Operational Plan for 2016/17

1. Introduction and Context

This narrative supports the finance, activity, quality and workforce elements of Heart of England NHS Foundation Trust's Operational Plan for 2016/17.

The 2015/16 financial year has been particularly challenging for the Trust which is currently subject to Monitor undertakings under sections 106 and 111. Work is on-going, with the support of Ernst and Young (EY), to finalise a Financial Recovery Plan (FRP) which aims to re-establish a sustainable financial position over the next few years while continuing to improve performance against access targets. The draft FRP is close to completion and will be submitted to NHS Improvement alongside the Operational Plan.

The Board of Directors have agreed to the conditions placed on acceptance of Sustainability and Transformation Funding (STF), including agreeing to achieve a maximum target deficit of (£13.6m) in 2016/17, subject to a number of caveats as set out in the response.

Since the appointment of Rt Hon Jacqui Smith and Dame Julie Moore as Interim Chair and Chief Executive of HEFT in late October 2015 a number of pieces of work have been commissioned, but not yet implemented or completed.

Those work programmes, over and above the financial and performance priorities, include:

i. Governance

The Good Governance Institute has commenced Board development work with individual interviews with all Board members.

ii. Organisational Structure

- A new operational delivery structure has been developed and was implemented on April 1 2016. It ensures clear roles, responsibilities and accountabilities across the organisation.
- Job descriptions have been written, a meeting structure has been mapped and senior clinical mentorship has been put in place.
- A review of the corporate structure of the organisation has commenced.

iii. Ensuring Clinical Quality

- CEO meetings with senior clinicians have been arranged, the importance of reporting has been emphasised to staff and monthly CEO-led Root Cause Analysis meetings have been established.

iv. Estate and Infrastructure

- An independent estates review has been undertaken and draft strategy produced identifying c£160m for investment needed in the first phase.

v. ICT

- A preliminary review of ICT has been undertaken and an infrastructure survey is underway.

vi. Capital Programme

- A review of the capital programme has been undertaken and a review of capital plans and discussions are ongoing with Clinical Commissioning Groups.

vii. Staff Engagement

- The response from clinical staff in the organisation is extremely positive and heartening, with large numbers of invitations being received from clinical teams to visit them as well as requests for meetings.

- There have been massive turnouts to the open briefings the interim CEO and Chair have given and many positive suggestions have been received as well as concerns raised.

viii. External Stakeholder Engagement

- External stakeholder engagement has been a priority since the arrival of the new executive management team.

- The new approach is one of transparency and honesty, has been proactive and, where possible, has been delivered face-to-face by the Chair, Chief Executive or appropriate member of the Executive Team.

- All key MPs, Councillors, as well as Birmingham and Solihull health-related organisations have been met with, or spoken to. Quarterly MP Stakeholder Meetings with the Chair and Chief Executive have been diarised. The Chair and CEO have given updates at the Health Overview and Scrutiny Committees and are playing an integral part in the Sustainability and Transformation Plan process.

- Meaningful relationships with the Clinical Commissioning Groups are also being built.

- Local pressure and patient support groups have been engaged with. However the external stakeholder strategy is to engage with as many members of the public and patients as is possible, using established forums and networks, to ensure that a consistent message is delivered in person to all interested parties.

2. Activity Planning

2.1 Operational Planning

Heart of England NHS Foundation Trust has seen a year on year increase in demand, a trend which has continued throughout 2015/16. In order to establish the anticipated demand during 2016/17, the Trust has used the following approach:

- Use of Month 6 year to date activity, at HRG and Point of Delivery (PoD) level, to inform a forecast out-turn level of activity, adjusted for agreed counting and coding changes and seasonally adjusted.

- Applied a general growth percentage for 2016/17 based on historic trends for each specialty by PoD.

- Adjustments made for specific growth in 2016/17 for example service developments, new services, services moved to an alternative provider, national initiatives (eg. NICE guidelines), recovery plans for key operational standards.

- QIPP schemes for 2016/17.

- Review of calculated activity to ensure the level is sufficient to deliver access standards.

For block contracts, the price activity matrices are under review to agree any changes to the block funding.

Table 1 below details the anticipated growth in demand for 2016/17 using the above approach.

Table 1: Anticipated Growth in 2016/17

Patient Class	Growth Assumption %
Accident & Emergency	1.7%
Daycase/Elective	14.3%
Emergency (Inc AEC/AMU)	1.7%
Outpatients/Treatments	1.2%
Adult Critical Care	1.8%
Paediatrics Critical Care	0.0%
Neonatal Critical Care	(0.0%)
Direct Referrals	6.0%
Births	0.0%
Ante Natal	(0.0%)
Post Natal	0.0%
Maternity	0.0%
Unbundled	1.5%

Based on the 2-3 year average, generally the growth is within a range of 1% to 2% with two notable exceptions in Daycase and Direct Referrals where the Trust is seeing significant growth in Endoscopy and Pathology referrals respectively.

