Operational Plan Document for 2014-16

University Hospital of South Manchester NHS Foundation Trust

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

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

Name	**Dr. Attila Vegh**
Job Title	**Chief Executive**
e-mail address	**attila.vegh@uhsm.nhs.uk**
Tel. no. for contact	**0161 291 2023**
Date	**31 March 2014**

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 *(Chair)*	Felicity Goodey

Signature

Approved on behalf of the Board of Directors by:

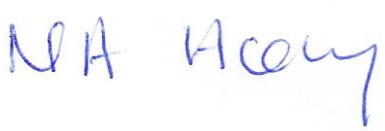
Name *(Chief Executive)*	Attila Vegh

Signature

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	NoraAnn Heery

Signature



Glossary of Terms

A&E	Accident & Emergency
APR	Annual Plan Review
CCG	Clinical Commissioning Groups
CIP	Cost Improvement Programme
CLRN	Comprehensive Local Research Network
COSRR	Continuity of Service Risk Rating
CPD	Continuing Professional Development
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
EPIP	Emergency Pathway Improvement Programme
EPR	Electronic Patient Records
EPRR	Emergency Planning Resilience and Response
GM	Greater Manchester
HEENW	Health Education England North West
HR	Human Resources
ICU	Intensive Care Unit
IM&T	Information Management and Technology
ITFF	Independent Trust Financing Facility
KLoEs	Key Lines of Enquiry
KPI	Key Performance Indicators
LHE	Local Health Economy
LLLB	Living Longer Living Better
MAHSC	Manchester Academic Health Science Centre
MRSA	Meticillin-Resistant Staphylococcus Aureusis
NICE	National Institute for Health and Clinical Excellence
PCT	Primary Care Trust
PFI	Private Finance Initiative
PMO	Programme Management Office
RAG	Red Amber Green
R&D	Research & Development
RPI	Retail Prices Index
RTT	Referral-to-Treatment
SPA	Supporting Programmed Activities
SLR	Service Line Reporting
UHSM	University Hospital of South Manchester NHS Foundation Trust

1. Executive Summary

This two year Operational Plan covering the period 2014/15 - 2015/16 focuses on UHSM's recovery programme to achieve financial stability and to allow the Trust to lay the foundations for a strategic plan going forward. The Operational Plan is comprised of four components which are summarised below.

1.2 Financial Recovery Programme

The Trust faces significant financial challenges over the medium term due to a historically weak liquidity position, along with a poor debt service metric as the Trust has proportionally more debt to service due to the PFI. This results in an overall weak Continuity of Service Risk Rating (CoSRR). The financial recovery programme will deliver financial stability over the coming two years.

(i) Deliver sufficient cost improvements to offset financial pressures so that a stable CoSR Rating is achieved.

The programme will deliver sufficient CIPs (totalling £50m over the next two years) to fully off-set the projected efficiency requirements in 2014/15 and 2015/16. This assists the Trust in maintaining its liquidity position in the short term. The Trust recognises that the CIP programme represents a significant step change from prior years. The scale of the programme is significantly increased from the 2013/14 level of £19m. Additionally the type of planned CIPs is significantly different with a recognition of the need to deliver transformational schemes which require new ways of working across the Local Health Economy (LHE).

The CIP plan has therefore been subject to extensive internal and external scrutiny to ensure that it is deliverable in full. The Trust has obtained external professional service support in the CIP scheme design and delivery. This includes a detailed bottom up piece of work to define the CIP schemes in detail, followed by a high level benchmarking exercise to confirm the efficiency opportunity.

Due to the importance of delivering the financial recovery programme in full, the Board of Directors have implemented a number of key enablers. Although significant savings are being planned, the Trust is planning to invest c. £8m over the next two year period to ensure the delivery of the CIPs. This includes investment in IT and business intelligence systems such as Service Line Reporting, performance dashboards and the planned investment in an Electronic Patient Records system. The Board of Directors have oversight and ownership of the recovery programme and the Executive Team are accountable for its delivery. Clinical engagement has been strengthened through the appointment of three senior practicing clinicians as Divisional Directors who also attend all Board meetings. A Programme Management Office has been established and this function will play an important role to ensure the programme objectives are achieved. The Trust's governance structure including risk management processes and the performance management framework have been refreshed.

(ii) Ensure sufficient liquidity to maintain operations at all times

The plan will deliver a positive cash position at each quarter end. This will be sustained in the medium to long term by finalising arrangements for a £25m loan over an eight year period with the Independent Trust Financing Facility (ITFF) and by arranging a 30 day working capital facility to smooth cashflow issues. The application was agreed in principle following consideration by the ITFF in January 2014 and is subject to formal confirmation.

The Trust's financial projections for the two year period are summarised in **Table 1.**

Table1

	2013/14 (Forecast Outturn)	2014/15 Plan	2015/16 Plan
Income	488.2	450.8	420.6
Expenditure	(467.2)	(425.7)	(394.1)
EBITDA	21.0	25.1	26.5
EBITDA %	4.3	5.6	6.3
Net Surplus	(1.6)	0.0	1.0
Exceptional Items	2.2	1.9	1.1
Normalised Surplus	0.6	1.9	2.1
Cash	59.5	30.4	31.3
CoSRR	2	2	2

1.3 Quality

The Trust's quality is generally high, however there are specific areas where the Trust has implemented key changes in order to improve or maintain quality. The quality plan is based on ensuring that the Trust maintains high quality, safe staffing levels in response to Keogh and CQC requirements.

(i) Quality Impact Assessment of CIP

The Trust recognises that the scale of the financial challenge potentially increases the risk to quality over the coming two years. All CIP plans have therefore been defined by clinicians within the Trust and the financial recovery programme has been quality impact assessed by a multi professional Clinical Advisory Panel, chaired by the Medical Director and Chief Nurse to sign off the impact assessments prior to approval of the recovery programme by the Board of Directors. This will ensure that patient care is not adversely affected and this process will continue through implementation of the financial recovery programme.

(ii) Mortality

Mortality has previously been identified as a risk given elevated mortality rates in 2012/13. Progress on this issue has already been made resulting in significant improvements in mortality measures. This plan builds on the work to date and defines the outstanding actions which need to be taken.

(iii) CQC

The Trust had a dementia themed CQC review inspection in February 2014 and it is indicated that the

Trust will receive a compliance action with a moderate impact. Following this inspection, work has been undertaken to continue to implement the Trust's dementia action plan and this has been highlighted as a key quality goal. An action plan Is in development and on formal publication of the CQC report a finalised plan will be presented to the Board and monitored by the Trust's Quality and Assurance Committee.

(iv) Infection prevention - C. difficile

Due to its variability, this C. difficile target remains a recognised risk within the Trust, however the Trust does have a good track record in achieving this target and therefore this has not been declared formally as a risk within the plan.

(v) Capital investment

The Trust recognises that significant investment is required annually to ensure that equipment and facilities are maintained to a safe standard. Whilst the weak liquidity position is challenging, the Trust is investing in its estate and equipment at levels greater than depreciation over the two year plan.

(vi) Assurance

The Board of Directors receives assurance of the quality of its services through a number of ways. This includes a monthly dashboard of quality and performance indicators, a ward accreditation scheme, patient stories, patient safety walkrounds and internal/external audit assurance. The Trust has in place a Quality and Assurance Committee chaired by a Non-Executive Director. Together with other implemented actions, this will provide scrutiny of the quality of services within the Trust and enable exceptions to be reported to Board and actions tracked, in a robust manner.

1.4 Operational performance

The key operational risk for the Trust is that the anticipated growth in activity (particularly non elective demand) exceeds the Trust's available capacity, given the substantial efficiency programmes being planned. The Trust is therefore planning to mitigate this risk through working closely with partners to manage demand, delivering a recovery plan for the A&E 4-hour target, building capacity where required, and by reducing length of stay or improving discharge. The key areas are:

(i) Clearly understanding demand and required capacity

The Trust has undertaken a detailed modelling exercise of demand and capacity in key services over the plan and corroborated this work with CCGs. This has formed the basis for projected demand assumptions in the plan and the requirement for beds, staffing levels and physical space.

(ii) Working closely with CCGs and Local Authorities

Demand management is critical to ensure that demand does not overwhelm the available capacity at the Trust, particularly in winter on the non-elective pathway. The Trust has therefore been working with Clinical Commissioning Groups (CCGs) on deflection schemes designed to reduce non-elective admissions through integrated care neighbourhood schemes and the Living Longer Living Better programme. These schemes are partially funded by CCGs and the Better Care Fund over the two years 2014-16 and have involved extensive engagement with the CCGs and the Local Authority.

(iii) A&E

Delivery of the 4 hour emergency access target has been a significant challenge for the Trust in 2013/14 and is a key workstream for improvement going forward. UHSM has an Emergency Improvement Plan in place, which focuses on the following work streams: discharge, urgent care, stroke, ambulatory care and

integrated-care development. Performance is regularly monitored through the Trust's Operational Board as well as through the formal performance review process. Models of Care are being redesigned internally to ensure that patients spend the shortest amount of time in hospital. The planned expansion of the Emergency Department in 2015/16 will align with the new models of care and will provide additional capacity within the two year plan period. The Trust works closely with its external partners in a regular system wide Urgent Care Board and in the creation of new integrated patient pathways designed to prevent hospital admission wherever appropriate.

(iv) Expansion of capacity

New developments and initiatives will also offer additional capacity over the two year period. This includes the construction of a new hybrid theatre in 2015/16 to meet the anticipated demand for vascular surgery and the expansion of cardiac imaging facility in 2015/16.

1.5 Positioning the Trust strongly within the local health economy

Within the two year period, the NHS and Local Health Economy (LHE) will face difficult challenges. The landscape of the NHS is changing and similar to other providers, the Trust faces forward challenges that will require new ways of working and the development of new service delivery models. With an ageing population and increased life expectancy, a shift in disease away from life-threatening conditions to long-term conditions and reduced future funding levels the NHS will be expected to provide more for less. The Trust recognises that the two year plan must position the Trust strongly within the local health economy so that it can meet its longer term strategic challenges. The key plans are described below:

(i) Better Care Fund

The Better Care Fund creates a significant financial challenge for commissioners and providers due to the shift of resources from health to social care and the transitional challenges associated with this movement.

