Trust & System Annual Operational Plans 19/20

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Executive Summary

Context

- The Trust submitted the 1st draft of the Annual Operational Plan for 19/20 on February 12th 2019.
- The aggregate system operational plan (at LLR level) was submitted on February 19th 2019; this plan was been prepared and submitted by a system wide team.
- A pre-final version of the plan was presented to the Finance and Investment Committee and the joint meeting of the People, Process and Performance Committee and the Quality Outcomes Committee on Thursday 28th March, with comments incorporated into the final version presented here.
- The AOP (as at April 2nd) is attached for approval, prior to final submission by midday on April 4th 2019, with the System Operational Plan to follow.
- Key changes include:
  - Inclusion of the final Trust priorities for 2019/20-2022/23, with the addition of a 12th priority relating to our workforce/people strategy implementation.
  - Updated financial plans & performance trajectories as at April 2nd 2019
- Final changes may be required to workforce and performance trajectories based on regulator feedback; these will be highlighted to Trust Board on April 4th prior to submission.

Input Sought

The Board is asked to:

NOTE the progress made to date on both the Trust and System Annual Operational Plans

APPROVE the Trust Annual Operational Plan

For Reference

The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[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	[No]
Board Assurance Framework	[No]

Related **Patient and Public Involvement** actions taken, or to be taken:	[Comply]
Results of any **Equality Impact Assessment**, relating to this matter:	[To be completed]
Scheduled date for the **next paper** on this topic:	[Monthly]
Executive Summaries should not exceed **1 page**	[Comply]
Papers should not exceed **7 pages**	[Does Not Comply]

University Hospitals of Leicester NHS Trust

Operational Plan 19/20

Chapter One: Our approach to planning for 19/20

University Hospitals of Leicester (UHL) NHS Trust is one of the biggest and busiest NHS Trusts in the country, locally serving the 1.2m residents of Leicester, Leicestershire and Rutland – and with specialist services catering for another two to three million patients from the East Midlands and further afield. The vast majority of our work takes place in the three city hospitals, the Glenfield, General and Royal Infirmary,

Our overall purpose is to provide 'Caring at its Best' for every patient, every time and our values are central to that purpose; they embody who we are, what we do, and how we behave. They are:

As we move towards delivery of the NHS Long Term Plan as an increasingly integrated system, the services we deliver as part of our local and regional networks and partnerships will need to adapt and transform to ensure we are able to deliver caring at its best to every patient, every time and that UHL and the wider system become clinically and financially sustainable.

Our long term sustainability necessarily includes our plans to reconfigure sites and services; this remains a key priority for the Trust and we will therefore continue to progress through the national assurance process to access capital funding as it becomes available. However reconfiguration and specifically the concentration of services onto two rather than three acute sites is by no means the only component of our future sustainability.

Thus, this this plan describes how we will use 2019/20 as a transitional year to begin to address some of the other fundamental drivers of our recurrent deficit and the key quality and performance issues that we believe stand between the Trust being CQC rated 'good' / 'outstanding' and our current, 'requires improvement'. The journey between present and future state is called ***'Becoming the Best'.***

In order to address the fundamentals we have made two significant changes to our previously established approach: First, through a long process of refinement and distillation we have focused down on a smaller number of strategic priorities; Three years ago there were 46 annual plan priorities, for 2019/20 there are now 12. Second, we have developed and launched our Quality Strategy; this is the unified strategy and subsequent plan which will see the Trust adopt a single, tried and tested quality improvement approach across all Trust priorities.

The Quality Strategy, or to give it its proper name, ***'Becoming the Best'*** sets out how we plan to deliver our priorities. These priorities will be described below, after which we will set out the Trust's approach to capacity and demand, our performance trajectories, our workforce plans and our finances.

Our Priorities for 19/20-21/22

The Trust has many strengths, notably a highly committed and caring workforce and a wide range of clinically excellent services. We also have a very large critical mass, having one of the largest catchment populations of any trust in the NHS. Despite these inherent strengths, we have struggled to achieve and in particular to maintain high standards of performance. We are characterised by many pockets of excellence and sometimes improved performance which is then not sustained.

There has been much research undertaken into the characteristics of excellent or "outstanding" healthcare organisations. Most recently, these characteristics have been summarised by the CQC in their report "Quality Improvement in Hospital Trusts" (September 2018). Our priority setting process for 19/20 has sought to learn from trusts which have shown significant, sustained improvement and are now judged to be "good" or "outstanding".

These Trusts have a number of common features:

- They have a small focused number of multi-year priorities
- They have an embedded Quality Improvement Programme to deliver these priorities
- They have strong programme governance and accountability processes aligned to Trust-wide governance

Based on this analysis and our own lessons learnt we have launched ***Becoming the Best***, reduced the number of priorities, adopted a combination of 'Institute of Healthcare Improvement' and Lean methodology to deliver these and put in place an executive-led programme of delivery. This has led to a multi-year programme of twelve priorities; six quality priorities and six supporting:

Our quality priorities

1. We will embed safe and effective care in every ward by introducing a Trust wide assessment and accreditation framework
2. We will consistently implement the safest practice for invasive procedures, with a focus on consent, NatSSIPS and the Five Steps to Safer Surgery; and we will improve our learning when things go wrong
3. We will implement safe and timely discharge for all patients in our care, seven days a week, by embedding safer discharge processes and eliminating avoidable delays
4. We will provide high quality and timely diagnosis & treatment for patients on cancer pathways by redesigning those pathways in conjunction with our partners
5. We will work as a system to create safe, efficient and timely urgent and emergency care, with a focus on embedding acute frailty and Same Day Emergency Care
6. We will provide high quality, efficient integrated care by redesigning pathways in key clinical services to manage demand, improve use of resources and deliver financial improvement

Our supporting priorities

7. We will begin implementation of our new Quality Strategy, focusing initially on developing the right culture, leadership and skills to encourage and enable improvement
8. We will implement our People Strategy, with a focus on attracting and retaining the staff that we need and developing new roles where these will help improve care
9. We will invest in our current estate in order to support the delivery of safe and effective care, including delivering the next stages of our reconfiguration and pursuing the business case for our longer term plan
10. We will support safe and effective care by progressing our e-Hospital plans to implement user-friendly and integrated solutions that make people's jobs easier to do
11. We will maximise the opportunities for our patients to benefit from research, including launching our new 'Academic Health Science Partnership'
12. We will provide more effective and efficient corporate processes to support our staff and CMGs

These priorities have been triangulated with our safety, complaints and quality data as well as feedback from internal and external patient groups and stakeholders. They are also congruent with the priorities of our system partners.

Chapter Two: Demand and capacity planning

In 18/19, we took a different approach to planning our capacity in response to anticipated demand, in partnership with our commissioners. Previously we have sought to balance the needs of elective and emergency pathways. This had resulted in periods of very poor performance resulting in large scale cancellations and inefficient use of resources. Thus far in 18/19, we have seen a far lower level of elective cancellations, partly due to this methodology used in planning at the start of the year. Building on this for 19/20, we have applied the lessons learnt in terms of core planning assumptions used and preparation for winter 20/21, resulting in what we believe are realistic activity plans.

Methodology applied (aligned with local commissioners):

- Each Clinical Management Group (CMG) Head of Operations will have ownership of the completed contract activity plan for their CMG and will be required to sign off that they have reviewed the plans with their services and are in agreement that they are realistic and deliverable.
- CMG Month 7 forecast outturn used as the starting point. An early view of Month 9 CMG forecast outturn shows that the 18/19 baseline for some PoDs/Services has been set too low and have therefore been adjusted through a confirm and challenge process with CMG's and commissioners.
- Continued with the methodology outlined in the 18/19 planning round; emergency demand will take priority with the remaining capacity allocated to cancer then routine elective demand.
- Demographics growth set at 0.8% with growth rates adjusted with local knowledge.
- Outpatient plans are capacity based plans, with initial plans not taking into account any efficiencies or shift of activity to the Alliance as yet.
- Adjustments made for pathway changes – for example the Children's pathway.
- Phasing agreed with CMG at specialty level, based on internal trend analysis of the previous 3 years

This impact of balancing the emergency and elective pathway has been mitigated, particularly learning from winter 18/19, in three key areas.

1. Drive delivery of our efficiency plans

The *first* is to **drive delivery of our efficiency plans**, including plans to decrease numbers of stranded and super-stranded patients by 40%* from our 17/18 baseline; delivery of local plans to hold and/or decrease length of stay for all other patients, including those with 7 and 14 day or more stays and reducing bed occupancy to manageable levels and embedded same day emergency care within the Emergency Floor at the LRI and the CDU at the Glenfield.

By reducing the number of long stay patients in hospital we will collectively reduce bed occupancy to increase safe flow through the system, greatly improving the working and care environment, reducing A&E crowding and enabling patients to be treated consistently in the right bed by clinical teams with the right skills. Achieving this will require concerted effort across the whole health and care leadership system by joint working with GPs, local authorities, community health and social care providers and others.

