Ernst & Young

Monitor - Contingency Planning Team

Mid Staffordshire NHS Foundation Trust

Assessment of Sustainability

January 2013

Contents

1. Summary report

1.1 Background

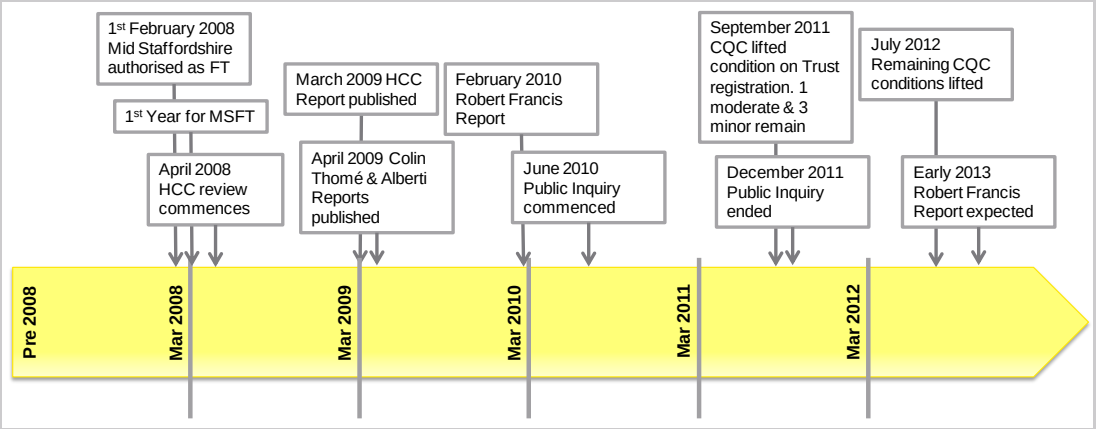
1.1.1 Mid Staffordshire NHS Foundation Trust

Mid Staffordshire NHS Foundation Trust ('MSFT' or 'the Trust') is a 344 bed acute Trust located on two sites: Stafford Hospital (built in 1984) and Cannock Chase Hospital (built in 1992). MSFT has an annual turnover of about £155m.

The Trust was authorised as a Foundation Trust (FT) on 1st February 2008. However in the following year, the Trust was subjected to a review by the Healthcare Commission into reported high levels of patient mortality and poor standards of care.

Following this review there have been a number of further reviews and a public inquiry that is expected to report shortly (see Figure 1 for a timeline of these reviews).

Figure 1: High Level MSFT external reviews from FY08 to FY12



In response to the recommendations of these reviews the Trust invested significantly in additional staff at a time when increasing financial constraints were being placed on NHS organisations. This investment has been one of the primary factors behind the Trust failing to generate a financial surplus leading to the Trust being in deficit. The Trust has therefore required significant external financial support from the Department of Health in order to pay its debts as they fall due.

Despite repeated attempts to turn around its financial position the Trust remains financially challenged and is expected to require further financial support to continue operating. Accordingly, the Trust has been in significant breach of its terms of authorisation as a Foundation Trust on financial and governance grounds since March 2009.

1.1.2 Monitor's changing role as the sector regulator

Under the Health and Social Care Act 2012, the role of Monitor is expanding. The legislation makes clear the primary duty of the new sector regulator is to protect and promote the interests of people who use healthcare services. As part of this revised role, Monitor has acquired new powers to ensure the continuity of services for patients if a provider's financial viability puts them at risk.

MSFT has been working closely with Monitor to improve its performance in recent years, and has made significant improvements in the clinical care provided for patients. The Care Quality Commission (CQC), the quality regulator, has said it no longer had outstanding concerns about the care delivered by MSFT.

However, the Trust is still losing money, and had to be given significant financial support from the Department of Health last year in order to maintain provision of services for patients. These circumstances cannot go on indefinitely. In order to ensure the continuity of services for patients, Monitor needs to be assured that the clinical improvements are sustainable for the long-term. It therefore appointed a Contingency Planning Team (CPT), led by Ernst & Young and supported by McKinsey & Company, to develop a plan for the long-term to ensure services are provided for local patients on a sustainable basis.

1.1.3 Objectives of the Contingency Planning Team

The terms of reference for the CPT were published in October 2012 and are available on Monitor's website (http://www.monitor-nhsft.gov.uk/home/news-events-and-publications/latest-press-releases/terms-reference---contingency-planning-team-).

The core objectives for the CPT are to:

- make an independent assessment of the financial, clinical and operational sustainability of MSFT in its current form;
- work with commissioners to identify those services which need to be maintained in the event of provider failure, in order to ensure there is no significant adverse impact on local health or health inequalities;
- engage with local commissioners and providers to explore the options for the future provision of all of the services currently provided by MSFT;
- evaluate whether proposed changes should be delivered through solvent restructuring or as part of Monitor's Trust Special Administration framework;
- make a recommendation on the future configuration of the services currently supplied by MSFT to ensure that they are delivered on a sustainable basis for the benefit of the local population.

This report addresses the first of these objectives.

1.2 Introduction

1.2.1 The purpose of assessing sustainability

Under the Health and Social Care Act 2012, Monitor has a duty to support commissioners to ensure that, in the event of a failure in a healthcare provider, patients can continue to access the care that they need. The Act states that to ensure 'continuity of services' Monitor should prevent healthcare providers from taking actions that could undermine their continued ability to deliver services.

Monitor proposes to establish a Risk Assessment Framework (RAF) to assess the financial performance and governance of healthcare providers (and is currently consulting publically on its proposed approach). This will assign one of four financial ratings to a provider ('Normal', 'Concern', 'Distress', 'Failure').

If a provider is rated as in 'Distress' then Monitor would appoint a CPT to determine whether there was a feasible turnaround plan for that provider, and if not, identify a plan of action that could be taken if that provider were to fail (the "Contingency Plan").

The first step for the CPT is therefore to conduct an independent assessment of the provider to determine whether there is a plan that, if successfully implemented, would sustain the delivery of services over the short, medium and long term. The focus of this assessment is on the actions that the provider can take that are within their own control.

1.2.2 How the assessment of sustainability fits into the overall programme of activity of the CPT

The assessment of sustainability is a critical activity for the project. The information and evidence that is gathered provides the foundation for the remaining work to be conducted, regardless of the conclusion around whether the provider is sustainable or not.

- If the CPT concludes that the provider is sustainable in its current form, then the next task for the CPT would be to fully develop the plan, including the governance, resources and funding that will be required to deliver the plan.
- If the CPT concludes that the provider is NOT sustainable in its current form, then the next task for the CPT would be to develop a Contingency Plan that it would recommend to Monitor. This would need to identify the changes required, either to the provider and/or to the services that it currently delivers, to ensure these services are delivered in a sustainable manner into the future.

1.3 The definition of sustainability

1.3.1 What is sustainability?

The CPT has been guided by the following understanding of the concept of sustainability:

The Trust can be said to deliver services in a sustainable manner if those services meet the needs of the present and there is an assurance that these services can be maintained into the future.

The critical factor for the CPT is ensuring that the local population of Stafford and Cannock can access services that are of an equivalent or better standard to that currently provided, and are assessed as being sustainable into the future.

It should be noted that the CPT has not been asked to draw a conclusion as to the 'viability' of MSFT – that being whether the Trust is fit to continue – as an organisation, rather whether there is a plan that enables it to deliver its current services in a sustainable manner.

1.3.2 How is the CPT assessing sustainability?

The CPT has assessed sustainability from three perspectives – operational, clinical and financial. Whilst there are clear relationships between the three, the CPT has assessed each in isolation and presented separate conclusions from each perspective. This will directly inform the nature of the solutions that will be explored in the next phase of the project. For example, the solution required for a trust that was clinically sustainable, but not financially sustainable, would be very different from those required if the judgements were reversed.

What is 'operational sustainability'?

Operational sustainability considers the extent to which the trust has the necessary organisational structure, operating model, governance, risk management procedures and operational processes in place to deliver its immediate corporate objectives and longer term strategy.

To inform the conclusions around operational sustainability, the CPT reviewed:

- The trust's current performance;
- The alignment of the trust's governance and operations with its strategy;
- The people, processes and systems in place;
- The impact recent changes to the operating model have had on clinical performance.

What is 'clinical sustainability'?

Clinical sustainability is whether the trust is currently delivering acceptable levels of clinical performance, and whether this level of performance is likely to be maintained into the longer term, that is three to five years.

There is a clear overlap between the assessment of clinical sustainability and operational sustainability, so the primary focus of the review has been to look at

the long-term viability of services. However, current performance has also been assessed from a clinical perspective in order to determine whether there are any immediate issues that need to be addressed.

In order to assess future clinical sustainability, current performance has been compared against the latest external standards set by the medical Royal Colleges, the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), and other professional bodies where appropriate.

The key tests considered when assessing clinical sustainability were:

- Is current clinical performance of an acceptable standard when compared with standard performance metrics?
- Is the trust serving a catchment population that is in line with national guidelines for a hospital that delivers the full range of acute services?
- Does the trust have sufficient consultant levels established across all services to maintain a 24/7 service?
- Is the trust able to recruit and retain appropriate clinical staff to meet the established consultant levels?

What is 'financial sustainability'?

The test of financial sustainability is the robust demonstration that a trust is:

- Forecasted to deliver a surplus for the current financial year and for each of the following five years;
- Able to generate cash;
- Able to pay its debts as they fall due without financial support.

If the trust is not able to demonstrate the latter two elements and is forecasted to deliver a deficit for the current financial year then from a technical accounting perspective it is insolvent. If a commercial entity was judged insolvent, it would have to cease its operations.

1.3.3 Why is sustainability important?

If a trust is not able to operate services in a sustainable manner then there may be a range of potential consequences. These include the following:

- The Department of Health and/or local commissioners may need to provide additional funding to enable the trust to keep operating – at a time when the NHS budget is static year on year.
- The trust's operations may be less efficient than they could be, which means that performance (clinical and financial) may be below the optimal level;
- The trust may not be able to:
    - effectively deliver tactical or strategic change as and when required;

  - manage crises as and when they occur;
  - identify in a timely manner that performance is falling below acceptable standards;
- The trust may deliver clinical outcomes that are below expected standards;
- The trust may not be able to deliver services 24 hours a day, 7 days a week;
- The trust may not be able to invest in the latest health technologies or medicines available.

This is by no means an exhaustive list and not all of the above has been noted at MSFT. However, it is evident that sustainability of service delivery is essential if Monitor is to deliver its mandate to protect patient interests.

1.4 Is MSFT operationally sustainable?

1.4.1 Approach

The CPT considered the extent to which the Trust has the necessary structures and processes in place to deliver its immediate corporate objectives and longer term strategy. To carry out this review, the CPT undertook a three stage process, as follows:

1. Conducted a desk-based review of key documents and reports (for example, MSFT Board reports, external reviews and staff surveys) to identify common themes related to operational sustainability;
2. Gathered evidence from structured interviews, meeting observations and Trust data / documents;
3. Collated the findings using an organisational design framework based on the:
   - Trust's strategy;
   - core elements of the Trust's organisational design (structure, roles, resources and capability); and
   - enabling areas of the Trust's organisational design (culture, people, process, governance, performance and infrastructure).

1.4.2 Findings

The Trust has made significant progress in establishing its operational sustainability by implementing both strategic and tactical change over the past 18 to 24 months. These improvements have been driven by greater alignment between the Trust's strategy, its organisational design and enabling functions. Examples include (but are not limited to):

- The engagement of clinical staff in the management of the hospital (e.g. through appointment of clinical directorates to head each of the Trust's four directorates);

- The development, implementation and embedding of a risk management process which is well used and understood by staff;
- Focused improvements in performance management through the implementation of specialty level performance meetings supported by an integrated performance dashboard;
- An established Project Management Office (PMO) which provides the necessary governance, infrastructure and support to transformation programmes; and
- A stable executive team and Board which has demonstrated the capability to drive sustained change.

The strategic and tactical changes the Trust has made have had a direct impact on both quality and performance. These improvements are demonstrated by:

- Care Quality Commission (CQC) reviews showing an improved standard of clinical quality at the Trust, going from 11 areas of concern in 2010 to none in 2012. All other hospitals in the region have had minor CQC concerns at some point during the same period;
- The Trust meeting its A&E waiting times target in Q2 FY13;
- The Trust is sustaining Hospital Standardised Mortality Rates (HSMR) of less than 100;
- Decline in mixed sex breaches from 635 (2011/12) to one incident of eight breaches in the year to date (to November 2012); and
- Improvement in the Trust's 18-week target, moving from 301 above 52-week breaches and 13,528 incompletes[1] (2011/12) to zero above 52-week breaches and 8,813 incompletes, with 18 weeks achieved Trust-wide in October 2012.

Whilst the Trust continues to make significant progress, further work required to fully embed operational improvements to ensure the changes are sustainable and continue to deliver improved performance outcomes. Examples include (but are not limited to):

- The committee structure has been developed and is, in the main, functioning well. Further work is needed to remove the duplication between some of the committees and to establish a more responsive referral process between committees;
- 18-week performance has been achieved over the past two months. One of the drivers of this was the implementation of weekly performance

[1] An 'incomplete' is a case where a patient has not completed their treatment.

meetings. The Trust must focus on the actions needed to sustain this performance so it can be embedded into "business as usual";

- Specialty-level governance meetings are not happening in all directorates due to resourcing issues.

Through investment in a number of areas (e.g. staffing and operational/clinical services), the Trust's performance level has improved markedly over the past 18 to 24 months and has done so across a range of quality and safety indicators. The challenge is for the Trust to ensure that it fully embeds the changes it has made.

However, this investment is one of a number of drivers behind the Trust's financial position with many of the costs associated with the operating model being significantly higher than the national average. For example, MSFT spends (as a proportion of its revenue):

- over six times the national average on Quality and Risk.
- over three times the national average in Information Management and Technology.
- Over twice the national average on HR.

The CPT concluded that if a plan could be identified to deliver long term financial and clinical sustainability, then the Trust's operating model is fit for purpose. To that extent, the CPT concluded that MSFT is operationally sustainable.

1.5 Is MSFT clinically sustainable?

1.5.1 Approach

The clinical sustainability review primarily looked at the viability of services for the longer term, i.e. three to five years. The CPT undertook the following activities to form a perspective on the clinical sustainability of MSFT:

1. Reviewed key documents and external reviews to assess current clinical performance;
2. Gathered evidence and opinions through interviews with senior clinical staff within the Trust;
3. Compared performance against external standards set by the medical Royal Colleges, National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and others; and
4. Explored the clinical workforce situation, focusing particularly on the ability of services to attract and retain staff.

The CPT is not a clinical peer review team and therefore used existing, accepted guidance and reports in order to conduct its clinical assessment.

1.5.2 Findings

Multiple clinical reviews have taken place at the Trust since concerns about the clinical standard of care were raised in a 2009 Healthcare Commission report that revealed a higher than expected number of deaths at Stafford Hospital.

In response to this, the clinicians and management at MSFT have taken considerable steps to drive improvements. The Trust has increased the presence of senior clinical staff, through recruiting more senior nurses and increasing the level of consultant-delivered care. The Trust is also working more closely with neighbouring NHS Trusts, particularly in certain surgical services, with several services now operating as a network across the region.

The impact of this effort is tangible and MSFT has demonstrated substantial improvements to the quality of care delivered and their clinical performance – as noted in the findings around operational sustainability.

Despite the recent improvements in performance, however, the Trust faces a substantial challenge of scale when comparing the volume of activity at MSFT with other trusts in England. In all services, the volume of activity at MSFT is below the national average and it is evident that, in some services MSFT is one of the smallest trusts in the country, for example:

- For maternity births, MSFT ranks 135th out of 148 services in England.
- For A&E attendances, MSFT ranks 132nd out of 150 services in England.
- For non-elective (emergency) surgical spells, MSFT ranks 133rd out of 166 services in England.
- For paediatric spells over 1 day, MSFT ranks 116th out of 167 services in England.

Patients and GPs can choose where patients are referred for acute care, and it is apparent that activity levels have dropped since the issues highlighted in 2008/09. Regardless of this, the catchment population for MSFT is well below the Royal College Standards (RCS) recommended size of 450,000 – 500,000 for an acute general hospital providing the full range of facilities, including specialist staff and expertise for both elective and emergency medical and surgical care.

Small hospitals such as MSFT face challenges in meeting these guidelines due to having lower patient volumes than larger hospitals, and, as a result, have less ability to support the number of senior staff required to maintain a consultant presence twenty four hours a day, seven days a week. This is particularly true for acute specialties where consultant presence is required at short notice any time of the day or week.

Estimating the catchment population is difficult and there have been a number of different attempts to estimate it. Staffordshire Public Health (SPH) recently reviewed these efforts in an effort to provide clarity on the catchment of MSFT, and noted:

"A catchment area refers to the geographical area from which the patients of a particular hospital or service are drawn. A catchment population represents the people who would normally attend the hospital if they needed treatment... Therefore, a catchment population is not simply the total number of people who live in the catchment area."

The catchment area for the two Clinical Commissioning Groups (CCGs) that primarily refer patients into MSFT (Stafford & Surrounds CCG and Cannock Chase CCG) has a combined population of 276,000. However not all these people will necessarily be referred to services provided by MSFT, and some may choose to be treated elsewhere. The SPH review estimated that the actual catchment population of the Trust is between 190,000 and 212,000.

The CPT notes and has seen that there are forecasts which predict a reasonable increase in the local population over the coming 5-10 years. However, it does not believe that these changes will have a material impact on the conclusions with regards to catchment population.

With many acute surgical services becoming increasingly specialised, it is likely that the Trust serves a size of population which is insufficient to provide exposure to enough conditions, treatments and procedures for many of its specialist consultants to achieve national standards and maintain their professional expertise.

Indeed, at present, in some services, the Trust is not currently meeting the minimum consultant levels for a twenty four hour, seven day a week service as recommended by the Royal Colleges and other national bodies.

Furthermore, recruitment is an ongoing issue in some areas with, at the time the information was gathered, almost one in five consultant posts not filled by substantive appointments – although there are signs that this situation is improving. In many cases, this is due to national shortages caused by increasing specialisation in medical training, but there is anecdotal evidence to indicate that applications are still affected by the historic reputational issues and the ongoing uncertainty about the future.

Despite the noted improvements, the Trust is still facing challenges in some services. Since 2009 there have been challenges to clinical performance, highlighted in several reviews – the most recent being the Cancer Network's peer review of breast surgery services conducted in March 2012.

Whilst the CQC has lifted any residual concerns about the quality of services at MSFT, there is a recognition within the Trust that there are still some cultural issues that need to be addressed. The CPT has observed that the Trust appears to be engaging rigorously and appropriately in performance management of medical staff, and the recent improvements in clinical performance measures do indicate that performance improvement in the Trust is going in the right direction.

Bearing in mind the available evidence, the CPT has concluded that although clinical performance has significantly improved in the past 24 months, MSFT is clinically unsustainable over a three to five year period. This is because it will struggle to provide high quality clinical services in the future, and meet national clinical standards, especially for emergency care.

1.6 Is MSFT financially sustainable?

The financial review focussed on three main areas of financial performance:

- The Trust's ability to generate a surplus;
- The Trust's ability to generate cash;
- The Trust's ability to pay its debts as they fall due.

The CPT undertook the following activities to form a perspective on the financial sustainability of MSFT:

1. Analysed the historical financial performance and the events that led to the deteriorating financial position using information obtained through interviews with key financial staff and analysis of the Trust's financial systems and reports.
2. Assessed MSFT's cash flows to understand the impact of operations and capital expenditure on cash. This was in the context of £21m of cash support provided by the Department of Health in FY12, and the Trust's ability to generate cash.
3. Benchmarked the cost base of MSFT against other NHS Trusts and Foundation Trusts to determine the extent to which the costs incurred compared with other organisations.
4. Developed a forecast outturn position for FY13 and modelled a five year forecast based on its findings and assumptions agreed with the Trust.

To further understand the Trust's sustainability, the CPT also looked at:

- A review of the 2013 cost improvement programme (CIP), processes and forecast; and
- A review of the cash and capital plan.

1.6.1 Findings

The first signs of financial difficulty were apparent in FY10 when, in response to well documented criticism of its standards of care[2], the Trust increased its pay expenditure by £9.1m (9.2%)[3] through recruiting additional staff. Further increases in staff the following year put additional strain on the financial position

[2] HCC report – Mar09, Colin Thorne & Alberti reports – Apr09, Robert Francis report – Feb10, Annual Accounts 2009-10
[3] I&E d_load 0910, Trust d_load month 12 10_11

at the same time as the Trust tried to improve its operational and clinical performance.

Since becoming a Foundation Trust in 2008, the retained underlying deficit has deteriorated by over £40m. The planned deficit for FY13 is £15m, with an underlying deficit of £18.8m[4]. The Trust is forecast to deliver a deficit for the foreseeable future with limited opportunities in its current form to sufficiently improve the situation.

In the Operational Sustainability assessment, the CPT identified that the costs associated with the operating model are higher than the national average. One other area where the Trust's costs are significantly higher than the national average is its estate costs. The costs associated with managing the estate are more than 6% of MSFT's annual revenue, which compares with a national average of less than 1% for all trusts and just over 1% for all Foundation Trusts.

In order to achieve breakeven in five years the Trust needs to achieve £53m of cost savings, which equates to at least 7% of relevant income in each year. Nevertheless this level of efficiency will still require an estimated total of £73m in extra funding from the Department of Health and local commissioners through the Strategic Change Reserve.

The 7% level of cost savings is higher than the average reported to have been achieved by NHS foundation trusts in Monitor's review of 2011/12 and the findings of the King's Fund Quarterly reviews, with only 5 out of 45 organisations recording efficiencies higher than 7%. There is no evidence to suggest any trust has delivered 7% of savings consistently over a five year period.

MSFT has achieved £16.6m efficiencies in 2011/12 and 2012/13. The CPT has concluded, and the Trust agrees, that this required level of extra savings and additional income is very unlikely to be delivered and sustained over the five year period.

On the basis of the evidence reviewed, the CPT concluded that the Trust cannot achieve financial sustainability within the next five years without significant external intervention. Moreover, without cash support the Trust is unable to pay its debts as they fall due and as such is deemed insolvent. The Trust has needed and will continue to require substantial cash support for the next five years.

[4] The underlying deficit being the 'trading position' of the organisation once non-recurrent costs and non-recurrent revenue is stripped out.

1.7 Overall conclusion

The CPT acknowledges that the Trust has made significant improvements in its operational structures and processes over the last 18 to 24 months. This has resulted in the improvements noted in key performance measures. There has also been significant investment in additional staff.

Despite this, the Trust has struggled to comply with the aspirations for improvements in care set out by the Royal Colleges and NCEPOD, notably the delivery of 24 hour consultant-led care, 7 days a week.

The Trust is forecast to make a deficit for the fourth consecutive year, and required £21m cash support in FY12. The Trust is forecasted to make a deficit for the foreseeable future.

The efficiency requirements needed to break even by FY18 would need to be a minimum of 7% each year for the next five years. This level of savings would exceed realistic targets and will still require an estimated £73m in additional support from the Department of Health and local commissioners.

The CPT has therefore concluded that MSFT is not financially or clinically sustainable and there is not a credible plan to deliver sustainability over the next five years in the Trust's current form.

1.8 Next steps

Although the CPT has determined that the Trust is not clinically sustainable in the long-term it has not identified any evidence that the Trust is delivering unacceptable standards of care. In the short-term, it is operationally sustainable. There is therefore no immediate threat to patient services provided by the Trust, which should continue to operate business as usual.

The purpose of assessing sustainability is to determine whether the CPT should develop a turnaround plan or a contingency plan. On this basis, the CPT will now focus on finalising a contingency plan.

The CPT has already started this second phase of work. The objectives for the second phase are to:

- Determine a preferred solution for the services currently delivered by MSFT. This includes an assessment of the financial and organisational implications of these solutions on the local health economy;
- Assess the main implementation challenges associated with this solution and propose how they are best mitigated;
- Develop a recommendation on the restructuring approach that is most likely to successfully deliver the preferred solution, and how that is best implemented;
- Manage the ongoing communications and stakeholder engagement associated with the project.

The CPT is due to present final recommendations to the Monitor Board by 31 March 2013.

2. Operational sustainability

Monitor has appointed a Contingency Planning Team (CPT) to assess the long term sustainability of MSFT from a clinical, operational and financial perspective.

The approach used by the CPT was to determine and agree the current and future clinical and financial challenges facing the Trust and assess the Trust's internal capabilities to assess, plan and implement the actions needed to meet those challenges sustainably.

This section describes the approach taken and findings of the operational sustainability review.

2.1 Process for reviewing operational sustainability

The CPT has undertaken the approach set out in Table 1 to review the Trust's operational sustainability. The review was conducted between 8th October 2012 and 3rd December 2012.

Table 1: Summary of process for reviewing organisational sustainability

Review stage	Areas of review
1 – Desk-based research	*Review key documents* • Documents include: Board reports, Performance reports, CQC reports, Alberti & Colin Thomé reports, Francis report, Wallwork report, King's Fund report, Forward Plan, Annual report (a full list is provided in section 2.1.1) *Summarise key themes related to operational sustainability* • Based on the review of key documents, bring out key themes for further scrutiny against operational sustainability • Using these key emerging themes, develop areas in which to gather evidence *Develop stakeholder questions based upon the research* • Develop questions to probe each of these themes • Tailor questions to each stakeholder to review the organisational design model *Develop data requests based upon the research* • Develop data requests to provide quantitative evidence

Review stage	Areas of review
2 – Gather evidence	*Structured interviews* • Conduct interviews with a cross-section of Trust staff to test hypotheses for each theme • Use these interviews to develop further areas to explore *Meeting observation* • Observe key meetings (Board, Performance Meetings, Finance Committee etc.) to provide further evidence to test hypotheses *Analyse data* • Analyse the data returned to provide additional evidence for the review
3 – Synthesise findings	*Synthesise data* • Using an established organisational design framework (covered later in this section), compare evidence against the elements of the framework *Collate report on operational sustainability* • The report summarises strengths and weaknesses in each area and the impact this has on operational performance and decision-making within MSFT

2.1.1 Step One: Desk-based research

In conducting the desk-based research the CPT reviewed a number of existing reports and documents (as set out in Table 2) to understand common themes related to operational sustainability.

Table 2: Documents reviewed for desk-based research

Ref	Title
1	Compliance Framework 2012/13: Monitor, 30 March 2012
2	Letter to Board of Governors Mid Staffs 15 07 09: Intervention by Monitor under section 52 of the National Health Service Act 2006 (the 2006 Act)
3	Update on progress following the Internal Audit report: Learnings and Implications from Mid Staffordshire NHS Foundation Trust, Monitor, 5 August 2010
4	Board reports for Mid Staffordshire NHS Foundation Trust (November 2011 to July 2012)
5	Authorisation of Mid Staffordshire NHS Foundation Trust, Monitor, February 2008

6	CQC reports (Review of compliance: Mid Staffordshire NHS Foundation Trust Stafford Hospital (August 2011), Review of compliance: Mid Staffordshire NHS Foundation Trust Stafford Hospital (July 2012), Review of compliance: Mid Staffordshire NHS Foundation Trust Stafford Hospital (March 2011), Dignity and nutrition for older people: Review of compliance Mid Staffordshire NHS Foundation Trust Cannock Hospital (May 2011), Review of compliance: Mid Staffordshire NHS Foundation Trust Stafford Hospital (December 2011), Review of compliance: Mid Staffordshire NHS Foundation Trust (December 2010))
7	Mid Staffordshire NHS Foundation Trust: A review of the procedures for emergency admissions and treatment, and progress against the recommendation of the March Healthcare Commission report, 29 April 2009 (“Alberti report”)
8	Mid Staffordshire NHS Foundation Trust: A review of lessons learnt for commissioners and performance managers following the Healthcare Commission investigation, 29 April 2009 (“Colin Thomé report”)
9	Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009, 24 Feb 2010 (“Francis report”)
10	Report on future clinical strategy and configuration of service provision, October 2010 (“Wallwork report”)
11	Taking it on trust: A review of how boards of NHS Trusts and Foundation Trusts get their assurance, Audit Commission, April 2009
12	Preparing for the Francis Report, King’s Fund, July 2012
13	Forward Plan Strategy Document for 2012-13, Mid Staffordshire NHS Foundation Trust
14	Mid Staffordshire NHS Foundation Trust Annual Report and Accounts - April 2011 / March 2012
15	Investigation into Mid Staffordshire NHS Foundation Trust, Healthcare Commission, March 2009
16	Quality Account & Report 2011/12, 31st May 2012
17	Board Governance Assurance: Framework for Aspirant Foundation Trusts, Monitor
18	Annual Report and Accounts April 2010 – March 2011, Mid Staffordshire NHS Foundation Trust, September 2011.
19	Annual Report and Accounts April 2011 – March 2012, Mid Staffordshire NHS Foundation Trust, May 2012
20	2011 National NHS staff survey: Brief summary of results from Mid Staffordshire NHS Foundation Trust, Department of Health
21	Survey of adult inpatients 2011 Mid Staffordshire NHS Foundation Trust, Care Quality Commission

22	Self Assessment: Board Governance Assurance Framework Mid Staffordshire NHS Foundation Trust, 3 December 2012
23	Corporate business plan 2012/13, Mid Staffordshire NHS Foundation Trust

On the basis of this research, the CPT established five key themes to test the Trust's operational sustainability[5]:

1. **The Trust's strategy**, in particular how this has addressed some of the recommendations from the reports listed in Figure 5, and how the Trust is delivering its current short- and long-term objectives;
2. **The Trust's approach to governance** and how effective this is;
3. **The Trust's directorate structure**, why this was recently changed, and how effective it is;
4. **The capability, organisational development and training resources** that the Trust has deployed to support operational sustainability; and
5. **The processes and systems in place** (including performance management, risk reporting and capital allocation) to deliver the Trust's strategy.

Note: When assessing capability the CPT concentrated on the effectiveness of the executive team, rather than at the level of individuals or teams across the whole organisation. The CPT also excluded complaints from its analysis.

2.1.2 Step Two: Evidence gathering

Interviews with a cross-section of staff

The CPT developed a series of questions for focused interviews based upon the themes that emerged from the desktop review. The interviews were scheduled with a cross-section of the Trust's personnel, including general managers, clinical directors, and executive and non-executive directors. Interviews were held with each individual separately; in total the CPT conducted 23 formal interviews.

Review of key Trust meetings

As well as these interviews, the CPT observed the following meetings:

- Trust Board Meeting, 1 November 2012
- Finance Investment and Operational Performance Committee, 27 November 2012
- 18 weeks performance meeting, 30 November 2012

[5] Appendix B sets out the process for establishing the key themes.

Quantitative evidence

The CPT assessed the following quantitative evidence:

- Quality, Innovation, Productivity and Prevention (QIPP) national workstream: back office efficiency and management optimisation (2010)
- MSFT's Month 6 income and expenditure (I&E) position
- 'I View' reports (an online service that provides aggregated health and social care data)
- Trust financial returns (TFRs), Estates returns information collection returns (ERIC), and Hospital Episode Statistics (HES)

2.1.3 Step Three: Synthesis of evidence

This information was supplemented by additional Trust documentation (including its annual report, business plan and operating plan) and are referenced where appropriate. All the evidence was synthesised using an organisational design framework.

