Operational Plan 2017-19 – Final Draft

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Trust Board paper A

Executive Summary

Context

Our operational plan describes how we will meet the expectations of our patients, the regulator, commissioners and other stakeholders on our journey to sustainability, whilst also focusing on tackling immediate performance issues and ensuring short-term resilience.

Our final draft plan, below, has been updated since the December submission to reflect our contract / agreement with commissioners.

Questions

1. What is the status of our operational plan?
2. Does our operational plan meet all the local and national planning requirements?
3. What are the next steps?

Conclusion

1. We submitted a second draft of our operational plan on the 23rd December, in line with the national planning timetable. This followed widespread engagement with stakeholders and patient and partner representatives over the past 3-6 months. However, work has continued since our last submission (alongside contract negotiations with local clinical commissioning groups) given the many complexities involved in this year's process i.e. alignment with the LLR sustainability and transformation plan assumptions and principles, affordability constraints, uncertainty around capital availability and so on. Therefore, we have a third and final draft plan, which is coming to the Trust Board today for approval.
2. NHS Improvement, in commenting on our draft submission, commended our ongoing commitment to quality improvement and workforce development, which remains front and centre in our plans. Unfortunately, other areas of our plan fall short of local ambitions and national requirements due in the main to the ongoing imbalance between demand and capacity (across the local system as well as within the Trust) as well as affordability constraints on the side of the commissioner.
3. Subject to Trust Board approval, we will submit our final draft operational plan and a letter highlighting the key risks associated with our planning assumptions, signed by John Adler, UHL CEO, on behalf of the Trust Board. We also plan to publish our plans to our wider stakeholders (including the public) before March. In addition, we are in the process of re-engaging our clinical management groups (CMGs) as we articulate the final expectations and

plans for the coming year in detail. We will also conduct a lessons learned exercise once the planning and contracting cycle has concluded in full in order to ensure we continue to improve the way we approach this part of our business. Lastly, work on our strategic objectives and priorities for the coming years will be finalised – this will likely see a narrowing of our focus to ensure we are concentrating our resources on the most important issues.

Input Sought

We would welcome the board's input regarding the approval (for submission to NHSI) of the enclosed operational plan and letter from John Adler, on behalf of the Trust Board.

For Reference

Edit as appropriate:

1. The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	[**Yes** /No /Not applicable]
Effective, integrated emergency care	[**Yes** /No /Not applicable]
Consistently meeting national access standards	[**Yes** /No /Not applicable]
Integrated care in partnership with others	[**Yes** /No /Not applicable]
Enhanced delivery in research, innovation & ed'	[**Yes** /No /Not applicable]
A caring, professional, engaged workforce	[**Yes** /No /Not applicable]
Clinically sustainable services with excellent facilities	[**Yes** /No /Not applicable]
Financially sustainable NHS organisation	[**Yes** /No /Not applicable]
Enabled by excellent IM&T	[**Yes** /No /Not applicable]

2. This matter relates to the following governance initiatives:

Organisational Risk Register	[**Yes** /No /Not applicable]
Board Assurance Framework	[**Yes** /No /Not applicable]

3. Related Patient and Public Involvement actions taken, or to be taken: [various, including discussions at Public Engagement events]

4. Results of any Equality Impact Assessment, relating to this matter: [EIA to be conducted on the final draft plan]

5. Scheduled date for the next paper on this topic: Regular updates to be presented to the Trust Board regarding progress made on plan delivery

University Hospitals of Leicester NHS Trust

Operational Plan 2017-19 – Final Draft

1. Introduction

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

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

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

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

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

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

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

UHL Values:

2. Our Approach to Activity Planning

2.1. Activity Planning

The activity plans have been developed by our Clinical Management Groups (CMGs) with the support of the Business Intelligence and Finance teams. We have also working closely with LLR CCGs to agree the activity for next year and ensure alignment with the STP. Progress has been made but the activity plans have yet to be jointly signed of between UHL and commissioners.

For high risk and high volume specialties the Trust has used the NHS Improvement agreed demand and capacity tools. This approach has been agreed with our lead commissioners.

A revised Trust level summary of the changes between 16/17 activity (the 'SLAM forecast outturn'), 17/18 contracted activity (and 18/19 including demographic growth are shown in table 1 below, for both UHL and The Alliance:

Table 1

Inpatients/Day Cases	16/17 Forecast Outturn	17/18 Activity Movement	17/18 QIPP	17/18 Activity Plan	% Change 17/18 Demand Plan vs 16/17 Forecast Outturn	18/19 Additional Activity	18/19 Activity Plan	% Change 18/19 Demand Plan vs 17/18 Demand Plan
Day Case	104,475	3,134	(745)	106,864	2%	1,069	109,809	1%
Inpatient	21,110	325	-	21,435	2%	214	22,828	1%
Emergency	85,687	1,713	(1,609)	85,791	0%	858	90,661	1%
Non Elective	22,688	179	-	22,867	1%	229	22,932	1%
	233,960	5,351	(2,354)	236,958	1%	2,370	246,230	1%

Outpatients	16/17 Forecast Outturn	17/18 Activity Movement	17/18 QIPP	17/18 Activity Plan	% Change 17/18 Demand Plan vs 16/17 Forecast Outturn	18/19 Additional Activity	18/19 Activity Plan	% Change 18/19 Demand Plan vs 17/18 Demand Plan
New Outpatients	242,254	12,845	(7,049)	248,050	2%	2,481	257,451	1%
Follow Up Outpatients	504,962	12,099	(13,652)	503,410	0%	5,034	531,476	1%
Non Face To Face Outpatients	48,067	961	-	49,028	2%	490	49,771	1%
Outpatient Procedures	120,106	2,402	-	122,508	2%	1,225	125,084	1%
	915,389	28,308	(20,701)	922,995	1%	9,230	963,782	1%

ED Attendances (Based on move to new ED floor)	16/17 Forecast Outturn	17/18 Activity Movement	17/18 QIPP	17/18 Activity Plan	% Change 17/18 Activity Plan vs 16/17 Forecast Outturn
Emergency Department	143,101	19,498	(21,724)		
Eye Casualty	21,186	(10,195)			
Urgent Care Centre	75,769	3,788			
	240,056	13,092	(21,724)	231,424	-4%

Notes:

1. QIPP/STP activity has been removed from the activity plans
2. 50% of Eye Casualty activity is to be transferred to outpatient settings which could negatively impact on ED performance by up to 1%.
3. ED attendances planned activity levels have been reworked following new pathways following the opening of the Emergency Floor in March. This includes the move of Children's Admission Unit activity into Paediatric ED.