Following the above described process, the latter half of the 2015/16 financial year has seen significantly higher levels of A&E attendances and emergency admissions than previously anticipated from previous year's trends. The difference between the two halves of the year in these areas is demonstrated in table 2 below.

Table 2: Emergency Growth in Two Halves of 2015/16

	Mth 1 to 6 Growth		Mth 7 to 12 Growth	
	No.	%	No.	%
Versus Same Period in 2014/15				
A&E Attendances	1,528	1.2%	11,628	9.6%
Emergency Admissions incl AEC & AMU	(917)	(1.9%)	4,972	10.1%
Versus 2015/16 Plan				
A&E Attendances	(1,610)	(1.2%)	7,147	5.7%
Emergency Admissions incl AEC & AMU	(1,566)	(3.2%)	2,869	5.6%

Contract negotiations have been based on the original growth assumptions set out above, however it has been flagged to commissioners that there is a significant risk that demand will exceed this during 2016/17 if the current level of growth in A&E attendances and emergency admissions were to continue.

2.2 Capacity Modelling

The Trust has used modelling tools built by the CSU on behalf of the commissioners. These tools are reconciled with the planning assumptions in HEFT's operational planning tools which support internal planning, budgeting and forecasting processes for 2016/17.

The Trust ran a Demand and Capacity Group which involved all divisional, corporate and relevant executive leads. This group agreed the activity projections detailed in the operational planning and then continued to:

- Apply the activity growth assumptions for 2016/17 to the Trust's capacity models for beds, theatres, outpatient clinics and diagnostic services.
- Highlight any potential gaps in capacity.
- Identify the requirements for productivity improvement, reconfiguration of capacity, and/or investment in capacity, to close the potential gaps in capacity.
- Prioritise areas for productivity improvement, reconfiguration and/or investment.
- Build these into the planning, budget setting and forecasting process.
- Highlight any capacity risks to commissioners.

As the need for productivity improvements are identified, the Trust will consider its current performance against both prior year's performance and external peer organisation productivity in order to prioritise where the key areas of improvement may be realised. These areas of productivity improvement are intrinsically linked to the overall financial recovery programme.

2.3 Trajectories for Key Operational Standards

The planning process has determined the Trust's performance trajectories and/or milestones where recovery is required. This builds upon the progress made in 2015/16 on a number of operational standards and also identifies emergent issues and productivity/capacity mitigations.

2.4 Flexibility to Meet Unplanned Changes in Demand

The Trust's plans for winter are based upon a seasonally variable bed model and capacity plan (elective and non-elective). There is also the identification of planned flex wards bought on line at identified thresholds where demand materially rises above plan.

The recent sustained hike in emergency demand since December has been beyond modelled seasonal variations and presents major risks to the Trust in delivering its Operational Plan for 16/17 should it continue. Contingencies to overcome this are being worked through with the wider system and will feed into the Trust's operational

improvement trajectories for 16/17.

Executive led internally focussed improvement work streams are being established during April that will focus on:

- Emergency and Acute Care Improvements
- Length of Stay and Complex Discharge Improvements
- Surgical Pathway Improvements

These work streams will target the improvements in productivity, efficiency and performance necessary to provide greater flexibility in dealing with unplanned changes in demand. They will also capture the relevant elements of the financial recovery programme. These work streams will be complemented by similar work streams for Cost Improvement Plans and Workforce Strategy.

There is a system wide winter resilience planning round that identifies admission avoidance and supported discharge schemes closely aligned with the Better Care Fund. In addition the Trust directly commissions significant year round out of hospital capacity and delivers community services in one of its localities. The volumes of both of these elements are seasonally adjusted.

For unplanned changes in demand for elective services, the Trust continues to monitor emergency demand, the leading indicators of referrals and the new to follow-up ratios to inform commissioners of the changes to planned activity. This will inform discussions about how best we should both prioritise internal and external capacity to meet the demand.

3. Quality Planning

3.1 Quality Standards and improvement

The Trust's Interim Deputy Chief Executive for Clinical Quality is the named executive lead for Clinical Quality. He is leading on the focus on quality, safety and the continual reduction of avoidable harm and developing sustainable systems that deliver high quality reliable healthcare. These systems are centred on patients and are devoted to learning, acknowledging the freedom to evolve locally and become rooted in a culture relentlessly focused on safety at every level.

The quality and safety improvement interventions currently underway at Heart of England NHS Foundation Trust are:

- Measuring accurately, reporting and publishing progress against key national and local quality and safety metrics; demonstrable actions that improve patient outcomes.
- Supporting the Trusts workforce to recognise that safety is the highest priority and to be vigilant to the opportunities of improving safety and promoting an organisational safety culture.

