Integrated business planning 18/19

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Executive Summary

Context

This paper sets out our progress towards delivery of an integrated business planning cycle for 2018/19, leading to the construction of the Trust's Annual Operating Plan, within the context of the LLR and wider health and social care system.

Questions

1. Are we on track to deliver an integrated business plan for 18/19?
2. What changes have been made since the initial submission in March?
3. What are the key areas for concern?

Conclusion

1. Our Integrated Business Planning process concluded on April 30th 2018, when the Trust submitted our refreshed 18/19 Annual Operational Plan and supporting templates to our regulators. Business planning for 18/19 had been delayed into April as a result of late planning guidance and releases of the NHS Mandate for 18/19, as well as further guidance to both Commissioners and provider Trusts. The final plan and supporting documents were approved by the Trust Chief Executive, 2 non-exec Directors, Director of Finance and Director of Strategy & Communications prior to final submission, as delegated by the Finance and Investment Committee.

2. In mid-April 2018, both commissioners and providers independently received guidance from regulators that plans should be far more realistic, in terms of finance, demand planning and performance. This led to a re-cut of plans at a late stage in the planning cycle. However, this also enabled a different approach to planning our capacity in response to anticipated demand.

   Previously we have sought to balance the needs of elective and emergency pathways. This has resulted in periods of very poor performance resulting in large scale cancellations and inefficient use of resources. Crucially this has led to unacceptable patient experience and high levels of frustration and fatigue amongst our staff. Given that we are unable to provide all of the necessary capacity to meet the demands of the emergency, cancer and elective patients, there has to be a prioritisation of resources.

The approach we have taken, in partnership with our commissioners, is to jointly accept across the LLR system that we will see growth in emergency demand above the very high levels seen in 17/18. We have reversed out some of the impact of this winter and then applied national planning guidance growth rates. This broadly equates to emergencies being outturn of 17/18 plus growth of 1%.

The modelling has taken, as the first principle, that emergency demand will be met and that this will be at current occupancy levels. The remaining capacity has then been allocated to cancer patients and subsequently to routine elective patients. This means that the impact of insufficient bed capacity is felt on the elective pathway with a reduction in the number of electives patients that we are planning to see compared to previous years plans.

This impact has been mitigated in three ways.

- The first is to drive deliver of our efficiency plans such as full implementation of red2green, admissions avoidance plans and theatre efficiencies – these are described later in this plan.
- The second is an attempt to protect some of the elective capacity by increasing overall bed capacity. This will be one ward at the Glenfield Hospital (modular build) for respiratory patients and one additional ward (made available through the move of AMU to the new emergency floor) at the LRI for acute medical patients as well as 30 escalation beds.
- Finally, we have agreed a system wide plan and commitment to directly outsource routine patients over the course of the year to alternative providers.

3. This option does carry risk for the Trust. Whilst it allows for the elective requirements of the planning guidance to theoretically be met, the complexity of the plan will require careful orchestration in terms of operations (workforce, capacity etc.) strategy (impact on reconfiguration) and finance (capital requirements, impact on income etc.).

   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 and assessing workforce opportunities (including the release of workforce to the independent sector during the winter months).

   The UHL planning team, in partnership with the Heads of Operations, are in agreement that the early planning & agreement of this additional capacity and early agreement to work with commissioners to deliver some elective activity through another provider puts the Trust in a much better position to deliver the requirements of both our commissioners and the requirements outlined in the planning guidance.

Input Sought

The Trust Board are asked to:

- **NOTE the significant risk to the Trust (as well as the impact at CMG level) in the plan as described.**
- **APPROVE the final draft of the refreshed Annual Operational Plan 18/19**

For Reference

Edit as appropriate:

1. 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]

2. This matter relates to the following **governance** initiatives:

a. Organisational Risk Register [Not applicable]

b. Board Assurance Framework [Yes]

If YES please give details of risk No., risk title and current / target risk ratings.

Principal Risk	Principal Risk Title	Current Rating	Target Rating
This plans covers all strategic risks on the BAF			

3. Related **Patient and Public Involvement** actions taken, or to be taken: [May 2018]

4. Results of any **Equality Impact Assessment**, relating to this matter: [May 2018]

5. Scheduled date for the **next paper** on this topic: [TBC]

6. Executive Summaries should not exceed **4 sides** [My paper does comply]

7. Papers should not exceed **7 sides.** [My paper does not comply]

University Hospitals of Leicester NHS Trust

Operational Plan 2017-2019
(Refreshed for 2018/19)

Chapter 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'.

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 vision, strategic plans and values will enable us to deliver the outcomes described in this plan through 2018/19.

This plan describes our strategic objectives and priorities for the year and outlines how these will enable us to improve quality and safety. Having experienced one of the most difficult and prolonged winter periods in 17/18, this plan will also set out how we have taken a different approach to planning for 18/19 in terms of demand and capacity in order to improve our patient experience and outcomes. We know that our performance deteriorated in line with the rest of the country and that some our patients experienced a sub-optimal patient experience of care in 17/18. This plan outlines how we will mitigate against this happening again through 18/19 through a much more realistic and coordinated approach to workforce, and financial planning, both internally and in partnership with our external provider and commissioner partners.

Chapter 2: Our strategic objectives & 18/19 annual priorities

Strategic objectives

We have reshaped our 5 year 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 such as progressing towards a paperless hospital and enacting our plans for reconfiguration

Our Priorities for 18/19

Our Primary priority – deliver of our quality commitment: To deliver safe, high quality, patient-centred, efficient healthcare

- **Clinical effectiveness**
  - We will embed the use of Nerve Centre for all medical handover, Board rounds and Escalation of Care in 18/19
  - We will ensure senior clinician led daily board or ward rounds in clinical areas & fully implement our plans to embed a standardised red2green methodology
  - We will ensure that frail patients in our care have a Clinical Frailty Score whilst they are in our hospital

- **Patient safety**
  - We will embed systems to ensure abnormal results are recognised and acted upon in a clinically appropriate time
  - We will empower staff to 'Stop the Line' in all clinical areas
  - We will improve the management of diabetic patients who are treated with insulin in all areas of the Trust

- **Patient experience**
  - We will improve the patient experience in our current outpatients' service & begin work to transform the outpatient model of care in ENT & cardiology
  - We will improve patient involvement in care and decision making, focusing on cancer and emergency medicine

- **Emergency Care and Cancer**
  - We will eliminate all but clinical 4 hour breaches for non-admitted patients in ED
  - We will resolve the problem of evening & overnight deterioration in ED performance
  - We will ensure timely 7 days a week availability of medical beds for emergency admissions
  - We will deliver the 62 day standard for cancer during 18/19

Our Supporting Objectives

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 5 year workforce plan by the end of Q1 18/19, with a delivery plan to reduce our nursing and medical vacancy rates and reduce time to hire
- We will launch our People Strategy in April 2018 to attract, recruit & retain a workforce that reflects our local communities across all levels of the Trust, with a specific focus on meeting the Workforce Race Equality Standards

To deliver high quality, relevant education and research:

- We will improve the experience of medical students at UHL and address specialty-specific shortcomings in postgraduate medical education, improving our local retention rate and the UHL medical student satisfaction score
- We will explore the model for an Academic Health Sciences Partnership as part of our 5 Year Research Strategy and align priorities with our local universities

To develop more integrated care in partnership with others:

- We will integrate the new model of care for frail people with partners in other parts of health and social care in order to deliver an end to end pathway by the end of 18/19
- We will increase the support, education and specialist advice we offer to our patients and our partners to help them receive/deliver care in the community in order to reduce demand on our hospitals
- We will lead the development of a 5 year regional Specialist Services Strategy which will place UHL at the heart of a regional network and supporting local DGH services

To progress our key strategic enablers:

- We will progress our hospital reconfiguration plans by developing our plans for PACH & the maternity hospital and finalising plans to relocate Level 3 ICU and dependent services at the LRI/Glenfield
- We will make progress towards a paperless hospital with user-friendly systems by replacing all computers over 5 years old, computerising services to outpatient clinics, using technology to support Quality Commitment objectives and implementing an in-house digital imaging solution in 18/19
- We will deliver the year 3 implementation plan for the 'UHL Way' to support & develop staff, (medical and non-medical) and offer tailored education programmes focusing on key areas
- We will implement Y2 of our Commercial Strategy in order to exploit commercial opportunities available to the Trust
- We will improve the efficiency & effectiveness of our key services and our operating theatres and implement our Carter-based LLR corporate consolidation programme

- We will continue on our journey towards financial stability as a consequence of the priorities described here, aiming to deliver our financial target in 18/19

Delivery of these priorities will enable the Trust to deliver high quality, safe and effective care for our patients as well as achieve the performance standards outlined in this document.

