Lancashire Teaching Hospitals NHS

NHS Foundation Trust

# Service Development Strategy 2010 - 2013

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## Section 1: Introduction

Lancashire Teaching Hospitals NHS Foundation Trust (LTH) has come a very long way in the five years since the achievement of NHS Foundation Trust status in 2005. We have received major investment in neurosciences and renal services, and have become the cancer surgical and treatment centre for Lancashire & South Cumbria, an ambition first articulated in 2007. We have developed a range of new services and invested in cutting edge technologies, and we have also improved the environment and facilities for our patients and users. Six years ago, in 2004, the first Education Centre at the Sharoe Green site had just been completed. In 2009 this was complemented by a second centre, enabling realisation and fulfilment of our medical student plan. We continue to increase the number of patients we treated every year, and currently employ approximately 7,000 members of staff.

In terms of performance, the Trust has consistently met and / or exceeded a range of national standards and targets. Year on year, we have met our terms of authorisation set out by Monitor, and achieved the planned risk rating of '3' for financial management. Based on the assessment of our Annual Health Check 2008/09, the Healthcare Commission has awarded us a 'good' rating for both quality of clinical services and use of financial resources in 2009. We also fully met all Core Standards for Better Health, and were rated 'good' for achieving the new national targets.

Most importantly, we are proud of our continuing commitment and achievements in improving the quality and safety of care delivered to our patients. In this we benefit from full support and encouragement from both the Board of Directors and the Governing Council. We are very pleased that LTH has been categorised as 'A Best Performing Hospital' in the national review of maternity services, and was placed in the top 25% of hospitals in the country. In the follow up report on the Review of Children's Hospital Services published by the Healthcare Commission in March 2009, the Trust has been identified as a consistently high performer across a number of indicators. During the past few years, the Trust has made steady and sustained improvements in a number of priority areas. Most noticeable of these have been the significant reduction in MRSA and C difficile rates, as well as improvements evidenced in patient experience feedback and reduction in mortality rates.

Since the last Service Development Strategy was prepared, there have been significant changes in the external operating environment. These include:

- NHS reconfiguration leading to formation of bigger Primary Care Trusts (PCTs) with stronger purchasing power
- The birth of World Class Commissioning and the role of PCTs as commissioning organisations
- Economic downturn, an end to very high levels of investment in the NHS, and the projected deficit in pubic finances

- NHS to deliver annual efficiency savings of £15bn to £20bn by 2013/14
- The emphasis of national policies on health & well being, and shifting of care out of hospitals
- Increasing level of competition with the private sector
- Advances in clinical practices and technologies
- Greater than ever focus in service quality

To continue as a successful organisation, LTH recognises that it must meet these challenges and respond to the changing needs of its commissioners, patients and users.

The purpose of this Service Development Strategy ( SDS ) is to set out the overall direction of travel for LTH, and identity key strategic priorities / themes. This will in turn inform the development of Service Development Plans (SDPs) in service areas, and provide a framework to guide the internal business and planning processes. Given the high level of uncertainty of the current operating environment nationally and locally, the SDS has placed a focus on the next 9 -12 months alongside a number of key assumptions. There is also a need to fully understand the implications of the emerging health policies and priorities of the coalition government, and formulate our responses in the near future. It is our intention to refine this strategy document at the end of 2010, when we expect that more information and clarity will be available to us, and thereafter review it on at least an annual basis.

To prepare this SDS, we have taken an inclusive approach to involve our stakeholders. A series of workshops and listening events have taken place with our clinicians, staff, governors and members to capture and refine their views. We have also discussed with our commissioners the emerging themes in our SDS and sought their thoughts. Together with input from the Board and the senior management team, their contributions have helped to shape the content of this strategy. We have also taken this opportunity to review our vision and values with our staff. Over 1000 people have responded by participating in the questionnaire exercise and focus groups, and as a result, we have developed an enhanced vision and set of values for the future.

LTH believes successful delivery of this strategy can only be achieved with support from our partners across Lancashire and South Cumbria. The Trust remains committed to working closely with our patients and users, staff and clinicians, commissioners, and other stakeholders, to make it happen.

## Section 2: Strategic Context

### 2.1 National policy direction

Health service professionals anticipate the emergence of a different kind of NHS in the coming years. Taking into account the state of public finances, the political development in relation to the health agenda, and recent Department of Health guidance including the recently published *NHS Operating Framework for 2010/11* and *NHS 2010 – 2015: from good to great*, a number of themes have been identified. They are:

- Much tighter NHS finances against a backdrop of rising demand
- Emphasis on quality as the organising principle: patient experience, safety & clinical outcomes
- Increase in productivity & efficiency
- Better access and more choice for patients
- Care closer to home & diversion from hospitals
- Support health & well-being
- Reforms of regulation and commissioning
- Co-operation and partnership working

#### 2.1.1 NHS Funding

There have been significant levels of investment in the NHS over the last 10 years, and this will come to end by 2011. The 2009 Pre Budget Report has confirmed that spending on the NHS will continue to rise in line with inflation after 2011. Despite the relatively positive financial settlement for the NHS, tough times are ahead. NHS Chief Executive David Nicholson has already indicated in his annual report and again in the NHS Operating framework that a tighter financial environment, and the need to release efficiency savings of £15-20 billion by the end of 2013/14. This requirement has been verified by the 2010 Budget. The SHA and PCT are expected to end 2010/11 with an aggregated surplus of £1 billion, which is 1% of the NHS allocation. In the meantime, foundation trusts have revised planning assumptions and prepared downsize plans as required by Monitor.

It is clear that with rising demand and an aging population, the current tariff system is not sustainable. The tariff system is also considered to be working in favour of the acute sector, with little incentive on demand management. In setting the national tariff for next year and beyond, the key emphasis is to incentivise providers to maximise efficiency and quality of care. Developments to the national tariff price so far have included:

- Zero per cent uplift in 2010/11 and for the following 3 years
- Zero per cent uplift for all prices in non-tariff services in 2010/11
- An requirement of 3.5% efficiency savings in 2010/11, and likely to be higher for the next 3 years

- Emergency activities above the value of the contracted baseline at the aggregated level will only attract 30% of the relevant tariff in 2010/11
- After 2010/11, the national tariff will be the maximum but not the mandatory price payable by the commissioners.
- A new currency for adult mental health services

There will also be more reward associated with quality and efficiency, and the Operating Framework also pledges to publish hospital trust level reference costs for specific treatment categories online in early 2010.

### 2.1.2 Quality

Amongst other DH documents, Lord Darzi's NHS Next Stage Review Final Report is probably the most significant, with its stated intention to put quality back at the heart of the NHS. Better quality care is defined through patient experience, safety, and clinical outcomes, and there will be continuing requirements to improve safety and reduce healthcare associated infections. Quality is seen as key to improving efficiency and productivity. Recent figures by the Chief Nursing Officer suggested clinical improvement could save the NHS £9bn a year.

Financial rewards will continue to be linked directly with quality. A proportion of providers' income is now conditional on quality through the CQUIN (Commissioning for Quality & Innovation) payment, and in 2010/11, up to 1.5% of the contract income (treble the current amount) can be earned when quality and innovation targets are met. Patient experience is featured as a compulsory element of the CQUIN schemes, and as from 2011/12, PCT will be given power to withhold up to 10% of the contract payment if providers fail to meet agreed patient satisfaction objectives on a service by service basis. Best practice tariffs will be introduced for cataracts, cholecystectomy, fragility hip fracture and stroke in 2010-11 to address variation in quality between providers, and there will be no payment for the never events.

In the future, the Care Quality Commission will also have new enforcement powers. NHS Evidence, Clinical Dashboard, a new National Quality Board, Annual Quality Account and Advancing Quality Scheme are some of the proposals intended to ensure quality is placed at the heart of our day to day business.

Healthcare providers must now show that they are meeting essential standards as part of a new registration system. Subject to legislation, all NHS trusts that provide regulated activities must be registered with the CQC as from 1st April 2010. Guidance from CQC has also been published to help providers meeting these standards which relate to aspects of care such as involvement and

information for people, personalised care and treatment, safety and safeguarding.

