Paper A

University Hospitals of Leicester NHS
NHS Trust

To:	**Trust Board**
From:	**Suzanne Hinchliffe, Chief Operating Officer/Chief Nurse** **Andrew Seddon, Director Of Finance**
Date:	**21 July 2011**
CQC regulation:	All

Title:	**FINANCIAL RECOVERY PLAN - STABILISATION AND TRANSFORMATION**

Author/Responsible Director:

Suzanne Hinchliffe, Chief Operating Officer/Chief Nurse
Andrew Seddon, Director Of Finance

Purpose of the Report:
To seek Board approval of the financial recovery plan

The Report is provided to the Board for:

Decision	X	Discussion	X
Assurance		Endorsement	

Summary / Key Points:

The Trust is reporting a deficit of over £8m at month 3. This paper sets out the Trust's proposed response to the current deficit. This comprises two stages:

1. 'Stabilise' the current position
2. 'Transform' our services

The action plan describes:

- the commissioner and clinician support
- the components of the Plan and its centralised nature
- the nature of the additional support that has been commissioned
- the outline communication plan.

Quality of care will be safeguarded through the recovery process.

A range of workforce proposals are included in the paper including a voluntary severance scheme (which requires HM Treasury approval).

Recommendations:
That the Board approve the plan.

Previously considered at another corporate UHL Committee?
Previous iterations have been discussed at the Board. A draft of this plan was approved by the Executive Team on 19 July 2011.

Paper A

Strategic Risk Register Various entries – particularly risk of not achieving statutory duties to break even / achieve EFL	**Performance KPIs year to date**
Resource Implications (eg Financial, HR) External support will be required – costs to be determined.	
Assurance Implications	
Patient and Public Involvement (PPI) Implications No explicit involvement at this stage.	
Equality Impact	
Information exempt from Disclosure Details of schemes affecting individuals	
Requirement for further review? At each Board meeting.	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO:	**TRUST BOARD**
DATE:	**21st July 2011**
REPORT BY:	**SUZANNE HINCHLIFFE, CHIEF OPERATING OFFICER/CHIEF NURSE**
	ANDREW SEDDON, DIRECTOR OF FINANCE
SUBJECT:	**FINANCIAL RECOVERY PLAN - STABILISATION AND TRANSFORMATION**

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1. Introduction

This paper sets out the Trust's proposed response to the current deficit. This comprises two stages:

- First, 'stabilise' the current position and then
- 'Transform' our services to create a sustainable, profitable future for Leicester's hospitals.

2. Context

Currently the Trust's financial position is poor. We have incurred losses of over £8m in the first 3 months of the financial year. Analysis shows that at least half of our services are loss-making and those which do make money don't make enough to cover the losses of others.

On March 31st 2011 the new tariff for hospital services came into effect and resulted in a 1.5% immediate reduction in income. This represents a reduction, in real terms, of 4% or £28m. On top of this, the new readmission penalties set out in the 2011/12 NHS Operating Framework impacted UHL by £9m. The combined effect was that the Trust had to deliver almost 6% CIP savings to "stand still" in financial terms. The Trust had no historical reserves of cash to buffer this position – but neither does it have any material historical deficits.

Executive director review of Clinical Business Unit (CBU) forecasts in the first week of July provided no assurance on local recovery plans and so a revised Trust–level plan, as set out in this paper, has been developed and is recommended to the Board. This is based on the twin themes of stopping excessive spend levels – a stabilisation phase – to be followed rapidly by a transformation phase.

Given the urgency of the situation it is necessary to:

- Exercise central control and intervention over key areas of current spend
- Secure external support to facilitate the transformation work and to give greater assurance on the stabilisation work.

The rest of this paper looks at these plans in greater detail.

3. Summary Financials

Month 3 results may be summarised:

	2011/12 Annual Plan £m	June Plan £m	June Actual £m	June Var (Adv) / Fav £m	April - June 2011 Plan £m	April - June 2011 Actual £m	April - June 2011 Var (Adv) / Fav £m
Service Income							
NHS Patient Related	589.2	49.2	**50.1**	0.9	146.6	**146.9**	0.3
Non NHS Patient Care	6.6	0.5	**0.4**	(0.1)	1.5	**1.2**	(0.3)
Teaching, R&D	67.1	4.4	**4.5**	0.1	16.8	**16.7**	(0.1)
Total Service Income	**662.9**	**54.0**	**54.9**	**0.9**	**164.9**	**164.7**	**(0.2)**
Other operating Income	18.8	1.6	**1.8**	0.2	4.6	**4.6**	0.0
Total Income	**681.8**	**55.6**	**56.7**	**1.1**	**169.6**	**169.4**	**(0.2)**
Operating Expenditure							
Pay	420.4	35.2	**37.5**	(2.3)	106.1	**111.5**	(5.4)
Non Pay	215.3	16.6	**18.0**	(1.4)	52.0	**55.2**	(3.1)
Total Operating Expenditure	**635.7**	**51.8**	**55.5**	**(3.7)**	**158.2**	**166.7**	**(8.5)**
EBITDA	**46.1**	**3.8**	**1.2**	**(2.6)**	**11.3**	**2.7**	**(8.7)**
Interest Payable	(0.6)	(0.1)	**(0.0)**	0.0	(0.1)	**(0.1)**	(0.0)
Depreciation & Amortisation	(31.1)	(2.6)	**(2.6)**	(0.0)	(7.8)	**(7.6)**	0.2
Dividend Payable on PDC	(13.2)	(1.1)	**(1.1)**	(0.0)	(3.3)	**(3.3)**	(0.0)
Net Surplus / (Deficit)	**1.3**	**0.0**	**(2.5)**	**(2.6)**	**0.2**	**(8.4)**	**(8.5)**
EBITDA %	**6.76%**		**2.13%**		**-**	**1.59%**	

After being behind Plan for the first 2 months, income recovered in June. Cumulative ytd income is however still behind Plan entirely due to a shortfall in emergency inpatient activity, partly as a result of the successful admission deflection schemes launched in the year.

