Operational Plan 2016 -17
1. Introduction

Northampton General Hospital Trust’s operational plan for 2016-17 provides joined up detail and narrative on activity, finance, workforce, quality and strategic plans for the year ahead. This document also provides an overview of our strategic intentions and forthcoming service developments scoped for implementation throughout 2016-17.

We are engaged in working with partners across the health and social care system to develop a system-wide Sustainability and Transformation Plan (STP). Our operational plan will support the development and delivery of the county-wide STP.

Our Strategic Aims
Our mission is to provide the best possible care for our patients. Our strategic aims are to:

- Focus on quality and safety
- Exceed patient expectations
- Strengthen our local clinical services
- Enable excellence through our people
- Ensure a sustainable future

Strategic Partnerships
We are clear that, in the current environment, we must change our service offering if we are to deliver excellence in clinical services and achieve financial sustainability. That is why we have made a commitment to develop strong and lasting partnerships with other providers both locally and regionally.
2. Strategic Priorities

Our operational plan summarises the approach we will take to ensure we deliver our strategic objectives during 2016-17. Our key strategic priorities are to:

• Provide resilient core district general hospital services
• Continue to improve urgent care services, including collaborating with partners to reduce admissions and delayed transfers of care (DTocs) and working towards new models of care as delivery mechanisms where appropriate
• Collaborate and integrate with other providers to provide care closer to home, e.g. out of hospital care, integrated pathways for the frail and elderly, musculoskeletal (MSK), dermatology and ophthalmology
• Develop partnerships with Kettering General Hospital NHS Foundation Trust
• Strengthen our hyper-acute services through collaboration and partnership working with our tertiary providers
• Repatriate patients currently lost to non-NHS providers
• Develop our capital plan to meet our future needs and develop a health and well-being campus
• Deliver excellence in the care of the elective patient, focusing on dedicated orthopaedic and ophthalmology services that increase quality, reduce clinical variation and provide centres of excellence in the county
Delivering our Strategic Priorities

During 2016/17 we will continue to work in partnership and collaboration with other providers to develop the vision for acute hospital transformation as part of the STP.

There will be a review of 10 specialities to ascertain the opportunities for collaboration between the two acute trusts in the county and wider community partners. This will include options for single, count-wide services where appropriate (note: a single service does not mean a single site. It means collaboration between the hospital trusts and community providers but with a focus on maintaining localism).

The services being reviewed are:

- Rheumatology
- Orthopaedics (initially MSK services)
- Dermatology
- Cardiology
- Radiology
- Ophthalmology
- Pathology
- ENT
- Gynaecology
- Urology
Delivering our Strategic Priorities

In summary, we will continue to develop and build on the following projects and relationships during 2016-17 to support delivery of our strategic priorities:

• Further develop the partnership for oncology with University Hospitals of Leicester NHS Trust and Kettering General Hospital NHS Foundation Trust
• Collaborate with Kettering General Hospital NHS Foundation Trust and community providers on the development of single services in a range of areas
• Develop a case for an additional 60 beds and reconfigure the gynaecology day case unit to increase bed capacity
• Develop the emergency assessment unit (EAU) medical take and speciality in-reach to EAU. This will include a separate cardiology on-call rota
• Develop the virtual community ward model for elderly patients in collaboration with GP Federations and Northamptonshire Healthcare NHS Foundation Trust
• Enhance our orthopaedic, urology, paediatric and upper gastro-intestinal services through new consultant appointments
• Continue to move towards 7-day services, particularly in radiology and endoscopy
• Co-locate all stroke beds in one area to improve efficiency and improve metrics
• Deliver efficiencies in theatre and outpatients to ensure streamlined pathways and sustainable services
• Implement the recommendations of the Lord Carter review
3. Approach Activity Planning and Operational Performance

Capacity and Demand Modelling
Detailed modelling of the proposed demand for services for 2016-17 and the capacity available has been undertaken as part of the planning round. This has been based on the demand during 2015-16 and assumes growth.

We have agreed to 3.5% non-elective growth and 4.7% growth for A&E attendances with commissioners. However, we are aware there is a significant risk of further growth related to the potential impact of a number of changes in the provision of social care as a result of the requirement for a £27m reduction in adult social care funding.

The growth of non-elective activity has reduced our ability to deliver elective capacity, with an increase in the number of day case and routine elective cancellations as day surgery wards are used as escalation areas. Delayed transfers of care remain high and are a key issue for NGH.