Chapter 3: Our approach to demand and capacity planning

This year we have taken a different approach to planning our capacity in response to anticipated demand. Previously we have sought to balance the needs of elective and emergency pathways. This has resulted in periods of very poor performance resulting in large scale cancellations and inefficient use of resources. Crucially this has led to unacceptable patient experience and high levels of frustration and fatigue amongst our staff. Given that we are unable to provide all of the necessary capacity to meet the demands of the emergency, cancer and elective patients, there has to be a prioritisation of resources.

The approach we have taken, in partnership with our commissioners, is to jointly accept across the LLR system that we will see growth in emergency demand above the very high levels seen in 17/18. We have reversed out some of the impact of this winter and then applied national planning guidance growth rates. This broadly equates to emergencies being planned at outturn of 17/18 plus growth of 1%.

The modelling has taken, as the first principle, that emergency demand will be met and that this will be at current occupancy levels. The remaining capacity has then been allocated to cancer patients and subsequently to routine elective patients. This means that the impact of insufficient bed capacity is felt on the elective pathway with a reduction in the number of electives patients that we are planning to see compared to previous years plans.

This impact has been mitigated in three ways.

1. The first is to drive deliver of our **efficiency plans** such as full implementation of red2green – these are described later in this plan.
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3. Finally, we have agreed a system wide plan and commitment to directly **outsource some routine patients** over the course of the year to alternative providers.

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. Our total activity plan and detail behind each of the mitigations described is outlined below.

The table below shows our activity plan for 18/19:

UHL and Alliance Activity Plan

Inpatients/Day Cases	17/18 Outturn	18/19 Plan	% Change
Inpatient	20,048	20,517	2.3%
Emergency	96,665	97,701	1%
Inpatient and Emergency Total	**116,713**	**118,218**	**1.3%**
Day Case	104,485	106,440	1.9%

Total Outpatients	17/18 Outturn	18/19 Plan	% Change
New Outpatients	242,423	246,094	1.5%
Follow Up Outpatients	493,034	494,309	0.3%
Non Face To Face Outpatients	70,956	72,583	2.3%
Outpatient Procedures	132,953	142,770	7.4%
Admission Unit Attendances	4,094	4,579	11.8%
Total Outpatients	**943,460**	**960,335**	**1.8%**

ED	17/18 Outturn	18/19 Plan	% Change
Emergency Department	214,480	218,314	1.8%
Eye Casualty	19,478	19,974	2.5%
	233,958	**238,288**	**1.9%**

Monthly activity trajectories are provided in supporting activity templates.

Capacity Planning

Delivering our efficiency plans

We will deliver our plans to decrease bed occupancy and hence enable increased elective activity by:

- Improving internal efficiency by maximising SAFER flow and red to green
- Reducing delayed transfers of care (DTOCs) to below minimum thresholds
- Reducing average length of stay, including a focus on those patients with the longest length of stay
- Focusing on decreasing stranded and super stranded patients to benchmarked levels
- Implementing a new model of step down care enabling UHL to use its current medical workforce more efficiently
- Developing the frail complex patient pathway and integrate the pathway with our community partners
- Working with LLR commissioners to mitigate the growing demand in all activity types
- Increasing efficiency & patient flow at the weekend and overnight
- Ensuring robust planning (both internal and system-wide) for seasonal variation, including a step change in admissions and length of stay as a consequence of opening the second phase of our Emergency Floor in June 2018.

Improving bed capacity

As described earlier, for 2018/19 we have taken a different approach to planning our capacity in response to anticipated demand. Increasing our capacity by 30 escalation beds and 2 x 28 bedded wards during winter periods will enable us to protect flow.

Our bed profile by month for 18/19 is therefore as follows:

	Month End Census												
Ward Type	Mar 18		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Adult Critical Care beds (Level 3 ITUs)	49		49	49	49	49	49	49	49	49	49	49	49	49
Other Adult Critical Care beds *	40		40	40	40	40	40	40	40	40	40	40	40	40
Paediatric Critical Care beds	20		20	20	20	20	20	20	20	20	20	20	20	20
Neonatal Critical Care beds	40		40	40	40	40	40	40	40	40	40	40	40	40
Other General & Acute beds - core	1500		1500	1500	1495	1495	1495	1495	1495	1495	1495	1495	1495	1495
Other General & Acute beds - escalation			0	0	0	0	0	0	0	0	86	86	86	86
Total G&A Beds excl critical care (as per KH03)	**1500**		**1500**	**1500**	**1495**	**1495**	**1495**	**1495**	**1495**	**1495**	**1581**	**1581**	**1581**	**1581**
Total General & Acute Beds	*1649*		*1649*	*1649*	*1644*	*1644*	*1644*	*1644*	*1644*	*1644*	*1730*	*1730*	*1730*	*1730*

Improving theatre 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 don't have enough theatre capacity for 2018/19; however we have identified efficiencies which can be realised by tackling cancellations, late starts and early finishes.

To improve the productivity of theatres specifically, we are taking a series of actions:

We will:

- Deliver an increased throughput per session
- Ensure sessions start on time and end on time
- Move cases from general anaesthetic to local anaesthetic where appropriate
- Increase the volume of day case surgery
- Review the opportunity to transfer activity into the community
- Continue to insource staff from the private sector
- Review staff retention options
- Build on successful theatre recruitment processes
- Phase non-elective and elective activity across the year

These actions will be driven and governed through our theatre productivity programme.

Outsourcing elective demand

We continue to work with our commissioners to directly outsource a level of elective activity that will enable the Trust to meet the requirements of the planning guidance. We will use community capacity preferentially and then utilise the independent sector to treat displaced patients. We are planning to do this throughout 18/19 in a planned way as opposed to the ad hoc way this has been done previously. This includes agreement of a monthly trajectory with commissioners within the next few weeks to ensure that this process starts as early in Q1 as possible.

Chapter 4: Performance trajectories

Emergency performance

The baseline for improvement is set at 17/18 actual levels. Many of the fundamentals – staffing availability, capacity constraints and physical environment are sufficiently similar to last year so we believe this is a reasonable base line.

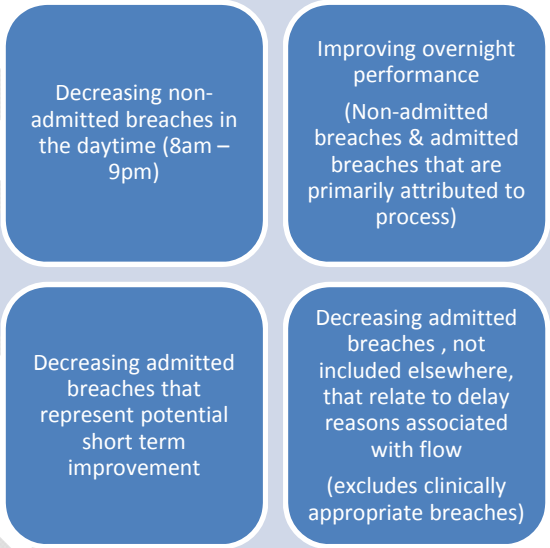
18/19 trajectory:

Month	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
ED 4 hr Trajectory	75.5%	80.3%	80.7%	84.3%	88.3%	89.9%	89.9%	88.6%	83.8%	85.3%	83.9%	87.2%

Whilst this does not achieve the requirement in the planning guidance, delivering an improvement in emergency performance remains the key focus for UHL and our partners across LLR. We remain under acute operational pressure caused by a combination of increased demand and suboptimal processes internally and across the system.