Pay costs remain materially ahead of Plan, driven by delays in CIP delivery and continued high usage of bank and agency. Despite three ward closures in late May / early June, the adverse position against Plan has persisted as the underlying CIP plan required higher delivery of savings in June than in preceding months. Agency controls are being strengthened as set out later in this report.

Non-pay is a particular area for concern in the month. Additional costs are being incurred on the outsourced sterile services contract as the new service provider beds in. There is also overspend on high costs drugs (with a contra in income) and in some areas of ward stocks. Investigations continue into the underlying causes.

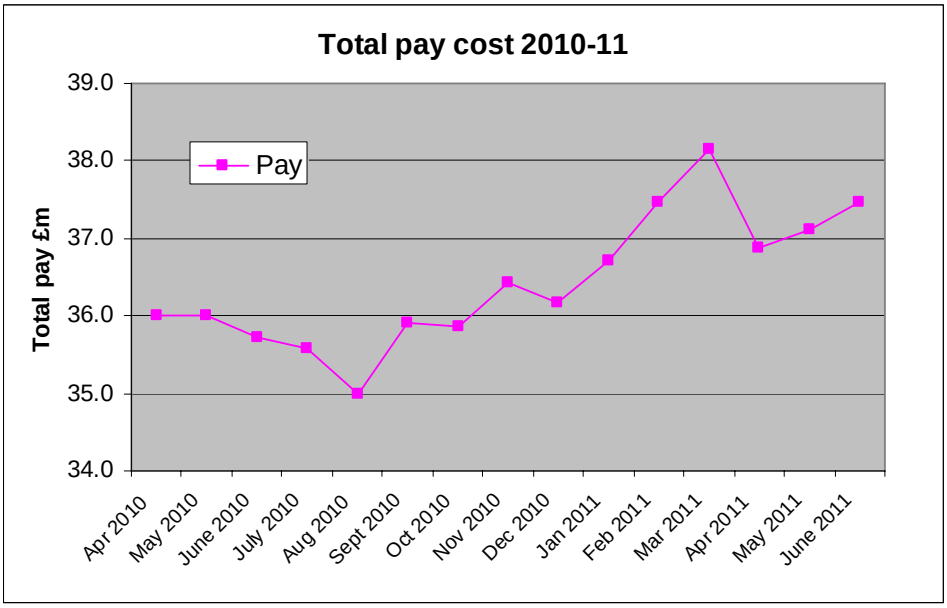
This third successive month of poor results coincides with the first month of strengthened operational controls and is thus particularly disappointing. The adverse position is across all Divisions (and the majority of CBUs) and triggered a full review of the full year forecast and the underlying CIP plans.

3.1. Expenditure trends

The following graphs provide an overview of key financial data and their position to date.

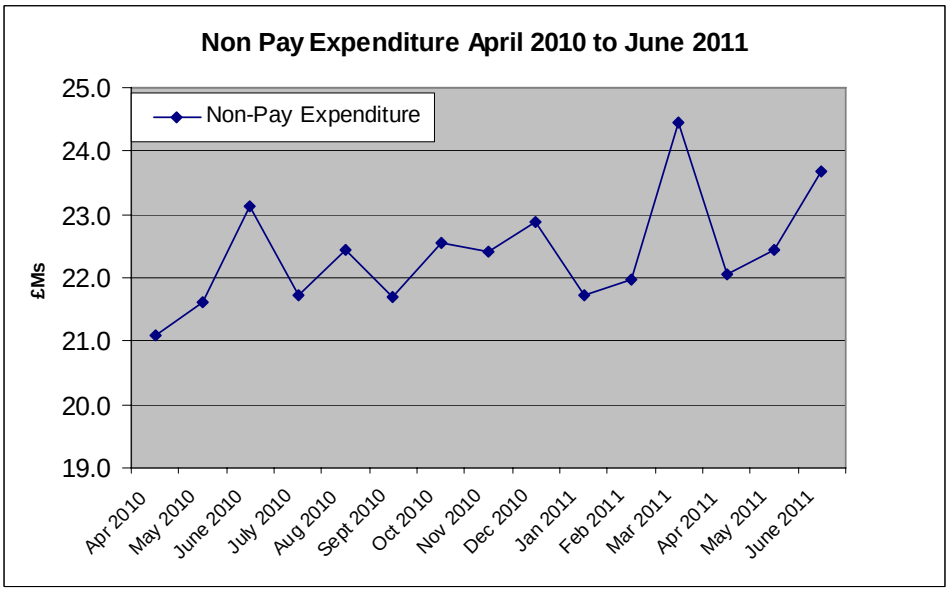
Pay Expenditure – April 2010 to date

The graph below shows the Trust's spend on pay. The trend is obvious. Our pay costs are increasing, some of which is to be expected over the busy winter months; however the expected and planned reduction in pay costs now that winter pressures are behind us has not materialised, despite a reduction in patient activity. Total pay cost is June was £1.7m higher than this time last year (4.9%) despite static patient numbers and relatively small salary increases due to the NHS pay freeze.



