Trust Board Paper W

To:	Trust Board
From:	Kate Shields
Date:	27 March 2014
CQC regulation:	All

Title:	**Executive Summary**: Two Year Operational Plan 2014/15 – 2015/16

Author/Responsible Director: Helen Seth/Kate Shields

Purpose of the Report:

- National planning guidance requires us to submit a comprehensive two year operating plan on 4 April
- The purpose of this report is to provide an Executive Summary of our plan highlighting those areas of work that are outstanding and the action being taken to address them
- To put forward some minor amendments to our strategic objectives which have been revised to take into account the significant change in context
- To summarise the 'plan on a page' for each of our strategic objectives
- To seek approval of the plan (noting specific caveats) ahead of submission to the TDA on 4 April

The Report is provided to the Board for:

Decision	X	Discussion	X
Assurance	X	Endorsement	X

Summary / Key Points:

National planning guidance requires the Trust to submit a comprehensive two year operational plan to the NTDA on 4 April. The plan submission comprises of 5 appendices:

- Annex A – Narrative Executive Summary
- Annex B – Activity and CDiff trajectory
- Annex C – Finance
- Annex D – Workforce Plan
- Annex E – Planning Checklist

Given the granular level of detail in Annex B-E these have not been circulated with this paper. They are however accessible on SharePoint.

PROCESS

The process to develop our two year Operational Plan was launched by the Director of Strategy in November 2013 at a workshop with all of the CMGs. This was followed up by CMG specific planning and strategy workshops and the weekly meetings of the Business and Strategy Support Team (BSST) which CMG managers now attend. In parallel the Trust is actively engaged in supporting the development of the five year LLR

wide strategy for submission nationally, by 20 June.

At an executive level, the iterative development of the plan has been reviewed, confirmed and challenged on a monthly basis through the Executive Strategy Board, Trust Board Development sessions and Trust Board. This has provided good opportunity to test the approach and to review evolving content.

It should be noted however that the Trust has focused predominantly on developing, confirming and challenging granular plans for 2014-2015 so that we create strong foundations on which to build. Plans for 2015 – 2016 are currently largely a product of broad assumptions including the need to deliver year two of our three year recovery plan. Given time constraints and the need to develop a robust service, quality and financial strategy by the end of Q1 (taking into account the CQC action plan) we need to be clear that the detail for 2015 – 2016 will be finalised retrospectively as part of the five year strategy programme (to be delivered by 20 June). This includes the financial, CIP and workforce plan.

On the 24 March the Trust received feedback on our interim plan submission of 5 March. The key message is that our plan lacks "ambition" and that we should be identifying a small number of big things that can be done in the next 2 years that will materially impact our financial position. Based on the risk analysis of our CIP programme for 2014 – 2015, the unknown outcome of contractual arbitration (which can only make the situation worse) and the lead time for large scale reconfiguration the **Trust is recommending that we do not change our forecast deficit for 2014 – 2015 however we make it clear in our response that we know there is significantly more work to be done on our plans for 2015 -2016 specifically in respect of workforce.** This will be addressed through our five year work programme to be concluded by 20 June.

STRATEGIC OBJECTIVES AND 'PLAN ON A PAGE'

The planning landscape has significantly changed since to Trust laid out our strategic direction in November 2012. We have therefore taken the opportunity to review our strategic objectives to ensure they remain fit for purpose.

Some minor changes to our strategic objectives are recommended and are outlined on p12 of the executive summary.

For each of the strategic objectives we have summarised a '**plan on a page**'. The metrics associated with the latter are currently being finalised through the respective programme of work. These will be available for Trust Board review by 24 April.

Once the budget setting process is concluded week ending 28 March a 'plan on a page' will also be generated for each CMG providing a tangible product that all CMGs can use to engage with their team and can show how what they do on the wards, in theatres, in outpatients, contributes towards the Trust's overall strategic direction.

Cutting across all of our plans are **three common themes**. In delivering our plans we will need to:

Effectively lead and manage service provision in line with defined standards whilst delivering our financial plan and improving productivity. We will do this by (illustrative examples):

- Delivering our CQC action plan

- Ensuring robust financial control and delivering on our financial plan
- Developing a robust service, quality, safety and financial strategy by Q1
- Developing and empowering our staff make changes through the roll out of LiA
- Centralising our outpatient function to simplify management arrangements, standardise process and deliver cash releasing savings

Build effective strategic partnerships to support delivery of safe and sustainable core and specialised services. We will do this by:

- Developing and agreeing a five year plan for health and social care across LLR
- Driving the development of an integrated, system wide capacity plan for LLR underpinned by an appropriate incentive framework that ensures all stakeholders are accountable for the delivery of their actions
- Driving the implementation of the LLR Alliance for community elective care to transform the model of delivery and associated standard operating procedures
- Developing our provider partnerships across the south East Midlands and north East Midlands to support sustainable delivery of more specialised services
- Following comprehensive service review of individual service lines, the Trust will consider the on-going viability of specialties that cannot demonstrate clinical and financial sustainability over an agreed time period

Prepare strong foundations for forthcoming, large scale transformation – including improvement activities at scale and pace and early enabling capital schemes. We will do this by (illustrative examples):

- Delivering the majority of day case activity out of an acute hospital setting
- Identifying options to ring fence elective capacity
- Delivering the emergency floor development and supporting sustainable delivery of the ED standard
- Delivering business cases to support our medium term strategy
- Deliver EPR/EDRM

FINANCIAL RISK

Based on an outturn deficit of £39.8 million for 2013/2014, we are projecting a deficit of £29.8 million for 2014/2015. This is an improvement in the position described in our first submission which reflected a £32.8 million deficit position. All of the key components contributing to the movement from the 2013/14 out-turn deficit of £39.8 million and the 2014/2015 Financial Plan are reflected in the **financial 'bridge'** on p23. A similar bridge for workforce will be presented once budget setting is concluded. This will be available for Trust Board review by 24 April.

The revised **financial position is not without significant risk**. The Trust is currently going through an arbitration process with the CCGs to agree the 2014/15 contract. This is expected to be finalised by the 4 April 2014 – the day we are required to submit our plan to the TDA. **If arbitration is unsuccessful, then the Trust deficit plan will increase**.

The overall CIP programme for 2014 – 2015 of £45m is very challenging and reflects 5.3% of the cost base. It is based on cost reduction from the 2013/14 FOT position, £9.9m, and a £35.1m reduction in the recurrent budget reflecting the 4% efficiency target. The initial work by Ernst & Young has indicated a risk adjusted CIP of £25m with further significant work required on the profiling of these schemes and alternative schemes to mitigate the risk of slippage. All approved schemes will be Quality Impact Assessed and corporately signed off by the beginning of April.

Based on the known financial risks the Trust would not recommend an improvement to the current £29.8 million deficit plan for 2014/15. It is clear however that there is significantly more work required on our plan for 2015 -2016 particularly in respect of the work being undertaken by the Trust and E&Y to scope cross cutting workstreams including medical and workforce productivity. It is anticipated that more information in respect of the opportunity will be available in the next two weeks and will be reported in more detail to Trust Board on 24 April.

The Trusts Standing Financial Instructions and Standing Orders set out requirements for the Trust Board to agree a balanced budget prior to the start of the year. Following a meeting with the Director of Finance of the NTDA the Trust does have agreement in principle to have a deficit plan in 2014/15. This is predicated on having a three year recovery plan to move back to break even.

WORKFORCE PLANS

As described above the workforce plan for 2015-2016 is still subject to refinement and executive sign off. This forms part of the five year strategy work programme that will be concluded by 20 June and will align to the national requirement for Trust Boards to spend protected time to look in detail at workforce, skill mix etc. on a six monthly basis. Based on the guidance, the first review is required in June.

The Workforce Plan for 2014 – 2015 (Annex D) reflects a pattern of qualified nurse worked WTE increase of 230 WTE during 2014 – 2015. This is in line with the nursing recruitment strategy. A detailed workforce 'bridge' for 2014 – 2015 will be presented in our final narrative plan submission on 4 April. No material change in skill mix is currently reflected in the plan which fits with the observations made by E&Y. This is an area that will require significantly more work as part of our five year plans (June 2014).

CAPACITY PLANNING

Following the recent planning and strategy workshops undertaken with the CMGs, a cross CMG capacity planning workshop is planned on the 7 April. This will provide opportunity for the Trust to consider the aggregate capacity assumptions that will underpin our five year plan and within that, our strategic capital plans for clinical reconfiguration. The output of this process will support a detailed refresh of the current workforce plan for 2015 – 2016 and will be reported to Trust Board by 20 June at the latest.

In complement the Trust will actively engage, shape and drive the development of a system wide capacity model that places appropriate incentives (or penalties) for all stakeholders to deliver their part of the LLR system wide plans for transformation over the next five years.

Recommendations:

The Trust Board is asked to:

NOTE that in line with the nationally set planning timeline the LLR five year strategy is

being developed and will be submitted on 20 June, after the submission of our two year plan on 4 April. For this year only this creates the need for retrospective reconciliation of plans.

APPROVE IN PRINCIPLE the Operational Plan for 2014-2015 noting the planning assumptions underpinning it.

APPROVE IN PRINCIPAL the Financial Plan for 2014-2015 noting the risk and mitigation identified**.**

NOTE the risk pertaining to the unknown outcome of the contractual arbitration process.

NOTE the risk pertaining to the risk analysis of our CIP programme for 2014 -2015.

APPROVE the broad parameters of the Operational Plan for 2015 – 2016 noting that at the point of submission on 4 April it will reflect broad planning assumptions which will be subject to significant refinement and retrospective reconciliation by 20 June as part of the five year strategy work programme. It is anticipated that on the basis of the work being undertaken with E&Y and across the health and social care community, that our plans for 2015 – 2016 will demonstrate more significant scale and pace of cost improvement across the cross cutting themes identified e.g. Productivity, procurement etc.

NOTE that there will be a need to retrospectively reconcile and review workforce plans particularly in light of the CIP plan review undertaken by E&Y and the LLR five year strategy.

Previously considered at another corporate UHL Committee? Yes Executive Strategy Board, Trust Board development sessions, Trust Board	
Strategic Risk Register: Yes	**Performance KPIs year to date:** N/A
Resource Implications (eg Financial, HR):	
Assurance Implications: Yes	
Patient and Public Involvement (PPI) Implications: Yes	
Stakeholder Engagement Implications: Yes	
Equality Impact: CIP – QEIA completed	
Information exempt from Disclosure:	
Requirement for further review?	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

TDA SUBMISSION FINAL DRAFT FULL TWO YEAR PLAN

REPORT TO: Trust Board

REPORT FROM: Kate Shields, Director of Strategy

AUTHOR: Helen Seth

RE: Executive Summary: Two Year Operational Plan 2014/15 – 2015/16

DATE: 27 March 2014

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1. PURPOSE

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2. NATIONAL CONTEXT - PLANNING GUIDANCE

The NTDA published the national planning guidance for NHS Trusts on the 23 December, 2013 "Securing Sustainability - Planning Guidance for NHS Trust Boards 2014/15 to 2018/19".

