Wirral University Teaching Hospital NHS
NHS Foundation Trust

Operational Plan Document for 2014-16

WIRRAL UNIVERSITY TEACHING HOSPITAL 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):

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Date	**4 April 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)*	Michael Carr

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	David Allison

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Alistair Mulvey

Signature 

1.2 Executive Summary

In 2013/14 Wirral University Teaching Hospital NHS Foundation Trust (WUTH) is proud to have continued to deliver against its core vision of being the 'First Choice Healthcare Provider for the communities we serve'. Amongst many other achievements, the Trust received a clean bill of health from the CQC in their unannounced three day visit in November 2013, being assessed as meeting all standards reviewed and its maternity and stroke services have been assessed as the best in the north west.

Despite these achievements the Trust continues to operate in a very challenging environment and did not deliver its financial plan for 2013/14. Following worse than expected financial performance in quarter two of 2013/14, Monitor initiated an investigation into why this had occurred and which has resulted in a number of recommendations for improvement. In February 2014, Monitor closed its investigation, satisfied that sufficient progress was being made to improve governance processes, although the Trust remains on monthly monitoring. In order to assure the process followed to develop our plans for 2014/15, the Trust has instructed the support of external advisors, who it is working with to ensure appropriate improvements are being made.

This Operational Plan covers the years 2014/15 and 2015/16 – years 2 and 3 of the delivery of our 'Locally Focused; Regionally Significant' strategy. Whilst the Board considers that the core tenets of this strategy continue to hold true, the Board recognises that the external environment continues to be extremely challenging and health community dialogue is essential if the Trust is to continue to transform services and change shape over the period of this plan and beyond to ensure a sustainable future for the Trust. The health community we serve is faced with some of the poorest health in England, hence the Trust is supportive of commissioner led review of health and social care system across the Wirral – 'Vision 2018' – which intends to lead the transformation of a wide range of services to meet the collective challenge to relentlessly drive up the quality of services in the face of continued financial pressures. Over the two years of the plan the Trust is proposing to incrementally change its shape – including transforming the use of capacity and a revised leadership model to ensure resources are used more efficiently and supporting health community initiatives already commenced, but which will continue under the auspices of the 'Better Care Fund' to improve care, closer to home. The Trust is also working collaboratively with a number of neighbouring Trusts to develop service models which result in real patient benefit, whilst also becoming more efficient and is at the same time investing heavily in a world class IT system to revolutionise patient care.

The Trust has a clear focus on quality improvement and these initiatives will continue over the next two years with targeted and measurable improvements being made in a number of areas. These include shared priorities with commissioners around improving dementia care for our most vulnerable patients, nutrition and hydration and targeting pressure ulcer and infection prevention, contributing to continuing to improve our patient experience as measured through the 'Friends and Family' test – an organisational priority. Another key priority is continuing to improve our mortality rates, where good progress has already been made and focusing on readmissions, where we know performance could improve.

Over the course of the development of this Operational Plan, the Trust has worked with its senior clinical and managerial leaders to ensure there is a much better understanding of the capacity and workforce needed to sustainably deliver improvements in quality, financial and operational performance over the course of this plan. The Trust will keep this under constant review through an enhanced performance management process over the course of the delivery of the plan. The Trust continues to face some performance risks, particularly in relation to emergency care and the prevention of infection – but the Trust has plans in place to address identified risks and is working with health community partners in both areas to continuously challenge levels of performance.

Underpinning this Operational Plan is an unprecedented financial challenge to deliver more care within a reducing financial envelope and the Trust is planning to deliver a deficit position over the next two years as it works to transform the shape of its services. The Trust has an open, but challenging, relationship with its main commissioner and contracting discussions for 2014/15 have been characterised by differences in opinion about in the maturity of health community schemes being developed to deflect demand away from the hospital into community settings. The Trust is committed to transforming models of care so that the acute hospital sees only those patients who need acute intervention, but is also conscious that it cannot reduce capacity without clear evidence that schemes to safely manage patients are in place and effective. As such the Trust has developed its Operational Plan having made an assessment of the current state of the development of primary and community schemes to deflect demand, which is divergent from that held by commissioners. The Trust recognises that this presents a risk and will keep these plans under review as the maturity of these schemes develops and implement further measures to adjust capacity, should these schemes impact as suggested in 2014/15.

Discussions with commissioners have resulted in the Operational Plan being developed on the basis of a Payment by Results contract over the two year period. There are a number of risks associated with this approach which have been laid out within the content of the plan and are based on a number of assumptions and formed out of a number of scenarios which have been developed and presented to the Board. The Board will use the recommendations of the external review currently underway to further strengthen the oversight needed to mitigate risk associated with these scenarios.

A further key and significant financial risk over the course of the plan is the delivery of a challenging cost improvement plan. Whilst significant improvements have been made in the development of a robust Programme Management Office and methodology to support the delivery of these plans, the efficiency needed over the next two years is unprecedented in the Trust's recent history and remains a high risk. The Trust is working with colleagues to ensure wide and deep engagement in the development of plans to ensure that improvements in efficiency are delivered through improvements in quality – such as reducing waste, duplication, error and delay and fundamentally the better use of our capacity.

The summary of our expected financial performance over the next two years is outlined below in table 1 –

Table1 – Summary of financial performance over the two years of the Operational Plan

Detail	**14/15 £m**	**15/16 £m**
Income	299.61	300.12
Expenditure	-290.03	-287.13
EBITDA	9.58	12.99
Non-Operating Expenditure	-13.81	-14.19
Surplus / (Deficit)	**-4.23**	**-1.2**
CIP Requirement	**13.00**	**16.00**
COS Rating at year end	**2**	**2**

1.3 Operational Plan

In this section the Trust describes the current position in respect of the delivery of its own strategy and how this relates to the development of a strategic plan for the local health economy.

1) Trust strategy – Locally Focused; Regionally Significant – 2013 - 2018

In the context of a changing and challenging external environment in which the NHS is delivering higher levels of quality performance in a constrained financial climate and with a strategic desire to see more care delivered closer to people's homes and out of hospital, the Trust, in 2013, agreed a new five year strategy – 'Locally Focused; Regionally Significant'. This strategy is based upon a clear vision to be –

"The First Choice Healthcare partner to the communities we serve, supporting patients' needs from the home through to the provision of regional specialist services."

This strategy indicated that over the next five years we will work together to transform our organisation, building on our considerable clinical capabilities, to place our patients and our customers at the heart of everything we do. The focus on exceptional customer service will be delivered through integrated, seamless, continuous pathways of care enabled by innovation and leading edge technology and is underpinned by a set of clear strategic objectives, which have agreed annual milestones attached to them.

•To be : The Top NHS Hospital Trust in the North West for Patient, Customer and staff satisfaction
•To Lead On: Integrated, Shared Pathways of Care with Primary, Social and Community Care
•To deliver : Consistently High Quality Secondary Care services enhanced through the provision of regional specialist services
•To ensure : Our people are aligned with our vision
•To maximise : Innovation and Enabling Technologies
•To build on : Partnering for value
•Supported by : Financial, Commercial and Operational Excellence

In the preparation of our Operational Plan (and for our strategic plan due for submission in June 2014), the Board agrees, that despite this extremely challenging external environment, the core aspirations of our strategy remain true to our vision to be locally focused – delivering excellent local health services for the population we serve and regionally significant – continuing to deliver a range of specialist service to our local and regional population, where the Trust can demonstrate exceptional outcomes. The Board accepts however that the delivery of this strategy will need to be carefully monitored and reviewed over the coming two years as the health and social economy progresses with the work it is currently undertaking to define a longer term vision, in light of the challenges it faces and which are described in the following section.

It is important to note that in light of the financial challenges the Trust faces and following worse than expected financial performance in 2013/14, the Trust commissioned an external advisor to work with it on the recommendations for the improvement of the planning process in 2014/15, which have been reflected in the development and approval of this plan. A separate report from external advisors has been submitted to Monitor on our plan for 2014/15.

The financial backdrop against which the Trust has made plans for 2014/15 and 2015/6 remains extremely challenging and the Trust will continue to be faced with the dual challenge of improving quality and safely reducing costs. This is particularly stark given the health needs of the population, which are explored further in the section 1.3. Balancing these issues are amongst the most significant risks the Trust faces. The Board has given these issues serious consideration over the period associated with the development of the plan and has concluded that the submission of a plan which delivers a planned deficit position over 2014/15 and 2015/16 offers the Trust the opportunity to work with all key stakeholders to deliver a redesigned model of care, changing the way our workforce operates and how we use our physical resources.

2) Annual Objectives 2014 – 16

In January 2014, the Board approved a five year milestone plan for the delivery of the 'Locally Focused; Regionally Significant' strategy, which will shape annual objectives for 2014/15 and 2015/16. These included a baseline position established in 2013/14 and represented incremental improvement across the following five years.

These Annual Objectives and link to the appropriate strategic objective are outlined in the table below (table 2). As part of an improved planning process in preparation for 2014/15, these objectives have been used to inform the development of Divisional and Corporate department plans and will feed into the Trust's appraisal process to ensure that the delivery of these objectives is tied to all department, team and individual objectives. Our Annual Objectives for 2014/15 are outlined in the table below and show specific and measurable targets which will be used to ensure delivery of our strategy. Objectives for 2015/16 will show incremental improvement from the position in 2014/15, but will be reviewed in January 2015 to ensure congruence with our health community plan at that stage.

