Leeds Teaching Hospitals NHS Trust

2017/19 Operational Plan Narrative

The Leeds Teaching Hospitals NHS Trust

Submission 23rd December 2016

1 Activity planning

1.1. Approach

The Leeds Teaching Hospitals NHS Trust (the Trust) has established a collaborative approach to capacity and activity planning. Forums with commissioners have been established which are linked to the Trust's Contract Management Board in order to review capacity and demand throughout the year. Commissioners have open access to the Trust's elective referral demand monitoring system as well as a real time understanding of non-elective demands through the joint System Resilience Group.

In calculating our activity we use the Checklist demand and capacity modelling software, which has been endorsed by our commissioners, to assess the required level of recurrent and non-recurrent elective activity for the next two years. The draft output is discussed with clinical teams to ensure that it takes account of the likely advances in medical technology, changes in other hospitals' provision, projected bed availability and other factors, such as workforce availability. This is used to inform collaborative discussions with commissioners about the demands for our services and the volume of work that we are able to supply.

Key milestones used to agree activity plans for 2017-18 are summarised below:

Oct 2016 - Nov 2016	• Checklist demand and capacity model using 16/17 YTD position and 12 month rolling average. • Refresh Year 2 (17/18) and 3 (18/19) from the 5 Year plan for the 2017-18 Operational Plan. Provide narrative to confirm changes. • Plan shared with commissioners 29th November.
Nov 2016 - Dec 2016	• Commissioners review the Trust's 2017-18 proposal. • Plan updated in response to queries. • Agreed plan split by commissioner and phasing for the year. Final case mix review. • Budget setting commences to reflect plans.

1.2. Capacity

The Trust has confirmed to commissioners those services where further action will be required to meet the anticipated demand for the coming year. The services where a formal capacity review has been requested are Endoscopy, Dental specialties and Spines.

We have also set out our assumptions about delivering the plan in year. This includes expected seasonal variation in elective capacity (winter), length of stay, volume of delayed transfers in the bed base, recruitment issues and efficiency factors such as expected levels of theatre and clinic utilisation. These variables have been factored into the plan.

Unplanned changes in demand are monitored on an on-going basis through weekly meetings and assessing performance against key operational standards which are scrutinised at specialty level. Elective surge capacity is mainly provided through additional sessions out of hours and the independent sector if required.

Discussions continue with the West Yorkshire Association of Acute Trusts to identify services across Yorkshire which are in danger of becoming unsustainable and could cause a significant rise in our referrals. Discussions have involved providers in Bradford, Calderdale, Harrogate and Mid Yorkshire, and include services such as Neurosciences, for example.

1.3. Performance Trajectories

Given that agreement on our contracts has yet to be reached, the performance trajectories have not been finalised. Important assumptions in the final trajectories will include:

- Referral demand is maintained at planned levels,
- Planned elective bed capacity will not be further affected by delayed discharges,
- The winter of 2017/18 will not have an exceptional impact above plan,
- Workforce assumptions are maintained at planned levels,
- There are no unforeseen major capacity constraints in individual specialties,
- Referring organisations achieve their agreed trajectories for referral of patients to the Trust by day 38 to prevent risk to the 62 day cancer waiting time standard.

1.4. Mandatory Standards and the NHS Constitution

- Referral to Treatment Times

The Trust has not achieved the referral to treatment time (RTT) for the incomplete performance standard since March 2016. We put plans in place to achieve this standard during 2016/17 but the plans were not successful due to the continued rise in acute admissions which eroded our planned elective bed base. We have not had any patients waiting over 52 weeks in 2016/17 to date, although the risks have increased. The Trust will maintain its policy of prioritising the longest waiting patients, with the same clinical urgency, for elective treatment.

As part of the 2017/19 planning process, all CSUs have established target patient activity levels, with specialties identifying specific measures to address RTT standards. There are, however, still services that have shortfalls in the capacity that we can provide to meet the demand expected. The services where RTT standards are unlikely to be met without further capacity include Endoscopy, Spines, Oral Surgery, Paediatric and Restorative Dentistry. This situation has been discussed with our commissioners.

- Cancer Waiting Times Standards

In 2016/17 (to date), the Trust has continued to achieve the two week wait Urgent Referral to First Seen and Breast Symptoms standards.

The Trust has also consistently achieved all of the 31 day cancer waiting time standards except for the 31 day subsequent surgery standard in quarter one due to surgeon capacity issues in the Melanoma team which has now been increased.

The 62 day Urgent Referral to Treatment standard has not been achieved in quarters one and two of 2016/17. This standard has been affected by the continued rise in acute admissions which has led to cancer patient cancellations at an unprecedented level. Our overall reported position also continues to be at risk due to the ongoing number of late referrals. We are continuing to work closely with all commissioners and referring hospitals to reduce delayed discharges and late referrals from other centres.

- Diagnostic Standard

The Trust has achieved the Diagnostic 6 Week Wait standard since September 2016 and expects to maintain this performance for the remainder of 2016/17. Commissioners have been informed that if this standard is going to be met over the next two years, additional capacity will need to be identified, particularly in MRI and Endoscopy.

- Emergency Care Standard

This standard has not been met across the Trust since October 2015 due to acute pressures, delayed transfers of medically fit for discharge patients and increased volumes of attendances and admissions through A+E. This has significantly impacted on bed availability and patient flow. Although a programme of actions has been identified with partners in the local health community and through the West Yorkshire Accelerator Zone (WYAZ), the acute flow position has continued to impact on the performance of this standard. The Trust anticipates continued difficulties for the remainder of 2016/17 and in 2017/18 if demand remains at present levels.

An Emergency Care Standard Trajectory has been prepared, as a separate return, to accompany the Operational Plan narrative. As stated above, the Trust anticipates difficulties in meeting this standard at current levels of demand. The important assumptions and risks relating to our trajectory are set out below:

- With the WYAZ schemes and counting measures, the March 2017 performance is predicted to be at 91%
- Although an extension has been requested, the WYAZ scheme funding currently ceases at the end of March 2017 so from April performance is expected to include counting schemes only which assumes 89.61% achievement. We expect to maintain this during quarter one.
- From quarter two, we have assumed that:
    - … We will receive further funding for the schemes previously included in the WYAZ initiative. Also that actions by the wider health system in relation to securing additional nursing bed capacity, to restore and enhance the 2016/17 levels (following the impact of the CQC process), have been successful.
    - … That actions in the wider health economy will lead to levels of A+E and assessment attendances, and acute admissions via all routes, returning to 2014/15 levels.
    - … That delayed transfers of care, repatriation and medically fit for discharge patients reduce from current levels.
    - … That demand remains within normal seasonal trends and that there are no unforeseen service collapses in other health organisations which impact on the Trust's demand or capacity.