Bed modelling indicates a bed shortfall of between 23 beds at 100% bed occupancy with no growth up to 115 beds shortfall with growth at 1% elective and 3.5% non-elective and running at 90% occupancy.

The following mitigating action is planned to increase bed capacity in order to recover the urgent care and emergency care performance as well as enabling us to make improvements in our planned care services.

• Work is ongoing around delayed transfers of care, length of stay and discharge processes over the weekend
• A business case for an additional 60 beds on site is being progressed
• Additional off site beds are being commissioned
Operational Performance

We are working to agreed revised performance trajectories for the following:

**Planned Care**
The incomplete Referral to Treatment (RTT) standard is currently being achieved with a trust average of 93%. Current pressures have resulted in several specialties having to cancel a large amount of activity. This in turn will make it difficult for those specialties to maintain their ongoing performance. A 2016/17 recovery plan is in place for orthopaedics, which is currently below the standard for incomplete RTT pathways. All other specialities are on plan to achieve the standard.

**Cancer**
There is a county-wide cancer recovery plan which will deliver recovery of the 62-day cancer standard in line with the agreed trajectory. The plan includes pathway reviews, inter-trust agreements and additional capacity for MRI, CT and endoscopy.

**Urgent Care**
We are working closely with health and social care partners to deliver an urgent care network with the aim of achieving a reduction in the number of delayed transfers of care (DTosCs) and non-elective demand. There is an urgent care recovery plan for the south of the county. Key actions progressed at NGH include:

- Work to improve pressures in the emergency department and patient flow
- Developing the emergency assessment unit take and a dedicated cardiology on-call rota with the aim of improving flow and reducing length of stay for patients
- Improving our inpatient productivity and flow
- Developing a new assessment hub
4. Our Approach to Quality Planning

The quality improvement strategy for 2016–2018 brings together a team of safety leaders who will drive quality improvement projects forward through a robust project management structure under the direction of the medical director and the director of nursing. The updated quality improvement strategy incorporates quality improvement plans, including Sign up for Safety, bringing together and clarifying the core streams of work currently focussed on quality and quality improvement. The prioritisation of quality improvement activity is aligned with our strategic aims and priorities and not only takes account of mortality/safety concerns, but also issues arising within the clinical divisions and those driven by local and national commissioning priorities.

To support delivery of our quality improvement strategy we will strengthen and raise the profile of our Patient Safety Academy. We will also support and educate our patient safety champions so that we can implement a human factor based approach within the clinical divisions.

Each of the projects and/or workstreams is led by a senior clinical member of staff, chosen for their specialist knowledge and practical experience of the subject matter. There is an extensive, diverse and challenging range of projects that will deliver real improvements to the quality of our clinical services.

The principal risks to clinical quality within the organisation relate to pressures within urgent care and difficulties in recruiting sufficient numbers of nursing and medical staff. These risks and our plans for mitigation are described in our corporate risk register which is reviewed by our quality governance, workforce, and finance/performance committees.
Quality Improvement
Across the organisation we have a combination of actively utilised and untapped specialist quality improvement expertise which is spread across a limited number of staff in different professions. Currently this expertise is not formally recognised within the organisation and the ability of these individuals to deliver quality improvement on the ground is, in many cases, unproven, despite the training provided.

We acknowledge there is work to be done to ensure that, for a large proportion of our workforce, the application of improvement methodologies to everyday working practices becomes part of the way we work, not solely when engaged in an improvement project. Our aim is for each member of staff to receive, as a minimum, training which raises awareness of quality improvement basics whilst others receive higher levels of training that are commensurate with their role and projects they are undertaking.

We will use the Institute for Healthcare Improvement’s (IHI) model for improvement and the breakthrough series collaborative model to provide a framework for our improvement training. We will develop a post graduate MSc programme in patient safety and quality improvement with the University of Northampton. This programme will be validated by both the University, and NGH staff, with the university faculty supporting the quality improvement team.

Subject matter experts will work with clinical teams to select, test and implement changes on the front line of care and systems will be redesigned from the bottom up using small tests of change. Engagement will be key to our success, along with alignment and collaboration. The use of a collaborative model will provide a framework to optimise the likelihood of success. This approach will be most effective when there is a deficit in quality which is identified by teams as ‘unacceptable’ and where there are pockets of excellence that can be used to promote learning.
Quality Priorities

Building upon the work of our previous quality improvement strategy, the focus for our 2016-17 quality priorities aligns our visions and values with clinical services, enabling us to provide the best possible care to every patient.

