CARING FOR YOU

United Lincolnshire Hospitals NHS
NHS Trust

Integrated Annual Operational Plan for 2016/17

Delivering the NHS Five Year Forward View: United Lincolnshire Hospitals NHS Trust

1. Introduction

The purpose of this Integrated Annual Operational Plan for 2016/17 is to demonstrate how the vision for United Lincolnshire Hospitals NHS TRUST (ULHT) will be delivered, with a clear focus on how we will achieve sustainable improvement in safer and better quality patient care over the next year.

The ambition for the Trust is to develop the potential to become a national, if not international, Centre for Rural Health and Care, through health and care reform working in collaboration with our wider health and care partners and stakeholders, which includes: Lincolnshire Partnership NHS Foundation Trust (LPFT), Lincolnshire Community Health Services (LCHS) and Lincolnshire Health and Care (LHAC), together with stakeholders in the wider community, including our local businesses, regional developments, universities and schools. We are looking to develop new and innovative models of care through a five year place based planning Sustainability Transformation Plan (STP). We will develop our research, development and education. The aim is to improve patients' access to services locally, improve our quality of services whilst meeting challenging financial balances across the health and care system in Lincolnshire.

This year we have developed our Integrated Annual Operational Plan for 2016/17 to clearly lay a strong foundation for sustainable improvement over the next 5 years. We aim to put in place the capability and capacity to deliver the STP, embracing new technologies and developing a dynamic and fully engaged responsive workforce through building bold strategies to:

- Initiate and implement a major **workforce review programme** which will focus on improving retention, thinking differently about skill mix, targeting our primary vacancies, extending roles and substantially reducing our dependency on agency staff.
- **Clinical service redesign** by executing the Trust's Clinical Strategy within the Lincolnshire wide strategic service review, LHAC and aligned to the STP.
- Redress the current imbalance between elective and urgent care delivery and to repatriate previously lost **market share** by creating capacity through improved non elective flows and elimination of delays for medically fit patients.
- Improve **productivity and efficiency** over and above the minimum national levels within the tariff inflator/deflator.

The following key strategic risks have driven our decision-making around identifying our priorities and activities:

- **Culture change:** Mitigation – focus on improved staff engagement and new models of working will continue to address the cultural change of the Trust.
- **Lack of clinical staff:** Mitigation – partnership working with other Trusts, building reputation, HEE support for new roles, develop Lincolnshire as a Centre of Rural Health and Care, build our Research, Development and Education footprint through collaboration with our University and regional Universities to attract medical recruitment to a centre of excellence through a 'Team Lincolnshire' approach.
- **Bed Capacity:** Mitigation – Lincolnshire commitment to eliminate DTOCs/MFFD, and reduced length of stay through urgent care flow improvement.
- **Agency cap delivery:** Mitigation – nurse workforce action plan in place, but high risk associated with the need to permanently open additional beds.
- **Lack of management staff:** Mitigation – NHS I support required short term,

task and finish groups to be set up, focus on building a positive reputation, improving opportunity access to targeted Sustainability Transformation Funding.

- **Lack of capital (e.g. invest to save and backlog maintenance) and revenue funding (e.g. winter and 7 day services):** Mitigation – Capital – NHS I improvement support, Revenue – escalate safety consequences.
- **System support:** Mitigation – new NHS Lincolnshire Leaders, STP, LHaC, NHS I support.
- **LHAC programme delays:** Mitigation – bring forward elements of the Trust's clinical strategy that are not dependent upon consultation.

These risks have shaped our priorities and our approach to assuring delivery will be to:

- **Prioritise the work programme** in line with the agreed objectives with clear lines of responsibility and accountability.
- **Develop an Integrated Business Management** approach to manage, monitor and report on agreed objectives and their supporting activities aligned to the Medium Term Plan, Long Term Finance Plan and the five year Capital Programme.
- **Integrate performance management** and delivery framework.

With clear governance through:

- **The Trust Board** to review and agree objectives, plans and deliverables, with this years Integrated Annual Operational Plan being year one of the transformational planning for the STP and the Trust's Medium Term Plan.

Finance, Service Improvement and Development review of financial plans with upward escalation to the Board, which aligns to the delivery of the Efficiency Programme, the five year Long Term Financial Plan and Capital Programme.

Quality assurance oversight by the Quality Governance Committee, with upward escalation to the Board, which aligns to the delivery of the delivery of the Quality Strategy.

Workforce and Organisational Development assurance and oversight through the Workforce and Organisational Development Committee, with upward escalation to the Board, which aligns to the Workforce Programme.

Our plan is to deliver the agreed financial control total of £47.9 million using the £16.1 million general allocation from the STF to reduce the deficit experienced in 2015/16; and within our financial framework to create the headroom, capability and capacity to implement our plans for new models of care.

2. About us

- **Lincolnshire is the second largest county in the UK and is characterised by dispersed centres of population in large towns and the city of Lincoln, and otherwise largely rural communities.**
- **Transport networks are underdeveloped resulting in transport times of around 1 hour between the respective hospital sites.**
- **Lincolnshire has one of the fastest growing populations in England projected to rise to 838,200 by 2033.**
- **We provide acute hospital care, to around 757,000 residents of Lincolnshire.**
- **Indicated levels of health care need are relatively high due to an accelerating population (above the national average) and the trend towards an ageing population profile will continue, with the proportion of people over 75 years of age predicted to increase by 101% between 2012 and 2037.**
- **These factors combine to increase pressure on hospital services, particularly urgent care (COPD, diabetes, CHD, and elderly frailty) and referral for cancer treatment, and it is widely acknowledged and understood that the way health and care services in the county are provided needs to change.**
- **In an average year, we treat more than 150,000 accident and emergency patients, over 600,000 outpatients and over 140,000 inpatients, and deliver over 5,000 babies.**

ULHT is one of the largest acute trusts in the country. We provide services from 3 acute hospitals in Lincolnshire:

- Lincoln County Hospital
- Pilgrim Hospital, Boston
- Grantham and District Hospital

The Trust also provides a wide variety of outpatient, day case and inpatient services from a range of other community hospitals operated by Lincolnshire Community Health and Care Services or local GP clusters. These include:

- Louth County Hospital
- John Coupland Hospital, Gainsborough
- Johnson Community Hospital, Spalding
- Skegness and District General Hospital

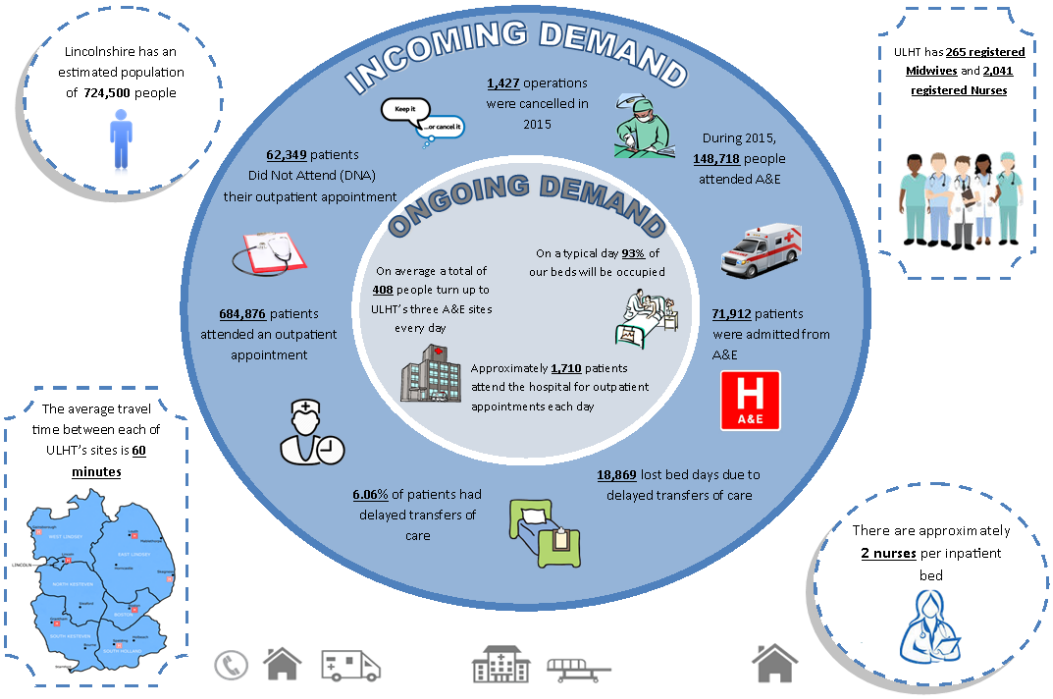
The Trust provides a broad range of other clinical services including community services, population screening services, a comprehensive range of planned and unscheduled secondary care services. We deliver services across:

