UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

TRUST BOARD

Annual Operational Plan for 16/17

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Context

Our annual operational plan sets out how we will deliver local and national priorities in meeting the commitments and vision set out in the NHS Five Year Forward View in 'Delivering the Forward View: NHS Planning Guidance for 2016/17 – 2020/21'.

Crucially, our plan describes the steps we will take to ensure our organisation returns to a sustainable position, operationally and financially, and how we will improve the quality of care to the population of Leicester, Leicestershire and Rutland and beyond.

We submitted our first draft plan to the NHS Improvement (NHSI) in February, which consisted of:

- A One-Year Plan Summary (with a focus on quality and finance)
- A financial plan
- An activity plan
- A workforce plan

NHSI provided feedback on our submission and confirmed no major changes were required. The NHSI were particularly impressed with the quality elements of our plan. However, a number of elements remain work in progress and/or lack full assurance at this stage: contract negotiations with commissioners are ongoing as is the work being done to close the gap between demand and capacity, and there is uncertainty around capital availability.

Despite some slippage nationally on the publication of key documents like the NHS standard contract and the revised national tariff, we are required to submit a Trust Board approved and commissioner aligned plan on the 11th April 2016.

Questions

1. Has our plan been considered by the necessary stakeholders as part of the development and approval process?
2. What are the key areas still being worked on?

Conclusion

1. A number of key stakeholders have been involved and engaged in the development of our plan, including patients, patient representatives (including the three local Healthwatch organisations), members of the public, our clinical management groups (CMGs), corporate executives and their respective teams, the clinical senate and local partners including Leicestershire Partnership Trust (LPT). Our plan has also been considered and endorsed by the executive board and groups that include the Integrated Finance and Performance Committee (IPFIC). Lastly, our latest plan incorporates / accounts for the most recent feedback from NHSI.
2. Our plan is subject to further refinement over the coming weeks as key elements are finalised, all of which are inter-related, including:
   - ✓ demand and capacity work, and the resulting implications for performance and quality
   - ✓ workforce plans to ensure these align with demand assumptions and are affordable
   - ✓ contract negotiations with commissioners, which has implications for our financial assumptions in particular.

Input Sought

The Trust Board is asked to:

1. Consider and approve the latest draft Annual Operational Plan, noting:
2. Work on demand and capacity is ongoing – we do not, at this stage, have a balanced plan in this regard. Very few acute trusts, if any, have a balanced plan.
3. Consider and approve the financial plan subject to finalisation of contract negotiations with commissioners, associated patient care income and CMG/Directorate level budgets including:
   3.1. Commitment to delivery of the £8.3m income and expenditure deficit control total which includes planned receipt of £23.4m Sustainability and Transformation (S&T) funding
   3.2. Commitment to deliver £35m CIP
   3.3. Plan to breach the current agency ceiling target of £20.6m with expenditure planned at £28.3m
   3.4. Capital expenditure programme of £108.3m including the external borrowing requirement of £48.5m.
4. Delegate authority for the final review and sign off of the Annual Operational Plan (when finalised over the coming weeks) to Mr Karamjit Singh, Chairman, and Mr John Adler, Chief Executive Officer, ahead of the formal submission to the NHSI on the 11th April.
5. Receive the final copy at the May Trust Board.

For Reference

Edit as appropriate:

1. The following objectives were considered when preparing this report:
   Safe, high quality, patient centred healthcare [Yes]
   Effective, integrated emergency care [Yes]
   Consistently meeting national access standards[Yes]
   Integrated care in partnership with others [Yes]
   Enhanced delivery in research, innovation & ed' [Yes]
   A caring, professional, engaged workforce [Yes]
   Clinically sustainable services with excellent facilities [Yes]
   Financially sustainable NHS organisation[Yes]
   Enabled by excellent IM&T [Yes]
2. This matter relates to the following governance initiatives:
   Organisational Risk Register [a number of items are inherently linked to our Annual Operational Plan]
   Board Assurance Framework [a number of items are inherently linked to our Annual Operational Plan]
3. Related Patient and Public Involvement actions taken, or to be taken: Our Annual Operational Plan (and priorities within) will again be discussed with the Members Engagement Forum at the next quarterly session.
4. Results of any Equality Impact Assessment, relating to this matter: Scheduled date for the next paper on this topic: [N/A]

Annual Operational Plan (2016/17)

1. Context

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. We are actively engaged with key stakeholders to implement NHS policy to improve health services in the local area through a range of formal and informal partnerships.

Our five-year plan is ambitious, as is that of the wider health economy's Better Care Together (BCT) plan, which reflect the scale of the challenge. In 2015, we launched our 5 Year Plan "Delivering Caring at its Best", which set out the vision for Leicester's Hospitals.

In the next five years, we will become a Trust that is renowned for placing quality, safety and innovation at the centre of service provision. We 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.

"Delivering Caring at its Best" reaffirmed the Trust's strategic objectives, detailed in the strategic triangle below.

2. Our Strategic Objectives - Draft Annual Priorities

Each year we set out our Annual Priorities in pursuit of our Strategic Objectives. For 2016/17, these are:

1) Safe, high quality patient centred care - 2016/17 Quality Commitment (see 5.3.2)

(a) Reduce avoidable mortality and re-admissions through screening of deaths and use of re-admissions toolkit
(b) Reduce harm through core 7 day standards, new EWS and observation processes and safer use of insulin
(c) Improve patient experience through involving them in their care, better end of life planning and improvements in outpatients
(d) Prepare effectively for the 2016 Care Quality Commission inspection
(e) Develop a high quality in-house Estates and Facilities Service

2) An excellent, integrated, emergency care system.

(a) Reduce ambulance handover delays in order to improve patient experience, care and safety.
(b) Fully utilise ambulatory care to reduce emergency admissions and to reduce length of stay (including ICS)
(c) Develop a clear understanding of demand and capacity to support sustainable service delivery and to inform plans for addressing any gaps.
(d) Diagnose and reduce delays in the inpatient process to increase effective capacity

3) Services which consistently meet national access standards

(a) Maintain 18 week RTT and diagnostic access standard compliance
(b) Deliver all cancer access standards sustainably

4) Integrated Care in partnership with others

a) Work with partners to deliver year 3 of the Better Care Together programme to ensure we continue to make progress towards the LLR vision (including formal consultation)
b) Develop new and existing partnerships with a range of partners including tertiary and local service providers to deliver a sustainable network of providers across the region
c) Progress the implementation of the EMPATH Strategic Outline Case

5) An enhanced reputation in research, innovation and clinical education

a) Deliver a successful bid for a Biomedical Research Centre
b) Support the development of the Genomic Medical Centre and Precision Medicine Institute
b) Develop and exploit the OptiMeD project, scaling this up across the Trust.
c) Improve the experience of our medical students to enhance their training and improve retention, and help to introduce the new University of Leicester Medical Curriculum.
d) Develop and implement our Commercial Strategy to deliver innovation and growth across both clinical and non-clinical opportunities.

6) A caring, professional, passionate and engaged workforce

a) Develop an integrated workforce strategy to deliver a flexible multi-skilled workforce that operates across traditional organisational boundaries and enhances internal sustainability.

b) Deliver the Year 1 Implementation Plan for UHL Way, ensuring an improved level of staff engagement and a consistent approach to change and improvement
c) Develop training for new and enhanced roles i.e. Physician's Associates, Advanced Nurse Practitioners, Clinical Coders.
d) Deliver the recommendations of "Freedom to Speak Up" Review to further promote a more open and honest reporting culture.

7) A clinically sustainable configuration of services, operating from excellent facilities

a) Complete and open Phase 1 of the new Emergency Floor
b) Deliver our reconfiguration business cases for vascular and level 3 ICU (and dependent services)
c) Develop and deliver a new model of care for outpatients, including a single point of contact, and implement new models of care for medicine and surgery that support our reconfiguration plans
d) Develop outline business cases for our integrated children's hospital, women's services, and planned ambulatory care hub.