2.2. Capacity Planning – Beds & Theatres

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

For 2017/18 there are 3 main scenarios modelled. All 3 scenarios show the absolute criticality of delivering both demand management targets and internal productivity. No delivery or partial delivery is likely to lead to, at best, occupancy standing still and therefore access standards at 16/17 outturn, or at worst increasing occupancy and further deterioration against access standards from 16/17 outturn.

2.2.1. Planning scenario 1 - Full Delivery

This scenario models the movement of occupancy to a level where bed accessibility was no longer an issue for the Trust (84%) and then we would forecast the delivery of 4 hour wait at 95% and RTT at 92%. Clearly, this is a highly unlikely scenario, but it is important to note it as it is the scenario required to be compliant with national targets. The demand and capacity gap within this scenario for 17/18 is 4,121 patients.

Full Delivery Summary	Activity through beds	Activity through theatres
Unmitigated Demand at current utilisation	**152,792**	**29,292**
Patients current bed base (at desired utilisation of 84%) can treat	144,142	**26,507**
Patients that couldn't be treated at current capacity	**8,650**	**2,727**
Patients who will then be treated by improved internal productivity (STP level of productivity improvement)	2,118	2,315*
Patients who will be managed through demand management by UHL and partners	2,496	745
Remaining gap	4121	None

*791 is dependent on bed activity gap being mitigated

2.2.2. Planning scenario 2 – Contract Plan

This scenario assumes that the contracted activity happens as planned, therefore assuming that QIPP within the 2017/18 contract delivers, which mitigates much of the growth in demand and that the Trust delivers the required level of internal bed efficiency described within the STP. If the beds are not removed as cost savings (and this will be a risk to the 2017/18 CIP) this will move Trust occupancy to 85.7% from the current 87.5% (-1.8%). At this occupancy there will be no gap in demand and capacity, but obviously this is an occupancy that remains 3.5% from the required level to consistently deliver the flow required to achieve national targets. Such a reduction in occupancy would lead to A&E 4 hour standard improving in the trajectory shown below although this trajectory also factors in a reduction in non-admitted breaches from the improvement of flow and from the new ED. The RTT and Cancer trajectories are also shown below for this scenario.

Contract Plan Summary	Activity through beds	Activity through theatres
Unmitigated Demand at current utilisation	**152,792**	**29,292**
Patients that current capacity (at current utilisation 87.5%) can treat	**150,628**	**26,507**
Patients that couldn't be treated at current capacity and utilisation	**2,165**	**2,727**
Patients who will then be treated by improved internal productivity (STP level of productivity improvement)	2,118	2315*
Patients who will be managed through demand management by UHL and partners	2,496	745
Remaining gap	None**	None

*791 is dependent on bed activity gap being mitigated
** Improvement in occupancy from 87.5% to 85.7%

Performance Trajectories for this scenario:

Month	April	May	June	July	August	September
RTT Performance	92.00%	93%	93%	92.78%	91.14%	92.45%
Cancer 62 day	83.14%	84%	85%	84.76%	85.40%	85.78%
Diagnostics	0.88%	0.88%	0.88%	0.88%	1.24%	0.88%
ED	78.49%	75.49%	81.90%	83.40%	84.10%	83.67%
	No Improvement due to ED new floor					
Month	**October**	**November**	**December**	**January**	**February**	**March**
RTT Performance	93.50%	92.70%	91.40%	91.20%	91.45%	92.04%
Cancer 62 day	85.78%	83.46%	85.00%	81.45%	81.27%	83.98%
Diagnostics	0.88%	0.88%	1.19%	0.88%	0.88%	0.88%
ED	83.67%	83.14%	79.90%	80.42%	82.90%	83.14%

2.2.3. Planning scenario 3 – Downside scenario

This scenario assumes that only 50% of the QIPP delivers and the forecast demand is 50% between the Trust forecast and what the CCGs have contracted for pre-QIPP. Again, if beds are not removed (risk to CIP), this scenario would lead to a stand-still in the occupancy of the organisation (87.5%), meaning that performance would likely be at similar levels to the out-turn at the end of 16/17 as shown in the below trajectories.

Downside Scenario Summary	Activity through beds	Activity through theatres
Unmitigated Demand at current utilisation	**153,832**	**29,292**
Patients that current capacity (at current utilisation 87.5%) can treat	**150,628**	**26,507**
Patients that couldn't be treated at current capacity and utilisation	**3,205**	**2,757**
Patients who will then be treated by improved internal productivity (STP level of productivity improvement)	2,118	2315*
Patients who will be managed through demand management by UHL and partners	1,248	373
Remaining gap	None	69

*791 is dependent on bed activity gap being mitigated

Performance Trajectories for this scenario:

Month	April	May	June	July	August	September
RTT Performance	91.60%	92%	92%	92.38%	92.00%	91.46%
Cancer 62 day	82.10%	84%	85%	83.20%	85.40%	85.00%
Diagnostics	0.98%	0.98%	0.98%	0.98%	1.60%	0.98%
ED	78.49%	75.49%	79.80%	80.14%	81.45%	82.50%
Month	**October**	**November**	**December**	**January**	**February**	**March**
RTT Performance	92.00%	92.38%	91.46%	90.89%	89.48%	89.32%
Cancer 62 day	85.00%	82.40%	84.60%	79.60%	80.40%	82.30%
Diagnostics	0.98%	0.98%	1.23%	0.98%	0.98%	0.98%
ED	79.50%	78.90%	77.40%	76.80%	79.62%	81.40%

