Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 9 March 2022

TB2022.018

Title:	**Annual Plan 2022/23 – Draft plan**

Status:	**For Discussion**
History:	**TME2022.23**
Board Lead:	**Chief Finance Officer**
Author:	**Jason Dorsett, Chief Finance Officer plus significant contributions from the Operations, People and Finance functions**
Confidential:	**No**
Key Purpose:	**Performance**

Executive Summary

1. The purpose of this paper is to share the draft annual plan for 2022/23 with the Board for comment. The full draft plan will come to the Board for approval in April.
2. The key contexts for planning are: the ongoing impact of COVID-19; the elective waiting list; the formation of the Integrated Care Board (ICB) in July; and the Trust's leadership transition in July.
3. The process for planning is similar to that pre-COVID, but affected by delays due to Omicron over the winter of 2021/22 and planning as an Integrated Care System (ICS) not one trust.
4. The Board is asked to comment on the draft high level objectives in advance of seeing the SMART[1] objectives and success measures in April. The objectives are similar to 2021/22, but with greater emphasis on quality improvement and on elective and cancer waits.
5. The Board is asked to comment on the draft activity plan and in particular on the level of ambition within the plan. The plan aims to deliver the required 104% of 2019/20 activity, to hold 104 weeks to zero and to eliminate 78 week waits (subject to patient choice).
6. The Board is asked to comment on the draft workforce plan which expects the workforce to rise from 13,632 to 13,816 in line with agreed business cases.
7. The Board is asked to comment on the draft finance plan which indicates that the £47m underlying deficit can be covered by underlying income. However, there is no clear source of funds for investment (other than in elective recovery) and agreed business cases may need to be delayed to achieve breakeven.
8. The Board is asked to comment on the draft £51.4m capital budget which is in line with the 2021/22 budget and to note that the detailed plan requires further assurance by TME.
9. Next steps include work to:
    a. seek input of the Trust's Governors, through its Performance, Workforce, and Finance Committee;
    b. ensure the alignment of all aspects of planning;
    c. complete the draft ICS submissions;
    d. complete detailed draft objectives;
    e. assure the detailed capital plan; and
    f. bring all of the above together into a stronger narrative document in April.

[1] Specific, Measurable, Achievable, Relevant, and Time-Bound

Recommendations

10. The Trust Board is asked to:

- Note and comment on the draft plan for 2022/23.

Contents

Annual Plan 2022/23 – Draft plan

1. Purpose

1.1. The purpose of this paper is share with the Board the draft annual plan for 2022/23 and allow for discussion of the work to date prior to the Board seeing a final plan in April.

1.2. The paper aims to share the substance of work completed to date and in progress. However, it is not formatted as a draft of the final document. Prior to COVID-19 the final annual plan document would typically have been 30+ pages.

1.3. All data tables are draft and have been circulated as annexes to the private Board papers.

1.4. OUH's clinical strategy work and ICS development will be key activities in 2022/23, but are out of scope of this paper.

1.5. The draft quality priorities will be presented to the Board as a separate paper.

2. Background

2.1. The key contexts for planning for 2022/23 will be:

- **COVID-19 pandemic:** the ongoing effects of the COVID-19 pandemic are likely to include pandemic disease with seasonal spikes, higher staff sickness, likely ongoing infection prevention and control requirements in excess of pre-pandemic levels and a workforce that on most measures shows signs of significant fatigue.
- **Elective waiting lists:** after success in reducing long waits in 2018/19 and 2019/20, the Trust currently has 968 patients waiting over 52 weeks and 61 patients waiting over 104 weeks. Cancer waits are generally longer than pre-pandemic levels as are urgent care waits.
- **ICB and Provider Collaboratives:** the ICS will be formed as a statutory ICB on 1 July and during the year it is likely that OUH will join two to three provider collaboratives during the year. This should improve the integration and co-ordination of services, but will require significant additional management time during the first year operation.
- **Leadership transition:** the Trust's Chief Executive will leave on 1 July. This means that the Board (and in particular the Chair and non-executives) will need to devote significant time to a search process. It also creates the risk of a period of uncertainty during the development and delivery of the 2022/23 plan.

