

Central Manchester University Hospitals NHS Foundation Trust

OPERATIONAL PLAN

2016/17



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1. Introduction - CMFT

Central Manchester University Hospitals NHS Foundation Trust is an integrated health, research and teaching hospitals group with a comprehensive range of services, an extensive research portfolio and state-of-the-art facilities.

Our group comprises six hospitals providing acute and community services. The six hospitals are:

- Manchester Royal Infirmary (MRI) – large acute hospital providing complex secondary and tertiary services
- Saint Mary's – specialist women's and genetics hospital
- Manchester Royal Eye Hospital (MREH) – specialist eye hospital
- Royal Manchester Children's Hospital (RMCH)– specialist children's hospital
- The University Dental Hospital is located within the University of Manchester, across the road from the main Oxford Road campus.
- Trafford Hospitals – local hospitals serving the population of north Trafford

Our vision is:

'To be recognised internationally as leading healthcare; excelling in quality, safety, patient experience, research, innovation and teaching; dedicated to improving health and wellbeing for our diverse population.'

This is under-pinned by a series of more specific strategic aims (see plan-on-a-page, page 4). Taken together, our vision and strategic aims describe where we want to get to over the coming five year period. We expect this to be a period of great change within Greater Manchester. Devolution will bring local decision-making and facilitate a new, more collaborative way of working across all health and social care organisations. Although this presents some threats, overall it is an opportunity to address some long-standing issues and deliver a sustainable configuration of services across GM.

Each year, through our annual planning process, we agree, in liaison with our council of Governors, a set of key priorities – these are the must-dos for the coming year and are developed in the context of our vision and strategic aims. The plan-on-a-page (shown overleaf) maps our key priorities for 2016/17 to our vision and strategic aims. The Operational Plan sets out how we plan to achieve our key priorities and meet all our quality, operational and financial requirements for 2016/17.

This plan represents year one of the delivery of our Sustainability and Transformation Plan – for Greater Manchester this is the GM Strategic Plan. Through the devolution programme, the health and social care system in GM is at a relatively advanced stage in its strategic development. The high level vision for GM is 'to deliver the fastest and greatest improvement in the health and wellbeing' to the population of GM. Five key transformation themes have been identified that will enable us to create a strong, safe and sustainable health and care system that is fit for the future. Our role in delivering the Strategic Plan and the transformation initiatives in 2016/17 is described in section 6.

CMFT Plan-on-a-Page 2016/17

Vision	<i>To be recognised internationally as leading healthcare; excelling in quality, safety, patient experience, research, innovation and teaching; dedicated to improving health and well-being for our diverse population</i>	
Strategic Aims	Key Priorities for 2016/17	
Improving the safety and clinical quality of our services	1	Delivering safe, harm-free care focusing on evidence based pathways, supervision and clinical leadership and embedding CMFT Clinical Standards in day to day practice
	2	Ensure professionally informed, evidence based nursing and midwifery establishments supported by recruiting and retaining an engaged workforce able to respond to future care delivery needs
	3	Achieve all key NHS commissioned standards and deliverables, including access and quality outcomes
	4	Delivery against the Trusts Transformation strategy with the aim to reach the top decile for quality - clinical outcomes, safety, patient and staff engagement & experience and operational efficiency measures.
Improving the experience for patients, carers and their families	5	Deliver well-led compassionate, individualised care in partnership with patients and families in appropriate environments, safeguarding vulnerable people
Developing our specialist services and, with our partners in health and social care, leading on the development and implementation of integrated care	6	Playing our part in transforming the health and social care system through supporting Greater Manchester Devolution, and the delivery of Locality Plans (particularly in Manchester and Trafford)
Providing our patients with cutting edge care through applied research and innovation to deliver improved safety, clinical quality and a patient centred approach to our services	7	Strengthen and drive the translation of cutting-edge science into new tests and treatments that benefit patients
	8	Drive engagement with research through participant recruitment, public and patient involvement (PPI)*, and communications *PPI in research can comprise using public and patient input to: shape the direction of our research; design studies in a way that maximises the retention of volunteers; and ensure patient information is accessible.
Providing the best quality assured education and training	9	Delivering excellent education and learning with the aim of further developing reputation, innovation and attracting and retaining a highly skilled workforce
Developing our organisation, supporting the well-being of our workforce and enabling each member of staff to reach their full potential	10	Implement the OD Strategy, focusing on: developing a high performing, inclusive and values based culture that increases organisational resilience and agility and City of Manchester system leadership and integration (LCO)
	11	Implement the people strategy focusing on: workforce information and policies, workforce design and succession planning, attraction and resourcing; staff engagement; talent and performance management
	12	Develop a clear action plan and measurement framework to implement three year ED&I strategy
Remaining financially stable	13	Ensure short & medium term financial stabilisation, the on-going management of cash and ensuring the delivery of CIPs
	14	To refresh the 'Going Digital' Informatics strategy for 2016-21, following engagement and consultation on this with stakeholders