### 2.1.3 Productivity & Efficiency

A recent report published by the Office for National Statistics revealed that productivity in the NHS as a whole has fallen by an average of 0.3% every year from 1995 to 2008. In the current economic climate, this has further focused the debates on cost efficiency, and there is a general expectation from the public for more productive services, particularly those in hospitals.

In order to cope with rising demand and restriction on finances, the NHS will have to respond to the challenge and begin making changes to increase productivity. The McKinsey review report in September 09 suggested a high level of wastage and inefficiency in the acute sector, and estimated a maximum potential saving of 38% of the 2008/09 spending on acute care. Other information also suggests if every NHS organisation improved its performance to match that of the top quartile in each Better Care Better Value indicator, NHS England could realise £2.4 billion on productivity benefits.

The report *Putting the Front Line First: Smarter Govt (Dec 2009)* sets out new comparator benchmarks for some back-office functions such as IT, finance, supply and HR. *NHS 2010 – 2015* again underlines the importance for NHS organisations to bear down on the back-office management, procurement and estate costs, and with a specific requirement to focus in 2010/11 on exploring ways to reduce spending.

As announced in the 2010 Budget, work at a national level through the Public Value and Operational Efficiency Programmes has already identified several potential areas able to release the efficiency savings required from the NHS. They have included:

- Raising staff productivity by systemically spreading good practice
- Better procurement, savings in management and back office costs
- More efficient use of hospital estate

### 2.1.4 Access & Choice

Much of the recent focus has been on reduction of waiting times, and faster access to drugs and treatment - regardless of where a patient lives - continue to be a priority. There is a strong emphasis on improving primary and community care services, with better access to GP services. There will be no ‘new’ national targets, and existing ones will be replaced by 'standards' and ‘rights’ in the future. As from the 1st of April 2010, anyone suspected of having cancer will have the legal right to be seen by a specialist within 2 weeks from their time of being

referred by their GP, and people referred for elective procedures will have the legal right to start treatment within 18 weeks. From April 2012, all those eligible aged 40-74 will also have the legal right to an NHS Health Check every five years to assess their risk of heart disease, stroke, diabetes and kidney disease.

There will also be greater choice for patients, supported by better information. This applies to treatment in secondary care organisations (NHS or private) as well as registration with GP practices. NHS Choices website and publication of hospital performance league tables are just examples of ways to empower patients to make 'informed' choices.

Plurality, competition and market management are considered by the commissioners as the vehicles to offer more choice to patients and drive up service quality. Many hospital services will be subjected to tendering exercises, and it is likely that more NHS services will be provided by independent and third sector organisations in the future.

### 2.1.5 Care closer to home

The government policy to bring care closer to a home setting was first laid out in the White Paper *Our Health Our Care Our Say (2006).* As well as being more convenient to patients, this development aims to provide better access to treatment and enhance patient choice. This agenda remains a high priority although progress so far has been slow. The recently published End Of Life Care Strategy also aspires to allow more people to spend their final days in a closer to home setting or in their own homes.

*The Next Stage Review: Our vision for primary and community care*, sets out a vision for primary and community care, and the Transforming Community Services programme is a new initiative in early 2009 with a purpose to create modern, responsive, and high quality services. Work is underway to take forward this development, and the impact of this is yet to come through.

More incentives will be development to move treatment of patients from acute to community settings, and this is confirmed in the *NHS 2010 -2015: from good to great. The Operating framework 2010/11* describes the characteristics of the new system are likely to have more services at home and less investment and activity in the acute sector.

### 2.1.6 Health & Well being

There is an emphasis on changing the perception of the NHS from a treatment service to one with effective prevention for lifestyle choices. Much of the emphasis is about patient empowerment, giving people more control and support

over their health and choice of services. This is particularly important as more people are living longer with long term conditions. Since the vision was outlined in the *Commissioning Framework for Health & Well Being (2007),* the personalised and independence agenda continues to evolve. *High Quality Care For All, the NHS Next Stage Review (July 2008)* further reinforces the need to create an NHS that helps people to stay healthy, and more recently, a national Personal Health Budget pilot to test out one of the approaches. There are many public health initiatives and screening programmes to promote healthy living and prevent ill health. Hospitals are also expected to play an active role in health education and supporting people to make healthy choices. In the Operating Framework 2010/2011, the need to provide cost effective services to keep people well has once again been reiterated.

2.1.7 Reforms & Regulations

Governance & Accountability

With recent high profile incidents emanating from foundation trusts, their value for money and their freedoms to operate have come under scrutiny. The review report of Mid Staffordshire reiterated FTs as part of the NHS family, and clarified the roles of PCTs as performance managers. These points will have implications on future working dynamics between the organisations and Monitor. FT governors and members are also encouraged to take a more proactive role in holding the Boards to account. In addition to this, Monitor now has power to regular poor care and de-authorise a foundation trust if it fails to maintain the high standards expected.

World Class Commissioning (WCC)

The WCC programme is intended to provide a more strategic and long-term approach to commissioning services, with a clear focus on delivering improved health outcomes. PCTs are being given a set of 11 competencies with a supporting development framework. So far, progress has been slow, and the impact of this is yet to be realised. Alongside this, PCTs are relinquishing their functions as providers of care in order to concentrate as commissioning organisations.

Recent reports by health policy think tanks the Nuffield Trust and the Kings Fund suggest clinician led ‘integrated care organisations’ and larger and more powerful primary care trusts are needed to boost commissioning in the NHS.

Practice Based Commissioning (PBC)

Since a full coverage of PBC in 2006, the take up from GP practices varies from region to region. This is recognised in the report *High Quality Care For All (2006)* which set out a commitment to reinvigorate and provide stronger support and incentive for engagement. PBC is also featured heavily in the Conservative Party's health policy, promising further roll out and more control to GPS over real commissioning budgets.

NHS Constitution

This establishes the principles and values of NHS England, and was introduced as part of the implementation of the report *High Quality Care For All*. It sets out the 7 key principles that guide the NHS, and outlines the rights and responsibilities of patients, the public and staff, a move away from central targets. From January 2010, all providers and commissioners of NHS care will be under a new legal obligation to 'have regard to' or 'take account of' the NHS Constitution in all their decisions and actions.

As the NHS continues to improve, there will be more patient rights in the future and work is already underway on the foundations for this. These rights could include the right to key diagnostic tests and results for patients suspected of having cancer within one week of seeing a GP, the right to die at home, the right to evening and weekend access to GPs, and access to NHS dentistry.

2.1.8 Co-operation & Partnership

The government has sent out a clear signal that it expects more cooperation between organisations, particularly to keep people well and avoid unnecessary visits to hospitals. This was first outlined in the *Commissioning Framework for Health & Well Being (2007)* and emphasized again in the Operating Framework 2010/11. There is no reason to expect that a different administration would demur from this.

Under the quality and efficiency agenda, there is also a strong emphasis on organisations working across boundaries to respond to the challenges ahead. Six principles of joint working have been recently outlined by the national Social Partnership Forum:

- Build and maintain respect
- Be clear about appropriate governance
- Aim for inclusively
- Co-operate for whole-system solutions
- Work within and build on existing policy commitments
- Work to retain confidence in the NHS

Increasingly, there is much advocacy and support for vertical integration between secondary care providers and community services. Smaller NHS organisations are being encouraged to share resources and / or consider organisation merger as a future option.

## 2.2 Local Context

### 2.2.1 Population

Central Lancashire

The health of people in Lancashire as a county varies, with just over half of the health indicators worse than the England average, such as binge drinking adults and life expectancy. There are also inequalities in Lancashire by deprivation, gender and ethnicity. For example, women and men from the least deprived district can expect to live 3 – 4 years longer than those from the most deprived district. The health of children and young people is generally worse than the England average.