3. Planning process

3.1. NHS England (NHSE) has attempted to run a planning process similar to that run prior to COVID-19. Outline planning guidance was published on 24 December. However, the operational pressures caused by the Omicron variant caused NHS England to delay certain milestones. In addition, we understand that financial negotiations with HM Treasury delayed the agreement of the financial settlement for elective recovery. Key elements of the finance and contracting guidance remain unpublished although drafts have been circulated. This has complicated and delayed the Trust's planning process. A comprehensive exercise has been undertaken to review hundreds of pages of national planning guidance and to identify relevant requirements on the Trust.

3.2. In addition, since 2021/22 planning is now conducted on an ICS basis and not a Trust basis with planning returns being submitted to NHS England by the ICS and not the Trust. This creates additional steps in the planning process without additional time. For example, income is still under negotiation. The majority of quality, activity, workforce and financial planning is done at Trust level. However, Urgent Care planning in particular involves significant joint work at an Oxfordshire level and certain elective specialities are attempting to plan demand and capacity at an ICS level (e.g. ophthalmology).

3.3. Against this background, OUH continues to do the majority of its planning at service and directorate level supported by divisional and corporate teams. There has been further progress to integrate activity, workforce and finance planning particularly for key objectives. However, we have not been able to make the decisive shift to a fully capacity based planning system that we hoped to for 2022/23.

4. Draft objectives

4.1. In 2020/21 the process of setting a Trust plan and executive team objectives were not fully aligned because national planning did not run on the expected timetable.

4.2. The intention is that the 2022/23 annual plan is built around a set of Trust-wide objectives which map to the strategic priorities. At this stage, the draft objectives are set out below. The drafting of SMART objectives and success measures is underway. It is proposed that these are reviewed and agreed by the Remuneration and Appointments Committee and then circulated as a supporting paper to the final plan at the additional April Board meeting.

4.3. **Our People: making OUH a great place to work**

- Objective 1: building a sustainable workforce and improving staff experience. [Drafting Note (DN): unchanged from 21/22]
- Objective 2: developing our teams and organisational capability [DN: unchanged from 21/22]

4.4. Our Patients: delivering high quality care and patient experience

- Objective 3: delivering quality improvement projects [DN: revised objective from 21/22 to reflect focus on the quality improvement programme as a vehicle for change]
- Objective 4: transforming the patient/staff experience [DN: revised objective from 21/22. Requires work to define difference to objective 1]

4.5. **Our Populations: working together to improve population health and wellbeing**

- Objective 5: improving access for planned elective care [DN: new objective to align OUH objectives to national planning requirements]
- Objective 6: improving access for cancer care [DN: new objective to align OUH objectives to national planning requirements]

The Board is asked to comment on the draft high level objectives in advance of seeing the SMART objectives and success measures in April.

5. Activity

5.1. The Trust has submitted a draft plan to the ICS which meets the national target that cost-weighted activity be at 104% of 2019/20 levels. This assumes ERF (Elective Recovery Fund) money is available to fund the use of the independent sector, insourcing and waiting list initiative work.

5.2. This is consistent with the level achieved in the first half (H1) of 2021/22 (and particularly the first quarter [Q1]), but not the activity delivered over the winter which was affected by Omicron.

5.3. The divisions are working up plans to exceed the 104% target and the final plan may include this over-performance if TME is assured over its delivery.

Waiting lists

5.4. 104 week waits are expected to be at close to zero by 31 March (subject to patient choice and a small number of complex procedures) and are planned to remain at this level (subject to the same caveats).

5.5. 78 week waits are planned to reduce from c.85 to zero responding to focus on this milestone in the national planning guidance. 52 week waits remain largely stable declining to 950.

