To:	**Trust Board**
From:	**Simon Sheppard - Acting Director of Finance & Procurement**
Date:	**25th September 2014**
CQC regulation:	
Title:	**Draft 2015/16 and 2016/17 Integrated Business Planning Guidance**

Author/Responsible Director:
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Purpose of the report:
This paper details business planning guidance for CMGs and Corporate Directorates to prepare Integrated Business Plans which addresses:

- Activity forecasting
- Capacity planning
- Income and expenditure budget setting
- Cost improvement programme (CIP)
- Workforce
- Capital expenditure planning

The report is provided to the Trust Board for:

Decision		Discussion	X
Assurance		Endorsement	X

Summary/Key points:

- CMGs are expected to submit one comprehensive business plan aggregated from service level business plans.
- Business plans will align with overall strategic aims and direction of the five year IBP and BCT directional plan through the use of key parameters during planning.
- The business planning process is split into 4 stages; stages 1 and 2 refer to first and second cut plans at CMG and Corporate Directorate level before the end of December.
- Activity and capacity plans will build on existing funded capacity, include the impact of various planning considerations and inform workforce planning and budget setting.
- The starting point for expenditure budgeting will be 2014/15 recurrent budgets.
- CIP plans will be developed in line within the already established CIP deadlines and targets.
- Capital planning will be managed through the Capital Monitoring and Investment Committee

Recommendations:
The Trust Board is **recommended** to:

- **Note** the contents of this guidance
- **Approve** the timescales and management responsibility for overseeing the plan development
- **Approve** arrangements for CMG Executive Dialogue meetings to be organised

Previously considered at another corporate UHL Committee? Not applicable	
Board Assurance Framework: Support delivery of controls within the BAF	**Performance KPIs year to date:** Not applicable
Resource implications (e.g. Financial, HR): None	
Assurance implications: Considered but not relevant to this paper	
Patient and Public Involvement (PPI) implications: Considered but not relevant to this paper	
Stakeholder Engagement implications: Considered but not relevant to this paper	
Equality impact: Considered but not relevant to this paper	
Information exempt from disclosure: Considered but not relevant to this paper	
Requirement for further review? None	

University Hospitals of Leicester NHS
NHS Trust

Integrated Business Planning Guidance 2015/16 and 2016/17

Final draft 12-09-14

Contents

1. Introduction

1.1. This paper sets out guidance for the development of the Trust's Integrated Business Plan (IBP) for 2015/16 and 2016/17. The proposed content of the business plan is consistent with the advice on the preparation of annual plans prepared by the National Trust Development Authority (NTDA) and Monitor.

1.2. This guidance sets out the basis of planning, the context behind within which it is set, the key outputs that will be required, and the process by which it will be produced.

1.3. The overall purpose of the business planning process is to integrate and align all dimensions of the strategic business planning which outlines the future vision and objectives and incorporates the achievement of targets and service improvements to achieve them. The core components of business planning include:

- Activity forecasting
- Capacity planning
- Income and expenditure budget setting
- Cost improvement programme (CIP)
- Workforce
- Capital expenditure planning

1.4. Whilst CMGs are expected to submit one comprehensive business plan this will be aggregated from service level business plans. As in previous years the agreed CMG business plans will provide the basis for monitoring progress of plans throughout 2015/16 via performance reviews.

1.5. The expectation is that CMGs will provide a two year business plan, which aligns with the overall strategic aims and direction of the five year IBP. For the purposes of this year's planning round, year one (15/16) will be built up by CMGs as described in section 6 onwards. It is anticipated that year two (16/17) will be based on the 15/16 outputs with high level assumptions applied, and then revised in the subsequent planning round.

2. Basis of planning

2.1. The Business Planning process needs to deliver an overall IBP for the Trust which is in part built up from – and is fully consistent with – the separate plans of individual services, CMGs and corporate directorates; the process will have both 'top-down' and 'bottom-up' elements.

2.2. The basic unit for the development of full business plans will be at service line level, see Appendix 1 **– service lines** for the list of 49 service lines. This means that individual service lines and directorates will develop business plans which feed into CMG plans. Clinical engagement is an essential part of the development of plans which will be achieved through the 'bottom-up' approach and CMGs must be able to demonstrate consideration to quality and patient experience.

2.3. CMG Clinical Directors and Corporate Directors will be expected to sign-off service and directorate plans and will be required to demonstrate that, in aggregate, the plans will deliver on the CMG and corporate directorate saving targets and meet the targets set in the performance framework.

2.4. It is essential that all business plans align with the Trust's vision and objectives (available on the Trust Intranet) and also acknowledge the external environment which may influence service development.

2.5. Where relevant business plans should be informed by key stakeholders e.g. patients, public and staff, and be demonstrable.

3. National context

3.1. It can be anticipated that the priority areas set out in guidance for 2014/15 will continue to be priorities in 2015/16 and the Trust will need to assure itself through the business planning process that realistic plans are in place to ensure delivery against these targets.