2.3. Internal productivity to maximise capacity

We know that bed capacity and theatre capacity are linked. The greater the bed capacity gap the less efficiently we utilise our theatres. Even with the available beds we know we have an unstaffed theatre gap. We are taking a series of actions to address an imbalance between the demand for theatres and the capacity available, including:

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

For beds, the productivity plans include:

1. Reduction in emergency and elective demand through the agreed better care together delivery boards.
2. Increase in internal staffed capacity (Ward 7 (LRI), and Ward 23a (Glenfield Hospital) and increased theatre and consultant staffing).
3. Planned use of the independent sector through the commissioning process (as opposed to ad hoc use via sub-contracting with the Trust).
4. Improvements in UHL efficiency as delivered through the internal efficiency programme most notably through the SAFER and Red/Green programmes

2.4. Delivery of Operational Performance Standards

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

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

2.4.1. Emergency Performance

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

In the spring of 2017, the new emergency floor opens and we want to be in the position where we have reduced demand and improve performance and care, before the service moves into the new build. However, we anticipate a worsening in performance initially (whether demand changes significantly or not) as seen by other hospital trusts that have recently opened new emergency departments.

2.4.2. Referral to Treatment (RTT) – the 92% standard

The Trust has remained compliant with the RTT incomplete target for the majority of 2016-17, meaning that at least 92% of patients were waiting less than 18 weeks for treatment. This is an important achievement in light of rising referrals, increasing emergency pressures over the winter period, and capacity constraints in key services. We know that we have had periods where we have failed the standard. This is directly linked to our known imbalance in Demand and Capacity. We are facing demand in excess of last year's plan and continued cancellations associated with excess emergency care work.

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

2.4.3. 52 week waits

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

2.4.4. Diagnostics

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

2.4.5. Cancer

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

2ww	Continued delivery - we will be planning for circa 11% increase in 2ww referrals during the coming year. We continue to try to limit the referral growth by utilizing PRISM referral forms.
31 days	Access to theatres in key specialties and the cancellations of patients, including cancer patients, in particular due to ITU capacity remains a significant risk. The opening of additional HDU / ITU capacity will mitigate this.
62 days	We have made significant progress in backlog reduction in 16/17 and will continue this in 17/18 we have increased performance to consistently above 80% and continue to work with referring providers to further improve performance. There is a clear and strong governance process around delivery through a joint CCG/Trust board and clear and agreed Cancer RAP. The key themes to the plan are demand and capacity (including: physical and staffing), detailed process management and patient choice. Compliance of the 62 cancer trajectory is dependent on rebalancing the capacity and demand – see demand and capacity assumptions / scenarios, described above at 2.2.

3. Our Approach to Quality Planning

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

3.1. Patient Safety and Quality Improvement

Our commitment to safety and quality remains unwavering. With increasingly complex care and within an exceptionally challenging financial environment, there is a greater need than ever to focus resources and actions to ensure the best value for money and a material decrease in avoidable death and harm. We will continue to focus on safety measurement and improvements

in our collection, analysis and use of safety information and data. This will enable us to identify safety themes, trends and clusters.

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

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

3.1.1. Improving Organisational Safety Culture

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

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

3.1.2. Growing Leaders for Safety and Quality Improvement

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

3.1.3. Building Capability in Safety and Quality Improvement

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

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

3.1.4. Undertaking Evaluation of Improvement Projects

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

3.2. Quality Improvement

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

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

We are in the process of developing Trust action plans to address these issues and these will be updated further once the final reports have been received from the CQC.

In preparation for our CQC inspection in June 2016, the Chief Nurse, Medical Director and their direct reports focussed their activities around the quality and safety agenda. CMG Quality and Safety Performance Review meetings were stepped up to take place monthly and this frequency has been maintained since the CQC inspection.

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

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

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

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

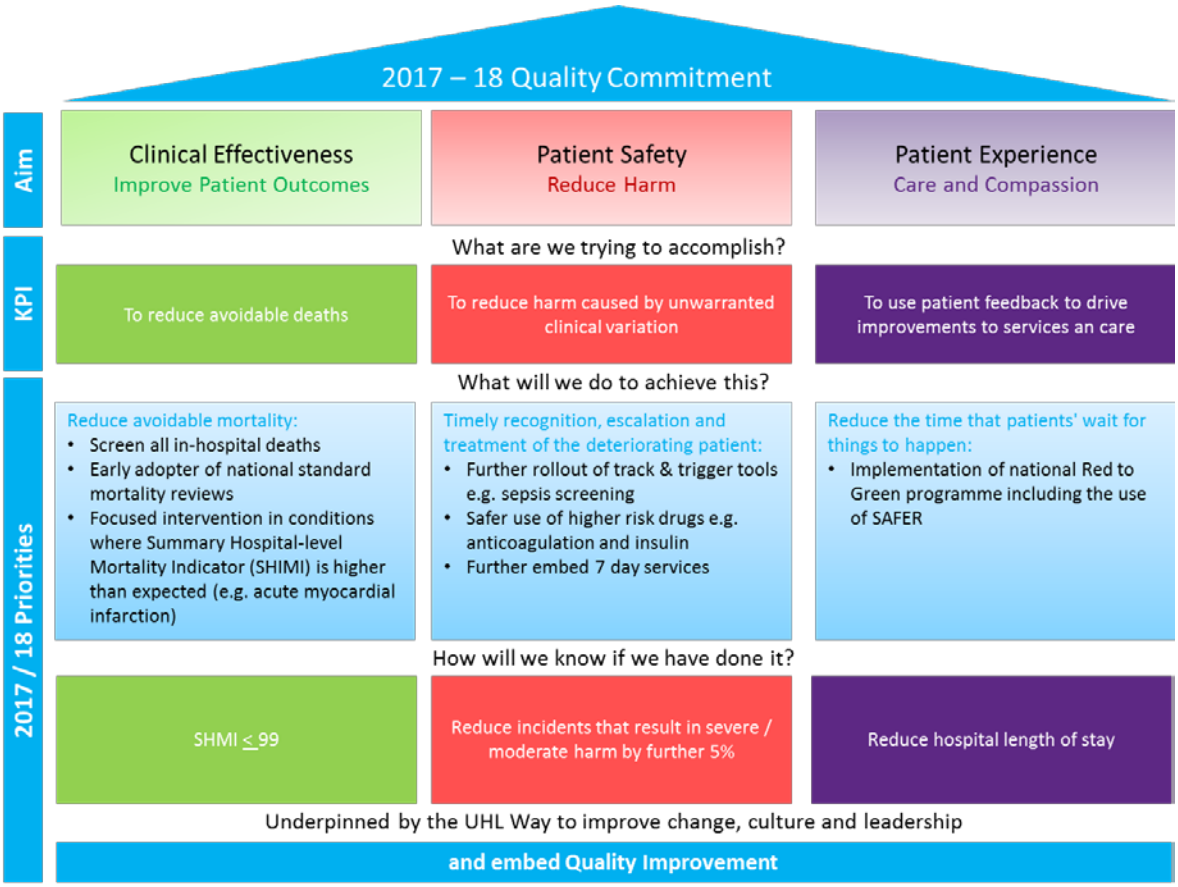
Once a primarily documentary review, our ward review tool is now a more interactive ward based process underpinned by the CQC key lines of enquiry and the five core domains; safe, effective, caring, responsive.

