Operational Plan 17-19 Refresh

Author/s: Gino DiStefano Sponsor: Paul Traynor Date: 4 May 2017 Trust Board paper I

Executive Summary

Context

Our operational plan describes how we will meet the expectations of our patients, the regulator, commissioners and other stakeholders on our journey to sustainability, whilst also focusing on tackling immediate performance issues and ensuring short-term resilience. It is made up of an overarching narrative (enclosed) and a number of detailed technical returns that are summarised within the main narrative itself and associated appendices.

There have been several iterations of our plan over the past 6 months in line with national requirements. Below is our final operational plan for 2017-19.

Questions

1. What is the status of our operational plan?
2. What are the key changes made to our plan since the last version to be signed off by the Trust Board?
3. What are the next steps?

Conclusion

1. We submitted our final revisions to our regulator, NHS Improvement (NHSI), in early April 2017. This is the plan (and the numbers) against which NHSI will monitor us throughout the year. The narrative below represents our final operational plan for 2017-19, accounting for a number of updates since the version signed off by the Trust Board in December. All revisions have been discussed in detail at Trust Board sub-committees, chaired by non-executive directors.

2. Over the course of the various planning submissions we have made (November, December, January, March / April), we have refined our planning assumptions for the years ahead.

   Our activity plan / forecasts are now based on what we are calling a 'downside scenario' where we assume demand is somewhat higher than our contract indicates due to part delivery of QIPP (50%). There is a general consensus that this scenario is the most realistic basis for planning. This was tested with NHSI during the deep-dive planning sessions in March and there was broad agreement that this was a sensible approach given the associated links to capacity planning, safety and performance.

   Our (final) financial plan shows a planned deficit of £26.7m and £21.7m for 17/18 and 18/19 respectively. This represents an improvement to our most recent assumption (expressed in our January and March submissions) of c.£3m for both years. This is due to the strict rules

associated with this final refresh; namely, financial plans could not show any deterioration from our December submission, which is what our final plan reflects.

Our workforce plan aligns our latest financial plan / affordable paybill envelope - we have worked all financial adjustments into our average cost per WTE / skill mix assumptions rather than assuming significant reductions in actual WTE.

In terms of expected performance, our latest trajectories align with our demand and capacity assumptions (including the timing of additional capacity coming on board). However, the recently published Next Steps on the NHS Five Year Forward View - a Delivery Plan for the NHS - detailed new performance expectations, which we have had to reflect in our local performance trajectories. Our emergency department (4 hours) target is most affected by this. As a result, our final trajectories do not align as closely with our demand and capacity assumptions as our previous trajectories, creating a level of risk in terms of timely delivery.

3. It is likely that we will need to refresh our plan at the beginning of 2018-19 but this will depend, in part, on what the national planning guidance requires. We are also in the process of translating the overarching narrative, below, into an easy read version for wider dissemination.

Input Sought

The Trust Board is asked to:

1. Consider the summary of changes made to our Operational Plan for 2017-19
2. Formally approve the final Operational Plan for 2017-19, including the overarching narrative below.

For Reference

The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Yes]
Consistently meeting national access standards	[Yes]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[Yes]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Yes]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Yes]

This matter relates to the following governance initiatives:
Organisational Risk Register: N/A
Board Assurance Framework: All strategic objectives and priorities are on the BAF
Related Patient and Public Involvement actions taken, or to be taken: There has been a number of engagement events during the development of our operational plan, with an easy read version of the document itself on its way within the coming weeks
Results of any Equality Impact Assessment, relating to this matter: N/A at this stage
Scheduled date for the next paper on this topic: Planning Updates to be shared with the executive, IFPIC and Trust Board throughout the year

University Hospitals of Leicester NHS Trust

Operational Plan 2017-19

1. Introduction

University Hospitals of Leicester NHS Trust (UHL) is one of the ten largest Trusts in the country and a leading teaching hospital with one of the strongest research portfolios outside of the "Golden Triangle".

We provide hospital and community based healthcare services to patients across Leicester, Leicestershire and Rutland (LLR) and specialist services to patients throughout the UK. As such, the main sources of income are derived from Clinical Commissioning Groups (CCGs), NHS England, and education and training levies.

Our five-year plan, "Delivering Caring at its Best" is ambitious, as is that of the wider health economy, which is now described in the local Sustainability and Transformation Plan (STP). Our STP builds on the work of our Better Care Together programme, the plans of which were already well advanced and articulated in many areas, particularly around proposals for reconfiguring acute hospital services to address long standing issues around the condition of our premises and how these are utilised.

Together, our plans will see UHL become a Trust that is renowned for placing quality, safety and innovation at the centre of service provision. We will continue to build on our strengths in specialised services, research and teaching; offer faster access to high quality care, develop our staff and improve patient experience. We call this 'Caring at its Best'.

We recognise the challenges facing our organisation and the LLR health and social care system which are the consequence of significant internal and external challenges which include:

- The financial pressures facing public sector organisations
- Rigorous regulation of healthcare providers
- Changes in the wider health and political landscape
- Focus on choice and greater patient and community involvement
- Inherent inefficiency of current configuration
- Fiscal drag of aging estate reflecting incremental development

Our vision is underpinned by a set of corresponding values. These values were developed with staff and reflect the things that matter most to them and the Trust. Most importantly they will characterise how our Trust will be seen by others.

Our Values:

2. Our 5 Year Strategic Objectives

We have reshaped our strategic objectives this year to provide even more focus on what matters most in terms of delivering our strategy.

In the centre is our Quality Commitment, putting safe, high quality patient-centred, efficient care at the centre of everything we do. This is our primary objective. Everything else will support the delivery of that:

Our People: We will have the right people with the right skills in the right numbers in order to deliver the most effective care

Education and Research: We will deliver high quality, relevant, education and research

Partnerships and Integration: We will develop more integrated care in partnership with others

Key Strategic Enablers: We will progress our key strategic enablers

2.1. Our Priorities for 17/18

Our Primary Priority

1. **To deliver safe, high quality, patient-centred, efficient healthcare (our Quality Commitment):**

- **Clinical effectiveness**
  - We will focus interventions in conditions with a higher than expected mortality rate in order to reduce our SHMI

- **Patient safety**
  - We will further roll-out track and trigger tools (e.g. sepsis care), in order to improve our vigilance and management of deteriorating patients.
  - We will introduce safer use of high risk drugs (e.g. insulin) in order to protect our patients from harm
  - We will implement processes to improve diagnostics results management in order to ensure that results are promptly acted upon

- **Patient experience**
  - We will provide individualised end of life care plans for patients in their last days of life (5 priorities of the Dying Person) in that our care reflects our patients' wishes
  - We will improve the patient experience in our current outpatients service and begin work to transform our outpatient models of care in order to make them more effective and sustainable in the longer term

- **Organisation of care**
  - We will align our bed capacity with expected demand (including by reducing delays through Red2Green, working more effectively to care for step down patients and increasing the medical bed base) in order to ensure that beds are available for patients who need them
  - We will optimise processes in our new Emergency Department in order that we maximise the benefit of the new facility
  - We will work to separate emergency and elective work, in order that one does not disrupt the other
  - We will transform the hospital pathway for frail complex patients in order that they get the most beneficial care
  - We will improve the efficiency of our operating theatres so that we can maximise the use of this key resource

Our Supporting Objectives

2. **We will have the right people with the right skills in the right numbers in order to deliver the most effective care:**

   - We will develop a sustainable workforce plan, reflective of our local community which is consistent with the STP in order to support new, integrated models of care
   - We will reduce our agency spend towards the required cap in order to achieve the best use of our pay budget
   - We will transform and deliver high quality and affordable HR, OH and OD services in order to make them 'Fit for the Future', (includes a new payroll supplier from August 2017)

3. **To deliver high quality, relevant education and research:**

   - We will improve the experience of medical students at UHL through a targeted action plan in order to increase the numbers wanting stay with the Trust following their training and education
   - We will address specialty-specific shortcomings in postgraduate medical education and trainee experience in order to make our services a more attractive proposition for postgraduates
   - We will develop a new 5 Year Research Strategy with the University of Leicester in order to maximise the effectiveness of our research partnership

4. **To develop more integrated care in partnership with others:**

   - We will integrate the new model of care for frail older people with partners in other parts of health and social care in order to create an end to end pathway for frailty
   - We will increase the support, education and specialist advice we offer to partners to help manage more patients in the community (integrated teams) in order to prevent unwarranted demand on our hospitals
   - We will form new relationships with primary care in order to enhance our joint working and improve its sustainability

5. To progress our key <u>strategic enablers:</u>

- We will progress our hospital reconfiguration and investment plans in order to deliver our overall strategy to concentrate emergency and specialist care and protect elective work
- We will make progress towards a fully digital hospital (EPR) with user-friendly systems in order to support safe, efficient and high quality patient care
- We will deliver the year 2 implementation plan for the 'UHL Way' and engage in the development of the 'LLR Way' in order to support our staff on the journey to transform services
- We will review our Corporate Services in order to ensure we have an effective and efficient support function focused on the key priorities
- We will implement our Commercial Strategy, one agreed by the Board, in order to exploit commercial opportunities available to the Trust
- We will deliver our Cost Improvement and Financial plans in order to make the Trust clinically and financially sustainable in the long term

3. <u>Our Approach to Activity Planning</u>

3.1. Activity Planning

Our 17/18 activity plans are based on what we are calling a 'downside scenario' where we assume demand is somewhat higher than our contract indicates due to part delivery of QIPP (50%). There is a general consensus that this scenario is the most realistic basis for planning. This was tested with NHSI during the deep-dive planning sessions in March and there was broad agreement that this was a sensible approach.