Non-pay expenditure – April 2010 to date

Non pay increases average c£0.8m a month over last year (representing an increase of 4% which is more in line with underlying inflation).



In summary the two graphs show the trend and the problem. Costs are increasing; CIPs are not being delivered and yet revenue is falling mostly through the national tariff but also from reduced activity.

3.2. Existing Efficiency Programmes and transformation schemes:

The Trust started the year with a CIP Plan requirement of £38m. The recent review identified that CBU / directorate savings plans have reduced to £25.6m of efficiency savings for the year ending April 2012. The following table shows the shortfall of £12.6m on existing efficiency plans attributed to each division and corporate directorate.

Due process has been undertaken to identify, test and risk assess the plans in line with the risk assessment matrix. With appropriate management action and external support, it is essential that the remaining target as identified by the divisions / directorates be delivered.

Division	CIP Target £m	Year End Forecast £m	Variance £m
Acute	13.4	7.3	(6.1)
Planned	8.7	6.1	(2.6)
Clinical Support	6.2	5.3	(0.9)
Women's & Children's	2.9	1.8	(1.1)
Corporate	3.6	3.6	0.0
Central schemes	3.4	1.5	(1.9)
Sub Total	**38.2**	**25.6**	**(12.6)**
Trust-wide stabilisation and enhanced transformation schemes (see page 7)	0.0	15.9	15.9
TOTAL	**38.2**	**41.5**	**3.3**

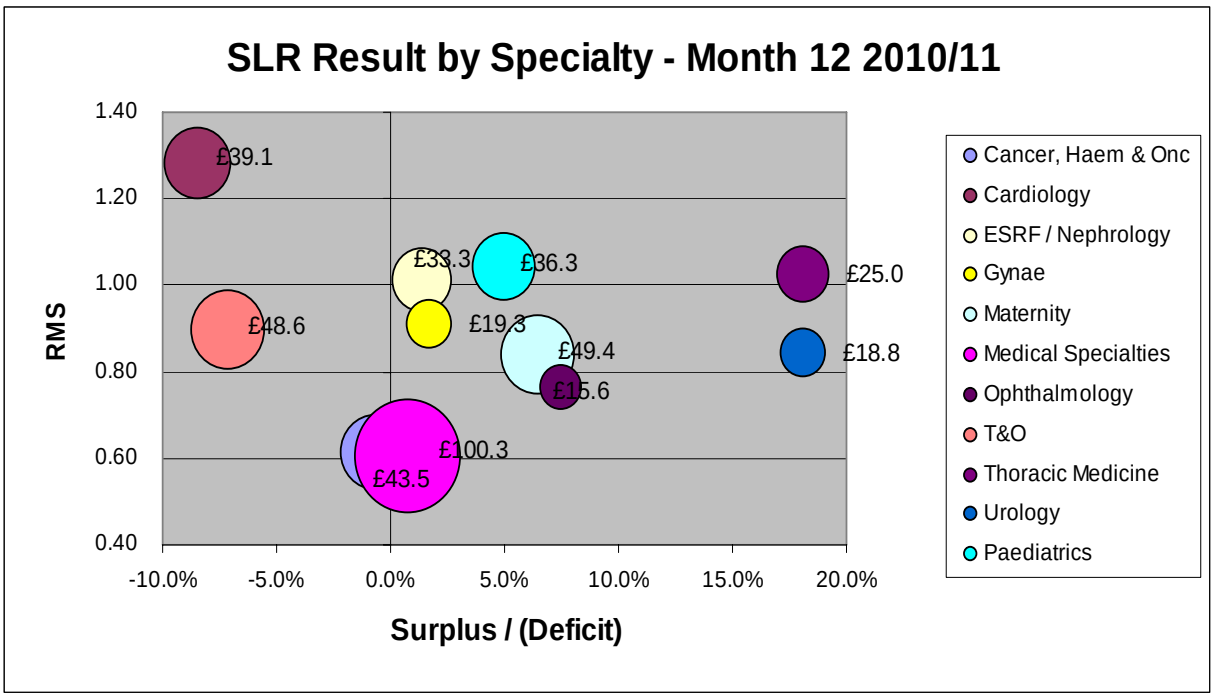
Underpinning the efficiency programme and transformational schemes, the values of which are shown above, there are a number of supporting strategies, these are listed below:

