Trust Board paper A

University Hospitals of Leicester NHS
NHS Trust

To:	**Trust Board**
From:	Director of Finance Director of HR Director of Strategy
Date:	**24 March 2011**
CQC regulation:	As applicable

Title:	2011/12 Draft Business Plan (Annual Operational Plan)

Author: Director of Finance, Director of HR & Director of Strategy

Purpose of the Report:
To provide the Trust Board with the draft Annual Operational Plan for 2011/12

The Report is provided to the Board for:

Decision	X	Discussion	
Assurance		Endorsement	

Summary / Key Points:

- This report contains the detailed Annual Operational Plan for 2011/12.
- The preparation of the 2011/12 Annual Operational Plan has been incorporated within the development of the Trust's Integrated Business Plan (IBP), which has been a bottom-up clinically driven process.
- The Annual Operational Plan is presented to the Trust Board with a recommendation for **conditional approval**, subject to the factors which are described in greater detail in the body of the plan.
- The financial pressure caused by the 2011/12 Operating Framework has provided a major challenge for the financial planning process. As well as the tariff's 4% in-built efficiency requirement (£24m), the impact of readmission penalties is particularly severe in UHL and amounts to a further 1.5% (£9m).

Recommendations:

The Annual Operational Plan is presented to the Board with a conditional recommendation for approval. The conditions are:

- Balanced Budgets are set by Divisions within the envelope and constraints contained in this Plan. Detailed budgets reflecting clinically risk assessed CIP schemes will be brought for Trust Board approval on 7 April 2011.
- Targeted turnaround support is available to reinforce delivery of the CIP plans by the Divisional Management Teams.
- Transitional/Transformational support of £20 million is received from LLR commissioners and the EMSHA.

Strategic Risk Register Yes	**Performance KPIs year to date** The Plan addresses all KPIs.

Resource Implications (eg Financial, HR)
Detailed in section 2 - Finance and section 3 - Workforce of the Annual Business Plan.

Assurance Implications **Yes**
Patient and Public Involvement (PPI) Implications We engaged with patients and the public through Divisional PPI leads as part of the Integrated Business Planning process. This will continue as a key workstream in the development of the Integrated Business Plan.
Equality Impact The plan will be subject to an equality impact assessment before returning to the Trust Board in April 2011.
Information exempt from Disclosure
Requirement for further review ? The Plan will be considered at the Trust Board in April 2011 to assess progress against meeting the conditions detailed above and is contingent on identifying plans for the full savings target.

University Hospitals of Leicester NHS
NHS Trust

Caring at its best





UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Annual Operational Plan 2011 – 2012

1. SECTION 1: Strategic Planning and Priorities

Section 1: Strategic Planning & Priorities

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1. SECTION 1: Strategic Planning and Priorities

1. Introduction

The NHS is at a crossroads. It is going through the biggest shake-up in its history as outlined in the 2011 Health and Social Care Bill. This is set against the backdrop of:

- Improving quality
- Delivering world class clinical outcomes
- Unprecedented financial pressures
- Increased competition and market-orientation of health services.

To help us to effectively respond to this challenging environment, the Trust is developing a 5 year Integrated Business Plan (IBP). This is a bottom-up clinically driven process that will form the core of our Foundation Trust Application and help us to build the capacity and plan for the longer term. This Annual Operational Plan (AOP) provides the foundation of our 5 year IBP.

2. Our journey 'from good to great'

Our core purpose at UHL is to provide 'Caring at its Best'. People who use our services rightly expect high-quality care and support. The importance of providing high-quality care and assessing that quality is central to the provision of services, and is therefore at the heart of the strategy and this Annual Plan.

In the autumn of 2009, we engaged and consulted with staff and patients to identify a set of values that we will live whilst delivering our strategy:

- We treat people how we would like to be treated
- We do what we say we are going to do
- We focus on what matters most
- We are one team and we are best when we work together
- We are passionate and creative in our approach to work

Staying true to these values will be even more critical as we enter one of the most turbulent and challenging periods the NHS and UHL have ever faced. Staff will need the necessary support to ensure that we continue to nurture these values in order to maintain high levels of confidence and motivation across all staff groups.

In order to succeed in our commitment to become a great hospital, we recognise that there are a number of fundamental shifts we will need to make in how we operate and how we deliver services:

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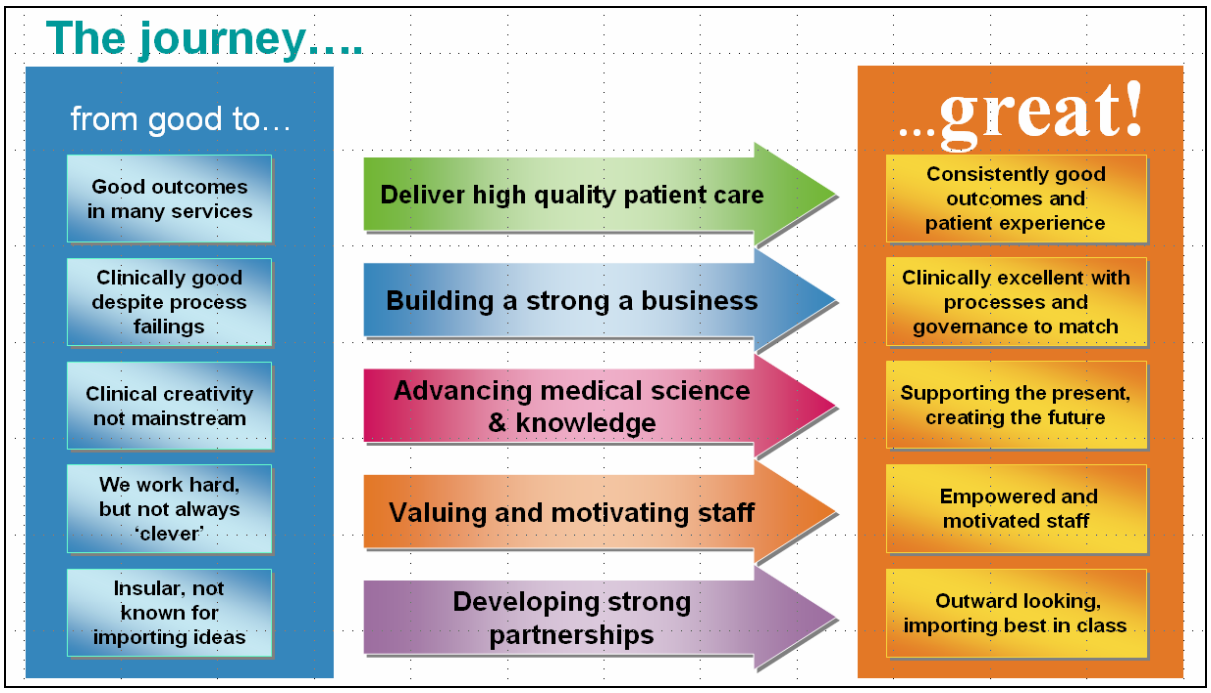

Underpinning this journey we have identified 6 principles that we will adopt in responding to the context of our strategic environment and delivering our Annual Plan:

Patients	All that we do is defined by what patients want and need
Process	Quality lies at the heart of our work, leading to efficient and effective services.
People	Staff feel rewarded, supported and trained to do their job.
Partnerships	We focus on what we are good at, partnering with others for their expertise.
Performance	UHL is the centre of a quality health system, patient friendly, with excellent access and communications.
Profitability	A trust which generates profit through clinical quality and process excellent which is then invested to create new, better services for our patients.

3. Strategic Environment

Nationally the clear focus for 2011/12 will be upon:

- Increasingly improving outcomes.
- Developing the quality framework in anticipation of the role of the new Commissioning Board.
- Maintaining tight financial control including delivery against the £20bn efficiency savings requirement.
- Maintaining performance against existing national priorities.

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- Completion of the Foundation Trust (FT) pipeline.
- Laying the foundation for the new health and social care system and system of economic regulation.

We face a number of system changes, most notably the transitional arrangements to support the shift from Primary Care Trust (PCT) commissioners to the creation of GP commissioning consortia. Significant emphasis will be placed on Provider Development, and supporting Trusts to achieve FT status. Promoting transparency and accountability and making further gains in quality and productivity will be at the forefront of these developments. Further to this we will see the establishment of Health and Wellbeing as part of the wider Health and Social care reforms NHS. This includes transferring the responsibility for Public Health from PCT's to Local Authorities.

Commitment to the Transforming Community Services (TCS) agenda remains clear. The Operating framework also points to the "right to provide" which will create opportunities for NHS staff to lead new social enterprises. With the new Health and Social Care Bill, competition will be augmented by the introduction of the 'Any Willing Provider' procurement landscape. It is likely that we will not only see a more competitive healthcare market, but new entrants coming into the market.

The contractual arrangements set out in the Health Bill impacting upon UHL are associated with the effective use of contracting processes, in particular:

- The requirement to use the standard contract. This will contain an extended list of never events, the costs of which in such an incident will be recoverable by the commissioner.
- Providers taking responsibility for managing demand within their own organisation.

The principles of financial rigor remain, and the changing landscape of commissioning indicates that GP consortia will have their own budgets by 2013/14. Planning in 2011/12 therefore requires that all legacy issues within the contract must be dealt with.

Integral to delivery of efficient high quality services will be the continued commitment to the QIPP (Quality, Innovation, Prevention and Productivity) agenda. Reducing length of stay, promotion of high day case rates and increased responsibility on acute providers around readmissions rates will be important indicators for UHL and other provider Trusts.