Following on from the progress made in 18/19, our plans will aim to deliver the following reduction to the 17/18 baseline:

	Beds occupied with long stay patients 2017/18	18/19 trajectory	19/20 trajectory	Reduction to be delivered by whole system
UHL	202	156	135*	67

**40% reduction of patients on acute wards excluding the rehabilitation wards at the LGH*

We recognise that this is a significant task. We have plans internally and with our external partners to move us to this position through:

- Implementing a new model of step down care enabling UHL to use its current medical workforce more efficiently
- Developing the frail complex & End of Life patient pathway, integrating services with our community health and social care partners
- Working with LLR commissioners to mitigate the growing demand in all activity types
- Increasing efficiency & patient flow at the weekend and overnight & improving internal efficiency by maximising SAFER flow and 'Red to Green'
- Reducing delayed transfers of care (DTOCs) to below minimum thresholds through our internal embedded social care team
- Reducing average length of stay, including a specific focus on those patients with the longest length of stay
- Focusing on decreasing stranded and super stranded patients to benchmarked levels, using local knowledge and any nationally available support tools made available

In addition, we agreed in 2018/19 at a system level that the Trust will lead a programme of work across the LLR STP area to design an enhanced system of care for frail and multi-morbid patients across the local health and care system, this will continue into 2019/20, and will be focussed on End of life care. The objective of this task force approach will be to ensure that this cohort of patients has access to evidence-based integrated care both pre-, during and post-hospital episodes. Our plans have been approved by the LLR Clinical Leadership Group as the right interventions to pursue for our system. To ensure interdependences are taken into account, we have morphed the delivery of our internal efficiency plans (described above) into this programme; this will allow strategic & operational planning, transformation and operational performance to triangulate through the year.

2. Increasing overall bed capacity during escalation

The *second* is an attempt to protect some of the elective capacity by **increasing overall bed capacity** as part of winter resilience plans. A CMG/Site based bed model has been developed incorporating CMG phased19/20 planned activity. Two scenarios have been run through the model:

1. Emergency bed occupancy 85% and elective bed occupancy 90%
2. Emergency bed occupancy 90% and elective bed occupancy 93%

Based on scenario 2 this means we plan to open the following escalation beds over the year

		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
GGH	Modular Ward	14	0	0	0	0	0	0	14	14	28	28	28
LRI	Esc Ward 1	28	28	28	28	28	28	28	28	28	28	28	28
LRI	Esc Ward 2	28	0	0	0	0	0	0	14	14	28	28	28
Total		70	28	28	28	28	28	28	56	56	84	84	84

3. Working as a system to manage demand (elective & non-elective care)

Finally, we saw a stabilisation of routine demand in 18/19 partly as a product of our joint initiatives in planned care including First Contact for MSK pathways - we will strengthen this in 19/20 by **exploiting the Referral Support Services** as they are rolled out across LLR, decreasing demand at source in high volume specialties whilst expanding the use of our non-face to face offer (e.g. virtual clinics) in specialties such as ENT, ophthalmology, dermatology and orthopaedics.

We have agreed with our local commissioners that Inter Provider Transfers will no longer be supported in 19/20. Historically there has been approximately £4.6m worth of activity transferred to the Independent sector due to capacity and RTT restraints - this mainly covers Orthopaedics, General Surgery and ENT. This has been taken into account within our capacity modelling; we will therefore manage all activity referred internally, utilise capacity within the Alliance or subcontract directly with the Independent Sector.

The Trust has agreed to a value of £5.9m to be included within the 19/20 contract for planned care QIPP following several confirm and challenge session with CMGs and CCG colleagues. As planned care activity is commissioned on a PbR basis, this is being held centrally within the activity/finance plan.

Our non-elective demand management plans are based on system-wide actions to increase deflection rates to non-LRI sites through extension of clinical navigation, increasing extended primary care access and increasing direct booking to other sites. We are also embedding the management of frailty and same day emergency care across our system in order to manage the non-elective demand on beds.

Planning in this way should give a greater opportunity for us to mitigate the performance and financial impacts of the growth in emergency care and deliver some ancillary benefits such as giving certainty to periods of theatre maintenance, deep cleaning wards and staff downtime etc.

Contracted activity plan

All 19-20 activity plans pre-QIPP are owned and signed off by the CMG's Clinical Directors and Heads of Operations.

The table below shows our contracted activity plan pre QIPP (UHL and Alliance) for 19/20:

	18/19 FOT	19/20 Plan	% Difference
New Outpatients	246,728	253,538	2.8%
Follow Up Outpatients	508,838	506,466	-0.5%
Outpatient Procedures	147,535	148,154	0.4%
Day Case	106,557	106,865	0.3%
Inpatient	20,538	20,431	-0.5%
Emergency/Non Elective*	100,365	100,779	0.4%
Emergency Department*	227,538	235,671	3.6%
Eye Casualty	21,158	21,488	1.6%

The table below shows our activity plan post agreed planned care QIPP (UHL and Alliance) for 19/20:

	18/19 FOT	19/20 Plan	% Difference
New Outpatients	246,728	246,904	0.1%
Follow Up Outpatients	508,838	494,662	-2.8%
Outpatient Procedures	147,535	132,069	-10.5%
Day Case	106,557	104,274	-2.1%
Inpatient	20,538	20,431	-0.5%
Emergency/Non Elective*	100,365	100,779	0.4%
Emergency Department*	227,538	235,671	3.6%
Eye Casualty	21,158	21,488	1.6%

*19/20 activity plan includes full year effect of pathway changes

We expect that delivery will enable the Trust to achieve the trajectories detailed in Appendix One for RTT, incomplete pathways, cancer and diagnostic waiting time standards and key recovery milestones for A&E.

Once received in spring 2019/20, we will assess and re-formulate our trajectories and delivery plans to reflect the ambitions outlined in the Clinical Standards Review where required.

Chapter Three: Operational Performance

This section summarises our expected performance against key national operational standards.

Emergency performance - 2019/20 trajectory:

Month	National Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
UHL ED 4 hr	95%	83.1%	86.9%	85.8%	83.9%	84.1%	85.1%	83.8%	82.4%	81.2%	77.7%	82.5%	82.8%
UHL/LLR ED 4hr wait	95%	87.5%	90.3%	89.5%	88.3%	88.4%	88.6%	87.5%	86.2%	85.3%	84.0%	87.1%	87.4%

Ambulance handovers - 2019/20 trajectory:

Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Arrivals (CAD)	5,458	5,662	5,429	5,506	5,393	5,532	6,089	6,130	6,241	6,108	5,518	6,028
Handover delays 15-30 mins CAD	1,999	2,222	2,295	2,477	2,466	2,566	2,666	2,431	2,448	2,616	2,236	2,455
Handover delays 30-60 mins CAD	665	550	393	340	288	278	289	455	420	569	399	402
Handover delays 60+ minutes CAD	235	110	45	0	0	0	0	0	0	0	0	0

Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
% Handover delays 15-30 mins (CAD)	37%	39%	42%	45%	46%	46%	44%	40%	39%	43%	41%	41%
% Handover delays 30-60 mins (CAD)	12%	10%	7%	6%	5%	5%	5%	7%	7%	9%	7%	7%
Handover delays 60+ minutes CAD	4%	2%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Referral to Treatment - 2019/20 trajectory:

Month	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
<18wks	54,666	54,939	55,351	55,711	56,073	56,017	56,073	56,213	56,242	55,988	55,736	55,458	55,081
>18wks	9,870	9,801	9,569	9,454	9,311	9,505	9,600	9,312	9,033	9,665	9,955	9,656	9,323
Total WL	64,536	64,740	64,921	65,166	65,384	65,522	65,673	65,526	65,274	65,654	65,692	65,114	64,404
RTT Performance	84.7%	84.9%	85.3%	85.5%	85.8%	85.5%	85.4%	85.8%	86.2%	85.3%	84.8%	85.2%	85.5%

52+ week waits - 2019/20 trajectory:

Month	National Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
52 Week Wait	0	0	0	0	0	0	0	0	0	0	0	0	0

Diagnostics - 2019/20 trajectory:

Month	National Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Diagnostics 6+ week wait	<1%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%

Cancer - 2019/20 trajectory:

Month	National Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Cancer 2 Week Wait	93%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%
Cancer 2 Week Wait - Breast	93%	93.5%	93.6%	93.3%	93.2%	93.3%	93.2%	93.1%	93.0%	93.5%	93.2%	93.3%	93.6%
Cancer 31 Day First	96%	93.2%	94.5%	95.4%	96.1%	96.5%	96.3%	96.1%	96.4%	96.6%	96.8%	96.8%	96.8%
Cancer 31 Day Drugs	98%	98.4%	98.3%	98.6%	98.3%	98.4%	98.7%	98.7%	98.1%	98.6%	98.2%	99.3%	98.5%
Cancer 31 Day Subs Surgery	94%	84.9%	86.1%	88.0%	85.8%	89.1%	84.5%	87.4%	85.4%	94.2%	91.0%	92.1%	94.2%
Cancer 31 Day Radiotherapy	94%	95.8%	96.3%	96.4%	97.4%	96.9%	96.4%	96.5%	97.4%	96.9%	95.5%	96.0%	95.9%
Cancer 62 Day	85%	73.9%	78.3%	74.8%	78.4%	74.3%	85.2%	85.2%	85.3%	89.0%	85.5%	85.2%	85.2%
Cancer 62 Day Screening	90%	86.7%	86.7%	83.8%	92.3%	90.1%	90.0%	90.9%	91.4%	92.3%	92.3%	90.0%	90.9%

Appendix One of this document provides details of our supporting analysis and covers:

- Learning from 2018/19,
- Improvement actions within the gift of the Trust
- Improvement actions in partnership with our wider health and care partners
- Any associated funding allocated
- Any identified risks to delivery

These performance trajectories will be monitored through our usual Trust governance processes as well as through the lens of our Quality Strategy.

Chapter Four: Our Approach to Quality Planning

1. Approach to quality improvement, leadership and governance

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

Our Quality Strategy

UHL's Quality Strategy seeks to learn from trusts which have shown significant and sustained improvement. Its goal is to enable us to deliver Caring at its Best to every patient, every time and thus be judged to be an outstanding organisation. Building on our strengths whilst also addressing what we need to do better, or differently, our Quality Strategy is designed to be a comprehensive, evidence-based approach, capable of transforming our organisation.