Table 2 – Annual Objectives for 2014/15/16

Strategic Objective	Annual Objectives for 2014/15	Annual Objectives for 2015/16*
To be the top NHS Hospital Trust in the north west for patient, customer and staff satisfaction	Improve our patient experience to deliver a Friends and Family Net promoter score of 65 or better Create a strong culture of empowered employees, delivering a Staff Engagement score of 3.59 or better, through implementation of our Nursing, Midwifery and a Customer service strategy	Improve our patient experience to deliver a Friends and Family Net promoter score of 75 or better Create a strong culture of empowered employees, delivering an improved Staff Engagement score,
Leading on integrated shared pathways of care with primary, community and social care	Work with partners in Wirral to reduce delayed transfers of care to no more than 4 per month and reduce readmissions to 7.5% of total admissions, by developing a range of plans to deliver care closer to home	Work with partners in Wirral to reduce delayed transfers of care to no more than 3.5 per month and reduce readmissions to 7% of total admissions, by developing a range of plans to deliver care closer to home
Delivering consistently high quality secondary care services, enhanced through the provision of regional specialist services	Implementation of our quality improvement strategy to reduce mortality to 85 (HSMR) Ensure that our harm free care score is no lower than 93% and no lower than 95% for 3 months	Implementation of our quality improvement strategy to reduce mortality to 80 (HSMR) Ensure that our harm free care score is no lower than 95%
Ensuring our people are aligned with our vision	Relaunch our values and behaviours strategy and improve attendance rates to 96% and appraisal rates to 88%	Further embed our values and behaviours strategy and improve attendance rates to 96.3% and appraisal rates to 91%
Maximising innovation and enabling technologies	Implement the next stage of our Cerner IT systems and deliver full electronic nursing documentation, pilot paper free outpatients and the ability to share documents with primary care (HIMMS level 5) To ensure patients are notified of opportunities to participate in suitable studies To participate in research to ensure the agreed recruitment goal is met for the Trust (400 patients)	Implement the next stage of our Cerner IT system, reaching HIMMS level 7 Further improve our R&D metrics associated with patient participation in clinical trials
Building on partnering for value	Deliver an increased market share to 77% of Wirral CCG referrals, through engagement with local GPs Develop a range of partnerships with NHS and non NHS providers to secure clinical sustainability, particularly in relation to our regionally significant services	Deliver an increased market share to 79% of Wirral CCG referrals, through engagement with local GPs
Supported by financial, commercial and operational excellence	Full Compliance with our registration with the Care Quality Commission Registration Delivery of our financial plans, including achievement of cost improvement programmes A Monitor Green governance rating, meaning we have met all our performance targets, including A&E, 18 weeks and cancer.	Full Compliance with our registration with the Care Quality Commission Registration Delivery of our financial plans, including achievement of cost improvement programmes A Monitor Green governance rating, meaning we have met all our performance targets, including A&E, 18 weeks and cancer.

*=subject to Board review in January 2015

3) The Short Term Challenge 2014/16

In this section we will describe the broad two year strategic, operational, financial and clinical challenges faced by the local health community and the process we are participating in to ensure we have plans in place to meet these challenges.

Consistent with the national trend, the Wirral health and social care system is facing the dual challenge of continuing to improve levels of quality, safety and patient experience, combined with a challenging financial climate. Commissioners and Providers each face significant savings challenges over the next five years. The savings target for the economy ranges from £21million to £32million per year. Given the scale of this challenge, the traditional approach to delivering efficiencies will not be enough to ensure high quality and affordable health and social care services continue in the future. Partners in Wirral have recognised that they must work together to ensure the Wirral population continues to receive high quality services from the available health and social care budgets.

i) Local health economy demographic context

Alongside financial pressures the demand for local services is increasing. Of the local population, those aged 65 years and above are projected to increase by 18% from the present level of 61,900 by 2021 (ONS 2011 based population projections, 2012). The population over 85 is projected to increase from 8,460 in 2011 to 10,985 in 2021, which equates to a 29.9% rise. This older population is also more likely to have a long term condition, with the 2011 census reporting that about 36,000 (57%) people living in Wirral, aged 65 years and over reported a long term condition or disability that limited their daily activities.

Wirral also has the widest inequalities in Disability Free Life Expectancy (DFLE) of any Local Authority in England in 2012. Men living in the most deprived areas can expect to spend 20 more years of their lives living with ill-health or disability than men living in the most affluent areas. For women the difference is 17.1 years.

Lifestyle related issues such as smoking, drinking too much alcohol and obesity are all more prevalent in the most deprived areas of Wirral, with rates of breastfeeding lower than in comparable parts of the north west. Alcohol is a significant problem and death rates from digestive diseases mainly caused by alcohol are increasing rapidly in the most deprived areas. Numbers of looked after children in Wirral are higher than the national average and amongst older people, dementia is a current concern and forecast to become a greater problem for Wirral, with an estimated 4,443 people over 65 living with dementia in 2011. This is projected to rise to almost 5,300 within the next eight years (Wirral CCG prospectus 2013-14). Admissions to nursing homes in the Wirral are also higher than comparable areas of England.

ii) Local health economy strategic planning approach

The partner agencies in Wirral have agreed that the significant challenges the Local Health Economy faces are best resolved through partnership working and ensuring the views of clinicians, local people and partner agencies inform what we do to deliver sustainability going forward to 2018. Through the establishment of the 'Vision 2018' programme, a vision for the future of health and social care on the Wirral has been established. The vision is –

'To ensure the residents of Wirral enjoy the best quality of life possible, being supported to make informed choices about their own care and being assured of the highest quality services'

A governance structure has been agreed including models of care groups in relation to primary care, secondary care and integrated care, with supporting groups around population modelling, contracting,

communication and workforce. The Trust is engaged with this process and is committed to delivering its share of transformational change. The focus of discussion to date has been primarily on the longer term vision which will be described in more detail in the Strategic Plan submission of June 2014.

The Trust accepts and supports that this will mean acute provision becoming smaller and more efficient, with more care delivered outside of the hospital, including outpatients within the community setting. This is a necessary but challenging vision, but which builds on the clinical strategies developed by the Trust in 2013/14 and which see the separation of non elective and elective workstreams to enhance productivity and improve quality of care.

iii) Health economy planning 2014/15 – 2015/16

Notwithstanding the development of the 'Vision 2018' strategic planning process, the health economy is faced with a challenge over the next two years to develop an Operational Plan which enables transformational change on the journey towards a less hospital centred care system. This will require both delivery of transactional efficiencies across the entire system but also investment in primary and community care to deflect activity currently undertaken in the acute sector into other areas. The Trust has been clear that its preference would be to work with commissioners to develop an approach to catalysing these changes, through an appropriate risk share based contract settlement over two years. To date this has not been possible and the basis of the 2014/15 contract remains on Payment by Results. The Trust recognises that this arrangement will pose a significant challenge to the system over the next two years to work towards the required transformation of health and social care provision, whilst ensuring providers and commissioners remain viable and has made activity and financial plans based on a number of scenarios. For the purposes of this plan, the Trust has made, given the current state of development of strategic transformational plans, a prudent assessment that income is assumed to be broadly flat over the next two years.

A recognised risk for the health economy going forward is in relation to non-elective demand. Emergency medical admissions, particularly from GPs and for patients with high acuity, continue to increase, placing pressure on the entire urgent care system. In a number of areas the health economy has agreed to continue to work together over the next two years. This includes a continued focus on non-elective admission avoidance through ongoing work to integrate models of care, reducing readmissions, continuing to improve our quality and focusing on efficiency. The Trust is also clear that the existing work being undertaken in respect of patients with long term conditions, who would benefit from better integration of acute, community, social and primary care should continue to have priority attached to it, particularly as evidence suggests that patients with long term conditions are more likely to be admitted to hospital in the Wirral than in other parts of the north west or many parts of England.

In addition and complementary to this work, a number of elective specialties have been highlighted for strategic review and redesign, particularly where there may be scope for services to be delivered closer to home.

iv) Better Care Fund

To support the integration of health and social care systems at a local level, the Better Care Fund submission has been developed by commissioning leads from Wirral CCG and Wirral Council. The submission provides a high level view of where the pooled resource across health, social care and public health will be spent in 2014-15 and 2015-16. It describes the delivery of a transformed service for the people of Wirral, aligned to the 'Vision 2018' process, which will support the significant movement of care from hospital to community setting enabling the concurrent reduction in the cost of acute care. The aspiration for the Better Care Fund to enable a 15% reduction in emergency admissions over 2 years will

require exceptional levels of service redesign with full engagement of partner agencies, including clinicians. The Trust recognises that this direction of travel is in line with its own aspiration to deliver more integrated care outside of the acute setting – and indeed is planning to reduce bed capacity in 2014/15 - but also that this is a challenging and 'step change' in delivery for the health and social care economy. It has sought assurance that this change will be thoroughly implemented and governance processes will quickly identify any deviance from the planned outcomes with a plan of appropriate mitigation taken immediately. In the absence of detailed implementation plans, the Trust has assumed flat levels of A&E attendances and non-elective inpatients over the next two years, but will keep these plans under constant review, as proposals for non-elective reform continue to develop. A downside scenario and associated mitigations has been developed to reflect the full impact of the proposals. Certainly current evidence suggests that the number of GP admissions received by the Trust in January 2014 was 37% higher than the number admitted by GPs in January 2013, an actual increase of 310 admissions (average 10 per day) and in January 2014 ambulance arrivals to the Emergency Department have risen by 4.36% compared to the same period last year.

The Better Care Fund submission also indicates that a 20% improvement in productivity in relation to planned care is required over the five year period 2014-2019. Through the 'Vision 2018' planning process and subsequent discussions with commissioners, the Trust has identified a number of elective specialties where it will work with commissioners to redesign currently based acute services into a possible community based model, delivering efficiencies. These include urgent care, long term conditions and care of the elderly. These plans remain at an early stage and will be kept under review as redesign proposals develop.

At present the Trust has modelled marginal increases in elective activity in 2014/15 and 2015/16, based on analysis of market share which the Trust believes offers opportunity for small levels of growth, related to existing NHS activity undertaken by competitors and linked to the Trust's existing reputational and clinical strength.

v) Specialist commissioning

WUTH is committed to working in partnership with NHS England: Cheshire, Warrington and Wirral Area Team (CWWAT) as it develops the North West 5 year strategic plan for Specialist Services Commissioning. 'Locally Focussed, Regionally Significant' demonstrates our intention to provide regional specialist services where we have the clinical capability and expertise to do so. In September 2013 the Trust outlined its compliance with service specifications for renal dialysis, urology cancers and neo-natal intensive care. The Trust understands that areas for priority consideration within specialised commissioning services in the north west and where the Trust currently provides services include neonatal services, aspects of renal care and compliance with cancer Improving Outcomes Guidance. The Trust is confident it is providing outcomes in these areas in line with specifications but will continue to work with commissioners as their plans develop.

From April 2014, the Trust will reconfigure vascular services in line with the agreed move of inpatient surgery to Countess of Chester Hospital to enable compliance in this area. This is a significant service change and one which has offered a number of learning points for future service change.