As part of the push for greater efficiency, objectives within the Health Bill also include a drive towards an 'Information Revolution'. This proposes a move away from the top down approach embodied by the National Programme for IT and towards information technology strategy which meets the needs of individuals and local communities.

Workforce implications of our strategic environment point increasingly to the absolute need for staff engagement to help deliver the quality and productivity challenges ahead. This is particularly important as we recognise that the level of service transformation expected over the next 3 years will have wide-ranging implications for all our staff.

We should expect to see a fundamental shift in transparency and local accountability towards local communities, as the government places a greater emphasis on patient power. In 2011/12 hospitals will be required to establish baselines for their services based on:

- Patient experience which specifically relates to the timely action in response to patient feedback and the extension to PROMs (Patient Reported Outcome Measures).
- Better information featuring a new information strategy that supports better decision making.
- Embedding of Quality accounts, building on the current year's quality account.
- Local publication of how expenditure translates into local achievement.
- The extension of the choice agenda including greater choice in diagnostic testing, choice for long term conditions, and choice in maternity services.

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4. Review of 2010/11 – what have we achieved in 2010/11?

To thrive in the challenging and changing healthcare market UHL must continue to build on successes of the past year. We have measured our performance against the '6P's' that underpin our strategy:

Patients:

Listening to patients is crucial in identifying what works well and where we need to target improvements. Based on what our patients have told us we have achieved a number of improvements in 2010/11:

In 2010/11 We said we would……..	We have…….
Improve patients' experience in our hospitals through: Being consistently in the top 20% of trusts nationally for positive patient feedback. We said we would use two key indicators of patient experience to track experience over time. To measure improvements we focussed on: • Overall respect and dignity score; • Self reported experience of patients; • Asking every patient about their experience of our hospitals through our patient polling.	Used the National Patient Survey scores as our target for improvement. This year our performance has remained in the middle 60% of Trusts, and so progressing in to the top 20% will remain a priority for 2011/12. Introduced a monthly Patient Experience Survey. Every month we are gathering patient experience feedback from approximately 850 patients. Four key themes are emerging from this: • Providing information for patients • Staff behaviours and attitude • Noise at night • Pain & comfort management
Further reduce healthcare associated Infections. In 2010/11 our aim was to have no more than 9 MRSA bacteraemia cases and no more than 212 patients newly identified with CDT.	Continued to work hard to maintain our success in reducing healthcare associated infections (HCAI). Whilst we did not achieve the very challenging targets set, we have delivered a 68% reduction in our MRSA figures and a 30% reduction in our CDT figures from 09/10 to 10/11. We have been able to demonstrate a continued reduction in these infections to date. Success has been celebrated by receiving the Healthcare Associated Technology award from the Department of Health for our success in reducing MRSA and CDT infections. The new electronic patient management system has been installed and will provide an invaluable resource to further assist us in our work to keep patients safe in our hospitals. Reporting for Non-elective MRSA screening commenced in January 2011 with early performance being reported at 93%. Mandatory reporting has now commenced in relation to MSSA with E-coli to follow in April 2011.

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In 2010/11 We said we would……..	We have…….
Reduce venous thromboembolism (VTE) Last year we said we wanted to increase the percentage of adult inpatients that had a VTE risk assessment on admission to hospital from 50% to 90%.	We are one of the 18 VTE Exemplar sites in the UK, with streamlined pathways of care for patients presenting with acute thrombosis. We have consistently increased the number of adult patients who are assessed for their risk of VTE to more than 75%, with an aim to reach 90% by the end of March 2010.
Reconfigure services enabling the most effective and efficient patient care across the 3 hospital sites including the reconfiguration of our Stroke services.	Delivered a number of improvements including: • the relocation of stroke services to concentrate them on the Leicester Royal Infirmary site; • the relocation of inpatient neurology services to the LRI site so that they are on the same site as our emergency department; • the consolidation of all acute medical emergency admissions at the Glenfield and LRI sites; • the development of a single site Hepatobiliary service at the LGH; and • a £9.3m development programme to deliver a state of the art neonatal facility at the LRI.
Continue the development of Releasing Time to Care Programme.	Implemented releasing time to care on 58 of our wards. Key changes that have had a significant impact include: • The introduction of "patient state at a glance" boards which enables staff to immediately understand what is happening with patients on their ward; • Improvements in scores on patient observation audits; • An average of 107 hour per ward per year reinvested inpatient care through the Well Organised Ward (WOW).
Improve performance in trauma, focussing on fractured Neck of Femur Outcomes.	Responded to the improvement target to get patients to theatre within 36 hours of their admission/diagnosis of fractured neck of femur. This target was 50% in April 2010 and increased to 90% in November 2010. Significant progress has been made on this target and the overall year to date performance is 74%. For any patient not getting to theatre for their operation within 36 hours, we review the reasons for this to further improve our performance. Mortality rates for these patients have also improved.
Work to secure designation in Paediatric Cardiac Services.	Worked as a team to ensure The East Midlands Congenital Heart Centre (EMCHC) at the Glenfield is included in one of the four options which are currently being consulted upon. The centre, which already serves a population of nearly 5 million, is in **'Option A',** which was rated the highest scoring option by

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In 2010/11 We said we would……..	We have…….
	the national Safe and Sustainable Review Team. The outcome of the review will be known later in 2011.
Implement the Enhanced Recovery programme for patients.	Implemented the Enhanced Recovery Programme (ERP) in MusculoSkeletal (MSK), Urology, Gynaecology and Colorectal services. We have used patient experience focus groups to evaluate our success and learn from the programme. A pilot project for breast patients undergoing mastectomy was initiated in February 2011. Length of stay has already reduced on average by approximately 2 days for eligible patients.

People

A motivated workforce is at the heart of our ambition to be a successful organisation. This is why we are committed to dedicating time, effort and financial resources to developing and supporting our employees. Examples of improvements we have delivered in 2010/11 include:

In 2010/11 We said we would……..	We have…….
Embed a new Divisional structure to ensure that we maximise the opportunities provided to do things differently and continue to build opportunities for Clinicians to lead the organisation.	Embraced a new Divisional structure, moving from thirteen Clinical Directorates into 4 new Clinical Divisions. Although still in its infancy, we have already seen benefits arising from this structure. Notable examples of this include: • Delivery of £31million savings through a series of cost improvement programmes (CIP's). • Enhanced clinical engagement in the business planning process. • Collaborative working to successfully plan and execute hospital site moves of clinical services. • A joint approach to tackling the key challenges within the Emergency Care System.
Develop a communication strategy which successfully navigates the trust through tough questions, maintaining stakeholder support and trust.	We have made progress on developing our communications strategy. We consulted our staff and key stakeholders on our ambition to become a Foundation Trust, who overall were very supportive. We have invested time in sharing our strategy "from good to great" with our staff. An inclusive approach has been taken to developing our business plans for the future, involving CBU's and Divisions. We have engaged at an early stage with our new GP consortia and recently appointed a Head of Service for GPs. We will continue to build this critical relationship in 2011.
Dedicate time, effort and financial resources **to developing and supporting UHL's**	Undertaken an organisational training needs analysis and subsequently put training plans in place. We can demonstrate that all areas have

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In 2010/11 We said we would……..	We have…….
employees.	learning and development plans in place. Processes are now in place to ensure that the learning and development plan for staff is reviewed and adjusted to meet the changing needs of the people who use our services. This will also ensure that services are able to meet essential quality and safety standards. We have invested time and effort to ensure that every member of staff receives an annual appraisal and has a personal development plan. CQC feedback from the Annual Staff Survey shows that UHL performs higher than the national average for acute trusts in both categories. 91% of UHL staff surveyed stated that they had been appraised. In addition to this we have continued to invest in leadership development for our clinical leaders.

Partnerships

The Partnership agenda has been a key driver of service improvement and delivery in a number of areas. The Trust has successfully built strong collaborations with healthcare partners, academic institutions, Social Care and the commercial sector during 2010/11.

In 2010/11 We said we would……..	We have……..
Work with our PCT partners to deliver a joint QIPP programme.	Worked jointly across LLR on the QIPP agenda, Facilities Management (FM) Shared Services and the transformation of some of our emergency services.
Engage in Transforming Community Services to ensure benefit for patients and staff.	Successfully worked with partners to achieve the transfer of some services to UHL under the Transforming Community Services agenda. These services will be managed by UHL with effect from 1st April 2011.
Work towards the consolidation of Pathology at a Regional level in line with the findings of the Carter Report.	Partnered with NUH in a joint venture to develop an East Midlands Pathology Service.
Collaborate with Partners to build a concept for the East Midlands Academic Health Science Centre (AHSC).	Continued to work with partners to develop the concept of an AHSC. Some specific achievements include establishing EMCoLL (East Midlands Collaborative in Health Service Management), and achieving designation as a HIIEC (Health Innovation and Education Cluster).
Build a successful **CLAHRC** (Collaboration for Leadership in Applied Health Research and Care) and **BRU** (Biomedical Sciences Research Unit).	Continued to develop the CLAHRC and the BRU is going from strength to strength with opening of the new facilities by the Health Minister in November 2010.

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Performance

UHL continues to meet key performance indicators in the majority of areas. Some specialties present challenges, but these are low volume and are being addressed through targeted performance management in the Clinical Business Units.