Efficiency Category	Programme	Supporting Strategies
Clinical Services VFM	Ward Manager Development Programme TPOT Medical Workforce Review AHP Review Support Function Review	Standardised planning of leave Improved rota management Reduction in agency usage Review of specialist nursing Nursing skill mix review Specialist nursing review
Clinical Services Productivity	Outpatient review Theatre transformation Diagnostic utilisation Length of Stay projects New to Follow-up reductions Coding transformation	Bed management review (new) Vacancy management processes Releasing Time to Care Enhanced Recovery Delayed discharges project TPOT (The Productive Operating Theatre) Reducing DNAs & cancellations Daycase basket project Ambulatory care pathway developments
Non-clinical staff productivity	Corporate directorate reviews A&C review	Outsourcing project FM Outsourcing IT Outsourcing
Workforce Review & Development	Performance Management Processes Succession Planning	Ward Manager programme Q Learning
Cost Control	Procurement & materials management Blood Products Medicines Management Pathology	Reduction in unit cost, waste and volume used

3.3. Service Line Reporting (SLR) Position

SLR reporting is the best means of looking at service profitability on a "full cost" basis. This is particularly key in a complex acute trust where many clinical support services are shared across front line specialties. The analysis is constantly being improved as we improve the quality of the underlying data – but the consistent message is that many of our services lose significant amounts of money.

This is highlighted in the diagram below.



The vertical line down the middle of the chart represents 'breakeven'. Any service to the left of the line loses money and any service to the right makes money. Unfortunately the results for Emergency Department and Cardiothoracic surgery are so far "to the left" in terms of losing money that they do not fit onto the chart as calibrated. Both these specialties are making losses of at least 30% of their revenue.

It is noteworthy that despite the current financial position there has been a recognisable shift of some services further to the right compared the last time the Board reviewed this. Nevertheless the key point is that still too many of our services lose money for the Trust as a whole to be in profit.

3.4. Liquidity

Cash is inevitably a concern when losses are being incurred. Cash is monitored on a daily basis and to date we have maintained monthly balances in excess of £3m (NB: the Trust consumes on average £2m per day).

An enhanced internal cash management programme has been enacted including:

- a reduction in the annual capital spend of £5m
- a communication programme with major suppliers on credit terms
- discussion with our commissioning PCT on cash phasing around SLA payments

Note that the liquidity programme highlighted as part of our Foundation Trust programme has been escalated to the SHA and we are still seeking technical solutions. Finally we have met with RBS, the Trust's cash handling bank, to apprise them of the recovery situation.

4. Stabilisation to Transformation

In the discussions that have taken place thus far between the Executive Directors and the divisional / CBUs teams it is clear that there is a reasonable understanding of the scale of the problems and possible solutions. However, the capacity to bring about the changes necessary to restore financial balance is lacking.

Recognising this, the Executive Team with Divisional Director support have developed a trust Stabilisation plan. This forms an integral part of the Trust's short and medium term financial plan and one where it is recognised that:

- Clinical quality must be protected
- It is unlikely that a traditional 'salami slicing' recovery programme would be successful
- Clinical frontline services must be prioritised over non-clinical support expenditure
- Emphasis should be placed upon making savings by reducing waste, improving productivity and enhancing value for money
- Immediate and substantial action is needed to prevent the financial deficit from increasing any further.

The resultant Stabilisation plan will work in parallel alongside the efficiency schemes included in the original 2011/12 CIP plan. Divisions and corporate directorates will continue to work on these original schemes, which include certain cross-cutting transformational schemes. Furthermore, actions identified and discussed by the Executive Team on 13th June 2011 and subsequently at the 23rd June and 12th July Trust Boards will continue – some of which are now being drawn into a centrally managed function which may be seen below.

In recognition of the scale of the challenge, The Executive Directors consider that there is insufficient internal resource to deliver the size and pace of change required. Accordingly, external resource has been commissioned as follows:

- The appointment of two interim managers with a focus on expediting efficiency gains within Glenfield Hospital and the Planned Care Division,
- Additional external support, (previously agreed by the Trust Board) is being procured under Framework arrangements to focus on 2011-12 CIP delivery with an emphasis on the Acute and Clinical Services Division. This will also support 2012-13 plans.

Additionally, a review of divisional management capacity and capability has also been undertaken and this is covered in section 4.7.

4.1. The Stabilisation Plan

We have taken both a "top-down" and "bottom-up" approach to identifying immediate actions to address the deteriorating position together with a series of central actions which will stabilise the trust position and enable the divisions to focus on transformational work. The following table provides an overview of current and enhanced areas of action being taken to achieve this.

Action	Update	Savings £
1. Enhanced pay controls 1a. Premium Payment Expenditure *(escalated)* 1b. Cessation of discretionary spend 1c.Vacancy Management Process, 'freeze' on all but essential posts. (escalated)	▪ *Authorisation levels escalated to central control for all locum medical expenditure* ▪ *Centralisation of Junior Doctor Administrator function (new)* ▪ *Introduction of Hospital at Night initiative (new)* ▪ Divisional or director level authorisation only (excludes statutory or mandatory training, and re-validation/PREPP) ▪ *Authorisation levels escalated to central management function with vacancy panel and weekly Executive Director authorisation only*	Combined savings of £4m
2. Cumulative 20% reduction in corporate directorate budgets *(new)*	▪ *20% identified through service reconfiguration and associated headcount reduction*	£1.5m
3. Corporate Accruals *(new)*	▪ *Identified through legacy education, research and training*	£5.0m
4. Medicine Transformation *(new)* Targeted at Cardiac and Medicine CBU	▪ *External support to be recruited to support stabilisation and medical CBU recovery*	£1.9m
5. Transformation projects(see 'Supporting Strategies table above)	▪ SRO appointment in place (starts 1/8/11) ▪ Additional schemes to include Hospital at Night initiative *(new)*	£1.5m TBC
6. Contract re-negotiation with key suppliers.	▪ All 2011-12 SLAs reviewed. Renegotiation on selected contracts in progress	£1.0m
7. Staff benefits / Tax and pension savings (new)	▪ Initial revision of annual plan prepared to reduce spend in 2011/12	TBC
8. Review and increase staff and public car parking charges (new)	▪ Last increases in car parking charges were 1996 / 2007 (dependent on site)	TBC
9. Bed reductions (new)	▪ Seasonal bed changes and bed management review.	£0.5m
10. E-rostering review (new)	▪ Review of working patterns and supported digital e-rostering software	£0.5m
Total	▪	**£15.9m**

