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Whittington Health NHS

The Whittington Hospital NHS Trust
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Whittington Health Trust Board

5 March 2014

Title:	**Operational Planning for 2014-16**		
Agenda item:	14/061	Paper	8
Action requested:	For Discussion		
Executive Summary:	This paper provides an update on progress in setting a balanced annual operating plan for the next two years, covering the financial budget, workforce plan, savings programme, contract and activity plan and the capital plan. Key risks: 1. Reaching agreement with commissioners over contract values. 2. Delivery of £15m savings plans in each of the next two years.		
Summary of recommendations:	The Board is asked to discuss: 1. Progress against the timetable. 2. Risks to delivering a balanced plan. 3. Further actions to deliver a balanced plan.		
Fit with WH strategy:	The plan underpins the delivery of all strategic goals.		
Reference to related / other documents:	NHS Trust Development Authority Planning Guidance 2014-19 (23/12/13)		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Deliver financial sustainability		
Date paper completed:	27th February 2014		

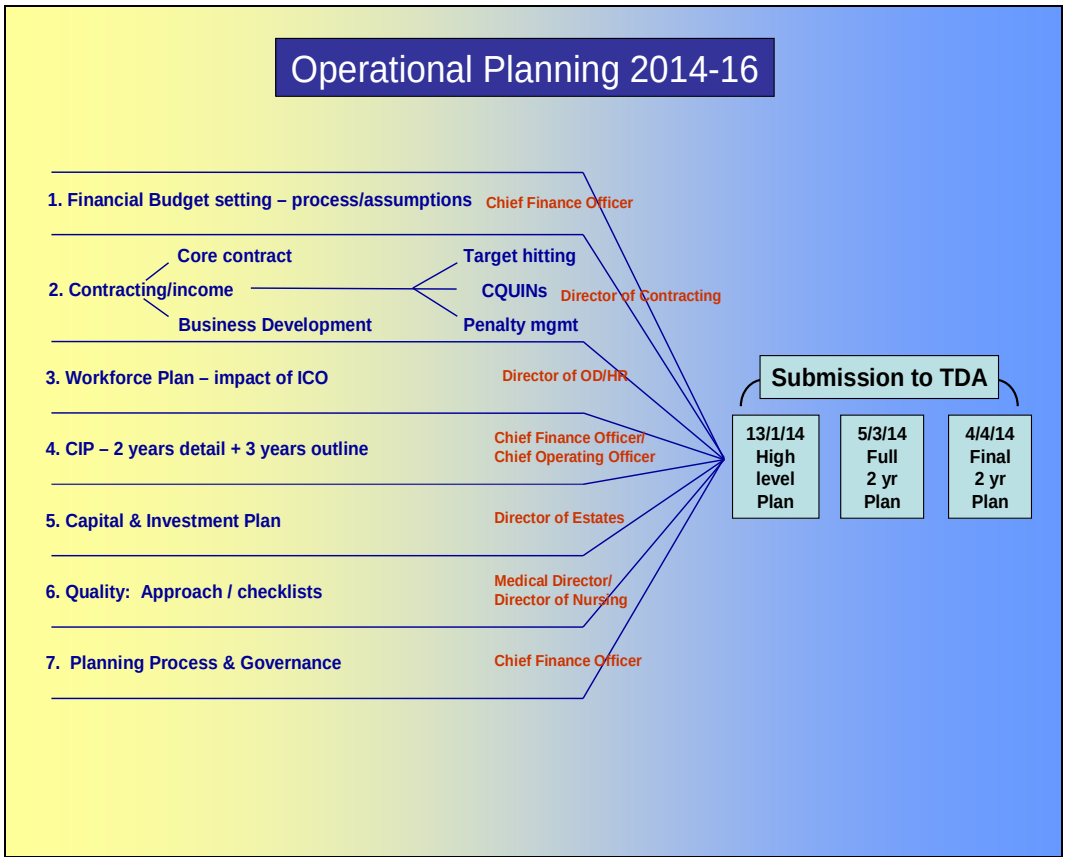
Author name and title:		**Richard Ellis Director of PMO**		**Director name and title:**		**Simon Wombwell Chief Financial Officer**	
Date paper seen by EC	**18/2/14**	**Equality Impact Assessment complete?**	**NA**	**Risk assessment undertaken?**	**NA**	**Legal advice received?**	**NA**

1. Introduction

At its January meeting the Trust Board was presented with a comprehensive report on the process being undertaken to deliver the Operating Plans for 2014-16, and meet the plan requirements set out in the NHSTrust Development Agency (NHS TDA) planning guidance.

