Annual Plan Update

Trust Board
Thursday 26 November 2026

Presented for:	Information, Discussion
Presented by:	Jenny Ehrhardt – Chief Finance Officer and Deputy CEO
Author:	Robert Hakin - Director of Healthcare Planning Chris Ellison - Deputy Chief Finance Officer Alison Wilkinson - HR Transformation Lead
Previous Committees:	None

Freedom of Information Act (FOIA) Exemption	☐**YES** (restricted from the FOIA) ☒**NO** (available to the public under the FOIA)

Link to Strategic Objective	Focus on care quality, effectiveness and patient experience
Link to Provider Capability Assessment	Governance, risk and regulatory
Link to CQC Well-led Statement	Governance, Management and Sustainability
Regulatory Impact	N/A

Key points	**Purpose**
1. The 2027/28 planning process has commenced, with governance arrangements and workstreams established to develop an integrated Trust plan.	*Information*
2. Initial activity, performance and financial assumptions have been developed pending publication of national planning guidance and funding allocations	*Information*
3. Early analysis highlights key risks and opportunities across performance, workforce, productivity and finance	*Information*
4. High level performance, finance and workforce trajectories have been developed to support early planning and require Board discussion regarding the level of ambition and deliverability for 2027/28.	*Discussion*

Risk Appetite Framework

Level 1 Risk	**Level 2 Risks**	**(Risk Appetite Scale)**	**Impact**
Workforce Risk	Workforce Performance Risk - We will deliver safe and effective patient care through having the right systems and processes in place to manage performance of our workforce.	Cautious	Operating within
Operational Risk	Business Continuity Risk - We will develop and maintain stable and resilient services, operating to consistently high levels of performance.	Cautious	Operating within
Clinical Risk	Capacity Planning Risk - We will ensure that capacity is planned to meet the demand for elective and non-elective	Cautious	Operating within

	(acute) admissions to our hospitals, managing this risk to provide safe treatment and care to our patients.		
Financial Risk	Financial Management & WRP - We will deliver sound financial management and reporting for the Trust whilst seeking to deliver against Waste Reduction targets but always with a focus on maintaining and enhancing patient safety.	Cautious	Operating within

1. Summary

The Trust has commenced the 2027/28 planning process and established a programme structure to develop an integrated plan across activity, performance, workforce, finance, productivity and quality. The planning process will be led through a triangulated approach, ensuring consistency of assumptions and alignment between key planning submissions.

A Planning Steering Group has been established with representation across operational, performance, workforce, finance and planning functions. A programme of CSU review meetings, executive oversight and Committee assurance has been agreed to support development of a credible and deliverable plan.

Whilst national planning guidance and submission deadlines are yet to be formally published, informal information has been received that a similar process to the 2062/27 planning will be followed. The Trust has therefore developed an internal timetable to ensure readiness for expected submissions and associated Board approvals.

Early engagement with regional and national planning teams indicates that organisations will be expected to produce realistic, affordable and fully triangulated plans, supported by robust governance and Board oversight. The emerging national approach is based on a "comply or explain" principle, whereby organisations are expected to deliver national planning requirements or provide a clear rationale, risk assessment and mitigation plan where this is not achievable. This approach aligns with the Trust's planning methodology and governance arrangements.

2. Update

A governance framework has been established to oversee development of the 2027/28 plan, including a Planning Steering Group, executive oversight arrangements and Finance & Performance Committee assurance. Structured engagement with Clinical Service Units (CSUs) will take place through a series of planning review meetings to develop, challenge and refine plans prior to final sign off.

Planning workstreams have been established across activity and performance, workforce, finance and productivity, with a focus on ensuring plans are fully aligned and deliverable. An internal planning timetable has been agreed pending publication of national planning guidance and submission requirements.

National and Regional Context

Although national planning guidance has not yet been formally published, early regional planning principles have been shared with providers. These place particular emphasis on:

Development of realistic, deliverable and affordable plans.