However it will also be an important enabler for the integrated care agenda. The LHE will need to work collaboratively to achieve the anticipated outcomes and make best use of this pooled funding. This will result in a shift in provision away from the acute setting and maintaining more patients in the community setting. The fund will become increasingly significant from 2015/16 when £3.8billion of national NHS resource will be pooled with Social Services. The LHE has responded to this challenge through the Living Longer Living Better programme and the Trust will continue to be an active participant in both the short and long term through the development of new service delivery models aimed at embedding out of hospital care with a funding contribution from the Better Care Fund. Within the two year period, in South Manchester, the Trust and it partners have agreed that the priority focus will be upon frail older people, adults with dementia and end of life care and a business case has been agreed for investment of over £2million from 2014/15.

(ii) Healthier Together

Within Greater Manchester, the Healthier Together programme aims to address the dual challenges of improvements in clinical standards and the delivery of consistent high quality care across the LHE whilst doing so on a long term financially sustainable basis. The Southern Sector partnership has been developed to provide a collaborative model of hospital services across East Cheshire, Stockport, Tameside and South Manchester and is a direct response to Healthier Together. The initiative has the potential to offer significant opportunities for improvements to patient care, systems and processes leading to measurable benefits. Progress in the next two years is planned to include the appointment of a Southern Sector Medical Director, a review of back office support to be completed and implemented, and

business cases for Level 1 clinical workstreams to be submitted and considered for approval. This will build on the progress achieved to date in Pathology and R&D.

(iii) Specialist Services

A challenge exists over the five year period where specialist commissioning is expected to consolidate into centres of excellence. This will additionally create an opportunity for the Trust. The Trust will respond positively building on its strengths and capability, particularly in respect of its specialist clinical services in cardiac, respiratory, burns and cancer services. Investment will be made over the two year period in respiratory and cardiac clinical services which are commissioner endorsed. This will help to strengthen the Trust's position and to establish itself as a Centre of Excellence in these specialist clinical services.

2-6 Operational Plan

(2) The short term challenge

This section provides the background and context to the challenges ahead. It will then outline the 2014/15 corporate objectives, further define the challenges within the local health economy (LHE) and discuss how these will be addressed.

2.1 Background and context

The NHS is facing unprecedented challenges in both the short and long term – future funding reductions will mean that the NHS will be expected to provide more for less. The landscape of the NHS is changing and similar to other providers, the Trust faces forward challenges that will require new ways of working and the development of new service delivery models. In order to continue to provide high quality patient services the Trust will need to adapt its offer accordingly. This two year Operational Plan will define the short term challenges ahead, outline how they will be addressed and discuss the foundations being made to deliver the longer term transformational change required in the LHE.

2.1.1 Demographic and health needs challenges for Greater Manchester

Within the LHE, there are a number of significant challenges. Manchester and its local area have some of the worst health outcomes and premature mortality rates in the country as detailed in **Table 2**.

Table 2 – Manchester Health Outcomes (Source South Manchester Clinical Commissioning Group (CCG) commissioning intentions letter 07/10/2013)

Cause of death	Premature mortality rate per 100,000[1]	Ranking (2009-11)	
		All local authorities	Similar local authorities
All causes	455	150th (out of 150)	15th (out of 15)
Cancer	151	150th (out of 150)	15th (out of 15)
Heart disease and stroke	115	150th (out of 150)	15th (out of 15)
Lung disease	51	148th (out of 149)	14th (out of 15)
Liver disease	30	148th (out of 149)	14th (out of 15)

In addition, several challenges within the LHE have been identified through the integrated care agenda and Living Longer Living Better (LLLB) programme. These are:

- **A shift in burden of disease away from life-threatening conditions to long-term conditions (LTCs)**: South Manchester has a slightly higher proportion (14%) of older people than the city as a whole and high prevalence of LTCs amongst adults registered with South Manchester GPs.
- **An aging population, with increasing life expectancy, and yet persistent and in some cases widening inequalities:** Within South Manchester life expectancy varies considerably across wards with a gap of eight years between Didsbury East and Sharston.
- The Index of Multiple Deprivation (IMD) 2010 indicates that South Manchester has **levels of deprivation substantially below the city average**; however, there are greater differences across wards within the area.
- **Rising patient and public expectations.** Patients expect to be offered choice and variety and to experience services that are convenient, personalised and provided in modern buildings and healing environments.

- **Financial sustainability for health and social care**: In South Manchester, within the context of growth in demand for services, an ageing population, technological developments in healthcare, and other economic pressures, such as inflation, underline the importance of securing a better health and social care return for each pound of investment.

2.1.2 Impact of the Better Care Fund

As the demand for health services grows, the ability of providers and CCGs to meet this demand will be constrained by future reductions in the funding envelope - there is an urgent need to focus on out of hospital care. In England, there is a national requirement to bring significant amounts of local funding together to integrate the commissioning of health and social care under the Better Care Fund. It is recognised that the fund will become increasingly significant from 2015/16 when £3.8billion of NHS resource will be pooled with Social Services. This means that an additional 2% of local CCG funding allocations will be transferred to Social Services by 2015/16. This represents a significant challenge and reinforces the need for NHS providers to work collaboratively with commissioners and local authority providers on out of hospital models of care. If these arrangements fail this will represent an additional operational and financial burden for the NHS in what is already a difficult landscape.

2.1.3 Healthier Together

Within Greater Manchester (GM), this programme aims to address the dual challenges of improvements in clinical standards and the delivery of consistent high quality care across the LHE whilst doing so on a long term financially sustainable basis. The programme has the following specific objectives:

- To see a substantial reduction in avoidable admissions to hospital and other care institutions and a significant improvement in outcomes from hospital services.
- With the ongoing care of people with multiple long term conditions the Health and Social Care system needs re-balancing to shift provision from hospital to community, primary, social and self-care. In addition, access to specialist care needs to be improved across the LHE to help attain the required national quality standards, improve outcomes and access.
- The current organisation of service provision across GM is not financially sustainable. The case for change is predicated on 'doing nothing is not an option' with future changes required to deliver financial sustainability – a financial gap of almost £1 billion across the GM health economy is estimated by 2017/18 in a do nothing scenario.

There are three GM programmes of reform that are contributing to the objectives outlined above:

(1) Healthier Together, which focuses on hospital reconfiguration and on three clinical workstreams. These are (i) urgent, emergency and acute medicine, (ii) emergency general surgery (iii) children's and women's services. UHSM is fully participating in these workstreams. The programme will potentially lead to hospital reconfiguration, however this will not be achieved within the next two years. The Southern Sector partnership is the Trust's response to Healthier Together to ensure that the requisite clinical standards are met along with striving to ensure financial sustainability – this will be expanded on in section (2.3.1).

(2) Integrated Care - local models of care are being developed to move resource from acute services and into community based services as outlined in (2.1.2).

(3) Primary Care – work is progressing between partners to develop a Primary Care commissioning strategy for GM and to enhance the provision of Primary Care services on a consistent seven day a week basis.

2.1.4 Strategic Planning

Monitor, Trust Development Authority and NHS England have identified the need for improvements in the quality of strategic planning across the wider NHS. In recognition of this. a five year strategic plan will be submitted to Monitor by 30 June 2014 outlining the Trust's long term plans to address the challenges ahead and deliver the transformational change required across the LHE. Monitor has recently confirmed that the organisations in the Southern Sector will receive external support in this process. The Trust welcomes this additional resource. The support will facilitate the bringing together of partners in the LHE and act as a critical friend in the process, thus helping to produce an integrated five year strategic plan that delivers high quality services on a sustainable basis.

2.2 UHSM's Corporate Objectives for 2014/15

UHSM's vision remains to be one of the leading healthcare providers in the NHS. With services provided to over 500,000 patients per annum, it is valued by its local community and by patients who travel from further afield to receive specialist services. In recognition of the short term challenges across the LHE and in response to these (to be further defined in this section) the Board of Directors has agreed a set of corporate objectives. Within these, four high level themes have been agreed and are based around the NHS Outcomes Framework and the financial recovery programme. A further 14 corporate objectives have been identified across the themes (see section (7)). A number of Key Performance Indicators (KPIs) have been defined to help inform if the Trust is on course to deliver the programme. Performance will be monitored through a performance dashboard and the objectives and KPIs further revised and amended for year two of the Operational Plan. The high level themes for 2014/15 are:

(1) Quality and Safety – *to provide a safe and high quality clinical service for our patients*

(2) Financial Stability – *to achieve financial stability through delivery of a financial recovery programme*

(3) People and Processes - *to enhance patient experience and Quality of Care by ensuring we have the right people, in the right place, at the right time, with the right skills and attitude*

(4) Partnerships – *to work effectively with our strategic partners*

The Trust continues to engage closely with its Governors within the annual planning cycle to ensure that the views of the Council and considerations of the Trust's members and the local community are represented in forward plans. A Governor-led Annual Plan Advisory Committee meets monthly during the APR process and plays an important part in influencing and challenging the organisation's objectives and their associated measures. Governors are regularly engaged on the development of recovery plans to ensure they are understood and to provide opportunities for feedback. The Council will continue to be provided with regular briefings about the progress of the Trust's plans to make sure that the interests of members and the public can be represented. Going forward, the Governors will have a crucial role in supporting the organisation to achieve stability over the next two years, and for the Trust become a sustainable leader in the long term.

2.3 The short term challenge over the next two years and programmes to address the challenges

Together with its partners in the LHE, the Trust has engaged in a number of significant programmes of work to address the challenges ahead. Methods of engagement include the commissioning intentions process, the development of collaborative models with other providers and joint working with LHE organisations on integrated care programmes. These are different programmes and at various stages, however they all share the same common purpose – to improve patient care and deliver high quality patient services on a sustainable basis. The challenges and responses are as follows:

2.3.1 Commissioning

(i) Local CCGs - Integrated Care/Out of Hospital Care/Better Care Fund

Locally, the integrated care agenda and the Better Care Fund are important commissioning issues that create both opportunities and challenges ahead. The Better Care Fund creates a significant financial challenge for commissioners and providers due to the shift of resources from health to social care and the transitional challenges associated with this movement. However it will also be an important enabler for the integrated care agenda. The LHE will need to work collaboratively to achieve the anticipated outcomes and make best use of this pooled funding. This will result in a shift in provision away from the acute setting and maintaining more patients in the community setting. The LHE has responded to this challenge through the Living Longer Living Better (LLLB) programme. Across the City of Manchester, UHSM is one of eight organisations who are taking a strong collaborative approach to developing new delivery models with local residents, local voluntary and community providers, acute trust providers, social care, CCG's, GPs and patient representative groups pioneering the delivery of integrated care at scale for the patients with the highest needs. The programme seeks to shift care out of the hospital and improve local health and wellbeing outcomes and will lead to the following benefits:

- Reduce admissions into residential care.
- Improve patient and carer experience.
- Reduce attendances to A&E and hospital admissions.