Key Risk

- There remains a significant risk due to the potential reduction in nursing home bed capacity across Leeds (316 or 15% of the current nursing home bed stock is facing closure following CQC review)

- Mixed Sex accommodation breaches

There have been no mixed sex accommodation breaches in 2016/17 and we hope to maintain this position if volumes of acute admissions do not rise further.

- Cancelled Operations not Rebooked within 28 Days

This standard will not be achieved in 2016/17 due to the impact of bed pressures and acute flow issues on elective bed capacity. Detailed reviews continue quarterly.

- No Urgent Operation Cancelled for a Second Time

No urgent operations cancelled for a second time have been reported in 2016/17. The Trust expects to continue to report no breaches of this standard in 2017/18 although risks are again much increased with our current acute bed pressure issues.

1.5. Supporting Delivery

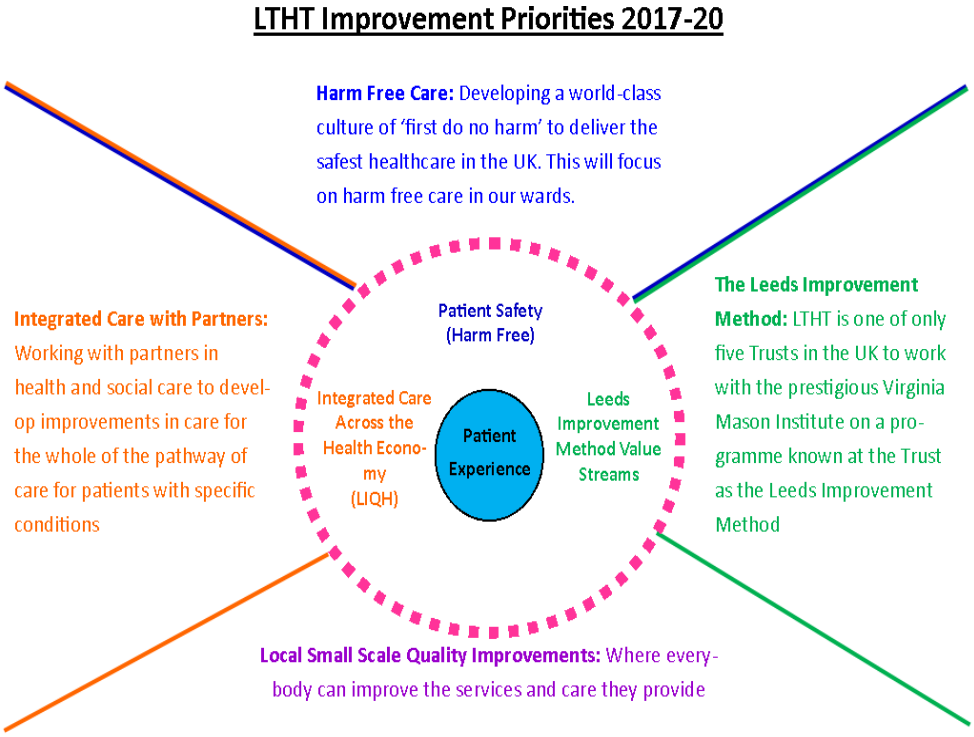
The Trust's Integrated Accountability process was introduced in 2015/16. This involves the comprehensive monitoring and dissemination of information to Clinical Service Units (CSUs), internal CSU oversight processes, weekly performance trigger meetings, and monthly CSU accountability meetings. Actions and issues are escalated for Executive Director intervention where required. Executive Directors also scrutinise all non performing services through the detailed weekly performance scorecard.

2 Quality

2.1 Approach to quality improvement

The Trust published its first Quality Improvement Strategy in 2014, setting out a comprehensive programme of work from 2014-2017. The Strategy was created to help the Trust realise the potential of its existing quality programmes and develop its ambition to work consistently to the highest level of quality and safety.

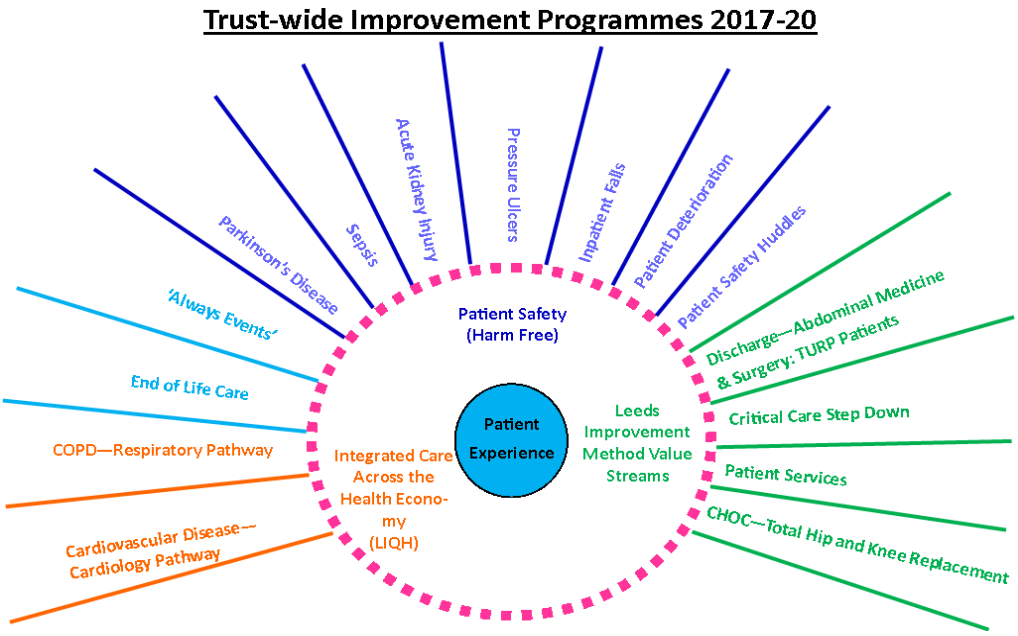
In less than three years we have taken significant steps in improving the quality of care provided to our patients. The Strategy is currently being refreshed and priorities re-defined following a second Quality Ambitions Workshop which was held in April 2016. Our aim is for the Trust to build a culture of continuous improvement across the organisation.