5.6. The overall size of the waiting list is planned to reduce slightly from c.55,000 to 53,581. This assumes that referrals do not rise significantly as a result of suppressed demand during the pandemic.

Cancer

5.7. The draft cancer plan makes the following assumptions:

- Recovery of breast 2 week wait performance
- Includes the impact of increased breast capacity from September in the Community Diagnostic Centre
- Assumes 10 theatres running at the Churchill site
- Assumes recovery of Radiotherapy through the linac replacement programme, opening of the new RT satellite at Great Western Hospital and addressing the workforce challenges in Q1
- Increased CT (Computerised Tomography) guided biopsy capacity includes in line with business case

Diagnostics

5.8. The draft diagnostics plan makes the following assumptions:

- Increased number of training lists in endoscopy linked to successfully being accepted as a training academy - overall reduction in 4 points per training list. Loss of activity should be mitigated if backfill of consultant time is in place – reliant on agency cover
- Endoscopy workforce constraints - Consultant, Clinical Fellows and nurse endoscopists
- Loss of productivity in MRI and CT due to IPC requirements (e.g. cleaning scanners between each patient) – circa. 12-16%. Note that IPC requirements are under review.

Bed numbers

5.9. The draft activity plan makes the following assumptions about beds:

- AICU will be in their new building and open to 18, rising to 24 by the end of Q1.
- Ward E at the Nuffield Orthopaedic Centre will be open to 24 beds.
- The two trauma wards will have moved into the new Trauma Building and will increment the beds up by 5 in April and 5 in May.

- Ring fenced elective beds remain the same as previous submission.
- Occupancy has been based on the % offered for October 2021.
- Length of Stay over 21 days has been based on the average for the last 6 months.

UEC

5.10. The draft urgent care activity plan makes the following assumptions:

- There is a pilot Urgent Care Centre to reduce activity in the Horton General Hosptial emergency department.
- The enhanced Urgent Care Response service and Rapid Intervention of Palliative and End of Life Care (RIPEL) service are launched in partnership with Oxford Health to reduce admissions (no benefit in activity modelling yet). Also learning from rapid improvement events e.g. “Call before convey”.
- There is no increase in OUH admitted capacity other than reopening trauma beds (in bed modelling).
- System working manages the risk to post-acute discharge associated with the end of the Home Assessment and Reablement Team (HART) contract and new suppliers operating from 1 April.
- There is a temporary locally funded extension to Hospital Discharge Programme while joint system work develops a sustainable long-term solution.

The Board is asked to comment on the draft activity plan and in particular on the level of ambition within the plan.

6. Workforce

6.1. The draft workforce plan results in an increase in WTEs from 13,632 to 13,816 largely due to the implementation of agreed business cases.

Assumptions

6.2. There is an expectation that there will be an increase in activity circa. 4%. The plan does not currently consider any allowance for additional funding to reduce waiting lists. If confirmed, there would be an assumption that the WTE may increase to support this.

6.3. There is an anticipated 1.5 % increase in staff due to approved business cases

6.4. There is an assumption that turnover will increase over the year, however we expect international recruitment to fulfil this pipeline.

6.5. The sickness KPI (Key Performance Indicator) predicted at 3.8% (ICS template rounds to 4%). The Trust is currently at 4.0% and are therefore assuming a reduction of 0.02% of sickness over the next 12 months due to a decrease in COVID absence.

6.6. Bank / agency assumed to remain at the current rate in the next 12 months.

Planned actions

6.7. The draft workforce plan currently also assumed the following significant workforce planning actions:

- The current and future business cases are being finalised, and the draft plan will be updated before final submission as and when further information is received.
- There is already a strong overseas pipeline that we expect to join through the year. However, the Trust needs to complement this with other strategies, including a strong focus on retention.
- Continue workforce planning and the alignment to activity and finance to ensure the workforce is in the right place to assist the best provision and access to care, specifically in relation to health inequalities.
- Monitoring sickness absence to provide appropriate support to enable people to return to work. Ensure that the retention work continues (specifically in relation to Health and Wellbeing) to assist with stability during Covid recovery through initiatives such as TRIM and RP3
- Attempt to review and reduce the bank and agency through recruitment and clarity on budgets.

