified that the financing gap between the application and source of funds shall be secured from our existing cash resource plus internally generated cash from our trading activities.

Planned investments over the next three years are shown below:

Summary Capital Programme: 2012/13 to 2015/16

	2012/13	2013/14	2014/15	2015/16	Totals
Application of Capital Expenditure	£m	£m	£m	£m	£m
Hospital Development Programme	0.5	11.1	17.3	22.5	51.4
Business Cases	5.2	3.2	0.0	0.0	8.4
Estates	0.8	1.0	1.0	1.0	3.8
Medical Equipment (Multi-various)	2.3	5.8	2.2	2.2	12.5
IT Developments	2.5	5.7	2.4	0.9	11.5
Contingency	0.0	0.5	1.0	1.0	2.5
Total Capital Expenditure	11.3	27.3	23.9	27.6	90.1

The final phase of the **'Building the new L&D'** will require a further expenditure of £9m in 2016/17 (making a total investment of £60m).

4.4 Revenue Affordability

The Board of Directors have determined three key financial operating metrics that will create the framework through which the Trust can demonstrate on-going financial viability and compliance with the Health Care Act. These are:

- **The FT shall maintain a cash reserve equivalent to 1/12th of operating expenditure**

- **The FT shall at all times maintain a minimum financial risk rating of 3** (*based on existing Compliance Framework*)
- **The FT shall retain a contingency budget of £3m in each financial year**

The Trust has recorded 14 years of financial surplus. However this has been achieved in the context of significant growth in NHS Funding. It is clear that the challenges from 2013/14 will be significant.

From 2013/14 and for the foreseeable future it is envisaged that the Trust will be disadvantaged by the twin impact of reduced income (as a result of the tariff decreasing) and unavoidable inflationary cost pressures. These two factors working in tandem will require the Trust to improve efficiency by 4.5% per annum (£10m).

The challenge in financial year 2013/14 is made harder by a recurrent shortfall carried into 2013/14 £3m (the FT only achieved financial balance in 2012/13 as a result of non-recurrent gains).

Furthermore aggregated commissioner QIPP plans year on year will add further to the efficiency burden (actual figures derived from Healthier Together Programme). These, in part, can be seen to be ambitious. Commissioner schemes are multi-faceted and would require a step change in the control of patient demand for hospital services. The Trust is placed in the unenviable position of second guessing whether schemes will be totally successful and then flexing capacity accordingly.

Additionally the interest and loan repayments represent further cost that the FT will need to accommodate.

The Trust has developed a plan designed to deliver its financial strategy. This contains more risk than has been evident in previous years and places significant emphasis on the abilities of Service Line Managers to deliver improved financial performance whilst maintaining operational targets.

The 2013/14 Annual Plan identifies in detail how the Trust is planning to maintain financial sustainability and trade in a manner consistent with its own key operating metrics.

Central to the efficiency gain will be both additional funds secured from commissioners and a reduction in costs. Practically it will need to be cost reduction that is the main driver. Each of these areas are shown below:

- **Specialist services** – the Trust's development in its specialist services portfolio will allow for income increases in stroke services with the development of hyper-acute services in 2014 onwards. The delivery of PCI represents the next stage of the Trust's cardiac services and there is potential for further growth as pressure increases to consolidate cardiac services within the sector. The Trust's bariatric

services remain a long-term investment as obesity issues continue to grow within the overall population.

- **Vertical integration** – the market testing of local community services in Luton and Bedfordshire in 2014 represents an opportunity for the Trust to broaden its service portfolio. The Trust does not consider that this represents any significant gain in respect of EBITDA margin, although the sums involved are relatively large (£16m for Luton CCG). It is unlikely that the Trust would bid for the whole community service portfolio but is more likely to selectively bid for lots which would allow the Trust to unlock potential for efficiency within its hospital services.
- **Core services** – the scope for income growth within its core service remains relatively limited albeit the FT will benefit from both Population and Demographic changes
- **Acute hospital reconfiguration agenda** – in line with the national picture neighbouring health economies to the L&D, including Buckinghamshire and Bedfordshire, are considering the reconfiguration of acute hospital services in order to ensure that hospitals have sufficient critical mass to deliver the required standard of care. Whilst the expected timeline for these changes is outside the timeframe of this plan, it may well be that some services which are currently experiencing pressure are subject to change in advance of more fundamental structural moves (e.g. paediatrics).