4.2. Health Economy Support:

Commissioners have been strongly supportive of the Trust during this difficult phase. In the annual contracting round, commissioning PCTs committed to providing £15m of transformational funding to support the Trust in 2011/12. A recent bidding process has confirmed the schemes that this resource will be targeted at and these are outlined in the table below.

In addition to the above, the Trust and commissioners have a joint interest in improving emergency care pathways in LLR. Joint plans have been developed through the Emergency Care Network and the impact of these plans is now being realised. The intent is to allow patients to be supported in non-acute

settings – in part through the proactive intervention of acute care physicians and surgeons. For the Trust this has the effect of reducing income whilst increasing costs – and so we are seeking further support as outlined in the second part of the table below.

Other cost pressures for the Trust have come from very late changes in 18 week targets and from an increase in community discharge pressures:

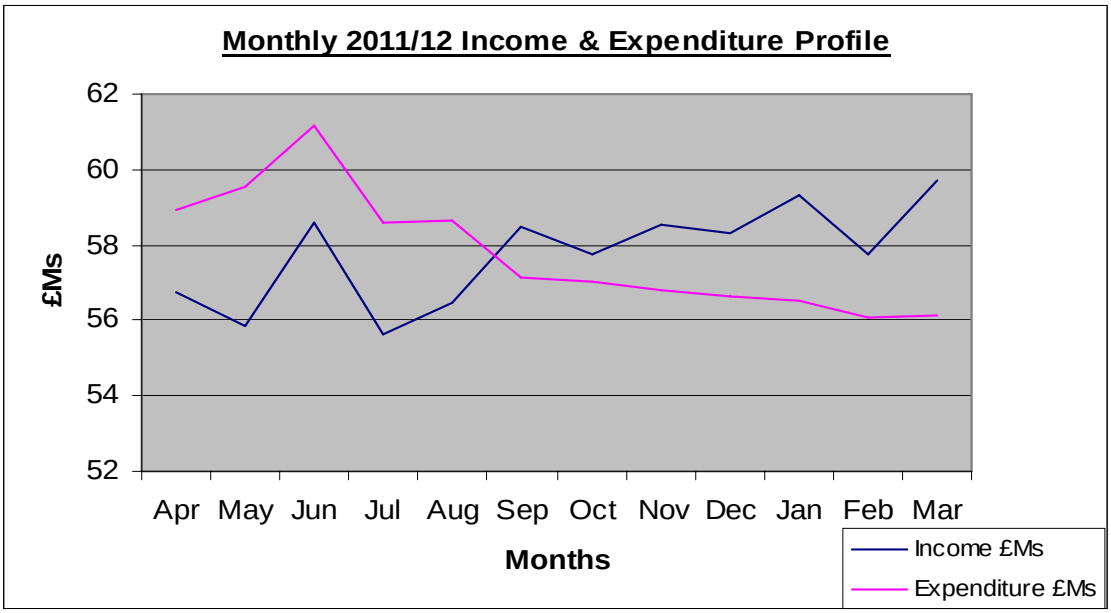
Investment	**£**
1. Service Transformation bid outcomes: ▪ Emergency Department capital ▪ Transformation of A&C services ▪ IM&T Transformation ▪ Electronic Prescribing ▪ Interface Geriatrics/Frail Older People	£15m
Cost pressures	**£**
2. Emergency Care Network expenditure	£548k – to date £1.6m FYE
3. Reduction of 26 to 23 weeks (OF April 2011)	£200k
4. Discharge delays post acute care	£1.5m
5. Expedition of improved data capture and coding	TBC