The following QIPP activity has been accounted for the downside scenario:-

- 373 fewer day cases
- 1,957 fewer non-elective admissions
- 3,525 fewer outpatient referrals and 1st outpatient attendances and 6826 fewer follow ups.

The 18/19 plans are based on 17/18, uplifted by the Public Health population growth %'s provided last year, with the exception of ED. No QIPP reductions have been applied to 18/19 at this stage.

Table 1 – Activity Plan 2017-19

Activity Line	16/17 Outturn	17/18 Plan	Increase 17/18 %	18/19 Plan	Increase 18/19 %
GP referrals (G&A)	211,021	216,758	2.7%	219,793	1.4%
Other Referrals (G&A)	119,106	126,027	5.8%	127,791	1.4%
Total Referrals (G&A)	330,127	342,785	3.8%	347,584	1.4%
Consultant led Total 1st Outpatient attendances	290,792	289,635	-0.4%	293,690	1.4%
Consultant led Follow up outpatient attendances	568,051	568,288	0.0%	576,244	1.4%
Total Elective admissions (ordinary admissions and daycases)	129,925	131,979	1.6%	133,695	1.3%
Total Non-elective admissions	94,857	97,640	2.9%	98,812	1.2%

Total A&E attendances excluding planned follow ups	237,863	246,599	3.7%	255,230	3.5%

Number of completed admitted RTT pathways	-	52,708	-	53,394	1.3%
Number of completed non-admitted RTT pathways	-	204,546	-	207,410	1.4%
Number of New RTT Pathways (clock starts)	-	306,185	-	310,472	1.4%

3.2. Capacity Planning – Beds & Theatres

For a number of years, we have operated with a mismatch in demand and capacity. That continued in 16/17 and is a possible scenario in 17/18. An unbalanced plan can have significant implications for quality of care, patient experience, performance, finance, delivery of cost improvement (CIP) and our overall strategy.

The most significant deficits are in the medical pathways at the Leicester Royal Infirmary site and Glenfield Hospital.

Our approach in 17/18 will be different to previous years in that it favours creating capacity sufficient to deal with peak demand and then reducing beds at time when demand is lower than the peak (i.e. flexing down rather than up). This is based on the fact that temporary additional capacity is often difficult to staff and generates quality issues.

3.2.1. Downside scenario

We forecast a peak deficit in-year of some 105 beds (at 85% occupancy to guarantee flow), broken down as follows:

Capacity Gap - overflow (at Flow Occupancy)	Bed deficit
Adult - Emergency Medical Pathway (LRI)	55
Adults - Emergency Cardiorespiratory Pathway (GH)	32
Paediatrics - Emergency Medical Pathway (LRI)	6
Adult Elective Pathway at LRI (ENT)	7
Adult Elective Pathway at LGH (General Surgery & Urology)	6
Total	**105**

The task for 2017/18 is therefore to create additional effective capacity (through actual beds, demand mitigation or improved productivity) to the tune of 105 beds.

Our plans for this will delivered via the Organisation of Care Programme (see Quality Commitment above) and include:

1. Increase (in the short term) the bed base - New actions to increase our bed base at the LRI and GGH
2. Improved internal efficiency - Delivery of all pre-existing actions including, SAFER flow, red to green & GPAU expansion
3. A new model of step down care - UHL working more effectively downstream to care for step down patients in a non-acute setting
4. A new hospital pathway for frail complex patients
5. Separate emergency and elective surgery

3.3. Internal productivity to maximise capacity

We know that bed capacity and theatre capacity are linked. The greater the bed capacity gap the less efficiently we utilise our theatres. Our modelling indicates that we have enough theatre

capacity (including weekend working) provided that we tackle cancellations due to lack of beds – the aim of plans immediately above.

For theatres specifically, we are taking a series of actions to address an imbalance between the demand for theatres and the capacity available, including:

1. Delivery of increased throughput per session.
2. Moving cases from general anaesthetic to local anaesthetic.
3. Increasing the volume of daycase surgery.
4. Reviewing the opportunity to transfer activity into the community.
5. Continue to insource staff from the private sector.
6. Continue to outsource activity to the private sector.
7. Review staff retention options.
8. Build on successful theatre recruitment processes.

3.4. Delivery of Operational Performance Standards

Our latest performance trajectories are detailed below:

Month	April	May	June	July	August	September	October	November	December	January	February	March
RTT Incompletes within 18 weeks	90.9%	91.2%	91.9%	92.0%	91.8%	92.3%	92.1%	92.3%	91.5%	92.0%	92.5%	92.7%
Cancer 62 day	82.0%	84.2%	85.4%	83.2%	86.1%	85.5%	85.9%	84.0%	86.1%	81.9%	84.8%	89.0%
Cancer 62 day Quaterly Performance			83.9%			85.0%			85.3%			85.3%
Diagnostics waits within 6 weeks	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%	0.98%
ED 4hr performance	80.7%	81.9%	83.8%	85.1%	87.9%	90.0%	90.1%	90.2%	90.1%	90.1%	90.3%	92.2%

The Emergency Department (4 hour target) trajectory has been modified based on the newly prescribed performance requirements laid out in the Next Steps on the NHS Five Year Forward View.

We will continue to work with partners across LLR through BCT to improve operational performance standards in the short, medium and long term. Action plans have been developed to improve Cancer and Diagnostic performance. UHL will also continue to make improvements to its internal process through the CIP programme and the four cross cutting work streams.

Central to this is the ability to work with LLR partners to reduce emergency admissions and thereby ring fencing ('protecting') beds for elective care, including cancer. This will be a step by step process to reduce the total number of medical outliers in order to support the ring fencing of elective beds.

3.4.1. Emergency Performance

Delivering an improvement in emergency performance remains one of the key focuses for UHL and our partners across LLR. Despite our best efforts we remain under acute operational pressure caused by a combination of increased demand and suboptimal processes internally and across the system. A refocus on high impact actions via the new A&E Delivery Board and A&E implementation group aims to decrease attendance, reduce admissions and improve processes, thus improving 4 hour performance. UHL continues to work with Emergency Care Improvement Programme (ECIP) and LLR to deliver these actions and rebalance capacity and demand.

The new Emergency Floor opened in April 2017 – this will give the Emergency Department (ED) the space it needs and enhance patient and staff experience. We anticipate a worsening in performance initially (whether demand changes significantly or not) as seen by other hospital trusts that have recently opened new emergency departments.

3.4.2. Referral to Treatment – the 92% standard

The Referral to Treatment (RTT) incompletes standard measures the percentage of patients actively waiting for treatment. 2016/17 has been a difficult year for the Leicester's Hospitals in terms of maintaining this elective target, the RTT incompletes standard. Compliance with the standard was maintained from April to August and during November 2016.

The factors that have impacted on our ability to deliver this standard consistently are:

- A continuing rise in referrals (8% increase, this equates to approximately 1,000 more new referrals per month)
- An increase in emergency pressures and admissions resulting in high numbers of operations being cancelled in some specialities

This compound effect has meant that month on month the numbers of patients waiting longer than 18 weeks has increased. The focus for our patients remains treating those most clinically urgent and the longest waiters.

We continue to have capacity constraints within some key services, notably adult and paediatric ear nose and throat and ophthalmology. These are being addressed by additional resource, in particular further investment in clinical staff.

We will continue to work closely with commissioners in building local capacity, both in terms of additional clinical appointments within UHL but also continued targeted use of Independent Sector providers where necessary. This will be required whatever planning scenario plays out, above. This also includes the continuing transfer of activity to the Alliance in the way we have undertaken in 16/17.

3.4.3. 52 week waits

We will eliminate 52 week waits in 17/18 and determine the future of the Orthodontic service.

3.4.4. Diagnostics

We made significant progress against this standard in 16/17 and our aim is to build on that to ensure continued compliance in 17/18 and 18/19.

3.4.5. Cancer

Performance against key cancer standards remains one of the highest priorities for the Trust:

Standard	Key messages for 17/18
2 weeks	Continued delivery - we will be planning for circa 11% increase in 2ww referrals during the coming year. We continue to try to limit the referral growth by utilizing PRISM referral forms.
31 days	Access to theatres in key specialties and the cancellations of patients, including cancer patients, in particular due to ITU capacity remains a significant risk. The opening of additional HDU / ITU capacity will mitigate this.
62 days	We have made significant progress in backlog reduction in 16/17 and will continue this in 17/18. We have increased performance to consistently above 80% and continue to work with referring providers to further improve performance. There is a clear and strong governance process around delivery through a joint CCG/Trust board and clear and agreed Cancer RAP. The key themes to the plan are demand and capacity (including: physical and staffing), detailed process management and patient choice. Compliance of the 62 cancer trajectory is dependent on rebalancing the capacity and demand.

