

**Operational Plan Document for 2014-16**

**University Hospitals Birmingham NHS Foundation Trust**

# Operational Plan Guidance – Annual Plan Review 2014-15

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

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

Annual plan review 2014/15 guidance is available [here](#).

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

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

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

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

The expected delivery timetable is as follows:

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

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

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

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Date	28 March 2014

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

In signing below, the Trust is confirming that:

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

Approved on behalf of the Board of Directors by:

Name (Chair)	Jacqui Smith
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Signature

Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Dame Julie Moore
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Signature

Approved on behalf of the Board of Directors by:

Name (Chief Financial Officer)	Mike Sexton
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Signature

## 1.2 Executive Summary

University Hospitals Birmingham NHS Foundation Trust's (UHB's) Operational Plan for 2014/15 to 2015/16 continues to focus on the Trust's vision to deliver the best in care. This is underpinned by the Trust's values of honesty, innovation, respect and responsibility and core purposes of excellent clinical quality, patient experience, workforce, and research and innovation.

The environment in which the Trust operates is becoming increasingly challenging due to the ongoing financial pressures, the disruption caused by the system reforms and the enhanced scrutiny on the quality of care across the NHS informed by the Francis, Keogh and Berwick reports. Ensuring improved quality, productivity and efficiency across patient pathways and collaboration and integration with partners to meet rising demand is a critical issue across health economies. Despite this many providers are now struggling to achieve their financial plans, with 40% of acute Foundation Trusts (FTs) in deficit at Q3 of 2013/14.

UHB expects to deliver a surplus of around £5m (excluding asset revaluations) for 2013/14 and the Trust remains well placed to meet the challenges facing the sector. Over the next 12 months the Trust will undertake a strategy refresh to address the key external drivers over the next 5 years including:

- The emerging NHS England 5 year strategy which underpins new models of care including the concentration of specialised services into a small number of centres of excellence. This is expected to have a significant impact for the Trust.
- The implementation of the Better Care Fund from 2015/16 onwards, and the associated financial risks of shifting resource from health to social care.
- A likely further period of flat funding despite rising demand.
- The expansion of 7 day working.
- Greater vertical and horizontal integration across the sector including mergers and acquisitions and the developments of chains and franchise models.
- Other potential policy changes dependent upon the outcome of the next election.

The Trust continues to have a strong clinical focus supported by a broad set of objectives within the framework of the four core purposes. With regard to specific quality objectives, these will be supported through the delivery of the Priorities for Improvement contained within the Quality Report and Commissioning for Quality and Innovation (CQUIN) schemes agreed with commissioners.

In terms of workforce, the Trust has a strong set of strategic objectives to ensure the workforce is fit for purpose to deliver safe and high quality services and support new service developments. The Trust has ensured that workforce plans are in place to address the challenges related to increasing patient expectations, increasing activity levels, and the impact of the new education tariffs.

The Trust's Financial Plan for the next 2 years shows total planned surpluses of £3.0m in 2014/15 and £16.2m in 2015/16, including £13.4m of grant funding and donated income relating to the Institute of Translational Medicine. During this period the reliance on Private Finance Initiative (PFI) transition funding continues to reduce, falling to well below 1% of turnover by 2015/16. Cash balances are projected to remain at healthy levels over the period of plan and the Trust expects to maintain a Continuity of Services Risk rating of 2 / 2\* over the next 2 years.

## 1.3 Operational Plan

### A. Short Term Challenge

#### Overview

The Trust faces a range of short term challenges over the 2 year period covered by this Operational Plan. These include:

- Managing capacity including seasonal peaks (Winter Pressures) – the Trust has experienced significant growth in emergency admissions over recent years resulting in the use of the private sector capacity to maintain elective waiting lists in 2013/14. Additional theatre, recovery and bed capacity has been opened in the old QEH to mitigate this.
- Improving quality – continuing focus on quality, clinical outcomes and patient experience are driving investment in front line services and the associated systems and support staff.
- Financial Performance – the Trust is required to deliver annual surpluses in order to maintain investment in its asset base, retain healthy cash balances and avoid regulatory action. This is increasingly challenging with 40% of acute Foundation Trusts in deficit as at Q3 2013/14. The main financial challenges facing the Trust over the next 2 years include:
  - Flat real terms health funding and growing demand resulting in annual efficiency requirements of 4% or more and year on year reductions in national tariffs.
  - The impact of commissioning changes such as downward pressure on local prices and the loss of CQUIN payments on excluded drugs and devices.
  - Continuing reductions in education funding of £1.3m per annum under the Multi Professional Education and Training (MPET) Review transition arrangements, building to an eventual recurrent loss of around £9.7m per annum.
  - Reducing the reliance on PFI transition funding by circa £2.0m per annum over each of the next 2 years.
- Cost Improvement Plan (CIP) delivery – the continued requirement for acute sector providers to identify the majority of savings across the NHS without having an adverse impact on clinical quality is putting significant pressure on FTs. This will require real productivity gains on a scale not previously achieved and radical system changes across local health economies to deliver.
- Targets – maintaining performance across all key targets including A&E waits, referral to treatment times and infection control.
- The Institute of Translational Medicine (ITM) – managing the building works during 2014/15 and the commissioning in early 2015/16 in line with the programme agreed with the Department of Business Innovation and Skills. Work with the partner organisations will also be required to agree an operating model that will best meet the objectives for the development.

The Trust will also need to undertake a strategy refresh to respond to:

- The NHS England 5 Year Strategy including the development of new models of care which include the ambition to concentrate specialised services in 15 to 30 centres of excellence. This presents a very significant opportunity for the Trust but will rely upon reductions in some non-specialised activity to create capacity.

- The Birmingham Cross City (BCC) Clinical Commissioning Group (CCG) strategy for the Local Health Economy which is currently under development.
- The Better Care Fund - due for implementation from April 2015.
- 7 day working – requirements for more services to operate on a 7 day a week basis.
- Tariff changes – managing the impact of Monitor's proposed changes to the 2015/16 tariff.
- Potential service reconfigurations involving local providers.
- Greater vertical and horizontal integration across the sector including mergers and acquisitions and the developments of chains and franchise models.
- Any restructuring or other significant changes arising from the next election in May 2015.

#### Local Health Economy Stakeholder Engagement

The Trust has good working relationships with the other organisations across the Local Health Economy (LHE). Engagement with key stakeholders takes place across a range of forums including:

- Joint Clinical Commissioning Group (JCCG) – The JCCG meets monthly and includes representatives from local CCG's, specialised service commissioners and providers. This group deals with all commissioning and contracting issues and has an annual programme of service reviews.
- Contract Monitoring Groups - detailed contract negotiations and ongoing reviews of the Trust's performance against contract take place through regular meetings with Birmingham Cross City CCG and the NHS England (NHSE) Local Area Team (LAT).
- Urgent Care Working Group – These monthly meetings include the Community Trust, Ambulance Trust, Acute Providers and the Local Authority. They are chaired by the local CCG and are used to monitor front door performance, discuss and agree service change/developments and approve LHE winter plans.
- LHE Capacity Monitoring – These fortnightly meetings include the Community Trust, Local Authority, CCGs, Acute Providers and Specialised Commissioners. This is an 'operational' meeting to review current pressures in the LHE system and to adjust services or service capacity to meet changing demand.
- Patient Discharge Meeting – Weekly meetings held with the Local Authority to review the number of patients in hospital beds ready for discharge.

All these meetings discuss opportunities and challenges within the LHE which feeds into the development of the operational and strategic plans for providers and commissioners. Additional specific meetings involving UHB Directors and the lead CCG have been held to share strategic intentions. Alongside the LHE forums listed above, the Trust plays an active role in the broader regional health system due to its tertiary responsibilities. The Trust is engaging with NHSE regarding their proposed five-year specialised services strategy which is scheduled for publication mid 2014.

Under national planning guidance for 2014/15 both CCGs and NHSE commissioners of Prescribed Services received notice of 2 year allocations to support short term planning i.e. 2014/15 and 2015/16. In addition, 2 year budgetary targets were set for the minimum Better Care Fund pooled budgets between NHS and Local Authorities to be managed by local Health and Well Being Boards (H&WBs).

Commissioners (CCGs, NHSE and H&WB) were required to submit their draft 2 year operational plans on 14 February 2014 with final plans due to be submitted in April, consequently there is still a degree of uncertainty at this time, adding to the challenge for Provider financial and operational planning.

### Clinical Commissioning Groups

For the next 2 years CCGs are required to hold a minimum 0.5% contingency and plan for a 1% cumulative surplus carry forward. The level of non-recurrent spending in 2014/15 has been increased to create funds for service change and prepare for 2015/16. CCGs are supposed to set aside 2.5% for non-recurrent spending (including 1% for transformation) in 2014/15 but following the introduction of the Better Care Fund (BCF) in 2015/16 this non-recurrent spend falls to 1%.

UHB's host Clinical Commissioning Group, Birmingham Cross City CCG, submitted a draft 2 year high level operational plan to the Birmingham and Black Country LAT on 14 February 2014. Final plans are due to be submitted in April, so at this time discussions between the two parties are ongoing via Executive Teams and the Joint Clinical Commissioning Group.

The key CCG priorities are:

- Integrated Primary Care, including improving the quality and capacity of general practice.
- Transforming the quality of and access to mental health services.
- Transforming the way in which our Urgent Care system operates i.e.
  - Streamline urgent care to ensure people are seen in the right place at the right time
  - Improve timely supported discharge from hospital
  - Develop community services and promote integration with Social Services and the 3rd Sector
  - Develop seven day services (link to Better Care fund)

In particular, for the Birmingham health economy Cross City CCG will lead the development of plans that focus on services for adults and older adults. To assist with their longer 5 year strategic planning and further development of the short term plans, BCC have engaged a strategic partner to support them in this work and to facilitate close dialogue with Providers.