The development of our Quality Strategy has involved a wide range of people within the trust, particularly those with quality improvement and organisational development expertise. It has also had extensive input through Trust Board Thinking Days and through our Leadership, Consultant & BAME network conferences.

Our Quality Strategy sets out our improvement methodology and our priorities for improvement; a "unified programme" approach will mean a single programme incorporating all the key things that we need to do using the overall approach set out in this strategy. It reframes our approach into one of constant learning and improvement and ensures that QI is our organising principle.

Our quality improvement governance system

We have recently introduced a new Accountability Framework for our Clinical Management Groups and Corporate Directorates. A partial Well-Led review (incorporating a Board Review) has also been undertaken which indicated broadly that our assurance systems and processes were fit for purpose. These two elements of our corporate architecture will therefore remain in place. However, it will be important to change the *conversations* that take place within those structures so that they focus on the things that are important within the framework provided through our Quality Strategy.

The governance structure is therefore as follows:

- The programme board for the Quality Strategy itself will be the **Executive Strategy Board**. This board will report progress direct to the **Trust Board** through the Chief Executive's Report
- An **Expert Reference Group** will be established to advise on the implementation and further development of the strategy
- A **Change Network** will be established; this will be a much larger group, representing a cross-section of the organisation. This is part of the approach used by the Culture and Leadership Programme in order to assist with the diagnostic phase and cultural shift
- The Executive Planning Meeting will provide oversight of the progress of our Quality Strategy Implementation Plan, ensuring that it is core business.

We will identify appropriate team structures and lead roles once we have further developed our "unified programme". The Trust is currently participating in the Culture and Leadership Programme (CLP). This is described in more detail in our People Strategy but it will be central to the Quality Strategy.

Quality improvement capacity and capability

The success of our Quality Strategy will depend on a complete commitment from the top level of the organisation to the approach set out in our Quality Strategy. This includes visible championing of the approach and changing the way in which we do things. It also depends on creating the head space for everyone to talk about how best to pursue this ambition.

Additional resource to deliver our Quality Strategy will require investment in key areas such as:

- Improvement skills training
- Communications
- Patient involvement
- Business intelligence
- External specialist support

In order to measure and evidence the impact of our investment in quality improvement, we carry out regular & systematic reviews of our reporting structures and processes to ensure that they continue to be fit for purpose. We

will introduce processes to ensure the basic quality and functioning of all our clinical services, combining both quality control and quality assurance.

In addition to the development of a Quality Strategy dashboard, we will develop a comprehensive Quality Strategy implementation plan to manage and monitor the actions set out in this strategy and others that are developed as we go forwards. Progress against this plan will be reported to the Trust Board.

2. Summary of the quality improvement plan

Our quality improvement plans

Our quality improvement plan takes account of both local and national priorities, incorporating patient experience, clinical effectiveness and safety. Further, we have triangulated harms and clinical outcomes data, patient complaints and GP concerns to identify the most pressing issues for improvement. Our quality improvement priorities for 2019/20 are a core part of our Quality strategy and are referenced on page two of this plan.

We welcome the proposed new national patient safety strategy and the new NHS Improvement Serious Incident Framework, both of which make positive strides in cementing quality improvement and just culture into their approach. We will align our safety priorities to the proposed three I's - insight, infrastructure and initiatives and share the ambition to reduce death and harm by 50% by 2023. We will be working collaboratively with partners across LLR to consider the specific safety and quality needs of our local population. We will use co-design approaches with partners and track and monitor progress and improvement against our quality priorities through KPIs.

Risks to quality

Our Board Assurance Framework (BAF) describes the 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. Our top three risks are:

	Risk	Mitigation
1)	If the Trust is unable to effectively manage the emergency care pathway, then it may result in widespread instances of poor clinical outcomes for patients and sustained failure to achieve constitutional standards, affecting business (finance) and reputation (breach in regulatory duty / adverse publicity) Current Risk Rating (IxL) = 5 x 4 = 20	• A new model of command and infrastructure • Daily operational command meetings • Electronic bed management system • Robust escalation protocols • Daily LLR system calls • System support provided by the National Emergency Care Improvement Programme • R2G embedded in medicine, RRCV and Trauma • In Hospital (SAFER) Care Bundle, Ambulatory Care and workforce and Out of Hospital (DTOC) as well as admission prevention & avoidance projects
2)	If the Trust is unable to achieve and maintain the required workforce capacity and capability standards, then it may result in widespread instances of poor clinical outcomes for patients and increased staff workloads, affecting business (finance) and reputation (breach in regulatory duty / adverse publicity) Current Risk Rating (IxL) = 5 x 4 = 20	• Governance structures established comprising internal and external groups • Strategic workforce • People strategy and programme of work • Revised robust five year workforce plan • Leadership and people management policies, processes and professional support tools • Staff communication & engagement forums • Embedded Medical Education Strategy
3)	If the Trust is unable to achieve and maintain financial sustainability, then it may result in a failure to deliver the financial plan, affecting business (finance) and reputation (breach in regulatory duty / adverse publicity) Current Risk Rating (IxL) = 5 x 4 = 20	• Annual and long-term financial model • CMG / Corporate review of financial plans, forecasts and CIP delivery • Reductions in agency spend • Finance / CIP reports for assurance • Investment supporting the resolution of the demand/capacity challenges • Financial governance and performance monitoring arrangements from Board to service line • NHSi performance review meetings • Commercial Strategy

	Risk	Mitigation
		• Financial Recovery Board and Operational Group

Gosport Independent Panel

Learning from excellence and learning from error are critical components of our safety work. This year we have established mechanisms to capture best practice so that this can be shared widely internally and externally to promote further improvement. National reports which have identified organisational failings such as the Gosport Independent Panel report and the Liverpool Community Health report have been carefully scrutinised and a full gap analysis has been undertaken against their recommendations and findings. These were reported on both at our Executive Quality Board and the Quality and Outcomes Committee (in June and July 2018) with confirm and challenge over our governance arrangements, Serious Incident process, safety culture, medical appraisal and the effectiveness of the 'Responsible Officer' arrangements, and our processes for staff and families to raise concerns.

Seven day services

The Seven Day Hospital Services Programme aims to tackle the variation in outcomes for patients admitted to hospitals in an emergency at the weekend across the NHS in England. Four clinical standards were made a priority, as they are most likely to have the greatest impact in tackling variations in mortality, patient flow and experience

The four priority seven day service standards

Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital	**Standard 5:** Hospital inpatients must have scheduled seven-day access to consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hours for urgent patients	**Standard 6:** Hospital inpatients must have timely 24 hour access, seven days a week, to consultant directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols	**Standard 8:** All patient with high dependency needs should be reviewed twice daily by a consultant and all other inpatients should be reviewed by a consultant once daily seven days a week, unless it has been determined that this would not affect the patient's care pathway

The new Seven Day Services Board assurance framework was introduced in a trial form in the autumn of 2018. The new framework requires Trusts to complete a seven day service self-assessment, formally assured by the Board on a bi-annual basis. The first self-assessment under this new framework was presented to the Board in February 2019, with full implementation of the assessment framework by June 2019.

Learning from deaths

During 2017/18, 3,360 patients were part of our Learning from Deaths process. By the end of March 2018, 328 case record reviews and 22 investigations were carried out in relation to these 3,360 deaths

Learning identified through our case record reviews, has included:

- The importance of recognising patients who are at the end of life and communicating with them and their relatives about their prognosis
- The importance of timely escalation of the deteriorating patient and sepsis treatment
- Acting on results in a timely way
- The importance of senior review and decision making
- More effective handover and transfer between specialties and sites
- Improved communication / handover using NerveCentre (our clinical information system)

In most of the cases reviewed, actions were around raising awareness and disseminating the lessons learnt to clinical teams.

Our Mortality Review Committee reviews the themes from our case record reviews and ensures that we have the appropriate work streams in place to take forward lessons learned. The Mortality Review Committee will assess the impact of actions taken to in response to lessons learnt from case record reviews.

Gram-negative bloodstream infections

Our plans to reduce Gram-negative bloodstream infections by 50% by 2021are reflected in our infection prevention annual work programme, which is overseen by our Infection Prevention Assurance Committee.

National Early Warning Score 2 (NEWS2)

Following the introduction of a modified NEWS1 in 2015, we implemented NEWS2 for all adult patients in December 2018. In inpatient areas this is recorded electronically on Nervecentre. In outpatient areas it is recorded manually. We monitor the escalation and appropriate responses to our deteriorating patients through our Deteriorating Adult Patient Board and our Sepsis Working Group.

3. Summary of quality impact assessment process and oversight of implementation

Quality impact assessment (QIA) 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.

The “unified approach” set out in our Quality Strategy will incorporate all 12 of our priorities; this includes our Productivity Improvement Programme.

Chapter Five: Workforce planning

Our People Strategy

Our workforce plan has been developed in the context of a five year Strategic Workforce Plan which was signed off by a subgroup of the Trust Board in July 2018. This sets out our short, medium and long term actions in relation to our workforce planning processes, ensuring sufficient staffing capacity and capability throughout the year to support the provision of safe, high quality services.

The Trust has produced a draft People Strategy which will be approved by the Trust Board in March 2019; this is appended by professional workforce plans for nursing and midwifery and the medical workforce in recognition of the significant challenges we face in the supply of workforce. Plans for other professional groups are currently in development. This strategy encapsulates the Trust approaches to improving supply and retention; maximising the benefit from pay reforms arising from the new Agenda for Change agreement; our approaches to improvement in the management and control of non-contracted pay expenditure and an emphasis on caring for our staff as much as we care for patients. The full plan is summarised in Appendix Two.