4. Our Approach to Quality Planning

Our executive leads for quality improvement are the Chief Nurse and the Medical Director.

4.1. Patient Safety and Quality Improvement

Our commitment to safety and quality remains unwavering. With increasingly complex care and within an exceptionally challenging financial environment, there is a greater need than ever to focus resources and actions to ensure the best value for money and a material decrease in avoidable death and harm. We will continue to focus on safety measurement and improvements in our collection, analysis and use of safety information and data. This will enable us to identify safety themes, trends and clusters.

Internally, our safety priorities for the next two to three years will mirror those of the East Midlands Patient Safety Collaborative and will focus on:-

- Improving organisational safety culture from board to ward;
- Growing leaders for safety and quality improvement;
- Building capability in safety and quality improvement;
- Undertaking evaluation of improvement projects.

4.1.1. Improving Organisational Safety Culture

We will continue to work on the principles and actions following the AQuA Board session, specifically focusing on transparency, visible-felt leadership, and learning and improvement.

Additionally, we have committed to a regional collaboration with all other eight acute trusts in the East Midlands on safety climate in the Emergency Department and the Maternity Units. This four year 'PASCAL Metrics' programme consists of Year 1 survey / Year 2 Quality Improvement interventions / Year 3 repeat survey / Year 4 Quality Improvement interventions. An ED network has been established to identify quality improvement interventions and to foster safety sharing and learning between departments.

4.1.2. Growing Leaders for Safety and Quality Improvement

We recognise that inspiring and enabling staff to be leaders in safety and Quality Improvement is critical to our success as a Trust in terms of credibility, reputation, impact and outcomes. Collaborating with Health Education East Midlands (HEEM), the East Midlands Leadership Academy (EMLA), the Leicestershire Innovation and Improvement in Patient Safety (LIIPS) unit and academic partners, we will use local expertise to coach, train, develop and support leaders and potential leaders in safety improvement.

4.1.3. Building Capability in Safety and Quality Improvement

We will continue to build safety and QI capability by growing a community of staff within the Trust who have undertaken recognised quality improvement study programmes, including the IHI Open School, the Health Foundation improvement modules or relevant degree courses. We will continue to run 'measurement master classes' and we are keen to develop Quality Associate and Safety Fellow posts which we will implement through the UHL Way Academy.

Specifically, we will increasingly use a human factors approach to safety, engaging with the Clinical Human Factors Group and the new Healthcare Safety Investigation Branch and employing new tools such as hierarchical task analysis, HFACs, system process review and human / technology interface experts. Where possible we will use improvement experts from other safety industries to support our work.

4.1.4. Undertaking Evaluation of Improvement Projects

Our quality improvement portfolio continues to grow and we are ambitious to develop this further over the next 2-3 years. Again we will collaborate across the health sector and with academic partners and improvement teams regionally and nationally. Will continue to present and publish our work and to ensure that we undertake formal evaluation of improvement projects. We will liaise with Health Education England and the Academic Health Science Network to seek funding for improvement and to seek opportunities for upscale and spread.

4.2. Quality Improvement

In June 2016, the Care Quality Commission (CQC) carried out a focused inspection of our services. The aim of this inspection was to check whether the services that we are providing are safe, caring, effective, responsive to people's needs and well-led. The draft reports from this inspection have been received from the CQC and have undergone factual accuracy checks by the Trust.

Key recommendations include:

- Ensuring the timely identification, assessment, monitoring, escalation and treatment of the deteriorating patient, including adherence to the Trust's guidelines for sepsis screening
- Ensuring sufficient numbers of suitably qualified, competent, skilled and experienced staff in key areas
- Ensuring the privacy and dignity of patients is respected in all areas
- Ensuring standards of cleanliness and hygiene are maintained at all times to prevent and protect people from healthcare associated infection

Our action plan to address these issues has been shared with both the CQC and stakeholders and was discussed in some detail at a CQC Quality Summit held on the 28th March 2017. Feedback from the Quality Summit was positive and the significant improvements that we have made since the June 2016 inspection were recognised and well received.

In early January 2016, a programme of quality visits was developed, with the ambition of ensuring that all clinical areas receive regular comprehensive peer quality reviews, using the principles used by the CQC in their inspection framework. These reviews have generated a significant amount of qualitative data and have helped to inform our CMG Quality and Safety Performance Review meetings. Any immediate concerns about clinical practice or patient safety identified in our quality visits are fed back immediately to the Senior Management Team within the relevant CMG.

Following our CQC inspection, a CQC Oversight Group was been established. Reporting to the Executive Quality Board, this group is responsible for ensuring that the appropriate work streams and governance arrangements are in place to develop and oversee the implementation of plans to address the immediate concerns raised by the CQC. Immediate plans have been developed to address the issues raised by the CQC in relation to the deteriorating patient (Early Warning Scores and sepsis).

Learning from other organisations, a Project Management Office (PMO) was established early on in the Trust's preparation for the visit. Key functions of the PMO are to co-ordinate the various aspects of the planning and preparation as well as management the CQC's data submission requests. The PMO continues and is now responsible for drawing together the various action plans to address the immediate concerns raised by the CQC as well as developing a longer term plan in preparation for the next CQC inspection. The PMO is also responsible for weekly reporting to the CQC.

An ongoing programme of quality visits covering both wards and non-ward clinical areas has been incorporated into our 6 monthly ward review tool.

Once a primarily documentary review, our ward review tool is now a more interactive ward based process underpinned by the CQC key lines of enquiry and the five core domains; safe, effective, caring, responsive.

These reviews give our Heads of Nursing the opportunity to spend quality time with the ward sister and include; a discussion on ward performance data and agreeing actions (using a checklist to prompt the discussion with documented agreed actions for improvement); interviewing staff with some CQC style questions (using the CQC intelligence we have); a discussion about what staff are proud of and opportunities to celebrate; and finally; meeting patients and discussing their experiences to gain real time feedback. The review also involves an inspection of the ward environment and agreeing actions and improvements.

4.3. Our Quality Improvement Plan (including compliance with national quality priorities)

Our Quality Commitment for the coming year/s sets out our quality improvement plan:

Through our Quality Commitment we aim to:

- Improve patient outcomes and provide effective care by delivering evidence based care/best practice
- Reduce harm to patients and improve safety by reducing the risk of error and adverse incidents
- Provide care and compassion and improve patient experience by listening to and learning from patient feedback

In developing our plans to improve quality we have taken into account both local and national priorities across the three domains: patient experience; clinical effectiveness; safety.

NHSE specialised CQUINS will have the same monitoring and performance approach as 2016/17.

The full 2.5% of annual contract value remains on offer to UHL. 1.5% will be assigned to deliver against mandated CQUIN indicators. There will be six mandated CQUINS which will have a minimum weighting of 0.25%. The remaining 1% is to be assigned to support engagement and commitment to the STP.

Specialised CQUIN Schemes are again multi-year, with most CQUINS continuing from 2016/17. New schemes are designed for implementation over two years Whilst some progress has been made in 16/17 – NHS England have been supportive in their approach to performance review and the thresholds have been mainly around scoping and base lining. There will therefore be an expectation of delivery and improvements for 17/18 which will be challenging without sufficient resourcing.

There are currently 39 Indicators in the Quality Schedule but most have more than one metric where performance is monitored (for example Clinical Effectiveness Assurance includes both Clinical Audit Programme and NICE compliance) and some have a suite of metrics (for example Infection Prevention includes C Diff numbers, C Diff reviews, CMG Self-Assessment against the IP Toolkit and reporting of other Infection rates). It is anticipated that most if not all of these will continue in the forthcoming year.

Our Quality Commitment has been developed in partnership with our patients and the public. We continue to use patient feedback (from sources such as patient survey results, complaints, 'message to matron', NHS Choices) to identify areas for improvement. Increasing our Friends and Family coverage remains a key focus in the forthcoming year.

Achievement of our quality improvement plan is monitored through a number of strategic groups including the Mortality Review Committee and reported through the Executive Quality Board and the Quality Assurance Committee.

4.3.1. 7 Day Services

We remain a Vanguard Early Implementer Site for seven day services. Progress has been made over the last year towards meeting the four priority areas in the delivery of seven day services, and plans for 2017 will build on these strong foundations. An estimated £3.1m of investment is required for full implementation and this remains a risk to delivery. Our service reconfiguration plans, if supported locally and nationally, will improve things further in areas such as imaging provision. In 2017/18, we will:

- Work towards improving delivery of Clinical Standards 2 and 8 at the Glenfield site in the specialties of respiratory medicine and cardiology – patient survey data has demonstrated key areas to improve; and process mapping has revealed inefficiencies that can be targeted. Money secured from HEEM will allow us to scope the role of specialist respiratory nurses in reducing demand on consultant time in outpatients.
- The seven day services programme will become more aligned with delivery of the Red to Green programme across the trust utilising NerveCentre as an electronic enabler.
- Improve delivery of Clinical Standard 2 in General Surgery at the LGH
- Use funds allocated by HEEM to drive quality improvement in Trauma and Orthopaedics – specifically around use of new workforce models in delivering care to patients with fractured neck of femur seven days a week.
- Set up a programme to train pharmacists as independent prescribers in order to support rapid discharge across seven days by reducing the writing of TTOs as a constraint. The

team has secured funding for a project manager to model and process map the TTO process in order to support this workstream.
- Continue to submit six-monthly audit data nationally.
- Appoint a part-time project manager to work up further bids for funding for projects aligned to seven day services.
- Continue to disseminate best practice and share experience nationally.