Improvement actions

Our model is based on making potential improvements in 4 major areas based on previous diagnostic work identifying areas of failure that have interlinked but distinct challenges.



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.

1. Decreasing non-admitted breaches between 8am – 9pm

System Linked schemes

- Floor manager in place, with a specific remit to manage flow
- Productivity review and change plan of our Injuries stream
- DHU (our primary care stream provider) maintaining/improving performance and potential streaming model Improvement in Q2, strengthened redirection approach
- Majors space review and pathway change to ensure continued assessment
- Increase in clinical triage of green ambulances
- 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)
- 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 medical staffing overnight
- 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
- Full implementation of e- beds
- EF2 pathway changes
- Improved GPAU functionality
- Glenfield pathway review and changes including community respiratory pathways
- 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 – more timely 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
- Improvements to LOS in community hospital though discharge initiatives (D2A, choice, interim beds, CHC funding agreement risk share etc)

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.

Referral to Treatment – the 92% standard

18/19 trajectory:

	<18wks	>18wks	Total WL	RTT Performance
Apr-18	55,057	9,335	64,392	85.5%
May-18	55,707	8,604	64,311	86.6%
Jun-18	56,153	7,930	64,083	87.6%
Jul-18	56,583	7,309	63,892	88.6%
Aug-18	57,222	6,737	63,959	89.5%
Sep-18	57,213	6,209	63,422	90.2%
Oct-18	57,010	5,723	62,733	90.9%
Nov-18	56,885	5,275	62,160	91.5%
Dec-18	55,625	6,383	62,008	89.7%
Jan-19	54,185	7,149	61,334	88.3%
Feb-19	55,589	8,150	63,739	87.2%
Mar-19	55,606	9,128	64,734	85.9%

The Referral to Treatment (RTT) incompletes standard measures the percentage of patients actively waiting for treatment. Compliance with the standard was maintained during 4 out of the 12 months in 17/18.

The main factor that has impacted on our ability to deliver this standard from December 2017 is the cancellation of non-urgent elective activity during January as instructed by NHSI. This has continued into February due to the continued emergency pressures on the bed base.

The result is 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. 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.

As per the national planning guidance the number of incompletes will be no higher in March 2019 than in March 2018 (WL was 64,751 as at 31st March 2018) and where possible the Trust will aim to reduce the number further.

52 week waits

18/19 trajectory:

Month	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
52 Week Wait	3	0	0	0	0	0	0	0	0	0	0	0

The Trust has worked hard to eliminate the 52 week backlog during 17/18. From May 2018, we will not have patients waiting longer than 52 weeks at the end of each month during 18/19.

Diagnostics

18/19 trajectory:

Month	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Diagnostics 6 week wait	5%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%

We were compliant throughout 17/18 with the exception of March 18. Our aim is to be compliant from May 18 onwards.

Cancer

Feedback from our original submission was that our trajectory did not fit with our current level of improvement; therefore we have re-modelled the trajectory. This trajectory showed recovery by July 2018 and compliance for the rest of the year. Our revised modelling takes into account that recovery from cancellations in early 2018 extended beyond the anticipated period through March and into April.

Our trajectory also recognises that we have had a 6 week delay in the start of our newly recruited oncologists – these are now in place. Equally, independent sector capacity issues have also led to a delay in outsourcing 50 diagnostic procedures and this will now be completed in May 2018.

Our revised 18/19 trajectory therefore shows recovery in Sept 2018 for the 62 day standard:

Month	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Cancer 2 Week Wait	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Cancer 2 Week Wait - Breast	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Cancer 31 Day First	94%	95%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%
Cancer 31 Day Drugs	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
Cancer 31 Day Subs Surgery	86%	86%	88%	90%	92%	94%	94%	94%	94%	94%	94%	94%
Cancer 31 Day Radiotherapy	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%
Cancer 62 Day	77%	78%	81%	83%	81%	85%	85%	85%	85%	85%	85%	85%
Cancer 62 Day Screening	86%	87%	88%	89%	90%	90%	90%	90%	90%	90%	90%	90%

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 7 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.

The Trust has an agreed cancer recovery plan with the local CCGs which has resulted in some clear signs of improvement. We have also taken part in several improvement events led by NHS Improvement and had our processes external audited and validated. We will continue to implement the actions outlined as part of this plan.

Chapter 5: Our Approach to Quality Planning

Patient Safety and Quality Improvement

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

Patient safety and quality improvement are the central objectives of the trust and remain our highest priority. We recognise that patient safety is a fundamental component of high quality care and in 2018/19 we aim to build upon a strong performance of harm reduction and improvement initiatives. NHS Improvement guidance, Health Foundation and IHI quality improvement models as well as HSIB and CHFG recommendations continue to inform our approach to safety and improvement. Our ambition is to drive down to zero preventable harm. To achieve this we seek to learn from the best, to become devoted to continuous learning and improvement, to develop effective and sustainable solutions and to work with system partners to support system-wide patient safety.

The central planks of our safety programme are:-

- Safety Leadership and Culture
- Safety Process
- Continuous Learning and Improvement

Safety Leadership and Culture

We are committed to being a Trust which:-

1. Openly and transparently identifies and acts on risks to patients. We will be open and honest about any failings and share any safety reports that may be helpful to other Trusts.

   How we will do this:- We will implement the National F2SU Guardian's recommendations on openness and transparency in full and meet all the requirements within the new NHSI Serious Incident Framework. We will monitor our compliance through Performance Review Meetings, RCA sign-off check lists and Duty of Compliance reports.

2. Demonstrates a just culture where everyone works to reduce harm, where individuals are not inappropriately blamed and there is candour with patients and families when things go wrong.

   How we will do this:- We will implement the new NHSI 'A Just Culture Guide'. Roll out 'Civility Saves Lives and the 'Cut it Out' initiatives. We will seek to better support our staff involved in adverse events through our Second Victim and serious incident aftercare work.

3. Empowers staff, patients and families to identify where safety improvement is needed and include these groups in improvement programmes.

   How we will do this:- We will increase patient / relative engagement in RCA reports, further develop our safety walkabout programme to identify safety improvements highlighted by staff and patients.

During 2018/19 we will continue to strengthen our Freedom to Speak Up work by rolling out the '5 Steps to Responding to Staff Concerns':-

We will ensure we provide a safe space for staff to raise concerns, promote the 3636 staff concerns reporting line and junior doctor gripe tool and analyse the feedback to ensure we are acting on concerns raised. We will further learn from the National Guardian's Office, implementing guidance and recommendations from peer reviews. This year we will also promote the 'Civility Saves Lives' campaign (supported by the RCOG, RCSEd, GMC and BMA) as much research has shown that incivility reduces quality and performance and is a significant safety issue. We have made some successful alliances with academic partners, the NHS Leadership Academy and others to increase organisational capability and leadership for safety, both at Trust level, and within our Clinical Management Groups. This year we will ensure that a human factors approach and systems thinking is further developed and embedded and will fuel a culture where patient safety is considered everyone's responsibility.