- Full triangulation of finance, activity, performance, workforce and quality assumptions.
- Board ownership and oversight of planning assumptions and risks.
- Early identification and escalation of risks and delivery challenges.
- A "comply or explain" approach to national planning requirements, with any areas of non-compliance requiring explicit justification and agreed recovery actions.

The regional framework also makes clear that plans will be assessed against their credibility, affordability, deliverability and degree of triangulation, with organisations expected to demonstrate robust governance and Board oversight throughout plan development.

Planning Approach

The Trust has established a number of planning workstreams covering:

- Activity and Performance
- Workforce
- Finance
- Productivity and Efficiency
- Governance, Assurance and External Engagement.

A core design principle is that activity, performance, workforce and financial assumptions will be developed and tested together rather than through separate planning exercises. This approach seeks to ensure consistency between submissions and reduce the risk of planning returns becoming misaligned.

The planning methodology will start from required performance outcomes and work backwards to determine the activity, capacity, workforce and financial requirements necessary to deliver these trajectories. Particular focus will be given to RTT recovery, diagnostics, cancer performance and urgent and emergency care standards.

CSU Engagement and Assurance

A structured CSU planning review process has been established comprising three stages:

Session 1: Initial Plans and Assumptions

- Review baseline plans and assumptions.
- Identify risks, dependencies and capacity constraints.

Session 2: Challenge and Refinement

- Triangulate plans across activity, workforce, finance and productivity.
- Refine trajectories and delivery assumptions.

Session 3: Final Review and Sign Off

- Confirm affordability, deliverability and alignment.
- Agree final risks, mitigations and accountability arrangements.

Outputs from CSU reviews will be incorporated into both the Trust planning submission and the Integrated Accountability Framework to support ongoing monitoring throughout 2027/28.

Governance and Timetable

The proposed governance route includes:

- Executive review of key planning assumptions and emerging risks
- Finance & Performance Committee scrutiny of planning submissions and affordability
- Trust Board approval of planning submissions prior to external submission deadlines.

The current planning timetable allows for:

- Initial CSU planning reviews during November and December

- Challenge and refinement phase during January
- Final CSU sign off during late January
- Trust Board approval ahead of final submission.

The internal planning timetable has been developed ahead of formal national deadlines to ensure sufficient time for challenge, assurance and Board consideration. It may therefore need to be adjusted if national deadlines require.

3. Initial Planning Outputs

a. Activity and Performance

The assessment below provides an initial high level view of the Trust's potential 2027/28 planning position based on current activity, performance and demand assumptions. National Planning Guidance, commissioning intentions and financial allocations have not yet been published and a number of key planning assumptions therefore remain uncertain. Specific 2027/28 performance trajectories have not yet been published. In the absence of national guidance, the assumptions set out in this paper are based on the Trust's three year plan submitted in 2026/27 and the national performance ambitions published for 2028/29.

- 28/29 Req: Nationally published performance expectation to be achieved by the end of 2028/29.
- 27/28 Ass: Assumed 2027/28 planning position based on progression towards the 2028/29 requirement.
- 27/28 Plan: Trust's 2027/28 trajectory as submitted within the three year plan in March 2026.
- Current: Latest reported performance.

The assessment should be viewed as an early indication of opportunities, constraints and potential risks. Further work will be required to validate assumptions, quantify risks and develop mitigating actions as national requirements and funding assumptions become clearer.

