Mid Cheshire Hospitals NHS
NHS Foundation Trust

Operational Plan Document for 2014-16

Mid Cheshire Hospitals NHS Foundation Trust

Operational Plan Guidance – Annual Plan Review 2014-15

The cover sheet and following pages constitute operational plan submission which forms part of Monitor's 2014/15 Annual Plan Review

The operational plan commentary must cover the two year period for 2014/15 and 2015/16. Guidance and detailed requirements on the completion of this section of the template are outlined in section 4 of the APR guidance.

Annual plan review 2014/15 guidance is available here.

Timescales for the two-stage APR process are set out below. These timescales are aligned to those of NHS England and the NHS Trust Development Authority which will enable strategic and operational plans to be aligned within each unit of planning before they are submitted.

Monitor expects that a good two year operational plan commentary should cover (but not necessarily be limited to) the following areas, in separate sections:

1. Executive summary
2. Operational plan
    a. The short term challenge
    b. Quality plans
    c. Operational requirements and capacity
    d. Productivity, efficiency and CIPs
    e. Financial plan
3. Appendices (including commercial or other confidential matters)

As a guide, we expect plans to be a maximum of thirty pages in length. Please note that this guidance is not prescriptive and foundation trusts should make their own judgement about the content of each section.

The expected delivery timetable is as follows:

Expected that contracts signed by this date	**28 February 2014**
Submission of operational plans to Monitor	4 April 2014
Monitor review of operational plans	April- May 2014
Operational plan feedback date	May 2014
Submission of strategic plans to Monitor (Years one and two of the five year financial plan will be fixed per the final plan submitted on 4 April 2014)	30 June 2014
Monitor review of strategic plans	July-September 2014
Strategic plan feedback date	October 2014

1.1 Operational Plan for y/e 31 March 2015 and 2016

This document completed by (and Monitor queries to be directed to):

Name	**Mark Oldham**
Job Title	**Director of Finance**
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Date	**02/04/14**

The attached Operational Plan is intended to reflect the Trust's business plan over the next two years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

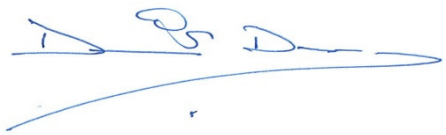
In signing below, the Trust is confirming that:

- **The Operational Plan is an accurate reflection of the current shared vision of the Trust Board having had regard to the views of the Council of Governors and is underpinned by the strategic plan;**
- **The Operational Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The Operational Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans; and**
- **All plans discussed and any numbers quoted in the Operational Plan directly relate to the Trust's financial template submission.**

Approved on behalf of the Board of Directors by:

Name **Dennis Dunn**

(Chair)

Signature 

Approved on behalf of the Board of Directors by:

Name **Tracy Bullock**

(Chief Executive)

Signature 

Approved on behalf of the Board of Directors by:

Name **Mark Oldham**

(Finance Director)

Signature 

1.2 Executive Summary

The two year operational plan builds on the Trust's significant achievements during 2013/14, including completion of the 5 year quality strategy which comes to an end in March 2014, maintained strong financial stewardship, performed well against operational targets and standards and delivered significant improvements in its infrastructure. Without doubt, 2014/15 will be a challenging year, however, quality, safety and effectiveness will remain pivotal to all decision making which will be supported by the launch of the next stage in the Trusts quality journey with a new 2 year strategy.

At the highest level the Trusts strategy in maintaining a clinically and financially viable organisation is twofold:

1. External Transformation Programme:

   a.Vertical Integration

   b.Partnerships with other Providers

2. Internal Transformation Programme which is based on driving greater productivity through:

   a.Outpatient productivity improving utilisation and reducing cancellations

   b. Theatre productivity and increasing the utilisation of the new operating theatres

   c. Non Elective Flow, allowing a more efficient and effective response to non-elective admissions whilst reducing length of stay.

1. External Transformation Programme:

The Trust is a key player in working alongside all providers in the economy through a Provider Board in order to redesign existing service provision and develop new services to better manage patients outside hospital and reduce emergency admissions. The Contract agreed with the CCG's for 2014/15 allows this to be done in an environment which supports income to fall in line with costs hence giving financial sustainability for all partners. This is a valuable precursor to the introduction of the Better Care Fund in 2015/16 and the Trust is working closely with the Health and Wellbeing Boards to understand the changes required.

Beyond the timescales of this two year plan the Trust fully understands that strong partnerships must be formed in order to meet significant efficiency challenges at the same time as meeting quality standards and maintaining clinical sustainability brought about by the increasing sub specialisation and centralisation of specialist activity. During 2014/15 the Trust agreed a memorandum of understanding with University Hospitals NHS Trust and a program of work has been established which will support the clinical and financial sustainability of both organisation. During 2014/15 the Trust has also been supporting this Trust with additional elective capacity to the benefit of both parties.

The Trust already has a significant number of partnerships with other providers. Over a two year programme, all of these will be reviewed to ensure they continue to align to the Trusts strategy; they meet the changing needs of the population, deliver the right clinical outcomes and are value for money. Where this is not the case, following appropriate consultation, changes to these partnerships will be made.

2. Internal Transformation Programmes:

The Trust remains committed to providing a high quality, financially and clinically sustainable service to the population it serves. To further this ambition, investments over the next two years will be particularly focussed on:

1. Delivering high quality clinical care 24/7

2. Addressing the higher than expected summary hospital-level mortality indicator (SHMI)

3. Delivering safe patient care within a theatre environment.

Significant investment in front line staff has delivered improved nursing ratios on the wards and increased on site consultant numbers thus allowing an extension to consultant led weekend working during 2014/15. The two year operational plan builds on this initial investment, and to support the expansion of high quality, Consultant delivered, clinical care 7 days a week, 9 additional consultants working across Emergency, Acute and General Medicine will be appointed. Along with the Trusts already extensive provision of out of hours diagnostics, these investments will support a reduction in the Trusts SHMI. The move into the new state of the art operating theatres will be completed and the best possible outcomes for patients will be secured through changes in working practice and by ensuring that the cultural aspects also deliver.

In addition to the investments in the non-elective patient care, the continued growth in elective referrals will see an expansion in consultant numbers in such surgical specialties as orthopaedics, ear, nose and throat surgery and general surgery. This will maintain the Trusts strong aggregate 18 week delivery and improve performance in those areas where the wait times are longer than the expected standard. In doing so significant progress will be made in delivering our clinical services strategy of growing the elective capacity and capability and thus ensuring greater clinical and financial sustainability.

This Operational Plan continues with its focussed infrastructure investments in both Estate and Information Technology. The Public Dividend Support which facilitated the Theatres and Critical Care build programme comes to an end in 2013/14, however the capital programme will remain a significant element of the Trusts overall improvement strategy with further key investments in:

1. Endoscopy and redesigning the treatment centre to make best use of opportunities presented by the new build theatres

2. Continuing the programme of work on ward refurbishments to comply with Improvement Notices from Cheshire Fire and Rescue

3. Completion of the Neonatal Intensive Care Unit

4. Provision of a second MRI Scanner to reduce the reliance on high cost external providers

5. Continued progress in line with the IM&T strategy towards the implementation of the Electronic Patient Record (EPR).

6. Redesign of the Trusts Main Entrance

Improvements in the Trusts estate are an important aspect of further improving the experience of our patients and staff. The Trust has received overwhelming public support for its main charity which will contribute in excess of £3M in 2014/15. The Trust will also be borrowing £4.3M in 2014/15 and a further £1M in 2015/16 to support the level of investment required.

On Financial performance the Trust will break even over the next two years (before exceptional items) and maintain a positive cash balance, ensuring that liquidity and the ability to service the debt remains at an acceptable level.

The Trust is well positioned to meet the challenges as laid out in the plan and has the necessary skills, expertise and partnerships to enable its success.

1.3 Operational Plan

Local Economic Factors

- CCG Allocations

During 2013/14 there was a national review of the CCG allocations formula aimed at identifying an indicative "fair shares" allocation for each CCG. Draft allocations indicated significant changes to existing allocations based on the removal of the deprivation weighting from the calculation as CCG's no longer have a role in respect of health promotion. Therefore, the weighting for an elderly population carries greater significance in determining resource levels. Table 1 shows indicative movements in allocations for the local CCG's based on this revised formula.

Table 1 – CCG allocations and distance from target

CCG	*2013/14 Funding Allocation £'M*	*2014/15 Indicative Fair shares £'M*	*Change in Funding allocation £'M*	*Indicative funding per capita £*
South Cheshire	193.5	206.4	+12.9	1,182
Vale Royal	120.0	119.7	-0.3	1,171
East Cheshire	219.3	237.3	+18.0	1,173
West Cheshire	308.3	306.3	-2.0	1,205
North of England				1,194
National				1,137

Whilst these figures illustrate a potential significant increase for the local health economy, particularly in South Cheshire, the final allocations for the next two years have now been published and table 2 below details the impact for the Trusts Local CCG's.

Table 2 – CCG's two year allocation uplifts

	2013/14	*2014/15*		*2015/16*	
CCG	*£'M*	*£'M*	*%*	*£'M*	*%*
South Cheshire	191.4	197.5	3.15	203.1	2.85
Vale Royal	114.3	116.7	2.14	118.7	1.70
East Cheshire	213.7	220.4	3.15	226.7	2.85
West Cheshire	297.9	304.2	2.14	309.4	1.70
North of England	19,379	19,808	2.21	20,161	1.78
National	62,744	64,336	2.54	65,680	2.09

Table 2 illustrates that South Cheshire CCG and East Cheshire CCG received a favourable allocation compared with both the NHS North catchment and the average national picture and recognises the distance from target highlighted in table 1. However, this does not deal with the total comparative gap and it is unclear beyond 2015/16 whether there is further 'pace of change' monies to close this further.