These reviews give our Heads of Nursing the opportunity to spend quality time with the ward sister and include; a discussion on ward performance data and agreeing actions (using a checklist to prompt the discussion with documented agreed actions for improvement); interviewing staff with some CQC style questions (using the CQC intelligence we have); a discussion about what staff are proud of and opportunities to celebrate; and finally; meeting

patients and discussing their experiences to gain real time feedback. The review also involves an inspection of the ward environment and agreeing actions and improvements.

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

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



Through our Quality Commitment we aim to:

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

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

Our CQUIN Scheme for 17/18 and 18/19 has been published. NHSE specialised CQUINS will have the same monitoring and performance approach as 2016/17.

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

Specialised CQUIN Schemes are again multi-year, with most CQUINS continuing from 2016/17. New schemes are designed for implementation over two years Whilst some progress has been made in 16/17 – NHS England have been supportive in their approach to performance review and the thresholds have been mainly around scoping and base lining. There will therefore be an

expectation of delivery and improvements for 17/18 which will be challenging without sufficient resourcing.

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

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

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

3.3.1. 7 Day Services

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

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

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

3.4. Quality Impact Assessment Process

Each week the Chief Nurse and Medical Director meet to review the quality impact assessments for any new or re-submitted Cost Improvement (CIP) schemes. Where the impact on quality is felt to be of significance (high) the scheme is referred back to the CMG for refinement or

rejected. Key Performance Indicators are determined for each scheme and these are recorded as part of the scheme details on the CIP Project Management Office tracking system.

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

3.4.1. Top 3 Risks and Mitigation

Our Board Assurance Framework (BAF) sets out a list of principal risks to the achievement of our strategic objectives, their current mitigating actions and internal and external assurance sources. The BAF also identifies further mitigating actions to be taken for each principal risk.

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

Objective	**An excellent integrated emergency care system**
Risk	Emergency attendance / admissions increase without a corresponding improvement in process and / or capacity.
Mitigations	• NHS '111' helpline. • GP referrals. • Winter surge plan. • Triage by Lakeside Health for all walk-in patients to ED. • Urgent Care Centre (UCC) now managed by UHL • Internal monitoring and reporting at executive level, including ED 4-hour waits, ambulance handover >30 mins and >60 mins, total attendances / admissions. • Comparative ED performance reports for attendances / admissions. • Reworking of LLR urgent care RAP- as detailed • in COO report • Admissions avoidance directory

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

	capital plan. • Project plans and resources identified against each project.

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

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

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

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

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

4. Our Approach to Workforce Planning / Clinical Engagement

4.1. Workforce Planning Methodology

Our workforce planning process for 2017-19 has been intrinsically linked to the financial planning process which derives its income assumptions from detailed capacity and activity levels modelled for each specialty (as described in the financial and activity planning sections).

Workforce plans have also been linked to our Cost Improvement Programme and the recommendations contained within the Carter review for maximising efficiency. Our clinical management group (CMG) teams, which include clinicians and leads from operations, finance and HR, have developed their workforce plans principally based on demand and capacity assumptions. Using the forecasted WTE and pay bill out turn position as a baseline, the following process has been adopted:

1. Derive baseline WTE position
2. Determine revised establishment position based on activity and capacity requirements (which will be driving any increases/ decreases in bed or theatres or outpatient capacity, any newly designed models of care, safe staffing levels, service changes and cost improvement assumptions
3. In deriving revised establishment consider new roles as an alternative where there are risks to the supply of workforce and establish any double running requirements in the development of such roles with a particular emphasis on apprenticeships

4. Determine recruitment /reduction trajectories and based on revised establishment.
5. Where significant gaps between establishment and in post arise, forecast non contracted WTE and paybill to meet gap and identify premium expenditure required ensuring no overall breach.

Triangulate outcomes of this process by comparing:

1. Forecast paybill (financial plan) to WTE plan to ensure affordability. This has been aligned to the financial plan described in section 5 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 have predicted 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
- Changes arising from acuity reviews
- Anticipated shifts in agency and bank usage as a result of NHS Improvement initiatives
- Understanding of turnover and predicted vacancies.
- Cost improvement measures including such interventions as skill mix review and reduction in average cost per whole time equivalent.