Audiology	Dermatology	Haematology	Ophthalmology	Respiratory Physiology
Breast Services	Diabetic Medicine	Hepatobiliary and Pancreatic Surgery	Oral and Maxillofacial Surgery	Rheumatology
Cardiology	Diagnostic Services	Maternity and Obstetrics	Orthodontics	
Chemotherapy	Dietetics	Medical Physics	Pain Management	Specialist Rehabilitation Medicine
Children's Community Services	Ear, nose and Throat	Medical Oncology	Palliative Care	Therapies
Clinical Immunology	Endocrinology	Neonatology	Pharmacy	Trauma and Orthopaedics
Clinical Oncology	Gastroenterology	Nephrology	Radiotherapy	Urology
Colorectal Surgery	General Medicine	Neurology	Rehab Medicine	Vascular Surgery
Community Paediatrics	General Surgery	Neurophysiology	Research and Development	
Critical Care	Gynaecology	Nuclear Medicine	Respiratory Medicine	

Whilst ULHT is the leading provider of elective care across all 4 CCGs in Lincolnshire, Northern Lincolnshire and Goole NHS Foundation Trust and Peterborough and Stamford NHS Foundation Trust achieve a significant share of elective care in Lincolnshire East and South Lincolnshire respectively. It is of note that South Lincolnshire CCG commissioners have more than 50% of its elective care from hospitals outside Lincolnshire.

3. Strategic context and direction

We are building bold strategies and integrating our plans to close gaps by focusing on priorities and developing new opportunities to reshape and improve the trust and confidence in high quality patient centred care in Lincolnshire, with a continued focus on improving accessibility in our localities.



We will be focusing on changing the culture and building a positive reputation through further embedding our values:

Patient Centred	*The delivery and development of our services will be patient centred*
Safety	*We put our patient safety and wellbeing above everything*
Excellence	*We measure and continuously improve standards, striving for excellence*
Compassion	*We offer our patients the compassion we would want for our loved ones*
Respect	*We show respect for you and each other*

We will be looking to achieve the following priorities to achieve clinical and financial sustainability of our services:

Finance

- Deliver no worse than £47.9m deficit control total, building financial capacity to support broader Organisational Development.
- Deliver cost improvement programmes through integrated strategic planning, improving accountability and transparency through delivery of improvements.
- Deliver a challenging 4.5% efficiency programme.

Workforce

- Truly engaging with our employees to ensure they are involved in developing the right services for our patients.
- Delivering a strategy that enhances the working experience of being employed at the Trust to ensure that we maximise retention and ensure that the Trust is seen as a great place to work and deliver excellent patient care.

- Introduction of new frameworks of accountability, empowering Clinical Directors with new workforce models; changing skill mix, improving retention and recruitment; and in doing so reduce our dependency on agency staff and reduce agency costs.
- Aligning supporting departments to support the work of the Clinical Directorates, making prioritisation easier and better aligned to the needs of patients.
- Building successful transformational capability across the Trust, delivering future plans whilst maximising the operational performance of existing services.
- Delivering effective and flexible training for all our employees through a combined and varied approach, enabling staff to both attend and maximise their own development.
- Ensuring we continue to build on successful recruitment date by continuing to focus on all areas of our strategy to include, local, regional and international recruitment.

Quality

- Reducing mortality, sepsis and reducing avoidable harm with an emphasis on falls with harm, as well as continuing to make progress on seven day services (subject to commissioner funding), infection prevention and control, medicines optimisation and management and improvements in the reliability of charting and checking.
- Maintain safe staffing.
- Continue to address backlog maintenance.

Performance

- Improve urgent care flow, reducing delays in care planning, delivery and eliminating delayed discharges and increase elective capacity and capability to see and treat elective patients, and improve our operational planning to get the right size staffed bed base.
- Maintain RTT and diagnostic delivery, deliver 85% 62 day cancer standard, deliver 88% A+E.

Developing organisational capacity and capability

- Roll out our digital strategy, improving quality and reducing costs in the medium to long term.
- Creating strategic capacity and capability.
- Strengthening programme management and delivery mechanisms to support transformation.
- Attracting talent.

Accelerate the delivery of the Clinical Strategy

- Transform areas of service delivery to deliver long term improvement plans which will support new ways of working in the wider STP.

Finalise the STP to be delivered through the Medium Term Plan

- Integrate our short, medium and long term planning to build in agility and transformation.

Develop a Framework for Partnership working

- By strengthening community partnerships, implement new pathways (e.g. supporting Lincolnshire's frailty strategy); shifting focus of care away from hospitals into the community in partnership with primary care (e.g. diabetes, dermatology).
- Build strategic alliances with other providers to develop collaborative provision for clinically vulnerable services.

We recognise that we cannot deliver this agenda alone. Within Lincolnshire, we will strengthen our alliances with providers in Lincolnshire and focus on pathway improvement through collaboration. We will build upon our experiences of develop our acute service alliances (e.g. urology, vascular, and EMRAD) outside of Lincolnshire and will look to create longer term partnerships and mutuals with other acute providers to ensure sustainability locally.

We have been developing our strategic framework, attached at **Appendix A**, demonstrating how we will be delivering our aims and objectives.

Our purpose	… is to deliver safe, excellent, compassionate and respectful healthcare for our patients					
Our vision	… working together to provide sustainable high quality patient-centred care for the people of Lincolnshire					
We aim to be…	**Safe and responsive**		**Caring and effective**		**Well-led**	
Our objectives are to deliver…	1. Consistently high quality and safe patient care	2. A clinically responsive organisation	3. Services shaped around patients' needs	4. Skilled, competent and motivated workforce	5. Performance improvement	6. Financial Stability and recovery
Achieving outcomes of…	**Positive patient experience**	**Openness and transparency**	**Efficient and effective services**	**Sustainable service delivery**	**Continuous improvement**	**Value for money**

Through identifying our risk based priorities, we have developed our key activities to be delivered over the next year, together with outlining our longer term activities which will be fully developed through our Medium Term Plan, which are outlined in the following table:

Challenges	Annual Plan Activities 2016/17	Focus for Q1 & Q2	2 to 5 Year Activities	National 'must do's' for 2016/17
Developing Partnership Working • Lincolnshire Recovery Programme slow in building traction, LHAC delayed • Clinical Strategy reconfigurations dependent upon LHAC consultation • STP that aligns with our Clinical Strategy ambitions	• Accelerate elements of the clinical strategy in line with the 5 year Clinical Strategy and the STP, together with our 3 year Medium Term Plan • LHAC early implementation initiatives	• Agree plans with LHAC partners to accelerate agreed elements of Clinical Strategy (June 16) • Develop plans to implement changes which are not dependent upon consultation (April 16)	• Partnership working, forming strategic alliances (tertiary, secondary and primary care) • Continue to build alliances (vascular, urology, Better Together) • Implementation plan aligned to the STP	**Develop a high quality and agreed STP** and subsequently deliver agreed milestones in 2016/17. Return the system to **aggregate financial balance**, including NHS providers engaging with Lord Carter's productivity work programme, and complying with agency rules, and CCGs delivering savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality. Developing and implementing a local plan to address **the sustainability and quality of general practice** including workforce and workload issues. Getting back on track with **access standards for A&E and ambulance waits.**
Financial gap • History of financial challenge since the Trust's inception • Financial position – forecast deficit £57.8million, £2.5 million higher than previously forecast due to non-resolution of fines and penalties – alternative proposals to bridge the gap under consideration • Delivering control total £47.9m in 16/17 • 2016/17 financial plans build on current clinical capacity • Main constraint is staffed bed capacity to support capacity plans - underfunded capacity (escalation beds) • Risks of fines and penalties • Winter pressure funding assumptions • Most services make a loss against tariff • Cost duplication – tariff modification • Loss of elective market share	• Develop the 5 year Long Term Financial Plan and 5 year Capital Programme • Develop a Management Equipment Strategy • Deliver 4.5% (£19 million) efficiency in 2016/17 to: ➢ Resolve recurrent service and cost pressures (£2m) ➢ 1% risk mitigation • Create strategic change headroom (£3.6m) for: ➢ Change capacity within business units and corporately ➢ Driving clinical efficiency improvement ➢ Enhanced governance and performance management • Reduction in agency costs (8%); Roster management • Invest to save 2016/17, e.g. ➢ Medicines optimisation and management (e-prescribing, robotics)	• Finalise alignment of budgets with the financial framework (mid April 16) • Formal sign off of budgets complete (mid April 16) • Agree investment priorities not factored into budget setting (May16) • Formal sign off of full efficiency programme (April 2016)	• Lord Carter Review improvements • Quality of coding • Procurement (clinical supplies) • Consultant job planning • Improvement of elective Market Share • • 3 Year Programme of targeted efficiency from individual service reviews • Economies of scale / QiPP programme improvements	
Workforce gap • Significant vacancy pressures in nursing and medical staff • Traditional workforce model • Over dependency on agency staff, impact of agency cap	**Nursing Staff** • Reduce agency usage through 2016/17 to below the 8% cap • Close escalation beds • Increase bank fill rates through bank review programme	**Capacity** • Trial QFI process at Pilgrim to improve flow (from April 16) • Reduce DTOCs/FFDs (June 16) – dependent upon community actions	• Developing and delivering our People Strategy • Develop sustainable workforce models that are not dependent on traditional recruitment	

Challenges	Annual Plan Activities 2016/17	Focus for Q1 & Q2	2 to 5 Year Activities	National 'must do's' for 2016/17
• Premium staffing costs • Limited workforce engagement • Winter planning • Bank staff • Job planning ➢ 84% of agency medical staff cover urgent care pathways ➢ Total medical vacancies 14% (27% at Boston) • Culture change	• Recruitment across the UK and overseas • Build stronger links with Lincoln University • Continue to reduce turnover and sickness rates • Design different models of working and new roles **Medical staff:** • Medium term focus is resolving site based problems, in addition to measures to: ➢ Review job plans ➢ Agency controls (volume and price) ➢ Develop new workforce models - skill mix, AHPs, Nurse practitioners	• Implement capacity expansion for Grantham ophthalmology (from June 2016) • Mainstream additional bed stock (June '16) • Implement elective capacity expansion at Louth (from Oct 16) **Workforce** • Deliver the bank staff improvement plan (April 16) • Complete 2nd phase international recruitment (May 16) • Embed 15/16 rostering improvement (June 16) • Evaluate skill mix review pilots (June 16) • Complete the current round of consultant job planning (June 16) • Increase compliance against medical price cap (June 16)	processes: • Further develop positive action with recruitment from oversees (Europe, Philippines and India) together with targeting local university and having an ambition to develop a research and education mulita-professional centre • Review of back office functions	Develop and implement an **affordable plan to make improvements in quality particularly for organisations in special measures**. In addition providers are required to participate in the annual publication of avoidable mortality rates by individual trust. Improvement and maintenance **of NHS Constitution standards for referral to treatment** including offering patient choice. **Deliver Constitutional standards on cancer care**, including the 62 day cancer waiting standard and the constitutional two week and 31 day cancer standards, making progress in earlier diagnosis and improving one year survival rates. **Achieve and maintain the two new mental health access standards** Continue to meet dementia diagnosis targets
Performance gap • Post CQC, improved performance but the equality position is under pressure due to vacancies, demand and escalation beds • Inconsistent performance levels • Urgent care delivery remains under significant pressure with concerns over the winter period - including MFFD/DTOCs • Elective and outpatient capacity • Successful delivery against diagnostic and RTT standards with good progress against cancer standards.	• Review of outpatients • Invest in additional elective capacity across the county to increase elective capacity; initial focus on Louth and Grantham • Improve emergency flow (QFI approach) with the initial focus at Pilgrim • Improve internal productivity (business unit planning priorities) • Develop partnership with independent sector for use of our Bostonian (PP facility) to repatriate elective work (e.g. arthroplasties) • Closure of escalation beds, through the elimination of delay	• Finalise winter plan 16/17 (April '16) • Deliver urgent care improvement programme to achieve >85% Q1 • Mainstream discharge hubs and Frailty services – depends on winter funding (June '16) • Deliver cancer improvement plan to achieve Cancer 62 day standard (July '16) • Designed winter resilience plan for Cancer 62 day (June '16)	• Sustained performance • Further increase to elective capacity	

Challenges	Annual Plan Activities 2016/17	Focus for Q1 & Q2	2 to 5 Year Activities	National 'must do's' for 2016/17
	(DTOCs and FFDs) • Successful delivery against diagnostic and RTT standards with good progress against cancer standards • Continuous improvement for cancer care • Improve A+E performance, maintain RTT & diagnostic performance and deliver cancer standards			

Quality gap
• Placed in special measures in 2013 following 1st wave "Keogh" reviews linked to high mortality rates, but came out of special measure in 2015 with four compliance notices, and 'requires improvement' ratings overall.
• 7 day services, little progress in 15/16 due to CCG funding decisions
	• 7 day services implementation plan (subject to funding)
	• Revised Discharge Policy
	• Improve Theatre productivity
	• Improve accuracy of clinical coding(Mortality)
	• Follow up ratios reduction
	• Key quality priorities:
	  • Reduction in Mortality
	  • Reduction in avoidable harm
	  • Improve the reliability of charting and checking (e-obs)
		• Start roll out of the e-obs system at Pilgrim (April onwards)
		Sepsis:
		• Sepsis task and finish group (April 16)
		• Sepsis nurse specialist in A+E and MEAU (April 2016)
		• Sepsis clinical summit (April 16)
		Falls
		• Multi-disciplinary scrutiny panels established
		• Pilot Wards identified
		• Intranet site being developed
		• Implement funded 7 day service priorities (April 16 onwards)
		• Finalise backlog maintenance
			• Internal Improvement Board embedded with detailed actions in place
			• Quality improvement programme progress,' beyond good'	

Estates • Poor estate condition with £52 million backlog challenge (pre recent additional TDA support)	• Invest to save 2016/17, e.g. Energy management • Increase investment in 16/17 capital programme • Refresh backlog assessment, and backlog reduction programme subject to additional capital and revenue support	• Implement the Estates Strategy and deliver against the Capital Programme	• Developing and deliver our Estates Strategy • Estates reconfiguration	
Technology • Implementation of digital services	• Invest to save 2016/17, e.g. Digital strategy implementation (e.g. E-obs, digital dictation)	• Delivering the Digital Strategy	• Digital strategy implementation (e.g. e-prescribing, EPR)	

4. Approach to activity planning

The 2016/17 activity plans are based on the forecast outturn of 2015/16 and have been developed in collaboration with Business Units and clinicians.

Capacity is based on the following:

- Activity provided within funded establishment.
- Adjust for full year effect of new appointments, part year business cases etc.
- Adjust for any planned service changes for 2016/17.

Validated by:

- Check outpatient capacity against clinic slots set up on Medway.
- DNA rates provided for information.
- New/follow up ratio, national comparison figures provided.
- 2013/14 plan and actual, 2014/15 plan and actual and 2015/16 plan provided.
- Continual referencing against forecast outturn updated bi-monthly throughout the process.