It outlined the planning landscape for the short (two year plans by April, 2014) and medium term (five year plans by June, 2014) time horizon and set out clear expectation of what our plans need to address. Illustrative examples are outlined overleaf:

Requirement	As demonstrated by (illustrative examples)
Safe services	Progress toward reducing avoidable deaths; early warning and escalation systems in place including weekends; all deaths in hospital reviewed
	Robust workforce planning underpinned by safe staffing levels that are sufficient to deliver safe care.
	Board to Ward reporting and learning culture - open and transparent
	Fit for purpose environment, cleanliness, continued improvement in HCAI
	Medicines optimisation
	Implementation of the national 5-year strategy for antimicrobial resistance

Requirement	As demonstrated by (illustrative examples)
Effective services	Improved outcomes and quality of life
	Effective use of resources - introduction of 7 Day working and the identification of the impact on quality and cost
	Admission avoidance, readmissions
	Proactive management of disease progression - improvement in geriatric medicine and dementia
	Fostering integration with strong relationships with social care - Appropriate access to and utilisation of the Better Care Fund

Requirement	As demonstrated by (illustrative examples)
Caring services	Respecting and involving service users – developing strong partnerships
	Working towards real time feedback
	Complaints management
	Implementation of the relevant recommendations of the Chief Nursing Officer's nursing strategy, Compassion in Practice, in particular to embed the 6Cs
	Adoptions of the forthcoming recommendations of the Leadership Alliance for the Care of Dying People

Requirement	As demonstrated by (illustrative examples)
Responsive services	Maintain delivery of Referral to Treatment 18 week maximum waiting time standards
	At least 95% of patients should be admitted, transferred or discharged within 4 hours of their arrival in accident and emergency
	Sufficient capacity is in place to deliver core targets: elective, ED and cancer waiting time standards
	All patients who have operations cancelled on or after the day of admission for non-clinical reasons are offered another binding date within 28
	Complaint management - Evidence of implementation of the Clwyd/Hart review
	The Trust is preparing for a potential move to paperless referrals in the NHS by March 2015

3. NATIONAL CONTEXT – SPECIALISED SERVICES

In parallel with the national planning process, NHSE is currently developing a revised five year strategy for nationally prescribed specialised services.

The direction of travel is predicated on improving outcomes and cost efficiency by a significant reduction in the number of centres providing specialised services from more than

200 to 15-25. Alignment with an AHSN is anticipated to be an essential requirement which places the Trust in a favourable position however we must ensure that the derogation plans we have submitted, are delivered.

4. LOCAL CONTEXT – LEICESTER, LEICESTERSHIRE AND RUTLAND HEALTH AND CARE

Leicester, Leicestershire and Rutland reflects a diverse, growing population of over 1 million people. It is a picture of two extremes: significant deprivation in Leicester city (higher than the England average) in contrast to low levels of deprivation (some small pockets of deprivation) across Leicestershire and Rutland (lower than the England average). Circa 110,000 of the City population (circa 306,000) is of BME background, whilst in Leicestershire circa 55,000 of the population (circa 650,000) is of BME background and in Rutland circa 1,400 of the population (circa 38,000) is of BME background.

Based on current planning assumptions and models of delivery, the Leicester, Leicestershire and Rutland (LLR) Health and Care Community will face a total financial gap of circa £350m in five year's time if major changes in models of care, philosophy and means of delivery are not secured.

To tackle this issue an integrated five year strategic plan for Leicester, Leicestershire and Rutland Health and Care is currently being developed. Its goal: to maximise value for the people of Leicester, Leicestershire and Rutland by improving the health and wellbeing outcomes that matter to them, their families and carers in a way that enhances the quality of care at the same time as reducing cost across the public sector to within allocated resources. Partners will do this by appropriately managing demand and restructuring the provision of safe, high quality, services into the most efficient and effective settings.

Once complete, the LLR Strategy will set out investments for long term benefit and the medium term direction of travel for the models of health, care and support services. It will also outline the steps needed to realise the shared vision described.

This plan will signal a move away from incremental, organisational specific improvement to a longer-term view that delivers transformational change. It will provide a framework against which each statutory NHS organisation and local authority will develop their own plans detailing how they will deliver on the component parts for which they are responsible.

The focus will be one a genuine reduction in the cost of provision whilst at the same time delivering better outcomes; providing services through redesigning whole care pathways and taking a life course approach, not just moving treatment from one part of the system to another. To achieve this, five areas have been selected that analysis would suggest has the greatest potential to deliver significant benefits during the period of the five-year plan. These are:

- Cancer
- Cardiovascular disease
- Respiratory disease
- Dementia
- Mental health (substance misuse).

A series of four workshops for each of the five areas have been completed with good multi-agency support. An initial action plan is forthcoming.

Once complete the plans will represent the combined strategy of the three LLR Health and Wellbeing Boards and will set the framework for joint working which will be reflected in each Health and Wellbeing Boards Better Care Fund plans.

In this context it is recognised that we are presenting our first draft, full two year operational plan before the LLR five year plan has been developed. Ordinarily it would be the other way round.

From 2014/2015 onwards the Trust will be developing a rolling five year plan on a continuous basis but for this year, there will be a need for retrospective reconciliation following the approval of the Trust's and LLR's five year plan.

5. PROCESS

The process to develop our two year Operational Plan was launched by the Director of Strategy in November 2013 at a workshop with all of the CMGs. This was followed up by CMG specific planning and strategy workshops and the weekly meetings of the Business and Strategy Support Team (BSST) which CMG managers now attend. In parallel the Trust is actively engaged in supporting the development of the five year LLR wide strategy for submission nationally, by 20 June.

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On the 24 March the Trust received feedback on our interim plan submission of 5 March. The key message is that our plan lacks "ambition" and that we should be identifying a small number of big things that can be done in the next 2 years that will materially impact our financial position.

6. ORGANISATIONAL CONTEXT – PERFORMANCE IN 2013/2014

6.1 Safe, high quality, patient centred health care

The Trust has robust governance structures, processes and controls in place to promote safety and excellence in patient care; identify, prioritise and manage risk arising from clinical care; ensure the effective and efficient use of resources through evidence-based clinical practice; and protect the health and safety of patients, public and Trust employees.

At a strategic level, the Quality Assurance Committee (QAC), a sub-committee of the Trust Board, has oversight of all activities being undertaken across the Trust in support of the delivery of safe, high quality, patient centred health care. QAC meets monthly and is chaired by a Non-Executive director. Each meeting considers compliance with contractual quality schedule, reports from the Executive Quality Board, monthly quality and performance report, progress against our quality commitment, patient safety report, 5 critical safety actions report, nursing workforce report. In complement QAC oversees the development and

implementation of action plans in response to external visits e.g. recent TDA visit to review infection protection procedures and the CQC inspection in January, 2014.

At an executive level the Executive Quality Board (EQB) meets monthly and is chaired by the chief nurse. Membership includes Clinical Management Group (CMG) Clinical Directors, executive and corporate representatives. EQB is currently supported by a series of sub groups and committee structures which are currently subject to review. Illustrative examples of what has gone well and what could be better in respect of safe, high quality patient centred care, is outlined below.

Illustrative examples What has gone well in 2013/2014?	Illustrative examples What could have been better?
Safe staffing levels - Significant investment made in nurse establishment following review. Successful nurse recruitment and international recruitment (predominantly Portugal). **Reducing harm** – Dramatic, sustained reduction in falls achieved by targeted support, strong leadership and simple solutions e.g. fall-risk bays. **Friends and Family test** – A sustained upward trend in the overall score for the F&F test continues. The Trust is in track to achieve the desired score of 75 by April 2014 (71.8 in January). **Patient centred care** - Meaningful Activity Facilitators have been appointed forming part of the Patient Experience Team. They attend the 'board round', along with the MDT where patients with dementia or suspected dementia are referred for meaningful activity support. They support people with dementia and their carers in hospital with: cognitive stimulation, support for sensory and psychological wellbeing, as well as reducing vulnerability. Implementation of the facilitators is showing early benefits by increasing nutritional support, increasing well-being of patients with dementia and strengthening carer support. **Maternity CNST level 3** – Significant achievement for Maternity and one of only twenty Trusts in the country. Financial and non-financial benefits realised.	**SHMI** - The latest SHMI by the Health and Social Care Information Centre (HSCIC) was published at the end of January and covers the 12 month period July 12 to June 13. As anticipated UHL's SHMI has gone up from 106 to 107 however, it remains in Band 2. Whilst this in within normal ranges it is higher than we would like. This slight increase was anticipated as the latest 'rolling 12 month' period includes April 13 where there was an increase in both UHL's crude and risk adjusted mortality. The Trust is utilising a Hospital Evaluation Dataset tool (HED) to internally monitor our SHMI on a monthly basis. The Trust's SHMI for May - October 2013 is predicted to be closer to 100 however, due to the published SHMI being based on a '12 month rolling figure', the trust's published SHMI is likely to remain above 100 until the Jan - April 13 period is not included. The HED tool is utilised to measure the Trusts Hospital Standardised Mortality Ratio (HSMR). This is rebased monthly. The Trust's HSMR for 2013 (Jan to Nov) is 100.3 and for Sept to Nov has been below 100. **Patient Safety -** In January a total of 20 new Serious Untoward Incidents (SUIs) were escalated within the Trust, the highest number for 3 years. 12 of these were patient safety incidents, 7 were Hospital Acquired Pressure Ulcers and 1 was a Healthcare Acquired Infection. Three patient safety root cause analysis (RCA) investigations were completed and signed off last month, the actions and learning of which have been shared internally. These will be further reviewed at the Trust's 'Learning from Experience Group'.

6.2 Joined up emergency care

As described in our Annual Operational Plan for 2013/2014, securing sustained improvement in and achievement of the ED 95% target has remained a very significant challenge for the Trust and local health economy. Poor performance in ED is symptomatic of wider system failure. It therefore calls for a multi-faceted, multiagency approach towards improvement.

Performance for emergency care 4hr wait in January 2014 was 93.6% - the best performing month for the last 15 months. There were 12 days of performance above 95% and two weeks above 94% including one week at 94.8%. By the end of January there had been eight consecutive weeks above 90%. Performance at this level was particularly pleasing because the month of January is often the most challenged month of the year.

Regrettably, performance in February has dramatically deteriorated, with no days above 95% and only one day above 90%. Year to date performance is 88.46%.This is extremely disappointing given the extra ordinary efforts made within the Trust and by other partners however once again there is the need to understand the key drivers for poor performance.

Increasing admissions - The Trust's bed shortage is clearly documented and recent admissions have been at an unprecedented level. A consequence of this is that when we have increased levels of admissions, we quickly become unable to cope. If you compare the first eight weeks of this year with the first eight weeks of last year, A&E admissions are 61 fewer this year but GP referrals for admission are 646 higher. Broken down by CCG, the majority of the increase for GP referrals for admission relate to the City CCG where it has increased from 108 per week to 218 (double) in ten months. 80% of the increase in GP referrals relates to 21% of GP practices (31 practices against a total of 146 practices).