If resource that has been applied for from central monies is secured, the CDU at Glenfield hospital will be extended to enlarge the area for ambulatory patients which will improve flow through the unit and ensure smoother seven day services are delivered.

4.4. Quality Impact Assessment Process

Each week the Chief Nurse and Medical Director meet to review the quality impact assessments for any new or re-submitted Cost Improvement (CIP) schemes. Where the impact on quality is felt to be of significance (high) the scheme is referred back to the CMG for refinement or rejected. Key Performance Indicators are determined for each scheme and these are recorded as part of the scheme details on the CIP Project Management Office tracking system.

CMGs are responsible for monitoring the potential adverse impact of CIP schemes on their assigned KPIs and this is discussed at the monthly CMG Quality and Safety Performance Review meetings

4.4.1. Top 3 Risks and Mitigation

Our Board Assurance Framework (BAF) sets out a list of principal risks to the achievement of our strategic objectives, their current mitigating actions and internal and external assurance sources.

The BAF also identifies further mitigating actions to be taken for each principal risk.

The following table summarises our three significant risks to quality and their mitigations.

Objective	**An excellent integrated emergency care system**
Risk	Emergency attendance / admissions increase without a corresponding improvement in process and / or capacity.
Mitigations	• New triage and treat model / GP streaming at the Front Door for all walk-in patients to ED (subject to procurement in 17/18). • New Emergency Floor / facility • Urgent Care Centre (UCC) • Internal monitoring and reporting at executive level, including ED 4-hour waits, ambulance handover >30 mins and >60 mins, total attendances / admissions. • Comparative ED performance reports for attendances / admissions. • Reworking of LLR urgent care RAP, overseen by the A&E Delivery Board • Admissions avoidance directory • New integrated urgent and emergency care services (subject to procurement in late 16/17, early 17/18)

Objective	**A clinically sustainable configuration of services, operating from excellent facilities**
Risk	Failure to deliver clinically sustainable configuration of services.

Mitigations	• UHL reconfiguration programme governance structure. • Strategic capital business case work streams aligned to STP. • Monthly meetings with the NHSI to identify new business cases coming up for approval. • A future operating model at service level which supports a two acute site footprint. • Out of hospital contract approved and project established to shift appropriate activity into the community. • A Reconfiguration Programme Strategic Outline Case (SOC) is in development, which will reflect the STP submission and the revised Development Control Plans. This SOC will demonstrate affordability of the programme as a whole; and therefore pave the way for approval of individual project Outline Business Cases (OBC). • Detailed programme plan identifying key milestones for delivery of the capital plan. • Project plans and resources identified against each project.

Objective	**Safe, high quality, patient- centred, efficient healthcare**
Risk	Lack of progress in implementing our Quality Commitment.
Mitigations	• Screen all hospital deaths. • Sepsis screening tool and care pathway. • 7 Day service standards (including implementation of 14 hour consultant review, diagnostics, professional standards and daily consultant review). • Tool for EWS and e-obs. • End of life care plans.

4.5. Triangulation of Indicators - Quality and Safety Metrics with Workforce Indicators

In order to ensure plans incorporate requirements in relation to quality, the 6 monthly nursing acuity review is currently in progress at the time of writing. This will be reviewed and changes incorporated into the planning process.

Plans for the nursing workforce recognise the challenges faced in respect of recruitment and therefore a number of medical wards are piloting changes in skill mix. These are being closely monitored against a range of quality metrics to ensure that there is no detrimental impact on patient care or staff engagement.

We also triangulate quality indicators with a range of performance and financial indicators through an integrated quality and performance report that is considered by both our quality board and our finance committees. The report, which is published on our public website, includes 98 indicators across a number of domains (safe, caring, effective, responsive and well led). A cover sheet / summary is provided by the CEO highlighting areas of good and poor performance. For areas of poor performance, we also produce exception reports and action plans.

5. Our Approach to Workforce Planning / Clinical Engagement

5.1. Workforce Planning Methodology

Our workforce planning process for 2017-19 has been intrinsically linked to the financial planning process which derives its income assumptions from detailed capacity and activity levels modelled for each specialty (as described in the financial and activity planning sections). From the resultant trust level paybill envelope, the workforce plan has been derived using the following key assumptions:

- A deficit position of £26.4m
- Baseline worked whole time equivalents as at month 11 forecast
- Assume a gradual reduction in the monthly paybill over 17/18
- Assume an agency reduction to the cap of £20.6m
- Assumed a gradual reduction in average cost per WTE through reductions in WLIs etc and internal locums.

This created the NHSI workforce plan submission for March 2017.

Our clinical management group (CMG) teams, which include clinicians and leads from operations, finance and HR, will continue to further develop their detailed workforce plans principally based on demand and capacity assumptions and the overall financial envelope (control totals). Using the forecasted WTE and pay bill out turn position as a baseline, the following process will continue:

1. Derive baseline WTE position
2. Determine revised establishment position based on activity and capacity requirements (which will be driving any increases/ decreases in bed or theatres or outpatient capacity, any newly designed models of care, safe staffing levels, service changes and cost improvement assumptions
3. In deriving revised establishment consider new roles as an alternative where there are risks to the supply of workforce and establish any double running requirements in the development of such roles with a particular emphasis on apprenticeships
4. Determine recruitment /reduction trajectories and based on revised establishment.
5. Where significant gaps between establishment and in post arise, forecast non contracted WTE and paybill to meet gap and identify premium expenditure required ensuring no overall breach.

Triangulate outcomes of this process by comparing:

1. Forecast paybill (financial plan) to WTE plan to ensure affordability. This has been aligned to the financial plan described in the financial section below and therefore reflects the control totals that the Trust believe to be achievable.
2. Forecast WTE percentage change to activity percentage change with a broad assumption that increases in activity will not necessarily translate into further staffing demand.

CMGs will continue to predict changes to their workforce based on a number of principles:

- Changes resulting from service configuration internally
- Changes arising from seven day service requirements
- Changes arising from volume changes particularly in relation to capacity requirements
- Changes arising from acuity reviews
- Anticipated shifts in agency and bank usage as a result improvement initiatives
- Understanding of turnover and predicted vacancies.
- Cost improvement measures including such interventions as skill mix review and reduction in average cost per whole time equivalent.

5.1.1. Alignment with the LLR Sustainability and Transformation Plan

Our processes generate an internal workforce plan, which is then be adjusted to account for activity and capacity shifts associated with the LLR STP (at the broadest level) to create a revised workforce model and aligned to the assumptions in the finance and activity models.

This methodology has been applied in the context of an overarching workforce plan which has six pillars of delivery:

- Reducing reliance on non-contracted pay
- Ensuring safe staffing
- Focus on urgent and emergency care
- Seven day service achievement
- Left shift of activity to the community/primary care/Alliance
- Increasingly specialised services

The overall paybill change is:

Year	16/17 Outturn £	17/18 £	18/19 £
Total Paybill	575,396	575,584	578,816
Bank	10,501	11,395	11,750
Agency	24,838	20,620	20,248
Substantive	540,057	543,569	546,818

The overall paybill including £2.764m apprenticeship levy cost (as shown in our financial plan) is:

Year	17/18 £	18/19 £
Total Paybill	578,348	581,580

Therefore, the overall WTE change (for 17/18 and 18/19) is:

	Outturn 16/17 WTE	17/18 WTE	WTE Change	% Change	18/19 WTE	WTE Change	% Change
ALL STAFF	13,416	12,717	(699)	**(5.2%)**	12,851	134	1.1%
Bank	369	379	10	**2.9%**	379	0	0
Agency staff (including, Agency, Contract & Locum)	307	228	(79)	**(25.9%)**	223	(5)	(1.9%)
Substantive WTE	12,741	12,111	(630)	**(4.9%)**	12,249	139	1.1%

5.2. Underpinning Workforce Strategy

In addition to the five year workforce plan, we have a number of workforce strategies in place, which have been consulted on widely. Examples include:

1. A comprehensive Organisation Development (OD) Plan which describes how the organisation will transform and develop through the adoption of the UHL Way. The latter incorporates methodology and an improvement strategy for achieving better change, better teams and better engagement. The better engagement methodology is underpinned by the Trust's overarching commitment to Listening into Action which has a track record of delivering small and large scale changes in the Trust

2. A medical workforce strategy which describes approaches to recruit, reshape, develop and engage the medical workforce and has led to a significant closure of Junior Medical workforce gaps
3. A Health and Well-being Strategy which describes how we will work with our workforce to develop resilience and well-being programmes to support them in delivering quality in a demanding workplace
4. A nursing workforce strategy which describes mechanisms to recruit and retain our nursing workforce including a piloting of the Nursing Associate programme, a comprehensive plan for overseas recruitment beyond Europe, a focus on retaining our European workforce
5. An e workforce strategy is in development which will ensure more efficient adoption of technology enabled processes and more comprehensive and accessible workforce analytics. The first of these in recruitment (TRAC) has been launched in 2016/17
6. An apprenticeship strategy which describes our plans to achieve the apprenticeship target of 334 in 2017/18 through new and innovative approaches to workforce and career development
7. Adoption of the LLR wide workforce strategy which includes integrated strategic workforce planning, attraction, organisational development, staff movement, capability and primary care.