Workforce Planning Methodology

Our annual workforce planning process for 2019/20 has been intrinsically linked to the financial planning process which derives its income assumptions from capacity and activity levels modelled for each specialty (as described in the financial and activity planning sections). From the resultant trust level pay bill envelope, the workforce plan has been derived using the following key assumptions:

- A deficit position of £48.7m before central adjustments
- Baseline worked whole time equivalents as at month 9 forecast outturn position
- Assume an underlying gradual reduction in the monthly paybill over 19/20 with adjustments made for winter planning
- Assume the same agency ceiling cap of £18.8m
- Assumptions relating to transformation changes in respect of ICU and East Midlands Congenital Heart Centre
- Agenda for Change associated inflationary pressures.

This created the NHSI high level workforce plan submission for February 2019. A further iteration is in progress to include more detailed modelling derived from service level planning based on more detailed activity assumptions. Using the forecasted WTE and pay bill out turn position as a baseline, the following process is being implemented:

1. The re-costing of our baseline workforce and vacancies to derive a basic paybill envelope has been completed.
2. The review of current expenditure inclusive of non-contracted to derive a calculation of indicative control totals at Clinical Management Groups levels has been completed. This gives a realistic starting point to prevent overspend.
3. Confirm the establishment position including triangulation with the most recent nursing acuity and establishment review to ensure adherence with the latest Developing Workforce Safeguards recommendations
4. Review establishment position against Model Hospital data and outcomes of Getting it Right First Time reviews to identify productivity cost improvements
5. A paybill profile based on activity and capacity requirements (which will be driving any increases/ decreases in bed, theatres or outpatient capacity; any newly designed models of care; safe staffing levels, service changes and cost improvement assumptions). In order to assume correct monthly profiling of pay bill, winter plans for emergency activity will be considered to ensure workforce is deployed proportionately in order that processing power and patient flow is maintained. Winter phasing is forming part of the WTE plan
6. In deriving a revised establishment consideration is being made to new roles as an alternative where there are risks to the supply of workforce. Any double running requirements in the development of such roles will be reassessed with a particular emphasis on apprenticeships, Nursing Associates, Physician Associates and Advanced Clinical Practitioners. In accordance with the recommendations contained within ‘Developing Workforce Safeguards’ any such changes will be accompanied by a full quality impact assessment
7. Determine recruitment / reduction trajectories based on revised establishment/ paybill profiles
8. Where significant gaps between establishment and in post arise, forecast non contracted WTE and paybill to meet gap and identify premium expenditure required while ensuring agency

cap levels are not breached

9. Where activity cannot be delivered within existing resources, forecast any waiting list assumptions and include in assumptions regarding average pay cost.

We will 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 will reflect the control totals that the Trust believe to be achievable
2. Forecast WTE percentage change to activity percentage change with a general 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/seven day service requirements
- Changes arising from volume changes particularly in relation to capacity requirements & acuity reviews
- Anticipated shifts in agency
- Increased adoption of bank workforce to cover significant challenges in workforce supply which are predicted to continue into 2019/20
- Understanding of turnover and predicted vacancies
- Understanding of the international labour market including turnover resulting from Brexit and lead times for other overseas recruitment as a temporary solution
- Adoption of mutually beneficial schemes in international recruitment such MTI schemes
- Cost improvement measures including such interventions as skill mix review and reduction in average cost per whole time equivalent
- Changes arising from national workforce imperatives such as the Safer Births Review, mental health, urgent and emergency care systems and cancer investment plans particularly in relation to diagnostics.

On an ongoing basis the workforce is managed through the Electronic Rostering System (Medirota for medics on a roll out basis) to ensure levels of staffing are safely maintained. This enables a bank first approach to the acquisition of temporary staff and control of agency cap prices for nursing. Currently fill rates are 70% bank and 30% agency. Electronic solutions for escalation of medical agency 'break glass' processes are being developed. The Trust implements the standards contained in National Quality Board standards for monitoring impact of nursing levels on quality indicators.

The overall paybill change is:

	2018/19 Forecast Out-turn £s	2019/2020 Plan £s
Total Pay-bill	**641.4**	**673.3**
Bank	21.6	22.3
Agency	18.4	18.8
Substantive	601.4	632.2

Therefore, the overall WTE change (for end 18/19 to end 19/20) is:

	Forecast Mar-19 WTEs	Planned Mar-20 WTEs	Planned Movement WTEs
ALL STAFF	**14354**	**14707**	**353**
Bank	715	729	14
Agency	228	228	0
Substantive	13411	13750	339

To ensure on-going triangulation with quality, activity and finance, our workforce plan has been reviewed at all stages of development by multidisciplinary senior teams (with representatives from all planning disciplines) who have ensured the proposed workforce levels are affordable, sufficient and able to deliver efficient and safe care to patients as well as 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 People Process and Performance Committee and quarterly to the Trust Board and Executive Workforce Board.

Current workforce challenges

Workforce challenge	Impact on workforce	Initiatives in place
Supply, recruitment and retention of nursing workforce. Ageing workforce profile	Difficulty in recruiting to establishment; difficulty in rostering; reliance on bank and agency	1. Implementation of a systematic process for the development of new roles, ensuring the appropriate governance and education plans are in place to ensure patient safety a. Nursing associates (STP level) – School of Nursing Associates b. Pharmacy technicians c. Therapy ward based roles in medical step down environment 2. International recruitment programme (Europe and beyond) 124 this year. 40 on alternate months throughout 2019/20 3. Introduction of new entry schemes for nursing. 10 commenced nursing apprenticeship with Open University. New Masters level nursing programme at University of Leicester with guarantees for graduates who demonstrate Trust values and behaviours 4. Recruitment and Retention Premia in the most challenging areas
Supply, recruitment and retention of junior medical workforce	Difficulty in recruiting to establishment; difficulty in rostering; reliance on bank and agency. Breach of NHSI capped rates.	1. CESR programme for doctors 2. Rotational Trust Grade programmes 3. Introduction of increased Internal Medicine training number posts 4. Development of multidisciplinary International Recruitment Hub 5. Doctors in training committee focused on engagement and improvement of well-being for junior doctors 6. Increased advanced practitioner roles
Supply and recruitment of consultant workforce for ED/Geriatrics/Breast Radiology/Oncology/ Dermatology/Rheumatology	High usage of expensive agency and	1. Shared posts in community 2. Increased advanced practitioner roles 3. Remodelling of working practices to enable introduction of Physician Associates
Supply and recruitment of specialist healthcare scientists roles	Projected challenges to recruitment in light of retirement trajectory	1. Successful introduction of Higher Level Apprenticeship scheme for some specialties
Supply and recruitment of sonographers and diagnostic radiographers	Impact on cancer wait targets and premium expenditure	1. Successful European recruitment in Italy 2. Internal development pathway for sonography
Retention estates and facilities staff	Difficulty in maintaining establishment levels, continuity of service provision	1. Maximise benefit of removal of Band 1 posts in Agenda for Change reforms

In terms of ensuring successful recruitment and retention across all staff groups, 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 challenges. This includes initiatives such as 'Grow your own' internal development programmes, education and training and career development incentives and development of apprenticeship roles. This approach helps mitigate the ongoing challenges we face in the supply of staffing across a number of staff groups and specialties.

Current workforce risks

Workforce risk	Impact of risk (H/M/L)	Risk response strategy	Timescales and progress to date
High turnover of Healthcare Assistants in the first year of employment particularly in	High	To review hotspot specialties, improve exit interview completion and reasons for leaving data and address issues arising. Implement use	Develop action plan based on findings by May 2019. Analytics underway. Commenced roll out in January 2019 of new starter welcome

medicine, cancer and haematology		of stay interviews. Use of apprenticeship schemes as an entry point to service.	scheme. Will be followed by stay surveys in July 2019.
Insufficient UHL capacity to train required numbers of Pharmacy technicians to cover demand	High	To develop an LLR wide approach to the design and development of the Pharmacy workforce to meet to the needs of the 10 year plan particularly in relation to Primary Care growth	Bid to LWAB for support monies end Feb 2019. Project manager in post to develop plan April –Oct 2019
20% of absence days related to anxiety and depression	Medium	Implementation of the Health and Well-being Annual Plan with specific themed focuses each month. Development of Time to Change action plan in partnership with champions. Programme has Board sponsorship.	Action plan in place for Time to Change initiative aligned to the Farmer and Stevenson 'Thriving at Work' report.
Deterioration in staff survey results relating involvement in improvements and Equality and Diversity	Medium	Quality strategy in place to develop whole organisation culture, leadership and skills development programme to address approach to quality improvement. Implementation and tracking of progress of Equality and Diversity Action Plan.	Quality Strategy and associated People Strategy launch March 2019. Detailed one year action plan in place

Long term vacancies

Description of long term vacancy, including the time this has been a vacant post	Whole time equivalent impact	Impact on service delivery	Initiatives in place, along with timescales
Capturing the most significant long term vacancies: Most significant consultant posts -Breast radiologists Immunology/Allergists Cardiology Respiratory Emergency Medicine Dermatology Rheumatology Neurology Geriatrics Max Fax Juniors Sonographers Nursing – most significant - Theatres, Children's, Medicine, Cancer and Haematology Diagnostic radiography	 2.0 2.0 4.0 4.0 2.0 3.0 Over 100	▪ Use of expensive agency to ensure no breach of cancer targets ▪ Use of agency and internal locums ▪ Inability to meet service demand	International recruitment, ensuring a focus on trainees approaching CCT, posts combined with research and education. Increased use of specialist nurse posts and Advanced Clinical Practitioners Two annual cohorts with local education provider of Children's nursing Benchmarking of Band 6 theatre nurses to develop career pathway (Dec 2019) Continued international recruitment of diagnostic radiographers

Alignment with the LLR Sustainability and Transformation Plan

Our processes generate an internal workforce plan, which will then form a critical component of the STP plan. The principle changes for UHL anticipate the changes that will be required to enable us to achieve a future two site configuration; improvements to enable emergency flow, capacity improvements for the delivery of East Midlands Congenital Heart Services and changes to maternity services – however these are all largely dependent on capital funding being awarded. Within our Reconfiguration Programme all such changes associated with this internal

reconfiguration have a robust workforce and organisational development plan to ensure that we are clear on the workforce required to enable future service model changes. These lead to a model of demand for workforce from which we model our projected supply. Some of these anticipatory plans are reflected in the Trust overall workforce plan for this year.