Delayed Transfers of Care - The number of patients with a delayed transfer of care (DTOC) has increased over the last couple of months. In early January, 3.5% of UHL bed's had DTOC patients in them. On the 5 March the Trust had 77 DTOC patients occupying beds equating to more than three wards.

Community capacity – Commissioners have taken the decision to reduce community capacity which reduces the Trust's ability to discharge patients, hindering flow. Reducing bed capacity at a time when emergency demand is significantly exceeding plan regrettably means cancelling a significant amount of elective and day case work.

Internal process - Internal processes are not as good as they need to be on a sustained basis: lack of continuous flow out of ED, increasing occupancy in ED, and ambulances waiting outside ED is not how we want to deliver services. With this level of sustained pressure, it is inevitable that quality and process will suffer.

In this context the Trust continues to work closely with CCGs and external providers to deliver compliant performance. Recent performance has been very disappointing and many difficult decisions to open additional capacity within the Trust have been taken. Whilst there is always improvement to be made in internal process there are a number of critical factors outside of the Trust that we need LLR support to resolve.

6.3 The provider of choice

The Trust provides elective (planned) services for both core (e.g. orthopaedics) and specialised (e.g. ITU and ECMO) services and is currently a sub-contractor for the elective care services provided across the LLR community hospitals under a contract currently held by Derbyshire Community Health Services (DCHS).

As we look to enhance and maintain our profile as the provider of choice for the majority of patients across LLR and wider afield there are a number of strengths and weaknesses that we must address to ensure clinical and financial sustainability both now and in the future.

Strength – The congenital heart services provided at the Glenfield Hospital are both nationally and internationally recognised however following the original safe and sustainable national review of congenital heart services there was the potential for services currently provided in Leicester to be transferred to Birmingham or other centres based on the option

appraisal undertaken. However the process was successfully challenged and the review halted. The driver for change however hasn't changed – fewer centres, operating to agreed specifications on more patients, improves outcomes. In this context the East Midlands Congenital Heart Service based in Leicester has been given further opportunity to carefully consider how it will address some of the key weaknesses identified.

Weakness – All patients requiring elective treatment should be seen and treated within a set Referral to Treatment Time (RTT). Throughout 2013/2014 the Trust's performance against the RTT standard has deteriorated both for admitted and non-admitted patients primarily due to the impact of clearing activity backlog. This has been compounded by an increase in referrals in excess of commissioner forecast demand. Operationally the main drivers for poor performance have been the adverse impact of emergency demand on elective bed capacity and in some cases access to intensive care. Accordingly, elective services have experienced the double hit of reduced income due to the adverse impact of emergency demand on elective bed capacity compounded by the fact that commissioners might be unable to pay for the activity undertaken. The Trust has been working closely with local commissioners to resolve this matter. On the 5 March the Trust had verbal confirmation of agreement to the proposed recovery plan. Written confirmation is expected to follow in the next couple of days.

Opportunity – During 2013/14 the Trust has worked in partnership with Leicester Partnership Trust (LPT) and LLR Provider Company Ltd. (a large group of GPs) to express an interest place a bid to win the tender for the LLR community elective care bundle contract. The provider alliance have been declared preferred bidder for the contract and are currently undertaking detailed due diligence and contract negotiation.

6.4 Enhanced Reputation in Research, Innovation and Clinical Education

Healthcare Research and Development (R&D) is focused on developing and testing new medical treatments and care pathways, implementing evidence into practice, stimulating health innovations and supporting and fostering quality in all areas of our work and workplace.

The Trust's R&D team has provided the necessary leadership to ensure that research is carried out to the highest ethical, scientific and financial standards. In line with our strategic objective, we strive to embed R&D activity throughout the organisation to stimulate an inquisitive approach to our work and to drive excellence and improvements in care in both clinical and non-clinical areas. This is crucial core activity for the Trust, and is vital to support our vision of providing *Caring at its best*.

Based on performance metrics the Trust is a 'premier league' performer in research, being in the top 10 of all trusts who return data about the volume of their research study activities centrally to the NHS. We recruit thousands of our patients into research studies – in 2013/14 recruiting just under 10,000 patients into various studies spread throughout our various Clinical Management Groups – significantly exceeding our target.

Our R&D activity also translates into many healthcare innovations and in September 2013, we received a Special Recognition Award for innovation at the Health Enterprise East NHS Innovation Awards.

Projected turnover for R&D activity in UHL for 2014 is £36 million. This reflects our collaborative research with academic partners whereby we carry out a wide portfolio of patient-centred research that includes almost every aspect of specialist medicine and surgery. Many of our research teams are recognised as international leaders in their field and include cardiovascular disease, respiratory disease, diabetes, cancer, renal and infection. Our main academic partner is the University of Leicester, but we have productive

and growing partnerships with Loughborough University and other academic institutions throughout the UK and overseas.

In 2011, after rigorous assessment of our applications by international experts, our research expertise was acknowledged by NIHR by the award of three Biomedical Research Units (BRUs): The Cardiovascular BRU: In partnership with the University of Leicester; the Respiratory BRU in partnership with the University of Leicester; the Nutrition, Diet and Lifestyle BRU in collaboration with Loughborough University.

We are the only NHS Trust outside Oxford, Cambridge and London to host three BRUs. Together the BRUs attract more than £19 million funding to our organisation.

We also have major strengths in cancer research that have attracted substantial external funding. Cancer Research UK Centre: Announced in November 2013 and in partnership with the University of Leicester, we are to house a prestigious Cancer Research UK Centre as part of a £100 million investment by Cancer Research UK to deliver new treatments to cancer patients and train the cancer researchers of the future.

From 2014 we will host a new NIHR Local Comprehensive Research Network whose function is to coordinate and support all portfolio research studies across Leicestershire and Rutland, Nottinghamshire, Lincolnshire, Derbyshire and Northamptonshire. We have been given the responsibility for all this externally funded work because our reputation for excellence in planning and delivery of R&D.

Despite this volume of activity we are not standing still and have more cutting edge opportunities to work on as we look to 2014/2015.

6.5 Professional, passionate and valued workforce

The Trust has a detailed Organisational Development Plan which has six substantial work streams focussed on a number of targeted priorities:

- Live our Values;
- Improve Two-way Engagement;
- Strengthen Leadership;
- Enhance Workplace Learning;
- Improve External Relationships and Workplace Partnerships; and
- Encourage Creativity and Innovation.

Progress against plan is progressing well. Illustrative examples include training for ‘putting people first’ and consultant recruitment. A junior doctors training committee has been established along with a Clinical Senate.

The Trust has presented exceptional staff and teams with ‘Caring at its best’ quarterly awards in the workplace, has held Listening into Action ‘Pass it on’ events, with a view to embedding LiA ‘as the way we do things at UHL’ and has held a ‘public engagement listening event’ for patients and their families.

Workforce plans continue to be implemented supported by rigorous marketing and recruitment activity including international nurse recruitment.

Mandatory training compliance is improving and showing an upward. It is anticipated the Trust will hit our improvement trajectory by the end of March.

6.6 Sustainable, high performing NHS Foundation Trust

The Trust has faced significant financial challenges over an extended period of time however it has always previously achieved its financial control total. In setting the 2013/14 financial plan it was important that there was a clear understanding of the Trust's underlying position by stripping out non-recurrent sources of income and expenditure. The impact of the unsatisfactory performance in year, the fiscal drag caused by the sub-optimal configuration of hospital services and the residual impact of non-PbR tariff arrangements meant that moving into 2013/2014 the Trust had an underlying deficit of c£12.5m (1.6% of turnover).

The 2013/14 plan was set in the context of the deficit and was designed to address the short-term operational challenges and the longer term strategic issues. Integral to this was the assumption that we would be able to access local Transformation Funding (circa £12m on a fair share basis), get approval of strategic transitional support to accelerate our estate reconfiguration plans (circa£15m) and an appropriate contractual settlement, including rebasing of MRET baselines. Not all these assumptions regrettably materialised in 2013/2014.

Financial performance during 2013/14 has therefore not been in line with plan. The position has deteriorated cumulatively throughout the year, despite controls in place. Key drivers of deficit include failure to secure anticipated transformational and transitional funding, pay costs (premium rate, nursing review and medical staffing) and contractual settlement.

Detailed forecast modelling has been undertaken and the Trusts projected outturn position for 2013/14 is a deficit of £39.8m.

The following table summarises the year to date position and full year forecast against the financial duties of the Trust:

Financial Duty	YTD Plan £'Ms	YTD Actual £'Ms	Forecast Plan £'Ms	Forecast Actual £'Ms	RAG
Delivering the Planned Surplus	2.4	(30.4)	3.7	(39.8)	R
Achieving the EFL	n/a	n/a	20.7	20.0	G
Achieving the Capital Resource Limit	31.1	20.6	36.7	34.7	G

As well as the key financial duties, a subsidiary duty is to ensure suppliers invoices are paid within 30 days – the Better Payment Practice Code (BPPC). The year to date performance is shown in the table below:

Better Payment Practice Code	April - February 14	
	Number	Value £000s
Total bills paid in the year	119,986	490,704
Total bills paid within target	57,961	357,942
Percentage of bills paid within target	**48.3**	**72.9**

Key issues:

- The Trust will not deliver its planned surplus and as such will not meet its breakeven duty. The forecast position remains as a deficit of £39.8m
- The Trust has formally had its External Financing Limit (EFL) target reset by the Department of Health for Month 11 reporting from a negative £1.4m to £20.7m. This will result in the Trust having between £0.2m - £0.7m in the bank at 31st March 2014

- The DoH has reduced the Trust's CRL by £6m to reflect the level of slippage on the programme. There needs to be continued focus on ensuring the capital projects deliver against the year-end forecasts

- The BPPC performance reflects the impact of the financial deficit of the Trust and the requirement to carefully manage the cash flow

The Month 11 results and year to date performance may be summarised as follows:

	Febuary 2014			April - Febuary 2014			Year End Forecast		
	Plan £m	Actual £m	Var (Adv) / Fav £m	Plan £m	Actual £m	Var (Adv) / Fav £m	Plan £m	Forecast £m	Var (Adv) / Fav £m
Income									
Patient income	50.3	53.3	3.1	580.3	600.6	20.3	634.2	655.0	21.8
Teaching, R&D	4.9	4.9	0.0	67.5	65.2	(2.3)	73.6	70.5	(3.1)
Other operating income	3.2	2.2	(1.0)	35.1	35.1	0.0	38.2	39.2	1.0
Total Income	58.4	60.5	2.1	682.9	700.9	18.0	746.0	765.7	19.8
Operating expenditure									
Pay	37.2	40.4	(3.2)	410.5	433.0	(22.5)	447.6	473.1	(25.5)
Non-pay	21.3	25.1	(3.7)	251.7	267.4	(15.7)	275.6	290.8	(15.2)
Reserves	(2.1)	-	(2.1)	(22.0)	-	(22.0)	(24.9)	-	(24.9)
Total Operating Expenditure	56.4	65.4	(9.0)	640.2	700.4	(60.3)	698.2	763.9	(65.6)
EBITDA	2.0	(4.9)	(6.9)	42.7	0.5	(42.3)	47.7	1.9	(45.9)
Net interest	0.0	0.0	(0.0)	0.0	0.0	0.0	0.0	-	0.0
Depreciation	(2.7)	(1.5)	(1.2)	(29.8)	(28.6)	1.2	(32.5)	(31.3)	1.2
PDC dividend payables	(1.0)	(1.0)	0.0	(10.6)	(10.3)	0.3	(11.6)	(10.4)	1.2
Net deficit	(1.7)	(7.3)	(8.1)	2.4	(38.4)	(40.7)	3.7	(39.8)	(43.4)
EBITDA %		-8.1%			0.1%			0.2%	