From January 2014, the Trust started to receive level three neonatal babies from north Wales as agreed with commissioners in Wales. This agreed service move will be kept under review to ensure we continue to deliver the highest quality care.

vi) Collaboration to enhance patient care

In line with our strategic objective to 'Partner for value', the Trust is involved in a number of operational

and strategic partnerships on the Wirral and beyond, intended to offer opportunities to enhance patient care, by removing the organisational boundaries from service provision and enabling services to meet the challenges of future commissioning arrangements. These are important, but challenging, relationships to deliver over the next two years -

Collaboration across the Wirral peninsula - The Trust already has well established partnerships and collaborative working relationships with health care organisations in the wider health economy. Through historical relationships and the Integration work stream (established in 2012) WUTH already works in partnership with Wirral Community NHS Trust and Cheshire and Wirral Partnership (Mental Health services) NHS Foundation Trust (CWP). Specifically in 2014/15, the Trust will work with CWP on partnership opportunities for joint delivery of services for children in Wirral. With the establishment of the Vision 2018 strategy, there are further opportunities for collaboration to achieve better care and improved efficiencies across the health economy. Areas of collaboration will include management of urgent care, delivery of diagnostic services closer to home and administrative services such as booking appointments.

Collaboration with Countess of Chester NHS Foundation Trust – The Trust has established a refreshed collaborative relationship to build upon existing collaborative services, e.g. renal medicine, in response to the challenge facing acute hospital providers to deliver sustainable clinical services in light of national challenges such as 7 day working, availability of trained staff, expanding the availability of care and new ways of delivering care. Through this partnership two services have been established and fully embedded

- Human resources and wellbeing services
- Microbiology services

Both services have delivered significant recurrent cost savings whilst simultaneously improving the delivery of services to their patients. More recently further work has progressed in a collaborative manner with the establishment of the South Mersey Arterial Centre (SMART). A key service reconfiguration is planned for 2014/15 with the transfer of vascular inpatient activity from the Trust to Countess of Chester Hospital, delivering the key principles of working collaboratively to deliver a quality service to patients, a networked approach to benefits and risks through transparency, whilst simultaneously delivering a service that meets national specifications. In addition, both organisations have worked together to provide a joint response to implement a collaborative breast screening service and await a decision from Public Health England on their submission. Discussions are also underway across a number of other specialties, where collaboration may be of benefit to patients.

Collaboration with primary care - Through its newly agreed Primary Care Engagement Strategy, the Trust is employing a range of methods to understand the priorities of GP practices in Wirral, ensure high levels of confidence and satisfaction in the service practices receive from the Trust and maximise its business with them. This work will continue into 2014/15 aligned to the health economy 'Vision 2018' process.

Collaboration with tertiary providers - The Trust also recognises a proportion of outpatient work is referred to tertiary providers in Liverpool. This specifically impacts upon the specialties of Cardiology, Respiratory Medicine and Gynaecology. The Trust is actively exploring opportunities to develop partnerships with these organisations, where there may be opportunities to partner for value to secure clinical sustainability and patient benefit.

vii) Using IM&T to transform our services

In 2008 the Trust signed a contract with Cerner limited for the provision of their Millennium electronic patient records system. The contract, based on a partnership between the Trust and Cerner has led to a bespoke solution known as Wirral Millennium. Both parties remain fully committed to the partnership and recently extended the contract until December 2020. The organisation now has a fully integrated system

including solutions for the emergency department, theatres, maternity, laboratory medicine and patient administration.

Wirral Millennium is enabling the organisation to meet its strategic objective to maximise innovation and enabling technologies. In its capital plan 2014-16 the Trust is investing to further enable IT systems that ensure our patients and staff get the right information at the right time to deliver treatment. The system will also improve the quality of treatment and recovery by enabling device integration i.e. compatibility which allows the transfer of results from diagnostic equipment directly into the patient's electronic notes.

The implementation of phase 2b of Cerner Millennium on November 2014 will enable radical change to the way clinical staff work in the ward setting. A care plan will be prescribed by medical staff which will be carried out within specific timelines by the multi-disciplinary team enabling a safe, timely approach to care. This will support the effective management of length of stay and improve patient safety. The Clarvia system will support efficiency and safety by enabling nurse staffing to be organised according to patient acuity and flow so that resource can be directed to appropriate area of need. Phase 2b implementation will also support the development of paperlite systems within the outpatient setting (2015) and inpatient setting (2016). These developments provide efficiency opportunities which are reflected in the organisation's CIP plans for 2015-16.

The Trust is already working with health partners on the HIE (Health Information Exchange) system which enables Cerner Millennium to view Primary care data which will support the safe and effective management of patients in secondary care. In time this information exchange will be reciprocated enabling GPs to view relevant secondary care data.

As part of the Wirral Health and Social Care Vision 2018 strategy an informatics work stream has been established. The work stream is tasked in the first instance, with the development and agreement of a health-economy wide Informatics strategy to enable sharing of information in the support of integrated care. This will include the ability to have shared documents e.g. multi-agency care plans, across organisational boundaries and the use of technology to support innovative service delivery models such as tele-health and tele-care. The work stream is led by the Director of Informatics from WUTH and is also attended by the Trust's Chief Medical Information Officer.

In summary, the challenges faced by the Wirral health economy mirror those faced by other parts of the NHS and social care, combining a desire to deliver continuously improving levels of quality, safety and patient experience, within a tightening financial envelope. The health economy and the Trust have adopted a number of evolving strategies to engender a transformational approach to health and social care over the next two years, aligned to a longer term vision, which presents a health and social care model in which the hospital plays a smaller part.

4) Quality Plans

i) National and Local Commissioning Priorities

National and local commissioning priorities for quality are encompassed in the CQUIN system and schedule 4 of the standard NHS contract. The local priorities for 2014/15 remain subject to contract discussions.

The national CQUINs for 2014/15 are improving the Friends and Family test results, improving the Safety Thermometer results particularly pressure ulcer development and improving care for patients with dementia and delirium. These are all work streams within the current Trust Quality Strategy. Early discussion with the local commissioners reinforces work in these areas and will encompass other priority areas including seven day working and integrated services (to support the "*Vision 2018*" and Better Care

Fund proposals). There is a Public Health CQUIN to support smoking cessation. Delivering these priorities is a component of the Quality Improvement Strategy, which operates under the umbrella of the 'Locally Focused; Regionally Significant' strategy.

The Friends and Family test was introduced during 2014/15; the focus was on the roll out, ensuring the rate of return to make this measure meaningful with more actions to drive an improved outcome in the later half of the year. For example, within A&E improvement was seen following the introduction of "intentional rounding" where patient's non-clinical needs are addressed. The focus going forward is to ensure a sustained response rate and using other local intelligence alongside these results to improve patients' experiences; this will be delivered in line with divisional action plans. By 2015/16, the organisational target is an outcome score consistently over 75.

The Safety Thermometer was introduced two years ago and WUTH took part in the pilot activity. Harm free care measured in this way has consistently been above 93% during 2013/14. Work is on-going with an organisational target of over 95% to be consistently achieved every month in 2015/16. Within the Quality Strategy our pressure ulcer target is no new pressure ulcers grade 3 or 4 and a 50% reduction in grade 2.

ii) Our Quality Strategy

Our Quality Improvement Strategy sets out our vision for the high quality service, it provides focus for our Quality Account priorities and is based on the three domains of quality – patient experience, clinical effectiveness and safety. Each domain has measurable improvements with annual milestones to ensure we can track our performance throughout the life of the strategy. We are using benchmarking where possible to ensure we can learn from others. Whilst there will be changes to our Quality Account priorities over time, it is anticipated these will be drawn from the Quality Improvement Strategy and overall strategic objective and vision to become the first choice healthcare provider for the communities we serve.

Seven day specialist working is becoming embedded. Over the next year, the Trust will have self-assessed against the Clinical standards from the "*NHS Services Seven days a Week Forum: Initial Findings*" and developed action plans agreed with our Commissioners, to ensure compliance with the standards.

The Trust will continue to manage hospital acquired infection having made significant improvements over the last few years. We are working towards our targets of zero-tolerance of MRSA bacteraemia and no more than 24 *C.Difficile* cases in 2014/15 (target of 33 in 2013/14), although there is a risk to delivering this performance. Managing the emergence of new resistant organisms remains an imperative.

For 2014/15, we have agreed the following priority areas will be included within the Quality Account and it is anticipated the focus areas will be unchanged in 2015/16.

a) Patient Experience

Quality care is care which aims to give the individual as positive an experience of receiving and recovering as possible, including being treated according to what that individual wants or needs, and with compassion, dignity and respect. The main measure is the Friends and Family test, on which a clear target has been set for the organisation. Work-streams underpinning this are providing patient choice, ensuring privacy and dignity, improving relative and carer experience and reducing complaints.

This will be supported by improved organisation of care: With improved efficiency and productivity in relation to access to services, capacity to deliver evidence-based care pathways, timely and effective hospital discharge; supporting the delivery of "*Vision 2018*". Specific areas for improvement include -

1. Improving care for patients with dementia.

Rationale: We are seeing more patients with dementia across all areas of the Trust. We know our population is ageing and therefore the prevalence of dementia is increasing; evidence suggests the care received could be improved and this influences both the patient experience of our services as well as their clinical outcomes. Delivering high quality care to these patients will be based on best practice standards as described by the National Institute for Health and Clinical Excellence (NICE). This year, we will focus on ensuring our staff are well trained across all areas of the organisation and that the information we provide to patients and their family both is appropriate to their needs at that time, robust and consistent.

1a: People with dementia receive care from staff appropriately trained in dementia care. In Quarter 1 (Q1) we will undertake a baseline audit to identify how many staff require training, develop the training pack to reinforce the NICE standards and develop the educational plan. Milestones will be set for remainder of the year.

1b: People newly diagnosed with dementia and/or their carers receive written and verbal information about their condition, treatment and the support options in their local area. In Q1 we will undertake a baseline audit to identify the information currently used within the organisation against the national recommendations. Milestones will be set for remainder of the year based in the findings. Further standards may be included later in the year subject to progress against the targets set.