2. Approach to Activity Planning

2.1 Activity planning

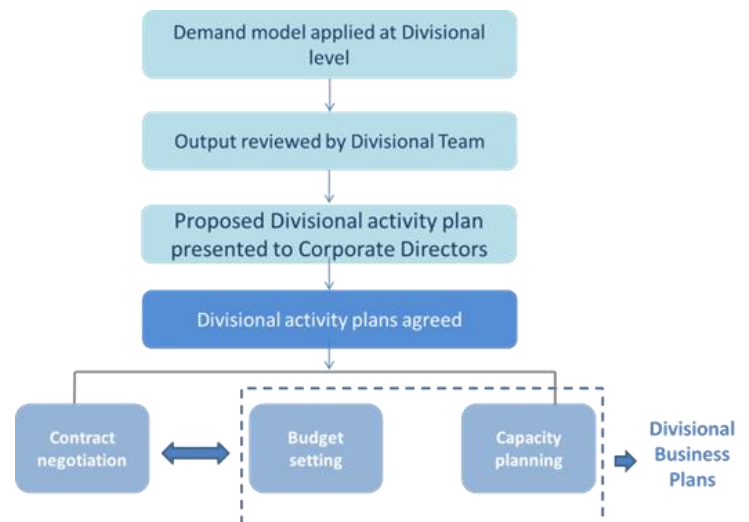
The Trust has a well-developed model that is used to assess the activity requirements for the coming year. The model (see schematic) is applied at Divisional level by the respective Divisional Analyst who is familiar with their Division's performance and activity data.

For **planned activity** the model starts with the forecast activity for the current year and then adjusts for the following:

- local and national performance standards e.g. RTT, cancer and diagnostic waiting times
- achievement of NHS constitution standards
- underlying population and demographic trends, recognising the comparatively poor health outcomes of the trust's catchment area.

For **unplanned activity** the model starts with the forecast activity for the current year and then adjusts for:

- recent trends in terms of growth
- achievement of A&E standards
- projected impact of service redesign



Any anticipated changes, forecast through commissioner's commissioning intentions that will impact on referrals or patient flows are considered and, if sufficiently evidenced, are incorporated into the demand model.

The output is then compared with forecast activity and contracted activity for the current year and sensed checked by the Divisional teams who then confirm a proposed plan for the year.

These plans are then presented to a group of senior corporate directors representing Performance, Finance, Contracting and Strategic Development. This allows directors to test and challenge the assumptions made regarding demand, capacity and productivity.

Total activity for the Trust is calculated by combining the individual Divisional plans. Total activity is apportioned across commissioners to give an activity plan for each CCG. As a result commissioners sometimes revert to their own planning figures rather than CMFT's, through the contract negotiation process. In such cases, both parties agree that commissioners will fund the actual level of activity; CMFT accepts that it must treat the patients referred in line with NHS standards and commissioners accept liability for funding the actual level of activity, subject to any standard contract terms and conditions e.g. the Effective Use of Resources policies. Total activity is profiled over the year taking into account seasonal variation.

This methodology has been agreed with commissioners and has been adopted and refined over a number of years.