This paper provides an update on progress against the original timetable, progress to deliver a balanced plan, the process to close planning gaps and potential risks to the delivery of the plan.

The Trust Board is reminded of the seven work streams being undertaken in order to produce the plan (see below).



An early draft high level plan was submitted to the NHS TDA on 13th January 2014, as per the guidance, with feedback received from the NHS TDA at the end of January. This feedback is being used to update the various components of the plan, to enable the submission of a more comprehensive **draft two-year plan by 5 March 2014**. The plan will remain incomplete and continue to be developed through March.

A further iteration will be presented to the Resource and Planning Committee on 10 March for discussion to support the completion of **a final draft plan** to go **to Trust Board** for - approval at it's meeting of **2 April 2014**. This **final two year plan will be submitted to the NHS TDA on 4 April 2014**.

Following the submission of the two-year plan the Trust is required to develop and submit a **five-year plan** (April 2014 to March 2019) **to the NHS TDA by 20th June**. This submission includes an Integrated Business Plan (IBP) and Long Term Financial Model (LTFM). The final submission to the NHS TDA is **Development Support Plan due in September 2014**.

A Programme Board has been established, and meets fortnightly to review progress and identify any risks to delivery.

2. NHS TDA reporting requirements

In order to comply with the reporting requirements of the NHS TDA, the Trust is required to submit detailed information using standardised documentation by 5 March 2014.

Requirement	Description
Two Year Plan Summary	Standard narrative template summarising the Trust's strategy and how this translates into annual operational plans.
Financial Plan	Series of templates outlining the detailed numbers describing the financial plan in terms of: • Income and Expenditure, balance sheet and cashflow; • Contracts; • Savings/Improvement Programme; and • Capital Investments.
Workforce Plan	Standard template providing staffing numbers, mix and costs across the plan period.
Activity Plan and C. Diff Plan	Standard templates outlining planned activity levels across all services.
Planning Checklists	Series of eight checklists describing our approaches to quality, sustainability, innovation, productivity and prevention.
Planning Process	Outline of the process the Trust is undertaking to deliver the necessary plans, along with governance arrangements and timetable.

3. Financial Budget setting

3.1 Progress

The final financial budget relies upon the completion of the contracting negotiations (to determine income targets and capacity requirements to inform expenditure budgets) and development of savings plans. Both of these sub-processes are still work-in-progress (see below). However, in the absence of final positions, estimates have been made of the likely outcomes. The contract/income position assumes income equal to outturn levels, with some growth in activity (as experienced in previous years). This position is predicated on moving from a fixed sum (block) contract to one that sees commissioners paying the trust based on actual volumes of activity.

In parallel, the expenditure budgets are being negotiated with divisional management based on a forecast outturn spend level i.e. the proxy for the cost to deliver outturn activity levels. Each clinical division has met with the Chief Finance Officer (CFO) and Chief Operating Officer (COO) to assess and agree budget requirements based on current year spending levels, adjusting for identified cost pressures and non-recurrent items. Corporate areas have met with the CFO. Our key objective in this process is to provide all management teams with a budget to support current levels of activity and quality.

3.2 Risks

The budget setting process requires a degree of challenge to ensure resources are allocated according to need. The use of outturn has its disadvantages, not least where departments carry vacancies and/or where financial controls require improvement. This has been addressed through some zero based budgeting and the allocation of challenging cost improvement targets (which will naturally drive out inefficiency). However, a number of risks remain in our numbers pending maturity in our timetable, namely;

- Affordability of outturn activity levels by commissioners (note: we may need to set income targets higher than contract values);
- Commissioner Quality, Innovation, Productivity and Prevention (QIPP) plans are addressed by capacity reduction;
- Funding of winter money is assumed to equal 2013/14 levels (c£3.5m);
- Savings programme will deliver £15m of improvements;
- NHS TDA will accept a break even plan (as opposed to surplus); and
- Cost pressures over and above budget levels are limited to the sum set aside as a contingency reserve (£1.4m).

4. Contracting

4.1 Contract approach for 2014/15

Contract discussions with the clinical commissioning groups (CCGs) are ongoing, but the key principles of the approach being adopted are as follows:

- Target contract value set to keep CIPs to max £15m;
- Gives the trust the flexibility to grow acute activity in response to demand;
- Protects commissioners from gains from coding changes unless specifically agreed;
- Balances risk and responsibility for managing demand – commissioners take the risk on externally generated demand, trust takes the risk once patients are in our care;
- Commissioners take the risk on delivery of QIPP schemes; and
- Overall protection for all parties through "Cap and Collar[1]" arrangement.