Quality Improvement framework and priorities 2017-2020

A Quality Improvement Steering Group oversees the programmes of work. The Steering Group is chaired by the Trust's Chief Medical Officer who is the identified Executive lead for the Quality Improvement Programme, working in conjunction with the Chief Nurse/Deputy Chief Executive. This Group receives updates on progress against specific work streams, including return on investment and cost savings, where these are identifiable.

The Trust reviewed its governance arrangements for quality and safety in 2015 and has embedded the resulting changes. These included the establishment of the Quality Assurance Committee (QAC), a formal committee of the Board, and an Executive Quality Management Group (QMG). An Executive Risk Management Committee will continue to review key risks relating to quality and safety with CSUs and corporate teams, and advise the Board on the high level corporate risks (score > 15) together with the actions that are being taken to address them.



2.2 Partnership with Virginia Mason Institute (VMI)

A key initiative in the Trust's approach to providing leadership to improve quality and safety is its partnership with the Virginia Mason Institute (VMI) in Seattle. This was established in 2015/16 together with four other NHS trusts. The resultant transformation programme, called the Leeds Improvement Method (LIM), will continue to be developed throughout 2017/18 and beyond. The programme is led by the Executive Director Team (Guiding Team) and coordinated by a Kaizen Promotion Office (KPO). The Trust has assembled a team of staff who have had Advanced Lean Training at the Virginia Mason Institute. The transformation programme started in 2016, focusing initially on Elective Orthopaedics (Total Hip and knee Replacement - Admission to Recovery), at Chapel Allerton Hospital.

Three further work areas, or Value Streams, are now being started, using the LIM namely:

- Urology (Transurethral Resection of the Prostate – Recovery to Discharge)
- Critical Care (Patient Flow to Neurosurgery Wards)
- Outpatients (Patient journey & experience in their Ophthalmology Appointment)

2.3 Leading on Quality and Safety

The Trust will continue to work with partner organisations to improve quality and safety. It will encourage innovation through a joint approach to develop new and more sustainable models of care and engage staff from all organisations across the city in the programme.

We will support our senior leaders to continue to improve quality and safety at the Trust, focusing on the continued development of Clinical Directors, Heads of Nursing, General Managers and those staff working in leadership roles in CSUs. The Executive Directors and

Non-Executive Director members of the Board will continue to undertake weekly leadership visits to clinical areas.

The Trust joined the Sign up to Safety Campaign in August 2014, developing its Safety Improvement Plan based on the quality improvement priorities identified in section 2.1. This will continue to be implemented in 2017/18 through the Quality Improvement Programme, and shared learning led by the Learning Lessons Group.

2.4 The Care Quality Commission

The Care Quality Commission (CQC) undertook a follow-up inspection at the Trust in May 2016, following their comprehensive inspection of March 2014. The inspection concentrated on the areas that were judged to require improvement, focusing on the five key lines of inquiry (safe, caring, effective, responsive and well-led) and the eight core services (medicine, surgery, critical care, urgent care, children's, maternity, outpatients/diagnostics and end of life care). The Trust's achieved its aim of improving its overall rating to "Good" in the inspection.

An action plan has been developed to follow up the CQC recommendations from the inspection, led by the Executive Director team working in conjunction with the CSUs and corporate teams. This has been shared with our stakeholders, and progress will be overseen by our Quality Assurance Committee on behalf of the Board.

2.5 Seven Day Services

The Trust is a significant provider of hospital based urgent and emergency care. Following an invitation from NHS England, the Trust became an early implementer of the seven day services standards and aims to deliver acute hospital services compliant with the four priority clinical standards (Standards 2, 5, 6 and 8) by March 2017. The Trust has a Seven Day Services Committee and includes membership from our lead Clinical Commissioning Group (CCG). The Trust has appointed a Lead Clinician for seven day services who is supported by a Clinical Leadership Fellow and the Associate Medical Director for Workforce.

Initial baseline audit work has been carried out against the four priority standards and the Trust will evaluate the financial implications of moving to a seven day service in compliance with the four priority clinical standards areas in the next few months. CSUs have been asked to consider seven day service provision in their Clinical Governance Forums and submit Quality Improvement Plans for consideration by the Executive Management Group and the Trust Board. The focus is on using the expertise of the clinical teams to utilise the standards to ensure that clinical outcomes, safety and patient experience are improved.

2.6 Quality impact assessment process

It is recognised that a key financial duty of all NHS organisations is to deliver on-going financial savings. Whilst organisations have been reasonably successful in delivering the required savings over recent years, this is becoming more difficult. Improved guidance on the process for completing Quality Impact Assessments (QIAs) has therefore been issued to clinicians and managers to ensure that quality was maintained, or improved, as a result of cost improvement programmes (CIPs) and service changes.

A QIA is undertaken for all major CIPs and service changes that have a potential impact on quality, safety and workforce, or on the working arrangements for staff. The responsibility for

initiating a QIA rests with the Clinical Director, Head of Nursing and General Manager for the particular area. An initial risk assessment is undertaken using the likelihood and impact against the five by five risk matrix. A full QIA is required for those CIPs and service changes that are risk assessed at greater than fifteen. The responsible CSU agree the measures they will use to judge how quality is affected by the change, based on the three domains of quality.

The Quality Impact Assessment includes a review of the potential impact on the 3 key domains, including the following areas (examples):

Patient safety

- Feedback from patients, including complaints relating to quality of care,
- Incident reports, including serious incidents,
- Healthcare associated infection,
- Key quality and safety indicators (dashboard) - pressure ulcers, falls, VTE risk assessment, dementia.

Patient experience

- Feedback from patients on quality of care through local and national surveys, including friends and family tests,
- Complaints,
- Waiting times,
- Cancelled operations or procedures on the day of admission,
- Breaches in same-sex accommodation,
- Breaches in the 4 hour emergency care standard.

Clinical outcomes and effectiveness

- Rate of 30 day readmissions,
- Length of stay,
- Mortality rates, including alerts issued by Dr Foster.

Assessment measures may also include feedback from staff to assess the potential impact on quality, e.g.