3.2. Clearly there are many standards that must be met. The following are considered the absolute "must do's":
- 4-hour Accident and Emergency standard
- MRSA and C. Difficile rates
- All cancer standards
- All 18-weeks standards
- All financial standards

3.3. Delivery of financial standards includes the national efficiency requirements of NHS Trusts. Current guidance suggests 4.5% requirement for 2015/16 and 4% per annum thereafter.

3.4. Key policies that will inform business planning are as follows:
- PbR guidance
- NHS Operating Framework
- Specialist commissioning Intentions
- NICE guidance
- Royal College Recommendations
- Quality standards relating to safe staffing models and seven day service provision

4. Local context

4.1. The local health economy has all signed up to delivery of the a system plan, Better Care Together (BCT). The strategic aims and objectives of BCT are as follows:
- High quality care – right place, right time, less time in hospital
- Reduced inequalities in care, leading to longer life
- More positive experience of care
- Integration and use of assets to reduce duplication and eliminate waste
- Financial sustainability for all health and social care organisations
- Better use of workforce, new capacity and capabilities in people and technology

4.2. In delivering the strategic aims of BCT the plan seeks to address the projected financial deficit of £398m by March 2019 if nothing is done.

4.3. In line with the BCT strategy the Trust developed and submitted its 5 year plan in June 2014 which seeks to ensure that the vision of "smaller more specialised hospitals" becomes a reality, and that the on-going issues with emergency and urgent care are solved and that the Trust returns to financial balance.

4.4. Becoming ***smaller***:

4.4.1. As a consequence of the shift to community settings with fewer patients, the Trust intends to consolidate acute services onto a smaller footprint and to grow its specialised, teaching and research portfolio; only providing in hospital the acute care that cannot be provided in the community.

4.4.2. In doing this the Trust expects to significantly increase the efficiency, quality and, ultimately, the sustainability of key services; shrink the size of the required estate; significantly rebalance bed capacity between acute and community settings, and thus reduce total costs.

4.5. Becoming more ***specialised***:

4.5.1. Further, the Trust's assessment is that the specialised portfolio is where the greatest opportunities for growth lie. There are a number of drivers that support the belief in this opportunity and these include:

- Significant evidence that smaller, district general hospitals will be unable to achieve the standards required by regional and national designation
- Advancements in technology and practice that are increasing the opportunities to offer specialised care and intervention to children and adults who would historically not have survived their illnesses e.g. long term ventilation in children
- The Trust's strong research credentials underpinning many of its specialised services

4.6. The combined effect of these material changes to the provision of services and their underpinning business models is expected to return the Trust to a breakeven position from 2019/20.

4.7. These aims must remain at the heart of each business plan and are wholly consistent and supported by the CIP and Better Care Together (BCT) agenda.

4.8. It is therefore important that CMGs and Corporate Directorates conduct their planning within the parameters of the Trust 5 year plan and the BCT 5 year plan. The parameters are based on delivering model of care transformation. The assumptions plans need to reflect include the following which are all in line with national benchmarks:

- Elimination of ambulatory care sensitive admissions and increased triage
- Inpatient to day case conversion
- Elimination of excess bed days of patients staying over 6 nights, in part through new sub acute pathways
- Reducing the delayed transfer of care (DTOC) rate to 2%

4.9. Appendix 2 **– bed capacity reduction** shows how these assumptions were applied to CMGs and therefore demonstrates the parameters within which CMG bed capacity planning needs to be completed.

4.10. The 5 year plan locally focused on detailed quantified improvements to bed capacity whilst making reference to savings delivered by other capacity improvements addressed by cross cutting CIP work streams, like theatres, outpatient and diagnostics productivity. So, whilst there are no specific parameters or targets for these capacity reductions they are expected to feature heavily in CMG plans to reduce capacity and deliver savings.

5. Business plan content

5.1. By the 31st March 2015 the Trust is required to submit a comprehensive two year business plan to the NTDA that reflects the delivery of its objectives within the agreed resources framework. The core outputs from the business plan are therefore as follows:

- A CMG overarching strategic plan (built from service level plans) that delivers the Trust objectives, targets and the business plan delivery risk
- An agreed activity and capacity plan
- A workforce plan reflecting agreed establishments and job plans
- A quality assessed CIP plan in support of the required Trust target for efficiency savings
- An income and expenditure plan with supporting agreed budgets
- A capital programme with planned expenditure clearly identified against the capital resource limit and external financing requirements

5.2. Templates to support the provision of the above will be provided to ensure consistency across all areas.

6. Planning process

6.1. It is anticipated that national guidance will be issued before Christmas 2014 setting out priorities for the NHS. It is reasonable to expect the NTDA to require submission of two year plans with an increasing level of detail starting in January 2015 through to the end of March/early April 2015.

6.2. The proposed timetable for development of service line business plans is shown in Appendix 3 **– planning deadlines** and primarily outlines the deadlines for the key component outputs. This may need to be revised once NTDA guidance has been published. However the entire process is to be completed by 10th March 2015 in order for the Trust's annual plan to be signed off at the Executive Strategy Board, Finance and Performance Committee and ultimately Trust Board during March.