In South Manchester, the Trust and it partners have agreed that the priority focus will be upon frail older people, adults with dementia and end of life care. A business case has been agreed for the Better Care Fund 2014/15. The following areas have been highlighted in the business case for implementation in 2014/15:

- Rollout of the EMIS web system to all community staff to enable shared records across teams.
- Development of the Neighbourhood Teams project to provide an enhanced service which will include providing specialist geriatrician and nursing support to GPs.
- Implementation of a frailty tool to support primary care practitioners in early identification of people who are frail. This tool will be utilised by staff, service users and carers.
- The development of a co-ordination referral point for community services.
- Expansion of a community palliative care team to provide comprehensive care during the out of hour's period.
- The Trust will work with commissioners and partners to develop further delivery models for patients with long term conditions and patients with complex needs.

During 2014/15, UHSM will work with partners from provider organisations which will include the South Manchester GP Federation, the Manchester Mental Health and Social Care Trust and Manchester City Council to determine how they may form an alliance model of working. This will provide a stronger basis for developing integrated care with commissioners in 2015/16 and beyond by continued collaborative working with partners for developing strong business cases to access the Better Care Fund in 2015/16.

The programme is a long term initiative and will significantly impact on the health and social care system over the next five to ten year period and as such will be further discussed within the strategic plan document. The impact of this scheme in respect of activity and financial considerations will be further expanded on in section (4) and sections (6) and (7).

(ii) Healthier Together and Southern Sector Partnerships

In recognition of the future challenges within the LHE, the Southern Sector partnership has been developed to provide a collaborative model of hospital services across East Cheshire, Stockport, Tameside and South Manchester and is a direct response to Healthier Together. A Memorandum of Understanding has been signed between East Cheshire NHS Trust, Stockport NHS Foundation Trust, Tameside Hospital Trust NHS and UHSM to take this initiative forward. The collaboration will deliver patient services to a community in excess of 1.1 million and presents a significant opportunity to provide new delivery models on a sustainable basis and achieve the transformational change required across the NHS. The collaboration encompasses a review of clinical delivery models and of sharing support functions across all four organisations. The four trusts have a combined turnover of c. £1.2 billion**,** with staff numbers in excess of 17,500. The initiative has the potential to offer significant opportunities for improvements to patient care, systems and processes leading to measurable benefits.

The partnership has already achieved productivity gains through its joint approach in pathology and has been strengthened with the appointment of a PMO to drive collaboration and integration. Two clinical congress meetings have been held with good engagement and positive feedback received. Progress in the next two years is planned to include:

- Appointment of a Southern Sector Medical Director in 2014/15.
- Review of back office support to be completed and implemented during 2015/16.
- Business cases for Level 1 clinical workstreams to be submitted and considered for approval – these include; urology, emergency department & acute medicine, trauma & orthopaedics, acute general surgery, paediatrics, pharmacy and radiology.
- Pathology – build on the progress to date - including the estates enablers required to allow the core disciplines of pathology to transfer from Stockport and Tameside, to be centralised at UHSM.
- R&D – the majority of studies active at UHSM will be open and recruiting at the Southern Sector partner sites (and vice versa) having been approved via UHSM's central office.

Although the full impact of this initiative will be realised in the long term, it is important that key milestones and decisions are made within the two year Operational Plan period to deliver the longer term objectives. The Trust and its partners will continue to help shape the future provider landscape over the next five years in response to Healthier Together. During the two year plan period, the Trust will be an active participant within the planning and implementation phases of the programme. A public conversation is currently being held for Healthier Together with formal consultation expected in summer 2014.

(iii) Specialist Commissioners

The Trust receives 30% of its clinical income from NHS England for the specialist services it provides – therefore strong relationships are required with specialised commissioners. For UHSM, this is via Wirral, Warrington and Cheshire Local Area Team. NHS England guidance recommends a need to significantly reduce the number of specialist services providers into concentrated centres of excellences, with around 15-30 centres expected. This will help to achieve consistent standards of care and maximise synergy from research and learning. Academic Health Science Networks are expected to play an important role over the next five years. The reduction is not expected to impact in the next 12 month period, however the Trust will respond positively and build on its strengths and capability, particularly in respect of its specialist clinical services in cardiac, respiratory, burns and cancer services.

A number of priority areas have been identified at a national, regional and local level for 2014/15. The Trust will engage with commissioners and respond to these reviews and initiatives as appropriate. The areas relevant to the Trust are Burns care (National review), HIV Commissioning (North West priority), Major Trauma, (North West priority). Cancer IOG Compliance (Greater Manchester priority) Vascular

Services (Greater Manchester priority) and Cystic Fibrosis (Greater Manchester priority). UHSM will be making investment over the two year period in respiratory and cardiac clinical services which are key areas of specialist strength for the Trust. These investments are commissioner endorsed. A new cardiac imaging facility will be developed through collaboration with Alliance Medical. Within respiratory, expansion of the following services will take place during 2014/15:

- Interstitial Lung Disease.
- Bronchoscopy unit expansion in partnership with the Medical Evaluation Unit.
- Severe Asthma service.
- Adult Long term Ventilatory Service (non invasive and invasive tracheostomy).

This will help to strengthen the Trust's position and to establish itself as a Centre of Excellence in respect of cardiac and respiratory specialist clinical services.

2.3.2 The Trust's Recovery Programme

UHSM faces a number of significant short term challenges, these are:

- **Patient Quality and Safety –** the Trust experienced an increase in mortality rates over the period 2012-13 – this is being addressed and the Trust's mortality rates are currently tracking below the peer average (i.e. better than). Detailed reviews of each mortality were undertaken to assess whether any preventable factors and to seek lessons for learning and dissemination as referred to in section (3.2). Operationally, the Trust has struggled to meet the 4-hour A&E targets especially in Q3 and Q4 in 2013/14 and this is the focus of the remedial action plan. The Trust is strengthening its response to quality governance issues in a number of key areas which are described in this plan.

- **Financial Recovery –** the Trust needs to implement a £50m CIP programme over the next two years in order to maintain financial stability and achieve a compliant Continuity of Service Risk Rating (CoSRR). Additionally the Trust requires external loan financing of £25m and a Working Capital Facility to maintain adequate liquidity.

- **Systems and processes** - the Trust manages its patient records via a paper based system – this is outmoded. Improvements are required in the standardisation of procedures, the coding of patients healthcare requirements and the need to improve the standard of technology and systems used to support patient care – this includes poor access times, inconsistent printing facilities, requirement to log-in to multiple systems and unplanned network outages.

In October 2013, a review of the 2013/14 annual plan (APR2) was commissioned by Monitor. This was due to concerns regarding financial stability. The review was undertaken by PWC on behalf of Monitor and highlighted several priorities specific to financial recovery:

- The need to develop a two-year recovery programme, including a diagnostic assessment of the size of the financial opportunity available to the Trust.
- Immediate increase in the pace of 2014/15 CIP development.
- Setting up a Programme Management Office (PMO) to support transformational CIP implementation.

Arising from the APR Stage 2 review, in December 2013 Monitor launched a formal investigation to determine if the Trust has breached its provider licence. The investigation focused on the Trust's financial position – with a review of the Trust's short term finances and to ensure financial stability. An Investigation Meeting between the Trust Board and Monitor took place at the end of February 2014 to

review the Trust's recovery programme and a decision on whether the Trust is in breach of its licence is expected by the end of April 2014.

To address the short term challenges the Trust embarked on a recovery programme to achieve financial stability and make improvements to the quality of patient care. Savings of £50m are required over the course of 2014/15 and 2015/16 and at the same time safeguarding the quality of patient care. The programme has been developed within the wider context of future reductions in funding and the transformational change required across the LHE. The recovery programme was submitted to Monitor in January 2014 and the two year Operational Plan is closely aligned to this.

Further details of the recovery programme and associated workstreams are provided in provided in section (5). To supplement the recovery programme, the Trust has put a number of robust systems, processes and enablers in place:

- The Board of Directors will have oversight of the recovery programme, own it, and be closely involved with delivery. The Board has appointed three leading clinicians as Divisional Directors to own and lead the recovery in their Divisions and attend all Board meetings. This will help to further strengthen clinical engagement and leadership.
- The Executive team will be accountable for delivery of the plan and will continue to provide the right leadership to realise the financial and non-financial benefits.
- A review of the Trust's governance structure including risk management processes, corporate/divisional meetings structure and the performance management framework. This is to support Service Line Management in the revised leadership structure.
- Backfilling of the Medical Director and Chief Operating Officer positions who are currently in a buddying arrangement with Tameside Hospital and appointed a Head of Communications and Engagement.
- All CIP schemes have undergone a quality impact assessment as outlined in section (3.2).
- The creation of a 'best practice' PMO staffed with experienced project managers to provide a clear monitoring function of Trust-wide and transformational change programmes through standardised performance reporting and assurance of delivery as outlined in section (5.2).
- Clinicians and a wide range of other staff have been engaged throughout the recovery planning process and will lead the transformation going forward through the development of a Guiding Team.
- Human Resources will support the programme and provide leadership and organisational development and training.
- Building capability and engagement is key to delivering the recovery programme and will be done through in-sourcing expertise and taking a multi channelled communication approach.
- Launch of a change champions and bright ideas initiative.

Business Intelligence and IT

The Information Management and Technology strategy is underpinned by infrastructure investment. These measures will help to ensure continued improvement in operational efficiency and that front line staff have the right and reliable IT infrastructure to enable them to execute their jobs. An action plan has been developed to address the IT challenges, this includes:

- Refreshing the entire UHSM data network to improve speed.
- Refreshing every desktop PC.
- Developing a facility for patients to access the hospital wireless network.

The Trust recognises the benefits that an electronic patient records (EPR) system can deliver in terms of patient information, enhanced patient level details to support better clinical decision making, integrate care pathways across primary and secondary care and strengthened analytics so the Trust understands its core business better. The Board of Directors has approved the decision to proceed to a procurement phase based on the condition that a joint procurement initiative is pursued with the Southern Sector partners. This will lead to significant value for money benefits. Procurement will commence in 2014/15 with implementation expected in 2015/16.