Each of these strategies support delivery of the numeric workforce plan and ensures that innovative approaches to supply and demand are adopted.

5.3. Governance

To ensure on-going triangulation with activity and finance, the workforce plan has been reviewed at all stages of development by a multidisciplinary senior team (with representatives from all planning disciplines) who have also ensured synergy between the plans for different clinical and corporate areas.

The plan will be signed off by the Trust Board and will be reviewed regularly through the workforce plan submission to the Integrated Finance Performance and Investment Committee and quarterly to the Trust Board and Executive Workforce Board.

5.4. Achievement of Efficiency- Capitalising on Collaboration

Our Workforce Cross Cutting Board had three key workstreams:

- Premium Spend - focused on robust plans and governance of agency and other non-contracted expenditure
- Nursing – focused on maximising efficiency and Nurse Specialists and nursing rotas
- Medical – focused on innovative recruitment and a robust comprehensive approach to job planning

This work will form part of a newly formed workforce and OD Board and a work programme is being established to ensure workforce priorities are aligned to the Trust strategy and targets relating to efficiency particularly those linked to the Carter review.

Additionally, the theatres, outpatient and bed reconfiguration programmes ensure we achieve maximum efficiency in these three core areas of our capacity.

Our Director of Workforce and Organisational Development has recently been appointed as SRO for a Back Office workstream within the governance arrangements for the STP. Detailed plans are at an early stage of exploring opportunities for further collaboration commencing with early work on consistency of processes and templates to drive efficiency.

Our Workforce Development Manager chairs an LLR Strategic Workforce Planning group which aims to develop a system wide approach to workforce planning to maximise efficiency across the system. This stream works in conjunction with other LLR workstreams to ensure opportunities are maximised in attracting high quality workforce to LLR/ensuring the right behaviours and skills are in place to work in a collaborative context, ensuring systems and processing are in place to enable staff to move readily across different care settings.

5.4.1. Workforce Transformation, New Care Pathways, Specific Staff Group Issues

At a local level, we have a New Roles Steering Group, which is designed to ensure a systematic process is in place for the development of new roles, ensuring the appropriate governance and education plans are in place to ensure patient safety. The initial focus has been on the Assistant and Advanced Clinical Practitioner roles and now Nursing Associates and new roles in pharmacy and Physician Associates (successfully recruiting four PAs from the National Physician Associate Expansion Programme). The approach to Assistant and Advanced Clinical Practice has been developed collaboratively with LPT to ensure a consistency of standard across the STP footprint. This work will again be subsumed into the Workforce and OD Board described above.

This approach helps mitigate the ongoing challenges we face in the supply of staffing across a number of staff groups and specialties.

In addition, each of our clinical areas has a Resourcing Plan, which details a number of ways in which workforce transformation activity is being adopted to address specific workforce shortfalls – these include:

- Grow your own internal development programmes
- International recruitment, Europe and beyond
- CESR programmes for Doctors
- Rotational Trust Grade Programmes
- Education and Training and Career Development Incentives

5.5. New Initiatives as part of Five Year Forward View

Each of the LLR strategic teams has received an allocation from HEEM Five Year Forward View monies. Initiatives include:

1. Use of complex workforce modelling techniques to develop system wide views of workforce demand across the system (Whole Systems Partnership). System uses a principle of high level functions for determining workforce skill levels in order to understand how workforce demand may shift in the system
2. Use of functional mapping for redesigning workforce in conjunction with care pathway development
3. Investment in workforce analytics skills to develop a numeric system wide plan
4. Investment to support an LLR wide attraction strategy with a specific focus initially on apprenticeships
5. Investment in Advanced Clinical Practice
6. Investment in Seven Day Service project management to develop ways of introducing seven day workforce models at minimal cost
7. Investment in mental health and learning disability training software
8. Investment in Organisational Development including expertise in transformational change and the development of an LLR Way
9. Investment in a Workforce Planning expert to support the Urgent and Emergency Care Vanguard in the delivery of revised models of care eg Clinical Navigation Hubs, tiered approaches to Urgent Care

5.6. Support for delivery of Workforce Plans in conjunction with Local Workforce Action Boards

We have been actively engaged with the Local Workforce Action Boards in developing local bids for education and training support which support Health Education England priorities.

A significant numbers of bids have been jointly submitted with STP partners to ensure education and training programmes support such ambition of left shift and improved discharge processes. Bids include the use of functional mapping / workforce profiling to support new workforce models; support for further development of the advanced clinical practitioner unit; support for improved infrastructure for delivering the national apprenticeship ambition; implementation of nursing rotational programme through community and acute settings; a range of skill enhancement initiatives to support up skilling of community based staff; support for the implementation of an overarching LLR Attraction Strategy; investment in infrastructure support to understand the impact of plans to remove bursaries for nursing and Allied Healthcare Staff.

6. Our Approach to Financial Planning

6.1. Financial Forecasts and Modelling

In 2016/17, we planned to deliver a deficit of £8.3m in line with the control total and included receipt of £23.4m of Sustainability and Transformation Funding (STF). This therefore represents an underlying deficit plan of £31.7m which includes a Cost Improvement Programme (CIP) of £35.0m

However, we ended 2016/17 with a deficit of £27.2m including receipt of £11.4m Sustainability and Transformation Funding (STF), which represents an underlying deficit plan of £38.6m and includes a Cost Improvement Programme (CIP) of £35.9m.
This forecast is an adverse position to the control total within the underlying position of £6.9m (pre STF).

The 2016/17 financial plan includes £83.0m capital programme, supported by internally generated funds (£30.2m) and external funding (£51.8m) in the form of capital loans from the Department of Health, finance leases and donations. The key elements of the capital programme are:

- Addressing backlog maintenance and investment within critical infrastructure;
- Investment in medical equipment;
- Redevelopments and investments to support the longer term estate reconfiguration plans and;
- Investment in an Electronic Patient Record (EPR).

At the time of writing (April 2017) we have yet to receive confirmation of the availability of some external capital resource and, as such, we are working to a reduced capital expenditure plan (£56.7m) in line with internally generated funds, pre-approved external loan funding for completion of the ED floor and finance lease additions.

On the 30th September 2016 the Trust received control total notification from NHSI; this was superseded by an update on 1st November 2016. The final control total issued by NHSI requires the Trust to deliver an £8.4m surplus in 2017/18, inclusive of £21.8m STF so an underlying deficit plan of £13.4m. This represents an improvement of £25.2m on the underlying financial performance of the Trust between 2016/17 and 2017/18.

In addition, the control total for 2018/19 was also confirmed. This requires the Trust to deliver a £11.6m surplus, inclusive of £21.8m STF so an underlying deficit plan of £10.2m. This represents a £3.2m improvement on the underlying financial performance in 2018/19, and £28.4m over 2 years. This is summarised in the table below.

	2016/17 £m	2017/18 £m	2018/19 £m	2 yr change £m
Total pre STF	(38.6)	(13.4)	(10.2)	
Underlying Movement	**-**	**25.2**	**3.2**	**28.4**
STF	11.4	21.8	21.8	(1.6)
Underlying total	**(27.2)**	**8.4**	**11.6**	
Total movement	**-**	**23.6**	**3.2**	**26.8**

For both of the planning years the agency ceiling control total has been set at the same level as 2016/17, this is £20.6m.

The control totals described above have been assessed against the next 2 years of the organisational financial strategy. This had led to the conclusion that the control totals are inconsistent and undeliverable given the financial improvement it requires.

The recently published tariff, contract negotiations with commissioners and the announcement of CNST contributions have all contributed to the assessment of our position alongside internal factors such as scale of CIP programme and current run rate. This assessment highlights a number of issues preventing the Trust from being able to plan for delivery of the control totals:

- CNST premium. The Trust's increase is £3.7m with only £0.2m provided for within the inflationary uplift included in national tariff guidance.
- Interest costs. The additional costs associated with operating a deficit including the interest costs of borrowing are not accounted for in setting our control total.
- Junior Doctors. Most acute providers will have an additional cost next year in implementing the new contract. Again, this does not seem to be covered in the inflationary uplift included in tariff nor considered as part of setting the control total.
- Impact of reconfiguration. A fundamental part of the Trusts financial recovery and clinical sustainability is the reconfiguration from 3 to 2 sites. Progress has been slowed in 2016/17 by a lack of overall capital and, as a result, we have increased costs in the vascular service in 2017/18 in advance of ITU consolidation.
- We have a number of cost pressures including the impact of ceasing the Interserve contract which needs to be managed in 2017/18.
- The scale of improvement required to deliver the control total represents a material reduction in either the structural deficit of the organisation without the required investment or a high risk operational deficit reduction with an ambitious CIP programme already planned to improve this over and above the level required in national guidance.