For 2016/17 the output of the process has resulted in planned activity levels that are broadly 1-2% above projected 2015/16 outturn position in terms of value and activity. There are exceptions in certain services where demand or specified commissioner change have been

identified, an example would be the higher levels of growth forecast in transplant activity. Further information on this is contained in the Financial forecasts and modelling section.

2.2 Capacity planning

The increasingly volatile operating environment, exacerbated by increasing demand for services from an aging population and tariff uncertainty, has meant that even greater assurance is being sought through internal processes to ensure that the planning assumptions around capacity are appropriate and deliverable.

This capacity and demand modelling tool, provided by Capita, allows for the incorporation and integration of all assumptions from the Trust's business planning process, such as workforce planning, service redesign and productivity expectations. The tool models the number of beds required by service, division and hospital site.

In 2015/16 private sector capacity for diagnostics has been used in Q3 and Q4, specifically around endoscopy. An increase in referrals and a decrease in qualified nurse staff resulted in a capacity and demand imbalance which is being addressed through a backlog clearance process. Work is on-going to realign capacity and demand and it is anticipated that some private sector provision will be required in the early stages of 2016/17. We recognise that some improvement in throughput is required in order to achieve our activity plans.

2.3 Achieving operational standards

The Trust's activity planning process starts by calculating the required activity to achieve targets. This then feeds in to the contracting process and the capacity planning process, thus we start the year with appropriate capacity available to deliver against all our targets; A&E, RTT, Cancer and Diagnostic targets (subject to demand fluctuations outside the forecasts contained in the activity planning model).

Inevitably issues can arise in-year that cannot be anticipated or have not been properly accounted for in the model. Our aim is to use past experience to minimise these. One example of this is the loss of capacity due to antibiotic resistant *carbapenemase producing enterobacteriaceae* (CPE) which impacts on the flow of patients. However we now have processes in place to ensure that the actions that we are taking to control the spread of CPE are effective, and the impact of the CPE has been considered in our capacity and planning processes for this year.

Another example is winter pressures, the extent of which can vary depending e.g. on the weather and the severity of any flu outbreak. During 2015/16 we implemented a number of winter resilience plans including, but not limited to; additional medical and nursing staff in ED and on wards, opening of escalation beds, increased numbers of social and re-ablement support workers. For 2016/17 we have made further assumptions about a continued level of resilience funding from commissioners and winter resilience schemes will again be identified and implemented in conjunction with the local System Resilience Group which includes commissioners.

Capacity constraints and unplanned changes in demand that arise operationally are dealt with immediately through the Trust's command and escalation systems that enable us to function at times of excess pressure and continue to achieve key operational standards. In the slightly longer term they are resolved through the Capacity & Demand Planning meeting. This meets fortnightly and is chaired by the Chief Operating Officer. Unplanned changes in demand would also, where appropriate, be raised as soon as possible with commissioners through regular contract and performance meetings.

3. Approach to Quality Planning

Continually improving the quality of our services is central to all that we do and this is reflected in our vision, strategic aims and key priorities (see page 4).

The Trust was inspected by the CQC in November 2015 and, having recently received the draft outline report, the Trust has been rated as 'Good' for each of our hospitals and 'Good' overall. We always aim to achieve a good or outstanding rating across all of our services, however we are clear about the risks to quality that we face and these were shared with the CQC during their inspection.

3.1 Approach to quality improvement

Maintaining quality and safety through the year - we aim to collaboratively work with patients, staff, commissioners and the communities that we serve (both directly and through our Council of Governors) to understand and improve quality and will continue to do this through 2016/17.

