Stockport NHS
NHS Foundation Trust

Strategic Plan Document for 2013-14

Stockport NHS Foundation Trust

Annual Plan 2013/14 – 2015/16

Executive summary

Stockport FT has reviewed the strategic climate in order to produce its plan for 2013-16. During 2012/13, changes in policy (legislative and advisory) have combined with a very testing financial environment. In response, the Trust maintains its commitment to balancing quality with resilience, so that we continue to provide local services, for local people, into the future. Whilst maintaining this balance, the Trust will be responding to strategic factors that include demographic changes, publication of the Francis report and a consequent sharp focus on evidence of service quality, a new commissioning environment and a strategic review of services in Greater Manchester. Our strategic plan reflects the way in which we will set about these challenges. Its aims are to:

- Provide quality, resilient care, highly rated by patients, their friends and families and by health regulators – ensuring a high performing and valued healthcare organisation;
- Provide comprehensive and consistent care for patients with acute care needs – particularly responding to service reviews being carried out by commissioners across Greater Manchester as part of Healthier Together;
- Provide convenient, safe, fully joined up care for patients with long-term conditions and for frail, elderly patients – particularly responding to the recommendations of the Francis report.

To increase capacity to deliver our aims, especially to deliver revised specifications anticipated during 2013/14 for core services, the Trust has joined a collaboration with neighbouring Trusts in south and east Manchester and east Cheshire. Known as the Southern Sector partnership, the Trusts have agreed that the partnership will:

- Build on existing patient flows to improve patient pathways and accelerate provision of care closer to home, reaping clinical and financial gains from sharing expertise and strengthening community services;
- Collaborate in provision of clinical services to offer Southern Sector access to local tertiary services and bolster secondary care services by delivering clinical compliance and financial benefit;
- Position the Southern Sector as a hub within Greater Manchester's forthcoming Academic Health Science Network (AHSN), hooked into Manchester Academic Health Science Centre, to offer the AHSN leveraged gains from a large patient footprint, delivering clinical and financial benefit.

The Trust's aims and the partnership's goals demand extensive service change. The Trust has set up service transformation programmes which, alongside a cost improvement programme, will deliver much of the service change required during the life of this plan. The programmes' objectives are the result of benchmarking services against best practice and performance and include:

- Outpatient improvement;
- Surgical pathways improvement;
- Development of out of hospital care;
- Improvement of unscheduled care;
- Workforce redesign and Organisational development.

Supporting these programmes and partnerships, aligning service delivery capacity with the requirements of service change, Stockport FT will develop its workforce or organisational development strategy and its IM&T and property strategies during 2013/14

In summary, Stockport FT's plan for 2013-16 is designed to respond to a broad range of challenges, arising from fundamental shifts in the Trust's environment. The plan is focused on maintaining the balance of quality and resilience necessary for the Trust to continue as a successful local provider of healthcare.

Stockport NHS
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Annual Plan 2013/14 – 2015/16

1. Introduction

During 2012/13, Stockport FT's board analysed the Trust's changing competitive environment, its strengths and weaknesses within that environment and established the Trust's response to the risks, challenges and opportunities faced.

Throughout its analysis, the board was guided by:

- Its commitment to maintaining and improving the quality of services the Trust provides;
- Its dedication to maintain financial resilience so that the Trust continues, for the long-term, as a local provider of services to local people;
- Its recognition of the valuable contribution of the workforce.

This plan is the outcome of that strategic analysis, based on a twin commitment to quality and resilience. The Trust has developed an on-going dialogue with Governors about its priorities and strategic plans through quarterly council of governors meetings and governors sub-committees for governance, membership and patient safety and quality.

2. The Trust's environment

Nationally, a changing and challenging NHS environment exists, created both by implementation of the 2012 Health Act and the continuing downturn in public finances. The Health Act introduces clinically-led commissioning with a consequently greater emphasis on quality of care, whilst the financial pressures create an imperative to create efficiencies on an unprecedented scale. Combined with demographics, these factors create an immediate need for strategic, sustainable, service change. Locally, the Trust's environment is characterised by:

- Demographic changes, particularly the ageing population;
- A commissioner-led review of health services across Greater Manchester which will lead to reconfiguration and transformation of major services;
- An increasing drive to evidence improvement in quality (e.g. provision of 24/7 services) in order to remain competitive in a changing and regulated market;
- Changes in commissioning relationships and structures, particularly the introduction of Clinical Commissioning Groups (CCGs);
- Developing relationships with neighbouring providers.

Each of these characteristics is described below.

2.1. Demography

The Trust serves populations in Stockport, High Peak and Tameside & Glossop. The populations served are diverse and degrees of affluence and deprivation vary across these boroughs. However, thematically, our populations are forecast to be increasingly:

- **Ageing**: For example, in Stockport, by 2014 there are projected to be an additional 5,400 people aged 65+ (an 11% increase) and an additional 900 people aged 85+ (a

13% increase).1 By 2019 there will be a further 3,800 people aged 65+ and a further 1,400 people aged 85+; an increase of 18% and 25% respectively in 10 years between 2009 and 2019 . 1 in 5 people over 85 suffer from dementia, often in conjunction with other long term conditions (LTCs) and so as the older population increases the number of patients with dementia will increase;

- **Polarised by health inequality**: Stockport's JSNA records that the causes of death contributing to inequalities in life expectancy are changing although lifestyles remain the key driver. Heart disease remains a major, though decreasing, cause of inequalities but the impact of deaths from digestive disease and cancer, thought to be mainly driven by alcohol, are increasing. Health inequalities remain rooted in differences within the borough's indices of deprivation with higher than average rates of death from heart disease, cancer and stroke all occurring in the three most deprived wards. The impact of unhealthy drinking behaviours is also seen in the rapid increase in admissions to hospital due to alcohol related harm. This increase is more significant in the most deprived areas, but is evident in all areas of the borough[2].

Activity at the Trust reflects these already established trends. Current pressure on urgent care services, particularly ED attendances, demonstrates the increasing acuity of older patients. The demographic trends noted will increase this population with consequent increased pressure on the Trust's services. In response, the Trust is working with primary care to introduce new service models of anticipatory care for identified groups of patients whose health is most at risk of deterioration with consequent admission to hospital. More detail of this programme is included in the Service Transformation section of this plan (section 5.2), together with other transformation programmes.

2.2. Commissioner-led review in Greater Manchester – *Healthier Together & Cancer Strategy*

The NHS Commissioning Board's local area team (LAT) is due to complete a strategic review of health services across the Greater Manchester conurbation during 2013/14. The review, entitled *Healthier Together*, affects Stockport FT's local populations, excluding High Peak, and aims to:

- Improve the health and wellbeing of people in Greater Manchester;
- Improve equality of access to high quality care;
- Improve people's experience of healthcare service;
- Make better use of healthcare resources.

Commissioners in Derbyshire (for the High Peak) have designated similar strategic priorities.

Clinically led, the *Healthier Together* review is set in the context of health and care service reform across Greater Manchester Commissioners share ambitions to: deliver better outcomes for Greater Manchester residents and patients at lower cost; enable more people to remain independent and in control of their lives; and achieve better quality outcomes from hospital services. A similar approach is also being adopted for improving the provision of cancer services across the conurbation.

Local health and social care leaders have declared support for the need to reconfigure major hospital services with parallel development and implementation of new, locally derived models of integrated care and more accessible primary care services. Their aim is to reduce

[1] Priorities and key findings – Stockport JSNA 2011, Stockport MBC
[2] Priorities and key findings – Stockport JSNA 2011, Stockport MBC

avoidable and unplanned admissions to hospital and other care institutions. The changes are being planned on a Greater Manchester footprint and form a cornerstone of the *Healthier Together* programme. The newly formed CCGs are expected to lead the changes, supported by the LAT. The Trust's response to *Healthier Together* lies largely in creation of the Southern Sector partnership, which aims to build on the strengths of each of its members and is described in more detail at section 2.5.

2.3. Evidencing quality improvement

The recent findings of the Francis Inquiry into standards of care at Mid-Staffordshire FT serve to reinforce Stockport FT's commitment to evidencing the quality of the care it provides in all settings. Introduction of best practice guidelines and standards that are currently emerging in the wake of the Francis report, and being incorporated into the *Healthier Together* review's service specifications, will encourage high standards of clinical care and provide evidence for assurance over the life of this plan. The Trust has introduced objectives this year to improve its response to feedback from patients and carers, has committed to improvements in care of patients with dementia and maintained its commitment to the Advancing Quality standards and use of the Safety Thermometer.

2.4. Relationships with new commissioning structures

Strategic plans

New commissioners, Clinical Commissioning Groups (CCGs) are now operational in each health economy served by the Trust. Commissioners' intentions and requirements respond to similar demographic and financial pressures and are informed by the *Healthier Together* strategy. They are therefore closely aligned. Stockport CCG's plan is typical. Its strategic objectives are:

- Transform the experience of care of adults with long-term and complex conditions;
- Improve the care of children and adolescents with long-term conditions and mental health needs;
- Increase the clinical cost-effectiveness of elective treatment and prescribing;
- Improve the quality, safety and performance of local services in line with local and national expectations;
- Ensure better prevention and early identification of disease, leading to reduced health inequalities.