2: Ensure patients are supported with eating and drinking based on their individual needs.
Eating and drinking are basic needs for our patients. Some patients require support and which can be as minimal as opening a sandwich packet or ensuring drink is in reach to more complex support for those with swallowing difficulties. Poor nutrition and hydration can increase the risk of poor healing and additional complications for our patients as well as causing distress. We agree this should be a constant focus for improving our patients' experience. Target: 75% of patients will report receiving appropriate assistance with eating and drinking through our Learning with Patients Survey.

b) Safety

*Q*uality care is care which is delivered so as to avoid all avoidable harm and risks to the individual's safety. Reducing serious harm is the key measure. The Trust continues to implement the Safety Express initiative to reduce patient falls, veno-thrombo-embolic disease (VTE), urinary catheter acquired infection and pressure ulcers. Each of these safety areas has a working group and agreed goals to achieve. For example in 2015/16, the goals are no avoidable falls leading to serious harm, and no avoidable VTE deaths. Both these workstreams have focussed on delivering consistent care in line with NICE standards. Specific areas for improvement include -

3a: Reduce harm to patients particularly in relation to newly formed pressure ulcers. Health care is not without risk of harm. We have been measuring harm free care using the safety thermometer, this is based on a monthly audit of a sample of patients from across the Trust noting whether they have fallen, had a blood clot, a catheter acquired urinary tract infection and/or a pressure ulcer. We believe this is a helpful monitoring tool and will continue to report it; we have progress still to make, with the baseline being between 93-95%. The key harm is pressure ulcers and therefore we will continue to focus on this and reduce new pressure ulcers further. Targets: Harm free care as measured by the safety thermometer monthly will be no lower than 93% and above 95% for at least 6 months of the year and we will achieve an 80% reduction in avoidable new pressure ulcers grade 3-4 and a 30% reduction in new grade 2 pressure ulcers.

3*b: Reduce the number of "missed medication" events.* Patients need to receive their prescribed medication in a timely way to speed recovery. During this year a pharmacy intervention monitoring audit has identified this as an area for improvement in the patient experience. We want to undertake targeted

work to reduce the occurrence of these events. Target: We will achieve a 20% reduction in missed medication events based on the pharmacy intervention monitoring audit for 2013/14.

c) Clinical Effectiveness

Quality care is care which is delivered according to the best evidence to improve an individual's health outcomes. Reducing readmissions and death are the measures used. The target is for 30 day emergency readmissions to be in the top quartile nationally and Hospital Standardised Mortality Ratio (HSMR) to be in the top decile of our regional peer group. Work streams underpinning these include delivering agreed care bundles, such as those developed in the Advancing Quality initiative, ensuring our services are working to deliver the standards defined by NICE and other national bodies, and making use of new technologies where appropriate.

4a: Reduce the hospital standardised mortality ratio (HSMR) A higher than expected mortality rate can be due to a number of factors not just poor health care given within an organisation. However, it is accepted that it provides a good overall indicator of care as when high rates have been investigated various quality issues have been highlighted within hospitals. Our HSMR is currently better than the national average and we have seen significant improvement over the past two years. We are not yet in the top ten per cent for our peer group and so want to continue to reduce this further. Target: The HSMR is no greater than 85 for 2013/14 against the baseline set in 2012/13.

4b: Reduce emergency readmissions within 30 days: Returning to the hospital for unplanned care is a measure of failure of the healthcare system. Quality issues that can underpin readmission include poor discharge processes, lack of communication, and lack of community service provision. Some cases will be completely unlinked. Our current readmission rate is "as expected" for the population we serve. However, we believe we can reduce this to help us provide better patient experience and support acute care to deliver high quality services by freeing up time and resources to see new patients. Target: We will reduce our readmission rate by 1% during 2014/15

iii) An outline of existing quality concerns (CQC or other parties) and plans to address these

There are currently no outstanding concerns from CQC. The 2013 annual unannounced assessment was completed in November 2013; the six standards assessed were all considered compliant.

A scrutiny panel from the Overview and Scrutiny Committee reviewed our governance systems and response to the Francis report in November 2013, the draft report documented no major concerns and we await the final report.

The Trust received *'significant assurance'* for its risk management processes from a review by internal auditors (Mersey Internal Audit Agency) in November 2013.

The Trust has an established process in place to monitor external reviews. There is a schedule held corporately and updated as new reviews are undertaken. The outcome of the review is shared with the relevant services and any actions required are documented and entered onto the risk register to facilitate monitoring by exception.

In addition, the Trust reviews inquiries and the subsequent national reports external to the Trust to ensure our systems and processes are robust. Following the publication of the Francis II report into Mid Staffordshire Hospital, a cross organisational event was held to ensure we learnt from this and an action plan developed, currently being monitored through the Clinical Governance Group biannually. This action plan also encompassed the Keogh Mortality Review Report and the Berwick Report "*A promise to learn*".

iv) Key quality risks inherent in the plan and how these will be managed

The Trust has analysed its risk systems, patient experience feedback and consulted with staff. This information has been used to identify areas for improvement to help determine priorities for next year and beyond. The key quality risks are:

(i) Insufficient Capacity to manage patient demand: The Trust will continue to work with partners to create transformation work streams which: a) reduce emergency admission and readmission rates, through the provision of alternatives to admission, rapid access outpatient consultations and ambulatory care b) reduce length of stay through seven day access to specialist care, enhanced recovery programmes and better discharge planning with partner organisations. In addition, there are regular acuity reviews in bedded areas to ensure the nursing compliment is safe and additional staff have been and are being appointed as required. This ensures the standard of care is high and facilitates speedy recovery and discharge

(*ii) Achieving the Trust's transformation programme whilst improving patient safety, clinical effectiveness and patient experience*: We believe that there are opportunities to improve care and in the process reduce cost. The Quality Strategy aims to deliver consistent care in focussed areas that should reduce length of stay, readmissions and mortality. For example, *"Safety Express"* will continue to reduce: Hospital Falls; Venous Thrombo- Embolic disease; Hospital acquired Pressure Ulcers and Catheter Acquired UTI, the Trust will continue the work streams for effective care delivery in all groups for the Advancing Quality Programme, acute myocardial infarction, pneumonia, heart failure, stroke and hip & knee replacement. There are plans to implement a care bundle for chronic obstructive pulmonary disease from April 2014, recognising the high prevalence of long term conditions in the Wirral. The Trust will continue to improve dementia care with measured improvement monitored by the national audit.

We are measuring our services against NICE quality standards guidance, to identify inconsistency in care and to introduce recognised best practice is as short as possible.

We will engage with the Academic Health Science Network to identify innovations to improve our services.

The Quality and Safety Committee plays a key role in our Quality Assurance programme receiving assurance that potential deleterious impacts of cost improvement programmes on safety, clinical effectiveness and patient experience are risk assessed during the development of the efficiency project outlines; Efficiency plans are approved by Divisional leadership teams and escalated for approval by the Executive Team if the risk score is 15+. In addition the Quality and Safety Committee receive a broad range of quality indicators on a monthly basis, specifically to detect potential deterioration in quality as the efficiency programme progresses; these assurance reports are in turn considered by the Board of Directors in their meetings which are held in public.

(iii) Delivering care closer to home: As it becomes increasingly apparent on the national stage that greater integration between care providers is essential we will enhance further our work in partnership with the Wirral Clinical Commissioning Group, Wirral Community Trust, the Local Authority and the 3rd Sector to develop. Progress in this area can be challenging against a complex organisational backdrop and we will mitigate this risk through the further development of relationships with external bodies we have been developing, a patient centred approach and remaining open to all opportunities.

(iv) Infection prevention and control: New risks to patient safety and experience and outcomes as well as business continuity and reputation are presented by infections such as VRE (Vancomycin-resistant Enterococcus) and CPE (Carbapenemase-producing Enterobacteriaceae) and delivering on existing targets around *C Difficile* in particular. In 2013/14, the Trust invited Public Health England to review its infection prevention and control processes in a number of areas and over the course of the next period, the Trust will implement their recommendations, including reviewing its' isolation facilities, further improve

environmental cleanliness, colleague engagement and communication and developing relationships with the Community Trust, Public Health, Primary Care to minimise the impact on patients and services and ensure we are working together to reduce the risk of infection coming into hospital.

v) An overview of how the Board derives assurance on the quality of its services and safeguards patient safety.

The Board has an extensive Board Assurance Framework (BAF).The BAF drives the Board's agenda, is referenced in the supporting papers and ensures that its time is prioritised to regulatory requirements governing quality, financial and operational performance as well as the delivery of the Trust's strategic plan. Following worse than expected financial performance in 2013/14, the Trust appointed external advisors to review and recommend improvements to governance processes, which will be implemented by early 2014/15.

The BAF is the Board's process for managing the identified risks that could prevent the achievement of the Trust's strategic objectives, which includes the quality and safety of its services. The BAF is reviewed by the Audit Committee and Board.

The Quality and Safety Committee delivers a cycle of business that involves the scrutiny of assurances on behalf of the Board; this includes receiving the minutes of the Clinical Governance Group (CGG) and Risk Management Group (RMG). The Chair of the Quality and Safety Committee provides a written report to the Board of Directors after each meeting, highlighting assurances received and identifying any risks or issues for the Board's attention.

The Quality and Safety Committee makes an annual assessment against the Monitor Quality Governance Framework, noting compliance and actions taken to fulfil these requirements.

The RMG is chaired by the Medical Director and is attended by the executive leads for the other assurance groups / subcommittees. It scrutinises the risk management systems and processes throughout the Trust. It obtains assurance from divisions of good risk and governance management and where deficiencies are found the executives support the areas until resolution is achieved. It monitors the progress of CQC monitoring and ensures that updates are recorded on the Trust risk register as well as ensuring actions are completed. RMG gives assurance to the Quality and Safety Committee and the Finance, Performance and Business Development Committee.

The Board dashboard is prepared monthly and performance managed at the CGG and then used to provide assurance to the Board and Quality and Safety Committee.. The dashboard report provides a summary of the Trust's performance against internal metrics of clinical quality alongside performance against mandated targets and standards within Monitor's Risk Assessment Framework. Although the metrics vary in time-frame – weekly, monthly or quarterly – the most recent data is presented. The dashboard focuses on 3 'big dots': clinical effectiveness / reducing mortality; patient safety / reducing harm; and patient experience/ Friends and Family Test. The dashboard also provides an integrated finance and performance view, which covers a range of operational and strategic indicators

Since the discontinuation of assessment of NHSLA risk management standards, the Trust has been developing an in-house assurance map to monitor the effectiveness of key clinical and non-clinical policies and procedures; this will be reported via audit and performance reports. This new process will be implemented in 2014/15. This follows a gap analysis of assurance already available across the organisation to maximise assurance whilst minimising the burden of collection.

i) Clinical Effectiveness: Reducing mortality

Mortality rates are presented as a headline supported by the most recent data on: Hospital Standardised Mortality Ratios and Summary Hospital-level Mortality Indicator, Community acquired pneumonia (AQ), Heart failure (AQ), Acute Myocardial Infarction (AQ), compliance with modified early warning scores (MEWS) policy and medication errors. Each component area is subject to scrutiny at the Quality and Safety Committee following scrutiny and challenge at the Trust's Clinical Governance Group.

ii) Patient safety: Reducing harm

Under this group of metrics the number of serious incidents reported to the Commissioners, in-month, is examined. These are classified as pressure ulcers and other causes. This headline is supported by the most recent data against tolerance on: harm from falls; pressure ulcers; venous thrombo-embolic readmissions within 90 days; readmissions to hospital within 30 days; and patient administered medications to which they were allergic. Again, each component area is subject to scrutiny at the Quality and Safety Committee following scrutiny and challenge at the Trust's Clinical Governance Group. WUTH continues to be a high reporting, low harm organisation.

iii) Patient Experience

The Friends and Family Test: Net Promoter Scores are the key measures along with the response rates for all areas covered by the Friends and Family test. Additional intelligence is provided by data from our Learning with Patients survey: assistance with eating and drinking; confidence in staff; care always being given as a measure of comfort; and a list of most reported delays including such as take home medications is provided.