BCC plans include a commitment, to reflect the national aspiration, that they will achieve a 15% reduction in emergency admissions over the next 5 years. This is required to deliver the BCF aspirations and UHB is generally supportive of this aim as additional hospital capacity will be required to meet the 5 year NHSE Prescribed (Specialised) services strategy i.e. rationalisation of specialised work at fewer large centres of excellence. It will however require sensible modelling to ensure the right services are targeted and it will require assurances that the right alternative provision is commissioned to enable a safe transfer of responsibility for this patient cohort.

Short term risks and challenges associated with CCG plans:

- If forecast activity reductions do not occur following transformation, then resources cannot be released from secondary care to fund alternative models of care; ideally these models need some pump-priming investment and clarity is required on how the healthcare economy shares the financial risk during this period.



- Finding investment to fund 7 day working and targeting this in the areas which will make most difference.
- Performance of neighbouring Providers; further activity drift arising from performance issues at other Trusts would compromise the ability of UHB to meet expected admission reductions.
- Contract agreement has yet to be reached regarding the level at which the Marginal Rate Emergency Threshold (MRET) adjustment for urgent care takes place. This was rebased in 2013/14 to 2012/13 outturn, in recognition of the Trust's capacity investment to manage significant growth in A&E attendances and non-elective (NEL) admissions at UHB as result of Major Trauma Centre (MTC) status, other provider issues within the region and patient choice. Agreement on what the correct level should be for the 2014/15 MRET has not yet been reached.
- Stroke Reconfiguration Programme – Birmingham, Solihull and Black Country. The decision on the future placement of hyper acute and acute stroke units is pending currently. The Programme Board recommendations are expected to be submitted to the CCG Governing Body in July or August 2014; this may affect activity flows into and out of UHB.

The lead Clinical Commissioning Group for services at University Hospitals Birmingham NHSFT, Birmingham Cross City CCG, also works closely with Birmingham South Central CCG. Together they commission circa £147m of acute services from the Trust. Each Clinical Commissioning Group faces a significant Quality, Innovation, Productivity and Prevention (QIPP) savings target. Consequently they have indicated that they will need to concentrate on developing schemes that limit or mitigate activity growth and develop or streamline care pathways.

Birmingham Cross City Clinical Commissioning Group is focused on the development of a number of areas as part of their medium term strategy, including a focus on older adults, including dementia care, end of life care and the management of long term conditions and urgent care. CCGs will also be focused on implementing national directives such as those relating to digital health innovations that support integrated working and seven day working, as well as the redesign of Learning Disabilities services.

In 2014/15 Birmingham Cross City CCG and Birmingham South Central CCG will continue to focus on the implementation of Referral Triage to support the management of referrals from primary care and streamline the pathway for patients. There is also a continued focus on rapid assessment diagnostic and treatment in acutely unwell, including working towards a two day inpatient stay for frail and elderly patients. Other key local commissioning intentions include implementing the outcomes of the Birmingham-wide review of Respiratory Services and reviewing Stroke Care Services.

There are also a number of planned procurements identified through local commissioning intentions, which are likely to impact on the Trust. These include: Diabetes Insulin Initiation, Anti-coagulation, and Pathology services, including primary care phlebotomy.

### NHS England

NHS England's commissioning intentions for 2014/15 continue to build on the changes already put in place in relation to the commissioning of prescribed specialised services, with an emphasis on addressing the strategic challenges faced by NHS England in delivering improved outcomes for patients within a fixed resource; in particular they are trying to close a reported £300m national deficit.

There are no major changes planned to the scope of specialised services commissioned by NHS England in 2014/15 following the major changes in 2013/14. The Clinical Reference Groups (CRGs) will continue to form a key part in the development of the future specialised services commissioning strategy. These CRGs have published specifications for each NHSE commissioned service which they wish to see



embedded in contracts. They are also publishing a range of commissioning policies defining what procedures, drugs and devices they will and will not fund for a range of discrete indications.

NHS England are currently developing a national five year strategy, which is likely to be published before July 2014. They have signalled an intention to review the numbers of centres which are designated to provide prescribed specialised services and have mentioned that there could be a reduction to commissioning services from circa 15-30 lead centres nationally. This would be a paradigm shift in the way specialised services are currently commissioned and would require a major review of capacity and a review of the potential different models of delivery and contractual arrangements e.g. 'hub & spoke' models etc.

The key areas of focus NHS England sets out in its strategic direction for 2014/15 and beyond are:

- Consistent patient access and prioritisation of services.
- A financial sustainability programme, including: non tariff price standardisation, securing best value with regard to the procurement of high cost drugs and devices.
- Clinical sustainability, through monitoring compliance with specialised service specifications and service specific quality dashboards.
- Market reviews of all services to ensure there is appropriate capacity.
- Developing integrated care pathways between clinical commissioning groups, NHS England and other parts of the health economy.
- Ensuring consistent contract management across all area teams.

The NHSE 'Commissioning through Evaluation' programme will continue to have a role in bringing innovative treatments to the NHS for which there is limited clinical evidence to support commissioning decisions. The Trust is currently participating in an evaluation scheme to provide Selective Internal Radiotherapy (SIRT) as part of the Commissioning through Evaluation scheme and bids are currently in train for several novel Cardiology procedures currently.

Operational Delivery Networks (ODNs) will become fully established in 2014/15 and their role is focused on operational delivery, ensuring outcomes and quality standards are improved and that evidence based networked patient pathways are agreed. All acute providers who provide specialised services under the scope of the ODN will be required to join networks for quality improvement.

Short term risks and challenges with NHSE plans:

- Service specifications – There is some potential risk associated with the full delivery of NHSE service specifications delivery i.e. cost of convergence associated with staffing ratios etc.
- A negotiated agreement is required regarding a sensible gain-share arrangement with regard to drug procurement, especially recognising historic savings underpinning service line costs and hence pricing.
- Any changes to non mandatory (local) tariffs could cause instability; NHSE wish to standardise prices nationally so it will not be possible to have a net zero impact at provider level. This process needs to feed into the annual financial planning process and providers need sufficient notice of impending change.
- Creating the capacity to meet the longer term strategy i.e. to be one of the main nationally

designated services for prescribed specialised services at a time of limited new investment and significant local service change.

- Changes to the calculation methodology for CQUIN payments, no longer on total contract bottom line value but now net of high cost drugs and devices, reducing overall income and allowing no direct funding stream for medicines quality and productivity initiatives.

NHSE's commissioning intentions have been discussed extensively amongst Shelford Group members and there is a general consensus that they will have a significant destabilising impact on major teaching hospitals if they are implemented in line with current proposals.

### Better Care Fund

The Trust is actively involved in LHE discussions regarding implementation of the £3.8bn Better Care Fund (BCF). In Birmingham, an Older People's Frailty working group has existed for the past two years and this has evolved into a BCF working group with UHB represented as a key stakeholder. It is envisaged that the local implementation of BCF will bring together NHS and local authority expenditure on over 65s (except initially primary and tertiary care) and that this would be jointly managed. Initial proposals suggest dividing the city into four units, based around the four acute hospitals with the view to the health and social care services for older people being planned around these units.

Commissioners are expected to include in their plans for 2014/15 details of how health and social care will work together to prevent hospital admissions. All CCGs were obligated to include the actions they will take in 2014/15 to ensure their contribution to the Better Care fund in 2015/16 is affordable. This is a significant challenge, not least for UHB's host CCG commissioner, Birmingham Cross City, as it must demonstrate a significant volume of savings to support the fund; there is an element of risk associated with this approach as the system redesign must deliver the savings to make the fund sustainable.

A material proportion of the fund is performance-related, with payments linked to progress against national metrics, such as delayed transfers of care and avoidable emergency admissions. The national metrics underpinning the Fund will be:

- Permanent admissions of older people (65 and over) to residential and care homes.
- Proportion of older people still at home 91 days after discharge from hospital into reablement / rehabilitation services.
- Delayed transfers of care from hospital.
- Permanent admissions of older people to residential and care homes.
- Avoidable emergency admissions.
- Patient / service user experience.

The H&WB draft plan outlines their strategic approach for Older Adults to "focus in year 1 on developing 'the enablers' to manage the Fund and deliver the plans including system wide schemes to support operational delivery moving forwards, focussing on the national priorities". There is a recognition that close engagement with providers is crucial and they aim to identify the impact upon providers and to discuss future options around contractual models to incentivise change at pace.

The first priority for change will focus on "care in a crisis" with the aim of helping to drive reductions in unplanned admissions to hospital and to support earlier discharge into more appropriate community based services to return people home following a crisis and hence reduce both social care and health related

demand on long term care and propose a two stranded approach looking at avoidable admissions and reductions in length of stay (LoS).

The H&WB have conducted audits of individual patient admissions in many district general hospitals (DGHs) and found a typical picture of 20-25% of admissions being 'non-qualified'. These audits have been carried out at Heartlands, Good Hope and Solihull hospitals but not at UHB. Commissioners will be required to use UHB source data to determine the potential impact of the intervention rather than extrapolating the results from other Trust due to the different provider configurations.

The H&WB have also looked at national models to consider the opportunity for reducing bed numbers can be assessed by taking current lengths of stay and reducing them to optimal levels and considering whether lower levels of need could be re-provided in alternative settings. These models will require careful analysis to take into account the variation in case mix between a DGHs and tertiary centres, due to the transfer of complex cases to specialist units. Other potential health economy re-configurations will also impact upon the Trusts ability to deliver its strategy such as the proposed new Midland Metropolitan Hospital project plans to provide 200 fewer beds and a single A&E to replace the current Sandwell and City hospitals. The reduction in bed numbers and the location of the new hospital could have the effect of dramatically increasing activity at UHB and therefore a robust system wide planning will be required.

The risk and challenge for Providers is that commissioners will require disinvestment from secondary care to achieve the BCF aims and yet if the forecast activity reductions are not realised providers will have to find the capacity to manage 'front door' pressures. In parallel with this, the H&WB aspire to improving 7 day working to improve discharges across the system which will have significant resource implications.