Progress will be further developed on the implementation of Service Line Reporting (SLR) and the potential for the Trust to move to the next stage, which is an automated Patient Level Costing system. A team has been established to drive this important initiative forward with implementation planned in 2014/15. Management reporting and information will be enhanced by the implementation of an automated performance dashboard with real time information and full drill down capability.

2.3.3 Commercial opportunities to diversify and other partnerships

As future levels of NHS funding are expected to reduce, diversification of income streams from non-traditional sources will help protect from such reductions. The Trust recognises the importance of developing strategic partnerships and will further build on the progress made in previous years with both public and private partners. Such partnerships are necessary to drive the transformational change required.

(i) MediPark

2014/15 will see continued progress on the MediPark initiative. The concept presents a significant and unique opportunity to develop a world class biosciences and healthcare enterprise linked to UHSM. The Medipark forms part of a wider cluster of businesses, academic institutions and hospitals situated within the South Manchester 'Corridor'. Together these represent an internationally important cluster of expertise and in consequence MediPark can be the catalyst for economic growth and employment at the heart of the Greater Manchester conurbation. During the latter part of 2013/14 a joint venture vehicle in the form of a Limited Liability Partnership was established between UHSM and local development company Bluemantle. This will focus specifically on the development of the parcel of land at the southeast corner of the site known as the Baguley Quarter. Masterplanning work is underway that anticipates the area being cleared of existing functions and replaced with new buildings, notably for the creation of a commercial hub linked to education and training, albeit this will be achieved over the medium term. Within the two year operational period, 2014/15 is expected to see planning approval submissions for the Baguley Quarter, the commencement of the decanting of existing functions and agreement with the first commercial tenants. 2015/16 should see the first developments taking shape immediately adjacent to the Education and Research Centre. In August 2013, UHSM entered an "exclusivity period" with a private hospital provider. During the early part of 2014/15 this is expected to result in a formal agreement to develop a new private hospital linked to and working in collaboration with UHSM. This will bring a number of benefits including a share of the financial turnover of the venture. It is anticipated that construction of the new facility will commence in 2015/16. However there is a strong likelihood of certain services commencing before then subject to the investment of capital resources by the private provider.

(ii) Medtronic and other partnerships

In 2013, the Board approved the contract for a managed service with Medtronic for the provision of Catheter Laboratory services in support of Cardiac Services. The Trust is now working with Medtronic and the refurbishment of the catheter labs is underway. Other innovative health care and education model partnerships are being discussed. The Trust's partnership with Alliance Medical will continue and

an agreement has been reached to develop an expanded cardiac imaging centre which is expected to be operational in 2015/16.

(iii) Research and Development (R&D)

Across the Southern Sector, strong management and clinical relationships in R&D have been formed via a network approach and a central office managed by UHSM. Main areas of activity continue to be breast cancer, cardiovascular and respiratory where the Trust is globally recognised, with musculoskeletal and malignant haematology having seen a significant increase in activity. The Trust continues to be a nationally recognised member of the National Institute for Health Research (NIHR) Translational Research Partnership which brings together world class investigators in the UK's leading academic centres with industry in exploratory development of new drugs and other interventions. UHSM for the last six years has successfully hosted the Greater Manchester Comprehensive Clinical Research Network. From April 2014 this network will cease to exist and will be replaced by a much larger research network which will amalgamate all seven networks which currently operate across Greater Manchester. This Local Clinical Network will be hosted by Central Manchester University Hospitals NHS Foundation Trust.

(iv) The Manchester Academic Health Science Centre (MAHSC) Centre for Cardiovascular Services – a new Concordat for Manchester

The Trust has signed a concordat to develop a joint cardiac service within the LHE. The Concordat sets out a new proposal to establish the MAHSC Centre for Cardiovascular Sciences embracing the strong tripartite collaboration of The University of Manchester, Central Manchester University Hospitals NHS Foundation Trust and UHSM. The concordat is built on a shared aspiration for world-class excellence that meets the health needs of the local population through a culture of multidisciplinary collaboration between scientists and clinicians across the respective hospital sites.

3.0 Quality plans

This section outlines the Trust's key quality considerations over the next two year period. Details are provided on The Trust's quality goals, the existing quality concerns and the plans in place to address these. Quality risks inherent in the plan and associated mitigation will be identified followed by how the Board derives assurance on the quality and safety of its services. It will then consider the Trust's response to Francis, Berwick and Keogh and conclude by outlining the workforce quality considerations in the plan. The Trust's key quality priorities over the next two years are as follows:

3.1 Quality goals, as defined by the quality strategy and quality account

Quality and safety are fundamental to the Trust's forward plan and is recognised as such through the overarching theme 'to provide a safe and high quality clinical service to our patients'. Further to this, five of the 14 corporate objectives have identified within this theme. Following on from the previous year's annual plan, the Trust intends to continue to deliver the highest levels of patient care, quality and efficiency by further reducing avoidable harm, providing clinical effective care and improving the patient experience in both hospital and community settings, in conjunction with local, regional and national strategic priorities. For 2014/15 and 2015/16, UHSM's priorities for quality improvement will include the following:

- Maintain safe staffing levels and reporting daily on each ward and monthly to the Board of Directors with clinical staffing levels benchmarked against national guidance.
- Reduction in avoidable harm to patients via monitoring of harm-free care and internal monitoring of specific safety metrics.
- Promoting 'Learning Lessons Once', via participation in a local CQUIN.
- Continue mortality review programme, with an aim of a further reduction in mortality indices and feedback from reviews supports improved practice.
- Development of frail and elderly strategy including dementia to support the integrated care agenda.
- Improve patient experience and quality of care on wards via development of a ward accreditation scheme.
- To utilise patient feedback methods across the hospital and community services, to ensure care and service changes support the needs of patients and carers.
- To continue to implement the dementia action plan and the care environment including colleague awareness and training.

3.2 Existing quality concerns and plans to address them/ Key quality risks inherent in the plan and how these will be managed

Recovery Programme

The Trust faces potential quality challenges over the next two years, due to its financial position and the implementation of the recovery programme. In order to fully understand the quality risks, comprehensive quality impact assessments have been conducted on all recovery programme initiatives. The impact assessment, developed based on National Quality Board guidance, looked at the impact on patient safety, clinical effectiveness and patient experience, and the clinical lead was asked to develop a set of quality metrics in order to monitor the ongoing impact of the recovery initiative. A multi professional Clinical Advisory Panel, chaired by the Medical Director and Chief Nurse was convened to sign off the impact assessments prior to approval of the recovery programme by the Board of Directors. The potential quality challenges have been recorded as a risk on the Trust's strategic risk register and the mitigation to this is the ongoing scrutiny of the recovery programme undertaken at the Quality and Assurance Committee and Board of Directors. The quality impact assessments will be continuously reviewed by clinical staff and recovery leads as the schemes are implemented to ensure that there is not an adverse impact on patient care. This will be overseen by the Trust Quality and Assurance Committee.

Mortality

In 2013/14, reports received from Dr. Foster alerted the Board to an increase in unexpected mortality rates from 2012/13. Work commissioned by the Board of Directors and led by the Trust's Medical Director included a review of coding and also appointment of a clinical mortality review group, so that all deaths were reviewed by a clinical team to look at causes of death and potential preventability index. This work has been ongoing since July 2013, so that every death in the Trust has been reviewed and accurately coded. This has demonstrated significant improvement in reduction of mortality indices in 2013/14. Whilst the mortality reviews did not evidence that there were significant numbers of deaths that may have been prevented, it did demonstrate learning for staff. This work will continue in 2014/15 to further improve mortality indices and to ensure that lessons from mortality reviews support improvements in practice.

Patient Harms

In certain areas, the Trust has seen increased reporting of patient harm e.g. pressure ulcers and falls. UHSM will strive to achieve zero avoidable hospital acquired grade three and four pressure ulcers and a reduction in avoidable patient falls. This will be achieved in 2014/15 by continued working on the harm free care project, the 'Open and Honest' care project and by improving the environment and education programmes. Work will continue with the Trust's planned reduction of C. difficile incidences and will aim for zero MRSA cases. Failure to meet the C. difficile infection target has been flagged throughout 2013/14 as a risk to the Board of Directors. The key focus in 2014/15 will be on antibiotic prescribing.

Nurse recruitment

The Trust has had concerns during 2013/14 regarding the ability to recruit nursing staff. Although this is a national issue, a risk has been logged on the Trust's strategic risk register with regard to meeting the safer staffing requirements, outlined within Chief Nursing Officer report of November 2013 and the forthcoming guidance expected from NICE. In order to mitigate this risk, a nursing staffing/recruitment plan has been developed – this includes a review of all baseline establishments and mechanisms in place to increase national and overseas recruitment. Further national and international recruitments event are planned in May 2014. In line with national guidance, the Trust continues to review and monitor its nurse and midwifery staffing levels and has provided reports to the Board in 2013/14. From April 2014, staffing levels by ward will be published and reported to the Board on a monthly basis. The Trust can draw upon bank/agency staff when needed and associated activity levels will also be monitored.

Dementia Themed Review

The Trust had a dementia themed CQC review inspection in February 2014 and it is indicated that the Trust will receive a compliance action with a moderate impact. However as at the 31st March 2014, as the report has not been received formally or published, there is not a compliance action outstanding to declare**.** An action plan Is in development and on formal publication of the CQC report a finalised plan will be presented to the Board and monitored by the Trust's Quality and Assurance Committee. This has been declared as a key quality goal within the Trust's quality accounts.

3.3 Overview of how the Board derives assurance on the quality of its services and safeguards patient safety

The Board of Directors receive a monthly dashboard, which incorporates quality and performance indicators aligned to the strategic and corporate objectives, with agreed thresholds for performance to monitor the quality of care delivered. The Board also receives a patient story at each meeting and scheduled reports to assure itself on the quality of services within the Trust. Other assurance mechanisms include patient safety walk rounds and receipt of internal/external assurance via audit. The Board utilises this information to assess risks to patient safety and the quality of the services provided. Any issues that are flagged as exceptions have improvement plans put in place, may have an external review commissioned and may be referred to the Audit Committee for an internal audit to be undertaken. This work will continue in 2014/15.

In October 2013, an independent external review of the Trust's Quality Governance Framework was undertaken and a number of actions put in place. This involved a review of the Clinical Leadership model to ensure that Divisional Directors were appointed as divisional accountable officers, revised dashboards and performance processes, and a new risk management process. The Trust has convened a Quality and Assurance Committee chaired by a Non-Executive Director. Together with other implemented actions, this will provide scrutiny of the quality of services within the Trust and enable exceptions to be reported to Board in a more robust way during 2014/15.