4.1.1. Alignment with the LLR Sustainability and Transformation Plan

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

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

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

The overall paybill change is:

Year	**16/17 Forecast Outturn £**	**17/18 £**	**18/19 £**
Total Paybill	572,813	584,111	583,574
Bank	10,501	11,449	11,807
Agency	23,668	20,620	20,240
Substantive	538,644	552,042	551,527

The overall WTE change (for 17/18) is:

	Outturn 16/17 WTE	**17/18 WTE**	**WTE Change**	**% Change**	**18/19 WTE**	**WTE Change**	**% Change**
ALL STAFF	13,272	12,911	(361)	**(0.9%)**	12806	(105)	(0.8%)
Bank	368	379	11	**2.9%**	379	0	0

Agency staff (including, Agency, Contract & Locum)	277	249	(28)	**(10.2%)**	244.5	(5)	(1.9%)
Substantive WTE	12,626	12,521	(105)	**(0.8%)**	12182.7	(100)	(0.8%)

4.2. Underpinning Workforce Strategy

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

1. A comprehensive Organisation Development (OD) Plan which describes how the organisation will transform and develop through the adoption of the UHL Way. The latter incorporates methodology and an improvement strategy for achieving better change, better teams and better engagement. The better engagement methodology is underpinned by the Trust's overarching commitment to Listening into Action which has a track record of delivering small and large scale changes in the Trust
2. A medical workforce strategy which describes approaches to recruit, reshape, develop and engage the medical workforce and has led to a significant closure of Junior Medical workforce gaps
3. A Health and Well-being Strategy which describes how we will work with our workforce to develop resilience and well-being programmes to support them in delivering quality in a demanding workplace
4. A nursing workforce strategy which describes mechanisms to recruit and retain our nursing workforce including a piloting of the Nursing Associate programme, a comprehensive plan for overseas recruitment beyond Europe, a focus on retaining our European workforce
5. An e workforce strategy is in development which will ensure more efficient adoption of technology enabled processes and more comprehensive and accessible workforce analytics. The first of these in recruitment (TRAC) has been launched in 2016/17
6. An apprenticeship strategy which describes our plans to achieve the apprenticeship target of 332 in 2017/18 through new and innovative approaches to workforce and career development
7. Adoption of the LLR wide workforce strategy which includes integrated strategic workforce planning, attraction, organisational development, staff movement, capability and primary care.

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

4.3. Governance

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

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

4.4. Achievement of Efficiency- Capitalising on Collaboration

Our Workforce Cross Cutting Board has three key workstreams:

- Premium Spend - focused on robust plans and governance of agency and other non-contracted expenditure
- Nursing – focused on maximising efficiency and Nurse Specialists and nursing rotas

- Medical – focused on innovative recruitment and a robust comprehensive approach to job planning

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

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

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

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

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

This 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

4.5. New Initiatives as part of Five Year Forward View

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

1. Use of complex workforce modelling techniques to develop system wide views of workforce demand across the system (Whole Systems Partnership). System uses a principle of high level functions for determining workforce skill levels in order to understand how workforce demand may shift in the system
2. Use of functional mapping for redesigning workforce in conjunction with care pathway development
3. Investment in workforce analytics skills to develop a numeric system wide plan
4. Investment to support an LLR wide attraction strategy with a specific focus initially on apprenticeships
5. Investment in Advanced Clinical Practice
6. Investment in Seven Day Service project management to develop ways of introducing seven day workforce models at minimal cost

7. Investment in mental health and learning disability training software
8. Investment in Organisational Development including expertise in transformational change and the development of an LLR Way
9. Investment in a Workforce Planning expert to support the Urgent and Emergency Care Vanguard in the delivery of revised models of care eg Clinical Navigation Hubs, tiered approaches to Urgent Care

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

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

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

5. Our Approach to Financial Planning

5.1. Financial Forecasts and Modelling

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

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

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

As at the end of December 2016, we have yet to receive confirmation of the availability of some external capital resource and, as such, we are working to a reduced capital expenditure plan (£56.7m) in line with internally generated funds, pre-approved external loan funding for completion of the ED floor and finance lease additions.

On the 30th September 2016 the Trust received control total notification from NHSI; this was superseded by an update on 1st November 2016. The final control total issued by NHSI requires the Trust to deliver an £8.4m surplus in 2017/18, inclusive of £21.8m STF so an underlying deficit plan of £13.4m. This represents an improvement of £18.3m on the underlying financial performance of the Trust between 2016/17 and 2017/18.

In addition, the control total for 2018/19 was also confirmed. This requires the Trust to deliver a £11.6m surplus, inclusive of £21.8m STF so an underlying deficit plan of £10.2m. This represents a £3.2m improvement on the underlying financial performance in 2018/19, and £21.5m over 2 years. This is summarised in the table below.

	2016/17	2017/18	2018/19	2 yr change
	£m	£m	£m	£m
Control total pre STF	(31.7)	(13.4)	(10.2)	
Underlying Movement	**-**	**18.3**	**3.2**	**21.5**
STF	23.4	21.8	21.8	(1.6)
Control total	**(8.3)**	**8.4**	**11.6**	
Total movement	**-**	**16.7**	**3.2**	**19.9**

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

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

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

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

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

	2016/17	2017/18	2018/19
	£m	£m	£m
I&E position pre STF	(31.7)	(26.7)	(21.8)
STF	23.4	21.8	21.8
I&E position	**(8.3)**	**(4.9)**	**0.0**

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

5.2. Activity

Our 2 year income plan for 2017-19 is based upon the demand and capacity assumptions modelled for each specialty. As described within the Activity Planning section, above, this is based upon 2016/17 forecast out-turn plus underlying demand movements.

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

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

A summary activity plan by point of delivery is outlined in section 2 above.

5.3. Income

5.3.1. Clinical Income

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

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

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

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

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

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

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

5.3.2. Other Income

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

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

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

5.4. Expenditure

5.4.1. Pay

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

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

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

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

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

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

5.4.2. Non pay

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

The value of commissioner funded high cost drugs and devices in the 2017/18 plan is £100.1m which is based upon the 2016/17 forecast outturn plus £7.0m (7.0%) growth on CCG and specialised drugs. These costs are 'pass through' in nature and as such are offset in full by income but do not generate any contribution.