The examples provided below show how we are planning to use role development to improve the processing power on our wards and increase discharge expertise across the Trust:

- Investment in the 'Frailty Front Door' Multidisciplinary team to enable improved processing of patients and avoid admission of the most vulnerable patients
- Continuation of acute medical staff input at the front door to increase adoption of Same Day Emergency Care (SDEC) pathways
- Improved organisation and management of the discharge team to enable more consistent staffing levels and approaches, aimed at reducing stranded and super stranded patients
- Investment in flow coordinators – non clinical roles to enable patient flow allowing clinicians to focus on clinical interventions.

Maintaining our bed base at levels slightly above current baselines requires significant changes within primary and community care including greater emphasis on admission avoidance practices and prevention. This requires more joint approaches to planning which are described in sections later in this plan.

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 for 19/20 will enable the delivery of both this operational plan and the LLR system operational plan and will include:

1. Use workforce modelling techniques to develop system wide views of workforce supply across the system. 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 with particular focus on Physician Associates
3. Investment to support an LLR wide attraction strategy with a specific focus initially on the development of an LLR wide recruitment portal
4. Investment in Advanced Clinical Practice education
5. Investment in Organisational Development including expertise in transformational change and system leadership
6. Funding to support the development of the Primary Care & Mental health Workforce Plans
7. Ongoing collaborative approach to the development of Nursing Associates

Chapter Six: Financial planning

1. Financial forecasts and modelling

2019-20 Financial Plan: Overview

The Trust has submitted a 2019-20 Financial Plan with an Income and Expenditure (I&E) deficit of £48.7m excluding centrally available funding defined as MRET Funding, Provider Sustainability Funding (PSF) and Financial Recovery Funding (FRF). This is in line with the Financial Control total and includes efficiency of £26.6m representing 2.5% of turnover.

The Financial Plan for 2019-20 takes into account 2018-19 exit run rate driven by the continued operational pressures with an I&E deficit of £51.8m. During the planning cycle, Finance continues to work closely with Workforce and Activity Planning colleagues to ensure an integrated plan whereby financial assumptions are consistent with operational planning assumptions including successful completion of the "Triangulation File" as part of the planning submission.

The submitted planned deficit of £48.7m represents an improvement of £3.1m from the 2018-19 financial position and an improvement of £9.7m on the underlying baseline after taking into account non-recurrent and full year effect of actions taken in 2018-19.

It should also be noted that the NHSI agency staff expenditure ceiling is £18.8m which is in line with the 2018-19 Agency ceiling and will require working through as part of the detailed budget setting process.

NHSI Control Total

The 2019-20 Control Total was issued by NHS Improvement (NHSI) on 15 January 2019 and required the Trust to deliver a £48.7m deficit. Signing up to the Control Total gives the Trust access to MRET central funding of £6.9m, Provider Sustainability Funding (PSF) deficit of £16.4m and Financial Recovery Funding (FRF) of £14.8m which supports a reported deficit of £10.7m

In consideration of the Control Total, the Trust has taken into account the delivery of 2018-19 financial Outturn and current run rate combined with the outcome of contract negotiations relating to demand and capacity. This assessment includes consideration of the following pressures and mitigations in order to deliver the NHSI control total and demonstrate financial improvement:

- 2018-19 Baseline deficit of £54.3m after taking into account non-recurrent items together with full year effect of investments;
- Inflationary pressures in relation to the pay awards for Agenda for Change and Medical staff together with contractual inflationary pressures;
- Reconfiguration and Major Business Cases including ITU and East Midlands Congenital Heart Centre together investment in the Quality Strategy ;
- Residual cost pressures within pay which needs to be more aggressively and pro-actively managed in 2019-20 together with funding cost pressures in relation to delivering the 2018-19 financial outturn; and
- Mitigation of the operational and financial impact of winter through provision of additional capacity.

Income - Clinical Income

The Trust 2019-20 income plan is based upon the demand and capacity assumptions modelled for each specialty, as described in Chapter 3 above. As this is a new contract year, the Trust has jointly refreshed the activity plans and contract values for Specialised Services and LLR CCGs, to reflect any significant changes in the past year. Contracted activity levels and financial values have been agreed with both CCG and Specialised commissioners and a full contract has been signed with CCGs. We are progressing contract signature with Specialised commissioners although based on feedback from them, this is likely to be after the AOP submission date.

The expected contract value for 2019/20 stands at £534m (60% of total clinical income) for local Clinical Commissioning Groups (Leicester City, West Leicestershire and East Leicestershire and Rutland CCGs, including the Alliance contract) and £286m (32% of total clinical income) for specialised activity commissioned by NHS England.

As part of the LLR STP there was a commitment from all organisations to support the delivery of QIPP & Demand Management schemes or services. The current contract proposal with LLR CCGs includes £5.9m of QIPP schemes across urgent and planned care.

In line with National Guidance, the contract values include 1.25% CQUIN payment for the delivery of National Schemes. Compared to 2018-19 of 2.5% this represents a reduction of 1.25% which has been embedded in base tariffs as part of the national tariff changes.

The current plan uses national prices in line with the draft guidance the 2019-20 national tariff package. This assumes:

- Inflation uplift for all local and national prices of 3.8%
- Efficiency deflator of (1.1%) efficiency deflator
- CQUIN uplift of 1.25%
- Procurement changes (0.36%) top slice uplift.

This translates to expected net income inflation of 3.59% which reflects NHSI's and NHS England's assessment of cost inflation. The £10.6m of national funding for 2018-19 Agenda for Change increases has been removed in 2019-20 as it is now included in the tariff inflation increases. The overall impact of changes to tariff in 2019-20 is anticipated to be a £15.9m increase in income.

As the Trust has submitted a Plan in line with the Control Total, the income plan assumes removal of the £7.6m contract discount provided to LLR CCGs in 2018-19 for protection against penalties.

Income - 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 have been modeled to reflect various changes including the reduction in transitional and non-recurrent funding.
- Income received through research and development which plans to remain static.
- Income received through other sources such as facilities management, car parking etc. which is not anticipated to change materially from 2018-19 Outturn.
- Income received in relation to PSF, FRF and MRET funding of £38.1m

Expenditure – 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 2018-19, the Trust aimed to recruit substantively to a full establishment but similar to other NHS organisations faced difficulties in completing this task. These resource supply constraints together with capacity constraints in delivering the planned level of patient activity contributes to significant amounts of non-core spend through elements of premium pay.

For 2019-20, the Trust continues with the ambition to fill the establishment on a substantive basis but recognises that an element of premium pay will be incurred as we move towards a fully established work force. 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 £18.8m as per the agency ceiling given to the Trust by NHSI. (See Chapter 4 above for more detail on workforce planning).

Pay inflation, is included at £16.1m (1%) based on the second year of the Agenda for Change pay scales together with the Medical Pay Award agreed in Autumn 2018.

Contingency reserves of £5m overall are included of which £4m (80%) is planned as pay.

Expenditure – Non pay

Non-pay inflation at £6.1m is based on specific, contractual inflation together with general inflation increases expected.

The value of commissioner funded high cost drugs and devices in the 2019-20 plan is £96.9 which is based upon the 2018-19 forecast outturn less £1.7m price reduction related to biosimilar switching. 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 £5m overall are included of which £1m (20%) is planned as non-pay.

Detail of major financial risks identified and mitigating actions

Whilst clinical activity has been agreed with local Commissioners there remains a risk against the delivery of planned activity in line with the contract and cost assumptions to deliver the activity.

Full delivery of the Efficiency programme is also a risk to the Trust. An established PMO function and associated governance arrangements are in place to drive more rigor into the Efficiency process, giving pace, accountability and clearly defined targets, militating against the risk of underperformance. In addition, the Trust is planning significant investment in Improvement to drive increased sustainable, cash releasing efficiencies to support the Trust's path to financial balance.

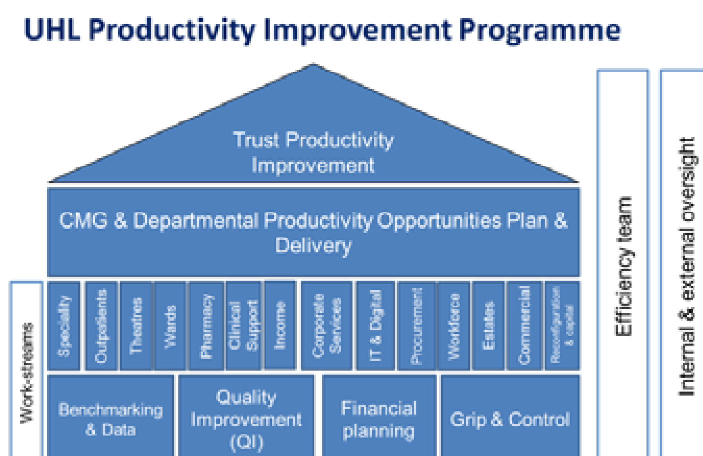
As outlined within the Capacity Planning and Operational Performance section above, there are risks associated with the delivering of the performance standards requirements, particularly for ED and Cancer Treatment standards.