Risks, issues and mitigation

6.8. The draft workforce plan currently identifies the following risks, issues and mitigation:

- Sickness rates may remain high as COVID-19 is still within the community. This may affect both staff absence rates, and stress and anxiety. Support mechanisms are being reviewed to ensure adequate signposting for all staff to wellbeing offers locally and nationally.
- The impact of Vaccination as a Condition of Deployment, current the subject of a consultation, may result in higher turnover of staff meaning skills and knowledge is lost. Interventions such as contacting any leavers, and looking at listening events for people to discuss any remaining concerns is currently being actioned.
- Bank usage has increased during COVID-19 and there is a risk that areas may have become reliant on some of the extra WTE supplied.

An in-depth view of establishment vs budget is taking place to look at where bank and agency use is high, and how this can be reduced longer term.

- Ensuring Divisional and particularly clinical leaders' capacity to support workforce planning activities to support the strategy to ensure that the right people are in the right place at the right time. Ensure this is supported by activity and finance alignment.

The Board is asked to comment on the draft workforce plan.

7. Finance

Underlying position 2021/22

7.1. The Trust ended 2019/20 with an underlying deficit of £45m. We estimate, after removing one-off items, the equivalent figure at the end of 2021/22 is £47m. NHSE data suggest that cost and WTE growth at OUH has been below the national average during the pandemic which will have contributed to the stability of the underlying deficit.

Inflation

7.2. Income inflation has been assumed at NHSE assumptions as has 2.8% pay inflation which is fully funded.

7.3. At present the draft financial plan is based on non-pay inflation being in line with NHS England budgeting assumption of 2.7% rather RPI which is double this rate and rising.

The rationale is that many Trust contracts are at a fixed price for 2022/23 (e.g energy) and nil inflation on these contracts will offset higher rises on others. Work is underway to test this and the potential for procurement savings to offset higher inflation

COVID-19 funding for 2022/23

7.4. NHSE has cut the ICS' COVID-19 budget from £140m to £60m of which OUH will bear a pro rata share. As the Trust has underspent its COVID-19 budget this will reduce overall financial performance unless COVID-19 costs are also reduced. Work is underway to quantify the potential to reduce COVID-19 spending.

7.5. Costs of staff and patient testing and vaccination are likely to be reimbursed on top of this budget.

ERF

7.6. The Elective Recovery Fund (ERF) mechanism for 2022/23 remains under discussion and is likely to include access to ERF upfront if the activity plan is set at 104% of 2019/20 activity levels plus further funding if activity above 104% is delivered.

7.7. The draft plan assumes a level of ERF as offered by the ICS and Specialist Commissioners.

Contract income adjustments

7.8. The ICS has made a “flat cash” proposal to its providers which incorporates all the variable elements of the ICS funding into a single cash offer. The proposal passes all possible ICS funding through to providers and is contingent on a system risk share being agreed.

7.9. NHSE has made a more traditional, and complex, contractual proposal.

7.10. The draft income plan is consistent with our assessment of both of these proposals.

Unwinding of 2020/21 accruals

7.11. The opening cost base now includes excess costs reflecting liabilities incurred in 2020/21 (e.g. carry over of significant annual leave) which are offset in 2022/23 by the unwinding of the relevant accruals.

Draft plan before business cases, cost pressures and efficiency

7.12. The draft plan is broadly breakeven after these assumptions with the underlying deficit covered by non-recurrent funding.