The Trust approach to quality is set out in our Quality Strategy. The Trust Quality Strategy was designed by the people who use our services and the staff who work here. It was launched in 2014 with a view to combining clinical and academic research, education and teaching with clinical practice, provided by people with the right skills, knowledge, attitude and behaviours. The Strategy provides an overarching framework for all of our quality work and is aligned with our vision, strategic aims and values and our Transformation Strategy, which reflects the ambition to be in the top decile for quality in its broadest sense. The Strategy sets out the following commitments:

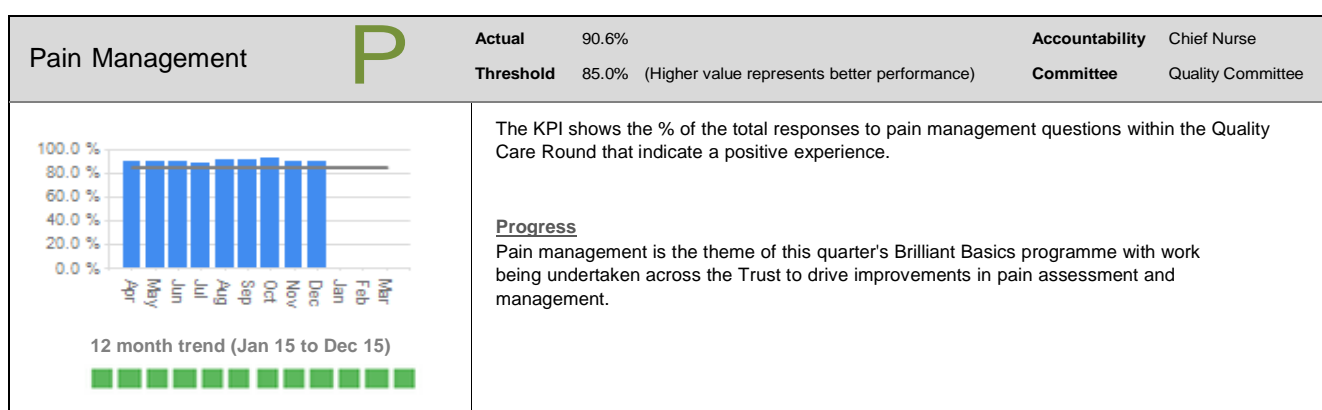
- Ensuring compassionate and effective leaders at every level through a focused leadership strategy
- Delivering the best patient care underpinned by evidence based practice and leading edge research and innovation
- Developing effective communication strategies to engage with our staff and users of our services.
- Developing a culture of listening and responding recognising when things go wrong and working quickly to put things right.
- Ensuring a culture of being open and honest with staff and people who use our services and holding each other to account for the care we provide.
- Ensuring ward-to-Board accountability for all frontline services to provide assurance to the public, the regulators and commissioners
- Continue to develop a culture which celebrates our achievements

The Trust encourages a 'bottom up' approach to quality improvement to ensure that we focus on the topics that really matter to staff and patients in 2016/17. Examples of this are:

- 'Change One Thing' campaign asks all staff to identify simple ideas that will make a big difference to both the experiences of staff and patients
- 'Transform Together' – a fund staff can bid against to create an environment which is less clinical and more patient friendly, provide state-of-the-art equipment or undertake research projects to improve our understanding of illness

The delivery of the Quality Strategy is monitored throughout the year using a number of different approaches and metrics.

- Trust Quality Committee - a number of metrics such as patient and staff feedback are triangulated and reviewed first by the Trust Quality Committee and then by the Board
- Quality report – this is the primary mechanism for feedback on the progress of the Quality Strategy. In 2015/16, as previously, it will include information on avoidable deaths.
- Quality Reviews – Governors, staff and students of all disciplines and seniority undertake a programme of peer review across the whole organisation. This review is closely aligned with the CQC key lines of enquiry and engages staff, patients, students and governors in quality monitoring and improvement.
- The Board of Directors maintains a focus on performance against the Trust's quality metrics through the organisational governance processes. The Board Assurance Report includes a range of quality, workforce and financial metrics and is reviewed at every Board meeting. An example of these quality indicators is shown below.



Quality improvement governance systems - all functions of the organisation are concerned with the improvement of quality. There are however a number of key committees and functions which oversee the delivery of the Quality Strategy itself. These include:

- Trust Quality Committee (chaired by the Chief Nurse) - direction agreed and progress monitored on clinical quality and patient safety
- Trust Clinical Effectiveness Committee (chaired by the Medical Director) - direction agreed and progress monitored on clinical quality and patient experience
- Quality and Performance Scrutiny Committee (chaired by a Non-Executive Director) - Board Members can drill down into the detail of particular metrics and hold Directors to account on progress.