#### Targets and Indicators

The Trust has seen a growth in emergency admissions of 18.8% over the last two years. This has placed significant pressure on the Trust's elective workload. In parallel the Trust has experienced a significant increase in GP referrals with growth of 8% for the year to date compared to 2012/13. This is on top of a 7% increase the previous year. This level of growth has resulted in demand outstripping both bed and theatre capacity in our new hospital. In response the Trust has invested in additional capacity in the retained estate, comprising additional beds and theatres, including the opening of dedicated new day case unit in December 2013. This expansion provides the additional capacity required to accommodate the current growth going forward and enable the Trust to bring down the elective waiting list that has increased as a result of the growth described. Whilst the Trust has now put in the additional infrastructure to expand capacity it is likely that bringing down the waiting list will impact on the admitted Referral to Treatment Time target over future months as increasing numbers of patients are treated.

The Trust has experienced an unprecedented increase in referrals for radiotherapy of 12% over the last year. This has included increases from a number of areas outside the Trust's usual catchment area for radiotherapy. A number of actions have been taken to increase capacity including extending the working hours of our linear accelerators, rescheduling maintenance out of hours to further increase capacity and utilising private sector capacity to treat prostate patients. The Trust has also met with NHS England to discuss its concerns with this level of growth and its impact on cancer performance. NHS England has acknowledged the impact of growth on performance and has supported the Trust's action plan including the provision of radiotherapy in the private sector. NHS England has also written to referring hospitals to reinforce their traditional referral pathways and is developing a strategic plan for radiotherapy in the region to respond to the growth. In addition the Trust continues to receive a significant proportion of late tertiary referrals, including a number after day 62, which affect 62 day GP performance. This number has increased year on year with an 18% increase in 2013/14 on top of a 15% increase the previous year. Despite ongoing discussions with commissioners regarding the future management of late referrals, a

system of breach reallocation that is in line with the Risk Assessment Framework has yet to be developed. Ongoing achievement of the Cancer 62 day GP Referral to Treatment target is therefore at risk largely due to factors outside the Trust's control.

## B. Quality Plans

### Quality Goals, Quality Strategy, and Quality Account

The Trust will continue to build upon its work to deliver its vision, values, and core purposes during the two financial years covered by this Operational Plan. The Trust's vision remains to deliver the best in care and the Trust's values (honesty, innovation, respect, and responsibility) provide the framework within which this is delivered. The Trust's strategy has been developed to ensure cohesiveness, consistency, and provide assurance that it contributes to the overall delivery of the Trust vision. Therefore, each core purpose is supported by a Strategic Aim, and four Strategic Enablers. These are refreshed every 12 months as part of the annual planning cycle. The Trust's strategy within the framework of the 4 core purposes is as follows:

<b>Core Purpose 1:</b>	<b>Clinical Quality</b>
Strategic Aim:	To deliver and be recognised for the highest levels of quality of care through the use of technology, information, and benchmarking
Strategic Enabler 1:	To strengthen the organisational systems and arrangements for the collection, access, use, and reporting of quality outcomes to key stakeholders
Strategic Enabler 2:	To deliver and communicate the best in quality outcomes
Strategic Enabler 3:	To improve quality and efficiency along the patient pathway working with local health economy partners
Strategic Enabler 4:	To support the local and regional health economy to ensure high levels of quality and performance are delivered

<b>Core Purpose 2:</b>	<b>Patient Experience</b>
Strategic Aim:	To ensure shared decision making and enhanced engagement with patients
Strategic Enabler 1:	To deliver improvements in the fundamental aspects of care and priority areas identified by patients
Strategic Enabler 2:	To provide patients with high quality information and support to allow informed choice and shared decision making
Strategic Enabler 3:	To ensure the needs of vulnerable patients are met
Strategic Enabler 4:	To deliver improvements in patient experience outcomes

<b>Core Purpose 3:</b>	<b>Workforce</b>
Strategic Aim:	To create a fit-for-purpose workforce for today and tomorrow
Strategic Enabler 1:	To strengthen the Trust's capacity and capability for developing the workforce
Strategic Enabler 2:	To ensure effective management of the workforce
Strategic Enabler 3:	To deliver high quality education and training to meet the needs of patients, staff, and the organisation
Strategic Enabler 4:	To enable the health and well-being of the Trust's workforce

<b>Core Purpose 4:</b>	<b>Research and Innovation</b>
Strategic Aim:	To ensure UHB is recognised as a leader of research and innovation
Strategic Enabler 1:	To strengthen and consolidate the Trust's capacity and capability to deliver research
Strategic Enabler 2:	To strengthen the Trust's capacity and capability for innovation
Strategic Enabler 3:	To maximise the opportunities for the commercialisation of Trust services
Strategic Enabler 4:	To strengthen the Trust's reputation and profile for delivering high quality research and innovation

In addition to the overarching Strategic Aims and Enablers, the Trust has developed its Quality Improvement Priorities (within the Quality Account) and CQUINS for 2014/15 and 2015/16. Key Quality Improvement Priorities include:

1. Improving VTE prevention
2. Improving patient experience and satisfaction
3. Electronic observation chart – completeness of observation sets (to produce early warning scores)
4. Reducing medication errors (missed doses)
5. Infection prevention and control

The main Commissioning for Quality and Innovation (CQUIN) indicators agreed with local commissioners (Birmingham Cross CCG) and NHS England (Specialised Services) include;

- Friends and Family – Patient and staff experience monitoring using friends and family test.
- NHS Safety Thermometer – improved data collection relating to pressure ulcers, falls, venous thromboembolism, and urinary tract infection in those with a catheter and improved performance in the rate of new pressure ulcers
- Dementia – Find, assess, investigate and refer; clinical leadership; and supporting carers of people with dementia.
- Inappropriate use of sedatives – deliver a reduction in inappropriate prescription of sedatives for inpatients aged 65 years plus who are admitted with a fall or have a fall during admission (excluding pre-admission chronic use of sedatives).
- Chronic obstructive pulmonary disease (COPD) care bundle – review and implement a COPD discharge bundle to ensure all NICE indicators are applied to all appropriate inpatients.
- Adults at risk – review of local actions which the Trust has been taken to identify, promote/disseminate, and improve practice in respect to the clinical management of patients with cognitive impairment (such as dementia).
- Discharge planning – increase the proportion of patients discharged before 1pm.

Other 2014/15 CQUIN indicators agreed with NHS England include embedding and demonstrating the use of the specialised services clinical quality dashboards. Other local CQUINS are being discussed as part of the annual contract negotiation. Each of the above goals has underpinning work programmes in place to ensure delivery and performance improvement. The Priorities for Improvement and CQUINS are reviewed and agreed on an annual basis so are subject to change in 2015/16 but some of those listed above cover a period longer than 12 months.

#### Existing Quality Concerns

Following a July 2013 Care Quality Commission (CQC) inspection, the Trust was judged as non compliant with minor improvements required within CQC Essential Standard Outcome 16 (Assessing and Monitoring the Quality of Service Provision). An issue was identified relating to the documentation of a patient's food intake. Actions are in place to address this by the Nutrition and Hydration Steering Group which reports to the Care Quality Group chaired by the Executive Chief Nurse. The Executive Chief Nurse provides a quarterly Care Quality Report to update the Board of Directors on progress in this area.

#### Key Quality Risks and Mitigation Plans

The Annual Plan sets out UHB's principal aims, and a risk assessment of the plan is undertaken by the Executive Directors to identify the key strategic risks to the achievement of these aims. The identified



risks are aligned to the Annual Plan aims and form the Board Assurance Framework (BAF) detailed within the Trust Procedure for the Assessment of Risks and Management of Risk Registers. All risks scored high and significant from Divisional and Speciality Risk registers and any risks arising from governance reviews will be automatically escalated to the appropriate Executive Directors. Key risks to quality inherent in this plan and the processes in place to mitigate and manage these risks include:

- Failure to deliver quality outcomes. The Trust has numerous systems in place for monitoring quality of care, controls include regular review of the patient environment, documentation and standards of care at review meetings undertaken by a Matron with ward staff, processes to monitor complaints, patient experience reports at the Executive Chief Nurse Care Quality Group, regular reviews of mortality, key performance indicators, quality indicators, readmissions, incident reporting trends and outcomes following serious incident investigations monitored monthly at the Medical Director's Clinical Quality Monitoring Group.
- Failure to meet new CQC fundamental standards or NICE Quality Standards. The Trust has a robust framework in place for assessing compliance and providing assurance to the Board of Directors against the current CQC Essential Standards of Quality and Safety. The underpinning processes are continuously reviewed to ensure that the Trust has continued assurance on the delivery of high quality services to patients. A process is in place to review the Trust position against published NICE Quality Standards and an update on implementation of NICE Quality Standards is reported to the Executive Medical Director's Clinical Quality Monitoring Group.
- Failure to deliver infection prevention and control targets leading to failure to maintain registration with the CQC or a breach of contract. Controls in place include; Infection Prevention and Control Action Plan, monthly review of risks and controls and compliance to mandatory training at Infection Prevention and Control Committee. Root Cause Analysis (RCA) reviews of all MRSA and CDI cases, local review of CDI RCA and Executive Review of Trust Apportioned cases of MRSA bacteraemia and CDI deaths.
- Healthcare activity demand pressures. Continued growth above that within this Operational Plan may result in additional quality and financial risks. To mitigate this risk additional capacity (theatres, recovery areas and wards) was opened during 2013/14 and improvements were made to discharge arrangements by contracting with a third party for the provision of healthcare at home.
- Failure to meet key performance indicators resulting in poor clinical outcomes, financial penalties and reputational damage. Controls in place include monthly performance indicators report to the Board of Directors, Chief Executive's Advisory Group, and the Chief Operating Officer's Group showing performance against targets, risks to achievement, and mitigating actions. Real time dashboards exist to monitor performance on a continual basis.
- Reputational / financial / organisational damage from failure to monitor the Trust's out of hospital care activities. Controls include the establishment of an Out of Hospital Care Board with oversight of all out of hospital care arrangements including all UHB subsidiaries, all care outside of hospital facilities provided by private sector providers and all care provided by UHB staff outside of the QE site. This will report to the Executive Medical Director's Clinical Quality Monitoring Group.