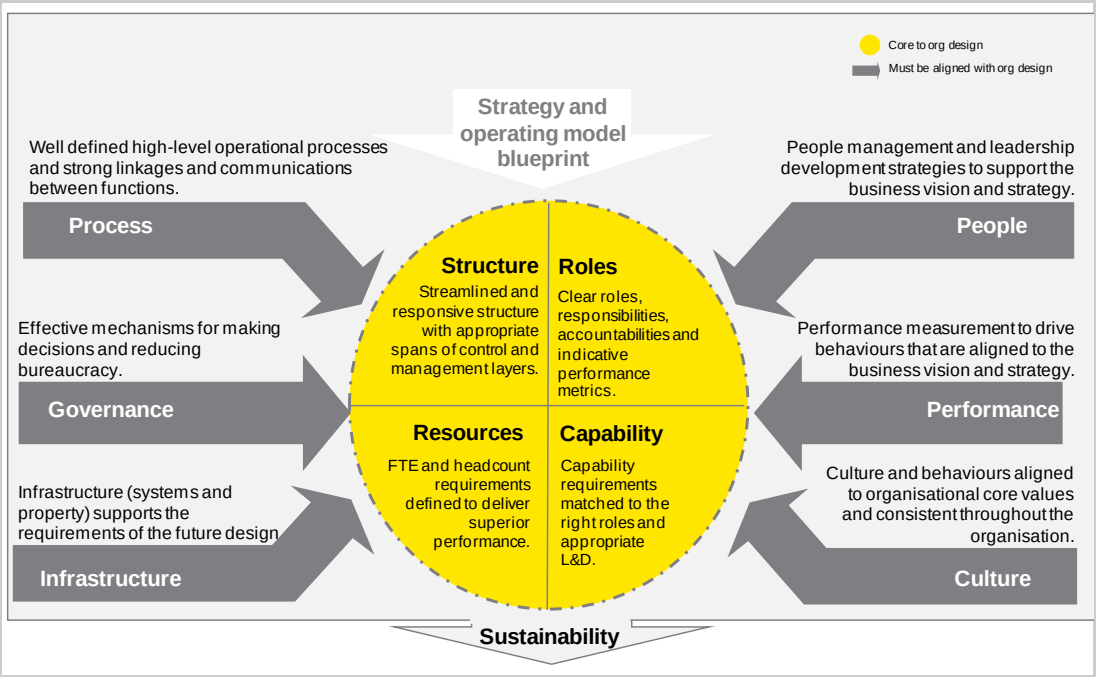
Framework for reviewing operational sustainability

An organisation exhibits operational sustainability "if it utilizes its human, social, economic, and ecological resources with responsibility"[6] and can be understood in the context of organisational design. Organisational design is defined as the way that structure, roles, capability and resources are designed to deliver the strategy and operating model blueprint. It is the formal system of accountability that defines key positions and enables the efficient allocation of resources to support business outcomes. Integrated designs are delivered by adopting a systematic and structured approach, aligning the interdependent components of an organisation. For the design to be effective, it should be regularly reviewed to ensure that it is sustainable and meets the strategic objectives of the organisation.

To effectively analyse the multiple components of operational sustainability from a top-down perspective, the following framework was used:

[6] Peter Docherty, Mari Kira, Abraham B. (Rami) Shani (2009), Organizational development for social sustainability in work systems, in Richard W. Woodman, William A. Pasmore, Abraham B. (Rami) Shani (ed.) *Research in Organizational Change and Development, Volume 17*, Emerald Group Publishing Limited, pp.77-144.

Figure 2: Framework for reviewing organisational sustainability



The CPT's findings are presented in the following five sections:

- Section 2.2: Assessing the Trust's strategy;
- Section 2.3: How aligned the Trust's structures (governance and operational) are to this strategy;
- Section 2.4: The alignment of the Trust's people with the Trust's structures;
- Sections 2.5 and 2.6: The alignment of the Trust's systems and processes with the Trust's structures;
- Section 2.7: Whether the Trust is successfully delivering.

2.2 The Trust's Strategy

2.2.1 Overview of the Trust's strategy

This section focuses on the Trust's strategy, and how it forms the basis for operational sustainability. It looks at how the Trust's previous strategy has addressed some of the recommendations made in the various reviews of the Trust, and at how the current strategy is performing.

2.2.2 Recommendations from reviews of the Trust

The Trust has a well-documented history of failures of care and has been in breach of its terms of authorisation as a Foundation Trust (FT) on financial and governance grounds since March 2009. The documents reviewed in the first stage of the operational sustainability review provide both an understanding of the Trust prior to 2009 and a baseline from which to measure the Trust's progress. In particular, there are three areas in which recommendations were made that provide a useful baseline against which to measure the success of the Trust's strategy. These are outlined in Table 3.

Table 3: Selected recommendations from Trust reviews

Area	Recommendation / comment	Source
Governance	"Recommendation 18: All NHS Trusts and Foundation Trusts responsible for the provisions of hospital services should review their standards, governance and performance in the light of this report"	Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009 (p. 28)
	"[C]ontrols and assurances were often poorly defined, making it difficult to see how boards could be clear that the controls were working effectively and that assurances were sound. Risks and controls were not always aligned to strategic objectives"	Taking it on trust: A review of how boards of NHS Trusts and Foundation Trusts get their assurance (p. 3)
	"The governance structures had been subject to external scrutiny as part of the process of acquiring foundation trust status. In addition, the NHS Litigation Authority had assessed the standards for risk management, and the Healthcare Commission had assessed standards as part of the annual heath check. For both of these, the trust provided evidence that the structures were adequate and this was accepted…As demonstrated in this report, the structures did not serve to raise awareness of serious problems with clinical care in emergency services in the trust, or the potential implications of the major reduction in staffing in 2006/07"	Investigation into Mid Staffordshire NHS Foundation Trust (p. 103)
Directorate structure	"Recommendation 11: The Board should review the management structure to ensure that clinical staff and their views are fully represented at all levels of the Trust and that they are aware of concerns raised by clinicians on matters relating to the standard and safety of the service provided to patients"	Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009 (p. 27)

	"An emergency care directorate should be established"	Mid Staffordshire NHS Foundation Trust: A review of the procedures for emergency admissions and treatment, and progress against the recommendation of the March Healthcare Commission report (p. 18)
Strategic planning	"Recommendation 1: The Trust must make its visible first priority the delivery of a high-class standard of care to all its patients by putting their needs first. It should not provide a service in areas where it cannot achieve such a standard"	Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009 (p. 26)
	"The needs of the local population should be clearly enumerated by the PCT and the Acute Trust and these should be reflected in the 5-year strategy for the Foundation Trust. The focus should be on what can be done safely and well by the Trust and what should be left for other trusts to do"	Mid Staffordshire NHS Foundation Trust: A review of the procedures for emergency admissions and treatment, and progress against the recommendation of the March Healthcare Commission report (p. 18)
	"Trusts should ensure that their strategic aims and objectives are clearly defined and few in number so they can be widely understood and clearly cascaded throughout the organisation, and that their strategic risks are identified and aligned to their strategic objectives"	Taking it on trust: A review of how boards of NHS Trusts and Foundation Trusts get their assurance (p. 5)

2.2.3 The Trust's current strategy

The Trust's most recent annual report (for the period April 2011 to March 2012) states that the Board agreed the following vision statement[7]: "To be recognised as the safest and most caring Trust in the NHS". This vision is being implemented through the delivery of the Trust's five strategic objectives (note that the strategic objectives are delivered through corporate objectives, and measured by key performance indicators (KPIs)).

1. Deliver the highest quality care through a culture of caring;
2. Zero harm is always the Trust's target to keep patients safe;
3. Improve patient experience by listening, responding and acting on what our patients and community are telling the Trust;
4. Support the Trust's staff to become excellent: giving responsibility but holding to account as well; and
5. Achieve financial stability and satisfy its regulators.

[7] Mid Staffordshire NHS Foundation Trust, *Annual Report and Accounts - April 2011 / March 2012*, p. 14.

The Trust's Corporate Business Plan 2012/13[8] stated that progress had been made in defining future strategy to ensure a clinically sustainable and financially viable organisation[9]. This future strategy is described in the Operating Plan 2011/12 – 2015/16, which states that the continued evolution of the Trust has three key components[10]:

- Reconfiguration of services to improve the quality of care and prevent unnecessary acute attendances and admissions, in line with commissioner intentions, as part of a locally-developed clinical services strategy;
- Improving productivity to bring costs in line with other small, best practice acute trusts; and
- Repatriating activity and attracting new activity for services the Trust can deliver at high quality in a financially viable way.

The operating plan acknowledges that delivering these key components requires a major operational transformation programme to deliver the clinical strategy and achieve financial balance in the future.

The next three sections describe the Trust's ability to meet its short-term corporate objectives and long-term strategy, and the context that this provides for the review of operational sustainability.

2.2.4 Ability to meet short-term objectives

The 2011/12 annual report stated[11] that by March 2012 there were four red rated corporate objectives (i.e. the objective has not been met):

- Emergency Admissions Improvement Programme/A&E;
- Meeting national access targets (18 weeks, cancer);
- Monitor rating Governance; and
- Monitor rating Finance.

An assessment against the corporate objectives was carried out in October 2012 to provide the Board with a summary of progress up to the second quarter. This assessment is outlined in Table 4.

[8] Corporate Business Plan 2012/13, p. 6.
[9] Corporate Business Plan 2012/13, p. 6.
[10] Operating Plan 2011/12 – 2015/16, p. 3.
[11] Mid Staffordshire NHS Foundation Trust, *Annual Report and Accounts - April 2011 / March 2012*, p. 16.

Table 4: Trust assessment against its corporate objectives (source: MSFT)

Strategic objective	Corporate objectives / KPIs	RAG rating
1. Deliver the highest quality care through a culture of caring	Thirteen objectives	9 x Amber 4 x Green
2. Zero harm is always our target to keep patients safe	Eight objectives	7 x Amber 1 x Green
3. Improve patient experience by listening, responding and acting on what our patients and community are telling us	Nine objectives	1 x Amber 8 x Green
4. Support our staff to become excellent: giving responsibility but holding to account as well	Nine objectives (with a total of 12 KPIs)	7 x Amber 5 x Green
5. Achieve financial stability and satisfy our regulators	Thirteen objectives	2 x Red 2 x Amber 9 x Green
Total	**55 objectives (including all KPIs)**	**2 x Red** **26 x Amber** **27 x Green**

Progress against the Trust's corporate objectives was positive with almost half rated as green and nearly the same rated as amber. There are only two red-rated objectives, and these are both related to finance. For comparison, there were 26 green-rated items, 27 amber-rated items and two red-rated items at the end of the first quarter[12] (the two red-rated items were the same in Q2). Although the CPT did not carry out a separate evaluation, a review of the Trust's evidence indicated that the self-assessment was reasonable.

The Trust acknowledged that this period has been "a challenging quarter for the Trust in particular because of the ongoing financial difficulties... the overnight closure of A&E, [and] the continuing day to day operational pressures. Despite these continuing pressures good progress has been made in working towards the delivery of our goals to achieve national access targets for A&E, 18 weeks and cancer"[13]. The Trust has therefore focused on clinical and operational improvements in the short-term, as demonstrated by the green and amber corporate objectives in these areas. In contrast, although the Trust has worked on

[12] Business Plan Quarterly Progress Report, 25 July 2012.
[13] Business Plan Quarterly Performance Report, 17 October 2012, p. 3.

financial improvement, the two red rated corporate objectives both relate to financial sustainability.

2.2.5 Ability to meet long-term objectives

In order to achieve its long-term strategy the Trust was aware that it needed to "transform the organisation not just from a clinical care perspective but also from an organisational design and cultural perspective"[14]. To this end the Trust participated in the Mid Staffordshire Health Economy Clinical Services Implementation Plan (CSIP). The CSIP summarised the outputs of five clinical working groups (CWGs) convened to evaluate current service provision, identify what best practice care should look like and set out the implications for the Trust[15]. It concluded that to ensure high quality services, the Trust will have to provide some services in collaboration with other providers; deliver top decile / quartile productivity across key areas to break even in 2013/14; and consider alternative revenue sources from repatriation to joint ventures with community provider services[16]. The Trust's own plans for its long-term objectives are set out in its Operating Plan 2011/12 – 2015/16, which is its operational response to the CSIP recommendations[17].

However, in the intervening period, the Trust has not been able to identify credible and substantial alternative revenue sources, and the detailed CPT financial sustainability review has concluded that reducing the deficit in line with CSIP recommendations will not be possible. That said, the Trust's response to CSIP still provides a useful guide to understanding how the Trust aims to meet its long-term objectives.

In line with the strategy set out in both the CSIP and operating plan, a key part of delivering the Trust's long-term strategy is the Memorandum of Understanding (MoU) with University Hospital of North Staffordshire NHS Trust (UHNS) approved by the MSFT Board in July 2012. The MoU establishes a framework for a formal collaboration between UHNS and MSFT and sets out the role of each organisation towards achieving common objectives[18]. Examples of the MoU's scope include:

- Working together to maximise recruitment and retention of staff;
- Developing a networking approach to clinical services where appropriate; Sharing resources (including clinical and management expertise) where this is in the interests of patients or for securing efficiencies;
- Sharing best practice;
- Sharing information in order to deliver services.

[14] Operating Plan 2011/12 – 2015/16, p. 8.
[15] Mid Staffordshire Health Economy Clinical Services Implementation Plan, summary report, 20th May 2011, p. 1.
[16] Mid Staffordshire Health Economy Clinical Services Implementation Plan, summary report, 20th May 2011, p. 11.
[17] Operating Plan 2011/12 – 2015/16, p. 1.
[18] Future Partnership Working (27 June 2012), presented to the Trust Board on 5 July 2012.

The Trust has set out its long-term objectives and has started to implement some of the strategic changes required to deliver these. However the Trust has acknowledged that it has come out of a "phase of crisis management" [19] and that it is aware of the need to implement and embed a comprehensive organisational development strategy to ensure that it has appropriately skilled and capable staff[20].

2.2.6 Conclusions on the Trust's strategy

The Trust's short-term strategy has been successful, as shown by the positive progress made against its corporate objectives. However, further work is required to ensure that the Trust is delivering against more of its corporate objectives, with around half remaining amber-rated (the only red-rated corporate objectives relate to finance).

The Trust has been subject to a number of reviews and subsequent recommendations. The Trust's strategy over the past 18 to 24 months has implemented these recommendations by putting in place a new governance structure, redesigning its directorate structure and creating and implementing a forward-looking, high-level plan. This has led to greater engagement of clinical staff in the management of the hospital. These changes have provided a stable foundation for implementing further change.

[19] Operating Plan 2011/12 – 2015/16, p. 1.
[20] Operating Plan 2011/12 – 2015/16, p. 8.

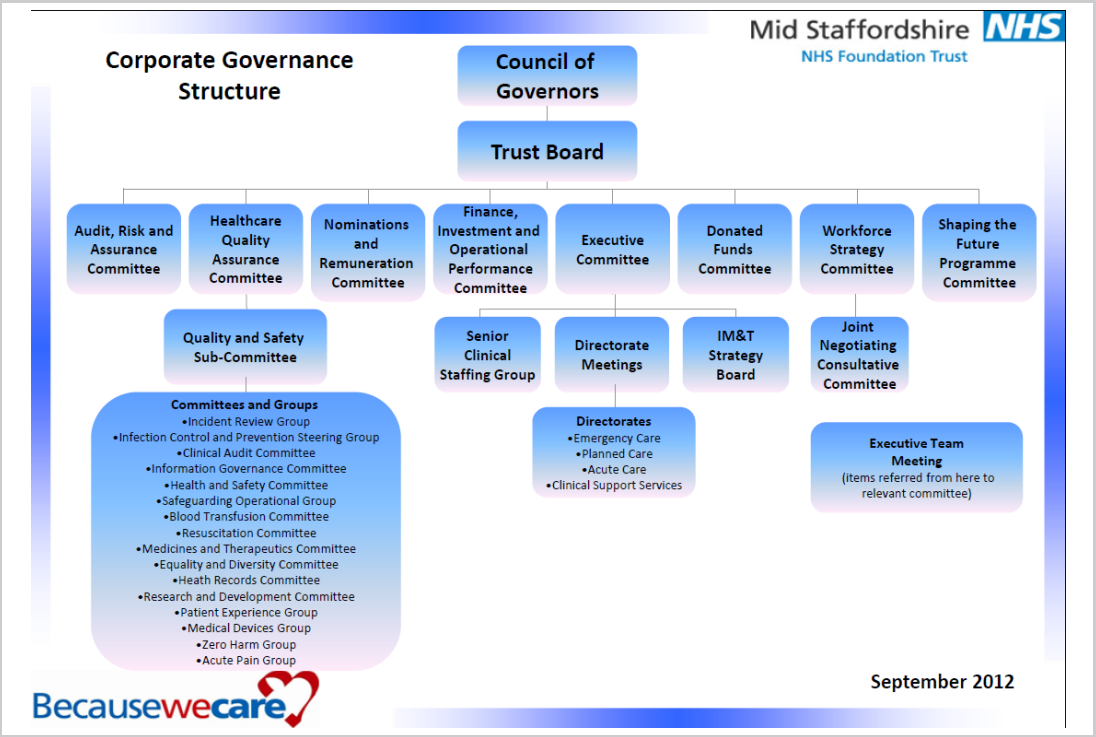
2.3 Alignment of the Trust's structure to its strategy

This section looks at the alignment of the Trust's governance (committee structure) and operations (directorates and PMO) to its strategy.

2.3.1 Changes to the Trust's committee structure

The Francis Report recommended that all NHS Trusts and Foundation Trusts responsible for the provision of hospital services should review their standards, governance and performance. Accordingly, a new committee structure has been implemented over the past 24 months. This is shown in Figure 3.

Figure 3: Corporate governance structure (source: MSFT)



Each committee has a clear line of accountability and a core group of attendees identified, as well as clear terms of reference. The Trust has extended the scope of these meetings to make them more inclusive. For example the head of information management and technology (IM&T) now attends the Executive Committee (Exec Co) to provide assurance and support on issues related to the data used to assess operational performance.

The changes made to the committee meetings have been well received by the NEDs. By ensuring that the right people are attending the committees, the NEDS have been able to challenge senior and middle management and hold them to account.

Whilst there have been improvements to the committee structure, there are areas which the Trust has recognised it still needs to develop. There are apparent areas of duplication in what is considered by committees. For example the integrated performance report that is considered by the Finance, Investment and Operational

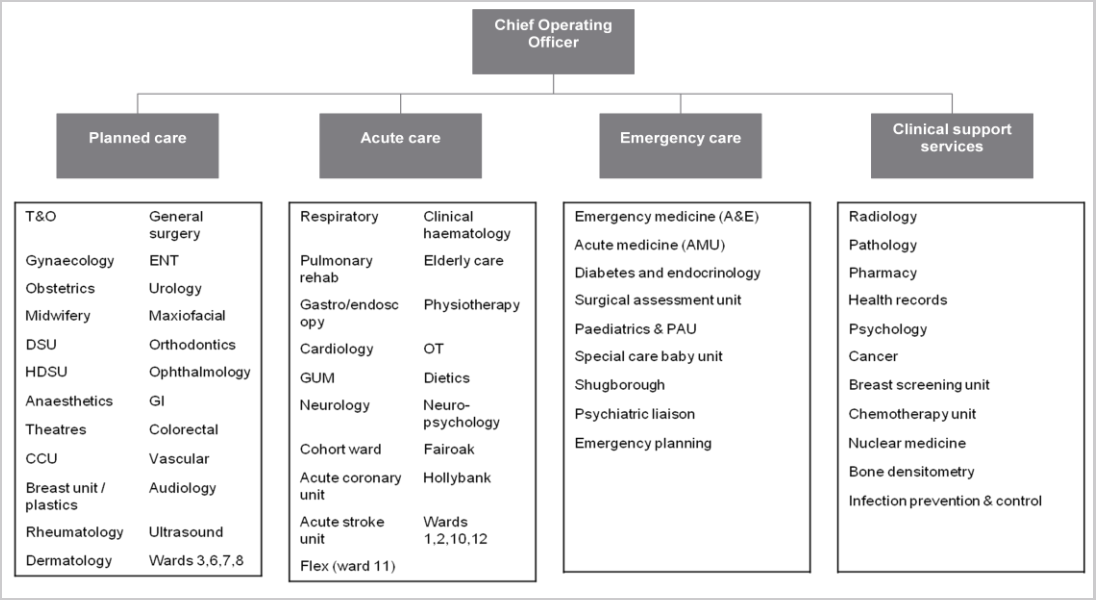
Performance (FIOP) committee is then presented at the Board meeting. It was reported that in some instances this led to the same levels of questioning and challenge at both meetings.

A review of the attendance records demonstrated that there is good attendance at the Board and Exec Co. The attendance at the other (sub) committees is more variable with some members not meeting the standard of 75% of meetings in a calendar year. An example of this is the Healthcare Quality Assurance Committee (HQAC), where in April 2012 one of the committee members noted in the minutes that they were disappointed in the attendance levels at this meeting. However a review of attendance at subsequent meetings shows that this has improved.

2.3.2 Changes to the Trust's directorate structure

The Trust restructured its directorates in October 2011 (an overview is shown in Figure 4), moving to four directorates (emergency care, planned care, acute care and clinical support services), each led by a clinical director who is a practising consultant, supported by a general manager.

Figure 4: The Trust's directorate structure (source: Annual Report 2011/12)



Rationale for the directorate restructuring

According to the Forward Plan Strategy Document for 2012-13, the restructuring was driven by the Trust's approach to ensuring effective clinical leadership and adequate management processes and structures over the next three years. As part of the objective "Continue to ensure that clinical leadership drives strategic priorities and key programmes of work"[21], the risk identified was that "Each programme of work requires clinical leadership and ownership on a strategic and operational level to ensure successful delivery". The mitigating actions were to:

[21] Forward Plan Strategy Document for 2012-13, Mid Staffordshire NHS Foundation Trust, p. 12.

- Implement divisional reconfiguration to ensure that the organisational structure is resilient and as part of this reconfiguration, create clinical director and specialty lead posts;
- Strengthen organisational resilience (as part of the restructuring) by the appointment of associate directors; and
- Put in place lead clinicians for each strategic programme of work within the Trust.

The general consensus amongst those interviewed was that reconfiguration of the directorates was necessary to produce a viable management structure.

Impact of the directorate structure

It appears that there are robust arrangements in place to manage each directorate. Typically, within each directorate, there is a governance meeting in which the agenda is tied to the Trust's five key priority themes (e.g. creating a culture of caring[22]). In some cases, each specialty area has a governance meeting which reports into the directorate-level governance meeting. The directorate-level meeting in turn feeds into the executive committee (Exec Co).

However in three out of the four directorates, concerns were expressed in relation to ongoing management of the directorate structure. These can be summarised as:

- For clinical directors, where they have been unable to satisfactorily appoint leads for their specialties, or where they have had to remove themselves from clinical duties for an extended period to concentrate on "shopfloor" problems, there has been an increasing strain on their capacity to balance their clinical and managerial roles;
- Although a leadership training programme has been developed for clinical directors and general managers, most senior directorate managers observed that training has tended to be mostly "on the job" and has led to some senior staff feeling under pressure due to lack of relevant experience and / or training;
- In some directorates there is a belief that senior management staffing is light and that a review of staff is required to rebalance this;
- Staff capability to support and drive a structure in which most governance is undertaken at individual specialty level. The majority of issues could and should be dealt with at that level, with both the minutes and more complex issues being taken to the directorate-level governance meeting. This would enable the directorate team to concentrate on more difficult issues whilst

[22] The strategic objectives in support of delivering the Trust vision are: (i) deliver the highest quality care through a culture of caring; (ii) zero harm is always our target to keep patients safe; (iii) improve patient experience by listening, responding and acting on what our patients and community are telling us; (iv) support our staff to become excellent: giving responsibility but holding to account as well; and (v) achieve financial stability and satisfying our regulators.

still receiving assurance that other issues are being managed accordingly. However, currently one directorate cannot organise the governance meetings and synthesise the relevant data due to issues with capability;

- There are issues with getting the right level of data to support governance. Although there seems to be a big improvement on previous years, and the Trust is now able to report on a number of useful areas, this does not provide directorates with all the information that they need to make informed decisions; and
- Governance arrangements need to be formalised with University Hospital of North Staffordshire NHS Trust (UHNS) and The Royal Wolverhampton NHS Trust with regard to visiting consultants. Although issues are currently managed by the directorates, they are not always formally addressed / discussed with the host trust.

The Trust recognises that additional work is required to further embed the new directorate structure, in particular in ensuring that there is sufficient capacity and capability at the middle management level.

2.3.3 Creation of a PMO

The other main structural change is the establishment of a programme management office (PMO). The PMO was identified[23] by the Trust as one of the key actions for delivering its strategy. The PMO is responsible for driving the transformation programme identified in the Trust's operating plan. The PMO was established in January 2011 and was initially resourced using staff from a professional services firm; by December 2011 the PMO was resourced using Trust substantive employees.

One of the other key areas of focus for the PMO has been to support the delivery of the cost improvement programme (CIP). It has established CIP workstreams and a robust governance process which has individual workstream steering groups coordinating and overseeing the agreed projects. To support this, the PMO has set up a workbook which collates all of the necessary workstream information: project plans, milestones, financial savings and forecasts, risks, quality impact assessments and stakeholder assessments. These workbooks are used by the workstream groups to track progress and delivery. The robust establishment of this programme by the PMO has resulted in the Trust forecasting a CIP delivery of £10.2m in 2012/13, which is just short of its £10.4m target. This is in addition to the Trust achieving its first year of CIPs (in 2011/12) of £6.4m.

The vast majority of staff members interviewed were positive about the impact of the PMO and reported that it was a key enabler for delivery. The success of the PMO has seen its role expand. For example it has played a role in the weekly 18-week performance meetings to provide support and challenge to the process and

[23] Operating Plan 2011/12 – 2015/16, Mid Staffordshire Foundation Trust, June 10, 2011, p. 8.

alignment with the Demand and Capacity CIP workstream. The Director of Human Resources reported that the workforce projects designed to deliver the sickness absence reductions are being passed on to the PMO to develop the supporting governance arrangements to monitor and track delivery.

The PMO is a good example of where there is alignment between the Trust's structure and its strategy. For example, the core function of the PMO is to deliver the Trust's transformation strategy and the work programme has been aligned to that. The PMO has the appropriate levels of capability and resources needed to deliver the work programme and underpinning this are the PMO's processes, governance and infrastructure. These have all been aligned to work together and as a result the PMO's programmes of work are being delivered.

2.4 People enablers

Sections 2.2 and 2.3 have demonstrated that the Trust has delivered new structures in response to their agreed strategy. This section describes the organisational enablers that support the Trust's staff to deliver and is in two parts: firstly, whether the organisational development plan gets the best out of the Trust's resources and secondly, whether or not there are enough resources to deliver.

2.4.1 Organisational development

In January 2012 the Trust Board approved the organisation development strategy and is implementing this to provide clarity on roles, responsibilities and performance expectations[24]. Creating a climate of high performance requires "identifying the tasks and responsibilities for which staff should be accountable, designing leadership roles within teams, developing a time-line for taking on new roles, and providing the information, training, and resources needed for staff to be successful"[25].

Training and development

The Francis Report in 2010 noted that appraisal and professional development were accorded a low priority at the Trust, as indicated by the staff survey. It also stated that there was evidence that staff were not supported by a robust appraisal system and that continuous professional development was sporadic[26].

The Trust has made a sustained effort to deliver against its appraisal and mandatory training requirements. For the year to date (September 2012) it has achieved 85.5% against the completed appraisal target of 90%, and 85.6%

[24] Organisation Development Strategy (draft presented to Board on 2nd October 2012), Mid Staffordshire Foundation Trust, p. 4.
[25] Organisation Development Strategy (draft presented to Board on 2nd October 2012), Mid Staffordshire Foundation Trust, p. 4.
[26] Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009 24 Feb 2010, p. 26. Recommendation 4 was that the "Trust, in conjunction with the Royal Colleges, the Deanery and the nursing school at Staffordshire University, should review its training programmes for all staff to ensure that high-quality professional training and development is provided at all levels and that high-quality service is recognised and valued".

completion of mandatory training against a target of 90%; this has been an improvement on previous years. Directorates are now provided with the details of their individual performance against these targets, which is monitored through each directorate's performance review meeting. Directorates are supported by the Trust to develop plans to achieve the target. The Trust is focusing efforts on the necessary actions to achieve the targets this financial year and is on track to deliver against the 90% goals.

One of the Trust's levers for delivering the training target is to make training more accessible for staff. Previously the Trust relied on face-to-face training as the sole delivery method, which was one of the contributing factors to the Trust missing its training rate target. The new OD programme identifies the introduction of e-learning as a priority to provide a blended training opportunity for staff.

At the FIOP committee meeting in November 2012 there was debate over the proposed increase in the target next year to 95%. Concerns were raised that this would lead to "chasing the target" rather than a focus on the quality of the appraisal itself, and that it would therefore be more appropriate to have additional quality-focused measures to support the existing 90% target, rather than an increase of the target itself. The robust debate and challenge presented at the meeting demonstrates the cultural change that has occurred within the organisation.

Middle management development

All four of the clinical directors referred to the leadership training that they are continuing to attend as part of their development programme. Three of the four general managers also cited the manager development programme. It was also noted that over the past few years there have been different management programmes as different HR managers have been in post. The general consensus was that directorate-level training (including that for clinical directors) was supported by the Trust and that the executive is willing to ensure investment in, and access to, learning and development. Specific training, for example on risk management, was also mentioned positively several times.

Capability development

The Trust's own appraisal against the Board Governance Assurance Framework (BGAF) assessed the balance and calibre of board members as amber / green. Areas of good practice identified by the Trust against capability included[27]:

- The majority of Board members have previously held Board-level positions;
- The Board has assessed the balance of skills, experience and knowledge as part of its Board evaluation and it is appropriate;

[27] Mid Staffordshire NHS Foundation Trust Self Assessment Board Governance Assurance Framework, 3 December 2012, p. 4.

- In selecting Board members, consideration was given to the various qualities essential to be effective in their Board role; and
- The Board has a good blend of non-executive directors (NEDs) from public, private and voluntary sectors.

The results of this self-assessment are supported by an evaluation facilitated by an external organisation, which covered all hard and soft dimensions of effectiveness. This review stated that Board members are regarded as accessible, open and transparent (by external stakeholders) and as open, approachable, visible and willing to listen (by internal stakeholders)[28].

This was reiterated in the interviews carried out by the CPT, which showed a consistent view that the Board is a high performing team. This consistency is shown in executive and non-executive backing for other members of the senior leadership team and the uniform backing for the Board expressed by staff in the directorates. This is reinforced by the fact that the NEDs provide an appropriate level of challenge to the executive team, which is supported by the new committee structure and appropriate data.

These findings on capability are strengthened by the evidence collected for the assessment of financial sustainability. This exercise demonstrated that the Trust has strong financial leadership and is gaining stability in the finance team which is helping instil quality reporting, forecasting and proactive planning. These improvements in processes, particularly in tracking, reporting and challenging of CIPs have led to the Trust forecasting an achievement of 6% cost efficiencies in FY13. Similarly, as part of the clinical sustainability work, internal performance measures have shown improved performance. In general recent external reports have suggested that there have been substantial clinical performance improvements, with the most recent Care Quality Commission (CQC) review identifying no areas of concern.

There remain some areas of capability development for the Trust at its senior levels. The BGAF noted that a relatively high proportion of the Board has only been recently appointed: only five of 13 positions have been held for longer than two years and the majority (seven of 13) are new to the organisation (i.e. within their first 18 months)[29]. In addition to this, the previous board evaluation stated that external stakeholders remarked that there is "a significant lack of strategic leadership from the Board"[30]. The Board has recognised this and held a workshop in May 2012 focused on strategic leadership.