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

5.5. Capital and Cash

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

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

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

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

Within the draft capital plan was £26.3m expenditure on implementation of the Trust EPR business case. On the 12th December the Trust received feedback from NHSI that the current business case presents a significant affordability issue in the context of the management of the national capital budget and therefore NHSI are not in a position to recommend its approval to their Resources Committee. As a result it has been removed from the Trust capital plan. Other changes include £7.1m reduction in reconfiguration expenditure associated with delays in the programme caused by lack of capital resource in 2016/17 and change in guidance regarding how finance leases are funded meaning that the Trust is required to fund £5.3m finance lease additions from within internal resources.

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

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

5.6. Detail of major financial risks identified and mitigating actions

The major financial risks facing the Trust are captured below for which there is little mitigation. Overall, the plan to deliver a £26.7m deficit in 2017/18 and £21.8m deficit in 2018/19 carries with it significant risks with potential upside or mitigations already planned to deliver that level of financial performance.

Risk remains against the delivery of planned activity and CQUIN targets whilst the cost base of delivering the contracted activity has been set in line with final contractual agreements. Although the Trust has a clinical and operational performance requirement to deliver activity reductions in line with the STP and QIPP plans the failure to do so, where capacity exists, does not present financial risk. In addition, as a consequence of the contractual agreements agreed with commissioners, there is minimal financial risk associated with fines and penalties.

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

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

As outlined within section 2.2 and 2.4 (Capacity Planning and Operational Performance) above, there are risks associated with the delivering of the performance standards requirements, particularly for ED and RTT standards due to the imbalance between demand and capacity over the winter months when we have excessively high occupancy. This potentially leads to a financial risk associated with the STF if the control total for the Trust is changed.

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

5.7. 2018/19 Financial Planning

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

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

Contingency reserves of £5.0m overall (0.5% of turnover) are included again of which £4.0m (80%) is planned as pay and £1.0m (20%) is non-pay.

5.8. Financial Plan Summary

In summary, we are planning to deliver a £26.7m deficit in 2017/18 and achieving £33.0m CIP. The plan for 2018/19 is a £21.8m deficit and achievement of a £32.0m CIP. This is subject to finalisation of contract the detailed activity plan within the contract, associated patient care income and CMG / Directorate level budgets.

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

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

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

5.9. Efficiency savings for 2017-19

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

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

5.9.1. Beds

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

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

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

5.9.2. Theatres

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

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

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

5.9.3. Outpatients

The Outpatients workstream incorporates a trust wide scheme to improve booking processes that commenced in 2016/17. This will continue into 2017/18 alongside additional schemes on the reduction in conventional face to face follow-up appointments. All elements of the outpatient work stream will overlap with technological developments and reference back to the achievements

described in the Digital First strategy as well as the Trusts own IM&T strategy. As within the other work streams there will be a significant focus on reducing variation by ensuring the standardisation of clinic templates across the specialities.

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

5.9.4. Non-pay / Procurement Target

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

5.9.5. Estates

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

5.9.6. Corporate / Back Office

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

5.9.7. CMG led

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

5.9.8. Workforce

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

5.9.9. Quality Assurance

We have a robust quality assurance process for its efficiency programmes, as outlined earlier within the Quality section. All schemes with a value of £50k or over require a quality impact assessment (QIA) document completing as part of the Project initiation document. This is then considered by the Chief Nurse and Medical Director and the scheme is not allowed to progress unless they have both signed the scheme off.

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

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

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

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

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

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

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

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

Equally important is the work we are doing with partners to agree realistic assumptions around activity given the existing mismatch between demand and capacity, particularly within emergency care. It is vital that the initiatives (many of them jointly owned) reduce demand on services and that we find new ways of delivering more efficient and effective care – rising demand will only add to the current capacity gap as we are constrained by workforce supply, our physical estate and, of course, affordability. Moreover, we remain committed to improving our performance across NHS Constitution standards and robust demand management will be key to this.

6.1. Collaboration and the Management of Risk

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

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

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

	2016/17 £m	**2017/18** £m	**2018/19** £m
NHS Patient Care income	780.1	812.4	821.7
Teaching, R&D income	79.8	80.2	80.2
Non NHS Patient Care income	6.8	6.8	6.8
Other operating income	46.9	46.3	46.3
Total Income	**913.6**	**945.7**	**955.0**
Pay	(549.1)	(561.7)	(561.8)
Agency	(23.7)	(20.6)	(20.2)
Non Pay	(331.6)	(346.9)	(349.6)
Total Operating Expenditure	**(904.4)**	**(929.2)**	**(931.6)**
EBITDA	**9.3**	**16.5**	**23.4**
Non Operating Costs	(41.0)	(43.2)	(45.2)
Total Expenditure	**(945.4)**	**(972.4)**	**(976.8)**
Total Surplus / (Deficit) excl STF	**(31.7)**	**(26.7)**	**(21.8)**
STF	23.4	-	-
Total Surplus / (Deficit) incl STF	**(8.3)**	**(26.7)**	**(21.8)**

