University Hospitals of Morecambe Bay NHS Foundation Trust

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Our operational plan 2014/16

1 Executive Summary

Over the last two years the Trust has continued to make significant progress in its recovery, following a three stage programme of stabilisation, transition and transformation.

This plan supports the transition phase, moving into the transformational stage as part of the better care together programme to create a sustainable future, both clinically and financially for our patients and local communities.

Throughout all of our plans, our priority remains that of delivering high quality, safe services that meets the needs and expectations of our patients.

Research is now producing the evidence that operating as we do, across three main sites, with relatively low volumes and across a wide geographical area is unsustainable and cannot continue.

Better care together is a clinically led, health economy-wide programme and is the main route through which the Trust's long-term future will be delivered. Reconfiguration options are currently being developed, with the aim of creating a strategic case for change by June 2014.

Exciting work is underway with staff, governors and volunteers to redefine our vision and values. All groups are now working together on a final version, which will underpin our plans; ensuring patients remain at the heart of everything we do.

A Quality Strategy has been developed, which identifies a range of improvement indicators that link to the Trust's Quality Account and CQUIN priorities. Fundamental to this is the patient experience, which will be further developed and monitored through the introduction of the 'I want great care' service.

The implementation of seven-day working for non-elective services is considered a key enabler to the delivery of high quality and efficient care. During 2014/15 plans will be developed in order to fully understand the implications and costs, and is a core part of the work of better care together.

In line with national drivers, the recruitment and retention of staff is a key strategic risk and has been a focus of attention during 2013/14 and beyond. The emphasis has been on the recruitment of medical and nursing staff, which has proven largely successful. A comprehensive approach to workforce planning and organisational development has been implemented, which is a dynamic process, taking into account the delivery of cost improvements, feedback from colleagues and emergent service models as part of better care together.

An estates strategy is also being developed as substantial capital investment is likely to be required in order to improve clinical efficiencies, safety the overall environment. Investment in the estate will have a positive impact on patient and staff experience as well as improvements in the Trusts trading position.

In 2013/14, the financial position was improved by around £3m in real terms; the plan for 2014/15 is to continue this trend.

The Trust is forecasting to improve its deficit position again by circa £2m in the next year. This will largely be achieved through further efficiency gains which have been assessed for any potential impact on quality and safety, together with re-current financial support from commissioners and a limited, risk based capital programme. This enables the Trust to demonstrate improved cost control and less reliance on central financial support.

The transformation of our finances, starting in 2015/16 will be driven by continued cost improvements combined with a pricing strategy aligned to the national pricing policy for Trusts such as ours.

2015/16 will be the first full year of better care together being implemented – the financial impact from which will be reflected in the Trusts five year strategy to be submitted in June 2014. An early sight of assumptions being developed by the Trust through better care together and potential financial impact are reflected in the commercial section of this plan.

Table 1: Summary finances - 2014/15 and 2015/16

	2014/15	2015/16
	£'m	£'m
Summary SOCI		
Total Income	266.9	273.0
Total operating costs	(270.6)	(267.7)
Operating surplus / defict / before depreciation and amortisation	(3.7)	5.3
Depreciation & Amortisation	(11.2)	(11.8)
Non-operating income/expenses	(4.1)	(4.3)
Net Surplus/(deficit)	**(19.0)**	**(10.8)**
Closing cash	**0.7**	**0.9**
PDC	**13.0**	**9.0**
Capital	**8.3**	**10.0**
Surplus/(deficit)	**(19.0)**	**(10.8)**
Includes		
Support	**6.0**	
CIP	**12.8**	**11.0**
Pricing Strategy		**15.0**

2 The short term challenge

Over the last two years the Trust has continued to make sustainable improvements in the delivery of high quality services to patients. This has been achieved through strong clinical leadership and effective team-working focussing on clinical quality, patient safety and experience. In order to effect these changes significant investment has been made in nurse staffing levels and a range of services/specialties, including maternity, haematology, oncology, diabetes and endocrinology.

Over the next two years understanding and responding to key changes in patient pathways and demand will be pivotal in order to continue to deliver high quality and cost effective services. Critical to this is integrated working across the heath economy alongside robust capacity and demand analyses in order to respond proactively to changes.

Alongside this the Trust is continuing to focus on developing its services in order to ensure:

- Better quality and patient outcomes;
- Improved clinical effectiveness;
- Improved efficiency of service delivery; and
- Enhancing patient experience.

These developments range from the roll-out of Early Supported Discharge to the transformation of the elderly care pathway, all of which are aligned to the emerging better care together clinical strategy.

The key challenges facing the health economy over the next two years can be summarised as:

- Delivering sustainable, high quality clinical services;
- Delivering a financially viable health economy;
- Delivery of better care together;
- Recruitment of staff (capability and capacity);

- Delivery of seven-day non-elective services;
- Effective management of non-elective patients and sustainable achievement of the emergency care standard; and
- Appropriate estates/environment in which to deliver services.

Details as to how the above challenges are being addressed across the health economy are contained within the Operating Plan.

Significant challenges also exist in achieving the following national standards:

2.1 Emergency Care - 95% Standard

The 95% standard was achieved for eight consecutive months between May and December 2013. However a combination of factors including the inability to open contingency beds due to the challenges to recruit additional staff and discharging medically fit patients resulted in failure of the standard in quarter 4 2014. Whilst the Trust and local health economy developed an Emergency Care Recovery Plan in 2013/14 it failed to fully deliver during the winter period. A review has been undertaken and Phase 2 of the plan will be agreed and implemented in 2014/15.

2.2 Admitted Referral to Treatment Time Standard

The standard was met at Trust level for 12 consecutive months from January to December 2013. In January 2014 the standard was failed due to significant increases in both elective and non-elective activity, which could not be accommodated within existing capacity. Remedial actions including additional capacity and recruitment to vacant posts are underway to ensure the Trust returns to a sustainable position, which will include targeting the incomplete patient pathway.

2.3 Cancer 62 Day Standard from Referral to Treatment

The standard was not achieved in May and November 2013 and January 2014, although it was achieved at Trust level in quarters 2 and 3. The majority of breaches have occurred due to patient choice, patients either being medically unfit or having particularly complex pathways. A recovery plan is in place to improve the timeliness and efficiency of both internal systems and to influence the timeliness of pathways within tertiary centres.

2.4 C. Difficile

46 cases of C. Difficile have occurred up to the end of February 2014 against a target of 36. A full review of infection control practices has been undertaken along with a re-launch of policies. Further work is also on-going within the community.

A governance framework has been put in place and investment has been made to ensure that the programme has sufficient capacity to deliver its remit, including the appointment of a programme director and support staff to administer the programme.

3 Quality Plans

3.1 Better care together – the next phase

The Trust, in partnership with its two local Clinical Commissioning Groups of Cumbria and Lancashire North, recognised two years ago the sustainability challenges associated with delivering safe, high standards of care, across the area of Morecambe Bay. Together, they have been reviewing services provided both in, and out of hospital. The aim is to develop, by June 2014, a set of potential options for reconfiguring services – this strategy is better care together.