Area	Initial Position	Key Implications
RTT 28/29 Req: 92.0% 27/28 Exp: 85.0% 27/28 Plan: 79.0% Current: 66.5%	Improvement on current performance but remains significantly below the 92% constitutional standard.	The Trust continues to face a growing admitted backlog, particularly within surgical specialties and remains significantly below the 92% constitutional standard and current national expectations. The Trust continues to face a growing admitted backlog, particularly within surgical specialties, where inpatient and day case capacity is the principal constraint to recovery. Whilst productivity, outpatient pathway redesign and validation activity may support further improvement, delivery remains challenging and will require further capacity and efficiency gains beyond those currently assumed. Any future national planning requirements may necessitate a higher level of ambition.
Cancer 28 Day 28/29 Req: 80.0% 27/28 Exp: 80.0% 27/28 Plan: 81.9% Current: 77.2%	Remains above the national standard and builds on strong recent performance.	Performance is expected to remain sustainable, supported by established diagnostic pathways and continued focus on pathway management, although increasing urgent suspected cancer demand will continue to place pressure on services.
Cancer 62 Day 28/29 Req: 85.0% 27/28 Exp: 82.5% 27/28 Plan: 82.5% Current: 74.0%	Continued improvement planned but initial plan was below national expectations. Options	Delivery remains dependent on diagnostic and treatment capacity across key tumour sites. Performance is increasingly affected by growing urgent suspected cancer referrals and the volume of late tertiary and specialist referrals received from partner trusts, reducing the time available for LTHT to complete treatment within standard.

	for internal review and improvement.	Sustainable improvement will require both local recovery actions and regional pathway improvements.
Diagnostics 28/29 Req: 99.0% 27/28 Exp: 98.0% 27/28 Plan: 98.0% Current: 90.0%	Maintains strong performance and remains above national standards.	Delivery remains dependent on sustaining diagnostic productivity and addressing workforce shortages in key specialties including radiology and ultrasound.
ED 4 Hour Wait 28/29 Req: 85.0% 27/28 Exp: 83.5% 27/28 Plan: 83.0% Current: 75.5%	Improvement from current levels but remains below the 95% standard.	Achievement remains heavily dependent on improvements in patient flow, discharge performance and reduction in patients with no criteria to reside. Many of the key levers sit outside the Trust's direct control and require sustained system-wide delivery.
Activity	Proposed growth includes 1.9% day-case growth, 2.4% inpatient growth and 1.2% first outpatient growth.	Current assumptions require further review against recent demand trends, particularly elective referral growth which has exceeded plan assumptions over recent years. Delivery of performance trajectories, especially RTT recovery, remains highly sensitive to referral growth, acute demand and wider system assumptions. Further discussion with the ICB will be required to confirm planning assumptions and align activity levels with underlying demand.

These trajectories represent an early planning assessment based on current operational assumptions. Whilst initial modelling indicates improvement across all major performance standards, significant challenges remain in relation to RTT, Cancer 62 Day performance and Emergency Care. The position will be refined following publication of national planning guidance, commissioning intentions and agreement of system planning assumptions, with a fuller assessment of demand, capacity, workforce, finance, risks and mitigations informing the final planning position presented to Board.

b. Finance

Revenue

As part of the previous Medium Term Plan, NHSE set the Trust a breakeven 'Plan Limit' from 2026/27 to 2028/29. The Board approved a breakeven revenue plan in each of the three years based on the principles, guidance and contracts at that time.

In the absence of planning principles, contract offers and confirmation of the Cost Uplift Factor (CUF), the initial plan submission expected for mid-December will broadly follow the principles approved in the previous Medium Term Plan, updated for the latest 2026/27 forecast outturn against key variables. Adverse variance against those key variables is likely to result in an initial deficit draft plan submission.

Table 1 below details the previous Income and Expenditure plan at summary level, and Table 2 details the latest 2026/27 forecast outturn against the original plan, which has been impacted by several items not least the approval of higher pay deals which have increased both the income and pay position.