#### Board Quality Assurance

Compliance with the Care Quality Commission (CQC) Essential Standards of Quality and Safety and other national requirements is a natural by-product of the effective operation of the Trust's groups and committees which report to the Board of Directors. The process and groups and committees that provide direct reports to the Board are detailed in the Trust's procedure for Monitoring Compliance Against the

## Care Quality Commission Essential Standards of Quality and Safety.

Following the Clinical Quality Monitoring Group the Executive Medical Director provides a quarterly Clinical Quality Monitoring Report to the Board of Directors. Each April the Medical Director provides a draft Quality Report / Account to the Board and the Final Quality Report / Account is provided in May.

Following the Care Quality Group the Executive Chief Nurse provides a quarterly Care Quality Report, Infection Prevention and Control Report and a 6-monthly Emergency Preparedness Update Report to the Board. The Executive Chief Nurse also provides an annual report regarding the National Inpatient Survey and an Annual Safeguarding Adults and Children report. Following the Director of Corporate Affairs Governance Group the Director of Corporate Affairs provides a quarterly report to Board on Audit Committee Activity, Clinical Compliance Activity and provides the Board Assurance Framework.

The Executive Director of Delivery provides a Performance Indicators report and the Monitor Quarterly Governance Declaration. A progress update is also provided to demonstrate delivery of the Annual Plan. The Board of Directors also receive the proposed Annual Plan and Strategic Plans as part of the consultation process and then receives the final versions for formal sign off.

### Quality Plans and Workforce Implications

The Trust has a 5 year strategic workforce plan aligned to its strategic plan and these plans setting out Trust workforce requirements for the next 5 years are submitted to Health Education West Midlands. Trust plans are reviewed against workforce supply both locally and nationally in order to identify key risk areas. This Operational Plan contains a number of workforce risks, these along with the mitigation plans will be set out in more detail in the 5 year Strategic Plan due for submission in June. Key workforce risks include;

- Failure to maintain a suitably educated and trained workforce across all professional groups:
- Failure to sustain or recruit staff, in particular the recruitment of experienced registered nurses remains a challenge, particularly across Critical Care, Theatres, and Renal Dialysis.

Actions to mitigate workforce risks include bi-monthly targeted recruitment events, oversees recruitment (specifically for critical care nurses), the up-skilling of existing staff through education and development programmes and a continued focus on staff retention, return to practice opportunities and leadership development.

### Workforce Planning

The Trust continues to grow its complement of Junior Specialist Doctors (JSDs) at both standard and higher grades to ensure it can provide an excellent level of junior medical cover and continue to reduce reliance on the use of external medical agency staff. JSDs are provided with a parallel training programme to Deanery trainees which aids recruitment of high quality individuals, promotes retention and ensures the delivery of a high standard of patient care. The Trust is also a partner with the University of Birmingham in the delivery of Physician Associate Training to support a plan to increase recruitment of departmental and ward based Physician Associates to work alongside medical and nursing teams particularly in acute and emergency medical areas. The expansion of PAs will enable the Trust to pre-empt forthcoming training reductions in key areas and also develop new workforce models in hard to recruit to areas i.e. emergency medicine.

### Trust Response to Francis, Berwick and Keogh

The Board of Directors has considered the findings of the Francis Enquiry and, subsequently, the government response. The Trust has linked all relevant recommendations from these reports to its



Governance Framework and work streams providing assurance as part of the compliance process. An overall plan is monitored by the Director of Corporate Affairs Governance Group. The relevant recommendations have been reviewed and considered throughout the development of the Trusts Operational and Strategic Plans. Specific responses include:

- Safe Staffing - the Trust is continuing its strategy of over recruitment to nurse (registered and unregistered) establishment across all areas to minimise the use of agency. Trust wide day to day and shift to shift staffing levels are shared with key stakeholders including Board Members. Clear processes exist to enable agreed staffing establishments to be met on a shift to shift basis and there is a clear escalation process around the actions required to mitigate any shortfalls or concerns.
- Evidence based tools – these have been piloted across the Trust to review current nurse staffing capacity and capability. Existing core job descriptions are being reviewed to consider additional responsibilities to the direct caring duties of each band of Staff to inform workforce planning requirements.
- Using Data to Drive Quality - Informatics helps the Trust with ongoing reviews of live clinical quality data across the Trust from ward to Board. Recent innovations include a 'junior doctor monitoring project' which uses the electronic prescribing system to monitor junior doctors performance in key areas of safe prescribing such as Enoxaparin for VTE prophylaxis and which has resulted in improved patient care. Two senior consultants lead the project, providing timely feedback and remedial support on prescribing performance to individual junior doctors.
- Harnessing Feedback from Trainees - weekly electronic junior doctor surveys gather information from junior medical staff on their education and work experiences. The survey is designed to provide addition real time feedback on service delivery and education models enabling the Trust to quickly react to any perceived patient quality and safety issues.
- Strengths Based Recruitment - last year the Trust undertook a project to carry out recruitment in a different way, developing a profile of an "excellent" practitioner and using this to select staff to undertake the role. The process is widely used in private business and the financial world and has been found to ensure that people are placed into roles in which they "fit". Results outside the health service show reduction in attrition, better satisfaction with jobs and more effectiveness in job roles. The programme started with Band 7 Ward Sisters and Charge Nurses and plans are being developed to complete a similar approach for Nursing Auxiliaries.
- Skills and Human Factors Training - the Trust has expanded its training capacity to provide and increased programme of technical and human skills training focusing on cognitive, social and personal resource skills that contribute to safe and efficient task performance. Particular sessions includes decision making, communication, leadership and coping with fatigue, these sessions will be offered to new and existing staff help manage increasing levels of patient acuity and complexity.

### Education

The Trust has increased its education infrastructure to reflect its workforce growth and to enable it to continue to provide excellent compliance level across all aspects of mandatory training. This investment ensures that the Trust can provide a productive and innovative approach to inducting new staff and to ensuring that the fundamentals of care are embedded in all education interventions.

The Trust has led the regional approach to 'year to care' working with Health Education England to provide a structured programme of education and experience as a nursing auxiliary for prospective

nursing students as part of the national pilot. The programme has enabled us to better understand the process of recruiting the right staff with the right values to deliver the fundamentals of care and working closely with one of our education providers to ensure we better inform and support the process of ensuring the right students are recruited into nurse training.

### **C. Operational Requirements and Capacity**

In June 2010, the Trust moved into its new PFI Hospital, the Queen Elizabeth Hospital Birmingham, consolidating its clinical services onto a single site. Initially all inpatient activity was planned to be undertaken in the new hospital, however, a capacity review was undertaken in 2011 which resulted in the opening of four new theatres and additional beds in the Wellcome Building (part of the retained estate) due to continuing activity growth following the new hospital opening. Since the 2011 capacity review, the Trust has:

- Designation as a Major Trauma Centre.
- Significant growth in emergency medical admissions.
- Increased in referrals from other centres for complex, specialist elective activity.
- Started delivering vascular services which transferred from Sandwell & West Birmingham Hospital.
- Started delivering more emergency spinal activity (transferred from the Royal Orthopaedic Hospital).

A further in depth review of operational requirements and capacity pressures was undertaken during 2013, this identified:

- Bed occupancy at 95%.
- Vacant theatre hours decreasing.
- Utilisation of Ambulatory Care, Critical Care and the Emergency Department increasing year on year.
- Average and pre-operative length of stay reducing.
- Waiting times for some specialities increasing.
- Increased use of high cost Waiting List Initiatives and the private sector capacity to mitigate some of the elective activity pressures.
- A need for additional capacity to support approved and forthcoming service developments including breast surgery, renal surgery, stroke, liver surgery, ophthalmology and urology.

As a result of the review, a further expansion in clinical capacity was agreed by the Board of Directors to meet current and future expected operational requirements. Changes approved included:

- Theatre capacity expansion - refurbishment of 4 additional theatres within the old QEH (East Block) plus the associated preparation, recovery and waiting areas.
- Ward beds expansion - refurbishment of 2 wards within the old QEH (West Block) to meet existing capacity pressures and support business case requirements.

- Rebasing of ward beds by specialty across the Trust.
- Creation of a dedicated Surgical Assessment Unit within the New Hospital to improve patient flows and ease pressure on the existing Clinical Decision Unit.
- Pilot of the Recovery@Home project to reduce in hospital length of stay.

The additional capacity was brought into operation in December 2013 and prior to this the Trust undertook significant pre-recruitment across nursing, theatres and medical staff from both our local catchment and across the UK. This has been complemented by overseas recruitment with a number of staff joining the Trust to fill gaps in medical rotas as a result of the international partnerships developed in recent years.

Barring any further significant service reconfigurations, changes to referral patterns or decisions by other local providers to restrict their provision, the Trust is confident that the physical capacity is in place to meet the planned activity growth over the next two years of this Operational Plan. The Trust retains an unoccupied ward for seasonal growth and has the potential to refurbish further wards in the old QEH. Workforce remains an ongoing challenge and the Trust will continue to actively fill existing vacancies but also seek to over recruit where suitable candidates exist in order to reduce the reliance on external agency staff and to enable future service developments.

#### **D. Productivity, efficiency and CIPs**

##### Overview

The Trust has a good track record of improving efficiency to improve services for patients and deliver financial savings. The Trust's Operational Plan for 2014/15 includes total Cost Improvement Programmes (expenditure reduction and revenue generation) of £18.9m for 2014/15 (2.5% of operating expenditure) and £14.3m for 2015/16 (1.9% of operating expenditure). Whilst savings are becoming increasingly difficult to deliver across the NHS, the level of CIPs planned by the Trust are broadly consistent with the value achieved in recent years and remain below the FT sector average due to the emphasis placed on cost control and managing the overall bottom line finances (rather than purely CIP delivery). This indicates that the Trust does not face a 'step change' in CIP delivery in the near term which provides a buffer against quality risks.