- Continuing to develop Ward to Board engagement by Executive-led assurance panels and the Board of Director's unannounced governance visits.

- Acting promptly on patient feedback from multiple sources including patient experience surveys, external visits, peer review, incidents, claims and complaints to improve all parts of the service.

- Driving improvements in quality and safety by enabling staff to understand and implement quality improvement e.g. Sign up to Safety.

- Sharing the learning through a variety of forums and materials: trust induction, educational programmes, learning events, podcasts, newsletters and safety boards 'Lesson of the Month' and 'SI at a glance' reports.

- Ensuring that all staff are trained and updated through planned programmes of induction and mandatory training including professional forums.

- Continuing to promote duty of candour at Trust and healthcare levels, ensuring openness and transparency with appropriate documentation and support for patients and families.

- Supporting and encouraging staff to adopt the Trust Values and engage in open and honest discussions about safe care.

- Delivering and improving robust incident reporting and management systems e.g. RCA forums and executive challenge through the Executive Care Omissions RCA.

- Taking a leading role in supporting local collaborative learning, so improvements are made across all of the local services that patients use. Maximising improvements in safety and quality through participation with regional, national and international collaboratives (Sign up to Safety, WMAHSN; Patient Safety Collaborative; The US Advisory Board Company).

- Continuing to develop a whole systems approach to share best practice.

- Continuing to develop and implement human factors training for all staff groups.

- Reviewing the approach to use of clinical simulation to promote learning.

- Using the National Staff Survey and Staff Friends and Family test to prioritise areas for improvement that are important to staff. Continuing to engage staff through the staff engagement events and the 'Engaging Teams' programme.

- Continuing to promote reflective practice and feedback through Schwartz Rounds and Grand Rounds.

3.2 Quality Priorities for 2016/17

The Trust is currently determining the key quality improvement priorities for 2016/17, with a focus on the key domains of patient safety, clinical effectiveness and patient experience. Key principles are:

- Reducing avoidable harm associated with omissions and delays in medicines.

- Reducing avoidable harm associated with sepsis (linked to a national CQUIN).
- Reducing avoidable hospital-acquired pressure ulcers (all grades).
- Reducing the number of follow-up complaints and complaints upheld or partially upheld by the Parliamentary and Health Service Ombudsman.
- Improving response rates and scores for the various Friends and Family Tests and National Patient Surveys.
- Improving the approach to incident reporting.

3.3 Key Risks to Quality

The Trust has identified the following key strategic risks to achievement of the Trust's priorities. Further controls are currently under development to mitigate these risks.

Assurance of clinical quality
Failure to have in place a sustainable governance infrastructure for all divisions, set against the Trust's quality and safety strategy and assurance frameworks.

Affordable care
Significant deterioration in the Trust's underlying financial position resulting in the inability to deliver the Financial Recovery Plan and a national recognition that money is as important as quality.

3.4 Responding to CQC and the Well-Led Domain of Quality

The Trust received 11 requirement notices and 'must do' and 'should do' actions. In response to the CQC inspection in December 2014, a full action plan was developed and reported to the Executive Team. Progress with completion of the actions is being tracked through the monthly Chief Executive's Group meetings. Embedding of the actions has been tested through the quality reviews and a mock inspection of all the actions was undertaken in February 2016.

The outcome of the CQC mock inspections have been informally shared with the divisional teams – formal progress will be reported to the May Chief Executive Group meeting and Public Trust Board.

3.5 Avoidable Mortality Review

The Trust significantly revised its approach to mortality governance as a result of 2014 Silverman Review, commissioned by the Medical Director. Mortality has been tracked and managed and is regularly reported to the Board.

The future Board reporting is being reviewed following the January 2016 NHSE mortality guidance.

3.6 Sign Up to Safety Priorities

Heart of England NHS Foundation Trust joined the Sign up to Safety campaign in December 2015 and made the following Sign up to Safety pledges. These priorities will reduce avoidable harm by 50% by 2018:

Reducing avoidable harm from failure to recognise and rescue deteriorating patients

- Reduce avoidable harm from failure to recognise deterioration.
- Reduce avoidable harm from sepsis.
- Reduce avoidable harm from acute kidney injury (AKI).

Reducing avoidable harm from medication

- Reduce avoidable harm from omissions and delays in medicines.
  - Timely administration of medication for Parkinson's Disease
  - Timely administration of one-off (stat) doses of antibiotics
- Reduce avoidable harm from medication errors relating to anti-coagulation and diabetes medications.
- Reduce avoidable harm by focussing on 'high-risk' medicines.