Table 1: Summary Income and Expenditure plan

Category	2026/27	2027/28	2028/29
	£m	£m	£m
Operating income from patient care activities	1,860.4	1,918.1	1,972.0
Other operating income	313.1	312.1	319.3
Total income	**2,173.5**	**2,230.2**	**2,291.3**
Pay Expenditure	-1,250.6	-1,284.1	-1,316.0
Non-Pay expenditure (including non-operating and technical)	-922.9	-946.1	-975.3

Total expenditure	**-2,173.5**	**-2,230.2**	**-2,291.3**
Plan Surplus/(deficit)	**0.0**	**0.0**	**0.0**
Memo - WRP	*95.0*	*95.0*	*95.0*

Table 2: 2026/27 Forecast Outturn compared to the original plan

Category	2026/27 Original Plan	2026/27 FOT	2026/27 Variance
	£m	£m	£m
Operating income from patient care activities	1,860.4	1,873.4	13.0
Other operating income	313.1	364.9	51.8
Total income	**2,173.5**	**2,238.3**	**64.8**
Pay Expenditure	-1,250.6	-1,307.0	-56.4
Non-Pay expenditure (including non-operating and technical)	-922.9	-931.3	-8.4
Total expenditure	**-2,173.5**	**-2,238.3**	**-64.8**
Plan Surplus/(deficit)	**0.0**	**0.0**	**0.0**
Memo - WRP	*95.0*	*95.0*	*0.0*

An indication of some variables that will impact the 2027/28 plan:

Non-Recurrent Waste Reduction

The 2026/27 Board approved plan assumed non-recurrent WRP delivery of £28.2m however the latest forecast outturn is £33.3m. This £5.1m adverse variance adds to the underlying position going into 2027/28 and will require mitigation to still achieve a breakeven plan.

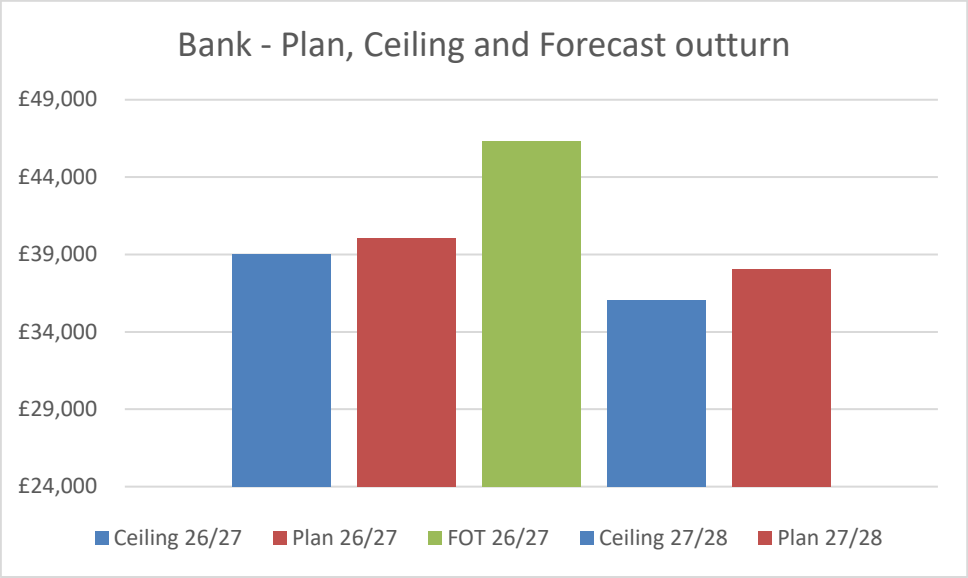
Bank and Agency spend

NHSE set all organisations a bank ceiling through to 2028/29 in the previous Medium Term Plan. As the Board is aware, the Trust set a bank plan at a higher level than the ceiling due to our position in the lowest quartile (i.e. lowest opportunity) and our plan assumed a shift from agency and overtime into bank.

Graph 1 below details that the current bank forecast outturn is £6.3m higher than the plan, which represents c104 WTE based on current average bank costs. The current forecast is £7.3m (c120 WTE) above the ceiling.

The context heading into 2027/28 is that we will need to reduce our forecast outturn costs by £8.3m (c138 WTE) to achieve the original plan set for next year, or £10.3m (c171 WTE) if we are mandated to achieve the ceiling.