Central Lancashire has a population of 452,500, and LTH provides a district general hospital service to approximately 390,000 people living in South Ribble, Chorley, and Preston boroughs. Preston is one the four districts in Lancashire with the most deprived neighbourhoods, and the life expectancy for both men and women in Preston is significantly lower than England average. In common with England & Wales, cardiovascular disease and cancers are the two major causes of death.

Like the rest of UK, the population in Central Lancashire is aging overall. By 2020, the number of people aged 75 and over will have risen by 43.2%. This rate is indeed greater and faster than the national trend, and as a result, this brings a quicker increase in the number of people with long term conditions, strokes and dementia. At the opposite end of the scale, the younger population (aged 5 – 49) is predicted to have decreased slightly by 2.5%.

Cumbria

The health of people in Cumbria is comparable to those in Lancashire. However half of the national indicators are similar to England average, and a number of others are significantly worse or better than average. There are inequalities in Cumbria by deprivation and gender, and again, men and women in least deprived district can expect to live 3 – 4 years longer than those in the most deprived area. The health of children and young people is varied.

### 2.2.2 NHS North West & QIPP

*'Healthier Horizons for the North West (2008')* sets out the outcome of the major service review in the NW as part of the contribution to the Lord Darzi review. Recommendations including those for the eight clinical pathways have provided a foundation for planning at a regional and PCT level.

QIPP (quality, innovation, productivity and prevention) is the new framework being adopted across the NHS to ensure the changes required to commission and deliver health services in the new economic context. In the NW, this is translated into whole system working and provides a framework to facilitate cross boundaries planning. There is also the establishment of the Advancing Quality Alliance (AquA), the North West's Quality Observatory, to support the scale and the pace of change agenda, and the introduction of performance metrics to measure the progress of the QIPP across the whole system.

It is estimated that the North West weighted capitation share of the national efficiency savings will be around £2.25 billion to £3 billion. A number of Summits have taken place to plan the responses from the NW to the productivity and quality agenda under the anticipated financial challenges. In particular, the NHS NW has outlined a number of expectations including:

- 10% reduction in demand on acute services by end of March 2011
- 15% reduction in the acute sector capacity by March 2013
- 10% reduction in expenditure in all sectors by March 2013

Local, countywide, and regional solutions are being explored to meet the quality and financial challenges. A Clinical Transformation Board has been set up to provide the clinical leadership as the QIPP agenda develops. The Lancashire Summit Programme Board will oversee the local delivery programme, and there is an expectation of the local community to release £500m of efficiency savings between 2010/11 to 2013/14. The providers have been allocated a target of £234 million, nearly half of the total amount. Premier Consulting has carried out a study to identify potential areas for quality improvement and efficiency gain, and they are:

- Rationalisation of services
- Clinical process improvement
- Procurement
- Workforce management

### 2.2.3 Local health priorities

NHS Central Lancashire (NHSCL) published its Commissioning Strategic Plan 2009 – 14 at the end of May 2009. The document sets out the PCT's priorities for the next 5 years, and has a strong emphasis on diversion of activity and

resources from the secondary care. Six areas of focus have been identified and they are:

- Cardiovascular disease
- Respiratory illnesses: chronic obstructive pulmonary disease & asthma
- Cancer
- Infant mortality
- Risk-taking behaviours: alcohol misuse, teenage pregnancy & drug misuse
- Mental health

Market management through competition and plurality are considered as key drivers to improve service quality and enhance patient choice. Service line management structure will be set up as the key structure to take forward service planning and commissioning.

## 2.3 Market assessment

### 2.3.1 District General Hospital services

Most of our services are commissioned by NHS Central Lancashire and this is equivalent to over 80% of both the activity level as well as contract value. The development of our local service will be strongly influenced by the recent Commissioning Strategic Plan 2009-14. Early indication from the PCT suggests the funding gap for central Lancashire could be around £150m between 2011 and 2014, and this will doubtless have an impact on the range and level of activities to be commissioned. The health priorities are outlined in section 2.2.3. At the time of writing, a detailed delivery plan is not yet available to the Trust.

There are 4 practice based commissioning (PBC) consortia in Central Lancashire, which cover a total of 87 GP practices. Of these, 3 of the 4 consortia have a similar catchment area as LTH. The development of PBC is in its infancy compared to some parts in the NW and England, and so far, there has been little impact on service commissioning. However, PBC commissioners are increasingly taking a leading role in service redesign and change initiatives, and it is certain that their influence in local commissioning will be much stronger in the near future.

The Trust also receives referrals for patients from the nearby PCTs. There is potential for LTH to expand into other geographical areas in the NW, and provide existing services to a wider population.

There are a number of private hospitals in the area, and they have continued to increase their market share in elective surgical procedures.

There are also signs that PBC consortia are starting to set up services in the community to divert patients away from hospitals. Commissioning intentions and progress of new services are provided in the monthly PBC update submitted to the Professional Executive Committee of NHSCL.

### 2.3.2 Specialist services

LTH provides a range of specialist services to residents of the six PCTs in Lancashire & Cumbria:

- NHS Central Lancashire
- NHS East Lancashire
- NHS Blackburn with Darwin
- NHS Blackpool
- NHS North Lancashire
- NHS Cumbria

In 2009/10, this was equivalent to about 7% of all our total activity and 8.5% of our income. On a day to day basis, commissioning of these services is managed by the NW Specialist Commissioning Team and the Lancashire & South Cumbria Commissioning Business Unit. It is likely that more services such as cardiology will be commissioned under the collaborative arrangement across the 6 PCTs.

There are a number of potential new entrants, both NHS and private providers, to the existing market. This is confirmed by the number and the range of suppliers which have expressed an interest in recent market testing and tendering exercises. For example, current services at the renal satellite units are already provided by the private sector, and there is a possibility that others in our portfolio could be provided by another organisation in the future.

## Section 3: Vision, mission & objectives

### 3.1 Vision

The following statement sets out what LTH wants to accomplish:

‘Dedicated to getting it right first time’.

### 3.2 Mission

To achieve our vision, the following approaches will be taken by LTH.

3.2.1 Right Care

Striving continuously to provide the safe, effective and well-organised care that patients want.

3.2.2 Right staff

Skilled, caring and motivated staff committed to promoting good health, and providing the highest standard of patient-focused care and treatment.

3.2.3 Right way

Progressive and responsible in how we think and act, working in partnership to develop high quality education and research in a modern healthcare environment.

### 3.3 Organisational Values

They define how our staff should behave towards each other, our patients and their families, and the partners we work with.

3.3.1 Caring and Compassionate

Being caring and compassionate is at the heart of everything we do, it is about understanding what each person needs and striving to make a positive difference in whatever way we can

3.3.2 Recognising Individuality

Appreciating differences, making staff and patients feel respected and valued

3.3.3 Seeking to Involve

Actively gets involved and encourages others to contribute and share their ideas, information, knowledge and skills in order to provide a joined up service

3.3.4 Building Team Spirit

Working together as one team with shared goals, doing what it takes to ensure we provide the best possible service

3.3.5 Taking Personal Responsibility

Individuals are accountable for achieving improvements to obtain the highest standards of care in the most professional way, resulting in a service we can all be proud of

## 3.4 Corporate Aims

The Trust has eight corporate aims. They reflect the complexity of our healthcare business, and provide a framework to focus and assure our service delivery.

Patient Experience
Quality health care will be delivered and developed in partnership with patients and their carers, respecting their diverse needs, preferences and choices.

Partnership
The profile of the Trust as a provider of choice will be promoted through the development of strategic networks, planning and health promoting partnerships that support and consolidate delivery of existing services and identify new opportunities.

Workforce
Care will be provided by a competent, capable, flexible, efficient and affordable workforce that is able to adapt to the changing context of healthcare and customer expectation.

Environment
Health care will be provided in an environment that promotes patient and staff comfort, well-being, privacy and safety.

Governance
Leadership and management accountability arrangements will provide a comprehensive overview and assurance of business systems ensuring compliance with Foundation Trust Terms of Authorisation.

Safety
Patient and staff safety will be enhanced by systems, processes and practices that prevent or reduce the risk of harm to patients and promote a culture that learns and shares lessons when things go wrong.