6.3. To support completion of the overall business planning process there will be a series of workshops, master classes, distribution of useful documents and guidance updates. Separate communications have already gone out providing more detail on the overall Strategic Planning Framework. This included specific guidance for developing strategic plans informed by market assessments, SWOT, external horizon scanning, patient and public involvement etc.

6.4. A key principle of the overall process is to ensure CMGs and corporate directorates engage their teams and are supported to develop 'bottom up' plans which are owned. The Strategy team along with Finance, HR and Informatics play a key role in working with the teams to produce the required outputs in a joined up and aligned way.

7. Contracting process

7.1. Through contract negotiations the Trust will seek to reach agreement with CCGs on the level of activity required to meet anticipated demand and to achieve national performance targets. This will be based on stages 1 and 2 of internal activity and capacity planning, described further in section 8.

7.2. Agreement with commissioners will include an assessment of the impact of Better Care Together work streams, QIPP initiatives, counting and coding change proposals and other service development proposals in CCG commissioning plans.

7.3. In addition, agreement with commissioners will also include a formal review of investments relating to the marginal rate for emergencies threshold (MRET) and readmissions.

7.4. For tariff services included in the Payment by Results (PbR) regime - and other services outside PbR but funded at local prices on a cost-per-case or cost and volume basis – the Trust expects to be paid for the level of work that it actually undertakes.

7.5. The process for capturing counting and coding proposals for 2015/16 began in July. CMG General Managers were issued standard templates to capture proposals for counting and coding and small scale service developments. Throughout July to September, the Contracts team and Finance worked in collaboration with CMG stakeholders, Business Intelligence Analysts and CMG Finance leads to complete proposals. Once fully completed, the suite of proposals will be circulated to the Cross Cutting Themes – PbR Workgroup for sign-off.

7.6. Proposals will be shared with Commissioners at the end of September, which follows the notice provisions within the contract. In terms of ideas generation, the Trust has networked with a number of providers both in and out of region to identify potential opportunities.

7.7. Ultimately, it will be for the Trust to take a view on the levels of activity to use as the basis for setting the business plan for the coming year and in some cases this may result in a disparity between CCG commissioning intentions and the level of activity anticipated in Trust plans.

7.8. The 2015/16 contract negotiations will involve clinician to clinician discussions to determine the activity levels to be commissioned. In addition, the negotiation strategy will also include representation from CMG General Managers and clinicians (as appropriate) to explain the benefit of the small scale service developments.

8. Activity & capacity planning

8.1. The contracted activity levels for 2015/16 are timetabled to be agreed with commissioners by the end of February 2015. To support the contract negotiation process and the Trust business plan, CMGs are required to submit indicative activity and capacity plans based on month 5 forecast outturn.

8.2. In assessing the likely levels of activity to be delivered in 2015/16 CMGs need to ensure that activity plans meet national targets and are delivered in the most cost efficient way and within available capacity (and/or seek to reduce capacity where not required)

8.3. Further consideration must be given to the Better Care Together targets that have been agreed at a high level with the Trust five year IBP and focus on reduction of activity within the Trust (LOS/Readmissions etc.). Details of CMG specific impacts have been circulated by Helen Seth 4th September and plans for 15/16 must reflect these.

8.4. As mentioned in section one, 15/16 plans should be at service level and have a granularity of detail. 16/17 plans should be based on 15/16 proposals with high level assumptions applied to provide a two year forecast.

8.5. <u>Activity</u>

8.5.1. The activity and capacity plans will be developed in conjunction with the service managers, business intelligence and finance teams and will include the following information sources:

- 2013/14 actual activity outturn
- 2014/15 UHL planned activity level
- 2014/15 forecast outturn activity (based on month 5 actual)
- July 2013 to August 2014 12 month activity trend

8.5.2. Using the above information sources as a baseline CMGs will then be asked to make 2 year activity projections with changes driven by the following:

- Demographic growth assumptions as per BCT financial modelling assumptions
- RTT backlog
- FYE of 2014/15 developments
- New developments
- Other activity movements
- QIPP and BCT work stream impact
- CIP and internal model of care change assumptions

8.5.3. There will be exclusions from CMG projections during stage 1:

- Excluded drug and device adjustments
- Counting and coding changes
- 2014/15 prices will be used with pricing changes applied centrally
- 2016/17 activity projections

8.6. <u>Capacity</u>

8.6.1. In order to build a robust capacity plan for 2015/16 the initial stage of capacity planning will be 2014/15 recurrently funded capacity for comparison to activity forecast outturn.

8.6.2. 2015/16 capacity plans will then be developed to include:
- Inpatient capacity (beds)
- Theatre capacity
- Outpatient capacity
- Critical care capacity
- Consultant PA capacity

8.6.3. CMGs are required to indicate the capacity required to deliver the indicative activity plans identified in the business planning activity templates and do so considering the same categories:
- Demographic growth assumptions as per BCT financial modelling assumptions
- RTT backlog
- FYE of 2014/15 developments
- New developments
- Other activity movements
- QIPP and BCT work stream impact
- CIP and internal model of care change assumptions

8.7. Activity and capacity planning process

8.7.1. The planning process has 4 clear stages, and this applies to clearly to activity and capacity planning. Throughout these stages services should be aware of the funding constraints the Trust and local health care economy is operating within.