The Quality and Safety Committee also receives the minutes from the Patient and Family Experience Group.

The Board of Directors receives an Annual Report from the Quality & Safety Committee against its Terms of Reference.

vi) What the quality plans mean for the Foundation Trusts workforce

The delivery of high quality care is at the centre of our Vision and Values, which drive our recruitment, retention and reward programme. The Trust has established its core values, PROUD which set out the expectations of our staff in providing an excellent service to our patients. These will be relaunched in 2014/15

- Patients are at the heart of everything we do
- Respect each other every day
- Our hospitals are your hospitals
- United to provide the best possible patient care
- Dedicated to excellence in all we do

Aligned to the Trust Vision and Values is the Workforce / OD Strategy (2014-2016). The Strategy ensures that the Trust can be confident in our ability to continue to deliver the challenging workforce modernisation agenda whilst still ensuring 'year on year' improvements in staff satisfaction / engagement levels. The Strategy's governance arrangements are focused on improving the Culture, Capacity and Competence of the workforce. The Strategy takes in to account the key National and Local drivers. For example the changes planned changes in commissioning decisions and limited resources, demographic changes, impact of local transformation and cost improvement programmes, reconfiguration of services, competition from other healthcare providers, Local competition for staff, impact of external reviews (for example

Francis report), improvements in healthcare technology and clinical practice

The Trust has already made significant progress in aligning our clinical workforce to the delivery of care, based on both demand/flow and demographics/acuity. Building on this work, further developments will be rolled out in terms of multidisciplinary workforce planning, integration of new/developing roles and team job/planning. The Trust submits workforce returns to NHS England on at least an annual basis in respect of workforce numbers (workforce projections for the period of the plan are noted in later sections).

The Quality & Safety Committee and Divisional Management Teams receive monthly updates on HR/OD Key Performance Indicators as well as annual update on the key characteristics of the workforce. The HR/OD Key Performance Indicators include specific workforce measures such as sickness absence, temporary staffing, spend, staff appraisal, staffing ratios and staff turnover. The Committee receive feedback on the results of the NHS Staff Survey and the measures that have been taken to ensure 'year on year' improvements. The performance management of these metrics both inform workforce strategy / planning (Trust & Divisional level) and serve to provide assurance the workforce challenges are being managed, with no adverse impact on the quality of services provided. (All workforce cost improvement programmes are assessed by the Medical Director and Director of Nursing & Midwifery). Colleagues are actively encouraged to report incidents and concerns through our risk management systems including staffing issues.

In order to bring about the transformation, having a trained and knowledgeable workforce which is aligned to our vision is essential. We are one of the first Trusts in the country to introduce value based performance management of colleagues to ensure that they are delivering the standard of quality care expected and that for senior staff this is directly linked to incremental progression. The Trust has made further progress on mandatory training rates (92%) as well as progressing appraisal levels to as high as 87% - challenging improvement targets have been set for 2014/15 and 2015/16. The Trust continues to be considered a pioneer organisation for Medical Appraisal and Revalidation and received very positive feedback following the Deanery visit. The Trust has also run a number of leadership programmes internally. These included an Institute of Leadership & Management (ILM) accredited Senior Multidisciplinary Leadership & Management programme for Divisional and Directorate medical, nursing and management leaders (54 senior leaders took part in the programme). The aim of the programme begins to equip our clinical leaders for the Trust's future challenges and for senior teams to work as a triumvirate. The Trust is committed to developing senior leaders through the North West leadership academy, with eighteen senior staff having undertaken one or more programmes of the North West leadership programmes (eg Transforming the NHS Leadership Programme). An Executive Development Programme and Consultant Development Programme has been agreed and will be rolled out in 2014/2015.

The Trust recognises that transformation in service delivery needed will only be realised through passionate, engaged workforce. Participation in 'Listening into Action' (LiA) has enabled us to engage our colleagues in our vision to become the first choice healthcare provider. Since the launch of LiA in October 2012, the Chief Executive has personally worked with more than 1000 colleagues through our LiA Staff Conversations, where they have described what matters to them and what changes they would like to see. A further 600+ staff have attended team-level LiA Conversations to adopt this way of working for themselves – setting a clear mission, connecting all the right people around it, sharing ideas, taking ownership of the changes they want to see, and celebrating their successes. As we moved into our second year, we worked hard to identify priorities which would be achieved faster and better through LiA, with an absolute focus on quality and safety of care, improving the patient experience, and enabling our frontline teams to do their jobs and deliver great services. The NHS Staff Survey 2013 (response rate of 60% from 43% in previous years) reported that the overall staff engagement level has improved for the second year running - improved from 3.59 to 3.64. The Trust remains committed to the Health & Wellbeing

Agenda and whilst sickness remains above the Trust target of 4% we are confident that this will be achieved within the period of the plan. The Trust's 'flu vaccination programme achieved a take up rate of over 75% which demonstrates the commitment the Trust has to support the critical Health & Wellbeing agenda.

vii) Trust Response to Francis 2, Keogh and Berwick Reports

Following the publication of Francis 2, a number of actions were undertaken to ensure staff had an opportunity to consider the recommendations and the implications for the Trust and to voice them either through Divisional or Corporate meetings. In addition, a summary document was produced and widely circulated that focused attention on those recommendations most pertinent to the Trust. This culminated in a workshop with representation from all WUTH divisions, different clinical disciplines, managers and Board members as well as representation from Wirral Clinical Commissioning Group. This meeting was also able to include the actions arising from the subsequent Berwick Report and Keogh Mortality Reviews both of which were widely circulated. An action plan was developed based on the primary drivers identified. The action plan delivery is monitored through the Clinical Governance Group biannually and also externally by our Commissioners.

viii) Risks to delivering the Quality Plan

The Trust remains fully committed to delivery of the Quality Plan. However, the key risks to delivering the Quality Improvement Strategy are:

- *Lack of engagement with the Quality Improvement Strategy*

The Quality Improvement Strategy is led by the Executive Medical Director, supported by the Chief Nurse and entire Executive Team. Monitored through the Quality and Safety Committee and reported to the Trust Board, the strategy has reported and measurable outcomes attached to it and is widely promoted and communicated through Trust lines of reporting and communications. Operationally the strategy is championed by the Associate Medical Director who liaises with all senior clinical leaders to ensure that progress is monitored and areas for improvement challenged. Priorities are shared and discussed across the health community and are a part of the 'Vision 2018' strategic planning process.

- *Conflicting priorities and imperatives – external targets, financial drivers, other eg IM&T Cerner rollout*

The priority of the organisation is the delivery of safe, high quality care in line with our vision and strategic objectives. The delivery of the Quality Improvement Strategy and associated metrics for improvement are reported to the Trust Board through the agreed objectives of the Board. All performance and efficiency related plans are reviewed for any impact on quality and safety and amendments made should any impact be ascertained. There is a robust process to risk assess any impact on quality through the delivery of competing priorities and this will continue to be applied as we accelerate our transformation programme in 2014/15.

- *Embedding change – staff turnover*

In 2014/15 the Trust will relaunch its values and behaviours – PROUD – which put pride in the quality of ou services, team work and putting patients first at the heart of our agreed behaviours. These run through ou recruitment, appraisal and reward systems and will be further enhanced through the programme o engagement we plan to relaunch our behaviours. Corporate induction has been reviewed to ensure that a new starters have an understanding of our organisational and quality priorities made clear from day one the organisation.

d) Operational requirements and capacity - Assessment of the inputs needed over the next two years

i) Activity projections for 2014 – 16

In preparation of this Plan, operational divisions (Medicine, Surgery, Clinical Support and Women and Children's) have engaged with clinical colleagues and with existing health community forums to establish a view on likely activity trends over the next two years, based on known strategic aspirations and plans already in place. Largely activity assumptions are flat or reduced in some areas, although in areas where demand is expected to increase through demography, increased market share or service reconfiguration this has also been noted. Detail of activity projections at a high level is contained within the Appendix 1.4.

For elective inpatients and daycases, the Trust has assumed a low level of growth, based on 13/14 outturn and some areas of market share growth in specialties where Trust market share, expertise and innovation are likely to attract additional business – some of which may come from outside of Wirral.

For non-elective, including A&E attendances, the Trust has assumed a broadly flat position across the two years of the plan, based on an assessment that current collaborative working and the developing aspirations of the 'Better Care Fund' will at the very least stem the growth in emergency admissions. The Trust will keep these assumptions under review as the schemes proposed under the Better Care Fund mature and the impact of their implementation is measured.

For outpatients, the Trust has assumed some growth, based on historical, demographic trends and improvements in efficiency. The Trust is participating in a number of discussions with commissioners in relation to reform of outpatient models of care and has agreed a number of priority areas for joint work including rheumatology, ophthalmology and dermatology. These discussions remain at an early stage of development.

At the same time in relation to vascular surgery, in 2014/15 there will be a significant service reconfiguration in the Wirral/West Cheshire/Warrington area with the centralisation of vascular inpatient surgery onto the Countess of Chester Hospital site. This is a reconfiguration which has been planned for some time and will see a reduction in activity and capacity in this specialty for the Trust. The Trust's plans include consideration of this service change.

ii) Physical Capacity - Changes 2014-16

Operational plans submitted by the operational divisions have described the following changes to physical capacity required.