To ensure patients have a positive experience of care, the Trust will continue to actively gather feedback by using a number of methods. These include the Friends and Family Test, patient surveys and patient complaints. Patient feedback is valued and will continue to be acted on in a timely manner; lessons learned will be communicated and shared throughout the Trust. A number of indicators have been set to monitor performance. A complaint review board chaired by a Non-Executive Director will continue into 2014/15.

A ward accreditation scheme will be implemented in 2014/15, this aims to improve patient experience and patient safety and provide a level of assurance about the quality of care and standards on wards within the Trust. Indicators will be developed in a number of areas (Clinical Care Management, Patient Experience, Dignity and Respect, Leadership and Training, Infection Control, Safeguarding, Environment and Equipment). Each ward will undergo an assessment against these indicators and a rating will be allocated. Ongoing assessment will then be undertaken for a ward to be/remain accredited. The process will be overseen by the Trust's Quality and Assurance Committee on behalf of the Board of Directors.

Additional quality improvement metrics have been identified, these include an increase in compliance with the surgical site checklist and the publication of consultant outcomes.

The nursing and midwifery team will continue to deliver the 2014/15 actions from the Care and Compassion Action strategy which is based around the national 6 c's of care, compassion, commitment, communication, competence and courage. Examples include the new interview and competency based questions for recruitment, the nurse staffing plans and the patient experience and complaint management training sessions.

3.4 Response to Francis, Berwick and Keogh

The Board of Directors have previously been appraised of actions required within the Trust following the publication of the Mid Staffordshire report. In 2013 the Trust commissioned a mock Keogh review. This involved the production of a data pack by external auditors PwC, which identified Key Lines of Enquiry (KLoEs), together with the additional intelligence from a CEO's staff survey, patient survey and the

listening events that had been conducted across the Trust. Following this, a multi professional team including patient representatives visited the Trust. Actions have been implemented and will continue to do so as previously outlined.

In December 2013, the Board was presented with a quality improvement document, bringing together recommendations from the Francis report, the government's response to Francis, 'Hard Truths', the Keogh report and the Berwick report. This included actions raised as part of the Trust's mock Keogh review. A gap analysis of all recommendations in these key external reports was undertaken and an action plan developed for any areas for improvement. The actions are themed to the CQCs domains of safe, effective, caring, responsive and well led. Some of the more significant actions from this action plan form the quality priorities for the year ahead e.g. ward accreditation, safe staffing, reviewing learning from incidents and rolling out safety initiatives like stop the line. This action plan will be monitored at the Trust's Quality and Assurance Committee.

3.5 What quality plans mean for UHSM's workforce

In order to deliver high quality care and an excellent patient experience, the Trust must recruit and retain the right numbers of staff, with the requisite skills, and uphold the values the Trust believes will make UHSM a leading healthcare provider. To this effect, an overarching 'people' theme together with a number of corporate objectives and KPIs has been agreed.

The Trust employs approximately 6,000 valued staff on a range of contracts; full, part-time, annualised hours who strive to deliver high quality services to its patients. Over 60% of the Trust's expenditure relates to the costs of the workforce - it is therefore imperative the Trust maximises the talents and flexibility of its workforce to ensure high quality and innovative care is given in the most efficient way and at the appropriate location for the patient.

As the Trust embarks on the recovery programme, effective leadership and management skills together with a motivated and talented workforce are required to drive the initiative forward. The following plans have been formulated:

- A process to enable staffing establishments to be met on a shift by shift basis, to monitor and publicise ward nurse staffing levels and to use the most cost effective solutions to cover vacancies. This will be supported by a nurse e-rostering system to be implemented during 2014/15. As part of the recovery programme, consultation has commences with nursing staff in March 2014 regarding changes to working schedules and patterns across wards, reduction of non ward based nurses (20 wte posts) and on the implications of the reduced length of stay project on ward based nursing and roles.

- Effective recruitment strategies for all categories of staff and for difficult to recruit positions, alternative ways of delivering the skills are considered and developed. This is especially pertinent for medical posts within the emergency care pathways. The Trust has recruited interim strategic planning resource from April, to facilitate planning for new roles, encompassing different clinical professions.

- A detailed analysis on the reasons for employee turnover, to ensure the right plans are in place to retain and attract staff. A significant factor to stopping attrition is the need to develop better CPD programmes and the UHSM Academy will help to achieve this.

- Absence management will continue to be a high priority to ensure planned establishment levels are maintained and variable pay costs controlled at budgeted levels. The current maximum target is 4%. In support of this, a new system will be piloted during the year, which will also provide enhanced transparency and accurate real time data and reporting. In support of this, an overhaul of all workforce information systems is underway, together with staff training in difficult conversations.

- Considerable time and resources will be invested in a Trust-wide medical productivity drive as outlined in section (5). The Trust is actively recruiting experienced HR professionals to assist in scoping and driving through such transformational changes in process and behaviour.

Changes to the Trust's workforce over the two year period are outlined in section (4.1).

The Trust's goals can only be achieved through the contribution of colleagues, both individually and collectively. To provide excellent patient care through the best staff will mean changing and developing; structures, processes, systems, management and leadership practices. These will need to be aligned with the organisational climate being worked towards.

The Trust will build on the 'South Manchester Way' to ensure that values are simplified, understood by all, and rooted in daily working practices. Over the next two years they will form part of a revised values and behaviours framework, and new staff will be recruited against these values.

The UHSM Academy brings all of the education and training delivered across the Trust under one umbrella. Within this, mandatory/essential training is key to delivering safe services and the programme will be further developed into 2014/15. UHSM recognises the importance of training all staff in caring for people with dementia and has therefore developed a three tier programme appropriate for all members of staff at any level within the organisation who may interact with patients with dementia - this will be delivered from 2014/15. The UHSM Academy will continue to play a central role in delivering undergraduate medical education across the Southern Sector and is one of only four base hospitals in the north west.

(4) Operational requirements and capacity

This section provides an assessment of the activity and demand pressures and the inputs required (such as physical capacity, workforce and beds) over the next two years. An analysis of the key risks is provided together with how the Trust intends to adjust inputs to match different levels of demand. The section is concluded by discussing the contingency arrangements in the plan.

4.1 Activity forecasts

Table 3 provides activity forecasts over the two-year period in addition to current forecast outturn activity for 2013/14. Future activity plans are calculated using five years of historic activity and prevailing operating performance against national targets such as referral-to-treatment waits. Historical trend analysis is used to assess the robustness of the activity forecast. The change in numbers on the outpatient and inpatient waiting lists is included in the forecast to account for prevailing demand. The effect of business cases, service developments, planned changes to service delivery, and deflections schemes agreed with commissioners, are also taken into account in developing the plans. The 2015/16 activity levels are informed by the growth figures submitted to the Healthier Together Programme.

Table 3

	2013/14 forecast outturn*	2014/15 Plan	2015/16 Plan	% change 2014/15	% change 2015/16
New outpatients	123,904	123,045	126,737	-0.7%	3.0%
Follow-up outpatients	344,665	355,683	366,353	3.2%	3.0%
Total outpatients	**468,569**	**478,728**	**493,090**	**2.2%**	**3.0%**
Elective day-case	31,616	31,536	32,797	-0.3%	4.0%
Elective inpatient	14,491	14,281	14,281	-1.5%	0.0%
Total elective	**46,107**	**45,817**	**47,079**	**-0.6%**	**2.8%**
Non-elective	42,307	43,938	44,512	3.9%	1.3%
A&E attendances	94,244	97,995	100,049	4.0%	2.1%

4.2 Analysis of demand and capacity requirements

UHSM has seen, on average, year-on-year growth of 5.2% in outpatients since 2011/12, with some of this growth relating to changes in activity recording (3% underlying growth). In line with best practice, activity that was previously carried out as an elective day-case is now recorded as an outpatient procedure (e.g. Urology and Breast Surgery).

Whereas elective day-case activity has realised average year-on-year growth of 4.2%, elective inpatient activity has decreased by an average of -1.6% each year. The move to carrying out elective procedures as a day-case rather than an elective inpatient stay is expected to continue in 2014/15. The Trust has consistently delivered aggregate Referral-to-Treatment RTT) performance, growth in elective and outpatient activity has impacted on the Trust's achievement of the required standards in General Surgery, Orthopaedics and Cardiac Surgery.

Year-on-year (average) non-elective growth of 3.7% has brought pressure to the emergency pathway, and

contributed to the failure of the emergency access 4-hour target in Quarters 3 & 4, 2012/13 and 2013/14. Increased activity from Trafford CCG, as a result of the downgrading of Trafford Hospital's A&E Department, has led to growth in UHSM's non-elective admissions in 2013/14 with a full year effect of this factored in the plans from 2014/15.

The Trust is working with CCGs on deflection schemes designed to reduce non-elective admissions, through integrated care neighbourhood pilots and the Living Longer Living Better programme as referred to in section (2.3.1). The forecast impact of these schemes has been reflected in the two-year plans presented in **Table 3**. Successful implementation of these schemes is estimated to reduce non-elective activity by 2.3% in 2014/15 and 1.2% in 2015/16, and lower A&E attendances by approximately 0.6% in 2014/15 and 0.3% in 2015/16. Despite these deflection schemes, the Trust is predicting growth in non-elective activity over the two years as a result of significant forecasted growth in surgical specialties (including General Surgery, Gynaecology, Orthopaedics, Urology and Plastic Surgery), Obstetrics, Paediatrics, Cardiology and specialist Respiratory Medicine.

An assessment of the physical capacity, workforce and beds needed to meet the expected demand over the next two years is summarised in the following sections.

(i) Emergency Department Expansion

Following the downgrading of Trafford A&E to an urgent care centre between midnight and 8am, increased non elective referrals and emergency attendances have been experienced at the Trust. In anticipation of the further downgrading of Trafford A&E to a Minor Injuries Unit in 2015/16 a business case to enhance capacity of the emergency department was submitted to the Department of Health in 2013. The case was approved with £12m of Public Dividend Capital funding earmarked and the scheme is due to be completed by September 2015.