Appendix 2 – 2017/18 and 2018/19 Financial Plan Bridge

	Gross I&E	STF	Net I&E
	£m	£m	£m
2016/17 forecast outturn	**(31.7)**	**23.4**	**(8.3)**
Net tariff inflator (0.1%)	0.7	-	0.7
Inflation funding	(16.3)	-	(16.3)
CIP (2%)	15.5	-	15.5
Impact of HRG4+	7.0	-	7.0
Additional CNST cost (above funded level)	(3.5)	-	(3.5)
Proposed STF change	-	(1.6)	(1.6)
2017/18 baseline	**(28.3)**	**21.8**	**(6.5)**
Contract discount	(7.9)	-	(7.9)
'Transactable' QIPP	(10.0)	-	(10.0)
QIPP related cost reduction	3.0	-	3.0
Counting and coding	4.0	-	4.0
Activity growth	5.2	-	5.0
Additional CIP target	17.5	-	17.9
Vascular services pre reconfiguration	(1.5)	-	(1.5)
Minimal contingency (0.5%)	(4.5)	-	(4.5)
Additional interest costs	(1.7)	-	(1.9)
Junior doctors' contract	(2.5)	-	(2.5)
STF non-compliance	-	(21.8)	(21.8)
2017/18 plan	**(26.7)**	**-**	**(26.7)**
Net tariff inflator (0.1%)	0.8	-	0.8
Inflation funding	(18.3)	-	(18.3)
CIP (2%)	16.2	-	16.2
Additional CNST cost (above funded level)	(4.0)	-	(4.0)
2018/19 baseline	**(31.8)**	**-**	**(31.8)**
Additional CIP target	15.8	-	15.8
Minimal contingency (0.5%)	(4.7)	-	(4.7)
Other cost pressures	(0.9)	-	(0.9)
2018/19 plan	**(21.8)**	**-**	**(21.8)**

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

	2017/18 £m	**2018/19** £m
Facilities	8.0	5.2
Aseptic Suite	0.5	-
YDU Refurbishment	0.5	-
MES Installation Costs	1.5	1.5
IM&T - general	3.5	3.0
IM&T - Nervecentre	0.5	-
Medical Equipment	4.4	3.0
Radiotherapy CT Scanner	0.6	-
Donations	0.3	0.3
Replacement, Repair & Maintenance projects	**19.8**	**13.0**
MES Finance Lease	5.3	5.0
TOTAL OPERATIONAL CAPITAL	**25.1**	**18.1**
Emergency Floor	7.0	-
EMCHC relocation	2.8	3.2
ICU Service Reconfiguration	12.0	3.4
Wards/Beds LRI	-	6.3
Wards/Beds GH	-	6.2
Imaging GH	0.1	0.5
Treatment Centre	0.6	4.0
ITU LRI	0.1	7.0
Women's Services	0.8	4.4
Childrens' Hospital	1.0	8.3
Theatres LRI	0.1	4.4
Additional Beds	3.7	11.9
Outpatients LRI	-	0.5
Pathology	-	0.3
Supporting infrastructure	1.0	0.9
Reconfiguration projects	**29.3**	**61.2**
EPR	-	-
TOTAL STRATEGIC CAPITAL	**29.3**	**61.2**
TOTAL CAPITAL EXPENDITURE	**54.4**	**79.2**
Funded by:		
Depreciation	*31.5*	*31.5*
Donations	*0.3*	*0.3*
DH Loan Funding - Agreed	*7.0*	*-*
DH Loan Funding - Proposed	*15.5*	*47.4*
Total Capital Funding	***54.4***	***79.2***

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

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20th January 2017

Sent via E-mail

Mark Mansfield
Operational Regional Finance Director
NHS Improvement (Midlands & East)

Jeff Worrall
Portfolio Director
NHS Improvement (Midlands & East)

Dear Mark and Jeff,

UHL Annual Operating Plan 2017/18 and 2018/19

I am writing alongside the formal submission of our Annual Operating Plan (AOP) for 2017/18 and 2018/19 to give you further details of the demand and capacity risk, to reconfirm our position on the financial control totals for these years and to describe our assumptions around the availability of capital and cash.

Demand and Capacity

For a number of years UHL has operated with a mismatch in the demand for our services and the capacity in place to deliver against that demand. UHL has experienced this again within 2016/17 and a continuation of a mismatch for 2017/18 is described within the AOP as a possible downside scenario.

Any mismatch can have significant implications for the delivery of our strategy and can have direct impacts within the quality of care, patient experience, performance, finance or the delivery of CIP.

In order to fully understand the impact of running our services at differing levels of capacity, an in depth review of demand and capacity for our inpatient and theatre services has been completed. The scenarios simulate the effect current contracted and increased demand for 2017/18 has on performance of both RTT and A&E 4 hour standards.

The analysis is formulated on historical actual demand and capacity, linked to performance, overlaying assumptions about 2017/18 anticipated demand in a number of scenarios. This work then integrates assumptions about successfully delivering internal productivity and efficiency improvements to increase capacity, (such as length of stay reductions) and 2017/18 community-wide demand management strategies as they stand today.

This complex and detailed analysis built from HRG and specialty mapped data demonstrates the impact an imbalanced demand and capacity plan would have on our ability to respond to access standards. At a high level, the model indicates that increases in demand for inpatient services above 152,746 spells/admissions (with current case mix and specialty spread) would lead to further deterioration in emergency and RTT standards and that this is a material issue.

The demand and capacity model is built up from demand, capacity, and occupancy at a specialty level. The scenarios have been run at an aggregated level in order to understand the overall picture for UHL as a whole.

There are 3 main scenarios that have been modelled. In all scenarios except full delivery, the level of occupancy and its relationship to access targets is the output of the modelling. As the full delivery scenario has a defined occupancy of 84% (the level required to deliver uninterrupted patient flow), the output for that scenario is the number of patients that demand management would have to influence.

- **Full delivery scenario** – this scenario models the movement of occupancy to a level where bed accessibility was no longer an issue for the Trust (84%) and then we would forecast the delivery of 4 hour wait at 95% and RTT at 92%. Clearly, this is a highly unlikely scenario, but it is important to note it as it is the scenario required to be compliant with national targets. The demand and capacity gap within this scenario for 2017/18 is 4,121 patients.

- **Contract Scenario** – this scenario assumes that the contract happens as planned, therefore assuming that QIPP within the 2017/18 contract delivers, which mitigates much of the growth in demand and that UHL delivers the required level of internal bed efficiency identified within the STP. If the beds are not removed as cost savings (and this will be a risk to the 2017/18 CIP) this will move the occupancy of UHL to 85.7% from the current 87.5%. At this occupancy there will be no gap in demand and capacity, but obviously this is an occupancy that remains 3.5% from the required to deliver the reliable flow required to achieve national targets. Such a reduction in occupancy would lead to A&E 4 hour standard improving in the trajectory shown below although this trajectory also factors in a reduction in non-admitted breaches from the improvement of flow and from the new ED. The RTT and Cancer trajectories are also shown for this scenario. We expect to maintain compliance with the diagnostic standard throughout the year.