8) A financially sustainable NHS Trust

a) Deliver our CIP target in full
b) Reduce our deficit in line with our 5 year plan
c) Reduce our agency spend to the national cash target
d) Implement service line reporting through the programme of service reviews to ensure the ongoing viability of our clinical services
e) Deliver operational productivity and efficiency improvements in line with the Carter Report

9) Enabled by excellent IM&T

a) Improve access to and integration of our IT systems
b) Conclude the EPR business case and start implementation

3. Regulation and Inspection

The Care Quality Commission (CQC) is the independent regulator for health and social care in England.

On Monday 30th November CQC inspectors visited our Emergency Department (on a major internal incident). It was a very challenging day and the inspectors witnessed over 100 patients in the department. Inspectors noted a number of concerns which they subsequently followed up by applying Conditions to UHL's registration with the CQC. Progress has been made against these Conditions as reflected at the second Risk Summit.

The CQC will conduct a comprehensive inspection of UHL in June (20th – 24th) 2016. This review will look at all of the core services that the Trust provides at the various locations, to make a judgement of overall performance providing a rating. As part of the planning for the inspection, the Trust will be submitting a wide variety of data at Trust and service level as well as undertaking a self-assessment against the key lines of enquiry. In preparation the Trust has completed quality inspection visits in the wards and departments and has held engagement events on each of the sites for staff. A variety of task and finish groups have been established to oversee improvement plans. A communication plan has been developed to keep all staff and external stakeholders informed about the forthcoming inspection. The CQC Executive Delivery Group meets weekly to monitor progress with preparation for the forthcoming inspection.

It is anticipated that the CQC report will be available in the autumn of 2016.

4. Our Approach to Activity Planning 2016/17

4.1. Demand Activity Planning

The demand activity plans have been developed by our Clinical Management Groups (CMGs) with the support of the Business Intelligence and Finance teams. Using the 15/16 forecast outturn, the CMGs submitted demand activity projections with changes driven by the following assumptions:

- Demographic growth
- Removal of 15/16 activity delivered non recurrently
- New RTT backlog clearance (non-recurrent)
- Growth in activity in excess of demographics
- Repatriation / Transfers Out e.g. BCT
- FYE of 2015/16 developments (where not already accounted for)
- New funded developments
- Internal Changes in setting (e.g. Inpatient to Day Case)
- Other activity movements

We have worked closely with commissioners to ensure a joint understanding of demand as well as the likely impact of various initiatives and service changes that may help reduce the demand on our services.

A Trust level summary of the changes between 15/16 activity (the 'forecast outturn') and 16/17 expected demand are shown in Table 1 – UHL and Alliance Demand.

Table 1 – 16/17 Demand (figures are subject to change following contract negotiations with our commissioners)

GRAND TOTAL - UHL + ALLIANCE			
Activity Line	**15/16 Forecast Outturn**	**16/17 Plan**	**Growth Assumption**
Consultant led Total 1st Outpatient attendances	301,256	310,968	3.2%
Consultant led Follow up outpatient attendances	591,472	604,616	2.2%
Total Elective admissions (spells)	127,151	132,178	4.0%
Total Non-elective admissions (spells)	121,908	124,774	2.4%
Total A&E attendances	226,393	234,487	3.6%

GRAND TOTAL - ALLIANCE			
Activity Line	**15/16 Forecast Outturn**	**16/17 Plan**	**Growth Assumption**
Consultant led Total 1st Outpatient attendances	31,677	33,405	5.5%
Consultant led Follow up outpatient attendances	66,209	72,620	9.7%
Total Elective admissions (spells)	10,733	13,337	24.3%
Total Non-elective admissions (spells)	0	0	
Total A&E attendances	0	0	

GRAND TOTAL - UHL			
Activity Line	**15/16 Forecast Outturn**	**16/17 Plan**	**Growth Assumption**
Consultant led Total 1st Outpatient attendances	269,579	277,563	3.0%
Consultant led Follow up outpatient attendances	525,263	531,996	1.3%
Total Elective admissions (spells)	116,418	118,841	2.1%
Total Non-elective admissions (spells)	121,908	124,774	2.4%
Total A&E attendances	226,393	234,487	3.6%

Notes

1. We are jointly (commissioners and the Trust) forecasting an increase in all forms of activity next year – elective, emergency, cancer and specialist care.
2. The level of expected demand in 16/17 (shown in table1) does not include any QIPP assumptions (initiatives that help reduce the level of demand on services while improving quality). However, the application of QIPP is not expected to materially change the demand / growth profile.

4.2. 2016/17 Capacity Planning – Beds

For a number of years, we have operated with a mismatch in demand and capacity. This position has worsened recently due to:

- increasing demand across elective, cancer, specialist and, in particular, emergency care services;
- beds being closed / capacity being reduced to support essential CQC compliance / quality standards; and,
- enabling works for our Intensive Care Unit (ICU) and Vascular clinical strategy.

An unbalanced plan can have significant implications for quality of care, patient experience, performance, finance, delivery of cost improvement (CIP) and our overall strategy.

Within our demand and capacity model for 16/17, there are three key determinants that determine the overall position and subtle changes to these can have a significant impact on the required number of beds:

1. Demand (and the associated activity this brings to the Trust) in line with our assumptions described above.
2. Occupancy – we have modelled this at 90%
3. Length of Stay (LOS) – we have modelled this using our current LOS in the absence of clear, robust plans to further this reduce.

In our model, we have also included the impact of five different types of interventions, which have helped to close the gap, but not fully:

1. External actions e.g. referral and admission avoidance
2. Internal actions e.g. use of ambulatory care models and admission avoidance
3. Internal action e.g. LOS improvements and greater use of community alternatives
4. Movement of activity (from the Trust to community settings)
5. Other e.g. service changes that impact on available capacity e.g. ICU changes.

The model currently suggests we still have a gap / mismatch between expected demand and capacity (for beds) at the Leicester Royal Infirmary (LRI) and Glenfield General Hospital (GGH) sites, particularly over the winter months when pressures on emergency care services and inpatient beds are greatest. We continue to explore all options with partners and commissioners to close the gap further by developing (and assessing) additional schemes that will help reduce emergency demand and/or outsource more elective work to the independent sector and/or the Alliance.

In summary, we have improved insight into our capacity gap this year and will take every effort with LLR partners to close the gap before winter 2016.

4.3. 2016/17 Capacity Planning – Theatres

We are also 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 anesthetic to local anesthetic.
3. Increasing the volume of daycase surgery.
4. Reviewing the opportunity to transfer activity into the community.

4.4. Delivery of operational performance standards

The Trust 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. We will start with our day ward and then progress to ward 7 at the LRI and ward 24 at the Glenfield hospital.

4.4.1. 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, emergency attendances and admissions continue to rise in the Emergency Department (ED) and the Clinical Decisions Unit (CDU) at the GGH. The high level of activity puts a lot of pressure on the clinical teams in both departments and some patients are waiting too long for admission.

The LLR health system has reworked its action plan to focus on three key items: reduction in emergency attendance and admissions which are being led by West Leicestershire CCG, improvement in internal process which is being led by UHL and improvement in discharge which is being led by Leicestershire Partnership NHS Trust (LPT).

Our trajectory for improvement recognises the challenging position we are in. We are committed to reducing attendance and admissions whilst also increasing the capacity available within UHL to care for these patients. In the spring of 2017, the new emergency floors opens and we want to be in the position where we have reduced demand and improved performance and care before the service moves into the new build.