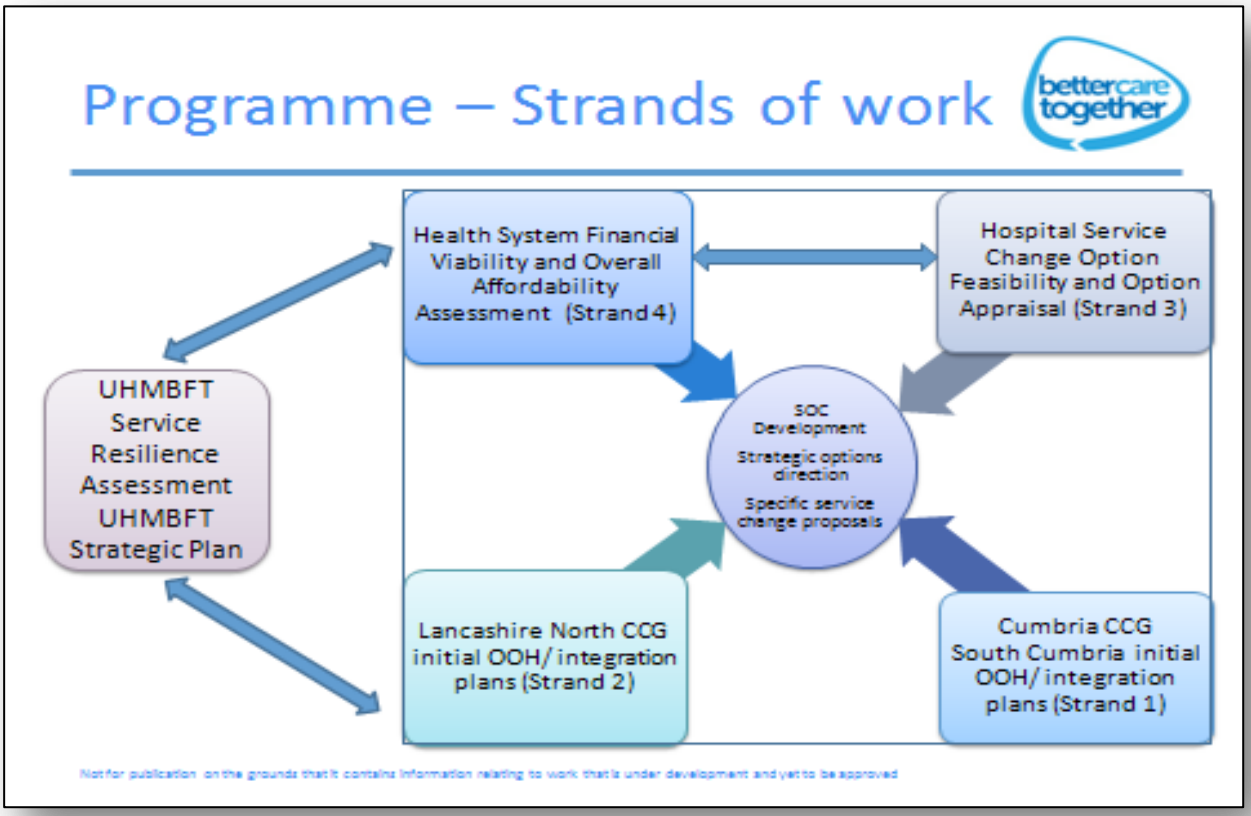
The next phase of work focuses on four “strands”, and exploring the implications of each of the potential service configuration options, as shown in the table below:

1. South Cumbria out of hospital services;
2. Lancashire North out of hospital services;
3. Acute hospital services; and
4. Health system financial viability and affordability assessment.

Both of the out of hospital strands will include consideration of potential for vertical integration of services. It is the Trust's belief that this will be a key element for ensuring the Trust's financial and clinical sustainability going forward.

These strands will be developed simultaneously, with a Strategic Outline Case to be developed by June 2014. This will then be subject to review by NHS England prior to any actions being implemented or public consultation process started.

Figure 1: Better care together - programme strands



In order to meet its objectives of delivering clinical and financial sustainability across Morecambe Bay, the Trust believes that the outcome of better care together should include the following key elements:

- An integrated system;
- Centralisation of service provision;
- Clear understanding of the impacts of changes on the whole system;
- Constant review of how to maintain and improve quality hospital services across Morecambe Bay.

A full governance framework has been put in place and investment has been made to ensure that the programme has sufficient capacity to deliver its remit, including the appointment of a programme director and support staff to administer the programme. The framework is defined within Appendix 1.

4 The commissioning landscape

4.1 National priorities

The commissioner landscape in 2013/14 changed dramatically with the Trust forging new relationships with its new Clinical Commissioning Group colleagues in Cumbria and Lancashire North, NHS England Local Area Teams and Public Health England.

In line with the recent reports in 2013, 'The NHS Belongs to the People: A Call to Action' and 'Closing the Gap' issued by NHS England and Monitor respectively, the Trust has demonstrated within the Quality Improvement Strategy its commitment to improving outcomes in the following areas:

- Preventing people from dying prematurely;
- Enhancing quality of life for people with long term conditions;
- Helping people to recover from episodes of ill health or following injury;
- Ensuring that people have a positive experience of care;
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

The Trust will work with commissioners of health and social care services to deliver a very different approach to strategic and operational planning for the future to deliver the vision set out within the 2013 guidance: 'Everyone Counts : Planning for Patients 2014 to 2019'.

To enable the Trust to deliver the quality outcomes within resource constraints, the clinical divisions are planning to implement significant change focusing on the local and national direction of service delivery and areas of quality focus:

- Seven Day Services;
- A step change in the productivity of elective care;
- Access to the highest quality emergency & urgent care.

4.2 Local commissioning priorities

The Trust has developed a strong working relationship with its commissioners. In the context of better care together, commissioners have focused their commissioning intentions in areas of work around Scheduled Care, Urgent Care, children and young people and maternity services, in line with the health economy's direction of travel.

Commissioners, in partnership with the Trust, are looking at how primary and community services will need to be transformed to work within the future service models and will work to assess the impacts of any proposed service changes which will influence the current model of Acute services provision.

Clinical teams are looking to develop service models in line with the national and local agenda over the next 2 to 5 years as outlined in the table 2 below.

Table 2: Commissioning priorities

Commissioning priorities	Examples of our response to priority areas
New approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own	• Capture Patient Experience in order to influence development and maintenance of health care provision • Continue Patient focus group and patient experience lead. • Schedule of business for patient experience • Link development work into the Datex quality submissions • Develop links to with external stakeholders

care	• Set up different methods to capture patient experience
Wider primary care, provided at scale	Working with commissioners on alternative models of care: Rheumatology within the Furness locality integrated pathways across primary & secondary care Allied Health Professionals (AHP) – integrated care pathways crossing primary and secondary care
Access to the highest quality urgent & emergency care	Improving access and provision by redesign of emergency floor at Furness General Hospital(FGH)
A step change in the productivity of elective care	• Ensure that where possible elective procedures are undertaken as out-patient or day cases. • Continue to drive improvement in theatre productivity and efficiency • Continue to work across agencies to ensure the optimum length of stay for all patients.
Specialised services concentrated in centres of excellence	• Striving to deliver services against the new national specifications. Maintain staffing / resource levels to meet future demand of services, i.e. increase in chemotherapy services in line with growth • Development of the age-related macular service as a centre of excellence • Sourcing Strategic partners for Maternity services in line with the Better Care Together strategy • Decommissioning of Vascular services
Improving health	• Ensure access to services across the trust for all members of the population. • Introduction of Early Supported Discharge (ESD) for stroke services in both localities. • Improvements of ambulatory care at FGH • Improvements in stroke services to 7 days • Develop in house new born screening programme
Reducing health inequalities	CQUIN – uptake of screening, providing wider access to services Develop a domiciliary Nutrition and dietetic service within South Cumbria to support patients out of hospital
Parity of esteem - ensuring that we are just as focused on improving mental health as well as physical health	• Improvements in access to mental health services for Emergency Departments and inpatients • Explore Allied Health Professional Provision to mental health and private caregivers

The Trust is working closely with local commissioners to look at new and innovative ways of delivering services in an integrated way with key stakeholders including community provider services, local authorities and social services to deliver integrated ways of working, which will also enable the Trust to access the Better Care fund.

The clinical leaders are ensuring that an integrated approach is reflected within their business plans.

In 2014/15 the Trust will be working collaboratively to:

- Improve access to 7 day services for Acute Services;
- Develop models of Integrated Care - Early Supported Discharge for Stroke across the health economy;
- Exploring Early Supported Discharge models for other disease groups;
- Exploring the potential to extend the reablement service provision, implementation of the Alcohol Liaison service and explore potential to extend the service to other localities.

4.3 NHS England

The lead responsible commissioner for NHS England commissioned services is Cheshire, Warrington and Wirral (CWW) and it will hold one contract for Specialised services, Public Health England including the national screening services and dental services. All North West Contracts will be of 1 year duration. The NHS England commissioned services from the Trust currently includes:

4.3.1 Specialised Services

- Cancer: chemotherapy (adult);
- Neonatal critical care services;
- Vascular services;
- Cardiology: Implantable cardioverter defibrillator (ICD) and cardiac resynchronisation therapy (CRT) (Adult);
- Specialised Ophthalmology (Adults).

Specialist commissioners will be decommissioning Vascular services from the Trust in-line with national guidance, with an expectation that the service will transfer within 2014/15. In line with these local commissioning decisions, the Trust is working collaboratively with local commissioners, NHS England and the designated providers on the decommissioning of Vascular services. The Trust will work alongside the new providers to ensure a robust and timely transfer of services whilst minimising the risks to patients and other local services which may be impacted by the transfer of this service – the Trust is fully involved and committed to this.