8.7.2. The 4 stages outlined below are designed to help focus on consistent content and timelines for each stage and allow for a reasonable period in which iterations can be made and also ensure accurate version control.

8.7.3. **Stage 1** – Plans demonstrating large scale activity increases unlikely to be supported by commissioners and growth in capacity which it requires will be challenged at the end of stage 1 when CMGs / Directorates will be required to present the proposed plans to the executive team.

8.7.4. The aim at **Stage 2** is to refine the first draft to formulate final activity and capacity plans to ensure that all impacts of them are captured in expenditure budget setting whilst also including projections for 2016/17.

8.7.5. Stage 3 will finalise the core activity and capacity plans through applying amendments for issues that cannot be reflected until this stage. These include excluded drug and device adjustments, counting and coding changes and the final tariff prices.

8.7.6. At the end of the process **Stage 4** is focused on formal sign off and submission of the plan.

9. Workforce

9.1. The workforce planning challenge for the short to medium term is to connect and integrate workforce plans at the service level with Trust workforce plans.

9.2. Workforce plans must be responsive to the complex nature of the organisation and to the level of planning required to deliver the plurality of service provision. The aim is for CMG workforce plans:
- To be reviewed and updated annually as part of the business planning process.
- To be aligned to, and reflective of activity, capacity, and budget, while producing workforce costs as a percentage of income within the band 57% - 60% NB Exact level to be agreed on a specialty basis and will include a workforce overhead cost.

- To move away from short term planning and towards medium and longer term strategic planning, informing the commissioning of education and training programmes.
- To reflect national requirements such as safe staffing models and seven day service provision standards.
- To reflect physical reconfiguration plans and efficiency gains to be made from co-location of services and interim enabling plans.

9.3. Workforce plans should start with recurrently funded establishment. Workforce Plans for 2015/16 must reflect, pay cost reduction plans (workforce CIPs by WTE and cost), future changes in service delivery and workforce developments. Plans must also link to QIPP, capacity planning, reconfiguration, plans for the implementation of seven day service provision standards and transformation plans. In accordance with the budget setting process, plans must, therefore, be underpinned by the following process:

9.3.1. Baseline of current FTE and recurrently funded establishment.

9.3.2. Resubmission of non recurrent establishment to the Revenue Investment Committee.

9.3.3. 2014/15 workforce CIPs must be fully achieved, or rolled forward if not. This will be automatically applied through the use of recurrent budgets.

9.3.4. Workforce plans associated with service developments such as strategic alliances. and income growth schemes must be fully approved by the Revenue Investment Committee.

9.3.5. Cost pressures identified through the 'double running of workforce' to allow reconfiguration plans to take effect or new roles to be developed and educated must be approved by the Revenue Investment Committee and funding sought from other stakeholders such as Health Education East Midlands.

9.4. Workforce plans should also consider the development of new/substitute roles to support the QIPP and transformation agendas and the impact of longer term service developments on workforce.

9.5. Service delivery plans should be developed with the explicit aim of maximising productivity of both facilities and workforce, including:
- Different models of work which fully utilise the ability for staff to work between 6.00am and 7.00pm at plain time while balancing the requirements of seven day service provision
- Scheduling elective activity across the year and matching workforce capacity accordingly, in preparation for expected peaks in emergency activity during winter.
- Transparency of the linkage between activity and consultant PAs.

9.6. Workforce plans must be explicit in the amount of workforce resource utilised for the delivery of undergraduate/postgraduate medical education and for research, in terms of FTE and cost/income.

9.7. On completion, service workforce plans will be subject to a 'confirm and challenge' process as part of the budget review process.

9.8. Previously year two of the operational workforce plan has been a top down process based on planning assumptions relating to forecasted changes in activity and cost improvement assumptions. These reductions have then been split across the current profile of occupational groups. In order to introduce a more bottom up approach for future planning and education commissioning, CMGs will be required to submit indicative plans in respect of any skill mix or occupational group shifts in year two of the operational plan.

10. Cost improvement plan

10.1. The following summarises how targets were set and the timescales for CMGs to identify and plan their 2015/16 programme. CMG planning will be focused on 2015/16 with assumptions from within the 5 year LTFM and BCT strategy used to inform 2016/17 plans to prevent the need for 2 year detailed plans to be produced at this stage.

10.2. The Trust annual cost reduction requirement is constituted of two elements:-
- The national efficiency requirement and subsequent reduction to prices through the national tariff.
- Internal Trust requirements to reduce costs to support local cost pressures and reduce the underlying deficit.

10.3. The initial start-point for the setting of the 2015/16 is therefore £33.8m to ensure the current guidance for 4.5% tariff efficiency is covered. This may need to vary once the 2015/16 tariff is released and the national efficiency requirement is confirmed.