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

The Trust has remained compliant with the incomplete standard during 2015-16, 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. Going into 2016-17, there are risks to maintaining this standard due to known capacity constraints in a small but significant number of specialities. These fall within the same 30+ specialities detailed earlier, as requiring more detailed capacity planning for the coming year, the largest of these being orthopaedics, adult and paediatric ENT and gastroenterology.

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. The LLR Alliance is another way of increasing elective capacity.

Pathway changes will also continue to play an important part in supporting delivery of the RTT standard. For example, the Back Pain triage service within orthopaedics ensures patients are seen quickly and directed to suitable alternative services (where appropriate). This helps reduce patient waiting times, provide a more convenient service and helps to free-up consultant time in secondary care for operating.

4.4.3. 52 week waits

The 231 orthodontics patients who have waited in excess of 52 weeks continue to be a focus for very senior conversations across the health system. We remain committed to providing these patients with suitable treatment either within the NHS or the Independent Sector. It is important that UHL, CCGs, NHSE and the NHSI continue to work together to identify ways to provide care to these patients.

With the support of NHS Improvement and NHS England, we have identified two private providers and enlisted support from 6 other NHS trusts to treat these patients. There is currently a trajectory / plan to reduce the 52 week waits to 100 by the end of the year. It is hoped that as other providers contracts are signed this can be revised down further still. The planned actions are given a high priority in the organisation and this workstream is overseen by the Chief Executive.

Our aim is to ensure that by 31st March 2017 no patients wait longer than one year and so the Trust will continue to source orthodontic capacity.

4.4.4. Diagnostics

We anticipate starting 2016-17 in a compliant position against the national diagnostic standard. Issues faced in endoscopy during 2015-16 have been resolved by a clear action plan, supported by the Intensive Support Team and NHSIQ. During 2016-17, the strategy for endoscopy includes further utilisation of available capacity within the Alliance, increased use of 3 session days and further maximising internal capacity.

4.4.5. Cancer

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

2ww	This is expected to be back on track throughout 2016-17. We will be planning for circa 11% increase in 2ww referrals during the coming year. This is based on forecast outturn for 2015-16. The work carried out with CCGs and GPs in 2015-16 to improve the use of standardised referrals will continue. A pilot to improve access to urgent consultation for lower GI referrals is planned for late 2015-16, early 2016/17
31 days	Access to theatres in key specialities 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 a detailed tumour site action plan, managed jointly with the CCGs. This is overseen by a joint Cancer Board Chaired by the CCG SRO. A 62 day backlog trajectory to ensure achievement of this standard by end September 2016-17 is in place, however, we aim to deliver this earlier (in July). The key themes to the plan are: • Demand and capacity (including: physical and staffing) • Detailed process management • Patient choice

The weekly Cancer Action Board which is chaired by the Director of Performance and Information has representation from all tumour site General Managers, support services and Cancer Clinical Leads.

During late 2015-16 and early 2016-17 the programme of 'Next steps' for cancer patients in 3 key tumour sites will progress, this aims to ensure all patients on a cancer pathway leave any attendance with their next date booked.

Capacity planning for cancer will anticipate a 9% increase in 2016-17 across all the tumour sites; this is based on the anticipated increase in 2ww referrals and subsequent conversion to 62 day treatment.

In partnership with LPT there has been an expansion and enhancement of the Intensive Community Support (ICS) service that will support more patients to be looked after in the right place, and improve flow in our hospitals. The ICS model of care operates across City and County, providing care for patients with complex needs, in their own homes. This service development will also see an expansion of LPT's in-reach team at UHL.

Working in collaboration with LLR commissioners and LPT we will continue to develop:

- Winter resilience plans - including the 'right sizing' programme detailed in Section 4, above.
- Arrangements for managing unplanned changes in demand
- Joint plans with East Midlands Ambulance Service (EMAS) to improve processes to ensure optimal handover efficiency and that patients enter the correct point of access to emergency care.
- Other areas for improvement in the whole emergency care pathway through both internal and LLR wide meetings.

5. Our Approach to Quality Planning

5.1.1. Our Quality Improvement Priorities

Our draft Quality Commitment for 2016/17 outlines our ambition to improve patient outcomes, reduce harm and use of patient feedback to drive improvements to services and care. This is summarised in the graphic below.

5.2. Local and National Priorities

In finalising our plans to improve quality throughout 16/17, we have taken into account both local and national priorities across the three key domains of quality (patient experience, clinical effectiveness and safety) which are reflected in our Quality Schedule.

We will continue to use our triangulated patient feedback (using patient survey results, complaints, “message to matron”; NHS choices, etc) to identify areas for improvement - reducing waiting times being the top area identified in 15/16. Increasing our Friends and Family Test coverage in the Emergency Department will be an area of focus for 16/17.

We have made good progress with improving our performance in the Sentinel Stroke National Audit Programme during 15/16 and are aiming to further improve and achieve an overall B in 16/17. Another priority for 16/17 will be to improve the care of patients with a fractured neck of femur – meeting the ‘time to theatre’ standard has continued to be a challenge throughout 15/16.

We are also committed to meeting the national requirement to publish avoidable mortality and will be implementing a new process for ‘screening’ and ‘retrospective care records review’ to ensure our data is accurate and leads to appropriate learning and actions, where applicable.

In addition, we will further embed all aspects of the Duty of Candour requirements.

With respect to the Commissioning for Quality and Innovation (CQUIN) arrangements for 16/17, our programme will likely include:

- Improving compliance with the sepsis and acute kidney injury care bundles, either as national or local CQUIN schemes.
- Further roll out of our Bereavement Support follow up service for the relatives and carers of patients who die in our hospital
- Improving the quality of care for children as they transition to adult services
- Improving the quality of care for patients at end of life
- Patient information to support informed consent
- Introduction of staff health and wellbeing initiatives
- Reduction in antibiotic consumption

5.3. Safety Overview

Our commitment to safety and quality is unwavering. The safety of our patients is our principal concern and we are relentless in our focus on reducing avoidable harm. But as healthcare becomes more complex, so the threats to patient safety increase which is why we are now seeking to tackle safety improvement in many ways. Our safety work includes seeking to better collect, understand and use data, to focus on the crucial activities which will reduce avoidable death and harm, and to implement actions and learning from previous safety incidents. But much more than this, our safety work is also about board leadership, safety culture and human factors work, all of which we are stepping up year on year.

As part of our commitment to improving patient safety, UHL signed up as a member of the national 'Sign Up to Safety' campaign in September 2014. We are now one of more than 300+ organisations that have signed up to the campaign taking part in every care setting in the NHS in England. The 'Sign Up to Safety' campaign aims to halve avoidable harm and save an additional 6000 lives over the next three years.

As part of the 'Sign Up to Safety' campaign, the Trust has pledged to:

- Put patient safety first
- Focus on continuous learning
- Be honest and transparent

- Collaborate with others to share learning and good practice
- Be supportive and help people understand why things go wrong

In support of the campaign in 2015, we submitted a successful bid and were allocated the full 10% incentive payment of £1,581,587 (which was one of the largest successful bids in England) from the National Health Service Litigation Authority (NHSLA) for funding to support the delivery of its safety improvement plan.

Our 'Sign up to Safety' safety improvement plan priorities are aimed at transforming the care of the deteriorating patient by improving recognition, escalation, response and effective on going management. Our Safety Improvement Plan priority of 'The deteriorating patient – womb to end of life' is considered integral to our existing and future priorities in our Quality Commitment for 16/17.

5.4. Human Factors

We recognise the importance of the role of Human Factors (HF) in improving patient safety and quality of care. The National Human Factors Concordat: published by the National Quality Board (NQB) outlines a wider understanding of HF principles and practices will contribute significantly to improving the quality of care for patients. The Concordat describes HF in Healthcare as *"Enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities and application of that knowledge in clinical settings".*

In order to prioritise HF at UHL, a Patient Safety Improvement Specialist with a background in HF and has been appointed to support a number of projects linking in with academics in the University of Leicester including;

- The roll out of safety briefings or 'huddles' across the Trust to improve communication and Situational Awareness (the ability to understanding what is going on with each patients and to be able to anticipate and plan for future risks)
- In-depth reviews of wards to understand factors affecting patient safety using HF framework
- Patient safety culture improvement interventions to improve speaking up in Theatres
- The development of e-learning and face to face training to develop staff's understanding of HF and its application in Healthcare.