In 2010/11 We said we would……..	We have…….
Ensure all national clinical quality targets are consistently met.	Achieved the overall target of 90% for 18 weeks admitted pathway. We continue to achieve the overall target of 95% of non-admitted pathways. UHL continues to provide 100% same-sex accommodation on wards. There is also a high level (93%) of same-sex accommodation in Intensivist settings such as A&E. Service redesign has taken place to create separate male and female facilities in areas such as endoscopy at the LRI. The Trust has maintained and steadily improved performance against national Cancer Targets. The main areas of focus are the 62 day target and the 31 day subsequent treatments for surgery targets, where we are maintaining the required performance.
Improve emergency care through co-ordinated response to Emergency Support intensive care team.	Actively engaged with the emergency support team. An action plan is being taken forward to improve emergency services across the health community.
Use robust clinical indicators to compliment caring at its best.	Continued to use a variety of clinical quality indicators which are reported at service level and are reflected in the Quality and Performance Report. These indicators are also reported to our commissioners as part of the quality schedule and CQUIN programmes. Some of the services have developed a dashboard approach covering a variety of metrics for example: • Maternity; • Care of patients undergoing fractured neck of femur, open fractures and shaft of femurs. We have implemented the Department of Health Patient Reported Outcome Measures (PROMs) for example: • Hip and knee replacement; • Groin hernia repairs; • Varicose vein procedures. Early evaluation shows that our patients' health benefit is in line with the National average for England. In other services we have adopted Clinical Reported Outcome Measures (CROMs) for example: • Stroke; • Kidney care; • Pneumonia.

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In 2010/11 We said we would……..	We have…….
Manage the risks around delivery of maternity and neonates service.	Opened a £9.3m neonatal facility at the LRI. Progress has also been made on developing an interim solution to mitigate the risks in Maternity. This includes securing funding from our Commissioners to support Maternity activity growth in 2011/12 at full tariff and additional funding for community midwifery services. We also have a plan to address service capacity constraints, the obstetric theatre environment, and the need for additional scanning capacity.
Build PPCI (Primary Percutaneous Coronary Intervention) **capacity** in line with our recent designation.	Through process changes we have improved performance in this area moving from 81.8% door to needle time at the end of 2009/10 to 96.3% in the last reporting period. This is against a target for achievement of 75%.
Improve discharge planning across all specialities.	We have changed the way we manage the discharge process at ward level and have begun to use an estimated date of discharge. We still have further work to do internally whilst working with colleagues from across the health and social care community to improving delays that are attributable to factors outside UHL.

Profitability

The Trust has improved profitability in 2011/12, and our overall Reference Cost Index has reduced from 102 to 100 in 2009/10. The position for 2010/11 will not be known until summer 2011. There has been a significant improvement in the delivery of cost improvement programmes with a total of £31m being delivered in 2010/11. This has included a marked improvement in the level of savings which are delivered on a recurrent basis.

The Trust is currently in the process of embedding Patient Level Information & Costing (PLICS), which will allow a much more detailed analysis of income, costs and contribution within Divisions. Early analysis of the profitability of service lines and the relative costs shows that many of the CBU's with a high reference cost were also poor performers in terms of profitability. This is an area for improvement going forward.

In 2010/11 We said we would……..	We have…….
Improve theatre utilization to 86%.	Made significant progress in theatre utilisation. This year we have achieved 78.7% against a target of 86% for elective procedures and a considerable improvement in day case theatre utilisation, reaching 89.8% in February 2011.
Improve Outpatient performance in line with all the national targets and reduce the number of clinic cancellations.	Made steps towards reducing clinic cancellations by making things easier for patients. Cancellations made by the hospital stand at 10.8% against a target of 13%. We have also reduced the need for patients to cancel appointments through better planning. Performance in this area stands at 10.7%. Our new to follow up ratios have consistently

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In 2010/11 We said we would……..	We have…….
	remained within target. We recognise that we still have further work to do on our DNA (did not attend) rates.
Achieve a target improvement in length of stay of 15%.	Consistently improved our length of stay for both our elective and emergency admissions. Elective average LOS remains below the target of 3.8 days. YTD performance for emergency admissions stands at 4.9 against an overall target of 5.0 days.
Reduce non-pay spend through proactively challenging and reshaping procurement demand and implementing more competitive commercial arrangements.	More than £20m of Non Pay Spend savings have been identified over the next 3 years. In 2010/11 the target of £4.2 m of savings has been exceeded.
Gain better value on non core business through productivity improvement, shared services / strategic outsourcing options	Improved our procurement through the following: • Consolidation of spend with fewer suppliers has achieved economies of scale and improved governance over spending • Introduction of improved Management of Materials • Phased payment for services to improve liquidity We have also: • Developed a joint venture with Nottingham University Hospital's in Pathology. • Finalised a Strategic Outline Business case with Health Economy Partners for a shared services and shared procurement in Facilities Management. • Developed a business case for a Shared Technology Service with Health Economy Partners. Whilst this could not be progressed in its entirety, a number of discrete work streams are being taken forward.

5. Review of 2010/11 – Where do we need to improve?

A&E Performance

The Trust has remained challenged throughout the year on its A&E performance. Year To Date (YTD) performance for our Emergency Department against the 4 hour target is 94.1% and for eye casualty 96.4%. The performance for February is 91.1% for UHL and 94.1% for LLR. The LLR emergency care system remains fragmented and there is considerable work to be done to improve patient pathways. In December 2010 the Trust Board agreed to a range of measures to urgently address the underlying performance issues. Focussed areas of work are targeted at:

- Redesigning the footprint of the department to make sure that clinical quality and patient safety is optimised.
- Redesigning the workforce to make best use of resources and to minimise the time patients wait for assessment and treatment.

Emergency admissions

We have continued to see significant increases in emergency admissions, despite efforts to work with partners across LLR to reduce demand. We know that the economic realities mean

that UHL will have to do much less work in an acute setting through the development of more efficient clinical pathways and interventions.

Readmission rates

Our readmission rates continue to be higher than the reported national average and also against our peers. In March 2010 readmission rates were 8.8%. This has reduced slightly in to 8.4%. Work is being undertaken at speciality level to review patient pathways and to emphasise the importance of communication on discharge. We have also introduced urgent outpatient appointments where clinically appropriate for some medical and surgical patients. This will continue to be an area of focus for 2011/12, and we are in the process of recruiting a Project Manager to help drive significant improvement.

Cancelled Operations

The number of operations cancelled by UHL increased in 2010/11 by 11%. The causes of this increase include growth in demand for emergency care, and in particular the outbreak of Swine Flu. We remain committed to improving this position, and we will continue work with partners to reduce inappropriate demand for emergency care as well as improving our internal processes and productivity.

IM&T

It was proposed to establish a health economy Shared Technology Service (STS) that would integrate UHLs current IM&T services with Leicester, Leicestershire and Rutland's Health Informatics Service from April 2011. This unfortunately has not secured the level of health economy support required, and is unlikely to do so in the short and medium term. We are therefore unable to proceed with STS as the vehicle for transforming our IM&T service delivery and management. We are developing an alternative improvement plan for UHL, as post the National Programme, there is an urgent requirement to improve the governance and accountability for IT in UHL. We also need a sustainable programme for replacing the majority of our clinical systems over the next 5 years.

6. Our Response to the Strategic Environment

In 2011/12 we will focus on delivering a successful Foundation Trust Application, with clinical quality, local accountability, and financial rigour being at the heart of everything we do. Our approach will be centred on our strategy, which is tailored to the different markets we serve:

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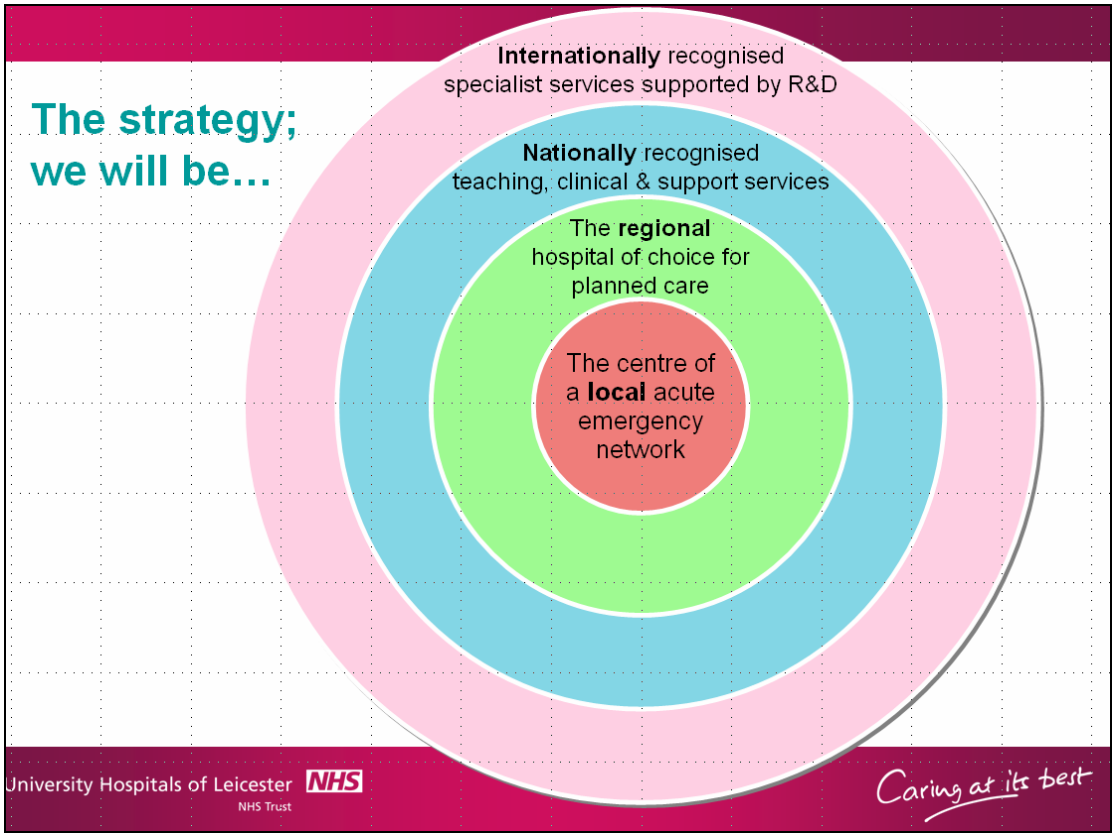


Putting patients and quality at the heart of everything we do.