Reducing avoidable harm hospital-acquired pressure ulcers (all grades)

Reducing avoidable harm in Maternity services

- Reduce the incidence of sepsis associated with category 1 caesarean sections.
- Implementing a Trust-wide telephone Triage service led by experienced midwives to ensure pregnant women are given the right information (on when / which site to attend) according to their clinical risk.

The Trust is developing a detailed Safety Improvement Plan and effective processes for monitoring progress over the next three years.

3.7 The Association of Medical Royal Colleges' Guidance on the Responsible Consultant

In response to guidance in the AMRoC document "Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients" the Trust purchased small white boards for each ward bed space. The name of the consultant with overall responsibility for the patient is written on the white board.

With regard to the "named nurse" policy, at the beginning of shift the nurse caring for a patient identifies themselves to the patient. The supervising ward sister is always available to speak to any patient on his/her ward. The use of the ward Jonah Board provides a further source of information.

3.8 Seven Day Services (7DS)

Heart of England NHS Foundation Trust is a fully participating member of the Birmingham 7DS Collaborative and has made good progress. The purpose of the Collaborative has been to draw together the health and social care communities across Birmingham in order to support the national 7DS agenda by sharing information and best practice, and collaborating where appropriate.

In November 2015, along with our BCC CCG commissioner, the Trust led the collaborative through a multidisciplinary action planning workshop focused on 'Standard 9 Transfer to Primary, Community & Social Care'. The action plan from this session is fully aligned with, and signed off by, the Birmingham BCF and the Systems Resilience Group (SRG).

The four priority standards currently under review are:
#2. Time to 1st Consultant review

#5. Diagnostics
#6. Intervention/Key Services
#8. On-Going Review

These four standards have been highlighted by Professor Sir Bruce Keogh as being clinically relevant in the debate about mortality for weekday vs. weekend admissions.

In order to address the problem of reductions in discharges at weekends, the Trust has proposed that the Collaborative focusses on #9. Transfer to Primary, Community & Social Care', in order that BCF and SRG focus to act on the various services provided by external partners that assist and enable 'no-delay' discharge.

3.9 Quality Impact Assessment

The Trust has recently redesigned the processes for the identification of CIPs and monitoring the delivery and impact of them. On identification of schemes, a full quality impact assessment is conducted within the Division.

Following the divisional process the Trust conducted a Confirm and Challenge meeting at which each Division were required to present their CIP programme to the relevant executive directors, including the Medical Director and Chief Nurse, in order to assure the Board that schemes do not represent a detrimental impact to the quality of the service the Trust provide.

The Trust then consider that the regular monitoring of KPIs, targets and patient outcomes would highlight any areas where an unexpected impact on quality became apparent and swift actions would be taken to rectify the impact.

3.10 Triangulation of indicators

The Trust is currently implementing a new programme of regular reporting which provides assurance to the Board of Directors that the interconnections and commonalities between finance, quality and performance measures are considered and where necessary acted on.

Divisional Performance Review
Quarter 4 of 2015/16 has seen the introduction of bi-monthly Divisional Performance Reviews, chaired by the Chief Executive and attended by Executive Directors. This review requires the divisional senior management team to present, on an exception basis, a suite of indicators across quality, workforce and finance. These indicators range from those which are national to those locally agreed with commissioners as part of the contracts.

Indicators cover all services delivered by HEFT across Community and Acute services and across corporate and clinical areas with relevant measures reflecting numeric or quality measures. Measures include waiting times within services for both emergency and elective waits, rates of repeat episodes, procedures or cancellations as a measure of quality, completeness of data such as NHS number, preventative and screening rates to support avoidance of avoidable items such as healthcare acquired infections and thrombosis and never events which indicate failures of care or process.

Where performance targets are not met or where quality does not meet standards remedial plans are developed internally in the first instance or agreed with commissioners.

Monitoring and Board Reporting
The Trust is monitored externally but also has a large degree of internal monitoring to allow for early indications of service issues and providing remedial opportunities. Internal monitoring is facilitated by a range of reports and processes along the hierarchy of clinical and managerial tiers ranging from individual appraisals and feedback to Trust Board performance reports by exception at intervals. The Board reporting was overhauled in January 2016 with new performance, clinical quality and care quality with streamlining Board subcommittees to ensure the Board of Directors has greater visibility on all issues and most notably quality. In this way, the Board has a clearer line of sight on all key issues and risks.

External monitoring is facilitated by reports covering quantitative and qualitative reports presented at regular intervals and formats in a variety of ways using narrative to describe issues and remedial actions with improvement targets and timelines.