4.2 Proposed contract structure

4.2.1 NHS England and local authorities - mix of block and Payment by Results (PbR) in line with national guidance/typical contract structures.

4.2.2 Clinical Commissioning Groups (CCGs):

- Hybrid contract with a mix of block and PbR;
- PbR where the CCGs are responsible for demand (eg. A&E, first outpatients);
- Block where the trust can influence demand (eg. non electives); and
- Block where no/limited activity data exists, including most community services.

4.3 QIPP (Quality, Innovation, Productivity & Prevention)

We have been presented with first draft QIPP plans and productivity metrics by the CCGs, which are still subject to agreement by the Trust, and which are summarised as follows:

£'000s	Haringey	Islington	Others	TOTAL
Acute Productivity	2,626	3,069	1,575	7,270
Contract challenges	257	56	-	313
Reduction in outpatient activity	153	268	-	421
Reduction in unplanned care	424	1,079	-	1,503
Reductions in mental health activity	-	75	-	75
Transfer of OP activity to community	702	92	-	794
	4,162	**4,639**	**1,575**	**10,376**

[1] Cap and Collar is a contractual mechanism which aims to limit risk in a variable contract i.e. setting limits on the maximum and minimum value of the contract.

The QIPP plans are being reviewed by the Trust and being reviewed where we consider schemes may not deliver as planned. The majority of the savings that the CCGs are aiming to deliver come from productivity metrics such as a reduction in follow up outpatient appointments, and a shift of care from day case to outpatient procedures. The basis of these requested savings is currently being reviewed; we need to understand the underlying data, at first sight the level of improvement requested appears excessive (e.g. asking us to go from median to top decile in a single year), and in several cases there is overlap between productivity metrics and QIPP schemes. This includes a QIPP scheme that plans to shift diabetic follow up outpatient activity into the community, and a performance metric requiring us to reduce the level of follow up activity.

Subject to interaction with the terms of the contract, the risk for delivery of QIPP schemes sits with the CCGs, and the financial impact will in a number of cases be off set by investment in community services to deliver the community element. The acute productivity and contract challenges pose a higher risk for the Trust as operational changes will be required in order to meet the required targets. The level of productivity metrics proposed for 2014/15 is significantly higher than the level agreed for 2013/14..

4.4 Potential Risks

Contract negotiations are moving forward, but progress is slow, especially with the CCG contracts. The position is not helped by not being able to provide activity data because of EPR reporting problems. However, we have given commissioners our opening position for negotiation based on available data.

There are still a number of areas to be resolved, which present a risk to both the timing of any agreement and the outcomes assumed within our current planning process:

- Significant risk of signature being delayed past 28th February;
- Increased financial pressure from non-CCG commissioners, as a result of offers received to date;
- Impact of Electronic Patient Record (EPR) system not being able to report activity (CCGs are using this to request a continuation of block contract arrangements);
- Impact of commissioner QIPP schemes on plan and actual performance;
- Loss of income from contract penalties; and
- Failure to deliver (fully) on CQUINs.

5. Workforce Plan – work in progress

5.1 Workforce Development

The workforce plan is developing but is dependent upon emerging operational savings plans. Further, the plan is being designed to take account of transformational change, already underway across the organisation through innovations such as ambulatory care. Skill mix and grade changes are expected to change in some areas due to internal changes and changes to commissioned services.

Key principles in the development of the Trust's Workforce Plan in the medium and long term are:

- **Set** a staffing establishment that meets operational needs within the cash envelope through substantive recruitment and significant reduction on agency staff in 2014/15;
- **Review** the pay bill against other peer trusts. Best practice could suggest that the pay bill should be between 65 – 67% of the cost base, not 70% as is current;
- **Support** a more productive workforce through IT systems and e-enabled solutions;
- **Improve** recruitment and temporary staffing to ensure a fast moving, proactive service with clear service level agreements and reduce reliance upon agency staffing;
- **Review** whether support and other non-patient care services could be improved through specialist outsourcing providers;
- **New types of roles** and workers are needed to deliver new models of care requiring different capabilities and skills necessary to lead and deliver the Trusts' service development plans. Integration of therapy, social services and district nursing – following examples in Greenwich and current N19 pilot being run by Islington/Whittington Health core community services will be more integrated in wider virtual or actual teams, wrapped around GP clusters.
- Incorporate **seven day working** to deliver consistent service levels into weekends;
- **Ensure** a robust succession planning strategy that will strengthen our leadership and management capacity to drive the change agenda and boost the apprenticeship programme; and
- **Review** the impact of demographic changes on people in the community living longer with more specialist health needs and the shift in the development of the integrated care organisation from acute to community-based health delivery, According to demographic projections, the local population in both Haringey and Islington is expected to increase by 6% every year, This will need to be factored into future workforce planning.