Demand is based on the following:

- Adjustments for activity required to hit 94% RTT incompletes (94% allows for phasing anomalies and fluctuations in demand).
- Adjustment made for change in size of incompletes.
- A general growth rate of 1.06% used as per the Clinical Strategy but with specific growth rates for:
  - Cancer
  - Therapies
  - Diagnostics
  - A&E
- PBWL backlog has been included.
- In year and future year service changes adjusted for.

The process for 2016/17 activity planning has taken a new, more robust approach with greater involvement from Business Units and support provided by the Analysis Team. Activity modelling has been a fundamental aspect of the Trust's new approach to Integrated Annual Business Planning.

Capacity has been openly shared with commissioners and where gaps exist, a health system wide discussion has and will agree an action plan. The effect on achievement of constitutional standards and delivery of STP trajectory milestones has been considered whilst discussing gaps in between demand and capacity. As part of this collaborative approach to addressing activity modelling, the Trust has helped to identify potential areas for commissioner QIPP schemes. This includes areas where there are known capacity gaps (for example CCGs have reduced demand in light of a newly introduced community dermatology service in the east of the county which will reduce demand). We also want to work with commissioners on the development of a clinical assessment service which will reduce front-door pressures. Wherever possible, we have endeavoured to ensure that there is full clinical participation in these discussions.

The known gaps are in four areas (which are continuing gaps from previous years), dermatology, neurology, breast surgery and MRI. The Trust provided a position statement to commissioners on each of the four areas and this has been progressed through contract negotiations. A solution for dermatology and MRI has been established. Breast and Neurology still have tangible capacity gaps which will incur premium rate additional activity to meet constitutional standards. Through the activity modelling process, there are some specialities which are showing available capacity above the predicted commissioner demand. Furthermore, the Trust has identified other areas with CCGs that require funding above an activity-based contract. This includes funding for winter and developments on seven day working.

A key development in our activity modelling process for 2016/17 is the correlation of demand to bed

requirements. We have assumed 95% bed occupancy and a variance of 5-9% of average to maximum bed usage that leaves a shortfall of 82 beds across the three sites. In 2015/16, the Trust has regularly relied on escalation beds to manage urgent care pressures – an average of 66 beds per day. This often incurs premium rate agency costs. The Trust therefore wants to review its core bed-stock to incorporate a greater number of routinely available beds and reduce the number of escalation beds. A key constraint on current availability is the number of patients who are medically fit for discharge but encountering a delayed transfer of care. This is a key priority of the wider Systems Resilience Group and any improvements in reducing delayed transfers of care will aid patient flow and reduce bed pressures.

5. Approach to quality planning

The Quality Improvement Strategy for 2016/18 is currently being formulated and will, moving forward, include improvement trajectories with progress reported through a newly developed quality dashboard. The quality dashboard will present the Trust view but will be underpinned by hospital site and clinical directorate performance. Each section of the dashboard will be aligned to the ambitions outlined in the Quality Strategy.

There is a clear governance framework in place where quality performance is reviewed with the overarching Quality Governance Committee reporting to Trust Board. A range of Trust quality meetings report to Quality Governance such as Infection Control Committee, Patient Safety, Patient Experience and Safeguarding Committee all of which provide upward reports summarising compliance against regulatory targets and statutory obligations, safety and quality priorities and clinically agreed measures for specialities.

The Trust has recently satisfied a compliance notice relating to oversight and understanding of governance at the Trust's smallest site.

The Trust also has an integrated improvement programme which is branded as "Beyond Good" which has six domains each one with a Trust executive director as the named responsible officer. Progress for quality is monitored through the quality improvement team meeting reporting to the Trust's Portfolio Improvement Board. To support the delivery of the "Beyond Good" programme there is programme management support through the "Hub". This will continue with the additionality of the key areas of improvement identified in this Plan.

Reviewing feedback from regulatory inspections, discussions with stakeholders, adverse clinical events, internal quality performance data and benchmarking against national quality standards and data, professional guidance and the existing "Sign up to Safety" Plan; the Trust has identified seven quality priorities of which the following three key quality priorities for 2016/17 are outlined below:

- **To reduce Trust mortality with a particular emphasis on Sepsis by 10%**
  Although now out of special measures, mortality remains a high priority for the organisation since being one of the 14 hospitals included in the Keogh Review for being a persistent outlier for mortality. The Trust has achieved significant progress in reducing mortality and the HSMR year to date 15/16 is 98.9 which is a 9% reduction from 2014/15. The Trust has a well embedded Mortality Review process with the quality assurance process in place to ensure that the clinical reviews are robust. A monthly performance report that summarises HSMR, SHMI and Crude Mortality performance is reviewed and discussed at the Patient

Safety Committee which is chaired by the Medical Director. The Trust will continue to participate in the annual publication of avoidable deaths.

Despite this improvement, the Trust still alerts for Sepsis and the Trust has responded through deep dive audits and formulating a multi-disciplinary working group to improve clinical outcomes based on the recommendations that have arisen from the self-assessment of the "just say sepsis?" (NCEPOS Sepsis report, 2015). The protocol for identifying sepsis has been made more robust with the introduction of "red flags" and improved documentation has been recently implemented. A Sepsis 6 awareness week has been facilitated across the Trust with visible presence from the Medical Director and Associate Medical Directors. Currently, the group is focusing on timely administration of antibiotics and full compliance with the Sepsis 6 Care Bundle. For 2016/17, the group will be instrumental to the Trust achieving the National CQUIN for Sepsis.

- **To improve the reliability of care by reducing avoidable harm with a focus on reducing the incident rate of falls with harm**
  Recent improvement has been made to the governance of the Trust's Falls Group leading to collecting nationally agreed sets of data thus allowing the organisation to be able to benchmark performance against other providers. This has highlighted the following:

  - Whilst the Trust is comparable to the National Average for all falls per 1,000 Occupied Beds Days (OBD) it is an outlier for falls with harm per OBD.
  - The Trust has achieved a reduction in the total number of falls in hospital however has not achieved this same trend for falls with harm which has remained fairly consistent.

  The Trust has completed a gap analysis of the NICE Quality Standards for Falls Prevention (2015) and the RCP National Audit of Hospital Falls which has informed the Trust's Falls Group work plan. The main risk to success is nurse recruitment with the Trust having a current CQC compliance notice for nurse staffing levels at one of the hospital sites. Despite this, review panels have been established to generate learning from falls and identify lessons to inform quality improvement initiatives. Additionally, new models of staffing including one to one care are also being reviewed.

- **To improve reliability of care with particular focus on safeguarding and Infection control**
  Following the CQC inspection of the Trust in February 2015 which led to an overall assessment as "Requires Improvement", a compliance notice was achieved regarding safeguarding across the organisation. In response, additional safeguarding training has been established to provide sufficient capacity to deliver training to all relevant staff which has led to some improvement; however, the main challenge to achieving improved training compliance is the clinical areas being able to release staff to attend training due to clinical pressures and demands. Additionally, further work is still required to improve compliance with Level 3 training. To address these challenges, the Safeguarding team are developing an e-learning package to compliment Level 2 face to face training. At the end of December 2015, compliance for Safeguarding Level 1 Core Learning was 80% against the CQUIN trajectory of 95% by 31 March 2016. In 2016/17, there will be a continued drive to improve training compliance rates with particular focus on Deprivation of Liberty and assessment of Lack of Capacity. To drive improvement, a further local CQUIN initiative is being negotiated with commissioners for 2016/17. Internally, performance is monitored through the Trust's Safeguarding

Committee, which upwardly reports to Quality Governance Committee.

In 2015/16, the Trust delivered improved performance with infection control through a newly restructured Infection Control Team and will likely be under the ceiling trajectory for Clostridium *difficile;* however, the Trust did report one MRSA bacteraemia. Additionally, the Trust has a Risk Score of 25 regarding consistent compliance with Criterion 2 of the Code of Practice for Prevention of Infection, which is related to the cleanliness of the clinical environments. The Trust has recently received the final report from an external review of housekeeping services and a priority for 2016/17 will be implementing those recommendations.