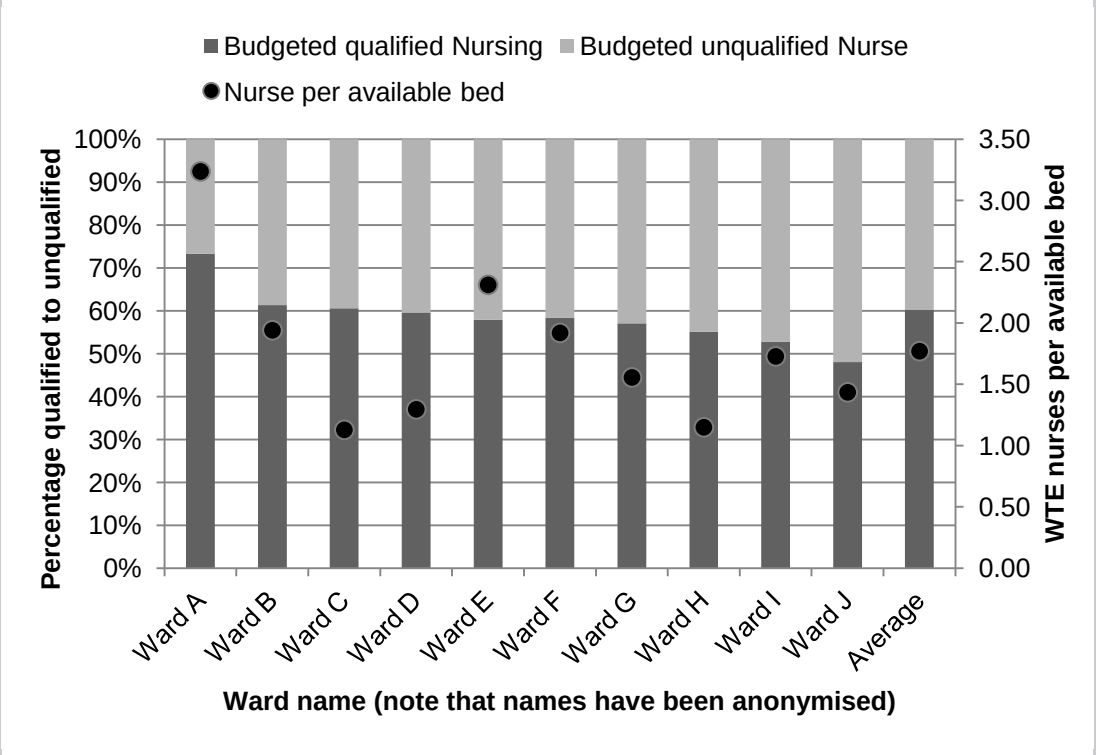
[28] Board development at Mid Staffordshire NHS Foundation Trust – Outcomes of Board coaching the NHS Institute for Innovation and Improvement, Summary report, May 2012.
[29] Mid Staffordshire NHS Foundation Trust Self Assessment Board Governance Assurance Framework, 3 December 2012, pp. 3-4.
[30] Board development at Mid Staffordshire NHS Foundation Trust – Outcomes of Board coaching the NHS Institute for Innovation and Improvement, Summary report, May 2012, p. 3.

2.4.2 Resources

Staffing levels

Based on figures provided in the annual reports and quality accounts for 2009/10 to 2011/12, the number of staff increased from 2,303 whole time equivalents (WTEs) in March 2009 to an average of 2,725 WTEs in March 2012 (an 18% increase). The Trust's historical income and expenditure accounts show that pay expenditure increased from £107m in FY11 to £111m in FY12 and the FY13 plan is to bring this down to £108m. The biggest pay spend area is for nursing, which accounted for 34% of the pay budget in FY12. Further analysis of the Trust's nursing staff levels shows the main wards are on average running at a 60:40 qualified to unqualified ratio. Although this is slightly less than the 65:35 average stated in the Royal College of Nursing's (RCN) guidelines[31], the Trust's skills mix is higher than its peers (see below). The number of nurses per available bed varies between wards based on acuity (see Figure 5): on average, on the main wards, there are 1.77 WTE nurses per available bed. This is higher than the RCN stated average of 1.4 WTE nurse per available bed. The makeup of the workforce for any ward should, to some extent, reflect the type of patients on that ward and their care needs. For example, the care needs of patients on a neurosurgical ward are very different from those on a rehabilitation ward. Since the mix of wards in any trusts will be different, this has to be taken into account when comparing the makeup of the workforce across trusts[32].

Figure 5: Nurses per available bed (source: M6 MSFT I&E budgets)



[31] Guidance on safe nurse staffing levels in the UK, Royal College of Nursing, 2010, p. 20.
[32] Ward staffing, Healthcare Commission, June 2005, p. 13.

An additional point raised in two directorates was the potential to further reduce the established posts. One directorate stated that this would be difficult to achieve next year because the relatively straightforward reductions had been made as part of this year's CIP. Another directorate stated that, despite the recognised and substantial gains in patient outcomes, there were ongoing plans to reduce workforce size in a key part of that directorate. The management of CIPs relating to staff reductions is described below.

Skills mix

In reviewing the skills mix across the Trust the staff group, which has a richer skills mix when compared to its peers, is nursing. Table 5 indicates that the Trust employs more Band 6 than Band 5 nurses compared to its peers. This richer skills mix is responsible for the higher than average pay spend in this area.

Table 5: Trust nurse skills mix (source: IView comparison of 20 similar sized trusts. October 2012)

	B4	B5	B6	B7	B8a	B8b
Mid Staffordshire FT		53%	32%	12%	3%	
Average (peer)	1%	62%	23%	13%	2%	1%
Top Quartile (peer)	1%	59%	24%	14%	1%	1%
Bottom Quartile (peer)	1%	63%	22%	12%	1%	1%

The rebalancing of the Trust's nursing skills mix is the subject of one of its CIPs. The documentation for this CIP recognises that any such rebalancing needs to be done on a sustainable basis, and this is reflected in the risk attached to this CIP. There are substantial internal checks to ensure any changes are clinically appropriate, for example clinical lead sign-off (where required) and ongoing monitoring of key quality metrics[33].

Capacity for change

Due to the scale of the change needed and the capacity of change resources, it has meant that the Trust has had to focus its efforts on particular areas. For example it is evident that in 2012/13 the focus has been on the delivery of 18 week referral to treatment (RTT) targets and embedding new structures, at the expense of other targets such as sickness absence.

The executive team recognises that this has been an issue and confirmed that the focus in previous months had been on delivery of 18 weeks. Now that performance on 18 weeks is coming under control, attention can be turned to managing other areas where performance is off track e.g. sickness absence.

[33] Project Initiation Document (PID) for Nursing Productivity/SABA (13th April 2012), section on CIP2 Risks.

2.5 Systems and processes

The Trust's systems and processes were reviewed to assess how aligned they are to its strategy, structures and people. The CPT's review focused on three areas: risk, performance, and the physical infrastructure.

2.5.1 The Trust's risk management process

Directorate risk management arrangements

The Trust has made many improvements to its risk management process. The current risk register is held electronically and is supported by a paper-based system for the identification of risks. The risk management process is sustained by a policy described by the Trust's Head of Risk Management as "well understood and used" by staff which was supported by the people interviewed. Risks are managed by directorates and any rated over 15 are reported to Exec Co, which provides the necessary checks and challenge to the directorates. Directorates have a standing item for risks at their governance meetings, which the Director of Quality and Patient Experience attends on a rotational basis. The Healthcare, Quality and Assurance committee (HQAC) is the formal forum responsible for the oversight of risk and governance. HQAC reports to the board and will refer items on to other committees as needed; it also has commissioner involvement from one of the local clinical commissioning groups (CCG).

Directorates have each implemented their own processes for developing their risk registers, with most devolving the detailed discussion of risks to a specialty- or department-level. The directorates have clear processes for managing the end-to-end process of putting risks onto a register, ensuring that mitigating actions are implemented and gaining agreement to close down a risk when appropriate. This process benefits from centralised risk management leads who are assigned to directorates. More than one clinical director mentioned that the risk management workshops held by an external company to develop the risk management framework within the Trust have been helpful.

In some areas, however, more work needs to be done to ensure that the ability to manage risks is truly sustainable. At the highest level, one clinical director felt that substantial progress was still required to define a directorate-level process to continuously manage risks, principally due to a lack of capacity within the specialty teams.

Process for capital allocation

The majority of directorates reported issues around the way the risk register is used in the capital allocation process. Two general managers noted that the capital allocation process is based on a prioritisation system that depends on the level of risk each directorate associates with its capital needs. In some cases, this has led to risk registers containing items that are more related to providing an input into the capital allocation process rather than understanding and mitigating the operational risks faced by a directorate. A review of the risk register submitted for

the September 2012 NHS Litigation Authority (NHSLA) assessment showed that 52 out of the 220 risks were related to equipment replacement.

This has two implications: firstly, that risk registers are being loaded with entries that potentially would not be there if a robust capital allocation process was in place. Secondly, the capital allocation process may not treat each directorate's requirements in the same way.

The Trust has recognised the issues surrounding capital planning and allocation and is implementing a Capital Investment Group (CIG) to oversee the process (this group was formed in October 2012). The CIG will be responsible for delivering a more transparent process for capital allocation which is not entirely dependent on risk ratings. It will report directly into the FIOP committee to bring this in line with the rest of the Trust's governance structure.

2.5.2 Performance management

Directorate performance review meetings

Each directorate has a monthly performance review meeting where the relevant performance and quality indicators are presented. The directorate performance review meetings are the primary vehicle for the leadership of the Trust to challenge the directorates on delivery and agree remedial action plans where appropriate.

The March 2012 board report expressed concern about the robustness of quarterly performance review meetings, through which progress of delivery in year is monitored. It was noted at the time by the Chief Executive that although the meetings were in their infancy, clinical directors would be required to attend them to present key areas of their directorate's performance. However, based on the CPT's interviews, three of the four clinical directors cannot regularly attend the performance review meetings. To fit the Trust's management team availability, the performance review meetings are all held on the same day for the directorates, and clinical directors cannot attend due to both difficulties in getting diaries synchronised and their clinical commitments.

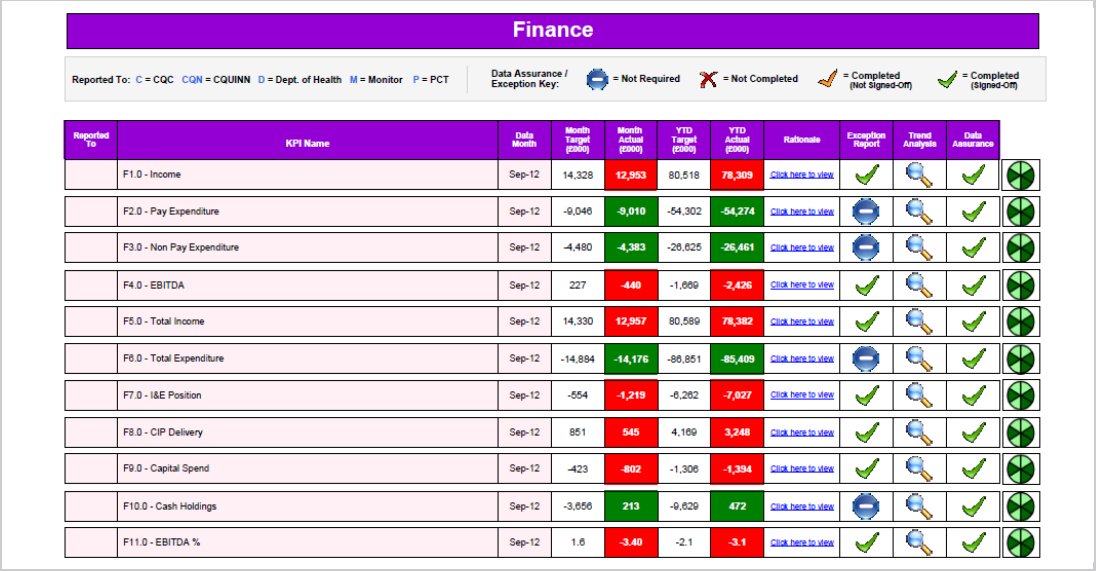
All of the directorates gave a positive account of the impact of this process since its introduction in the previous 12 months. However, if the clinical directors continue to struggle to attend these meetings, the issue of how they are held to account for their directorate's performance remains open.

Integrated performance dashboards

The Trust has implemented an integrated performance dashboard (an example is shown in Figure 6). The dashboard details performance against the relevant national and locally agreed indicators and is split into four sections: quality, performance, workforce and finance. As well as describing performance, the dashboard identifies where the data has been assured and signed off by the relevant owners. Each indicator has a "kitemark" which shows whether the data

are assured and signed off by the directorate. This provides greater assurance to the board on performance.

Figure 6: Example MSFT Integrated Performance Report (source: MSFT)



Finance

Reported To: C = CQC CQN = CQUINN D = Dept. of Health M = Monitor P = PCT

Data Assurance / Exception Key: = Not Required = Not Completed = Completed (Not Signed-Off) = Completed (Signed-Off)

Reported To	KPI Name	Data Month	Month Target (£000)	Month Actual (£000)	YTD Target (£000)	YTD Actual (£000)	Rationale	Exception Report	Trend Analysis	Data Assurance
	F1.0 - Income	Sep-12	14,328	12,953	80,518	78,309	Click here to view	✓		✓
	F2.0 - Pay Expenditure	Sep-12	-9,046	-9,010	-54,302	-54,274	Click here to view			✓
	F3.0 - Non Pay Expenditure	Sep-12	-4,480	-4,383	-26,625	-26,461	Click here to view			✓
	F4.0 - EBITDA	Sep-12	227	-440	-1,669	-2,426	Click here to view	✓		✓
	F5.0 - Total Income	Sep-12	14,330	12,957	80,589	78,382	Click here to view	✓		✓
	F6.0 - Total Expenditure	Sep-12	-14,884	-14,176	-86,851	-85,409	Click here to view			✓
	F7.0 - I&E Position	Sep-12	-554	-1,219	-6,262	-7,027	Click here to view	✓		✓
	F8.0 - CIP Delivery	Sep-12	851	545	4,169	3,248	Click here to view	✓		✓
	F9.0 - Capital Spend	Sep-12	-423	-802	-1,306	-1,394	Click here to view	✓		✓
	F10.0 - Cash Holdings	Sep-12	-3,656	213	-9,629	472	Click here to view			✓
	F11.0 - EBITDA %	Sep-12	1.6	-3.40	-2.1	-3.1	Click here to view	✓		✓

The indicators which make up the performance dashboard are relevant to the Trust in executing its strategy. For example, the performance report tracks performance against appraisals and mandatory training, which both support the delivery of the strategic objective of supporting staff.

The consistent use of this dashboard by the Trust ensures the appropriate people are held to account for the same measures and staff see the impact that performance has on other areas, e.g. on finance, which supports the delivery of the Trust's strategy. This was confirmed by the general managers and clinical directors who all reported that they were held to account on the performance targets in the integrated performance dashboard.

Data quality assurance

One of the issues highlighted to the CPT was data quality. This year there has been significant investment in IM&T to develop the systems and processes to provide assurance on data quality. To support the organisation, a data quality steering group has recently been established by the Trust. Chaired by the medical lead for data in the Trust, this group has the responsibility for defining and overseeing the rolling programme of data assurance.

Whilst the Trust has focused efforts on data quality assurance, it recognises that there is still more work to do in this area. The Board receives reports on data quality issues in relation to its performance indicators. This is evidenced by the BGAF self-assessment which identified a red flag for this area. Where there are data quality issues as reported through the kitemarks on the integrated performance dashboard, an exception report is required to support this which

details the data quality issues and what is needed to address them. These are overseen by the data quality steering group.

Whilst the Board recognises that there are still data quality issues within the Trust, it has identified the necessary actions to identify these issues (kitemarks) and the process for resolving them (the data quality steering group).

Process for managing 18 week RTT performance targets

The Trust has recently made significant progress in achieving its 18-week referral to treatment (RTT) performance targets through undertaking both waiting list initiatives and diverting referrals so that the backlog could be dealt with. For the first time this year, the Trust has met its in-month targets for 18-weeks (for October 2012). During 2011/12 the Trust had 301 52-week breaches, compared to none in 2012/13 year to date (November 2012).

To achieve this improved performance, substantial work was undertaken in 2011 to ensure that the Trust had the correct data to understand its RTT pipeline. The business intelligence system (a System C data warehouse populated overnight from the electronic patient record (EPR) systems) now provides more "richness" to the data. For example, previously patients not meeting the 18 week RTT target were merely flagged on a list; this has been improved so that for each patient it is possible to drill down to the pathway to see what they have had done and what they are waiting for. This enables managers to manage treatment more effectively.

The Trust also worked with commissioners to manage the external demand during this time and in some areas referrals were diverted to other providers. Whilst this has had a positive effect on the delivery of the operational targets, it has had an adverse impact on the income position of the Trust. In the year to October 2012 the Trust was behind plan on activity, which has resulted in the Trust being £1.8m behind plan on income. The Trust has recognised this and plans to target GPs whose referral patterns have changed (as discussed at the November FIOP meeting).

In order to deliver the improved performance, the 18 week RTT target currently has its own performance management meeting and is not undertaken within the Planned Care directorate's main performance meeting. This system was implemented due to the size of the issue being confronted. The initial focus of this meeting has been on matching capacity to demand and managing the demand by diverting referrals. This has had the desired effect and the Trust is shifting the focus on the actions needed to sustain the performance against the 18-week target. This will be done by developing specialty-level dashboards which show current performance by consultants on: new to follow up ratio, 'did not attend' (DNA) rates and session utilisation. These dashboards will be tracked through fortnightly meetings with directorates which will replace the weekly meetings established earlier in 2012. Going forward the performance against the 18-week target will be managed as "business as usual" through the directorate performance review meetings, and through the demand and capacity CIP workstream.

2.5.3 Physical capacity

The Trust provides services from two sites, Stafford and Cannock, with the majority of acute services being provided at Stafford.

Cannock has nine available wards, of which only three are used: two wards run by the Trust and a ward run in collaboration with local Community Trust (Staffordshire and Stoke-on-Trent Partnership NHS Trust) as a step-up facility. The CPT's review of space utilisation at Cannock shows the following occupancy: 43% MSFT, 37% third party and 20% not utilised. Most of the third party utilisation is taken up with short term leases.

At Stafford there are fifteen ward-based areas, including Paediatrics and Maternity. One of these wards remains empty and is currently being used as a decant to facilitate general improvements to the others.

Figures 7 and 8 show that bed utilisation has increased in the period 2010/11 to 2011/12 and that the Trust's utilisation of its available beds is high compared to peers (57 other trusts nationally who submit TFR returns). The figures also show that in 2011/12 the Trust had an average of 156 admissions per available bed (highlighted in yellow), compared to a peer average of 132. This was driven in part by a low mean length of stay (3.7 days) compared to the peer average (4.17). This indicates that the Trust is utilising its bed capacity well compared to the 57 other trusts in the peer group.

Figure 7: 2010/11 MSFT available bed utilisation compared to its peers (57 other trusts nationally who submit TFR returns). (source: HES 2010/11, ERIC returns)

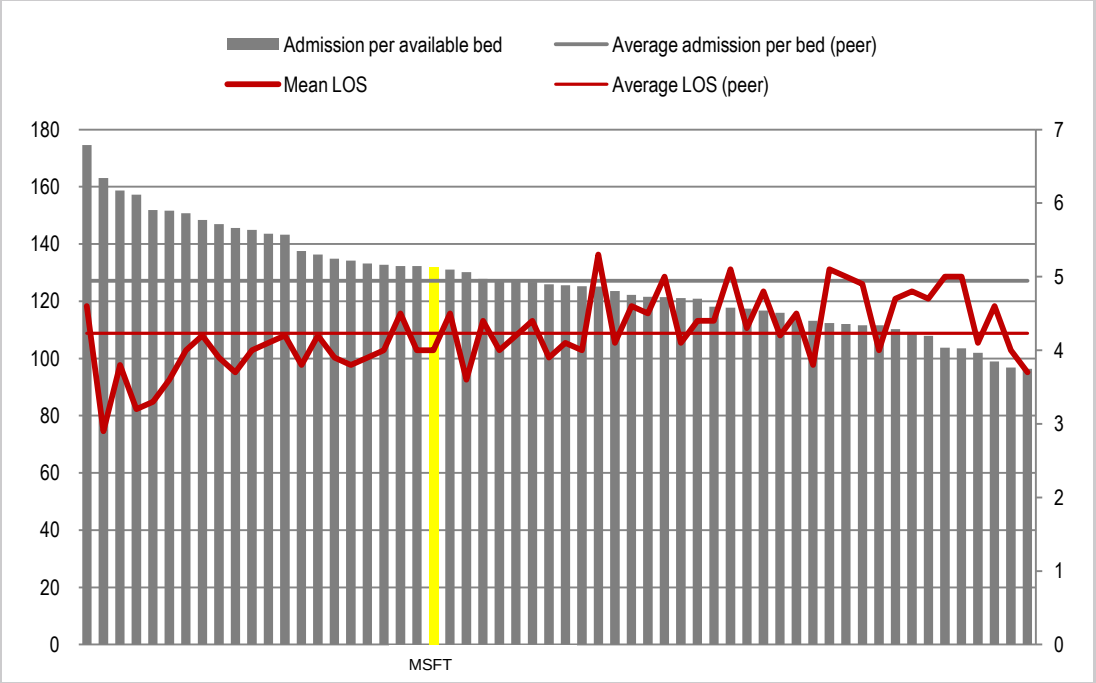
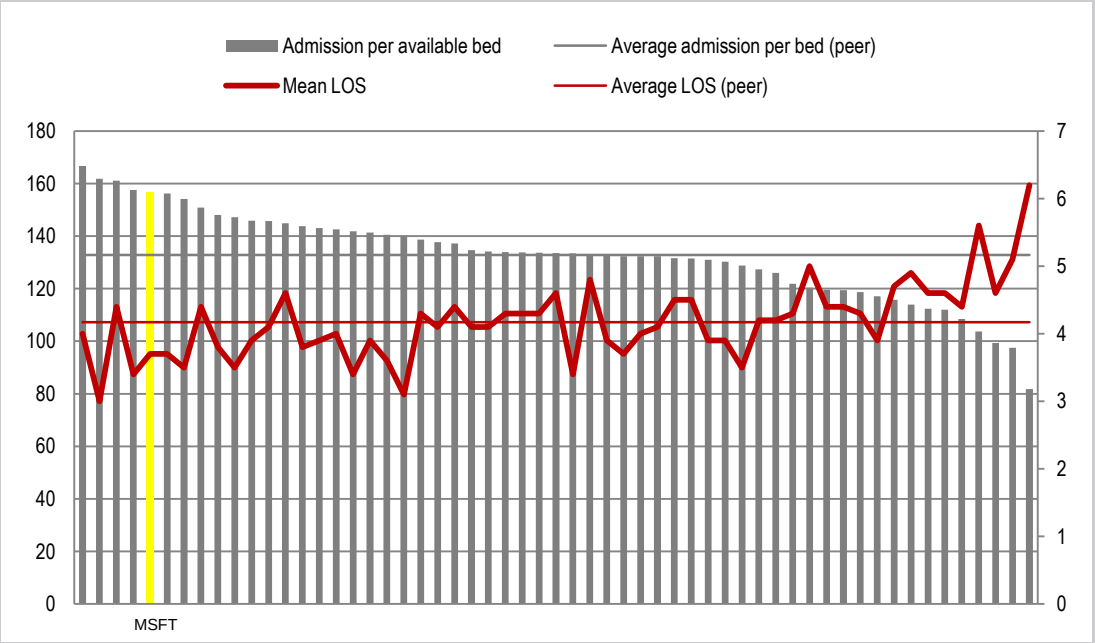


Figure 8: 2011/12 MSFT available bed utilisation compared to its peers (57 other trusts nationally who submit TFR returns). (source: HES 2011/12, ERIC returns)



There are seven theatres in use at Stafford and five at Cannock. Table 6 shows the current utilisation rate by specialty.

Table 6: Current theatre utilisation rate (source: Trust data 22 Oct – 4 Nov 2012)

Specialty	Utilisation
General Surgery / Vascular	97%
Breast	95%
Colorectal	93%
ENT	92%
Upper GI	91%
Ortho	78%
Gynaecology	76%
Urology	74%
Oral	68%

The main surgical specialties have a utilisation rate of over 90%, however the specialist surgical specialties have a lower utilisation rate. This indicates that the systems in place to govern the use of theatres support the delivery of appropriate utilisation rates (as seen for the main surgical specialties). These systems could be used to improve the utilisation in the other specialties, assuming that there is

sufficient demand. If there is insufficient demand in these specialties then there is a small amount of capacity which could be used to either repatriate activity back from Cannock or from other providers.

The usage of the theatres at Cannock is low. For the period 8 Oct 2012 – 4 Nov 2012 there were 160 available half-day sessions for the four theatres used for orthopaedics (data was not available for theatre 5). Only 96 (60%) of these sessions were used indicating a significant amount of unused capacity. The utilisation for the 96 sessions was 85%, compared to the target of 90% demonstrating some additional capacity available even within the sessions that were being used.

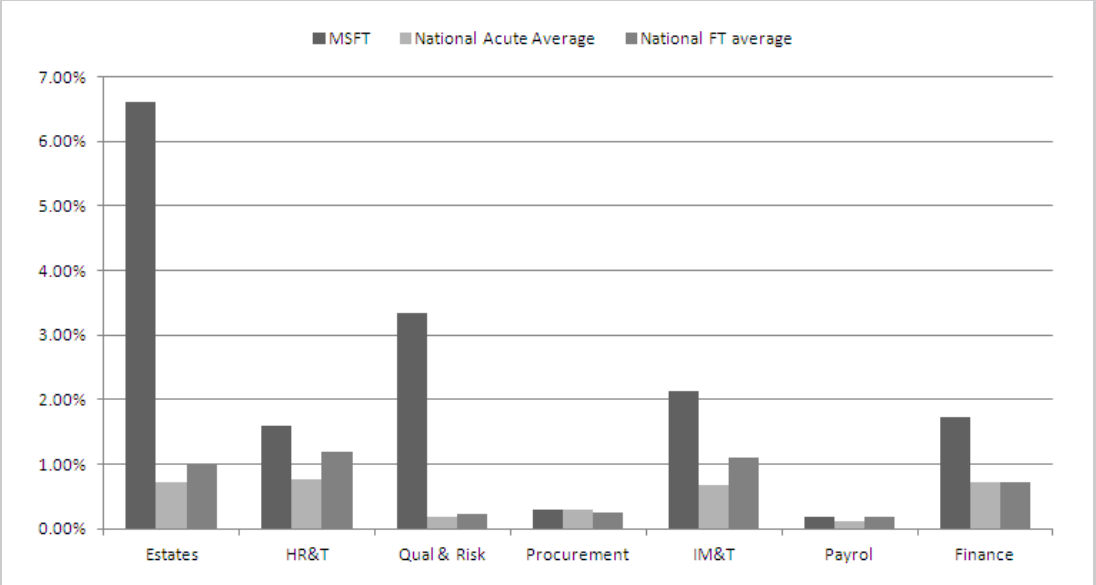
The Theatre utilisation rates at Cannock would suggest that either: there is insufficient demand compared to the capacity available or sessions are cancelled due to poor management. There were no reports given of sessions being cancelled due to poor management which would suggest the issue for Cannock is insufficient demand. This view is supported by the underperformance against plan for activity within orthopaedics which is reported in the December Finance report at the Board.

2.5.4 Back office costs

Whilst the developments in systems and processes previously presented have been necessary to deliver the observed improvements in the Trust's patient outcomes, they have come at a cost. Figure 9 shows the comparative spend on infrastructure as a percentage of turnover, comparing the Trust to the national average for both NHS Trusts and Foundation Trusts.

In all areas (except procurement and payroll) the Trust has a higher spend as a percentage of turnover when compared to national averages.

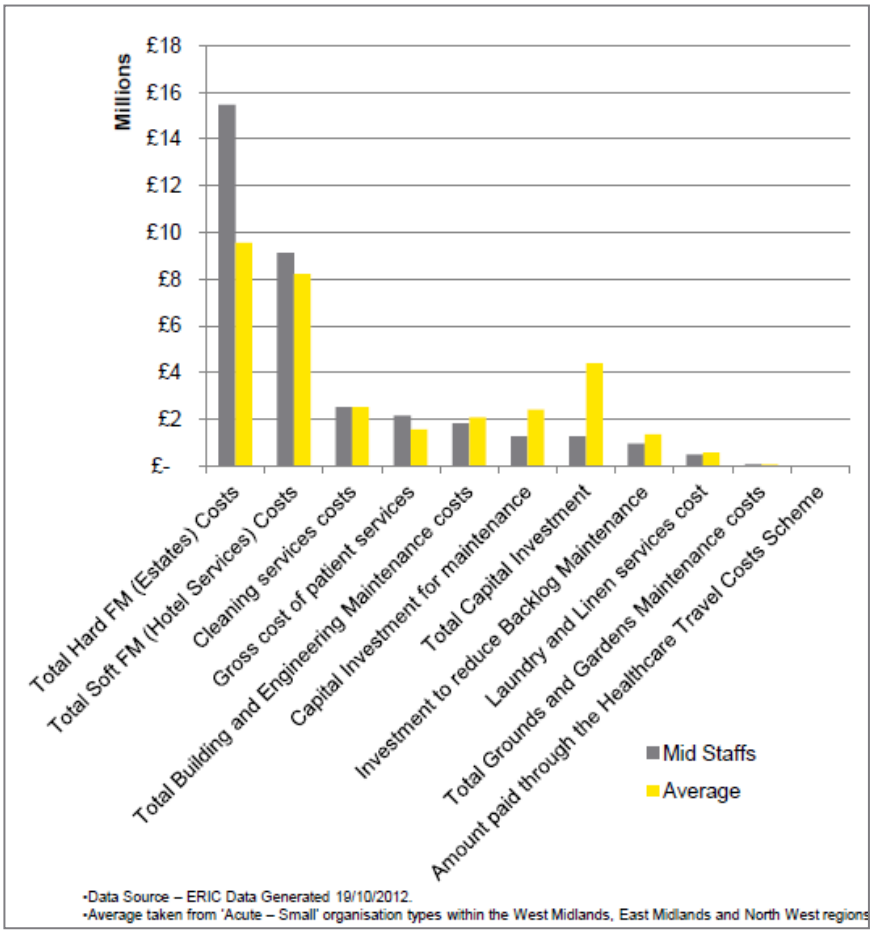
Figure 9: Comparative spend as a percentage of turnover (source: QIPP Back office efficiency paper, MSFT M6 I&E accounts)



These findings for HR&T, Quality and Risk, and IM&T are consistent with areas of additional investment highlighted in this report. For example to deliver the revised risk management process investment was needed in systems and training. The higher than average costs for Estates are driven by two factors:

- The Trust having to operate two sites, with the utilisation of sessions at Cannock being as low as 60% for the 4 orthopaedic theatres, as discussed in section 2.5.3; and
- Higher than average costs (as shown in Figure 10).

Figure 10: Comparison of estate costs from ERIC returns



2.6 Impact of the new structure and enablers on operational performance

The evidence presented in sections 2.2 to 2.5 shows that the Trust has made significant changes to how it operates. Whilst there is still more work to do in embedding these changes, i.e. sustaining 18 weeks, there is clear evidence to show how the organisation has developed in recent years. This section explores what the impact has been on operational performance in the context of how well the new structures, systems and processes are working.

2.6.1 Effectiveness of governance

The Trust undertook an exercise to assess its governance against the BGAF framework. The BGAF was developed by the Department of Health to assist boards through a combination of self and independent assessment processes to ensure that they are appropriately skilled, and prepared to achieve Foundation Trust (FT) authorisation[34]. Against each section of the BGAF, the assessment showed a series of 'red flags' which suggest poor Board governance on a particular activity. The CPT used the Trust's self-assessment against the BGAF (including these 'red flags') as a proxy measure for the Trust's operational sustainability in relation to its governance (see Table 7).

Table 7: The Trust's summary BGAF assessment (source: MSFT)

Summary Results

Ref	Area	Rating	Red Flags	Good Practice non compliance
	1. Board composition and commitment			
1.1	Board positions and size	Amber/Green	1	1
1.2	Balance and calibre of Board members	Amber/Green	1	1
1.3	Board member commitment	Green	0	0
	2. Board evaluation, development and learning			
2.1	Effective Board-level evaluation	Green	0	0
2.2	Whole Board development programme	Green	0	0
2.3	Board induction, succession and contingency planning	Amber/Green	1	2
2.4	Board member appraisal and personal development	Green	0	0
	3. Board insight and foresight			
3.1	Board performance reporting	Amber/Green	1	1
3.2	Efficiency and Productivity	Amber/Green	0	1
3.3	Environmental and strategic focus	Amber/Green	0	1
3.4	Quality of Board papers and timeliness of information	Amber/Green	1	2
	4. Board engagement and involvement			
4.1	External stakeholders	Amber/Green	1	0
4.2	Internal stakeholders	Amber/Red	2	0
4.3	Board profile and visibility	Green	0	0
4.4	Future engagement with FT Governors	Green	0	0

The Trust's assessment identified eight red flags out of a possible forty-seven:

1. There has been a high turnover in Board membership during the last two years with only five out of thirteen positions being held for longer than two years;

2. The majority of Board members (seven of thirteen) are new to the organisation (i.e. within their first 18 months);

3. The deputy chair and deputy chief executive officer (CEO) have not been formally designated and noted in the Board minutes;

[34] *Board Governance Assurance Framework for Aspirant Foundation Trusts*, London: Department of Health, 15 December 2011.