Executive lead - whilst all Executive Directors have responsibility for the delivery of quality improvement, the named Executive leads for quality are the Medical Director and the Chief Nurse.

Quality priorities for 2016/17 – following extensive dialogue and engagement with leadership teams and our governors, the Medical Director and Chief Nurse have set five clinical quality objectives for 2016/17. They are:

- Mortality
- Sepsis
- End of Life Care
- Dementia
- Out-patient Care

Delivery of the Quality Strategy commitments will be underpinned by the development and delivery of a new Patient Experience Framework during 2016/17.

Risks to quality - the Trust Risk Management Committee oversees the management of all high level risks to the delivery of the organisational strategic aims. A thematic review of the Trust risk register highlights the following three overarching risks to clinical quality:

- Demand - maintaining and improving the quality of clinical services with an increasing demand on services
- Staffing - maintaining and improving the quality of clinical services whilst reducing the nursing vacancy rate
- Finance – maintaining and improving the quality of clinical services within the current financial constraints

Detailed plans are in place to reduce all of these risks to an acceptable level. Mitigation plans include, for example:

- Daily review of staffing levels
- Recruitment campaign
- Overseas recruitment
- Upgrade to resuscitation area

Risks that score 15 and above are monitored bi-monthly at the Trust Risk Management Committee.

Leadership - to deliver high quality services and continuous improvement the organisation will maintain a continued focus on leadership. The organisation invested significantly in the development of all of its leaders in 2013/14 and 2015/16. This includes:

- Newly Appointed Consultants Development Programme - supports consultants within their first year, focusing on leadership and management skills.
- Leadership for Excellence – support for c. 225 of the most senior leaders to develop skills and knowledge to deliver the Trust's key strategic objectives
- Vision to Action - build the capabilities of Trust leaders to lead their specialities in an autonomous manner and to lead on the delivery of major change programmes

Sign up to safety' priorities for 2016/17 - the organisation participates in the national Sign Up to Safety Campaign and the priorities for the year are as follows:

- Safety conversations
- Safety in Theatres
- Obstetric Improvement Project
- Patient Information Improvement
- Improving communication of test results including AKI
- Anti-Coagulation management and VTE

The Association of Medical Royal Colleges' guidance on the responsible consultant has been fully taken into account and quality improvement work streams are fully aligned with the guidelines.

3.2 Seven Day Services

The Trust has completed an initial 7 day services baseline assessment in order to establish:

- which services are already providing 7 - day provision
- work currently in train to meet 7 - day services
- consideration of future work in relation to implementation of 7 - day services

These baseline assessments have formed the foundation for a number of programs of work developing services in order to meet the standards. Through 16/17 focusing on acute and emergency areas, gap analyses are being completed by each clinical Division in order to establish which standards the relevant services currently meet and those areas where further action is required to mitigate any gaps in provision. This work also includes the development of a job planning tool to help support service redesign, in addition to consideration of service demand and delivery requirements.

Nationally the intention is to meet four of the ten key standards. As an identified early implementer the Trust will strive to meet all ten standards, if possible, in 2016/17 and to do this in an affordable way through service review and redesign.

3.3 Quality impact assessment process

Identification of impact on quality - all transformation, cost saving or revenue generating schemes are managed through a project management / PMO approach. As part of the planning phase and during delivery, schemes with a full year savings of above £50,000, which may have an impact on Trust workforce and/or clinical services, will undergo a scheme level Quality Impact Assessment. We use the Quality Impact Assessment approach defined by the National Quality Board. This is a systematic identification, assessment and evaluation of the potential impact of a scheme on patient safety, clinical effectiveness, operational performance and patient experience.

Board QIA - all Quality Impact Assessments will be examined and approved as part of the Scheme Gateway Review. Schemes with QIA scores between 15 and 25 require

- Approval from the Trust's Clinical Effectiveness Committee, which is chaired by the Medical Director and reports to the Board
- Inclusion on Divisional Risk Registers in line with the Trust's Risk Management Strategy. Any which are scored as 15 or above will appear on the trust Risk Register and be tracked through the Trust Risk Management Committee which reports to the Board.