5.5. Our Approach to Quality improvement

5.5.1. Improvement Methodology

In reflecting best practice the Trust have developed the "UHL Way" to provide a comprehensive staff engagement and improvement framework and tools.

The UHL Way is a way of accelerating Listening into Action - building better teams; improving the things we really care about in a planned and systematic way to enhance our chances of success; and most of all it's a way of delivering "Caring at its Best".

The UHL Way will also provide the framework within which the Trust manages change in a consistent and sustainable way, and in a way that engages and empowers the staff involved in, and affected by that change. The UHL Way is about embedding a culture of continuous improvement across the Trust which will in turn improve the quality of care we provide to patients, reduce harm, increase efficiency and effectiveness and support cost reduction.

In summary, the three components to the UHL Way are:

1. Better Engagement: continuing Listening into Action
2. Better Teams: targeted improvement and development
3. Better Change: Adopting the best in change and improvement methodology

This is all underpinned by the UHL Academy, which will provide hands on support, training and development in leading and managing change and quality improvement. There will be a web portal with direct access to learning tools, materials, publications and case studies and will be supported by Faculty of Specialists (working system-wide) with skills in organisational development, change, quality improvement, patient safety and human factors. It will also maintain strong links with external partners including LIIPS (Leicester Improvement, Innovation and Patient Safety Unit) and East Midlands Leadership Academy.

5.5.2. Named Executive Responsible

The named Executive lead for quality improvement is joint between Chief Nurse and Medical Director.

5.5.3. Identification of Top 3 Risks and Mitigation

Our Board Assurance Framework (BAF) sets out a list of strategic risks, current mitigating actions and internal and external assurances. The BAF also identifies further mitigating actions to be taken for each risk area. The following table summarises the 3 top risks (based on risk score).

Objective	**An effective and integrated emergency care system**
Risk	Emergency attendance / admissions increase
Mitigation	• NHS '111' helpline • GP referrals • Local / National communication campaigns • Winter surge plan • Triage by Lakeside Health (from 3/11/15) for all walk-in patients to ED. • Urgent Care Centre (UCC) now managed by UHL from 31/10/15 • Admissions avoidance directory • 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 summaries for attendances and admissions.

Objective	**A clinically sustainable configuration of services, operating from excellent facilities**
Risk	Limited capital envelope to deliver the reconfigured estate, which is required to meet the Trust's revenue obligations
Mitigation	• Five year capital plan and individual capital business cases identified to support reconfiguration • Business case development is overseen by the strategy directorate and business case project boards manage and monitor individual schemes. • Capital plan and overarching programme for reconfiguration is regularly reviewed by the executive team. • Capital Investment Monitoring Committee monitors the programme of capital expenditure and ensures early warnings to issues. • Monthly reports to Executive Strategy Board (ESB) and Integrated Finance and Performance Committee (IFPIC) on progress of reconfiguration. • Highlight reports produced for each project board. • Revised programme timescale approved by IFPIC.

Objective	**A clinically sustainable configuration of services, operating from excellent facilities**
Risk	Insufficient estates infrastructure capacity and the lack of capacity of the Estates Team may adversely affect major estate transformation programme
Mitigation	• UHL reconfiguration programme governance structure aligned to BCT • Reconfiguration investment programme demands linked to current infrastructure. • Estates work stream to support reconfiguration established • Five year capital plan and individual capital business cases identified to support reconfiguration • Survey to identify high risk elements of engineering and building infrastructure. • Monthly report to Capital Investment Monitoring Committee to track progress against capital backlog and capital projects • Regular reports to Executive Performance Board (EPB). • Highlight reports reported to the Reconfiguration Programme Board.

5.5.4. Well-led Elements

The Trust Board is carrying out a self-assessment against the Well-Led Framework in quarter 4 2015/16 and findings and consequential actions will be carried forward into the Board's development plans for 2016/17.

5.5.5. Assurance that the Academy of Medical Royal Colleges' guidance on responsible consultant has been taken into account

We have a named consultant and named nurse on a label above the bed on all inpatients. This is monitored as part of the monthly measurement of ward metrics and also picked up as part of regular quality and safety visits by senior UHL staff to all areas of the hospital.

5.6. Seven Day Services

5.6.1. Overview

We are an early implementer for Seven Day Services (7DS), one of nine Acute Trusts in England - covering 25% of the population of England. 7DS will also be part of the Urgent Care Vanguard which has 6 strands –

1. Integrated Urgent Community Care.
2. LRI Front Door.
3. Mental Health
4. 7 Day Services
5. Contracting for Transformation.
6. Predictive Modelling

5.6.2. Key Objectives

During 2016/17, we will work to deliver against a number of clinical standards (CS) within Medicine, Surgery, Women's and Children's (patients on the emergency/urgent pathway) namely:

- CS 02 - 90% of patients seen within 14 hours of admission by suitable consultant
- CS 05 – timely availability of key diagnostic services
- CS 06 - Key Interventions available 24 hours with timely access (as determined by speciality guidelines)

- CS 08 – Patients admitted as emergencies to be reviewed every 24 hours 7 days a week where appropriate

Significant progress has already been made across Medicine, Surgery, Women's and Children's achieving CS02, CSO5 and CS06 - the main challenge is going to be achievement of CS08. This will be addressed by completing a gap analysis in determining what can be achieved within existing resources and what will need additional resource. Work is on-going with the relevant CMGs to determine what can be achieved by different deployment of existing resources and what will genuinely extra resource. Audits of progress will be undertaken in April 2016 and October 2016.
Other key actions include:

- Establish what variability there is across 7 days in key outcomes – e.g. readmissions / LOS / Deaths by day of admission
- Audit across the specialities in scope to re-establish current status (as some improvements have been made)
- Work with CMGs to deliver a plan to manage the Gap (March / April 2016)
- Through the Vanguard Programme – work in partnership to establish 7 day service support across the Wider Health System (primary, secondary, social care and mental health)
- Named Senior Management and Clinical Leads are established to drive implementation.

5.6.3. Anticipated Impact (by March 2017)

- Improved mortality in emergency and urgent patients
- Decreased variability of outcomes across 7 days
- Improved patient care

5.6.4. Risks associated with Delivery of 7 Day Services

There are a number of risks associated with the delivery of the ambitions for 7 day services, above. These include:

1. Uncertainty of funding to support the programme in 2016/17 both through the Vanguard and Early Implementer programmes
2. What can be achieved without extra resource is undetermined at present and may affect the ability to achieve the standards. Specifically around Clinical Standard 05 – Diagnostics and Clinical Stand 08 – On Going Review
3. Impact on workforce – in terms of capacity, availability, cost
4. Impact on finance – high level assumptions have been made regarding the financial cost of delivery – these need to be challenged and verified further

In the short-term, work is on-going with the relevant CMGs to determine what can be achieved by different deployment of existing resources and what will genuinely need more investment. Audits of progress will be undertaken in April 2016 and October 2016 respectively.

5.7. Our Quality Impact Assessment Process

Quality Impact Assessments (QIAs) provide information on quality, clinical effectiveness or safety risks for the CIP scheme within the Project Initiation Document (PID). A risk score, using the Trusts risks scoring matrix, is also provided for each scheme. This aids the stratification of the quality and safety risks of the schemes and therefore the priority for review by the Medical Director and Chief Nurse. In addition, CMGs will also be asked to identify the key quality and safety metrics that currently exist on their quality and safety dashboards that will need to be monitored along with the project implementation.