We recognise that care must be patient centred, safe and effective. We want to make sure that efficiency, equity and timeliness are embedded within any service improvement and changes we make. We will therefore continue with our commitment to continually developing and improving care provision for patients, their relatives and carers through providing 'Caring at its Best'. This will be delivered in a way that is in keeping with our values.

Our priorities will include:

- Getting it right, first time for our patients – we will focus on addressing the known issues that are a cause of concern for our patients as part of our requirement to meet our 'licence to operate'.
- Maintaining and measuring national minimum quality standards – We recognise that it is important that the Trust achieves and maintains excellent performance against minimum national standards such as Care Quality Commission (CQC) registration criteria, national imperatives, NHSLA Risk Management Standards and other external inspection or accreditation schemes.
- Taking action on the intelligence received to date, streamlining our efforts with each Division acting to improve the patient experience within some clearly defined parameters.
- Developing Key Performance Indicators for improving quality and reducing costs. These will be developed by the Clinical Business Units (CBUs) and Clinical Divisions through annual Quality Plans.
- Taking forward a number of key work streams which will positively impact on the engagement and profile of patient experience within the organisation. In particular we aim to:

    - Have the lowest mortality across all services

- Have the lowest infection rates across acute hospitals
- Risk assess all patients for VTE and provide prophylactic treatment
- Eliminate preventable hospital acquired pressure ulcers
- Ensure all patients undergoing surgery have the WHO checklist completed prior to surgery

Through these actions we aim to be in the top 20% of Trusts for patient experience. In particular we hope that:

- patients report pain control is excellent and that
- we improve our performance in relation to complaints (reducing those related to attitudes) and
- patients would recommend UHL as somewhere to receive high quality care.

This focus on improving the quality of care we provide will be coupled with a trust wide efficiency drive. This will include the following themes:

- Incremental schemes. These will be better informed and targeted by application of the Trust's SLR / PLICS analysis.
- Major schemes (e.g. our Pathology joint venture with Nottingham University Hospitals)
- Care settings – moving care to lower cost settings in conjunction with our healthcare partners
- Operating model – a "UHL Lean" or similar total quality system with the intention of improving outcomes, patient experience and efficiency in a joined-up, systematic manner. This would include the reduction of UHL's rate of readmission.

To become the centre of a local acute emergency network, in 2011/12 we will:

- Partner GP's and Local Authority colleagues to redesign emergency care across LLR to create an effective and integrated system of urgent and emergency care.
- Transform the emergency care workforce to better serve the demands placed upon the emergency department. This will include an investment of £785,000 in additional staffing.
- Invest £1.5million to achieve interim improvements in the emergency department to improve patient flow, streamline A&E processes and optimise patient safety.
- Invest £130,000 in developing and redesigning the emergency care pathway for children.
- Reduce emergency readmissions by 75% by the end of 2011/12, recognising the financial and quality impact if we fail to address this issue. This will include working with Health and Social Care partners to ensure optimal discharge arrangements are in place.
- Reconsider how and where services such as Sexual Health are provided in order to fully integrate provision across UHL and the community. We will invest £70,000 in nursing and pharmacy support roles in this service.
- Develop 24 hour walk in emergency services within Gynaecology.

To become the regional hospital of choice whilst for planned care, in 2011/12 we will:

- Repatriate patients currently treated outside Leicester, recognising that patients on the borders of Leicestershire and Rutland may choose another provider. We will focus initially on the repatriation of £3million of elective orthopaedic activity.
- Whilst recognising that patients on the borders of Leicestershire and Rutland may choose another provider, some patient and GP choice has been constrained by a lack of UHL's capacity and there may be an income opportunity of over £20 million.

- Make the best use of our staff and assets through the reconfiguration of elective orthopaedic services so that they are provided on one site at the Leicester General Hospital (LGH). The aim is to improve the quality of services for orthopaedic patients. We anticipate the following productivity improvements :
  - 215 hours additional operating time per year.
  - Capacity for an additional 112 elective inpatients/day cases.
  - The ability to attract additional income up to the value of £362,000.
  - Opportunities to secure future market share and the capability to target new market opportunities.
- Work with our commissioners as part of QIPP to find ways of reducing elective activity to the value of £4million in line with national benchmarks. This in turn will help us to reduce our cost base and support the delivery of other cost improvement schemes.
- Embed the enhanced recovery programme (ERP) across all elective specialities to promote the optimal journey time for our patients and further reduce length of stay. We will determine other relevant procedures where ERP principles can be rolled out. We will review and remodel the pre assessment process for breast care. We will also trial local infiltration anaesthetic for knee replacement (orthopaedics) to assist in early mobilisation and further reduction in length of stay.
- Create new care pathways which are easier for patients and give best value for commissioners. In this context we will make sure that care is provided in the most appropriate setting. This will mean that more elective procedures will be done in a day case setting and that procedures traditionally carried out as day case procedures will in future be done in an outpatient setting. This will include implementing the 53 procedures mandated to be undertaken in this manner. This will be funded through the application of the outpatient tariff.
- Develop a Day of Surgery Admissions facilities (DOSA), exploring the potential to work with a commercial partner to fund such a development. We are investing £50,000 to support the initial planning of this development. We will expect to have identified whether or not to proceed with a commercial partner and to have developed a full business case to support this scheme by the end of 2011/12.
- Continue to develop our direct access services for diagnostics, attracting a further £15million as part of our contract with commissioners.
- Redesign our endoscopy services, developing more streamlined pathways that ensures high quality clinical and increases profitability.
- Redesign our outpatient clinics to reduce the footprint and optimise the patient experience. This will be achieved in a number of ways through:
  - Responding to the commitment from our commissioners to develop multi disciplinary outpatient clinics. This will improve the patient experience through the avoidance of multiple outpatient attendances.
  - Continuing to develop one stop and virtual clinics, with a continued roll out to further clinics from April 2011.
  - Developing Healthcare at Home for cancer patients from April 2011 in order to avoid unnecessary admissions and ensure that patients are treated in the right place at the right time.
  - Developing nurse led services within Gynaecology to improve access to services.
- Invest £450,000 in developing the Brachytherapy services. UHL has a very well established gynaecological Brachytherapy service based around an ageing unit. We will therefore seek to replace this device and refurbish the accommodation which will improve the patient experience and enable us to comply with national guidelines.
- Implement the first stage of the Next Stage Review (NSR) for Maternity services through the relocation of Gynaecology services to the LGH and the shift of Obstetric services to the LRI.
- With additional funding secured from our commissioners we will increase the number of midwives to meet national standards. We will invest a total of £1.9million in these services.

1. SECTION 1: Strategic Planning and Priorities

To become a nationally recognised provider of teaching, clinical and support services, in 2011/12 we will:

- Implement our theatre modernisation programme to improve quality standards and cost efficiency throughout the surgical patient pathway. This will include:
  - Investment of up to £2million in refurbishing 3 theatres at the LGH and supporting wards.
  - Reorganising theatre sessions and current working practices.
  - Reducing the number of operating theatres by 4 by the end of the financial year.
  - Eliminating the necessity for waiting list initiatives from April 2011.
  - Undertaking a full theatre staffing and skill mix review to develop a flexible workforce and reduce our pay costs.
- Commence the implementation of Electronic Prescribing and Medicines Administration (EPMA) and the associated transformation of processes at ward and dispensary level. The EPA project will transform the way medicines are prescribed, ordered, dispensed and administered, delivering safer, more efficient, and effective processes for medicines use.
- Work in partnership with a commercial provider to provide new high quality aseptic suite facilities that will replace the temporary facilities that currently exist. Our preferred option is to enter into a partnership with a commercial provider for the majority of chemotherapy and to create an onsite 'hot lab' facility for the provision of time critical products and clinical trial material. This will require capital investment of up to £890,000, and will maintain the current income associated with chemotherapy provision.
- Progress the Pathology joint venture with NUH. This will include exploring the options for developing a strategic partnership with the commercial sector to bring additional resource and expertise to complement that which exists within the single managed service. The new business model will be confirmed by mid to late 2011.
- We will use IT systems more effectively to further improve our communications with GP's. This includes speeding up the turnaround time for discharge letters and outpatient letters supported by outsourcing some of our typing services.
- Linking the development of our Forensic Radiology service with the Muslim Burial Council to ensure that the needs of the local Muslim community are met.
- Consolidate our Facilities Management provision and procure an external partner to support the delivery of these services.
- Complete business case for a strategic technology partner to provide an integrated Electronic Patient Record.
- Complete business case for telephony and communications transformation, and procure external partner to support delivery.