- Impact of the Better care fund

Table 3 shows the impact of the BCF on the local CCG allocations in 2015/16, with an expectation that this will be a recurrent change.

Table 3 – Better Care Funding Transfer 2015/16

CCG	*2015/16 Funding Allocation £'M*	*Add back 2014/15 BCF £'M*	*Transfer to Better Care Fund £'M*	*Remaining CCG allocation £'M*
South Cheshire	203.1	3.2	(10.5)	195.8
Vale Royal	118.7	2.0	(6.3)	114.4
East Cheshire	226.7	3.5	(11.6)	218.6
West Cheshire	309.4	4.7	(15.8)	298.3
North of England	20,161	342	1,066	19,437
National	65,680	1,100	3,460*	63,320

- Contract Settlement and funding gap

Contracts have provisionally been agreed with the principal CCG's aligned with the activity in the plan. In addition the Trust has included elective repatriation plans which amounts to £2.3M which is based on increasing market share as described in the demand section of this report. The CCG are aware of this plan and the financial impact should be offset to them by reduced demand in other providers.

- Provider efficiency challenge

Impact of the national tariff

National tariff was published in December 2013 and the forecast outturn activity has been valued at the 2013/14 tariffs and the 2014/15 tariffs, the difference being the impact of the national tariff movement.

Table 4 below shows the impact

Table 4 – Impact of National tariff 2014/15

Point of Delivery	*2014/15 £000's*	*Recurrent £'000*
Non Elective and Assessments	(832)	(832)
Accident and Emergency	(74)	(74)
Elective admissions and Day cases	(357)	(357)
Outpatients and Ward Attenders	(346)	(346)
Direct Access and unbundled diagnostics	(71)	(71)
Maternity	(4)	(4)
Non PbR	(287)	(287)
CQUIN's removal in respect of HCD	(120)	(120)
Impact of National Tariff rebasing	(2,091)	(2,091)

The impact of the national tariff in 2015/16 cannot be broken down into its constituent parts as a detailed tariff has not yet been published. Monitor has published their expectations of the efficiency requirement continuing at 4%. Table 5 below shows the impact of this efficiency in 2015/16 taking into account the Trusts inflation expectations on the national tariff.

Table 5 – Impact of National tariff 2015/16

Point of Delivery	*2015/16 £000's*	*%age*
Opening Contract Income Value	166,653	
Inflationary pressures accounted for in Tariff:		
Pay inflation	(1,304)	
Incremental Drift	(600)	
Clinical excellence awards	(50)	
Non pay inflation	(1,100)	
Pension adjustments	(1,340)	
CNST Premium	(360)	
Sub Total recognised pressures	(4,754)	2.9%
Assumed inflationary deflator		(4.0%)
Impact of National Tariff efficiency	(1,822)*	(1.1%)

*The Tariff deflator has been applied to the forecast contract income including activity growth and full year impact of 2014/15 activity.

Quality Plans

- National and local commissioning priorities

The planning guidance makes reference to three non-negotiables that are expected between every commissioner and provider:

i. Getting the right staff with the right skills to care for patients all the time and references the *Francis Report*, *Hard Truths*, and the National Quality Board's *how to ensure the right people, with the right skills, are in the right place at the right time*.

ii. Protecting children, young people, adults and older people with learning disabilities and/or autism who display, or are at risk of displaying, behaviour that challenges. This is driven by *"Transforming Care: a national response to Winterbourne View Hospital"*

iii. CCG to take an active part in patient safety by ensuring that they satisfy themselves that the providers they commission services from are effectively reporting and learning from safety incidents and implanting patient safety alert actions in a timely manner. This is driven by the *Berwick review into patient safety*

Whilst Guidance is not prescriptive on actions the impact on the Trust will be through increased levels of assurance and probity through the CCG Contract. In addition to the above non-negotiables the guidance asks commissioners to support providers in the following areas.

i. Implementation of *Compassion in practice*, the 6C's in the national nursing, midwifery and care giving vision.
ii. Using staff satisfaction surveys and the staff friends and family test to be a marker of quality services.
iii. Provision of Seven Day Services. Local Contracts for 2014/15 will include an action plan to deliver the clinical standards within the Service Development and Improvement Plan (SDIP).
iv. Safeguarding vulnerable adults and children

Locally both Clinical Commissioning Groups have focused their commissioning intentions around the development of integrated teams where care is wrapped around vulnerable individuals to improve their health and avoid admissions.

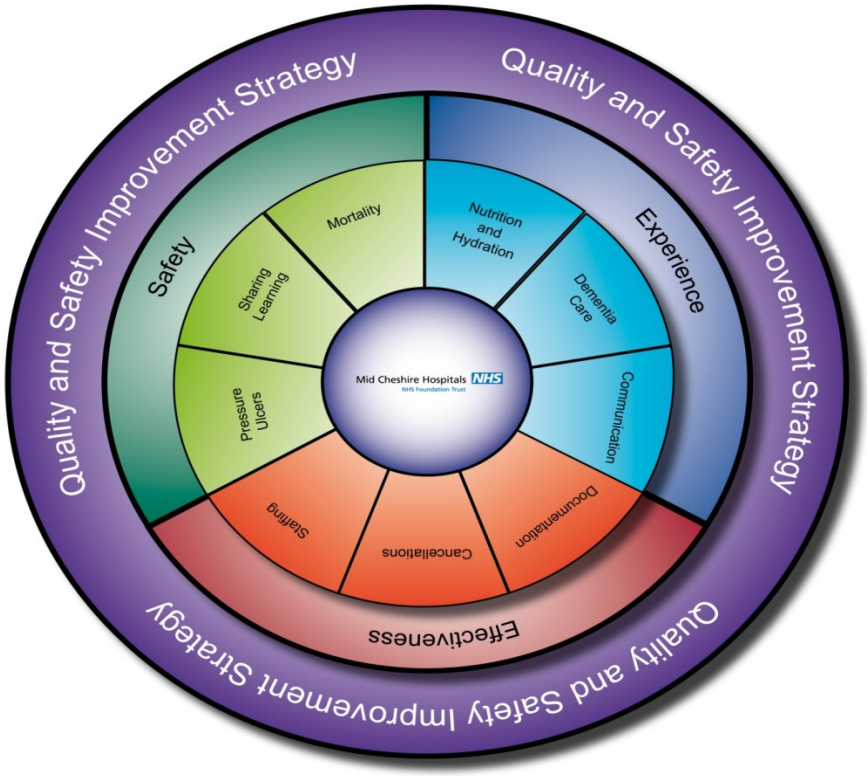
These integrated teams will be jointly developed through a newly established Provider Board where MCHFT are a key member, alongside Community services, primary care representatives, local authorities and Mental Health Providers.

- The foundation trust's quality goals

During 2013/14, the Trust conducted an extensive engagement programme based on the key themes from the Francis Enquiry into the failings at Mid Staffordshire Hospital NHS Foundation Trust. This informed a new quality and safety strategy which will run from 2014/16 inclusively.
The purpose of this strategy is to support the delivery of the organisation's vision and mission:
'To Deliver Excellence in Healthcare through Innovations and Collaboration"
The Trust will be a provider that:

1. Delivers high quality, safe, cost-effective and sustainable healthcare services
2. Is committed to patient-centred care
3. Treats staff and patients with dignity and respect
4. Provides a working environment that is underpinned by values and behaviours

The quality and safety improvement strategy links closely with other key strategies such as the clinical services strategy and the organisational development strategy, collectively supporting delivery of the vision and mission of the organisation.
The strategy focuses its improvement aims under the three domains of quality as determined by the Health and Social Care Act (2012); safety, experience and effectiveness. There are three quality goals within each domain and these are illustrated below:



Experience

- Improving nutrition and hydration for patients

"We will continue to provide an environment that promotes healthy nutrition and is tailored to individual patient need."

- Supporting patients with dementia and their carers

"We will support patients who have concerns about their memory and we will work with patients who have dementia and their carers to promote a positive experience whilst in hospital."

- Improving communication

"We will ensure that our staff improve their understanding of our patients and their care needs. We will use this knowledge to communicate effectively with patients and involve them in their care"

Effectiveness

- Improving documentation and reducing duplication

"We will review and improve our paper documentation so that it is relevant, adds value to care and avoids duplication."

- Reducing cancellations

"We will reduce the number of hospital initiated outpatient clinic cancellations by 20% by 2016"

- Improving staffing levels and skill mix

"We will ensure we have levels of staffing and skill mix that meet the needs of our patients"

Safety

- Reducing pressure ulcers

"We will eliminate avoidable hospital acquired pressure ulcers by 2016."

- Sharing learning from feedback and incidents

"All clinical staff will work together to respond to feedback from patients and carers and to learn from incidents that occur. We will then ensure we respond to such learning and embed this into practice."

- Reducing mortality rates

"We will reduce our mortality rates each quarter so that they reach expected levels as measured by the Summary Hospital-Level Mortality Indicator (SHMI)."

Delivery of these outcomes will be monitored by the Boards Quality, Effectiveness and Safety Sub Committee (QuESt). QuESt is responsible for providing information and assurances to the Board of Directors that the Trust is safely managing the quality of patient care, the effectiveness of quality interventions and patient safety.

- Existing quality concerns (CQC or other parties) and plans to address them;

An unannounced inspection undertaken by the Care Quality Commission (CQC) in December 2012 raised minor concerns for Outcome 9, Medicines Management. A subsequent review inspection in October 2013 found that the Trust had made significant improvements in relation to the majority of the concerns raised, but found that action needed to be taken with regards to medication omissions. In response to this, the Trust developed an action plan to address the issues raised. The completed action plan with supporting evidence has been submitted to the CQC and a re-inspection took place in February 2014, the final report from CQC is awaited.