Graph 1: Bank spend current year compared to plan and original 2027/28 plan

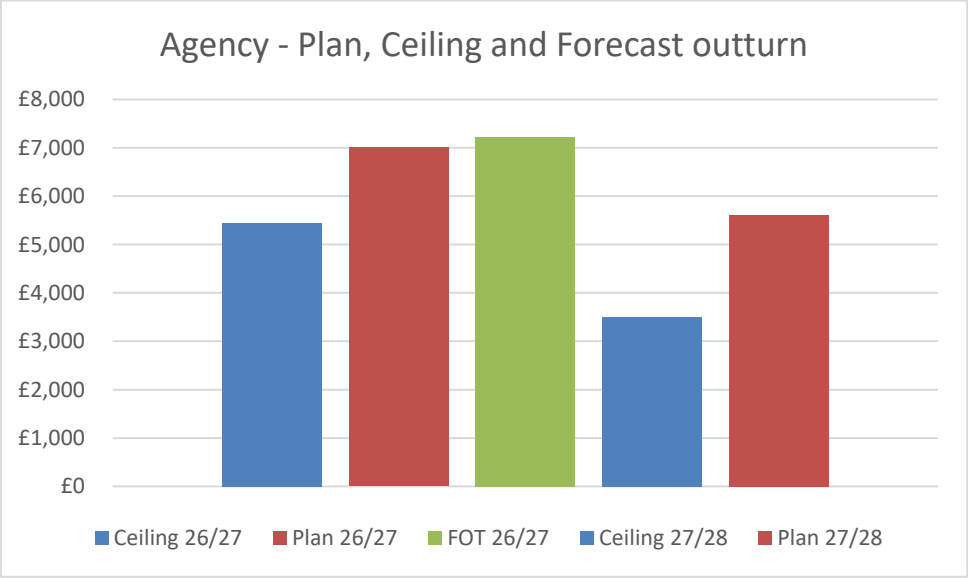


NHSE also set all organisations an agency ceiling through to 2028/29, and as with bank the Trust set an agency plan at a higher level than the ceiling due to the level of reductions previously delivered and our position in the second lowest quartile.

Graph 2 below details that the current agency forecast outturn is £0.2m higher than the plan, which represents c3 WTE based on current average agency costs. The current forecast is £1.8m (c27 WTE) above the ceiling.

The context heading into 2027/28 is that we will need to reduce our forecast outturn costs by £1.6m (c24 WTE) to achieve the original plan set for next year, or £3.7m (c56 WTE) if we are mandated to achieve the ceiling.

Graph 2: Agency spend current year compared to plan and original 2027/28 plan



Underlying position

The underlying position coming into 2026/27 was £60m deficit. The latest assessment of the exit run-rate heading into 2027/28 submitted in the Month 7 Provider Assurance Model is an underlying deficit of £70m. We will continue to refine this assessment and review the recurrent and non-recurrent items throughout the Medium Term Plan process.

Waste Reduction Planning

The Board approved plan included Waste Reduction targets of £95m in each year through to 2028/29 to achieve breakeven in each year. This requirement will be reviewed in the context of the 2026/27 exit run-rate, planning principles, CUF and contract offers. In particular, the current 2026/27 gross identification is c£12m below the target, which will be required to be found in 2027/28 if it is not identified recurrently in 2026/27.

Following the Waste Reduction Conference on 5th November the current assumptions were communicated in a letter to Clinical Directors and Executive leads for non-clinical CSUs, requesting plans to be built up for the 4% tactical target, equating to c£58m, and issuing a support pack for ideas generation. A first submission deadline of 18th December has been set with an ambition to have 75% ideas identified at a gross level.

In addition, the grip and control, cross cutting schemes and difficult choices agreed through Turnaround Executives have an estimated full year effect next year of c£24m. Therefore, at the draft plan stage we have a gap of c£13m if the target can be maintained at £95m.