Once completed the QIA is used in 2 stages:

1. Sign off (or rejection) of the project by a group comprising of Chief Nurse, Medical Director, Director of Safety & Risk, Director of Clinical Quality along with a report into the Executive Quality Board (Chaired by the Chief Executive)
2. Via the Trusts quality assurance process, there is on-going monitoring of the quality and safety indicators. This allows correlation with adverse movement in these indicators with CIP projects in those areas. This can trigger mitigating actions that can be taken in the event of adverse outcomes and in some cases lead to the cessation of the project.

As part of the implementation of the scheme the existing quality dashboards will be monitored by the CMGs (monthly) at their Quality & Safety Board as per current practice. Where indicators show a material adverse movement, analysis takes place to understand causes.

Where a CIP project is shown to be directly leading to adverse outcomes on the specific quality indicator, the scheme will be referred to the Director of CIP and the relevant corporate Director for the quality indicators (Director of Clinical Quality, Director of Safety & Risk etc). Those Directors will then review the scheme with the CMG management team.

This review will trigger one of 3 decisions:

- The project continues without the need for mitigation action as the scheme is not validated to be the material factor in the adverse movement of the quality indicator
- The project should cease due to a validated quality issue leading to an adverse variance in a quality indicator
- Mitigation actions will be agreed to provide greater assurance that quality will be maintained. This action will be reviewed via the PMO performance management process and formally at the 4 weeks CMG CIP review meetings.

All projects that trigger such a review will be logged, including the date of the review, the outcome, and related actions. The actions are followed up via the monthly CMG CIP review meetings and the action progress reported into corporate medical and nursing colleagues following these meetings.

Each quarter, a quality impact report on the CIP programme is provided to the Executive Quality Board (Chaired by the CEO), the Quality Assurance Committee (Chaired by the Non-Executive Director responsible for quality assurance) to test assurance of the process and its outcomes. It is also reported to CCGs via the Quality Review Group.

This process has been signed off by the Executive Team at UHL and by the Quality Assurance Committee of UHL, a subcommittee of the Trust Board.

5.8. 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 has taken place in tandem with the budget setting process and no additional nursing staff have been identified other than those required to meet our establishments set at the previous acuity review. This review was be approved by the Trust Board in February 2016 and the outputs incorporated into the overall workforce plan.

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.

6. Our Approach to Workforce Planning / Clinical Engagement

The workforce plans for 2016/17 have been developed through an integrated process of activity and capacity planning combined with cost improvement and productivity plans to ensure plans are financially viable. CMG management teams which include leads from operations, finance, HR and clinical leads have developed their workforce plans principally based on activity and capacity requirements. Using the forecasted WTE and pay bill out turn position for 2015/16 as a baseline, CMGs have predicted changes to their workforce based on a number of principles:

- Changes resulting from service configuration both internally and across the LLR system
- 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.

As part of the budget setting process, forecasted activity has been translated into bed, theatre and outpatient capacity at a high level which has then been used to calculate staffing requirements. The output of this has been triangulated at CMG Level working from a broad assumption that any increases in activity will not necessarily translate into further staffing demand.

The Annual Planning Executive Confirm and Challenge sessions highlighted the outcome of this initial triangulation and further iterations of the workforce plan were received on 22nd January 2016 following a further refinement of the activity plans. Subsequent Annual Planning Executive Confirm and Challenge sessions in late January focussed on confirming activity growth - workforce plans have been further refined prior to the April submission particularly following completion of the ‘deep dive’ review of 30 service lines, as described above.

6.1. Alignment with Clinical Strategy and Health and Care Commissioning / Workforce Transformation

These plans have been developed in the context of a drive for increased theatre, beds and outpatient efficiency through our overarching plan to become smaller and more specialised in line with the ambition of BCT and the Trust’s Clinical Strategy.

Commissioners have been actively involved in the confirm and challenge sessions and wider planning process to help align commissioning intentions and any workforce risks and challenges for example full utilisation of the Intensive Community Support Service to enable discharge and therefore bed capacity modelling. The Trust is actively addressing the behavioural and working practice changes required to ensure full utilisation of this service.

At a strategic planning level, activity levels shifting to the Alliance and Primary and Community Care settings have been used to determine workforce levels recognising that some Models of Care include UHL staff working in different settings. The Alliance have also been active participants in the confirm and challenge sessions focusing on specific services which can be ‘left shifted’ into community settings most notably pain and dermatology services.

All plans take into consideration the impact of capital planning business plans where the impact of these are known, most specifically the move of ICU level 3 which creates some short term

staffing inefficiencies and vascular surgery drives staffing expansion to support service development.

Workforce plans also include some inefficiencies arising from invest to save programmes for the development of new roles, most specifically Physician Associates. Plans for 2016/17 also include plans for increased usage of assistant practitioners where it is safe and appropriate to do so and greater expansion of Advanced Nurse Practitioners to enable services to be delivered over seven days and in different health care settings. The latter programmes are undertaken in partnership with LPT to ensure consistency of approach and education.

Our workforce plans also reflect the acquisition of the Interserve workforce from across LLR with effect from May 2016. These plans are based on the best known data received by 11 April 2016 and are classed as a transactional change on our workforce bridge. The turnover and establishment levels for this staffing group are currently unknown and therefore plans throughout 2016/17 are based on the best estimate of changes to substantive and non-contracted workforce.

6.2. Alignment with Local Education and Training Board Plans

The Trust has been actively engaged with the Local Education and Training Council in developing local bids for education and training support which support Health Education England priorities. Significant numbers of bids have been jointly submitted with BCT 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.

6.3. Effective use of E-rostering and reduction in reliance on agency staff

In order to maximise efficiency, the acuity review has also included a review of rotas held within electronic rostering not only to ensure safe establishment but also to ensure maximum efficiency in the distribution of rotas for example the adoption of 12 hour shifts. Electronic Rostering is now fully implemented in ward areas and is being rolled out progressively across other staff groups. Through tight premium spend monitoring processes, the management information from Electronic Rostering is being used to ensure robust controls and processes are in place for the authorisation and use of premium spend. CMGs have produced action plans to support their premium spend reduction plans which are monitored through a Workforce Cross Cutting Board. Much of the premium spend reduction activity is focused on new and innovative ways to recruit and retain staff and has included further international recruitment, a focus on the closure of the junior doctor gaps through Trust grade rotational posts and more proactive use of exit interviews.

Budget setting processes have defined the required WTE establishment phased throughout 2016/17, projected recruitment and turnover levels have been applied to current levels of substantive staff in post to provide a realistic projection of non-contracted WTE and pay bill usage. Agency maximum percentage usage for nursing and assumptions regarding application of the agency caps have been used to determine these projected figures.

6.4. New Workforce Initiatives as part of Five Year Forward View

We are actively involved in the Urgent and Emergency Care Vanguard and specifically a review of the impact of the Single Front Door which will be incorporated into plans for the Emergency Floor.

A whole systems approach to workforce and OD is in development across LLR. Currently the community is working in partnership with Whole System Partnership to undertake workforce modelling across all Better Care Together work streams. UHL is an active partner in this work leading on a holistic, joined up approach to workforce planning.

6.5. Cost Improvement including Quality Impact Assessments

As described above cost improvement forms a key component of the operational planning cycle and CIPs all include a quality impact assessment. Workforce themes currently in the cost improvement programme include medical productivity schemes and Clinical Nurse Specialist reviews.

6.6. Governance Processes and Regular Review of Workforce Risk Areas

The overall workforce plan will be submitted to the April Trust Board prior to final submission to the NHS Trust Development Authority (NNHSI). As described above the workforce plans have been subject to rigorous confirm and challenge which will continue through the refinement process.