4.3. Revised forecast following recovery actions:

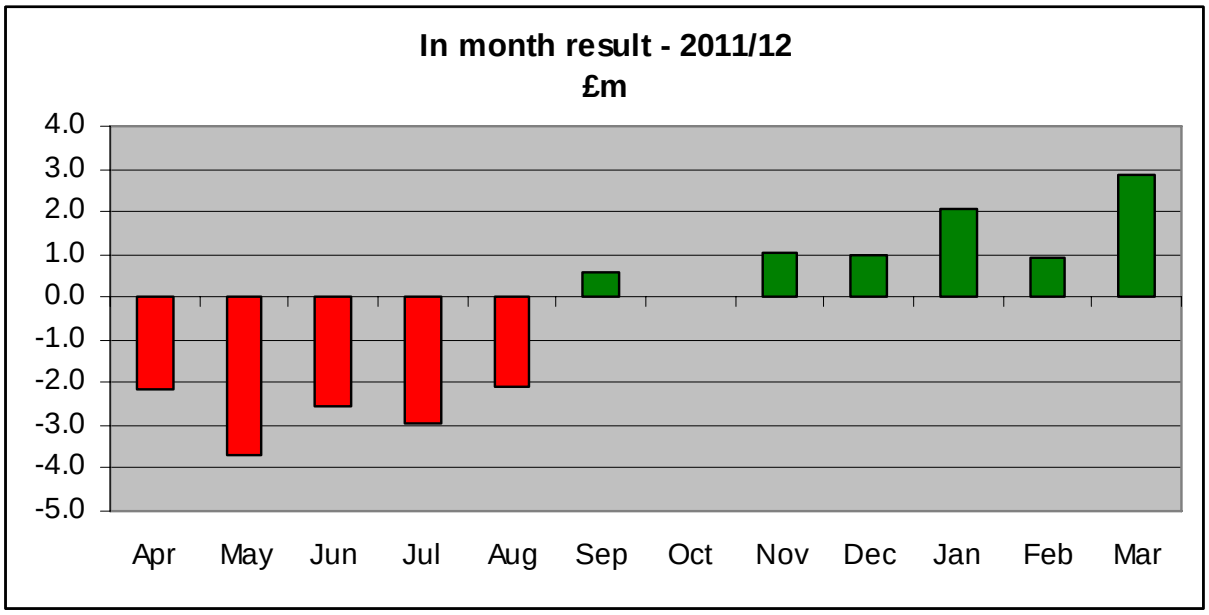
The graph below reflects the impact of the plans discussed above. From August the recovery begins and the return to 'run rate' is established in September with a steady improvement in the balance sheet until the year end. However as can be seen by the graph there remains a year end deficit of £5m, even with the interventions described in this paper.

The first graph shows our current 'run rate' i.e. our monthly profit and loss. The blue line represents income and the pink line expenditure. Year to date the expenditure has exceeded the income and hence the deficit of £8m. The graph then shows the impact of the stabilisation proposals, with the Trust returning to a positive run rate in September.

I&E profile – April 2011 to date



The result by month may be summarised:



4.4. Workforce

There are real opportunities to improve value for money aspects across the divisions whilst at the same time addressing the quality issues that the current inefficient and duplicative processes have for both our patients and the Trust itself.

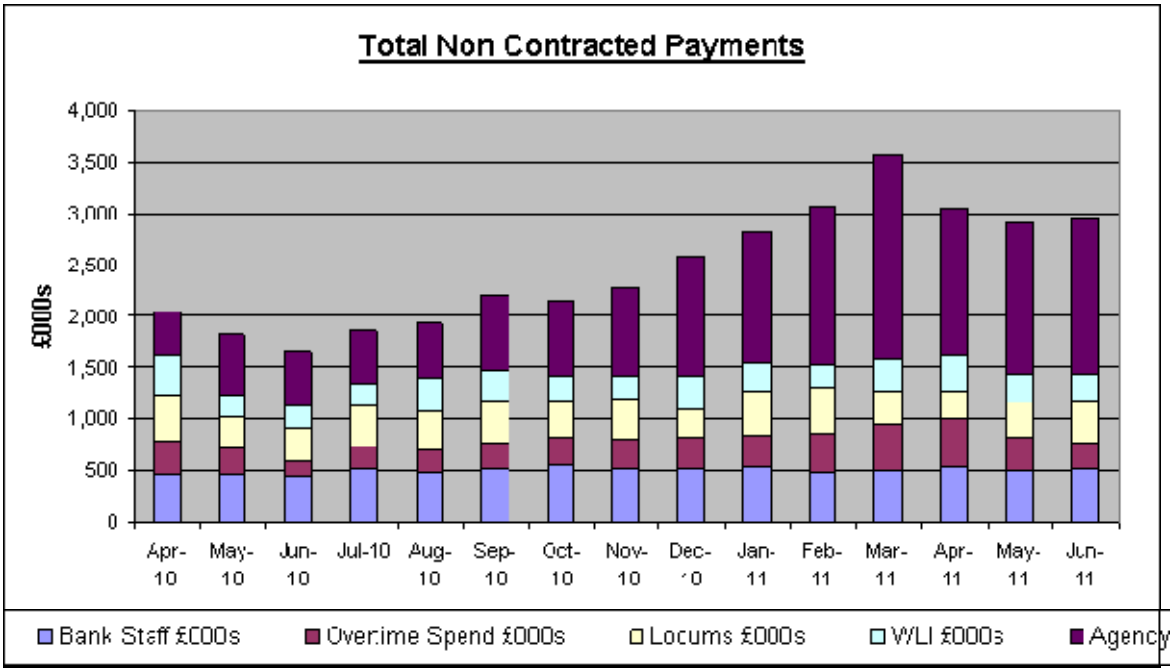
Transformation and efficiency schemes will both realise operational and workforce change together with the need to reduce service expenditure in corporate directorates. In doing so however, workforce profiles and headcount reduction or re-distribution is likely to culminate as a result of:

- Performance management processes
- Skill mix review
- Banding review
- Voluntary Severance Scheme – see below
- Vacancy management processes
- Flexible labour reductions