Safety Process

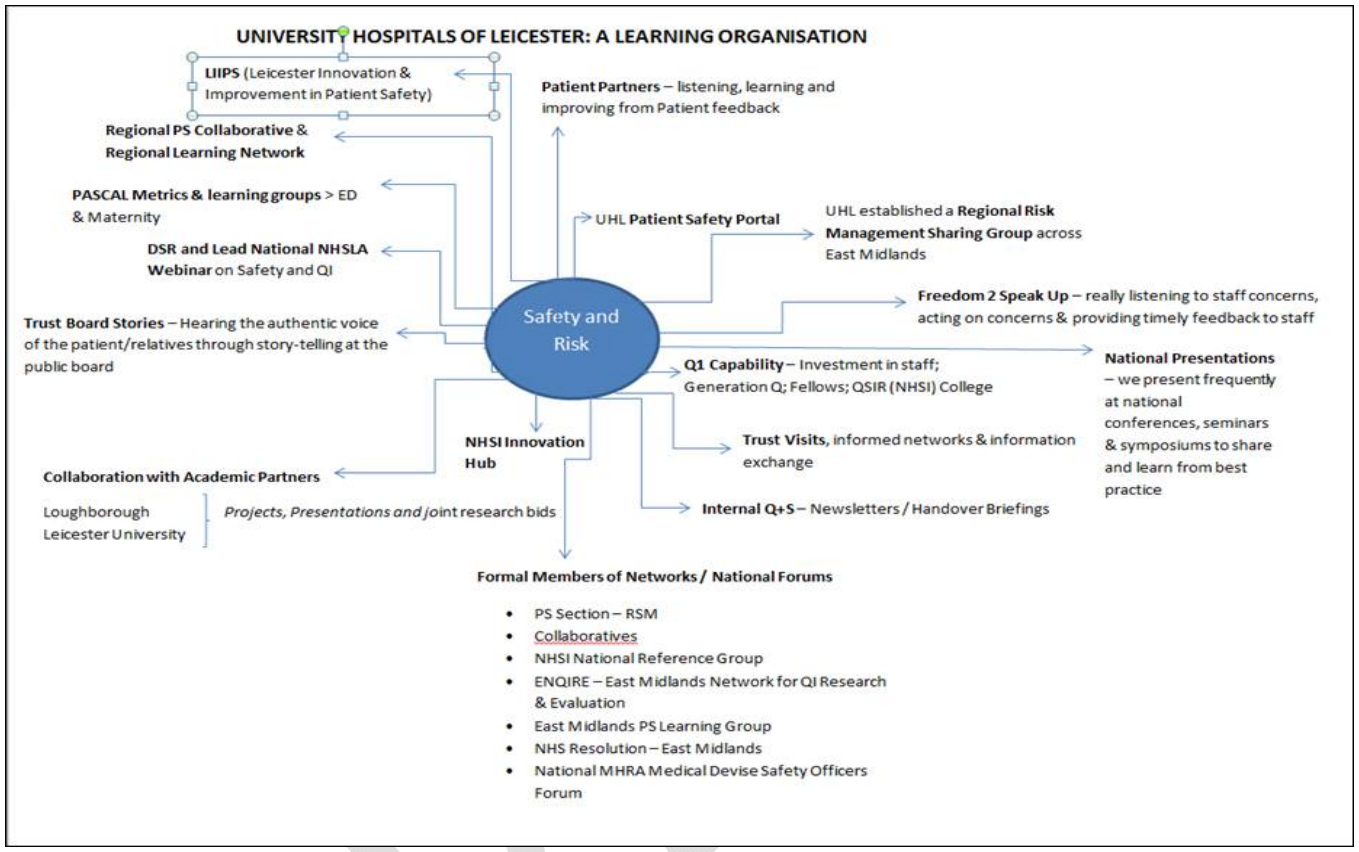
Working in line with the new NHS Improvement Serious Incident Framework due for publication this year we will seek to improve the way serious incidents are investigated and learned from. Improvements will include a focus on quality rather than quantity, better support and engagement with patients and families during the process and better support and engagement of staff involved in the incident. The aim of the investigation process is to prevent or significantly reduce recurrence by identifying causes of patient safety related harm and designing solutions which target these causes. We will use the safety resource to investigate those incidents with the greatest potential learning and endeavour to have a wider, more sustained focus on common underlying causes which could provide the greatest potential for learning. This may inform the prioritisation of safety work away from repeat investigations and towards improvements and the effective reduction of causes.

Building on the success of our safety essentials training programme, we will roll this out this year, prioritising relevant Clinical Management Groups, teams and staff groups.

Our specific safety targets for 2018/19 are detailed in the safety pillar of the UHL Quality Commitment, referenced further in this chapter. In addition to these, we will collaborate with system partners to meet NHSI's desire to improve safety across the system for preventable birth injury and medication safety.

Continuous Learning and Improvement

The chart below demonstrates some of the methods by which we seek to be a learning organisation but we know there is more we need to do.



Central to our learning and improvement work this year will be detailed reviews to ensure learning from deaths, which include the structured judgement reviews. We will ensure that learning and recommendations produced by the Healthcare Safety Investigations Branch (HSIB) are implemented and we will use tools promoted by CHFG and QSIR to drive safety improvement. Internally we will continue to develop our own Patient Safety Portal, provide learning bulletins for every serious incident and extend our patient safety walkabout programme. Learning from Never Events will be a critical action for us this coming year and we will be engaging with system-wide and industry partners at a national Never Event Hackathon. For maternity safety we will continue to contribute to the NHSR Early Notification Scheme and implement the national learning emerging from RCO&G.

We will further equip our staff in human factors awareness and training and support greater learning through safety grand rounds, 'vital and lightening learning' sessions and hot-debrief sessions.

We are committed to ensuring the full potential is harnessed through good investigations, thematic reviews of incidents and deep-dive reviews into harm to inform learning and measurable patient safety improvement. Our quality improvement portfolio continues to grow and we are ambitious to develop this further. Again we will collaborate across the health sector and with academic partners and improvement teams regionally and nationally. We 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.

Quality Improvement programmes

Notable areas of good practice for 2017/18 include significant progress with sepsis

management, embedding of e-obs, positive patient and student feedback, good team work & leadership, low levels of patient harm, improvement in appraisal & training uptake and management of same sex accommodation compliance.

Areas for improvement included nurse staffing, improvements in some areas of leadership, hand hygiene, infection prevention metrics, management of the deteriorating patient including the diabetic patients, storage of equipment and general environmental issues to improve privacy and dignity as well as the workplace environment for staff.

Responding to CQC inspections

In November and December 2017, the Care Quality Commission (CQC) carried out unannounced inspections of our urgent and emergency care, medical, maternity, outpatients and diagnostics services. This was followed by an announced well-led review in January 2018. The aim of these inspections was to check whether the services that we are providing are safe, caring, effective, responsive to people's needs and well-led. The CQC published their reports from these inspections on the 14th March 2018 and rated the Trust as 'requiring improvement' whilst recognising that progress had been made in many areas since the last comprehensive inspection.

Key recommendations include:

- Ensuring equality and diversity is promoted and the causes of workforce inequality identified and addressed
- Ensuring all staff are up to date with mandatory training and receive an annual appraisal
- Ensuring continued learning from Never Events
- Ensuring formal processes are in place to handle administration systems in relation to the Mental Health Act

Our action plan to address these issues has been shared with both the CQC and stakeholders and will be implemented through 2018/19. Immediate action was taken to address the issues raised by the CQC in relation to combined resuscitation trollies and an immediate and robust action plan developed in response to the Section 29A Warning Notice issued by the CQC in relation to insulin safety.

Monthly updates are reported to both the Executive Quality Board and Quality & Outcomes Committee. These reports detail progress against ongoing CQC action plans as well as more immediate actions, such as in relation to insulin safety.

A CQC Project Management Office (PMO) has been in operation since 2016. Key functions of the PMO are to co-ordinate the various aspects of the planning and preparation for CQC inspections and reviews, as well as management the CQC's data submission requests. The PMO is also 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 day to day reporting to the CQC.

The CQC's recently developed Insight Report (which pulls data and intelligence from a number of sources) is reported to our Executive Quality Board, Quality & Outcomes Committee and is used to inform discussions at the monthly Clinical Management Group Performance Review Meetings.