The Trust has reflected these aims and their accompanying programmes and objectives in its strategic planning and in its objectives for 2013/14. The CCGs have initiated whole health economy programmes to improve care for those with complex needs and long-term conditions.

Increasing competition on quality

During 2012/13, PCTs, with CCGs in shadow form, let a number of Any Qualified Provider (AQP) contracts for services including podiatry, audiology, minor eye conditions and ultrasound services. This brought a number of new entrants into markets where the Trust had previously encountered little competition. Given the national policy-driven intention to market test, where appropriate, to establish efficiencies and improve quality, further AQP procurements are anticipated during the life of this plan. The Trust has qualified as a provider of the new AQP services (apart from minor eye conditions where a strategic decision was taken to concentrate on complex ophthalmic work) and is monitoring the effect of these new contracts on established activity and income.

The Trust's contract to provide community services in Tameside & Glossop comes up for

renewal in 2014/15. Commissioners have signified their intention to set up a new pooled budget arrangement with Tameside Metropolitan Borough Council (TMBC). It is anticipated that TMBC will, through this agreement, hold the contract for integrated adult health and social care services across the borough. This arrangement is likely to lead to a review of contractual arrangements with us as provider, and may result in parts or all of the contract being re-tendered.

Stockport FT is in a strong position as an incumbent provider to be successful as a supplier in this newly specified service but recognises the importance of providing strong, responsive services with well-implemented developments in order to maintain this position. We will keep abreast of these plans during 2013/14 and will consider establishing local partnerships with fellow providers to strengthen our position.

2.5. Relationships with neighbouring providers

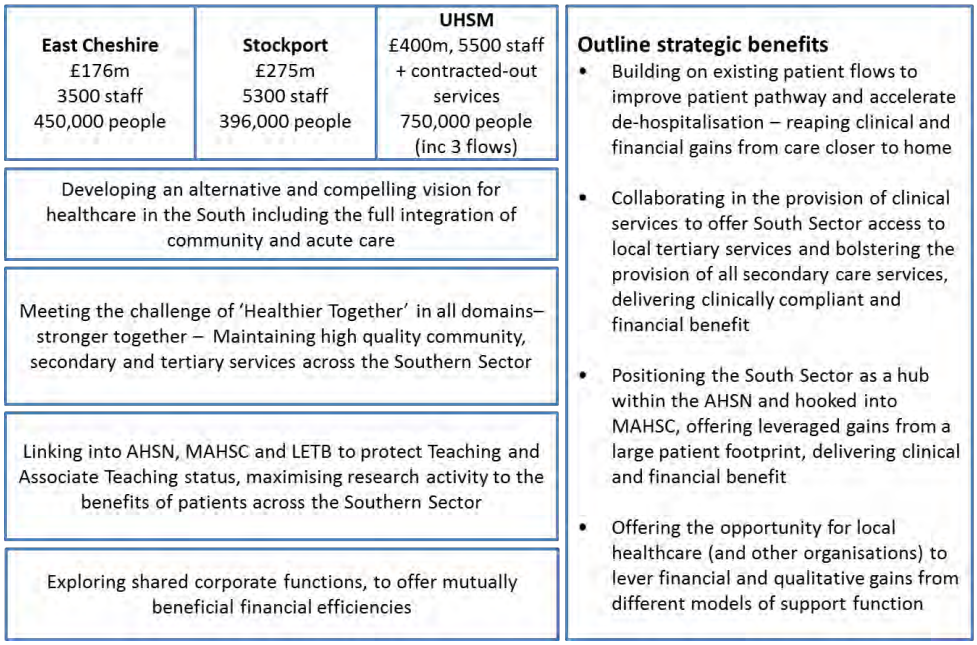
Historically the Trust has considered its neighbouring providers in nearby health economies as its major competitors. We have co-existed with them in a market that has been largely insensitive to provider differentiation, other than in a few specialist areas, and in which referral patterns and local patient habits have guaranteed a predictable market share. There has been little market penetration within the Trust's core business from new providers of hospital or community services in Greater Manchester. In the main, new entrants have been commissioned to provide new services such as intermediate care and referral management. The introduction of AQP illustrates that this situation is unlikely to persist and that competition, on quality, will become a more significant feature of the Trust's business analysis and planning, particularly where entry costs are low, as in community services.

The impact of the *Healthier Together* strategy on the Trust's established market will most quickly be felt in re-issued specifications for major core services provided by most Greater Manchester providers, including Stockport FT, e.g. paediatric services, unscheduled care, emergency surgery. The quality standards of the new specifications, particularly for the competence and accessibility of the medical workforce, will be higher than those currently in place. They will be aligned with a proven evidence-base which demonstrates better patient outcomes when senior staff are actively present and involved, often round the clock, in directing and planning patient care. Further, medical staff competence will, in future, be assured by minimum standards of practice and sufficient volumes of procedures and patients to establish documented and statistically significant outcomes data for each practitioner.

Establishing partnerships

Anticipating these new standards, Stockport FT is not unusual in Greater Manchester in being unlikely to meet them within its current workforce configuration and unable to add to costs in order to provide the required medical manpower. These twin facts have encouraged a new era of collaboration between providers as a mechanism to respond to the service quality issues raised by *Healthier Together*. During 2011/12, Stockport FT had entered a collaborative agreement with East Cheshire NHS Trust, signified by a formal memorandum of understanding (MOU). In October 2012/13, University Hospital South Manchester also signed the MOU, creating a three-way partnership. Having established the Southern Sector Partnership, the Boards of all three Trusts share a commitment to work together to create a configuration of services across the southern sector of Greater Manchester and Cheshire that will conform to the standards to be set out as a result of the "*Healthier Together*" review. The partners' shared aims and associated anticipated benefits are outlined in the table below.

Developing a shared service vision – Southern Sector, Greater Manchester



At the end of 2012/13, Tameside Foundation Trust declared its interest in joining the collaboration and is planning to sign the MOU in due course.

Southern sector plans
The three-way partnership has so far established plans for collaborative services in a number of specialties. No "one-size fits all" configuration is expected and services are encouraged to respond to local conditions and establish partnership arrangements that suit their individual circumstances. A framework of principles surrounds service collaboration, including:

- Services remain local, maintaining current patient flows, where possible
- Where service location change is inevitable, early involvement of stakeholders, including patients, is required
- Specialist skills should be shared to improve the patient offer at partner Trusts
- Different financial and contractual arrangements will be required to enable the partnership to work effectively.

On behalf of all three boards, the partnership steering group, chaired by chief executives in turn, remains mindful of Monitor's provider license conditions regarding competition and cooperation and will ensure that service plans are compliant.

The Trust's overall response to its strategic environment is set out in its strategic plan, in section 3.

3. Stockport FT's strategic plan

Stockport FT's strategic plan remains true to its themes of quality and resilience, setting strategic aims with ambitious outcomes and taking a comprehensive approach to the range of issues facing the Trust. The table below, the Trust's "plan on a page", mirrors that created by Stockport CCG and identifies Stockport FT's strategic aims, describing the outcomes our major programmes will achieve by 2016.

Strategic aims		Three-year ambition	Strategic outcomes	Programmes	Enablers
Quality and Resilience	Provide quality, resilient care, highly rated by patients, their friends and families and by health regulators	By 2016, Stockport FT aims to be amongst the best Trusts in England for the following indicators: • SHMI • w/e HSMR • National CQuIN achievement • Patient survey • Friends and family test • PROMS To drive for more consistent care, we will introduce 24/7 services where evidence shows this will improve safety, effectiveness and patient experience. Incidences of health-care related harm including HCAIs will have reduced significantly & in the case of MRSA been eradicated. Patient experience of local health services in terms of compassion, communication, dignity & respect, cancellations & reported out-comes will have improved significantly and, as a result, patient reported satisfaction will have increased.	Our services will increasingly: • Prevent people from dying prematurely • Treat and care for people in a safe environment, and protecting them from harm • Help people to recover from episodes of ill health or following injury SFT's continuous improvements in quality will contribute to financial resilience	• Weekend mortality improvement projects • Patient experience improvement projects	Communications IM&T systems investment Organisational development and workforce Capital programme
	Provide comprehensive and consistent care for patients with acute care needs	Stockport FT's services will meet all performance & quality standards in the NHS constitution in full. The Unscheduled Care improvement programme will largely have been completed, ensuring waiting times in A&E are sustainable. Patients will continue to receive high quality treatment from all services provided by the Trust, with increased cost efficiency achieved through streamlined pathways and supporting processes. For inpatients, lengths of stay will be notified at the outset of treatment and discharge processes will be consistent and safe, with community support provided whenever necessary. For out-patients, much more follow-up activity will either take place remotely or in primary care. Over 3 years significantly fewer face-to-face follow-up appointments will take place for Stockport residents. Children with complex conditions will be managed out of hospital whenever clinically safe to do so, supported by consultant-led care provided by locality-based community nursing teams All of the above changes will be underpinned by introduction of 24/7 services where evidence shows this will increase efficiency SFT's Urology and Orthopaedic services will remain highly respected for their expertise in a wide range of conditions and treatments	People will experience: • Consistent service standards, 24/7 • Services that are fully compliant with NHS constitution undertakings • Traditional outpatient activity, replaced by telehealth consultations and primary care follow-up • Reduced unplanned hospitalisation for asthma, diabetes, epilepsy in < 19's. • Reduced emergency admissions for children with lower respiratory tract infections These improvements will be reflected in better scores in the Friends & Family Test and patient surveys, reflecting overall improvements in efficiency and effectiveness	• Outpatient improvement programme • Service integration projects • Surgical pathways improvement programme • Cost improvement programme	
Integrated services	Provide convenient, safe, fully joined up care for patients with long-term conditions and for frail, elderly patients	In each Stockport locality, patients with long-term or complex conditions will experience high quality, anticipatory, integrated care. We will start to introduce teams, dedicated to working in support of primary care localities, which will help primary care to maintain the health of people with long-term conditions so that they are admitted less, or not at all, to hospital. Pathways will rely on: • Improved access to high quality primary care services 24/7, • Easily accessible, rapid specialist support We expect to work with Stockport CCG over the next two years to develop a single, 24/7 integrated service which will use medical consultants, social care, nurses and allied health professionals to proactively manage patients in localities. SFT is also committed to support such a change when commissioned by the CCG. If admission is required, patients will be pulled along evidence-based pathways by locality teams to return home as soon as possible. Shared electronic information systems and tele-care will underpin integration.	There will be improvements in the rates of people who: • Feel supported to manage their long term conditions • Are admitted as emergencies for Chronic ACS conditions and for acute conditions not usually requiring hospital admission • Are discharged to their own home • Are readmitted within 30 days of discharge from hospital • Die in a place of their choosing	• Unscheduled care programme • Stockport One project • Out of hospital care programme	