The range of quality improvement projects are sizeable, diverse and challenging but will deliver real improvements to the quality of clinical services as long as they are well led and adhere to the robust improvement methodology. The Trust aims to deliver this through building capacity to undertake quality improvement through the established Listening in Action Programme. This programme brings teams together over a fixed period where they attend learning sessions as well as undertake a quality improvement project supported by the Trust's Service Development Team.

The Trust also uses Plan/Do/Study/Act model for improvement and is currently using this approach in the implementation of E-Observations. Additionally, the Falls Group are using the Institute for Health Improvement's (IHI) Breakthrough Series Collaborative Model in developing a falls prevention resource toolkit with four initial wards identified to begin the project. The aim is that change is facilitated at the front line using bottom up small tests of change.

Seven Day Services

The Trust is committed to ensuring that high standards of care are consistently delivered across 7 days. Plans to implement 7 day working have developed over the last 12 months with every service identifying their requirements to meet these standards. Whilst the Trust's progress has compared favourably against East of England benchmarking data, local commissioners funding decisions have hampered progress. Despite this, the Trust has embedded senior reviews across the organisation with routine review over 7 days for all emergency areas is in place. Additionally, access to diagnostics (including endoscopy, CT and MRI) across the 7 days is available for urgent and emergency patients, though at present this is provided across the different sites which means greater travel for patients. For 2016/17, an implementation plan will progress the Trust's commitment to deliver 7 day services, however this is dependent on funding from commissioners and discussions are on-going. This funding is essential to improving access to out of hours care closer to patients' homes.

Quality Impact Assessment Process

The Trust is clear that pursuing quality and efficiency improvement cannot be perceived as mutually exclusive options particularly if a 4.5% efficiency improvement is to be realised for 20/17. The efficiency plans will be influenced by the STP, the Lord Carter Review and the Clinical Strategy 2016/18 which are integral to the Trust improving quality and delivering the Five Year Forward View.

Top-down and bottom-up approaches are taken to ensure that schemes identified are strategic and transformational as well as realistic and supported at the operational level. Therefore, the plans are a blend of clinical directorate initiatives allied to their clinical service reviews and corporate initiatives and programmes, so striving to achieve whole organisational support and commitment to delivery. An integral part of cost saving improvement plans is an evaluation of safety using an agreed Trust template. Stage one of the assessment process is to quantify

potential impacts (across 6 domains of quality) of the cost saving programme whether these are positive, neutral or negative. This analysis then informs a risk score as per the NHS Litigation Authority template. A more detailed assessment is required if the risk score is greater than 8, ensuring that there is a robust process to safeguard patient safety and this step is part of stage 2 of the governance process.

Whilst the whole Board is accountable for quality, the named executive leads for approving cost saving plans based on the quality impact assessments are the Medical Director and Director of Nursing. This forms stage 3 of the governance process. A quarterly report is generated which provides a brief description of the cost saving programme, the risk score based on the quality impact assessment and whether the plan has been approved or not. The report is submitted to Quality Governance which is a Board subcommittee. The progress of the Cost Saving Plan together with the monitoring of the associated quality metrics is presented at the Trust's Portfolio Improvement Board Committee. This process involves triangulating quality, workforce and financial data. The cost saving programme is supported by the Trust's PMO team.

Triangulation of indicators
Triangulation of quality, workforce and financial indicators is undertaken monthly by the Board through the recently strengthened Integrated Performance Report. The report includes multiple indicators (75) including those relating to patient safety, clinical effectiveness, patient experience, constitutional standards, workforce and finance. Triangulation also occurs at Clinical Directorate Level though further work is required to ensure consistency of templates given the recent changes to the Integrated Performance Report. How the organisation utilises this data to make informed decisions regarding service development has been identified as requiring strengthening and this will be addressed by establishing a new joint FSID/Transformation committee.

Triangulation of quality and workforce data is also provided at ward level through the Ward Health Check and this informs lower governance processes where the quality of nursing care is monitored and may escalated to the facilitation of internal risk summits where concerns are identified.

6. Approach to workforce planning

Workforce planning is a vital component in delivering the workforce to meet the increasing challenges faced by the Trust. Whilst the analysis of the staff numbers to meet the demands of the services are essential, we consider that to truly deliver a dynamic and responsive workforce we need to fully develop and engage each and every employee of the Trust.

Employees will be supported by truly effective appraisal and development throughout their time with us. We will develop a fully engaged and flexible workforce through opportunities, including secondments, shadowing and enhancements to roles. Staff will be engaged in decision-making at all levels, to ensure that we develop excellent services for our patients.

We recognise that the recruitment and retention of the required staff numbers is dependent upon all of these aims, but must be built upon the identification of the skills and competencies we need to deliver identified clinical requirements.

To ensure that we are as attractive as possible, to both new and existing staff, our policies and practices will consider how we can work flexibly across the Trust. This will include consideration of skill mixing, coupled with working hours and patterns for staff, wherever possible to maximise patient facing time.

We will continue to develop our workforce, including how we develop existing staff and potential future staff, through apprenticeships and career development, through our talent academy approach, to include work with local colleges, schools, universities and other institutions.

Clinically led annual workforce planning is therefore essential and Clinical Directorates will be supported in delivering this with joint input from senior managers of Business Units and Departments, supported by Finance and Human Resources. All areas of the Trust are required to undertake workforce planning. Workforce plans include the consideration of internal / external drivers, such as demand and current capacity, along with the development needs required to deliver the workforce required by the Trust's ongoing plans. These will need to be constantly considered, and will be underpinned by clear targets, and plans, for recruitment and retention, both for each directorate and the Trust overall. Workforce plans consider the current pressures affecting the availability of workforce supply, and consider the available financial resource, including any requirements in delivering national standards and directives. These include safer staffing consideration and Agency 'price caps'. Baseline information along with previous and ongoing plans are provided in advance, along with clearly defined outcomes expected.

The Trust is committed to working with our regulators, partners and stakeholders to deliver the required workforce. As part of this process, we continue to work closely with NHS Improvement to focus on delivering reduction in reliance on all areas of agency costs. We face particular challenges in respect of both medical and clinical agency costs, and continue to develop detailed plans to ensure we reduce both the need and cost of agency staff. To aid this approach we will:

- **Governance process for board approval of workforce plans**
  Workforce plans alongside financial plans at department level are subject to assurance and agreement via confirm and challenge meetings undertaken by Executive Directors, and assured through the Trust Board governance process via the sub-committees of the Trust Board, Director of Operations and Finance, and Human Resources.

- **Link to the Clinical Strategy**
  The ULHT Clinical Strategy Board oversees work to define how the future configuration of services may look in the future, across a number of clinical areas, including: surgical services, medical specialties, women and children's services, Orthopaedic services and Accident and Emergency. This includes specific consideration of issues such as the most appropriate site(s) for future location of services

- **Reference to local workforce transformation programmes**
  ULHT is a partner provider organisation within the LHAC initiative, which will transform healthcare provision and delivery by 2020 county wide, with a focus on treatment being provided as near to the patient as possible. Final proposals, and therefore future potential workforce shape, and implications for ULHT, await finalisation prior to public consultation in 2016. Outcomes from workforce planning meetings at Business Unit and Specialty level are expected to include opportunity for wider workforce roles and collaboration across speciality and or site.

- **Effective use of e-rostering and reduction in reliance on agency staffing**
  We have introduced new on-line services for staffing bank services, which will increase flexibility of booking, and overall availability of bank staff. This enables staff to book directly on to available shifts from mobile devices and is aimed at further reducing

reliance on agency staff. This is further enhanced allowing managers to directly book staff, supported by the efficient utilisation of our staff through close effective management of our on-line e-rostering system. Regular reports, including baseline data and historical bank and agency costs are utilised by managers, to ensure that all areas are able to constantly manage rosters and effectively manage leave, sickness and utilisation. We will be widening further the scope of the services provided by the bank office ensuring further flexibility and governance of all temporary staffing services.