5.2 Workforce statistics: Current establishment levels

The Trust currently employs 4,249 WTE staff (the baseline establishment figure calculated on month six times two (ref. Resources & Planning Committee report Operational Plan). The table below reflects the workforce statistics as current and broken down by division and corporate services.

Current Workforce breakdown:- The workforce implications are based on the average worked between April – September 2013/14. This figure includes:

Staff Type	Numbers	Percentage against overall
Permanent	3,516	82.7%
Bank	449	10.6%
Locum	12	0.3%
Agency	272	6.4%
Total	**4,249**	**100.0 %**

5.3 Known service transformational developments

Workforce implications arising from the transformation programme, as well as a 2% savings target for all cost centres in 2014/15, are currently being developed as part of the budget setting process. Resourcing plans with workforce implications are being developed (in parallel) for each of the savings initiatives and transformational projects as detailed below for 2014/15 and 2015/16.

a) Ambulatory Care Centre (ACC)

Whittington Health is opening its new £2.9m ambulatory care centre at the end of March 2014; the new purpose built centre for all ages is a major expansion of our current ambulatory care service and is designed to deliver better patient centred care and avoid unnecessary admission to hospital. The Centre will have five times more capacity for adult services. The Centre will provide a one-stop consultant and senior nurse led diagnostics service giving patients easy access to hospital consultants and specialist staff in one place.

The transition to the new centre will move a significant number of patients being treated in the emergency department. This will impact on staffing levels to reflect the balance of provision. A resourcing strategy is being developed and includes the following:

- 6% of ED activity will be diverted into the ACC by the 2nd quarter of 2014/15. The reduction in demand will allow the reallocation of staff into the ACC;
- The emergency short stay unit will amalgamate into the Acute Admissions Unit by the 2nd quarter of 2014/15 releasing 11 WTE who will transfer to the ACC;
- There will be further adjustments to staffing levels in ED during the latter part of 2014/15 as the ACC becomes more established (see new care pathways below). However, it is worth noting that emergency demand is predicted to continue to increase and close monitoring of demand and staffing levels will need to be in place;

- The establishment of 22 staff (WTE) to run the ACC in 14/15, will be gained form the reallocation of staff currently attached to areas where ACC will impact on activity;
- After the funding for Hospital at Homes closes at the end of March 2014, the two senior staff will transfer to the ACC; and
- Dorothy Warren Day Hospital and its staff will move to the ACC.

b) Emergency care pathways
A redesign of emergency care pathways aimed at reducing twilight medical agency workers, reducing emergency re-admissions and enabling greater access to emergency theatres will reduce delays to treatment. As new pathways change, these staff will be absorbed into ACC over 2014/15.

c) "Bed plan" for the hospital
The strategy is to maintain the overall requirement for bed allocation, as new patient pathways are established (reducing the need for inpatient stays) and a greater shift from hospital to community based services takes place. This will also give us enough capacity for new services and models of care required in the future. In parallel we will use this capacity to increase inpatient numbers through .

d) Review of nursing staffing levels on adult wards (ICAM and SCD)
The high spend on agency and bank staffing has required radical action to address the recruitment of nurses. The nurse recruitment strategy is to fill existing vacancies for qualified nurses on a permanent basis from within the UK, to build up the nursing fixed term pool and to strengthen the numbers of qualified nurse bank workers which together will impact on the downward trend of agency spend. Careful rostering will manage sickness and holiday periods**.**

e) Outpatients
The aim of this transformation project is to create a single point of access, moving from seven call centres to one.

f) Radiology, pathology and pharmacy
This transformational project is to review all three services to seek efficiencies. The first phase will reconfigure the management arrangements in line with future demand levels.

g) Musculoskeletal (MSK) Service
The project aims to shift the emphasis in the way that patients are treated, allow patients to work with clinicians and choose the treatment pathway best for them. This will impact upon surgery and allied staffing levels.

h) Mental health
Targeting improvements to services for vulnerable elderly patients to meet their needs in a better way and create improved productivity with reduced admissions.