4. There were significant unplanned financial variances in performance during 2011/12;

5. The Board receives assurance regarding data quality against all performance metrics. However, there are issues reported regarding the data quality supporting some of the metrics;

6. The Trust has received adverse negative publicity in relation to the services it has provided within the last 12 months;

7. The Trust's latest staff survey results were poor, despite the significant improvements made. In the past there has been a poor return rate to the survey; and

8. There are a few cases of unresolved staff issues of significance, not at Board level but involving those in senior positions within the Trust. That said, the Trust has demonstrated productive relationships with staff side / trade union representatives with formal mechanisms through the Joint Negotiation and Consultative Committee (JNCC).

For the red flags the Trust has identified the actions needed to address these areas. The Trust has therefore rated itself as green or amber / green in all areas except one: managing internal stakeholders, which has been rated as amber / red.

The self assessment provides assurance of the board governance arrangements in place within the Trust and the assessment is consistent with the evidence collected through the CPT review. This demonstrates that in the main the new board and committee structure has been a success.

2.6.2 Effectiveness of staff engagement

The May 2012 Board Development summary report stated that the communication from the Board / senior management to staff is described by internal stakeholders as poor, with staff feeling insufficiently informed about events and development[35]. The 2011 staff survey showed that the Trust is in the bottom 20% of trusts nationally in terms of overall staff engagement[36].

There is evidence of clinical engagement activities within the Trust's committees; however this is largely restricted to the clinical directors, who are invited to Exec Co and the FIOP. They are also invited, individually, to Board workshops on a quarterly basis. Attendance by the clinical directors at these meetings is variable. One clinical director attended Exec Co just three times in an 11 month period, and on two of these occasions only attended for part of the meeting. Conversely another clinical director only missed one Exec Co in the same time period.

Outside of the Board and committees, there is some limited evidence of clinical engagement in other areas. There is a nominated clinician responsible for data and

[35] Board Development at Mid Staffordshire. Outcomes of Board Coaching by the NHS Institute for Innovation and Improvement. 2012, p4.

[36] 2011 National NHS staff survey; Brief summary of results from Mid Staffordshire NHS Foundation Trust. 2011 p4.

information who provides some line management for the current head of IM&T. This clinician helped develop the IM&T strategy and consulted on this with the wider body of clinicians.

Whilst the new structures have been successfully implemented the Trust still has further work to do in engaging its staff with the changes. This is recognised by the Trust and forms part of the organisational development programme.

2.6.3 Ability to recruit to post

All four directorates reported issues with staffing, split between issues around the level of staffing establishment being too low in specific areas (e.g. in directorate senior management teams) and the inability to recruit to existing establishment levels. This difficulty in recruitment was recognised as having a consequent impact on the use of locum staff and of bank / agency.

At the consultant grade, almost one in five consultant posts (18.8%) are not filled by substantive staff: 11.2% are filled by locums, temporary staff or staff 'acting up' and 7.6% of posts are vacant (see Section 3 – Clinical Sustainability - for further information). The executive acknowledges that this is due to a mix of factors, including the fact that some strong candidates have a preference for working in either teaching hospitals or tertiary centres rather than a traditional district general hospital (DGH); that there is a national shortage of candidates in some specialties (e.g. accident and emergency (A&E); and that the reputation of the Trust can still have a negative effect on prospective employees. There are also a number of vacancies at middle grade; the Trust aims to use a clinical staffing group to look at new models for roles, especially in its use of nurses and therapists.

At a more operational level, roles identified in the new structure are still not being filled in some areas. Within the new structure each directorate has a clinical director and each specialty in the directorate has a nominated clinical lead. However there are specialties where there is no clinical lead in place due to a lack of either interest or available resources. Whilst the Trust has made efforts to solve this, with the current vacancy rate it is unlikely to be resolved in the short-term as additional capacity will not be forthcoming. This will have an impact on the ability of directorates to deliver their governance structures without a lead clinician role. Two clinical directors reported that they were unable to complete all of their clinical director-related tasks due to taking on some lead clinician duties. Moreover, three of the four directorates reported insufficient clinical attendance at directorate-level meetings, due to clinical commitments.

Whilst the new structures are designed to deliver the appropriate level of governance and operational delivery, the current vacancy rate is holding back the implementation and delivery in some areas. The vacancy rate in some areas is largely due to external factors.

2.6.4 Assessment of operational performance

One of the most important criteria to assess the impact of the changes is the Trust's performance against key indicators. Table 8 shows how well performance has changed against a select group of indicators.

Table 8: Selected indicators of Trust performance (source: CEO update report Nov 2012)

Indicator	Performance in 2011/12	YTD October 2012
Quality indicators		
Mixed sex breaches	635	1 incident of 8 breaches
Quality governance score	21	3
MRSA	2	0
Operational targets		
18 week referral to treatment	301 >52 week breaches 13,528 incompletes	0 >52 week breaches 8,813 incompletes 18-week RTT target achieved Trust-wide in October 2012
Diagnostics (target is 99% of patients seen within 6 weeks)	82%	97%
Cancer breaches	2 week wait from GP referral not met	All cancer-related targets met
People		
Posts	100 unfunded posts	All posts funded
Consultant appraisal rates	36%	90%

These improved outcomes suggest that the Trust is in a strong position to meet its short-term corporate objectives, although the Trust recognises that there are some significant areas where further work is required (principally in meeting its financial objectives sustainably).

2.7 Summary on the Trust's operational sustainability

The Trust has made significant progress in establishing its operational sustainability by implementing both strategic and tactical change over the past 18 to 24 months. These improvements have been driven by greater alignment between the Trust's strategy, its organisational design and enabling functions. Examples include (but are not limited to):

- The engagement of clinical staff in the management of the hospital (e.g. through appointment of clinical directorates to head each of the Trust's four directorates);
- The development, implementation and embedding of the risk management process which is well used and understood by staff;
- Focused improvements of performance management through the implementation of specialty level performance meetings supported by an integrated performance dashboard;
- An established Project Management Office (PMO) which provides the necessary governance, infrastructure and support to the transformation programme; and
- A stable executive team and Board which have demonstrated the capability to drive sustained change.

The strategic and tactical changes the Trust has made have had a direct impact on both quality and performance. These improvements are demonstrated by:

- The Care Quality Commission (CQC) reviews showing an improved standard of clinical quality at the Trust, going from 11 areas of concern in 2010 to none in 2012. All other hospitals in the region have had minor CQC concerns at some point during the same period;
- The Trust is meeting its A&E waiting times target in Q2 FY13;
- The Trust is sustaining Hospital Standardised Mortality Rates (HSMR) of less than 100;
- Mixed sex breaches have declined from 635 (2011/12) to one incident of eight breaches in the year to date (November 2012); and
- The Trust's 18-week target improved, moving from 301 above 52-week breaches and 13,528 incompletes (2011/12) to zero above 52-week breaches and 8,813 incompletes, with 18 weeks achieved Trust-wide in October 2012.

Whilst the Trust continues to make significant progress, there is some further work required to fully embed operational improvements to ensure the changes are

sustainable and continue to deliver improved performance outcomes; examples include (but are not limited to):

- The committee structure has been developed and is, in the main, functioning well. Further work is needed to remove the duplication between some of the committees and to establish a more responsive referral process between committees;
- 18-week performance has been achieved over the past two months; one of the drivers of this has been the implementation of weekly performance meetings. The Trust must focus on the actions needed to sustain this performance so it can be managed as "business as normal"; and
- Specialty-level governance meetings are not happening in all directorates due to resourcing issues.

Through investment and focus in a number of areas (e.g. staffing and operational/clinical services), the Trust's performance level has improved markedly over the past 18 to 24 months and across a range of quality and safety indicators. As mentioned above, the challenge now is for the Trust to ensure that it fully embeds the changes it has made.

Taking the above factors into account the CPT concluded that if a plan could be identified to deliver long term financial and clinical sustainability, then the Trust's operating model is fit for purpose. To that extent, the CPT concluded that MSFT is operationally sustainable.

3. Clinical sustainability

The clinical sustainability review primarily looked at the viability of services for the longer term, i.e. three to five years. It should be noted that the CPT is not a clinical peer review team and therefore has used existing, accepted guidance and reports in order to conduct the clinical assessment.

3.1 Approach

The CPT conducted four different activities to form a perspective on the clinical sustainability of MSFT:

1. Reviewed key documents and external reviews to assess current clinical performance;
2. Gathered evidence and opinions through interviews with senior clinical staff within the Trust;
3. Compared performance against external standards set by the Royal Colleges, NECPOD and others;
4. Explored the clinical workforce situation, focusing particularly on the ability of services to attract and retain staff.

3.2 Background

Multiple clinical reviews have taken place at the Trust since concerns about the clinical standard of care were raised in a 2009 Healthcare Commission report that revealed a higher than expected number of deaths at Stafford Hospital.

- In March 2009, the HCC published its investigation into emergency admissions and the apparently high mortality rates at MSFT. The review was conducted between March and October 2008 by the Healthcare Commission. Its recommendations included:
  - *The A&E department must be adequately staffed and equipped at all times such that it meets the needs of patients and the service is safe*
  - *Improve access/advice from critical care team*
  - *Resource non-elective theatre sessions to reduce delays*

- In April 2009, Professor Sir George Alberti published his report. He reviewed the procedures for emergency admission and treatment at MSFT and reviewed the progress against the recommendations of the HCC report. His recommendations included:
  - *Increase senior cover and training in A&E*
  - *Improve care of elderly, particularly in enhanced networking with community, primary and social sectors*

- *Accelerate towards new ways of working, including networking particularly for emergency surgery*
- *Increase number and training of qualified nurses*

- In October 2009, the Royal College of Surgeons conducted a review on concerns raised about the general surgical service following a series of serious untoward incidents. This review was requested by the trust and included these quotes:
  - *"The service provided by the general surgical unit is inadequate, unsafe and at times frankly dangerous"*
  - *"The general surgical department must not be allowed to continue to operate as it does currently"*
  - *"The general surgical team is probably the most dysfunctional encountered by any member of the review team"*

- In February 2010 Robert Francis QC published his report into the care provided at MSFT. He reviewed the period January 2005 – March 2009 and was tasked to investigate individual cases causing concern at MSFT and consider what action is necessary. His report commented:
  - "The trust should not provide services where it cannot achieve a high-class standard"
  - "The Trust should promote the development of links with other NHS trusts and foundation trusts to enhance its ability to deliver up-to-date and high-class standards of service provision and professional leadership"

- In October 2010 John Wallwork published his report on the future clinical strategy for MSFT. He was tasked to give his view on the optimal clinical structures and configuration of services in the area. His recommendations included:
  - Improve integration with primary care and encourage joint working with paediatrics
  - Agree the model of intermediate care potentially splitting step-up and step-down
  - Agree plan for development of stroke services including development of acute services at Mid Staffs
  - Continue work on gastrointestinal and emergency surgery to develop partnerships
  - Build a single paediatric emergency pathway (as opposed to A&E and Paediatric Assessment Unit)

- Develop sustainable plan for maternity services given the challenge of appropriate level of neonatal care service
- Develop a plan for Cannock which builds on rehabilitation and day-case strengths

In response to this, the clinicians and management at MSFT have taken considerable steps to drive improvements. The Trust has increased the presence of senior staff, both recruiting more senior nurses and increasing the level of consultant delivered care. The Trust is also working closer with neighbouring providers, particularly in certain surgical services, with several services such as vascular surgery now operating as a network across the region. The Trust has also changed internal processes to enable clinicians and managers to better understand their service performance and to help identify any potential problems.

In 2011, MSFT was part of a joint provider and commissioner health-economy wide review of clinical services to inform local commissioning intentions. This involved collaborative work involving over 100 people through five Clinical Working Groups (CWGs), who met to review current service provision, identify what best practice care should look like and set out the implications for MSFT. Most of the CWGs were co-chaired by both a local GP and a consultant from MSFT and included a hospital governor representing the perspectives of patients. Subsequently, these implications were turned into actions which MSFT has started to implement to improve the quality of care it provides.

3.3 General Trends and Emerging Standards

3.3.1 Context

Trends in the development of healthcare across the NHS are leading to increasing concentration of specialist services and localisation of more routine services with movement of care out of the hospital setting

- The population of Staffordshire is facing major changes in its health needs and these are placing ever greater demands on the local NHS. People are living longer, the population as a whole is getting older, and there are more patients with chronic conditions such as heart disease, diabetes and dementia. Providing suitable care to meet these demands will mean providing more proactive services in the community and spending proportionately more on those services in local communities, and less on hospitals.
- There are currently big differences in the quality of care patients receive depending on which hospital they visit and when they visit. There is increasing evidence of the link between quality and scale for some services, e.g. Trauma, Stroke, Heart Attack, Emergency Surgery, Specialist Surgery, High Risk Pregnancies, Acute Paediatrics etc. Furthermore, the lack of more senior staff and availability of specialist equipment at night and weekends has been associated with poorer clinical care. Larger scale

services with high volumes of patients are more likely to have experienced staff available at any time of the day, and are more able to maintain the skills of their staff i.e. staff are more likely to have recently reviewed a patient with a similar condition. Smaller units are less able to provide sufficient staff to cover seven days a week, 16-24 hours a day. The link between outcomes and the time of the week that a patient is admitted to hospital has been well documented by the Royal Colleges during the last year. Recent analysis has shown that people attending and admitted to hospital during evenings, nights or at the weekend are more likely to die than people admitted at times when more senior staff are available (Seven Day Consultant Present Care, Academy of Medical Royal Colleges, December 2012).

- Additionally it is a time of unprecedented economic pressure, which affects the whole economy, not just the NHS. Hospitals will have significant financial challenges even if they become as efficient as they can be. As part of the four year plan to reduce the cost of the NHS by £20bn by 2014/15 the National tariff is reducing in real terms by between 0.5% and 1.5%, leading to an efficiency requirement of 4% every year. In addition, in order to provide better care to meet the needs of the elderly and those with chronic conditions, there is the need to provide increased services within the community setting which also requires reducing spend in hospitals through QIPP initiatives. The demand for health services will continue to grow and, given the economic pressure, the NHS and the local health economy in Staffordshire needs to focus even harder on improving quality, safety, outcomes and experience, whilst also providing care in the most effective way.

There is, therefore, a national case for providing a better quality of care through a hub and spoke model of service delivery with specialist centres providing major acute care while more routine services are performed out of hospital in the community.

There is an inevitable tension between providing access for patients to the best possible care whilst providing care as locally as possible. Many regions within the UK are therefore looking to improve high quality care provision for their local populations by reconfiguring their services to improve local access for routine or non-urgent care whilst concentrating specialist services to improve patient outcomes.

This has already started to happen in Staffordshire with the creation of specialist centres for major trauma, stroke, cardiac and vascular surgery and in the increased management of long term conditions such as diabetes outside of the hospital setting. If the NHS is to provide more consistent high quality hospital care, it needs to ensure that senior doctors and teams are available more often, seven days a week, twenty four hours a day. Achieving this from a workforce perspective in the future will involve consolidating and increasing the scale of services to ensure that not only are there sufficient consultant staff at all times (Hospitals on

the Edge? The Time for Action, Royal College of Physicians, September 2012) but that they are also able to maintain their skills.

3.3.2 Royal Colleges and Other National Clinical Guidance

Royal Colleges and Faculties recommend clinical standards for different specialties. They have a major role in driving developments in their speciality to benefit patients and healthcare more broadly. The Royal Colleges periodically produce evidence-based guidelines and conduct audits to support their fellows and members in improving and scrutinising clinical care.

The CPT has reviewed guidelines for the delivery of high quality clinical services set by Royal Colleges and other national clinical bodies, e.g. NCEPOD (National Confidential Enquiry into Patient Outcome and Death).

These guidelines are reflective of the direction of healthcare evolution and call for a move towards more consultant delivered care on a seven day a week basis and for fourteen to twenty-four hours a day. Over recent years they have articulated both the size of workforce and the scale of catchment populations required to support the delivery of high quality care. Both these measures are an attempt to capture the need to have sufficient senior staff to provide round the clock cover whilst also having sufficient volumes of patients so that each consultant is able to regularly see sufficient specific types of patients to maintain their skill in treating patients.

Small hospitals, such as MSFT, face challenges in meeting guidelines due to having low patient volumes and as a result less ability to support the volumes of senior staff required to maintain a consultant presence twenty four hours a day, seven days a week. This is particularly true for acute specialties where consultant presence is required at short notice any time of the day or week:

- The Royal College of Surgeons released a paper in 2011 called 'Emergency Standards for Unscheduled Care' which stated that an appropriately trained consultant (typically capable of conducting laparoscopic – keyhole – surgery) should be available on site within 30 minutes any day or time and be available immediately by telephone. They also suggested that a consultant surgeon should be present at all operations where there is a greater than 5% risk of mortality.

- In 2010 the Royal College of Emergency Medicine released workforce recommendations that proposed that there should be at least 10 whole time equivalent consultants to support a sixteen hour a day, seven day a week service.

- The Royal College of Paediatrics and Child Health published in 2011, 'Facing the future: A review of Paediatric Services', recommending that all general acute paediatric rotas are made up of at least ten Whole Time Equivalents (WTEs), all of whom are European Working Time Directive

compliant (EWTD). EWTD restricts each WTE to 48 hours per week for service, learning, teaching and research.

- The Royal College of Obstetricians and Gynaecologists published in 2009, 'The Future workforce in Obstetrics and Gynaecology', recommending substantial increases in the level of obstetrician presence for delivery suites setting thresholds for the number of hours of consultant presence required as the volume of births of a unit increased

Other regions are beginning to set aspirational targets to ensure the delivery of high quality care. An example of such targets is shown in Table 9 that outlines the clinical standards that are being set for emergency care across London. The Clinical Advisory Group (CAG), consisting of the medical directors for the local region, recognises these standards and believes that the local Staffordshire population should have access to the best standard of care that people living in other regions of the country receive. The group agreed that continued changes are required to the local health system to enable it to raise the standard of care provided across the region.

Table 9: Adult Commissioning Standards – NHS London extract

Standard	Adapted from source
▶ All emergency admissions to be seen and assessed by a relevant consultant within 12 hours of the decision to admit or within 14 hours of the time of arrival at the hospital.	▶ NCEPOD (2007) Emergency admissions: A journey in the right direction? ▶ RCP (2007) The right person in the right setting – first time ▶ RCS (2011) Emergency Surgery Standards for unscheduled care
▶ All hospitals admitting medical and surgical emergencies to have access to all key diagnostic services in a timely manner 24 hours a day, seven days a week to support clinical decision making: – Critical – imaging and reporting within 1 hour – Urgent – imaging and reporting within 12 hours – All non-urgent – within 24 hours	▶ RCP (2007) The right person in the right setting – first time ▶ RCS (2011) Emergency Surgery Standards for unscheduled care ▶ NICE (2008) Metastatic spinal cord compression
▶ All hospitals admitting medical and surgical emergencies to have access to interventional radiology 24 hours a day, seven days a week: – Critical patients – 1 hour – Non-critical patients – 12 hours	▶ RCS (2011) Emergency Surgery Standards for unscheduled care
▶ All hospitals admitting emergency general surgery patients to have access to a fully staffed emergency theatre immediately available and a consultant on site within 30 minutes at any time of the day or night.	▶ NCEPOD (1997) Who operates when? ·ASGBI (2010) ▶ RCS (2011) Emergency Surgery Standards for unscheduled care
▶ Hospitals admitting emergency patients to have access to comprehensive 24 hour endoscopy services that has a formal consultant rota 24 hours a day, seven days a week.	▶ British Society of Gastroenterology

3.3.3 MSFT Consultant Scale

As it stands, MSFT is unable to meet the relevant Royal College standards for the number of consultants required to deliver twenty four hour, seven days a week cover across a number of services, including A&E, Emergency Surgery and Paediatrics (see Table 10).

Table 10: Consultant 24/7 cover

Specialty	Minimum WTE for sustainable 24/7 rota	Current MSFT WTEs
Paediatrics	8-9	5
A&E	8-10	5 (14/7 service)
Emergency Surgery	8-9	5[2]

Specialty	Minimum Hrs of consultant cover on labour ward	Current Hrs of consultant cover on labour ward
Maternity	Based on local need	40 hrs / week

1 40 hours of consultant cover per week on the labour ward
2 Only one consultant trained in laparoscopic surgery. Includes three locums.
SOURCE: The Medical Royal Colleges

Minimum WTE sources based on running a full rota

- Facing the Future: A review of paediatric services (2011)
- Emergency Medicine Consultants – workforce recommendations (2010)
- The Future Workforce in Obstetrics and Gynaecology (2009)
- Emergency standards for Unscheduled Surgical Care (2011)

It should be noted that this is not an indication of whether the current care is safe. As outlined later in this report, the most recent review of the Trust by the Care Quality Commission did not identify any safety concerns.

The non-compliance with Royal College guidelines for consultant staffing levels is not isolated to MSFT as there are other trusts facing similar pressures and constraints. However this non-compliance cannot be viewed in isolation and must be balanced with the other pressures facing MSFT.

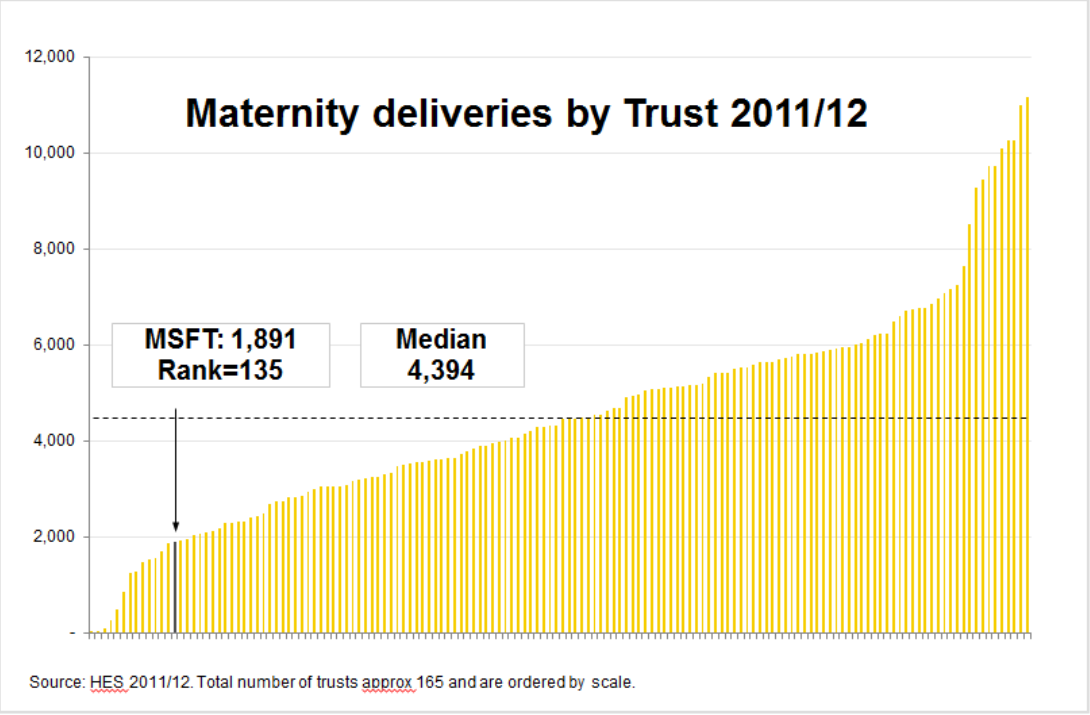
3.3.4 MSFT activity Scale

As might be expected, MSFT is comparatively small when comparing the volume of activity by service with trusts nationally. As a result, even if MSFT were able to attract and recruit enough consultants to meet the guidelines for these services, it would reduce the number of cases that each consultant oversees. In order for clinicians to maintain their skills they need to have adequate exposure to identify and treat specific patient cohorts so increasing staff numbers will enable the delivery of a consultant led service but would result in the deskilling of the consultants if they work only at MSFT.

Comparison of scale across Trusts is not completely transparent as Trusts record activity in different ways and some Trusts have more than one hospital site. However, ordering the Trusts in terms of size can provide an indicative view of the size of a Trust in comparison to other Trusts in the UK (Figures 11-14)

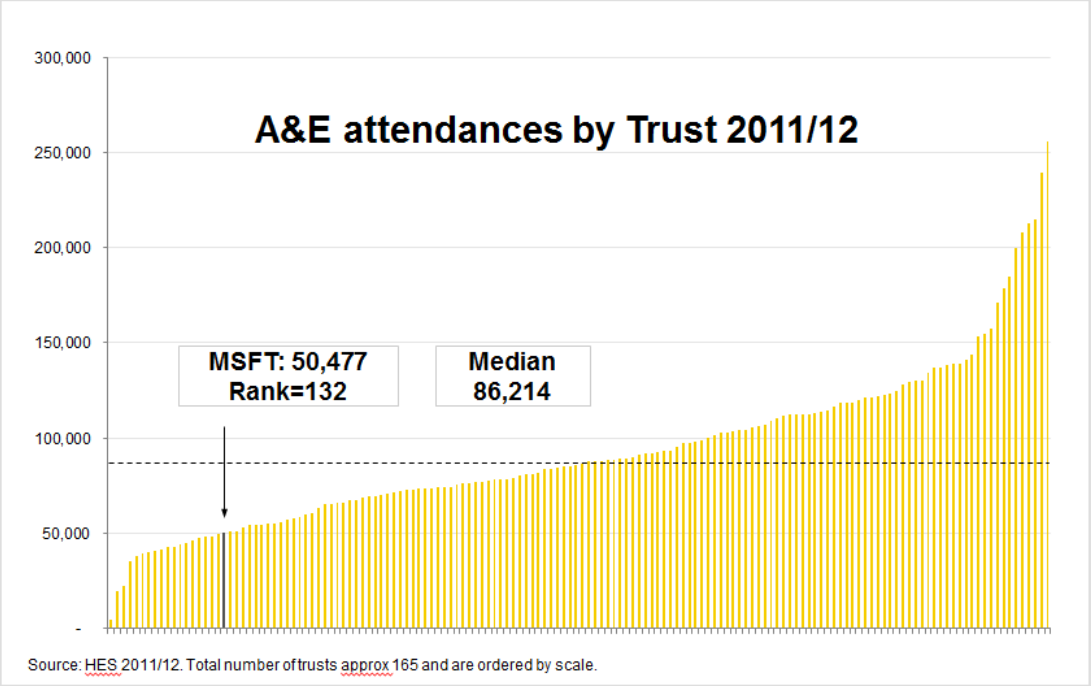
For maternity births numbers, MSFT ranks 135th out of 148 services nationally with 1,891 births compared to a national median of 4,394.

Figure 11: MSFT maternity deliveries compared with rest of England



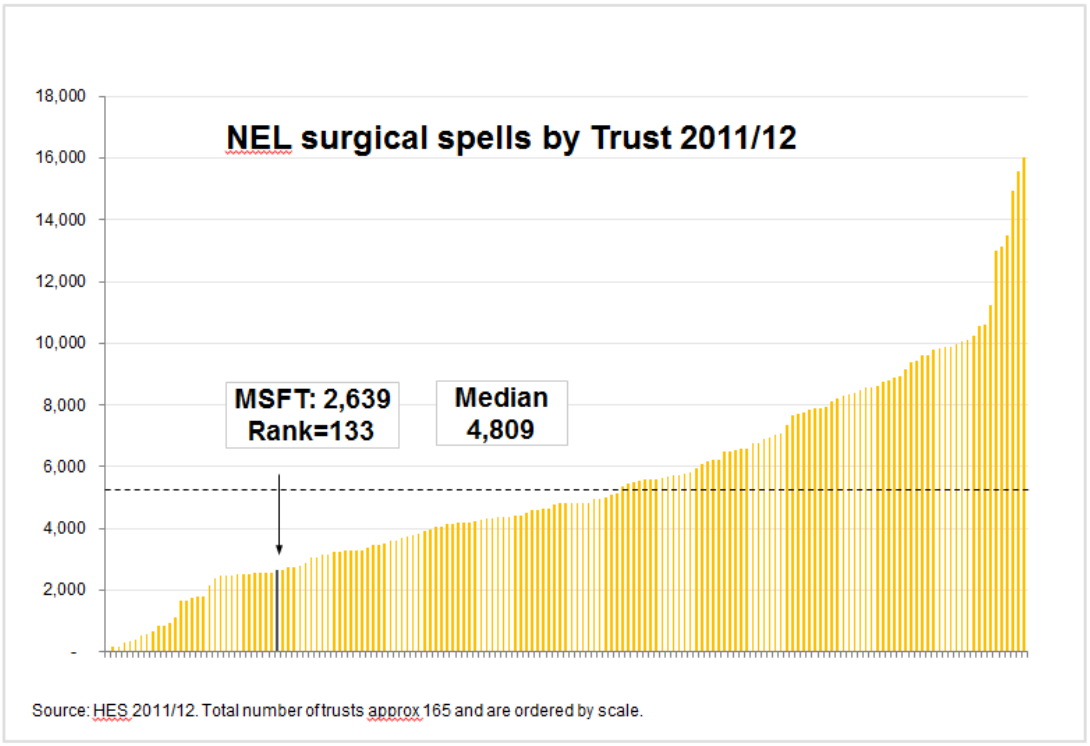
For A&E attendances, MSFT ranks 132nd out of 150 services nationally with 50,477 attendances compared to a national median of 86,214

Figure 12: MSFT A&E attendances compared with rest of England



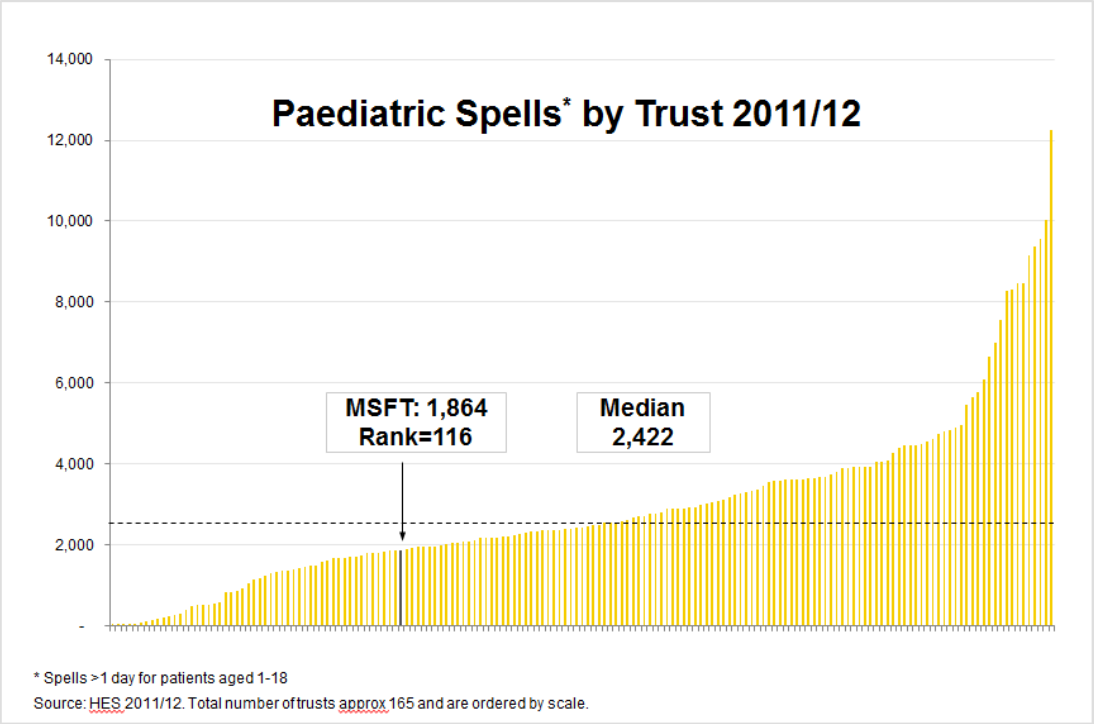
For Non-elective surgical spells, MSFT ranks 133rd out of 163 services nationally with 2,639 spells compared to a national median of 4,809.