In 2014-15 the Trust is planning to reduce bed capacity in line with changes in a number of areas to deliver shorter lengths of stay e.g. Cardiology and Medicine for the Elderly. In order to increase levels of operational efficiency, a shared surgical and medical day case service will be established and with the re-location of vascular service provision from April 2014, an inpatient bed reduction in surgery will be implemented. These changes are aligned to the Trust's efficiency programme, but also reflective of the wider health economy plans to incrementally shift care outside of the hospital. The completion of the Endoscopy capital plan will provide an additional 3 procedure rooms, to meet growing demand for these diagnostic tests. These changes will be accelerated in 2015/16 with further challenges to the Trust's internal efficiency metrics, including length of stay.

In response to changes in levels of patient acuity, resuscitation capacity in the Emergency Department will increase and additional capacity will be created for ambulatory patients referred by their GP to the Acute Medicine service – ensuring that wherever possible, these patients can be seen and treated and then

discharged home, without being admitted to a hospital bed.

In line with the efficiency programme, there will be ongoing redesign of outpatient capacity to ensure capacity can flex to meet demand, particularly where the Trust is working with tertiary providers to repatriate DGH activity closer to people's homes in the Wirral. In addition, the Trust is actively working with a number of specialties to relocate outpatient activity into community outpatient facilities to provide specialist services closer to the patient.

Through 2014/15 and into 2015-16 the non-elective bed base will be reviewed in line with the development of further internal efficiencies and 'Better Care Fund' work streams which aspire to a reduction in the number of non-elective admissions and a reduction in length of stay of patients who do require acute hospital care.

The configuration of elective services across the Arrowe Park and Clatterbridge sites will be reviewed in tandem with the outputs of ongoing efficiency work, national specialised services reviews being undertaken in a number of areas and following clinical service reviews that are underway with neighbouring providers in a number of areas. This is linked to the overall service and site strategy to separate elective and non elective patient flow to ensure maximum opportunity to improve efficiency and increase quality.

iii) Workforce

Operational Plans submitted by the Divisions have been used to map out the workforce capacity required. It is evident from workforce planning, given the changing landscape, that workforce profiling will be a fundamental enabler to deliver the changes required within this Plan.

The size of the Trust's workforce will reduce in the future (whether due to clinical pathway redesign and transformation including integration of services, efficiencies or related to the organisational redesign which will take place from 2014/15), with particular staffing groups exhibiting a more rapid reduction (e.g. Administration & Clerical, Managerial). In line with recommendations from Francis, Keogh and Berwick Reports and the Trust's commitment to improve the quality and safety of care, the Trust has recently increased nursing establishment in Care of the Elderly nursing and neonatal care. Workforce modelling has demonstrated that the likely impact of these changes will be a slight percentage increase in the number of nursing positions within the Trust (to achieve a safer Nurse: Bed ratio and in the context of wider redesign). Medical Workforce numbers will increase very slightly for the period of the plan (working alongside this slight increase will be the productivity gains which have been identified during the recent Job Planning programme, e.g. increased Direct Clinical Care, increased 24/7 working). A plan for Advanced Nurse Practitioners has been developed throughout the Trust and is currently being implemented, including the introduction of ANPs to support the medical rota out of hours (to mitigate the anticipated 2-3% reduction in Junior Doctors). Allied Health Professional reviews are underway to ensure the services we provide now are fit and sustainable with a focus on care in the community.

Working alongside the anticipated changes in the size of the workforce, the Trust is undertaking regular skill mix and grading reviews, the purpose of this being to ensure staffing levels, remain safe and appropriate. Specific work has been completed and is being progressed an safe nurse staffing along with a midwifery review. The Trust will be addressing the National Quality Board and the expectations relating to nursing, midwifery and care staffing and capability. Work is well underway to ensure that the Trust is maximising National Terms & Conditions for both Medical & Non-Medical Staff.

As the 'Vision 2018' and 'Better Care Fund' workstream plans are developed for implementation in year 2, further reviews of workforce requirements will take place and inform year 2015-16 projections.

iv) Key risks and how the Trust will be able to adjust inputs to match different levels of demand

A summary of the high level risks associated with the delivery of the plan is included in Appendix 1.4.

When assessing the activity and demand pressures and the resource required addressing these, the operational divisions identified a number of common key risks. Their plans describe how they will adjust their resources to respond to different levels of demand.

The effective management of non-elective demand is vital to ensure safe, high quality care is provided to our patients and key performance indicators are achieved. As part of the 'Vision 2018' strategy, the CCG anticipates a proportion of non-elective activity will be transferred from the acute hospital site to be delivered within the community reducing the acute sector bed base. However, given the maturity of these schemes and the Trust is planning that whilst these schemes will succeed in reducing levels of growth in non-elective admissions, there will not be an overall reduction. However, the Trust does plan to reduce bed capacity in 2014-15 based on the development of its own efficiency programme and existing health community schemes to better manage long term conditions and urgent care.

From 2015-16 the 'Vision 2018' strategy plans an expansion of the transition of acute to community care with indicative work streams having a focus on preventing hospital admission and supporting early discharge. Furthermore, the progression of work streams via the Urgent Care Board (e.g. discharge to assess model), will develop confidence that Divisions can progress plans to reduce their non-elective bed base.

The Divisions have reviewed the 2013-14 activity baseline, commissioning intentions and any capacity constraints whilst developing their predicted activity for 2014-15. Due to the uncertainty regarding commissioning intentions of the CCG, activity projections 2014-16 are based on known strategic aspirations and plans that are already in place. The Divisions have prepared plans to enable a level of flexibility should the level of demand vary from prediction however and these plans will be reviewed prior to implementation to ensure no adverse impact on quality or efficiency.

Capital equipment is core to the delivery of safe and effective care in many areas, and any unexpected failure requires prompt resolution. The Trust's capital plan has identified some provision for replacement equipment should this situation arise, although this will be closely reviewed in line with the wider financial position.

Operational effectiveness within an acute hospital environment may be adversely affected by infection outbreaks in ward areas as well as having significant implications for a patient's safety and wellbeing. In order to minimise this risk the Trust, led by the Director of Infection Prevention and Control and the Infection Control lead clinician, have implemented a range of mitigating actions including the availability of a *C.difficile* cohort unit to reduce the risk of *C.difficile* transmission in hospital. A decant ward is in place to allow a full ward decontamination programme to be provided. The rise in trends associated with Multidrug Resistant Organisms (MDRO's) has been placed on the Trust's risk register and the recommended actions will support the management of other MDRO's such as VRE.

v) Performance against healthcare targets and indicators 2014 – 16

Following risk assessments completed by the Clinical Divisions and Corporate teams risks to achievement of targets and indicators have been noted and mitigation plans identified -

i) 4 hour emergency access target

Achievement of the 4 hour access target is a whole Trust and Health Economy responsibility. The Trust is working with the Urgent Care Board on a range of demand management schemes to help in the delivery of this target in 2013-14 and this work will continue into 2014-15 including the following work streams

i) A review of the current medical model of assessment
ii) Implementation of the Discharge to Assess model of care
iii) Ambulance pathfinder scheme (diversion to alternative healthcare providers)

The Trust is further engaging with ECIST (Emergency Care Intensive Support Team) and has commissioned external support to better understand the reasons for internal delays and external factors affecting the 4 hour performance. This has provided some clear areas that require additional work which will be implemented by the organisation.

As the 'Better Care Fund' work streams begin to impact upon admission avoidance and shorter lengths of stay (which will improve bed availability if patients do require admission) during 2014-15, it is hoped that this will contribute to a reduction in the number of patients attending the Emergency department

ii) Cancer targets

The volume of cancer work into urology (in particular robotic surgery) puts significant pressure on the 31 and 62 day treatment target for cancer patients. The Division experienced this issue in October 2013 but was able to put in specific mitigating action to address the issue and the remainder of Q3 achieved and achieved overall. This will be kept under specific monitoring and action plans developed as required. The Trust expects to meet this target for 2014/15.

iii) Infection prevention

The Trust takes infection prevention extremely seriously and has a zero tolerance approach. In 2013/14 the Trust invited Public Health England to undertake an independent review of infection prevention processes and is producing an action plan to address their recommendations, including improved communication, enhanced training and leadership and some capital improvements. In 2014/15 the target level of infections related to *C Difficile* reduces to 24 cases and whilst challenging, this does represent a risk which the Trust will keep under close review.

4 Productivity, efficiency and CIPs

i) Overall CIP Programme and Governance Framework

The approach to the 2014/15 and 2015/16 Cost Improvement Programme (CIP) is a theme based, whole systems, transformational approach. The approach to transformation is based broadly on transforming the shape of our workforce and leadership model, transforming our business processes and transforming the use of our estate. Within this programme, there are five themes each with a lead director and three sub themes that have a lead manager, PMO lead and finance lead. The overall cost improvement target has been set at a level higher than that which is required, to ensure that schemes are developed to cover any in year slippage. The CIP requirement within the overall financial plan is £13m for 2014/15 and £16m for 2015/16. This programme was designed following a review of the methodology for cost improvement being employed by the Trust undertaken by KPMG in 2013/14. The programme is based on the review and recommendations made for the establishment of a robust Programme Management Office and associated supporting function. The overall programme aligns both service and cost improvement plans underpinned by a robust and embedded performance management framework. The Chief Nurse and the Medical Director take an overall lead role on quality and safety. All schemes are individually assessed for quality and safety impact on patient care and the process is integral to the Trust wide risk governance framework.

All schemes in excess of £50k require an outline project document supported by a comprehensive project plan which includes milestones, dates for delivery, auditable evidence of delivery, qualitative and quantitative outcomes showing baseline, current state and target and a risk assessment. A CIP Steering

Team is in place to approve all schemes over £50k and/or a risk rating of 10 or more. All schemes in excess of £100k and/or a risk rating of 15 or more are approved by the Executive Director Team.

Performance against plan is reported monthly to the Transformation Programme Group, which is Chaired by the Director of Operations and which closely monitors the service improvement aspects of the schemes, Financial Management Group which closely monitors the financial delivery aspects of the schemes and then to the Finance, Performance and Business Development Committee – a committee of the Board which seeks assurance on all aspects of overall delivery.