A quarterly Workforce Update is provided to the Executive Workforce Board and Trust Board which describes our progress in respect of the workforce plan and highlights specific risks. A number of workforce risks are also contained on the Trust and individual CMG risk registers with the medical workforce continuing as a priority for 2016/17. Particular hotspots include nursing (within medical specialties and the ED department, Endoscopy and Cancer and Haematology, Theatres and Children's); Medical Posts (including ED , Geriatrics, Radiology, Middle Grade Trauma and Orthopaedics, Paediatric Subspecialties); Sonographers and Diagnostic Radiographers; Pharmacists at band 4 and 7; specialist Cardiac Investigation Scientists.

7. Our Approach to Financial Planning

7.1. Financial forecasts and modelling (Background)

In 2015/16 the Trust originally planned to deliver an income and expenditure deficit of £36.1m that was predicated on the delivery of a Cost Improvement Programme (CIP) of £43.0m. However on 31 July 2015, and in response to the worsening of the national financial position of the provider sector, the Trust was asked to develop a plan for a deficit of £34.1m, representing a £2m improvement on the original plan.

A revised plan was submitted to the NNHSI on 11th September 2015 with an income and expenditure deficit of £34.1m, predicated on the delivery of a CIP of £43.0m. At the same time, the Trust had to undertake a review of the ambitious capital programme that had been originally planned at £107m, supported by internally generated funds and external funds in the form of capital loans from the Department of Health. The key elements of the original capital programme were:

- 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).

Following a strategic review and recognising the limitations around external capital funds, the final capital expenditure plans were set at £49.5m supported by £10m of capital loans from the Department of Health.

The above means that the Trust enters 2016/17 in a different place financially than was anticipated within its five year strategic plan. In addition to this, and following communication

from the NNHSI in January 2016, the Trust has been offered Sustainability and Transformation Funding (STF) of £23.4m on the understanding that the Trust will deliver a deficit in £8.3m for 2016/17. Excluding STF, this implies that the Trust will deliver an underlying deficit position of £31.7m within 2016/17 compared to the 2015/16 deficit of £34.1m.

Stepping off from this point, the financial plans within the 2016/17 operational delivery plan are outlined below.

7.2. Activity

The income plan is based upon the detailed capacity and activity levels modelled for each specialty and will be signed-off by each CMG over the coming weeks. As described within the Demand Activity Planning section, above, this is based upon 2015/16 forecast out-turn plus underlying demand movements in 2016/17 that include:

- Demographic growth;
- Impact of specific changes within referral patterns or change of setting of treatment;
- Adjustments for known non-recurrent effects within 2015/16 and full year effects of new developments within 2015/16;
- Shifts of activity out of the acute hospital setting into the Alliance as part of the wider BCT programme.

Whilst activity plans are subject to further refinement and final agreement with commissioners, the trends witnessed within 2015/16 are expected to continue throughout 2016/17. In particular, 2015/16 witnessed significant growth in ED attendances and Emergency Admissions, it is anticipated that these areas will continue to be pressurised with forecast percentage growths of 3.6% and 2.4% respectively.

Elective activity reflects growth to deliver demand in RTT performance. This is coupled with the of 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 in Table 1, above.

7.3. Income

7.3.1. Clinical Income

The plan is modelled under full PbR rules.

The Trust is currently planning for £467.3m (59% of total clinical income) from local commissioners (Leicester City, West Leicestershire and East Leicestershire and Rutland CCGs) and £234.0m (30% of total clinical income) from specialised activity commissioned by NHS England. The Trust has not agreed the 2016/17 contract associated with these plans and income is therefore subject to change.

The plan assumes PbR tariff in line with the guidance and draft national prices as published in December 2015. This assumes a 2% efficiency deflator and 3.1% inflation uplift for all local and national prices, plus an additional 0.7% specifically on national tariff prices, related to increases in the CNST premium. This translates to expected income inflation of +1.1% for local prices and +1.8% for national prices. This reflects Monitor and NHS England's assessment of cost inflation including the effect of pension changes and CNST. The overall impact of these changes is anticipated to be an £14.3m increase in income; this can be separated into tariff inflation of £11.0m and £3.3m relating to the removal of marginal rates on specialised commissioning.

7.3.2. 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 have had a negative impact within the educational income of £2.2m.
- Income received through research and development continues to remain stable with no material change from 2015/16 currently anticipated.
- Income received through other sources such as facilities management, car parking etc. remain stable.

The Trust has also recognised other income relating to general Sustainability and Transformation Funding (STF) of £23.4m which we understand to be channelled through lead commissioners, quarterly in arrears.

7.4. Expenditure

7.4.1. 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 2015/16 the Trust 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 2016/17 the Trust continues with the ambition to fill the establishment on a substantive basis but recognises that an element of premium pay will be incurred 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 £28.3m. See section 7.9 below.

Pay pressures of incremental drift, national insurance contribution changes and pay uplift combined are included at £13.5m (2.6%) based on national pay structures.

Contingency reserves of £4.4m overall are included of which £3.1m (70%) is planned as pay.

7.4.2. Non pay

Non-pay inflation at £5.8m is based on drugs at 4.5% and a 1.7% 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 £6.6m (39%) against the Trust's CNST contributions.

The value of commissioner funded high cost drugs and devices in the 2016/17 plan is £94.0m which is based upon the 2015/16 forecast outturn plus £7.0m (8%) 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 £4.4m overall are reinstated of which £1.3m (30%) is planned as non-pay.

7.5. Detail of the major financial risks identified and mitigating actions

Until the clinical activity contract with the main commissioners is signed there remains a level of risk to the NHS Clinical Income value as included in the financial plans. Thereafter, risk remains against the delivery of planned activity and CQUIN targets whilst the cost base of delivering the contracted activity will be set in line with final contractual agreements.

Full delivery of the CIP programme is 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.

The proposed agency expenditure ceiling is a risk for the Trust in 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. As a result the Trust has planned to exceed this performance measure.

7.6. Financial Plan Summary

In summary, we are planning to deliver a £8.3m deficit in 2016/17 after receipt of £23.4m S&T funding and achieving £35.0m CIP. This is subject to finalisation of contract negotiations with commissioners, associated patient care income and CMG/Directorate level budgets.

Appendix 1 shows the summarised 2016/17 income and expenditure plan with appendix 2 detailing the bridge from 2015/16 outturn to 2016/17 plan.

The capital expenditure plan is £108.3m including the external borrowing requirement of £48.5m and reflects the outcome of discussions with NHSI.

We remain committed to delivering financial recovery over the forthcoming years.

The timescale for this is largely dependent on the availability of capital. This overarching direction and timing will be detailed in June 2016 through the five year sustainability and transformation plan (STP).

7.7. Efficiency savings for 2016/17

The work on our efficiency programme for 16/17 began in September 2015. It is run by the Director of Cost Improvement and Future Operating Model (DCIP) reporting into the Chief Operating Officer, the Executive Performance Board (Chaired by the CEO), the Integrated Finance & Performance Committee (Chaired by the Deputy Chairman) and the Trust Board. The support functions beneath the DCIP are delivered by Ernst Young (EY). The target for 16/17 is £35m, which represents 3.6% of gross costs of £985m, this target is disaggregated to all CMGs and Corporate functions.

The delivery mechanism runs through 5 high cost cross cutting themes that are shown below with the indicative financial impact for 16/17:

Cross Cutting Theme	SRO	Efficiency metric	Financial impact (£000s)
Beds	Chief Operating Officer	LOS	3884
Theatres	Chief Operating Officer	Mean cases per list, % of lists run	2079
Outpatients	Chief Operating Officer	% of slots booked, % DNA rate	1802
Procurement	Chief Financial Officer	N/A	7700
Workforce	Director of Workforce & OD	Pay bill as a % of income	8578

All these areas have an efficiency focus linked to the savings with the lead measures associated with the savings as the crucial indicator. This is complemented by smaller savings schemes that

originate in a bottom up manner from within the clinical services (such as a review of instrument usage in theatres) that all contribute to build up to the higher programme and bring our plans up to the £35m. Given the scale of demand that is expected on the organisation to deliver in 16/17 a substantial element of the programme this year is associated with meeting this demand through current capacity by becoming more efficient rather than cost reduction.