The Trust had its unannounced annual inspection for 2013-2014 on the 4th and 5th February 2014. This was a dementia themed inspection and reviewed the following outcomes:

- Outcome 4 – Care and Welfare of people who use services
- Outcome 6 – Cooperating with providers
- Outcome 14 – Supporting workers
- Outcome 16 – Assessing and monitoring the quality of service provision.

The CQC inspectors requested evidence to support the Trusts compliance with the inspected outcomes. This evidence has been submitted and we await the report.

- The key quality risks inherent in the plan and how these will be managed;

Table 6 – Key Quality Risks inherent in the plan

Objective	Risks	Mitigation
Delivering High Quality Clinical Care 24/7		○ 24 hour senior medical staff cover ○ Increased Consultant on site presence at weekend ○ Separating of Consultant Anaesthetist rotas to establish specific Critical Care on call rota achieved November 2013 ○ Critical Care Outreach Service 24/7 ○ Early Warning scores in place and escalation plan for the detection and management of the deteriorating patient ○ 24 hours senior nursing staff cover including Night Nurse Practitioners ○ Advanced Nurse Practitioners recruited to support non-elective emergency admissions ○ High level Clinical Workforce Model for Medicine in progress ○ Incremental investment in staffing related to acuity monitoring data ○ Recruitment and Retention Strategy for Nurses and Midwives

	○ Successful international recruitment ○ Proactive recruitment of newly qualified nurses ○ Urgent Centre Care pathway – integrated working at the front door ○ Corporate Strategic Flow Group, three main areas of focus:- flow; admission avoidance and readmission avoidance ○ Clinical NHS Services – Seven Days a Week Forum-: Clinical Standards. Clinical Divisions undertaking a gap analysis as part of the contracting process for 2014/15
Higher than expected Summary Hospital–Level Mortality Indicator (SHMI)	○ A series of inter-related projects to reduce the Trust's mortality rates are currently in progress under the primary drivers of: Reliable clinical care; Effective clinical care; Medical documentation, clinical coding and data consistency; End of life care; Leadership ○ Delivery of the reducing mortality action plan ○ Revised senior medical leadership structure in place from November 1 2013 ○ All inpatient deaths reviewed weekly ○ All coding reviewed on inpatient deaths weekly ○ Benchmark of Trust's medical staffing levels completed ○ AQUA Review – January 2014. Feedback March 2014 ○ All frontline medical staff have attended a mortality workshop – programme being developed for nursing and allied health professional staff ○ CCG review of out of hospital deaths included in SHMI in progress ○ Foundation doctor project with coders around clinical documentation in progress and due for completion June 2014 ○ Emergency Care including Critical Care and Surgery and Cancer Divisions undertaking a piece of work relating to weekend mortality ○ 30 key members of staff undergoing AQUA quality improvement training May/June 2014
Delivering Safe Patient Care within a Theatre Environment	○ Quality/Safety Improvement Programme led by Pascal Metrics for all Theatres including Maternity ○ Updated Standard Operating Procedure for 'Swab, instrument and needle counts' ○ Consistency of practices across all theatre environments ○ Revised surgical practices following Root Cause Analysis reviews including the removal of all non-x-ray detectable swabs from theatre environments ○ Monthly audits monitoring compliance with WHO safety checklist

- An overview of how the board derives assurance on the quality of its services and safeguards patient safety

There is an established system of risk management and an organisation wide Risk Register. The risk control objective of the Trust is to reduce risks to a reasonable level consistent with its vision "*To deliver excellence in healthcare through innovation and collaboration".* The assessed rating of the risk determines what action is taken, who is authorised to manage the risk and the subsequent review dates. Risks are reviewed by the Divisions, Integrated Governance Department and Board Committees. The Board is kept fully informed of all significant risks and the plans to manage and mitigate them.

The Quality, Effectiveness and Safety Committee (QuESt) is responsible for providing information and assurances to the Board on quality, effectiveness and safety through monitoring progress against the quality and safety strategy and through implementation of initiatives such as FallSafe; Safety Thermometer and Open and Honest Care. The quality directorate, under the supervision of the Director

of Nursing and Quality, supports the implementation of the Trust's Quality and Safety Strategy and a number of quality initiatives such as Advancing Quality and delivery of the Commissioning for Quality and Innovation (CQUIN).

The Board meets its statutory duty of quality by ensuring arrangements are in place for maintaining, monitoring and improving the quality of health care which the Trust provides to individuals. The Board receives assurance through the Audit Committee on the system of internal control and through its internal governance processes.

The Board of Directors have used Monitors Quality Governance Framework since 2011 to formally assesses quality governance arrangements An action plan is developed to address any gaps identified and is monitored by the Board until implemented.

- What the quality plans mean for the workforce

Delivery of the Trust's quality plans requires an increase in the multidisciplinary clinical workforce. A reduction in the Trust's mortality rates and the delivery of a seven day service will require an increase in the number of Consultants in all four clinical Divisions. Using national guidance as the benchmark, each Division has established the number of Consultants required in each specialty to deliver the two year operational plan and beyond. Using these figures, the number of Consultants required in the "diagnostic services" (e.g. radiology, pathology) to support the implementation of the plan has been established. The appointment of these additional Consultants has been scheduled over a 3 year plan, subject to the availability of the required specialists.

The Trust recognizes that the national direction of travel is to reduce the number of trainees in a number of acute specialties and therefore alternative medical, and non-medical, workforce solutions have been identified. The Trust is in the early stages of discussions with local Trusts about establishing rotations at "middle grade" level for non-training grade doctors in acute specialties. Furthermore each business case for a new Consultant is asked to identify the workforce support for the post. .

The quality and workforce plans mean that the availability of senior decision makers, particularly out of hours, will increase. This will be achieved by the planned increase in Consultant numbers and changes in the working pattern of the current Consultant body. More weekend working will be included in a Consultant's job plan, compensated for by time off during the week. In certain circumstances this change in working practice is likely to require the support of an updated Consultant Contract, which is currently the subject of on-going negotiation.

The Trust has continually invested in the growth of qualified nursing posts to support rising acuity and dependency. In addition, clinical workforce developments have been progressed in roles such as assistant practitioners and advance practitioners.

Addressing the acuity gap on core wards within the emergency care division has been a priority resulting in investment of approx. £980,000 (26 additional qualified nursing posts) during 2013/14. An effective recruitment and retention plan delivered recruitment to these posts and has supported a significant reduction and sustained position in the number of vacant posts. A key success of this strategy has been due to effective international recruitment. Further investment is required during 14/15 to support this continued growth in acuity and dependency.

- The response to Francis, Berwick and Keogh

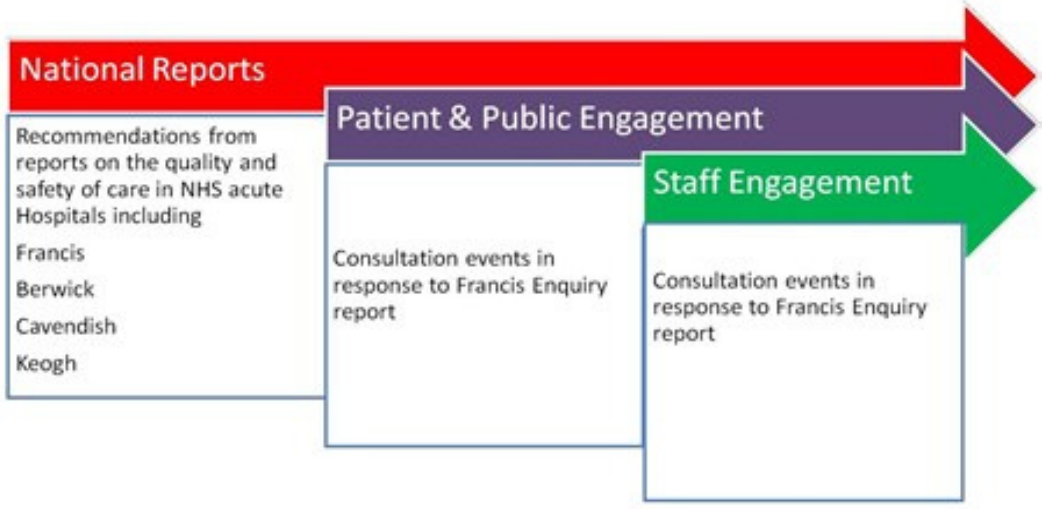
In February 2013 the second report by Robert Francis into the care provided at Stafford Hospital was published. Following the first report, published in February 2010, MCHFT developed a robust action plan to address any gaps identified. The plan was fully implemented and was subsequently reviewed prior to the release of the second report to ensure that the actions taken were fully embedded.
Following the second Francis publication the Trust undertook a number of actions, all of which supported the Trust in developing its response to the recommendations. These actions included:

1. reviewing recommendations from a number of reports, namely:

a. Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry, led by Robert Francis QC (February 2013)
b. Review into the quality of care and treatment provided by 14 hospital trusts in England, led by Professor Sir Bruce Keogh (July 2013)
c. An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings, led by Cavendish (July 2013)
d. Improving the Safety of Patients in England, led by the National Advisory Group on the Safety of Patients in England, also referred to as the Berwick Report (August 2013).

In spring 2013, the Trust heard from its patients, public and staff through a series of consultation events, about occasions when it had got things right, when things could have been done better, and where it should focus on further improvements going forward.

After reviewing key national reports, six themes were identified around the overarching topic of changing



culture within the hospital environment:

- having common values; ensuring that staff (and the organisation as a whole) are open and transparent with patients;
- having strong patient-centred leadership;
- having fundamental standards of care;
- ensuring that staff are compassionate, caring and committed;
- providing accurate, useful and relevant information.