(ii) Cardiology

Elective cardiac electrophysiology (EP) work is an ongoing pressure. The Trust plans to appoint a dedicated device consultant in Cardiology to increase market share for device work and respond to the additional ICD (Implantable Cardioverter-Defibrillator) work that will be generated by the forthcoming NICE guidance. This in turn will enable the transfer of elective device work from existing Cardiologists to release capacity for EP work. The Trust is currently refurbishing its Catheter Labs in partnership with Medtronic. Two of which were completed during 2013/14 and the remaining two will be completed in 2015/16. The Trust expects to improve the efficiency of the Catheter Labs thereby releasing additional capacity. As part of the Southern Sector, the Trust has made a number of joint Cardiology posts with Stockport NHS Foundation Trust in order to consolidate strengths in this specialty.

The construction of a new cardiac imaging unit by Alliance Medical will commence in 2014/15 for commission in 2015/16. This will host a dedicated Cardiac CT and an additional 3T MR Scanner to enable compliance with respect to chest-pain investigation pathways, to provide capacity for the rapid expansion and clinical need for CMR imaging in the Greater Manchester area, to future proof existing services and the position of UHSM as a premier cardiac service provider. This is a collaborative approach to service delivery and will help to address the increased demand for this specialised commissioned service.

(iii) Cardiothoracic Surgery and Transplant

The Cardiothoracic Directorate has made good progress during 2013/14 to halve the referral-to-treatment backlog and reduce lung-cancer waiting times. The Trust has initiated a programme of work to increase efficiency across the Cardiothoracic Surgery pathway (beds, theatres, ICU and outpatients) to meet the

increasing growth in elective and non-elective Thoracic Surgery as well as future Cardiac Surgery growth. ICU bed capacity is a particular constraint, which is being addressed by reducing critical care length-of-stay and creating Level One bed capacity within the Scheduled Care ward footprint.

In 2013/14 the Cardio-pulmonary Transplant Team has carried out the most transplants in the Trust's twenty-six year history as an adult transplant centre. This increased level of activity will continue to be managed through length-of-stay reduction within the Cardiothoracic Unit.

(iv) Vascular Surgery and Hybrid Theatre

Best practice in vascular procedures now advocates a Hybrid Operating Room model and failure to keep pace with technology for elective and non-elective Vascular Surgery would present a significant risk in terms of the Trust's strategic aims, not only in relation to vascular but to its wider surgical portfolio. Having recognised the importance of this development £2.8m of capital funding has been agreed for this project. The capital programme will start in 2014/15 and the theatre will be operational in early 2015/16.

(v) Withington Community Hospital

Increased utilisation of key assets such as Withington Community Hospital will be achieved in 2015/16 and beyond. This facility will become an important driver in the recovery programme and also in the future provision of integrated care. Extended days and weekend working will be investigated and utilised where possible.

(vi) Respiratory

The demand for specialist activity within Respiratory Medicine continues to grow year-on-year. The Trust is putting plans in place to ensure that it is compliant with the specialised commissioning requirements. A consultant has been appointed to help to reduce the long outpatient waiting times in Severe Asthma and to support a planned increase in activity in the second-half of 2014/15. Plans have been approved for a new build to accommodate the Long-Term Ventilatory Service (LTVS) for inpatients and creation of a North-West step-down weaning service. Plans for expansion of the Bronchoscopy service are expected to result in a 10% increase in day-case activity during 2014/15. The unit will be expanded in 2014/15 to accommodate this.

(vii) Medical Specialties

Although the current outpatient wait for Dermatology is improving, there remains an average wait of over fifteen weeks for a new outpatient appointment. The availability of Dermatology consultants is significantly affecting access to outpatient services at UHSM and across the health economy. Discussions about the future provision of Dermatology in Greater Manchester, including the degree to which it can be provided in Primary Care, will continue in 2014/15.

There is a national predicted increase in demand of circa. 8% for Gastroenterology in general, and endoscopy in particular, over the next five years with some of the demand relating to extension of bowel cancer screening to younger age groups. A new consultant was appointed in March 2014 to further-develop specialised endoscopic procedures (e.g. ERCP and EUS). The Trust is developing plans in discussion with commissioners to address the gap in day-case and outpatient capacity within Gastroenterology. The Community Endoscopy Service based at Withington Community Hospital (WCH) will cease in June 2014, releasing capacity for suitable endoscopy patients to access care closer to home and ease some of demand pressures. In 2014/15, the Trust in partnership with Central Manchester University Hospitals NHS Foundation Trust will deliver a national bowel screening programme for Greater

Manchester at WCH.

(viii) Workforce

The Trust's workforce is based on the 2013/14 establishment adjusted for service developments, agreed service changes, skill mixes, and Cost Improvement Plans (CIP). **Table 4** provides the key changes for 2014/15 and **Table 5** provides the same analysis for 2015/16.

Table 4 – 2014/15

	Plan 2013/14	CIP	Service Changes/Business Cases	Other changes	Full Year Plan 2014/15
Total Establishment	**5585**	***-141***	***101***	***45****	***5590***

* Includes unidentified CIP from 2013/14 net of the transfer of hosted services (NHS Leadership, CLRN).

Table 5 – 2015/16

	Plan 2014/15	CIP	Service Changes/Business Cases	Other changes	Full Year Plan 2015/16
Total Establishment	**5590**	***-157***	***102***	***0***	***5535***

Over a two year period the workforce numbers remain broadly stable. The Trust is looking to increase productivity within its existing clinical resources and reduce dependency upon locum medical and nursing staff. However, investment will be made in key areas as outlined in this plan.

As part of the recovery programme planning the Trust is confident it has sufficient workforce capacity to grow in a range of specialities and these plans will form part of the Trust's five year strategic plan.

(ix) Other service reconfigurations

Work will continue on the enhanced recovery programme where a personalised pathway ensures that individual needs are assessed whilst enabling patients to recover from surgery, leave hospital sooner and get back to normal everyday activities**.** 2014/15 will see the expansion into further areas such as Thoracic Surgery, Vascular Surgery and Upper GI Surgery. In addition a new 7-day model of care for medicine was implemented in August 2013 in order to address how the Trust will respond to service needs and patient demand, providing benefits for patients, carers and staff. The model is in the early stages of implementation and work will continue into the second phase of the programme over the next two years.

4.3 Analysis of key risks and how the Trust is able to adjust inputs to match different levels of demand

The Trust has considered the risks associated with the two year Operational Plan and aligned to the Trust's strategic risk register, the key risks are as follows:

4.3.1 Internal risks

Recovery programme

The Trust has undertaken a robust risk assessment against delivery of each of the schemes within the recovery programme. The risk assessment is based on financial risk of delivery of each scheme and as previously indicated within section (3.2) a quality impact assessment to assess the risk of impacting on patient care has been undertaken. A number of the recovery programme workstreams outlined in section (5) will also lead to capacity improvements and help mitigate potential risks.

Targets and indicators

A risk analysis has been undertaken of all the targets and indicators (see finance template). One key risk has been identified and declared, this is described below with the associated mitigation:

1. Meeting the A&E access target – UHSM has an Emergency Improvement Plan in place, which focuses on the following work streams: discharge, urgent care, stroke, ambulatory care and integrated-care development. Performance is regularly monitored through the Trust's Operational Board as well as through the formal performance review process. Models of Care are being redesigned internally to ensure that patients spend the shortest amount of time in hospital. The planned expansion of the Emergency Department in 2015/16 will align with the new models of care and will provide additional capacity within the two year plan period. The Trust works closely with all of its external partners and there is regular system wide Urgent Care Board of which the Trust is an active member. Work continues with external partners on the creation of new integrated patient pathways designed to prevent hospital admission wherever appropriate.

The Trust had a dementia themed CQC review inspection in February 2014 and it is indicated that the Trust will receive a compliance action with a moderate impact. However as at the 31st March 2014, as the report has not been received formally or published, there is not a compliance action outstanding to declare. Please refer to section (3.2) for further details and mitigating actions.

In 2013/14 the Trust's C. difficile target for the year was 36 and this target was achieved. Due to the nature of the target relating to clinical practice and the essential treatment for some patients, achieving this target will always be a risk. This was demonstrated in 2013/14 with variable month on month performance and the fact that two quarters were missed. However, the Trust did reduce the 2013/14 rate by 25% on the previous year and have put in place a focused action plan with a strong emphasis on antibiotic prescribing. Due to its variability, this C. difficile target remains a recognised risk within the Trust, however the Trust does have a good track record in achieving this target and therefore this has not been declared formally as a risk within the plan.

Other internal risks

Quality risks have previously been outlined within section (3.2) of the plan – this highlights mitigations around areas such as nurse recruitment, patient harm and mortality.

There are a number of risks associated with the workforce, these include nurse staffing levels, interim staff, mandatory training, sickness and absence. Mitigations to these risks have been outlined in sections (3.2) and (3.1).

Fluctuations in demand will be managed through the capacity arrangements outlined in section (4.2) and the contingency arrangements outlined in section (4.4) will offer flexibility to respond to unplanned events and provide additional operational reliance within the plan. Other risks to meeting demand include having

the required infrastructure in place such as IT and estates. The Trust's capital programme has been risk assessed, in order to ensure that priority areas and key enablers of the recovery programme have been resourced. As outlined in section (2.3.2) investment in IT and business intelligence will be a key enabler for the recovery programme and further beyond. Winter planning arrangements offer system wide resilience and the Trust will continue to work collaboratively across the LHE to deliver this.

The key financial risks associated with delivery of the two year Operational Plan are provided in section (7.6).

4.3.2 External risks

The key external risks identified are;

- Unexpected factors outside the control of the Trust, such as Department of Health changes to tariff rules or unplanned organisational disruption.
- Future changes to national spending round.
- The impact of local initiatives such as Healthier Together, which whilst present an opportunity for growth, also present a risk of loss of market share for some services.
- The Southern Sector initiative failing to establish itself as intended.
- Limited opportunities for growth in some areas as commissioner funding is constrained. The focus is on diverting patient flow from elsewhere.

Whilst some of these issues are outside of control of the Trust to influence, there has been ongoing dialogue with key stakeholders and to ensure that the Trust is in the best position to influence where possible.

4.4 Operational contingency that is built into the plan

The Trust has arrangements in place for Emergency Planning Resilience and Response (EPRR) that correspond with the NHS Commissioning Board Core Standards EPRR Framework. This includes continuous improvement of various emergency and business continuity plans and the exercising of such to ensure they are fit for purpose. The following arrangements are in place:

i) Staff sickness arrangements - corporate plan setting out local responsibilities.

ii) Major incident management/response - a well rehearsed major incident plan.

iii) Flu pandemic plans - an outbreak policy and pandemic plans are currently under review following new national guidance.

iv) Adverse weather plans - severe weather plan that covers both summer and winter and are in line with the Met Office Alerts and DH Health Watch system.

v) Supply chain failure plans - the Trust links into NHS Supply Chain contingency plan and ensures that local suppliers also have contingency plans in place.

vi) IT system failure plans - a corporate IT business continuity plan and procedures in place for local areas.

vii) Utilities failure plans – strategic management plan, resilience measures and various contingency plans.