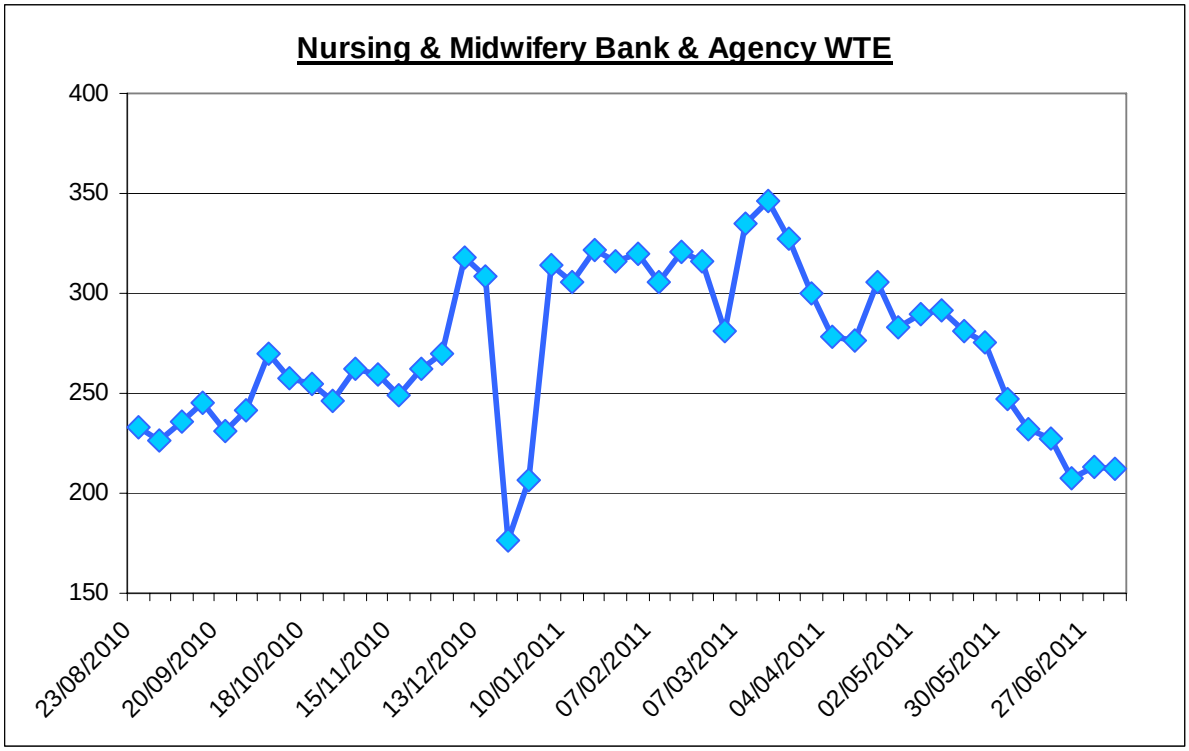
In addition to the already identified efficiency savings of 417WTE (April 2011) as described in previous reports – largely achieved through natural turnover and the movement of staff from permanent posts to posts currently filled by individuals on fixed term contracts, further work has been undertaken within the corporate directorates to identify additional areas of efficiencies in line with the cumulative 20% reduction in costs.

4.5. Premium payment spend (medical staff)

The graph below shows the profile of premium payments spend. Clearly the trend shows increased expenditure, with April and May 2011 being £1m up on the same period in 2010. In order to stem the concerning increase in premium medical expenditure, divisions have reviewed and introduced more robust processes for locum authorisation and booking in line with corporate functions.



Nursing & Midwifery Bank & Agency August 2010 to date



4.6. Vacancy controls:

Each month, 60–70 members of staff leave the trust. Up to the end of May, CBUs reviewed each vacancy. From that point, control was escalated to Divisional level and from 18 July controls have been further escalated to a central vacancy panel – a control that the Trust deployed for much of 2010/11. The panel, which includes the director of nursing, ensures that we are appointing only to essential clinical posts. Final sign off is now at executive director level.

We monitor the number of starters and leavers by month and will provide this data on a monthly basis to illustrate reduction in the recruitment of individuals who are external to UHL.

4.7. Performance Management

In some areas there are individuals who for a number of reasons are in discussions about continuing in their current role. These discussions may centre on performance or career development. There are a number of different outcomes for individuals in this group including moves to alternative roles in the Trust, resignation, action on the grounds of performance or use of the voluntary severance scheme.

4.8. Voluntary Severance Scheme

In order to respond to the necessary reduction in workforce described earlier, the Trust is considering implementing a Voluntary Severance Scheme, where business continuity allows, which creates the facility for individuals to leave their role, for a range of personal reasons. Such schemes have proved to be popular in other NHS Trusts and would follow the due process set out below:

1.	Scheme agreed internally including ratified by the Trust Board at the August meeting	August 2011
2.	SHA ratification and Treasury approval	August 2011
3.	Communication through Trust via Team Brief and Staff Forums	August 2011
4.	Letters to go to individuals	Early September 2011
5.	Expressions of interest received	30th September 2011
6.	Decision to release individuals commence	October 2011

5. Managing the Change – Governance Arrangements

5.1. Risk Assessment of Actions

In line with previous reports, all proposals will be risk assessed using standardised project documentation to ensure any impact on patient experience, safety or quality of care is identified and mitigated. Importantly, key areas covered will include:

- Certainty of delivery
- Impact on service levels
- Impact on clinical care
- Impact on staff

5.2. Maintaining and improving Quality

On most of the current measures of quality we are improving despite the financial problems. So, infections continue to decline, waiting lists are under control, patient experience is improving as is ED performance and overall, our Hospital Standardised Mortality Rate (HSMR= the likelihood of death in a hospital) is in the top 25% of Trusts nationally. We should all be justifiably proud of this.