The above themes were considered alongside the comments received from the consultation events, and an analysis took place which demonstrated that many of the recommendations were already in place and

had been for some time, whilst a gap analysis identified the remaining areas for further improvement. These themes were key drivers in the development of the Quality and Safety Strategy for 2014-2016 and the supporting Organisational Development Strategy, which also contains lessons learnt from the review.

a. Operational requirements and capacity

Demand assumptions and rationale:

The annual plan for the elective pathways has been based on the trend seen in referrals over the last 12 months. Total referrals grew by 5.6% in 2013/14 and are forecast to grow by 3.5% in 2014/15. Significant growth has been observed in Dermatology, Ophthalmology, Breast and Cardiology. The demand for new outpatients has been forecast to grow at the same rate as referrals and the current conversion rate for elective procedures and follow up attendances has been applied to the new outpatient activity. In addition, where specific plans are in place to increase capacity to reduce waiting times and repatriate activity from other providers further activity increases have been planned. These initiatives have been labelled as QIPP and are outlined in section 7 of the finance chapter, QIPP Productivity Schemes.

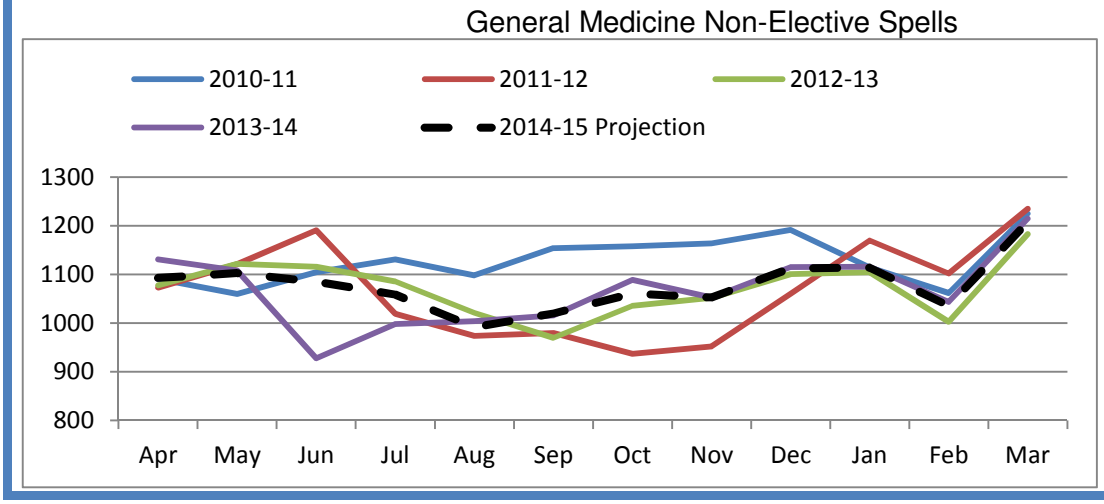
The specialties where additional activity is planned other than demographic growth is included in the table 7 below:

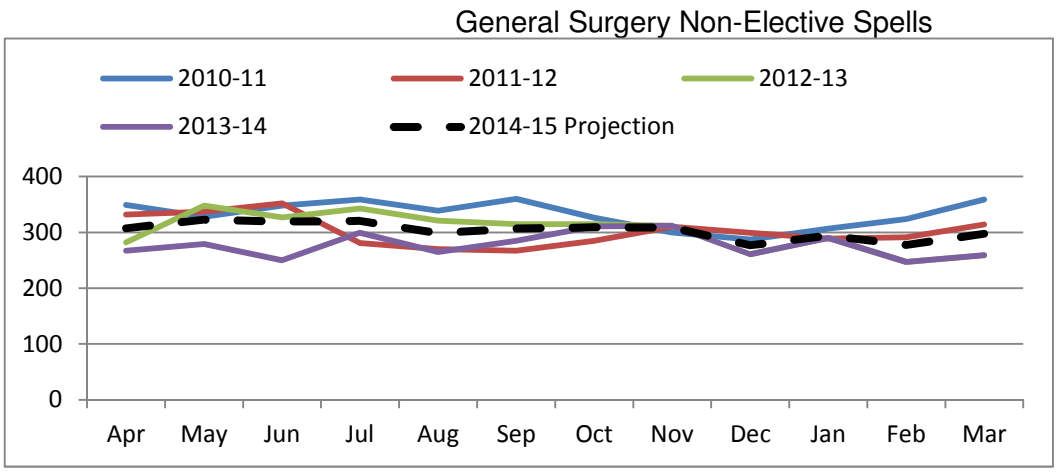
Table 7 – Additional activity growth

Specialty	New Patients	Current Market Share	Market Share Gain Assumption
ENT	343	84%	5%
General Surgery	205	88%	3%
Gynaecology	392	83%	5%
Orthopaedics	479	66%	11%
Urology	124	80%	5%

The basis of marketing assumptions are a reduction in the first outpatient appointment to less than 6 weeks, the expansion of activity in Northwich and increased contact between acute and primary care clinicians though visits and educational support.

In respect of non-elective activity, the Trust has seen a reduction in demand in 2013/14 that was not predicted, peaking in the summer quarter but maintaining a lower level than plan since that time. In addition, the Trust and the CCG have been working on moving towards a collaborative provider model that manages non-elective demand to the hospital. This includes changing pathways of care to non-bed based services including the Urgent Care Centre, GP neighbourhood teams and outreach elderly care specialist teams. It is therefore not expected that there will be growth in non-elective demand over and above the level this year. The graphs show the historical trends.





In addition to the planning assumptions in regard to non-elective activity, the Trust will be changing the current counting of emergency short stay activity to align with national guidance. Activity that present to Assessment Units for less than 12 hours will change from ward attender (outpatients) to a non-elective admission. The impact of the change will be to increase the total activity for non-electives by 10,012 to 34,371.

Capacity requirements:

The predicted demand and QIPP plans have been assessed against the current establishment of medical sessions and where deficits have been found, the Trust plans to invest in additional posts to make up the shortfall or to revise current job plans. These investments include the following:

- ENT – additional consultant and nursing staff
- Urology – additional consultant, nursing and admin staff
- General Surgery – additional consultant, nursing and admin staff
- Orthopaedics – additional 3 consultants, nursing, therapy and admin staff
- Breast – additional 0.7wte consultant, nursing and admin staff
- Cardiology – additional consultant

In addition, to support the additional activity further investment in Anaesthetics and theatre nursing will be made.
A review into the physical capacity for outpatient clinics is underway. The relocation of theatres into a purpose built facility from October, together with some scoping of community premises, gives rise to an opportunity to rationalise the current estate with regard to the delivery of outpatients. With regard to bed capacity, the Trust has modelled the predicted demand for elective and non-elective beddays for 2014/15 and together with expected improvements in ward efficiency, has opportunities to reduce the bed capacity in the summer period. In addition, the programme of reducing length of stay, enhanced recovery programmes and the high rate of day case surgery means the Trust does not require additional bed capacity to deliver its plans for increased elective activity.
Sensitivity Analysis

The risk associated with the demand plan is the assumption in regard to the level of non-elective activity. If activity in 2014/15 remains at the level of 2013/14, there will be a reduction of income of £1.4M. However, the Trust is currently negotiating a new approach to the management of emergency pathways that will protect the Trusts income at the expected level, this being reduced when the impact of the new initiatives allow the Trust cost base to be lowered.

Further risk may exist in the plans to increase activity as a result of attracting market share from other providers, this is particularly so for Orthopaedics, where targets are planned from Q3 2014/15 totalling £0.7M. However, the Trust has already been approached by a neighbouring hospital to support their shortfall in this area and has agreed to consider their request should its own plans not deliver fully in the short term, therefore mitigating this potential risk.

b. Productivity, Efficiency

An analysis of the cost improvement and efficiency schemes are detailed in the financial plan section below, this section details the Trusts key transformational schemes and the approach to delivery over the next two years

Transformation

To meet the Trust's strategic objectives the Trust will need to respond positively to a number of significant challenges in the next couple of years, with a specific emphasis on developing and implementing a number of service redesign and reconfiguration proposals. The Trust has established a Programme Management Office (PMO) to play a key role in supporting this work and will do so as follows:

- Development of Service Redesign and Reconfiguration proposals, providing:
  - project management support
  - service redesign - including facilitation and process redesign skills & expertise
  - analytical information on service proposals
- Providing programme management and information support to
  - collaboration exercises across the Trust
  - ensure Trust input to whole health economy developments
  - commissioner led reviews
- Promoting cultural change though supporting change in a positive, participative and facilitated approach

The Trust has a number of transformational schemes that are currently delivering or are planned for future delivery and are detailed below in table 8:

Table 8 – Transformational Schemes

Programme	Sub projects	Benefits	Timescales
Improving Patient Flow	Front of house assessment • Triage GP referrals	Reduced Length of Stay Admission Avoidance Reduction in readmissions	2012 to 2015
	IV@Home Centralised Model		
	Ambulatory Care Pathways • PE • Chest Pain • SVT • CCF • Cardiac BNP Testing • Medical Thoracoscopy		
	24/7 Urgent Care Centre		
	Short Stay Unit		
	Event Led Discharge		
	Extend PIU • Anaemia • Detox • Heart Failure		
	Elderly Care Pathway		
	Diabetic Specialist Nurse/ In reach Service		
	Improved complex discharge process		
	Care/Nursing home redesign process		

	Readmission review • Respiratory • Cardiology		
Theatre Productivity	Endoscopy Orthopaedic Urology Ophthalmology Gynaecology	Improved Theatre utilisation Market Growth/ income generation Improved process	2013 to 2015
OPD Utilisation	Administration and Quality Clinical Services Strategy and pathway redesign Workforce Marketing strategy Environment	Improved clinic utilisation Reduced DNA/Can Improved administrative processes OPD rationalisation Market Growth/ income generation	2013/2015

c. Financial plan

Table 9 below shows the income and expenditure position for the planning period to date and is followed by an analysis of the key movements from the 2013/14 approved financial plan, which are detailed in the following pages.