To become an internationally recognised provider of specialist services supported by advanced R&D, in 2011/12 we will:

- Achieve designation for the provision of Paediatric Congenital cardiac Services and expand and invest in the service to meet national guidelines. A final decision on the centres to be designated will be announced in September 2011. We will continue to lobby to keep these services in Leicester.
- Promote partnership working with NUH to maximise the efficiency and effectiveness of the Renal service and Renal Transplantation and help us to reduce our cost base.
- Further develop and invest £241,000 in our neonatal, paediatric surgery and high dependency care services.
- Consolidate and expand our Genetics service within the regional network.
- Continue to develop our tertiary services within Adult cardiac Surgery including the Transcatheter Aortic Valve Implantation (TAVI) Programme. Over time the aim of this specific programme is to:
  - reduce patient mortality and morbidity
  - attract referrals from across the UK and overseas and
  - develop a profitable and sustainable service.

1. SECTION 1: Strategic Planning and Priorities

- Develop a state of the art HOPE Research Clinical Trials Centre for Cancer services as part of our journey to become a leading centre for clinical trials.
- Continue to develop regional academic partnerships in line with the concept of an Academic Health Sciences Cluster (AHSC).
- Continue to build on our successful partnership with Leicester University as reflected in the prestigious National Institute for Health Research funded units and awards.
- Respond to the recommendations of external advisory panel who reported on the CLAHRC in 2010.
- With our partners achieve designation for a further BRU in Respiratory Disease.
- Invest £550,000 in the development of Centre of Excellence for Diabetes research based on the LGH site.

Section 2: Financial Plan

Contents:

SECTION 2: Financial Plan

1 Introduction

1.1 This report contains the detailed Financial Plan for 2011/12. The plans in this report formed the basis of the draft financial plan submission to East Midlands SHA on 17 March 2011. The Business Plan is presented to the Trust Board with a recommendation for **conditional approval**, subject to the factors which are described in greater detail below.

1.2 The preparation of the 2011/12 budget has been incorporated within the development of the Trust's Integrated Business Plan (IBP), which has been a bottom-up clinically driven process.

1.3 The financial pressure caused by the 2011/12 Operating Framework and national tariff is well publicised and has provided a major challenge for the financial planning process. As well as the tariff's 4% in-built efficiency requirement (£24m), the impact of readmission penalties is particularly severe in UHL and amounts to a further 1.5% (£9m).

1.4 In 2011/12 these pricing pressures are combined with limited growth in activity, an underlying deficit from 2010/11 and the need to create a level of surplus consistent with an aspirant Foundation Trust. Together these factors generate the need for £38m of CIPs and an additional £20m of transformational support. Note that there are similar pressures across the LLR health economy. **The size of the challenge facing UHL for 2011/12 is therefore very substantial.**

2 Summary Financial Position

2.1 The draft Income & Expenditure account for 2011/12 may be summarised as follows:

	2010/11 Forecast	2011/12 Plan	Change	
	£m	£m	£m	%
Income				
NHS income	597.5	**595.9**	(1.6)	-0.3%
Education, training & research	75.4	**73.2**	(2.2)	-2.9%
Service income	672.9	**669.1**	(3.8)	-0.6%
Other operating income	27.5	**25.8**	(1.7)	-6.2%
Total income	**700.4**	**694.9**	**(5.5)**	-0.8%
Operating costs				
Pay	(433.7)	**(423.4)**	10.3	-2.4%
Non pay	(222.6)	**(225.5)**	(2.9)	1.3%
Total operating costs	**(656.3)**	**(648.9)**	**7.4**	-1.1%
EBITDA	**44.1**	**46.0**	**1.9**	4.3%
Financing				
Depreciation & amortisation	(29.4)	**(31.0)**	(1.6)	5.4%
Interest receivable	0.1	**0.1**	0.0	0.0%
Interest payable	(0.5)	**(0.5)**	0.0	0.0%
PDC dividend	(13.3)	**(13.3)**	0.0	0.0%
	(43.1)	**(44.7)**	(1.6)	3.7%
Net surplus	**1.0**	**1.3**	**0.3**	30.0%

2.2 The Trust's income is currently forecast to reduce by £6m in 2011/12 from the 2010/11 outturn, largely as a consequence of the NHS Operating Framework and the relatively flat activity position agreed with Leicester, Leicestershire and Rutland (LLR) commissioners.

2.3 Although the IBP is a 5 year document, the size of the challenge facing the Trust has meant that the substantial majority of planning effort thus far has focused on 2011/12. Identification of robust and safe CIP plans for the remaining years remains a key challenge for the trust and the Divisions and work on this will continue through April.

SECTION 2: Financial Plan

2.4 There is the opportunity to **repatriate** elective services for LLR patients that are currently provided in Trusts outside Leicestershire. Whilst recognising that patients on the borders of Leicestershire and Rutland may choose another provider, some patient and GP choice has been constrained by a lack of UHL's capacity and there may be an income opportunity of over £20 million. This is not reflected in the Plan.

2.5 There have been two principal strands of work over the last two months:

1. Agreeing the annual contract with commissioners
2. Cost improvement plans (CIP) - including a risk assessment of the clinical impact

2.6 The target surplus for next year has been reduced from that originally presented to the Board in January 2011 as a result of the contracting round but also late reductions in education and training funds, some of which were communicated only in the last week.

2.7 At this stage the Plan carries a high delivery risk. This risk is driven primarily by:

3. The scale of the **CIP challenge** (£38.2 million or 5.5% of the cost base), taking the NHS and UHL into historically unrealised levels of savings
4. The currently unconfirmed **access to transitional and transformational funds**
5. **Organisational capacity** - delivering this level of efficiency improvement at the same time as managing the operational pressures of the Trust – particularly the ongoing pressures on emergency care systems.

2.8 It should be noted that the Trust is assuming £20 million of non recurrent transitional/transformational income (£6 million from LLR funding and £14 million from the 2% "top slice" health economy funds). Receipt of this income is subject to agreement with LLR commissioners, and the submission of business cases to EM SHA. It is essential that these funds support genuine transformation and do not just provide bridging finance.

2.9 The route to sustainable financial balance is therefore made up of these principal components:

- A **robust efficiency drive**, to bring down the operating cost base of the Trust. This will include the following themes:
  - Incremental schemes. These will be better informed and targeted by application of the Trust's SLR / PLICS analysis.
  - Major schemes (eg our Pathology joint venture with Nottingham University Hospitals)
  - Care settings – moving care to lower cost settings in conjunction with our healthcare partners
  - Operating model – a "UHL Lean" or similar total quality system with the intention of improving outcomes, patient experience and efficiency in a joined-up, systematic manner. This would include the reduction of UHL's rate of readmission.
- These themes in turn reflect the key drivers of UHL's strategy:
  - Patients – with the focus on pathways
  - People – seeking to liberate the creative talent that lies in all our people and to free time for front line care
  - Process – a quality focus, eliminating waste in all its manifestations
  - Partnerships – recognising that together we are stronger and

2.10 As a result of the above risks, the Plan is presented to the Board with a conditional recommendation for approval. The conditions are:

- **Balanced Budgets** are set by Divisions within the envelope and constraints contained in this Plan. Detailed budgets reflecting clinically risk assessed CIP schemes will be brought for Trust Board approval on 7 April 2011.
- **Targeted turnaround support** is available to reinforce delivery of the CIP plans by the Divisional Management Teams.
- **Transitional/Transformational support** of £20 million is received from LLR commissioners and the EMSHA

3 Income

3.1 The table below shows the roll-forward of income from the 2010/11 Plan and the current 2011/12 Plan position:

	Plan Assumption @ 17/03/11 £m
Total Income Plan 2010/11	**692.3**
2011/12 Movements	
2010/11 Non Recurrent Income / Local Planning	(14.8)
Other Activity Movements	3.1
Demographics	6.3
Paediatric HDU / Neonates repatriation	1.4
QIPP/Demand Management	(4.0)
Goodwin Unwind / Other	6.4
Stroke	0.4
DSC (Disablement Service) transfer	(4.6)
Maternity expansion	0.5
NICE & High Cost Therapy (HCT) uplift	3.0
TCS (transforming Community Services)	0.4
Readmissions	(5.4)
Net efficiency	(8.6)
LLR transitional support	6.0
2% Transformational Support	14.0
TAVI	0.8
Non Leics / Other	(2.1)
Private Patients	(0.3)
Education Levies	(1.2)
Non Patient Care	1.4
Total	**2.6**
Total Income Plan 2011//12	**694.9**

3.2 The revised position in the draft Plan reflects the anticipated outcome of the negotiation process with commissioners. The main features are:

- **Limited service developments** agreed with commissioners, e.g. maternity and neonates
- **Demographic growth** has been fully funded.
- The **Disablement Services Centre** (DSC) is due to transfer to a third party provider on 1 April 2011. This will mean a recurrent reduction in income (and cost) of £4.6 million.

- The impact of the 2011/12 tariff on **readmissions** has been negotiated with commissioners and has been valued in the contract as a reduction in income of £5.4 million (from Plan). This is a key area of risk for the Trust
- **Demand Management and QIPP** proposals from LLR commissioners have resulted in a reduction of £4 million in contract income.

3.3 **LLR contract update.** Contract negotiations with commissioners have been largely concluded as follows:

- A financial envelope has been agreed, and this is reflected in the income assumptions contained within the Plan. The overall income level negotiated was in line with the Trust's expectations.
- The 2011/12 UHL acute contract is now based on the standard national PbR document. In setting this objective, we recognised that the financial impact of certain contract terms was valid and various means of dealing with the same underlying issues (e.g. N12s in maternity) would commonly be found in acute contracts. This removes the historical pricing issues ("Goodwin") adjustments from the contract.
- Detailed terms are still to be agreed, but are expected to be resolved by 31 March 2011.