The Trust's actual delivery of planned CIPs over recent years is summarised in the table below:

<b>Financial Year</b>	<b>CIP Target £m</b>	<b>Delivered %</b>	<b>Delivered £m</b>
2009/10	12.1m	93.6%	11.3m
2010/11	15.9m	94.5%	15.2m
2011/12	18.8m	90.5%	17.0m
2012/13	18.3m	96.4%	17.6m
2013/14	16.7m	90.1%*	15.1m*

\* Forecast at Q3

This shows delivery against the original programme for each year. In practice any in year slippage is covered by contingencies including additional non-recurrent savings or early commencement of future year schemes.

##### CIP Identification and Monitoring Process

The Trust's annual Financial Plan (including CIP targets) is approved by the Board of Directors although

responsibility for developing the plan and setting the CIP target for the organisation rests with the Chief Financial Officer. However, the identification and delivery of schemes is the responsibility of each executive director for their share of the target. In practice this means that the Chief Operating Officer is responsible for delivering around 85% of the annual target, although the majority of this is devolved to Divisions with responsibility delegated to divisional management teams led by the Divisional Director (lead clinician) and Divisional Director of Operations.

Delivery of CIP projects is monitored via the Trust's existing planning, monitoring and control systems with a consolidated register of all CIP schemes held centrally within Finance. This contains details of each individual scheme and is updated each month for actual performance. This enables CIPs to be reviewed by service, division, by project and to monitor delivery in terms of savings achieved, slippage against plan and what % slippage may be due to phasing / timing issues. All targets are posted to the ledger in equal twelfths unless specific approval is granted for exceptions to this. This ensures that a worst case position is reported in the first half of the year and that there are no surprises in Q3 and Q4.

The Trust does not have a formal Project Management Office (PMO) or equivalent. Instead the Trust's philosophy is to embed the CIP delivery into the roles and responsibilities for all managers and clinicians and to make the monitoring and reporting a key component of the monthly financial reporting. This has proven to be a sustainable way to ensure a strong culture of efficiency across the Trust and reduces potential risks to quality as it is unlikely that individual specialties will put forward schemes that have a detrimental impact on the quality of their own services. Project management support is available from the Trust's project team to assist with the management and delivery of larger schemes and any strategic or transformational projects. This may include expertise from support functions such as Pharmacy, IT, Informatics, Finance, Commercial Development, HR and Procurement.

Performance against individual CIP schemes is reviewed at a number of forums including:

- Monthly finance meetings attended by Finance Managers, Directors of Operations, Associate Directors of Nursing, the Director of Finance, the Director of Operational Finance and the Chief Operating Officer.
- Specific bi-monthly CIP delivery meetings between the Chief Operating Officer, the Director of Operational Finance and divisional management teams which review the progress of schemes, identify problems and allow other divisions to challenge assumptions on a peer review basis. Alternate meetings are also attended by the Executive Director of Delivery, the Chief Financial Officer and the Director of Finance.
- Fortnightly strategic CIP planning meetings which include the Chief Financial Officer, Chief Operating Officer, Chief Nurse, Director of Delivery and New Hospital Project Director. These meetings review progress of current projects and the pipeline of future projects to ensure CIP delivery.

Performance updates are provided to the Board of Directors through the monthly finance and activity report and assessment of the Trust's savings plans and monitoring arrangements are also part of the Internal Audit programme with the findings reported to the Audit Committee.

#### Quality Impact of CIPs

As detailed above the vast majority of CIPs are identified and delivered by individual specialties, wards and departments on a bottom up basis. This generally ensures that schemes which have a high potential risk to quality are not brought forward, however all proposals are quality impact assessed by divisional management teams and signed off at a Divisional Board meeting by the Divisional Director (Lead

Clinician) and the Associate Director of Nursing. Following this process the Divisional programmes are collated along with corporate schemes and the Trust's overall programme is reviewed by executive directors including the Medical Director and Chief Nurse prior to formal sign off by the Board of Directors.

CIPs are just one of many input factors to the level of resources available and more widely the quality of care provided. Therefore organisational focus is placed primarily on the monitoring of output measures of quality and safety, such as healthcare acquired infections, falls, complaints, incidents, etc., using the clinical dashboard and other advanced IT systems, rather than trying to measure the input factors (CIPs, etc.). Any deterioration in performance against the quality indicators is fully investigated and a Root Cause Analysis is undertaken to determine any causal factors including the level of resources available. Action plans are then developed which could involve additional investment.

#### CIP Schemes 2014/15

Trust CIP programme generally fall into two categories:

- Incremental schemes – these schemes are typically generated at a departmental, specialty or divisional level and involve discrete changes to do things more efficiently or generate new revenues. Examples include procurement savings, skill-mix reviews, revised clinical protocols (drug / product rationalisation) and reviews of SLA charges to other Trusts.
- Transformational schemes – these are larger schemes which may have a strategic dimension or affect multiple services or divisions. They are often identified centrally, for example from specific initiatives, clinical redesign, learning gained elsewhere or benchmarking and are usually implemented via a project group (task and finish group) led by an executive director. Recent examples include the creation of the Outpatient Pharmacy Subsidiary, the development of Homecare Services, the EPR project and New Hospital Single Site Savings.

In recent years a significant proportion of the savings have been generated from the larger strategic transformational projects. This follows the successful transfer into the new hospital which necessitated and enabled significant clinical redesign, a reduction of service duplication and increased automation in certain services. The Trust has also benefited financially during this period from some significant service developments including the transfer of specialised activity from other providers.

For 2014/15, as in 2013/14, it is the smaller incremental schemes that make up the majority of the expected savings. The Trust's Cost Improvement Programme for 2014/15 involves around 500 individual schemes with an average value of £37,800. The approved schemes have been grouped into the following main themes as shown in the Finance Template:

1. Procurement Schemes (£2.9m) – including further tender savings and product standardisation including collaborative procurement initiatives with other Shelford Group Trusts.
2. Service Redesign / Productivity & Efficiency (£2.9m) - further improvements to individual consultant productivity and reduction of clinical variation across specialties. Reductions to lengths of stay, improvements to theatre utilisation, reductions in cancelled operations and improvements to outpatient clinic throughput are also planned along with the expansion of Recovery@Home. These schemes are based on clinical benchmarking data, service redevelopments and other operational improvements to improve productivity across theatres, wards and outpatients and will ensure that the Trust fully exploits the additional capacity that it has opened. This will result in expenditure savings such as reductions in waiting list initiative payments and use of private sector capacity as well as enabling the delivery of additional activity at a low marginal cost. Delivery of these schemes will be supported by limited use of external consultancy resource which will also

identify opportunities to be targeted over the longer term (next 2-4 years).

3. Workforce Efficiency CIPs (£2.8m) – a continued focus on workforce efficiency including reducing reliance on locums and external agency staff, skill-mix reviews, changes in on-call arrangements, targeted WTE reductions in some back office services and reductions in incremental drift due to new arrangements for pay progression. There may be further opportunities around pay inflation if the 1% cost of living rise is not applied to the whole workforce as indicated by latest government announcements.
4. Pharmacy related schemes (£3.3m) – pharmacy procurement initiatives and changes to prescribing protocols via the Prescribing Information and Communication System (PICS) will result in further expenditure savings.
5. Other expenditure reduction schemes (£3.6m) – other schemes include rates reviews, energy efficiency projects, rental savings following lease renegotiations and IT savings.
6. Revenue Generation Schemes (£3.4m) – primarily linked to growth in commercial revenues through Birmingham Systems (Healthcare Evaluation Data system (HED), PICS, etc.), consultancy revenues (PFI implementation), additional service level agreement (SLA) and trading income (price and volume increases) and new private patient revenues linked to technology investments (Cyberknife, Da Vinci robot, etc.).

Each individual scheme is in the process of being risk assessed, both for delivery and the potential impact to quality. Due to the high number of schemes and the low average value of each scheme there is a lower risk of significant slippage occurring than if the programme was contingent upon a few very large schemes.

Transformational CIP schemes are again limited in 2014/15. Although the Trust continues to work on service redesign initiatives in conjunction with local CCGs, the benefits of these efficiency gains usually accrue to commissioners via reduced activity or lower tariffs. It is anticipated that there will be further opportunities for transformational savings in future years as NHS England publish their 5 year strategy setting out the new models of care and in response to the changes required by the implementation of the Better Care Fund.

In light of this, detailed CIP proposals are not yet finalised for year 2 of the plan (2015/16) however the main opportunities will include further productivity and efficiency savings, the redesign of dialysis services, estate rationalisation (Selly Oak), further automation / IT developments and commercial income growth as well as potential transformational savings as mentioned above.

## **E. Financial Plan**

### Overview

The Trust's Financial Plan for 2014/15 and 2015/16 is set out in the APR template and summarised in the table below. This shows total planned surpluses of £3.0m in 2014/15, increasing to £16.2m in 2015/16 (including £13.4m of grant and donated income relating to the Institute of Translational Medicine).



<i>£ million</i>	<b>13/14 <u>plan</u></b>	<b>13/14 <u>outturn*</u></b>	<b>14/15 <u>plan</u></b>	<b>15/16 <u>plan</u></b>
Operating Revenue within EBITDA	646.1	681.6	688.7	704.6
Operating Expenses within EBITDA	-602.7	-637.5	-643.7	-657.7
<b>EBITDA</b>	<b>43.4</b>	<b>44.1</b>	<b>45.0</b>	<b>46.9</b>
Donations received as Assets	2.5	2.4	0.2	0.2
Grant / Donated income	0.0	0.0	0.0	13.4
Interest Revenue	0.8	0.5	0.5	0.5
Interest Expense - PFI assets	-18.0	-17.5	-17.0	-16.6
Depreciation and Amortisation	-20.0	-19.8	-20.2	-20.4
PDC Dividend Expense	0.0	0.0	0.0	0.0
Corporation Tax	-0.2	-0.1	-0.1	-0.1
Non operating PFI costs (contingent rental)	-4.6	-4.7	-5.4	-7.7
<b>Profit (Loss) before impairments</b>	<b>3.9</b>	<b>4.9</b>	<b>3.0</b>	<b>16.2</b>
Impairment (Losses) / Gains net	0.0	24.0	0.0	0.0
<b>Profit (Loss)</b>	<b>3.9</b>	<b>28.9</b>	<b>3.0</b>	<b>16.2</b>
 <i>EBITDA Margin (%)</i>	 6.72	 6.47	 6.53	 6.66

\* Forecast as at Q3

The assumptions underpinning the financial templates are summarised below with further details provided in the appendices.