10.4. The current 5 year LTFM does not assume any CIP delivery over and above the national efficiency requirement. However, implicit in this assumption are the following:-
- The LTFM is accepted by the TDA as an aggressive enough plan in reaching financial balance.
- That there are no other income reductions other than tariff.
- 2015/16 inflation requirements and cost pressures can be managed within any national tariff allocations for these areas.
- Investment in services is cost neutral – i.e. there is an income flow that offsets expenditure for any transitional costs or service change costs.
- That actual outturn is recurrently delivered to plan in 2014/15 – i.e. a deficit of £40.7m without any non recurrent funding streams to support delivery.

10.5. On the basis of the above, it is prudent to deliver more than the minimum national requirement. It is proposed that a further 1.0% is delivered making the target £41.0m. This is detailed below.

	%age	£m
National Efficiency requirement	4.5%	33.8
Loss of education and training transition funding	0.2%	1.3
Local requirement	0.8%	6.0
Total	**5.5%**	**41.0**

10.6. The target for CMG/Directorate's has been set based on:
- R&D to receive a £250k target
- Each CMG and Directorate to be allocated a CIP of 5.5% of expenditure net of non controllable costs.
- A reduction of 1% to the CIP allocation will be given to CMGs with a positive PLICS position. A 1% increase to the CIP allocation for each 5% negative PLICS margin, i.e. 1% increase for -4%, 2% increase for -7%
- Any remaining balance to get to £41m will be allocated over CMGs and directorates on a proportionate basis.

10.7. The areas of expenditure excluded from the CIP target includes NICE drugs for which costs are passed through to commissioners and fixed contracts such as Interserve. In total exclusions represent £160m, which is 21% of the total expenditure budget.

10.8. The targets for each CMG/Directorate were discussed at the EPB on the 26th August along with the excluded items. The targets shown in the table below were circulated on Monday 1st September:

Area	CMG	Total CIP target	CIP Percentage of adjusted spend
		£m	
CMG	CHUGGS	5.53	8.65%
CMG	CSI	4.87	7.36%
CMG	ESM	7.17	7.50%
CMG	ITAPS	4.12	5.99%
CMG	MSS	4.87	7.50%
CMG	RRC	6.58	7.50%
CMG	W&C	4.75	5.19%
Grand Total		**37.89**	**7.03%**
Corporate	Communications & Ext Relations	0.05	6.35%
Corporate	Corporate & Legal	0.07	6.35%
Corporate	Corporate Medical	0.27	6.35%
Corporate	Facilities	0.53	6.35%
Corporate	Finance & Procurement	0.30	6.35%
Corporate	Human Resources	0.43	6.35%
Corporate	Im&T	0.19	6.35%
Corporate	Nursing	0.49	6.35%
Corporate	Operations	0.34	6.35%
Corporate	Strategic Devt	0.19	6.35%
Corporate Total		**2.86**	**6.35%**
Research and Development		**0.25**	
Total		**41.00**	**7.02%**

10.9. The timescales for developing the 2015/16 programme is as follows:

- CMG idea generation/CIP master class sessions 01/09/14-19/09/14
- High Level Divisional Plans to CIP Board 22/09/14
- CMG confirmation of cross cutting enabling actions 03/10/14
- Green / Amber plans in place for 30% of target (£12.3m) 13/10/14
- Green / Amber plans in place for 40% of target (£16.4m) 31/10/14
- Green / Amber plans in place for 60% of target (£24.6m) 30/11/14
- Green/Amber plans in place for 80% of target (£32.8m) 31/12/14
- Green / Amber Plans in place for £41m (PYE) 31/01/15
- Green plans in place for £41m (PYE) 30/03/15

11. Revenue budget setting

11.1. Budget Setting Principles

11.1.1. Following the detailed budgeting exercise for 2014/15 for pay and non-pay **the starting point for expenditure budgeting will be 2014/15 recurrent budgets**. The process from the start point will therefore include:

- Baseline of 2014/15 recurrent budget
- Non-recurrent items in 2014/15 will need to be re-submitted if relevant for inclusion.
- Adjustments for full year effects (FYE) for income, pay, non-pay and CIPs 2014/15 (i.e. schemes delivering across financial periods), where not already transacted.
- The 2014/15 CIP target must be met in full recurrently before identification of 2015/16 CIPs. Non recurrent delivery in 2014/15 will not be bought out through planning.
- Inclusion of agreed service development business cases agreed by the Revenue Investment Committee and Capital Monitoring and Investment Committee.
- Adjustments for increases/decreases in activity in year and for the next year, and at which level this change will be funded / cost reduction required:

- Expenditure budget needed to support 14/15 income outturn.
- Expenditure budget needed to support 15/16 proposed activity and income plan (excluding excluded drugs and devices).
- All expenditure to support the activity plan for 2015/16 and 2016/17.

- Specific contract inflation.
- Cost pressures not supported by activity / income.