Table 9 – Income and Expenditure Account 2014 to 2016

2013/14 Forecast £'000		*Plan 2014/15 £000's*	*Plan 2015/16 £000's*
160,235	NHS Clinical Income	166,618	169,830
21,103	Other Income	20,421	22,113
181,339	TOTAL INCOME	187,039	191,943
(124,102)	Pay Costs	(128,217)	(132,091)
(49,112)	Non-Pay Costs	(51,471)	(52,173)
8,125	EBITDA	7,351	7,679
(4,518)	Depreciation owned and leased assets	(4,832)	(5,343)
63	Interest receivable	44	44
(100)	Interest payable	(273)	(308)
(2,368)	PDC Dividend/Other	(2,103)	(2,103)
1,202	NET SURPLUS / (DEFICIT) before exceptional items	188	(31)
0	Donated Asset Income	3,046	500
(14,590)	Impairments	0	0
(13,388)	NET SURPLUS / (DEFICIT)	3,234	469

The key movements in the financial plans are detailed below:

Table 10 – Key Movements from 2013/14 plan to 2015/16 plan

	2013/14 To 2014/15	*2014/15 to 2015/16*	*Note*
Opening Plan b/fwd.	2,414	188	
Planned full year impacts	(1,599)	(57)	(1)
Recurring baseline b/fwd.	815	131	
Full year impact of cost pressures from 2013/14	(2,821)	0	*(2)*
Contract over performance 2013/14 consolidated	3,352	0	*(3)*
Sub Total	1,346	131	
Inflationary Pressures	(2,897)	(4,754)	*(4)*
New pressures for 2014/15	(356)	37	*(5)*
Cost Improvements	3,684	5,018	*(6)*
QIPP programmes	2,057	1,949	*(7)*
Other movements in contractual Income	(1,311)	(1,219)	*(8)*
Movements in dividend /interest and depreciation	67	(546)	*(9)*
Net position prior to investments	2,600	616	
Investments	(2,413)	(647)	*(10)*
Normalised Income & Expenditure Position	188	(31)	
Exceptional Items (Donated Asset Income)	3,046	500	
Income and Expenditure position	3,234	469	

The exceptional donated asset income relates to the charitable contributions to capital projects. Further details are shown in the capital programme funding analysis

1. Full year impacts

This movement consists of 3 elements:
- Neonatal Intensive Care Unit Charitable donations (£1,800K)
- Non Recurrent Costs/CIP's £190K
- Full year impact of spending plans for 2013/14 £11K

2. Emerging Pressures 2013/14 onwards

In developing the plans for 2014/15 each division has undertaken a detailed analysis of its expenditure in 2013/14 to identify increasing pressures which have emerged during the year that are expected to be recurrent. Some of these pressures will have been offset in year by non-recurrent savings.

The key items included within are detailed below:

Table 11 – Recognised 2013/14 cost pressures in 2014/15 plan

Pressure	*2014/15 Total £'000*	*Pay £'000*	*Non Pay £'000*	*Income £'000*	*Recurrent Total £'000*
Surgery and Cancer	(740)	(384)	(483)	127	(740)
Emergency Care	(401)	(366)	(35)	0	(401)
Women and Children	(32)	0	(26)	(6)	(32)
Diagnostics & Clinical Support	(449)	(77)	(141)	(231)	(449)

Estates and Facilities	(19)	40	(44)	(15)	(77)
Corporate	(388)	(96)	(223)	(69)	(388)
Therapies pressure	(250)	0	(250)	0	(250)
Drugs pressure	(2,258)	0	(2,258)	0	(2,258)
Cost pressures	(4,537)	(983)	(3,460)	(204)	(4,537)
Pass through income for High Cost Drugs	1,716	0	0	1,716	1,716
Net pressure	(2,821)	(983)	(3,460)	1,508	(2,821)

These pressures are in line with the expenditure forecast at month 10 where total operating costs are forecast to overspend by £4.8M. It can be seen that £3.4M of these costs are associated with non-pay pressures and directly driven by increases in activity particularly in outpatients and elective spells.

Clinical staffing

In addition to the non-pay pressures there have also been a number of commitments in clinical staffing, the full year impact of which will be recognised recurrently in the 2014/15 plan. One key element of this relates to additional nursing support to respond to pressure caused in year in relation to the increasing acuity of the patients. Table 12 below identifies the key elements.

Table 12 – Analysis of clinical staffing pressures

Pressure	*Emergency Care £'000*	*Surgery £'000*
Nursing staffing		
Ward 14 additional establishment	(204)	
Acute Oncology nurses	(95)	
Increased one to one nursing costs	(66)	
Utilisation of security support for 1:1 requirements	(52)	
Extend Advanced Nurse Practitioner working hours	(16)	
Skill mix impacts on medical Wards	(16)	
Additional hours for Breast Care Nurse		(19)
Total Nursing pressures recognised	(449)	(19)
Medical Staffing		
Cover for Deanery shortfall on 2 SHO's in ENT		(115)
Ophthalmology additional capacity		(240)
Additional PA for QA lead in Pathology		(5)
Total Medical staffing pressures recognised	0	(360)

Whilst the table above shows the increased establishment invested in Ward 14 over and above the initial planned investments, a number of other responses have been initiated in year which have demonstrated good progress towards responding to the increased acuity and areas for development as highlighted from the Francis and Keogh reviews. These include:

i. Additional nursing investment in Wards where acuity figures showed a shortfall; this has not shown as a pressure in year as funding has been available from the Trusts provision for a winter ward. The investments section of this report proposes that these investments are made recurrent.
ii. Opportunity has been taken in year to replace some administrative staff who undertakes discharge coordinating duties with qualified nurses, which has improved acuity and given a greater emphasis on discharge planning. Again these are detailed in the investments section.

Medical Staffing pressures are associated with:

i. Continuing gaps in the allocation of ENT doctors from the deanery and the anticipated need to continue to source these doctors through agencies at premium rates.

ii. Additional capacity in Ophthalmology which has seen significant increases in demand for both the AMD service and general ophthalmic activity. A business case is under production to deliver this activity under a more stable model. In the interim the costs allow for an element of continued outsourcing and weekend working in the short term.

Other support staff

In addition to the clinical pressures in year there have also been a number of investments in support services, which will continue into 2014/15 and are detailed in table 13.

Table 13 – Support services pressures

Pressure	*£'000*
Non recurrent deferral of Waste Management porter CIP to facilitate logistics review.	(18)
Annual leave and sick leave cover not funded in Integrated Discharge Team	(18)
Pathology CIP Pressure	(50)
Finance support and Information Analyst to support UHNS transformation agenda	(52)
Procurement Officer to support theatres scheme initially and recurrently to support the national procurement strategy	(40)
Other	(40)
Total other staffing pressures	(218)

3. 2013/14 Contractual Income over performance impact

The proposed CCG contract includes consideration of the 2013/14 activity

Table 14 below shows the key areas of over performance.

Table 14 –2013/14 Contractual Income over performance

Point of Delivery	*2013/14 £000's*	*Recurrent Impact in 2014/15*
Contract Variations	106	106
Non Elective activity (including assessments)	(2,154)	(2,154)
Accident and Emergency	88	88
Elective activity including day cases	1,297	1,297
Outpatients (including Ward Attenders)	1,601	1,601
Maternity (Births and Bookings)	50	50
Unbundled Radiology and Direct Access Services	705	705
Other activity based income	444	444
Other non-activity based	(12)	(12)
Movement in planning assumptions between budget sign off and contract sign off.	(223)	(223)
Fines and Penalties	(90)	0
High Cost Drugs	1,450	1,450
Total contract over performance 2013/14	3,262	3,352

The key points to note are:

1. Contract variations include contract variations for Dementia Care support worker and Integrated Discharge Team Support posts agreed by the CCG for funding in year.
2. Non-Elective activity in 2013/14 is under plan with reduced volumes of activity being seen in the early parts of the year. Later months have seen non-elective increasing towards plan and this is

anticipated to continue going forward and reflected in 2014/15 growth assumptions.

3. Both Elective and Outpatient activity is significantly ahead of plan; the main variances are in Orthopaedics, General Surgery, Breast, Endoscopy and Ophthalmology. These are being driven by significant increases in referrals with GP referrals up by almost 7% on plan at the end of January.
4. Maternity income is ahead of plan for 2013/14 due to over performance against bookings however this is offset by reduced number of births. The over performance against bookings is primarily associated with an under assessment of the initial target rather than a real terms increase in activity.
5. High Cost Drugs are significantly above plan offsetting increased drug costs, particularly in Ophthalmology and Clinical Haematology.

4. Inflationary Pressures

The increased costs associated with inflationary pressures are shown below:

Table 15 – Inflationary increases

Inflationary factors	*2014/15 £000's*	*2015/16 £'000*
Wage awards	(1,075)	(1,302)
Incremental Drift	(488)	(600)
Employer pension contributions	0	(1,348)
Non-pay and other income inflation	(1,004)	(1,094)
CNST Premiums	(300)	(360)
Consultant excellence awards	(30)	(50)
Total	(2,897)	(4,754)

The wage awards are based on anticipated agreed National Wage deals 1% across all staff groups for both 2014/15 and 2015/16.

Incremental Drift is calculated based upon actual staffing in post and their expected progress through the incremental scales; Progression through increments is no longer an automatic process and will be linked more closely to appraisal. Whilst this gives greater flexibility; it is anticipated that in the main staff would continue to deliver on their performance therefore the sums included in the budget represent a worst case scenario.