2. Efficiency savings for 2019/20

The Trust has a comprehensive three year Efficiency Strategy with the aim of achieving upper quartile productivity across all areas of the Trust to enable caring at its best for staff and patients.

The strategy was based around a wide range of data sources including NHSI Model Hospital, recommendations from the Carter Programme, the Getting It Right First Time (GIRFT) Programme, NHSI Theatre Efficiency Programme (using Four Eyes consultancy) and the Trust's 5 year Strategy.

We have incorporated learning from previous years; this has led to the deveropment of our formal Trust Productivity programme. The outline of this programme is detailed in the diagram below:



Clinical Management Groups (CMGs) and Corporate Directorates

Our overall Trust efficiency target has been allocated to CMGs and Corporate Directorates for delivery during 2019/20. To ensure focus on the key opportunity areas for CMGs, allocation has been undertaken using national benchmarking data (Reference Costs / Model Hospital) and a detailed overview of the known opportunities; all these opportunities have been developed and discussed in conjunction with our CMGs and Corporate Teams. A Trust Accountability Framework has been developed and each of the Heads of Department will be held accountable for delivery of their efficiency targets in a robust manner.

All CIP opportunities will be developed using our comprehensive Project Initiation Documents (PID) (with full phasing, Key Performance Indictors (KIPs), risk assessment, ownership and cash releasing impact) and subject to full Quality Impact Assessment (QIA) process.

During the year we will re-assess any gaps in CIP plans and ensure that plans are developed to mitigate financial risk.

Work-streams

The purpose of each workstream is to identify efficiency opportunities to help the Clinical Management Groups (CMGs) / Corporate Directorates achieve their efficiency targets through a robust and standardised approach. There are 18 workstreams in total (detailed in the diagram above) and each work-stream has a project charter

which details the desired outcomes, outputs, activities and resources. Each workstream has a lead and Executive sponsor who will be held to account for delivery.

The programme includes four underpinning workstreams focused around data, quality improvement and robust controls. Some of our key workstreams are:

- Benchmarking & Data workstream is focused on maximising the use of the benchmarking tools available to the Trust with a view to identifying and delivering on the opportunities identified (this includes making full use of the Model Hospital Portal, Carter, GIRFT and PLICS data). For example the Trust has so far had 18 GIRFT visits which is more than any other Trust in the country.
- Theatres & Outpatients – UHL has been working closely with consultants, Four Eyes, during 18/19 across both our Theatres and Outpatients programmes. Our CIP targets for 19/20 incorporate £5.5m of efficiencies which have either already been delivered through this work or will be delivered during the year.
- Clinical Support – during 2018/19 our colleagues in Clinical Support enabled £1.4m of schemes across the Trust through improvements to our length of stay and patient flow e.g. through enhancing support from therapists and pharmacists. We plan to expand on this work further in 19/20 to achieve over £2m of efficiencies across our clinical specialties.
- Corporate Services – The NHS Improvement benchmarking exercise highlighted opportunities within a number of our back office areas. Our corporate services workstream is aiming to deliver a minimum of £3.5m of opportunity in 2019/20.

A portion of our efficiency plans arising from collaboration and consolidation across the LLR system are inherently included within our plans for pathway transformation; *however we are in discussion with commissioners with regards to other system-wide plans – these will be detailed in our final submission*.

3. Agency rules

The Trust is committed to delivering an Agency in line with the NHSI ceiling of £18.8m. Agency spend continues to be controlled with initiatives in place as described within our Workforce Planning chapter of this plan.

4. Capital planning and Cash

a. Capital Plan

The capital plan submitted is pending NHSI confirmation of external funding as part of the “Emergency Capital” requirements process. The current view of the 2019-20 Capital Plan is a range of £46.9m and £66.1m depending on the outcome of this process.

The final capital plan has been through a prioritisation process for each of the funding scenarios to ensure that our capital spend is in the right places. At present the capital funding includes £24.3m depreciation; £21.6m approved PDC relating to the ICU project and £1m grant funding. Two items that are not subject to the prioritisation process are loan repayments of £2.2m and £4.5m relating to the capital element of finance leases. The plan will also include up to £25.9m of loan funding which has yet to be approved.

Taking this into account, together with internal capital requirements that has followed a period of constrained investment, this drives a capital plan for 2018-19 of up to £66.1m.

The 2019-20 capital plan is predicated on the delivery of the 2018-19 capital plan without receipt of any additional external funding. The key elements of the 2019-20 plan are:

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

b. Cash

The net deficit for 2019-20 of £48.7m with central funding agreed of £38.1m (£6.9m MRET; £16.4m PSF; and £14.8m FRF). Predicated upon signing up to the Control Total, this leaves a funding shortfall of £10.7m which the Trust expects to be funded through uncommitted loans. This does not take into account any additional funding for working capital support and the Trust is not assuming that we will require any such support in the plan at present.

Chapter Seven: Links to the local Sustainability and Transformation Plan (STP)

Alignment of the vision between the STP's system operational plan and our operational plan is important and already apparent through our joint service reconfiguration plans, new care models and in mitigating plans to manage demand across the sub-region in each of our key programmes of work.

Our commitment to system working is reflected in the revised planning processes put into place for 2019/20; we now have a system-wide approach to the development of our operating plans, ensuring aligned and credible early assumptions with our commissioners and alignment of priorities with other provider Trusts such as Leicestershire Partnership Trust and East Midlands Ambulance Service.

We are well engaged in the STP process and will continue to move towards an 'Integrated Care System' model of working; our role within this model is clear with leadership of priority transformational programmes, such as the A&E Delivery Board, and joint leadership of the both the planned care and cancer programmes. For other priority transformational programmes where we do not have direct leadership, we have a mixture of clinical and senior managerial representation with a series of named deputies to ensure pace of delivery.

To enable our 2019/20 system plan, we have aligned our priorities for delivery with those of the system and vice-versa. Both system and UHL priorities align – for example, both the system plan and the UHL plan outline progress of:

- Our plans to deliver (at system and operational level) key programmes / strands of work:
  - Urgent care
  - Planned care
  - System/pathway redesign
  - Workforce planning across Primary care Networks and 'place' or 'system' based models of care
- System-wide efficiency opportunities such as reducing avoidable demand and unwarranted variation, or sharing clinical support and back office functions
- Our strategic, system-wide review of estates, developing a plan that supports investment in integrated care models, maximises the sharing of assets, and the disposal of unused estate
- Plans to enhance the capability of the system including stronger governance and aligned decision-making, and greater engagement with communities and other partners.

In addition, as described in previous chapters, we have agreed at system level to merge the programme of work focused on implementing enhanced systems of care for frail & multi-morbid patients and patients at the end of their life across the local health and care system with the Integrated Community and Primary Care Boards. This will bring together the interdependent deliverables of several STP workstreams, resulting in a systems of care which will help deliver place-based integration within the context of our emerging primary care networks across LLR. These programmes will be key to enable the system to realise the quality, financial and demand management aspirations outlined in this document.

Specific improvement actions to accelerate progress in recovering emergency care, elective care & cancer standards are fully described in both our system plan and summarised in Appendix One.

Appendix One: 19/20 Performance trajectories for key operational standards

Emergency performance

2019/20 trajectory - ED 4 hr performance:

We remain committed to resolving the areas that cause under performance within our own gift and working across the system to support a reduction in attendances and admissions alongside returning patients to their home more quickly. The aim of UHL/LLR is to eliminate the number of ambulance handover delays 60+ minutes by the end of Quarter 1 and reduce significantly the number of ambulance handover delays waiting 15+ minutes.

Month	National Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
UHL ED 4 hr	95%	83.1%	86.9%	85.8%	83.9%	84.1%	85.1%	83.8%	82.4%	81.2%	77.7%	82.5%	82.8%
UHL/LLR ED 4hr wait	95%	87.5%	90.3%	89.5%	88.3%	88.4%	88.6%	87.5%	86.2%	85.3%	84.0%	87.1%	87.4%

Improvement actions

The starting point for the 19/20 trajectory is this year's performance with the following assumptions applied:-

- Injuries and primary care will achieve 95% non-admitted performance throughout the year
- A 50% reduction in non-admitted breaches in the Majors location
- A 10% reduction in overnight breaches
- An improvement in Children's breach numbers back to performance pre the September 18.
- Removed single cause variation in certain months, for example, in July/August there was a CRO outbreak.

The schemes outlined below have been used to determine how much of the opportunity for improvement can be realised and will be delivered through our LLR A&E Delivery Board.

System Linked schemes:

- Flow Managers are now in place working between the hours of 0800hrs – 0130hrs, with a specific remit to manage flow working with the Consultant in Charge and the Nurse in Charge within the Emergency Department.
- Senior Management support on the daily basis for escalation.
- Productivity review and change plan of our Injuries stream to reduce non admitted breaches. Further support is now been given from Orthopaedics and closer links with Fracture Clinic.
- DHU (our primary care stream provider) maintaining/improving performance and potential streaming model Improvement in Q2, strengthened redirection approach. Performance has been improved by ensuring that the right case mix is being seen by the GP's.
- Majors space review and pathway change to ensure continued assessment. This has been achieved by ensuring quicker senior review and opening an area specifically for ambulatory patients that require support from the Majors area. This stream has its own medical and nursing support and separates these patients that are likely to require inpatient beds.
- Increase in clinical triage of green ambulances.
- There is now increased support for triage over a 24 hour period and enables the Emergency Department to cohort patients safely when it is required.
- Targets for ambulance handovers set, i.e. 15 minutes to handover, 15 minutes for rapid assessment. Escalation processes in place for delayed handovers.
- Increase in deflection to non-LRI sites, through extension of clinical navigation, increase in extended primary care access and increase in direct booking to other sites.
- Alternative frailty response (in community with EMAS and Home Visiting Services/Clinical Navigation Hub)
- Design and delivery of specific 'out of hospital' ambulatory pathways.
- Mental Health triage with EMAS (also impact on overnight breaches).