Improving quality of care on our wards

An ongoing programme of quality visits covering both wards and clinical areas has been incorporated into our 6 monthly ward review tool. This tool is an interactive ward based process underpinned by the CQC key lines of enquiry and the five core domains; safe, effective, caring, responsive and well-led. 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
- 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. The findings of this review are fed back to the ward Sister / Matron and form the basis for improvement work on the ward / clinical area as well as being reported to our Nursing Executive Team and Executive Quality Board.

Learning from deaths

In 2017/18 we rolled out the Medical Examiner Process across the Trust for the deaths of all patients aged 16 or above – we will continue this process into 18/19. The aim of the Medical Examiner process is to improve the quality of death certification and identify those patients that need a further review by the relevant clinical team or as part of the specialty mortality and morbidity review process. We have also implemented a Structured Judgment Review (SJR) process – the aim of this process is to identify any problems in care that might have affected the patient's outcome or experience in order to ensure learning and actions are taken to improve the care of all patients.

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.

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

Our Quality Improvement Plan covers delivery against:

- Our quality commitment and associated metrics,
- Our quality schedule
- CQUINS across the Trust

Our **Quality Commitment**

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

Through our Quality Commitment we aim to:

- To improve patient outcomes by greater use of key clinical systems and care pathways
- To reduce harm by embedding a 'Safety Culture'
- To use patient feedback to drive improvements to services and care

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.

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.

Our Quality Schedule

There are 31 indicators within the Quality Schedule for 2018/19 some of which have more than one metric where performance is monitored. There is reduced reporting within many of the indicators for 2018/19 with some indicators moving to dashboard reporting only.

CQUINS

NHSE specialised CQUINS will have the same monitoring and performance approach as in previous years. The current CQUIN schemes will last for two years (2017-19), which will provide greater stability with the aim to improve quality of outcomes for patients.

Whilst some progress has been made in 17/18 – NHS England has 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 18/19 which will be challenging without sufficient resourcing.

There are only 5 mandated National CQUINS for 2018/19. On the basis that there are multiple initiatives supporting the discharge agenda, there has been agreement by NHS England and NHS Improvement to suspend the 'proactive and safe discharge' CQUIN for acute providers, with the

remaining five CQUINS in the scheme increasing their weighting from 0.25% to 0.3% as a temporary measure for 2018/19.

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 five mandated CQUINS which will have a minimum weighting of 0.3%. The remaining 1% is to be assigned to support engagement and commitment to the STP.

Achievement of our quality improvement plan is monitored through a number of strategic groups including the CMG Quality & Safety Boards and reported through the Executive Quality Board.

Delivery of 7 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 2018/19 will build on these strong foundations. An estimated £3.1m of investment is still 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 2018/19, we will:

- Work towards continuing improved delivery of Clinical Standards 2 and 8 at the Glenfield site in the specialties of respiratory medicine and cardiology.
- A 7 day a week Pneumonia Nurse Specialist Service will continue to be trialed until the end of May 2018 – Dependent on the outcome of this trial a formal business case will be submitted.
- The seven day services programme will continue to be aligned with the 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
- The TTO Programme will continue into 2018/19, funded by UHL to Sept 2018
- Continue to submit six-monthly audit data nationally.
- 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.

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

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.

Risk 1	If the Trust is unable to manage the level of emergency and elective demand, caused by an inability to provide safe staffing and fundamental process issues, then it may result in sustained failure to achieve constitutional standards in relation to ED; significantly reduced patient flow throughout the hospital; disruption to multiple services across CMGs; reduced quality of care for large numbers of patients; unmanageable staff workloads; and increased costs.
Mitigations	• New model of command and infrastructure across the Trust; • Daily improvement meetings, chaired by the Chief Executive, including the Chief Nurse, Chief Operating Officer, and Medical Director working with the clinical teams in the component parts of the Trusts Emergency care system to make improvements; • Electronic bed management system introduced across UHL.

Risk 2	If the Trust is unable to achieve and maintain staffing levels that meet service requirements, caused by an inability to recruit, retain and utilise a workforce with the necessary skills and experience, then it may result in extended unplanned service closures and disruption to services across CMGs
Mitigations	• Governance structures established comprising internal and external groups, including Workforce OD Board and the Local Workforce Action Board and subgroups thereof who oversee delivery of the workforce and organisational development components of the Sustainable Transformation Plan; • Current workforce plan relating to reduction in dependency on non-contracted workforce, safe staffing, review of urgent and emergency care, impact of seven day services, shift of activity into community settings and increased specialised services where appropriate; • People strategy and programme of work to address the leadership priorities, wellbeing of our workforce and ensure we focus on addressing actions to improve the diversity of our workforce. • Revised robust five year workforce plan by the end of Quarter 1 addressing placement capacity; alternative routes to nursing qualifications; non-medical solutions to medical workforce gaps; alternative ways of staffing wards; increased use of apprenticeships to address skills shortages - led by professional leads.

Risk 3	If the Trust is unable to achieve and maintain its financial plan, caused by ineffective solution to the demand and capacity issue and ineffective strategies to meet CIP requirements, then it may result in widespread loss of public and stakeholder confidence with potential for regulatory action such as financial special measures or parliamentary intervention
Mitigations	• Regular CMG/Corporate meetings to review financial plans including CIP delivery and forecast. • Reductions in agency spend moving towards the NHSI agency ceiling level. • Revised control totals set for all CMG and Corporate Directorates. • Finance / CIP reports for assurance to Audit Committee meetings.

Triangulation of Intelligence

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. The nursing workforce will continue to produce a full

performance report which highlights a range of workforce indicators including appraisal rates, turnover and sickness as part of a balanced scorecard of quality measures.

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.

An Electronic Rostering solution for the medical workforce will commence implementation in 2018/19 to ensure transparency of safe staffing and adoption of appropriate seven day service standards for this workforce group.

A monthly medical workforce dashboard is produced and reviewed by the Medical Oversight Group which highlights areas of high agency and locum spend and vacancy and sickness rates to identify areas of potential risk.

We also triangulate quality indicators with a range of workforce, performance and financial indicators through an integrated quality and performance report that is considered monthly at a joint meeting of our Quality and Outcomes Committee and Finance and Investment Committee, reporting to the Trust Board. 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, which in particular are used to both support improvement and inform decision making at relevant levels of the Trust.

Chapter 6: Our approach to workforce planning / clinical engagement

Workforce Planning Methodology

Our workforce planning process for 2018-19 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 paybill envelope, the workforce plan has been derived using the following key assumptions:

- A deficit position of £29.9m
- Baseline worked whole time equivalents as at month 12 forecast outturn position
- Assume a gradual reduction in the monthly paybill over 18/19
- Assume an agency reduction to £18.8m

This created the NHSI workforce plan submission for March 2018.

Our clinical management group (CMG) teams, which include clinicians and leads from operations, finance and HR, have continued 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 inclusive of bank, agency and substantive elements.
2. Determine revised establishment position and paybill profile 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). Particular focus will be on reconfiguration schemes relating to the LLR wide STP workstreams. In order to assume correct monthly profiling of pay bill, winter plans for emergency activity have been considered to ensure workforce is deployed proportionately in order that processing power and flow is maintained.
3. In deriving 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 addition to new roles our plans include developments for increased use of therapy and pharmacy input on wards and across our emergency pathway to facilitate discharge and fully utilise the skills available to us for example in the development of the 'Frailty Emergency Squad' at the front door designed to ensure a multidisciplinary approach to the avoidance of admission and facilitation of discharge where safe to do so. This squad is supported by consultant decision makers to maximise processing power. Investment has been made in consultant processing power in ambulatory areas to enable rapid turnaround of patients who do not require a hospital stay.
4. Determine recruitment /reduction trajectories and based on revised establishment/ paybill profiles.
5. 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.

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
- Increased adoption of bank workforce to cover significant challenges in workforce supply which are predicted to continue into 2018/19 particularly in respect of qualified nursing.
- 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.