Increase in employer pension contribution is due to a change in the NHS pension scheme. Monitor guidance for the annual planning review asks Trusts to assume an increase in employer costs of 0.7% of budget in 2015/16 rising to 1.4% in 2016/17. At this stage it is anticipated that this additional pressure will be reflected in the tariff inflationary adjustments prior to the efficiency challenge and therefore not an additional burden on NHS providers over and above the notified efficiency.

Non pay costs, excluding Utilities and CNST, have been increased by an average of 2.1% which is in line with the tariff considerations. The annual consumer price index all items in December was at 2.0%. However, the first of the expected gas and electricity bill price increases also resulted in a small upward contribution to the CPI and this is likely to impact on all prices in the coming year as manufacturers look to pass on these increases.

Energy Costs continue to see significant increases in 2013/14. In line with the 7% included in last year's plan, it is assumed for the future plan that energy will continue to increase by a further 7% in 2014/15.

The Clinical Negligence Scheme for Trusts (CNST) have indicated that total contributions will need to increase by a rate of 10% per annum this equates to an increase of £300K for the Trust. This increase is factored into the 4% efficiency requirement built into the national tariff.

5. Emerging Pressures in 2014/15 onwards

In addition to the pressures experienced in 2013/14 associated with delivering the growth in activity and other service pressures expected to continue, there are a number of pressures which are emerging for 2014/15. The key elements are:

Table 16 – New Pressures emerging in 2014/15

Pressure	*2014/15 £'000*	*2015/16 £'000*
High Costs Drugs Growth	(1,032)	
Upper GI Clinical Nurse specialist	(20)	
International recruitment premium	(21)	21
BNP Testing	(20)	
Bed Cabin Store Lease	(17)	
Treatment Centre Hose replacement	(7)	7
Carbon Reduction Tax price increase	(31)	
Residences non-recurrent loss of Income	(19)	19
Paediatric Medical Staffing vacancy held non-recurrently to fund additional Paediatrician	(59)	
Non-Recurring holding Obstetric Post	(60)	
Medical Gases for new theatre	(20)	
Approved Clinical Haematology Business case	(58)	
Deanery reduction in LAS funding notified from August	(20)	(10)
Medical Revalidation Process	(4)	
Gross Pressures	(1,388)	37
Less pass through income for high cost drugs	1,032	
	(356)	37

6. Cost Improvements Plans (CIP)

In addition to these CIP schemes divisions will also deliver improved financial efficiency through improved productivity which is detailed under the QIPP section 7. In total divisions have been targeted to deliver efficiencies and Cost improvement plans up to 6%. Work continues to ensure all targets have clearly identified schemes attached and the Director of Finance, Chief Operating Officer and Director of Transformation and Workforce have met with all divisions to review their proposals and support has been provided through the Programme Management Office to develop specifications. Subsequently these have been reviewed through the Executive Management Board by the senior leadership team.

Divisions have quality impact assessed these schemes and a formal review will be undertaken by the Director of Nursing and the Medical Director.

The table below indicates the level of identified savings schemes by division:

Table 17 – Cost improvement schemes by Division 2014/15

Division	*Recurrent Savings £000's*	*2014/15 Slippage £'000*	*2014/15 Impact £'000*
Emergency Care	821	0	821
Surgery and Cancer	0	0	0
Women and Childrens	182	0	182
Diagnostics and Clinical Support	738	(234)	504
Estates and Facilities	410	(22)	388
Sub Total identified schemes	2,151	(256)	1,895
Corporate Schemes	1,717	(352)	1,365
National wage award proposal	424	0	424
Total Cost improvement target	4,291	(608)	3,684

The national pay deal has now been released for 2015/16 and is financially favourable compared with the anticipated 1% cost of living plus the incremental drift. The settlement now only awards the 1% to staff who are on top of scale and receive no incremental progression. Detailed guidance has yet to be received and the expected benefit of £424K reflects the worst case scenario.

Each of the CIP schemes will be formally quality risk assessed as part of the contract discussions with the CCG's through the "Star Chamber". Table 18 below shows the key individual schemes.

Table 18 - Cost improvement schemes 2014/15

Scheme	*Full year Impact £000's*	*2014/15 Slippage £'000*	*2014/15 Impact £'000*
Closure of Medical Ward for the summer	353	0	353
Full year impact of ward 19 closure	280	0	280
Sickness absence reduction	126	0	126
Less sickness absence reduction target 2013/14	(100)	0	(100)
Other medical budget adjustments	162	0	162
Reduction in Business Rates	122	0	122
Lease income from Renal Unit	70	0	70
Enhanced contribution from catering investment	133	(22)	111
Reduced residences running costs from relocating finance and Information teams relocation	6	0	6
Catering efficiencies	12	0	12
Lease Buyout savings	67	0	67
CNST achievement of level 3 discount in maternity	182	0	182
Pathology reconfiguration of Blood sciences and sendaways	217	(108)	109
Reduction in Radiology premium reporting costs	219	(126)	93
Drugs cost reductions	300	0	300
Other	2	0	2
Total	2,151	(256)	1,895

In addition to the Divisional schemes identified to date, a number of corporately led schemes have been proposed which are detailed below in table 19.

Table 19 – Corporate Cost Improvement Schemes

Scheme	*Full Year Impact £000's*	*Slippage £'000*	*2014/15 Impact*
Procurement savings	400		400
Apprenticeships	449	(352)	97
Removal of Working Capital Facility	36		36
Salary Sacrifice Schemes	30		30
Provision removed	100		100
Reduction in legal fees	60		60
Release of redundancy provision	152		152
CNST Premium reduction	425		425
MPET training tariffs gain	65		65
Total	1,717	(352)	1,365

In addition to the new schemes identified for 2014/15, there are a number of schemes which are expected to begin to deliver benefits during 2015/16; these are detailed below in table 20.

Table 20 – 2015/16 Cost Improvement Schemes

Scheme	*Full Year Impact £000's*	*Slippage £'000*	*2014/15 Impact*
Procurement savings	400	0	400
Energy Efficiency schemes	150	0	150
Drug Initiatives	400	0	400
Reduction in sickness absence	100	0	100
Non-Elective Pathway Improvements	1,280	0	1,280
Non Pay Standardisation	100	0	100
Pathology Collaboration	250	0	250
Public Private Partnerships	250	0	250
Horizontal Integration Schemes	1,000	0	1,000
Estates Rationalisation	250	0	250
Training Income	83	0	83
Other minor Schemes	147	0	147
Full year of 2014/15 schemes	608	0	608
Total	5,018	0	5,018

The non-elective pathway improvements will be delivered through a programme of work associated with non-elective flow and will be facilitated by reducing length of stay through:

- Continued roll out of event led discharge facilitated by the additional investments in qualified nursing numbers
- Improved discharges at the weekend facilitated by the investment in 7/7 working and improved senior clinicians cover in the Emergency Department
- A focus on reduction in delayed transfer of care where local performance shows significant opportunities for improvement.

The Pathology Collaborative will be delivered through the continued rationalisation of pathology services across the Mid Cheshire and East Cheshire Sites and builds on the work undertaken in 2014/15 which brought together Microbiology and Histology on to single site working.

Public private partnerships will be delivered through continued discussions with a number of private sector partners. This will be associated with more efficient access to surgery by utilising the Trusts additional theatre capacity and through working with other providers to access new markets.

The Horizontal Integration scheme will be focused on NHS partnerships. In particular the Trust will continue to develop its work programme with University Hospitals of North Staffordshire following the principals agreed in the memorandum of understanding. A work programme has already been established which is being overseen by a Joint Collaborative Board, priorities are set and a project structure is in place. This will bring additional financial sustainability, better clinical pathways, enhanced services on the Mid Cheshire site and through joint appointments, improved access to recruitment in areas where there continue to be national shortages.

Estates rationalisation savings will be realised through careful investment in capital schemes which enable the facilities to be better utilised. A key element of this on-going programme in 2015/16 will be the realisation of the residential strategy where external consultants are already working with potential partners to develop this case.

7. QIPP Productivity schemes

In addition to the cost improvement targets included above the divisions have identified productivity schemes which relate to meeting additional demand through improved productivity. The Schemes for 2014/15 and 2015/16 with their net contribution are shown below in table 21 and 22:

Table 21 – QIPP Productivity schemes 2014/15

Specialty	*Start date*	*Recurrent Contribution £000's*	*Slippage £'000*	*2014/15 Impact £'000*
Orthopaedics repatriation	October	1,241	(580)	661
ENT	April	146	0	146
Urology	October	208	(40)	168
General Surgery	October	217	(54)	163
Breast Service	April	173	0	173
Sexual Health	April	41	0	41
Colorectal Surgery	April	139	0	139
Flexible sigmoidoscopy programme	Phased	632	(562)	70
Gynaecology	April	107	0	107
IVF Contribution current catchment	April	85	0	85
Additional IVF market	October	74	(37)	37
Additional births repatriated	October	200	(100)	100
Cardiology	April	185	0	185
Pathology Direct Access	April	(18)	0	(18)
Total QIPP		3,430	(1,373)	2,057

Table 22 – QIPP Productivity schemes 2015/16

Point of Delivery	*% Growth*	*Gross Income £000's*	*Delivery Cost £'000*	*2015/16 Impact £'000*
Accident and Emergency	1%	72	(14)	58
Day Cases	2.5%	445	(334)	111
Elective activity	2%	213	(160)	53
Outpatients	2.5%	709	(354)	354
Total QIPP		1,438	(862)	576

The impact of the better care fund schemes, which have yet to be quantified, are assumed to deal with historic demographic growth and therefore no non-elective increases are forecast beyond 2014/15. The total QiPP contribution in 2015/16 is therefore expected to be £1,949 (£1,373K slippage plus £576K new schemes)

8. Other movements in contractual income

The remaining movement in income falls into 3 categories which are summarised below:

1. Impact of the National Tariff: £2,091 (adverse)
2. Other Impacts of demand plans for 2014/15: £30 (favourable)
3. Other allocations: £750 (favourable)

Impact of the national tariff

National tariff was published in December and the financial impact of this has been detailed in the short term challenge section in tables 4 and 5.