4.5 Expenditure

The 2013/14 Annual Plan articulates productivity and efficiency gains built into plans, including financial impact of projected gains, in areas such as:

- Length of stay;
- Bank and agency spend;
- Bed occupancy;
- Medical Productivity;
- Theatre productivity; and
- Workforce.

Plans are provided in detail for 2013/14 (budget line level) and at a summary (theme) level for 2014/15 and 2015/16.

CIPs	Enabler	2013/14	2014/15	2015/16
		£m	£m	£m
Outpatient Efficiency	Outpatient Project		0.50	0.50
Vanguard	Theatres Project		1.00	0.00
Staff Utilisation	Theatres Project		1.00	0.50
Ward	Length of Stay Project		1.25	0.00
Reduced Payments / Extra Income	Medical Productivity Project		0.25	0.20
Reduced Temporary Staff	Workforce Project		1.00	1.00
Buying Better / Cost Avoidance	Procurement Workplan		1.00	1.00
IT / Administration Costs	IM&T Projects		0.50	0.50
Corporate / Facilities	Zero Based Budgets		0.50	0.50
Efficiency linked to new builds	Hospital Development Project		0.35	1.00
Divisional Plans	Review of service lines	9.70	1.25	2.00
Totals		9.70	8.60	7.20

The Trust will undertake more work in conjunction with the development of the OBC to drive further clarify on medium and long term cost improvement schemes.

5 COMMERCIAL CASE

5.1 Purpose of the Commercial Case

The purpose of the Commercial Case is to describe how the preferred option will be procured. During the development of the Outline and Full Business Cases, the commercial case will summarise the outcome of dialogue with any potential partners around the potential of third party investment into discrete elements of the programme. The Trust will be seeking innovative solutions to achieving a sustainable future and will seek to encourage these from prospective bidders at any stage where a competitive approach is embarked upon or entered into.

5.2 Current assumptions regarding the Commercial Case

Given the nature of the scheme it is intended that the overall programme is broken into discrete construction elements. The precise procurement solution will be explored further during the development of the OBC however; a range of options will be explored including the possible use of Procure 21+ in addition to more traditional standard contract methods.

It is anticipated that the Trust will procure for third party investors to deliver the main entrance and the retail offering and the energy centre. This will enable third parties to invest capital in return for the income generated from the area or the utility bills paid. Significant precedent exists elsewhere in the NHS regarding this type of deal and if advantageous for the Trust they will be utilised.

The Trust will also explore the potential benefit of establishing a 100% wholly owned subsidiary – Prop Co. If deemed appropriate the Trust does have the legal freedom to establish the separate entity and could run discrete elements of the estate or the whole estate through it. The most obvious advantage of such a subsidiary is a potential VAT saving. The Trust will continue to explore and critically appraise benefits of such a transaction.

6 MANAGEMENT CASE

6.1 Project Management

6.1.1 Overview

The CEO, Mrs Pauline Philip is the Senior Reporting Officer (SRO) for the programme. John Garner a Non-Executive Director of the Trust will Chair the Hospital Redevelopment Programme Board. From mid – August Sarah Wiles will return to the Trust after a brief break and will focus on leading the re-development programme as the **‘Building the new L&D’** Programme Director. She will report into the SRO and will be supported by Philippa Graves, the Director of Strategic Projects and John Griffiths, the Programme Manager. Ian Allen, Director of Estates and Facilities Management, will assume the role of Project Director for the Infrastructure Project, as part of his existing role, which will be delivered within the **‘Building the new L&D’** programme resources.

The re-development team will expand as the workload requires. A Project Office will be set up in the coming weeks in order to create a base for the programme.

Resources are being identified to establish the Project Management arrangements and will be agreed by the finance, Investment and Performance Committee (FIP).