7.8. Lord Carter's provider productivity work programme

In August 2015, UHL joined the cohort of trusts linked into the Productivity Programme. As part of this expanded cohort, the Trust has supplied significant amounts of data, business intelligence and resource to the three sub-workstreams of workforce, diagnostics (pathology and radiology) and procurement. The single point of contact and the co-ordination for the Trust's involvement within the Carter programme is under the delegation of Paul Traynor, Chief Financial Officer, as the Executive lead.

In November 2015, Lord Carter and his team visited the Trust to deliver the Trust's data pack. This data pack identifies at service-line level an initial view of potential saving opportunities with those opportunities calculated under the Adjusted Treatment Cost (ATC) methodology, a development of the ATI methodology. Following receipt of the data pack, the Trust has been working in conjunction with the Carter Team to validate the above savings opportunity. A small team of Finance, CIP and Workforce colleagues has been aiming to replicate the methodology used in order to enable all the possible opportunities to be validated and referenced back to existing CIP plans. This will in due course ensure that all the opportunities are being exploited and also enable us to provide detailed feedback on the robustness of the methodology.

We continue to work with the Carter Team to validate the data sets and potential savings opportunities. Once complete, this will be reviewed against those opportunities already taken as part of the 2015/16 CIP programme and compared against the current 2016/17 programme ensuring that all potential opportunities are explored within an appropriate delivery timeframe.

7.9. Agency Rules

We welcomed the introduction of both the registered nurse agency ceiling and the capped agency rates for all staff and has actively used them to further progress the control of premium pay, in particular of agency staff. We have a programme of actions that preceded the introduction of these national controls and has further developed and refined these in the light of them.

From 1 April 2016 percentage based expenditure ceilings for agency nursing will be replaced with an absolute expenditure ceilings expressed in pounds which apply to all agency staff groups. We have been given a target of £20.62m which equates to a 35% expenditure reduction based on actual agency expenditure between April 2015 and December 2015 annualised. The following concerns were logged on the 31st March 2016 with NHSI and have been incorporated into our plans.

1) The baseline data used includes only 2 months of the Trust operating an Urgent Care Centre for which management transferred at the end of October 2015. This area uses a higher than average proportion of agency staff at present (in excess of 50%) and the target therefore under-represents expected use of agency staff in that service.

2) The baseline data excludes the currently outsourced estates and facilities function (c1800 WTEs) which will transfer in-house at the end of April 2016. We are currently working with the incumbent provider to establish the level of agency use in those services but as a material change to our workforce profile this needs to be considered in the ceiling calculation.

In addition, the proposed ceiling is a risk for us 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. As a result, we are not in a position to agree this target at this stage.

We have concluded we will plan for agency expenditure of £28.3m.This reflects a target reduction in expenditure of 15% in contrast to the 35% proposed in the ceiling. In order to achieve this target the Trust will maintain focus on agency expenditure reduction through a Premium Spend working group, reporting to the Cross Cutting Workforce Board. The working group has senior representation from all clinical management groups and is focusing on the following:

All staff groups:

- The roll-out of e-rostering.
- A temporary staffing policy that clarifies levels of authorisation for booking of agency staff and good practice requirements (such as the prior checking of all alternatives).
- Required each CMG to produce detailed action plans to address premium pay spend, including recruitment plans and referencing the NHSI/Monitor diagnostic tool.
- Reviewed management controls and booking practices.
- Set overall pay control targets, and within these, premium pay control targets for each CMG. CMGs are performance managed against these and their underpinning action plans.
- Supported the improved use of a workforce planning tool to project future staffing including premium pay spend.
- Developed an improved monitoring and reporting dashboard on premium pay spend and related information.
- Supported the implementation of the national capped agency rates, developing escalation, governance and monitoring processes. See section below regarding expenditure caps.

Nursing:

- Since the introduction of the national requirement that agency nurses are only booked via framework agencies, UHL has not breached this requirement
- The introduction of spot rates of pay for bank work at different grades.
- Automatic registration of nursing staff and medical staff to the bank/locum bank on commencing at UHL.
- The re-introduction of weekly pay for bank nursing staff.

Medical:

- Moved to a ‘master vendor’ agency for medical locums

7.9.1. Progress towards capped agency rates

We have made progress towards the agency capped rates by:

- Advising all key agencies from the introduction of the rates that we required them to comply with the capped rates.
- Making agencies that are compliant with the capped rates our ‘tier 1’ agencies, to which bookings will be first sent.
- Ensuring that senior level authorisation is required for escalation to agencies supplying above the capped rates, with a clear confirmation of the clinical safety risk of not doing so, and confirmation that all alternatives have been considered.
- Regularly reporting to CMGs and to the executive team on progress towards achieving the capped rates, highlighting and reviewing the clinical risk areas where breaches are occurring.

The process of gaining agreement of agencies and the master vendor to capped rates has been challenging but there is currently agreement from several agencies and the master vendor to first seek agency staff at compliant rates. We have assigned such agencies Tier 1 being the first agencies from which staff are sought. Agencies that are not able to fill at Feb 2016 are requested

to fill at Nov 2015 rates (subject to further escalation and controls in the Trust). We continue to persist in terms of compliance.

7.9.2. Escalation

1. All requests are first referred to Tier 1 agencies
2. CMGs requested to reassess alternatives to agency. If required for clinical safety this is escalated to Senior CMG authorisation to move to Tier 2. Tier 2 are agencies who have agreed to fill at November rates if not able to fill at Feb 2016 rates.
3. If no success CMG is asked to reconfirm requirement, then consideration to fill at Tier 3 which is agencies not able to fill at November rates.

This escalation process is currently being trialed.

7.9.3. Current Breaches

These are reported as required weekly to the NHSI. The maximum breaches has been 800 and the minimum 500 and we are currently tracking approximately 600. Breaches for nursing have decreased.

There have been no breaches of off framework for nurse agency.

7.9.4. Internal Governance Arrangements

Breaches of capped rates are reported:

- Weekly to the Chief Nurse Medical Director and Director of Workforce and OD together with the reported narrative and clinical risk areas
- Weekly to the Leads for the Premium Spend Group and discussed as described below
- Monthly to the Executive Performance Board

Regular reports are also provided to the Executive Workforce Board and Integrated Finance and Performance Committee.

As described above the Premium Spend Group members are accountable to the Workforce Cross Cutting Board for delivery of premium spend action plans which underpin their trajectories for a reduction in premium and specifically agency expenditure. During the setting up of governance arrangements, this group met fortnightly and will continue to meet monthly.

7.9.5. Forthcoming Actions

In the coming year, we will use the workforce planning processes described in section 5 to continue to reduce reliance on agency staffing. We will continue to push for adherence to the capped agency rates and other controls where clinically safe to do so, through tighter control of agencies and internal booking processes; in addition we are working collaboratively with trusts across the East Midlands, and with the East of England Procurement hub, to ensure that the approach is supported and strengthened through the region.

We will continue to pursue robust recruitment and attraction strategies in order to reduce the number of vacancies which drive dependency on agency staffing. The Medical Workforce Group continues to report to the Workforce Cross Cutting Board and has made tangible differences to the numbers of vacancies for junior medical workforce. Innovative solutions with robust education and development programmes have led to increases in Trust Grade Doctors. This year an internal rotational programme for groups of trust grade specialties will be introduced to create attractive 12 month posts and reduce the impact of regular training rotations. The National Physician Associate Expansion Programme is expected to support the introduction of new teams around the patient and the first cohorts of Advanced Practitioners will qualify.