4.3.2 Public Health England

The Trust will work with NHS England to implement the national service specifications for:

- Bowel Screening;
- Breast Screening;
- Cervical Screening (colposcopy services);
- Antenatal and Newborn Screening.

4.3.3 Dental Services

The Trust will work with commissioners to:

- Implement the further roll out of the Minor Oral Surgery scheme to the North Lancashire and Blackpool areas;
- Introduce service specifications for all secondary care providers of dental care in the Lancashire area. This would be in line with the national pathway work currently being developed.

5 Quality Improvement Strategy

In October 2013, the Trust published its Governance Strategy which outlined the Trust's quality vision and outcomes that the Trust must deliver in line with the NHS Outcomes Framework. To augment and support the Governance Strategy the Trust has developed its Quality Improvement Strategy.

Over the last year the Trust has concentrated efforts on improving performance. During the early part of 2014, the Board has prioritised the improvements it wants to make over the next 2-3 years. The Quality Improvement Strategy links closely to the Trust's work with Commissioners to define the Trust's service strategy (better care together), it is aligned to the new Care Quality Commission Hospital Inspection Programme and it builds on work to date relating to Patient Safety and CQUIN.

To achieve improvements, the Trust has developed a portfolio of projects that will not only improve the safety of the care given to patients, but also improve their experience of that care.
The Trust will focus attention on 3 key goals:

1) Better – To reduce mortality and harm
2) Care – To provide reliable care
3) Together – To improve patient and staff experience

The Quality Improvement Strategy will be discussed with the Trust's commissioners and other partners over the coming months in order that they can help further shape this work. It will be published in April 2014, along with the Trust's two year service plan. It will also be refreshed on completion of the Strategic Outline Case in June 2014.

The Quality Improvement Strategy will align with the work on service developments and the Cost Improvement Programme (CIP).

5.1 Our response to Francis, Berwick and Keogh reports

Over the last year the organisation has completed an in-depth review of the Francis Report into quality of care at the Mid Staffordshire NHS Trust, along with an examination of a number of other associated reports including the report on hospital mortality rates by Professor Sir Bruce Keogh and the report on patient safety by Don Berwick.

In response the Trust, through its Programme Management Office (PMO), has consolidated the recommendations and actions that are applicable to the Trust into an overarching action plan which is monitored by the Trust Board. Over the last 12 months the Trust has been successful in delivering change against a number of these recommendations; however the Trust recognises that positive change in these areas will need to be combined over the coming two years and beyond, therefore the Trust action plans, in response to the three external reports, will continue to be monitored.

The review of Mid Staffordshire NHS Foundation Trust has re-emphasised the need for all providers of NHS services to put patients at the heart of everything that the NHS does and to transform organisational culture. Francis, Keogh, Berwick and Cavendish have all highlighted the need for core values and behaviours to be fully embedded in the organisational culture and ethos. This has been enshrined in the revised NHS Constitution, the NHS Outcomes Framework and the national vision, *Developing a Culture of Caring & Compassion.*

To support staff there is a principle of caring for our staff with care and compassion. Staff are supporting us to develop the values which will underpin the care we provide, together with the behaviours and actions that they are all wish to see for each other, and our patients.

To support staff we are looking to implement Schwartz Rounds. These have been evaluated by the King's Fund as having a positive impact on staff's health and well-being. With the support of one of our non-Executive Directors and the Associate Medical Director, we are looking to implement this work in 2014/15.

5.2 Stability partners

The Trust is evaluating the potential to establish "partnering" arrangements with other providers. This may include outsourcing of non-core services, franchising of services at Trust sites, or other collaboration arrangements with other providers. It is hoped that this will benefit the Trust by:

- Improving the ***resilience*** of services through greater flexibility in staffing (e.g. smaller teams will not be disproportionately impacted by sickness/absence);
- Increasing the ***quality*** of services by expanding opportunities for staff development in larger teams and more effective sharing of best practice and innovation; and
- Providing potential for improved ***efficiency*** through flexible staffing models, shared governance structures, sharing best practice and reduction in duplication of activities.

5.3 Summary of plans to address existing quality concerns

Over the last two years the Trust has made significant improvements in performance. The Trust is safer, with improved levels of patient experience and efficiency.

In addition to the improvement of the national performance metrics, the Trust is encouraged by the progress shown in recent external inspections of its services. While identifying that there is still work to be done, these have consistently identified improvement in the Trust's services over the last two years.

But this has come at a cost, and has increased pressure on the Trust's finances at a time where increasing demand and static funding is putting pressure on the whole NHS. There are still areas for efficiency improvement that the Trust must address over the coming years in order to deal with this financial challenge while continuing to improve clinical performance and patient experience.

While much of this efficiency potential is in the Trust's gift to deliver, there are areas, such as readmissions and length of stay, that are impacted by services outside the hospital. The Trust expects the work conducted through better care together to deliver a transformation of services that forms a basis from which the Trust can push to greater levels of efficiency in the long term.

5.4 The management of key quality risks inherent in the plan

The Trust, through its Board Assurance Framework and Corporate Risk Register, have identified a number of areas that present a challenge to the organisation in the achievement of the Trust's strategic objectives and quality goals. Action plans are in place to mitigate these risks as outlined below.

Table 3: Top 3 strategic risks

SR no.	Risk	Mitigating Action
6	Failure to recruit, retain & develop staff	• A Workforce Plan has been approved to underpin review of vacancies and models of care within divisions, linking to the models of care and clinical strategy • Executive Chief Nurse undertaking review of Nursing and Midwifery Staffing level • The Trust has and continues to take innovative approaches to recruitment
7	Failure to secure the financial viability of the Trust	• The CEO and Finance Director have been holding discussions with the two Clinical Commissioning Groups(CCGs) and the two Area Teams on the levels of funding available and contracts for 2014/15 • PWC have undertaken review of additional Structural Costs incurred by the Trust and he Financial Position has been discussed with Monitor. • Funding arrangements are being discussed with Monitor and a PDC request will be made. This formed part of the Transition Plan submitted to Monitor in February 2014 • Workshops and other activities are being undertaken to strengthen 2014/15 CIP planning process • The plan for long term financial viability of services will be presented as part of the better care together (BCT) programme in June 2014.

11	Failure to deliver a strategic Outline case from better care together	PwC have been commissioned to provide a support programme. This includes:- 1. An analytical and baseline assessment called 'Single Version of the Truth' that covers baseline assessment of population health needs, finance, service quality, workforce and performance issues. This assessment will be used to provide insights into the key opportunities for service and cost change as well as provide a single version of the baseline position to evaluate options; 2. Facilitate a care system design and option development process including all stakeholders across the Morecambe Bay three main localities. This will be concluded with a proposed Clinical Summit on 29th April; 3. Develop, in conjunction with the better care together team and the Delivery Group, a Strategic Outline Case – outlining the case for the preferred options and stepped charges, taking a 1-2 year to 3-5 year perspective.

These risks are managed through the Trust's governance framework and performance management structures with assurances on progress reported to the Trust Board regularly. In addition the Trust has identified the following Quality Risks which are managed through the Corporate Risk Register and Divisional Teams through the Divisional Risk Registers and Divisional Management Teams. Assurances on progress are reported to the Trust Board through the Finance and Performance Committee and the Clinical Governance and Quality Committee.

Table 5: Local quality risks

Quality Risks	Issue	Action
Harm Free Care – Falls, Health Care Acquired Infections, Pressure Ulcers	• High level of low level falls incidents • Health Care Acquired Infections and Pressure ulcers are not improving at the desired rate.	• Harm Free care initiative • Harms free care group • Intentional rounding • Focus on hand hygiene • Focus on antibiotic prescribing • External review of HCAIs commissioned by Executive Chief Nurse – January 2014
Never Events	• Cluster of NEVER Events has identified a theme of a failure to check all information pertinent to delivering safe care, much of which is potentially avoidable by adherence to WHO surgical checklist.	• Programme to enhance awareness of WHO surgical checklist • Audit of adherence to processes in the WHO surgical checklist
Mortality	• Historical outlier in Mortality	• Sustain the monitoring arrangements for mortality • Mortality Review Group to continue
Emergency Pathways	• Sustained improvement in the performance of both Emergency Departments against the 4 hour target	• Facilities have been improved • Programme of staff development • Improvements to out of hospital care (Better Care Together)

7 Day Working	• Challenges remain in ensuring the Trust can maintain delivery of both elective and emergency pathways effectively in medical and surgical specialties.	Divisions have undertaken a gap analysis against the ten clinical standards and will develop action plans to deliver 7 day services, in line with the national timetable. In 2014/15, the Trust will focus on emergency pathways. 7 Day working will be incorporated into our quality requirements of the NHS standard contract in 2015/16 and 2016/17.
Communication	• The immediate discharge summary to GPs after an admission is still not hitting the required targets for completion and dispatch (electronic) within 24 hours	• Performance measures developed and implemented • Performance overseen by Trust Management Board
Changing Demography	• Increased demand for patients with long term complex medical conditions	• Trust to continue to participate in national work streams on long term conditions e.g. Dementia.