Finance
Financial stability will be achieved through robust financial management and strategic planning programmes.

Efficiency
Patient outcomes will be optimised through the provision of accessible, efficient, effective services that are based upon reliable evidence.

## Section 4: Strategy for 2010 - 2014

Our ambition is to build on our success and further develop LTH as the regional hospital for Lancashire and South Cumbria. Given the high level of uncertainty of the current operating environment nationally and locally, we have worked on a set of assumptions and identified 4 strategic priorities for the near future. It is our intention to further refine this strategic document at the end of 2010 when more information becomes available to us. The four strategic priorities are:

- Enhance quality
- Improve productivity
- Reform service delivery
- Build partnerships

To develop the priorities, a number of key factors have been taken into account, including:

- Assessment of strategic drivers and local context as described in section 2
- Outputs of visioning workshops with Board of Directors, trust management team (clinical directors and general managers), governors and foundation trust members
- Inputs from the members through the membership survey and governors listening events
- Commissioning intentions in the NHSCL Commissioning Strategic Plan (2009 – 2014) and 2010/11 draft contract
- Clinical network service strategies
- Focuses of the Lancashire QIPP programme

The strategic priorities attempt to describe a vision for what 'excellent' will look like in LTH in 3 years time. The priorities will also be used to inform our internal investment prioritisation process, and enable a clear line of sight to be demonstrated between service development at directorate level and the over-arching strategic priorities.

LTH has a recognised track record in delivery. The Trust will meet and / or exceed the standards and requirements defined by Monitor, CQC and NHSLA, and continue to strengthen our position as a high performing organisation in the NW and beyond, influencing and taking part in local, regional and national development of health services.

### 4.1 Enhance quality

#### 4.1.1 Clinical quality

High performing health care organisations achieve success through quality-based service improvements, linked to improved patient care processes and

outcomes. The introduction of the best practice tariff in 2010/11 has connected payment directly to care quality. Increasingly, a large element of the providers' income is conditional on quality through CQUIN. With this in mind, the Trust has published a strategy for safety and quality: *Safe, Reliable & Compassionate*. We have set out three ambitious, measurable, and patient-centred goals to be achieved by 2013:

- To reduce in-patient mortality
- To improve safety and reliability of care
- To demonstrate year-on-year improvement in the patient experience

A focused approach to improving safety and quality has been adopted, and there are four cornerstones to underpin their delivery:

Safe Care – Improving the safety and reliability of care in relation to early recognition of the sick patient, patient falls, medication error, peri-operative care and healthcare associated infections.

Effective Care – Improving patient care pathways and outcomes of care in relation to stroke care, end of life care, dementia care and those identified through the 'Advancing Quality' programme. In addition, there is focus on nutritional care, pain management, prevention of venous thromboembolism and tissue viability care; elements of care that impact on the wider patient population.

Experience of Care – improving patient care experience in relation to privacy and dignity, compassion and respect, information giving and involvement in decisions about care and treatment.

Organisation of Care – improving efficiency and productivity in relation to access to services, delivery of evidence-based care pathways, timely and effective hospital discharge. It also includes how quality-based service improvements will be supported in order to increase productivity and reliability of care delivery.

The above cornerstones are strongly connected with the other two strategic priorities: improving productivity and reform of service delivery, and together, they provide the opportunity to release potential savings and enhance care delivery.

The full strategy including focuses for each cornerstone and success indicators is available on the intranet.

LTH will subscribe to the North West Quality Observatory in line with our commitment to innovation and quality improvement. This supports the delivery of our current and future programmes. The Trust intends to align quality initiatives, and national learning and reporting systems. It will also seek further opportunities to participate in regional / national partnership forums to promote and support innovation in the NHS.

In the market of plurality and patient choice, quality is what distinguishes one provider from another, and therefore, a critical success factor for LTH to sustain in the competitive environment. The Trust is due to publish our first set of annual quality accounts in June 2010. LTH has made significant advances in service quality over the past few years, and will continue to build on that success and make quality the cornerstone and organising principle of our services.

### 4.1.2 Education & research

Clinical education and research play a key role in enhancing patient care and developing service innovation, and as teaching hospitals and a tertiary centre, the Trust is fully committed to supporting these activities.

Clinical Education

There is an established medical education programme, and LTH contributes to the delivery of the curriculum for medical students, foundation trainees, and post graduates. The Trust also provides work-based experience to support the training of nurses, allied healthcare professionals and healthcare workers. A variety of clinical programmes for qualified nurses are delivered by LTH for University of Central Lancashire, and these training courses are vital to ensure safe care is provided. Health care workers at LTH and other local trusts are offered a wide range of City and Guilds accredited clinical support NVQ courses run by our in-house staff. There are also the essential skills (literacy and numeracy and ESOL) accredited programmes for staff provided in conjunction with local colleges.

In order to equip our staff for the type and scale of challenges expected of the NHS workforce in the years ahead, LTH will "translate" those changes in requirement into education commissioning and provision of training and education. The principles outlined in *Education Commissioning for Quality* will be used to refocus our current system, and we will review the numbers of our post grad medical trainees, and the number of non-medical commissions. The Trust recognises the role of clinical education in helping to deliver a quality patient service, and will continue to work in partnership with the Universities, Deaneries, Royal Colleges and other stakeholders to provide first class and responsive training facilities and experiences to students and learners alike.

Clinical training is an integral part of our business, and the Trust is committed to further incorporate it into service delivery. The Trust will ensure the best use of our current patient case mix to optimize the training experience, and develop IT systems to support teaching where possible. The Trust is already leading the way in simulation training in the region, and will seek opportunities to further expand the facility with Manchester University and open up the access to all grades of staff. There is also potential to front-end the information held in the

Trust, and the pace of developing our IT system further will depend on securing the initial educational funding and revenue resources to provide the on-going support.
There is likely to be changes in the distribution of the Multi-professional Education and Training Levy, although early indications suggest the financial impact on LTH will be minimal. However this may potentially affect our ability to provide the level of supervision required, and the situation will need to be assessed at a later stage and responded to accordingly.

LTH is a member of the newly established Cumbria & Lancashire Health Innovation and Education Cluster (HIEC), and intends to play an active part in supporting and shaping the future education agenda.

A NW governance framework was launched in summer 2009, and the Trust has further developed this into a local Educational Governance Framework in September 2009. The framework will allow the Trust to assess and monitor the quality of our education provision, and will be used to further improve our service. There will also be the introduction of an appraisal system for individual educators. We believe first class supervision of those involved in patient care is central to the quality, safety and effectiveness of our services, as well as training and education.

## Research

The Operating Framework 2010/11 stated all NHS organisations must play their full part in supporting health research. At LTH, we have a very active programme, and both the level of research activity and the allocated funding from the Department of Health have continued to rise. Achievement is evidenced not only by the large number of articles and research reports for publication being accepted in peer review journals, but also by the continued success in attracting external research funding. Over the coming years, LTH will continue hosting multiple disease specific research networks and the Cumbria and Lancashire Comprehensive Research Network (C&LCRN). Through the funding provided by C&LCRN, the number of research nurses has been increased to provide support to clinical directorates to further engage in national multi-centre research trials, and this situation is likely to continue.

As an active member of the National Exemplar Northwest Pilot Project, LTH will be working with C&LCRN and the Department of Health to encourage and maintain industry investment.

With the establishment of improved governance systems provided by the R&D department, LTH offers an excellent facility for industry sponsored studies. LTH will continue to advance our partnership with the private sector, and take part in multi centred projects as well as acting as Lead Trust in many cases.

The Research Directorate has now an accredited 'Good Clinical Practice in Research' course. To further improve our research quality, LTH is to provide education and guidance for both current and potential researchers.