- Staff sickness absence/turnover rate,
- Staff satisfaction - survey, willingness to recommend hospital to friends and family,
- Bank and agency usage.

Full QIAs (risk assessed at >15) are reviewed and signed off by the Chief Medical Officer and Chief Nurse/Deputy Chief Executive. The change is then monitored and reviewed by the clinical team to ensure that the risks identified relating to the CIP, or service changes, are successfully mitigated. Assurance is provided through the Trust's governance structure.

Oversight of the CIP programme is provided by the Finance and Sustainability Board which is chaired by the Chief Executive. The Medical and Nursing Directors for the three Leeds CCGs meet with providers prior to the commencement of the contractual year to receive outline details and assurance of providers' CIP proposals. The purpose of the meeting is to understand the nature and content of the CIPs and be assured that they have been appropriately assessed for their impact upon quality of care.

2.7 Risks to Quality and Safety

The Trust will continue to review its top risks relating to quality and safety. These are set out in the Corporate Risk Register and reviewed at the Executive Risk Management Committee before being reported to Trust Board. Emerging risks, including potential serious incidents and serious complaints are also reviewed by the Chief Medical Officer and Chief Nurse at a weekly meeting.

The Trust faces challenges that affect services across its hospitals, consistent with other organisations both locally and nationally. These include pressures on non elective attendances, including patient flow for discharge where reviews of the city's services and estate are being undertaken by commissioners. This programme of work will continue in 2017/18. Mitigating the risk of harm to patients has been supported by the work with NHS Improvement (NHSI), and partner organisations, resulting in changing assessment and referral processes in the Trust and new ways of working with partners. A robust escalation process is in place to maintain patient safety. Regular reports are provided to the Trust Board, NHSI and the System Resilience Group.

The Trust has continued to face challenges relating to Health Care Acquired Infections and, although it has met the commissioners' threshold for CDI post unavoidable refresh, incidences of MRSA have exceeded the Trust's plan. Root cause analysis and face to face reviews take place for all reported incidents together with ribotyping to determine incidence of transmission. Support continues to be provided by NHSI with lessons learned shared through Trust-wide quality and safety briefings.

In line with the national picture, staffing challenges remain in hard to recruit areas. The impact of workforce pressures has been mitigated by the Trust's robust escalation processes involving the Executive Directors. Internally nurse staffing levels are reviewed every six months for planning purposes and daily for operational delivery. A professional support team is in place for any clinical area that demonstrates signs of deterioration. Workforce reports are provided to the Trust Board at each meeting. The Trust Board has agreed a significant nursing investment plan with a net increase of over five hundred registered nurses which will continue to be delivered in 2017/18.

The Trust is experiencing an increased incidence of patients with challenging behaviour. This includes patients with mental health needs and whose behaviour may be influenced by medical co-morbidities. This has resulted in some serious incidents and opportunities for significant learning. Closer working with partner organisations, including the Leeds Partnership Foundation Trust, has taken place to address areas such as referral protocols, patient transfer and training. Internal changes to patient risk assessment have also taken place and have been shared as an example of good practice nationally. The Trust has been involved in a national pilot for 'specialing' within this patient group and we have been successful in the recruitment of a bespoke workforce to support patient requirements. Where required, we have commissioned external support to deal with incidents requiring investigation. All of the above areas are documented in the Trust corporate risk register.

2.8 Triangulation of indicators

A summary of indicators relating to quality, workforce and finance is included in the Trust Board Quality and Performance Report (QPR). This is also reviewed at the Trust's Finance and Performance Committee and at the monthly quality review meeting with commissioners

at NHS West Leeds CCG. A combined report on incidents, complaints, claims and coroner's inquests is reviewed at the Trust's Quality Assurance Committee together with a summary of the actions agreed where improvements are required. These indicators, together with the Ward Healthcheck, help us assess the effectiveness of our improvement programmes.

The Ward Healthcheck helps assess quality and safety in individual ward areas. This provides a RAG rating based on a percentage compliance with standards that are key to influencing patient outcomes and experience. Against this is mapped information from the Ward Workforce Healthcheck, drawing information on staffing levels, attendance, recruitment, turnover, and temporary staff utilisation, for each clinical area. In Midwifery the ratio of midwives to deliveries is measured against the national standard. The collated information is used to promote and target recruitment into high need areas.

Twice yearly a review of the level of patient acuity and dependency across the wards is undertaken, and of the proportion of direct care contact time that nursing staff are engaged in with their patients. The whole package of information then informs biannual reviews of nursing and midwifery establishments and budgets to deliver an evidence based plan to support effective care delivery.

3 Workforce planning

The Trust provides workforce planning submissions to Health Education England, NHSI and the CQC. Our HR team have been active in developing the pan Leeds approach, the West Yorkshire Association of Acute Trusts work plan and, more recently, the development of the local Sustainability and Transformation Plan (STP).

The Trust's overall approach to workforce planning is set out in The Trust's current People Strategy, which has five supporting chapters:

- The Workforce Plan - operational & strategic plan,
- The Best Place to Work - our staff engagement plan,
- The Best Place to Volunteer - our volunteering plan,
- Leading Excellence in Leeds - our talent & leadership plan,
- The Best Place to Work & Train- our education, learning & development plan.

The Trust Board approved The People Strategy in 2015 and all the chapters are in the process of being updated as part of a managed programme of work.

A central principle of The People Strategy is the positive impact of staff engagement. We have worked hard to engage with our staff and we will continue to do so. The approach is called The Leeds Way and the feedback to date has been positive. The Trust uses a number of different engagement tools and surveys to collect vital information and feedback from staff. Work continues to build sustainable engagement across all staff groups, especially those who are traditionally hard to reach, such as doctors in training, facilities staff and support workers. The results of our engagement with staff are analysed at Trust, CSU and Departmental level to ensure that appropriate action plans are in place.

The workforce plan for 2017/19 has been developed from our CSU plans which have been reviewed for consistency with our activity and financial assumptions. Over the coming months all our plans will be refined to provide more detailed analysis of the planned changes in workforce and to identify key interventions the Trust will need to make, in collaboration with local STP partners, to ensure that services can be properly staffed.

The workforce plans reflect local commissioning strategies and priorities through the close working between Trust and commissioning colleagues. The aim is to ensure that the workforce plans support the delivery of clinical priorities through an on-going dialogue and all workforce risks are identified and mitigated against.