The overall paybill change is:

Analysis	2017/18 Forecast Out-turn £s	2018/19 Plan £s
Total Pay-bill	**613,905**	**617,276**
Bank	20,403	22,377
Agency	20,390	18,813
Substantive	573,112	576,086

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

Analysis	Actual Mar-18 WTEs	Planned Mar-19 WTEs	Planned Movement WTEs
ALL STAFF	**14,018**	**13,208**	**-809**
Bank	845	831	-14
Agency	185	162	-23
Substantive	12,988	12,215	-773

We will continue to work with CMG's to assess their costed workforce plans against this to ensure triangulation with finance, activity and performance plans. This includes further work on:

- Premium spend (i.e. a significant shift from WLI/Internal Locum costs – currently running at c£1.7m per month)
- Significant skill mix change that would lower the average cost of each wte
- Holding vacancies and other recruitment controls to manage costs within the financial year

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 relate to the changes required to enable us to achieve a two site configuration, changes to enable emergency flow, capacity improvements for the delivery of East Midlands Congenital Heart Services and changes to maternity services – however these changes are 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 changes required to enable service model changes. These lead to a model of demand for workforce from which we model our projected supply and actions to deliver the changes including such interventions as education and training. Some of these plans are reflected in the Trust overall 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 Nursing Associate/ Assistant practitioner roles to enable better functioning of 'red to green' processes
- Investment in the Frailty Front Door Multidisciplinary team to enable improved processing of patients and avoid admission of a most vulnerable patients
- Continuation of acute medical staff input at the front door to increase adoption of ambulatory pathways
- Improved organisation and management of discharge team to enable more consistent staffing levels and approaches
- Increased investment in porters to enable just in time movement of patients
- Investment in flow coordinators – non clinical roles to enable patient flow allowing clinicians to focus on clinical intervention
- Commence recruitment to midwifery workforce to address 'Birth Rate Plus' requirements.

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.

Underpinning Workforce Strategy

The Trust has a five year workforce plan with the following core themes:

- Reduction in non-contracted workforce
- Safe Staffing
- Urgent and Emergency Care
- Seven Day Services
- Movement of services into the community
- Increasingly specialised services

This plan is currently being refreshed to link to a revised People Strategy and the requirements of the National NHS Workforce Plan. This refresh will be completed in Quarter One and will reflect robust plans for improving student and learning placement capacity; improved plans for the adoption of alternative routes to nursing and more comprehensive plans for apprenticeships. 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. A workforce analytics workstream aiming to improve our predictive workforce modeling capability
6. An apprenticeship strategy which describes our plans to maximise opportunities to increase apprenticeships in the workplace through new and innovative approaches to workforce and career development
7. Comprehensive Equality and Diversity plans to improve the experience and development opportunities of those from protected characteristic groups.
8. 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.

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 People Process and Performance Committee and quarterly to the Trust Board and Executive Workforce Board.

Achievement of Efficiency - Capitalising on Collaboration

The Trust has a Premium Spend Group which meets with senior CMG leaders to review our non-contracted pay expenditure and supporting reduction plans. There has been a significant decrease in agency expenditure as a result of comprehensive approaches to long term bookings and highest earners and the performance management of robust recruitment and alternative workforce plans. In addition significant investment has been made in encouraging staff to work on our local bank which improves quality and continuity of patient care.

There is a current programme of work reviewing demand and capacity through the Operations team. The review of theatre capacity has enabled us to triangulate use of Waiting List initiatives and determine more cost effective solutions to meeting demand including improving the average cases per list by driving changes in work practices and working to reduce weekend lists This work is also informed by the Carter efficiency benchmarking (Model Hospital) and the work undertaken by Four Eyes consultancy in reviewing opportunities for improved efficiency. Actions include:

- Improved scheduling
- Improved start on time work practices
- Better communication with admitting wards

The Trust is currently reviewing the outputs of the national Corporate Services review to scope

opportunities for back office efficiency. A deep dive review of the Model Hospital outputs relating to medical staffing will enable identification of opportunities for further efficiency particularly understanding those specialties with the highest cost per WAU.

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.

Workforce Transformation, New Care Pathways, Specific Staff Group Issues

At a local level our Deputy Chief Nurse has implemented systematic process 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 Nursing Associate training and Advanced Clinical Practice has been developed collaboratively with Leicestershire Partnership Trust to ensure a consistency of standard across the STP footprint.

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
- Development of new Trail Blazer Programmes

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 and the development of an LLR wide recruitment portal
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, system leadership and the development of the LLR Way
9. Funding to support the development of the Primary Care Workforce Plan

10. Funding to support the development of the Mental Health Workforce Plan
11. Worked in collaboration with LLR partners to develop a systematic and joint approach to clinical placements to improve our ability to provide high quality training to attract and retain nurses within LLR.

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 number 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 the 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; and support with clinical engagement and STP Systems Leadership Team Development.

Chapter 7: Financial planning

2018-19 Financial Plan: Overview

The Trust submitted the final Financial Plan to NHS Improvement (NHSI) on 10th April 2017 covering two financial years of 2017-19 with an Income and Expenditure (I&E) deficit of £21.7m for 2018/19.

The updated Financial Plan for 2018-19 takes into account 2017-18 exit run rate driven by the continued operational pressures in relation to demand and capacity constraints. As a result the financial target for 2018/19 is set at a £29.9m deficit.

The submitted planned deficit of £29.9m represents an improvement of £6.9m from the 2017/18 financial position of £36.8m (deficit) and an improvement on the baseline after taking into account non-recurrent and technical actions executed in 2017/18.

The Control Total issued by NHSI on 6th February 2018 requires the Trust to deliver a £18.2m surplus inclusive of £30.7m Sustainability and Transformation Funding (STF).

Excluding STF, this represents an underlying deficit plan of £12.5m which would require the Trust to improve on its updated 2017/18 forecast financial deficit of £36.8m by £24.3m which is summarised in the table below:

	2017/18 Outturn £'m	2018/19 Plan £'m	2018/19 Control Total £'m	18/19 vs 17/18 Plan £'m	18/19 vs 17/18 Control Total £'m
Total I&E deficit exclusive of Winter Funding	(39.0)	(29.9)	(12.5)	9.1	26.5
Winter Funding	2.2			(2.2)	(2.2)
Total I&E inclusive of Winter Funding	**(36.8)**	**(29.9)**	**(12.5)**	**6.9**	**24.3**
STF			30.7	0.0	30.7
Total I&E deficit inclusive of Winter Funding / STF	**(36.8)**	**(29.9)**	**18.2**	**6.9**	**54.9**

In making a decision regarding the control total, the Trust has assessed this against both the organisational financial strategy together with 2017/18 outturn including operational pressures which has led to the conclusion that accepting the Control Total is unrealistic.

On the basis that the Trust does not sign up to the issued Control Total, it is not eligible for any STF and may trigger action under the Single Oversight Framework. It should also be noted that the NHSI agency staff expenditure ceiling has been reduced from £20.6m to £18.8m.

The delivery of 2017/18 financial Outturn and current run rate including funding the emergency pathway and operational Winter pressures combined with the outcome of contract negotiations relating to demand and capacity and the announcement of CNST contributions have contributed to the assessment of our position. This assessment highlights a number of issues preventing the Trust from being able to plan for delivery of the control totals:

- 2018/19 Baseline deficit of £54.6m after taking into account non-recurrent actions executed to deliver the 2017/18 planned deficit of £36.8m together with full year effect of part year changes and full year effect of costs being incurred to support the emergency pathway
- 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.

The Trust has a number of cost pressures particularly within the pay run rate which needs to be more aggressively and pro-actively managed in 2018/19.