Risks	Impact	Risk score	Controls and mitigation
Additional demand above that anticipated through modelling historical data	Improvements negated by growth Delivery of mandatory requirements at risk	Red	Risk share arrangements with commissioners and partners Close monitoring and acceleration of improvement plans
Inadequate stakeholder engagement fails to engage commissioners, staff or public	Slower delivery of transformation plans	Amber	Partnership approach to planning with early implementation
Commissioners requiring service reconfigurations under the *Healthier Together* initiative	Loss of local services and loss of income to SFT	Amber	Southern sector partnership
Financial constraints may impede or slow progress	Cost improvement and quality improvement delayed	Amber	Manage financial risk on coordinated, health economy-wide basis

4. Quality at Stockport FT

4.1. Approach to quality

Quality drives the Trust through an infrastructure comprising a dedicated quality improvement team, quality boards in every business group and a Board of Directors whose meetings begin with a patient story and in-depth monthly review of quality across the Trust. Structurally, business group quality boards report to the Trust's Clinical Quality and Safety committee which reports, through the Assurance and Risk committee, to the Board of Directors.

Our strategic aims reflect the importance of quality, with improvement objectives which address issues of patient safety, clinical effectiveness, and the patient and carer/family experience. As an immediate response to the Francis report[3], the Trust has implemented listening events, led by the Chief Executive and will incorporate feedback from these into a review of its quality strategies this year, maintaining and strengthening its commitment to using feedback from frontline staff to improve quality of service. An action plan has been developed which addresses key themes of the Francis report's recommendations, in particular medical and nurse staffing, whilst other themes are will be factored into relevant strategy or policy reviews such as Risk Management, Whistle-blowing and Complaints procedures. The Trust also recognises a direct relationship between staff morale and the quality of care and is using the listening events as a tool to gauge elements of its evolving OD strategy.

To maintain Care Quality Commission (CQC) compliance, the Trust carries out its own internal reviews of wards and departments to ensure compliance against the CQC's *16 Essential Standards for Quality and Safety*[4]. To date 33 wards/departments/services have been inspected with 13 reviewed within a 6 month period, following minor/moderate action plans. Internal spot reviews will continue throughout the life of this plan. The Trust currently has no outstanding quality and safety concerns and in 2012/13 was found by CQC to be compliant with all essential standards.

Quality objectives
Commissioning for Quality and Innovation (CQUIN) has extended its contractual reach during 2013/14, reflecting the advent of clinical commissioning and the increased emphasis on quality evidence arising from the far-reaching recommendations of the recent Francis report. The Trust has constructed its 2013/14 quality objectives to reflect these priorities – see 3.2.

Risks to quality
High risks to quality, arising from external pressures or internal concerns are recorded in the corporate risk register and reviewed monthly at the Assurance Risk committee, a sub-committee of the board of directors. Current high risks to quality on the corporate risk register are:

Risk description	Outstanding actions	Initial/residual risk scores
Delivery of CIP 2013/14	Director of Nursing is attending all the CIP review sessions in order to provide the Director of Nursing and Medical Director with information to sign off the quality and safety aspects of the Trust's CIP programme	20/20
Failure to deliver ED	This risk is being managed through a combination of	20/20

[3] The Mid Staffordshire NHS Foundation Trust Public Inquiry - Chaired by Robert Francis QC
http://www.midstaffspublicinquiry.com/report
[4] http://www.cqc.org.uk/sites/default/files/media/documents/gac_-_dec_2011_update.pdf

Risk description	Outstanding actions	Initial/residual risk scores
waiting time standard	actions and a health-economy wide business continuity plan, supported by daily escalation processes	
Failure to achieve 25% reduction in prevalence of grade 2 and above pressure ulcers	Tissue viability team to continue training, intervention, and monitoring, including reporting to the Board	16/16
Failure to achieve *C.Diff* target	Progress against the action plan is reviewed at the Quality and Safety Committee	20/20
Staff failure to adhere to Trust polices and guidelines	Monitoring of results of instigated changes in Quarterly SUI/SAE report due April 2013 and for discussion at Clinical Quality and Safety Committee	20/16
Reduced number of nursing staff	• Minimise use of Escalation Wards • Agency partnership programme to be commenced • Winter planning to be undertaken early 2013.	20/20
Potential loss of acute stroke unit service	• Maintain high performance of stroke service • Continue to exert influence on CSB regarding final • decision • Reach trajectory for ED 4 hour target for Q4	20/20
Impact of pathology redesign in Greater Manchester	Full business case results expected	20/16
Potential for Healthier together to alter significantly Trust's paediatric service	• Continued engagement with the Healthier Together clinical workshops • Arrange to meet Healthier Together Clinical Lead and Network Manager to further discuss possible options around the units in the South • Continue to update commissioners and Southern Sector Steering Group on discussions • Proactively propose to Healthier Together team Southern Sector provided models of care (HT Team currently excluding ECT from discussions)	20/16

In addition, the Trust's business groups review their own risk registers, related to lower-rated risks within their own area of operation.

Risks to quality – transformation programmes

When planning service change through its transformation programmes, the Trust routinely applies risk assessment criteria to the projects, benefits and risks of the programme, ensuring that quality maintenance and improvement is thoroughly identified and remains integral to programme and project management throughout the life of the plan.

Risks to quality - cost improvement programmes (CIP)

Cost improvement projects and actions are assessed and any risks mitigated through a standardised quality impact assessment before implementation. Any residual risks during and after implementation are handled through the Trust's risk management framework. The Director of Nursing and Midwifery and the Medical Director are both members of the Trust's Productivity and Efficiency Board where progress with cost improvement is monitored both for achievement and risks to quality. The Director of Nursing and Midwifery attends each business groups' cost improvement progress meetings, monitoring quality impacts of plans and, additionally, ensuring the Medical Director is appraised of all necessary issues. Inclusion of quality improvement objectives and transformation objectives with the CIP target in the corporate objectives ensures regular reporting to the board of directors of quality-related risks through the board's assurance framework. Additionally, the Trust's CIP is

formally “signed off” by the Director of Nursing and Midwifery and the Medical Director.

Quality assurance process review
As responsible officer, the Director of Nursing and Midwifery periodically uses Monitor’s quality governance assurance framework to assess the Trust’s quality assurance processes, including the measures described above. To test further the Trust’s governance framework’s fitness for purpose, an external review was commissioned during 2012/13. The recommended actions are being implemented. Internal Audit also has the Quality Governance Framework included in the work plan for 2013/14.

5. Clinical Strategy

Guided by a need to balance resilience and quality, the Trust’s strategy for clinical services is founded on a determination to:

- Provide a range of services locally, easily accessible for local people;
- Ensure services meet the requirements of best practice with regard to quality and safety;
- Aim to achieve a positive financial contribution from all services by driving efficiency. Where this is not possible, the underlying financial impact will be understood and under-written by remaining services.

5.1. Service reviews

Within the framework above, the Trust’s plans to undertake specialty and service reviews have been revised to account for the *Healthier Together* review’s timescales and to be undertaken in parallel with Southern Sector partners’ reviews of services. Emerging plans from CCGs are also built in to service review plans, particularly in those services related to anticipatory care for people with long term conditions.