In-year monitoring of QIA – assessments will be reviewed on a six monthly basis.

3.4 Triangulation of indicators

Approach to triangulation - the Trust utilises indicators extensively to inform and monitor the quality agenda. The Board Assurance Report is based on triangulated quality, workforce and financial indicators. This report is presented and reviewed on a regular basis at a number of different forums, including the Operational Managers Group chaired by the Chief Operating Officer and at every Board of Directors meeting.

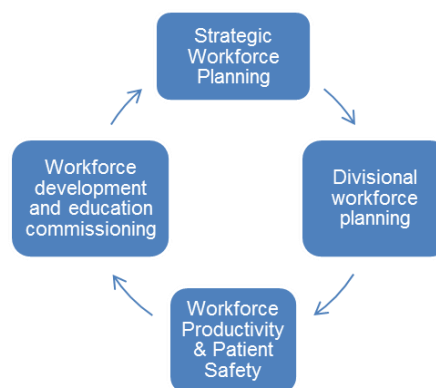
Indicators - indicators for the following areas are included within the Board Assurance report: finance, patient experience, patient safety, regulatory framework, performance, ward view, compliance and human resources. The full set of indicators is attached at appendix A.

4. Approach to Workforce Planning

4.1 Workforce planning and clinical engagement

Our future workforce requirements are driven by our clinical strategy. The workforce planning process is driven by the Trust's overall strategic aims and is operated through the cycle shown to the right.

The Trust ensures clinical engagement in the workforce planning process by ensuring that clinical professional leads play a key role in the development of our workforce plans. The trust Workforce Plan must be signed off by the Medical Director and Chief Nurse.



4.2 Governance and board approval

The Human Resources Scrutiny Committee, which is a sub-committee of the Board of Directors, receives the strategic workforce plan for formal sign off.

4.3 Strategic and locality workforce planning

The Trust will be required to play a key role in the delivery of new models of care in response to the Five Year Forward View and the work being progressed through GM Devolution. This will require different ways of working and we will continue to undertake integrated workforce planning with our partners in order to ensure that we have the right staff in place to deliver the best care for our local population.

The transformation plans being developed across Manchester and Greater Manchester will require changes to the workforce. The main strands of work are:

- Greater Manchester Health and Social Care Devolution
- Living Longer Living Better / One Team – development of community services and shift of care from hospital to community settings through neighbourhood teams
- Healthier Together – development of a single acute service operating across CMFT & UHSM
- Single Hospital Services – alignment of services across the three hospitals in Manchester (CMFT, UHSM and North Manchester General)

These changes will require a significant shift in culture. Leadership will be essential in achieving this and will require the design and delivery of targeted change strategies and interventions.

The implications of these changes on service design and workforce capability are:

- a transformation of community based care & support with the vertical integration of primary, community, mental health, hospital and social care services.
- a need to develop our current workforce around clinical skills, clinical accountability and care co-ordination. This will affect all staff groups but particularly our nursing and therapy workforce.
- there will be 12 neighbourhood teams as part of the Local Care Organisation (LCO) across Manchester and this requires further development of a collaborative multi-disciplinary team model.

- changes in the way acute hospital services are provided
- through a city wide Practitioner Design Team, a set of operating standards and core offer are being developed which include workforce considerations around the health and social care workforce which will be addressed within the Target Operating Model for the Integrated Access, Intermediate Care and Reablement and the Integrated Neighbourhood Teams. Across the city there is a governance structure supporting health and social care integration. The Trust's Chief Executive sits on the Executive Health and Wellbeing Board and the Deputy Chief Executive sits on the Locality Plan Programme Board and chairs the Manchester Provider Board (MPB) which focuses on Local Care Organisation and One Team (including Primary Care).
- there is a city wide LLLB Programme Board with a number of enabler workstreams with multi-agency membership reporting to it including a workforce workstream on which CMFT is represented. As part of that work, a set of key principles regarding management of workforce change have been developed jointly by all agencies involved to facilitate the delivery of the strategic aims of One Team. Internally the Trust has an Adult Social Care Project Group whose membership consists of senior colleagues across CMFT and MCC. Its remit is to deliver the integration of health and social care and it is accountable to the CMFT Shaping the Future of the MRI Board at a locality level and to the City Wide Leadership Group for the city approach.