## 4.2 Improve productivity

The significant level of investment in the NHS will come to an end by 2011/12, and this is therefore particularly important to ready the Trust for the financial challenges ahead. There is also an expectation that almost half of the anticipated efficiency savings for Lancashire of £500m by 2012 would be contributed by service providers. Early indications from NHSCL suggested a figure of £173m for central Lancashire. The Trust's continuing ability to deliver a financial surplus in line with our terms of authorisation from Monitor is critical in ensuring success and sustainability as a foundation trust. Significant efficiencies will have to come from innovation and culture change, and the Trust does not underestimate the effort that will be required and the need to deploy a range of methods to achieve this.

Taking into account the economic situation and the reduction in NHS funding, the emphasis will be on 'delivering more and better for less'. This could either be delivering the current amount of activity with less resource, or providing a higher level of output with existing level of resources. With the freeze in tariff price and other measures such as caps on emergency activity, there is suggestion that hospitals will need to be 15-20% more productive by 2015 to break even. Implementation of clinically and cost effective care pathway is strongly promoted by the QIPP as a way to realize the efficiency savings. At the time of writing this strategy, a copy of our PCT's delivery plan for its Commissioning Strategic Plan 2009-14 has not been made available to the Trust. It is also unlikely that the actual loss of income due to the level of demand management or service decommissioning at this stage, will match our cost reduction in service provision. For that reason, the key focus particularly for 2010/11 is to increase our productivity and efficiency, and eliminate waste. There are opportunities here to improve service quality and enhance patient experience, as well as release savings.

The Trust has set an ambitious productivity and efficiency target of £17m for 2010/11, and each directorate will be required to contribute an equivalent of 6.04% of baseline budget. Pending the outcome of the current negotiations with our commissioners, the final figure for 2010/11 may increase further. For future years, the Trust envisages a recurrent saving of a similar magnitude, and differential targeting will be employed to allocate the saving targets.

### 4.2.1 Workforce

Like the rest of the acute sector, our major cost is our staffing. In order to achieve the level of efficiency target, we need to develop a much better understanding of our current pay expenditure, and focus on identifying opportunities to reduce costs such as bank and agency staff usage.

Workforce reviews will be carried out to ensure we are maximising our single biggest resource. We will streamline our operational processes, and standardise the working practices of specific staff groups in different parts of our organisation, ensuring the relevant duties are being carried out by staff at the appropriate banding / level. Over the years, different types of staff benefits and remuneration systems have been introduced to meet the needs of the Trust, and we will be examining the package to make sure they are fair, appropriate and fit for purpose in the current economic state. Workforce policies will also be revisited and aligned accordingly. We will be working closely with the relevant staff committees on these issues.

### 4.2.2 Technology

Technology can facilitate more efficient service delivery, and we aim to exploit the full advantage of new technologies and IT to better support our staff on a day-to-day basis.

Digital dictation and voice recognition have already been adopted in some specialties, and we will continue to roll this out to other clinical areas where appropriate. E-rostering and integration of different temporary staffing banks will be introduced to streamline current processes and allow better planning. This will in return enhance service quality and avoid unnecessary costs by better management of bank and agency staff. Digitalisation of health records can revolutionise our existing practices, and provide timely information for our clinicians to manage their patients. This is part of the wider Clinical Record Strategy and will be rolled out to all clinical areas in phases.

### 4.2.3 Back office functions

We will review our back office functions. As part of the QIPP, the Trust is working jointly with Lancashire Collaborative Working Groups to explore if payroll, IT and elements of HR functions could be provided as shared services for the health economy. To identify areas for further improvement, we will be benchmarking some of our management information in confidence with other acute partners. Where appropriate, we will be working towards a consistent approach in managing some of the common issues. Locally we intend to review

our current financial and procurement system, and explore a just-in-time stock management system for the clinical areas.

Internally, there is potential opportunity to rationalize some of our management functions taking place at the directorate and corporate level e.g. waiting list management, to avoid duplication and free up resources.

### 4.2.4 Service reconfiguration

To release the anticipated level of savings in the local health economy, it is very likely that the numbers of our hospital beds alongside other facilities will be reduced as a result of service redesign and reconfiguration, and / or a reduction in commissioned activity. Indications from NHS NW suggested up to 15% of the current capacity in the acute sector could be reduced by 2013, which would be an equivalent of approximately 150 beds at LTH. It is unclear at this stage how this would be delivered across the whole of North West or in Lancashire.

However at a local level, NHSCL has signalled its intention to reduce the level of 2010/11 commissioned activity by over 5,000 HRGs. This is equivalent to an income reduction of around £12.5m, and would have a major implication on the level of infrastructure required to support service delivery. Initial impact assessments have already been carried out by the directorates, and pending the final contract agreement with our commissioners, we will take action accordingly.

### 4.2.5 Reduce variations

Currently there are wide variations in performance amongst different clinical specialities, and in some cases, the cost of providing a service is actually more than the actual income (tariff) received. A number of tools will be used to benchmark our performance against national and regional indicators, and identify potential areas to release savings (cash / resource) while improving quality. They include:

- National reference cost
- Better Care Better Value indicators for providers
- Comparison against our peers in the ‘Benchmarking Club’
- Case studies of major savings and service quality improvements featured in NHS Evidence

To provide an all round assessment, we plan to produce a LTH productivity matrix scorecard including some of the indicators from the ‘organisation of care’ improvement programme. The Trust will continue to develop service line reporting and patient level costing systems to support directorates in monitoring and managing their services. Alongside with consultant level income & expenditure information and an improved information management system, these

tools will help to empower the front line clinicians and operational managers, and use intelligence to drive up operational performance.

### 4.2.6 Improvement methodologies

The Trust has been working with the Manufacturing Institute to introduce 'Lean Working' since 2008, but so far, much of the effort has been limited to emergency pathways. The Trust believes that improvement methodologies such as Lean and the 'productive' series, enables people working at the front-line to use their own experience and understanding of processes to help improve services and release savings, and we have committed to further investment. Lean working will be rolled out to other departments as a key mechanism to harness the creativity and innovation of our front-line, and engage our staff in service improvement. There will also be a Service Improvement Strategy setting out the approach we intend to take to empower our staff, and providing more detail on both improvement and on sustaining achievement.

## 4.3 Reform Service Delivery

The NHS is entering a period of significant consolidation, while demand for its services continues to increase. This raises challenges for the future that require planning and preparation now, including the testing and adoption of health economy wide radical solutions. In particular, the approach to service commissioning and provision will have to be very different from where it is now. Our quest is to improve on patient experience and clinical outcomes, while at the same time, reduce the cost of service delivery. Reform service delivery goes hand in hand with the four cornerstones in our Strategy for Safety & Quality: safe care, patient experience, effective care and organisation of care, and is the key to improving our productivity.

### 4.3.1 Avoid duplication

We need to maximise our current resources in order to provide the best possible experience and clinical outcomes for our patients. This principle will be used to underpin future service redesign and reconfiguration. Change should only happen if it will deliver quality improvements for our patients. There are currently a number of clinical services being provided on both hospital sites. The Trust will carry out reviews to ensure the existing care models and associated infrastructure are sustainable and offer value for money, and most importantly, that they are enhancing service quality and patient experience and outcome. There will be alignment of our current resources and consolidation of some of our

services. In some cases, this could help to release savings than can be diverted into other service developments.

In situations where services have to be provided on both hospital sites, these facilities will need to be utilised to their full potential wherever appropriate and possible. This will mean people being prepared to change from the way they work now, and services to be recognised in a different way.

### 4.3.2 Promote access

The Trust will work towards creating a single point of access for patients who require elective and emergency services. This means the Emergency Department and assessment wards and areas will be co-located at the front end of the hospitals. Elective facilities will be consolidated and the requirement of a dedicated day case area will be explored.

The Telephone Appointment Line (TAL) leads to poor user and patient experience, and also consumes unnecessary organisational energy. Currently, a small number of specialties contributes to over half of the total patients on the TAL. A lot of work has been carried out to improve the situation, and more can and will be done to ensure a sufficient level of clinic capacity to meet demand. The Trust will consider the impact of consolidating the capacity on both hospital sites into a single list. There is also demand forecasting to assist in capacity management, and will be rolled out to all specialties. To balance a variable demand to supply and, particularly in the current economic climate, avoid over-capacity, it is inevitable that there may be patients on TAL at times. However, this should be limited to a small number of patients for a short period of time (days) while clinic capacity is being created. The Trust is totally committed to the elimination of TAL due to clinic capacity wherever possible.