Figure 13: MSFT Non-elective surgical spells compared with rest of England



For Paediatric spells over greater than 1 day, MSFT ranks 116th out of 167 services nationally with 1,864 spells compared to a national median of 2,422.

Figure 14: MSFT Paediatric spells compared with rest of England



3.3.5 Staffordshire Catchment Population

The low volume of cases at MSFT is partly a result of the catchment population being small, meaning that attendances of specific patient cohorts are low.

Royal Colleges have in the past quoted indicative catchment populations required to provide sufficient cases to support an acute general hospital that provides the full range of facilities for both elective and emergency medical and surgical care. This has been estimated to be 450,000-500,000 and that the minimum should be 300,000 (this was originally stated in 'Provision of Acute General Hospital Services, Royal College of Surgeons of England, 1998' but has subsequently been quoted in other reports including 'Delivering High Quality Surgical Services for the Future, the Royal College of Surgeons, 2006'). It should be noted that these figures are based on clinical practice requirements for high quality care rather than for any financial rationale.

Staffordshire has a population greater than 300,000, however this population is served by multiple providers. This means that estimating the catchment population for one provider is difficult and has led to contradictory figures.

Staffordshire Public Health Authority recently reviewed the various figures and released a paper to provide clarity on the catchment of MSFT noting the difference between catchment area and catchment population:

"A catchment area is usually different from a catchment population. A catchment area refers to the geographical area from which the clients of a particular hospital or service are drawn from. A catchment population represents the people who would normally attend the hospital if they needed treatment. Not everyone who lives in Stafford, Rugeley or Cannock will go to Mid Staffordshire NHS Foundation Trust (MSFT), for example. Therefore, a catchment population is not simply the total number of people who live in the catchment area.

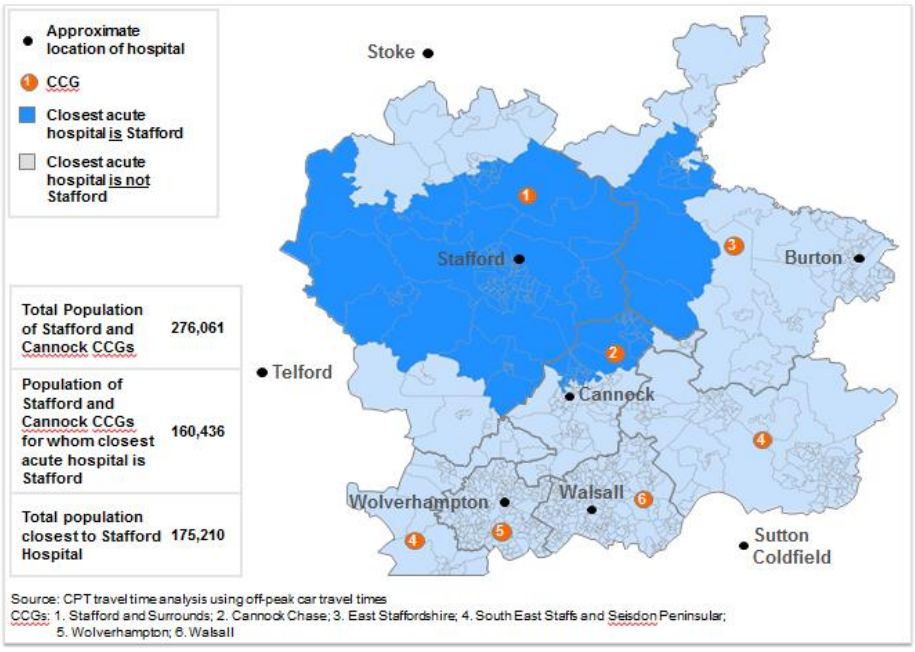
On its website MSFT says that the trust 'provides healthcare for people in Stafford, Cannock, Rugeley and the surrounding areas, serving a local population of over 300,000 people' - this describes the catchment area…

…Based on admissions between 2009/10 and 2011/12 the catchment population is likely to be between 190,500 and 212,400…

…The catchment population should be sufficient to ensure that clinical teams can keep their expertise and skills up to date by receiving a sufficient number of patients in their specialty. Evidence shows that a relationship exists between the volume of procedures and the outcome of treatment. This means that, although some services may be appropriate for continued provision to this catchment population, other services may need to change. Specifically, it may be appropriate to centralise some services at a smaller number of providers in the region."

Staffordshire Public Health Authority's estimate of 190-212,000 is consistent with travel time to the nearest acute hospital in the region. Figure 15 shows the number of patients whose closest acute hospital is Stafford is approximately 175,000 based on travel times by car. This is less than the 276,000 population of Stafford and Cannock CCGs as Cannock is not an acute hospital and much of Cannock CCG is closer to Walsall and Wolverhampton hospitals than Stafford.

Figure 15: Patient proximity to nearest acute hospital



3.4 Review of Current Performance

As a result of the changes made at the Trust over the last two years, in general, internal performance measures and recent external reports have indicated that there have been substantial clinical performance improvements with the most recent CQC review identifying no areas of concern. This reflects the considerable effort that the MSFT clinical teams and the Trust management have made to drive improvements.

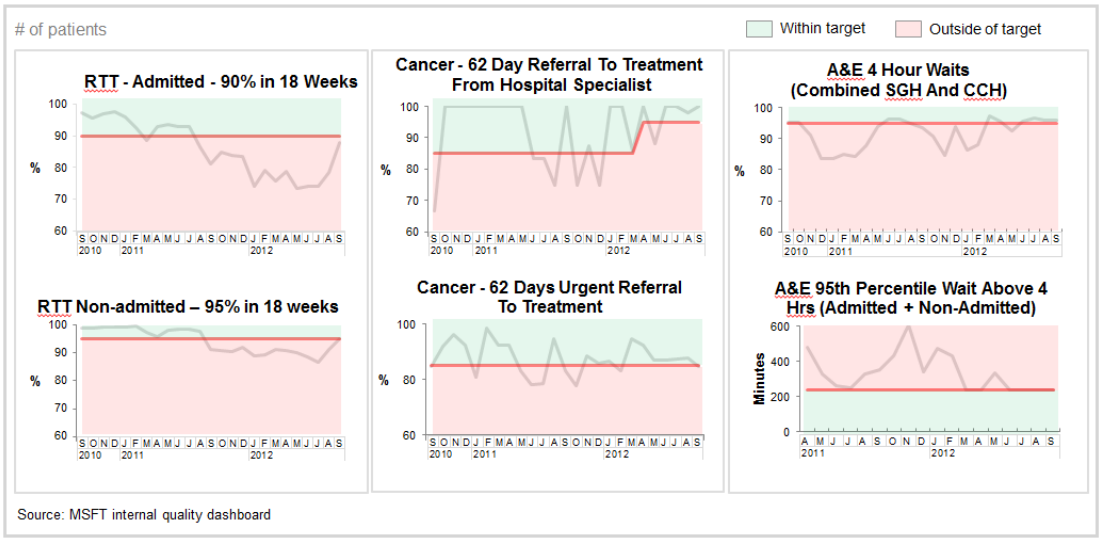
These standard clinical quality measures indicate that the Trust is performing better than peers in some areas and the same or better in most areas. However the CPT does note that there are still some challenges being identified through external service reviews and some areas that were mentioned by clinical leaders as areas of concern.

3.4.1 Delivery of national targets

As part of the review, the CPT studied internally reported dashboard measures (see Figure 16). As in many trusts these covered standard metrics set nationally. A fuller review of these measures is contained in the operational performance review.

In September 2012, national access targets such as the "4 hour A&E wait" and "2 week wait suspected cancer referrals" were being met however there have been challenges over the previous six months, particularly in meeting "18 week wait" targets (although, as noted in Section 2, the Trust did meet the target in September and October 2012).

Figure 16: MSFT Internal performance dashboard extract



3.4.2 Comparison with National and Local Health Economy Performance

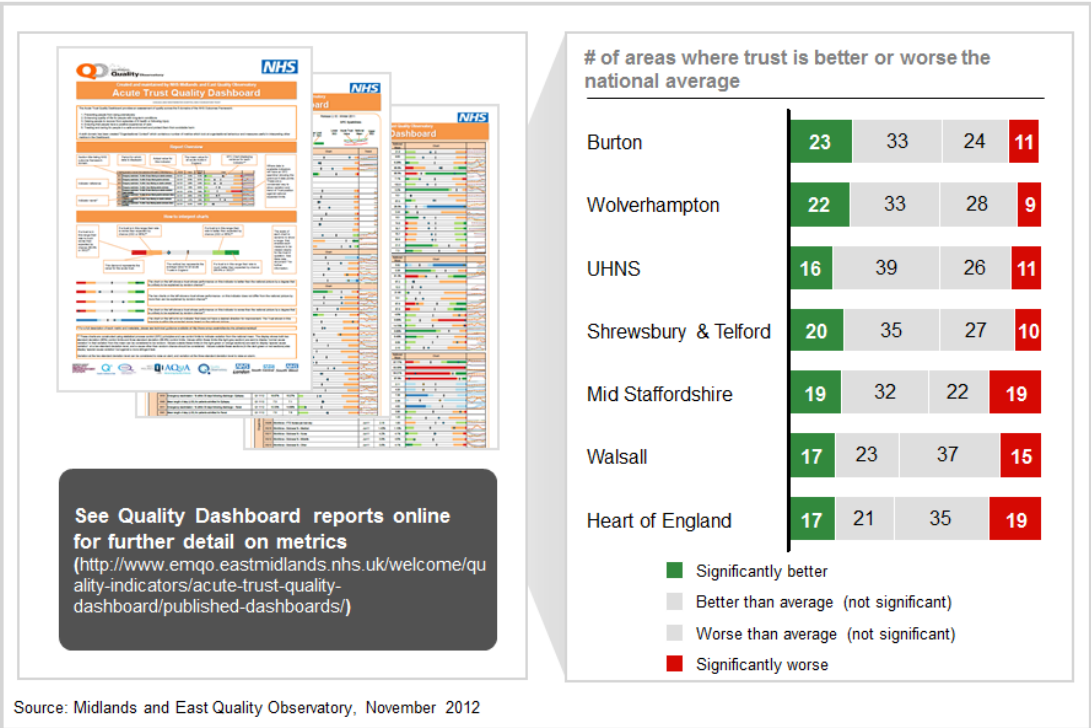
Conducting quality comparisons is notoriously challenging due to the different nature of a given service from one hospital to another. In order to understand the comparative performance of the trusts being compared, the CPT has relied on reports produced nationally by recognised bodies such as the CQC and the Midlands and East Quality Observatory (MEQO), supported by standardised information from companies such as Dr Foster.

Midlands and East Quality Observatory & Dr Foster

The measures contained within the standard reports produced by the MEQO on every secondary care provider within the NHS, showed MSFT to have comparable clinical performance to local neighbours and in line with national averages (see Figure 17). At MSFT, there was no statistically significant variation from the national mean in the majority of measures. Out of 92 measures, 19 were statistically better than the national average and 19 statistically worse.

However it should be noted that there is a natural time lag between the data contained within the reports resulting from the time taken to compile metrics nationally and conduct the analysis. As such any measures only show the position of the Trust around three to six months in the past and it is the view of the clinical leadership that performance has continued to improve within this time period.

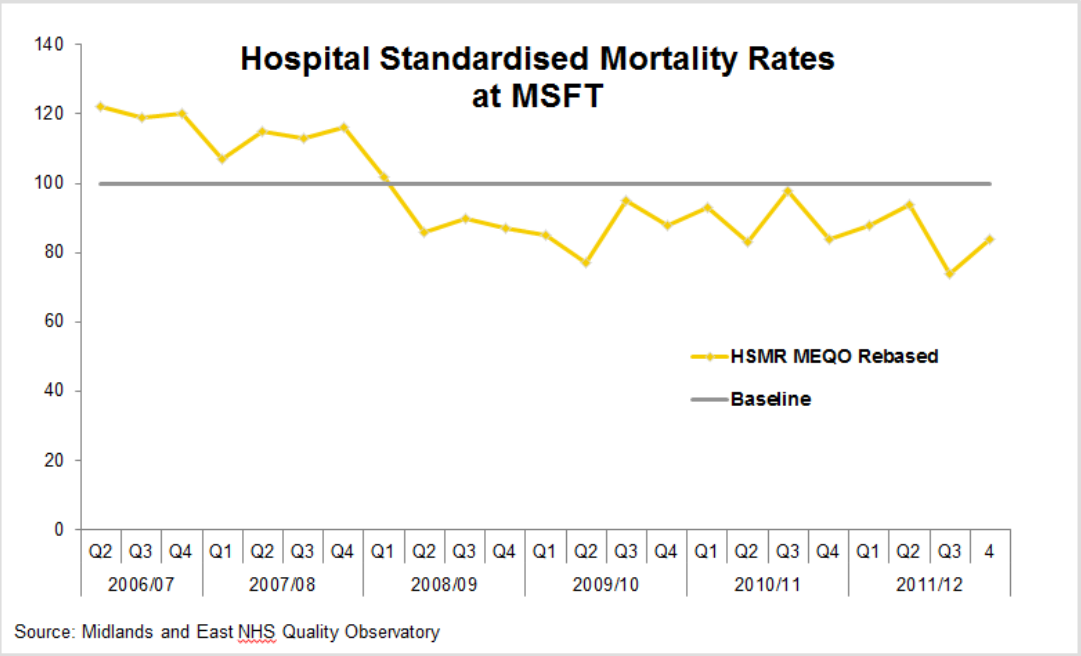
Figure 17: Midlands and East Quality Observatory Summary



Source: Midlands and East Quality Observatory, November 2012

In addition, standardised mortality rates at MSFT have shown considerable improvement over the last 5 years as shown in Figure 18.

Figure 18: HSMR FY08 to FY12



Some areas were identified as statistically worse than average (see Figure 19). These included some access metrics such as '95th percentile wait for elective inpatient treatment that, as noted earlier, have improved since the data in the East Midlands Quality Observatory report.

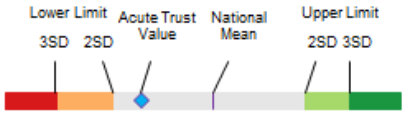
The staff patient survey in 2011 raised some issues that are captured in the quality observatory report. The proportion of staff recommending the Trust as a place of work or recommending the Trust as a place to receive treatment were both low with comparison to the national average. It should be noted though that the 2012 staff survey had not been released at the time of writing this report and since 2011, this may well have improved.

The rate of 'serious harm' patient safety incidents reported during October 2011 to March 2012 and the level of written complaints per thousand episodes reported in 2011/12 were high with respect to the national average. However interpreting these measures can be difficult. They can either be driven by a high level of incidents but equally can also be driven by a higher level of reporting. Given the focus on the Trust over the last two years it is the view of the Trust that this is related to the higher level of reporting which is a positive thing as it means that all issues are raised transparently and can be addressed appropriately. As described in the following section the Trust did not raise any safety concerns in the recent CQC review which would support the Trust's view.

However the Trust recognises that some measures are still issues such as absenteeism and sickness. Midwife sickness was at 7.5% in August 2012 versus a

national average of 4.5% and nursing sickness was at 6.2% versus a national average of 4.2%.

Figure 19: MSFT Quality performance dashboard - East Midlands Quality Observatory



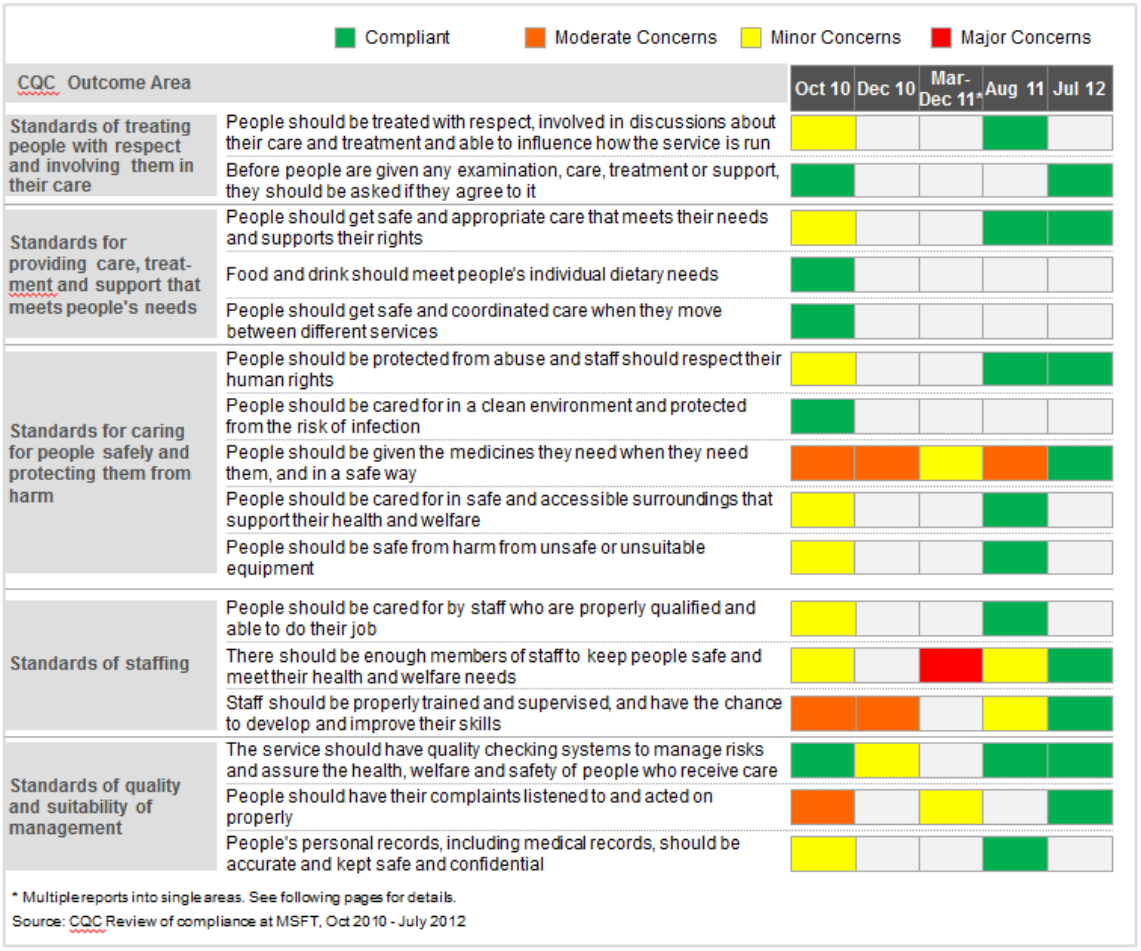
Code	Area	Period	Value	National mean	Chart
EQ04	Ambulatory care sensitive conditions – % of emergency admissions for cellulitis and DVT (based on SQU04_01)	Q1 1213	2.55%	1.61%	
IH23	Patient Reported Outcome Measures – % Patients reporting an improvement following hip replacement (Apr-Dec 11)	1112	78.3%	87.0%	
PE00	95th Percentile wait for elective inpatient treatment (weeks)	Aug-12	30.0	21.0	
PE02	Diagnostic Waits – % of patients waiting over 5 weeks	Q1 1213	9.15%	5.79%	
PE03	Cancer waits – % seen within 14 days of GP referral to first out-patient appointment (HQU14)	Q1 1213	91.4%	95.2%	
PE21	Delayed Transfers of Care per 1,000 occupied beds – NHS Responsibility	Q1 1213	741.4	598.0	
PE22	Delayed Transfers of Care per 1,000 occupied beds – Social Care Responsibility	Q1 1213	739.2	167.3	
PE23	A&E – % of patients admitted, transferred or discharged within 4 hours of arrival	Q1 1213	93.0%	94.0%	
SC02	Rate of "serious harm" patient safety incidents reported in trusts per 100 admissions	Oct-11 – Mar-12	1.66	0.43	
SC12	Emergency readmission – % babies within 30 days following delivery	Q1 1213	11.85%	7.15%	
OQ01	Admitted Patient Care – % valid data (Average for all fields)	Aug-12	97.3%	97.95%	
OQ02	Out Patient – % Valid data (Average for all fields)	Aug-12	93.4%	95.26%	
OQ07	Rate of written complaints per 1,000 episodes	1112	7.13	4.43	
OQ08	NHSLA Claims per 10,000 bed days	1112	4.26	1.91	
OQ10	Workforce – Sickness % – Medical	Aug-12	1.58%	0.94%	
OQ11	Workforce – Sickness % – Nurse	Aug-12	6.2	4.2%	
OQ12	Workforce – Sickness % – Midwife	Aug-12	7.5%	4.5%	
OQ14	Staff recommendation of the trust as a place of work (CQC survey)	2011	35.0%	52.4%	
OQ15	Staff recommendation of the trust as a place to receive treatment (CQC survey)	2011	50.3%	62.8%	

Source: East Midlands Quality Observatory Autumn 2012

3.4.3 Care Quality Commission Reviews

This picture of improvement continues in the improvement in the Care Quality Commission reviews. Despite raising a 'major concern' in 2009, MSFT raised no concerns in the most recent review conducted in June 2012 reinforcing the opinion that there has been substantial change at the Trust (see Figure 20).

Figure 20: CQC Outcomes



3.4.4 Remaining Clinical Challenges

Despite the noted improvements, the Trust is still facing challenges in some services. Since 2009 there have been challenges to clinical performance, highlighted in several reviews – the most recent being the Cancer Network's peer review of breast surgery services conducted in March 2012 which noted:

- "*The MDT remains deeply dysfunctional and the review team is seriously concerned about the effect on patient management and safety. There has been little evidence of progress over the last two years resulting in repeated significantly low compliance against the measures and the review team continues not to be assured of the quality and safety of the service*"

During interviews with the MSFT clinical leaders, several areas are consistently mentioned as areas of concern including emergency surgery, general surgery and paediatrics. The Medical Director and CEO are aware of the challenges in these services.

There is recognition within the Trust, that part of the reason for these remaining clinical challenges – as in many trusts – is a culture among a small number of staff of not accepting external findings:

- "*Two Mid Staffordshire FT surgeons* - within the breast unit - *at the centre of a row about safety concerns have blamed the Trust's management for problems and called for an investigation.*" *HSJ* November 2012.

The Trust appears to be engaging rigorously and appropriately in performance management of medical staff and has assured the CPT of their readiness for clinician appraisals.

3.5 Workforce Sustainability

In addition to looking at quality indicators and standards, the CPT also considered the ability of the Trust to continue to deliver high quality care from a workforce perspective.

It is recognised that within the NHS there are certain services that are experiencing staff shortages nationally such as Radiology and A&E:

- "The NHS and emergency medicine face a "tipping point". With too few trainees entering the specialty to even maintain current workforce levels, many emergency departments will become unsafe", Dr Clifford Mann, registrar at the College of Emergency Medicine. *HSJ* November 2012.

The Trust has successfully recruited into many posts over the last two years and benefits from the support of the medical school in filling some vacancies. It was mentioned anecdotally during interviews, however, that MSFT struggles to attract the best trainees, often being selected low in the list when trainees choose where to work.

MSFT is facing additional challenges to recruiting in some areas partly due to national shortages but in others due to 'reputational impact'.

In order to successfully fill some consultant and midgrade workforce gaps, the Trust is either paying a premium or is forming joint appointment roles with neighbouring trusts. Interviews identified challenges in several services, for example:

- Emergency Medicine has three long term A&E mid-grade locums being paid on hourly rates equivalent to £180k per annum;
- Emergency Surgery service is currently particularly fragile with only five surgeons planned to cover the rota and of these only two are covered by substantive consultants as one post is vacant and two further posts are being covered by locums for staff that are on long term sickness. More importantly for patients, only one of the staff is laparoscopic trained, meaning that some patients may not be benefiting from the faster recovery times and better outcomes associated with the use of this surgical technique. In addition, a surgical alliance review in 2010/2011 recommended that MSFT should no longer provide emergency surgery;
- Dermatology has had long term vacancies due to the uncertainty around the future of the service within the Trust; and
- *"Core staffing is complete but there is a pending retirement in radiology and also a vacancy, with the team unable to describe a clear succession plan. This will potentially make the service unsustainable"*[37].

However, in some areas even networking has proven difficult as networking is reliant on clinical teams integrating and there are strong personality challenges in some specialities which are hindering improvements:

- *"The current MDT lead clinician has only just been appointed by the Trust. During the review meeting it was evident that this was welcomed by the nursing team members but it was clear that the surgeons did not support this appointment. The absence of the support of the surgeons for this leadership role could seriously impede the addressing of the multiple problems faced by this service"*[38].

There is a general sense that the lack of a clear future for the organisation and the recent reputational challenges has made recruitment more difficult. However some people in the organisation believe that networking arrangements (and rotation) with other hospitals can allow staff to maintain their skills and make recruitment easier. Examples of comments made during interviews included:

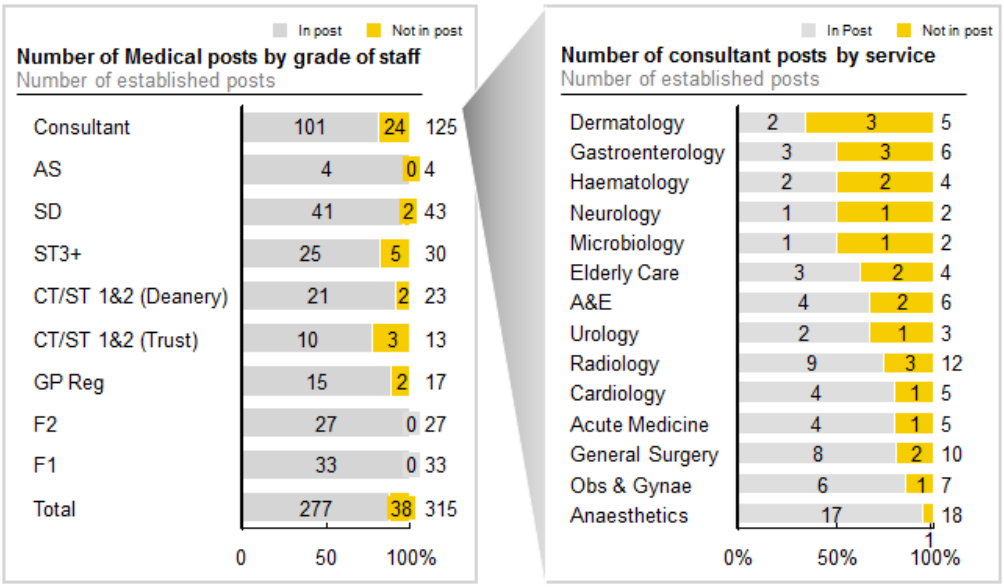
[37] CQUINS Peer Review Visit Report for Mid Staffordshire NHS Foundation Trust - Breast MDT (published: 17th May 2012).
[38] – CQUINS Peer Review Visit Report for Mid Staffordshire NHS Foundation Trust - Breast MDT (published: 17th May 2012).

- *"We have no problem recruiting nurses";*
- *"In order to attract consultants to some roles we need to offer joint posts with other neighbouring trusts"*; and
- *"There are not lots of people that want to come here"*.

At the time of review, almost one in five consultant posts (18.8%) are not filled by substantive staff: 11.2% are filled by locums, temporary staff or staff 'acting up' and 7.6% posts are vacant (see Figure 21). This could potentially lead to lack of continuity of care and over reliance on locums or the over-working of substantive staff.

Since the analysis was conducted the Trust has informed the CPT that four new, substantive consultants have been accepted to fill some of the vacancies.

Figure 21: Analysis of the Trust's consultant posts



3.6 Summary on the Trust's clinical sustainability

The Trust has made substantial clinical improvements to the quality of care as a result of the efforts made by the clinical and managerial teams during the last three years.

Clinical performance has, in general, improved substantially, although the Trust's clinical leaders have ongoing concerns in some areas including breast surgery, general surgery, emergency surgery and paediatrics. This is backed up by Quality Observatory reports.

However, on the basis of the available clinical evidence, the Trust is clinically unsustainable in the long term, especially for emergency care, in light of established national standards. Furthermore:

- The Trust does not currently have the level of staffing required, as recommended by the Royal Colleges and other national bodies, to run a twenty four seven, high quality, consultant delivered service across a number of services including A&E, Emergency surgery and Paediatrics;
- If the Trust was to increase its minimum consultant levels – and ignoring the cost of doing so – it is likely that the number of patients referred to it would be insufficient for consultants in certain specialities to maintain their skills and experience;
- MSFT is relatively small and due to the size of the catchment population (estimated to be 190k to 212k) there is limited opportunity for growth. It is well below the preferred catchment population articulated by the Royal College of Surgeons (450k to 500k) and is in fact below their minimum threshold population (300k);
- Recruiting workforce in some competitive areas is challenging due to national shortages. There is also a general sense that the lack of a clear future for the organisation and the recent reputational challenges has made recruitment more difficult (almost one in five consultant posts are not filled by substantive appointments). As a result, MSFT has had to bring in expensive locum consultants in order to establish the current staffing levels.

4. Financial sustainability

The CPT has set out to determine and agree the current and future clinical and financial challenges facing the Trust. This section focuses on the financial sustainability element of the CPT review.

4.1 Methodology

The financial review focussed on three main areas of financial performance:

- The Trust's ability to generate a surplus;
- The Trust's ability to generate cash; and
- The Trust's ability to pay its debts as they fall due.

The review analysed the historical financial performance and the events that led to the deteriorating financial position using information obtained through interviews with key financial staff and analysis of the Trust's financial systems and reports.

In order to report the underlying cash position of the Trust and confirm its ability to generate cash an assessment of MSFT's cash flows was undertaken to understand the impact of operations and capital expenditure on cash. This is especially in light of the £21m of cash support provided by the Department of Health (DH) in FY12.

The cost base was benchmarked against other NHS Trusts and Foundation Trusts to determine the extent to which the costs incurred compare with other trusts.

In order to assess the future financial sustainability of the Trust the CPT assessed the forecast outturn position for FY13 and modelled the five year forecast based on the findings above and an agreed set of financial assumptions.

To further understand the Trust's sustainability, the CPT has assessed:

- The 2013 cost improvement programme (CIP), processes and forecast;
- The cash and capital plan.

4.2 History of the underlying deficit

Since 2008 MSFT has moved from a surplus financial position to a recurring deficit. Table 11 summarises this transition across the financial periods since achieving FT status in 2008.

Table 11: MSFT's High Level Financials

Currency: £ 000	Pre 2008	FY08	FY09	FY10	FY11*	FY12
Recurrent Income		136,314	144,929	147,402	151,756	152,239
Recurrent Expenditure		(135,430)	(142,914)	(156,650)	(167,468)	(171,659)
Underlying Surplus/(Deficit)		**884**	**2,015**	**(9,248)**	**(15,712)**	**(19,420)**
Non Recurrent Income:	Prior 2 Years in surplus					
SCR		-	-	4,500	6,075	2,433
Other		-	-	-	-	783
Non Recurrent Expenditure		-	-	-	(4,330)	(3,707)
Reported Surplus/(Deficit)		**884**	**2,015**	**(4,748)**	**(13,967)**	**(19,911)**
Cash Balance		3,725	7,575	10,012	1,361	455
Cash Support Received		-	-	-	-	21,000
Trade Payables		12,765	9,102	16,140	18,545	14,711
Trade Receivables		5,568	5,721	7,792	5,680	5,804

* FY11 Reported in year deficit differs by c.£106,000 to MSFT's I&E accounts
Source: Annual report and accounts 09-10, Final Accounts 200708, Annual report accounts 10-11, MSFT annual report & accounts 2011-12

Following two years of surplus prior to authorisation as an FT on the 1st February 2008, MSFT continued to further improve its financial position during FY09 achieving an in year surplus of £2.0m and increasing its accumulated surplus position to £3.9m[39].