4.4 Divisional Workforce Planning process

Divisional Workforce plans are developed and aligned to Divisional Business Plans as part of the annual business planning process. This is supported by divisional workforce planning events. Plans are monitored by the Operational Workforce Committee.

Workforce Plans are aligned to our commissioner's requirements to ensure we deliver appropriate care to the local population. These are also triangulated with the strategic workforce plan to ensure all plans are congruent with the overall strategy.

As part of this process, each Division has an annual 'Our People' Plan which is designed to ensure each division sets a clear direction and commitment to leading and enabling staff aligned to the Trusts overall People Strategy. The key areas of focus are on workforce information and policies, workforce design and effective planning, attraction and recruitment, motivating, involving and engaging staff and talent and performance management.

All new consultant posts are subject to the business case process. The Trust has a consistency panel to approve requests to recruit to all consultant posts which reviews the job plans of all consultants within the team to ensure consistency internally, with the application of Trust processes and that there is a need for the post.

4.5 Cost Improvement Programmes

Cost improvement programmes (CIPs) may lead to organisational change which requires consultation with staff members where there may be changes to their roles. Quality Impact Assessments (QIAs) are undertaken to ensure any changes do not adversely affect the delivery of our services. This process is described in more detail under section 3.3.

4.6 Quality, Safety and Risk Management

The Trust uses a recognised acuity and dependency tool (AUKUH) to inform the requirements in terms of nursing establishments alongside professional judgement for those areas where a NICE recognised tool is available (adult and children's in patient ward areas).

The Trust has implemented SafeCare software, which now allows matrons, lead nurses and Heads of Nursing to review all ward areas for a specific shift highlighting where staffing does not match acuity and dependency and enables action to be taken in real time.

During 2015/16 it was recognised there was a shortage of clinical staff in some key areas across the Trust that could not be met through traditional recruitment campaigns. As a result, the Trust undertook a recruitment campaign across the UK, Europe and in India. The recruitment has focused on nurses and acute physicians. As a result, nursing and midwifery vacancies have reduced by over 20% since August 2015.

In addition, a Nursing and Midwifery Retention Strategy has been developed supported by divisional retention plans to reduce the turnover rate of registered nurses and midwives, with a plan to reduce turnover further in 2016/17.

This strategy will also support a reduction in bank and agency spend and taken together with the recruitment campaigns will mean that there will be a net increase of substantive Nursing and Midwifery staff during 2016/17.

The Board of Directors of Central Manchester University Hospitals NHS Foundation Trust is kept informed via the bi-annual reports on nursing and midwifery staffing of:

- the current issues affecting the Trust's ability to achieve a fully established nursing and midwifery workforce
- the mitigating actions that are being undertaken
- the monitoring and triangulation of outcome indicators that provide a composite level of assurance that patient safety is being maintained.

Workforce indicators are triangulated with quality and financial indicators through the 'Board Assurance Report'. This provides assurance to the Board of Directors through a series of simple dashboards. It also enables areas of risk to be identified. The Trust indicators included in the report relating to human resources are detailed in Appendix A.

4.7 Workforce Efficiency & Productivity

The Trust utilises an E-Rostering system (HealthRoster) across our nursing and midwifery workforce. This helps the Trust deliver safe, efficient care across both our hospitals and in community settings. The system interfaces with our temporary staffing provider (NHS Professionals) to ensure that all shifts are appropriate and at safe level required to deliver the best care to our patients. This supports a reduction in the Trust's demand for more expensive agency staffing.

Agency price caps were introduced nationally in November 2015. The Trust has established an Agency group to support the introduction of these caps. This will help inform any long term workforce planning to reduce any dependence on agency staff, where there is a current under-supply of skilled staff.