5.5 Regulatory action plans

The Trust is currently subject to a number of Regulatory concerns. The Trust currently has five conditions attached to its Provider Licence by Monitor; these include three Enforcement Actions and two Discretional Requirement. In the last twelve months the Trust has also been in receipt of a number of other regulatory concerns from Care Quality Commission, Ofsted and the Health and Safety Executive. Although they do not relate specifically to the Trust's Provider Licence were attributed the appropriate level of priority in order that the Trust address the issues raised.

In 2013/14 the Trust developed a series of action plans to address the regulatory concerns raised. Progress against these plans has been and continues to be monitored by the Trust Management Board. To date the Trust has worked hard to implement improvement in the areas highlighted with the action plans due to be signed off according to the below schedule.

It is anticipated that further actions will be required to sustain the improvements made in line with the regulatory action plans. Furthermore, the Trust was recently inspected as part of the Care Quality Commission Wave 2 inspection schedule in February 2014. The Trust have undertaken a briefing session with staff to ensure any further lessons that can be learned are captured and shared in an effective manner across the Trust. In light of any further recommendations from the CQC, the Trust will review and revise where appropriate its action plans and will continue to oversee progress at the Trust Management Board.

Table 1: License Conditions

Action Plan Title	Regulators	Expected sign off/completion date	Lead director	Assurance committee
Maternity	Monitor	31/03/2014	Executive Chief Nurse	Trust Management Board
Governance	Monitor	31/03/2014	Director of Governance	Trust Management Board
Emergency Care Recovery Plan	Monitor	31/03/2014	Chief Operating Officer	Trust Management Board

Table 2: Other Regulatory Action Plans

Action Plan Title	Regulators	Expected sign off/completion date	Lead director	Assurance committee
Safeguarding	CQC Ofsted	31/03/2014	Executive Chief Nurse	Trust Management Board
COSSH	HSE	28/08/2014	Director of Governance	Trust Management Board
Sharps	HSE	31/03/2014	Director of Governance	Trust Management Board
Section 48 – Report into Emergency Care	CQC	31/03/2015	Chief Operating Officer	Trust Management Board

The Trust is on course to deliver against all the regulatory action plans and there has been significant investment and progress within the following areas to ensure the Trust delivers high standards of quality of care:

5.5.1 Staffing

During 2013/14 there have been a number of national reports and recommendations relating to nursing and midwifery staffing and skill mix. The Trust has made significant improvements in relation to nursing and midwifery workforce. An on-going, proactive recruitment campaign has enabled the Trust to close the gap between funded establishment and those nurses and midwives in post over the last 12 months and have achieved a net gain of 135 Nurses during the last year.

Whilst the Trust recognises the significant improvements made to staffing and skill mix during the past year, however it is also important to recognise that there is still more work to do.

There has been a programme of improved communications and engagement activity at Board, executive and divisional level to ensure that key messages have been cascaded to staff and also improved processes for feedback to Executives. There have been regular CEO briefing sessions, smaller staff meetings with the CEO and the introduction of monthly, face to face management briefings for all managers. Divisional activity has also taken place to improve engagement and involvement. This has included local newsletters, management team walkabouts, staff forums etc.

5.5.2 Clostridium Difficile: Infection Prevention and control

Under the direction of the Executive Chief Nurse, the Trust has commissioned an external review of current practice and approach to Clostridium Difficile.

A number of actions have been taken to address patients acquiring Clostridium Difficile in our hospitals. The Trust is working closely with commissioners to develop a healthcare economy approach to reducing instances of this infection.

The Trust has a work plan and presents a quarterly report to the public Board of Directors Meeting.

Key actions taken include:

- Learning from Root Cause Analysis;
- Antibiotic prescribing;
- Hand Hygiene/Bare Below the Elbow (BBE) promotion;
- External review demonstrated no major concerns; however it has been useful in highlighting additional considerations that have been built into the annual work plan.

The Trust has reviewed its governance processes and membership includes the Clinical Commissioning Groups and Public Health representatives.

Cleaning processes are frequently monitored and reviewed. The Trust is currently assessing advantages of fogging wards and departments.

5.5.3 Patient Paper Notes

The Trust recognises that there are concerns regarding availability of case notes in outpatient areas. There are a number of factors that can influence the availability of case notes which including poor tracking and tracing of the record by the user (wards/departments/clinicians) and short notice requests.

As part of our on-going commitment to improve case note availability a Clinical Records Steering Group was set up in March 2014. The new Accelerated Clinical Content Project, which strives to deliver on the Trust's vision as a 'paper-lite' organisation is also on track with a target for 80% of patients to be seen without notes using the clinical content held on our Lorenzo patient information system. The Trust has a programme to move to a 'paper lite' organisation over the next few years, focusing on Outpatients Departments by June 2014, moving to emergency departments and inpatient areas in later years.

The Trust has also relocated its largest medical records library to an off-site facility in the centre of Lancaster improving security, storage and availability of the patient records.

5.5.4 Safeguarding

The Trust has developed Key Performance Indicators for safeguarding Children and Adults and has significantly increased training levels over 2013 providing a greater level of assurance for the Trusts ability to safeguard children and adults. A key risk for the Trust is its ability to provide quality care for an increasing number of children admitted to paediatric wards as a place of safety and awaiting Tier 4 CAMHS beds in tertiary services. The Trust is working with local and specialist commissioners to try to resolve the issues.

5.5.5 Patient and Family Complaints

Over the last 6 months there has been a series of actions undertaken to improve the time taken to respond to complaints. Considerable progress has been made in the time taken to respond to complaints. In December 2013, 100% of cases were acknowledged within 3 working days and 79% of cases received after 1st October 2013 were responded to within 35 days. The management of complaints has significantly improved in the last 3 months. Changes have been introduced with new processes and systems having a positive impact on the number of complaints we are able to resolve and close within the specified timescale.

The Patient Advice and Liaison Service (PALS) was re-introduced to the Kendal and Lancaster sites from 1st October 2013. This, in conjunction with the Nursing 'intentional rounding', is helping to resolve patient concerns as they arise, at the bedside, rather than waiting until patients are discharged and make a formal complaint. There is a visible presence by PALS staff in ward and department areas along with associated publicity, and a seven day matron presence ensures leadership support is in place across the whole week to support our patients, relatives and visitors.

5.6 Commissioning for Quality and Innovation (CQUIN)

Working closely with all commissioners we are developing a comprehensive CQUIN programme for 2014/15 and beyond, focusing on delivering key quality outcomes for patients, rather than process outcomes. The local schemes have been developed jointly focusing on key quality priorities for commissioners and the Trust. The delivery of schemes will be via teams from across our clinical divisions supported by colleagues in Information and Governance teams so that improvements are fully embedded in a sustainable way. The schemes for 2014/15 will include:

Table 7: CQUIN scheme proposals for 2014/15

National & Regional CQUIN Scheme
Patient Safety Thermometer – to include a 20% improvement goal in reducing the number of pressure

ulcers
Dementia and Delirium – to expand the 90% FAIR delivery into delirium care
Friends & Family Test – to increase response rates and implement a staff FFT
Regional - Advancing Quality Schemes: Pneumonia, Hip & Knee, Acute Myocardial Infarction, Heart Failure & Stroke, COPD – delivery of stretched targets in each pathway
Local CQUIN Schemes
End of Life & Spirituality – to include GSF accreditation, personalised care plans and holistic needs assessments
Children's Transition Care – transition care plans for 14-18 year olds with long term conditions moving into adult services
Frail & Elderly Care (inc 7 day working) – geriatric assessment of over 75 year olds within an agreed time frame
Harm Free Care - Medicine Management – implementation of training to support nursing staff on counseling patients at discharge and compliance of antimicrobial prescribing
Harm Free Care - Fragility Fractures - to look at alternative pathways of patient care to improve outcomes
Harm Free Care - Early Warning Scores - reduction in cardiac arrests outside critical care, learning lessons once and utilising agreed warning tool
Shared Decision Making – Roll Out To Other Elective Services (e.g. Colorectal Enhanced Recovery & Hip Surgery) - to build on the successful methodology for shared decision making
NHS England CQUIN schemes (Yet to be finalised and agreed)
Dental – to improve the clinical coding of patient care and implement family and friends
Breast Screening – setting up focus groups to understand why patients DNA
Adult Chemotherapy – to include the reduction in chemotherapy waste and introducing patient held self-care plans
Neonatal Care - to achieve 95% screening rate for retinopathy of prematurity and to improve access to breast milk in preterm infants

The Trust will strive to maintain and improve upon its very good year on year improvement of CQUIN achievement building on the 92% achievement in 2012/13 and predicted achievement of 95% in 2013/14.