The role of this team will be to:

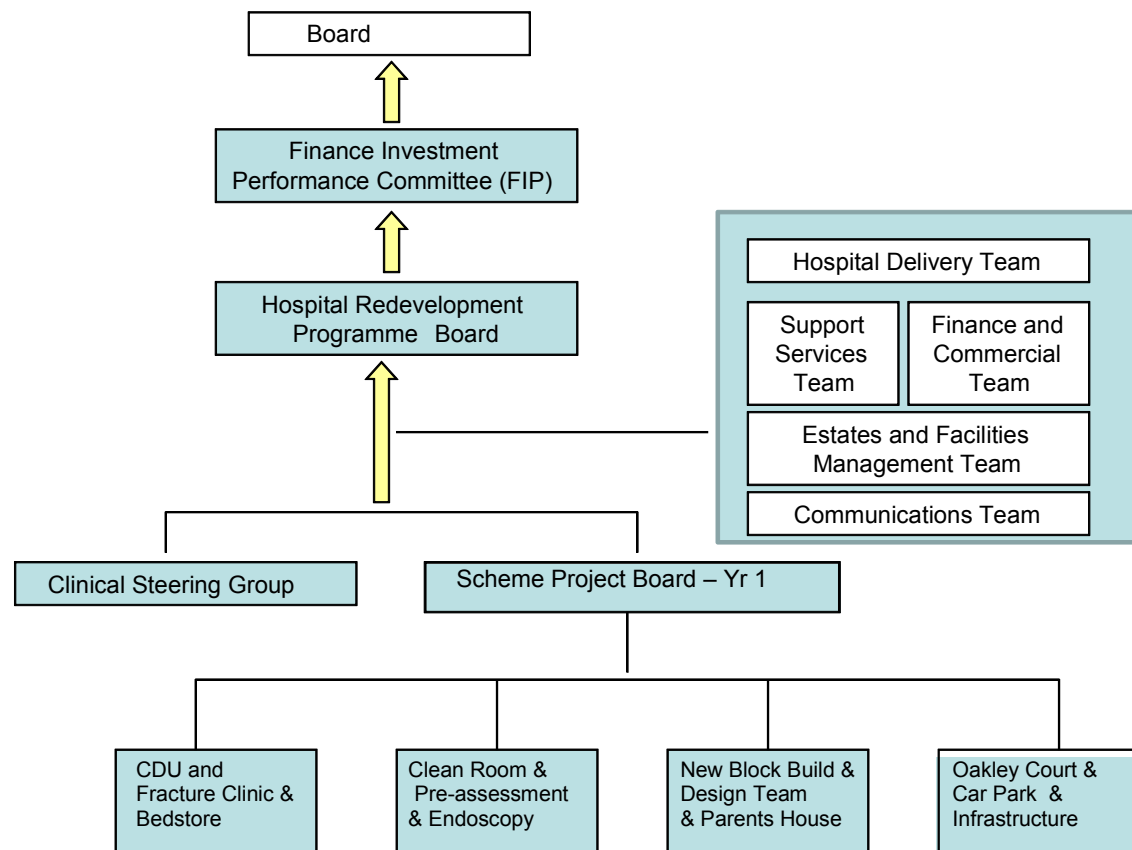
- validate the proposed high level Masterplan;
- develop a more detailed and costed design solution;
- cost the revenue consequences of delivering the programme;
- develop a robust transition plan including enabling schemes and decant arrangements;
- identify the most appropriate procurement solution for the programme overall;
- and finally to prepare a robust business case for submission to the Board of Directors in November 2013. The business case will be aligned with the approved investment Strategy and Funding Strategy.
- Oversee the delivery of the construction and commissioning phases.

6.2 Programme Governance

The programme will be overseen by the Hospital Redevelopment Project Board (HRPB). The HRPB is accountable to the FIP Committee, a formal sub-committee of the Board.

The project management approach aims to be open, transparent, fair and equitable and will explore the range of options available in the most efficient way possible without incurring undo cost for both the Trust and potential partners. Prince 2 project management methodologies will be applied where relevant. The programme structure is detailed in figure 2.

Figure 2: Project Structure & Governance



The programme will be delivered in a phased approach, with a number of bespoke work streams, which will include a Clinical Chair, a dedicated project manager, and a member of the finance team, a General Manager or nominated lead and key team members. They will meet on a regular, at least fortnightly basis, and will present progress reports into the Hospital Redevelopment Programme Board. They will have a full risk and issues log for each work stream, and will escalate any severe deviations from the programme to the Programme Manager.

The Work Streams are:

- Oakley Court
- Endoscopy
- Car Parking
- CDU & Fracture Clinic
- Clean Room, Bed Store & Pre-assessment & Body Store
- Parents accommodation
- New Block
- Comet, Front Entrance & access & egress
- Infrastructure

A robust engagement and communications strategy will ensure that there is involvement with key stakeholders throughout the course of the project. A clear focus within this will be the need to ensure early and continuous engagement with patients and staff in order to ensure that the programme can achieve the objectives set and realise the benefits.