11.1.2. This overall approach, as established during the setting of 2014/15 plans, is designed to address the fundamental shortcomings of using forecast outturn/rolled forward budgets as a starting point, which allows inefficiencies, previous errors and non-recurrent items to be rolled forward.

11.1.3. Other basic rules will be applied throughout the process; these include:

- Any management re-structures/changes will be reflected within the budget.
- Pay costs will be calculated based on actual cost of staff in post and mid-point for vacancies. Incremental drift will be identified as part of this exercise.
- Pay awards will be subject to national guidance and are unknown at this stage. Pay budgets will be amended once the impact is known, as such all pay costings will be at 2014/15 prices in the first instance
- Unavoidable cost pressures will be considered, but will undergo a detailed review and prioritisation process.
- Inflation will be funded as set out in the national PBR guidance for 2015/16 and 2016/17.

11.1.4. **NOTE**: Funding for cost pressures or developments cannot be deemed confirmed until the budget is formally approved by the Board.

11.2. Budget holder responsibilities

11.2.1. The Chief Executive has overall responsibility to the Trust Board for all expenditure and budgetary performance within the Trust. However, the Trust operates a devolved budget control structure whereby financial duties, including budgetary control, are delegated downwards from Chief Executive to individual budget holders via the Trusts organisational structure.

11.2.2. Budget holders are identified and agreed with the CMG and Directorate management teams and monthly financial performance review meetings are in place throughout the Trust, which supports budgetary control.

11.2.3. Annually budget holders are responsible for proposing, signing off and controlling their budgets afterwards. Budget holders, at any level within the structure, must be involved in the budget setting round in order to be able to set appropriate levels of budgets as well as control their budgets effectively, otherwise they are unable to fulfil their duties under the SFIs (Standard Financial Instructions).

11.2.4. The budgets will be prepared in accordance to this guidance and all budget holders be asked to be engage in the process, will receive a copy of final agreed budgets and asked to sign them off.

11.2.5. Finance Managers will prepare baseline budgets, based on the above basic principles, to aid the process, but it is the responsibility of the budget holder to review, input and sign off the ultimate assumptions used.

11.2.6. Budget Holders are therefore required to read and understand the SFIs which can be accessed via insite.

11.2.7. Budget Holders will be required to manage activity within their budgets in 2015/16. Adverse variance from budget will require an action plan to be developed and

implemented. This will be subject to review at CMG Performance meetings, EPB and Finance & Performance Committee.

11.3. Budget preparation process

11.3.1. The planning process has 4 clear stages, and this applies to clearly to budget preparation. Throughout these budget holders should be aware of the funding constraints the Trust is operating within. Additional requests for funding that are not supported by income will require a supporting case and detail on why the cost is unavoidable. In addition, increases to the income target to fund additional costs will also be reviewed in detail to ensure ability to deliver and alignments with BCT.

11.3.2. Detailed budget setting assumptions and processes will be written in specific financial planning guidance to support this overarching guidance document.

11.3.3. The 4 stages outlined below are designed to help focus on consistent content and timelines for each stage and allow for a reasonable period in which iterations can be made and also ensure accurate version control.

11.3.4. **Stage 1** – Budget holders should identify the required level of resource to deliver their service in 2015/16. This will include pay, non pay and where relevant expected levels of income and activity. This first stage is draft. The aggregation of all budget holder requirements will form the basis of the CMG / directorate budget setting submission.

11.3.5. The aim at **Stage 2** is to further build on the first draft, ensuring that all impacts of activity and income plans are captured in individual budgets. This should include impact of CIP plans on individual budgets.

CMGs / Directorates will be required to present the proposed budget to the executive team. This will include detail on the requirement for additional funding and supporting evidence, as well as where the most significant changes to the activity and income plan are anticipated.

In addition, stage 2 will also include the requirement for projections for 2016/17 to be made on the basis of the assumptions that were included in 2015/16 plans.

11.3.6. **Stage 3** will be the final draft of the budget, including all agreed changes to the expenditure budget and income plan.

11.3.7. At the end of the process **Stage 4** is focused on formal sign off and submission of the plan.

12. Capital

12.1. The Capital Monitoring and Investment Committee (CMAIC) are responsible for managing the Trust's capital requirements with subject specific groups for medical equipment (Medical Equipment Executive), facilities and IM&T.

12.2. The CMAIC also has responsibility for production of the Trust's 5 year capital programme, ensuring that this is updated and refreshed on an annual basis as a minimum. The overall objective is to produce a comprehensive capital plan that includes all known requirements and, where appropriate, is within the available funding identified in our capital resource limit (CRL) or links to external financing requirements identified in the Trust LTFM.

12.3. All CMG's, corporate divisions and reconfiguration teams are invited to submit capital bids identifying their capital requirements for the next 5 years. For medical equipment the prioritised lists produced during the Medical Equipment Executive (MEE) bidding process will be taken to

represent the requirements of the CMG's. All capital bids must be submitted including those planned through charitable funds and external applications.