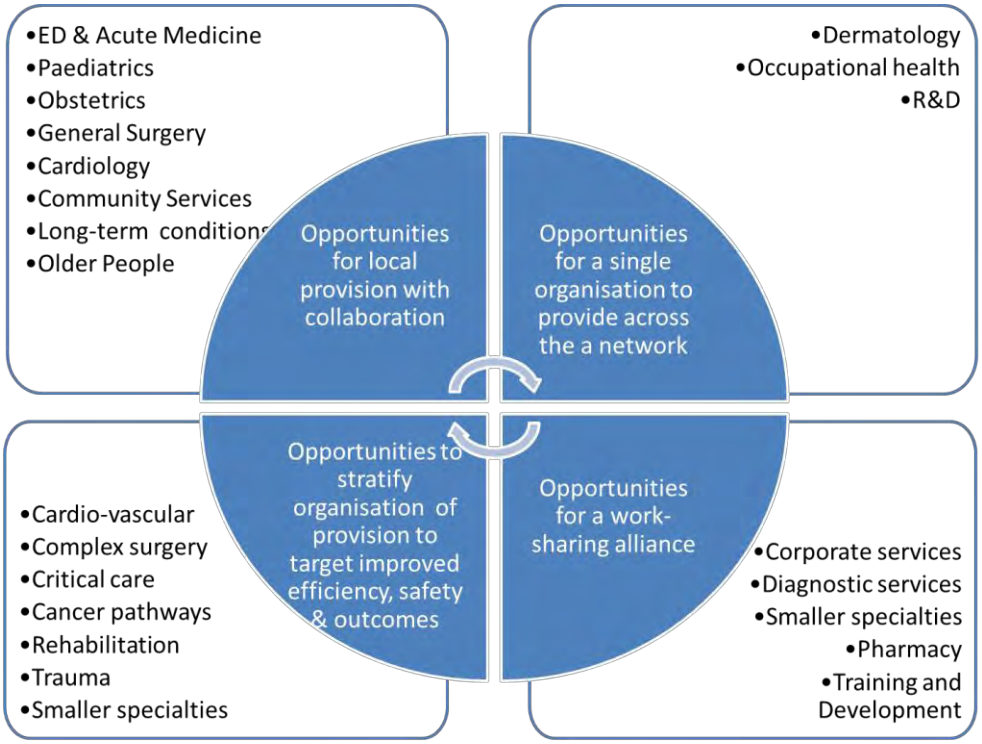
As the *Healthier Together* review begins public consultation on published service change in November 2013, the Trust expects to review major services, (e.g. emergency surgery, cardiology services, stroke, cancer services, paediatric services) against newly published service specifications. Early work on service reviews has been carried out using a method agreed by the partners to gain consistency of outputs, enabling useful comparison of similar services in partner Trusts and to identify where services will benefit from collaborative solutions in future. The method incorporates an external review of the specialty’s context, including required regulatory standards, Royal College guidelines (especially for medical staffing), clinical practice guidelines and requirements. The reviews contrast this context with internal strengths and weaknesses, both current and forecast, to complete with a strategic solution to each Trust’s specialty or service position. The solutions are then compared by specialty or service representatives from each Trust at a facilitated meeting to develop jointly, collaborative plans.

The reviews began in 2012/13 with radiology, pharmacy emergency surgery and obstetrics and gynaecology and have further incorporated:

- Paediatrics;
- Cardiology;
- Some smaller specialties: dermatology, clinical haematology;
- Community services and out of hospital care.

These early discussions are in addition to work underway between the partner Trusts to collaborate on provision of Carter review compliant pathology services.

The potential collaborative models being considered by specialties can be found in the following diagram.



Service line strategies will be developed following reviews. The Board of Directors has agreed a set of core services over which "sovereignty" will be maintained, including Urology, Orthopaedics, ED and Emergency Medicine, Critical Care and Older People's care. Partner Trusts have developed similar intentions so that remaining services are to be considered for collaborative position within a network of partner Trusts. The core services will also benefit from collaboration where specialist skills in partner organisations can augment services for local residents.

From the foregoing, it is clear that the shape and scope of Stockport FT will begin to change radically during the life of this plan. The partner Trusts' boards have established a steering group comprised of representatives from all Trusts and led by Chief Executives. A jointly appointed, dedicated Programme Director is being recruited and will be supported by a jointly provided programme management office (PMO). These elements will develop existing governance processes to ensure boards remain assured of progress and appraised of risks in their own and partner organisations as the Southern Sector develops. Such arrangements will be developed to be compatible with partner Trusts' existing governance frameworks.

5.2. Clinical Workforce and Organisational Development Strategy

Background & Context
In its recent strategic analysis, Stockport FT's board took into account that the Trust:

- Is learning to operate as a single Trust from a number of sites/premises, having absorbed two community organisations during the last two years;

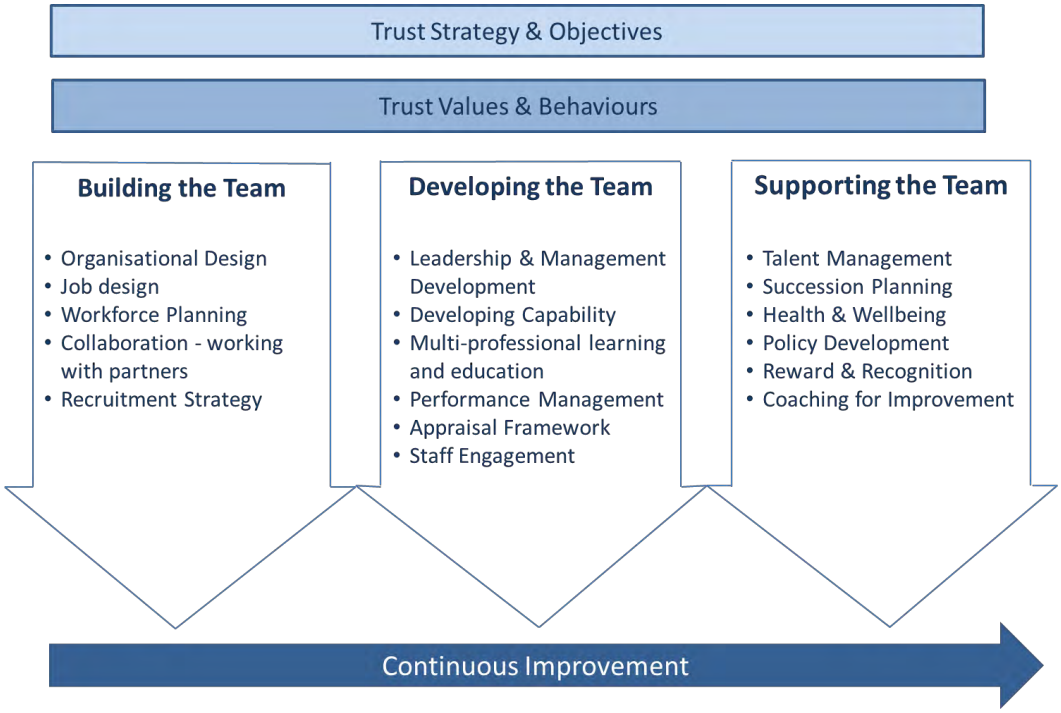
- Has grown in that time to employ 5,700 staff, working in teams of various sizes & complexities;
- Is a high performing organisation with ambition to do still better;
- Seeks to unify its culture as one in which staff have clarity of expectations, are accountable & feel valued ;
- Aims to establish continuous improvement to deliver sustainable high performance.

To deliver its ambition, the board agreed to refresh its Workforce and Organisational Development Strategy to ensure the Trust is joined together through common aims, values, structures, processes & performance management arrangements. The strategy will be a live document and will be subject to further reviews and refinement to ensure it remains fit for purpose. The key elements of the strategy are shown below.

The board has adopted the following timeline for this work.

- 26th April 2013 – Broad principles agreed by Board of Directors;
- May 2013 - August 2013 – Develop the strategy & plan with key stakeholders;
- September 2013 - December 2013 – Share strategy with team across the Trust as part of implementation & engagement process.

Broadly, the Trust's strategy has three elements:



The board's strategic rationale recognises a need to develop further the Trust's workforce to align the human resource contribution with new models of service delivery and to ensure the culture, capacity and capability of the organisation is sufficient to deliver our objectives. The Trust has control over much of that development through its internal work on education and training, promotion of shared values, performance appraisal and talent management. Developing a culture in which all staff are clear about what is expected from them; are held to account and in which they feel valued, will play a significant part in our workforce journey over the next twelve months. Aligned with this will be continuing development and embedding of leadership structures and increasing individual capability in management and leadership. We will support this work by a root and branch review of our appraisal and performance management framework which is already underway. The revised arrangements will be underpinned by a behavioural framework which is being developed as part of our *Listening to You* programme of staff engagement. Thus we will review not just what staff do but how they do it. Once in place, the behavioural framework will be used as part of recruitment processes to ensure we recruit staff who recognise and subscribe to our values and behaviours every day.

In common with other Trusts, we face a number of labour supply challenges as we look to either replace or hire to new, hard to fill roles. To ensure a strategic approach to workforce reduction, review and redesign within the Trust's annual planning cycle, we are reviewing our workforce planning processes. These will be continually refined and reviewed over the next three years, supporting delivery of required efficiencies and a well-planned workforce approach to service change and reconfiguration.