The Nursing Executive will also monitor progress of the closure of nursing gaps with particular emphasis on support workers.

7.10. Procurement

We recognise the vital importance of having robust procurement procedures and protocols to manage the main elements of its non-pay spend and capital expenditure. Within 2015/16, our Trust Board approved a revised 5 year procurement strategy that defined the key characteristics of an efficient and effective procurement function focusing on the core elements of category management, value for money and clinical engagement. We are progressing with the implementation of this strategy and is on track to deliver the actions as described within the strategy.

At a local level, we are actively involved with regional procurement groups and has board representation on the West and East Midlands Regional Procurement Customer Board. This has resulted in the Trust embarking on a joint initiative with NHS Supply Chain to review all aspects of the supply chain to ensure this is as robust as possible whilst maintaining alignment to the core features of our procurement strategy.

In addition, and as described earlier, we are within the cohort of Trusts linked into the Productivity Programme lead by Lord Carter. We are playing an active role within the procurement work stream helping to shape the programme of work and define the national agenda.

7.11. Capital and Cash Planning

Capital expenditure is planned at £108.3m which is made up of internally generated resources of £33.8m, agreed Emergency Floor funding of £21.8m, finance lease funding of £4.0m and donated assets of £0.3m. The remaining £48.5m of expenditure is assumed to be funded through a mix of Department of Health loans of £25.5m and financing arrangements with the Trust's EPR supplier of £22.9m.

This plan reflects discussions with the NHSI which confirmed the expectation that Trusts should include capital funding to support the delivery of the Trust's reconfiguration strategy and implementation of a Trust-wide EPR solution. The Trust recognises national constraints on capital availability and will re-shape the capital programme if the applications for external financing are unsuccessful.

The breakdown of the capital plan is shown in appendix 3 and can be classified as essential estate maintenance, schemes connected to the reconfiguration programme, clinical equipment investment and investment within IM&T.

Significant capital developments for 2016/17 include:

- Emergency Floor continuation of £21.7m
- Estates and facilities critical infrastructure works £13.7m
- Reconfiguration related investment of £31.2m
- IM&T infrastructure of £5.4m
- EPR solution £22.9m
- Medical equipment replacement of £7.6m

We recognise that liquidity is crucial in both keeping the financial base safe and our ability to fund our transformation based capital investment programme.

Additional external cash support will be required to sustain the plan and it is assumed a receipt of £8.3m cash support in year in order to maintain a cash balance at £3.0m which represents the maximum amount of cash that can be held when in support of interim cash funding.

In an environment of limited cash resource the Trust recognises that robust processes for cash management and planning will be needed if it is to keep the ambition of maintaining strong performance within the Better Payment Practice Code (BPPC).

It should be noted that there is no inclusion in the financial plans of any fixed asset impairments and reversals of impairments which are exceptional in nature.

8. Link to the emerging 'Sustainability and Transformation Plan' (STP)

As stated above, the LLR health economy has set out a vision to improve health and social care services, from prevention and primary care through to acute secondary and tertiary care. Successful delivery of this programme will result in greater independence and better outcomes for patients and service users, supporting people to live independently in their homes and out of acute care settings.

The programme (known locally as Better Care Together) was initiated in January 2014 to enact system wide change that would both improve the quality of care from a citizen or patient perspective, while also achieving overall system sustainability. The programme has the following strategic goals for delivery by 2018/19:-

- Deliver high quality, citizen-centred, integrated care pathways, delivered in the appropriate place and at the appropriate time by the appropriate person, supported by staff/citizens, resulting in a reduction in the time spent avoidably in hospital.
- Reduce inequalities in care (both physical and mental) across and within communities in LLR local health and social care economy.
- Increase the number of those citizens with mental, physical health and social care needs reporting a positive experience of care across all health and social care settings.
- Optimise both the opportunities for integration and the use of physical assets across the health and social care economy, ensuring care is provided in appropriate cost effective settings, reducing duplication and eliminating waste in the system.
- All health and social care organisations in LLR to achieve financial sustainability, by adapting the resource profile where appropriate.
- Improve the utilisation of workforce and the development of new capacity and capabilities where appropriate, in the people and the technology used.

Following the recent publication of the NHS planning guidance, chief officers locally have nominated LLR as the place around which the local STP will be developed, overseen by the Managing Director of Leicester City CCG.

Given that an accepted place based sustainability and transformation programme and the associated governance structure is already in place locally, this will be used for taking forward the development and delivery of the STP. A good proportion of the potential requirements of a sustainability and transformation plan have already been developed locally. As such, partner organisations (including local government) are currently nominating their STP leads to develop the *Better Care Together* plan into the STP and the mechanisms for doing so have been agreed.

Appendix 1 – 2016/17 Income and Expenditure Plan

	2015/16 Outturn £m	2016/17 Plan £m	2016/17 Movement £m
NHS Patient Care Income	737.3	767.8	30.5
Sustainability & Transformation funding	-	23.4	23.4
Other Income	126.2	125.0	(1.1)
Total Income	**863.4**	**916.2**	**52.8**
Pay	516.9	536.1	(19.2)
Non Pay	336.8	341.2	(4.4)
Total Operating Expenditure	**853.7**	**877.3**	**(23.6)**
EBINHSI	**9.7**	**38.9**	**29.2**
Non-Operating Costs	43.8	47.2	(3.4)
Retained surplus/(deficit)	**(34.1)**	**(8.3)**	**25.8**

Appendix 2 – 2016/17 Income and Expenditure Bridge

		Total £m
2015/16 Outturn		**(34.1)**
Non recurrent adjustments		(4.0)
2016/17 Recurrent Baseline		**(38.1)**
Inflation	11.0	
Removal of specialised marginal rate	3.3	
High cost drugs	7.0	
Volume growth	15.3	
Sustainability & Transformation funding	23.4	
Education and training	(2.0)	
ICS beds	(5.3)	
QIPP	(10.3)	
Total income movements		**42.5**
Inflation	(25.9)	
Contingency	(4.4)	
High cost drugs	(7.0)	
Volume growth	(8.9)	
Business cases	(1.3)	
Total expenditure movements		**(47.6)**
CIP		**35.0**
2016/17 Plan		**(8.3)**

Appendix 3 – 2016/17 Capital Plan

	2016/17 Capital Plan £k
Estates & Facilities	8,906
IFM Facilities asset purchase	1,376
Paediatric Daycase / Dentistry	1,229
Clinical Sciences Building	2,200
Estates & Facilities	**13,711**
IM&T Infrastructure	4,250
Heartsuite Information System	272
Electronic Blood Tracking	696
Renal Transplant Lab System	100
Learning Management System	70
IM&T Schemes	**5,388**
Medical Equipment Executive	4,250
Linear Accelerator	3,300
Medical Equipment Schemes	**7,550**
Reconfiguration BC development	5,000
Emergency Floor	21,700
Vascular	9,768
ICU	15,780
EMCH Interim Solution	683
EPR Programme	22,966
Reconfiguration	**75,897**
Diabetes conversion of W2 LGH	1,122
Donations	300
Paediatric & Genetic CRF	328
Contingency	-
Corporate / Other Schemes	**1,750**
MES Finance Lease Additions	2,774
Hybrid Theatre Addition	1,200
Finance Leases	**3,974**
TOTAL EXPENDITURE	**108,270**
FUNDING	
Forecast Depreciation 2016/17	32,660
Finance Lease Additions	3,974
Donations	300
Funding for Diabetes	1,122
External Funding: ED Floor	21,700
External Funding: Vascular	9,768
External Funding: ICU	15,780
External Funding: EPR (CRL only)	22,966
TOTAL FUNDING	**108,270**