Other allocations
In addition to the impact of the national tariff and the growth assumptions there are two additional income movements which have been factored into the overall plan; these are detailed below in table 23 and are explained in the section on contract progress.

Table 23 – Other Income adjustments

Detail scheme	*Recurrent £000's*	*Slippage £'000*	*2014/15 £'000*
Reduction in provision for fines	150	0	150
Impact of move to assessments tariff	1,200	(600)	600
Total Other movements	1,350	(600)	750

9.Movements in capital charges (2014/15 £67K; 2015/16 (£546K))
The key movements in capital charges are associated with:

- Change in depreciation charges 2014/15 (£59K); 2015/16 (£511K)
- Interest payable on financing 2014/15 (£129K); 2015/16 (£35K)
- decrease in dividend payable 2014/15 265K; 2015/16 £0K

Depreciation charges
The depreciation movement reflects the full year impact of the 2013/14 programme based on month 10 Forecast and the in-year impact of the capital programme detailed in the next section. Assets have been depreciated based on a straight line method over their estimated life. For buildings this life has been based on the District Valuer's assessment.

The movement is associated with the revaluation of the estate which has been undertaken by the District Valuer (DV) on a Modern Equivalent Asset (MEA) basis. This valuation has reduced the value of the Trusts estate by approximately £16M as at the 31st March 2014. The impairment impact has been reflected in the 2013/14 forecast.

The capital section below indicates an additional leasing requirement of £938K in 2014/15 primarily associated with replacement of medical equipment currently owned by the Trust reaching its end of life and a major programme to replace all defibrillators. These have been factored into the on-going lease payments.

Interest Payable
Interest is payable on finance leases and any borrowings to support the capital programme. The capital programme detailed in the following section assumes that the Trust secures loans of £4,430,000 in 2014/15. These loans will be secured through the Foundation Trust Financing Facility (FTFF) with the interest rate fixed at the beginning of the loan based upon the loan term.

In addition to the FTFF loans, interest will be payable based on the inherent rate within the agreement for all finance leases, based on the increased leasing detailed above at an inherent rate of 3.5% this equates to an additional £8K in interest, giving a total movement of £129K.

Dividend Payable
The Trust secured £25.2M PDC support in 2011/12 in support of its capital programme primarily associated with the theatres and critical care build. At the end of 2012/13 £8.1M had been drawn down against approved schemes. To the end of February 2014 a further £16.1M has been drawn down, the remaining £1.0M will be drawn down by 31st March 2014 in line with spend.

The dividend calculation is based on applying a 3.5% rate to the average of opening plus closing balances of relevant net assets less average monthly balances in the GBS account. The opening budget position brought forward from 2013/14 anticipated this remaining draw down by the end of the financial year and therefore includes 50% of the impact of the further £17.1M PDC support. The remaining full year impact in 2014/15 equates to £300K (£17.1M/2*3.5%).

The revaluation exercise referred to in the depreciation section above will also impact on the dividend calculation. As detailed in the Theatres and Critical Care business case there was already an expectation that the valuation would be less than the total cost of the scheme by £7.1M, this was built into the 2013/14 plan when estimating the dividend payable. The provisional valuation has had an impact of reducing the value by an additional £9.1M, which reduces the dividend payable in 2014/15 by a further £601K.

The final impact on the dividend payable is the impact of average cash balances held in the GBS Account. An estimated impact of £36K adverse has been built into the plan based on an average reduced cash balance of £1,041.

Table 24 below summarises the impacts on the PDC dividend payable.

Table 24- Summary of PDC movements

Movement	*2014/15 £000's*	*2015/16 £'000*
Full year impact of PDC draw down	(300)	0
Impact of revaluation exercise	601	0
Reduction in average cash balance	(36)	0
Movement in PDC charges	265	0

10. Investments (2014/15 £2,373K; 2015/16 £647K)

The investments are categorised into 4 key priorities:

1. Investments in 7/7 care (2014/15 £302K; 2015/16 £570K)
2. Investments in Nursing Acuity (2014/15 £601K; 2015/16 £65K)
3. Investments in Theatres build (2014/15 £322K; 2016/17 £121K)
4. Implementation of IT strategy (2014/15 £312K; 2015/16 (£147K))

In addition to these key priorities there are also a number of other investments which supports national agendas, additional capacity or meets statutory requirements in support departments and this totals £876K in 2014/15 with a further £38K in 2015/16.

A response to 7/7 working
As previously described, a working group led by the Medical Director has been established to review the implications of moving towards 7 day working and table 25 below shows the provisions made in this plan for 2014/15.

Table 25 –Investments in supporting 7 day working

Scheme	*Full Year Impact £'000*	*2014/15 Slippage £'000*	*2014/15 Revenue Cost £'000*
General provision for additional consultants	(600)	450	(150)
Increase in A&E consultant numbers	(247)	120	(127)
Additional PA's to support Trauma Centre status	(25)	0	(25)
Total activity investments	(872)	570	(302)

Investments in nursing
As detailed earlier the Trust is already on a path to improving the nursing numbers. The latest acuity analysis in January suggested a shortfall of circa 40 qualified nurses across the Trust. The response in year, as detailed in the pressures section of this report, has already moved to address some of the issues on Ward 14.

Table 26 below indicates the additional proposed investments in 2014/15 which address the gap in the latest acuity for qualified nurses and increases Health Care assistant support overnight.

Table 26 –Further Investments to acuity and Nurse staffing in 2014/15

Scheme	*Recurrent Cost £'000*	*Slippage £'000*	*2014/15 Cost £'000*
Core Wards			
Additional Qualified nurses on Ward 2,4 & 7 currently funded from Winter pressures	(275)	0	(275)
Additional Band 5 on Medical Wards to replace discharge coordinators	(295)	0	(295)
Provisions for Maternity and WTD and sickness	(20)	0	(20)
Additional Qualified on Medical Wards for each day shift	(261)	65	(196)
Additional Health Care Assistants on Nights	(274)	0	(274)
Increase AMU handover to 30 minutes	(32)	0	(32)
Additional HCA on Ward 1 on nights	(66)	0	(66)
Additional costs over existing provision to open Winter Ward	(264)	0	(264)
Sub Total Core Ward Investments	(1,487)	65	(1,422)
Emergency Department			
Extra advanced Nurse Practitioner on nights	(166)	0	(166)
Extend existing ENP cover by 30 minutes per day	(19)	0	(19)
Increase HCA transfer team	(76)	0	(76)
Sub Total ED Nursing	(261)	0	(261)
Total New Nursing investment	(1,748)		(1,683)
Anticipated existing source of funds			
Winter ward contingent on winter monies	614	0	614
Reduction in one to one nursing	357	0	357
Management of Supernumerary new starters in numbers	111	0	111
Net new investment required	(666)	65	(601)

These funds assume that winter funding released over the last few years will continue and that this will be sufficient to fund a winter ward.

In addition the division has historically been funded to deal with one:one nursing requirements and to allow new starters to operate in a supernumerary role during their first few weeks. The investment detailed above in substantive qualified nurses will allow flexibility for these to be dealt with by existing staff.

Revenue impacts of the Theatre build

Table 27 below details the impact of the new theatre build; most of these costs were included in the theatres business case although a greater clarity now exists in respect of the scheme.

Table 27 –Revenue impact of the theatres scheme

Cost	Full Year Impact £'000	2014/15 Slippage £'000	2014/15 Impact £'000
Staffing for Surgical Assessment Lounge	(241)	121	(120)
Building Services	(37)	0	(37)
Additional Store man to staff bulk store	(25)	0	(25)
Additional Portering	(20)	0	(20)
Utilities	(39)	0	(39)
Monitoring and Anaesthetic Equipment Maintenance	(43)	0	(43)
Rates	(14)	0	(14)
Other	(24)	0	(24)
Total Theatres Impact	(443)	121	(322)

Implementation of IT strategy

In line with the realignment of the IT strategy there are a number of revenue implications which will impact in 2014/15, these are shown below in table 28 and are associated with resources to implement and the on-going maintenance of the systems.

Table 28 –Revenue costs of IT strategy

Cost	Recurrent Impact £'000	2014/15 Non recurrent £'000	2014/15 impact £'000
E Prescribing (Chemo Care)	(75)	(48)	(123)
Ehandover	(49)	(99)	(148)
Revalidation of Doctors software	(41)	0	(41)
Total	(165)	(147)	(312)

The E Prescribing and E handover investments are in line with previous business cases and the revalidation package is a package to maintain and support the revalidation of Doctors.

Other Investments

Table 29 below details the other investments included within the plan

Table 29 – Other Investments

Cost	Recurrent Revenue Cost £'000	2014/15 Slippage £'000	2014/15 impact £'000
Lung Cancer Service as per respiratory business case	(207)	0	(207)
8th Paediatrician business case shortfall	(48)	0	(48)
Gastro Business case (Anaesthetics admin)	(40)	0	(40)
ENT admin staffing	(66)	0	(66)
Wheelchair Maintenance	(5)	0	(5)
Legionella Risk Assessments	(16)	0	(16)
Increased Fire Testing	(15)	0	(15)
Friends and Family Test (Maternity)	(8)	0	(8)
Additional oncall rota for Labour ward	(5)	0	(5)
Additional POAC in Women and Childrens	(2)	0	(2)

Additional staff to support delivery of CNST level 3 Maternity	(56)	0	(56)
Additional sexual health capacity to support growth	(13)	0	(13)
Additional Medical Records staff to support growth in Outpatients	(95)	48	(47)
Additional CT Capacity brought forward	(143)	0	(143)
Additional ECG staff to support reporting	(18)	0	(18)
Additional capacity as per Dermatology Business case	(53)	0	(53)
Band 2 Support to meet dementia CQUIN	(10)	0	(10)
EU Sharps Directive	(60)	0	(60)
Asbestos inspection	(28)	0	(28)
Notes Cages for Integrated Governance	(25)	0	(25)
Clear Backlog of Fire Risk Assessments	0	(10)	(10)
Total	(914)	38	(876)

CAPITAL PROGRAMME

Table 30 below shows the key elements of the Capital Programme.