The Southern Sector partnership has the potential to offer important contingency opportunities and arrangements. Good relationships with other local NHS providers and private providers can assist with capacity issues if required. In addition, established local and national networks arrangements also help to provide contingency should the need arise e.g. Critical Care, Cardiac, extracorporeal membrane oxygenation (ECMO), Burns.

The continued integration of community and acute pathways will provide the opportunity to develop new

roles and bring about greater mobility within the workforce. Regular rotations of staff between the different settings will be expected and this will help alleviate resource pressures. The Trust can also call upon a number of nursing staff who have recently retired, utilise bank and agency staff and engage in international recruitment should the need arise.

The financial contingency considerations are provided in section (6).

(5) Productivity, efficiency and CIPs

This section outlines UHSM's planned cost improvement programme/recovery programme over the next two years and will distinguish between traditional/incremental schemes and those which are transformational in nature. The extent to which transformational schemes are ready for implementation will be discussed followed by the programme's governance and assurance arrangements.

5.1 UHSM's programme of traditional incremental and transformational schemes to maintain or improve quality and drive up productivity.

As outlined in section (2.3.2), the Trust has developed a two-year recovery programme to address its £50m financial challenge to realise financial stability by 2016/17. A detailed programme of work was undertaken to identify how the Trust's financial position could be brought into line through internal productivity and efficiency gains.

This programme of work consisted of two phases and the Trust was supported by external professional services firms in this process. The first phase took place over a two month period and consisted of a bottom-up analysis across a range of key cost categories identifying savings of £18m-£28m. The second phase took place over a 10 week period and consisted of a top-down benchmarking of all cost categories, comparing UHSM to 24 peer NHS organisations selected by the Trust (FT and non-FT, teaching and non-teaching, similar case mix and bed base). Benchmarking of performance enabled the Trust to better understand the potential scope of opportunities from a transformational change in the way it currently provides its services and deploys it clinical and non-clinical workforce. The CIP programme will be subject to a third party assurance review for completion in April 2014.

Historically, the Trust's CIP programme has focused largely on transactional opportunities. This is consistent with the majority of NHS trusts where key cost categories are focused on with incremental improvements year on year. This plan marks a step change in approach and includes a sizeable proportion of CIPs that are dependent on strategic changes to current clinical services portfolio, collaborative working with external partners and infrastructure changes to its core back office functions. The move to transformational CIPs reflects the success achieved in previous years in cost reduction through driving productivity and quality gains. Financial stability now mandates a move to sector-wide reconfiguration, and UHSM's role in the Southern Sector partnership affords an opportunity for the long-term improvement of patient care and financial stability for local health partners.

Of the £50m identified cost reduction schemes, £25.7m will be implemented in 2014/15 and have been detailed to a level of clear action plans, detailed workings on delivery, financial and HR impact and risk assessed. £24.2m of schemes will be implemented in 2015/16, some with a lower level of detailed plans but with a level of confidence that they can be converted to the same level of detail as 2014/15 plans.

A full breakdown of the £50m by scheme has been defined in **Table 13.**

5.1.1 Traditional CIPs and cross cutting CIPs based on Trust-wide transformational change

(i) Cross cutting CIPs

Six key cost categories where productivity and efficiency gains could be achieved were identified; these will be implemented during 2014/15 – 2015/16. Savings achieved in these areas in the two previous years reflect the Trust's transactional approach to savings realisation. Moving forward, the focus will be on organisation-wide changes to how staff work and how services are delivered. This represents a more ambitious approach for UHSM, and marks a step change in how CIPs have been developed historically. In this two-year plan, cost category savings are based on a trust-wide approach to identifying opportunity and efficiency gains through a restructuring of both clinical workforce patterns and service delivery.

Medical Productivity (£9.9m)

The Trust has a higher spend on its medical workforce when compared to the income generated from the medical workforce of its peer group. This suggests that the Trust can deliver the same level of activity as it currently does through a smaller number of medical staff. The reasons are varied, but analysis shows an opportunity to reduce PA's in outpatients and theatres through improving productivity in certain specialties to the upper quartile of peer group. An improved job planning process will be introduced to address historical variances in the allocation of supporting programmed activities (SPA's) through aligning consultant job plans in a fair and consistent manner and through prioritising consultant activity against Trust priorities to a greater effect. A focused effort on recruitment will reduce dependency on agency staff and deliver a strengthened and permanent workforce. The Trust also has a higher non-consultant spend which provides further opportunity for efficiency savings. A review of all middle and junior doctor rotas will take place. This is likely to result in a reduction in wte's together with a reduction in banding payments to bring the Trust nearer to better performing trusts in the peer group. Savings will be achieved through reducing consultant base pay elements, optimising capacity in theatres and outpatients, reducing the costs of the non-consultant workforce and minimising the need for locums.

Improved patient flow (Length of Stay) (£2.3m)

In many areas of the Trust, length of stay is aligned to or better than the peer medium, however there are specialities where improvements still need to be made through improved efficiency of discharge planning, optimising bed utilisation, increasing the proportion of day cases, and reducing unnecessary admissions.

Procurement (£1.6m)

Over the past 3 years, £5.3m in savings have been achieved. Focused effort on expenditure in remaining areas, assumed to be 10%, will generate savings through contract renewal and negotiation, rationalisation and standardisation in product ranges, and benefits derived from collaborative purchasing with Southern Sector NHS organisations.

Nursing Productivity (£1.2m)

Investment in nursing wards will occur to meet new standards, however benchmarking shows a higher level of skilled staff in specialist non-ward based nursing when compared to peer trusts suggesting an opportunity to improve productivity through a productivity review. Ward nursing will move to long days and reduce handover periods and specialist nursing will reduce by minimising duplication of clinical care.

Outpatients optimisation (£0.7m)

Analysis shows there is significant variation in utilisation across outpatients which provides a productivity opportunity through improved current booking processes, a reduction in DNA rates to a Trust average of 6%, and maximising all contracted sessions are delivered.

Theatres optimisation (£0.7m)

The Trust's utilisation of theatres currently average 81%***.*** Ensuring greater consistency in individual consultant productivity to peers presents a significant opportunity, as does a reduction in bank and agency spend. A move to standardisation and rationalisation of products within theatres will also realise financial benefits.

In taking this approach to CIP development, the Trust has drawn heavily from 'best practice' models of care from elsewhere in the NHS, as well as national guidance on staffing levels, particularly in nursing care. In doing so, the Trust has assured itself that new ways of working will facilitate productivity improvements whilst maintaining or improving both operational and quality standards.

(ii) Divisional based CIP schemes

A range of other schemes have been developed for implementation in 2014/15, based on internal analysis and include:

Clinical Recording (£10m)

A review of this function identified that historic data capture was sub-optimal when compared to its peers. Investment in this area will deliver improved recording resulting in moving specialties with a mean price per spell closer to the national average. While addressing historic challenges with recording, it moves the Trust to more robust activity data and internal assurance of patient activity. This has been agreed and contracted with commissioners as outlined in section (7).

Operational Division and Corporate (£7.7m)

CIPs have also been developed within operational directorates and corporate services to deliver current levels of service through a reduced cost base. These have been delivery assessed and are deemed to be deliverable.

Obstetrics (£1.3m)

Benchmarking demonstrates an opportunity to optimise midwifery staffing levels by aligning to national guidance of a skill mix of 90% midwifes to 10% midwifery support workers. A move to align to a birth rate plus ratio of 29.5:1 further supports a clinically safe and effective service and through expanding the number of births supports the organisations strategic aim to become a centre of obstetric excellence.

The Trust has a good track record of CIP achievement, with the exception of 2013/14 where it has not fully achieved its CIP target for the year. However it recognises a strengthened and more focused approach is required in order to realise a £50m reduction in the cost base. Delivery of £45m savings in the first two years of the previous CIP programme 'fit for fifteen' identified expected savings opportunities and the challenge for the Trust moving forward is to strive towards upper quartiles of productivity when compared to its peer organisations.

Cardiothoracic (£0.7m)

Efficiency gains through improving processes to support an overall reduction in length of stay and moving the service to above peer median levels. A move to overall improvements in how care is delivered will facilitate the repatriation of non-elective activity back to the Trust.

5.1.2 Transformational schemes and the extent to which such schemes are implementation ready

In order to achieve financial stability, the Trust recognises that strategic change across the LHE will be required both in terms of how clinical services are delivered through collaborative working with partner NHS organisations, as well as how corporate services are configured across local partners. This supports the current policy direction established by Healthier Together. The majority of the CIP programmes (85%) will be delivered through internally driven changes to how clinical and other services are provided. Transformational CIPs – those that require new ways of working and subject to agreement with commissioners and other providers - account for a much smaller percentage (15%) of the recovery programme and will be implemented in 2015/16. The Trust acknowledges that delivery of these CIPs can only be achieved through extensive consultation, close working and agreement with local CCGs and NHS partners. This approach reflects the fact that the fact that such schemes will have a longer gestation period.

A review of any reconfiguration of current services will need to be weighed against the impact on neighbouring trusts, commissioners and the wider health economy. The already established Southern Sector partnership and on-going engagement with all partners is vital to securing a LHE that is fit for

purpose and sustainable in the long term as outlined in section (2.3.1).

Back office review across Southern Sector

The Southern Sector review of the potential for consolidation of a range of back office functions across four NHS Trusts will be progressed for implementation in 2015/16. The restructuring of these functions into a collaborative model reflects moves elsewhere in the NHS to drive efficiencies and quality of support provision through process standardisation, economies of scale benefit realisation and staffing alignment. An external review has identified potential savings in the region of £12.8m to £30.4m in total across the four trusts. A conservative estimate of £4m has formed the cost reduction specific to the Trust and will be realised through an assumed 12% reduction.

Service Reconfiguration

Financial stability of UHSM in the long-term will require a change to its current service portfolio of specialties. Building on the progress previously described, a strategic review will be commissioned to support UHSM in defining future speciality portfolio and opportunities for collaborations across the sector. Specialties such as maternity, paediatrics major surgery and emergency care will form part of this review as set out in Healthier Together. This will support the strategic commissioning of services to sites where concentration of a service to a single provider improves clinical care, or through a 'hub and spoke' model that drives efficiencies through better allocation of clinical resource.