The Trust is reporting:

- A deficit at the end of February 2014 of £38.4m, which is £40.7m adverse to the planned surplus of £2.4m

- In month position is a £7.3m deficit, £8.1m adverse to the Plan

- The revised base-case forecast, taking account of the Month 11 results, is consistent with the agreed year end control total at £39.8m deficit

Key points to note:

- Income variance – Continued emergency activity in excess of plan is significantly contributing to the overall financial position although this impacts of the Trusts ability to deliver elective activity (bed capacity constraint) and incurs MRET reduction

- Pay variance – Reflects the impact of investment in nursing establishment and protected supervisory time. Premium spend on nurse agency is expected to reduce over time as the success of international recruitment and newly qualified staff starts to reach scale

Key financial risks

The key financial risks that must be effectively managed to deliver our control total include:

- Winter pressures beyond the levels planned resulting in premium costs and the loss of elective income

Mitigation: The Trust is closely monitoring the impact providing additional resource as required. The position will be escalated with CCGs through the contract management process

- CCG income assumptions; Whilst activity and income assumptions are aligned between the Trust and Commissioners, there is a 'subject to affordability' clause within the CCG position

  Mitigation: Contract settlement has been agreed with Specialised Commissioning and negotiations continue with local CCGs

- Unforeseen events: The Trust has very little flexibility and a minimal contingency to manage unforeseen financial pressures and as such these risks will impact on the bottom line position if they materialise

- Liquidity: The projected £39.8m deficit creates liquidity issues for which an EFL adjustment has been agreed with the NTDA/Department of Health

In conclusion:

- The Trust will not meet its statutory break even duty

- The Trust has had its EFL reset to enable the creditor backlog to be reduced but continues to have liquidity issues

- The CRL has also been reduced by £6m to reflect the level of capital slippage.

6.7 SUMMARY OVERVIEW 2013/2014

Given the scale of our forecast deficit in 2013/14 and the associated underlying deficit the Trust will require a medium-term financial recovery plan which will be prepared in conjunction with the LLR Five Year Strategy work programme (by June, 2014).

The Accountability Framework for NHS Trust Boards sets out five different categories by which Trusts are defined, depending on their performance against key quality, delivery and finance standard.

As a consequence of our poor financial and emergency performance year-to-date, the Trust has been graded at **Level 4** (material issues) by the NTDA, reserved for those Trusts that have submitted a deficit AOP or are reporting material adverse deficits year-to-date.

In parallel following the release of the first look 'Intelligent Monitoring' reports the Care Quality Commission placed the Trust in **Band 1** for their planned inspections. The Trust was subsequently visited by the CQC on the week beginning 13 January 2014.

The draft report was received by the Trust on the 10 March and checked for factual accuracy. A Quality Summit will take place on 26 March during which a high level action plan will be agreed with our stakeholders. The Trust will develop detailed action plans within one month of the Quality Summit (26 April) at which point our Operational Plan will be retrospectively amended to integrate the key actions agreed.

7. ORGANISATIONAL CONTEXT – STRATEGIC DIRECTION

The environmental context within which our strategic direction was originally set (November 2012) has materially changed. It therefore makes sense for the Trust to take this opportunity to review and test that our vision, strategic objectives and previously described strategic

direction remain sound and that they continue to provide an appropriate framework within which to develop our plans in the short (two year) and medium term (5 years).

OUR PURPOSE - (i.e. the thing we ultimately strive for) is to provide **"Caring at its Best"** for our patients, their relatives and our staff.

OUR STRATEGIC DIRECTION – describes ***where*** we are going at a high level

OUR TWO YEAR OPERATIONAL PLAN - Describes ***what*** we are going to do in the next two years to help us move in the right direction – this includes our refreshed approach towards improvement and innovation **"*Supporting* Caring at its Best".**

OUR VALUES – describe how we behave whilst we strive achieve **"Caring at its Best"**

- 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 passionate and creative in our work
- We are one team and we work better when we work together

OUR STRATEGIC OBJECTIVES - Underpinning our purpose and values we previously agreed **seven strategic objectives**. These were represented in our strategic triangle, with safe, high quality, patient centred healthcare being the 'golden thread' that encompasses them all. Given the significant changes in the environment we have taken the opportunity to review and refresh our strategic objectives to ensure that they remain fit for purpose.

Some minor changes are recommended as below. The Trust Board is asked to **CONSIDER** and **APPROVE** the changes made. Following approval our diagrammatic strategic triangle will be revised.

Original strategic objective	Proposed strategic objective	Rationale
Safe, high quality, patient centred healthcare	No change	NA
Joined up emergency care	An effective, joined up emergency care system	Effective emergency care requires a system wide response
The provider of choice	Responsive services which people choose to use (secondary, specialised and tertiary care)	It is our services that people choose. To be attractive we need to be responsive. There is a need to be explicit about the markets we serve
Integrated care closer to home	Integrated care in partnership with others (secondary, specialised and tertiary care)	Effective integrated care doesn't sit with one organisation. Partnerships are a key enabler
Enhanced reputation in research, innovation and education	No change	
Professional, passionate and valued workforce	Delivering services through a caring, professional, passionate and valued workforce	Caring added – reflecting CQC domain
Sustainable, high performing NHS Foundation Trust	A safe, sustainable, productive, high performing NHS Foundation Trust	Safe added – reflecting CQC domain. Explicit emphasis on improving productivity
New addition: Objective 8	Enabled by better estate, equipment and technology	The consequences of the above

8. ENGAGEMENT

During March and April 2014, the Trust together with our health and care partners will be holding engagement events with key stakeholders. This will provide opportunity to share the above, outline our plans for 2014/2016 and to test out our early plans for the next five years. Patients and the public will have the opportunity to provide constructive comments on how our plans for the future may be enhanced. Events include:

- The Trust's Prospective Governors (Members Forum) including representatives from local BME groups

- Stakeholder Event for the LLR Five Year Strategy (12 March)

These events provide an opportunity for our Clinical Management Groups to share the emerging themes for their five year plans and enable patients, the public and other key stakeholders to contribute towards there further development.

9. OPERATIONAL PLAN 2014 – 2015 and 2015 - 2016

An overview of the Trust's Operating Plan for 2014-2015 and 2015-2016 is outlined below.

For each of our strategic objectives we have summarised our 'plan on a page', the governance structure within which performance will be managed and assurance will be sought and what success will look like. The metrics associated with the latter are currently being finalised through the respective programme of work.

The budget setting process will conclude week ending 28 March at which point a summary 'plan on a page' for each CMG will be generated. This will provide a tangible product that all CMGs can use to engage with their team and can show how what they do on the wards, in theatres, in outpatients, contributes towards the Trust's overall strategic direction.

Cutting across all of our plans are **three common themes**. In delivering our plans we will:

Effectively lead and manage service provision in line with defined standards whilst delivering our financial plan and improving productivity. We will do this by (illustrative examples):

- Delivering our CQC action plan
- Ensuring robust financial control and delivering on our financial plan
- Developing a robust service, quality, safety and financial strategy by Q1
- Developing and empowering our staff make changes through the roll out of LiA
- Centralising our outpatient function to simplify management arrangements, standardise process and deliver cash releasing savings

Build effective strategic partnerships to support delivery of safe and sustainable core and specialised services. We will do this by:

- Developing and agreeing a five year plan for health and social care across LLR
- Driving the development of an integrated, system wide capacity plan for LLR underpinned by an appropriate incentive framework that ensures all stakeholders are accountable for the delivery of their actions
- Driving the implementation of the LLR Alliance for community elective care to transform the model of delivery and associated standard operating procedures
- Developing our provider partnerships across the south East Midlands and north East Midlands to support sustainable delivery of more specialised services

- Following comprehensive service review of individual service lines, the Trust will consider the on-going viability of specialties that cannot demonstrate clinical and financial sustainability over an agreed time period.

Prepare strong foundations for forthcoming, large scale transformation – including improvement activities at scale and pace and early enabling capital schemes. We will do this by (illustrative examples):

- Delivering the majority of day case activity out of an acute hospital setting
- Identifying options to ring fence elective capacity
- Delivering the emergency floor development and supporting sustainable delivery of the ED standard
- Delivering business cases to support our medium term strategy
- Deliver EPR/EDRM

With these themes in mind the 'plan on a page' for each strategic objective is as follows:

In the next 5 years, UHL will become a Trust that is internationally recognised for placing quality, safety and innovation at the centre of service provision. We will build on our strengths' in specialised services, research and teaching and offer faster access to high quality care, develop our staff and improve patient experience, we call this…."Caring at its Best"

8.1 OVERRARCHING STRATEGIC OBJECTIVE: TO PROVIDE SAFE HIGH QUALITY, PATIENT CENTRED CARE

		Timeline
OBJECTIVE 1: EFFECTIVENESS Deliver evidence based care/best practice and effective pathways	**We will do this by:** Embedding the mortality review process across all specialities;	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
	Improving pathways of care to improve outcomes examples including pneumonia, Heart failure, Acute Kidney Injury (AKI), Out of hours care;	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
	Undertaking outcomes and process reviews e.g. Consultant assessment following emergency admission, clinical utilisation tool critical care, breast feeding neonates	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
	Embedding best practice including compliance with NICE and performance against national clinical audit	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
OBJECTIVE 2: SAFETY - Reduce avoidable death and injury; to improve patient safety culture and leadership and to reduce the risk of error and adverse incidents	Continued attention to Safety Actions including sepsis, handover, acting on results, Early Warning Score (EWS), Ward rounds	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
	Safety Thermometer – VTE, pressure ulcers, CAUTI, Falls, medication safety	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
	To pursue Patient Safety Collaborative Topics – HCAI, Nutrition, hydration, Diabetes (including think glucose) *	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
OBJECTIVE 3: EXPERIENCE Improve the patient experience	To actively seek views of patients across all services	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
	Improve the experience of care for older people by implementing the recommendations from national quality mark; improve/continue positive feedback across CMGs: involvement in care Help to toilet, buzzers answered	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
	Improve experience of care for patients with dementia/carers	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
OBJECTIVE 4: RESPOND to the recommendations made following the recent CQC inspection and LLR mortality review	Improve programme of AMBER across the Trust *	
	Develop action plan following the recent inspection. Share at a Quality Summit (26 March). Implement necessary action.	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4

Overseen through the following governance arrangements:

Trust Board – Quality and Performance

Quality Assurance Committee

Executive Quality Board

Sub committees of Executive Quality Board

Measured by the following critical success factors:

Reduced deaths

Reduced harm

Improved patient experience

By applying our values:
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8.2 OVERRARCHING STRATEGIC OBJECTIVE AN EFFECTIVE, JOINED UP EMERGENCY CARE SYSTEM