The six key quality priorities for 2016-17 are:

- Reduce harm from failure to rescue
- Reduce avoidable harm from failures in care
- Deliver patient and family centred care
- Lead and promote a reflective culture of safety and improvement
- Ensure operational processes support essential planning, delivery and record keeping
- Deliver reliable and effective care (care bundles)

Each quality priority is underpinned by a number of workstreams to enable us to measure successful outcomes.
**Measurement, Assurance and Triangulation**

Robust and ambitious targets will be set for each of our quality goals which we will measure ourselves against to indicate whether we have been successful in achieving the quality strategy. An important element of our training programme will be teaching ‘measurement for improvement’ skills and knowledge.

Safe nurse staffing information and nurse sensitive indicators are triangulated to identify improvement activity. Currently, nurse staffing levels are recorded every day by all wards in the hospital and displayed at the entrances to our wards. We will take this a step further and develop a real-time staffing tool that is available from ward to board via the intranet. We will build on our existing nurse-sensitive metrics by developing a robust ward assessment and accreditation programme to ensure that we deliver the best possible care to our patients.

In line with the well led framework we have a strong board focus on all aspects of quality. The board receives regular reports on all aspects of quality through:

- Monthly performance reports and scorecards from both a divisional and directorate level
- Monthly reports on patient safety, patient outcome, patient experience and organisational safety
- Scrutiny of divisional quarterly quality governance reports through the clinical quality and effectiveness group
- Regular review of the assurance framework and trust risk register and related actions to mitigate risks
- Quarterly updates reports of progress compliance with Care Quality Commission, using Health Assure

All board members regularly conduct unannounced visits to clinical areas (called “go-sees”) to observe practice, meet and talk with staff and patients to discuss quality issues and concerns.
Leadership for Quality

The drive for continuous quality and safety improvement requires exceptional leadership at every level of the organisation. There is strong commitment from our board of directors to lead the quality improvement agenda. This will be done by:

• Keeping the patient and their family at the centre of all we do
• Creating an environment where staff feel empowered to lead change
• Promoting patient involvement in our quality improvement activities
• Ensuring transparency of quality performance and improvement activities
• Providing support for quality improvement training programmes for staff
• Senior meetings which will focus on quality and safety improvement

Our commitment to quality will be at the heart of leadership at all levels. We will ensure that continuous quality improvement remains a key element underpinning our leadership development programmes.

The importance of quality improvement for our strategic and day to day objectives will be communicated to all our staff, to support their engagement. The board will oversee implementation of our quality improvement strategy, promoting a culture of improvement, supporting effective local leadership, and ensuring an appropriate infrastructure is in place to enable delivery. The board will ensure successes are recognised and communicated widely internally and to our community, patients, and partner organisations.

The Francis Crick leadership and management development programme will equip our leaders and managers with the skills, knowledge and tools they need to provide effective leadership.
7 Day Services

We are making progress towards delivering sustainable 7 day services in line with our clinical strategy, with a focus on compliance with the key clinical standards. A seven day services project group has been set up and compliance is measured through a dashboard. Two rounds of case note audits have been undertaken and from April 2016 there will be a monthly case notes audit to enable us to monitor progress towards implementing the standards at specialty level.

The project group is concentrating on time to first consultant review within 14 hours (standard 2), access to diagnostics (standard 5) and daily senior review (standard 8). We are close to achieving the standards relating to patient experience (standard 1), mental health psychiatric liaison assessment (standard 7), and access to consultant intervention 7 days a week (standard 8).

Business cases have been approved for consultant recruitment within surgery and radiology. There is a significant nationwide shortage of radiologists and in mitigation we also have plans to recruit and train additional reporting radiographers. Service reviews have been completed in all specialties and gaps are being addressed at directorate level, including changes to consultant rota cover to improve senior review.

Quality Impact Assessment

There is a defined process for assessing which cost improvement programme (CIP) schemes require quality impact assessments (QIA), in line with our QIA policy. Depending on the nature of the scheme, either a summary or full QIA is required.

All QIAs for the 2016/17 CIP schemes have been signed off by the director of nursing and medical director prior to implementation the schemes being implemented.