6.3 Approval Process

The OBC and then the final FBC will be presented for approval to the HRPB and then to the FIP committee, and finally to the Board of Directors for approval and then to the Board of Governors for validation. Once this has been done delegated, authority will be given to the HRPB to sign off each individual element of the business case against set criteria. If there is a deviation from the agreed project allocation by more than 10%, then an exception report will be written and passed to FIP for final approval. The overall scheme will then be re-profiled to allow for the deviation in funds.

Until the overall design solution is developed further it is possible that there will be a shortfall between the capital required and that available. If the overall funding allocation is not sufficient to cover all of the approved schemes, then a ranking in priority of all schemes remaining will need to occur by the Clinical Steering Group and the HRPB will recommend to the Board of Directors to decide which schemes are not delivered as part of the c. £50m package.

6.4 Advisors

PwC have been appointed under a framework arrangement as the Trust's financial advisors and they will assist the Trust with: the development of an Investment Strategy which will be considered at the July FIP; financial and commercial support with the re-development business case and the development of a funding strategy and lean application. PwC will also assist the Trust in undertaking the Risk Evaluation for Investment Decisions (REID).

Balfour Beatty, the Trust's P21+ partner have been re-engaged with the clear remit to develop the design solution for the new build elements of the programme. The Balfour Beatty team is made up of:

- BDP - Architects,
- CPW - M&E Engineers
- Gardiner & Theobald – Cost Advisors.

Local Architects and other design team members will be procured locally to undertake the refurbishment schemes as necessary.

6.5 Project Plan

The project timeline is shown below and gives an overview of the schemes.

	Year 1 2013/14				Year 2 2014/15				Year 3 2015/16				Year 4 2016/17			
SCHEME	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
Endoscopy																
Car Park																
Oakley Court																
ED Expansion																
Clean Room and Pre op Assessment																
Bed Wash																
Delivery Suite Theatres																
Ward Refurb																
Parents House																
Infrastructure * Assumes 3rd party contribution																
Fracture Clinic permanent																
New block (inc enabling)																
Body Store																
Main Entrance																
Access and Egress																
Theatres 1-6 refurb.																
COMET																

Below is the key milestones relating to that Time Line are shown below in table 2:

Approval of OBC by HRPB/FIP/Board	November 2013
Approval of FBC by FIP	February 2014
Approval of FBC by Trust Board	March 2013
Individual Business cases approved by HRPB – delegated Authority	Throughout programme – linked to year of deliver for funding pull down
Oakley Court Delivered	Q4 2012/3
Building a new L&D completed	Q2 2016/7

6.6 Key risks to delivery and measures to mitigate and manage these risks.

Key Areas Of Risk	Probability	Impact	Risk Management & Mitigation
Changes in Demand	Medium	Medium	Given the limited new build in this plan – areas that are refurbished or misused are constrained by current space. For new areas full health planning has been applied to these, understanding the fixed budget. Later phases will need to address any future growth – as the budget is fixed.
Financial Viability	Medium	Medium	Budget set at circa £50 m based on risk profile and affordability. Standing Risk of drop in income from Commissioners & lack of financial control within Trust managed through Contract setting and performance reviews with Directorates.
Clinical Models	Low	Medium	Each work stream has an Clinical Output specification and a model of service delivery. These have been formulated and are owned by the Clinical groups. Where necessary these will be tested by peer groups to ensure strategic fit and operational delivery.
Planning	Medium	High	Key elements of the programme are dependent on planning in order to deliver their functionality – examples of this are Oakley Court and the New Front entrance. Both of these schemes are at risk if planning is denied. Mitigation is good design and build plans, intelligence of the planning process and early engagement to allow for changes to meet the planner's needs.
Operational	Low	Low	In some of the work streams there is little change in operational delivery, just a refurbishment of their environment. Where there is the opportunity for major service change,