		Timeline
OBJECTIVE 1: At least 95% of patients should be admitted, transferred or discharged within 4 hours of their arrival in accident and emergency	**We will do this by:** Working in partnership to implement the agreed Urgent Care Improvement Plan (pre-hospital care, out of hospital care, care within the ED and on base wards through to safe, effective discharge)	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
	UCC - Explore the procurement opportunities to bid for the re- provision of the UCC service to facilitate a truly integrated single front door to urgent care	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
OBJECTIVE 2: Increase capacity in the short term to cope with peaks and troughs in demand	**Capacity – To effectively ma**nage the peaks and troughs in emergency demand in the short term (2 years), evaluate options to increase bed capacity (75 beds maximum). Seek approval to move forward (interdependency with elective capacity)	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
OBJECTIVE 3: Support the phased move towards 7 day services	**7 day services** – Active Engagement in the East Midlands 7 day working party and with local partners to scope current provision against the 7 day service standards. Complete gap analysis and develop a mutually agreed Service Development Improvement Plan to be implemented in 2014-2015 2015-2016 subject to the availability of resources	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
OBJECTIVE 4: Implement a fundamentally redesigned emergency floor ultimately co-locating ED and AMUD and AMU	**Emergency Floor – Capital development of a new** "emergency floor" at the LRI by 2015/2016. Construction will begin on site early 2015 following a period of enabling.	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
OBJECTIVE 5: Implement direct admission pathways for known patients to improve patient experience and avoid ED	**Admission avoidance/readmission** – Identify key pathways for known UHL patients (respiratory and heart failure) who traditionally may have been admitted but who can be appropriately managed out of hospital through a virtual ward or if admission is required this is directly to GGH thereby avoiding the ED.	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
OBJECTIVE 6:Improve the support for carers of people with dementia	**Dementia** – Provide carers of people with dementia wih appropriate support. Action required raising the patient profile, improving the information provided to carers	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4

Overseen through the following governance arrangements:

Trust Board – Quality and Performance

Finance and Performance Committee

Executive Performance Board

LLR Urgent Care Board

Measured by the following critical success factors

Sustained achievement if ED standard

Patient experience; improved cost efficiency

By applying our values:
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8.3 OVERRARCHING STRATEGIC OBJECTIVE: RESPONSIVE SERVICES WHICH PEOPLE CHOOSE TO USE (CORE SERVICES)

Operational Plan objective 1: Maintain delivery of Referral to Treatment 18 week maximum waiting	**We will do this by**: Implementing the **Improvement Plan** for **RTT performance** across all specialties most notably ophthalmology, ENT, orthopaedics and general surgery in order to achieve the agreed trajectories with commissioners for non-admitted patients by August 2014 and admitted patients by November 2014. N.B. the plan is predicated on an agreed level of demand	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
Operational Plan objective 2: Ensure there is sufficient capacity is in place to deliver core targets including elective, ED, cancer waiting time standards and cancelled operations	In the short term as QIPP schemes build up scale and pace, we will evaluate options to **protect and increase elective bed capacity** (circa 18 elective beds) in support of RTT delivery and tertiary activity and seek approval to move forward. N.B. note the interdependency and risk with emergency bed capacity	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
	Implementing stage 2 (3 beds) and 3 of phased **ICU capacity increase** at LRI to meet elective and emergency demand thereby reducing cancellations and reducing the risk of LLR patients going out of county.	Stage 2: Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Stage 3: Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
Operational Plan objective 3: To optimise both the opportunities for integration and the use of physical assets across the health and social care economy, ensuring care is provided in appropriate cost effective settings, reducing duplication and eliminating waste in the system	Subject to contract, THE Trust will work with local partners in implementing a novel **Alliance Contract** for the LLR elective care bundle. The current service will transfer over on an 'as-is' basis on 1 April, 2014. A period of stabilisation will follow. In 2015-2016 it is envisaged that the Alliance will move forward significant shifts in elective service provision to lower acuity, lower cost settings closer to home.	Transfer Stabilise Phased transformation Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4

Timeline

Overseen through the following governance arrangements

- Trust Board
- Alliance Leadership Board
- Executive Performance Board
- Clinical Management Groups Boards

Measured by the following success criteria:
Sustainable delivery of RTT standard; reduced cancellations; Increase in productivity of elective care; financial recovery; Improved friends and family results

By applying our values:
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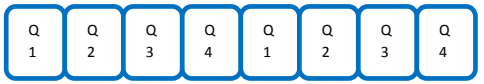
8.3 OVERRARCHING STRATEGIC OBJECTIVE: RESPONSIVE SERVICES WHICH PEOPLE CHOOSE TO USE (SPECIALISED SERVICES)

Operational Plan objective 1: To proactively rise to the challenges of the national Specialised Services Strategy and improve the utilisation of our expert workforce across a wider geographical area - enhancing capacity and capability and maintaining services as close to home as possible.

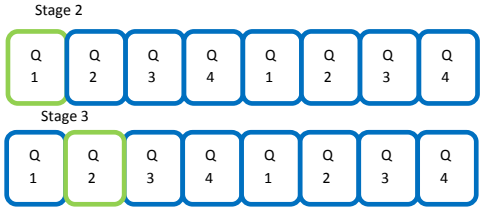
We will do this by: Developing a **strategic partnership** with Northampton General Hospital (and Kettering General Hospital) and establishing a **South East Midlands Cancer and Oncology Service** rising to the challenges of the nationally prescribed service specifications and providing greater opportunity for patients to access clinical trials.

Timeline



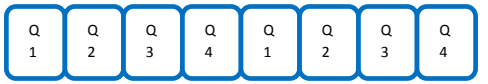
Operational Plan objective 2: Ensure there is sufficient capacity is in place to deliver core targets including elective, ED, cancer waiting time standards and reduced cancelled operations

We will do this by: Implementing stage 2 (3 beds) and 3 of phased **ICU capacity increase at LRI** to meet elective and emergency demand thereby reducing cancellations and reducing the risk of LLR patients going out of county.



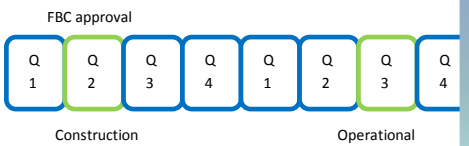
Operational Plan objective 3: To deliver high quality, patient centred, integrated care pathways, delivered in the appropriate place and at the appropriate time by the appropriate service

We will do this by: CMGs taking the necessary action to **address the specialised services derogation plans** currently in place for specific specialised services e.g. East Midlands Congenital Heart Services to ensure that we remain a designated specialised service centre. In complement the Trust will optimise the benefit of being a partner in the EM Academic and Health Science Network given the importance placed on this feature for the future of specialised services centre



Operational Plan objective 4: To optimise both the opportunities for integration and the use of physical assets, ensuring care is provided in appropriate cost effective settings, reducing duplication and eliminating waste in the system

We will do this by: Finalising the **OBC for the transfer of Vascular Services** (Vascular inpatient accommodation and Vascular Studies Unit) from the LRI to Glenfield Hospital (GH) and the establishment of a Hybrid Theatre to exceed the threshold requirement of specialised service specification and to facilitate the consolidation of cardio-vascular and thoracic services. It is UHL's ambition to be the main regional centre for complex endovascular services.



Overseen through the following governance arrangements

Trust Board

Partnership structures

Clinical Management Groups Boards

Measured by the following success criteria:

Increase in productivity of elective care; Growth in tertiary income; financial recovery; Improved friends and family results

By applying our values:
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8.4 OVERRARCHING STRATEGIC OBJECTIVE: INTEGRATED CARE IN PARTNERSHIP WITH OTHERS (SECONDARY AND SPECIALISED SERVICES)

Operational Plan objective 1: To deliver high quality, citizen centred, integrated care pathways, delivered in the appropriate place and at the appropriate time by the appropriate person, supported by staff/citizens, resulting in a reduction in the time spent avoidably in hospital

We will do this by: Fostering integration and developing strong relationships by actively engaging in shaping and testing the **Better Care Fund plans** for implementation in 2015/2016 in collaboration with our partners. These will be underpinned by robust KPI's. The plans being developed focus on four key strands: Prevention, Long Term Condition management, Crisis Response (within 2 hours) in the community, Discharge and re-ablement.

We will do this by: Implementing with our local partners a fundamentally redesigned pathway for diabetes patients (**Diabetes Super 7**) in April 2014. This will see a fundamental shift of most diabetes care into primary care or the home but with appropriate access to an acute services as/when required for complex cases and/or unstable diabetes.

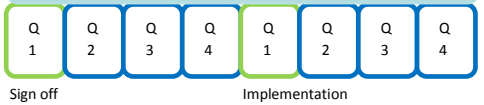
Operational Plan objective 2: To increase the number of frail older people and their carers benefiting from an integrated care pathway and reporting a positive experience of care across all health and social care settings

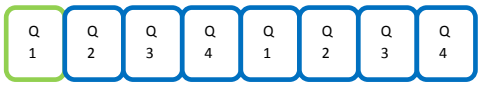
We will do this by: Implementing a **vertically integrated Model of Care for Frail Older People** – including FOPAL, Interface geriatrics (consistent geriatric input to base wards in the hospital setting and in the outpatient community setting), Emergency Frailty Unit (EFU), and Acute Frailty Unit (AFU) in partnership with health and social care. Subject to budget setting this will include enhanced service provision on the Emergency Frailty Unit (EFU) and the interface geriatric service which will support the base wards and outpatient services in the community.

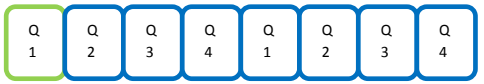
Operational Plan objective 3: To optimise the opportunities for service integration and the use of physical assets across the health economy, ensuring care is provided in appropriate cost effective settings, reducing duplication and eliminating waste in the system

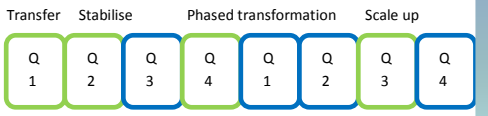
We will do this by: Implementing the **LLR Elective Community Services Alliance** the primary objective of which is to support and facilitate end to end delivery of community based elective activity within a framework of joint accountability. First priorities include dermatology, gastroenterology and ophthalmology.