The workforce priorities are managed through a Workforce Productivity Programme Board (WPPB) which reports to the Trust's Financial Sustainability Board, chaired by our Chief Executive. A key area of focus for the WPPB is workforce productivity identified by Lord Carter's work. The Trust has been involved in a number of work streams, such as the ninety day rostering collaborative, as well as working with Lord Carter's team on developing key metrics.

The Trust continues to improve the medical and job planning process across the Trust and this approach will be rolled out to other clinical staff, such as nurses, pathology and AHPs.

Obviously the Trust's CIPs will have an impact on our workforce and this plan. In a number of areas the detail is still being developed in conjunction with our commissioners. There is an

on-going programme of work to assess the workforce CIPs, which involves finance, operations, performance and HR staff, with input from key professional leads (medical and nursing). The workforce CIP's have been developed from bottom up CSU plans and from top down corporate assessments. The CIP's will be achieved through a mix of workforce changes, agency reduction and improving unit cost.

The Trust anticipates a sustainable increase in the deployment of apprentices to ensure that we maximise the benefit of the apprentice levy. This will be supported by the Trust's involvement in the Skills for Health Centre of Excellence and the pan Leeds work on the development of a Health and Social Care Academy. The Trust's Director of HR & OD chairs a working group which is developing the Academy. Its aim is to integrate research, education and workforce development to enhance innovation and quality.

All workforce changes are supported by a Quality Impact Assessment. These are assessed by an independent group within the Trust. To ensure that the assessment is comprehensive, it considers the impact on the quality of services and the impact on the relevant staff.

There is a continued effort to reduce the use of all temporary staffing. This includes a range of approaches to reduce our reliance on agency, build our bank capacity and reduce the unit cost of agency staff. The Trust is currently under the current agency ceiling trajectory and is working to reduce the number of individual breaches. We have tendered for a new provider of our nurse bank with the aim of increasing the bank's capacity.

All workforce developments will be integral to CSU and Trust wide plans, linked to specific funding streams and aligned with the Five Year Forward View. The Trust works with a range of partner organisations to ensure collaborative working across networks and the STP. As part of this work the Trust is working with education partners to embed new roles across its services including Advanced Practitioners, Physician and Nurse Associates.

Efficient staff rostering is important and this is achieved through our e-Rostering system and the team that supports it. The Trust has an audit function that reviews the roster templates, and how they are used, in order to improve staff deployment. Rostering is used across Medical, Pathology, Allied Health Professions, Administration and Nursing and Midwifery staff groups.

The Trust's workforce approach is underpinned by leadership development within the organisation, particularly clinical leadership. The education, training and development of staff is an essential element in the Trust's pursuit of financial sustainability. To support this approach the Trust is working with the Virginal Mason Institute to develop The Leeds Improvement Method which engages clinical staff in developing improvement opportunities and implementing them in line with The Leeds Way.

The Trust's Workforce Intelligence team is working to ensure there is a wide range of information available. This is derived from a range of sources and is available to all management levels in the Trust to support visibility of data and effective decision making.

The key workforce risks at this time include:

- Implementation of the new contract for Doctors in Training,
- Expanding 24/7 working in collaboration with our partners,

- Key workforce shortages in respect of recruitment and retention, including senior medical staff in Emergency Care, sonographers and Nursing (theatres, critical care).

The Trust has a strong governance structure which monitors workforce plans. The main process for monitoring workforce efficiency is through the Workforce Productivity Programme Board which is chaired by the Director of HR and OD. This Programme Board reports into the Trust's Financial Sustainability Board, chaired by the Chief Executive. There are additional reports provided to the Trust's Finance and Performance Committee.

The Workforce Productivity Programme Board has agreed Terms of Reference and is currently focusing on the following work streams:

- Agency staffing and costs:
- Medical contracts:
- Lord Carter: workforce productivity and efficiency
- Health and wellbeing
- Workforce modernisation

The Lord Carter work stream covers all workforce efficiency work streams with a current focus on the roll out of key systems and the efficient use of rostering.

The medical contracts work stream also covers job planning. To date the project team have focused on increasing the number of job plans held in the central database and has run a series of workshops with local managers on best practice in reviewing and updating job plans. This work is supported by a Job Planning Steering Group. This group ensures that a consistent and fair approach is taken across the Trust and the guidance has been interpreted appropriately. The result of the work is an improvement in the response rate on job plans held and operational managers are reporting better engagement in the review process which is leading to better quality discussions and job plans. This is supported by our Chief Medical Officer. This work will continue through the next round of job planning. The Trust is also looking at options for an on-line tool for recording job planning although, to date, the commercially available systems do not meet our needs.

The lessons from medical job planning are being taken to expand job planning into non-medical staff groups.

4 Financial Planning

4.1 Economic Context and Financial Pressures

The NHS financial situation is set within the context of the wider economy and, whilst there are suggestions that the United Kingdom economic situation has begun to improve, there remains a requirement to reduce public sector expenditure to tackle the national deficit.

In 2012 the identified gap, between the funds available to deliver the health needs of the population and the estimated costs going forward, was circa £20bn. Efficiencies have been made to narrow the gap, however, due to the increased pressure from an ageing population and multiple co-morbidities the gap between 2015 and 2020 between the resources available to fund health care and the demands on the services is circa £30bn.

Despite these increasing challenges, the Trust has historically delivered a good performance, balancing the need to deliver financial and operational performance with high quality patient care. Trusts are funded through a national tariff for all of the acute services they deliver. However, the prices that the Trust receives have been deflated year on year and this, together with zero or marginal growth in the NHS budget and an increasingly ageing population, has put further pressure on our ability to maintain a healthy financial position whilst continuing to deliver high quality, safe and caring services to our patients.

The Trust with our local commissioners has agreed plans to ensure the needs of the local population can be met and this will continue into the future. Continually increasing demand for hospital and community services however, means that the local health economy and the Trust are facing a period of real term reductions in funding in 2017/18, resulting in the Trust setting the plan at a deficit of circa £21.2m in 2017/18.

4.2 Introduction

In 2016/17 the Trust is forecasting an improved financial performance compared to previous years despite a number of continuing challenges and financial pressures across both internal and external environments. The forecast out-turn is a £1.2 million surplus, and is consistent with the control totals accepted as part of the planning process at the beginning of the financial year.

4.3 Forecast Performance 2016/17

The Trust is forecasting the delivery of a surplus of £1.2 million in line with the plan submitted to NHS Improvement in April 2016 which included £22.8 million Sustainability and Transformation Funding required to deliver the financial position.