Monitor's Compliance Framework stipulates very clearly our requirement to meet the performance targets and national core standards, and many of them are related to access and waiting time. The NHS Constitution has also sets out the rights of patients and the public to access NHS services. At LTH, we have a track record of successful delivery, and will continue to ensure there are robust and sustainable plans in place to meet and / or exceed those 'existing commitments' and vital signs tier 1 & 2 priorities.

### 4.3.3 Streamline services

Clinical pathways will be streamlined and integrated where possible across different sectors to improve flow and patient experience, and more one stop clinics will be developed. We intend that hospital services will be better co-ordinated, recognised and located to minimise wasteful and unproductive

activities for both patients and staff. This will require re-alignment of some of our current facilities.

Successful re-redesign of the emergency pathway is a high priority. There are also a significant number of our beds currently taken up by patients without a healthcare need. One of the Trust's aims is to ensure the right type of patients occupying the right number of in-patient beds in each directorate based on good and evidence based clinical practice. This will in turn promote care continuity, reduce the number of 'sleep outs' and minimise unnecessary patient transfers between different wards due to non-clinical reasons. Some separation of elective and emergency workload has already taken place across the two hospital sites in some specialities. More work will be carried out to explore the benefits of further alignment to enhance clinical outcome and patient safety. The Trust also needs to work with other health & social care partners in the health economy to promote timely and safe transfer of care. The recently introduced 'integrated discharge summary' will improve the timeliness and quality of the discharge communication to our GPs, and the plan is to transmit this electronically to our GPs with 24 hours in the near future.

### 4.3.4 Develop work practices

More day case procedures could help to release resources in the system, and for most of our patients and their families, this will also cause less disruption to their lives. The Trust has been using the information from the British Association of Day Surgery to identify potential areas for improvement, and with advances in medicine and technological, we believe more could be done at LTH. The Trust is committed to further increase our day case activities, and develop our facilities to promote a patient friendly environment.
With advances in technology, many day case procedures can also be performed in an out patient setting. We will continue to work with our clinicians to explore the possibility of introducing them locally.

7-day working remains an aspiration, and the challenge is our ability to re-recognise and extend the availability of clinical expertise and services to evenings and weekends in conjunction with our health economy partners. While it is unlikely that a full implementation will be in place within the timescale of this strategy, the Trust is determined to make significant progress in the coming years, and move towards achieving the goal.

Using evidence based interventions to improve quality and productivity is crucial, if the NHS is to continue delivering high quality care whilst making significant changes. We will exploit every opportunity to identify and implement good clinical practices, and make use of resources such as NHS Evidence to support this work. We will benchmark our clinical performance against national markers,

and ensure any significant variations in intervention rates are being scrutinized and addressed accordingly.

### 4.3.5 Care closer to home

Most of the district general hospital services are currently provided on the two hospital sites, and the Trust is committed to provide more services in the community where possible. This will also help to release some capacity on what are already saturated hospital sites. Some services for people with long term conditions have already moved out to the Minerva Centre in Preston and more will follow. Currently, there are a limited number of alternative facilities available. There are also telemedicine and telehealth which could provide the solutions for more people to be cared for in the community. LTH will work with NHSCL and the Practice Based Commissioners (PBCs) to examine and learn from the national pilots, and exploit future opportunities.

As Practice Based Commissioning continues to develop, GPs will require more responsive access to diagnostic services to support care in the community. Both the pathology and radiology departments have close links with the GPs / PBCs, and the Trust will continue to seek feedback from our users and develop our existing services to meet the changing needs whenever possible.

The type of hospital services will be different as a result of more care closer to home. The dependence of our future patients will be much higher, and this requires us to recognise our resources and deliver the care responsively to the changing needs of our patients.

At the Listening Events, our members have also suggested to us a number of services to be developed in the community. We will consider them very carefully when we review our services.

### 4.3.6 Demand Management

Whilst reducing variation in cost and quality will release resources, this alone will not be sufficient to deliver the scale of savings we anticipate will be required. Whole system service redesign across the entire patient pathway with demand management is key in order to be confident of securing this. Locally, service lines groups are considered to be the vehicles to drive forward service changes in Central Lancashire. There is also a number of commissioning advisory groups attempting to address the issue of rising referrals. So far, there is little evidence to show effective demand management is in place.

LTH recognises its responsibility as a major healthcare provider to plan for the future climate of NHS finances. We believe we can play a leading role in

identifying and implementing possible demand management solutions, and will be actively working with commissioners and other partners in the health economy to make them happen. These could include initiatives around GP education, referral protocol, and system redesign through the Clinical Transformation Board for Lancashire. LTH will respond constructively to system-wide and local plans, and support measures which are equitable to all NHS and private acute providers, even if it is the case that such propositions carry with them the potential to have a detrimental impact on the Trust's income.

### 4.3.7 Service Specialisation

Being a tertiary centre compliments our role as teaching hospitals, and sets us apart from other acute general hospitals. It enables us to attract and retain high calibre clinical staff, which in turn, allows our patients to have local access to a comprehensive range of high quality clinical services.

The Trust currently provides a range of specialised services to people in Lancashire and South Cumbria, and these include:

- Neurosurgery and neurology
- Oncology (radiotherapy and chemotherapy) and complex cancer surgery
- Renal
- Burns and plastic surgery
- Disablement services such as artificial limbs and wheelchairs

The Trust wishes to strengthen its position as the tertiary centre for these services in the region, and will work with our commissioners, patients and other district general hospitals to further develop our existing services. Local service strategies for specialised services will be produced to outline our approach in taking this forward.

We believe a centrally managed specialised service will improve the current care provision and enhance patient experience. LTH is committed to taking on this responsibility and will work with our commissioners and partner hospitals in the health economy to achieve this goal by the end of 2011/12 at the latest.

The Trust will explore future opportunities to further expand the range of specialised services, and when opportunities arise, seek to establish ourselves as a designated centre for other services. For example, LTH has the aspiration to become Regional Trauma Centre. In the meantime, LTH believes our existing clinical infrastructure provides a strong foundation to support repatriation of some of the specialised services back to the region. This development will further enhance patient choice and access, and the Trust will actively work with our commissioners to make this happen.

4.3.8 Service development

Under the current economic climate, there is still opportunity for developing our services. However this is not necessarily about new investment, but in many cases, working differently to free up existing resources to develop the services. In some cases, current spending elsewhere can be re-diverted back to local development. There is also a need to our profile, and raise awareness amongst our GPs the range and level of clinical expertise of our medical team. This will help to avoid patients are being referred to other hospitals unnecessary.

Service Repatriation

Some of the elective procedures are currently being carried out by the private sector, partly due to an imbalance of demand and capacity in the past. The Trust intends to create the resources required to allow these activities to be channelled back to LTH. This will enhance patient choice and access to local services. To support this development, the Trust will explore modifying and streamlining the current interface between the referrers and the Trust.

Existing services new markets

A number of our existing services are already serving patients / customers from areas outside Central Lancashire, and potentially more can be done. Some directorates / services are also better placed and more ready than others to realise these opportunities. The Trust will review and identify suitable opportunities through the market assessment and tendering exercises, and extend our current portfolio of services to other areas as appropriate.

More clinical reconfiguration may occur as a result of medical staffing shortage, stronger governance and higher quality standards. This will require closer collaboration between different hospitals in the region, and may lead to further prospects of service expansion. LTH currently operates a hub and spoke model for specialised services for Lancashire and South Cumbria, and this experience could be easily transferred to other services if needed. On the other hand, other hospitals / providers may be more suited to provide some of our existing services locally, for example those services for patients with Long Term Conditions. The Trust will keep an open mind for this option, providing this does not compromise service quality for our patients.