Table 30 –Capital Programme 2014/15 to 2016/17

Scheme	*c/fwd spend £'000*	*2014/15 £'000*	*2015/16 £'000*
Estates Development Schemes			
Theatre and Critical Care	922	2,400	0
Asbestos / Fire breaks	30	300	250
Restaurant and main entrance	490	250	0
Ward refurbishment Maternity	400	410	0
2nd MRI Scanner (inc IT)		2,404	0
Endoscopy and Treatment Centre		1,330	0
Site rationalisation priming	200	250	250
Ward Refurbishment		1,500	1,500
Way finding		100	0
Neonatal intensive care		1,932	0
Lease Buyouts		157	0
Backlog maintenance schemes			
Outpatients Refresh		60	0
Backlog maintenance	15	1,203	1500
Design Team and Painters		250	250
Visitor Car Parking		40	
CT/VT Mains	100	175	175
IM&T Schemes			
IM&T Infrastructure	65	241	206
Radiology Information System		458	0
E Prescribing, E-Handover and EDMS	79	488	1,352
VOIP		0	640
EMIS Integration		36	36
Unisoft		0	36
Lab Centre upgrade		108	0
Interfacing		30	30
Equipment Leasing			
Defibrillators		458	0
Orthopaedic equipment		90	0
General Equipment replacement		500	500
Total indicative Programme	2,301	15,170	6,725

The Ward refurbishment programme and the asbestos removal scheme are fully committed and the balance of the programme builds on the previous 5 year capital strategy approved by the Board. The most recent backlog maintenance assessment suggests that an annual investment of £1.5M is required to maintain the current facilities up to appropriate standards.

Funding for the proposed programme is detailed in Table 31 below.

Table 31 – Source of funds for capital expenditure

Source of Funds	*2014/15 £'000*	*2015/16 £'000*
Scheme carry forwards	2,301	0
Finance and Operating Leases	1048	500
Charitable contributions*1	3,046	500
Depreciation charges	3,375	3,835
Less capital repayments	(119)	(269)
FTFF Loans	4,430	1,000
Sub Total	14,081	5,566
Capital Programme	17,471	6,725
Net funding from Cash Reserves	(3,390)	(1,159)

*1 the charitable contributions are based on the following schemes:

		2014/15 £'000	2015/16 £'000
i.	Neonatal Intensive Care Unit	2,000	
ii.	MRI Charitable appeal	1,000	
iii.	League of Friends contribution	15	
iv.	Contribution to Sky panels	30	
v.	Other charitable appeals		500
	Total	**3,045**	**500**

STATEMENT OF POSITION

The Summary Statement of Position is forecast as shown below in table 32

Table 32 - Statement of Position 2014/15and 2015/16

	Forecast 2013/14 £'000	*Plan 2014/15 £'000*	*Plan 2015/16 £'000*
ASSETS			
Assets non-current	72,142	85,667	89,183
Assets Current			
- Trade and other receivables	7,142	6,038	6,220
- Inventories and prepayments	4,901	4,922	4,943
- Cash and cash equivalents	10,056	5,529	4,325
Total Current Assets	22,099	16,489	15,488
TOTAL ASSETS	94,241	102,156	104,671
LIABILITIES (Current)			

Finance Lease	(1,344)	(1,267)	(1,598)
Provisions	(306)	(328)	(340)
Trade and Other Creditors	(7,988)	(8,812)	(8,693)
Loans outstanding	0	(242)	(305)
Other financial liabilities	(6,184)	(5,268)	(5,352)
Total Liabilities Current	(15,822)	(15,917)	(16,288)
Net Current Assets/(Liabilities)	6,277	572	(800)
LIABILITIES (NON-CURRENT)			
Finance Leases	(3,388)	(4,055)	(5,091)
Loans	0	(4,069)	(4,737)
Provisions	(1,480)	(1,330)	(1,300)
Total Liabilities Non-Current	(4,868)	(9,454)	(11,128)
TOTAL ASSETS EMPLOYED	73,551	76,785	77,255
Taxpayers' and Others' Equity			
Public Dividend Capital	75,146	75,146	75,146
Retained Earnings	(12,795)	(9,561)	(9,091)
Revaluation Reserve	11,200	11,200	11,200
TOTAL FUNDS EMPLOYED	73,551	76,785	77,255

CASH FLOW

The impact of the spending plans and capital programme along with assumptions in the movement in working capital shows the following impact on the Trusts cash position.

Table 33 – Cash Flow Statement

	Cash Flow 2014/15 £'000	*Cash Flow 2015/16 £'000*
Surplus/(deficit) after tax	3,234	469
Non cash flows in operating surplus/(deficit)	5,061	5,608
Increase/(Decrease) in working capital total	220	74
Net Cash inflow/(outflow) from operating activities	8,515	6,151
Net cash inflow/(outflow) from investing activities	(15,780)	(6,555)
Net Cash inflow/(outflow) before financing	(7,265)	(404)
Financing activities		
Payments against Finance lease rentals (capital and interest)	(1,496)	(1,454)
Interest received on cash and cash equivalents	44	44
Loans received	4,430	1,000
Repayment against loans (Capital and Interest)	(240)	(390)
Net cash inflow/(outflow) from financing activities	2,738	(800)
Total movements in cash and cash equivalents	(4,527)	(1,204)
Opening Cash balance	10,056	5,529
Closing Cash Balance	5,529	4,325

FINANCIAL RISK RATINGS

An analysis of the Trusts Continuity of Service Risk Ratings resulting from the plan is shown below in table 34.

Table 34 – Revised Financial Risk Ratings 2014/15

Risk Factor	*Planned Score 2014/15*	*Planned Risk Rating 2014/15*	*Planned Score 2015/16*	*Planned Risk Rating 2015/16*
Liquidity Ratio (days)	-5.80	3	-8.40	2
Capital servicing capacity	1.93	3	1.96	3
Overall Score		3		3

The Minimum requirement under the compliance framework is to deliver an overall risk rating of 3 or greater. Each rating carries a 50% weighting and final results are rounded up. The ratings now work on a range of 1 to 4 with 4 representing the least risk and 1 representing the highest risk.

To understand the sensitivity against the Trusts compliance with its provider licence table 35 below indicates the clearance against the targets for the risk ratings in 2014/15;

Table 35 – Risk rating sensitivity 2014/15

Risk Factor	*Planned Risk Rating 2014/15*	*Planned Score 2014/15*	*Minimum score*	*Financial clearance £'000*
Liquidity ratio	3	-5.80	-7	600
Capital servicing capacity	3	1.93	1.75	675
Overall CoS Rating	3			

The financial clearance figures indicate that in order to deliver a financial risk rating of 2 under the existing continuity of service, the Income and expenditure position would have to deteriorate below the plan by £675K, at which point both indicators would fall to a level 2 giving an overall rating of 2.

SENSITIVITY ANALYSIS

The Plan detail so far highlights the anticipated position, but also highlights a number of risks. Table 36 below provides an analysis of the potential worst and best case scenario's taking into account the risks identified.

Table 36 – best and worst case scenario analysis 2014/15

	Best Case £'000	*Worst Case £'000*
Anticipated Income & Expenditure position excluding exceptional items	188	(31)
Risk adjustments		
Delivery of CQUIN and quality targets	200	(1,000)
No winter funding available	0	(650)
18 Week failure by 2% on admitted	0	(500)
Cdiff target missed by 10 cases over plan	0	(100)
Achieve full Best Practice Tariff	400	0
Additional CIP and productivity delivery	500	(1,000)
Slippage on investments	500	0
Total risk adjusted sensitivity	2,388	(3,281)

As can be seen from the table above the financial position, if there is a shortfall on the cost improvement targets, coupled with a failure to meet national standards and the Commissioners quality expectations will be challenging.

The most notable risks are associated with:

- The reliance on winter funding to support additional capacity during the winter months.
- the CIP delivery
- CQUINs Delivery, as yet the schedule of schemes and associated monies has yet to be agreed for the local schemes.

Opportunities exist in respect of improving the Trusts position against best practice tariffs therefore attracting further revenue.

MITIGATION ACTIONS

The sensitivity analysis highlighted in Table 36 is challenging and detailed plans to mitigate this level continue to be developed, however should these risks begin to materialise, then the following outlines areas for mitigation:

1. Closure of beds, this would require discussion with commissioners and would be supported by effective, swift utilisation of funding in the community to manage demand. The key risk is that beds are closed and activity continues with a knock on impact on the Trusts ability to deliver the elective activity resulting in lost income and failure to hit national standards.
2. Vacancy Freeze. The Trust is already operating a stringent vacancy control process for all non patient facing posts, this would continue to apply.
3. Freeze on investments highlighted in section 10
4. Curtailment of the Capital programme to maintain liquidity. The key impact would be on the IT strategy implementation as the Theatres project scheme in 2015/16 has significant opportunity costs if not completed.
5. System reconfiguration. This would require acceleration of the collaborative partnership strategy with UHNS, although the early release of resources in 2014/15 would be unlikely without further investment and commitment from all parties. Acceleration of the work of the Provider Board and Integrated Community Teams would also be required.

1.4 Appendices: commercial or other confidential matters

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