- **Alignment with Local Education and Training Board**
  The results of The Trust's own annual organisational workforce planning and Training Needs Analysis feed directly into Health Education England through the local LETC, and the regional LETB. LETB collates workforce numbers / key workforce issues / day to day business and, in addition, transformational workforce changes which feed into Health Education England, (East Midlands), informing the requirements for the future workforce, which form the basis of future years' workforce planning.

- **Triangulation of quality and safety metrics with workforce indicators**
  Quality and safety dashboard data is available across the Trust at ward and department level where appropriate, and includes a number of key workforce metrics and data alongside quality indicators. This is used on an ongoing basis as part of internal confirm and challenge meetings and highlights the links between workforce activities and quality outcomes, as such is embedded in ongoing management and will be incorporated into the workforce plans.

- **The application and monitoring of quality impact assessments for all workforce CIPs**
  All workforce CIPs are fully assessed for quality impact prior to being implemented.

- **Balancing of agency rules with the achievement of appropriate staffing levels**
  Business Units are required to demonstrate medium to long term plans to minimise reliance on temporary staffing solutions, along with short term achievement of internal KPIs relating to agency use and price.

- **Systems in place to regularly review and address workforce risk areas.**
  All areas have regular meetings to assess risks relating to workforce, especially recruitment and retention issues, current sickness rates, etc. The key issues for workforce planning over the short and medium term are:

Nursing recruitment	Nursing staff risks	Medical staff risks
• Overseas - Europe (minimal impact) • Overseas - Philippines and India (long lead in, up to one year) • Target local university cohorts (100 per year)	• Reduction in agency usage 2016/17 to below 8% cap • Close Escalation Beds • Increase bank fill rates through bank review programme • Recruitment UK & Overseas • Stronger links with Lincoln University • Continued reduction in turnover rates • Different models of working	• 84% of agency medical staff cover urgent care pathways • Total medical vacancies 14% (27% at Boston) • Medium term focus is resolving site based problems, in addition to measures to: • Review job plans • Agency controls (volume and price) • Develop new workforce models - skill mix, AHPs, Nurse practitioners

7. Approach to financial planning

The ULHT 2016/17 financial plan is a fully integrated component of the Operational Plan, which in turn will be built on as the base year in the 5-year planning submission. The Trust Board signed off the final plan at its April meeting, including the revenue and capital plans and profiles.

The Trust's 2016/17 revenue plan is fundamentally built on the 2015/16 outturn overlaid with the forthcoming financial year's key assumptions, as set out below. The financial plan has been produced with consideration given to the local reflection of the planning assumptions set out in Delivering the Forward View: NHS planning guidance 2016/17 to 2020/21, plus the impact of the 2016/17 National Tariff, NHS Standard Contract and CQUIN guidance. The financial model produces a stretched target, taking full advantage of efficiency opportunities (including those identified by Lord Carter and the new rules around agency staff).

The financial submission, as required, is inclusive of a 5-year capital plan. The schemes are consistent with the Trust's clinical strategy, and clearly provide for the delivery of safe, productive services, with years 2-5 being draft at this stage. Further detail in respect of capital planning is provided below.

The ULHT 2015/16 year-end revenue position is £56.9 deficit, with an underlying position estimated to be a £67.4m deficit.

In a joint letter on 15th January from Monitor and the TDA, the Trust was notified of its 2016/17 control total of £47.9m inclusive of £16.1m Sustainability and Transformation Funding (STF). This is a significant improvement to the current year's position and the plans to deliver it are stretching, representing the maximum that the Trust can reasonably be expected to deliver whilst ensuring funds are available for investments in quality including the continuing expansion of seven-day services and safer staffing levels.

The top down approach to the draft submission has been triangulated with a bottom up validation to ensure consistency between activity, capacity, demand, income and costing. The final version is based on the latest contract offers from CCG partners. The submission is inclusive of a series of internal confirm and challenge meetings with key clinical staff and led by the Trust Executives to stress test the deliverability of key assumptions at an operational level. This will result in workforce, activity and capacity targets (including efficiency plans) and financial envelopes signed off by the Clinical Director in each Business Unit. This will ensure ownership and facilitate embedding the re-launched accountability framework within the Trust, which will underpin delivery within stretch targets without diluting patient quality.

Table 1 – Underlying 2015/16 position

2015/16 Reported Deficit	-56,918
Non-recurrent benefits (+) and costs (-)	
Reduction in provisions and expenditure benefits	-3,166
Cap to Rev Transfer	-5,000
Non Contract Technical Income	-474
Fines and Penalties - CCGs & Specialised	-1,368
Other Income	-432
Estimated total non-recurrent items	**-10,440**
Estimated 2015/16 Underlying Position	**-67,358**

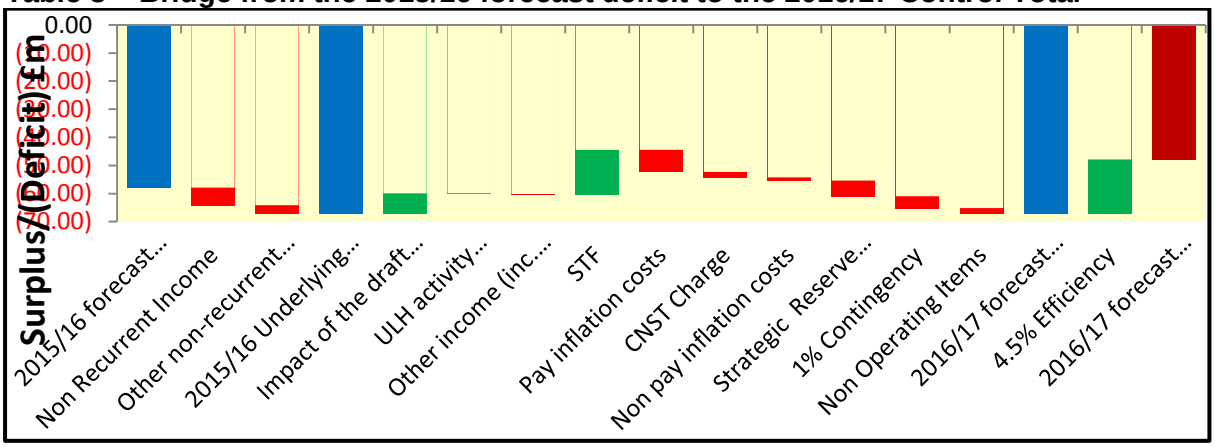
Table 2 – Scenario and sensitivity modelling - Base Case, Best case and Worst Case 2016/17

	Base case (most likely)	Worst case	Best case	Base case (most likely)	Worst case	Best case
	£000s	£000s	£000s	Assumptions if differ to base case		
2015/16 forecast deficit	-57,838	-57,838	-57,838			
Estimated 2015/16 Underlying deficit	-67,037	-67,037	-67,037			
Impact of the draft tariff inclusive of fines and penalties	7,080	4,530	9,580		No Fines & Penalties reinvested, 2016/17 case mix contingency	All Fines & Penalties reinvested
ULH activity modelling - Capacity	-180	-500	0		Contingency built into modelling	Capacity = 2015/16 outturn
Other income (inc. Education)	-380	-380	-380			
STF	16,100	16,100	16,100			
Pay inflation costs	-7,920	-7,920	-7,920			
CNST Charge	-1,900	-1,900	-1,900			
Non pay inflation costs	-1,100	-1,650	-550	1.00%	1.50%	0.50%
Strategic Reserve and Cost Pressures	-5,630	-5,630	-5,630			
Contingency	-4,223	-4,223	-4,223	1.00%	1.00%	1.00%
Non Operating Items	-1,750	-1,750	-1,750			
2016/17 forecast deficit pre Efficiency	**-66,940**	**-70,360**	**-63,710**			
Efficiency	19,040	19,040	19,040	4.50%	4.50%	4.50%
2016/17 forecast deficit post efficiency	**-47,900**	**-51,320**	**-44,670**			
Variance from Base Case		-3,420	3,230			

The 2016/17 financial plan is an iterative process that is inclusive of top down and bottom up approaches to activity, capacity, demand, income and costing. As external guidance moves from draft to final version, the analysis will be updated. Running parallel to this is a series of confirm and challenge meetings inclusive of key clinical staff and led by the Trust Executives to ensure that key assumptions at a granular level are tested for consistency and deliverability. This will result in workforce, activity, capacity, targets (including efficiency plans) and financial envelopes signed off by the Clinical Director in each Business Unit to ensure ownership and facilitate embedding the re-launched accountability framework within the Trust which will underpin delivery within stretch targets without diluting patient quality.