Month	April	May	June	July	August	September
RTT Performance	92.00%	93%	93%	92.78%	91.14%	92.45%
Cancer 62 day	83.14%	84%	85%	84.76%	85.40%	85.78%
Diagnostics	0.88%	0.88%	0.88%	0.88%	1.24%	0.88%
ED	78.49%	75.49%	81.90%	83.40%	84.10%	83.67%
	No Improvement due to ED new floor					
Month	**October**	**November**	**December**	**January**	**February**	**March**
RTT Performance	93.50%	92.70%	91.40%	91.20%	91.45%	92.04%
Cancer 62 day	85.78%	83.46%	85.00%	81.45%	81.27%	83.98%
Diagnostics	0.88%	0.88%	1.19%	0.88%	0.88%	0.88%
ED	83.67%	83.14%	79.90%	80.42%	82.90%	83.14%

- **Downside scenario** – this scenario assumes that only 50% of the QIPP delivers and the forecast demand is 50% between the Trust "bottom up" forecast and what CCGs have contracted for pre-QIPP. Again, if beds are not removed (risk to CIP), this scenario would lead to a stand-still in the occupancy of the organisation (87.5%), meaning that performance would likely be at similar levels to the out-turn at the end of 2016/17 as shown in the below trajectories.

Month	April	May	June	July	August	September
RTT Performance	91.60%	92%	92%	92.38%	92.00%	91.46%
Cancer 62 day	82.10%	84%	85%	83.20%	85.40%	85.00%
Diagnostics	0.98%	0.98%	0.98%	0.98%	1.60%	0.98%
ED	78.49%	75.49%	79.80%	80.14%	81.45%	82.50%
Month	**October**	**November**	**December**	**January**	**February**	**March**
RTT Performance	92.00%	92.38%	91.46%	90.89%	89.48%	89.32%
Cancer 62 day	85.00%	82.40%	84.60%	79.60%	80.40%	82.30%
Diagnostics	0.98%	0.98%	1.23%	0.98%	0.98%	0.98%
ED	79.50%	78.90%	77.40%	76.80%	79.62%	81.40%

As you know, we submitted provisional STF trajectories alongside our initial draft AOP which complied with the national guidance, noting that we would submit final trajectories when our demand and capacity modelling was complete post-contract. Therefore our formal trajectory submission should now be taken to be that shown within the Contract Scenario above.

Financial Control Totals

As previously described within Paul Traynor's letter of 24th November 2016 to Mark Mansfield, UHL cannot accept the financial control totals for 2017/8 and 2018/19 as they are inconsistent with our financial strategy and undeliverable given the stretch they require.

The scale of improvement required to deliver the control totals represents a material reduction in either the structural deficit of the organisation without the required investment or a high risk operational deficit reduction with an ambitious CIP programme already planned to improve this over and above the level required in national guidance.

The published tariff, completed negotiations around clinical contracts and the announcement of CNST contributions have all contributed to the assessment of our position alongside internal factors such as CIP and current run rates. This assessment highlights a number of different assumptions from perhaps those considered when setting control totals:

- CNST premium. The Trust's increase is £3.7m with only £0.2m provided for within the inflationary uplift
- Interest costs. The additional costs associated with operating a deficit including the interest costs of borrowing are not accounted for in setting the control totals for such organisations
- Junior Doctors: Most acute providers will have an additional cost next year in implementing the new contract. Again, this does not seem to be covered in the inflationary uplift or considered as part of setting the control total
- Impact of reconfiguration: As you are aware, a fundamental part of financial recovery and clinical sustainability for UHL is the reconfiguration from 3 to 2 sites. Our progress has been slowed in 2016/17 by a lack of overall capital and, as a result, we have an increased vascular cost in 2017/18 in advance of ITU consolidation
- We have a number of cost pressures including the impact of ceasing the failing Interserve contract which needs to be managed in 2017/18

Despite the difficulty we have in meeting the control totals it is recognised that financial improvement is required. The AOP describes an improved financial position that is summarised below and recognises the forfeiting of the access to STF as a result of not agreeing to control totals:

£m	I&E Position	STF	Net
2016/17	(31.7)	23.4	(8.3)
2017/18	(26.7)	-	(26.7)
2018/19	(21.8)	-	(21.8)

This year-on-year improvement and overall reduction in deficit is consistent with the Trust's Financial Strategy (recovery trajectory), with the remaining structural deficit of approximately £25m being directly linked to the current 3 site operation.

Overall, good progress is being made in terms of deficit reduction, from £41m in 2014/15 to a proposed £26.7m and £21.8m in 2017/18 and 2018/19 respectively. As already noted, the acute reconfiguration programme will eradicate the remaining deficit in due course, provided that the required capital investment is forthcoming, as described in the LLR Sustainability and Transformation Plan.

Capital and Cash

The 2017/18 and 2018/19 capital plans are predicated on external funding being made available to maintain progress within the previously mentioned acute reconfiguration programme. The total external capital requirement is £22.6m for 2017/18 and £47.4m for 2018/19. This will support UHL with addressing the structural deficit that is directly linked to the current 3 site operation.

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

Conclusion

The contents of this letter have been approved by the UHL Trust Board as part of the sign-off process for the Annual Operating Plan. I hope that it is helpful in clarifying the demand and capacity position of the Trust post the contracting round, and therefore our expectations in terms of performance against the three key access standards. This letter also confirms the Trust's previous position that we cannot accept the proposed control total and sets out what we are able to achieve by way of further financial improvement over the two year period.

Yours sincerely,

John Adler
Chief Executive

CC: Paul Traynor, Chief Financial Officer, UHL
Laura Mills - Head of Business and Finance, NHS Improvement
Alexandra Coull - Head of Business and Finance, NHS Improvement