The forecast income and expenditure position at the end of the financial year is shown in Table 1:

Table 1: *Forecast Income and Expenditure in 2016/17*

2016/17 Income and Expenditure Forecast	£m
Patient Care Income	995.3
Other Operating Income	158.6
Sustainability and Transformation fund	22.8
Sub Total - Income	**1,176.7**
Pay Costs	(661.5)
Non Pay Costs	(461.1)
Sub Total - Expenditure	**(1,122.7)**
EBITDA	**54.0**
Non-operating Expenditure	(49.8)
Retained Deficit	**4.2**
Technical adjustments	(3.0)
Adjusted Deficit	**1.2**

There are a number of risks inherent to the delivery of the forecast out-turn, and the Trust has articulated these risks to NHS Improvement. Plans are in place to mitigate them wherever possible.

During the year the Trust has faced a number of challenges. The plan assumed delivery of a £65.6 million Cost Improvement Programme, the third year in a row where CIP was in excess of £50 million, and significantly higher than the planned national efficiency levels. Despite those difficulties, the Trust is currently delivering against its overall CIP programme.

4.4 Plan 2017/18 and 2018/19

In signing up to the proposed control totals, Boards must be satisfied any financial gap can be closed. Moreover, the closure of the gap must be stretching but achievable.

Summary impact analysis identifying the gap between income and expenditure for the next two years has been undertaken. In order to deliver the targeted position confirmed by NHSI on 1st November a gap of expenditure over income of £71.6m would need to be closed in 2017-18 (equating to c. 5.9% of turnover) falling to £31.2m (c. 2.7% of turnover) in 2018-19.

The Trust has continued to support the financial challenge up to ,and including, 2016-17 by using a range of non-recurrent measures and whilst some of these non-recurrent measures will continue to be available they will be significantly less than in previous years. In light of the significant challenges this scenario presents an alternative option that has been considered from the perspective of the Trusts ability to close a financial gap that is both

stretching and achievable. As a consequence, a scenario has been modelled to indicate a level of delivery equal to 4.8%. This scenario considers the impact of not signing up to the control totals and not receiving the STF. This scenario assumes a headline deficit of £21.2m is maintained for 2017-18 whilst the Trust addresses the underlying recurrent financial gap. This would result in a gap to close in 2017-18 of £56.7m (c. 4.8% turnover) reducing to £43.4m in 2018-19 (or c. 3.6% of turnover). In this way the Board still remains committed to drive financial recovery. In this scenario, the Trust would achieve financial balance in 2018-19 and in so doing will spread the recurrent burden of the financial gap over two years. Inevitably, the Trust will have an additional cash borrowing requirement.

This approach would require the following actions:

- Stabilising the financial position in 2017-18 and deliver an outturn deficit of no worse the £21.2m.
- Continue to plan to achieve performance standards and minimise penalties.
- Work with NHSI to agree an associated cash plan.
- Deliver a cost improvement plan of £56.7m in 2017-18 followed by a further £43.4m in 2018-19.
- Return to financial balance in 2018-19 with a surplus of £2.9m.
- Remove the underlying recurrent deficit.
- Over 2017-18 and 2018-19 the Trust would be required to close a gap of £100.1m

The plan submitted to NHSI reflects this scenario and as a consequence, the Trust is planning for a deficit of £21.2m in 2017-18, reflecting the view that the Board has taken to balance the requirement to maintain high quality and safe care against delivering challenging efficiency savings. The ability to continually deliver efficiencies over the next two years, and into the future, will be extremely challenging under this scenario, but is no different to that facing the majority of Trusts. With sound financial control and management, the Trust is well placed to continue to deliver incremental improvements in the quality of services delivered to our patients and deliver the financial performance targets agreed.

In summary, the Trust is not in a position to meet the ambitions associated with the published control totals but will, however continue to work with partners to understand how to bridge the gap and to return the Trust to surplus in 2018-19. The Trust continues to work hard to deliver the challenging control total established for 2016-17. The Trust is fully committed in its support of the national imperative to return the provider sector to balance.

The Income and expenditure position for both years is highlighted in Table 2 below:

Table 2: Planned Income and Expenditure in 2017/18 and 2018/19.

2016/17 Income and Expenditure Plan	2017/18 £m	2018/19 £m
Patient Care Income	1,024.9	1,069.4
Other Operating Income	162.2	151.1
Sustainability and Transformation fund	0.0	0.0
Sub Total - Income	**1,187.1**	**1,220.5**
Pay Costs	(666.8)	(660.7)
Non Pay Costs	(480.4)	(504.5)

Sub Total - Expenditure	**(1,147.2)**	**(1,165.2)**
EBITDA	**39.9**	**55.3**
Non-operating Expenditure	(52.2)	(52.0)
Retained Deficit	**(12.3)**	**3.3**
Technical adjustments	(8.9)	(0.4)
Adjusted Deficit	**(21.2)**	**2.9**

Key assumptions within the Income and Expenditure plan for 2017-18 and 2018-19 are:

- Pay and non-pay inflationary pressures as per NHSI guidance.
- Pay price growth estimates are based on a combination of pay award and incremental increases.
- A small amount of local cost pressures for specific items are included in the above.
- Agency will be contained within the Trust's notified ceiling of £26.035m.
- Increase in CNST contributions of 10% for both years.
- CIP at 4.8% of turnover in 2017/18 and 3.6% in 2018/19, resulting in total CIP of £56.7m and £43.4m respectively.
- Marginal cost of activity growth funded at 40% of income.

4.5 Financial Strategy

Transformational change is required across health and social care to enable the Trust to continue to deliver high quality, safe and affordable services. The emphasis on delivering clinical pathway improvements across acute and community enabling patients to be treated closer to home is essential for transformation but requires all health and social care partners to work together.

In addition to this wider context in which the Trust will operate throughout 2017/18, a number of short term challenges and objectives exist, not least delivering quality initiatives such as improved staffing ratios, 7 day services and improved cancer pathways, to improve access and the quality of care for patients.

The 2017/18 financial plan, has been set based on provisionally agreed activity levels (accounting for demographic growth and developments) with local CCGs. The major risks to delivery are forecasts for continuing growth in emergency demand (in the range of 3-7%), and the impact of such growth, if not mitigated by demand management measures, on the Trust's ability to deliver its elective activity plan.