i) Intermediate care pathway
Whittington Health has a primary leadership role in the pathway for intermediate care, our integrated community and inpatients services will be reviewing potential new capacity.

j) Tuberculosis (TB) Service for North Central London
From April 2014 Whittington Health will be the lead for outpatient TB services across North Central London. A new hub will be based at the Whittington Hospital in partnership with UCLH (and possibly the Royal Free) including the transfer of staff from the Royal Free under TUPE regulations.

k) Locality-based teams
Greater economies of scale will be identified through organising teams on a locality basis, this will fundamentally increase the local ownership of the care team in the community they serve.

l) District nursing and health visiting review
E-enabled solutions and productivity improvements will enable existing district nursing and the health visiting workforce to work more flexibly. The introduction of technology to support district nurses to allow more time with patients and reduce the administration burden. This will allow greater productivity of nursing in community settings. Changes in the skill mix through the introduction of more generic roles.

m) Endoscopy
The Trust is in partnership with UCLH to deliver capacity for the national bowel screening programme. The business case, currently being amended, includes staffing for a Business/Project Manager, consultant, band 5/6/7 nurses with a go live date of June 2014. The costs of endoscopy will be offset by additional income and, therefore, it does not represent a cost pressure to the Trust.

n) Education
The introduction of an Integrated Care Education Manager to centrally manage the Trust's education business (current value £15.6m income), to draw together new education pathways which will be multi-disciplinary and will move across to community roles via ambulatory care. Also managing the Whittington Education Centre (WEC) the post is key in reaching our stated goals to host the Islington Community Practice Education network.

Director of Integrated Care Education / Professor: Jointly funded role which UCLH Medical School.

o) Improving Access to Psychological Therapy (IAPT)
IAPT offer high quality psychological therapies for people with mild problems of depression anxiety or chronic stress to help them manage and overcome these problems in the local community. Whittington Health is currently the provider for IAPT in Haringey. We plan to submit a bid to tender for Barnet IAPT during 14/15 which, if successful, will incur an indicative income of between £1.5m and £2m for staff transferring under TUPE. These posts are dependent on IAPT winning the tender, therefore, they have not been included in the table of posts until confirmed. For IAPT in Haringey, it is anticipated that the NHS England's mandate for IAPT services will increase to 15% during 14/15 which equates to c£500k increase in funding.

5.3 Other known changes

- **Prison Healthcare Pentonville** – Following a recent tender, healthcare services will transfer to Care UK and Barnet, Enfield and Haringey NHS Trust. This will impact on 46 whole time equivalent (WTE) posts being transferred under TUPE;
- **Camden and Islington (Pharmacy) –** Transfer of Pharmacy Mental Health services to CANDI MHT on 1/4/14.
- **Award of new catering contract** to Sodexo will mean that current staff (22 WTE) will transfer under TUPE, subject to the final stage of the procurement process.

5.4 Workforce implications, mechanisms for achieving transformational change

With a savings target in 2014/15 of £15m and a pay cost (as a proportion of total costs) of 70% we are likely to identify savings of similar proportions from the pay costs i.e. £10.5m. Both corporate and divisional resourcing strategies will be necessary to support the overall savings plans. This will be achieved through a range of measures including the following:

- Reductions in the use of Agency workers from quarter 2, 2014/15. Whilst comparative figures are available between 2012/13 and 2013/14, the proposed spend reductions will be clearer once the CIP programmes are more fully developed;
- Natural turnover and vacancy rates. The current rate of turnover is circa 13% which could assist in managing the workforce changes;
- Organisational changes in relation to transformation will create new opportunities;
- Tighter controls for the recruitment for all posts that are not front line.
- Mutually Agreed Recognition Scheme could be introduced during 2014/15, subject to funds being identified;
- Attendance management is a key priority in tackling short term absence. The plan outlined in the dashboard performance report sets out the measures for reducing sickness levels

In line with previous commitments it is not anticipated that any compulsory redundancies will be necessary.

6. Cost Improvement Plans (CIP)

6.1 Progress

Since December, all divisions have been developing their CIP projects to contribute to the forecast £15m cost reduction target in 2014/15. These projects have been split into three categories:

- Transformational projects (described in paragraph 5.3 above);
- High financial impact, Trust wide efficiency projects; and
- 2% cost reductions, service led low scale projects.

Each project has been developed by the operations teams with the support of Finance and the PMO. Quality Impact Assessments (QIAs) have been completed for each project.

6.2 Where we are against plan and what still needs to be done

The timetable below outlines the process for delivering the CIP programme for 2014-16. As indicated, a couple of the dates have slipped which has had an impact on the development of the Financial Plan and the Workforce Plan.