The first sign of financial difficulty was apparent in FY10 when the Trust, in response to well documented criticism of the standards of care[40], increased its pay expenditure by £9.1m (9.2%)[41] on additional staff.

Despite the additional non recurrent income provided by the Strategic Change Reserve funding (£4.5m) the Trust reported a financial in year deficit of £4.7m in FY10.

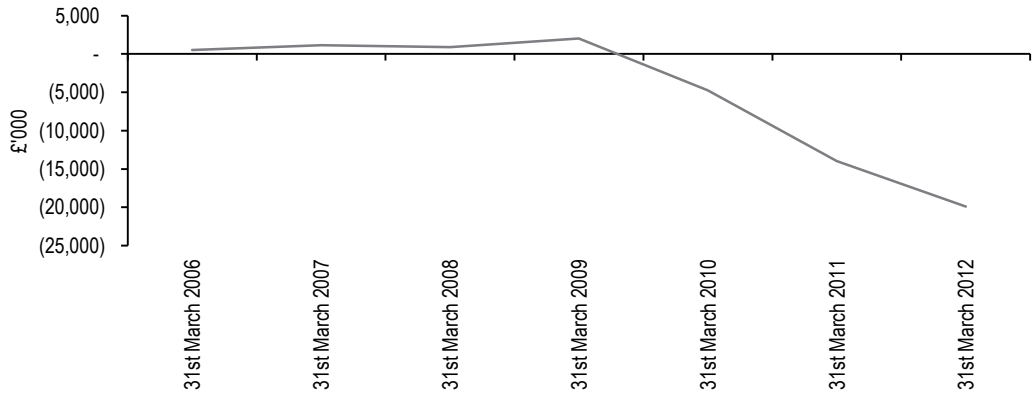
With these significant shifts in expenditure the Trust stated that, "the Trust will operate with a deficit for the foreseeable future as the Trust focuses on delivering both improved clinical quality whilst seeing a value return from any investment"[42].

To this end the Trust set a deficit budget for FY11 based on the realities of ongoing investment requirements linked to implementing the remaining

[39] Restated FY09 I&E Reserve value based on Annual Accounts 2009-10
[40] HCC report – Mar09, Colin Thorne & Alberti reports – Apr09, Robert Francis report – Feb10, Annual Accounts 2009-10
[41] I&E d_load 0910, Trust d_load month 12 10_11
[42] Annual Accounts 2009-10

recommendations from the reports published in 2009. The historic financial position is presented in Figure 22.

Figure 22: MSFT's Surplus/(Deficit) Positions from FY06 to FY12[43]



4.2.1 Causes of the underlying deficit

The CPT analysis identified the key areas of historical expenditure that contributed to the deficit position. It is based on the detailed I&E Trust data (see Table 12 for a summary) which reconcile to the reported financial performance, though the categorisation of income and spend will differ due to the classification specifics within the annual accounts.

Table 12: **Summary of Historical I&E Accounts**[44]

Currency: £ 000	FY10	FY11	FY12
Recurrent Income	147,361	151,875	152,144
Recurrent Expenditure	(146,311)	(157,506)	(161,592)
Underlying EBITDA	**1,050**	**(5,631)**	**(9,448)**
Depreciation and Amortisation	(6,532)	(6,580)	(6,529)
Net Financial Interest	41	51	17
PDC Dividend	(3,725)	(3,445)	(3,460)
Other	(82)	-	-
Underlying Surplus/(Deficit)	**(9,248)**	**(15,606)**	**(19,420)**
Non Recurrent Income	4,500	6,075	3,216
Non Recurrent Expenditure	-	(4,300)	(3,707)
Total Surplus/(deficit)	**(4,748)**	**(13,861)**	**(19,911)**

For both FY11 and FY12 the Trust planned for in year deficit positions of £7.4m and £18.0m despite introducing efficiency programmes of £7.5m and £6.4m respectively. The planned deficit position was a culmination of prior year

[43] Annual Accounts 2006-07, 2007-08, 2008-09, 2009-10, 2010-11, 2011-12
[44] I&E d_load 0910, Annual Accounts 09-10, 1.09 & 1.10 I&E Analysis 10-11\M12 I&E by Account Code (180411), 1.09 & 1.10 I&E Analysis 11-12\M12 I&E by Account Code

investments in staffing and a combined inflation and tariff deflator impact of 3.5% and 4%[45] in FY11 and FY12 respectively.

The Trust did not achieve the planned financial position in either year reporting deficits of £13.9m and £19.9m in each of the years.

Expenditure continued to increase from the initial investment in pre-FY10 with FY11 and FY12 showing increases of 10% and 2% respectively. The majority of the increase in FY11 was to be expected as the full year effect of the FY10 investment in staff took hold with pay expenditure having increased 9%. In comparison, non pay expenditure increased 3% in FY11.

Table 13 is an extract of which staff groups received additional investment during FY10.

Table 13: Summary of WTE, by staff group, employed at the end of Mar09 and Mar10[46]

WTE	Mar09	Mar10	Change	% of WTE
Add Prof Scientific and Technical	94.8	93.5	(1.3)	3.9%
Additional Clinical Services	379.8	402.6	22.8	16.6%
Administrative and Clerical	465.7	492.6	26.9	20.3%
Allied Health Professionals	117.3	137.5	20.2	5.7%
Estates and Ancillary	225.7	227.3	1.6	9.4%
Healthcare Scientists	84.4	91.3	6.9	3.8%
Medical & Dental	269.0	275.5	6.5	11.4%
Nursing and Midwifery Registered	666.6	700.7	34.1	28.9%
Trust Wide total	**2,303.2**	**2,420.8**	**117.6**	**100.0%**

Following the initial investment in nursing the Trust further increased the number of substantive and temporary nursing posts in both FY11 and FY12 in response to the Healthcare Commission report and the absence of a fully recruited nursing workforce to staff the rotas. Additional investment in Medical and Administrative staff was also funded.

Excluding non recurrent costs, non pay expenditure has remained relatively static since FY10 at c.£60m, with drugs showing a slight increase though this is mainly expenditure on drugs which are directly recharged to the commissioners. Table 14 presents the gross non-pay for each of the years.

[45] Monitor's financial assumptions letter dated 1 April 2010
[46] Annual Accounts 2009-10

Table 14: Summary of Non Pay Expenditure[47]

Currency: £ 000	FY10	FY11	FY12
Drugs	(13,293)	(14,049)	(14,483)
MSE	(4,859)	(5,025)	(5,078)
Pathology	(3,357)	(2,900)	(3,082)
Other Clinical Supplies/Services	(4,785)	(5,001)	(5,733)
Consultancy	(1,017)	(4,184)	(2,755)
Depreciation	(6,532)	(6,580)	(6,529)
PDC Dividend	(3,725)	(3,445)	(3,460)
Other Non Pay Costs	(20,771)	(23,360)	(22,877)
Total Non Pay Costs	**(58,339)**	**(64,546)**	**(63,997)**
Non Recurrent Non Pay Costs	-	(4,330)	(3,707)
Total Recurrent Non Pay Costs	**(58,339)**	**(60,216)**	**(60,290)**

After these substantial increases in costs the Trust recorded a Reference Cost Index (RCI) for FY11 and FY12 of 1.15[48] and 1.18[49] respectively, indicating that the costs of delivering services are significantly higher for the Trust than other NHS organisations.

It should be noted that RCI includes non recurrent expenditure, which has been c.£4m in both years which would, in part, contribute to a higher RCI. However at less than 2% of the total cost base the non-recurrent expenditure does not account for a RCI which is 18% above the national average cost of delivering the same activity thus concluding that the underlying cost base is high for the level of activity performed.

This is demonstrated through further benchmarking against other trusts. The Trust's level of pay per available bed day is within the data set average, however, costs are in the upper quartile when pay and non-pay is considered per occupied bed day. This supports the RCI in that costs are considerably higher compared to other trusts and with its low average length of stay and high utilisation of beds suggests that MSFT suffers from a low activity level for such a high cost base.

The charts in Figures 23 and 24 illustrate this highlighting, in yellow, the Trust's pay and non pay cost per available bed day and by occupied bed day compared with other trusts within the dataset.

[47] I&E d_load 0910, 1.09 & 1.10 I&E Analysis 10-11\Trust d_load month 12 10_11, 1.09 & 1.10 I&E Analysis 11-12\Trust d-load month 12 11_12, LTFM Account code mapping
[48] Reference Cost Index 2010-11
[49] 1.17 Reference Cost Index

Figure 23: MSFT FY11 Pay Cost per available bed day and per occupied bed day against dataset

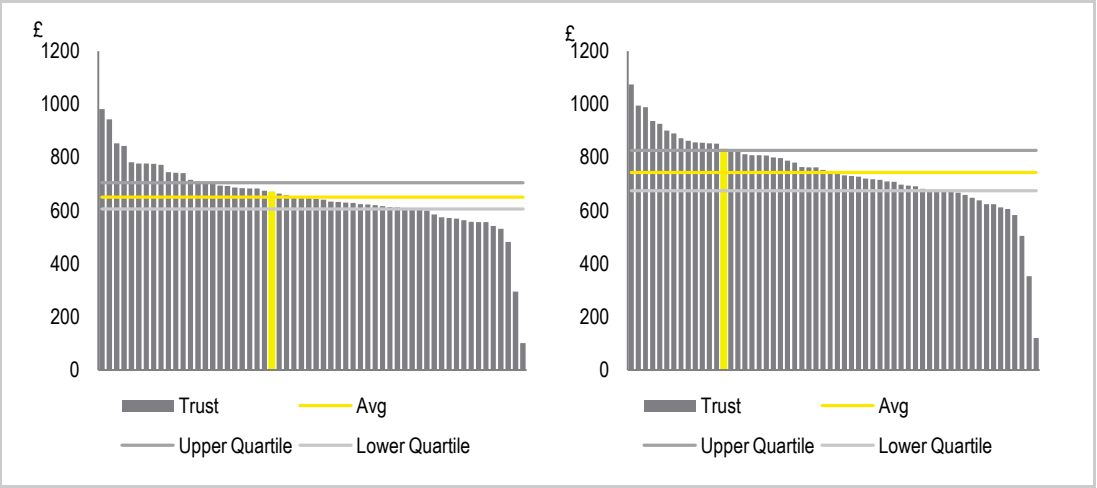
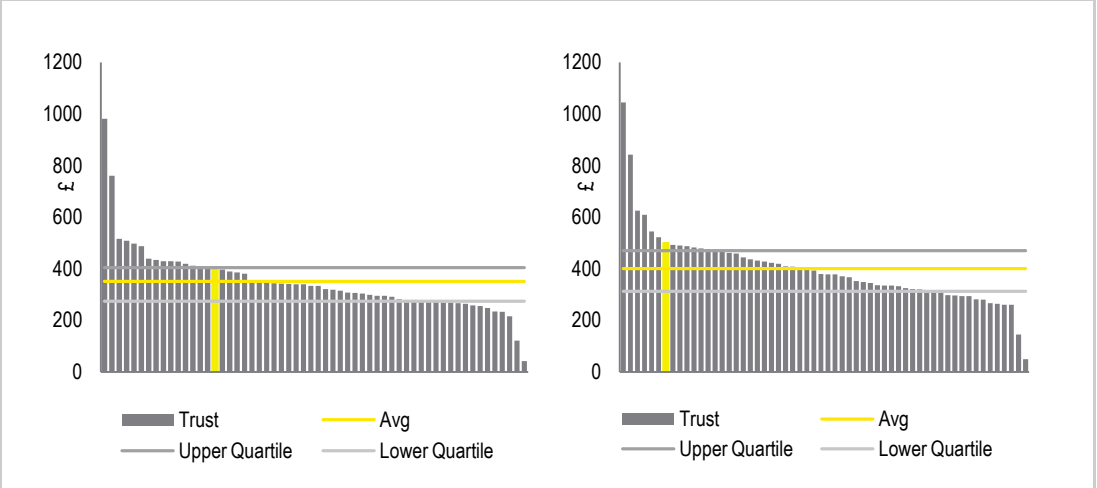


Figure 24: MSFT FY11 Non Pay Cost per available bed day and per occupied bed day against dataset



4.3 Liquidity consequence of historical financial performance

4.3.1 Cash

The ability to pay debts when they fall due is a key criteria in determining whether an organisation is solvent or insolvent. The following section highlights the movements in cash that have occurred due to the historical financial performance and the financial support that the Trust has received up to and including FY12.

Cash Performance in FY11 and FY12

Figure 25 and Table 15 show the dramatic reduction in the cash balance that the Trust held. Starting with an opening balance of £10m this had reduced to a closing cash balance of £1.4m and a further reduction to £0.5m at March 2012. This movement included additional cash support of £21m in March 2012 of which £5m was to allow MSFT to pay PDC dividend arrears and a PDC dividend that fell due.

Figure 25: Monthly Closing Cash Balance for FY11 and FY12[50]

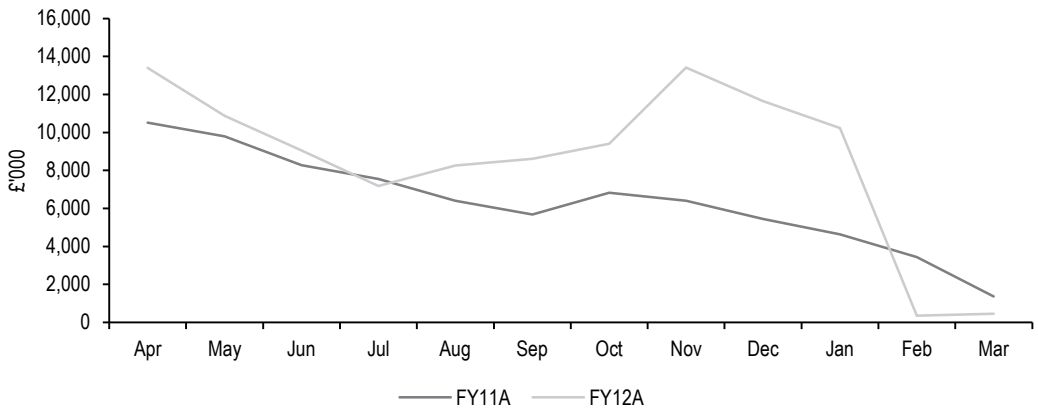


Table 15: Historical Cash Flows[51]

Currency: £ 000	FY10	FY11	FY12
EBITDA*	**6,024**	**(3,882)**	**(8,475)**
(Increase)/Decrease in Trade and Other Receivables	(2,113)	1,760	(424)
Increase/(Decrease) in Trade and Other Payables	6,174	339	(3,777)
Other Movements	495	(99)	889
Net Cash from Operating Activities	**10,580**	**(1,882)**	**(11,787)**
Finance Received	41	51	95
Capital Expenditure	(3,746)	(4,670)	(4,629)
Net Cash from Investing Activities	**(3,705)**	**(4,619)**	**(4,534)**
PDC Received	217	-	21,000
Finance Leases	(688)	(671)	(622)
PDC Dividend Paid	(3,967)	(1,479)	(4,963)
Net Cash from Finance Activities	**(4,438)**	**(2,150)**	**15,415**
Increase/(Decrease) in Cash	**2,437**	**(8,651)**	**(906)**
Opening Cash Balance	7,575	10,012	1,361
Closing Cash Balance	10,012	1,361	455

* EBITDA includes non recurrent items and add back of impairment that are presented below I&E positions

The cash flow shows that the operating EBITDA losses of £3.9m and £8.5m, including net non recurrent income of £1.7m and net non recurrent expenditure of £0.5m in FY11 and FY12 respectively has created an unstable cash position.

One of MSFT's goals for FY11 was to achieve financial security and ensure short-term cash flows. Trusts can improve the cash position by holding cash for longer by increasing the time it takes to pay its creditors. To this end by March 2010 the Trust had already stretched its NHS creditors to £8.4m and over FY11 and FY12 this position has unwound by £3.2m and £2.9m over the respective years to a closing liability of £2.3m at March 2012 as additional cash support from the DH has been received.

From FY10 to FY12, MSFT has absorbed £7.1m of cash despite stretching its trade and PDC creditors to allow cash availability of £3.2m, reprioritising and reducing the capital expenditure in order to hold cash and receiving £21m cash support

[50] 1.06 Monthly Cash Flows 2010 11, 1.06 Monthly Cash Flows 2011 12
[51] Annual Report-2010-11, 1.11 Year End Accounts 2011-12

from the DH in order to fund aggregate EBITDA losses of £6.3m, capital expenditure of £13.0m and finance costs totalling £12.4m.

Overall the Trust's underlying performance has absorbed cash in both FY11 and FY12 and has been historically unable to pay its debts that fell due from internally generated cash flows. Excluding the non recurrent I&E transactions, adjusting for income based on performance and £21.2m of non recurrent cash support, the Trust would face a cash requirement of £27.0m at March 2012.

Whilst MSFT had access to a working capital facility of £12.5m for both years, the Trust did not use the facility due to the cash support requested and received from DH in FY12. It should be noted that the working capital facility has expired in January 2012.

4.4 Current Financial Position

4.4.1 Purpose

The CPT assessed MSFT's current balance sheet position as at September 2012 to understand the opening position of the Trust going into the outturn period. Specifically, a review of the balance sheet will assist in the identification of any areas that may impact FY13's outturn financial position in terms of I&E and cash performance.

This analysis also reviews MSFT's ability to meet Monitor's expectations of FTs to manage its risk around receivables and payables.

4.4.2 Balance Sheet

Table 16: Balance Sheet as at March 2012 and September 2012[52]

Currency: £ 000	March 2012	Sept 2012	Movement
Total Non Current Assets	**111,296**	**110,008**	**(1,288)**
Stock	2,288	2,328	40
Trade and Other Receivables	5,804	12,853	7,049
Cash	455	472	17
Total Current Assets	**8,547**	**15,653**	**7,106**
Total Current Liabilities	(20,522)	(22,074)	(1,552)
Total Non Current Liabilities	(1,032)	(702)	330
Total Net Assets	**98,289**	**102,884**	**4,595**
Public Dividend Capital	89,492	101,127	11,635
Revaluation Reserve	42,084	42,071	(13)
Income and Expenditure Reserve	(33,287)	(40,314)	(7,027)
Taxpayers' Equity	**98,289**	**102,884**	**4,595**

[52] M06 12-13 Cash Flow And Balance sheet

The main changes to MSFT's financial position since March 2012, as stated on the balance sheet as at September 2012, are the increase in PDC to reflect the cash support received, the movement in the I&E reserve due to the deteriorating financial position and the increase in debtors and creditors.

Reserves

PDC reserve has increased in line with cash support received by MSFT during the first six months of FY13 by £11.6m. It is understood that the cash support received to date from DH is regarded as not repayable and therefore has been accounted for as capital.

However, during March 2012 when the Trust received £21m of cash support, there was correspondence from DH detailing that the PDC advance is temporary and not estimated to be repaid in FY13. Furthermore, a decision on the level of repayment, if any, is to be decided following its assessment of MSFT's recovery strategy.

Any level of repayment that may be agreed with DH shall significantly erode any value in the balance sheet on top of the value eroded from the year on year deficits seen to date and forecast for FY13.

MSFT's plan includes £26.6m of cash support for FY13 which the Trust has agreed with DH (although there is no recorded evidence to confirm this).

The I&E reserve account has decreased over the period due to the current trading performance of the Trust which is an in year £7m deficit to give an accumulated loss of £40.3m at September 2012. The actual financial performance to September 2012 is discussed in subsequent sections.

Current Assets

Table 17: Current Assets as at March 2012[53]

Currency: £ 000	March 2012	Sept 2012	Movement
Inventories	2,288	2,328	40
Receivables NHS	3,829	7,743	3,914
Receivables Non-NHS	1,485	1,599	114
Bad Debt Provision	(532)	(608)	(76)
Accrued Income	-	2,463	2,463
Prepayments	1,022	1,656	634
Cash	455	472	17
Total	**8,547**	**15,653**	**7,106**

Current assets have increased in value since March 2012 by £7.1m largely due to increases in debtors (£3.9m) and accrued income (£2.5m). The Trust's cash holding remains consistent with its approach in requesting cash support from DH which is supported with a forecast cash flow with a maintained £0.5m cash balance.

[53] Agenda Item 6.1_M06 Financial Position

The increase in NHS receivables relates to outstanding contract invoices and is consistent with the slippage seen in cash receipts. Included within this increase in debtors is £2.5m of SCR income due from South Staffordshire PCT, with a further £2.5m of SCR funds expected in the following six months. MSFT has confirmed that discussions are ongoing with the commissioners as to the payment of £5m SCR in FY13.

It should be noted that of the trade receivables summarised in Table 18, £1.0m is not accounted for within the aged debtor data of which £0.7m relates to accrued income largely from RTA work.

As at September 2012 MSFT is exceeding Monitor's metric for forward risk[54] in that trusts should have less than 5% of total receivables greater than 90 days. Based on the aged debtor information available, MSFT currently has 36.5% of total receivables greater than 91 days assuming that credit has been applied to the oldest debt.

Table 18: Aged debtors to September 2012[55]

Currency: £ 000	Outstanding	On Account	Current	31-90 days	>91 days
South Staffordshire PCT	5,978	(2)	958	3,349	1,673
UHNS	420	-	29	120	271
South Staff & Shropshire HC NHS FT	367	-	9	14	344
Stoke on Trent PCT	353	(5)	42	41	275
Staffs & Stoke Partnership Trust	135	(6)	48	10	83
Other	418	(48)	197	129	140
Total NHS Receivables	**7,671**	**(61)**	**1,283**	**3,663**	**2,786**
Non NHS Receivables	679	(163)	252	108	483
Total Receivables	**8,350**	**(224)**	**1,535**	**3,771**	**3,269**

The delay in being paid for services has worsened the Trust's cash availability over the six month period. This has meant that MSFT has had to draw down on cash support from DH and reprioritise the use of capital through pull back of capital spend in order to fund working capital.

According to the plan submitted to Monitor, MSFT assumes that there is no working capital movement in relation to debtors and as such the increase in debtor balances to the period to September 2012 would be expected to unwind over the next six months, and therefore generate cash, in order to achieve the planned position at March 2013. There is risk that certain debtors may not materialise, such as the £2.5m SCR debt, which would worsen the Trust's cash position and would require the Trust to reprioritise its capital within its agreed cash funding from DH of £26.6m in FY13.

[54] Compliance Framework 30 March 2012
[55] Agenda Item 6.1_M06 Financial Position

Liabilities

Table 19: Current Liabilities as at March 2012 compared to September 2012[56]

Currency: £ 000	March 2012	Sept 2012	Movement
Payables NHS	(2,297)	(1,806)	491
Payables Non-NHS	(6,252)	(4,156)	2,096
Payables – Tax & Social Security Costs	(3,419)	(3,493)	(74)
PDC Dividend Creditor	(221)	-	221
Capital Creditors	(1,484)	(691)	793
Accruals	(3,587)	(8,808)	(5,221)
Provisions <1 year	(1,373)	(1,301)	72
Deferred Income	(1,889)	(1,819)	70
Total Current Liabilities	**(20,522)**	**(22,074)**	**(1,552)**

Current liabilities have increased by £1.6m to September 2012 and the Trust is failing the Public Sector Payment Policy (PSPP) paying only 45% of bills within 30 days.

The increase in current liabilities is due, in the main, to a significant increase in accruals over the last six months. According to MSFT £4.3m of the £5.2m increase is primarily due to material accruals around SLA underperformance (£2.2m), liabilities incurred but not invoiced (£1.6m) and an accrual in relation to Anti TNF drug cost (£0.5m).

Whilst there has been an overall reduction in creditor balances as at September 2012, the Trust maintains a level of creditor stretch and is likely to do so in the foreseeable future. Indeed the plan submitted to Monitor assumes a decrease in overall creditors by £2.4m in the period to March 2013 which has been achieved in the first six month period.

4.5 Actual and Forecast Financial Performance

4.5.1 Purpose and Methodology

In order to assess the Trust's future efficiency and cash requirement over the next five years using a forecast model, the YTD financial performance and financial position was assessed to understand any sensitivities or vulnerabilities to the forecast FY13 outturn.

Assessment of six months of trading to September 2012 was compared to the plan submitted to Monitor in May 2012 to understand any material changes to the plan and how this would impact the forecast outturn position. The significant changes from I&E performance in FY12 to the FY13 plan is also considered.

Furthermore, a review of the cash performance of the Trust over the last six months was undertaken in light of the agreed cash support for FY13 of £26.6m.

[56] Agenda Item 6.1_M06 Financial Position

4.5.2 Recent Financial Performance

The Trust has moved to a full PbR regime for its South Staffordshire PCT contract after two years of trading within a cash envelope. This provides the Trust with the opportunity to generate additional income through over performance against its contract but also exposes the Trust to financial risks associated with under performance against the contract.

Table 20: Summary of Months 1 to 6 FY13 I&E Compared to Plan and Plan to Prior Year[57]

Currency: £ 000	YTD actual Month 6	YTD plan Month 6	FY13 Plan	FY12 Actual
Recurrent Income	75,730	75,511	150,102	152,144
Recurrent Expenditure	(80,394)	(79,115)	(158,408)	(161,592)
EBITDA	**(4,664)**	**(3,604)**	**(8,307)**	**(9,448)**
Depreciation and Amortisation	(3,127)	(3,277)	(6,841)	(6,529)
Net Financial Interest	(23)	(25)	(50)	17
PDC Dividend	(1,803)	(1,796)	(3,591)	(3,460)
Underlying Surplus/(Deficit)	**(9,618)**	**(8,702)**	**(18,789)**	**(19,420)**
Non Recurrent Income	2,635	2,500	5,000	3,216
Non Recurrent Expenditure	(44)	(596)	(1,192)	(3,707)
Total Surplus/(Deficit)	**(7,027)**	**(6,798)**	**(14,981)**	**(19,911)**

The plan submitted to Monitor forecasts an overall deficit of £15.0m for FY13, being an underlying deficit of £18.8m. This includes an income figure of £155.1m which is comparable with the previous years total. The underlying income for FY13 is expected to be £150.1m being a 1.3% decrease from that in FY12.

Expenditure is planned to reduce by £5m on the previous year to £170m. This cost reduction is driven by the Trust's CIP targets to deliver a cost efficiency of £10.4m and at September 2012, MSFT has forecast that this will be achieved at £10.2m, albeit £1.3m will be non recurrent savings. Recurrent cost efficiencies achieved in FY12 totalled £5.3m.

On the back of the plan submitted to Monitor in May 2012, the Trust's expectation is that the DH will support the Trust and effectively underwrite its in year deficit of £15.0m with the remaining £11.6m supporting both working capital movements and capital programme with cash support totalling £26.6m, of which £11.6m has been drawn down to September 2012.

The Trust's capital plan for FY13 is forecast to be £17.4m, which includes brought forward capital expenditure of £1.3m from FY12. At September 2012, MSFT forecasts this to be £17.0m although it is envisaged that some £14m will be spent in FY13 due to current slippage within certain capital projects.

It is anticipated that the Trust will manage its cash position within the expected cash funds assuming that it has flexibility over the usage of cash from capital to

[57] 1.14 APR Submission May 12, M06 I&E by Account Code (171012)

operating working capital, in particular to cover the risks around certain I&E items such as non receipt of SCR income.

The above plans will effectively limit the liquidity rating within FRR assessment submitted to Monitor to a rating of 1 based on the Trust's level of operating expenditure at c.£160m.

Income and expenditure is analysed in the subsequent sections.

4.5.3 Income

The plan for FY13 has been based on FY12 activity, and takes into account national tariff deflation of 1.5% on PbR tariff related income. MSFT has also planned, within their contract, for a reduction of 1.8% in non mandatory tariff related income. These reductions are consistent with the 2012-13 PbR tariff guidance and the contract value is broadly in line with the previous year.

In addition, the plan includes a payment (CQUIN) of £1.7m which will be made on sustainable achievement of national and local quality improvements. As at September 2012 MSFT was delivering on the required targets with a minimal shortfall of £0.06m on an overall six month target of £1.2m.

Planned contract income for South Staffordshire PCT also includes £6.3m income relating to delivery of 18 week RTT. Subsequent to the plan being submitted, MSFT has agreed a value of £5.9m with local commissioners giving an immediate adverse variance to plan of £0.4m.

Currently MSFT is failing to meet the activity targets set out within the contract and following on from discussions with the Trust's Director of Finance it is deemed likely that total income during FY13 for 18 weeks will total £1.2m instead of £5.9m. This is reflected in MSFT's under performance against its main contract by £2.4m as at September 2012.

In addition, another cause of the under performance includes the reduction in non-elective inpatients, partially due to the closure of the observation bay in the A&E department to admissions.

Overall, YTD actual income in September 2012 is in line with planned expectations as submitted to Monitor in May 2012 at some £78.0m.

Table 21: Summary of Income in September 2012 compared to Plan and Plan compared to Prior Year[58]

Currency: £ 000	YTD actual Month 6	YTD plan Month 6	FY13 Plan	FY12 Actual
South Staffordshire PCT	64,644	65,143	129,798	130,939
Other PCTs	3,288	3,284	6,544	5,026
Total Signed Contract Income	**67,932**	**68,428**	**136,342**	**135,965**
Other Clinical Income	748	912	1,818	946
Other Income*	7,050	6,170	11,942	15,233
Total Recurrent Income	**75,730**	**75,510**	**150,102**	**152,144**
Non Recurrent Income	2,635	2,500	5,000	3,216
Total Income	**78,365**	**78,010**	**155,102**	**155,360**

*Excludes Interest Income

A number of movements have occurred in Other Income where income previously falling within this category has, for FY13, been included in the main contract.

Table 22: YTD Other Income to Plan and Plan compared to Prior Year as at Sept 2012

Currency: £ 000	YTD actual [59]	YTD Plan[60]	FY13 Plan[61]	FY12 Actual[62]
Education and Training	2,219	2,097	4,194	4,638
Research and Development	539	488	977	1,020
RTA	203	203	405	262
Private Patients	262	185	370	493
Other	3,827	3,198	5,996	8,820
Total Recurrent Income	**7,050**	**6,171**	**11,942**	**15,233**
Other Non Recurrent Income	135	-	-	783
Total Other Income	**7,185**	**6,171**	**11,942**	**16,016**

[58] 1.14 APR Submission May 12, M06 I&E by Account Code (171012)
[59] M06 I&E by Account Code (171012)
[60] 1.14 APR Submission May 12
[61] 1.14 APR Submission May 12
[62] Trust d-load month 12 11_12

4.5.4 Expenditure

Table 23: Summary of YTD Operating Expenditure as at Sept 2012 compared to Plan and Plan compared to Prior Year

Currency: £ 000	YTD actual[63]	YTD Plan[64]	FY13 Plan[65]	FY12 Actual[66]
Drugs	(8,164)	(7,652)	(15,276)	(14,483)
Clinical Supplies	(6,426)	(7,973)	(15,947)	(13,893)
Non Clinical Supplies	(8,489)	(6,467)	(12,934)	(17,078)
Total Raw Materials and Consumables	**(23,079)**	**(22,092)**	**(44,157)**	**(45,454)**
Permanent Staff	(50,514)	(52,586)	(104,702)	(105,381)
Agency and Contract Staff	(3,760)	(1,663)	(3,615)	(5,988)
Total Employee Expenses	**(54,274)**	**(54,249)**	**(108,317)**	**(111,369)**
Research and Development Expense[a]	-	(31)	(64)	-
Education and Training Expense	(167)	(118)	(237)	(210)
Consultancy Expense	(244)	(202)	(357)	(2,755)
Misc. Other Operating Expenses	(2,673)	(3,019)	(6,469)	(5,511)
Total Other Operating Expenses	**(3,085)**	**(3,370)**	**(7,127)**	**(8,476)**
Total Operating Expenses within EBITDA	**(80,438)**	**(79,711)**	**(159,600)**	**(165,299)**
Owned Assets	(2,997)	(3,147)	(6,581)	(5,997)
Assets held under Finance Leases	(131)	(130)	(260)	(532)
Total Depreciation and Amortisation	**(3,127)**	**(3,277)**	**(6,841)**	**(6,529)**
Total Operating Expenses	**(83,566)**	**(82,988)**	**(166,441)**	**(171,829)**

Note a - Unable to split out R&D cost from FY12 Actual and YTD Actual I&E accounts

MSFT planned an overall reduction in operating expenditure in FY13 from FY12 of £5.4m (3%). The key drivers of this cost reduction are:

- A significant reduction in agency staff cost of £2.4m and £0.7m of reduced substantive pay cost;
- £1.3m net reduction in raw materials and consumables cost of which the increase in drug cost of £0.8m relates to pass through drugs that are recharged to PCTs;
- £2.4m reduction in consultancy costs; and
- An increase in other costs totalling £1.3m including depreciation cost (£0.3m).