Whilst initial priority has been given to agreeing the CCG contract, progress has also been made with NHS England Specialist Commissioner and the initial reported financial gap of £31m currently stands in the region of £11m, mainly around forecasts and delivery of activity growth, which is critically dependent upon workforce recruitment and retention. NHS England is also concerned about the affordability of its own high cost drug growth projections. Whilst these are real risks, they are not considered to be significant and should not prevent the Trust signing off an indicative contract plan. The Trust is now prioritising agreement with NHS England and do not believe it will require external mediation or arbitration to achieve this.

Good progress has been made with both sets of commissioners to agree Commissioning for Quality (CQUIN) schemes, as well as quality, information and service development schedules required by the contract.

The CCG are planning demand management initiatives to prevent a reoccurrence of the increase in non-elective growth. If these initiatives do not have the desired effect and the Trust continues to experience this unplanned level of demand, significant costs on opening additional beds, agency and locum staff at short notice will be incurred to ensure the safety of our patients. If this is not supported by additional funding from the commissioners the continued financial viability of the Trust will be threatened. In light of this, the Trust is currently considering alternative solutions in preparedness for any future demand.

The strategy outlined above articulates the need to sustain high quality, effective patient care, to do this, changes to the local health and social care system are essential, some of these changes are outside of the control of the Trust. Investment is required to enact this change, at a time when resources are scarce; this coupled with the level of efficiency built in to the tariff option has prevented the Trust from planning for a surplus in 2017/18.

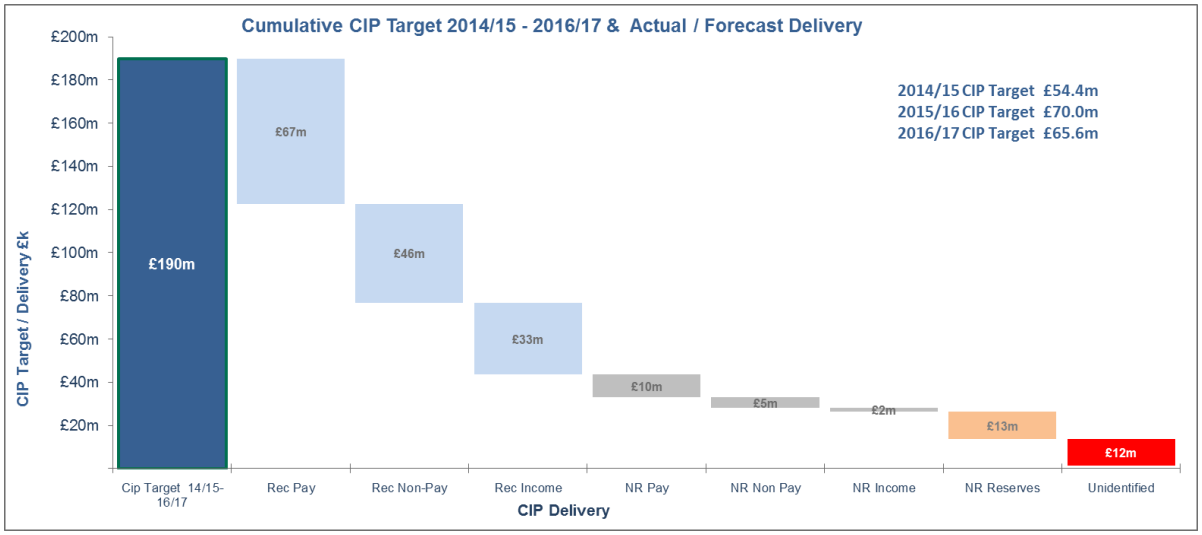
4.6 Efficiency

The Cost Improvement Programme is integral to the Trust's financial planning and require good, sustained performance in order to be achieved. The Trust continues to face a national tariff with built in efficiencies, reduced overall funding in the local health economy and inflationary price pressures. Given limited Clinical Commissioning Group and NHS England resources within the overall Leeds catchment there is limited opportunity to use income generation to offset savings requirements going forward.

To ensure the organisation remains financially sustainable into the future CIP requires to be transformational and cross cutting in nature which may ultimately lead to difficult choices about services, and how they are provided.

The Trust has performed strongly in recent years of delivering it's CIP target, which over the last three financial years amounts to £190m. This is illustrated in the diagram below which highlights the actual and forecast delivery since 2014-15.

Diagram: CIP Delivery 2014-15 to 2016-17.



At the time of writing it is predicted that the Trust will not be able to deliver the target of £65.6m for 2016-17 by £12.1m (including assumed non-delivery of high risk schemes). Given the progress the Trust has made over this timeframe the Trust believes that the maximum efficiency that can be achieved is 4.8% (£56.7m) in 2017/18 and 3.6% in 2018/19 (£43.4m). This target, whilst realistic will remain challenging for the organisation to deliver and is clearly significantly higher than the NHS national tariff efficiency deflator of 2%.

To facilitate the development of robust CIP schemes that can be implemented from April 2017-18 the finance team have been working with Clinical / Corporate Support Unit's across the Trust to drive and develop plans so the Trust is positioned to deliver the challenging efficiency agenda and has identified £27.7m (49%) of potential schemes for implementation in the next financial year. These are documented in the table below.

Table: Identified schemes for 2017/18

CIP Category	£'000
Income (Other operating income)	445
Income (Patient Care Activities)	85
Pay (Skill mix)	2,337
Pay (WTE reductions)	9,942
Non pay	14,899
Grand Total	**27,708**

The Trust continues to develop schemes for 2017-18 and the longer term, supported and evidenced by benchmarking data, PLICs, reference costs data and Lord Carter information. Ongoing updates will be provided as to progress in identifying additional schemes for 2017-18 and 2018-19 at intervals prior to the start of the new financial year, and as part of the monthly monitoring returns thereafter.

4.7 Conclusion

As indicated above, based on the Trusts current financial trajectory, the Trust is not currently in a position to meet the published control totals. Nevertheless, we continue to work with partners to understand how to bridge the gap and to return the Trust to surplus in 2018-19.

The Trust remains committed to delivering the challenging control total established for 2016-17 and understands the national imperative to return the sector to balance.

Although the Trust is not in a position to deliver the control total in 2017-18, the plan submission anticipates that at the end of 2018-19 the Trust will return to surplus without recourse to the Sustainability and Transformation Fund over that same 2 year period.