Capital

NHSE issued 4-year capital allocations last year through to 2029/30 (excluding PFI lifecycle replacements and donated/grant funding as these do not impact on the Trust CDEL allocation), with the allocation for 2027/28 set at £74.3m as per table 3 below.

Table 3: Capital allocation

LTHT allocation	2026/27 £m	2027/28 £m	2028/29 £m	2029/30 £m
Operational Capital	42.1	43.6	44.9	48.5
Estates Safety Fund (PDC)	10.0	10.0	10.0	10.0
Maternity and LGI BLM mitigations (PDC)	10.0	5.0	10.0	10.0
Return to Constitutional Standards (Elective) – CAH (PDC)	18.7	11.2	0.0	0.0
Return to Constitutional Standards (Diagnostics) – Seacroft CDC (PDC)	12.0	0.0	0.0	0.0
Urgent and Emergency Care – UEC (PDC)	1.3	3.5	16.0	32.0
Mental Health, Learning Disability and Autism (PDC)	1.0	1.0	0.0	0.0
Total	**95.1**	**74.3**	**80.9**	**100.5**

The capital position for this year and subsequent years continues to be fluid due to regional slippage, additional PDC allocations such as the Digital fund and other national funding priorities. The Trust continues to engage regionally and nationally on additional funding opportunities to increase the capital allocation and the draft plan will include the latest known position.

The Capital Planning Group is currently working through the prioritisation of schemes for 2027/28, with an initial indication of c£25m pressure against the allocation. This represents a significant risk to the Trust, which is reflected in the Corporate Risk Register.

Cash

Delivery of the 2026/27 financial plan to start next year with a strong cash position is fundamental. The current year forecasted cash balance at the end of March 2027 in the Month 5 Fundamental Review best case is c£85m. Achieving the 2027/28 financial plan of breakeven, including full delivery of the waste reduction plan would result in no requirement for revenue cash support throughout next year, however continued focus is required on delivery of the revenue plan, phasing of the capital programme and phased delivery of the waste reduction programme as these have a significant bearing on the cash position.

c. Workforce

Our year-end workforce plan requires contracted workforce to reduce to 19,290.40 FTE. In October 2026, in-month contracted workforce remained 62.2 FTE (0.3%) above the year-end target.

Our start point for the 2027/28 plan will be to review the Year 2 of the previous year's plan and then to work with colleagues through the planning group to understand where any activity, performance and finance changes impact on the previous plan.

The current 2026/27 FTE position reflects a number of planned and operational workforce pressures, including:

- Targeted investment in priority services, particularly Maternity and Neonates.
- Support to maintain fragile regional services, including Neurology provision at CHFT.
- Independent Review
- Development of a clustered CSU model
- Increase in resources within NIHR

Contracted workforce reduction

A targeted workforce strategy is in place to deliver the required year-end reduction, with a strengthened focus on workforce grip, control and productivity. Key actions include:

- CSU-specific FTE reduction targets, with delivery and trajectories monitored through Integrated Accountability Meetings (IAMs).
- Strengthened vacancy controls, with Executive Director approval required for recruitment within CSUs rated Red or Amber for Finance.
- Focused action to reduce sickness absence, improving workforce availability and reducing reliance on additional staffing.
- Closer alignment of flexible working arrangements with service and operational requirements, supporting effective deployment of workforce capacity.
- Job Planning Consistency Panels to identify and address anomalies and strengthen consistency and efficiency in job planning.

Bank and agency reduction

Alongside the contracted workforce actions, a targeted strategy is also in place to deliver the required reduction in bank and agency usage and expenditure (as referenced in the finance section above), with a particular focus on strengthening control, reducing dependency and improving workforce planning. Key actions include:

- CSU-specific variable pay reduction targets, with delivery and trajectories monitored through IAMs.
- Centralisation of bank arrangements, creating greater grip and control over usage and expenditure through a consistent, Trust-wide approach.