New services existing markets

Health and well being is high on the modern NHS agenda, together with a strong emphasis on risk prevention and management, and support to patients with long term conditions. There are also services which could facilitate timely hospital

discharge. Provision of these services could complement our current hospital services, and potentially, allow better care integration and patient experience. The Trust will work with the clinical directorates to consider and assess each future opportunity. There may also be o

Advances in clinical practice and the requirements of commissioners and patients will continue to drive changes in service delivery. Development of new services is likely in areas where they have clear linkages with our current clinical expertise, and are aligned to the Trust overall aims and vision

New service new market

To respond to the future financial constraints, there may also be possibilities of system wide service developments such as vertical integration with community healthcare providers and horizontal integration of acute providers. Foundation Trusts such as LTH are potentially well equipped to take on such a proposition, and at this stage, we do not exclude the possibility of entering these new markets.

4.3.9 Fit for purpose infrastructure

Enabling strategies will be developed to support the delivery of service reform. In particular, our information and technology (IT), estate and workforce will be modernised and aligned to new ways of working. It is likely that there will be resource implications, either as a one-off upfront investment or on-going revenue. In some cases, the initial expenditure could be offset by longer term savings at a later stage. Work has already started in some areas to review our systems, processes, and staffing and we expect more will be necessary. As part of the Lancashire wide response to QIPP, LTH will be working with other partner organisations to explore a countywide approach for some of the backroom functions such as finance.

Workforce

To meet the quality and productivity agenda we are facing, there will be significant changes in the health service over the coming years. We need to equip our workforce to be able to respond effectively and flexibly to the challenges ahead, and to adapt new models of care as they emerge. Planning and developing this, working with our workforce, are critical elements of success.

It is crucial for us to have the right number and type of staff with the appropriate skill mix in the organisation to deliver the reform agenda and beyond. In particular, we need to draw on the expertise of our clinicians and harness their creativity. Effective leadership is key to driving the changes forward and

securing successful improvements. We will introduce license to care to all consultant medical staff.

We believe the contributions from a diverse workforce add richness and value to our services, and allow the Trust to provide a responsive service to patients with different needs. Our Single Equality Scheme describes our approach in embedding and promoting quality and diversity in all aspects of our business, especially our workforce. This will continue to provide us with a strategic framework of standards to fulfil our duty and responsibilities towards our patients and staff. Tools such as the Equality Performance Improvement Toolkit will be used to assess and benchmark our performance against delivery of the equality and diversity agenda, and identify areas for improvement.

Work has started to review the Organisational Development Strategy, and this will be further developed and finalised. Together with the recent Educational Training and Development Strategy and the Management & Leadership Strategy, will bring together the Trust's approach and actions in developing the skills, knowledge, attitudes and behaviour of our staff. There is also a need for a clinical led Workforce Plan to make sure our manpower is aligned to the commissioning intentions, service reform and developments, and changes in clinical education. There is also an opportunity to maximise the potential of our AHP workforce in service redesign, which could provide us with the solutions to meet the quality and productivity challenges ahead.

To raise our state of readiness to respond, we will be reviewing our internal HR policies, investing in staff redeployment, and ensuring we have high quality information on our management systems. We will be benchmarking our workforce across different organisations, as well as exploring flexibility and mobility issues. At a more local level, we aim to reduce our back office and management costs, and continue to reduce our sickness absence rates. Workforce reviews and job redesign will be carried out to ensure they are fit for the current purpose. Staff well being and satisfaction remain high on our agenda, and we are confident that people will work together to meet the challenges that lie ahead.

The Trust has 15 clinical specialty directorates with devolved autonomy and infrastructure. It is important to ensure that the current management structure supports efficient and effective care delivery, and in the current economic situation, provides value for money. The Trust will assess the current managerial arrangements, and is prepared to review the situation as required.

Information & Technology

A Clinical Record Strategy has recently been produced setting out the Trust's vision of a 'paper-light' organisation and our approach on seven strategic areas.

This will provide the framework to align current initiatives and inform future investment in our IT system. As well as logistic management, the strategy has a strong focus on accessibility and provision of timely and accurate information to support effective clinical management of our patients. This includes digitalisation of case notes which will provide instant and easy access to patient information, as well as the potential to release significant savings by streamlining current process. Information governance is an integral part of our IT development, as well as a requirement of the Care Quality Commission compliance framework. The challenges of implementation across different hospitals sites and professional groups should not be under-estimated, and much focused effort will be needed to ensure our working processes promote integrated and seamless care delivery.

An integrated hospital discharge summary has been developed, and this will improve the timeliness and quality of our discharge communications. We are currently working with NHSCL and our GPs to implement this new development, and in the very near future, they will be sent out to our GPs electronically within 24 hours after a patient has been discharged. There may also be opportunities to further develop our IT systems to enhance the process, and we will explore them accordingly.

Estate

The hospital environment and the condition of our buildings are critical to deliver safe, effective and efficient services. This is reinforced in NHS Constitution, stating the requirement to provide services in a clean and safe environment that is fit for purpose. In addition, buildings and hospital facilities often provide our patients and visitors with their first impression of the Trust and the quality of our services. Increasingly, this is also an important consideration for our patients when choosing the healthcare provider. With this in mind, re-development of our main entrance, thoroughfares and facilities are of high priority.

Over the years, the Trust has made considerable investment in upgrading the ward areas on both hospital sites. However as a significant proportion of our estate and mechanical and engineering infrastructure are approaching the end of its typical life cycle, more resources will be invested to continue maintaining our assets.

The Trust has made good progress in complying with the requirements of single sex accommodation, and will continue to develop our clinical areas to promote patients' privacy and dignity.

The current Estates Strategy and Development Control Plans will be updated shortly to reflect the future requirements of our clinical services as described in this strategy. A Space Utilisation Group (SUG) has been established, and much

of the work to date has been focused on maximising the space on both hospital sites to meet immediate / short term service requirement. The Trust recognises successful delivery of our plans on service reform is likely to require significant alignment and development of our current estate. There are also other assets that have to be considered in the overall planning. The SUG will provide the vehicle to drive forward the development of an Estate Strategy to underpin the SDS.

There is also the need to put in place a centralised well managed medical equipment programme for both new purchases and replacements, ensuring value for money and effective delivery of patient treatment.

There has been a growing focus on environmental issues, and the Trust has already begun to play its role in combating climate change. As part of the Government objective on sustainability, LTH has been given a target to reduce our current level of carbon emissions. A range of reduction programmes will be developed to meet this requirement. These include improvement of our existing engineering infrastructure, staff involvement to help reducing utility consumptions and waste, better building design and changes to the type of consumable items we procure.

## 4.4 Build Partnership

Radical changes in healthcare are only possible with agreement and partnership working from all organisations in the whole local economy. It is also the case that successful implementation of this strategy can only be achieved through collaboration with our internal and external stakeholders. Increasingly, there is also stronger emphasis on local accountability and more decisions will continue to be devolved to the local system. Working on the 6 principles described by the national Social Partnership Forum, the Trust is totally committed to develop a productive and effective partnership with our stakeholders, particularly with regard to a collective response to the financial challenges ahead. We also recognise the role of effective communication to support the development of our relationships, and a Corporate Communications Strategy will be produced to detail our approach and actions in taking forward this issue.

### 4.4.1 Internal

Our staff plays a key role in delivering service change. In particular, clinical ownership and leadership are vital, and the Trust will continue to support and engage its staff to jointly deliver this strategy. We will continue to empower our frontline clinicians and operational managers. Through service line management, the clinical teams and general managers will be given greater

autonomy and responsibility for their own services. LTH is committed to support our staff through the four pledges set out in the NHS Constitution.

We have active involvement and support from our members and governors in a range of activities, and the Trust will seek to further strengthen and develop this link. The Trust currently has over 25,000 members. We aim to maintain the level of membership, and develop innovative ways to engage our members effectively.