### Income 2014/15

Total planned Operating Revenue within EBITDA is £688.7m in 2014/15. This represents an increase of £7.1m against the projected 2013/14 outturn of £681.6m. Within this the main components are:

- NHS Clinical Income (£560.9m) – 2013/14 projected outturn activity has been re-priced using the 2014/15 national tariff and local prices. Adjustments have been made for approved business cases (Service Developments), cost per case growth and payment risks linked to commissioner intentions. At the time of writing contracts have not been signed with CCGs or NHSE specialised commissioners and therefore the plan is based on the Trust's assessment of the likely outcome based on current negotiating positions.
- Non-NHS Clinical Income (£19.9m) - 2014/15 plan values are based on 2013/14 outturn plus revenue generation CIPs.
- Education income (£30.8m) – planned to reduce by a further £1.3m in 2014/15 reflecting the second year of transition to tariffs under the MPET review.
- Research and Development (£21.3m) – the Trust is planning for a £9.0m reduction in R&D income in 2014/15. This is largely attributable to the transfer of the Birmingham and Black Country Comprehensive Local Research Network to Royal Wolverhampton Hospital NHS Trust under the new hosting arrangements. The majority of this income was passed through to other organisations and therefore there will be a corresponding reduction in R&D expenditure in 2014/15.



- PFI transition funding (£7.2m) – planned usage of PFI transition support in line with the long term trajectory.
- Other operating income within EBITDA (£48.6m) – 2014/15 plan values reflect 2013/14 outturn plus revenue generation CIPs.

Revenues outside of EBITDA are planned to total £0.7m. Donations Asset income is planned to fall back from £2.4m in 2013/14 to £0.2m in 2014/15 due to the one off impact of the donated Cyberknife in 2013/14. Interest receivable is expected to be £0.5m in line with 2013/14.

#### Expenditure 2014/15

Total Operating Expenses within EBITDA are planned to increase by £6.2m (0.97%) from £637.5m in 2013/14 to £643.7m in 2014/15. The main changes are as follows:

- National Cost Pressures (+£3.9m) including:
  - Pay inflation (+£3.3m) – an assumed 1.0% cost of living increase in line with public sector pay policy and the national tariff guidance. Latest announcements suggest that the actual impact may be less than 1% if the award is only applied to those staff not receiving increments and on a non-consolidated and non-pensionable basis.
  - Other pay drift (+£0.4m) – based on an assessment of incremental drift and increases in local Clinical Excellence Awards
  - NHSLA Premiums (+£0.2m) – based on notified increases in CNST, LTPS and PES costs for 2014/15.
- Specific Non-Pay inflation (+£1.9m) – specific contractual inflation for 2014/15 including maintenance contracts, waste, transport, and decontamination services. The largest single item is the £0.4m increase related to the service charge component of the Unitary Payment (UP) for the PFI scheme which is indexed in line with the Retail Price Index as at February 2014 (+2.5% estimated). The balance of the UP inflation is recorded as contingent rental within non-operating expenditure.
- Other non-pay inflation (+£4.1m) – other inflationary cost changes identified through the financial planning process.
- Service Developments (+£13.1m) – covering investment in workforce and activity related non-pay costs associated with investments including Endocrinology, Cardiac Surgery (ACHD), ENT and other General Surgery. The marginal costs vary dependent upon the individual costing for each business case. Further detail is provided in the Service Developments section below.
- 2014/15 Activity Growth (+£10.6m) – funding has been included in the plan for growth in cost per case drug and device treatments in line with the estimates included within the income plan.
- Other local cost pressures identified through the bottom up financial planning process (+£2.2m) – includes expenditure associated with the introduction of Pathology Cell Tracking, investment in Anaesthetic medical staffing and compliance with NICE guidance and legislative standards.
- R&D expenditure (-£9.0m) – expenditure reductions primarily attributable to the transfer of the Comprehensive Local Research Network to Wolverhampton as detailed within the R&D income narrative.

- Other Non-recurrent expenditure in 2013/14 (-£5.1m) – removal of non-recurrent expenditure in 2013/14 including PAS development and demolition works on the Selly Oak site.
- Expenditure Cost Improvements (-£15.5m) – as detailed in section D above.

Operating expenses outside EBITDA (i.e. Depreciation) is expected to increase by £0.4m from £19.8m in 2013/14 to £20.2m in 2014/15.

Non operating expenses are planned to increase by £0.2m to £22.5m in 2014/15. A £0.7m increase in contingent rental is largely offset by a £0.5m reduction in interest payable against the PFI scheme.

### Service Developments

This Operational Plan includes clinical service development expenditure of £13.1m in 2014/15. This is funded by additional healthcare income under national tariff or local prices. Significant service developments include:

#### 1. Cardiac Surgery Expansion (full year effect)

The adult cardiac surgery service at UHB is one of 4 units in the West Midlands. It accepts referrals from across the region and offers a range of coronary artery surgery procedures including valve surgery, thoracic aortic surgery, open heart procedures, Coronary Artery Bypass Grafts (CABG) and Atrial and Mitral Valve Replacements (AVR and MVR). In addition, the unit is a nationally designated centre serving predominantly the West Midlands and Wales for transplant procedures, the second highest performing Cardiopulmonary transplant centre nationally.

The service is expanding its operating capacity in response to increasing referrals and case complexity, to avoid increases in cancellations or waiting list delays and to ensure that the performance indicator for 7 day cardiac surgery requirements are met. This will be achieved through an increase in critical care beds, additional nursing for the enhanced recovery areas, improving theatre list scheduling to increase utilisation, additional advanced nurse practitioner posts and the appointment of new consultants. This development commenced during 2013/14 and the investment included in the 2014/15 plan reflects the full year effect.

#### 2. Liver Services Expansion (full year effect)

This service development involves the continued expansion of the Trusts liver services (surgery and medicine) to meet increasing demand, improve service quality, reduce cancelled operations, manage waiting times and reduce the need for ad hoc premium rate waiting list initiative sessions.

Combined liver activity (elective, emergency and outpatient) has grown year-on-year particularly in areas such as Liver transplantation, transplant assessments undertaken in outreach clinics across England and Wales and Major Hepatobiliary Surgery including liver resections due to increased incidence of primary liver cancer and chronic liver disease.

The investment required includes additional ward beds, ITU capacity and additional theatre operating time. Staff implications include 1 wte consultant, an additional HPB Clinical Nurse Specialist along with the nursing and administrative support costs.

#### 3. Neuro Endocrine Tumour (NET) Service

This service development involves the establishment of a sustainable service to support patients diagnosed with Neuro Endocrine tumours (NETs). NETs encompass a wide range of cancers (pancreatic, insulinoma, gastrinoma (bowel tumour) but are relatively rare, are usually small and

grow slowly. Management of these conditions, often with SIRT (Selective Internal Radiation Therapy), also known as brachytherapy or radioembolisation, at a specialist centre by a multi-disciplinary team has been shown to greatly improve survival.

This service development will ensure that patients can access comprehensive specialist care and provides additional capacity to meet rising patient demand. This is a regional service which is expanding into the East Midlands area and has recently applied to be designated as a 'Centre of excellence' by the European Neuro Endocrine Tumour Society [ENETS]. If successful, this is expected to lead to further increases in referrals and the catchment population.

Expenditure included in service development includes medical staff PAs to enhance the multi-disciplinary team, as well as additional nursing, support staff (imaging, dietetics etc.) and administration time. Significant non pay costs are included in relation to complex treatments (lutetium isotopes, sir-spheres and SIRT consumables) required for these patients.

#### 4. Ophthalmology (full year effect)

This service development aims to further develop the Trust's Ophthalmology service by increasing clinical and research capacity to enhance service quality and ensure waiting times continue to be met. This service development includes increased activity within corneal surgery, lucentis, macular oedema and vitreo-retinal surgery. Some of these developments were planned for 2013/14 but have only commenced during the later part of the year. To deliver these developments, expenditure is included for additional medical staff (senior and junior), nursing staff and capital equipment.

#### 5. Endoscopy (full year effect)

This service development facilitates the expansion of the Trust's existing endoscopy service in response to national changes around bowel cancer screening age and symptom awareness. The service development also provides additional capacity for colonoscopy, gastroscopy, flexible sigmoidoscopy, and endoscopic ultrasound in response to increased demand. This development was originally contained within the Trust 2013/14 operational plan but has yet to be fully implemented.

#### 6. Other Schemes

A number of other service developments will contribute to the income growth included within this Operational Plan. Other approved service developments and business cases include the appointment of additional consultants (and the associated support teams) within ENT (Otology), Breast Pathology, Colorectal Surgery and Stroke. Expansions are also planned across the Trust's Renal Transplant Programme, HIV services, immunology and oncology departments.

There are a number of key risks common to the implementation of all service developments including recruitment of additional staff, procurement of equipment, delivery of planned activity and securing payment from commissioners. The Trust has a good track record of managing these challenges and will seek to mitigate risks wherever possible, for example by planning for realistic lead times and including proposed service developments within contract negotiations. Major developments are subject to post project evaluation and any lessons learnt from this exercise are used to inform future developments.

A number of further developments are planned over year 2 of the Operational Plan, although these are not yet included in the financial template as the business cases remain under development.

## Transactions

There are no changes or developments within this two-year Operational Plan which would be classified as a “transaction” (Monitor: Transaction Guidance for Foundation Trusts).