Performance Measurement to Support Triangulation
HEFT uses a variety of methodologies:

- Investigations to identify and explain incidents, causative factors, actions to prevent performance failures, and describing lessons to be learnt, such as root cause analysis.
- Numbers measuring trends across time and supporting forecasting of future performance. Benchmarking performance against others externally and internally to give context, for example if the Trust has long waiting times for a particular speciality how does that compare to others, does this indicate inefficiency or complexity, is it a local or a national issue, will it be improved by training, additional capacity or a piece of equipment.
- Graphs that visually display performance so that patterns and trends are easy to spot. Graphs also allow annotation to highlight impact.
- Using statistical techniques that evidence normal variation, hot spots or items of high value or importance to support focused actions.

4. Workforce Planning

4.1 Development of Workforce Plans

The workforce plans have been developed taking close consideration of the activity forecast for 2016/17 from the Demand and Capacity Group and the Trust's restricted financial situation while at the same time focusing on quality of care. The plan demonstrates the next 12 months but also takes consideration of the longer term plan to support and retain a highly motivated workforce that meets the Trust's service demands.

The Workforce Directorate have been integral to developing new ways of working and supporting operational and clinical colleagues to express the required capacity to support the development of the Trust's services and focus on clinical quality.

The plan supports an increase of staff primarily associated to clinical staff and where reference is made to administrative staff, they are identified to support clinical services directly. The planned increase in the workforce for 2016/17 is anticipated to be lower than the increase of workforce that occurred in 2015/16.

The investment in the substantive workforce is aligned to enhancing the quality of clinical services and meeting the expected demand in the next 12 months. This investment will be offset in part by efficiencies associated with having less reliance on temporary workforce.

The Interim Chief Executive has introduced a weekly Workforce Approval process where all administration/non-clinical roles and clinical roles (Band 7 and above) are brought to the Executive Team meeting. They are discussed, approved or declined based on need to support the delivery of patient care.

All new consultant roles are brought, discussed and receive approval to go to Board of Directors for consideration as part of a new monthly Chief Executive's Group (CEG). Other new clinical positions are considered and approved as part of business cases that go to CEG.

4.2 Particular Areas of Change

Nursing & Midwifery

The Trust has seen significant investment over the last 3 years regarding midwifery services in order to meet birth rate plus standards. Therefore significant investment over the next 12 months in midwifery services is not anticipated. The Trust is expecting an increase in the nursing workforce associated mainly with acuity reviews and supporting the highest standards of quality. In addition, there are plans to support increasing demand for elderly care and therefore the qualified nursing capacity is planned to increase to meet the expected demand and enhance the quality of care.

In order to meet the expected demand for elective work there are plans to extend theatre nursing staff alongside additional ODP staff. This is taking consideration of new ways of working and extended roles in order to attract candidates to this area. This strategy is being developed alongside a known recruitment issue to ensure planned changes are aligned to the Trust's recruitment and retention strategy. In addition, this will support extended services to allow further development towards seven day service provision.

Medical & Dental

The predominant focus is on extending the middle grade role, ensuring that substantive appointments can be made to offset the current dependency on temporary staff in Emergency Medicine. There are also plans to develop middle grade roles in surgery to support the shortfall of FY junior doctor posts from the deanery. There are plans for consultant posts in Radiology to support increased activity as well as additional Obstetric consultant posts.

In order to support the medical workforce plans there continue to be planned increases to Physician Assistant posts in Obstetrics and Neonates alongside further

development of ACP posts in Paediatrics. As such the Trust has recently commissioned further training places in order to continue to build this workforce group in the medium to long term.

Support to Clinical Staff
There are further developments planned for Assistant Practitioner roles at band 3 and 4 across Medicine, Surgery and Emergency Care. This will support career development opportunities as well as providing the basis for developing quality standards in clinical areas.

In addition, there are plans to further develop the HCA role with particular emphasis on Elderly Care and Emergency Medicine. This will support expected increases in activity levels and provide the basis for further support to the nursing teams as well as enhancing the patient experience.

4.3 Use of e-Rostering

Heart of England NHS Foundation Trust is an established user of e-rostering for the nursing workforce. The Trust has recently purchased an additional module which enables a divisional view on productivity. These reports are reviewed on a regular basis in order to identify areas for further improvement.

4.4 Agency Staffing

The Trust has introduced authorisation processes which ensure that the rate caps, introduced since November 2015, are adhered to. This has proved challenging in some areas in particular the middle grade level within Emergency Medicine and consultant level across Gastroenterology and Radiology.

Any proposed escalation of rates above the caps is routed through the recruitment department who will escalate the authorisation to an appropriate level before a booking is made. This has minimised the breach of the rate caps to this point but is becoming increasingly challenging as the caps move through the phases of reduction.

The Trust intends to continue to adhere to the rate caps throughout 2016/17 whilst ensuring that if escalation is necessary for the safety of patients, the authorisation is achieved at the appropriate level.