12.4. The Capital Monitoring and Investment Committee review these bids via a confirm and challenge session where the various bids will be evaluated and assessed to produce a prioritised list of capital requirements. This list will be combined with the known pre-commitments from on going schemes to produce a final plan for submission to the Trust Board in March and inclusion in further iterations of the Trust LTFM and BCT health economy financial model.

12.5. Summary outline timetable:

- 15th Sep 2014 CMAIC request issued for capital bids to all CMG's, corporate areas and reconfiguration teams for 2015-16 with outline plans for the following 4 years.
- 27th Oct 2014 Deadline for submissions. Long list of submitted bids compiled.
- 17th Nov 2014 MEE, Facilities and IM&T to review the relevant sections within the bids.
- 10th Dec 2014 CMAIC confirm and challenge (C&C) held to evaluate and prioritise bids.
- 16th Jan 2015 Queries and questions from C&C to be resolved.
- 20th Feb 2015 Final prioritised list of bids to be agreed.
- 10th Mar 2015 Sign off and submission of capital plan as part of wider financial plan to Executive Strategy Board, Finance and Performance Committee and Trust Board.

13. Business Planning Governance and Risk Management

13.1. Comprehensive business planning is essential to provide assurance both internally to the Trust Board and externally to the NTDA and Monitor. The plans articulate how the organisation will achieve its objectives and performance. Therefore it is imperative that the plans submitted are realistic and based on robust planning and evidence base where relevant.

13.2. All service, CMG and corporate plans must be locally owned and departments will be monitored on their performance to plan through the subsequent years. There are a number of governance structures in place to support the development and submission of the business plans:

- Planning Group meeting
- CIP Performance Board
- CMG monthly performance meetings
- Revenue Investment and Capital Monitoring and Investment Committees

13.3. These forums provide guidance and reference useful sources to enable plans to be developed. These can also be used to escalate concerns, identify and mitigate risks to delivery. CMGs and Corporate areas should be represented at these forums.

13.4. All business plans must give due consideration to quality assurance and demonstrate a level of stakeholder engagement (patients, public and staff). Plans should incorporate evidence of such involvement and there should be measures in place for ongoing touch points through subsequent years.

13.5. Consideration to quality assurance means allowing and planning for all relevant Quality Outcome Measures and or KPIs such as:

- NICE guidance
- CNST Standards
- NHSLA Risk Management Standards
- Local and National audits
- Professional and Royal College Reviews
- CAS Alerts – NPSA, Medical Devices, Estates, Pharmaceuticals

13.6. To provide assurance of delivery against proposed business plans CMGs and Corporate directorates should carry out a risk assessment and include mitigations as required.

13.7. Delivery against plan will be monitored internally through the established CMG Performance meetings, the Executive Performance Board and the Finance and Performance Committee. Externally the Trust will be required to submit quarterly updates to the NTDA on achievement of plan against actual delivery on a quarterly basis. The basis of the submission will be formulated from the regular internal reviews undertaken with the Executive.

13.8. Throughout the business planning cycle, CMGs are required to maintain an audit trail which as a minimum captures:
- CMG Board approval of service level plans
- CMG Board approval of CMG level plans
- Stakeholder engagement (including patient, public and staff) in the development of service level plans
- Quality and equality impact assessments of cost improvement plans

13.9. The Trust level two year and five year business plans will be subject to formal approval by the Trust Board and where appropriate the relevant sub-committees of the Trust Board, prior to submission to the NTDA.

14. Management responsibilities

14.1. The Executive Team will be jointly responsible for coordinating the work required to prepare the Trust business plan and its associated deliverables. Specific areas of responsibility are set out below:

Area of responsibility	**Lead**
Activity forecasting	Director of Finance and Procurement
Capacity planning	Chief Operating Officer
Income and expenditure budgets	Director of Finance and Procurement
Cost improvement programme	Chief Operating Officer
Workforce	Director of Human Resources
Capital expenditure planning	Director of Finance and Procurement