Activity	Target Date	Status	Revised Date
Longlist of CIP schemes agreed by CIPSG and TOB	16/12/13	16/12/13	
Summary position presented to the Executive Committee	17/12/13	17/12/13	
Summary position presented to Resource and Planning Committee	13/01/14	13/01/14	
Discussion of CIP programme at Trust Board Seminar	15/01/14	15/01/14	
Project Briefs developed and agreed at CIPSG	w/c 20/01/14		28/02/14
Draft CIP programme incorporated into overall Financial Plan	31/01/14		28/02/14
Exec Committee discussion on additional CIPs	18/02/14		+ 4/03/14
Full PIDs developed for key CIP schemes	28/02/14		
Further development work to close residual gap to achieve target	3-18/3/14		
Additional CIP PIDs and QIAs completed	19/03/14		
QIA assessed at divisional boards and signed off	19/03/14		
QIA assessed at CAP and signed off	26/03/14		

6.3 Progress against the financial target (£15m)

As CIP plans are progressed and more detailed costing work undertaken, some of the predicted numbers have changed. For the full CIP plan, as at 24th February 2014, see Appendix 1. The table below outlines a current analysis of projected savings vs the £15m target.

CIP Programme	2014/15 £000	2015/16 £000
CIP Target	**15,000**	**15,000**
Transformational Projects	2,717	1,254
High financial impact, Trust wide efficiencies	2,650	3,200
Serviced low level efficiencies	3,681	3,607
Total CIP Plan reduction (progress to date)	**9,048**	**8,061**
Balance to be found	**5,952**	**6,939**

6.4 Process moving forward

Further work is still to be undertaken, especially on the transformational projects to finalise the savings. In addition, the Executive Team will consider other means by which the gap may be closed, including re-visiting schemes that have previously been deemed unsuitable to progress for one reason or another. This will include identification of schemes to address the gaps for 2015/16 and periods beyond.

6.5 Risks

There are a number of risks, which still require managing, which could impact on the timing and the scale of the CIP programme.

Risk	Mitigation
Timeline for developing CIPs and capturing the savings is being impacted by other priorities.	CIP development is confirmed and communicated as the key short-term priority for the organisation.
Transformation work and some low level projects may be double counted	Finance and PMO to cross reference all projects to allocate savings to appropriate cost centers and eliminate any duplication.
Inability to identify CIP programme to deliver required savings, results in a deficit in financial plan	Exec to agree further work including some projects which were previously ruled out.
CIP schemes involving organisational and staff changes are delayed due to consultation requirements, impacting on savings delivered in year.	Realistic timescales need to be set for implementation of these schemes through planning documentation and project sign-off. Additional schemes will need to be identified to make up any shortfall due to late implementation.

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7. Capital & Investment Plan

7.1 Introduction

This section summarises the draft five-year capital investment plan. The plan has been developed in consultation with the operations directorate.

The plan focuses on the investment needs of the estate, the need to replace life expired medical equipment, and the need to replace legacy IT infrastructure. In addition, where the trust has been able to identify the need to invest in new services or equipment, these have been included under business case investment.

The plan is ready for approval, and has been reviewed informally by the Trust Operational Board and formally by the Estates Strategy Delivery Board, but is subject to further development as business case investment needs are identified and requests for capital investment are made. The Trust has premises backlog maintenance to be circa £20 million, and we are investing approximately £4 million per annum (40% of our Capital Resource Limit (CRL)) to address this backlog. The recent acquisition of community premises has increased the freehold floor space by approximately 50%, but only increased the CRL by 7%.

In general, medical device replacement is keeping pace with expiry of legacy equipment as is IT systems and equipment.

7.2 Process

7.2.1 The five-year investment plan undergoes a process of continual review and updating as schemes are undertaken and investment completed. Upon completion of each scheme, the six-facet survey and asset registers are reviewed and updated to reflect the investment made. Approximately every five years the six facet survey is "baselined" to ensure that the annual amendments have been properly recorded and assessed. Within the six-facet survey adjustment is made to identify critical backlog items. These items are separately identified and are prioritised in year to ensure that they are addressed without undue delay.

7.2.2 To create "headroom" in the plan to allow for business case investment, the backlog programme has been further adjusted. Investment relating to legal statutory compliance in premises has been maintained within each year over the next five years. Estate's KPI's are used to guide this process to test that trust backlog does not rise against the average backlog reported by the NHS for similar London trusts. This 10% reduction creates approximately £500k "headroom" to support strategic investment schemes.