### 4.4.2 Commissioners

Externally, the Trust is committed to building an effective partnership with our commissioners and stakeholders. We believe it is in our mutual interest to work together and grow from each others success. In particular, our relationships with the NHS Central Lancashire (NHSCL) and Central Lancashire PBCs are of high importance, and require attention and nurturing. We intend to work closely with NHSCL to develop a shared understanding of the commissioning and delivery plans, and agree on joint service priorities for future years. To meet the challenges ahead of us together, it is critical that the two organisations are equal partners in this relationship, and we respect each other and value the respective contributions. The Trust considers the best way to make this happen will be through clinical leadership, with clinicians working together to improve the services for our local population.

Currently most specialised services are commissioned by the NW Specialised Commissioning Team, and in the near future, it is likely more services will be transferred to the Collaborative Commissioners for Lancashire and South Cumbria. As a specialist centre, it is critical for the Trust to have a strong partnership with both commissioning teams and we will continue to strengthen our partnerships.

Clinical networks and commissioning advisory groups also play a key role in local service improvements, and it is important LTH is able to contribute and participate effectively in these forums. To do this, we will review the current representations, and make sure the appropriate person is attending from LTH.

### 4.4.3 Other external stakeholders

Local Involvement Networks (LINks) provide a vehicle to involve our local citizens and service users, and we plan to forge a connection to Lancashire and Cumbria LINks.

Contributions from the private sector have the potential to further enhance innovation and improvement in areas such as research, and future partnership opportunities should be explored.

There are also a number of higher education partners that we regard as key in our role as teaching hospitals.
Some of our clinical services have forged close links with voluntary sector organisations, and this liaison is to be consolidated.

Much of our clinical service, particularly that for people outside central Lancashire, relies on the peripheral hospitals working with us as a network. There is also opportunity to further develop the existing services together. Under the current economic climate, there is even a greater need to have a stronger tie with other acute partners to respond to some of the challenges. The Trust will continue to foster a strong relationship with our acute partners in the region, particularly those in Lancashire & South Cumbria.

### 4.4.4 Wider community

There is a growing focus on improving health as well as treating sickness, and acute hospitals are expected to engage in the public health agenda and work with our local partners to address the wider determinants of health. This is not just good for our patients but is also a necessity given the current state of public finances. The Trust is totally committed to this agenda, and intends to apply to be a Health Promoting Hospital in 2010/11.

Local Strategic Partnerships brings together representatives from the local authorities, health, voluntary, and community sectors, and provide the opportunities for joint working. LTH has already started to involve itself with the three local partnerships: Chorley, Preston and South Ribble, and participate in some of the work initiatives. In the coming years, LTH will continue to build on the progress and contribute as an active member of the local community.

QIPP has provided a vehicle for the local economy to work together on a range of strategic issues in Lancashire, and LTH will play its full part as a member of the health community.

## Section 5: Delivery

This section describes how Lancashire Teaching Hospitals will implement this strategy. To underpin delivery, it is important to ensure that implementation is a 'live' process integrated into the day to day operational business of the hospital, not regarded as an isolated add-on. Ownership of the strategy, and responsibility for its delivery, will require shared action by many people, under the leadership of the executive team. The culture of the organisation, including the senior management and clinical team, will need to reflect this greater commitment to planning. The remainder of this section focuses on the actual process of delivery, but the challenge to win hearts and minds cannot be underestimated.

### 5.1.1 Service development plans

Based on the strategic priorities, each directorate / clinical specialty will be asked to translate them into a series of local actions, and outline specific service initiatives to underpin the vision. A series of dedicated workshops with clinicians and managers from each directorate / specialty will take place to facilitate this piece of work, and they will begin once the refreshed strategy is in place towards the end of 2010. In the meantime, directorates will be preparing local business plans for 2010/11, describing their actions to respond to the immediate challenges and priorities ahead.

### 5.1.2 Prioritisation

In the first instance, business development projects / business cases will be aligned to each strategic priority, and classified into 3 categories: confirmed, priority, and aspirational. They will also be recognised and placed under one of each of the three year periods covered by this strategy. All proposals without the support of a costed and approved business case will be considered as 'aspirational' at this stage. An integrated SDS plan will then be produced to provide a graphic summary of the following:

- The 4 strategic priorities
- The focus under each strategic priority
- Service developments and their classifications under each priority for 2010/11, 2011/12, and 2012/13

It is envisaged that major service reconfiguration will not take place during 2010/11, but only impact assessments and preparations for change. Our commissioners will be kept closely informed of developments, and depending on the nature and scale of the changes, they will be included in the decision making process. Staff and public consultation will be carried out as appropriate.

### 5.1.3 Leadership & governance

The Board of Directors will lead the implementation of the SDS, and the Executive Team will be responsible for its overall management and delivery. The Assistant Chief Executive will provide a stewardship role for the SDS, and work with individual directors to monitor progress and resolve non-compliance issues arising from their respective areas, should this happen. Accountability for progress rests with the person or people that own that aspect of the plan.

In some cases, a manager and a clinician will be also assigned to support the delivery of a focus area. Together with the designated director, they will be responsible for the successful implementation of the specific initiatives once these have been assigned as 'confirmed'.

### 5.1.4 Delivery framework

This integrated summary SDS will provide a framework to inform the service improvement priorities for the next 3 years. Clearly the SDS will need to be responsive to the dynamic operating environment, but it is envisaged that the annual business planning process will be the main mechanism to review the contents of the SDS. Unless there are significant in-year changes, the annual plan should be a translation of the relevant time period of the SDS, providing more details regarding the priorities, risks, actions and milestones of the specific financial year. Existing planning processes and functions of committees such as the Corporate Review Group will also needed to be considered and adjusted accordingly. The intention is not to create a further layer of oversight, if existing governance mechanisms are proving effective

To ensure successful delivery, the Trust will ensure the SDS is integrated into its day-to-day operational processes. The corporate, directorate, and individual staff members' objectives including those of directors, will be aligned to the Trust's vision, strategic objectives and priorities for actions respectively. Service performance reviews and staff appraisals will be assessed against objectives in the directorate annual plan and local service development plan.

Regular co-ordination and monitoring of the SDS and service initiatives will require the support function of programme management. Key milestones / indicators will be identified, with an initial baseline for each of the strategic priorities. A monthly assessment of the progress against the SDS will be provided by the Assistant Chief Executive to the executive team for information and action. A quarterly update will be made available to the Board of Directors and Governing Council.

As part of the quarterly Integrated Performance Review, clinical directorates will be asked to account for progress in delivering the strategic priorities.

### 5.1.5 Communication

In the first instance, existing forums and meetings will be utilised to communicate the content and ambition of the SDS and further engage our internal stakeholders including members and governors. A copy of the SDS will also be available on the intranet. Further consideration to methods of communication will be given, including use of posters and graphics to illustrate the strategic objectives, priorities for action and service initiatives.

Externally, a launch event will be organised for us to communicate with our stakeholders, including NHS North West, our commissioners, acute hospitals in the region (particularly those in Lancashire & South Cumbria), and other stakeholders. This will take place once the refreshed strategy is available in autumn.

It is important our strategy is described in such a way that is meaningful to our patients and users. We will set out the strategy using the 'Plain English Campaign's' guidance, together with a basic version for members of the public.

A dedicated area will be created on the intranet and internet. This will help to raise the profile and staff awareness of the strategy, as well as providing a vehicle by which to post updates on progress and encourage staff involvement. There will also be regular communication in the Trust's magazines and newsletters.

### 5.1.6. Risk assessment

Risk assessment of individual service developments will be carried out, forming part of the initial risk log of the programme.

Strategically the five key issues are:

- Financial resources
- Organisational capacity and capability
- Commissioning intentions
- Competition
- Political

These risks will be revisited at least every six months and assessed for their impact against the developing action plan as part of the business planning process and assurance framework.

In order to achieve the service reforms required, The Trust will need to work together with the commissioners, particularly NHSCL, to manage some of the strategic risks across the system.

### 5.1.7 Review

The SDS will be reviewed and refreshed accordingly on an annual basis as a minimum. We intend to carry out our first review in autumn 2010 to sense check assumptions against emerging health policies and priorities of the coalition government, and latest developments on service commissioning.