4.8 Capital planning

As in previous years, capital will be allocated very carefully in 2017-18 and beyond to ensure that the very limited resource is directed at protecting patient safety, modernising capacity where possible, and increasing the productivity of Trust systems and processes. Available capital is restricted by the offset of repayment loans and PFI capital payments.

There are estate, equipment and infrastructure strategies in place to deliver the Trust's longer term ambitions and recognise the backlog difficulties. Each of the Trust's capital programmes has an agreed process for deciding spend which starts with the CSUs and ends with the Trust Board, based on a system of prioritisation against agreed criteria.

The capital plans identified for action in 2016-17 which are designed to support agreed clinical and commissioning strategies (upgrading the generating complex at LGI, reopening of a previously redundant theatre at LGI and opening a gynaecology ambulatory unit) have now taken place. The upgrading of the LGI generating station will be completed in 2018/19 with a new substation and increased electrical capacity in 2017. The proposal to create a CRF facility and centralising the Trust's Research and Innovation HQ in a vacant grade 2 listed building has now been agreed, along with a successful bid for funding for staff and work has just started.

The capital strategy is focussed on the strategic outline case "Building the Leeds Way" which will be submitted to NHSI shortly following the Trust Board meeting. This brings together many of the Trust's capital priorities which includes increasing inpatient and day case theatre capacity, improving the co-locations of outpatients, increasing endoscopy capacity and improving patient and staff environments. The capital strategy also reduces B&E backlog by over £40m and the size of the estate by approximately 35,000sqm. This facilitates the potential further disposal of estate.

Investment in IT is also planned to ensure the Trust has a resilient infrastructure and to facilitate the transformation of services to move towards paperless systems with a strategic outline case being submitted to the Trust Board in January. St James's Energy Centre will be replaced in 2018 ensuring the continuity of an efficient supply of heat and electricity on the St James's site

5 Link to the Sustainability and Transformation Plan

5.1 West Yorkshire and Harrogate Sustainability & Transformation Plan

The Trust is located at the centre of the West Yorkshire and Harrogate STP (WYSTP) footprint and we have been closely involved in the development of this plan. The WYSTP covers all of the six local acute trusts (five in West Yorkshire plus Harrogate) and eleven CCGs. All local health and social care organisations in the STP are committed to working together to support the changes needed to improve our services for the two and half million people who live in the area.

The STP aims to address the health and wellbeing gap across the local population with a focus on supporting people to live longer, healthier lives, and ensuring a good and equitable service for all, regardless of postcode. The STP also stresses the importance of improving people's health through better coordination of services whilst improving the quality of care received.

Specifically for the Trust there are a number of proposals which directly support our operational plan. The overall aims of 'focusing on prevention, early intervention and inequalities', 'supported self-care' and' joined-up community services across mental & physical health and social care' are key to resolving some of the pressures the Trust is experiencing with sub-acute care patients.

Further efficiency and uniformity across CCGs and back office functions will assist the health economy to deliver a number of gains. It is also imperative that a more sustainable model is developed for a number of potentially unsustainable hospital services across the region. This is highlighted within the STP requiring 'a smaller number of centres of excellence providing specialist care'. This latter piece of work is being developed by the West Yorkshire Association of Acute Trusts.

5.2 West Yorkshire Association of Acute Trusts (WYAAT)

An important role of WYAAT is to develop a collaborative programme of clinical and non-clinical work streams to reduce variation and deliver sustainable services. This will involve designing safe and efficient services over the STP footprint using new models of care.

The five key steps to developing the WYAAT Collaborative Programme approach are set out below;

1. Developing 'Centres of excellence',
2. Developing West Yorkshire and Harrogate standardised operating procedures and pathways,
3. Collaborating to develop clinical networks and creating alliances,
4. Developing workforce planning at scale,
5. Delivering economies of scale in back office and support functions.

5.3 The Leeds Plan

As well as the principles set out in the West Yorkshire and Harrogate STP, each of the six council areas within the STP has their own contributory plan. The Leeds Plan emphasises the need to work with its residents through its eighteen neighbourhood teams to improve the

health of the poorest people the fastest. It focuses on prevention programmes for key groups. It also intends to improve the integration of its primary and community services for proactive care, rapid response, self-management, secondary care and urgent care. Strengthening general practice will be the cornerstone of new models of care designed around GP registered lists. The Leeds Plan includes:

Health and wellbeing

- Progress the twelve priorities in the Leeds Health and Wellbeing Strategy to reduce premature morbidity and mortality and help narrow the health inequalities gap,
- Reduce smoking rates from 21% to 13% by 2020/21 (for adults aged 16 years +),
- Increase uptake in breast cancer screening to the England average of 75% by 2020,
- Increase the uptake of bowel cancer screening by 3% by 2020,
- Bring the Leeds suicide rate down below the national average by 2020/21,
- Support the 2,880 people who have been identified to be at risk of developing diabetes to attend the NHS National Diabetes Prevention Programme by 2019/20.

Care and quality

- Ensure 60% of those on Severe Mental Illness register undergo a physical health check each year,
- Eliminate acute mental health out-of-area placements by 2020/21,
- Deliver the Emergency Care Standard,
- Reduce the numbers of patients admitted as emergency cases for bed-based care,
- Reduce bed days lost due to delayed discharges to 2.5% of the acute bed base by 2020/21,
- Reduce the numbers of learning disability inpatient placements to 40 per million of population by 2019/20,
- Reduce staff shortages by building multi-disciplinary teams and ensuring wider skills base for specific functions (e.g. care home worker),
- Ensure that 80% of people with a diagnosis of dementia will have been offered information and support to live with the condition, and a named contact with a 'care navigator' role, by 2020.

Finance

- With current plans, the forecast for 2020/21 Health and Social Care is a deficit of c. £46m.
- It is assumed that Leeds will receive a ‘fair share’ of national Sustainability and Transformation Funds to bridge the gap in conjunction with the actions in the STP.

5.4 Trust involvement in the STP

The Trust has been a key contributor to the development of the STP and the Leeds Plan, and will continue to be so in the future. Members of the Executive Directors team, and several other senior managers and clinicians, are members of the various sub committees, some chairing key groups. All of the work streams align with the Trust’s operational plan which itself focusses on developing a high quality specialised centre whilst also providing efficient and effective secondary care for the public of Leeds.