2. Decreasing non-admitted breaches and admitted with process related delays 9pm – 8am

System linked schemes:

- Increased junior medical staffing overnight following the recruitment of 14 additional Trust grade Doctors.
- Improved position in the day (pull forward) from improved discharges.
- EF2 pathway changes resulting in decreased base ward admissions.
- Processes to minimise variation and decrease deterioration overnight.
- EMAS 'urgent' crews reducing surge in GP referrals in the late pm.
- Increase in triage of green ambulances, reducing attendances.

- Passporting scheme with primary care and clinical navigation/Home Visiting.
- Out of hospital ambulatory pathways.

3. Decreasing admitted breaches for patients breaching by up to 30 mins

System linked schemes:

- Rapid flow process review
- Floor manager in place
- See also schemes below

4. Decreasing admitted breaches (that are not process related and breaching by more than 30 mins)

System linked schemes:

- Full implementation of Red to Green
- Reduction in stranded and super stranded patients
- Full implementation of e- beds across the organization.
- EF2 pathway changes to improve flow and enable the patient to have the best chance of getting back to their home early.
- Improved GPAU functionality.
- Glenfield pathway review and changes including community respiratory pathways.
- Increased capacity within the CDU and additional ward space capacity.
- Achievement of Medical step down ward efficiencies.
- Implementation of care Home telemedicine and transfer schemes – reducing attendances and admissions for care home residents.
- Improved support to primary care to prevent admission.
- Implementation of End to End CHC process – timelier DST in hospital.
- Improvement to ICS model – rapid admission or turnaround from ED/EF2.
- Implementation of re-procured Discharge to Assess model.
- Increases in hospital discharge team.
- Implementation of Trusted assessment.
- Improved pick up of PoC in County.
- Increased medical ward capacity combined with an annex attached to the Acute Medical Unit.
- Improvements to LOS in community hospital though discharge initiatives (D2A, choice, interim beds, CHC funding agreement risk share).

Our system-wide winter plan for 18/19 has taken into account learning from previous years, a realistic view on demand and capacity as per our 18/19 modeling and the system-wide actions required to enable patient flow across the system.

Ambulance Handover - 2019/20 trajectory

Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Arrivals (CAD)	5,458	5,662	5,429	5,506	5,393	5,532	6,089	6,130	6,241	6,108	5,518	6,028
Handover delays 15-30 mins CAD	1,999	2,222	2,295	2,477	2,466	2,566	2,666	2,431	2,448	2,616	2,236	2,455
Handover delays 30-60 mins CAD	665	550	393	340	288	278	289	455	420	569	399	402
Handover delays 60+ minutes CAD	235	110	45	0	0	0	0	0	0	0	0	0

Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
% Handover delays 15-30 mins (CAD)	37%	39%	42%	45%	46%	46%	44%	40%	39%	43%	41%	41%
% Handover delays 30-60 mins (CAD)	12%	10%	7%	6%	5%	5%	5%	7%	7%	9%	7%	7%
Handover delays 60+ minutes CAD	4%	2%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Improvement actions

System linked schemes:

- New SOP for local and system escalation which gives more rigor than the national SOP
- MADD event which has given the evidence to system behaviours – monthly audits planned going forward
- Strengthening Fit to Sit pathway
- Implementing DVT pathway straight to clinic
- Strengthened clinical leadership in ambulance assessment
- Reviewed corridor SOP to give more flexibility of use
- Identified and completed SOP for additional capacity of patients on the clock – GPAU out of hours and off the clock - Balmoral Xray
- Rapid assessment to GPAU and other specialty assessment
- Avoidance pathways with Loughborough Urgent Care Centre
- Physicians in ED 24/7

- Extending ambulatory majors pathways
- System education (in progress)
- Deep dive into the correlation of batching on performance
- Co-design a breach style report for any patient that tips into the 60 min timeframe to understand the patient journey

Risks:

- Urgent care activity continues to increase
- Nurse staffing
- Ambulance batching i.e. 15+ ambulances an hour

Referral to Treatment

2019/20 trajectory:

Month	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
<18wks	54,666	54,939	55,351	55,711	56,073	56,017	56,073	56,213	56,242	55,988	55,736	55,458	55,081
>18wks	9,870	9,801	9,569	9,454	9,311	9,505	9,600	9,312	9,033	9,665	9,955	9,656	9,323
Total WL	64,536	64,740	64,921	65,166	65,384	65,522	65,673	65,526	65,274	65,654	65,692	65,114	64,404
RTT Performance	84.7%	84.9%	85.3%	85.5%	85.8%	85.5%	85.4%	85.8%	86.2%	85.3%	84.8%	85.2%	85.5%

Improvement actions

As per the national planning guidance the number of incompletes will be no higher in March 2020 than in March 2019 and where possible the Trust will aim to reduce the number further.

During 19/20 the Trust is forecasting an improved incomplete RTT position 0.8%. A further 1% improvement in the RTT incomplete % had been identified; however the Trust remains committed to the key priority of Cancer which limits the ability to achieve further improvements in RTT performance. The trajectory follows seasonal trends and local knowledge of performance. Over the winter months between December and February RTT performance is known historically to fall which is reflected in the 19/20 trajectory.

We plan to further improve our waiting list position during 2019/20; our capacity plans demonstrate that we will increase elective treatment so that our waiting list number will decrease by the end of the year. Additionally, we will implement a simple mechanism (agreed with our commissioners) to ensure that every patient waiting 6 months or longer will be contacted and offered the option of care at an alternative provider. Finally, we will assess and implement plans to adhere to the agreed standards as set out in the Clinical Standards Review to be published in spring 2019/20.

The Referral to Treatment (RTT) incompletes standard measures the percentage of patients actively waiting for treatment. The focus for our patients remains treating those most clinically urgent and the longest waiters. The Trust will continue to work closely with LLR commissioners through our Planned Care programme of work to reduce demand where possible and look for more opportunities to move activity to the Alliance. This includes:

- Working with system partners to deflect patients to community based treatment including the use GP's with Specialist Interests.
- Rolling process of updating Specialty Directory of Service to reduce inappropriate referrals into UHL
- Increased update in GP Advice and Guidance resulting leading to increased learning and reduced need for referral.
- Reductions in outpatient follow up rates, moving to alternatives such as non-face to face appointments. Freeing capacity for patients on an incomplete pathway.
- Implementation of two way text reminders to improve both clinic utilisation and theatre utilisation, treating patients in a slot that would have otherwise been left fallow.
- Continued admitted efficiencies increasing number elective surgery rate. Includes improvements in scheduling, reduction in cancellations from hospital, patient and due to clinical reasons via improved operative assessment.

52+ week waits

2019/20 trajectory:

Month	National Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
52 Week Wait	0	0	0	0	0	0	0	0	0	0	0	0	0

The Trust is proud of eliminating 52 week breaches in 18/19. We will continue to deliver this standard in 2019/20 having no patients waiting longer than 52 for treatment at the end of each month.

Diagnostics

2019/20 trajectory:

Month	National Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Diagnostics 6+ week wait	<1%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%

We made significant progress and redelivered the standard in 18/19. We intend to continue to achieve this standard, with fewer than 1% of patients waiting for their diagnostic test.

Cancer

2019/20 trajectory:

Month	National Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Cancer 2 Week Wait	93%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%
Cancer 2 Week Wait - Breast	93%	93.5%	93.6%	93.3%	93.2%	93.3%	93.2%	93.1%	93.0%	93.5%	93.2%	93.3%	93.6%
Cancer 31 Day First	96%	93.2%	94.5%	95.4%	96.1%	96.5%	96.3%	96.1%	96.4%	96.6%	96.8%	96.8%	96.8%
Cancer 31 Day Drugs	98%	98.4%	98.3%	98.6%	98.3%	98.4%	98.7%	98.7%	98.1%	98.6%	98.2%	99.3%	98.5%
Cancer 31 Day Subs Surgery	94%	84.9%	86.1%	88.0%	85.8%	89.1%	84.5%	87.4%	85.4%	94.2%	91.0%	92.1%	94.2%
Cancer 31 Day Radiotherapy	94%	95.8%	96.3%	96.4%	97.4%	96.9%	96.4%	96.5%	97.4%	96.9%	95.5%	96.0%	95.9%
Cancer 62 Day	85%	73.9%	78.3%	74.8%	78.4%	74.3%	85.2%	85.2%	85.3%	89.0%	85.5%	85.2%	85.2%
Cancer 62 Day Screening	90%	86.7%	86.7%	83.8%	92.3%	90.1%	90.0%	90.9%	91.4%	92.3%	92.3%	90.0%	90.9%

Improvement actions

Trajectories take into consideration improvement that will occur as a result of transformational projects which have been funded by the East Midlands Cancer Alliance which are focused on Lung, and prostate. We also have a system wide action plan which will improve pathways and increase efficiency across all of the standards.

The aim is that the 62 day cancer standard will be delivered for all tumour sites with the exception of Urology. Urology (nationally a problem) has the largest backlog, limited capacity and late tertiary referrals have a significant impact on this tumour site.

A new cancer diagnosis standard, designed to ensure that patients find out within 28 days whether or not they have cancer, will be introduced in 2020 and we are required to submit data from April 2019. Following UHL communication and education to all cancer sites we have started to collect this data across all Cancer specialties from January 2019. It is recognised there will be occasions where a patient cannot be given a definitive diagnosis within the timeframe, and some may require several diagnostic tests to confirm or refute a diagnosis which will protract a patient's pathway. This will be reflected in the tolerance set by NHS England which is yet to be decided.