- Reduction in agency dependency through targeted conversion of agency workers to bank or substantive employment, where appropriate.
- Strengthened Executive oversight of non-clinical overtime and non-clinical agency usage, ensuring additional expenditure is appropriately controlled and challenged.
- Improved annual leave planning, supporting more effective workforce deployment and reducing avoidable reliance on temporary staffing.

4. Quality and Performance Implications

The planning process will support development of a deliverable 2027/28 plan, with activity, performance, workforce and quality assumptions developed in a fully triangulated way. Particular focus will be placed on delivery of national performance standards, including Urgent and Emergency Care, RTT, Cancer and Diagnostics.

No specific service changes are proposed within this report. Any quality or patient safety impacts arising from individual planning proposals will be assessed through the Trust's Quality Impact Assessment process.

5. Financial Implications

There are no direct financial implications arising from this report. The paper provides an update on the Trust's approach to developing the 2027/28 annual plan and does not seek approval for expenditure or investment.

A key objective of the planning process is to develop an affordable and sustainable financial plan aligned to activity, workforce and productivity assumptions. Financial risks, efficiencies and affordability assessments will be reviewed through the planning governance process and reported to future meetings of the Committee.

6. Risk

The principal risks at this stage are:

Risk	Mitigation
National planning guidance and submission timetable not yet published	Internal programme mobilised early with local timetable established to maintain readiness.
Potential gaps between activity, finance and workforce assumptions	Structured triangulation process and multidisciplinary review through workstreams and CSU sessions.
Delivery assumptions not meeting emerging regional planning tests	Early executive oversight and application of regional planning principles throughout development.
Areas of potential non-compliance against future planning requirements	Adoption of a comply-or-explain framework with clear mitigation plans and Board oversight where required.
Commissioner affordability of activity levels to achieve performance standards	Continued dialogue with ICB and Specialised Commissioning colleagues.

These risks will continue to be reviewed through the Planning Steering Group and escalation routes established as part of the programme governance arrangements

7. Communication and Involvement

Engagement with Clinical Service Units (CSUs) is being undertaken through a structured programme of planning review meetings to develop, challenge and agree activity, performance, workforce, productivity and financial assumptions. This process is designed to ensure local ownership of plans and provide opportunity for challenge and refinement prior to Trust sign off.

The Trust is also working closely with the West Yorkshire ICB and regional NHS teams to ensure alignment with emerging planning guidance, system priorities and planning assumptions throughout the development of the 2027/28 plan.

8. Impact on Equality & Health Inequalities

A Quality Impact Assessment (QIA) and Equality and Health Inequalities Impact Assessment (EHIA) will be completed alongside the final planning submission. At this stage, no adverse impacts have been identified and the planning process is intended to support improvements in access, outcomes and patient experience through delivery of national priorities and performance standards.

The final assessments will inform the completed 2027/28 plan and identify any actions required to mitigate inequalities and support equitable access to services

9. Publication Under Freedom of Information Act

This paper is exempt from publication under Section 22 of the Freedom of Information Act 2000, as it contains information which is in draft format and may not reflect the organisation's final decision.

10. Recommendation

The 2027/28 planning process has been mobilised, governance arrangements established and key workstreams launched. Early engagement with regional and system partners has commenced and an internal timetable is in place pending publication of formal national guidance and submission requirements.

The Finance & Performance Committee and Board will receive further updates as national guidance is published and as planning assumptions mature, including reviews of activity and performance trajectories, workforce plans, productivity assumptions and financial affordability.

The Board is asked to:

- Note the progress made in establishing the 2027/28 planning process.
- Take assurance regarding the governance arrangements and planning timetable.
- Note the key risks and mitigations currently identified.
- Support the proposed approach to the development of a triangulated Trust plan for 2027/28.