In addition to being creative about how we market difficult to recruit roles, and intelligent in our timing and overall offer to potential candidates, we will also work in a more collaborative way with partners. Our partnership with East Cheshire, South Manchester and Tameside presents opportunities to consider key services across two or more organisations as opposed to one organisation filling a workforce gap at the expense of others. Initially, where we have services that are dependent on small teams for continued delivery, this partnership approach offers an opportunity to help each other through transitions and periods where key posts may be vacant. In time, we will develop our relationship to establish a network

approach to workforce planning in response to networked service need and will learn from the strengths of each other's organisational cultures.

In summary, the Trust's revised workforce and organisational development strategy, evidence-based in national and international research, will continue to recognise the valuable contribution of the Trust's workforce and the benefits an engaged and satisfied workforce brings to patient experience and mortality rates. To leverage this benefit for patients, the board is committed to increasing its focus on supporting staff to enhance their own health and wellbeing.

5.3. Clinical sustainability

The Trust has compared its services against the guidelines and standards shown below and is confident that its major services are sustainable, but in some cases this will require collaboration with partners identified earlier.

Policy/guidance	Key guidelines
Consultant physicians working with patients, 4th edition (2008)	• Round-the-clock consultant supervision of AMU • Consultant reviews of all acute admissions within 12 hours of initial assessment through twice daily post-take ward rounds • Increased consultant coverage required when >25 admissions/ 24 hours
Emergency Medicine Consultants – Workforce Recommendations (2010)	• 10 WTE minimum coverage for all A&E providing 16 hour/7 day consultant coverage; minimum coverage higher for A&E departments with >80,000 attendances per year • 24/7 emergency medicine consultant coverage of A&E
Emergency Standards for Unscheduled Surgical Care (2011)	• Consultant available by telephone 24/7 and available onsite within 30 minutes • Consultant review of high risk patient within 4 hours • Consultant surgeon present for operations where predicted mortality >5%
Facing the Future: A review of paediatric services (2011)	• Consultant paediatrician review within 24 hours of child's acute admission to paediatric unit • Short Stay Paediatric Assessment can access consultant opinion throughout operational hours • Paediatric consultant present during peak hours • Minimum 10 WTE per rota
The Future Workforce in Obstetrics and Gynaecology (2009)	• 24/7 consultant coverage for delivery suites with >5000 births per year = 12.5 consultant WTE rota • 60hr/week consultant coverage for delivery suites with 2.5k-3.5k births/year

Smaller specialties, provided by smaller teams, such as rheumatology, clinical haematology and some visiting specialties will benefit from provision through a network approach and will be reviewed during the life of this plan to improve their sustainability. Dermatology is an early example – the Trust is currently establishing a networked service in collaboration with partners to address difficulties in recruiting to consultant posts.

5.4. Innovations in care

A number of innovative changes to services are underway. Some highlights include:

- Introduction of an electronic "cas-card" to create a paperless ED;
- Introduction of a workforce scheduling and diary management system for district nurses;
- Continued implementation of electronic prescribing – e-pma;
- Continued digitisation of paper patient records – the e-record system;
- Surgical "masterclass" training sessions in endourology;
- Daycase, laparoscopic hysterectomy;
- EPMA.

The Trust has included a number of the DH's High Impact Innovations in its plans. We have introduced the wheelchair service standard, "Child in a Chair in a Day" and we include intra-operative fluid management in surgical practice. Improved support for dementia sufferers and their carers is included in 2013-14 objectives and our out of hospital care programme has plans to incorporate telehealth and telecare in its service developments.

We look forward to sharing innovative solutions with our partners in the Southern Sector. One fruitful growth area is our plan to create a Research and Development network, led by UHSM, which will increase Stockport FT's capability to undertake clinical trials and take part in clinical research.

6. Annual objectives for 2013/14

To summarise, for 2013/14, planned progress towards the Trust's strategic aims is shown in the annual objective table below.

2013/14 objectives

	Annual objectives	Delivery date	KPI
	Quality and Safety		
1.	Improve weekend mortality rate	31st March 2014	Maintain monthly rate within expected cohort (Dr Foster data)
2.	Avoid MRSA infection	31st March 2014	100% of patients
3.	Reduce *Chlostridium difficile* infections	31st March 2014	No more than 38 hospital-acquired infections
4.	Reduce pressure ulcer prevalence	31st March 2014	Hospital and community - Reduce prevalence by 25%
5.	Complete VTE assessment for eligible patients and analyse root cause of any subsequent hospital-associated thrombosis	31st March 2014	95% assessment rate each quarter
6.	Provide care according to the Advancing Quality improvement programme for patients admitted for: • myocardial infarction • heart failure • hip and knee replacement • pneumonia • stroke	31st March 2014	Deliver AQUA target levels of clinical interventions for these patients
7.	Introduce safety thermometer for monitoring medication errors	31st December 2013	2 quarters' baseline data collected, validated and submitted to AHSN for planned 2014/15 programme
8.	Improve transfers of care between teams and organisations	31st March 2014	No of changes made to clinical practice, services or patient pathways as a result of quarterly peer reviews of transfers of care
9.	Improve uptake of adult safeguarding training	31st March 2014	40% of staff trained to at least basic level (85% over 2 years within mandatory training cycle)
	Communication		

	Annual objectives	Delivery date	KPI
10.	Implement all elements of Friends and Family Test and act on feedback	31st March 2014	Response rate of at least 20% each quarter
11.	Improve the experience of care for patients with dementia and their carers	31st March 2014	• Proportion of patients with dementia identified and referred for specialist help • Proportion of staff completing dementia care training
12.	Improve care provided at end of life	31st March 2014	• Increase in number of end of life care plans recorded • Increase in number of patients who die in their place of choice
13.	Identify, record and support patients' carers	30th June 2014 then quarterly	• Number of carers identified • Number of carers referred to Stockport *Signpost*
14.	To develop an open and transparent communication channel between the FT and commissioners in respect of quality monitoring	31st March 2014	Joint Stockport quality surveillance forum established with weekly, monthly and quarterly information flows
15.	Improve communication between primary, secondary and community care clinicians	31st March 2014	Completion of quarterly workshop events
	Service		
16.	Meet NHS guarantee of maximum pathway length of 18 weeks	Each quarter	• Achievement of 90% & 95% standards • Backlog maintained below 200 (admitted)
17.	Meet NHS standard of 4 hour maximum time in ED	31st December 2013	• Achievement of ED Monitor recovery plan by required timescales
18.	Achieve all cancer targets	Each quarter	14, 31 and 62 day standards
19.	Ensure ED-related provider license enforcement notice lifted	30th September 2013	• Consistent compliance with ED national standards • 2013 KPMG governance report implemented
20.	Meet access standards for people with a learning disability	Each quarter	6 x standards achieved
21.	Reduce avoidable short-stay admissions	31st March 2014	No of changes made to clinical practice, services or patient pathways as a result of quarterly reviews of short-stay admissions
22.	Reduce cancellations of community contacts and appointments	31st March 2014	• No of contacts cancelled by service • No of appointments cancelled by service
23.	Work with Community Nursing Teams to reduce attendances at the Emergency Department for people with COPD and Heart Failure by improving personalisation of care plans and community support	31st March 2014	• Numbers attending ED • Personalisation: LTC 6 scores

	Annual objectives	Delivery date	KPI
24.	Reduce number of patients admitted to hospital from nursing homes where primary cause of admission is dehydration	31st March 2014	Number of admissions for rehydration
25.	Improve identification and signposting for patients whose alcohol consumption is unhealthily high	31st March 2014	Increase in eligible patients referred to Lifestyles service
26.	Increase the number of mothers who choose and sustain breastfeeding	31st March 2014	• Breast feeding initiation rate • Breast feeding rate at 6 weeks post delivery
27.	Develop quality and resilience of services through partnerships	31st March 2014	Number of service changes implemented.
28.	Develop workforce plan to support creation of integrated locality teams	31st March 2014	Plan established
29.	Ensure patients on urgent care pathways receive high quality, safe, timely care	31st March 2014	• Reduction in avoidable admissions • Increase in numbers of patients with ACS conditions treated and discharged • ALOS reduced to benchmark level
30.	Improve quality of experience for people receiving outpatient care	31st March 2014	• Improve clinic utilisation • Reduce hospital cancellation rates • Reduce DNA rates • Reduce new to follow-up ratios in targeted specialties to benchmark levels
31.	Improve quality of experience for people receiving care on surgical pathways	31st March 2014	• Improve theatre utilisation • Reduce pre-op LOS • Increase daycase rates in targeted specialties
	Finance and governance		
32.	Deliver Monitor Risk Assessment Framework, ensuring Trust remains financially viable	30th September 2013 31st March 2014	• Financial Risk Rating >3 • Continuity of Services Risk Rating >4
33.	Meet CIP requirements in full	31st March 2014	CIP achievement - £15m
34.	Participate in Greater Manchester's Academic Health Science network	31st March 2014	Completion of action plan as result of readiness self-assessment