7.2.3 To increase this surplus further, decisions are made to reduce backlog investment in alternate years for premises and Information Technology investment. In the next financial year, full investment will take place across all categories, but then in alternating years from 2015 onwards, first premises investment, and then IT investment is reduced. Managers responsible for programme delivery will know in advance that in any particular year they will need to manage investment across a 24 month period rather than the 12 month period currently. If business case investment needs are not forthcoming or identified, the surplus generated for investment can be fed back into backlog reduction.

7.3 5-Year Summary Plan

	2014-15	2015-16	2016/17	2017-18	2018-19
Available CRL (Estimated by year)	£9,067,656	£9,239,328	£9,417,390	£9,191,762	£9,428,617
CRL (Estimate based upon community properties)	£732,052	£708,742	£704,005	£703,535	£703,535
Totals	**£9,799,708**	**£9,948,070**	**£10,121,395**	**£9,895,297**	**£10,132,152**
Applications					
Premises, Health and Safety, Backlog and DDA	£4,145,678	£4,685,000	£4,790,000	£4,305,000	£5,240,000
Medical Equipment	£1,226,560	£1,691,000	£1,064,400	£1,055,000	£693,000
IM&T	£550,000	£640,000	£ -	£730,000	£ -
Project Management Costs	£500,000	£500,000	£500,000	£500,000	£500,000
Strategic Investment [internal business cases]	£1,260,000	£	£	£	£
WFL lifecycle costs	£324,303	£473,041	£717,449	£917,914	£981,844
Asteral life cycle costs	£1,597,857	£553,364	£1,947,858	£1,655,493	£2,104,790
Cumulative Total	**£9,604,398**	**£8,542,405**	**£9,019,707**	**£9,163,407**	**£9,519,634**
Over / under commitment	**£195,310**	**£1,405,665**	**£1,101,688**	**£731,890**	**£612,518**

7.4 Commentary

The summary plan presented in section 7.3 above identifies the key elements of the Capital Plan going forward for five years.

7.4.1 Total Capital Resource Limit (CRL) - this is the total amount of capital available to invest in all backlog, equipment, plant replacement and business case investment schemes.

7.4.2 Premises, health and safety, backlog and DDA - this is the total sum to be invested in schemes relating to premises management and occupation. The sums have been identified by analysis of the six facet survey, and use of estate key performance indicators submitted as part of the Estates Returns Information Collection (ERIC) process. Investment is needed to ensure that the trust maintains legal statutory compliance in its role as an employer, and the provider of an undertaking. It is also needed to ensure that it manages premises backlog to eliminate high-risk elements and reduce life expired and near life expired elements to a lower level.

7.4.3 Medical equipment - this is the total sum to be invested in equipment replacement as identified on the medical physics equipment register. Replacement is based upon the anticipated life of a device projected forward from its original purchase date. Investment is necessary to ensure that devices are replaced before they become a liability, which could have an adverse impact upon patient safety or service delivery.

7.4.4 IT (Information Technology) - this is the total sum to be invested in infrastructure renewals including replacement hardware, switches, and cabling. Investment is necessary to ensure that IT services continue to operate optimally. Failure to invest could have an inverse impact upon services if there are infrastructure failures.

7.4.5 Project management costs - this is a sum identified to ensure that staff costs associated with delivery of capital projects are capitalised and do not become a cost pressure on revenue budgets.

7.4.6 WFL life-cycle costs - this is the sum identified by our PFI partner as being the in-year investment they will be making on our behalf on infrastructure renewal within the buildings under their control. This is an accounting treatment of sums that previously used to be off-balance-sheet and must be included in the capital plan.

7.4.7 Astral life-cycle costs - this is the sum identified by our Managed Equipment Service provider as being the in-year investment they will be making on our behalf on equipment replacement on imaging equipment contained within the managed equipment service

7.5 Risks to the Capital & Investment Plan

The trust has managed the capital plan by adopting a category approach to investment. As an example if the amount needed for roof repairs exceeds the allocation in any particular year, a judgement call will be made upon the need to invest in other categories and adjustments made, or investment years would be pushed together so that in effect the allocation on one-year could be added to the allocation for the following year in effect doubling the amount of investment.

Likewise if there is unexpected plant or equipment failure this would be managed in the same way.