2014/15 CIP requirement

The 2014/15 CIP includes a mixture of:

i) Incremental and productivity efficiencies and internal transformation change - these involve new ways of working within the organisation to improve productivity and quality of services to patients. These will result in no change to the way services are provided but involve using fewer resources as a result of taking out waste and non-value added tasks and processes from the system.

ii) Transforming the way in which we structure our workforce and leadership model to deliver swifter decision making and more effective empowerment of colleagues to change the way in which services are delivered.

iii) Transformational change that involves new ways of working across the health economy – these require working in partnership with other health and social care providers to improve outcomes and quality of services to patients. These will include a shift in provision from acute to community and primary care for some services as well as a more effective and efficient use of resources between health and social care.

iv) Income related schemes – by increasing efficiency in patient flow to drive down length of stay and reduce cancellations and DNA (Do Not Attends) it will be possible to take on additional work that otherwise would have gone to other providers. It will also allow for reductions in waiting times in some specialities in agreement with commissioners. Also notice has also been given to commissioners on a number of new/additional coding areas that will capture activity previously undertaken but not charged.

The majority of cost reductions plans within the 2014/15 programme fall into i) or ii) above with iii) being further developed in 2015/16 in line with the health economy 2018 vision. Many of the plans in iii) do prepare the way, or are a preliminary stage, in the wider health economy transformational plans for service provision. Plans within i) allow the internal transformation changes to go ahead to ensure optimal benefit - both in terms of savings being released as early as possible and ensuring that no inefficiencies are built into future service configurations.

Transformational change plans – include:

- Bed reconfiguration through improved patient flow - this involves a pathway review leading to improved pathways for frequent attendees, the introduction of admission avoidance plans and a therapy led early supported discharge team. This does involve working with partner agencies in both health and social care.

- Release of beds post vascular transfer – by working with the Countess of Chester NHS Foundation Trust a centralised vascular service will be provided by both hospital trusts but on only one site allowing for the rationalisation of resources to deliver

- Cerner implementation – this is the roll out of the first phase of the new clinical IT system which will

transform many clinical, clinical support and non-clinical working practices including reduction in case note handling, electronic delivery of patient correspondence, improved bed management and reduction in confidential waste.

2014/15 plans are in an advanced stage of development although a number do depend on commissioner agreement and other external partnership negotiations being concluded. However, this is not preventing planning continuing and all internal plans being written to include actions to deal with any uncertainties, risks and mitigating actions. These actions will be included in the detailed plan that support all schemes with a value of £50k or more - as described in the governance section above.

Actions to deliver all of the above are already underway and all are crucial to the delivery of the strategic plan.

2015/16 CIP requirement

There will be further integration opportunities within the health economy in 2015/16 involving the horizontal integration across health and social care to reduce duplication and improve effective coordination of services and pathways. This will, subject to agreed health community actions, further reduce the number of beds and length of stay and reduced emergency readmissions.

In addition to this there will continue to be internal efficiencies associated with procurement and medicines management, specific opportunities associated with national changes to terms and conditions of employment as well as further corporate restructuring and productivity improvements associated with the continued roll out of the Cerner IT system.

Market share is also expected to further increase by approximately 2% as well as an increase in private patient income with the introduction of a new service model.

Some of the above will be a continuation of work that is on-going in 2014/15 but with some step changes to the way services are delivered to reflect the more developed partnership working across health and social care and in line with the health economy 'Vision 2018' vision.

Plans for 2015/16 are still in the very early stage of development however the Trust has in place a CIP process that continually develops plans as part of a an ongoing business improvement cycle throughout the financial year. This cycle is supported by the PMO both in terms of performance management of all schemes and by the use 'lean' production improvement techniques. It is intended that a further cohort of staff will be trained in these techniques in both 2014/15 and 2015/16 to a 'certified leader' level status to further support the identification of waste and productivity efficiencies that will support the overall strategic objectives of the organisation.

5 Supporting financial information

i) Overview of 2013/14

Whilst the Trust has had an historic track record of financial achievement, it has faced significant challenges in delivering its operational and associated financial plan in 2013/14. At the beginning of the financial year, in recognising these present and future challenges, the Trust established a formal Programme Management Office (PMO) to supports its cost improvement identification, planning, delivery and performance management. It is anticipated that the full benefits of this significant in year change in approach will be delivered into 2014/15 and beyond.

As a consequence the Trust has forecast out turn deficit range between £2.5m and £3.5m with a best case forecast deficit of £3m (before technical adjustments), against a planned surplus of £2.8m.

Achievement of this level of deficit continues to attract risk from both an income and expenditure perspective with a financial agreement on the outturn contract yet to be secured and continued excess pressure on non-elective care challenging the Trusts core capacity.

While the Trust planned to deliver a Continuity of Service (CoS) rating of 3 for the year, failure to deliver a rating of 3 in quarter 2 – together with the weak financial performance resulted in the instigation of a financial investigation by Monitor. While improved financial performance in quarters 3 and 4 (to date) has resulted in a restoration of the CoS rating of 3, together with the conclusion of the Monitor investigation, considerable challenges remain for the remainder of the year, to achieve a rating of 3.

The poorer than planned performance has also reduced the Trusts cash balances with a slowing in capital investment to support the Trusts overall liquidity. Slowing of investment as a means to managing liquidity is not a sustainable position for the future organisational success and the Trust is exploring, with external support, opportunities for improvement in its cash management processes.

The Trust also saw variation in its financial forecasting and is taking steps to align operational performance and forecast financial outcomes to improve prospective management.

ii) Overview of the financial plan for 2014/15 and 15/16

The financial plan for the next two years is dependent on a number of key variables. At the current time (4.4.14) the Trust is yet to reach agreement on its 2014/15 contract with its main commissioning CCG and therefore material risk continues to exist within the overall planning context. These principally include;

• 2013/14 forecast outturn implications for 2014/15
• Agreeing Contracts with Commissioners
• Finalisation of Expenditure Budgets (Including Cost Pressures / Developments)
• Finalisation of the Cost Improvement Programme for 2014/15

In recognising these risks the Trust has incorporated within its base line plan a risk associated with income and additional costs from 2013/14 carrying over into 2014/15. In parallel with the recognition of these potential costs the Trust is developing a deeper transformational plan to secure a more sustainable operational and associated financial position on a longer term basis.

In addition to explicitly recognising the above two risks within the base plan, the Trust also has a series of downside risks/scenarios against which mitigation plans have been developed.

Given the significant challenges over the next two years, the plan assumes a deficit position in both 2014/15 and 2015/16 – rather than a breakeven or surplus, although the Trust would hope to minimise any deficit where possible. Planning for a deficit does impact on the availability of cash to resource the capital programme, and also on the liquidity position of the Trust. In supporting the cash position the Trust is planning to dispose of one of its buildings in quarter 2 of 2014/15 and is working actively on revisions to its cash management processes internally.

The level of robustness within the plan is therefore contingent upon the degree to which the Trusts assumptions come to fruition in the coming weeks as the Trust concludes its contracting discussions with CCG partners. The key planning assumptions developed by the Trust include;

- A deficit plan in each of the coming two financial periods, returning to a stronger normalised position in 2016/17 and beyond, driven by a deeper transformational programme
- A largely Payment by Results contract settlement built upon
    - 2014/15 Trusts forecast outturn, less tariff deflation, plus full year effect of activities started in 2013/14 plus marginal targeted growth less know contractual reductions e.g. Vascular

- 2015/16 a largely “flat cash” settlement

- Requisite activity volumes are delivered within core capacity and cost without recourse to opening additional capacity;
- Costs increasing to accommodate inflationary pay and non-pay pressures, agreed business cases, high cost drugs costs and limited funding for cost pressures and new developments
- Minimum CIP requirements of £13m in 2014/15 and £16m in 2015/16 being delivered in full in each individual year
- That a robust transformational plan through the current planning period and beyond is developed so that revisions to the operational delivery model return a balanced normalised financial position in the longer term.
- That operational variations to the plan are only committed to where they attract sufficient income to cover their costs as a minimum.

Based upon the Trusts underpinning assumptions the financial plan for the next two years identifies the following position -

Table 3 – Summary financial projections for next two years

Detail	14/15 £m	15/16 £m
Income	299.61	300.12
Expenditure	-290.03	-287.13
EBITDA	9.58	12.99
Non-Operating Expenditure	-13.81	-14.19
Surplus / (Deficit)	**-4.23**	**-1.2**
CIP Requirement	**13.00**	**16.00**

Given the current operating environment and increasingly austere financial outlook the financial plan, by necessity, has limited headroom within the base position to accommodate variation from the plan which does not attract specific additional financial resource.

iii) Income, and the extent of its alignment with commissioner intentions/plans

The Trusts planning assumptions have developed a financial value associated with the Trusts contract income position based upon;

- 2013/14 forecast outturn
- Less tariff deflation
- Plus full year effect of 2013/14 activities
- Plus specific targeted growth
- Less known contractual reductions

The combination of the above factors delivers a contract value, with the Trusts main CCG of c£223m relative to a forecast outturn value for 2013/14 of c£220m. It is assumed that other CCG Associate contracts will mirror the contract held with NHS Wirral which accounts for c85% of then Trusts clinical income. In recognising the risks associated with this assumption and the affordability of the CCG of this contract the Trust has provided, within its baseline plan a risk reserve against contract income shortfalls.

There has been a significant increase to income plans over the last 12 months, partly as a result of generic growth, and partly as a result of agreed CIP schemes aligned to targeted growth in volumes. The

Trust's future financial planning in part in 2014/15 into 2015/16 will rely less upon the generation of additional core income as CCG allocations reduce and elements are transferred to social care commissioners, through the 'Better Care Fund'.

High cost drugs: In addition to the growth in clinical activity, it is assumed that there will also be some growth in high cost drugs. Such income growth is directly offset by an equal and opposite increase in expenditure i.e. a pass through cost. As long as agreed funding mechanisms remain in place – increases or reductions in income or expenditure will have an offsetting effect.

Other income: Other income is assumed to be largely constant, with the exception of a planned increase in the Education & Training Tariff – which is in line with previously notified transitional arrangements following a national rebasing exercise. This is currently under review and there is a risk that this may not materialise depending on the outcome of the national activity.

The 2014/15 contracting discussions have yet to be finalised, without a formal agreement the Trust has assumed a Payment by Results contractual approach. Whilst there are areas of agreement and alignment there are different interpretations of key issues including;

- 2013/14 outturn which forms the base for 2014/15 plan
- Approaches to the marginal rate for unplanned care above the threshold levels
- Likely future growth
- The application of contractual penalties relating to issues such as readmissions

The Trust is continuing to work with the local CCG with the goal of seeking a negotiated contractual position with balanced risk and reward to meet organisational and economy requirements during April 2014.