5. Financial Planning

5.1 2016/17 Financial Plan Summary

The Trust's 2016/17 financial plan forecasts a financial deficit of (£13.6m) in line with the control total communicated to the Trust in January 2016. This is based on an assessment of the financial tariff published in March 2016 and includes the Trust's £23.3m general allocation from the Sustainability and Transformation Fund (STF).

There is still some uncertainty in the following areas at this stage of the process, including:

- Contract negotiations with commissioners.

- Finalisation of Financial Recovery Plan, with the support of EY, to identify the scale and ambition of recovery over the next 2 to 3 years.

This control total of (£13.6m) represents a challenge to the Trust as detailed in table 3 below.

Table 3: Income and Expenditure Summary Including General STF Allocation

	£m
FY 15/16 (forecast)	**(47.4)**
Add Back 2015/16 Non Recurrent Adjustments	(18.5)
Impact of Planning Assumptions	(1.2)
Draft Plan 2016/17 pre STF	**(67.1)**
General STF funding	23.3
Draft Plan post STF	**(43.8)**
Control Total 2016/17	**(13.6)**
Total Savings Target	**(30.2)**

This plan acknowledges the lack of Targeted STF but still aims to achieve the required control deficit of (£13.6m). However, it should be noted that the additional stretch savings target of £5.2m, required as a consequence, is considered to be high risk.

5.2 Approach to Financial Planning

Key assumptions made whilst developing the financial plan include:

- Trust achieving a forecast outturn normalised deficit of (£65.9m) for 2015/16.
- Local prices are increased by 1.1% in line with national tariff.
- Forecast activity growth is paid for in line with Payment by Results rules.
- Fines are suspended in full for 2016/17 including those related to readmissions.
- CQUIN funding is received at 100% irrespective of delivery and that additional cost is not required to deliver.
- Commissioners do not implement QIPP schemes besides genuine reductions in PbR activity.
- General STF is received at £23.3m as communicated in January 2016.
- Full delivery of £12.0m of new cost improvements based on 2% within tariff.
- Further delivery of recovery.

Forecast Outturn Deficit

During the 2016/17 planning process, a detailed piece of work has been conducted, with the support of EY, in order to identify a detailed forecast year end position together with the underlying position moving into 2016/17. Each Division was asked to submit a year end forecast, based on months 1-8 actual position, which clearly identified:-

- Prior month's non-recurrent gains and losses within the position.
- Delivery of CIP split between income generating schemes and expenditure related items.
- Delivery of non-recurrent CIPs within current position.
- Any risks and opportunities anticipated in remaining months of the year.

Following a review of the submissions, confirm and challenge sessions took place where senior staff members of both the Trust and EY tested the assumptions submitted by each of the Divisions. This challenge process led to some adjustments being made but has satisfied the Trust that the underlying deficit is robust subject to a number of risks and benefits which may swing the position dependant on activity demand and delivery of recovery.

Base Case Operating Income

Healthcare income has been calculated using the final tariff and business rules published in March 2016 applied to the forecast 2015/16 outturn activity based on months 1 to 6 as detailed in section 2.1 above. The impact of the revised national tariff is expected to be an increase of circa £12.1m, split between £9.1m due to tariff inflation and £3.0m due to the removal of the marginal rate for specialised services growth. The plan assumes that there is no reduction in healthcare income as a result of QIPP or CQUIN under delivery in order to get from the normalised base case deficit of (£65.9m) to the control total deficit of (£13.6m).

So far the 15/16 baseline (activity and value), the growth level in activity and value terms for 16/17 and the transformational QIPP schemes have been agreed. Discussions are on-going with commissioners regarding proposed counting, coding and pricing changes in terms of validity and notice period. A further escalation meeting took place on Friday 15 April and it is currently expected that contracts will be agreed by 25 April.

Base Case Operating Expenditure

The expected increase in costs driven by factors external to the Trust is greater for HEFT than the tariff increase. Primarily this is driven by CNST costs increasing by 40% (£6.1m) compared to an national average increase of 17% and the changes to Employers NI costs of (£8.0m) in 2016/17 due to our particular mix of staff.

The main movements in operating expenditure include:

- £6.1m for Clinical Negligence Scheme for Trusts (CNST) premiums.
- £3.9m for 1% pay award.
- £2.2m for other incremental pay cost pressures.
- £8.0m for the estimated impact of changes to employer's national insurance contributions relating to the NHS pensions.
- £3.2m relating to non-pay inflation.
- £6.6m of estimated increased cost associated with delivery of activity growth, assumed at 100% of growth income.

- £4.7m of new cost pressures identified by departments as part of the 2016/17 business planning process.

- £0.7m of non-recurrent cost pressures which are expected to be incurred during 2016/17.