11. **Supporting Information:** Appendix 1: 2027/28 Planning Project Structure

Leeds Teaching Hospitals 2027/28 Planning Process. SRO: Robert Hakin

To deliver a Board approved integrated plan for 2027/28, underpinned by triangulated activity, performance, workforce and financial assumptions. The plan will set out how the Trust intends to deliver NHS operational standards, improve quality and productivity, maintain financial sustainability and support delivery of strategic priorities. Including governance arrangements will provide assurance on plan delivery, risks, mitigations and progress throughout 2027/28.

Internal Governance, Assurance & Approval: Robert Hakin

Ensure Executive Engagement and secure formal approval of the Trust's 2027/28 plan.

- Executive review of emerging plans and key planning assumptions.
- Resolution of cross-cutting risks, dependencies and resource issues.
- Review of the draft plan through Finance & Performance Committee.
- Board approval of the final 2027/28 plan.
- Agreed governance arrangements for monitoring delivery throughout 2027/28.

External Engagement & System Planning: Tanz Rayaz-Pinder and Andrew Baines

Ensure alignment with NHSE guidance and system requirements throughout plan development.

- NHSE planning guidance reviewed and translated into Trust assumptions and trajectories.
- Ongoing engagement with the ICB regarding plans.
- Participation in system planning and negotiation processes.
- Alignment of Trust plans with agreed system priorities and assumptions.
- Submission of the Trust's final plan and response to any feedback or required revisions.

Activity & Performance
James Burrows and Paul Cook

- Agreed activity plan by specialty and service line.
- Performance trajectories (ED, RTT, Cancer, Diagnostics, etc)
- Elective recovery and waiting list reduction plans.
- Capacity and demand assessment, including bed and theatre requirements.
- Agreed assumptions for non-elective growth and outpatient activity.

Financial
Chris Ellison and Andy Sadowskyj

- Balanced financial plan aligned to system requirements.
- Income and expenditure plan.
- Cost improvement and productivity benefits reflected in budgets.
- Capital programme and cash plan.
- Financial risk assessment and mitigation plan.
- Monthly financial control totals and monitoring framework.

Productivity & Efficiency
Chris Ellison

- WRP/Productivity programme with quantified schemes.
- Productivity improvement trajectory (e.g. theatre utilisation, outpatient transformation, LOS reduction).
- Benchmarking against national and peer performance.
- Transformation opportunities identified and quantified.
- Risk-assessed delivery plan for efficiency targets.

Workforce
Alison Wilkinson and Alisdair Hall

- Workforce plan aligned to activity, finance, productivity and service requirements.
- Recruitment and retention plan.
- Temporary staffing reduction trajectory (bank and agency).
- Medical and nursing workforce productivity assumptions.
- and pay cost plan.

CSU Planning Review Meetings, Lead Tanz Rayaz-Pinder

A structured review process with each CSU to develop, challenge and agree a deliverable 2027/28 plan, ensuring alignment across activity, performance, workforce, productivity and finance.
Corporate Attendees: Director of Planning and Performance, Performance Manager, Planning Manager, ADoF, Unit Accountant, DoOp, Workforce Business Partner, Workforce Manager

Session 1: Initial Plans & Assumptions
Mid November to Early December

- Initial activity, performance, workforce and financial plans reviewed and agreed.
- Key assumptions, risks, capacity constraints and dependencies identified.
- Early assessment of deliverability against NHS priorities and Trust objectives.
- Actions agreed to address planning gaps and refine trajectories.

Session 2: Challenge & Refinement
Early to Mid-January

- Plans refined through challenge and triangulation across activity, performance, workforce and finance.
- Productivity and efficiency opportunities agreed and incorporated where appropriate.
- Risks, mitigations and resource requirements reviewed and validated.
- Revised trajectories agreed, with delivery actions confirmed.

Session 3: Final Review & Sign Off
Late January

- Final integrated CSU plan agreed and recommended for inclusion in the Trust plan.
- Confirmation that activity, workforce, productivity and financial plans are aligned and affordable.
- Residual risks, dependencies and escalation requirements agreed.
- CSU accountability and implementation arrangements confirmed for 2027/28 delivery.