7. Productivity and Efficiency

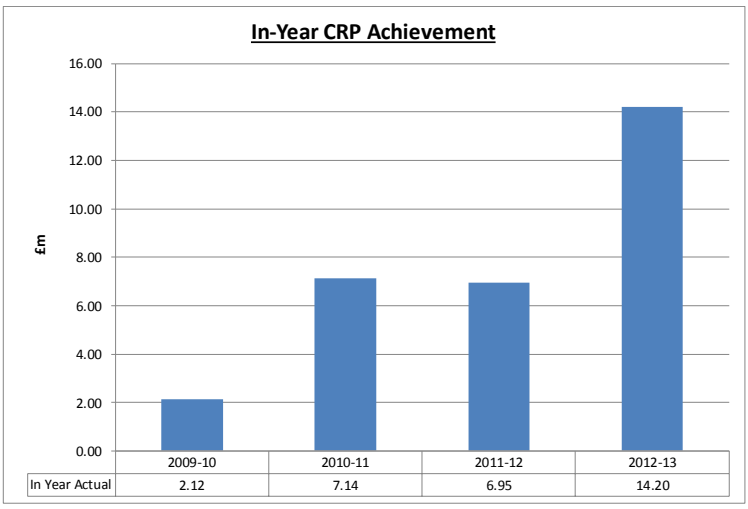
Overview

The Trust's current productivity and efficiency plans are a combination of Business Group cost improvement plans, and a number of programmes intended to delivery transformational change and efficiencies over the medium term, in line with our service line strategy. Overtime most of our efficiencies are expected to be derived from transformational change. The current programmes being pursued include:

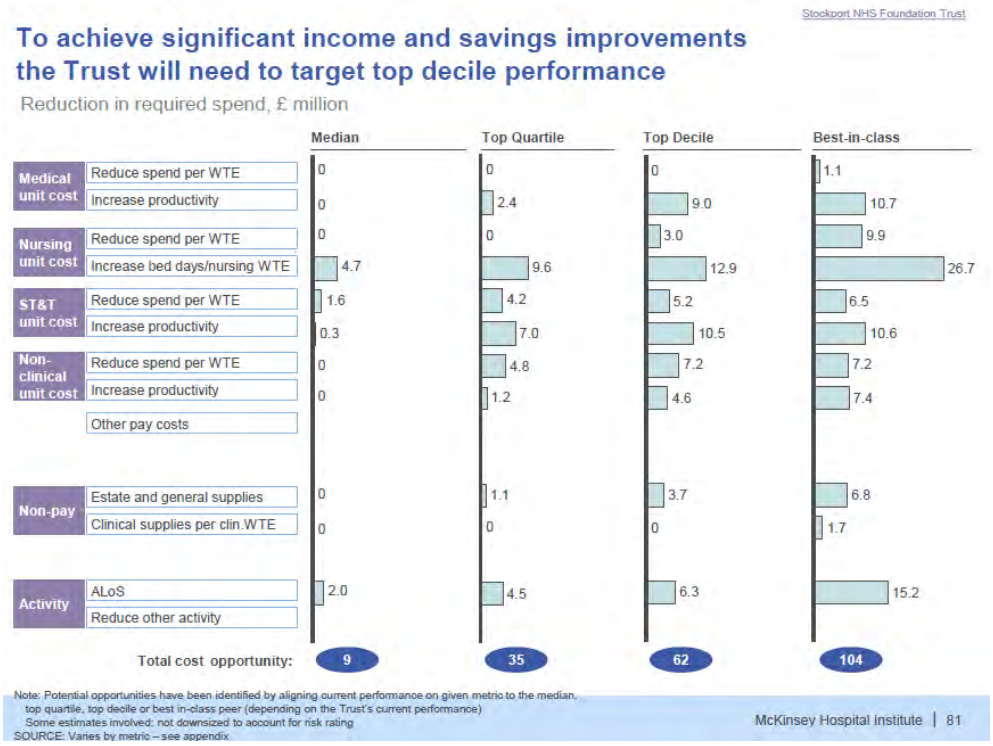
- **Outpatient redesign** – which is focused on the productive use of clinic time, reducing unnecessary follow appointments.
- **Theatre productivity** – which is focused on maximising the productive use of theatre time, maximising day case activity and reducing variation in practice;
- **Integration** – which will ensure the most efficient use of our community resources across the localities we serve, and fully integrate provision with secondary care;
- **Workforce** – which is aimed at appropriately standardising our structures and terms and conditions across the organisation, as well as facilitating operational rotas that allow 24/7 working wherever required to deliver consistent, safe, efficient services;
- **Out of hospital care** – scoped to develop community resources and links to primary care including design of locality-based integrated health and social care teams and anticipatory care pathways and care plans for identified cohorts of patients;
- **Property rationalisation** – increases utilisation of community property and allows regeneration of Stepping Hill hospital as a smaller, more streamlined acute environment;
- **Information Technology** – specification and investment planning of systems that support integrated working with shared records, accessible guidelines and electronic staff management systems.

CIP governance

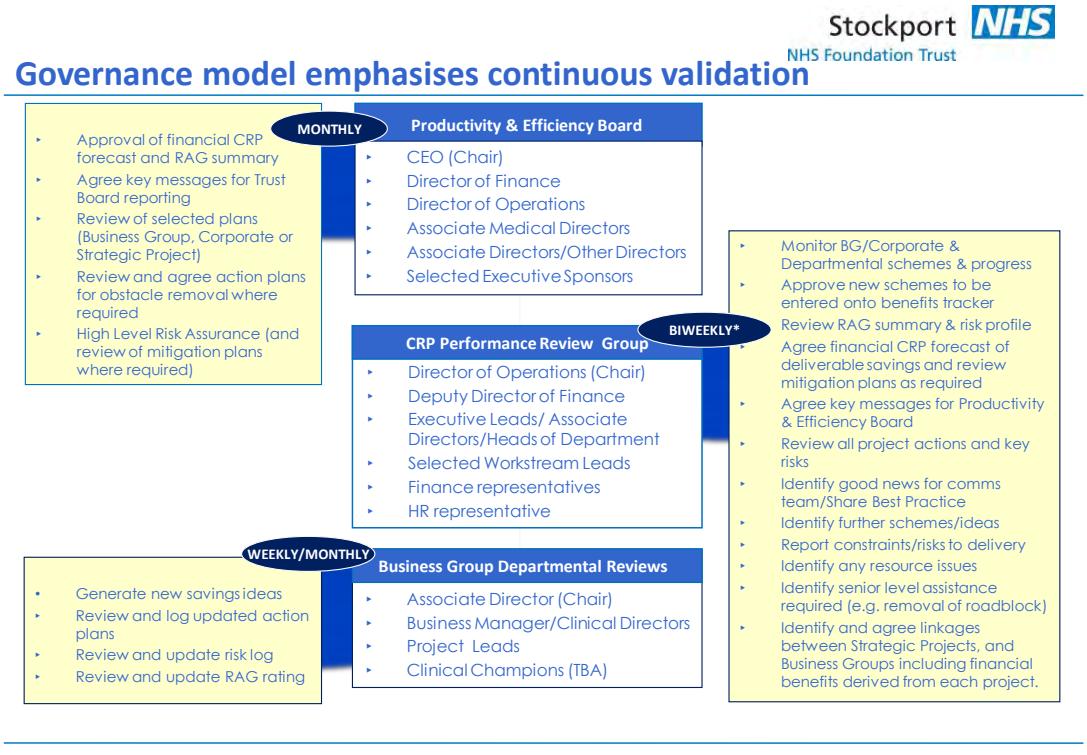
The Trust has a good track record of delivering its Cost Improvement targets and our historical achievement is shown below:



During 2012/13 the Trust engaged McKinseys to work alongside to help identifying priority areas for CIP and longer term transformational change, and this has helped shape the programmes highlighted above. The benchmarking indicates potential savings of between £17m and £54m, in order to achieve this, due to the Trust's current position in benchmarking, it would need to consistently target top quartile or decile performance compared to its peer group. Furthermore, from the analysis below it can be that the majority of savings are not simple spend reductions and therefore will be more challenging to release as cash.



During 2012/13 the Trust managed its Cost Improvement Programme through a monthly Savings Board, chaired by the Chief Executive and through the Business Group's monthly Finance Performance Management meetings. The Trust has recently reviewed its governance processes and implemented a revised, strengthened process designed to be more focussed, and to hold managers to account more effectively. The new governance model is detailed below:

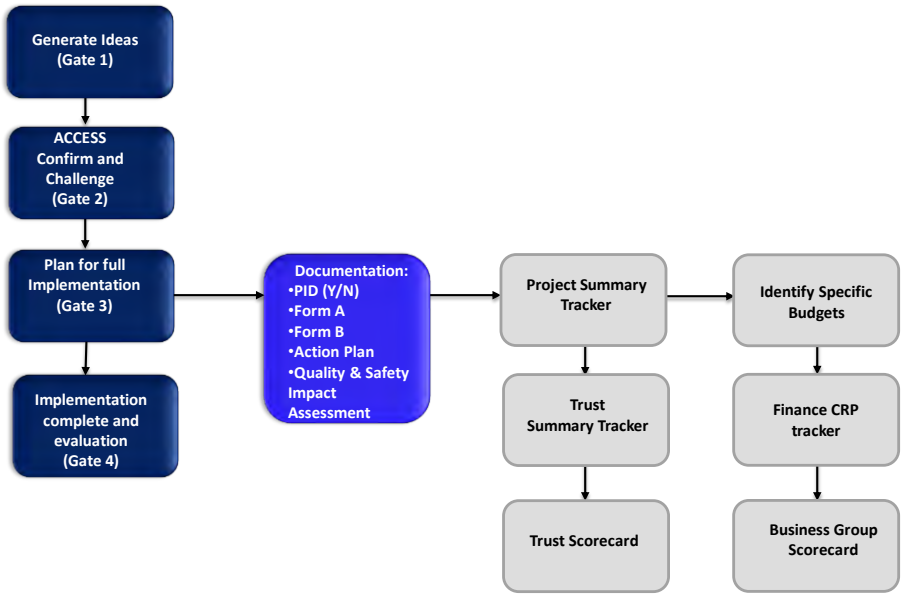


Slide 12

The methodology uses a programme management approach to assess progress and move schemes, projects and Business Groups through a series of “Gateways”.