The Trust also holds a contract for delivery of specialist care with NHS England. This contract is forecast to be valued at c£20m in 2014/15 and includes a reduction associated with the transfer of specialist vascular activity. In 2014/15 the income loss associated with vascular is abated in part by transitional funding relating to non-releasable costs, reserves to cover the residual of the non-releasable element of costs, with the expectation that the remaining value of costs will be extracted from budgets / utilised to generate additional income to replace that lost through the vascular transfer. It is anticipated that this contract will be finalised in the coming weeks.

2015/16 contract income has largely been assumed to be "flat cash" with variations in tariff prices, growth and reductions in volumes assumed to net to zero within a financial value context. The consequence of this assumption is that while there is an increase in income relating to activity, there is a broadly comparable reduction for price, and as a result the Trust would be required to deliver the increased activity, largely within the same resources.

iv) Costs

Through 2013/14, the Trust experiences a range of additional costs as a function of operational delivery pressures, largely associated with the provision of urgent care. Whilst components of these costs were non recurrent, the Trust anticipates that elements of these costs will persist into 2014/15. These costs have been reflected in the base position.

Inflationary pressures: A detailed assessment has been made of inflationary pressures for 2014/15 and these are contained in the plan. This includes an allowance for general pay inflation, increments, general non-pay inflation and other anticipated increases in non-operating costs.

High Cost Drugs: As noted in the income section (above) it is assumed that any changes to income relating to high cost drugs will have an equal and opposite effect on expenditure.

Costs of delivering activity: As the Trust's volume of activity has grown through 13/14 costs associated with maintaining this activity, at a marginal cost basis have been identified, these costs have been factored into the base case. Additionally as noted above, the Trust has provided for additional risk within its baseline plan to accommodate any further excess costs associated with operating beyond anticipated levels of activity.

Non-operating expenditure: Increased costs of depreciation as stages of the Cerner Millennium IM&T project go live and changes to Public Dividend Capital (PDC).

The Trust has established a number of reserves to support business case related expenditure on additional nursing staffing related to reviews undertaken since the Francis Report, actions associated with meeting infection prevention targets and a number of other contingency arrangements, intended to support the delivery of the Trust's activity. The Trust is fully committed to ensuring safe levels of staffing across its clinical areas and whilst a provision for a further investment in nursing has been included within the plan, should there be a reduction in the Trusts bed base then the application of this reserve will be reflected upon.

v) Capital Plans

Over the two years of the plan the Trust has identified resource totalling £12.03m and £8.750m to support its capital programme. The resource available is the internally generated resource from depreciation and, in 2014/15, an allocation of £3.5m of PDC resource which has been confirmed from the "Safer Hospitals, Safer Wards Technology fund".

Schemes have been allocated by considering the existing commitments (e.g. Cerner IM&T implementation, Endoscopy refurbishment and extension, further works to support the Emergency Department and a number of smaller projects) and the ongoing requirement to support the Trust (e.g. backlog maintenance, day to day IT spend). An equipment replacement programme covers a wide range of requirements across the Trust. As these are developed the Trust will also consider the option to lease the assets

In 2007 The Trust entered into a contract directly with Cerner for the provision of an Electronic Patient Record outside the scope of the National Programme for IT. The Trust therefore is not impacted by the ending of the major national IT agreements, though has had to make provision in its capital programme for the termination of the national agreement with Oracle for the provision of the database licences that support a number of clinical applications in the Trust, including Cerner.

There is no assumption of borrowing for at least the short term of the financial plan. Other funding options (e.g. leasing) will be explored as required, although the Trust is currently in discussion with its banking partner to establish an accessible overdraft facility should this be required.

As the Trust is forecasting a deficit position in the next two financial periods it will not create additional resource to supplement its internally generated resources for further capital investment. The emphasis of the capital programme is therefore to support previously agreed initiatives and focus on maintain the existing asset base to an acceptable standard.

Table 4 – Capital plans 2014/15/16

Capital Programme	2014/15 (£M)	2015/16 (£M)
Cerner Millennium	6.094	3.418
IM&T strategy	0.75	1.0
Backlog maintenance	1.1	1.2
Site development	2.925	1.7
Equipment replacement programme	1.164	1.432
TOTAL	12.033	8.750

Table 5 – Resourcing the capital plan 2014/15/16

Resource	*2014/15 (£M)*	*2015/16 (£M)*
Slippage from 2013/14	0.283	0
Internally generated capital (Depreciation)	8.25	8.750
DH Funded capital (PDC)	3.5	0
Base resource	12.033	8.750

vi) Liquidity

Cash Position 2014/15 and 2015/16

The Trusts underlying cash and liquidity position into 2014/15 is weak as a function of the Trusts deficit in 2013/14 and the position will remain challenging into 2014/15 and 2015/16. Additionally in April 2014, as part of its Cerner contract staged payments are made which further reduces cash balances. The Trust is planning to sell one of its buildings in Q2 of 2014/15 and this improves the cash balances into Q3 and beyond, the building is currently held on the balance sheet as a finance lease under IFRS.

Table 6 – Cash position 2014/15

Quarter End 14/15	Cash £m's	Liquidity CoS
Q1	5.71	2
Q2	3.93	2
Q3	3.31	2
Q4	5.66	2

In strengthening the cash position the Trust has undertaken an externally facilitated review of its cash management and forecasting processes and anticipates that through the implementation of the recommendations contained within that report that there will be a series of cash retention opportunities which will add additional headroom within the Trust cash plan for the coming two years, but which are not included within the base case. As noted above the Trust is also exploring the opportunity to secure an accessible overdraft facility to act as a contingency against unforeseen cash variations throughout the year.

Table 7 – Cash position – 2015/16

Quarter End 15/16	Cash £m's	Liquidity CoS
Q1	4.12	1
Q2	1.23	1
Q3	2.50	1
Q4	4.39	1

vii) Risk Ratings

2014/15 and 2015/16 Continuity of Service (CoS) Ratio

Given the above financial plan, the Trust expects to deliver the following profile of CoS ratings over the two year period.

Table 8 – Risk rating

	Overall Risk Rating 2014/15	Overall Risk Rating2015/16
Q1	2.00	2.00
Q2	2.00	2.00
Q3	2.00	2.00
Q4	2.00	2.00

The overall COS rating for the Trust is a 2 in 2014/15 and 2015/16. The Trust continues to explore what further improvements it may make to achieve a rating of 3 as a minimum by the year end and requires its transformation programme to be further developed to achieve that position.

viii) Downside planning

The financial plans outlined are predicated on a range of assumptions, each of which will have varying elements of risk associated with them. The purpose of this section is to consider the resilience / sensitivity of the proposed financial plan against the possibility of less favourable assumptions being applied. The key downside scenarios considered are as follows;

- Requirement to utilise unplanned capacity during the winter months.
- Failure to deliver CIP [10% of 2014/15 programme not delivered].
- Further operational overspending driven by operational pressures and not accommodated within the base plan
- 15% urgent care contract value decrease in 15/16 (in line with aspirations of Better Care Fund)

Analysis of the downside conditions has been carried out and has been included in the Appendix to the Plan.

ix) Key risks

The key risks and associated mitigation to the financial plan are summarised as follows -

Risk	Proposed Mitigation
That in managing organisational activity and capacity requirements, there is a risk that excess costs are incurred where additional unplanned capacity is required to deliver the service.	Where unplanned capacity is required resulting from the increased demand for services, the trust will actively pursue additional funding to compensate e.g. winter pressure funding received,
The plan assumes that CIP is delivered in full in year. The risk that CIP required to deliver the plan is not a) identified in full; and b) not delivered in full in year and recurrently would result in an immediate impact on the bottom line.	Governance structure in place through the PMO to ensure that detailed and deliverable plans are identified, with regular meeting to assess progress and to identify corrective action where necessary, Executive leads in place for each of the key CIP themes, and regular reports to the Finance Committee. Current full year plans exceed the value of in year requirement

	and additional proposals are in the pipeline. Continued process of ideas development through PMO. The Trust has provided a modest mitigation reserve to address in year slippage should that occur.
Whilst an element of additional cost has been accommodated within the baseline plan, there may be further operational pressures which require unplanned resource. This has been estimated at a risk value of £2.5m	General mitigation/reserves held to offset unforeseen pressures should they arise.
In terms of the indicative CoS ratings, margins are relatively narrow. As a consequence it will only take relatively small changes to the overall financial position or its profile to have an adverse effect on the CoS ratios.	Mitigation will require close management of the financial and cash position. The Trust commissioned a cash management review by external advisors which has highlighted a range of opportunities. The Trust has developed an action plan to implement these changes where appropriate to maximise its cash management and retention opportunities.. A prudent approach to the delivery of these benefits has been incorporated within the baseline plan. The achievement of the action plan will be monitored through the Trusts governance structure. The Trust also plans to dispose of a building in Q2, sale proceeds in excess of those planned will further support the Trusts cash position. Should the sale not happen, this will be further mitigated by the implementation of the recommendations from the cash management review which are planned for 2014/15.
The outline capital plans are limited as a result of the financial constraints. Any slippage or adverse performance within income & expenditure will reduce the cash resource necessary to enable the program. In addition, the limited level of resource available could expose the Trust in the event that unplanned equipment / kit need to be replaced / repaired during the year. In 13/14 the Trust tactically slipped its capital expenditure to support the in year cash position, this is not a sustainable position going forwards as the Trusts estate requires maintaining and further slippage may cause operational difficulties and pressures.	This will be managed through the Capital Monitoring Group which meets on a monthly basis, and which will reprioritise the programme where this is necessary and possible, both in terms of the schemes included on the programme, and the profile of planned spend.
The Trust currently has a gap of £5m between what is required as a contract value with Wirral CCG, and the latest proposal that has come forward. Failure to agree a contract at an appropriate level will have a significant impact on the financial position. There is a further risk against clinical income plans if the Trust were to agree a Payment by Results contract, in that commissioners may seek to mitigate over performance through increased use of penalties, challenges and contract levers. While block contracts do not remove risk altogether, if set at an appropriate value they can provide greater certainty and stability.	Discussions in respect of the main clinical contracts are ongoing with the default position being a PbR based contract. Activity plans have been worked through in detail and agreed with Divisions. Activity plans have been agreed through in conjunction with the PMO. The CCG and Trusts have a series of Director led weekly meetings through April with a view that the contract position will be resolved no later than end of April 2014. The Trust has provided a reserve within its baseline position for an element of this.