Once QIAs are agreed, a QIA scorecard will be maintained by the project management office which tracks agreed quality metrics. Progress is monitored monthly by the quality & governance committee.
5 Approach to Workforce Planning

Workforce planning is an integral part of our business planning cycle. All our divisions have to develop workforce plans for future service provision as part of their annual planning cycle. A bottom-up approach is adopted to developing these plans to ensure they are driven by our clinical leaders in the new clinically-led organisational structure. Divisional workforce plans are aligned with activity and financial planning, which are then aggregated into our trust-wide plan.

Workforce plans are also driven by system-wide changes such as commissioning decisions and system-wide transformation programmes.

Workforce profile
The workforce profile is driven through a number of approaches which includes:
• Workforce growth as driven by service changes
• Workforce productivity
• Workforce reductions
• Pay control
Workforce Monitoring

The E-rostering system is used by the majority of our workforce. We have undertaken a data quality review of E-rostering and a number of actions were identified to improve the efficiency and compliance.

E-rostering metrics for nursing are measured on a weekly basis and shared with the assistant directors of nursing, matrons and ward sisters. These metrics are used as part of the budget/establishment reviews that are undertaken within our divisions/directorates. Key E-roster metrics will also be included on the divisional score cards to enable us to measure their effectiveness.

Ward staffing is monitored on a daily basis through our clinical safety huddle. All wards have criteria, in line with NICE guidance to assess the staffing levels within their areas.

The introduction of the new contract for junior doctors will see us establish a new system for monitoring compliance in line with the national terms and conditions of employment.
Agency Staffing Costs

We are working to reduce our agency spend by 26% compared to 2015/16 levels. This will be achieved through the following actions:

Agency Rate Reduction
We are working to fully implement the agency rate caps set by NHS Improvement. Significant progress has been made on nursing rates, with the majority of general nursing shifts now down to the April 2016 caps. Robust escalation procedures have been established for medical locum rates and collaborative work is underway with neighbouring trusts to establish common positions on rates. Significant reductions have also been achieved for other staff groups, and these are being reviewed to see where further reductions to the April 2016 caps are required.

Promotion of Bank Staffing Arrangements
Considerable progress has been made over the last year in increasing the availability of our own bank nursing staff to reduce dependency on agencies. We also have a medical bank, which currently is largely confined to the emergency department. We are reviewing what measures can be taken to encourage doctors in other specialties to work under bank arrangements. Our own bank staff already provide for most of our requirement for contingent administrative and clerical staff.
Reduction of Demand for Contingent Staff

The demand for contingent nursing staff has been reduced over the past year by improvements in rostering. A current priority is to embed best practice for enhanced care, which is one of the key drivers for the use of contingent health care assistants. Work has been done to identify where vacancies are the drivers for medical locum use, and plans are being developed to recruit substantively to those posts.

Divisional Planning

Our divisions have been set targets on agency spend that are designed to ensure we achieve our planned overall 26% reduction in spend. Divisions are developing plans to achieve this. Given the scale of the challenge, success will require a combination of actions around price negotiation, demand reduction and innovative approaches to workforce management to enable alternative solutions to providing safe and effective staffing.
5 Approach to Finance Planning

We have developed our financial plan based on the following assumptions:

- The current plan baseline is the 2015-16 outturn of a £20.15m deficit (this position remains subject to audit)
- The plan assumes a net tariff inflator of 1.7% made up of an inflationary uplift of 3.7% less an efficiency factor of 2%, consistent with national planning guidance
- The cost of increased employers NI contributions (£3.1m) and 1% pay awards
- A cost improvement target of £12.9m
- CNST premium increase of £2.2m for 2016-17. (£5.8m - £8.0m)
- Agreed developments such as the additional 60 bed business case
- We have agreed a control total of £15.1m deficit with NHS Improvement (NHSI), including the receipt of £9.7m of additional funding from the sustainability and transformation (STF) fund. To secure this funding we must deliver our financial performance to plan and achieve our access target performance in line with agreed trajectories.
- CCGs will levy re-admissions penalties in 2016-17 (FY15-16 £2.6m).
- Activity growth modelled in conjunction with the host commissioner give rise to a capacity shortfall equivalent to approximately 3,000 non-elective admissions
- Our capital plan includes provision of additional 60 acute beds on site at a capital cost of £10m which is assumed to be funded through a finance lease (subject to NHSI business case approval).