Creation of CRP and Project Implementation

Stockport NHS
NHS Foundation Trust



Slide 7

There is also clear expectations about outcomes and a clear escalation process should issues arise:

CRP Delivery Governance

Stockport NHS
NHS Foundation Trust

CRP DELIVERY GOVERNANCE

Responsibility	Where	Frequency	Delivery Requirement	Escalation Process
Chief Executive/Finance Director	Productivity & Efficiency Board	• Monthly	• CRP update in the form of Trust CRP Scorecard, supplemented by individual Business Group CRP scorecards which detail progress against plans. Overview of identified risk to delivery plus mitigation in place to address shortfalls which will be discussed and agreed in advance of submission to Trust Board.	• Where a Business Group and/or Corporate Department performance has been off track for a period of 1 Quarter the AMD/AD or Head of Department will be required to present their formal rectification plan outlining actions to mitigate risk to delivery prior to the next Productivity & Efficiency Board.
Director of Operation /Deputy Director of Finance	CRP Performance Review Group	• Monthly (alternates with Confirm & Challenge Group)	• CRP update in the form of individual Business Group scorecard to be provided by each Business Group alongside an update report on actual CRP project progress which outline any risks to delivery which will then be agreed in advance of submission to Productivity & Efficiency Board.	•Where individual Business Group/Corporate Department CRP performance is off track discussions will focus on alternative actions to mitigate risks to delivery which will be developed and presented to the next meeting. •If a Business Group or Corporate Department show no sign of improvement over a period of 2 months, a formal meeting will take place between the AMD/AD and/or Head of Department with the Director of Operations and the Deputy Finance Director to agree a formal course of action to ensure agreed delivery.
Director of Operation /Deputy Director of Finance	CRP Performance Review Group	• Monthly (Confirm & Challenge Process)	• AMD, AD and Finance Accountant to report on ongoing CRP performance with a detailed overview of specific project actions and risks to Director of Operations/Deputy Director of Finance at CIP Confirm & Challenge Group. •The meeting will provide a forum for discussion and challenge between and across business groups and corporate departments. • CRPs from all Business Groups /Corporate areas will be shared and all projects proposed will be checked for implications to other services, be they positive or negative.	•Where individual Business Group/Corporate Department CRP performance is off track discussions will focus on alternative actions to mitigate risks to delivery which will be developed and presented to the next meeting. •If a Business Group or Corporate Department show no sign of improvement over a period of 2 months, a formal meeting will take place between the AMD/AD and/or Head of Department with the Director of Operations and the Finance Director to agree a formal course of action to ensure agreed delivery.
AMD / AD / FA	Business Group Performance Meetings	• Weekly • Monthly	• Formal notification to each Clinical Director/Business Manager outlining expectations and financial responsibilities including delivery of CRP and notification of this governance structure. • All Business Group and Speciality business plans will include delivery of CRP as a core objective and this will be reflected in the AMD/AD/HON/CD/BM personal objectives to enable individual and ongoing performance review via the Trust appraisal process. • Each Speciality/Departmental area to establish an agreed process to plan, deliver and report CIR performance to AMD/AD.	• Where individual Speciality/Department performance is off track discussions will focus on alternative actions to mitigate risks to delivery which will be implemented prior to next meeting. •If a Speciality/Department show no sign of improvement over a period of 1 month, a formal meeting will take place between the AMD/AD to decide an appropriate course of action.

REVIEW

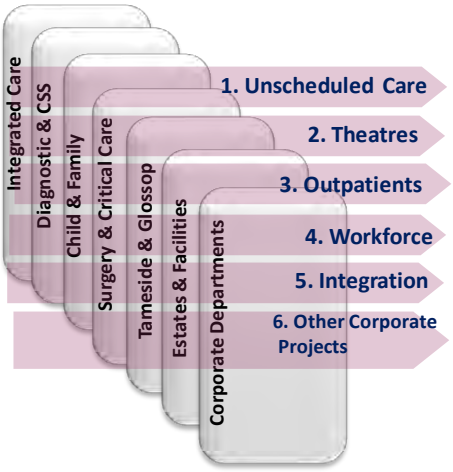
ACTION

MONITORING & REPORTING PERFORMANCE

Slide 13

CIP profile

The Trust's Cost Improvement Programme consists of several cross-cutting transformational / service re-design "corporately-led" projects, some of which are shown in the diagram to the left, which cover key areas of efficiency improvements identified from the McKinseys work.



Business Groups and Corporate Departments also have been given specific targets, and are developing a variety of schemes to meet these, including meeting a mandated headcount reduction target. These are detailed in the table below.

The CIP target delivery is profiled evenly throughout the year, and more than 50% is expected to be delivered from pay, with the remaining being from Clinical Supplies, Other Non-Pay, Drugs and revenue generation.

2013/14 CRP Plans		
	Base Case Target (£000)	Current Plans (£000)
Staff Flow	568	300
Drugs	500	448
PACS	225	225
NHSLA	269	80
E-records	100	100
Non-Pay	484	498
Integration	1,000	122
Energy	300	300
Readmissions	600	500
Outpatients	1,000	200
Theatres	1,000	500
Unscheduled Care	1,000	-
Workforce including MARS / headcount reduction	1,500	1,600
Regent House	25	100
Specialty Margin Review	250	-
Payroll	50	50
Pathology	500	-
CQUIN	-	500
Business Group Projects	5,704	2,877
Total	15,075	8,400

Whilst we are working closely with our collaboration partners, and in particular our Southern Sector partners, our CIP programme does not have an explicit target within it yet for any benefits which may accrue.

CIP enablers

The Trust's medical management have been fully involved in the development of the Trust's CIP. Each Business Group has an Associate Medical Director, and specialties also have a Clinical Director. These were all invited to the McKinseys sessions, and then to a CIP summit we held on the 23rd January 2013. Big launch events have been held for the key transformational corporate-led projects, which have had wide clinical attendance. Over the past few months, the Director of Finance has attended the Associate Medical Director's meeting to work with them on the financial challenges, and a Consultant body event took place on the 21st May 2013, with a Clinical Director forum event planned for the 4th July 2013.

All Business Group CIP schemes are developed and signed off for through the Business Group Boards, on which Associate Medical Directors and Clinical Directors sit.

Proposals have been put forward to develop a Southern Sector PMO to drive forward these schemes, and each Trust will share the costs of establishing this.

Within our capital programme we have identified a small budget as a CIP "Invest to Save" budget, for which spending is approved by the CIP Operational meeting.

Our overall capital programme, and particularly the IT element of this, gives a high weighting to those schemes which contribute to increasing efficiency – for example, there is a significant amount being invested in community IT solutions to aid scheduling and to make the system paper-lite.

Quality impact of CIPs

The Trust has developed a Quality and Safety Impact assessment tool, and each CIP scheme is required to be entered on this. Each scheme is risk-assessed either by the Business Group and signed off by the Associate Medical Director and Associate Director or corporate Project Manager the risk score is confirmed via the CIP Operational Group.

Either the Director of Nursing or Medical Director have attended recent Business Group CIP meetings to get a full understanding of the individual schemes and to challenge these where necessary, in order that they are in a position to sign off the overall Quality and Safety Impact Assessment.

8. Financial and investment strategy

Current financial overview

Over the last three months, the Board of Directors have been kept informed of the assumptions being used to derive the 2013/14 Annual Plan, and key issues within it.

The Trust aims to ensure that our financial risk rating is maintained at a minimum of 3, under Monitor's compliance framework. The plans presented in April secure this goal, but require the delivery of a £15.1m Cost Improvement Programme (CIP). As part of our on-going financial management we continually update our planning assumptions to take account of the changing environment and model the impact of this in order to take advantage of opportunities or devise mitigation strategies if required.

In doing this two factors stand out as risks to the financial plan, which have become increasingly concerning since the publication and Board approval of the base financial plan in March 2013. These are, the escalating costs associated with the recovery and sustainability of the 4 Hour Accident and Emergency Target, and the associated eight point

plan; and progress with the Trust's productivity and efficiency programme, particularly the transformational or "corporate project" aspects of delivery.