The scale of improvement required to deliver the control total represents a material reduction in either the structural deficit of the organisation (i.e. the excess costs associated with operating three acute sites) 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 experienced in meeting the 2017/18 planned deficit, it is recognised that financial improvement is required. Therefore, in order to mitigate and improve the recurrent position the 2018/19 financial plan shows additional actions of £5.9m plus CIP delivery of £51.5m representing 5% efficiency. Taking into account how the Trust delivered its 2017/18 deficit and an 2018/19 baseline deficit of £54.6m this still represents an ambitious plan dependent upon delivery of CIP and actions to address the 2017/18 exit run rate.

Activity

The Trust 2018/19 income plan is based upon the demand and capacity assumptions modelled for each specialty, as described earlier in this plan.

Emergencies are based on 17/18 +1% growth, reflecting the reversal out of some of the impact of this winter and then applied national planning guidance growth rates. Plans include the impact of opening 2 additional wards over winter to help manage this demand, with elective activity then modeled on this basis.

We have worked closely with CCGs to ensure that the total system demand is understood and that alternative capacity is sought from other providers where needed.

Income

Clinical Income

Whilst this is the second year of a two year contract, we have jointly agreed to refresh the activity plans and contract values for Specialised Services and LLR CCGs, to reflect any significant changes in the past year. At this stage in the planning process, contract negotiations are still on-going and the figures included in the AOP are therefore subject to the outcome of these negotiations.

The expected contract value for 2017/18 stands at £504.1m (61% of total clinical income) for local Clinical Commissioning Groups (Leicester City, West Leicestershire and East Leicestershire and Rutland CCGs, including the Alliance contract) and £277.0m (33% of total clinical income) for specialised activity commissioned by NHS England. All contracts are tariff based, full cost and volume.

The value of £504.1m for LLR includes 1.5% of CQUIN payment for the delivery of National Schemes and 1.0% of CQUIN payment for full engagement in the STP programme (up from 0.5% in 2017/18). Further to new national guidance, the 0.5% CQUIN related to the national risk reserve has been withdrawn in 2018/19.

Our current plan uses PbR tariff in line with the guidance and national prices as published as part of the 2017/19 national tariff package. 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 2018/19 is anticipated to be an £2.3m increase in income; this can be separated into tariff inflation of £14.7m, efficiency requirement of £14.0m) and £1.6m year 2 impact of HRG4+.

The contract with NHSE for the delivery of Specialised Services will be a full PbR based agreement. The full 2.8% (2.5% CQUIN and 0.3% Hep C) value will be included in the 2017-18 agreement.

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 funding from having a lower level of medical undergraduates. This results in a reduction in income of £1m through reduced transitional relief together with £1m reduction with respect to non-recurrent income received in 2017/18.
- Income received through research and development – the 2018/19 plan shows a reduction in research income driven by 2017/18 non-recurrent deferred income release which requires subsequent funding in 2018/19.
- Income received through other sources such as facilities management, car parking etc. which is not anticipated to change materially from 2017/18 outturn.

In addition to the above, the 2017/18 financial outturn included income in relation to the estates strategy which is wholly non-recurrent and drives a substantial year on year reduction of c£12m.

We have not recognised other income relating to general STF of £30.7m as we are not planning to deliver to the NHSI control total.

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 2017/18, 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 2018/19, we continue with the ambition to fill the establishment on a substantive basis but recognise 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 section 4 above for more detail on workforce planning.

In order to provide additional capacity to support emergency pressures driven by the anticipated demand and reduce the impact on elective activity, the 2018/19 Plan includes the cost of opening two additional 28 bed Wards over the Winter period.

Pay inflation, is included at £5.7m (1%) based on existing national pay structures. This does not take into account outcome of the NHS pay review body which will require additional government funding.

Contingency reserves of £4.6m overall (0.5% of turnover) are included of which £3.7m (80%) is planned as pay.

Non pay

Non-pay inflation at £6.1m is based on drugs at 2.1% and a 2.1% increase generally in line with guidance. In addition to this there is an increase of £4.5m (16.5%) against the Trust's CNST contributions.

The value of commissioner funded high cost drugs and devices in the 2018/19 plan is £107.0m which is based upon the 2017/18 forecast outturn plus £6.4m (6.4%) 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 £4.6m overall (0.5% of turnover) are included of which £0.9m (20%) is planned as non-pay.

Capital and Cash

The capital plan submitted as part of the two year process was £79.2m including £47.4m in relation to the reconfiguration programme for Ward capacity at Glenfield and the LRI, Theatres and ICU which requires external funding.

Since the plan was submitted the NHSI, the following has changed:

- A delay in the timing of the ICU business case whereby the Outline Business Case was submitted to NHSI in November and the Full Business Case in June 2018;
- Revised timeline for the major reconfiguration programme;
- Delayed Congenital Heart decision making process driving a revised profile of the capital spend required to relocate EMCHC from Glenfield to LRI.

Taking this into account, together with internal capital requirements that has followed a period of constrained investment (particularly in IMT development and estates which provides a challenge in terms of meeting statutory requirements), this drives a capital plan for 2018-19 of £54.5m funded by £26.8m CRL which includes asset sale and £27.7m external funding which is dependent on approval of business cases in 2018/19. The Appendix 3 shows the outturn for 2017/18 and the 2018/19 capital plan together with funding sources.

The key elements of the 2018/19 capital plan remain consistent with 2017/18 which are:

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

In order to support the planned deficit of £29.9m together with the external funding for the capital programme of £27.4m (excluding donations of £0.3m) there will be a need for further borrowing of £57.3m.

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 £29.9m deficit in 2018/19 contains 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 activity has been set in line with anticipated costs to deliver the demand plan. 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, the currently plan assumes a similar contractual agreement with commissioners in relation to fines and penalties as in 2017/18 which has been agreed as part of contract negotiations.

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 rigor into the CIP process, giving pace, accountability and clearly defined targets, mitigating against the risk of underperformance.

A key financial risk is the identification and execution of mitigating actions to address the 2017/18 step-off point and baseline deficit. This is currently dependent upon identifying and delivering actions with a value of £4.4m over and above the 2018/19 CIP programme of £51.5m. Given the risk it is recommended that a specific function is assigned with the responsibility to identify, monitor and track delivery of these additional actions.

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. As stated above, the 2018/19 Plan includes additional capacity in order to help towards mitigating this risk.

Financial Plan Summary

In summary, we are forecasting to deliver a £29.9m deficit in 2018/19 and achieving £51.5m CIP.

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

The capital expenditure plan for 2018/19 is £54.5m and is summarised in Appendix 3. These plans include external funding requirements for 2018/19 of £27.7m.

The monthly phasing of the income and expenditure surplus/deficit is summarised in Appendix 5.