Commercial opportunities to diversify and other partnerships

As referred to in section (2.3.3), a number of transformational programmes are already underway which will lead to significant long term benefits within the LHE – these include MediPark, Living Longer, Living Better and the MAHSC Cardiac Concordat with Central Manchester University Hospitals NHS Foundation Trust. Progress has already been made and plans are in place for the two year period as previously outlined. The programmes will be further expanded on within the five year strategic plan.

5.2 Governance arrangements

All CIP schemes have been quality impact assessed as referred to in section (3.2). A delivery risk assessment was also applied to RAG-rate the total number of schemes and financial value of schemes as detailed in **Table 6** and the assessment was based on the definitions given in **Table 7.**

Table 6

Rating	No. of Schemes	Total Value (£m)	Scheme Overview
Green	51	34.1	Year 1 and some year 2 schemes
Amber	12	8.6	Mix of income and year 2 schemes
Red	2	7.3	Back office, service reconfiguration

Table 7

Key	Description
Green	Full plans developed. High level of confidence schemes will deliver stated savings against plan.
Amber	Full and/or moderate plans in place. Moderate level of confidence schemes will deliver stated savings against plan.
Red	Full plans still to be developed. Levels of actual savings to be confirmed

The central PMO will provide Board and organisational oversight and assurance against delivery. This will ensure delivery of the plan remains a key day to day priority of all teams and embeds this framework as part of the daily business rhythm of the organisation. The reporting and monitoring framework applies a rigorous approach at every level to frequently monitor progress and to highlight where issues arise so that mitigating actions can be taken with rapid effect. This approach to scrutiny is essential to maintain clear oversight of the transformational CIP schemes, given their impact both on financial savings and on quality, safety and operational performance. The PMO will be resourced to ensure the right capability and capacity is in place with an increase in staffing in specialised areas such as medical staffing (human resources) and purchasing (procurement) to meet the additional demands resulting from the recovery programme and external short-term expertise. To achieve the objectives of the recovery programme, several key enablers have been identified as outlined in section (2).

(6) Financial plan

This section provides a summary of the key financial considerations in the two year plan. Details are provided on income, revenue expenditure, Continuity of Service Risk Rating (CoSRR) projections, liquidity requirements, capital expenditure plans and sensitivity analysis. A more detailed analysis is provided in section (7). As identified in section (2.2), one of the Trust's four corporate objective themes is to achieve financial stability through delivery of a financial recovery programme.

6.1 The Trust's current financial position

Financial performance in 2013/14 has been challenging, in particular the pressure on expenditure due to a shortfall on the delivery of the Cost Improvement Programme (CIPs), premium agency staff costs, excess costs on clinical supplies, including the need to use private sector capacity to support the delivery of the elective programme. The Trust is forecasting a £600k normalised surplus position for 2013/14 against a planned surplus of £1.9m. This result will generate a CoSRR of level 2. The revised rating methodology serves to highlight the Trust's significant liquidity challenge along with a capital servicing metric which means that trusts with PFIs (and therefore more debt to service) will be treated as being at more risk.

6.2 Summary income and expenditure

The income & expenditure financial forecasts for 2013/14 – 2015/16 are provided in **Table 8**.

Table 8

	2013/14 (Forecast Outturn)	2014/15 Plan	2015/16 Plan
Income	488.2	450.8	420.6
Expenditure	(467.2)	(425.7)	(394.1)
EBITDA	21.0	25.1	26.5
EBITDA %	4.3	5.6	6.3
Net Surplus	(1.6)	0.0	1.0
Exceptional Items	2.2	1.9	1.1
Normalised Surplus	0.6	1.9	2.1
Cash	59.5	30.4	31.3
CoSRR	2	2	2

Income

Trust income for 2014/15 and 2015/16 have been adjusted for the Payment by Results (PbR) tariff deflation. In reaching agreement with Commissioners for 2014/15 the Trust is assuming income growth resulting from coding and new service developments. The Commissioners have also indicated that contract income will be reduced by the potential imposition of performance penalties and the impact of deflection schemes.

Table 8 shows that there will be a reduction in income over the life of the plan (2013/14 forecast to 2015/16 projected) of £19.3m, which mainly relates to the cessation of the Trust hosting arrangement for

the Comprehensive Local Research Network (CLRN) and National Leadership Academy, and a reduction in tariff for clinical income, offset by an increase for predicted levels of activity growth. This reduction is offset by £48m relating to reduced expenditure associated with hosting the CLRN and National Leadership Academy.

Revenue Expenditure

Pay expenditure is aligned with the Department of Health decision in March 2014 for pay inflation of no more than 1% in 2014/15 and 2015/16. Non pay inflation has been added where there is a contract specific rate e.g. the PFI is aligned to February RPI, a general inflation assumption has been used for all other remaining lines based on experience. For 2015/16 the Trust has followed the assumptions detailed in the NHS England guidance "Everyone Counts" coupled with the recent pay award announcement. Key assumptions being pay and non-pay inflation increase of 2.2%, and in addition 0.7% has been assumed for the increase in the employer's pension contributions, arising from the revaluation of public sector pension contributions anticipated in 2015/16.

Table 8 shows that Trust expenditure will reduce over the life of the plan (2013/14 forecast to 2015/16 projected). This reduction is primarily the reduction of cost due to the CIP programme and the cessation of the hosting arrangement for the CLRN and Leadership Academy offset by the inflationary pressures summarised above and additional expenditure associated with:

- Delivering the Trust's financial recovery programme is forecast to cost the Trust £3.9m in 2014/15 and £4.1m in 2015/16 these include the costs for implementation of Electronic Patient Records (EPR) across the two years, Project Management Office and external expert advisors.
- Increased activity resulting from the changes at Trafford General Hospital Accident and Emergency unit plus other service in the areas of specialist respiratory services.
- Costs associated with the expansion of integrated care and the introduction of the ambulatory care initiative in partnership with the Clinical Commissioning Groups across Manchester.

The consequence of these movements in both income and expenditure is an increase in EBITDA of £5.5m over the period from the 2013/14 forecast outturn position to 2015/16.

6.3 Continuity of Service Risk Rating (CoSRR)

The Trust is planning a CoSRR of level 2 for 2014/15 and 2015/16, related to the delivery of CIP through the recovery programme. The CoSRR is forecast to be 1 for the first three quarters of 2014/15 and the first quarter of 2015/16 as shown in **Table 9**.

Table 9

	2014/15				2015/16			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Capital Service Cover	1	1	1	2	1	2	2	2
Liquidity Rating	1	1	1	1	1	1	1	1
CoSRR	1	1	1	2	1	2	2	2
Normalised Surplus/(Deficit) (£m)	**(1.1)**	**0.9**	**0.3**	**1.8**	**(0.3)**	**0.9**	**1.2**	**0.4**

6.4 Liquidity

In the medium and longer term, liquidity remains a significant issue for the Trust. In addition to the need to deliver the £50m financial recovery programme over the period of this Operational Plan, the Trust also needs to find a solution to stabilise liquidity pressure created by the increasing PFI tariff payments which will apply in the medium term. The PFI payments are increasing each year as a result of an uneven tariff profile, the profiling of the PFI tariff is such that increased payments will continue for the next 10 years which will adversely impact cash.

Over the last 12 months the Trust has continued discussions with the Independent Trust Financing Facility (ITFF) and has formally submitted an application to the ITFF for:

- A £25m loan which will be drawn down over an eight year period and then repaid over the following ten years.
- A 30 day working capital facility to mitigate against the short term cash pressures.

The plan assumes that the loan is drawn down from quarter 1 of 2015/16.

The application was agreed in principle following consideration by the ITFF at the end of January 2014. A formal decision is pending subject to the outcome of a review by Treasury on the use of Working Capital Facilities and in consideration of the loan, the outcome of the investigation by Monitor into the Trust's finances.

6.5 Capital Expenditure Plans

The Trust has an overall strategic objective to provide safe and high quality clinical services for its patients. The financial priorities and investments are aligned to this objective. 2014/15 and 2015/16 will see investments in the Trust's infrastructure as provided in **Table 10**. Trust expenditure on capital infrastructure is planned at £30m for the two year period with £12m of this funded through approved Public Dividend Capital (PDC) funding. Net of this funding capital expenditure is in line with depreciation.

Table 10

Scheme	**2014/15 (£'m)**	**2015/16 (£'m)**
Accident and Emergency	5.7	6.3
Equipment Replacement	1.9	2.0
Hybrid Theatre	2.8	
Cardiac Imaging (funded from charitable funds)	0.7	
Backlog Maintenance (inc PFI)	2.5	5.9
Other Clinical		0.4
IM& T Developments	1.3	0.7
Total	15.5	15.3
Funding Stream		
Internally Generated	8.8	9.3
Charity	0.7	
PDC	6.0	6.0
Total Funding	**15.5**	**15.3**

The investment supports;

- The Accident and Emergency department expansion as outlined in section (4.2).
- The investment in the hybrid theatre is intended to protect and enhance vascular and respiratory services and to generate additional income as outlined in section (4.2).
- Investments in IM&T as outlined in detail in section (2.3.2). The Trust is investing in Electronic Patient Records to generate efficiency and effectiveness through transformational change. In 2014/15 procurement and detailed design will take place. In 2015/16 the Trust will continue to invest in the Electronic Patient Records programme at current estimates this requires c£30m of investment to generate £16m of cash releasing benefits and between £60m-£70m of non cash releasing benefits. This will be rolled out over the three year period from 2015/16 with the full year effect of benefits expected beyond the five year strategic planning period. These cash releasing benefits are not currently reflected in the Trust's two year recovery programme.
- Pump- priming of the building infrastructure to support the expansion of the Trust's cardiac imaging service in partnership with Alliance Medical. This is funded from a charitable donation.

6.6 Sensitivity Analysis

The Trust has undertaken sensitivity analysis against the financial plan. In doing so a downside scenario has been modelled. This assumes reduced income/savings of £7m against the Trust's recovery programme, £2m in 2014/15 and £5m in 2015/16. The quantum of the downside assumption aligns with work completed by a third party professional services firm which identified those schemes at most risk of delivery. The impact of this downside scenario being a CoSRR of 1 through all quarters of the plan period. The Trust has plans to mitigate against this downside risk and the adverse impact on the CoSRR through a pipeline of efficiency and cost management schemes that would yield up to £4m in 2014/15 and £11m in 2015/16.