The two new steps we will implement are:

- Where a diagnosis of cancer is reached the patient should be seen face to face within 28 days to be given their diagnosis. The date of this must be recorded on the Cancer database and will end the Fast diagnosis pathway.
- Where cancer is no longer suspected it must be clearly documented that the patient has been informed within 28 days, this can be via letter, telephone call or face to face. The patient will no longer be tracked as a suspected cancer patient but may be followed up as part of an RTT pathway where required. The date of this must be recorded on the Cancer database and will end the Fast diagnosis pathway.

2019/20 has a focus on transformation to enable pathway improvement and sustainable change against a growing demand. The key projects include:

Provision of a Radiology Academy 2019 / 20 (£392,510 of capital funding has been provided by East midlands Cancer Alliance). The aim of the Radiology Academy is to increase the numbers of learners (both medical and non-medical) and make the best use of available teaching faculty in the M&E by providing a dedicated multi-site facility for Clinical Radiology, Diagnostic Radiography and Sonography. This will increase training capacity with a flexible, high quality learning environment. There would subsequently be an increase in CCT holders and other diagnostic imaging staff able to enter the workforce locally.

Implementation of FIT testing in primary care (£21,250 has been provided by East midlands Cancer Alliance). FIT offers primary care a triage test for symptomatic patients in the lower GI pathway who only have a change in bowel

habit +/_ abdominal pain. Only on a positive result would a 2WW Lower GI referral be made. Using FIT as a primary care triage tool supports GPs to identify low-risk symptomatic patients at risk of colorectal cancer

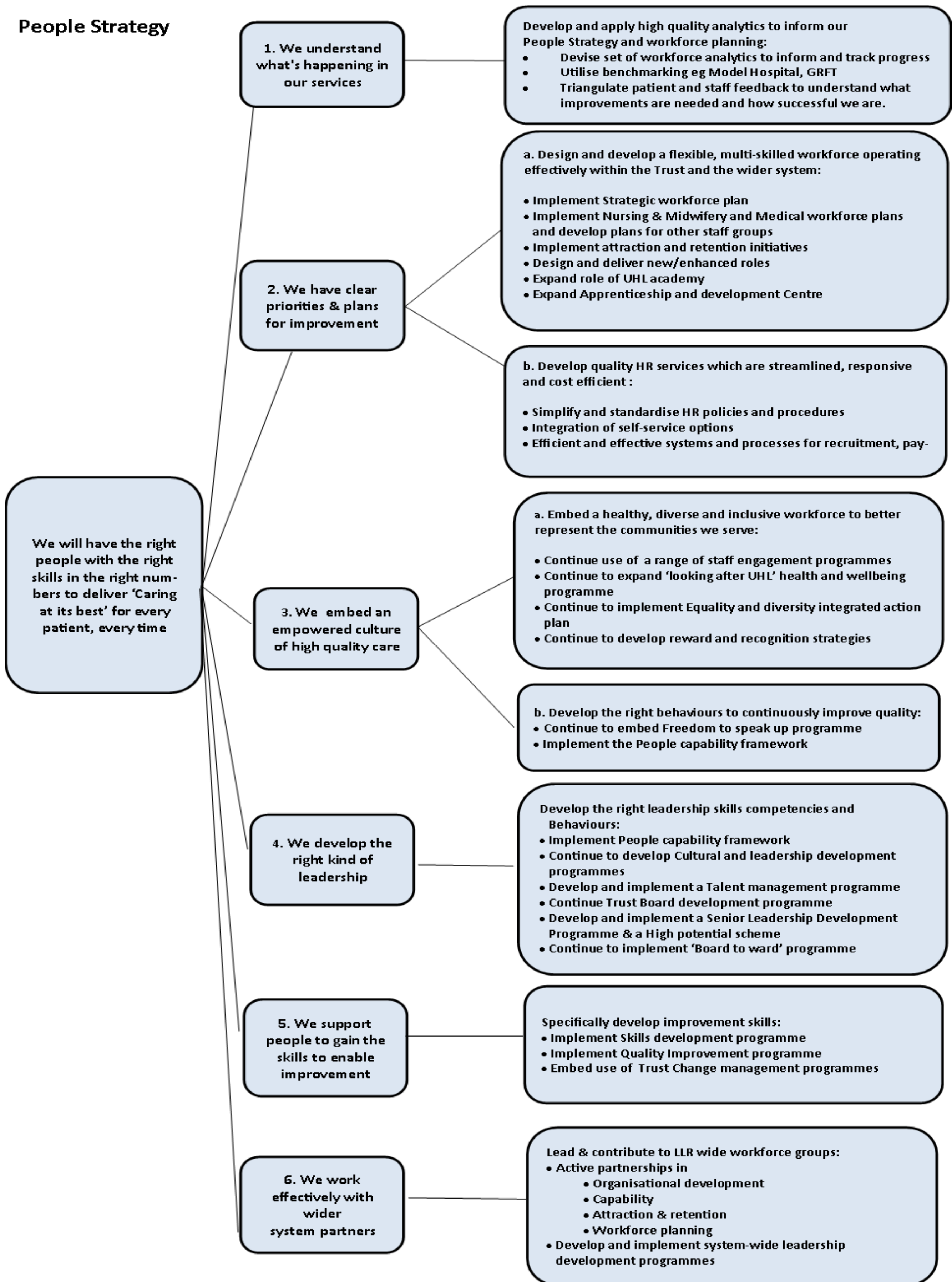
Implementation of the Optimal Lung Cancer Pathway in 2019/20 (£593,219 has been provided by East midlands Cancer Alliance). The redesign of the lung cancer pathway is split into three areas: early diagnosis, reducing variation and living with and beyond cancer.

Implementation of the RAPID Prostate Pathway (£76,500 has been provided by East midlands Cancer Alliance) The new pathway will help to support early diagnosis, shortening the pathway to 28 days. The new pathway involves conducting an mpMRI before the first prostate biopsy improving the detection accuracy of clinically significant cancer.

Living With and Beyond Cancer (£194,744 has been provided by East midlands Cancer Alliance). The Living with and Beyond Cancer project will include the Recovery package and Risk Stratified Follow Up, and will primarily focus on Lower GI, Breast, Prostate and Lung pathways over the next 2 years.

Alongside improvements in our ‘Next Steps’ programme (which ensures all patients who are on a suspected cancer pathway know what their next step is and they receive the date for that within an agreed timeframe) we will continue to embed processes that result in a shorter wait for first appointments. We are now seeing more patients within seven days of referral which has allowed us to tell patients more quickly that they do not have cancer and to focus on those patients who do.

Appendix Two – Summary of the UHL People Strategy



Appendix Three – 2019-20 Financial Plan Summary

	2018/19 M9 FOT £'m	2019/20 Plan £'m	19/20 vs 18/19 Change £'m
NHS Patient Care	856.1	894.6	38.5
Other Operating Income	132.0	125.5	(6.5)
Total Income	**988.1**	**1,020.0**	**31.9**
Pay	(623.0)	(654.5)	(31.5)
Agency	(18.4)	(18.8)	(0.4)
Non-Pay	(369.0)	(358.9)	10.1
Total Operating Expenditure	**(1,010.5)**	**(1,032.2)**	**(21.7)**
EBITDA	**(22.3)**	**(12.2)**	**10.2**
Non-Operating Costs	(29.7)	(36.8)	(7.1)
Retained deficit	**(52.0)**	**(49.0)**	**3.1**
Adjustment for Donated Assets	0.2	0.2	(0.0)
Net Deficit excluding PSF, FRF and MRET Funding	**(51.8)**	**(48.7)**	**3.1**
MRET Funding		6.9	6.9
Provider Sustainability Funding	2.3	16.4	14.1
Financial Recovery Fund		14.8	14.8
Net Deficit including PSF, FRF and MRET Funding	**(49.5)**	**(10.7)**	**38.8**

Appendix Four – 2019-20 Planning Bridge

Section		2019/20 Financial Plan £m	2019/20 Financial Plan £m
2018/19 Outturn	**2018/19 Forecast Outturn**		**(51.8)**
	Non- Recurrent in 18/19	1.8	
	FYE of costs in 18/19	(4.3)	
	2018/19 recurrent impact		**(2.5)**
	2019/20 Plan including recurrent issues carried forward		**(54.3)**
National Technical Assumptions	Tariff Inflation	17.0	
	Pay Inflation	(16.1)	
	Non Pay Inflation	(6.1)	
	Tariff Price	8.1	
	CIP - national tariff requirement (1.6%)	16.7	
	CNST	0.0	
	MRET/Readmissions Non LLR	3.0	
	CQUIN	(9.3)	
	2019/20 Technical planning assumptions		**13.4**
	2019/20 Plan including technical planning assumptions		**(40.8)**
Contract	Coding and Counting	3.8	
	Net Contribution of volume growth	(0.4)	
	Drugs & Devices (pass through)	0.0	
	CQUIN	1.3	
	QIPP	(5.2)	
	Other	(3.5)	
	2019/20 Contract negotiations		**(3.9)**
	2019/20 Plan including activity changes & QIPP		**(44.8)**
Internal / Discretionary planning assumptions	Major Business Cases	(1.7)	
	Pay Investment: Realign with Establishment	(3.4)	
	Winter Capacity	(3.7)	
	Non-Op Costs	0.5	
	Contingency	(4.9)	
	Other	(0.7)	
	Local CIP	10.0	
	2019/20 discretionary planning assumptions		(4.0)
UHL Plan	**2019/20 Plan exluding MRET, PSF and FRF**		**(48.7)**
	MRET, PSF and FRF		38.1
	2019/20 Plan including MRET, PSF and FRF		**(10.7)**