3.4 **QIPP/Demand Management.** The standard form acute contract makes it incumbent on commissioners to manage demand for acute services. LLR commissioners' QIPP plans are based on this requirement and identify a relatively modest £4 million of QIPP savings. A stepped change is required to help secure LLR's financial sustainability.

3.5 **Income Risks.** There are two areas where UHL has proposed risk sharing as a solution to closing the contractual gap:

- Pathology Direct Access: 50% marginal rate for activity above 2009/10 outturn
- Diagnostic Imaging ; growth at 50% marginal rates

3.6 Historically, the Trust has also entered into a risk share with the East Midlands Specialist Commissioning Group (EMSCG) regarding the NICE and High Cost Therapy budgets. However, we note that UHL is the only East Midlands trust to risk share with EMSCG and proposals have yet to be agreed for 2011/12.

3.7 In 2010/11, there was a nationally mandated contract term that emergency activity above 2008/09 would only be paid at 30% marginal rates. This term has been rolled-forward into 2011/12.

4 Expenditure

4.1 The table below shows the roll-forward from the 2010/11 Plan, the expenditure assumptions included in the draft Plan on 20 January 2011 and the current 2011/12 Plan position:

	Plan Assumption @ 20/01/11 £'m	Plan Assumption @ 17/03/11 £'m	Variance £'m
Pay	(428.7)	(428.7)	-
Non Pay	(219.4)	(219.4)	-
Dividends	(13.3)	(13.3)	-
Depreciation	(28.3)	(28.3)	-
Provisions	(0.3)	(0.3)	-
Interest Payable	(0.6)	(0.6)	-
Interest Receivable	0.1	0.1	-
Don Asset Depreciation	(0.8)	(0.8)	-
Total 2010/11 Expenditure Plan	**(691.3)**	**(691.3)**	**-**
2011/12 Movements			
Non Recurrent Provision Release	-	(3.0)	(3.0)
Plan to Outturn	(4.3)	0.0	4.3
Research Funds	-	(1.2)	(1.2)
FYE Orthopaedics	-	(2.5)	(2.5)
FYE Stroke	-	(0.4)	(0.4)
FYE EDS	-	(0.4)	(0.4)
TBM Contract	-	(0.3)	(0.3)
Developments	-	(4.4)	(4.4)
TCS	-	(0.4)	(0.4)
Consultant Contract	-	(1.0)	(1.0)
Consultant Awards	-	(0.5)	(0.5)
VAT	-	(2.8)	(2.8)
Non Pay Inflation	(6.2)	(4.9)	1.3
Pay Inflation	(5.6)	(3.7)	1.9
R&D FSF / PMO / Corporate Exp	-	(2.8)	(2.8)
NICE	-	(3.0)	(3.0)
Marginal Costs	-	(2.0)	(2.0)
DSC Transfer	-	4.6	4.6
Depreciation Volume	-	(2.0)	(2.0)
Contingency	(10.0)	(5.0)	5.0
Redundancy		(5.0)	(5.0)
Cost Improvement Plan	35.5	38.2	2.8
Total Movements	**9.4**	**(2.3)**	**(11.8)**
Total 2011/12 Expenditure Plan	**(681.9)**	**(693.6)**	**(11.8)**

4.2 Since 20 January 2011, the expenditure assumptions have been refined through the detailed planning process with CBUs and Divisions. Key movements are:

- **2010/11 developments** - the Plan includes £3.3 million for the anticipated full year effect of developments started part way through 2010/11

- **Non pay inflation** – reflecting amounts identified by Divisions
- **NICE/marginal costs** - UHL has additional NICE and marginal cost commitments of £5 million, reflecting the agreed contract envelope.
- **Capital charges** - the Trust invested £29 million in new capital developments in 2010/11, and this together with investment of £44 million in 2011/12 has generated additional charges of £2 million for depreciation.
- **Contingency** – The planned level of contingency reserve has been reduced to £5 million. However, an additional provision for transitional or redundancy costs of £5 million has been created.
- **Non Recurrent Provision –** The Trust has benefited from a one off release of £3 million from provisions in 2010/11. This will not be available in 2011/12.

5 Efficiency

5.1 The Trust has set an efficiency target for 2011/12 of £38.2 million (5.5%). This is predominantly due to the impact of the reduction in the national tariff, readmission penalties combined with local inflationary pressures and the creation of a contingency to provide headroom.

5.2 The current position in respect of the Trust's CIP plans is illustrated in the table below:

Division	CIP Target £'m	Identified £'m	Unidentified £'m
Acute	13.4	10.5	2.9
Planned	8.7	3.9	4.8
Clinical Support	6.2	4.0	2.2
Women's & Children's	2.9	2.5	0.4
Corporate	3.6	1.9	1.7
Trust-wide schemes	3.4	6.1	(2.7)
TOTAL	**38.2**	**28.9**	**9.3**

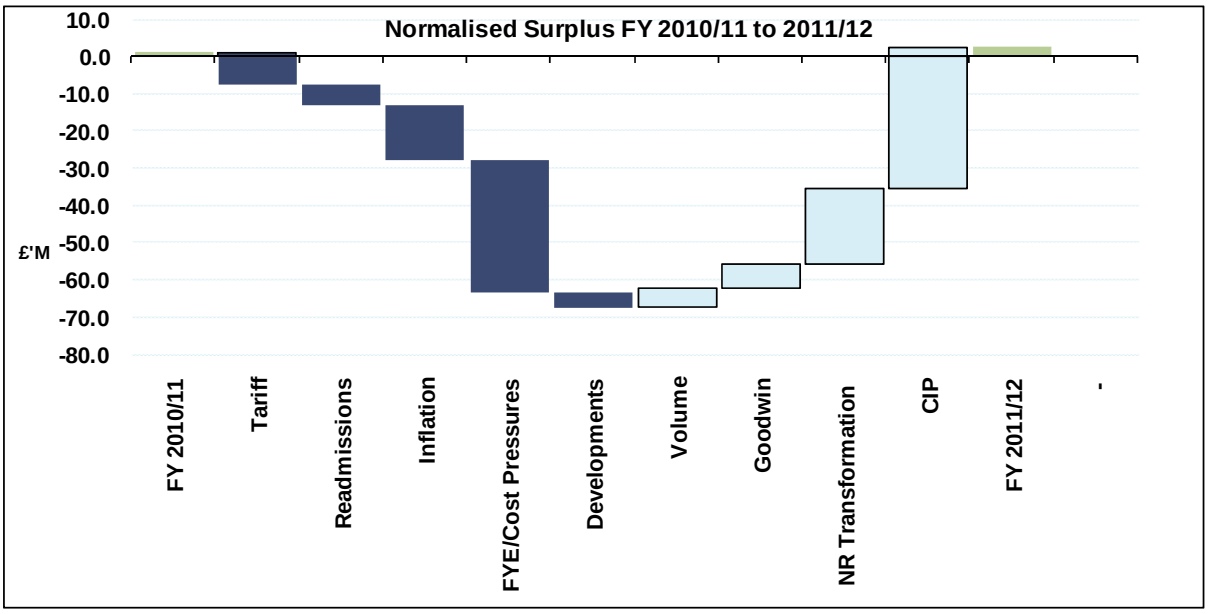
Note: The Trust Wide plan and actuals will be allocated to the Divisions

5.3 This shows that the Trust is making progress in identifying CIP schemes to meet the challenge, but there is currently a shortfall of £9.3 million against the £38.2 million target. The Director of Finance and Procurement and Chief Operating Officer/Chief Nurse are undertaking Confirm and Challenge meetings with CBUs to support them in identifying additional savings. Final approval of the financial plan by the Trust Board on the 7 April 2011 is contingent on identifying plans for the full savings target.

6 Profit Move Analysis

6.1 The key movements from the 2010/11 forecast outturn to the 2011/12 plan are summarised in the Profit Move Analysis (bridge) below. The impact of each of these changes has been discussed in more detail above.

Table 5– 2010/11 to 2011/12 Profit Move Analysis



7 Balance Sheet

7.1 **The balance sheet and cash flow are detailed in Appendices 2 and 3. These reflect the following** assumptions:

- Inventory – agreed stock reduction (£2 million)
- Creditors – increase predominantly due to movement to 60 day payment terms (£5.9 million)
- Liquidity – increase in the cash balance at year end to £25 million as a result of reduced capital expenditure, the impact of the inventory and creditor policies and the planned surplus.

8 Capital Plan

8.1 The Capital Plan submitted reflects the requirement to invest in essential infrastructure items in year, including backlog maintenance, equipment and IM&T schemes. Overall, planned capital expenditure in 2011/12 is £3.9 million less than forecast depreciation. This action has been taken to support the Trust's liquidity position. The proposed land and buildings exchange with LPT is shown as both a source and application of funds. This is because the disposals of £19.8 million from the Trust's balance sheet will generate the funds to be re-invested in the new capital assets, also £19.8 million. The Capital Plan is detailed in Appendix 4.