Timeline









Overseen through the following governance arrangements

Trust Board

Better Care Fund governance

LLR Better Care Together

Clinical Management Groups Boards

Measured by the following success criteria:

Reduction in hospital emergency activity for specified cohorts; Increase in productivity of elective care; Achievement of system objectives

By applying our values:
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In the next 5 years, UHL will become a Trust that is internationally recognised for placing quality, safety and innovation at the centre of service provision. We will build on our strengths' in specialised services, research and teaching and offer faster access to high quality care, develop our staff and improve patient experience, we call this…."Caring at its Best"

8.5 OVERRARCHING STRATEGIC OBJECTIVE: ENHANCED REPUTATION IN RESEARCH, INNOVATION AND CLINICAL EDUCATION

		Timeline
Operational Plan objective 1: To build capacity and capability through research and development in services, education and training of people and advancement in treatment	**We will do this by:** Explore the options to enhance our infrastructure to support **interdisciplinary education** with a future aspiration to support and enhance patient and carer education for those with a long term condition. The Trust will explore the feasibility of reutilising the Brandon Unit on the Leicester General Hospital site for educational use.	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
Operational Plan objective 2: To reduce inequalities in physical across and within communities resulting in the long term to additional years of life for citizens with treatable physical health conditions	**We will do this by:** Optimising the benefits of **exercise as a prescribed treatment** in the management of long term conditions. Working in partnership with Loughborough University, Leicester University and Nottingham University Hospitals we will actively participate in research and service provision at the newly established East Midlands Centre for Sports and Exercise Medicine Service – part of the Olympic legacy.	Develop operational plan Opened Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
Operational Plan objective 3: To develop new capacity and capabilities with and through our staff and through the appropriate availability of resources	**We will do this by**: **Further enhancing the quality of medical education** by improving the education facilities at the LRI (conversion of what was Odames Ward) and through quality assurance of specialty level delivery via the robust CMG management structure.	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
Operational Plan objective 4: To reduce inequalities in care within and across the East Midlands resulting in additional years of life for citizens with treatable conditions	**We will do this by**: Optimising the benefit of our engagement in the **East Midland Academic Health Science Network** bringing together multiple high profile programmes of work with a view to achieving a step change in outcome improvement across key diseases including: cancer, respiratory, CVD, dementia (LLR priorities)	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
	We will do this by: Hosting and leading the research agenda of the **East Midland National Institute of Health Research (NIHR)**	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4

Overseen through the following governance arrangements:

Trust Board

R&D Committee

Clinical Management Group Boards

Measured by the following success criteria:

Increased recruitment to trials

Increase in commercial trials

Improved return on investment

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8.6 OVERRARCHING STRATEGIC OBJECTIVE: DELIVERING SERVICES THROUGH A PROFESSIONAL, PASSIONATE AND VALUED WORKFORCE

Operational Plan objective 1: Build capacity and capability by ensuring that our staff have the right tools, training and support to deliver care, and are supported to develop and progress.

We will do this by: Embedding the Listening into Action methodology and approach in to the organisation, spreading it as a mechanism for making staff led improvements. We will train key clinical leads to enable the facilitation of 'Listening Events' within all ward and clinical department areas and to support staff led improvement

We will do this by: Implementing the Leadership into Action strategy which will improve quality and access to learning, education and development with the key focus being on inclusive leadership development across all professions and at all levels including the Trust Board.

We will do this by: Refreshing our three year organisational development plan in the context of our strategic direction and the outcome of the recent CMG planning and strategy workshops. We will define deliverables for the previously agreed key workstreams: Live our Values, Improve Two-way Engagement, Strengthen Leadership, Enhance Workplace Learning, Improve External Relationships and Workplace Partnerships, Encourage Creativity and Innovation.

Operational Plan objective 2: To improve the utilisation of current our workforce and where necessary build new capacity and capability to support short and medium service plans as a Trust and local economy.

We will do this by: Refreshing our three year workforce plan as above Identify and map key shifts in staffing numbers and skill mix required. Contribute towards the development of the LLR workforce plan. Utilise the output to inform commissioning plans via the LETC and LETB. Review progress and compliance with safe staffing ratios twice a year at Board.

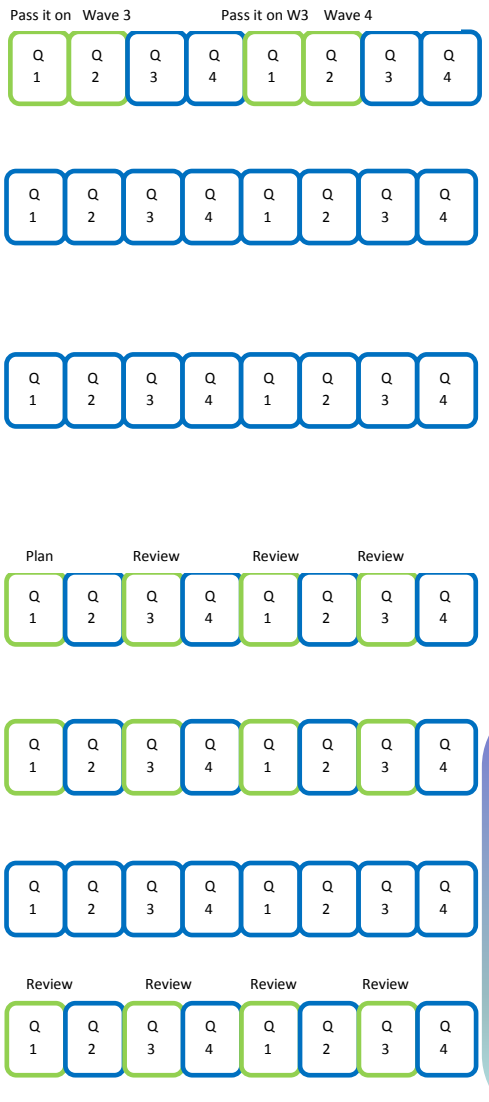
We will do this by: Improving the appraisal process to enhance quality, experience and align with pay progression with the aim that 100% of staff are responsible for having an appraisal that is valuable, productive and provides positive feedback

Operational Plan objective 3: To improve staff survey results in those areas that have materially slipped and to maintain or improve all remaining areas by xx

We will do this by: Undertaking analysis to better understand the drivers behind those areas where our staff survey results have slipped into lowest 20% of Acute Trusts. Compare and contrast the analysis with the more favourable results and identify plans for sustained improvement

We will do this by: Introducing the Friends and Family Test for NHS Staff from the 1 April. We will ask two satisfaction questions (would you recommend the Trust as a place to work? Would you recommend the Trust as a place to be treated? We will compare/contrast to the above and agree a plan for improvement

Timeline



Overseen through the following governance arrangements

- Trust Board
- LETB
- LETC
- Clinical Management Group

Measured by the following success criteria

- Improved recruitment and retention
- Improved Staff survey results
- Pulse check

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8.7 OVERRARCHING STRATEGIC OBJECTIVE: A SAFE, SUSTAINABLE, PRODUCTIVE, HIGH PERFORMING NHS FOUNDATION TRUST

Operational Plan objective 1: As a key partner in the LLR health and care economy we will maximise value for the citizens of Leicester, Leicestershire and Rutland (LLR) by improving the health and wellbeing outcomes that matter to them, their families and carers in a way that enhances the quality of care at the same time as reducing cost to within allocated resources by restructuring the provision of safe, high quality services into the most efficient and effective settings	**We will do this by:** Actively participating, confirming and challenging the development of the **5 year Leicester, Leicestershire and Rutland Strategy** which will show how as health and social care partners we intend to rise to the challenges and needs of the local population and address them given a forecast, cumulative gap in financial resources of circa £380m (health and social care)	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
	We will do this by: Implementing our two year operational plan with a view to our focus in **2014/2015** being on **delivering performance today** whilst **laying down strong foundations** for the future and **2015/2016** focusing on **driving forward our strategic agenda**. Once the LLR five year strategy is complete by June 2014, the Trust will retrospectively reconcile our two year plans with the five	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
Operational Plan objective 2: To deliver high quality, citizen centred, integrated care pathways, delivered in the appropriate place and at the appropriate time by the appropriate person, supported by staff/citizens, resulting in a	**We will do this by**: Implement the **'Sustainable Future' 3-7 Year Strategy Programme** with the CMGs building on the work done to date. This will bring together all aspects of our future plans including service strategies, reconfiguration etc. This framework will support the iterative development of the Trust's sustainability plan for years 3-7 (operational plan for years 1-2) to ultimately be signed off by Trust Board on 20 June 2014	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
Operational Plan objective 3: To achieve financial balance by the end of 2016/2017 and long term clinical and financial sustainability, reflecting any changes in resource profile where appropriate	**We will do this by:** Implementing **"Enabling Caring at its best"** the revised framework for cost and quality improvement activities to include Stage 1: CMG specific work programmes and cross cutting workstreams Stage 2: Support detailed analysis to inform the scope of opportunity areas to secure sustainability. This will be supported by significant external support.	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
	We will do this by: Delivering our significant **Cost Improvement Programme**	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
	We will do this by: Developing and implementing a **financial strategy** to support our recovery plan and achieve financial balance by no later than the end of 2016/2017.	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
Operational Plan objective 4: To optimise both the opportunities for integration and the use of physical assets across the health and social care economy, ensuring care is provided in appropriate cost effective settings, reducing duplication and eliminating waste in the system	**We will do this by:** Completing a **robust strategic case for change** for consideration by the TDA which will provide the framework for estate reconfiguration in years 3-7.	Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4

Timeline

Sign off | Review yr. 2 | Implement yr. 1 | Implement yr2

Overseen through the following governance arrangements:

- Trust Board
- Executive Performance Board
- Executive Strategy Board
- Clinical Management Group Boards

Measured by the following success criteria

- CIP delivery in line with plan
- Delivery year one financial recovery plan
- Agreed LLR five year strategy

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8.8 OVERRARCHING STRATEGIC OBJECTIVE: ENABLED BY BETTER ESTATE, EQUIPMENT AND TECHNOLOGY

Operational Plan objective 1: To deliver high quality, patient centred, care pathways, delivered in the appropriate place and at the appropriate time by the appropriate person, supported by staff/citizens, resulting in a reduction in the time spent avoidably in hospital by 30%

We will do this by: Securing TDA approval and delivering the **Emergency Floor Business Case**. This will involve significant enabling works including: demolition of the Langham building in October 2014, the development of a modular ward block and out patients accommodation, re-provision of the urgent care centre in clinics 1 and 2 and refurbishment of space previously housing a Linac in the building. It is expected that the Full Business Case will be considered and

Operational Plan objective 2: To optimise the use of physical assets, ensuring care is provided in appropriate cost effective settings, reducing duplication and eliminating waste in the system

We will do this by: Developing the **Vascular OBC** which is scheduled for completion by June 2014 and for consideration at Trust Board followed by NTDA consideration in July 2014.

We will do this by: **Implementing Electronic Document Record Management (EDRM)** system. The pilot studies in 2 areas (genetics and MSK) which are underway are to be completed and reviewed. Based on the results a plan for roll out will be developed.