For the period to September 2012, MSFT is broadly on plan with a small overspend totalling £0.6m over planned operating expenditure of £83.0m.

Total non operating expenses i.e. cost of finance is excluded from Table 23.

[63] M06 I&E by Account Code (171012)
[64] 1.14 APR Submission May 12
[65] 1.14 APR Submission May 12
[66] 1.09 & 1.10 I&E Analysis 11-12\Trust d-load month 12 11_12

Pay Expenditure

Planned pay expenditure for FY13 is £108.3m compared to FY12's cost incurred of £111.4m. The plan assumes an overall increase in WTEs for clinical staff and a reduction in WTEs for non clinical staff compared to that in FY12. The ratio of pay to non pay expenditure as at Sept 2012 is similar to that in FY11 and FY12 accounting for 63% of the total expenditure.

The reduction in planned pay expenditure compared to prior years takes into account a level of redundancies in the Trust as well as the second year of the government's pay freeze which limited pay rises except for staff earning less than a full time equivalent of £21,000 where they received a £250[67] increase.

As at Sept 2012 MSFT is broadly on target with the planned expenditure on pay. However MSFT continues to face significant recruitment issues in certain staff groups including: Consultants, junior doctors, nursing, managers and administration. As a result, there have been high agency and bank costs that have offset under spend in certain staff bands. Table 24 summarises the planned reduction in pay expenditure through reduction in permanent and agency staff cost in FY13.

Table 24: Summary of historical, planned and YTD pay expenditure with WTE data

Currency: £ 000	FY11[68]	FY12[69]	FY13 Plan[70]	YTD as at M6[71]
Cost:				
Clinical Staff	(79,079)	(82,170)	(82,037)	(39,218)
Non Clinical Staff	(22,539)	(23,205)	(22,665)	(11,296)
Total Non Agency Staff	**(101,618)**	**(105,374)**	**(104,702)**	**(50,514)**
Agency Staff	(5,698)	(5,995)	(3,615)	(3,760)
Total Staff	**(107,316)**	**(111,369)**	**(108,317)**	**(54,274)**
WTE:				
Clinical Staff	1,806	1,702	1,834	1,657
Non Clinical Staff	807	807	775	756
Total Non Agency Staff	**2,613**	**2,509**	**2,609**	**2,414**
Agency Staff	-	-	-	-
Total Staff	**2,613**	**2,509**	**2,609**	**2,414**

Non Pay Expenditure

The Trust has applied an effective inflation impact from FY12's baseline drug cost (£14.6m) of 2.5% plus adjustments for growth in PBR excluded drugs and changes to the drug cost as a result of service developments and CIPs. Subsequently the planned drug expenditure for FY13 is £15.3m.

[67] Pay Circular (AfC) 2/2012
[68] Trust d_load month 12 10_11, LTFM Account code mapping
[69] Trust d-load month 12 11_12, LTFM Account code mapping
[70] 1.14 APR Submission May 12
[71] M06 I&E by Account Code (171012)

Whilst MSFT appears to have overspent against planned drug cost as at September 2012, it should be noted that £6.4m[72] of cost relates to pass through drugs and blood products to which the Trust is fully reimbursed through income received from PCTs.

Expenditure planned for clinical and non clinical supplies total £27.1m, phased equally across the quarters, and assumes a 2% cost inflation on FY12's baseline expense plus adjustments for changes to the cost as a result of service developments and CIPs.

Expenditure as at September 2012 for clinical and non clinical supplies totalled £14.9m compared to plan of £14.4m.

Significant cost within expenditure for clinical supplies relates to medical and surgical equipment (£2.5m) and pathology costs (£1.5m). These cost groups are considered relatively static costs through the year and, on an annualised basis, these costs would amount to £5.1m and £3.1m respectively. The respective costs incurred for these cost lines in FY12 are £5.1m and £3.1m.

Significant costs within expenditure for non clinical supplies relate to Energy and Environment Charges and Works i.e. day to day maintenance that totals £1.5m and £1.3m for 6 months to September 12. On an annualised basis, these would amount to £3.0m and £2.6m respectively. These cost lines totalled £2.8m and £2.5m in the previous year, therefore based on an annualised amount, FY13 outturn costs could be some £0.3m higher than that incurred in prior years for these two cost groups.

Whilst the Trust argues that there is a high energy bill associated with summer months due to air conditioning, energy costs from the effect of winter months in the next six months are considered to be higher than the current run rate which could worsen this cost further.

Other planned miscellaneous expenditure totals £6.5m and is spread equally across the quarters with the exception of £0.5m capital write off in Month 12. The cost also assumes a 2% cost inflation on FY12's baseline expense (£5.5m) plus adjustments for changes to the cost as a result of CIPs.

As at September 2012, costs totalling £1.5m relate to the outsourcing of activity to other NHS Trusts, other FTs, local authorities and private organisations. The Trust confirms that there is a level of outsourcing required and includes: procurement, the eye centre services at Cannock, health information services, elderly care, healthcare at home and radiology. This suggests that there may be further opportunities for the Trust to explore regarding the provision of these services.

[72] Discussion with Adam Houliston, Commissioning Contract Accountant

The Trust confirms that the total depreciation and amortisation expense planned of £6.8m is calculated in accordance with the planned capital plan in the year of £16.2m. Due to the nature of the capital to be capitalised, further significant depreciation cost is expected to be written to I&E beyond FY15.

As such there is a planned underlying expenditure, inclusive of operating and non operating costs, of £168.9m in FY13 compared to that in FY12 of £171.7m. The 1.6% decrease in underlying cost is largely driven by the Trust's planned CIP target of £10.4m in order to mitigate inflationary and other cost pressures expected in FY13.

4.5.5 Cost Improvement Plans (CIPs)

Table 25: Summary of CIP target, performance to date and forecast outturn for FY13[73]

Currency: £ 000	FY13 Plan	YTD actual M6	FY13 forecast
Length of stay	122	-	-
Demand and capacity	2,857	189	2,317
Estates and Facilities	1,200	486	1,200
Non clinical Staffing	2,100	828	1,842
Nursing	800	115	406
Procurement	1,000	691	1,636
Scientific, Technical and Therapeutic	800	356	800
IM&T	393	282	763
Other	1,128	302	1,267
Total	**10,400**	**3,249**	**10,231**

As previously noted, the Trust was able to achieve its first year of CIPs in FY12 of £6.4m, of which £1.1m were non recurrent cost savings. On the back of previous consultancy work performed, the plan submitted to Monitor for FY13 included a CIP target of £10.4m split into eight workstreams including £1.1m of unidentified cost savings and £0.3m of cost improvement relating to capital charges. As the latter is a non cash item and would be achieved through reduced capital asset values and/or change in depreciation policy, this would improve the Trust's year end deficit but would not assist in MSFT's cash position.

The Trust has a rigorous process in place to track and report its performance against its cost efficiency target which includes various levels of validation and sign off before the numbers are presented to the board.

To September 2012, there has been a 31% achievement of the original target. Specifically, there has been a shortfall in income from 18 week activity as a result of under achievement against the demand and capacity CIP. Furthermore, there has been an under achievement of the cost efficiency relating to nursing staff costs that has seen high agency and bank costs in the last six months as a result of recruitment issues in this staff group.

[73] Agenda Item 6.1_M06 Financial Position

It is highlighted that whilst CIPs can be achieved, as they were in FY12, there is evidence of overspend in certain pay groups that fall outside of the CIP workstreams that would offset the cost efficiencies achieved in other staff groups. As such, the sustainability of the pay CIPs must be closely monitored.

At Month 6, the Trust has presented to the board a revised outturn CIP target of £10.2m, of which £1.3m is forecast to be non recurrent cost savings.

4.5.6 Recent Financial Position

Cash

At April 2012, the Trust had an opening cash balance of £0.5m and the closing cash balance at September 2012, after six months trading, was £0.5m as the Trust generated a net nil cash flow in the period.

Table 26: YTD Cash Flow as at Sept 2012 and FY13 Plan

Currency: £ 000	YTD actual M6[74]	FY13 Plan[75]
EBITDA	**(2,074)**	**(8,060)**
(Increase)/decrease in Trade and Other Receivables	(6,717)	-
Increase/(decrease) in Trade and Other Payables	2,062	(2,433)
Other movements	(72)	(1,414)
Net Cash from Operating Activities	**(6,801)**	**(11,907)**
Finance Received	17	-
Capital Expenditure	(2,770)	(14,416)
Net Cash from Investing Activities	**(2,753)**	**(14,416)**
PDC Received	11,635	26,623
Interest on Finance Leases	(40)	(80)
PDC Dividend Paid	(2,024)	(221)
Net Cash from Finance Activities	**9,571**	**26,322**
Increase/(decrease) in Cash	**17**	**(1)**
Opening cash balance	455	455
Closing cash balance	472	454

As the Trust plans to rely on DH's cash support in the foreseeable future, limiting cash holdings to £0.5m will limit the Trust's ability to increase its liquidity FRR assessed by Monitor. However, this rating would be artificial if the cash holding was not from internally generated cash by the Trust.

In addition to the agreed cash support, the plan assumes the cash impact of £14.4m of capital expenditure. The capital plan for FY13 is forecast to be £17.0m.

Despite MSFT's efforts to reduce creditor levels on FY12, the historic build up of trade creditors in FY10 and FY11 has left an opening trade creditor liability of

[74] M06 Cashflow & Balance sheet
[75] 1.14 APR Submission May 12

£9.4m in FY13. The plan assumes a reduction of NHS payables and other payables of £2.4m in its cash flow, and an unwinding of provisions of £1.4m.

The Trust's internal monthly cash flow plan excludes cash support from DH and as such shows a cash requirement for FY13 of £25.7m[76] which is in line with that communicated to DH[77] in May 2012. However, MSFT has currently drawn down more in the period to September 2012 at £11.6m compared to that communicated of £10.1m. Without this cash support the Trust would be £11.5m overdrawn.

Internally, the Trust had forecast a cash requirement of £9.6m at September 2012 compared to the actual closing cash balance of £0.5m. The positive variance of £10.1m is made up of the benefit of cash support (£11.6m) and reduction in operating and capital expenditure spend (£2.4m) which has offset slippage in income receipts from contracts (£2.4m), slippage in cash from other income (£1.3m) and increased payment of PDC dividend (£0.2m).

Table 27 summarises the historical and current planned cash position of the Trust before cash support. As previously discussed, the FY13 plan assumes a £5m non recurrent income line from SCR and £1.2m of non recurrent expenditure. As such these I&E items and the cash support can be deducted to provide an underlying in year cash requirement of £30.4m.

On an underlying basis, the Trust's cash position has and is due to worsen cumulatively over the three year period from FY11 to FY13 inclusive, by £62.7m, being £32.3m of EBITDA losses and trading items, £23.7m of capital expenditure and £6.7m of PDC dividend being paid.

Table 27: Historical and Planned FY13 Cash Flow

Currency: £ 000	FY10	FY11	FY12	FY13 Plan
EBITDA*	6,024	(3,882)	(8,475)	(8,060)
Working Capital Movements	4,556	2,000	(3,312)	(3,847)
Capital Expenditure	(3,746)	(4,670)	(4,629)	(14,416)
PDC Received	217	-	21,000	26,623
PDC Dividend Paid	(3,967)	(1,479)	(4,963)	(221)
Other	(647)	(620)	(527)	(80)
Increase/(Decrease) in Cash	**2,437**	**(8,651)**	**(906)**	**(1)**
Closing Cash Balance	**10,012**	**1,361**	**455**	**454**
Adjustments:				
Non Recurrent I&E items	(4,500)	(1,745)	491	(3,808)
Over/(Under) Contract Performance	-	425	(885)	-
Cash Support	(217)	-	(21,000)	(26,623)
Revised Increase/(Decrease) in Cash	**(2,280)**	**(9,971)**	**(22,300)**	**(30,432)**
Revised Closing Cash Balance	**5,295**	**(4,676)**	**(26,976)**	**(57,407)**

* EBITDA includes non recurrent items and impairment that are presented below I&E positions

[76] M06 12-13 Cash Flow And Balance sheet
[77] Email from Sarah Preston to Alastair MacLellan dated 11 May 2012

Capital Expenditure

Whilst the Trust recognised historically that its cash constraint forced it to reprioritise its capital, MSFT had submitted a plan to Monitor that included a capital plan to spend £16.1m. As such cash support for urgent capital and money for patient safety has been approved by DH covering the FY13 forecast in year deficit of £15.0m and a further £11.6m towards the Trust's working capital and capital programme.

Table 28 summarises MSFT's approved budget of capital spend by project of which £2.2m has been spent to September 2012 and £8.3m has been committed.

Table 28: Summary of Capital Expenditure in FY13[78]

Currency: £ 000	FY13P	YTD actual at M6	M6 Committed	FY13 outurn
CT Scanner	(2,292)	(66)	(1,920)	(2,292)
Endoscopy Unit	(3,000)	(7)	-	(3,000)
Urgent Care Centre	(700)	-	-	(700)
Digital Mammography	(864)	-	-	(164)
Other	(1,157)	(298)	(380)	(1,782)
Total Engineering and Building	**(8,013)**	**(371)**	**(2,300)**	**(7,938)**
EPR Project	(2,500)	(2)	(5,233)	(1,984)
IM&T	(1,220)	(167)	(43)	(1,085)
Planned Care M&SE	(1,534)	(506)	(73)	(1,540)
Facilities Plant	(1,866)	(124)	(290)	(2,097)
Other	(1,008)	(168)	(81)	(1,008)
Total Plant and Equipment	**(8,129)**	**(967)**	**(5,720)**	**(7,714)**
Charitable Funds Schemes	-	(56)	-	(56)
Total Capital Expenditure	**(16,142)**	**(1,394)**	**(8,020)**	**(15,708)**
Carry Forward from 11/12	(1,300)	(777)	(291)	(1,295)
Total Capital Expenditure inc c/f	**(17,442)**	**(2,171)**	**(8,311)**	**(17,003)**

MSFT has historically and currently taken advantage of its flexibility to use the cash support as it wishes, be it to fund working capital or to progress its capital plan.

Despite its forecast outturn position being revised to a £17.0m capital spend against a plan of £16.1m, the Trust confirms that it is likely to spend some £14m due to current project slippage in the Endoscopy Unit, Urgent Care Centre and EPR.

[78] Agenda Item 6.1_M06 Financial Position

4.6 End of year financial forecast

The forecast expenditure for FY13 outturn is predicated on the Trust achieving the majority of its CIP programme which is dominated by the realisation of the 18 week activity and the margin gained from that activity.

Due to the cost behaviour of much of the expenditure, the progress made on the recruitment of staff and the £4m of unutilised reserves, the YTD expenditure as at month 6 was deemed appropriate to use as an approximation for the remainder of the financial year adjusted for a number of sensitivities.

I&E sensitivities:

- SCR – the Trust is currently in discussion with the commissioners over the payment of the previously agreed SCR, which as of November 12 was still an outstanding debt. Non payment of the FY13 SCR exposes the Trust to a £5m I&E impact. The forecast outturn assumes payment of this but warns of the risk should payment not be received.
- Contractual challenges for prior year activity. The financial challenge is estimated at £1.7m by the commissioners but £350k has been assessed by the Trust as being a more realistic figure. Top level analysis of the SLAM (the service level agreement reporting software used by commissioners) report indicates that the Trust's estimation of the impact is reasonable based on the total activity seen.
- The Trust has indicated that, following a deep dive review of the 18 week activity, it is confident that the activity will be achieved and that referrals are increasing. It is anticipated that this will generate £1.2m though estimated costs will be incurred in generating this income (reflected in the outturn forecast). In addition the Trust expects to achieve the remainder of its contract. The only shortfall in value assumed is the shortfall in income as at Month 6.
- The sensitivity applied to expenditure includes the fact that in some cases the expenditure for the full year has been incurred as at month 6 and the budget has been apportioned appropriately to reflect this. This expenditure has not been deemed to continue in months 7-12.
- The largest movement is in the cost of utilities. Previous years analysis indicates that the 55% of the expenditure is incurred in months 7-12 thus the spend for month 1-6 equates to 45% of the full year spend for FY13. This equates to an additional £380k being applied to the cost base.
- The forecast figure also includes the release of £300k of the allocated reserve for winter capacity. After discussion with the Director of Finance this may need to be increased to £650k but will be covered within the release of reserves.

- Taking the above conditions into consideration the CPT has estimated that the Trust will not exceed the external cash support required in FY13 provided that the trust achieves the deficit of £15m, the capital spend does not exceed £17m plan and the SCR is paid. The outstanding contractual challenge is a risk to the cash position. As stated earlier it is estimated that this will be between £0.35m and £1.7m.

4.7 Forecast outturn

Table 29: High Level FY13 Forecast outturn

Currency £m	12/13 plan	MSFT Forecast outturn	CPT Forecast outturn
SLA Income	(144)	(139)	(139)
Non-SLA Income	(18)	(19)	(19)
Total Income	**(161)**	**(158)**	**(158)**
Pay Expenditure	109	110	110
Non-Pay Expenditure	62	63	63
I & E Budget Reserves	6	0	0
Total Expenditure	**176**	**174**	**173**
(Surplus/(deficit)	**15**	**15**	**15**

The CPT derived forecast position for FY13 is not dissimilar to the plan or the forecast outturn proposed by the Trust. However a number of key risks and the potential impact of those risks must be noted.

Table 30: High Level risks to FY13 Forecast Outturn

Currency £m	CPT assessed risk	Description
Non achievement of CIPs	1.4	Continuation of the 22% attrition rate against plan as demonstrated in months 1 to 6
11/12 contract challenges	1.4	Worse case scenario of compromise payment
Non recurrent benefit of vacancies	0.5	As at month 6 the Trust had substantial vacancies. Should the posts be filled the Trust would no longer see this benefit.
Additional cost of winter pressures	0.4	Should the extension of capacity be required
Non payment of SCR	5	Outstanding debt - failure to resolve
Estimated impact	**8.6**	

The Trust holds £6.2m in reserves of which it has utilised £1.2m as at month 6. Should these risks materialise the Trust will have insufficient funds to mitigate the increase in cost.

4.8 Summary of FY13 Forecast Outturn

The Trust generated a deficit of £7.0m as at September 2012 compared to a planned deficit of £6.8m for the period. The plan submitted to Monitor in May 2012 shows a full year deficit of £15.0m for FY13.

The CPT forecast that the Trust will achieve the planned deficit of £15m through the management of I&E reserves and the over-achievement of non-SLA income.

The CPT highlights a number of key areas that could potentially exceed the contingency reserves available should the risks be realised.

On an underlying basis, the Trust does not generate sufficient income to cover its underlying expenditure which is reflected in the cash performance of the six month period.

Overall, it can be concluded that the Trust has generated insufficient cash in the period to meet its obligations. The slippage in cash receipts has further exacerbated MSFT's requirement for cash support from DH. Without external cash support the Trust would be deemed insolvent as it would not be able to pay its debts as they fall due.

Furthermore, it is noted that the Trust has operated with the expectation of receiving continued financial support from the DH during the period FY13 to FY15. No formal paperwork of the agreed financial support is available though discussions with Monitor indicate that there was an agreement. Monitor is currently looking into the arrangements.

4.9 Assessment of Financial Challenge

4.9.1 Purpose

In order to assess the sustainability of the financial position the CPT modelled the financial position for the five years up to and including FY18.

The future financial challenge is assessed in terms of the cash requirements to remain solvent, the estimated I&E position for each year and the Trust's ability to cover its debts as they fall due without external financial support.

4.9.2 Methodology

The CPT used the findings from the forecast outturn analysis as a baseline on which to forecast the impact of tariff deflation, cost inflation, non-recurrent funding and the subsequent financial position of the Trust across 5 years up to and including FY18.

The basis for the applied assumptions was formed through debate and subsequent agreement in the Operational and Finance Group which comprised Directors of Finance from neighbouring NHS Trusts and was led by the Director of Finance for the NHS Trust Development Authority while awaiting final tariff deflators and assumptions. The main assumptions are that efficiencies will remain at 4% through a mixture of a tariff deflator and pay and non pay inflation. A list of the assumptions can be found in Appendix F.

The CPT conducted various interviews as part of the overall sustainability piece of work and used the findings to support the assumptions going forward.

The submitted plan to Monitor included a significant capital investment of £16.1m, £16.8m and £7.6m in each of the respective years from FY13 to FY15.

The financial support assumed for modelling purposes in each of the years is outlined in Table 31.

Table 31: FY12 to FY15 Agreed external funding support

Currency: £ m	Mar13F	Mar14F	Mar15F
Capital programme	14.4	16.8	7.6
Deficit as per plan	15.0	14.1	8.1
Working capital movements	3.8		
Interest payable	0.1	0.1	
P&L balancing figure	(0.1)		
PDC carry over	0.2		
less depreciation	(6.8)	(7.1)	(7.9)
PDC increase	26.6	23.9	7.8

The repayment of any temporary PDC has not been included in the modelling.

A meeting with the Chief Operating Officer, Director of Finance and Deputy Director of Finance concluded that there were no known I&E implications as a consequence of the significant capital investments being made in FY13 to FY15 in terms of additional expenditure or an increase in income generation.

The Trust was still waiting for the FY14 Divisional Business Plans and CIP workplans to be submitted at the time of producing this report. Contract negotiations for FY14 had yet to be commenced.

The level of CIPs that have been forecast as non-recurrent in FY13 equates to 13.5% of the total achieved. This percentage of non-recurrent achievement of CIPs has been included within each of the subsequent years to reflect the reality that

not all schemes will be recurrent. This is broadly in line with Monitor's observations that 15% of CIPs are non-recurrent.[79]

The level of CIPs as a percentage of income was included at zero percent for the model. The purpose was to provide transparency in the sensitivity to determine what level of efficiency was needed in order to achieve breakeven by FY18 and achieve a sustainable cash balance without the need for additional financial support over and above the £58.3m assumed to be agreed.

This formed the base case from which the upside and downside scenarios were modelled. The findings and assumptions were compared with the findings of the Trust to sense check the assumptions and challenge any anomalies.

4.9.3 The scale of the challenge

The model indicates that over the 5 years from FY13-18 without the introduction of efficiencies the Trust's recurrent income will reduce by £2.2m (1.5%) from £152.9m to £150.7m. This reduction is based on the assumption that non-demographic growth (2%) will be offset by recurrent QIPP initiatives of the same value. Thus the reduction is mainly due to the continuous tariff deflation of 0.5%.

The expenditure over this period is estimated to increase by 15.3% or £25.8m due to the 2.5% non-pay inflation and the reintroduction of pay awards at 1% in FY14 following a two year pay freeze. Additionally the cost of depreciation is expected to increase following the significant capital investments in FY13 and the two successive years after.

If the Trust applied the efficiency requirement of the downside scenario as forecast by Monitor and extended the programme to cover FY18 the Trust would not breakeven and would require cash support in excess of £24.2m.

Table 32: Forecast financial position using Monitor's efficiency predictions

Surplus/(Deficit) £'000						Closing Cash Balance £'000					
FY12/13F	FY13/14F	FY14/15F	FY15/16F	FY16/17F	FY17/18F	FY12/13F	FY13/14F	FY14/15F	FY15/16F	FY16/17F	FY17/18F
	5.5%	5.5%	5.0%	5.0%	5.0%		5.5%	5.5%	5.0%	5.0%	5.0%
(15,145)	(14,027)	(11,447)	(11,205)	(7,991)	(4,708)	263	1,288	(337)	(11,541)	(19,532)	(24,240)

In order to breakeven by FY18 the Trust needs to extend the current 4 year efficiency programme[80] by 3 years to FY18 and achieve an average efficiency of 7% of relevant income in each of the 5 years (average of 6.3% of cost). At this level of efficiency the Trust would still require additional cash support c. £5.1m above the £58.3m already assumed within the model.

[79] *http://www.monitor-nhsft.gov.uk/home/browse-category/reports-nhs-foundation-trusts/reviews-nhs-foundation-trusts-annual-plans/review Accessed Dec 2012*
[80] White paper

Table 33: Forecast CIP requirement using the CPT model

		Surplus/(Deficit) £'000						Closing Cash Balance £'000					
CIP requirement to breakeven	CIP requirement to maintain breakeven	FY12/13F	FY13/14F	FY14/15F	FY15/16F	FY16/17F	FY17/18F	FY12/13F	FY13/14F	FY14/15F	FY15/16F	FY16/17F	FY17/18F
13%	3%	(15,145)	(4,353)	7,091	2,525	2,413	2,558	263	10,961	27,875	30,401	32,814	35,372
12%	4%	(15,145)	(5,841)	4,262	1,322	2,544	4,011	263	9,473	23,558	24,880	27,423	31,434
11%	5%	(15,145)	(7,330)	1,433	118	2,674	5,463	263	7,985	19,240	19,358	22,032	27,495
10%	2%	(15,145)	(8,818)	(1,396)	4,834	2,251	1,035	263	6,496	14,923	19,757	22,008	23,043
9%	4%	(15,145)	(10,306)	(4,225)	670	1,183	2,622	263	5,008	10,606	11,276	12,458	15,081
8%	2%	(15,145)	(11,794)	(7,055)	(3,493)	3,065	991	263	3,520	6,288	2,795	5,860	6,851
7%	0%	(15,145)	(13,283)	(9,884)	(7,657)	(2,430)	2,993	263	2,032	1,971	(5,686)	(8,117)	(5,124)
6%	0%	(15,145)	(14,771)	(12,713)	(11,820)	(7,926)	(3,834)	263	543	(2,347)	(14,167)	(22,093)	(25,927)

Cash is internally generated through two mechanisms; the ability to generate surpluses and non-cash expenditure (depreciation charges). As such any deterioration on the operational profitability of the Trust has a direct consequence on the amount of cash available for the Trust.

For the Trust to achieve a stable cash position within 5 years, without the need for additional cash support, and maintain a breakeven position it will have to achieve an 8% efficiency (ave. 7.2% of cost) for 4 years followed by 2% in FY18.

The shortest timeframe modelled in which the Trust could breakeven would require an efficiency achievement of 13% in FY13 and FY14 followed by a year on year efficiency of 3% to maintain a surplus position. At this level of efficiency the Trust would be deemed solvent.

The Trust does not believe that this level of saving is achievable within its current structure and that significant reconfiguration of services is required. It reports that, in its current form, the likely level of CIPs in the coming years would be 5.6% of cost in FY13 and 4.6% in subsequent years. This opinion is consistent with the findings of the King's Fund quarterly review[81] which notes that only 5 out of 45 organisations surveyed achieved 7% during FY12 and quotes a survey of Finance Directors as believing that savings and productivity gains are becoming harder to deliver. In Monitor's review of previous years' efficiency achievements, the average achieved was 4.3%[82] of cost in FY12 and it was noted that savings are going to become harder to achieve moving forward without fundamentally transforming services and that the opportunities to income generate will become less.

Applying the Trust's estimation of achievable savings and extending the period that the savings would be required by 2 years would generate savings of £41.4m. The financial position would deteriorate and the deficit would worsen by a further £58m across the 5 years and additional cash support of £32.8m would be needed to remain solvent. A further £10.2m of efficiencies would have to be found

[81] Kings fund quarterly report September 2012
[82] Monitor Q4 2011/12 report final version

through service reconfiguration in order to achieve and maintain a surplus position by year 5 and be deemed solvent.

Analysing the ability of the Trust to achieve the efficiencies it becomes apparent that the opportunities diminish over time with the fixed elements of cost, hence non controllable, e.g. capital charges becomes a larger percentage of the cost base. In the case of capital charges where the 7% efficiency is applied this moves from 5.72% of cost to 10.06%. The proportion of pay as a percentage of the total cost over the same period and using the same efficiency reduces from 63.18% to less than 56.39%. Applying the logic that pay will attract the proportionate amount of CIPs to non-pay the equivalent reduction in WTEs to deliver the required CIPs equates to 697WTE or 26.6% of MSFT's workforce to deliver the same level of activity.

The current year's attempt to generate income has been limited in its success. Within its FY13 CIP plan the Trust aimed to generate £5.9m income through additional activity in order to achieve and maintain the 18 week target. The Trust has now forecast that it will achieve £1.2m against this target having underperformed at month 6 by £2.4m suggesting that the additional activity/demand does not exist.

4.9.4 Sensitivity of the financial challenge

The CPT estimated the likely downside scenario to include the two main disputed items that the Trust is currently negotiating – the release of SCR and the outstanding contract challenge.

Should the £5m SCR not be released by the commissioners in FY13 and the £2.5m in years FY14 and FY15 the Trust's CIP requirement would stay at 7% to breakeven but would remain insolvent without £13.9m additional cash support. At 8% CIP efficiency for four years and 4% in FY18 the Trust could achieve an internally generated cash balance of £1m by year 5.

The assumed QIPP for the model has been set at 2% to offset the 2% non-demographic growth as assumed by the OFG. The estimated percentage of costs that can be removed for each £1 of income lost is estimated at 65% or £0.65. This figures assumes that the overheads which are more difficult to remove are set at 35%.

If the QIPP recovery rate changed from 65% to 50% the Trust could still breakeven by year 5 using CIPs of 7% though the cash support required would double to £10m. The recovery rate could go as low as 44% and still breakeven at which point the cash support required would be £14m.

However, should the commissioners increase the amount of demand management through QIPP by just 0.8% the Trust would need to increase the CIP requirement above 7% to break even. The cash support required should this occur would be £13m.

As the pay freeze comes to an end in March 2013 the new national agreements have yet to be finalised. The CIP requirement of 7% could tolerate an increase of 0.5% above the 1% assumed in the model.

An increase of 1% above the assumed 2.5% inflation rate for all non-pay would maintain the CIP requirement at 7%. Likewise in order to reduce the CIP requirement to 6% and breakeven in year 5 the inflation rate would need to reduce from 2.5% to 1.0%.

If, after FY15, the tariff prices are no longer deflated and are held at zero growth or are inflated by 1% each year the Trust will still require a CIP of 6% to achieve breakeven and cash support of £12m.

4.9.5 Assessment of efficiency opportunities available to reduce the deficit

In the high reference cost index of 1.18 (2011/12), MSFT was the highest within the peer group of similar size trusts reviewed, which indicates that there is still an opportunity to reduce the cost base further (c.£27m) or identifies a need to increase utilisation.

Benchmarking against other trusts shows MSFT is within the upper quartile in relation to both high pay and non pay costs per occupied bed day. However its average length of stay is low and it has a high utilisation of beds thus indicating that the Trust's cost base cannot be maintained by current activity levels.

To assess the opportunities available to reduce the cost base a review of the CIP schemes that other Trusts have developed to deliver larger efficiencies was undertaken. The following schemes (Table 34) were assessed to determine their suitability for MSFT and if the savings would be sufficient to recover the deficit position. The figure below gives an indication of the types of schemes that were considered to deliver larger savings without fundamental reconfiguration.