Our ambition for 2014/15 is to maintain a 95% delivery as a minimum, carrying this through to 2015/16. For schemes in future years we plan to start the process of agreeing CQUIN schemes much earlier in the financial year. For example for 2015/16 we will be looking to start discussions with commissioners from July 2014.

6 Assurance Framework

In line with Monitor's Quality Governance Framework, the Trust has in place robust structures to assure itself as to the quality and safety of its services and to enable itself to act to safeguard areas of patient safety. Led by a Trust Board that fully understands its accountability with regard to Quality, the Trust regularly monitors and assesses success with regard to Quality. The Trust has in place a Governance Strategy which clearly defines the roles and responsibilities of all members of staff with regard to quality, the mechanisms used to monitor quality outcomes and the committee structure through which assurances are provided. To further strengthen governance in the Trust a Director of Governance was appointed in September 2013 to lead the newly formed Governance Division. Following an external review the Trust has implemented a programme of improvements to further strengthen its governance arrangements.

The Trust has five clinical Divisions, each of which are led by a Clinical Director supported by a divisional General Manager, Assistant Chief Nurse (or Lead Allied Health Professional), and a governance lead. Matrons and Service Managers support these divisions. Regular Divisional Management Meetings are held and Divisional Governance Frameworks are being standardised in line with the Governance Strategy to further embed a culture focused on quality at all levels of the Trust. The Director of Governance chairs a Divisional Governance Forum to ensure that there is a consistent of approach taken by divisions and learning can be shared.

The Trust Board and its Sub-Committees derives assurance on quality and safeguards patient safety through the following key activities.

- Governance and Quality is a standing agenda item on the Trust Board Agenda with Quality Reports submitted monthly, including a Patient or Staff Story;
- A full programme of Risk Management activity including the Board Assurance Framework is monitored by Trust Board and Risk Committee;
- Monthly Risk Committee with Non-Executive membership reviews Corporate Risk Register and Board Assurance Framework and monitors mitigating action;
- Clinical Governance and Quality Committee and its working groups receive reports on all quality areas including; Harms Free Care, Safeguarding, Complaints, Clinical Audits, Infection and Prevention Control, NICE Guidance. The Committee has oversight on action plans that are produced. These follow a standard format and regular updates are submitted with exceptions escalated to Trust Board;
- Each Divisional Management Teams attend Risk Committee and Clinical Governance and Quality Committee on a rotational basis to offer assurance and escalate concerns;
- Trust Management Board to resolve operational issues

The Trust monitors through its Audit Committee the effectiveness of the Trust's processes in fulfilling its duties with regard to Quality, supported by internal audit, with a schedule of annual reports submitted to the Trust Board. The Trust has recently received a series of internal audit reports which offer significant assurances regarding the Board Assurance Framework and Corporate Risk Register but has highlighted the need for the Trust to refine its structures at a Divisional Level to provide rigour to the assurance process.

The Director of Governance, supported by the Company Secretary, is undertaking a review of the corporate governance structures. A steering group has been established and the purpose of the review is to standardise assurance processes at both operational and strategic level.

Trust Management Board will have oversight of divisional performance and assurance. Risks and exceptions will be reported to the Trust Board Assurance Committees. There will be three main assurance committees dealing with finance, quality and performance and workforce. These arrangements will provide the board with the ability to focus on key strategic risks.

The Trust is currently working with its Auditors to refine and update its Board Assurance Framework and governance structures for 2014/15 and beyond.

The governance structures and processes across the Trust ensure the risks associated with the delivery of key plans are sighted on by the Board and systematically monitored and mitigated against. Detailed within appendix 2 is an assessment of risks, including mitigating factors.

7 Clinical Workforce Strategy

7.1 Workforce Planning

The ability to recruit, retain and develop staff is one of the Trust's three key strategic risks and has been the centre of focussed attention through 2013/14, which will continue into 2014/15 and in future years. The initial emphasis has been on recruiting staff, particularly nursing and medical staff, into long-standing vacancies through local, national and international recruitment strategies. This has been largely successful, with outstanding vacancy rates (once appointments take up post) of 9% for medical staff and 2% for nursing staff.

It has been a Trust priority to introduce a comprehensive approach to workforce planning in 2013/14. This approach has seen the introduction of the 6-step methodology in order to establish the workforce baseline and immediate priorities, which will be further developed in future years. The approach has involved divisional and departmental discussion alongside workforce analysis and benchmarking in order to establish workforce priorities, potential savings and skill mix reviews, including the development of nursing 'red rules' on minimum nursing skill mix to bed ratios.

The workforce plans take account of the delivery of Cost Improvement Programme targets and the development of the better care together clinical service strategy. A detailed narrative workforce plan and a Plan-On-a-Page summary have been produced by each Division. Clearly, the longer-term workforce solution (in terms of sustainability) will be driven through better care together's redesign of clinical pathways and the development of the workforce to support the emergent clinical models. These new clinical models will be available in June 2014.

Workforce plans are live documents which are subject to regular review at divisional management meetings – these are updated as a result of on-going service developments, to respond to issues/pressures within the divisions, planning around cost improvement schemes and to reflect the emergent service models developed and agreed through better care together. These plans are owned at the divisional management level with regular input from their designated Human Resources and Financial Management support.

The Trust is committed to developing its approach to workforce planning and has started to develop improved partnership engagement in the process through the better care together work. Over the last year, workforce dashboards have been developed to support managers in accessing and analysing workforce data and to assist workforce planning. Specifically, analysis has focused on the workforce priority areas (medical and nursing workforce) as outlined above to support the strategic recruitment interventions.

7.2 Workforce profile

The Trust's overall workforce increased in terms of contracted whole time equivalents (WTEs) from 4028 in 2012/13 to 4065 in 2013/14. This reflected the Trust taking action in terms of recovery to address under-resourced clinical areas to ensure the delivery of safe services and enhanced patient experience. In addition, the Trust provided additional capacity and capability in terms of the turnaround process.

Significant emphasis has been placed on analysing and benchmarking the Trust's workforce against regional, national and external benchmarks. The key conclusions from this review are that:

- The current workforce profile is broadly in line with comparator trusts when comparing grade distribution;
- Absence rates have increased and are at or above the level of peer Trusts (North West average 2013/14 = 4.6%);
- Turnover rates are low in comparison to other peer Trusts.

7.3 Improving Workforce Metrics

Table 8: Key workforce metrics

Workforce Measure	2012/2013	2013/14
Staff in post (WTE)	4,028	4,065
Absence	4.63%	4.53%
Turnover	7.21%	7.74%

7.4 Absence Management

The Trust has continued to actively manage its absence levels, although these still remain higher than in 2012/13. The Trust will be adopting a renewed and rigorous approach to employee Health and Wellbeing through a number of different work programmes designed to support improved attendance at work and ensure that it meets the requirements of the NHS Constitution's Staff Pledges.

The attendance management programme will include increased HR support for corporate and clinical managers, programme of sickness absence training, return-to-work interview training and improved management reporting. The Trust has also implemented an Employee Assistance Programme (EAP) providing free 24-hour support to staff on a range of issues. We are also investing in a new senior post, Employee Health and Wellbeing Manager, to support work in this area.

7.5 Organisational Development

The focus of the Organisational Development Strategy is the establishment of University Hospitals of Morecambe Bay as **a great place to be cared for, a great place to work** – it is a rallying call for internal stakeholders to deliver 'better care together'.