9 Summary of Key Assumptions

9.1 The key planning assumptions within the 2011/12 plan are summarised in the following table:

Table 1 - Summary of Key Financial Planning Assumptions

Issue	Planning Assumption
Tariff	1.5% decline nominal (National guidance)
"Goodwin" tariff unwind	Target 20% unwind net in 2011/12 (c£7m) – actual £6.4m
QIPP (Quality, Innovation,	£4m reduction in income due to QIPP demand

Issue	Planning Assumption
Productivity and Prevention)	management plans from PCT's
Repatriation and service developments	£3m elective care repatriated No material service developments other than: • agreed expansion of community and hospital based midwives and • full year effect of orthopaedic theatres project
Risk sharing	Some marginal rates – but not shifting the marginal cost of additional activity onto UHL.
Implicit CIP requirement	4% (National guidance)
Actual CIP requirement	£38.2m (5.5%) in 2011/12 to achieve contingency and target surplus
Pay	1.3% uplift overall to reflect NIC increases, AfC incremental drift and uplift for lower paid staff in 11/12; no other pay awards.
Non Pay	Inflationary increases of 3.5%
Contingency / Redundancy reserves	£5m risk contingency, £5m redundancy provision
Transformational Support	£20m in 2011/12
Financial Risk Rating	FRR = 3 (minimum)
Working capital	Assumes an extension of creditor days to 60
Capital	Reduction in capital expenditure in 2011/12 to support the liquidity position.

10 Risks and Opportunities

10.1 The key risks that have been identified in the preparation of the 2011/12 Business Plan include:

- **CIP Delivery risk** – actual delivery of CIPs remains a risk. External support could mitigate this risk, together with the detailed work undertaken to date.
- **Organisational capacity** – a challenge to obtain sufficient headroom to focus on business development and focus on key financial metrics.

Further work is required to prepare detailed mitigation strategies in respect of each of these risks.

10.2 Opportunities include:

- **Repatriation of LLR elective work** from other providers
- **Research and Development funding** – with increased focus in this area
- **Better analysis** of our business – with the roll out of the patient level costing systems ("PLiCS") giving greater insight into areas needing focus

Appendix 1: Summary I&E statement

	£'m
NHS acute activity revenue	
Inpatient	69.4
Day case	54.8
Emergency IP	156.8
Outpatient - new	37.5
Outpatient - follow up	40.7
Emergency dept	14.1
Maternity	28.9
Other activity	167.2
Goodwin unwind	6.4
Non recurring income	20.0
NHS clinical revenue total	**595.8**
Non NHS clinical revenue	
Private patient revenue	4.1
Other non NHS clinical revenue	1.2
Non NHS clinical revenue total	**5.3**
Other operating income	
Education & training - other	35.5
Education & training - SIFT	18.4
Research & development	19.3
Other income	19.8
Transfer from donated asset / govt grant reserve	0.8
Other operating income total	**93.8**
OPERATING & REVENUE INCOME TOTAL	**694.9**
Pay & benefits	
Consultant costs	(75.4)
Junior medical costs	(60.0)
Nursing, midwifery & health visitors costs	(153.7)
Scientific, therapeutic & technical costs	(55.2)
Other clinical staff costs	(10.5)
Other non clinical staff costs	(60.7)
Agency staff costs	(7.9)
Pay & benefits total	**(423.4)**
Non-pay costs - variable	
Drug costs - high cost	(39.6)
Drug costs - Other	(18.4)
Clinical supplies and services - high cost	(7.6)
Clinical supplies and services - other	(70.5)
General supplies	(24.1)
Variable non pay costs total	**(160.2)**
Clinical negligence (CNST) premium	(13.2)
Other expenses	(25.1)
Establishment expenses	(5.0)
Premises & plant	(22.0)
Fixed non pay costs total	**(65.3)**
OPERATING EXPENSES TOTAL	**(648.9)**
EBITDA	**46.0**
Non-operating income & costs	
Depreciation & amortisation	(31.0)
Interest receivable - cash balances	0.1
Interest payable - cash balances	(0.5)
PDC dividend / capital charges	(13.3)
TOTAL NON-OPERATING COSTS	**(44.7)**
Net surplus/deficit	**1.3**

Appendix 2: Summary Balance Sheet

	Opening Balance 01/04/11 £m	Closing Balance 31/03/12 £m	Movement £m	Movement %
NON-CURRENT ASSETS				
Property, Plant and Equipment	415.3	**411.9**	(3.4)	-0.8%
Intangible Assets	4.5	**3.9**	(0.6)	-12.2%
Other Financial Assets	4.7	**4.5**	(0.2)	-4.2%
TOTAL NON-CURRENT ASSETS	**424.5**	**420.4**	**(4.1)**	**-1.0%**
CURRENT ASSETS:				
Inventories	11.8	**9.8**	(2.0)	-16.9%
Trade and Other Receivables	24.2	**24.2**	0.0	0.0%
Other Financial Assets	0.2	**0.2**	0.0	0.0%
Cash and Cash Equivalents	10.3	**25.0**	14.8	143.9%
CURRENT ASSETS:	**46.4**	**59.2**	**12.8**	**27.5%**
TOTAL ASSETS	**470.9**	**479.5**	**8.6**	**1.8%**
CURRENT LIABILITIES				
Trade and Other Payables	(62.9)	**(69.2)**	(6.3)	10.0%
Borrowings	(1.0)	**(1.0)**	0.0	0.0%
Provisions for Liabilities and Charges	(0.6)	**(0.7)**	(0.1)	16.6%
TOTAL CURRENT LIABILITIES	**(64.5)**	**(70.9)**	**(6.4)**	**9.9%**
NET CURRENT ASSETS/(LIABILITIES)	**(18.1)**	**(11.7)**	**6.4**	**-35.1%**
TOTAL ASSETS LESS CURRENT LIABILITIES	**406.4**	**408.6**	**2.2**	**0.5%**
NON-CURRENT LIABILITIES				
Borrowings	(6.5)	**(7.8)**	(1.4)	21.1%
Provisions for Liabilities and Charges	(2.6)	**(2.1)**	0.5	-19.3%
TOTAL NON-CURRENT LIABILITIES	**(9.1)**	**(10.0)**	**(0.9)**	**9.4%**
TOTAL ASSETS EMPLOYED	**397.3**	**398.7**	**1.4**	**0.3%**
FINANCED BY TAXPAYERS' EQUITY:				
Public Dividend Capital	273.9	**273.9**	0.0	0.0%
Retained Earnings	15.3	**16.7**	1.4	9.3%
Revaluation Reserve	108.1	**108.1**	0.0	0.0%
TOTAL TAXPAYERS' EQUITY	**397.3**	**398.7**	**1.4**	**0.4%**

Appendix 3: Summary Cashflow

	Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000	2011/12 Full Year Plan £'000
CASH FLOWS FROM OPERATING ACTIVITIES													
Operating Surplus	1,131	1,150	1,180	1,154	2,043	1,498	1,144	1,144	1,142	1,136	1,144	1,142	**15,008**
Depreciation and Amortisation	2,513	2,556	2,557	2,557	2,563	2,497	2,602	2,601	2,601	2,665	2,665	2,664	**31,041**
Interest Paid	(37)	(41)	(41)	(41)	(41)	(42)	(41)	(41)	(41)	(41)	(41)	(42)	**(490)**
Dividend Paid	0	0	0	0	0	(6,635)	0	0	0	0	0	(6,634)	**(13,269)**
(Increase)/Decrease in Inventories	167	167	167	167	167	167	167	167	167	167	167	163	**2,000**
(Increase)/Decrease in Trade and Other Receivables	(2,639)	(2,791)	(2,903)	7,578	(1,549)	(903)	(456)	(911)	(1,570)	4,549	(969)	2,558	**(6)**
Increase/(Decrease) in Trade and Other Payables	4,004	4	1,004	10,004	4	(7,632)	4,004	4	(996)	4,004	4	(7,555)	**6,853**
Increase/(Decrease) in Provisions	16	(4)	(44)	6	16	(43)	6	16	(44)	6	16	0	**(53)**
Net Cash Inflow/(Outflow) from Operating Activities	**5,155**	**1,041**	**1,920**	**21,425**	**3,203**	**(11,092)**	**7,426**	**2,980**	**1,259**	**12,486**	**2,986**	**(7,704)**	**41,085**
CASH FLOWS FROM INVESTING ACTIVITIES													
Interest received	8	8	8	8	8	8	8	8	8	8	8	8	**96**
(Payments) for Property, Plant and Equipment	(1,500)	(1,000)	(1,000)	(1,000)	(1,000)	(2,000)	(2,000)	(2,000)	(2,000)	(2,000)	(3,143)	(5,000)	**(23,643)**
(Payments) for Intangible Assets	(67)	(33)	(33)	(33)	(67)	(67)	(67)	(67)	(33)	(100)	(100)	(334)	**(1,001)**
(Payments) for Other Financial Assets													**0**
Net Cash Inflow/(Outflow) from Investing Activities	**(1,559)**	**(1,025)**	**(1,025)**	**(1,025)**	**(1,059)**	**(2,059)**	**(2,059)**	**(2,059)**	**(2,025)**	**(2,092)**	**(3,235)**	**(5,326)**	**(24,548)**
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**3,596**	**16**	**895**	**20,400**	**2,144**	**(13,151)**	**5,367**	**921**	**(766)**	**10,394**	**(249)**	**(13,030)**	**16,537**
CASH FLOWS FROM FINANCING ACTIVITIES													
Other Capital Receipts	67	67	67	67	67	67	67	67	67	67	65	65	**800**
Capital Element of Finance Leases and PFI	(219)	(219)	(219)	(219)	(219)	(219)	(219)	(219)	(219)	(219)	(219)	(216)	**(2,625)**
Net Cash Outflow from Financing	**(152)**	**(152)**	**(152)**	**(152)**	**(152)**	**(152)**	**(152)**	**(152)**	**(152)**	**(152)**	**(154)**	**(151)**	**(1,825)**
Net Increase/(Decrease) in Cash and Cash Equivalents	**3,444**	**(136)**	**743**	**20,248**	**1,992**	**(13,303)**	**5,215**	**769**	**(918)**	**10,242**	**(403)**	**(13,181)**	**14,712**
Cash and Cash Equivalents at the Beginning of the Period	10,250	13,694	13,558	14,301	34,549	36,541	23,237	28,453	29,222	28,304	38,546	38,143	**10,250**
Cash and Cash Equivalents at the End of the Period	**13,694**	**13,558**	**14,301**	**34,549**	**36,541**	**23,237**	**28,453**	**29,222**	**28,304**	**38,546**	**38,143**	**24,962**	**24,962**