			the risk will be mitigated by good planning, strong operational policies signed off by the clinical groups, and full clinical engagement using model based on best practice.
Construction	Medium	Medium	The full 6-facet survey information enables local knowledge to be greater in terms of understanding the challenges. This links into the infrastructure work stream, which should support the new buildings to mitigate the power and services risks, and a clearly informed architectural plan of building deployment to ensure safety and deliverability at all times.
Approval Process & Procurement	Medium	Medium	The overall delivery of the multi-faceted programme relies on approval of each work streams business case. As well as this is the delivery method of each scheme, some are from charitable funds, some are third party investment and others are to be delivered in house with partners. Therefore each project has its own risk profile and these will vary depending on the route chosen.
Enabling schemes are not delivered	Medium	Medium	Outsourcing of the patient feeding function must be delivered to enable the production kitchen to be demolished. This is currently be looked at by a dedicated group, but the outcome of the feasibility study is not yet known. In addition, Max Fax has to be re-sited temporarily, and this may be difficult to achieve but a solution must be found.
Infrastructure not deliverable within the allocated budget	Low	Medium	The state of the site infrastructure is poor, and £9m has been allocated to it, assuming £5m is delivered by developing an energy centre with a partner. There is a feasibility study ongoing, to see if this is the best option for delivery.

Glossary

Abbreviation	Description
A&E	Accident & Emergency
ALOS	Average Length of Stay
ARM	Accounting Reporting Manual
ASR	Acute Services Review
BoD	Board of Directors
CA-UTI	Catheter Acquired Urinary Tract Infections
CCG	Clinical Commissioning Group
CD	Clinical Director
CIP	Cost Improvement Programme
CLRN	Comprehensive Local Research Network
COB	Clinical Operational Board
COSQ	Clinical Outcome Safety & Quality
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DBU	Divisional Business Unit
DD	Divisional Director
DoH	Department of Health
EBITDA	Earnings Before Interest Tax Depreciation & Amortisation
ED	Emergency Department
EDL	Electronic Discharge Letter
EDS	Equality & Diversity Strategy
ENT	Ear Nose and Throat
EoE	East of England
EWS	Early Warning System
EWTD	European Working Time Directive
FIP	Finance, Investment & Performance
FT	Foundation Trust
#NoF	Fractured Neck of Femur
FYE	Full Year End
GOSH	Great Ormond Street Hospital for Sick Children
GP	General Practitioner
HAIs	Hospital Acquired Infections
HDU	High Dependency Unit
HR	Human Resources
HRG	Healthcare Resource Group
HSMR	Hospital Standardised Mortality Rate
I&E	Income & Expenditure
IAS	International Accounting Standards
IFRS	International Financial Reporting Standards
IG	Information Governance
ISO	International Standardisation Organisation
ISSB	Information Systems Strategy Board
IT	Information Technology
IM&T	Information Management & Technology
KPI	Key Performance Indicator

Abbreviation	Description
L&D	Luton & Dunstable Hospital
LDP	Local Delivery Plan
LNC	Local Negotiating Committee
LSP	Local Service Provider
MRSA	Methicillin Resistant Staphylococcus Aureus (infection)
MSK	Musculo Skeletal
MUST	Malnutrition Universal Screening Tool
N/R	Non Recurrent
NED	Non Executive Director
NHSFT	National Health Service Foundation Trust
NHSI	National Health Service Institute of Innovation
NHSLA	National Health Service Litigation Authority
NICU	Neonatal Intensive Care Unit
NICE	National Institute of Clinical Excellence
NPSA	National Patient Safety Agency
OF	Operating Framework
OMFS	Oral Maxillo Facial Surgery
PBC	Practice Based Commissioning
PbR	Payment by Results
PCT	Primary Care Trust
PDC	Public Dividend Capital
PE	Pulmonary Embolism
PEAT	Patient Environment Assessment Team
PET	Patient Experience Tracker
PFI	Private Finance Initiative
PI	Performance Indicator
PMETB	Post graduate Medical Education Training Board
PTL	Patient Tracking List
QIPP	Quality Innovation Productivity and Prevention
RICS	Royal Institute of Chartered Surveyors
ROA	Return of Assets
RTT	Referral To Treatment
SHA	Strategic Health Authority
SiC	Statement of Internal Control
SIRO	Senior Information Risk Owner
SLA	Service Level Agreement
SLR	Service Line Reporting
SLM	Service Line Management
SoC	Statement of Compliance
SOS	Staff Opinion Survey
SOVA	Safeguarding of Vulnerable Adults
SPI	Safer Patient Initiative
UCL	University College London
UKCRN	UK Clinical Research Network
VTE	Venous-thromboembolism
WTE	Whole Time Equivalent