The Trust has recognised the significant demands for change across the NHS and is working towards developing its vision and strategic plan to move the Trust forward from its current position, taking into account all its inherent challenges and complexities.

Whilst strategic development needs to address all aspects of service planning and implementation, it is important to simultaneously develop the organisation's workforce to address current needs as well as prepare them for future ways of working.

Typically an approach to culture change would be aligned to strategic change, led by the Board, to drive and engender both vision and values throughout the organisation. It is therefore proposed to introduce a cultural change programme, developed with Lancaster University, to launch 'Creating Better Care Together' and to commence a programme of work to embed the vision and values within all aspects of organisational culture.

There will be three initial strands to this launch programme:

- *Developing the Better Care Together Charter:* Creating an underpinning approach to " how we work with one another" through the development, promotion and employee engagement with shared values and behaviours*;*

- *Developing leadership* capacity to promote positive role modelling and constructive , collaborative involvement in bringing in best practice (innovation) and contribution to strategic development and implementation;

- *Building capacity and agility* in the workforce for further change – through a focus on learning, reflection, problem solving, innovation and improvement – creating resilience, responsibility, team working, ownership and contribution to the future.

The *Creating Better Care Together* Organisational Development Strategy will be formed around the NHS Constitutional pledge to give every employee the opportunity to be involved in decisions that affect them and the services that they provide, and will continue the drive to give all employees an increased voice on how their organisation can be improved and encourage them to personally take action to achieve this.

Creating Better Care Together will be about developing an iterative programme that seeks to incrementally make changes and continuous improvement. The scale of the transformation required should not be underestimated – it will require a dispersed leadership model to embed cultural change in everything that the Trust does.

A comprehensive account of the Trusts draft vision and values are within appendix 3.

7.6 Workforce Innovation

A variety of methods are being utilised to redesign roles and develop alternative career pathways in areas of long-standing recruitment difficulties (local and/or national). Examples include:

1. Development of Trainee Advanced Practitioners in Allied Health Professions and Nursing to supplement Consultant-delivered services (Nurse Endoscopists, Radiographers, Physiotherapists, Dieticians);
2. Developing succession plans by appointing to roles with built-in development plans (Neonatal Nurses);
3. Introducing a careers programme for Trainee Healthcare Scientists (Practitioner Training Programme, Scientist Training Programme);
4. Outsourcing of diagnostic support services (e.g. imaging reporting) and/or rotating Radiologists into UHMB from an overseas practice are both currently being explored;
5. A collaboration with Risedale nursing home in Barrow is under development (potentially international recruitment), to jointly recruit nurses who spend some time with the Acute Trust over winter before taking up substantive appointments at UHMB or, dependant on our vacancy situation, continuing with permanent contracts with Risedale.

In addition, strategic alliances are being developed to provide enhanced sustainability through job rotations, role swaps and expert mentorship.

Work is also in place to modernise the Trust's approach to recruitment including:

- Improved vacancy monitoring and reporting to Executives;
- Bespoke recruitment website;
- Local and national recruitment fairs;
- Improved technology to make recruitment processes easier and quicker for applicants and recruiting managers.

8 Operational delivery

Detailed activity and demand analyses have been undertaken and, where appropriate, have fed into discussions with Commissioners in order to ensure the health economy understands and can respond effectively to significant changes. As a result, investment has already been made in a number of services ensuring capacity meets demand. Other responses to match capacity with demand include improvements in efficiency and productivity, which has resulted in more activity being undertaken within baseline.

An example of this relates to improvements in theatre utilisation and productivity, which has increased by 10% over the last 12-months with an associated increase in 0.2 procedures per list. Other efficiencies relate to reductions in length of stay of 0.2 days (90,000 admissions) resulting in a reduction of 85-beds (including re-badging of 22 as step-down). Day case rates have also improved significantly and are 86.67% (December 2013), which is in-line with peers.

The forecasted increases in activity relate to the following service areas:

- Cardiology;
- Respiratory;
- Rheumatology;
- Trauma/Orthopaedics;
- Ophthalmology;
- General Surgery;
- Gastroenterology.

Work is on-going with specialties and commissioners in order to remodel services and patient pathways. Given the on-going work in relation to reductions in length of stay, it is not anticipated that any increases in beds will be required. However, as a result of the reconfiguration of vascular services, 12 inpatient beds and 8 theatre lists will be relinquished once the service is decommissioned from the Trust (expected timescale January 2015). This capacity will be used to offset increases in trauma and other surgical specialties.

Detailed analysis is continuing in relation to the impact on workforce however, this will also need to be reviewed in light of the outcomes of the better care together strategy and bids to the Better Care Fund as more integrated pathways are likely to be developed. A number of admission avoidance proposals are being considered, although their impact is as yet unknown. Based on current modelling the Trust has worked through the activity projections, as outlined in table 9 below, for the next 2 years, with an understanding that these projections may change in light of the outcomes of better care together.

Table 9: Activity projections

	Forecast 13/14	Plan 14/15	Plan 15/16
A&E(attend)	83,440	83,857	84,274
DC & EL(spells)	46,536	47,855	48,750
Nonelective(spells)	45,483	45,954	46,191
Outpatients - Firsts(attend)	146,774	149,394	149,926
Outpatients - Follow up(attend)	337,500	340,284	340,855

One of the key risks in relation to responding to fluctuations in demand is fully understanding and being able to forecast on-going trends against capacity and achievement of operational targets. In order to mitigate against this the Trust is looking to introduce a specialist web-based tool, which will systematise capacity planning and profiling, patient scheduling and waiting time management. This will also provide a forward look at capacity and waiting time trajectories so that elective work can be planned around emergency peaks in winter.

8.1 Estates and facilities

An Estates Strategy has been formulated that identifies short-term work to improve the interface between clinical activities and estates, and to overcome other identified problems. The strategy is flexible so that it can accommodate different outputs from the pathway redesign work now underway through better care together.

The delivery of the Estate Strategy is dependent on the outcomes of the better care together design work and securing additional investment. This will be outlined more fully in the Trusts 5 year strategic plan but is referenced in the commercial section of this report. For the purposes of the 2 year Operational Plan, a capital investment plan is included that supports priority spend areas only based on clinical risk assessment predominantly.

Constantly looking for ways to improve support to clinical divisions, the Facilities teams will introduce two improvements in the coming year. Improvements will see the replacement of production lines of plated food, in favour of hot deliveries in bulk tins for serving onto plates in each ward, to better improve patient experience and nutrition. To help bring down *clostridium difficile* cases we are investing in hydrogen peroxide foggers and an ultra-violet light decontamination device, to be used in conjunction with radiator removal and duct cleaning on a rolling programme for wards, a training programme is in place for all domestic staff to achieve the British Institute of Cleaning qualification.

The trust is very aware of the difficulties faced by patients and staff when trying to park at the RLI. This challenge has got worse over a long period to the point where patients and staff are frustrated on a daily basis when attending appointments/ work. Initial discussions have taken place with local planners for the creation of a significant scheme to improve car parking; the most likely result will be a multi- story car park solution.

8.2 Information and Informatics

Our Information and Informatics strategy (I^3) is integral in supporting clinicians to deliver high quality services to our patients. The strategy demonstrates that there are the tools and skills available within the Morecambe Bay area to deliver a professional day to day service for our patients both internally and also to enable and improve communications across organisational boundaries. Over the next two years, the I^3 Strategy will drive many Information Technology (IT) and informatics solutions to improve patient care, some of which are outlined in the table below.

Table 10: I^3 Service Developments

I^3 service developments	**Activity from 2014 to 2016**
Complete the Lorenzo Patient record deployment and roll out	Complete major development phase of ePrescribing and Maternity. Commence the whole ePR platform rollout across all areas
Develop our business intelligence portfolio	Develop Enterprise Level Data Warehouse Alignment with Strategic Requirements Publish Performance Dashboard Develop Business Intelligent analysts for the divisions
E Hospitals and Paper-lite hospitals	Paper lite Outpatients near completion, medical devices strategy published. Lorenzo capability extended to cover medical device integration and the charting of observations and physiology Progress with paper-less healthcare agenda from Outpatients and move into Emergency Care and Inpatients .
Deployment of the Advice and Guidance system	Following a successful pilot in 2013/14 of the Advice and Guidance system, within the Lancashire North locality, this service will be rolled out across specialties and the Morecambe Bay footprint
Community Midwife Digi Pen deployment. To improve the collection of crucial information in real time without disrupting the current workflow	Predicted roll out from April 2014 will support improved decisions, more complete record
Deploy large screen touch screen monitors on every ward to use the new eWhiteboard capability. Software displays key status of a range of KPIs supporting patient assessment; treatment and discharge plan.	Roll out from April 2014 will provide better management of patient inpatient stay, more effective discharge planning, improved information reporting, improved monitoring of adherence to standards

9 Productivity, efficiency and cost improvement programmes

9.1 Cost Improvement Programme (CIP) Delivery

Efficiency targets of 4.5% for the two years 2014/15 and 2015/16 would suggest a requirement for CIP plans of around £11M per annum. Schemes totalling £12.8m have been identified for 2014/15, achievement of which will begin to erode the deficit position year-on-year. The target for 2015/16 will be £11m.