Table 3 illustrates the base case forecast in a bridge format, restating the 2015/16 forecast to the underlying position through to the planned delivery of the £47.9m control total, inclusive of the financial consequence of the assumptions underpinning the model.

Table 3 – Bridge from the 2015/16 forecast deficit to the 2016/17 Control Total



Although the financial model has been stress tested it is a draft, based on early not final national guidance and contracting discussions with commissioning partners. Also it has not been subject to the internal detailed confirm and challenge programme scheduled for February and therefore due to these and other factors it

is pertinent to outline the key risks inherent in the model. **Key Risks to delivery of the 2016/17 control total:**

- Delivery of the 2015/16 outturn.
- Impact of the final tariff for 2016/17 inclusive of CNST uplift clarification.
- Outcomes of 2016/17 contract discussions with CCG partners.
- Reinvestment of fines and penalties.
- Management of readmissions and agreement with CCGs in respect of financial support.
- Maximising elective Income.
- The refinement of internal activity modelling.
- Full identification, ownership and delivery of the 2016/17 efficiency programme.
- Non-compliance with the conditions relating to central release of the STF £16.1m, and the subsequent consequence of not receiving it.
- Workforce – recruitment and retention to key posts, specifically nursing and medical staff, which in turn will impact on the Trust's ability to meet the agency cap threshold of 3%.
- Cost pressures over and above those provided for.
- Business Units ability to live within 2016/17 agreed budgets and deliver income targets.
- Trust's ability to plan for and deliver increasing and fluctuating demand, inclusive of clear policy in respect of escalation beds.
- Non delivery of operational and clinical KPIs that result in financial penalties from commissioners.
- Outcome of the 2016/17 pay-award.

Assumptions

Patient contract income:

- The *Capacity* derived from the modelling produced by each Business Unit has been used to determine the activity volumes used in the draft financial model. Based on the current market conditions the modelling identifies significant opportunities to increase income although this is predicated on the Trust's ability to deliver and commissioner partner's willingness and ability to pay.
- The activity has been priced at the draft 2016/17 tariff inclusive of the net inflator of 1.1%, case mix changes, with an addition of 0.7% CNST premium where applicable. Once the final tariff is released this will be re-calculated.
- Where the increase in demand from the 2015/16 plan is due to a pass-through payment (E.g. Non PbR drugs, devices) then an offsetting entry has been accounted for in expenditure.
- The current model includes fines and penalties at the same levels as those in the 2015/16 forecast.
- CCG winter support has been assumed at £2.25m as per the latest contract offer. (This is a reduction in commissioner support of £2.15m from 2015/16 levels).
- The draft patient contract income excludes any impact of CAS and other QUIP schemes, Grantham ICU and outpatient coding reclassification. activity, relating to underlying demand,
- Quality, Innovation, Productivity and Prevention' (QIPP) schemes are currently being developed with CCG partners.
- As part of the contract planning negotiations the Trust are discussing CCG support for 7 Day services, the outcome of these discussions is unknown at this stage and therefore £0 income is included in the current figures (although the Trust is committed to investing in this quality initiative).

Non contract patient related income:

- The revenue to capital transfer in 2015/16 of £4.0m was a non-recurrent benefit and therefore not part of the 2016/17 plans.

- The STF centrally allocated funding has been assumed at £16.1m, this exclusively relates to the 'General Fund', with £0 included at this stage of the planning process in relation to the 'Targeted Element'. Internal plans are being worked up to identify both capital and revenue investments that generate a great than 1:1 benefit to facilitate accessing this funding.
- Education income is reflective of the removal of the transitional relief and at 2016/17 contract values.
- Other minor contracts are inclusive of service and inflationary changes.

Expenditure
Pay

- The 2016/17 pay cost pressures in relation to National Insurance (pension), Incremental drift and an assumed 1% pay inflation have been calculated at individual staff level.
- The staff numbers and costs will be adjusted for known and applicable efficiencies and investments as the model is progressed.
- The model includes the effective implementation of the agency rules recently introduced by NHS Improvement and the subsequent and significant savings this will release. This needs to be and will be managed against the back-drop of significant workforce and service pressures across the Trust to ensure that patient quality is not diminished. Work streams are in place to minimise agency volumes and adhere to the mandatory use of frameworks for nursing agency staff and the mandatory use of an hourly cap on rates for nursing, medical and other staff groups. Implementation of the cap is anticipated to reduce agency costs by c. £6.0m with workforce plans to reduce the number of agency workers through recruitment, retention and expanding the internal bank in addition to this.
- The Trust has accepted the £21m agency ceiling. The Trust has developed plans to reduce agency spend in 2016/17 however this does not fully bridge the gap between the 2015/16 outturn and the 2016/17 target. The Trust recognises this risk and is developing plans to mitigate it.
-

Non Pay

- A provision of 1% for non-pay inflation has been provided to cover price increases identified by the Business Units over and above the 15/16 outturn. Accessing this fund will require justification through the detailed budget setting process and be subject to confirm and challenge, i.e. it is not a given.
- The ULHT CNST premium has risen by £2.0m from 2015/16 to 2016/17. The £19.6m charge for 2016/17 has been fully provided for in the plan. This is a significant cost in the Trust and although the approach to the tariff in 2015/16 has seen the in year impact minimised this has not addressed the underlying cost pressure generated from significant stepped changes in recent years. In the long-term this is one of the key issues that the STP will attempt to address through proposals to improve the quality of key services especially women's and children's.

Efficiency

- A 4.5% efficiency has been included in the financial model.
- The delivery of the full year effect of 2015/16 cost improvement plans is built in, although the additional impact in 2016/17 is minimal.
- The detailed split of the 2016/17 target is being developed but will be inclusive of productivity (income), the price impact of

national agency caps rates (as mentioned above), procurement, corporate and Business Unit led initiatives and inclusive of opportunities presented by Carter.

- The Trust has established a HUB office which will encompass taking the recommendations of Carter with specific focus on Workforce, Medicines Optimisation, Estate Management and Procurement to drive through cost savings throughout the organisation. The 'Carter' themes underpin several of the ULH identified efficiency schemes, with a further £1.0m targeted for additional Carter related opportunities in the Trust
- Any efficiency that can be delivered from utilising the Target Element of the STF has not been included at this stage. However, key schemes that fit the Strategic direction of the Trust and provide a payback ratio greater than 1:1 are being collated to ensure that when guidance on how to access this funding is published the Trust is positioned appropriately. Key schemes will relate to the digital strategy, automation, managed equipment services and site configuration.

Procurement

The Trust is developing a procurement strategy which will further embed the national agenda and priorities incorporating the principles released by the Department of Health and Lord Carter Review. The strategy will also promote the role and remit of procurement within the organisation to encourage early involvement and wider clinical engagement projects and ensure all influence able spend is dealt with through the procurement team and procurement using appropriate / compliant processes.