Although the identified backlog is relatively low in community freehold properties, there is a need to invest to improve patient and staff experience. The increase in the CRL created by the addition of Freehold properties is insufficient to make significant short term investment. Although not yet identified, it is inevitable that there will be requests for capital to invest in improvements identified through the service development review process. These investments although outlined in the main plan have not been fully formed, and therefore there is no assessment of the financial impact. If no case is made then the sums identified through developing the plan outlined above can be released back into elimination of backlog. If however schemes are identified that exceeds the capital available for investment further decisions will need to be made about reducing investment in backlog.

Appendix 1: CIP Plan

CIP Scheme	Director	Service Lead	Savings 2014/15	Savings 15/16	Savings 16/17	Savings 17/18	Savings 18/19	Total Savings
Transformation					(£000's)			
Emergency Care pathway	Lee Martin	Paula Mattin	289	0	0	0	0	289
Ambulatory Care pathway	Lee Martin	Carol Gillen	452	192	tbc	tbc	tbc	644
Planned Care pathway (Inc Theatres)	Lee Martin	Fiona Isacsson	300	tbc	tbc	tbc	tbc	300
Outpatients pathway	Lee Martin	Fiona Isacsson	300	tbc	tbc	tbc	tbc	300
Diagnostics	Lee Martin	Nick Harper and Sam Page	500	tbc	tbc	tbc	tbc	500
Locality Based Teams	Lee Martin	Carol Gillen	852	852	0	0	0	1704
Mental Health Raid implementation	Lee Martin	Carol Gillen	24	0	0	0	0	24
MSK	Lee Martin	Mary Jamal	0	0	0	0	0	0
Primary Care	Lee Martin	Greg Battle	tbc	tbc	tbc	tbc	tbc	0
Intermediate Care Pathway	Lee Martin	Carol Gillen	0	210	0	0	0	210
Increase Private Return	Lee Martin		tbc	tbc	tbc	tbc	tbc	0
Enfield Community Contract	Simon Wombwell		tbc	tbc	tbc	tbc	tbc	0
Transformation Subtotal			**2,717**	**1,254**	**0**	**0**	**0**	**3,971**
Productivity / Efficiency								
Procurement Shared Service + process efficiencies	Simon Wombwell	Alan Farnsworth	1000	1000	1000	1000	1000	5000
Staff & Patient catering market testing	Simon Wombwell	Phil Ient	300	400	300	tbc	tbc	1000
Medical Physics market testing	Simon Wombwell	Phil Ient	0	100	tbc	tbc	tbc	100
Other outsourcing opportunities	Simon Wombwell	Alan Farnsworth	0	500	1000	tbc	tbc	1500
Review of T&Cs	Jo Ridgway	Chris Goulding	250	750	tbc	tbc	tbc	1000
Reduce impact of inflationary pressures	Simon Wombwell		0	tbc	tbc	tbc	tbc	0
Non-clinical Admin review	Simon Wombwell	Richard Ellis	500	tbc	tbc	tbc	tbc	500
Estates / Facilities strategy	Simon Wombwell	Phil Ient	150	tbc	tbc	tbc	tbc	150
IT	Simon Wombwell	Glenn Winteringham	250	250	250	250	250	1250
New income / contracts	Simon Wombwell	Simon Currie	200	200	200	200	200	1000
Productivity/Efficiency Subtotal			**2,650**	**3,200**	**2,750**	**1,450**	**1,450**	**11,500**
Divisional Targets @ 2%								
ICAM 2%	Lee Martin	Carol Gillen	832	815	799	783	767	3997
SCD 2%	Lee Martin	Fiona Isacsson	825	809	792	776	761	3963
WCF 2%	Lee Martin	Sam Page	836	819	803	787	771	4016
Finance 2%	Simon Wombwell	Paul MacAuliffe	88	86	85	83	81	423
IT 2%	Simon Wombwell	Glenn Winteringham	136	133	131	128	125	653
HR 2%	Jo Ridgway	Chris Goulding	74	73	71	70	68	355
Estates & Facilities 2%	Simon Wombwell	Phil Ient	587	575	564	552	541	2820
Nurse Director 2%	Bronagh Scott	Alison Kett	78	76	75	73	72	375
Procurement 2%	Simon Wombwell	Alan Farnsworth	89	87	85	84	82	428
Planning and Programmes 2%	Simon Wombwell		41	40	39	39	38	197
Medical Director 2%	Martin Kuper		33	32	32	31	30	159
COO	Lee Martin		40	39	38	38	37	192
2% Subtotal			**3,659**	**3,586**	**3,514**	**3,444**	**3,375**	**17,578**
Total			**9,026**	**8,040**	**6,264**	**4,894**	**4,825**	**33,049**