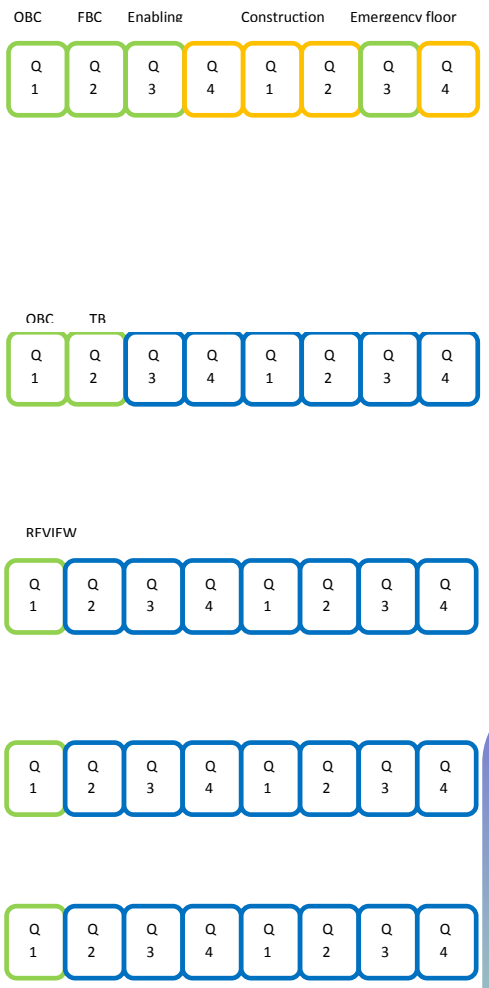
Operational Plan objective 3: To improve the utilisation of our workforce and the development of new capacity and capabilities in the technology we use

We will do this by: Progressing the **Electronic Patient Record** (EPR) procurement following Trust Board approval of the business case.

We will do this by: Optimise the productivity and quality opportunity created through technology enabled **nurse led agile working**

We will do this by: Securing robust plans for the replacement of critical medical equipment (LINACs) and the **potential feasibility and business case for PETCT and robotics**

Timeline



Overseen through the following governance arrangements:

Trust Board

Executive Strategy Board

Sustainable Future Programme Board

Measured by the following success criteria:

Footprint reduction

Improved occupancy

Environmental quality

By applying our values:
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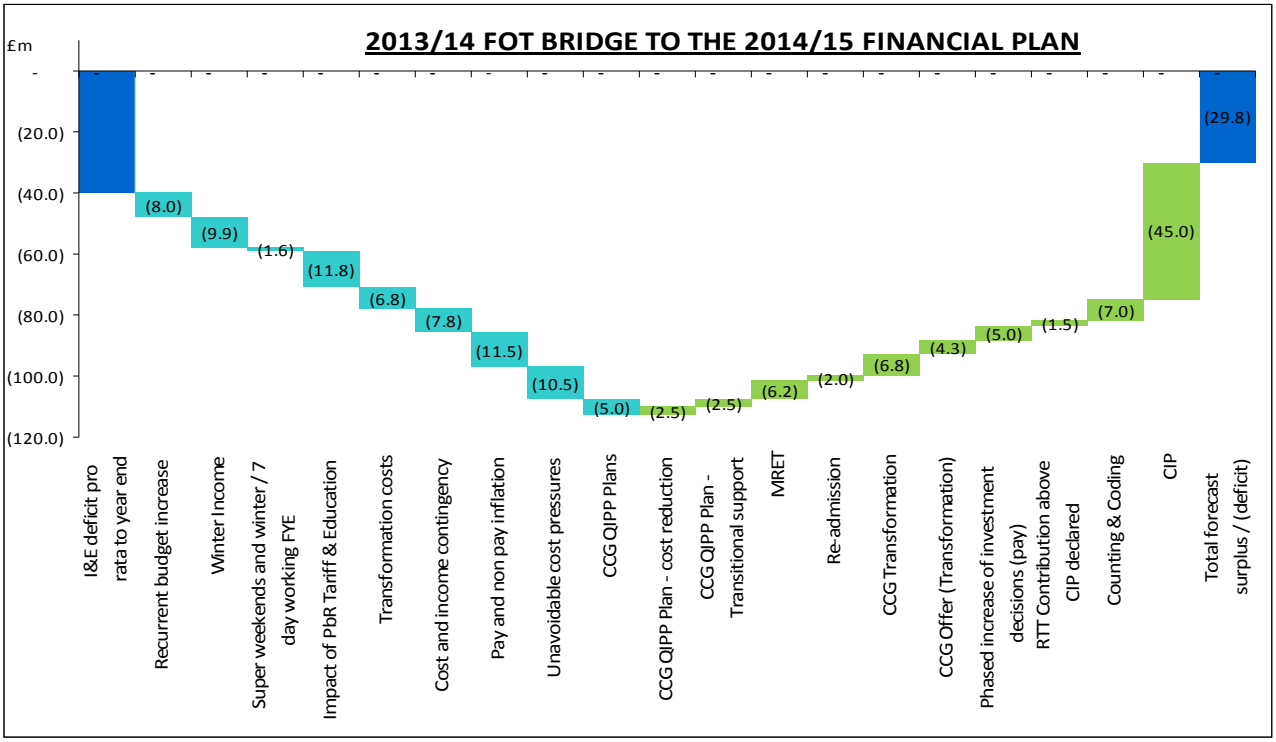
10. HIGH LEVEL OVERVIEW OF THE FINANCIAL PLAN 2014 -2015

At present, based on an outturn deficit of £39.8 million for 2013/2014, we are projecting a deficit of £29.8 million for 2014/2015. This is an improvement in the position described in our first submission which reflected a £32.8 million deficit position.

The key assumptions behind the plan and the movement from the 2013/14 out-turn deficit of £39.8 million are reflected in the following bridge:



Key points to note against the categories are as follows:

10.1 RECURRENT BUDGETS (£8 MILLION)

There is an £8 million impact in 2014/15 non recurrent budgets agreed in 2013/14 to support service delivery and quality standards. These include:

- Ward based nursing acuity review, £4.0 million
- Managed business partnership (IBM), £1.8 million
- Approved investments e.g. Outpatient booking centre, medical cover, £2 million

10.2 WINTER / 7 DAY WORKING (£11.5 MILLION)

The Trust received almost £10 million of non-recurrent money in 2013/14 to support the delivery of the winter plan and emergency activity. The recurrent costs of this, mainly staff related, are approximately £11.5 million. This investment covers the following key areas:

- Super weekends to support the emergency process, £2.8 million
- Additional bed capacity plus therapy support, £3.0 million
- Emergency flow from ED, £2.0 million
- Assessment Unit beds, £0.8 million
- Hospital at night, £0.5 million
- Outpatient Antibiotic therapy, £0.5 million

- Pharmacy TTOs, ward clerks, cancer support, discharge team, £1.2 million

10.3 TARIFF (£11.8 MILLION)

This reflects the national efficiency requirement of 4% plus the impact of the education and training review (MADEL and SIFT).

10.4 TRANSFORMATION COSTS (£6.8 MILLION)

Assumed non recurrent costs to support the delivery of recurrent efficiencies, the key schemes are:

- Workforce Review (Skill-mix/Reductions, Voluntary Severance Scheme/Redundancy)
- Reconfiguration of Services
- External Review of Financial Transformation and CIP
- Major Service Changes including East Midlands Pathology, Theatres and Outpatients
- Outsourcing of IM&T – non recurrent costs to deliver recurrent savings (Managed Print Project, Electronic Document Records Management)

10.5 COST AND INCOME CONTINGENCY (£7.8 MILLION)

The Plan assumed a cost contingency of £4.3 million (0.5% of turnover) to cover unexpected costs and £3.5 million for in year contractual penalties.

10.6 INFLATION (£11.5 MILLION)

Assumed costs for incremental drift and pay awards, plus specific (e.g. contract inflation) and generic non pay inflation (e.g. drugs).

10.7 COST PRESSURES (£10.5 MILLION)

Cost pressures have been identified via the CMG/Corporate Directorate reviews to the value of £10.5 million. This reflects unavoidable costs required to deliver the activity plan.

10.8 QIPP, NET OF £0 MILLION

The Trust is reflecting a part year reduction of £5 million of the CCG QIPP schemes. The income loss is offset by a £2.5 million reduction in the marginal costs and £2.5 million from transformation support.

9.9 MRET (£6.2 MILLION)

Assumptions that the Trust will secure MRET rebasing and has therefore assumed a circa £6.2 million increase in income that was not reflected in our first submission. It should be noted that the Trust requested that commissioners rebase the baseline for MRET to 2013/14. However, commissioners have declined. The Trust has confirmed in writing that this position is not acceptable and has since written to Monitor to request an external review to inform resolution.

9.10 TRANSFORMATION FUNDING (£11.1 MILLION)

The Trust has submitted business cases for transformation funding. Our first draft financial plan assumed no transformation funding in our plan. Our first full draft plan reflects circa £11.1 million which remains a prudent assumption. We have had initial confirmation of support for £4.3 million, excluding RTT backlog, mainly around winter costs and support to the strategic reconfiguration team.

This excludes the £2.5 million contribution as transitional support relating to CCG QIPP programmes.

10.11 RTT CONTRIBUTION (£1.5 MILLION)

A £1.5 million contribution is reflected in our plan in support of RTT.

10.12 COUNTING & CODING (£7 MILLION)

A £7 million assumption within the contractual negotiations.

10.13 CAPITAL

Appendix A details the draft 2014/15 capital plan, broken down by CMG / Corporate Directorate and by schemes to be funded via the Trust's internal capital resource limit (CRL) and those requiring external funding - these will require business cases to the NTDA

The Trust Board is asked to note and approve the draft plan including;

- 2014/15 draft plan totalling £47.7m
- CRL funding of £34.5m
- An initial gap against the CRL of £13.2m – this does include £7.8m of ED Enabling schemes which will be subject to a bid for external funding
- A revised gap of £5.4m against the CRL, which based on the number of schemes already committed, is a manageable over commitment against the 2014/15 capital programme
- The capital programme in 2014/15 will be proactively managed via the recently established Capital Group, chaired by the Director of Finance.

The final capital plan submitted to the NTDA on the 4 April will be brought back to the Committee / Trust Board in April for formal approval

10.14 COST IMPROVEMENT PROGRAMME (£45m)

Our CIP programme equates to £45m. The programme is based on cost reduction from the 2013/14 FOT position, £9.9m, and a £35.1m reduction in the recurrent budget reflecting the 4% efficiency target. The initial work by Ernst & Young has indicated a risk adjusted CIP of £25m with further work required on the profiling of these schemes.

In addition to the CIP, cost control is clearly central to delivery of the financial plan and will be underpinned by feasible mitigations including:

- Enhanced non pay control – improved governance processes; stock management systems
- Strengthening vacancy management
- Recruitment campaigns for the key professions – fill substantively and we will reduce premium pay
- Targeted areas for focus — nursing agency, medical model, ED, theatre efficiency, tariff, site and the economic drag of running three sites (total of £50m)
- Increasing the productivity of fixed costs already in place (particularly in respect of RTT)

10.15 RISK

The revised financial position is **not without significant risk** however the key changes are associated with:

The key risks within the current plan are;

The Trust is currently going through an arbitration process with the CCGs to agree the 2014/15 contract. This is expected to be finalised by the 4 April 2014. These areas are;

- MRET rebasing
- Re-admissions
- Counting and Coding,
- CCG QIPP
- Non recurrent CCG funds (2.5%)

If arbitration is unsuccessful, then the Trust deficit plan will increase.

The overall CIP programme of £45m is very challenging and reflects 5.3% of the cost base. The Trust has secured support from Ernst & Young to support delivery of the target. The initial work by Ernst & Young has indicated a risk adjusted CIP of £25m with further significant work required on the profiling of these schemes and alternative schemes to mitigate the risk of slippage. All approved schemes will be Quality Impact Assessed and corporately signed off by the beginning of April.