### Capital Expenditure Plans 2014/15

The total capital investment budget is £21.3m for 2014/15. Key projects planned during 2014/15 include:

#### 1. Estates - Institute of Translational Medicine (ITM) Facility £8.7m

This involves the development of an Institute for Translational Medicine (ITM) in partnership with the University of Birmingham (UoB) and Birmingham Children's Hospital NHS Foundation Trust to support translational research projects within the healthcare and life science environment. The planned ITM will bring together academic staff, commercial organisations and NHS clinical research, with a view to deliver direct improvements in patient outcomes and quality of life. External funding of £12m has been secured from the Department of Business, Skills & Innovation through the City Deal initiative. Further funding has been approved by the two principal partners, UHB and UoB. Enabling work began in 2013/14 to prepare the building including removal of asbestos, old cabling and support services. Planning permission for the refurbishment has been granted and a main contractor has been selected with works anticipated to last around 12 months.

#### 2. Estates - Site Development Projects £3.3m

This covers several estates projects to refurbish several areas across the Trusts QE site. This includes improvements the general environment for several wards (£2.0m) and refurbishment of clinical areas including linear accelerator rooms (£0.4m). It also includes £0.7m for lifecycle maintenance on the New Hospital undertaken by the PFI operator.

#### 3. Estates – Renal Dialysis Project £0.8m

A specification is being developed to design and build a renal dialysis facility in the community to reduce patient travel. The draft project programme shows tenders for the facility being issued in the August and specialist developer being selected in November. Subject to the tender exercise being completed as planned, the works would begin in early 2015.

#### 4. Equipment - Major Medical Items Replacement £3.6m

The 2014/15 capital plan for includes the replacement of several items of high value medical imaging equipment including;

- 1x Linear Accelerator (£1.6m)
- 1x Cardiac Catheter Lab (£1.0m) and
- 1x MRI Scanner (£0.8m) and several mobile x-ray machines, image intensifiers and ultrasounds (£0.2m).

#### 5. Medical Equipment Rolling Replacement Programme £3.5m

This includes the replacement of medical equipment across the Trust including equipment which may be no longer supported by manufacturers, at the end of its useful asset life or identified by the clinical service or medical engineering departments as requiring replacement. Items identified for 2014/15 include scopes, laboratory equipment, patient monitors, anaesthetics machines, probes,

EEGs and ECG machines. Procurement and delivery of these items will continue throughout the year.

#### 6. ICT Modernisation & Replacement £1.2m

This ICT budget funds a range of investments in the Trusts ICT capacity, resilience, functionality and security. It includes server replacement, network upgrades, applications and systems development. The detailed project plan is led by the Director of IT. Expenditure will be incurred throughout the financial year.

#### 7. Donated Assets £0.2m

This includes a provision for any items purchased by external charities and donated for Trust use. Expenditure will incur as the organisations such as QEHBC charities approve bids, the final figure may differ depending on the approvals and bids approved in the year.

### 2015/16 Capital Programme

The Trusts outline capital programme for 2015/16 is £17.8m and includes:

- £3.8m ITM refurbishment & equipping
- £4.0m Estates Projects and new hospital lifecycle work
- £2.3m Renal Community Facility
- £2.7m Major Equipment replacement (linear accelerator & CT scanner)
- £3.6m Rolling Replacement of Medical Equipment
- £1.2m ICT Refurbishment & Modernisations
- £0.2m Donated asset forecast.

### Capital Funding

The Trusts 2014/15 capital programme (£21.3m) includes £9.0m of external funding including £8.8m from the Department of Business, Innovation & Skills (BIS) in relation to the ITM development and £0.2m relating to donated equipment. The balance is funded from the Trust's internally generated funds.

The 2015/16 capital programme (£17.8m) includes £3.4m of external funding, including the final £1.8m from BIS and a potential £1.4m contribution from the University of Birmingham for the ITM project. The balance of external funding relates to a £0.2m forecast for donated equipment with the balance of the capital programme resourced from the Trust's internally generated funds.

### PFI Repayments

In addition to the traditional capital expenditure outlined above, the Trust incurs two other balance sheet payments which relate to the New Hospital. This operational plan includes the following values:

- Repayments of the PFI finance lease rental (part of the Unitary Payment) of £12.1m in 2014/15 and £12.6m in 2015/16 and
- Lifecycle maintenance of the new hospital. Additions of £0.7m and £2.6m are included in the capital programmes for 2014/15 and 2015/16 respectively – see above. However the lifecycle

payments are greater than the additions by £2.3m in 2014/15 and £0.3m in 2015/16 resulting in increases in the PFI lifecycle prepayment on the balance sheet.

### Capital Risks

The general quality of Trust estate is high as most clinical services are provided from the new PFI hospital opened in 2010. The Trust is gradually reopening older buildings on the QE site for clinical and support services. Programmes of refurbishment for these older buildings are being developed.

Risks to the capital programme for 2014/15 and 2015/16 include;

- Slippage due to delays to the appointment contractors for works projects. The single material (over £3m) project is the ITM refurbishment. The works specifications for this were drawn up in 2013/14 and tender responses were received in February 2014. These have been reviewed and validated and a preferred bidder selection was selected in March. Final contracts are due to be agreed in April with works starting in May 2014. Other lower value works projects will be tendered over the 2 year period to meet the Trusts operational requirements.
- This plan excludes the cost of the agreed solution to relocate the final support services (Finance / HR/ Payroll/ Occupational Health/ Medical Illustration) off the Trusts Selly Oak site. At present, plans are still being developed regarding the short & long term locations for these services.
- Additional capital investment requirements identified in the period either as a result of a business case approved or unanticipated expenditure relating to an equipment failure or urgent estates problems. Should either of these arise, a review of the planned capital projects would take place to identify the risk and options for slippage on other schemes which could offset the unanticipated costs.

### 2015/16 Plan Assumptions

Operating revenue within EBITDA is projected to increase by £15.9m to £704.6m in 2015/16. The main assumptions include:

- NHS Clinical Income -
  - The net tariff impact for 2015/16 is neutral based on assumed cost inflation of around +3.0% (including 0.7% in respect of pension changes) and an equivalent efficiency requirement. This reflects the growing acceptance that providers cannot keep delivering a 4.0% year on year efficiency gain in light of the quality pressures and other demands (as evidenced by the increasing number of providers reporting deficits).
  - The underlying increase in NHS clinical income is 3% due to activity and case-mix changes.
  - The potential changes to the scope and structure of tariff in 2015/16 have no overall impact on income – in reality it is expected that greater granularity should benefit the Trust through better recognition and reward of highly complex patients.
- Education Income – reduces by a further £1.3m in 2015/16 reflecting the third year of transition to tariffs under the MPET review.
- PFI transition funding – planned usage of PFI transition support reduces to £5.2m in 2015/16 in line with the long term trajectory.



- All other operating income streams within EBITDA remain broadly in line with 2014/15 planned values.

Operating revenues outside of EBITDA and non-operating revenues in 2015/16 remain consistent with 2014/15 planned values save for £13.4m of new income relating to the ITM. This comprises the £12.0m grant from BIS which will be recognised as the building opens and an estimated contribution to the scheme (donation) of £1.4m from the University of Birmingham.

Operating expenses within EBITDA are planned to increase from £643.7m in 2014/15 to £657.7m in 2015/16. The key assumptions include:

- Pay inflation is 1.0% based on cost of living increases.
- The pay bill increases by a further 0.75% for the impact of the pension changes.
- Non –pay inflation remains at 3% for drugs and 2% for other goods and services.
- The indicative CIP requirement is £14.3m in 2015/16 (see section D above), including £2.4m of revenue generation schemes.
- The 3% underlying income growth within the plan is delivered at an average marginal cost of 70%.
- RPI inflation, on which the PFI payments are indexed, is 2.5% for 2015/16.

#### Other Assumptions

- No account has been taken in the plan of either revenues or costs associated with the sale of the Selly Oak site in either 2014/15 or 2015/16 as the value and timing of these cash flows remain uncertain.
- No account has been taken of any potential transactions during the 2 year period which the plan covers.

#### Liquidity

The Trust's cash balances are predicted to reduce from around £62.2m forecast at 31/03/14 to £51.4m at 31/03/15 and £41.9m at 31/03/16. The main drivers of this reduction are:

- Continued usage of PFI transition funding over the period – a total of £12.4m is profiled into the plan over 2014/15 and 2015/16 reducing deferred income and therefore cash.
- Capital Expenditure, including PFI lease repayments and lifecycle maintenance, exceeds internally generated funds by £20.2m over the period. Of this £11.9m is covered by grants and donations and therefore there is a net reduction in cash of £8.3m based on the current capital programme.

It is anticipated that cash balances should actually exceed the plan projections as the Trust is likely to start to receive payments relating to the Selly Oak land sale during 2015/16. As stated above this is not currently reflected in the plan as the value and timing of payments remain uncertain.

Liquidity pressures should ease in future years as the reliance on PFI transition reduces significantly beyond 2015/16.



## Risk Ratings

Throughout 2014/15 and 2015/16 the Debt Service Cover metric remains at 2 and the Liquidity metric remains at 1. On this basis the overall Continuity of Services Risk Rating is calculated as 2 each quarter although the Trust anticipates that this will be increased to 2\* by Monitor, in line with the discretionary powers set out in the Risk Assessment Framework.

## Financial Risks

There are a number of potential downside risks which could result in Trust's actual financial performance being different to the operational plan. The Trust maintains a Long Term Financial Plan which is updated annually and reviewed by the Audit Committee. This includes a summary of the downside risks which may impact on the Trust and the potential mitigating actions available to offset these. A number of known downsides are already built into the financial plan including:

- MPET review - under the current proposals the Trust stands to lose £9.7m of education funding at steady state. Based on the agreed transition arrangements the reductions are capped at £1.3m per annum and therefore the full effect will not be felt until 2021/22. The eventual impact is likely to differ from this figure dependent upon the outcome of the Education Reference Cost exercise (which will determine new tariffs for education) and changes in student numbers over the period. The Trust would also expect some of the losses to be recovered through PbR as reference costs increase for tertiary services as a result of lower education funding (tertiary centres are the main losers nationally under the MPET review).
- PFI transition funding – this is due to reduce year on year under the trajectory set out in the Trust's Long Term Financial Plan. The financial plan includes £7.2m in 2014/15 and £5.2m in 2015/16 with further tapered reductions through to 2018/19.
- Technology investments - in recent years, the Trust has invested heavily in new technology such as Tomotherapy machines, a Da Vinci robot and a Cyberknife. The financial plan reflects the revenue costs of these treatments although they are not currently fully reflected in national tariffs or local prices. This impact may reduce over time should new national prices be introduced to properly reimburse these expensive treatments.