9.2 Progress on 2014/15 Planning:

Work began on bottom up CIP planning with Clinical Divisions in November 2013 and with corporate teams in December. To date, some 170 schemes have been produced and passed first validation. These schemes generate savings of £12.8m and are summarised in table 11 below.

Table 11: CIP schemes

Division	Divisional Scheme	Income Gen - clinical	Income Gen - non-clinical	Procurement	Productivity	Technology	Work force	Grand Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Acute Medicine	-	-	-	25	81	-	449	555
Elective Medicine	167	40	-	40	158	-	1,704	2,109
Surgery & Critical Care	-	652	45	778	55	-	607	2,137
Womens & Childrens	656	145	-	40	-	-	582	1,423
Core Clinical	18	77	113	305	39	2	453	1,007
Estates & Facilities	89	-	50	1	414	-	172	726
Corporate	1,000	-	85	15	14	450	1,127	2,691
Trustwide	1,569	-	200	138	-	-	300	2,207
Grand Total	**3,499**	**914**	**493**	**1,342**	**761**	**452**	**5,394**	**12,855**

In addition, other areas are under review include:

- Schemes are still being worked up by divisions, for which currently no values have been agreed. As these are reviewed by divisional teams viable schemes will be added to the list. Some of these will form part of the 2015/16 plan;
- Ideas generated by other trusts, ideas developed in previous years but not yet delivered and which are still to be evaluated. These have been shared with divisional teams and will be evaluated in the same way as internally generated schemes.

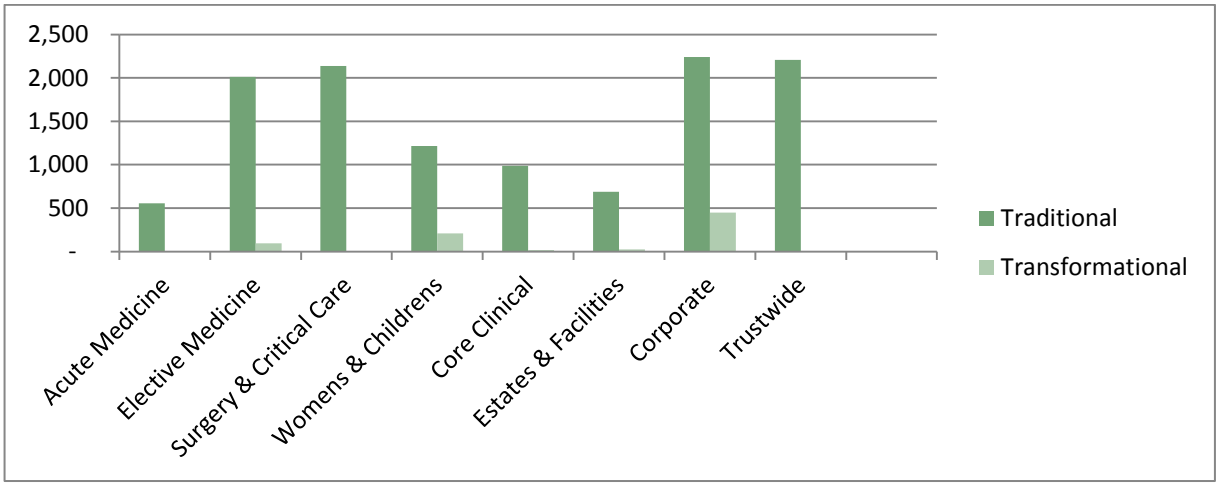
The CIP Delivery Office (CDO) is being restructured and from 1 April will be more closely aligned with the Finance team, who will continue to monitor and report on delivery of the programme throughout 2014/15.

Divisional and Corporate Schemes cover a mix of both traditional and transformational projects (see table 12). In 2014/15 there are fewer transformational schemes as the Trust has still to complete its work with

the Local Health Economy on better care together, which will inform the strategic changes to be undertaken in future years.

The impact of efficiency programmes on whole time equivalent (WTE) staff numbers across the plan period is still being finalised and agreed with Human Resources, but most reductions are either assumed to be handled within normal churn rates over the relevant years, or the reductions in spend will impact primarily on non-established labour (bank, agency, overtime etc.).

Table 12: Traditional and transformational project areas



9.2.1 Governance:

The CIP delivery team works closely with Finance and Quality colleagues on completion of documentation to support scheme delivery. Quality Impact Assessments are required for all relevant projects. These are being reviewed with Medical and Nursing Directors in scheduled meetings before final sign off.

In addition, relevant projects will this year complete an Equality Analysis (EA), with these reviewed with the Director of HR. EAs will also be completed at Divisional and Directorate level to confirm any cumulative impact masked at individual scheme level.

9.2.2 2015/16 Planning

As the work on better care together unfolds, more transformational schemes will be added, although the timing of such plans is likely to deliver little significant benefit to 2015/16 but rather add to the totals for 2016/17 and subsequent years. The CIP schemes will be restricted to local schemes under the Trust's control until the outcomes of better care together is clear.

The initial plans for delivery of the £11.0m target for the 2015/16 period are set out in table 13 below.

Table 13: CIP programme 2015/16

Future Schemes	**2015/16**
	£'000
Back office/outsourcing shared service arrangement	500
Workforce productivity	3,000

Travel policy and other HR changes	300
Catering cost reduction/outsource	400
Theatre/patient care improvement	1,200
Sickness absence management	1,000
Procurement	1,200
PPU income/non-contract income	400
Big 4 spend elimination	200
CIP BAU 1%	2,800
TOTAL	**11,000**

Transformational elements of the 2015/16 programme total around £5m, and this figure will be firmed up as more detail is added for these schemes. Divisions will start to complete workbooks for their elements of the programme once the quality impact assessment and equality analysis process for 2014/15 has been fully signed off.

10 The financial plan

10.1 Years 2013/14

The Trust is forecasting to finish 2013/14 with a deficit of £19.9m, which means that the deficit is £0.5m worse than planned. This is mainly because of the use of agency staff to both cover vacancies and deliver extra activity. In addition, further non-recurrent support of £1.5m has been agreed which will reduce the deficit further to £18.4m. Whilst the support has been agreed for 13/14, the payment will not be received until April 2014.

As regards cost improvement (CIP), the Trust is forecast to deliver its CIP target of £18m over the two financial years 2012/2014 in full. This includes £4.8m non-recurrent CIPs which moving into 14/15 are offset by the balance to full year effect of recurrent schemes of £ 3.7m, leaving a pressure in 14/15 of £1.1m.

This higher than planned deficit has created a cash pressure in 2013/14 which the Trust has managed through working capital at the year-end.

10.2 Years 2014/15 and 2015/16

The key assumptions for each year are as follows:-

In 2014/15 a CIP of £12.8m has been planned. This is in addition to the balance to full year effect of 2013/14 schemes which are required to offset in part the non-recurrent element of CIP achievement in 2013/14. The current plans in 2014/15 include £2.0m non-recurrent CIP and the recurrent schemes have a balance to financial year end of £1.5m, resulting in a £0.5m pressure in 2015/16. As regards 2015/16, a CIP of £11.0m is planned, which is broadly in line with the requirement in the tariff.

Commissioner support of £6m is included in 2014/15 and is in line with the amount received in 2013/14. Moving into 2015/16 no support is included; however the income includes a minimum £15m in respect of the Trust's anticipated successful use of the National pricing policy.

Public dividend capital (PDC) of £13m is included for 2014/15 and £9m in 2015/16.