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

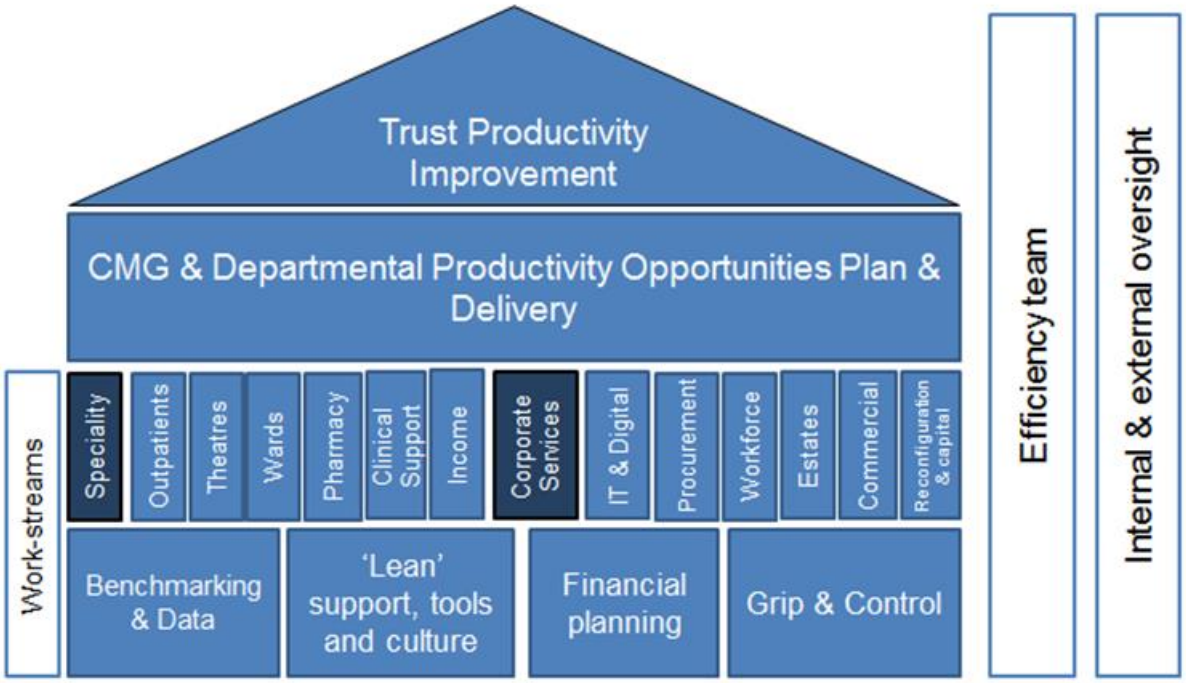
Efficiency savings for 2018-19

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

The strategy was based around a wide of sources including the following:

- NHSI Model Hospital
- Recommendations from the Carter Programme
- The Getting It Right First Time (GIRFT) Programme
- NHSI Theatre Efficiency Programme (using Four Eyes consultancy)
- The Trust's 5 year Strategy

To deliver the challenging CIP target for 18/19 (detailed in Appendix 4) we have developed a formal Trust's 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 2018/19. To ensure focus on the key opportunity areas for CMGs, allocation has been undertaken using national benchmarking data (Reference Costs / Model Hospital).

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.

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, lean and robust controls. Some of our key workstreams are:

- Lean - Our lean programme is being rolled out through our partnership with Complete Lean Solutions who are supporting 140 lean apprenticeships (focused on Improving Operational Performance) across the Trust. Colleagues undertaking the course will complete a lean project within their work area/specialty which will support delivery of our CIP programme.
- Data - Our data workstream is focused on maximizing 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 work undertaken by NHS Improvement with the UHL has identified material model hospital efficiency opportunities, particularly related to workforce and these opportunities have now been included in our CIP plans for 2018/19.
- Theatres – UHL is working closely with Four Eyes who have identified up to £4m of efficiency opportunities within theatres. A key focus of our 18/19 CIP plans will be to deliver on the opportunities highlighted in a robust and efficient manner.
- 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 £3.7m of opportunity in 2018/19.

Efficiency Team

The central Efficiency Team will be overseeing the implementation and delivery of the Trust Programme. Key activities will include:

- Overall Efficiency Strategy and approach (including our 5 year efficiency planning cycle)
- Annual productivity improvement programme management
- Escalation meetings as required
- Engagement with regional networks (CIP) and national improvement agencies including NHSI / GIRFT etc.
- Monthly Board reporting and external reporting
- Quality Assurance
- Engagement with our STP on wider health economy efficiencies and improvements

Internal & External Oversight

Our CIP plans will be fully identified and risk assessed by 30th April, with schemes subject to a robust QIA process by 31 May 2018. We will report progress monthly to be our Trust Board and NHSI with quality assurance provided quarterly to our Quality Outcomes Committee (QOC). In addition each of our workstreams has their own reporting mechanism and assurance process, such as our Theatres Programme Board which meets monthly.

Chapter 8: Links to the local Sustainability and Transformation Plan (STP)

Alignment of 'strategic intent' between the STP and our operational plan is important and already apparent through our service reconfiguration plans, new care models and in mitigating plans to manage demand across the sub-region. Our commitment to system working is reflected in the revised planning processes put into place for 2018/19; we have put into place a system-wide approach to the development of our operating plans, ensuring aligned and credible assumptions with our commissioners and alignment of priorities with our 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 collaboratively.

To enable 2018/19 plan we will continue to implement:

- Our plans to deliver (system level) 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
- 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 or under utilised estate
- Plans to enhance the capability of the system including stronger governance and aligned decision-making, and greater engagement with communities and other partners.

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 – 2018/19 Financial Plan Summary

	2017/18 £'m	2018/19 £'m	Change £'m
NHS Patient Care	810.7	827.2	16.6
Other Operating Income	150.6	129.5	(21.1)
Total Income	**961.3**	**956.7**	**(4.5)**
Pay	(593.2)	(598.5)	(5.3)
Agency	(20.7)	(18.8)	1.9
Non-Pay	(348.4)	(339.1)	9.3
Total Operating Expenditure	**(962.3)**	**(956.4)**	**5.9**
EBITDA	**(1.0)**	**0.4**	**1.4**
Non-Operating Costs	(35.1)	(30.5)	4.6
Retained deficit	**(36.1)**	**(30.1)**	**6.0**
Adjustment for Donated Assets	(0.6)	0.2	0.8
CQUIN Risk Reserve	(2.3)		2.3
Net Deficit excluding Winter Funding Tranche 1	**(39.0)**	**(29.9)**	**9.1**
Winter Funding - Tranche 1	2.2		(2.2)
Adjusted Net Deficit	**(36.8)**	**(29.9)**	**6.9**

Appendix 2 – 2018/19 Planning Bridge

	2018/19 Financial Plan £m	£m
2017/18 Outturn		**(36.8)**
Less: Tranche 1 Winter Funding		(2.2)
Add: CQUIN 0.5% Risk Reserve		2.3
2017/18 Outturn exlcuding Tranche 1 Winter Funding		**(36.7)**
Non-recurrent	(2.1)	
FYE of costs in 2017/18	(22.1)	
Net Tariff inflator (0.1%)	0.7	
Inflation funding in tariff (2.1%)	(11.7)	
CIP - national tariff requirement (2%)	20.4	
HRG4+	1.6	
QIPP	(0.5)	
CQUIN	0.3	
CNST	(4.5)	
		(18.0)
2018/19 baseline		**(54.7)**
Coding and Counting	3.0	
Net Contribution of volume growth	(0.1)	
Drugs & Devices (pass through)	0.0	
PCI Provisions	(3.3)	
MRET/Readmissions	(0.5)	
ED Floor: Phase 2	(2.2)	
ICU/Reconfiguration Business Cases	(0.6)	
Winter Cost: Additional beds Dec-March	(2.4)	
Step down	0.3	
Non-Op Costs	(1.5)	
Contingency: 0.5%	(4.6)	
CIP - locally defined (3%)	31.1	
Agency Controls	1.0	
Other	0.1	
Cost Controls and further mitigations	4.4	
		24.8
2018/19 Plan		**(29.9)**

Appendix 3 – 2018/19 Capital Plan

		2018/19 £'m
Capital Plan	Interim ICU Project	27.4
	Donations	0.3
	Externally Funded Capital Expenditure Schemes	**27.7**
	Estates and Facilities	6.3
	IM&T Schemes	6.2
	Medical Equipment Schemes	4.2
	EMCHC	3.0
	Reconfiguration programme	2.7
	MES Finance Lease	4.4
	Internally Funded Capital Expenditure Schemes	**26.8**
	Grand Total	**54.5**
Funding	External Funding	27.4
	Donations	0.3
	Internal Depreciation Funding	23.3
	Sale of asset	5.7
	Capital Loan Repayments	(2.2)
	Total Capital Funding	**54.5**

Appendix 4 – 2018/19 CIP schedule

Project (Enabler / Workstream)	Sum of Total Plan PYE
Clinical Support	209
Commercial	111
Income	3,439
IT & Digital	39
Pharmacy	500
Procurement	4,606
Reconfiguration & Development	19,609
Speciality Led (including theatres, outpatients and workforce)	22,967
Grand Total	**51,480**

6.7 -

Appendix 5 – Income and Expenditure Surplus/(Deficit) phasing