Appendix 4: Summary Capital Plan

Capital Plan 2011/12		2011/12
		£'000
Source of Funds	Depreciation	27,194
	Transformational monies for ED	1,500
	Disposals	**19,800**
	Donated Additions	800
	Less cash support	-5,000
	Total Capital Plan	**44,294**
Application of Funds		
Backlog Maintenance	IM&T	2,500
	Medical Equipment	4,522
	Facilities - LRI	2,500
	Facilities - LGH	1,800
	Facilities - GGH	1,700
		13,022
Essential Developments		
	Carbon Management	1,000
	Diabetes Research	550
	GGH CDU Phase II	900
	LRI Disabled Car Park	190
	Gwendolen House Reprovision	400
	MES Installations	900
	Paediatric Heart Surgery	800
	MacMillan Information Centre	300
	ED Interim Improvements	1,500
	LGH Theatre Refurbs & Support Wards	2,000
	Cancer Trials Unit, LRI	100
	Decontamination	300
	Encoder for Clinical Coding	131
	DOSA Units Initial Planning	50
	Divisional Bids	1,850
		10,971
Land Swap - LPT	Land & Building Swap	19,801
Donated	Donated Assets	500
	Total Applications	**44,294**

Section 3: Workforce

Contents:

SECTION 3: Workforce Plan

1 Key Assumptions

A key element of UHL's Foundation Trust Application is the development of a robust workforce plan which details the future shape of the workforce and populates the Long Term Financial Model (LTFM).

Staff costs represent approximately 2/3rds of the Trust's cost base. It has been agreed that the Trust needs £135 million cost savings to be found over the next 5 years. This equates to efficiency savings of 5% per annum. The Trust has informed the Strategic Health Authority that it intends to reduce its pay bill by 25% over the next 5 financial years. This will be through a combination of reduced whole-time equivalents (wte) and other reduced staff costs such a bank/agency usage, sickness level reductions and skill-mix changes.

In 2011/12 we will see significant challenges for the Trust's workforce arising as a consequence of the expectation of unprecedented level of efficiencies, increased financial rigor, changes in commissioned levels of activity, more effective demand management and service configuration. Clearly the scale and range of the cost improvement schemes for 2010/11 will have significant implications for the workforce. The workforce plans have therefore been developed on the basis of a future financial envelope and 4 overarching HR assumptions.

The 4 overarching HR assumptions for the Trust are:-

- Administrative and Clerical staff numbers will significantly decrease
- The sickness target for 2011/12 will be set at a target reduction to 3%
- Agency usage should be kept to a minimum.
- Corporate Directorate savings will be 5% per annum

2 Development of Service Improvement and Cost Improvement Programmes

The workforce plans are being developed as a series of Service Improvement Programmes (SIPs) and Cost Improvement Programmes (CIPs). Each cost centre will have increases and decreases in staffing numbers and/or costs applied to its agreed baseline position to form the workforce planning figures.

The SIPs and CIPs will not only deliver workforce savings through reduced staff numbers but will include financial savings through changes in working practices, role design, role evaluation, salary sacrifice and reviews to local terms and conditions.

Some SIPs and CIPs schemes that commence in 2011/12 will make significant in year savings others will deliver savings in future financial years.

Division and CBU Management Teams, HR and finance are developing Service Improvement and Cost Improvement Programmes that support service delivery whilst maintaining quality and affordability. These plans and models will continue to be developed and refined on an iterative basis throughout 2011 as an integral part of the development of our Integrated Business Plan in preparation for Foundation Trust status.

We are forecasting full year effect reductions in wtes in the order of 500 wtes in 2011/12. To date the following reductions have been identified:

SECTION 3: Workforce Plan

Division	2011/12 wte
Acute	164.90
Planned	75.52
Women's	12.35
Clinical Support	27.79
Corporate	20.70
Total	**301.26**

Workforce implications for all CIP schemes will be identified, quantified and the impact assessed. This work has involved the phasing of workforce reductions or change in composition of the workforce so that, for example, where there are changes in theatre capacity and the bed base we can ensure that we can maximise the opportunities for the redeployment of staff into other areas and wards to minimise the level of change for individuals. This will in turn help to reduce the demand for the use of agency, locum and bank staff and will help to minimise the need for overtime.

A phased and coordinated approach in conjunction with proactive vacancy management will also help reduce the potential for redundancy. The turnover of staff across UHL equates to approximately 60/70 individuals per calendar month so as CIP schemes are implemented we are able to redeploy staff into suitable alternative posts as colleagues leave the Trust. Clearly we are working with staff-side to ensure that staff are appraised of the changes at the earliest opportunity and that changes are handled appropriately with agreed Management of Change policies and procedures. In addition all CIP schemes will undergo a risk assessment and associated monitoring from a safety and quality perspective.

Increased productivity is a key element of the workforce implications for the CIP programme. Built into each Division's plan is a target related to the reduction of sickness absence. This has been quantified in terms of financial reductions for the year.

As a consequence of some services moving to UHL under the Transforming Community Services agenda a small number of staff equating to 69.58 wte will transfer to UHL with effect from 1st April 2011. Other increases in workforce numbers will be seen in Obstetrics in response to a national drive to increase the number of midwives. Further to this additional investment will support the transformation of the Emergency Department (ED).

3 Trust wide Cost Improvement Programmes

In addition to Divisional and Clinical Business Unit specific Cost Improvement Programmes the Trust has identified a number of major Trust wide programmes that should generate considerable savings. These will have workforce implications and will therefore contribute to the overall headcount reductions in 2011/12:

- Re-admissions
- Coding
- Theatres

- Outpatients
- 3 to 2
- Estates
- IT
- Procurement savings
- Pathology Service review

As each of these programmes are highly complex it has been agreed that they will be headed up by dedicated Projected Managers who will report to a CIP Lead / Project Director who in turn will report to the Chief Operating Officer / Chief Nurse.

Initial Project briefs have been drafted for each of the Trust wide CIPs – detailed Project Initiation Documents (PIDs) will be developed by each of the Project Managers

4 HR Specific Programmes

Additionally there are a number of HR specific work streams that will be initiated in 2011/12 that will generate significant savings. These are:-

- **Specialist Nurses:** work is ongoing with Divisional Heads of Nursing to define the numbers of Specialist Nurses employed and establish their job plans. Following on from this their roles are being reviewed.

- **Assistant and Advanced Practitioners:** the development of both Assistant Practitioner and Advanced Practitioners roles was identified as essential within the Trust 2010 Workforce Development Plan. Drivers for change being; the efficiency and productivity agenda within the NHS, changes in the Medical Workforce, the implementation of nursing as a degree-only profession and changes in service delivery. A Trust wide Steering Group is being established to review opportunities, define roles, establish protocols, define training and implement changes during the next two financial years

- **Review of Roles:** Agenda for Change implemented from October 2004 harmonised pay terms and conditions but brought with it considerable costs, with most employees benefiting from its introduction. Evidence from post implementation evaluations suggest that a significant number of roles have been generously banded or that there is scope for post holders to take on greater responsibilities whilst remaining in their current band. Additionally roles and ways of working have change since 2004 and these need to be reflected in both job descriptions and job evaluations. In line with the NHS efficiency and productivity agenda it is timely to review roles as they are now in 2011. The exact scope of the project is currently under discussion, however, if all roles are to be reviewed this is likely to take two years.

- **Apprentices:** the Trust currently has 36 apprentices working within it and we intend to take on 30 more in 2011/12. These are an integrated work based training and development programme designed around the needs of employers, reflecting required knowledge and competencies which lead to nationally accredited qualifications. They provide work and training opportunities for individuals and allows the Trust to “grow our own staff”. In 2010/11 we successfully recruited and trained plaster technicians in this way.

- **Review of protection arrangements:** the Trust has a pay protection policy that protects individual earning should their grading be reduced as a result of organisational change. A number of employees are currently receiving pay protection. This is being monitored on a monthly basis. As protection ceases the cost savings will be entered into the Clinical Business Units financial models.

SECTION 3: Workforce Plan

- **Bank usage and Agency usage:** The Trust intends to reduce its bank and agency usage in 2011/12 so that it is only ever used to minimise clinical risk. A project led by the procurement team is looking to reduce demand and external expenditure on temporary staffing.

- **Review of local terms and conditions:** around £3.5 million is spent on local pay elements. Divisions and CBU will investigate and critically analyse payments being made and reasons and schemes associated with payments.

- **Salary sacrifice:** salary sacrifice schemes will be examined as they have the potential to provide tax and national insurance savings for both the employees and the Trust – subject to satisfying certain criteria.