The forecast income and expenditure (I&E) surplus/ (deficit), as per the annual plan, is shown below and includes the following:

Table 14: I&E surplus/ (deficit)

Summary SOCI	***2014/15***	***2015/16***
Total income	266.9	273.0
Total operating costs	(270.6)	(267.6)
Operating surplus before depreciation & amortisation	*(3.7)*	*5.3*
Depreciation and Amortisation	(11.2)	(11.8)
Non-operating income/expenses	(4.1)	(4.3)
Net surplus/(deficit)	**(19.0)**	**(10.8)**
Closing cash	0.7	0.9
	2014/15	***2015/16***
Surplus/(deficit)	(19.0)	(10.8)
Includes:		
Support	6.0	
CIP	12.8	11.0

We have laid out the other assumptions we have used in developing our financial plan below.

10.2.1 Income

10.2.1.1 External support

In the financial year 2013/14, the Trust received £6m in support from commissioners. Support for 2014/15 has been assumed at the same level. Moving into 2015/16 it is assumed that support will cease and will be replaced with a local price modification of £15m. This is based on the initial work done by PWC in relation to our structural deficit.

10.2.1.2 Activity

We have assumed that our activity levels will increase above the forecast 13/14 level. This increase comprises two elements firstly an increase of between 0.5% and 0.9% has been included across all activity for anticipated demographic changes. In addition to this for outpatients and elective work (day-cases and inpatients) further growth has been included in some specific specialties to reflect recent referral trends and pressure on waiting lists in those areas.

The work being undertaken with our Clinical Commissioning Groups (CCGs) to develop a clinical strategy for the health economy, Better Care Together, may produce an output that would require us to change our assumptions around future activity levels. Prior to this work being completed we have based our 2014/15 and 2015/16 activity outturns on the current configuration of services.

Table 15: 2014/15 and 2015/16 forecast

Summary of income changes		
£m	***2014/15***	***2015/16***
Prior year income	269.9	266.9
Non-recurrent income in prior year	(4.4)	(0.2)
Balance to FYE	(0.1)	0.0
CIPs in prior year	(0.3)	(0.1)
Net tariff /inflation	(4.0)	(4.0)
Activity changes	4.7	4.5
CIP schemes	0.9	0.4
Change in commissioner support	0.0	(6.0)
Local price modification	0.0	15.0
Other changes and movements	0.2	(3.5)
	266.9	**273.0**

10.2.1.3 Costs
Our CIP programme in 2014/15 is £12.8m and 2015/16 is £11m. .

The inflation assumptions used are outlined in the table 16 below:

Table 16: Summary of inflation assumptions

%	***2014/15***	***2015/16***
Pay	2.5	2.5
Non-pay	2.7	2.7

The table below maps the assumed costs changes between 2013/14 and 2015/16.

Table 17: Summary of assumed cost changes

£m	***2014/15***	***2015/16***
Prior year costs	272.9	270.7
Non-recurrent costs	(3.3)	0.0
CIP's in prior year	0.8	0.2
Pay inflation/increments	3.5	3.5

Non-pay inflation	2.1	2.1
Other cost uplifts	1.3	1.3
Activity changes	4.7	4.5
Other cost pressures and movements	0.5	(4.0)
CIP impact(total)	(11.8)	(10.6)
	270.7	**267.7**

10.2.1.4 Capital expenditure

In view of the forecast deficit and pressures on cash facing the Trust, the board have taken the decision to restrict capital expenditure to only essential areas. £6m has been forecast in 2013/14 and £8.3m in 2014/15, returning to regular levels of £10m in 2015/16.

Following completion of the clinical strategy work currently being undertaken with the CCGs, further capital expenditure may be required in order to reconfigure the existing estate. We will provide an update on this in our "Strategic Plan" which we will submit to Monitor in June 2014.

The current proposed capital plans for 2014/15 & 2015/16 are summarised below.

Table 18: Capital schemes

£m	***2014/15***	***2015/16***
Information Technology	0.7	0.6
Medical Equipment - Purchased	1.2	2.0
Estate schemes	4.6	3.0
Other schemes	1.1	3.9
Total	7.6	9.5
Charitable Capital	0.7	0.5
Total	**8.3**	**10.0**

10.2.1.5 Cash

The Trust received PDC of £16m in 2013/14. In 2014/15 we have assumed PDC of £13m. In addition, as identified in the section on capital, the board have taken the decision to restrict capital expenditure to only essential areas. £6m has been forecast in 2013/14 and £8.3m in 2014/15, returning to regular levels of £10m in 2015/16.

The table below summarises the forecast cash-flow position.

Table 19: Summary cash flow

£m	***2014/15***	***2015/16***
Net surplus/(deficit)	(19.0)	(10.8)
Less depreciation included in surplus/(deficit)	11.2	11.8
Net cash receipt - capital	0.7	0.0

Capital Expenditure (including charitable capital)	(8.3)	(10.0)
Working capital	2.4	0.2
PDC	13.0	9.0
Net cash flow	**0.0**	**0.2**
Opening cash	0.7	0.7
Closing cash	**0.7**	**0.9**

10.3 Risks and mitigation

Key risks to delivery of the financial plan are:

- Delivery of the CIP programme;
- Timing/amount of PDC provided;
- Timing/level of support and finalisation of the contracts for 2015/16;
- Containing expenditure within the amounts assumed: and
- Successful pricing strategy

The potential impact of the risks is assessed in the tables below.

Table 20: Best case

	2014/15	2015/16	2014/15	2015/16
	SOCI	SOCI	Cash	Cash
	£m	£m	£m	£m
Net surplus as per Plan(base case)	**(19.0)**	**(10.8)**	**0.7**	**0.9**
Upside Opportunities				
Local Price modification - partial year impact	7.5	0.0	7.5	7.5
Additional CCG support-nonrecurrent	1.0	1.0	1.0	2.0
Additional CIP's - recurrent	1.0	2.0	1.0	3.0
Further contribution from growth-recurrent	0.2	0.4	0.2	0.6
Total Upside opportunities	**9.7**	**3.4**	**9.7**	**13.1**
Best case	**(9.3)**	**(7.4)**	**10.4**	**14.0**

As the trust is in receipt of PDC we would be unable to draw this down if we had additional cash available

Table 21: Downside Case after mitigations

	2014/15	2015/16	2014/15	2015/16
	SOCI	SOCI	Cash	Cash
	£m	£m	£m	£m
Net surplus as per Plan(base case)	**(19.0)**	**(10.8)**	**0.7**	**0.9**
Downside risks before mitigations				
CIP slippage 2014/15 – non-recurrent	(2.0)	(2.0)	(2.0)	(2.0)
Growth overestimated 2014/15 - recurrent	(0.5)	(1.0)	(0.5)	(1.0)
Contingency insufficient 2014/15 – non-recurrent	(0.5)	(0.5)	(0.5)	(1.0)
Higher than planned BCT implementation costs –non-recurrent	(0.5)	0.0	(0.5)	(0.5)
Reduced amount for LPM 2015/16 -recurrent	0.0	(3.0)	0.0	(3.0)
Total Downside risks before mitigations	**(3.5)**	**(6.5)**	**(3.5)**	**(7.5)**
Downside case before mitigations	**(22.5)**	**(17.3)**	**(2.8)**	**(6.6)**
Mitigations				
Further Recurring CIP's 2014/15	1.0	1.0	1.0	2.0
Cost control recurring 2014/15	0.5	0.5	0.5	1.0
Central funding for BCT implementation costs	0.5	0.0	0.5	0.5
Total Mitigations	**2.0**	**1.5**	**2.0**	**3.5**
Downside case after mitigations	**(20.5)**	**(15.8)**	**(0.8)**	**(3.1)**

10.3.1 Capital Investment

Backlog maintenance identified at £11 million is being addressed through a detailed risk-based approach to capital expenditure, whilst the Capital Plan will finance planned improvements in clinical activity and the need to replace ageing medical equipment. Work is progressing to detailed design stage for the relocation of the Blood Sciences Unit and the Oncology Unit at Lancaster, and 40 other building schemes (many of modest size but high importance) are planned for the Trust's sites in 2014-15. A further 30 are planned for 2015-16, including long-term rolling programmes to address the biggest items of backlog maintenance such as the need to replace all windows throughout Furness Hospital over the next few years. A capital plan of £8.3 million will be submitted to the Trust Board for approval in 2014-15.

A number of other schemes including asset sale and potential further investment in efficient energy included in the 2 year Operational Plan are reflected in the Commercial section.