Table 34: Potential CIP schemes

Currency £'000		FY13/14F	FY14/15F	FY15/16F	FY16/17F	FY17/18F
	Efficiency shortfall MSFT reported CIP achievability and required CIPs	**(2.1)**	**(5.9)**	**(9.6)**	**(13.5)**	**(8.5)**
Back office reductions	Reduction in the cost of the finance, IM&T and HR departments towards the QIPP national benchmark would achieve further savings.	2.4	2.4	2.4	2.4	2.4
Procurement	The Trust currently spends £33.3m on non-pay less pass through costs, capital charges and PDC. A target reduction of 5% would generate a saving of £1.7m.	1.7	1.7	1.7	1.7	1.7
Cannock	Reprovision of services at Cannock onto Stafford site (exc. Capital costs and duplicate running costs) and reutilise the facility to generate rental income on the basis that 50% is currently generating £1.6m.		1.6	1.6	1.6	1.6
Income generation	At a margin cost of 35% the Trust would need to increase in activity over and above the assumptions in the model by 1000 elective patients per year from FY16 at an average tariff of £3,098 as per FY13 contract at a time.			2.0	4.0	6.0
	Revised financial position	**1.9**	**(0.3)**	**(2.0)**	**(3.9)**	**3.1**

The findings suggest that the estimated savings of the schemes would be insufficient to recover the deficit position in full and that the Trust had included some of the schemes within their existing CIP plans.

Back office reductions and procurement have been addressed by the Trust within their existing CIP plans and thus can be deemed a duplication of savings available. The difficulties of income generation have been demonstrated in 2011/12 in the Trust's attempts to increase 18 week activity thus to assume a year on year increase of 1000 elective inpatients, over and above demographic growth, is unrealistic unless the commissioners fail to deliver their QIPP targets.

Based on the high utilisation of beds and the low length of stay it can be assumed that any reprovision of activity from the Cannock site to the Stafford site would require further capital investment on the Stafford site for which the Trust has no cash without additional support.

A review of the estate and facilities at the Cannock site has indicated that alternative use of the site can be accommodated and could potentially increase the rentable value of the site and further reduce the existing outgoings by £1.5m. The estimated capital cost of achieving this is £5.4m.

It has been deemed by the CPT that closure of the Cannock site is not within the immediate gift of the MSFT Board, therefore alternative use of the site and the receipt of additional rental income is the main opportunity available.

The review of the potential large schemes highlights that the Trust has already included within its CIP plans some of the schemes that other Trusts have already implemented. Where this has not occurred the estimated value of the schemes would be insufficient to bridge the whole of the deficit and would likely require additional capital.

4.9.6 Summary of financial modelling

Table 35: Summary of financial modelling

Early modelling findings	Early conclusions for MSFT
If MSFT were to deliver their planned efficiency targets for an extended 5 year period, the Trust would require a further £12.6m savings through reconfiguration in order to achieve breakeven at year 5.	MSFT cannot become financially viable within a realistic period of 5 years through traditional efficiency measures alone.
If MSFT were to deliver the efficiencies at the level suggested by Monitor the Trust would be deemed insolvent and would not be able to generate a surplus in any of the next 5 years.	MSFT cannot become financially viable within a realistic period of 5 years without significant external intervention.
It would take annual CIPs of 13% p.a. of relevant income to breakeven in 2 years and a further 3% year on year to maintain a surplus position.	It is unrealistic for MSFT to become financially viable in the next two years.
MSFT cannot internally generate sufficient cash on a sustainable basis over a 5 year period at an efficiency level of 7% of relevant income (ave. 6.3% of cost).	Without cash support the Trust is unable to pay its debts as they fall due and as such will be deemed insolvent.
To achieve the level of CIPs required at 7% of relevant income would require an estimated reduction of 697wte or 26.6% of the funded wte as at month 6 FY13.	This level of wte reduction would place the Trust at risk of further clinical sustainability issues.
The Trust is forecast to generate a deficit for the foreseeable future with limited opportunities in its current form to sufficiently improve the situation. The Trust is planning to receive a cash injection of £31.7m over FY14 and FY15 and will need a further £7m in year 5.	The Trust has needed and will continue to require substantial cash support for the next five years.

4.10 Summary on the Trust's financial sustainability

MSFT achieved two years of financial surplus prior to and one year following the achievement of Foundation Trust status but the financial position quickly deteriorated following the Trust's reaction to the recommendations from the various reviews that followed the Healthcare Commission publication on high mortality rates.

This has led to the Trust reporting a deficit position for the third consecutive year with an underlying retained deficit worsening by over £40m since becoming a Foundation Trust.

Cash is internally generated through two mechanisms; the ability to generate surpluses and non-cash expenditure (depreciation charges). As such any deterioration on the operational profitability of the Trust has a direct consequence on the amount of cash available for the Trust.

To this end the cash position has deteriorated by £3.3m since achieving Foundation Trust status despite receiving cash support in FY12 of £21m. Due to the planned deficit in FY13 the Trust is expecting to receive an additional £15m of

cash support and a further £11.6m towards the Trust's working capital and capital programme.

The underlying cash position without cash support has deteriorated by over £24m since become a Foundation Trust.

To improve its cash position the Trust stretched its creditors in FY10 & 11 by increasing its creditor days to 96 days. This improved in FY12 to 76 days by using the additional £21m cash support received.

Without cash support the Trust is unable to pay its debts as they fall due and as such is deemed insolvent.

The Trust is forecast to deliver a deficit position for the fourth consecutive year of £15m in FY13 despite achieving a cost improvement programme of £10.2m and has required an additional £26.6m to cover the deficit position and fund its capital plan.

Using the forecast position and applying assumptions agreed within a forum of Directors of Finance from both commissioners and providers for cost inflation and tariff deflators over the next 5 years the Trust's financial position is set to worsen in both I&E and cash terms.

With the assumption that the Trust will receive additional financial support of £31.7m across FY14 and 15 the Trust will not achieve breakeven with less than a recurrent cost improvement programme delivering 7% of relevant income (ave. 6.3% cost) in each of the next 5 years. At this level of efficiency the Trust will still have a cash shortfall in year 5 in excess of £5m.

Distributed across the type of expenditure incurred this level of efficiency would equate to a workforce reduction in excess of 25% to deliver the same level of activity.

The CPT has concluded and the Trust agrees that this level of CIP and additional income, having already achieved £16.6m efficiencies over FY12 and 13, is unlikely to be delivered and sustained over the five year period.

APPENDIX A – Abbreviations

A&E	Accident and Emergency
AfC	Agenda for Change
BPPC	Better Practice Payment Code
Capex	Capital expenditure
CCG	Clinical Commissioning Group
CEA	Clinical Excellence Awards
CIP	Cost Improvement Program
CPT	Contingency Planning Team
CSIP	Clinical Services Implementation Plan
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DH	Department of Health
EBITDA	Earnings Before Interest, Tax, Depreciation and Amortisation
EWTD	European Working Time Directive
FCE	Finished Consultant Episode
FRR	Financial Risk Rating
FT	Foundation Trust
FY13OT	Outturn financial performance for the year ending 31 March 2013
FYXXA	Actual financial performance for the year ending 31 March 20XX
FYXXF	Forecast financial performance for the year ending 31 March 20XX
FYXXP	Planned financial performance for the year ending 31 March 20XX
GRR	Governance Risk Rating
HCC	Healthcare Commission
HMRC	Her Majesty's Revenue & Customs
HRG	Health Resource Group (Version 4)
I&E	Income and Expenditure
IBP	Integrated Business Plan

KPI	Key performance indicators
LTFM	Long Term Financial Model
m	Million
MADEL	Medical and Dental education Levy
March 2013OT	Outturn financial position as at 31 March 2013
MarXXA	Actual financial position as at 31 March 20XX
MarXXF	Forecast financial position as at 31 March 20XX
MarXXP	Planned financial position as at 31 March 20XX
MEQO	Midlands and East Quality Observatory
MSFT or the Trust	Mid Staffordshire NHS Foundation Trust
NHS	National Health Service
NCA	Non contract activity
NICE	National Institute for Health and Clinical Excellence
NRAF	Net return after financing
OFG	Operating and Finance Group
PBC	Prudential Borrowing Cap
PBL	Prudential Borrowing Limit
PBR	Payment by Results
PCT	Primary Care Trust
PDC	Public Dividend Capital
PPE	Property, plant and equipment
RCI	Reference cost index
SDP	Service Development Plan
SHA	Strategic Health Authority
SIFT	Service Increment for Teaching
SLA	Service Level Agreement
SLM	Service line management
SLR	Service line reporting
TSA	Trust Special Administration
UHNS	University Hospital North Staffordshire NHS Trust
Var	Variance
WLI	Waiting list initiative
WTE	Whole time equivalent
YoY	Year on Year

APPENDIX B – Desktop research sources

Most of the material in Appendix B has been taken verbatim from the sources reviewed and this is indicated by the use of quotation marks.

Ref	Theme	Area and evidence from reviewed sources	Source
1	Strategy	*Ability to meet strategic goals* "The Top 5 "Must do's" for 2012/13 have been approved by the Board as part of the Business Plan for 2012/13 as follows: 1. Meet all Monitor targets, become green rated for governance and off special measures 2. Deliver a sustainable safe and consistent A&E service 24 hours a day 7 days a week 3. Deliver key Organisational Development milestones: a. Deal with all performance management issues b. Embed an effective directorate management structure c. Launch the Leadership Improvement Academy 4. Clarify the future strategy for the Trust and communicate to all internal and external stakeholders by June 2012 5. Improve public confidence by demonstrating continuous improvement across quality & safety measures and reduced complaints for key areas; A&E/Emergency Admissions, Maternity, Breast, Surgery in Partnership, Older patients/dementia."	Annual Report and Accounts – April 2011 / March 2012, p. 15
	Strategy	*Ability to set strategic goals* "There is an urgent need for a coherent 5-year plan for the Trust with a timed action plan taking into account the changing nature of medicine as outlined in Professor Lord Darzi's report last year. The Trust needs to see clearly where it fits into the overall health economy and should be clear about what it can do well and safely and what should be networked with others e.g. hyper-acute stroke care and some branches of surgery. The plan should be developed together with the PCT and other partners including the public. This will give the public and the staff a clear indication of how the Trust is developing and at what speed and remove much of the current uncertainty and unhappiness."	Mid Staffordshire NHS Foundation Trust: A review of the procedures for emergency admissions and treatment, and progress against the recommendation of the March Healthcare Commission report, 29 April 2009, p. 7
3	Structure	*Ability to change internal structure* "The organisational structure was altered to reflect the changing needs of the Trust in how the organisation should be more effectively operationally managed. Four Clinical Directorates were established with a Clinical Director being accountable to the Chief Operating Officer for all aspects of operational, performance and risk management for their respective clinical areas. The formation of an Executive Committee (which replaced the Management Board) also focussed Clinical Directors in their accountability for all aspects of operational management including risk management."	Annual Report and Accounts April 2011 – March 2012, p. 74

Ref	Theme	Area and evidence from reviewed sources	Source
4	Roles	*Ability to set clear roles, responsibilities and accountabilities*	
		"Areas where performance or progress fell short in 2011/12 [are]... Recruitment to key clinical vacancies"	Annual Report and Accounts April 2011 – March 2012, p. 17
5	Resources	*Ability to deploy resources appropriate to deliver superior performance*	
		"I have already said that recruitment is proving difficult for the Trust but an overall increase in numbers of trained and other ward-based staff must be a major priority for the Trust."	Mid Staffordshire NHS Foundation Trust: A review of the procedures for emergency admissions and treatment, and progress against the recommendation of the March Healthcare Commission report, 29 April 2009, p. 14
		During the year the Trust employed an average of 2,725 full time equivalent staff, an increase of 63 on the previous year. The average staff cost rose from £40.27k to £41.07k.	Annual Report and Accounts April 2011 – March 2012, p. 29
6	Capability	*Ability to match capability to capacity*	
		"For 2011/12 the Annual Plan focused on five key goals to support the overall delivery of the Trust's 5 Themes [including]...To improve leadership capacity and capability"	Annual Report and Accounts April 2011 – March 2012, p.16
		"Our Focus for 2012/13 [includes] Clinical leadership capacity and capability improved through leadership development programmes"	Annual Report and Accounts April 2011 – March 2012, p.17
		"With regards to capabilities and culture, the Board has improved its skills and knowledge to support effective delivery of the quality agenda by supplementing its' previously already effective leadership"	Annual Report and Accounts April 2011 – March 2012, p. 80
7	People	*Role of staff development and training*	
		"Appraisal and professional development were accorded a low priority, as indicated by national surveys. There was evidence that staff were not supported by a robust appraisal system and that continuous professional development was sporadic. There was also evidence of a reluctance to take robust disciplinary action where this appeared to be needed. Concerning cases of alleged misconduct and deficient performance have either not been addressed at all or only in a hesitant manner. This is starkly evidenced by two Royal College of Surgeons' reviews of the hospital's surgical division and the dysfunction brought to light by them."	Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009, 24 Feb 2010, p. 20

Ref	Theme	Area and evidence from reviewed sources	Source
8	Process	*Ability to manage risks* "From the different versions of the registers that were supplied to us and from what we were told by staff, it was evident that there had been a move to produce and review risk registers in the divisions in the trust. However, the head of governance told us that this was still not fully embedded within the divisions. We have previously noted the existence of certain items on divisional risk registers from one year to another. We had some concerns about whether the divisions had been expected to resolve problems that were partly trust-wide in nature, such as poor staffing levels. A trust-wide panel to moderate risk was introduced to review and ensure consistency in the scoring of risks. Any risk with a score of more than 15 was added to the corporate risk register that was considered by the executive governance group and the board. The trust supplied us with information about what the divisions had considered were the risks of the reduction in the workforce in 2006/07. We could not find any evidence that the trust had at a corporate level considered these risks."	Investigation into Mid Staffordshire NHS Foundation Trust, Healthcare Commission, March 2009, p. 94
9	Process	*Control of 18 week RTT target* "Achievement of performance against the eighteen week referral to treatment standard remained a risk. Whilst the greatest risk remained in Trauma and Orthopaedics, plans were in place in the majority of specialities to achieve performance, although a number were not structured to meet demand."	March 2012 board report
10	Governance	*Lack of attendance at key meetings* "[A] Non Executive Director expressed disappointment that having re-established the Health and Safety Committee the meeting had been cancelled through not being quorate. The Chief Executive confirmed that she had raised her concern with the Interim Director of Human Resources and had recorded it on the risk register, explaining that certain scheduled meetings should be sacrosanct"	November 2011 Board Report
11	Governance	*Composition of committees and sub-committees* "The evidence and my own experience show that there is a major problem in communications between the Trust, patients and the public. I suggest that it would be extremely helpful if there were patient/public representatives on all the major Trust committees and sub-committees – whether clinical or managerial…There should also be regular meetings between the Board and patient/public organisations including the Local Authorities' Overview and Scrutiny Committees. These measures can both help improve real care of patients as well as begin to restore public confidence in the Trust."	Mid Staffordshire NHS Foundation Trust: A review of the procedures for emergency admissions and treatment, and progress against the recommendation of the March Healthcare Commission report ("Alberti report"), 29 April 2009, p. 16

Ref	Theme	Area and evidence from reviewed sources	Source
12	Performance	*Robustness of performance review meetings* "Responding to the Chair's question about the robustness of quarterly performance review meetings, through which progress of delivery in year would be monitoring, in holding directorates accountable the Chief Executive advised that those meeting were in their infancy and that Clinical Directors would be required to attend them to present key areas of their directorates performance."	March 2012 Board Report
13	Infrastructure	Ability to invest in infrastructure appropriate to delivering superior performance "The total operating expenditure incurred in 2011/12 was £172.211m. This was an increase on the expenditure of £168.275m in 2010/11."	Annual Report and Accounts April 2011 – March 2012, p. 28
14	Culture	*Culture aligned to organisational values* "A key objective for 2012 is to change culture"	Quality Account & Report 2011/12, p. 5
15	Culture	*Clinical engagement* "The culture of the Trust was not conducive to providing good care for patients or providing a supportive working environment for staff. A number of factors contributed to this…disengagement from management – the consultant body largely dissociated itself from management and often adopted a fatalistic approach to management issues and plans. There was also a lack of trust in management leading to a reluctance to raise concerns."	Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009, 24 Feb 2010, p.15
		"The Director of Finance and Performance went on to highlight the significant improvements in clinical engagement… Focus before the rescheduled proposed reopening [of A&E] in October needed to be on clinical engagement"	May 2012 Board report
16	Culture	*The ability to communicate effectively with staff* "He added that the Staff Survey results were a cause for concern and therefore the engaging and valuing staff workstream would have a greater focus and leadership capability would be strengthened to focus on people management skills. The Strategy would also evolve to recognise the changing circumstances and influences on the Trust."	April 2012 Board report
17	Culture	*Ability to change culture and sustain this change* "A key objective for 2012 is to change culture; one driver is by launching our "Improvement Academy". The Academy will grow an internal resource of staff that will be trained and become experienced in continuous improvement tools and techniques that will enable and empower them to systematically identify and solve problems. The tool kit will draw upon "Lean" and other continuous improvement methods. The Director of Quality and Patient Experience has set up the Academy and recruited the first team who start the programme of learning and coaching in May 2012, with a second cohort of staff recruited for October 2012. Each cohort of staff will focus their project work on service and quality improvement."	Forward Plan Strategy Document for 2012-13, Mid Staffordshire NHS Foundation Trust , p. 7

APPENDIX C – MSFT performance compared to Peer group

Figure 28 shows the 2011/12 RCI index compared to a peer group of small to large trusts based on as defined within the national ERIC dataset. It can be seen that from this peer group MSFT suffers the highest RCI significantly above both average and upper quartile performance.

Figure 28: RCI index compared to peer

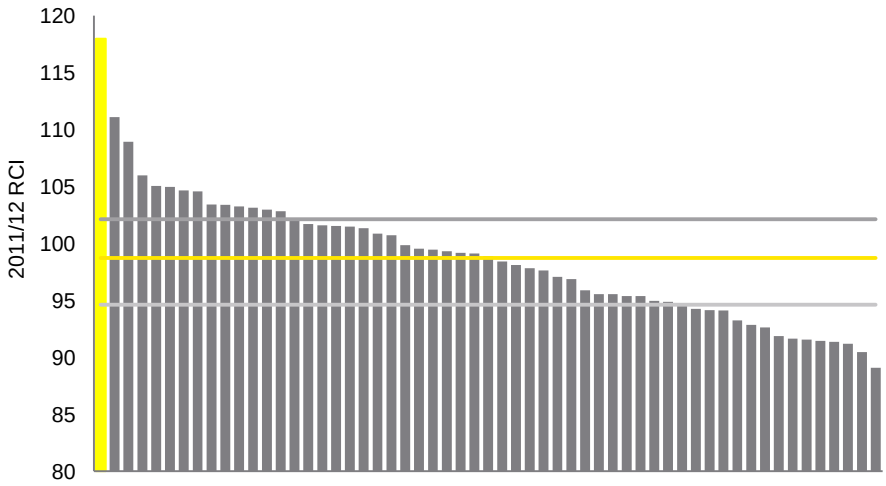


Figure 29 shows mean LOS for MSFT based upon 2011/12 HES data compared with a peer group of small to large trusts based on the ERIC definitions. This shows that during 2011/12 the Trust had a good mean LOS far below that of both the peer group average and lower quartile.

Figure 29: Mean LOS

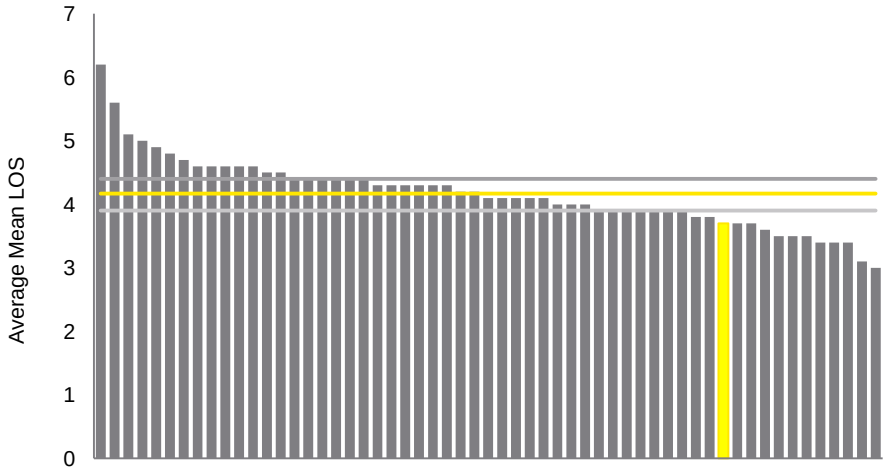
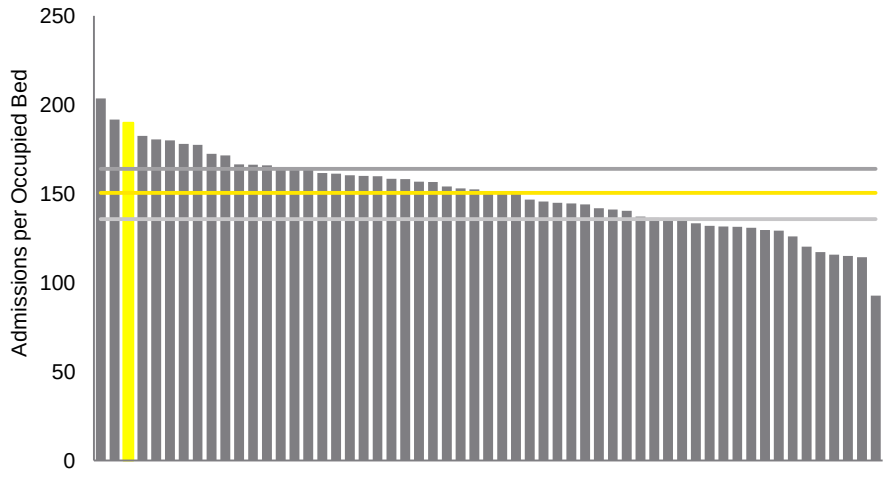


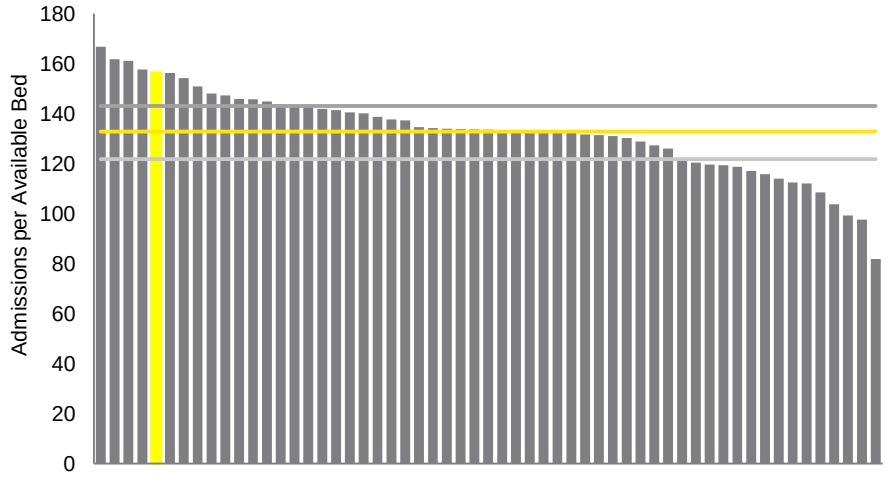
Figure 30 shows MSFT performance of number of admissions per occupied beds against the same peer group. This shows that MSFT have had a high turnover of patients in comparison with other trusts.

Figure 30: Admissions per occupied bed



Similarly Figure 31 shows MSFT also has a high number of admissions per available bed against the same peer group demonstrating a high throughput of admissions to the number of beds available to them.

Figure 31: Admissions per available bed



APPENDIX D – Service line reporting detail

The table below outlines the Trust SLR performance for the Year 2011/12.

Service Line	Year-to-Date				
	Income	Costs	Net Contribution	Overhead	(Profit)/Loss
A&E	(6,401,905)	9,407,572	3,005,667	947,417	3,953,083
Audiology	(818,276)	424,536	(393,740)	125,512	(268,228)
Breast Surgery	(1,788,874)	1,690,841	(98,032)	271,385	173,352
Cardiology	(6,414,150)	6,044,851	(369,299)	924,561	555,262
Chemotherapy	(3,735,877)	4,185,300	449,423	573,023	1,022,446
Chronic Fatigue Services	(157,436)	123,722	(33,714)	23,866	(9,849)
Clinical Oncology	(1,804,200)	1,552,876	(251,324)	270,061	18,738
Critical Care Services	(3,533,086)	3,618,923	85,838	534,788	620,626
Day Care / Rehabilitation	(532,364)	440,016	(92,348)	80,938	(11,410)
Dermatology	(2,337,556)	2,143,789	(193,767)	352,252	158,485
Diabetes	(1,009,732)	690,333	(319,399)	144,207	(175,192)
Dietetics	(128,425)	161,980	33,555	19,405	52,960
ENT	(2,613,079)	2,836,327	223,248	381,020	604,268
Gastroenterology	(5,952,924)	6,634,322	681,398	884,575	1,565,972
General Medicine	(6,203,021)	7,061,403	858,382	913,937	1,772,319
General Surgery	(12,885,632)	13,300,861	415,229	1,899,495	2,314,724
Genito-Urinary Medicine	(1,833,251)	1,795,496	(37,755)	272,744	234,989
Geriatric Medicine	(6,280,960)	7,423,724	1,142,764	929,217	2,071,981
Gynaecology	(6,274,885)	5,173,636	(1,101,250)	932,224	(169,026)
Haematology (Clinical)	(3,276,430)	3,271,555	(4,874)	490,370	485,496
Imaging	(2,107,875)	1,359,607	(748,268)	318,256	(430,011)
Littleton	(1,589,531)	1,302,574	(286,957)	241,140	(45,818)
Mammography	(2,772,528)	1,492,006	(1,280,522)	424,792	(855,730)
Nephrology	(128,412)	125,132	(3,280)	19,024	15,744
Neurology	(1,304,547)	1,126,746	(177,801)	194,669	16,868
Obstetrics	(7,672,139)	9,213,192	1,541,053	1,117,385	2,658,438
Occupational Therapy	(677,366)	1,245,389	568,023	101,008	669,031
Ophthalmology	(2,202,988)	1,849,233	(353,756)	336,456	(17,300)
Oral Surgery & Dental	(1,026,320)	1,158,405	132,085	152,542	284,628
Paediatrics	(5,931,814)	5,358,944	(572,870)	869,321	296,451
Pain Management	(651,416)	181,174	(470,243)	99,610	(370,633)
Pathology	(3,999,990)	3,441,499	(558,491)	603,960	45,469
Patient Transport Services	(870,921)	850,706	(20,215)	133,531	113,316
Physiotherapy	(926,375)	1,230,971	304,596	140,204	444,800
Respiratory Medicine	(3,467,585)	4,479,215	1,011,630	510,665	1,522,295
Rheumatology	(12,549,185)	10,429,309	(2,119,876)	1,526,324	(593,553)
Speech & Language Therapy	(45,045)	90,302	45,257	6,898	52,155
Trauma & Orthopedics	(20,557,085)	19,234,336	(1,322,749)	3,053,087	1,730,338
Urology	(3,447,864)	2,803,009	(644,855)	518,097	(126,758)
Wheelchair Services	(1,231,311)	1,438,543	207,232	177,724	384,956
Rents Received	(1,174,048)	319,471	(854,576)	-	(854,576)
Trust Total	**(148,316,408)**	**146,711,825**	**(1,604,583)**	**21,515,690**	**19,911,107**

APPENDIX E – CIP programme

This table outlines the planned CIP plan split by service area.

Project	Workstream	Plan £'000	Central Ops £'000	Planned £'000	Acute £'000	Emergency £'000	Outpatients £'000	CSS £'000	Estates £'000	Corporate £'000	To be devolved £'000	Total £'000
Nursing	CNS Review	75								75		75
	Band 5/6 Establishment Review	27	27									27
	Out of Ward Nursing Review	273	6	172	38	33	9	5	-	10	-	273
	Sickness Rates	168	-	75	75	17	-	-	-	-	-	168
	Agency Reduction	193	-	49	85	58	-	-	-	-	-	193
	Overtime Reduction	23	0	14	1	5	-	2	-	-	-	23
	No plan	38									38	38
	Total	**797**	**33**	**310**	**200**	**113**	**9**	**8**	**-**	**85**	**38**	**797**
Length of Stay		122	122									122
	Total	**122**	**122**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**122**
Demand & capacity	Theatres Utilisation 85% / 90%	169									169	169
	Theatres Additional Capacity	823									823	823
	Outpatients DNA	82									82	82
	Outpatients Slot Utilisation	67									67	67
	Consultant Rostering	360									360	360
	Outpatients Implement Capacity	800									800	800
	Senior Medical staff	132		60	26	19	-	27	-	-		132
	Junior Consultants	75	75	-	-	-	-	-	-	-		75
	Agency/Bank	35		13	12	9	-	-	-	-		35
	WLI	206		107	72	-	-	27	-	-		206
	No plan	126									126	126
	Funding Entitlement	125									125	125
	Total	**3,000**	**75**	**181**	**110**	**29**	**-**	**54**	**-**	**-**	**2,552**	**3,000**
Estates & Facilities		1,200							1,200			1,200
	Total	**1,200**	**-**	**-**	**-**	**-**	**-**	**-**	**1,200**	**-**	**-**	**1,200**
Non Clinical Staffing		1,000								1,000		1,000
	Outsourcing	113									113	113
	Post reduction	828									828	828
	Overtime, bank & agency	134									134	134
	Med Secs	10									10	10
	CRB checks	15								15		15
	Total	**2,100**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**1,015**	**1,085**	**2,100**
Procurement	Not devolved	1,000									1,000	1,000
	Total	**1,000**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**1,000**	**1,000**
ST&T	Structures and Skill Mix	636	-	27	160			448	-	-	-	636
	Other Pay and Supplements	70	-	- 10	- 1	-	-	81	-	-	-	70
	Demand Management	94	-	-	9	-	-	85	-	-	-	94
	Total	**800**	**-**	**17**	**169**	**-**	**-**	**614**	**-**	**-**	**-**	**800**
Other	Capital charges	300								300		300
	to be identified	1,078									1,078	1,078
	Total	**1,378**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**300**	**1,078**	**1,378**
TOTAL		10,397	230	508	479	142	9	675	1,200	1,400	5,754	10,397

APPENDIX F – Financial modelling assumptions

		FY13/14F	FY14/15F	FY15/16F	FY16/17F	FY17/18F
Cost assumptions:						
Underlying growth in demand	1	2.5%	2.5%	2.5%	2.5%	2.5%
Growth factor based on 89% of income growing	2	89.0%	89.0%	89.0%	89.0%	89.0%
Marginal cost element	3	35.0%	35.0%	35.0%	35.0%	35.0%
Reduction in activity driven by QIPPs	4	- %	- %	- %	- %	- %
One off reduction due to movement from block to tariff contract	5	- %	- %	- %	- %	- %
Pay inflation	6	2.7%	2.7%	2.7%	2.7%	2.7%
Agency costs inflation	7	2.5%	2.5%	2.5%	2.5%	2.5%
Drug inflation	8	2.5%	2.5%	2.5%	2.5%	2.5%
Clinical supplies inflation	9	2.5%	2.5%	2.5%	2.5%	2.5%
Other cost assumptions	10	2.5%	2.5%	2.5%	2.5%	2.5%
Percentage acheivement of CIP	11	100.0%	100.0%	100.0%	100.0%	100.0%
PDC dividend	12	3.5%	3.5%	3.5%	3.5%	3.5%
Addtional redundancy costs	13	-	-	-	-	-
QIPP marginal cost element	14	65.0%	65.0%	65.0%	65.0%	65.0%

Income assumptions:						
Underlying growth in demand	1	2.5%	2.5%	2.5%	2.5%	2.5%
% of growth allocated to MSFT	2	89.0%	89.0%	89.0%	89.0%	89.0%
Reduction in activity driven by QIPPs	3	- %	- %	- %	- %	- %
Deflation of tariff prices	4	(0.5%)	(0.5%)	(0.5%)	(0.5%)	(0.5%)
Training income to match pay award	5	1.0%	1.0%	1.0%	1.0%	1.0%
Non clinical income	6	(1.8%)	(1.8%)	(1.8%)	(1.8%)	(1.8%)
Underlying QIPP for flat cash	7	(2.0%)	(2.0%)	(2.0%)	(2.0%)	(2.0%)
Over/under charge of services correction	8	- %	- %	- %	- %	- %
Drug inflation	9	2.5%	2.5%	2.5%	2.5%	2.5%