Contingency and Investment in Quality

- At this early stage in the planning round, it is felt prudent to provide for a 1% contingency.
- A further reserve has been set aside to meet the strategic investments and in year and historic cost pressures identified in the Business Unit planning process. As per non-pay inflation allocations this has been subject to scrutiny through the confirm and challenge process.
- This will be specifically although not exclusively focused on patient quality including seven day working and safer staffing levels and will be finalised in agreement with commissioners and is envisaged financially supported by them as a quality investment
- The Trust has produced a number of costed business cases that are under discussion with CCG partners with the aim of increasing the level of clinical cover and diagnostic services available in ULH hospitals at weekends
- In a separate but linked joint work-stream the Trust and the local commissioners are reviewing the access to out-of-hours care, by achieving better integration and redesign of 111/walk-in clinics/urgent care to enhance the patient offer, this will be built into the STP as part of the medium term vision of the Health Community.
- Further investments will require a funding source; an increase in the efficiency programme and / or be supported by additional income generation. Beyond the budget setting round such investments will need to be supported by a business case and be submitted to the Trust Investment Programme Board for consideration.

Non-Operating Items

- Due to the significant capital investment, primarily in relation to £21m of pump primed TDA funding under the umbrella of P21 in the last two financial years, the depreciation charges are calculated to increase by and

planned for by £747k in 2016/17 from 2015/16.
- Similarly the continued borrowing requirement of the Trust due to its significant deficits will incur additional interest payable charges that are estimated and included in the plan at £1.0m.

Capital Investments

- As part of the submission, the Trust is required to submit a 5-year capital investment programme, identified in table 3. Year 1 of the capital programme has been signed off by the Board as part of the Trust financial framework.
- The Capital plan has been built up initially from draft proposals submitted in September 2015 from Business Units. These have been cross referenced against the Trust risk register and reviewed against the medium and long term strategy. IT, Medical Devices and Estates working groups are well established within the Trust and they have debated and prioritised the investments within their areas of expertise before reporting to the Trust Investment Programme Board (IPB) their recommendations. IPB have coordinated a proposal to the Clinical Executive Committee for consideration and ultimately ratification.
- This has produced a 5 year draft capital programme that the organisation is fully sighted on and within the Trust Capital Resource Limit, i.e. it allows the organisation to stand still by replacing the risk critical clinical and IT equipment with a £5m annual investment in the Estate Backlog Maintenance.
- This has therefore generated a draft capital plan for years 2 to 5 that is significantly short of the funding the key service and quality investments that the Trust requires to meet the medium and long term clinical strategy and invest to save schemes. The financial return is inclusive of investments in relation to service developments beyond the CRL that the Trust will be looking for financial support to facilitate, including accessing the 'Target Funding' that is to be released as the second phase of the STF.
- The Trust acknowledges that as part of this process it must review opportunities for land disposal and has identified significant proceeds to part fund the required capital investment in 2016/17 to transform patient care facilities within the Trust.
- In order to maximise the Trust capital available a work stream has been established to review the opportunities presented by a managed equipment service and a review of the Estate inclusive of maximising disposals which will be addressed in the Estate and Clinical Strategies that will underpin the STP submission.

Table 4 – 5 Year Capital Programme (Years 2 – 5 draft)

Capital Programme 2016/17-2020/21					
Category	**Plan 2016/17 £000s**	**Plan 2017/18 £000s**	**Plan 2018/19 £000s**	**Plan 2019/10 £000s**	**Plan 2020/21 £000s**
Medical Equipment	4,404	3,000	3,000	3,000	3,000
ITRelated Investments	2,756	3,336	3,561	3,151	3,000
Estates Backlog Maintenance	10,616	10,000	10,000	10,000	10,000
Service & Modernisation	2,515	500	275	0	0
Strategic Developments	5,000	5,000	5,000	5,000	5,000
Transformational Developments	200	11,800	17,150	12,500	1,000
Contingency	1,000	1,000	1,000	1,000	1,000
Totals	**26,491**	**34,636**	**39,986**	**34,651**	**23,000**
Funding sources					
Estimated Depreciation	13,089	15,083	15,623	16,295	16,676
Disposals - other	2,000	0	0	0	0
Additional capital PDC	4,000	0	0	0	0
Requests for Further funding	7,699	19,672	24,422	18,356	6,324
Repayment of loans	-119	-119	-59	0	0
Capital cash b/f	-178	0	0	0	0
Totals - excluding donated assets	**26,491**	**34,636**	**39,986**	**34,651**	**23,000**

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

The current footprint for the STP is the county of Lincolnshire: Lincolnshire West CCG, Lincolnshire East CCG, South Lincolnshire CCG, South West Lincolnshire CCG, Lincolnshire Community Health Services, Lincolnshire Partnership NHS Foundation Trust and ULHT. Devolution for Greater Lincolnshire has been approved for North Lincolnshire CCG, North East Lincolnshire CCG, and North Lincolnshire and Goole Hospitals NHS Trust.

Currently, the commissioner led Lincolnshire Health and Care Programme is the "whole" health and care system transformation piece of work in planning. The scope of the LHAC programme includes transformation to the current service delivery models, and in the way contracts between commissioners and providers are approached through a move towards "Place Based" alliance or Accountable Care Organisation type arrangements. The LHAC programme is currently developing more detailed plans to put forward the affordability and deliverability options that will be shared in a public consultation process starting in the autumn of 2016. The actions identified to implement the preferred option will form part of the STP for Lincolnshire.

ULHT will be a major contributor to the STP and in addition to bringing together longer term deliverables and strategic options from the LHAC Programme. The STP will also include short to medium term plans within ULHT that will contribute to the reduction of the financial deficit until, such time as the longer term strategic options have been out to public consultation and subsequently implemented.

The health and social care system in Lincolnshire faces significant challenges. The Keogh review identified key areas of concerns over quality and safety of some services, and some services have significant patient outcome challenges. In Lincolnshire, like the rest of the NHS and social care nationally, there is evidence from patients and service users of services being fragmented, that service models do not reflect published clinical evidence, some elements of care can be better provided closer to home, workforce structure and roles and Information Technology and incentives in the system do not support transformational change. Lincolnshire employers also find it difficult to recruit and retain staff. It is acknowledged that the current models of care are not sustainable now, and in the future. Lincolnshire has a current financial deficit, with a possible deficit of £100m predicted in five years if nothing changes.

All four Lincolnshire CCGs have above average disease prevalence for the majority of disease categories. This, coupled with the impact of growth for services in the elderly and children, is made even more complex by the rurality of the county, and where current services are placed.

Aims of the LHAC programme
The review of health and care services has an ambition to develop a model of care that will help the health and care community provide quality services that are safe, accessible and suitable for future. Its aims are how to best provide the right service, at the right time, in the right place to achieve the best outcome within the resources available, in addition to integrate the delivery of a health and care model that is seamless to the patient, and finally to achieve financial balance across the health and care system in Lincolnshire.

Accelerating the delivery of the ULHT Clinical Strategy

As part of the ULHT planning process, we will determine how elements of our future Clinical Strategy for 2016/21 can be implemented without the need for public consultation, for example:

- Introduction of innovative ways for addressing workforce recruitment and retention challenges, for example: the development of nurse roles to take on more responsibility in the areas of stroke medicine, colorectal and general surgery and vascular services.

- Transformation of our hospital estate to maximise the efficiency and flow of our patient activity for example: concentration of elective care on sites where beds are not put at risk through emergency admissions. This includes significant upgrade of the surgical facilities at Louth and Grantham Hospitals to establish an Arthroplasty Centre for Lincolnshire located at Louth, and two additional operating theatres at the Lincoln site to sustain a 7-day elective surgical service at the Grantham Hospital.

- Consolidation of selected services to maximise the utilisation of the workforce, which in turn will deliver sustainable clinical services.

- Implementation of 7-day services across our hospitals.

- Transformation of our emergency care systems in partnership with our commissioning and provider colleagues across Lincolnshire so that the Emergency Department in acute hospitals receive the “real” emergency cases. Urgent Care Centres will be set up on each of our hospital sites, these will receive, triage and treat patients, and only those patients requiring care from the acute hospital emergency department will enter the doors of the emergency department. The commissioners have recently commissioned the “CAS” (Clinical Assessment Service), which aims to sign post patients to the most appropriate place for care.

- Introduction of Endoscopic Ultra Sound (EUS) at the Lincoln Hospital site, this will significantly reduce the length of the diagnostic pathway for both cancer and non-cancer patients.

Appendix A: Delivery Plan