In addition to the known downside factors included with the Financial Plan templates there are a number of other key financial risks facing the Trust over the 2 years covered by the Operational Plan. On the income side these include:

- Outcome of 2014/15 Contract Negotiations - as set out above, 2014/15 healthcare contracts have not been finalised with commissioners at the time of writing. Therefore the value of planned income is based on the Trust's assessment of the likely outcome and hence there is a downside risk that the values included are overly optimistic.
- National Tariff 2015/16 - the Operational Plan assumes a net tariff reduction of 0% in 2015/16 based on gross inflation of +3.0% (including a 0.7% increase for employer's pension costs) and a corresponding -3.0% efficiency requirement. There may be a net tariff reduction if inflationary cost pressures are not fully funded or the efficiency requirement is greater, although there is a limit to what can be achieved by the sector.
- Delivery of planned income / activity growth. The 2014/15 plan includes £17.0m of income growth linked to service developments and the 2015/16 plan assumes further underlying income growth of 3%. There is a risk that this is not fully delivered although this would result in a corresponding

reduction in marginal costs.

- Better Care Fund (BCF) – as outlined earlier in the plan, the key strategic risk is probably the impact of the BCF on the local health economy. At this stage the risk cannot be accurately quantified but there are a number of potential financial downside scenarios e.g.
  - Schemes fully deliver and the Trust faces significant rapid activity reductions for which it cannot remove full costs.
  - Schemes fail to deliver and activity does not fall but commissioners have reduced contract values and cannot afford to pay for over-performance leaving the Trust to bear the costs.

The trust is potentially less exposed to this risk than some other providers as circa 60% of its NHS clinical income relates to NHSE specialised activity rather than CCG contracts. An ideal scenario for the Trust would actually be gradual reductions in CCG activity to create the capacity to expand tertiary services in line with the NHSE strategy to consolidate these in fewer centres.

- Contract Penalties - rigorous enforcement of contract penalties will continue in 2014/15 and 2015/16 and downside risks include potential fines for breaching national targets or locally agreed quality standards.
- Achievement of CQUIN targets in 2014/15 and 2015/16 – there is a risk of income losses should CQUIN targets not be fully achieved.
- National Tariff and Business Rules - Monitor have indicated that they intend to make “widespread changes to the payment system from 2015/16”. This could potentially have a downside impact on the income projections included in the Operational Plan, although the Trust would expect to benefit from a refinement of the current payment system (e.g. introduction of HRG 4+) as one of the key aims should be to better recognise and reward complexity.
- Tender of Sexual Health Services – Birmingham City Council have confirmed that they intend to issue a tender during 2014/15 for this service which is currently provided in part by the Trust. This could result in an income reduction during 2015/16 either as a consequence of the loss of the contract or a reduction in the price paid. If the contract was lost there would also be a significant expenditure reduction, although there would be some overheads and fixed costs that cannot be removed. Conversely the Trust may actually increase its income by gaining activity from the other incumbent as there is an intention to award the contract to a single provider.
- R&D – possible further loss of income if existing grants are not renewed or if fewer new awards are obtained in future. It may not always be possible to remove full costs in line with any loss of income.

On the expenditure side the main risks include:

- CIP Delivery - the Operational Plan includes expenditure CIP targets of £15.5m in 2014/15 and £11.9m in 2015/16 compared to the £13.6m forecast to be delivered in 2013/14. These targets are increasing challenging to deliver year on year as confirmed by Monitor’s assessment that providers can realistically only achieve incremental efficiencies of 1.5% - 2.0% per annum. Clearly significant slippage in terms of CIP delivery will affect the annual surplus delivered by the Trust unless mitigating action is taken or gains are made elsewhere.
- Pay - the financial plan assumes cost of living rises of 1.0% during both 2014/15 and 2015/16. Higher awards would create a financial pressure unless covered by an increase in the tariff,

although latest announcements indicate that the net impact may be less than 1% if cost of living awards only apply to staff not receiving increments and are non-consolidated and non-pensionable.

- RPI Inflation - the Unitary Payment relating to the PFI scheme is indexed annually by the RPI in February e.g. the payments for 2014/15 will be based on the February 2014 RPI figure. At the time of writing the February 2014 RPI has not been released and the PFI model is based on assumed RPI inflation of 2.5% for both 2014/15 and 2015/16. This is slightly below the latest published rate of 2.8% as at January 2014. Should actual RPI inflation be higher than 2.5%, the PFI Unitary Payment will increase with each 1.0% of RPI adding around £0.5m to the annual cost.
- National quality initiatives – the Trust continues to make targeted investments in improving clinical quality. However the financial plan does not reflect the potential impact of any new national policies which may be announced e.g. minimum staffing levels.
- 24/7 working – there may be further unfunded cost pressures dependent upon the development of policy in respect of expanding the services provided on a 24/7 basis.

### Downside Sensitivity Analysis

As outlined above there are a range of potential downside risks facing the Trust. Given the number of possible permutations and the inherent levels of uncertainty relating to most of these areas, it would be extremely difficult to quantify most of the risks with any degree of accuracy. Therefore the downside sensitivity input has been completed on a more generic basis to reflect the following scenarios:

1. 1% reduction in NHS clinical income in 2014/15 (plus a recurrent impact in 2015/16) due to pricing issues e.g. loss of block contracts or lower local prices agreed in the contract or the impact of fines, penalties or loss of CQUIN premiums. The loss of income is shown on the Sensitivity Input in the Other NHS Clinical Income line. No corresponding cost reduction is assumed.
2. 1% reduction in NHS clinical income in 2015/16 due to activity losses e.g. failure to deliver plan growth, loss of sexual health tender, impact of BCF, etc. A corresponding expenditure reduction is assumed at a 50% marginal rate. The loss of income is shown on the Sensitivity Input in the Other NHS Clinical Income line and the cost reduction is shown in the Employee Expenses line.
3. Only 75% of planned cost improvements are achieved in both years – shown as higher expenditure in the Other Non-Pay line of the Sensitivity Input.

In aggregate the gross downside impact on the Trust would be (£10.2m) in 2014/15 and (£16.6m) in 2015/16. The base case plus downside sensitivity would see the Trust incurring deficits in both years and the COSRR falling to 1. In reality it is unlikely that all 3 scenarios would occur concurrently and any significant deterioration in planned performance would be offset by mitigating actions (see below).

### Mitigations

There are a number of mitigating actions available to the Trust to counteract any unexpected downturn in the Trusts financial performance during the period covered by this operational plan. Examples of the potential actions include:

- PFI transitional funding - the Trust is able to increase the level of transitional funding utilised in either 2014/15 or 2015/16. This would only provide a non-recurring benefit but would provide the short term headroom to deliver additional efficiencies. Bringing forward additional funding into

2014/15 or 2015/16 would increase the challenge in the later years of the plan.

- Short Term Cost Controls – the Trust has a good record of cost control and managing cost pressures on a proactive basis which has helped to minimise the CIP requirement over recent years. Despite this it is acknowledged that there is a level of discretionary expenditure which occurs each year for which tighter controls could be implemented if required. This includes expenditure such as consultant waiting list initiatives, use of private sector capacity to relieve waiting list pressures and the use of external agency and locum staff. These costs could be reduced in response to any downturn in financial performance, although there may be operational impacts. Tighter controls could also be implemented to cover expenditure such as consultancy costs, course fees, furniture, advertising, etc. Previous modelling has indicated that up to £10m could be saved from these measures over a 12 month period.
- NHS Clinical Income Growth - as set out above the Trust has made strategic investments during 2013/14 to provide additional clinical capacity, including wards and theatres. This will ensure that the planned growth included in the Operational Plan can be delivered but also provides the capacity for future expansion. The Trust has a good record of delivering planned activity growth and has significantly over-performed its NHS clinical income targets in each of the last 5 years. The plans for 2014/15 and 2015/16 have again been prepared on a relatively prudent basis and therefore it would not be unrealistic to assume that the Trust will again exceed planned income targets providing a benefit to mitigate the downside risks.
- Non NHS Clinical Income Maximisation - there are several income growth opportunities not currently included within the Operational Plan which may result in additional non-clinical income over the two year period. These include commercial opportunities listed in the appendix, potential growth in education and research via Birmingham Health Partners and harnessing the potential of the ITM and increasing the value of services provided to other organisations.
- CIPs – the Trust has a good track record of delivery with over 90% of planned savings delivered in year in each of the past 5 years and no reliance on non-recurrent schemes other than to cover in year slippage. The Trust has well established processes in place to plan, deliver and monitor CIPs. Whilst the targets for 2014/15 and 2015/16 will undoubtedly be challenging they are at the lower end of the range faced by the FT sector and further savings could be targeted if necessary.

#### Upside Sensitivity

As with the downside sensitivity there are a large number of potential impacts from the mitigating actions and therefore the following generic responses have been modelled in the sensitivity template:

1. Additional cost reductions of £7m per annum via short term cost controls or extra non-recurrent CIPs. This is shown on the Misc. Other operating Expenses line on the Sensitivity Input sheet.
2. Additional commercial income of £2m in 2014/15 rising to £5m in 2015/16 – shown on the Other Operating Revenue line on the Sensitivity Input.
3. Additional PFI transition funding of £3m in 2015/16 – also shown on the Other Operating Revenue line on the Sensitivity Input.

In aggregate the gross upside impact on the Trust would be £9.0m in 2014/15 and £15.0m in 2015/16. The base case plus downside sensitivity plus mitigations would see the Trust maintaining surpluses in both years, although the COSRR would fall to 1 by the end of year 2 (2015/16).