A&E 4 Hour Target

At the time of publication of the original financial plan the costs relating to the recovery plan and sustainability of the A&E target were estimated at £2.3m based on the plans that had been developed at that stage, and partially supported by £1.1m of resources agreed in our contracts with Clinical Commissioning Groups (CCGs). Since then the more fully developed plan incorporates additional costs in particular in medical and nursing resource in the A&E department, acute rotas, and continuing use of escalation capacity. The current estimated costs are £3.8m, this is on top of significant resources invested in emergency medicine over the last three years.

Whilst the objectives associated with each element of the eight point plan are clear, for a number of elements the actual costs will only be known once detailed planning is complete and implementation commences. In addition, the market for emergency department staff is difficult and costs above this level will be incurred if the Trust decides to deploy more expensive locums.

Cost Improvement Programme

The Board have previously identified the need to deliver significant efficiencies as key risks to the 2013/14 plan, and have become increasingly concerned about the organisation's progress in securing the required level of savings. Whilst initial planning commenced sufficiently early, initial focus has been placed on "Corporate" projects supported by a centralised Programme Management Office (PMO) rather than the traditional focus which has been on Business Group targets. Whilst this process has yielded some results progress is currently not sufficient.

The Director of Finance discussed concerns about the pace of progress with the Board of Directors and as a result was fully supported in accelerating the pace and tasked with creating proposals to strengthen the governance and accountability of the Cost Improvement Programme.

Over the last month, the Director of Finance, Deputy Director of Finance, have met with each Business Group twice to assess their progress against "gateways", and where possible the Director of Nursing and the Director of Operations have joined these review sessions, and progress is now being made by individual business groups. "Corporate" projects have been reviewed as part of the Executive Team meetings, and "Corporate" departments will also be reviewed.

Despite these steps being taken, there is still a significant gap between the required savings and identified savings of at least c.£6.7m (based on schemes identified at a business group level and assessment of progress with corporate schemes).

Summary financial position

The CCG has been made aware of the challenges the Trust faces, and the CCG's Chief Finance Officer has made the Local Area Team aware, the Chief Executive and Director of Finance had a meeting with the CCG's Managing Director and Chief Finance Officer on the 20th May 2013 to discuss the options further.

Given the current risks identified above and the on-going CCG discussions, in addition to the "Base case" financial plan approved in March 2013, four additional scenarios have now been modelled and are summarised below:

- Scenario 1 – This scenario assumes that only the cost reductions of £4.1m currently signed off by Business Group Associate Directors and Associate Medical Directors will be delivered.
- Scenario 2 – This scenario adds to scenario 1 an assessment of what can realistically be expected from the Corporate Projects based on current progress. This does not set a revised target for these projects, and with enhanced effort more benefits should be deliverable. Nevertheless this scenario adds a further £3.4m, giving a total of £7.5m which is only 50% of our required Base case target.
- Scenario 3 – This scenario builds on Scenario 2 and assumes a further £0.9m of savings will be delivered during the year, in order to deliver the total of £8.4m of savings identified earlier in the CIP process are delivered.
- Scenario 4 – This scenario assumes that £11.2m of savings can be delivered in year, and this is the minimum amount that will secure us an FRR of "3" for the year, but it is likely that we will have an FRR of "2" in at least two quarters during the year due to income phasing and override rules.

Scenario	Surplus / (Deficit) (£m)	FRR (to 2 dp)	Final FRR (overriding rules)	Cash Balance (£m)	Liquidity (Days)
Baseline Plan	2.8	3.50	4	41.6	51.2
CRP Scenario 1 (£4.1m)	(8.1)	2.60	2	33.7	38.9
CRP Scenario 2 (£7.5m)	(4.8)	2.80	2	37	43.6
CRP Scenario 3 (£8.4m)	(3.8)	2.80	2	38	45.1
CRP Scenario 4 (£11.2m)	(1.1)	3.00	3	40.8	52.2

* Note: scenarios have been modelled outside of Monitor's model, and therefore the actual cash balance may differ slightly

The Board of Directors considered the merits and risks associated with each of these scenarios, before concluding that Scenario 3 represents the most realistic basis for our financial plan at this time, taking account of the Trust's assessment of its underlying position and the tangible CIP plans to date. The Director of Finance has also advised Monitor of the range of scenarios we have examined. By adopting Scenario 3, the Trust is therefore proposing that the 2013/14 Financial Plan be for a deficit of £4.0m, and a minimum CIP requirement of £8.4m. This will result in initial Financial Risk rating (FRR of a 2).

In reaching this conclusion, the Board were also clear that work should continue on CIP identification and delivery in 2013/14 with an overall objective of improving the position to secure an FRR of 3 during the year. Furthermore, work on the transformational projects highlighted at the beginning of this section should be progressed to ensure efficiencies in future years can be fully secured.

Whilst our opening plan will result in a reduced financial risk rating by our regulator, a detailed Going Concern paper was presented to the Audit Committee on the 24th May 2013, which recommended that due to the Trust's strong cash position, the adoption of the going concern principle remains valid. This principle was approved by the Audit Committee.

The summary financial position is presented below:

2013/14 Annual Plan

	2012/13 Plan £m	2012/13 Outturn £m	2013/14 Plan £m	2014/15 Plan £m	2015/16 Plan £m
Income					
Clinical Income	255.9	258.9	255.5	249.0	244.7
Non-Clinical Income	26.4	31.0	27.7	27.7	27.7
Total Income	**282.3**	**289.9**	**283.2**	**276.7**	**272.4**
Expenditure					
Pay Costs	(199.3)	(201.2)	(205.7)	(192.1)	(187.0)
Non-Pay Costs	(69.1)	(74.4)	(69.9)	(70.6)	(71.8)
Total Expenditure	**(268.4)**	**(275.6)**	**(275.6)**	**(262.7)**	**(258.8)**
EBITDA	**13.9**	**14.3**	**7.7**	**14.0**	**13.7**
Depreciation	(7.3)	(6.9)	(7.1)	(7.0)	(7.0)
Fixed Asset Impairment (Exceptional Item)	0.0	(0.8)	0.0	0.0	0.0
Profit on Asset Disposals	0.0	0.0	0.0	0.0	0.0
Restructuring Costs	0.0	0.0	0.0	0.0	0.0
Other Non Operating Income	0.0	0.0	0.0	0.0	0.0
Other Non Operating Expenses	0.0	(0.1)	(0.4)	(1.1)	(0.7)
Financing Costs	(4.0)	(3.8)	(4.2)	(4.1)	(4.1)
Net Surplus / (Deficit)	**2.6**	**2.6**	**(4.0)**	**1.9**	**1.9**

	2012/13 Plan	2012/13 Outturn	2013/14 Plan	2014/15 Plan	2015/16 Plan
Criteria					
Underlying Performance	2	2	2	3	3
Achievement of Plan	5	5	5	5	5
Financial Efficiency	3	4	2	3	3
Liquidity	4	5	4	4	4
Total Weighted Score	**3.00**	**3.65**	**2.80**	**3.45**	**3.25**
Financial Risk Rating	**3**	**3**	**2**	**3**	**3**

Key financial priorities and investments

The Trust's main financial priorities for 2013/14 will be to maximise CIP delivery for 2013/14, develop a full CIP programme for delivery for 2014/15 in order to improve the Trust's margin and secure a sustainable underlying financial position. This is critical as without this, the cash earmarked for planned capital developments, such as "D Block" are at risk.

The Trust still plans to spend £8.9m on capital in 2013/14 to continue to improve patient facilities. This investment is funded by £6.0m of resources that will be generated from our own resources in year (depreciation less loan repayments), plus the £3.8m expected carry forward from 2012/13 slippage and underspend (a proportion of which will also be carried forward to 2014/15). The key elements of the programme for 2013/14 are shown below:

- E-records project (£0.4m);
- ED Patient Flow Whiteboards (£0.4m);
- PACs and workstation refresh (£0.4m);
- Catering strategy that was approved by the Board during 2011/12 (£0.5m);
- CCTV and other security arrangements (£0.7m);
- Commencing the redesign of the Emergency Department (£0.4m);
- Continuing refurbishment of maternity facilities (£0.3m);
- Design of the new D-Block development (£1.0m).

Key risks to financial strategy and mitigations
The key risks and mitigation plans are summarise in the following table.

Key Risk to Financial Strategy	**Mitigation**
Unexpected increases in costs associated with the implementation of the recovery plan of the A&E target	Close working between operational and financial teams to quantify and minimise costs associated with programme. Financial tracking to be reported to the Board. Detailed review of all additional costs incurred (recurring and non-recurring) for effectiveness. Early closure of escalation capacity.
Delivery of CIP for 2013/14	Revised governance and accountability structure will be used to drive CIP delivery as close to the original targeted £15.1m, whilst maintaining quality and safety.
CIP requirements in 2014/15 and 2015/16 not fully identified	Early planning to commence on delivery for future years using new governance structures. Service improvement resource to be re-focussed on transformation change implementation.
Securing CQUIN and KPIs from Commissioner	System of tracking progress being led by Director of Nursing, reported regularly to Board.
Cash position deteriorates due to shortfall on CIP delivery	Maintenance of system of cashflow forecasting and on-going review of capital commitments.