15. Appendix 1 – service lines

15.1. UHL service lines:

Number	Clinical Management Group	Service line
1	Emergency & Specialist Medicine	Emergency Department
2	Emergency & Specialist Medicine	Acute Medicine
3	Emergency & Specialist Medicine	Diabetes & endocrinology
4	Emergency & Specialist Medicine	Infectious diseases
5	Emergency & Specialist Medicine	Geriatrics
6	Emergency & Specialist Medicine	Dermatology
7	Emergency & Specialist Medicine	Rheumatology
8	Emergency & Specialist Medicine	Neurology
9	Emergency & Specialist Medicine	Stroke
10	Renal, Respiratory and Cardiac	Renal & Transplant
11	Renal, Respiratory and Cardiac	Nephrology
12	Renal, Respiratory and Cardiac	End Stage Renal Failure
13	Renal, Respiratory and Cardiac	Renal Transplantation
14	Renal, Respiratory and Cardiac	Cardiology
15	Renal, Respiratory and Cardiac	Cardiac Surgery
16	Renal, Respiratory and Cardiac	Thoracic Surgery
17	Renal, Respiratory and Cardiac	Respiratory Medicine
18	Renal, Respiratory and Cardiac	Clinical Immunology and Allergy
19	ITAPS	Critical care
20	ITAPS	Theatres & anaesthetics
21	ITAPS	Pain
22	ITAPS	Sleep
23	CHUGS	General surgery
24	CHUGS	Haematology
25	CHUGS	Oncology & palliative care
26	CHUGS	Gastroenterology
27	CHUGS	Urology
28	Women's & Children's	Paediatric Respiratory
29	Women's & Children's	Paediatric Oncology
30	Women's & Children's	Paediatric Surgery
31	Women's & Children's	Paediatric Medicine
32	Women's & Children's	East Midlands Congenital Heart Centre
33	Women's & Children's	Paediatric Intensive Care
34	Women's & Children's	Obstetrics
35	Women's & Children's	Gynaecology
36	Women's & Children's	Neonatology
37	Women's & Children's	Clinical Genetics
38	CSI	Imaging
39	CSI	Pathology
40	CSI	Pharmacy
41	CSI	Therapies
42	MSK and Specialist Surgery	Trauma and orthopaedics
43	MSK and Specialist Surgery	Ophthalmology
44	MSK and Specialist Surgery	ENT & audiology
45	MSK and Specialist Surgery	Vascular Surgery
46	MSK and Specialist Surgery	Max Facs, orthodontics & restorative dentistry
47	MSK and Specialist Surgery	Plastic surgery
48	MSK and Specialist Surgery	Breast Surgery
49	MSK and Specialist Surgery	Sports & Exercise Medicine

16. Appendix 2 – bed capacity reduction

16.1. CMG bed capacity reduction planning parameters, taken from Trust 5 year plan:

CMG	2015/16					2016/17					2018/19
	ACS / Triage	BADs	EBDs (>6 LOS patients)	DTOCs to 2%	**TOTAL**	ACS / Triage	BADs	EBDs (>6 LOS patients)	DTOCs to 2%	**TOTAL**	**TOTAL**
CHUGGS	21.2	7.0	12.4	2.0	**42.6**	26.0	7.0	20.6	2.6	**56.2**	**67.5**
ESM	49.1	0.4	16.9	17.7	**84.2**	81.8	0.4	28.2	22.6	**133.0**	**173.7**
ITAPS	1.4	0.0	0.0	0.0	**1.4**	2.3	0.0	0.0	0.0	**2.3**	**3.0**
MSS	5.2	9.9	8.0	2.5	**25.7**	8.7	9.9	13.3	3.2	**35.1**	**43.0**
RRC	55.2	4.9	15.4	3.0	**78.5**	92.0	4.9	25.7	3.9	**126.4**	**166.3**
W&C	0.5	2.4	2.3	0.0	**5.2**	0.8	2.4	3.8	0.0	**7.1**	**8.6**
TOTAL	**132.5**	**24.6**	**55.0**	**25.4**	**237.5**	**211.6**	**24.6**	**91.7**	**32.3**	**360.1**	**462.2**

17. Appendix 3 – planning deadlines

17.1. The table below outlines key dates for CMG and Corporate Directorate planning:

		Completion Date
Stage 1	Guidance approval at Executive Team	16/09/2014
	Guidance sign off by Finance & Performance Committee	24/09/2014
	Guidance sign off by Trust Board	25/09/2014
	CMG Business Planning Master Class	26/09/2014
	High level CIP plans for 15/16	22/09/2014
	Submission and receipt of counting and coding proposals	30/09/2014
	CMG confirmation of cross cutting CIP enabling actions	03/10/2014
	Draft activity plans for 15/16	10/10/2014
	Capacity Plan draft for 15/16	24/10/2014
	Draft workforce plan (based on capacity plan) for 15/16 and 16/17	24/10/2014
	Draft expenditure plan (based on activity, capacity and workforce) submission for 15/16	24/10/2014
	Executive dialogue regarding initial draft CMG plans	w/e 07/11/2014
Stage 2	Activity plans for 15/16 and 16/17	05/12/2014
	Capacity Plan for 15/16 and 16/17	05/12/2014
	Workforce plan for 15/16 and 16/17	05/12/2014
	Expenditure plan submission for 15/16 and 16/17	05/12/2014
	High level view of Trust plan to Finance & Performance Committee	18/12/2014
	Executive dialogue regarding final draft CMG plans	w/e 19/12/2014
Stage 3	Update paper to Finance & Performance Committee	28/01/2014
	Green / Amber CIP plans in place for total £41m target	31/01/2014
	Contract sign off with commissioners	28/02/2015
	Adjustment of CMG activity, income, capacity and expenditure plans for contract negotiations and material planning changes	06/02/2015
	Green CIP plans in place for £41m	30/03/2015
Stage 4	Executive signoff of CMG plans / directorate plans	06/03/2015
	Executive Strategy Board sign off of Trust two year plan	10/03/2015
	Finance & Performance Committee	25/03/2015
	Trust Board	26/03/2015