The concern is that as we tackle the finance issues we will lose sight of quality. We hear this from staff, stakeholders and our own board. In fact there have been well publicised examples in other parts of the country of what can happen when a Trust focuses on money to the detriment of all else.

We are not going to let this happen in Leicester. We will risk and quality-assess every decision we make to ensure that we are striking the right balance between looking after our patients and looking after the finances. For example when we say that we will freeze all but essential recruitment this will mean that it is highly unlikely that we will be recruiting over the next 6 months to jobs which are not predominantly patient facing. However, we will still be recruiting to, for example, midwife posts.

As we go through this necessarily difficult period to bring the Trust back into balance we will continue to scan the quality radar for anything which indicates that the suite of actions described above is having a detrimental effect on patients. An illustrative but not exhaustive list of indicators are:

1. complaints
2. monthly patient polling
3. staff polling
4. HSMR
5. infections
6. Serious untoward incidents

5.3. Engagement:

We will be as open and transparent as possible with staff and external stakeholders during this process, even when we know the message will be unpopular. A full communication plan has been developed in support of this recovery plan using current and special dedicated sessions with our staff and stakeholders.

These are the current mechanisms for engaging staff.

- Team Talk: monthly briefing to clinical, nurse and general managers for onward discussion with their teams.
- Trust Talk: 6 weekly staff magazine
- INsite: staff intranet and news updated daily
- All staff e-mails
- SMS messages to UHL mobiles
- Desk top messages: updated twice daily
- Ask the Boss: discussion forum for staff to post questions to senior clinical and general managers.
- Chief Executive breakfasts: monthly hour with staff to meet and discuss topics with Malcolm
- Executive walkabouts

We have in preparation for discussing the recovery plan at the public board taken steps to ensure that all our stakeholders are sighted to the proposals.

5.4. Medical staff engagement

The Medical Director and Divisional Directors have been extremely encouraged by the strong commitment of the medical staff to help resolve the current situation for the benefit of UHL's' patients.

Two extraordinary well attended meetings of the consultant body led by the Medical Director and Divisional Directors have taken place in which the consultant body was fully apprised of the financial position. There have been a number of significant contributions from both individuals at the meetings and by email correspondence from those unable to attend. There as also been helpful input from Junior Doctors about immediate measure which could help reduce cost at a ward level.

Specific actions being taken forward include but are not limited to:

- Increased consultant input to coding in order to ensure accurate information is available on which to base financial decisions.
- Increased oversight by consultants of the need for medical locums. This would go hand in hand with strengthening of the consultant-led team to ensure locums only recruited when there was a clear need to do so and any locum was appropriately equipped to provide value to the patient pathway.
- A number of additional consultants have been identified to contribute to defining appropriate models of care to support the current work streams around readmissions, theatre productivity and outpatient pathways. Additional work will also focus on LRI theatre recovery; LRI access to emergency theatre; Access to imaging / pathology to ensure the optimum patient flow and length of stay.

Other initiatives to support and encourage enhanced engagement have also been put in place, including:

1. Establishing a CBU leads meeting
2. Increasing attendance by executive directors to consultants' existing specialty meetings.
3. Establishing a junior doctors' forum.
4. An "ideas" button to allow submission of suggestions to a clinical forum to be reviewed weekly by the Divisional Directors. There have been many constructive posts already.
5. Establishing a UHL locum doctor bank.

Future Meetings of the consultant body will be held at least monthly in the evenings, rotating sites and meeting on different days of the week to allow as many as possible to attend. Topics will include a regular financial update, contracting, plans about site reconfiguration, progress on reducing readmissions, theatres productivity and administrative efficiency.

5.5. Transformation Schemes

For transformation schemes, each project has a lead manager, with an individual named senior manager or corporate director accountable for each project. Supporting the project delivery will be a Transformation Board attended by Executive Directors to provide assurance of the governance arrangements underpinning the agreed transformation projects.

5.6. Divisional Metrics and Assurance

Further to the introduction of divisional metrics, weekly meetings are held to enable individual feedback against a range of metrics and RAG rated targets. Further assurance will be provided through the CBU and Divisional Confirm & Challenge meetings

5.7. Stabilisation Plan

It is proposed that assurance against the above plan will be provided to the executive at the weekly formal executive meeting and to the board via the monthly Finance & Performance Committee. The board may wish to consider whether these controls and assurances are sufficient.

5.8. Impact on the Foundation Trust trajectory

The implications of the Trust's financial position and recovery plan will clearly have an affect on the FT trajectory; through the Board this will be discussed with the EM SHA.

6. Summary

The plans outlined above, supported by our commissioners, the leadership of our clinicians and the dedication of our staff will create a sustainable future for Leicester's hospitals. The actions will be difficult at times but will be pursued with vigour by the Executive team and we recommend the plan to the Board.

Suzanne Hinchliffe

Andrew Seddon

19th July 2011