The baseline for the 2016/17 budget setting process was calculated as part of the EY Baselining Report therefore is based on forecast outturn expenditure for the 2015/16 financial year. The Divisions were each asked to submit known cost pressures for review which were new, recurrent, material and unavoidable. The resulting budget envelope has been circulated to Divisional Senior Management teams and a process is underway to challenge the assumptions made and reach a mutual agreement.

All areas of efficiency identified within the Lord Carter review form part of the Financial Recovery Plan (FRP) currently under development with the support of EY.

CIP Efficiency Savings

The Trust is finalising CIP schemes for 2016/17 and the 3 year recovery plan to drive clinical, operational and financial stability by 2018/19. Whilst the national tariff includes an expected efficiency of 2%, the Trust's plan assumes a total savings target of £30.2m (4.4%).

In addition to delivering the 2% transactional savings this will rely on the recovery work conducted with the support of Ernst and Young which to date has identified opportunities to:

- Reduce operational costs through productivity and efficiency savings.

- Apply increasing focus on the core business and reduce overheads associated with non-core activities.

- Assess variation in clinical practice to improve quality of care and use of resources.

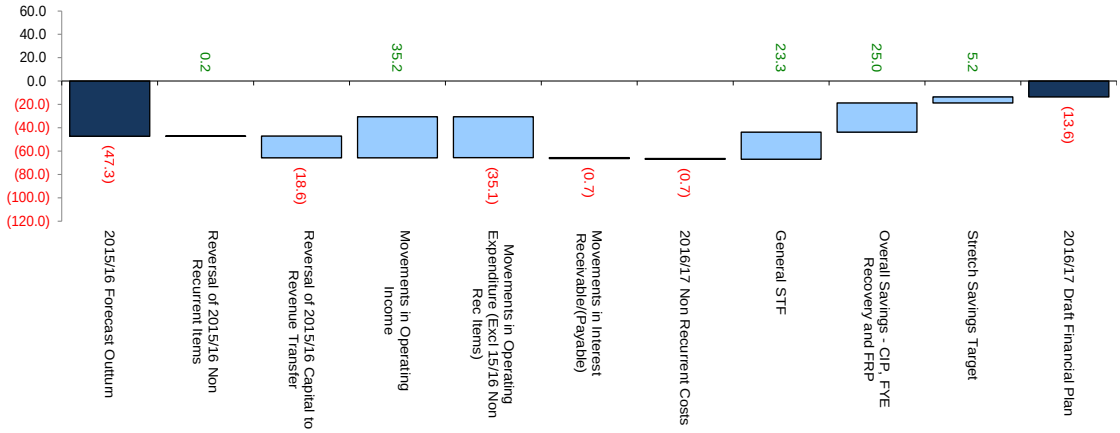
The Trust continues to contribute to the collaborative work as part of the Lord Carter review. In particular on specific projects involving region wide procurement exercises, working closely with NHS Improvement focussing initially on data gathering, sharing and interpretation, but moving quickly to implement change where early opportunities have been identified.

The Trust has recently appointed a Head of Financial Recovery to support the delivery of the total savings programme including the schemes identified within the FRP developed by EY.

5.3 Summary Draft Income and Expenditure Position

Table 4 below summarises the 2016/17 plan based on the income and expenditure assumptions listed above.

Table 4: Bridge Chart from 2015/16 Forecast Outturn to 2016/17 Draft Financial Plan



5.4 Agency Rules

In the summer of 2015 the Trust led the Birmingham wide initiative to ensure all the major employers of agency nurses adopted a shared approach for working with agencies. A pricing structure was implemented that brought an end to the excessive rates and opportunistic working practices. As this approach developed into a national initiative, the Trust continue to use the frameworks to ensure an hourly cap on rates for nursing, medical and other staff groups.

All agency bookings are routed through one department in the Trust and so compliance can be closely monitored. The Trust has continued to enforce the agency controls, although it should be noted that the final phase of rate caps introduced 1 April 2016 has proved challenging, particularly with regard to medical staff.

5.5 Procurement

As an established user of procurement benchmarking software packages the Trust continue to benefit from having good visibility of price comparisons and where further savings opportunities exist. Recent investment in systems to improve visibility of product use, stock levels and ordering patterns will support the ability to benefit from the development of national contracts.

5.6 Capital Planning

Approved schemes of £6.9m were deferred in 2015/16 as part of the financial recovery programme, but remain necessary in 2016/17.

A total list of £7.8m of new prioritised bids for medical equipment, scanners and theatres equipment is required to deliver existing services safely with the vast majority of this being replacement equipment. The exception to this is an additional MRI scanner at Good Hope which has been identified as necessary to meet demand.