Despite the difficulty the Trust has in meeting the control total it is recognised that financial improvement is required. The 2 year financial plan shows this improvement and overall reduction in deficit. This is shown below including STF however, unless the control total for the organisation is changed the I&E position pre STF is the planned trajectory.

	2016/17 £m	2017/18 £m	2018/19 £m
I&E position pre STF	(38.6)	(26.7)	(21.7)
STF	11.4	-	-
I&E position	**(27.2)**	**(26.7)**	**(21.7)**

Stepping off from this point, the financial plans within the 2017/18 and 2018/19 operational delivery plan are outlined below.

6.2. Activity

Our 2 year income plan for 2017-19 is based upon the demand and capacity assumptions modelled for each specialty. As described within the Activity Planning section, above, this is based upon a downside scenario (part delivery of QIPP).

The trends witnessed within 2016/17 are expected to continue (to some extent) throughout 2017/18. In particular, 2016/17 saw significant growth in ED attendances and emergency admissions; it is anticipated that these areas will continue to be pressurised. Delivery of QIPP and demand management (aligned to / part of the LLR STP) therefore remains critical going forward into 2017/18.

Elective activity reflects growth to deliver demand in RTT performance. When combined with the forecast emergency growth, the accurate modelling of the numbers of beds, number of theatre sessions and diagnostic capacity becomes critical.

6.3. Income

6.3.1. Clinical Income

The agreed contract value for 2017/18 stands at £464m (57% of total clinical income) for local Clinical Commissioning Groups (Leicester City, West Leicestershire and East Leicestershire and Rutland CCGs) and £257m (32% of total clinical income) for specialised activity commissioned by NHS England.

The Trust has signed up to a contract with the local commissioners for 2017-19 which is a PbR based agreement. As part of the LLR STP there was a commitment from all organisations to support the delivery of QIPP & Demand Management schemes or services. In recognition of this commitment, our contract with LLR CCGs includes £17.6m of QIPP for 2017/18.

As part of the signed agreement with LLR CCGs, it was agreed that no financial sanctions will be applied or any other financial penalties available to commissioners within the standard contract. These potential fines based on current performance would be approximately £11m.

The value of £464m includes 1.5% of CQUIN payment for the delivery of National Schemes and 0.5% of CQUIN payment for full engagement in the STP programme. Further to new national guidance, 0.5% CQUIN payment has been withheld by commissioners as part of the national risk reserve. Further details are described in section 5.6 of this document.

Our agreement uses PbR tariff in line with the guidance and draft national prices as published in October and November 2016. This assumes a 2.0% efficiency deflator and 2.1% inflation uplift for all local and national prices. This translates to expected income inflation of 0.1%. This reflects NHSI's and NHS England's assessment of cost inflation.

The overall impact of these changes in 2017/18 is anticipated to be an £7.8m increase in income; this can be separated into tariff inflation of £16.3m, efficiency requirement of (£15.5m) and £7.0m impact of HRG4+.

The Contract signed with NHSE for the delivery of Specialised Services is a full PbR based agreement. This agreement as well as CCG agreements has been impacted by the application of the new Identification Rules (IR) ensuring the correct recharge to responsible commissioner. It is important to note that the risk highlighted for the LLR commissioner agreement linked to the withholding of 0.5% of CQUIN is not applicable to specialised services. The full 2.8% (2.5% CQUIN and 0.3% Hep C) value has been included in the 2017-18 agreement.

6.3.2. Other Income

As a large teaching acute hospital, the Trust has significant non-clinical income streams. These are summarised as:

- Income received through teaching and education. The changes within the Educational funding calculations and funding streams are planned to remain static.
- Income received through research and development has been modelled to reflect the impact of various changes, most notably the successful application to become a Biomedical Research Centre. This results in a reduction in income of £1.0m.
- Income received through other sources such as facilities management, car parking etc. is planned to increase by £2.2m associated with the hosted element of the Estates and Facilities service.

We have not recognised other income relating to general STF of £21.8m as we are not planning to deliver to the NHSI control total.

6.4. Expenditure

6.4.1. Pay

Workforce continues to be the largest area of expenditure for the Trust. The workforce planning section details the key assumptions and challenges that have been built into the workforce models. These workforce models describe the number of whole-time equivalents (WTE), the skill-mix and also recognise that some of the workforce will be deployed in different settings.

Within 2016/17, we aimed to recruit substantively to a full establishment but like many organisations faced difficulties in completing this task. Hence, a significant amount of non-core spend through elements of premium pay had been seen.

For 2017/18, we continue with the ambition to fill the establishment on a substantive basis but recognise that an element of premium pay will be incurred in the short term. This element has been included based on the assumption that the national pay caps for all agency staff will be applied and the total amount of agency expenditure will be limited to £20.6m as per the agency ceiling given to the Trust by NHSI. See section 4 above for more detail on workforce planning.

Pay inflation, including the apprenticeship levy, is included at £8.8m (1.5%) based on national pay structures.

Contingency reserves of £4.5m overall (0.5% of turnover) are included of which £3.6m (80%) is planned as pay.

For 2018/19, agency expenditure will reduce to £20.24m, which is below the agency ceiling given to the Trust.

6.4.2. Non pay

Non-pay inflation at £7.5m is based on drugs at 2.8% and a 1.8% increase generally in line with guidance, recognising differential rates for material contracts such as Facilities Management, IM&T, decontamination services, utilities and managed equipment services that follow their own specific contractual arrangements. In addition to this there is an increase of £3.7m (15.5%) against the Trust's CNST contributions.

The value of commissioner funded high cost drugs and devices in the 2017/18 plan is £100.1m which is based upon the 2016/17 forecast outturn plus £7.0m (7.0%) growth on CCG and

specialised drugs. These costs are 'pass through' in nature and as such are offset in full by income but do not generate any contribution.

Contingency reserves of £4.5m overall (0.5% of turnover) are included of which £0.9m (20%) is planned as non-pay.

6.5. Capital and Cash

The 2017/18 and 2018/19 capital plans are predicated on the delivery of the 2016/17 capital plan without receipt of any additional external funding. As the external funding position remains uncertain in 2016/17 any change to the current, in year, assumptions will impact on the 2017-19 plans.

The 2017/18 financial plan includes £54.4m capital programme, supported by internally generated funds (£31.5m) and external funding (£22.6m) in the form of capital loans from the Department of Health, finance leases and donations. The key elements of the 2017/18 capital plan remain consistent with 2016/17, they are:

- Addressing backlog maintenance and investment within critical infrastructure;
- Investment in medical equipment;
- Redevelopments and investments to support the longer term estate reconfiguration plans.

This is a material reduction to our draft capital plan submission for 2017/18 which was a total plan value of £94.9m in line with feedback received from NHSI on our draft submission.

Within the draft capital plan was £26.3m expenditure on implementation of the Trust EPR business case. On the 12th December the Trust received feedback from NHSI that the current business case presents a significant affordability issue in the context of the management of the national capital budget and therefore NHSI are not in a position to recommend its approval to their Resources Committee. As a result it has been removed from the Trust capital plan. Other changes include £7.1m reduction in reconfiguration expenditure associated with delays in the programme caused by lack of capital resource in 2016/17 and change in guidance regarding how finance leases are funded meaning that the Trust is required to fund £5.1m finance lease additions from within internal resources.

The themes described above continue into 2018/19 with a total capital programme of £79.2m, supported by internally generated funds (£31.5m) and external funding (£47.4m) in consistent forms to previous years.

Within 2016/17 the Trust has faced significant cash flow pressure that needs to be resolved through a working capital loan facility rather than a revolving working capital facility. The planned deficit will require cash support to avoid further cash flow pressures in the plan years in addition to external capital expenditure loans the Trust will liaise with NHSI Treasury Department to ensure the necessary facilities are in place.

6.6. Detail of major financial risks identified and mitigating actions

The major financial risks facing the Trust are captured below for which there is little mitigation. Overall, the plan to deliver a £26.7m deficit in 2017/18 and £21.7m deficit in 2018/19 carries with it significant risks with potential upside or mitigations already planned to deliver that level of financial performance.

Risk remains against the delivery of planned activity and CQUIN targets whilst the cost base of delivering the contracted activity has been set in line with final contractual agreements. Although the Trust has a clinical and operational performance requirement to deliver activity reductions in line with the STP and QIPP plans the failure to do so, where capacity exists, does not present

financial risk. In addition, as a consequence of the contractual agreements agreed with commissioners, there is minimal financial risk associated with fines and penalties.

A risk remains around 0.5% CQUIN payment from LLR commissioners equating to £2.2m for 2017/18. This is due to national guidance and the withholding of payment for the national risk reserve. This value is currently being held by CCGs due to the Trust not signing up to the control total for 2017/18. It is agreed however that if national approval allows the funding will flow to the Trust, how this funding is then used will depend on national guidance at the time.