7.13. However, there is no funding for investment other than in elective recovery and all increases in costs (even if agreed in prior business cases) can only be funded by efficiency or further income generation.

7.14. The level of risk associated with these remaining items is still being evaluated. This will be challenging and may require a delay to some agreed or proposed business cases and investment plans until funding is identified.

The Board is asked to comment on the draft finance plan and in particular the potential need to slow down investment (other than in elective recovery) until funding is identified.

8. Capital Budget for 2022/23

8.1. The Trust’s likely capital budget for 2022/23 is £51.4m and is built up from the following elements:

- ICS core allocation: set by NHSE for Buckinghamshire, Oxfordshire, and Berkshire West (BOB) and the shared by BOB amongst its members. Numbers in this paper are OUH's share if the national methodology is cascaded, but this has not been confirmed;
- Other ICS allocations: these are allocations set by NHSE for BOB for CDCs, endoscopy and digital. The allocations to OUH are our estimates and have not yet been agreed;
- National bids: these are allocations held nationally or regionally for the New Hospitals Programme, the Elective Recovery Programme and other central programmes. This paper assumes OUH is not successful in its bid for the Horton or JR theatres, but is successful in its bid to host a TRE in 2022/23 and in other smaller bids each year;
- Disposal proceeds at net book value: these create additional OUH capital budget. This paper assumes a land sale at the Churchill to the University in 2022/23 of the strip of land between the parcels sold in 2018/19;
- Charitable donations; these are modelled at current levels plus an enhancement for specific donations from condition specific charities (e.g. transplant). No assumption is made about an increase in Oxford Hospitals Charity donations; and
- PFI life-cycle investment; this is estimated based non the PFI models and provides for significant investment to keep the three PFI hospitals up-to-date. This is made up of two elements, the residual interest which counts towards the CDEL (Capital Departmental Expenditure Limit) envelope, but outside of the ICS allocation, and the life-cycling which is based on when specific new equipment is installed based on the PFI agreement. The latter is treated outside of CDEL in the same way as donated assets.

8.2. From 2022/23 we have the impact of the introduction of IFRS 16 - leases, which will transfer the majority of operating leases to Right of Use assets, which will impact CDEL for any amendments or new leases. We are still waiting information from NHSEI as to how this will be managed via CDEL. There is a likelihood that the total CDEL envelope will be increased to accommodate the change, but this will be accompanied by further pressure on the budget from new leases.

8.3. All of these sources of funds contribute to the total capital investment each year in renewing Trust's fixed assets and in investing in new fixed assets.

8.4. In principle, the Trust must budget for each of these elements separately and underspends on one element cannot be offset against overspends on another element. In practice it is currently possible in most cases to offset

underspends against national bids or other ICS allocations against overspends on the core ICS allocation.

8.5. TME (Trust Management Executive) has proposed a draft capital budget for 2022/23 of £51.4m from all funding sources, but consistent with meeting our ICS capital control total. This is set at a similar level forecast spend in 2021/22.

8.6. TME and Investment Committee has reviewed a first draft plan on how this budget should be allocated. TME has proposed a further executive team lead review involving the divisional directors before a final draft capital plan can be brought forward for approval.

The Board is asked to comment on the draft capital budget noting that the detailed plan requires further assurance by TME.

9. Conclusion

9.1. The challenges of returning to a pre-COVID planning process are significant and the draft plan reflects that context.

9.2. Overall the draft plan:

- Delivers the key national requirements that activity is at 104% of 2019/20 level with 104 and 78 week waits eliminated (other than due to patient choice).
- Includes the baseline workforce to deliver that plan, but with further work identified on bank and agency staffing;
- Achieves breakeven prior to new investment, but requires savings to offset any new investment which will be challenging.
- Includes £51.4m of capital expenditure the allocation of which is subject to further TME assurance prior to presentation to the Board

10. Recommendations

10.1. The Trust Board is asked to:

- Note and comment on the draft plan for 2022/23.