The plan includes a capital programme of £40.0m during 2016/17 which includes urgent Estates and ICT schemes required to maintain the infrastructure or to bring services up to the required level. It also includes electrical infrastructure works that are required before any new major building work can begin. The large build programmes are for the preliminary works on identified large builds which include outpatients, endoscopy, A&E, ITU facilities on the Heartlands site and reconfiguration

work on the Solihull site. The £17m of planned equipment expenditure (inc. core ICT) can be delivered from within the Trust's own internally generated funds, however, the wider ICT and Estates expenditure will be dependent upon securing external financing. The total requirement for the BHH site, based on the phase 1 review, is estimated to be £160m with £23m currently profiled into 2016/17.

All capital expenditure is prioritised based on safety concerns for patients and investments which will deliver efficiencies to aid the Financial Recovery Process. Table 5 below details the capital investments assumed within the plan for 2016/17.

Table 5: Breakdown of Current Capital Plan for 2016/17

	£m
Deferred 2015/16	6.9
Prioritised list for 2016/17	7.8
Contingency	2.3
Equipment Total	**17.0**
Estates	23.0
ICT	
Large build programmes 2016/17 costs	
Total	**40.0**

The detailed list of this capital plan was submitted, reviewed and discussed at the Board of Directors meeting on 4 April 2016. The Board agreed that the prioritised list was a fair reflection of the most urgent/essential patient safety needs and the plan was approved.

The funding for this programme is anticipated to be drawn from a combination of the following sources:

- Depreciation
- Department of Health Distressed Finance
- Other Commercial Sources of Borrowing

5.7 Distressed Funding Requirement

In January 2016, the Trust notified Monitor that it will require a working capital loan during quarter 1 in 2016/17. The extent and duration of this requirement will be determined by the timing of total STF payments and the anticipated delivery of the Financial Recovery Plan.

If the Trust can achieve the planned deficit of (£13.6m) for 2016/17, it may be that this working capital facility is only required in the short term whilst the phased delivery of savings, including both CIP and FRP, materialise.

5.8 Risks and Caveats

There are a significant number of variables which impact on this financial plan. The main uncertainties and risks include:

- Finalisation of 2016/17 contracts including commissioner plans for local CQUIN and QIPP targets which may result in either income reductions or additional costs to deliver the targets.

- Further variances (expenditure and income) relating to an increase in unplanned activity (emergency admissions and A&E attendances) and the potential full year impact if the growth continues.

- Delivery of CIP and Financial Recovery Plan savings.

If healthcare income contract negotiations materially change the operating income estimate, it may be necessary to revise the financial plan and the Trust's ability to meet the required control deficit of (£13.6m).

6. Link to Sustainability and Transformation Plan

The Trust is required to report to Monitor discussions regarding the Sustainability and Transformation Plan to date as well as emerging themes. As the local footprint and leadership have only just been confirmed by NHS England there has been limited progress to date. This section is therefore significantly shorter than the two pages requested by Monitor. The Executive Delivery Group of the local footprint has confirmed that :

- We are committed to work collaboratively to improve the health and wellbeing of all our citizens and developing a sustainable health and care system for both Birmingham and Solihull.

- We will work with the public, provider and commissioning partners within the Local Authority boundaries on the development of our Sustainability and Transformation Plan which will identify the gap within the system triple aims and describe how to close that gap .

- We have agreed governance arrangements under the leadership of Mark Rogers, Birmingham City Council CEO, which reflect an inclusive leadership approach headed by a Chair and Leaders Group.

- This group and the System Board will own the plan and commit our organisation to delivering our identified and agreed contribution.

7. Membership and Elections

7.1 Membership Strategy

For a number of years the Trust has aimed to broadly maintain its membership at around 100,000; comprising around 90,000 public and 10,000 staff members. This was done by auto-enrolling recent patients to offset reductions from members who had died or 'gone away'. Each year the Trust updated the ACORN profiling and socio-economic grouping of its membership to ensure its demographics were as

representative of the local community as was reasonably possible with focussed recruitment to address any significant variances.

The Trust has recently re-visited its membership strategy and is developing a proposal to reduce its total membership over the next 12 months to a number more in line with other large acute foundation trusts but to maintain representative demographics. The driver behind this is to encourage a more engaged membership whilst reducing membership costs.

A Governor committee reviews membership and community engagement matters. The Trust regularly runs community engagement activities both at weekends and on evenings throughout the year which include work with a youth forum and election of a 'young governor'.

7.2 Governor Elections and Recruitment

In accordance with the Trust's constitution, the last Governor elections were held in the summer of 2013 for all seats. The next elections are planned for the summer of 2016.

Governor recruitment is expected to focus on two areas in the run up to the 2016 elections (1) seeking nominations direct from current members, and (2) community engagement events to encourage non-members to join and nominate. It is anticipated that the Trust will utilise a mixture of its own and Govern Well resources for both induction and continuing Governor training during the next 12 months.