Full delivery of the CIP programme is also a risk to the Trust. An established PMO function and associated governance arrangements are in place to drive more rigour into the CIP process, giving pace, accountability and clearly defined targets, militating against the risk of underperformance.

As outlined within the Capacity Planning and Operational Performance sections above, there are risks associated with the delivering of the performance standards requirements, particularly for ED and RTT standards due to the imbalance between demand and capacity over the winter months when we have excessively high occupancy. This potentially leads to a financial risk associated with the STF if the control total for the Trust is changed.

We are also planning for a significant reduction in agency expenditure of 11.5% from 16/17 baseline in order to meet the agency ceiling. However, delivery of this is a key risk for the Trust in terms of maintaining quality, safety and capacity in the context of our existing vacancy levels, forecast fill rates and underlying trends in agency use despite price caps and internal controls already being applied.

6.7. 2018/19 Financial Planning

2018/19 financial planning adopts many of the same principles described above for 2017/18. Assuming recurrent delivery of the 2017/18 financial plan national planning assumptions are applied to income incorporating a 2.0% efficiency deflator and 2.1% inflation uplift for all local and national prices. This translates to expected income inflation of 0.1%.

Pay inflation is included at £10.0m (1.7%) based on national pay structures. Non-pay inflation of £6.0m is included in 2017/18 based on drugs inflation at 2.1% and a 1.8% increase generally in line with guidance. In addition to this there is an increase of £4.0m (15.5%) against the Trust's CNST contributions, again, in line with guidance which advises Trusts to plan for a similar level of growth to that seen in 2017/18.

Contingency reserves of £4.5m overall (0.5% of turnover) are included again of which £3.5m (80%) is planned as pay and £1.0m (20%) is non-pay.

6.8. Financial Plan Summary

In summary, we are forecasting to deliver a £26.7m deficit in 2017/18 and achieving £33.0m CIP. The plan for 2018/19 is a £21.7m deficit and achievement of a £32.0m CIP.

Appendix 1 shows the summarised 2017/18 and 2018/19 income and expenditure plans alongside 2016/17 forecast outturn with appendix 2 detailing the bridge from 2016/17 forecast outturn to 2017/18 plan and 2018/19 plan.

The capital expenditure plans for 2017/18 and 2018/19 are £54.4m and £79.2m respectively. These plans include external funding requirements for 2017/18 and 2018/19 of £22.6m and £47.4m respectively. Appendix 3 shows the capital plans for the 2 planning years.

We remain committed to delivering financial recovery over the forthcoming years. The timescale for this is largely dependent on the availability of capital.

6.9. Efficiency savings for 2017-19

The development of our 2017-19 Cost Improvement Schemes / CIP builds on the Trust wide benchmarking and analytical work conducted by Ernst Young (EY). In addition, other opportunities from national best practice schemes such as Getting It Right First Time (GIRFT), Carter Review and Digital First schemes have been considered in its construction.

Our CIP is structured in workstreams that cut across our CMGs and in some cases Corporate Services. Given the reduced availability of income within the contracts the 17-19 programmes will require at least 50% of the programme required to be delivered through workforce, 28% via non-pay procurement, and 22% via income.

6.9.1. Beds

Beds is a critical area within the LLR STP. Internally to UHL, the beds cross-cutting work stream targets the effective and efficient use of our bed stock. This workstream builds on a number of existing best practice improvement projects on efficient flow and discharge process including 'Red to Green', the SAFER bundle, integrated and streamlined discharge processes and improved sign-posting. Readmission improvement projects developed throughout 2016/17 will continue into 2017/18 delivering further reductions in the demand on inpatient bed capacity. The programme is also likely to work with community beds work across the STP to reduce the overall composite LOS across the patch. A particular focus will be on reducing unnecessary variation within the way different wards and their teams practice.

In addition to schemes that are active in 2016/17 additional projects targeting Ambulatory Emergency Medical patients and Same Day Surgical discharge rates will also contribute to reduced demand on inpatient wards.

Quantification of the level of improvement has been produced using analytical information from recent length of stay datasets. This data has been benchmarked against relevant peers and where the Trust has longer length of stay the opportunity to improve to the upper quartile has been used.

6.9.2. Theatres

The theatres workstream incorporates efficiencies across all theatres within the Trust. Some of the active projects from 2016/17 will continue to deliver increased benefits, such as the improvements in scheduling, utilising best practice tools from NHSi (IMAS) and improved control and escalation systems to reduce wasted time in theatres. A particular focus will be on reducing unnecessary variation within the way different Theatres and their teams practice. Across LLR there continues to be, as part of the STP, the movement of day case work to the LLR Alliance providing surgery within community hospitals, outside of the acute Trust.

In addition to these projects additional improvements include developments in Day Case Surgery and actions stemming from the Getting It Right First Time Review. These look to improve multiple facets of theatre productivity both utilisation, but also important elements of non-pay expenditure.

Quantification of the level of improvement has been produced based on increase in utilisation of theatres. Estimated 50% achievement of this target level of productivity is projected for 2017/18 with the remainder in 2018/19.

6.9.3. Outpatients

The Outpatients workstream incorporates a trust wide scheme to improve booking processes that commenced in 2016/17. This will continue into 2017/18 alongside additional schemes on the

reduction in conventional face to face follow-up appointments. All elements of the outpatient work stream will overlap with technological developments and reference back to the achievements described in the Digital First strategy as well as the Trusts own IM&T strategy. As within the other work streams there will be a significant focus on reducing variation by ensuring the standardisation of clinic templates across the specialities.

Quantification of these large schemes of work have been derived from benchmarking and analytics that moves booking efficiency to 95% and achieving the peer median on all outpatient specialties for New: Follow-up ratio. The full opportunity for this is split across the two years.

6.9.4. Non-pay / Procurement Target

Centrally and CMG led procurement projects will include the development of a category management strategy, as well as more transactional improvements in non-pay cost reduction. This will also incorporate national programmes focussing on reducing price per unit for common consumables, most notably working closely on the Carter procurement standards.

6.9.5. Estates

Improvements in estate management and upkeep, together with rationalisation and procurement schemes will be delivered across 2017/18 and 2018/19. These schemes will interrelate with the Beds, Theatre and Outpatient workstreams as each area delivers benefits. The Trust has a well-developed site reconfiguration programme which is where most of the financial strategy exists and delivers Carter benchmarks for clinical/non-clinical estates use. A further major area within Estates is the delivery of energy efficient estate.

6.9.6. Corporate / Back Office

Going further than what is suggested within the Carter review, the corporate and back office schemes will deliver improvements in cost where duplication and waste occur, rationalising the total resource required across the 2 years. This programme will re-examine and redefine the role of corporate/back office functions, leveraging better use of technology to support a whole new model. Some of this model is likely to lead to significant collaboration within partners across LLR and potentially beyond as part of the STP.

6.9.7. CMG led

Smaller grouped improvement schemes delivered in the CMGs will be delivered as part of day to day management. These schemes although smaller in size are greater in number and vary in nature, therefore are captured as one overall work stream.

6.9.8. Workforce

Workforce improvements contained in other cross cutting streams such as Beds, Theatres, Outpatients, are described as part of those programmes. However, in line with the Carter programme, more centralised control systems review, role redesign and rota management projects will also deliver benefits across the Trust. Identification of these areas to improve have come from NHSi agency workforce review tools, as well as utilising HRD network and other national exemplar practice. Benefits will largely manifest themselves in the form of more effective, efficient and greater value for money clinical staff and reduce the total capacity of staffing required.

6.9.9. Quality Assurance

We have a robust quality assurance process for its efficiency programmes, as outlined earlier within the Quality section. All schemes with a value of £50k or over require a quality impact assessment (QIA) document completing as part of the Project initiation document. This is then

considered by the Chief Nurse and Medical Director and the scheme is not allowed to progress unless they have both signed the scheme off.

The QIA describes the quality risks for the scheme along with the key quality and safety metrics that the scheme links to. These indicators are linked to each scheme in a CIP Quality matrix' which is then used to track the on-going impact on the quality metrics as the scheme becomes operational. If an adverse variance on the quality metrics is seen, the scheme is either adjusted or stopped to mitigate the risk.

The programme presents quarterly to the Executive Quality Board and through Quality Assurance Committee to the Non-Executive Directors. Each year the programme is presented to lead Quality Directors within the local CCGs to approve or highlight risks to the programme.

7. Links to the local Sustainability and Transformation Plan (STP)

The LLR STP builds on the work of our Better Care Together programme, the plans of which were already well advanced and articulated in many areas, particularly around proposals for reconfiguring our hospital services to address long standing issues around the condition of our premises and how these are utilised. However, the STP is a plan that will take time to deliver not least because some of the proposed service changes will require formal public consultation before final decisions can be taken. In addition, the new models of care set out will require our front line staff to work together in new roles and different ways.