Capacity to deliver the planned activity and mitigating the risk of excessive levels of emergency demand negatively impacting on RTT recovery

LLR Community Elective Care Tender – the plan currently excludes the I&E impact of the Elective Care tender which UHL in partnership with LPT and LLR PCL is the preferred bidder

Based on the current risks around CIP delivery of the £45 million, the impending arbitration on the income assumptions (outcome not anticipated until early April), plus the impact of the key changes above, the Trust would not recommend an improvement to the current £29.8 million deficit plan for 2014/15. It is clear however that there is significantly more work required on our plan for 2015 -2016 particularly in respect of the work being undertaken by the Trust and E&Y to scope cross cutting workstreams including medical and workforce productivity. It is anticipated that more information in respect of the opportunity will be available in the next two weeks and will be reported in more detail to Trust Board on 24 April 2014.

The Trusts Standing Financial Instructions and Standing Orders set out requirements for the Trust Board to agree a balanced budget prior to the start of the year. Following a meeting with the Director of Finance of the NTDA the Trust does have agreement in principle to have a deficit plan in 2014/15. This is predicated on having a three year recovery plan to move back to break even.

In this context the Trust Board is asked to APPROVE the deficit plan for 2014/15, and the provisional CMG and Corporate budgets herein. The detailed final budgets will be provided to Trust Board in April.

11. HIGH LEVEL OVERVIEW OF THE WORKFORCE PLAN 2014-2015 and 2015-2016

A full nursing acuity and safe staffing review in 2013/14 has led to a rebasing of nursing establishment which in turn has led to a recruitment challenge. To address this challenge investment will continue to be made in International Recruitment and employer branding to ensure we remain an attractive employer. Recent international recruitment has been very successful. Looking forward, we anticipate recruiting a minimum of 20 international nurses on a monthly basis.

In complement, the workforce implications for 7 day service provision are being reviewed by the Deputy Medical Director and other potential shortfalls identified CMGs. The opportunity to develop alternative roles is being explored including assistant practitioners in areas such as theatres, outpatients and ‘step down’ wards.

11.1 Workforce Plan 2014/2015

The workforce plan the workforce plan for 2015-2016 is still subject to refinement and executive sign off. This forms part of the five year strategy work programme that will be concluded by 20 June and will align to the national requirement for Trust Boards to spend protected time to look in detail at workforce, skill mix etc. on a six monthly basis. Based on the guidance, the first review is required in June. Annex D at this stage reflects a pattern of qualified nurse worked WTE increase of 230 WTE during 2014/2015 which is in line with the nursing recruitment strategy described above. A detailed workforce 'bridge' will be presented in our final plan submission on 4 April.

11.2 Longer term strategy

To address potential longer term reductions in trainee posts and consultant shortfalls, extended roles in the form of advanced practitioners will be developed. A competency framework in the Emergency Department is in development to be used as a baseline for further roles in the Trust.

In complement the apprenticeship route for Healthcare Assistants will continue to be expanded to provide an appropriate developmental pathway for future care workers.

11.3 Capacity planning

Following up the recent planning and strategy workshops undertaken with the CMGs, a cross CMG capacity planning workshop will be undertaken on the 7 April. This will provide opportunity for the Trust to consider the aggregate capacity assumptions that will underpin our five year plan and within that, our strategic capital plans for clinical reconfiguration. The output of this process will support a detailed refresh of the current workforce plan which will be reflected in our five year plan by June, 2014.

In complement the Trust will actively engage, shape and drive the development of a system wide capacity model that places appropriate incentives (or penalties) for all stakeholders to deliver their part of the LLR system wide plans for transformation over the next five years.

12. RECOMMENDATION

The Trust Board is asked to:

NOTE that in line with the nationally set planning timeline the LLR five year strategy is being developed and will be submitted on 20 June, after the submission of our two year plan on 4 April. For this year only this creates the need for retrospective reconciliation of plans.

APPROVE IN PRINCIPLE the Operational Plan for 2014-2015 noting the planning assumptions .underpinning it.

APPROVE IN PRINCIPAL the Financial Plan for 2014-2015 noting the risk and mitigation identified**.**

NOTE the risk pertaining to the unknown outcome of the contractual arbitration process.

NOTE the risk pertaining to the risk analysis of our CIP programme for 2014 -2015**.**

APPROVE the broad parameters of the Operational Plan for 2015 – 2016 noting that at the point of submission on 4 April it will reflect broad planning assumptions which will be subject to significant refinement and retrospective reconciliation by 20 June as part of the five year strategy work programme. It is anticipated that on the basis of the work being undertaken with E&Y and across the health and social care community, that our plans for 2015 – 2016 will demonstrate more significant scale and pace of cost improvement across the cross cutting themes identified e.g. Productivity, procurement etc.

NOTE that there will be a need to retrospectively reconcile and review workforce plans particularly in light of the CIP plan review undertaken by E&Y and the LLR five year strategy.

Capital Plan 2014/15 (Draft)

Version 08 - March 2014	Scheme Committed (Y/N)	2014/15 TOTAL £'000	Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Project Lead	Project Director
CHUGGS CMG								
Linear Accelerator	N	0					Lorraine Williams / John Sage	John Jameson
Endoscopy GH	N	309	150	159			Capital Planning & Delivery Team	John Jameson
Lithotripter Machine	N	430		430			Michael Nattrass	John Jameson
Sub-total: CHUGGS CMG		**739**	**150**	**589**	**0**	**0**		
CSI CMG								
Aseptic Suite	Y	400	200	200			Pharmacy	Suzanne Khalid
MES Installation Costs	N	1,250	400	250	300	300	Helen Seth / Nigel Bond	Suzanne Khalid
Sub-total: CSI CMG		**1,650**	**600**	**450**	**300**	**300**		
Women's and Children's CMG								
Maternity Interim Development	Y	1,000	300	300	400		David Yeomanson	Ian Scudamore
Bereavement Facilities	N	62	62				David Yeomanson	Ian Scudamore
Sub-total: Women's & Children's CMG		**1,062**	**362**	**300**	**400**	**0**		
Renal, Respiratory & Cardiac CMG								
Renal Home Dialysis Expansion	N	708	200	200	200	108	Samantha Leak	Nick Moore
Sub-total: Renal, Respiratory & Cardiac CMG		**708**	**200**	**200**	**200**	**108**		
Corporate / Other Schemes								
Stock Management Project	N	2,949	699	750	750	750	Andrea Smith	Peter Hollinshead
Medical Equipment Executive Budget	N	3,737	750	900	900	1,187	Paul Spiers / Mark Norton	Kevin Harris
LiA Schemes	N	500	50	200	200	50	Michelle Cloney	John Adler
Odames Library	N	1,500	100	650	750		Capital Planning & Delivery	Sue Carr
Donations	N	300	75	75	75	75		Peter Hollinshead
Sub-total: Corporate / Other Schemes		**8,986**	**1,674**	**2,575**	**2,675**	**2,062**		
IM&T Schemes								
IM&T Sub Group Budget	N	3,000	600	750	750	900	IT - John Clarke	John Adler
Safer Hospitals Technology Fund	N	1,150	1,150				IT - John Clarke	John Adler
EDRM System	N	3,300	600	1,000	1,000	700	IT - John Clarke	John Adler
EPR Programme	N	3,100	100	1,000	1,000	1,000	IT - John Clarke	John Adler
Unified Comms	N	1,850	50	600	600	600	IT - John Clarke	John Adler
Sub-total: IM&T Schemes		**12,400**	**2,500**	**3,350**	**3,350**	**3,200**		
Facilities / NHS Horizons Schemes								
Facilities Backlog Maintenance	N	6,000	500	1,500	1,500	2,500	Horizons - Andrew Chatten	Rachel Overfield
Accommodation Refurbishment	N	2,400	300	700	700	700	Clare Blakemore / Andrew Chatten	Kate Bradley
CHP Units LRI & GH	Y	800	600	200			Capital Planning & Delivery/Nigel Bond	Rachel Overfield
Sub-total: Facilities / NHS Horizons Schemes		**9,200**	**1,400**	**2,400**	**2,200**	**3,200**		
ED Enabling Schemes								
ED Enabler: Clinic 1 & 2 Works	N	814		214	600		Capital Planning & Delivery/Louise Naylor	Kate Shields
ED Enabler: Old Cancer Centre Conversion	N	1,050	300	300	450		Capital Planning & Delivery/Louise Naylor	Kate Shields
ED Enabler: Oliver Ward Conversion	N	1,260	400	400	460		Capital Planning & Delivery/Louise Naylor	Kate Shields
ED Enabler: Clinical Genetics	N	158			158		Capital Planning & Delivery/Louise Naylor	Kate Shields
ED Enabler: Chapel Relocation	N	315	100	100	115		Capital Planning & Delivery/Louise Naylor	Kate Shields
ED Enabler: Victoria Main Reception	N	525	50	200	200	75	Capital Planning & Delivery/Louise Naylor	Kate Shields
ED Enabler: Modular Wards LRI	Y	3,700	500	2,500	700		Capital Planning & Delivery/Louise Naylor	Kate Shields
Sub-total: ED Enabling schemes		**7,822**	**1,350**	**3,714**	**2,683**	**75**		
Reconfiguration Schemes								
Theatre Recovery LRI	N	2,785	500	750	535	1,000	Capital Planning & Delivery/Ian Currie	Kate Shields
Interim ITU LRI	Y	500	300	200			Capital Planning & Delivery	Kate Shields
Interim ITU Development GH	N						Capital Planning & Delivery	Kate Shields
Vascular Enabling	N	520	100	200	220		Capital Planning & Delivery/Debra Green	Kate Shields
Kensington Reception	N						Capital Planning & Delivery	Kate Shields
KSOPD Refurbishment	N	250	125	125			Capital Planning & Delivery	Kate Shields
Ward 4 LGH	N	1,000	200	400	400		Capital Planning & Delivery/Nicky Topham	Kate Shields
Feasibility Studies	N	100	25	25	25	25	Capital Planning & Delivery	Kate Shields
Sub-total: Reconfiguration Schemes		**5,155**						
Total Schemes funded via internal sources		**47,722**	**9,486**	**15,278**	**12,988**	**9,970**		
CRL Funding		***34,507***						
ED Enabling Schemes (assumed external funding)		***7,822***						
CRL Funding Gap		***5,393***						
Schemes to be funded via external loans								
Emergency Floor		11,523	tbc	tbc	tbc	tbc	Capital Planning & Delivery/Nicky Topham	Kate Shields
GGH Vascular Surgery 9inc.Ward, Ang, Hybrid		4,000	tbc	tbc	tbc	tbc	Capital Planning & Delivery/Rachel Griffiths	Kate Shields
Sub-total: External Loans		**15,523**						
Total Capital Plan		**63,245**						
Funding								
Depreciation / CRL		32,995						
DoH Loan		15,523						
DoH Loan - ED Enablers		7,822						
Safer Hospitals Technology Fund		1,150						
Improving Maternity Care Settings		62						
Donations		300						
Total Source of Funds		**57,852**						
Over / (Under) Spend		5,393						