The STP has five overarching priorities / solutions, each designed to help buy off demand on health and social care services (particularly the acute sector) while improving outcomes and financial performance:

- Strand 1: New models of care focused on prevention, moderating demand growth – including place based integrated teams, a new model for primary care, effective and efficient planned care and an integrated urgent care offer.
- Strand 2: Service configuration to ensure clinical and financial sustainability – including, subject to consultation, consolidating care onto two acute hospital sites, consolidation maternity provision onto one site and moving from eight community hospitals with inpatient beds to six.
- Strand 3: Redesign pathways to deliver improved outcomes for patients and deliver core access and quality - including actions to improve long term conditions, improve wellbeing, increase prevention, self-care and harnessing community assets, as well as our work to improve cancer; mental health and learning disabilities.
- Strand 4: Operational efficiencies - to reduce variation and waste, provide more efficient interventions and support financial sustainability - the Carter recommendations; provider cost improvement plans, medicines optimisation and back office efficiencies.
- Strand 5: Getting the enablers right - to create the conditions of success, including workforce; IM&T; estates; workforce, engagement and health and social care commissioning integration.

Alignment of 'strategic intent' between the STP and our operational plans is important and already apparent i.e. our service reconfiguration plans and new care models.

We are well engaged in the STP process and emerging governance arrangements and directly involved in shaping (system level) delivery plans across the various programmes / strands of work. For example, where plans involve the move of services from hospital to the community (e.g. outpatient clinics), our CMGs are fully sighted to this and reflect joint assumptions in service level plans.

Equally important is the work we are doing with partners to agree realistic assumptions around activity given the existing mismatch between demand and capacity, particularly within emergency

care. It is vital that the initiatives (many of them jointly owned) reduce demand on services and that we find new ways of delivering more efficient and effective care – rising demand will only add to the current capacity gap as we are constrained by workforce supply, our physical estate and, of course, affordability. Moreover, we remain committed to improving our performance across NHS Constitution standards and robust demand management will be key to this.

7.1. Collaboration and the Management of Risk

There is a commitment across local NHS clinical commissioners and main NHS providers to seek to change the 'terms of trade' in order to align more effectively the incentives across all parts of the system (rather than continuing the zero sum activity/income mechanisms of historical contract arrangements). Effectively, we have worked with LLR CCGs in constructing a local two year 'system deal' that hardwires the distribution of the 'LLR pound' to the strategic transformation model and direction set out in the STP. In headline terms, this would result in substantially lower levels of financial growth over the period into the acute hospital sector than has been the case over recent years (which is not without its risks if demand continues to rise) in order to enable a greater proportionate shift of resources into primary care and out of hospital services.

Seeking to develop such an approach will require a balance to reflect the relative control over the drivers that impact on demand and activity risk, which has informed our contract settlement for the next two years.

Appendix 1 – 2017/18 and 2018/19 Financial Plan Summary

	2016/17	**2017/18**	**2018/19**
	£m	£m	£m
NHS Patient Care income	775.1	807.7	823.7
Other operating income	137.7	133.3	133.2
Total Income	**912.9**	**941.0**	**956.9**
Pay	(550.9)	(557.7)	(561.3)
Agency	(25.0)	(20.6)	(20.2)
Non Pay	(339.1)	(347.0)	(351.6)
Total Operating Expenditure	**(915.0)**	**(925.3)**	**(933.1)**
EBITDA	**(2.1)**	**15.7**	**23.8**
Non Operating Costs	(36.7)	(42.5)	(45.5)
Total Expenditure	**(951.7)**	**(967.8)**	**(978.6)**
Retained Surplus / (Deficit)	**(38.9)**	**(26.8)**	**(21.7)**
Donated Assets	0.3	0.1	0.1
Net Surplus / (Deficit)	**(38.6)**	**(26.7)**	**(21.7)**

Appendix 2 – 2017/18 Financial Plan Bridge

	Gross I&E	STF	Net I&E
	£m	£m	£m
2016/17 forecast outturn	(38.6)	11.4	(27.2)
Non- Recurrent	(8.4)		(8.4)
FYE of costs in 16/17	(7.8)		(7.8)
Net Tariff Inflator (0.1%)	0.7		0.7
Inflation funding in tariff (2.1%)	(16.3)		(16.3)
CIP - national tariff requirement (2%)	15.4		15.4
HRG4+	8.2		8.2
Alliance	0.4		0.4
Additional CNST	(3.4)		(3.4)
Proposed STF change		(11.4)	(11.4)
2017/18 baseline	**(49.8)**	**0.0**	**(49.8)**
Junior Doctors Contract	(2.3)		(2.3)
Coding & Counting	4.2		4.2
Net Contribution of volume growth	2.3		2.3
PCI Provisions	(2.0)		(2.0)
CQUIN	0.3		0.3
Net impact of ED Floor and Front Door streaming	2.9		2.9
Transactable QIPP	(5.3)		(5.3)
QIPP related cost reduction	1.5		1.5
ED Floor	(2.3)		(2.3)
Winter cost	(1.5)		(1.5)
Apprenticeship Levy: Cost Recovery	1.4		1.4
BRC bid	(0.3)		(0.3)
Vascular	(1.9)		(1.9)
RIC/Exec Approved Funding	(4.7)		(4.7)
E&F LPT/NHSPS	1.0		1.0
Non-Op Costs	(0.7)		(0.7)
Contingency (0.5%)	(4.5)		(4.5)
CIP - locally defined (2.3%)	17.6		17.6
Agency Controls	1.2		1.2
Cost Control and further mitigations	16.1		16.1
2017/18 plan	**(26.7)**	**0.0**	**(26.7)**

2018/19 Financial Plan Bridge

	Gross I&E	STF	Net I&E
	£m	£m	£m
Net tariff inflator (0.1%)	0.8		0.8
Inflation funding	(18.3)		(18.3)
CIP (2%)	16.2		16.2
Additional CNST cost (above funded level)	(4.0)		(4.0)
2018/19 baseline	**(32.0)**	**0.0**	**(32.0)**
Additional CIP target	15.8		15.8
Minimal contingency (0.5%)	(4.7)		(4.7)
Other cost pressures	(0.8)		(0.8)
2018/19 plan	**(21.7)**	**0.0**	**(21.7)**

Appendix 3 – 2017/18 and 2018/19 Capital Plan

	2017/18 £m	**2018/19** £m
Facilities	8.5	5.8
Aseptic Suite	0.5	-
MES Installation Costs	1.5	1.5
IM&T - general	3.5	3.0
IM&T - Nervecentre	0.5	-
Medical Equipment	4.4	3.0
Radiotherapy CT Scanner	0.6	-
Other Schemes	0.2	-
Donations	0.3	0.3
Replacement, Repair & Maintenance projects	**20.0**	**13.6**
MES Finance Lease	5.1	4.5
TOTAL OPERATIONAL CAPITAL	**25.1**	**18.1**
Emergency Floor	7.0	-
EMCHC relocation	2.8	3.2
ICU Service Reconfiguration	12.0	3.4
Wards/Beds LRI	-	6.3
Wards/Beds GH	-	6.2
Imaging GH	0.1	0.5
Treatment Centre	0.6	4.0
ITU LRI	0.1	7.0
Women's Services	0.8	4.4
Childrens' Hospital	1.0	8.3
Theatres LRI	0.1	4.4
Additional Beds	3.7	11.9
Outpatients LRI	-	0.5
Pathology	-	0.3
Supporting infrastructure	1.0	0.9
Reconfiguration projects	**29.3**	**61.2**
EPR	-	-
TOTAL STRATEGIC CAPITAL	**29.3**	**61.2**
TOTAL CAPITAL EXPENDITURE	**54.4**	**79.2**
Funded by:		
Depreciation	*31.5*	*31.5*
Donations	*0.3*	*0.3*
DH Loan Funding - Agreed	*7.0*	*-*
DH Loan Funding - Proposed	*15.5*	*47.4*
Total Capital Funding	***54.4***	***79.2***

Appendix 4 – 2017/18 and 2018/19 Cash Flow

	2016/17 £m	2017/18 £m	2018/19 £m
Operating Deficit	**(42.0)**	**(15.8)**	**(7.8)**
Non-cash income and costs			
Depreciation and Amortisation	26.5	31.5	31.6
Donations	(0.3)	(0.5)	(0.5)
Impairments and reversals	24.8		
Change in working capital	(14.6)	8.0	11.6
Net cash generated / used in operations	**(5.3)**	**23.2**	**34.9**
Net cash generated from/(used in) investing activities	**(63.2)**	**(54.2)**	**(84.7)**
Cash flows from financing activities			
Public dividend capital received	2.1	0.0	0.0
Loans from Department of Health - received	83.1	80.6	69.1
Loans from Department of Health - repaid	(4.6)	(32.6)	(2.2)
Capital element of finance lease rental payments	(4.8)	(4.5)	(4.2)
Interest paid	(2.0)	(3.2)	(3.3)
Interest element of finance lease	(0.8)	(0.8)	(0.9)
PDC dividend (paid)/refunded	(6.5)	(8.6)	(8.9)
Net cash generated from/(used in) financing activities	**66.5**	**30.9**	**49.8**
Increase/(decrease) in cash and cash equivalents	**(2.0)**	**0.0**	**(0.0)**
Cash and cash equivalents at start of period	3.2	1.2	1.2
Increase/(decrease) in cash and cash equivalents	(2.0)	0.0	(0.0)
Cash and cash equivalents at end of period	**1.2**	**1.2**	**1.1**