The proposed Apprenticeship levy of 0.5% of the Trust's paybill is a risk and Trust will need to plan for its introduction in April 2017.

The Trust has established a number of workstreams around workforce efficiency. In particular, administrative and corporate function efficiencies are planned for 2016/17 which may result in a reduction in headcount.

4.8 Workforce development and education commissioning

To support strategic workforce changes, Health Education England (HEE) has developed a workforce planning process ensuring employers are actively engaged in establishing the future requirement for staff and in agreeing the investment plans of their respective Local Education and Training Boards. As part of that process the Trust submits an annual Workforce plan detailing risks and training requirements along with narrative concerning the future workforce supply and demand (5 year demand) which informs HEE education commissioning numbers. The plans have Board level sign off.

The Trust has an established Strategic Workforce and Education Committee chaired by the Executive Director of HR and Corporate Services. The Strategic Workforce and Education Committee focuses on three key strategic areas:

1. Workforce planning and design
2. Learning culture and talent development
3. Education and teaching

The aim of the Committee is to raise standards in education, teaching and learning for all our staff by setting direction, developing a learning culture, implementing effective quality and governance arrangements and further developing collaborative partnerships with professional groups, R&I and education providers.

The role of the committee is to oversee the commissioning of the Trust's annual education and training programme, to develop the Trust's education and training strategy and to ensure that an effective strategic workforce plan is developed in line with Trust plans. The committee is also accountable for the commissioning, monitoring and the reporting of performance of education, training and development across the Trust. It also ensures education, teaching and learning is aligned to the OD and ED&I strategies including the development of the widening participation agenda.

The Trust has a well-developed OD Strategy that aims to develop a high performing, inclusive and values based culture that will ensure we are both a resilient and agile organisation and able to meet the strategic change challenges outlined above. The key areas of focus are on:

- Leadership and Management development for all staff groups but with a particular focus on our senior leadership teams, medical staff and frontline managers. These programmes set out our expectations of staff and the value of distributed leadership in achieving success
- Values and Behaviours programme led on by our COO and focused on embedding the Trusts behavioural framework through recruitment, appraisal and communications
- Further developing High performing teams through evidence based diagnostics and interventions (based on Michael West's research)
- Developing a patient experience framework based on the features of a high performing, inclusive & values based culture, which aligns the work to build an inclusive and engaged workforce with the objective of delivering a better patient experience.
- Staff engagement and wellbeing through staff surveys, initiatives and interventions, staff support and counselling.
- Building change capability and staff engagement around transformation, financial and quality improvement programmes
- Participating in a national culture change programme led by Monitor and The Kings Fund and based on Michael West's research.

The Trust has a track record of successfully delivering apprenticeship programmes with over 200 apprentices enrolled in 2014/15. We will continue to deliver programmes in Healthcare Support, GP Practices, Pharmacy and Business Administration and also scope out the need to deliver apprenticeships within AHP and A&C staff groups within the next 12 months.

The Trust will continue its successful 'Proud to Care' campaign which has successfully contributed to increased nurse and midwifery recruitment. A small number of pilots are being developed to support a values based approach to recruitment to enable us to attract and select candidates for nursing, midwifery and wider staff groups, who share the Trust's values. The Trust's values are Pride, Respect, Empathy, Consideration, Compassion and Dignity.

In partnership with the University of Bolton the Trust has developed a non-commissioned nursing programme, in order to increase the supply of newly qualified nurses for CMFT. This will help the Trust address the medium to long term workforce supply needs. The Trust will also continue to deliver its successful Return to Practice programme to enable nurses to return to the profession.

The Trust is proud to be a major local employer and has worked with the local community to deliver opportunities for the population. The nursing assistant pre-employment programme is one of the trust's most successful initiatives and has allowed it to attract and retain a significant number of young people into the workforce.

The benefits to the Trust include the opportunity to recruit high quality staff members who have demonstrated they have the required key skills.

5. Approach to Financial Planning

5.1 Financial forecasts and modelling 2016/17

Run Rate and Financial Pressures

The Trust's Financial Plan for 2016/17 continues to aim for full delivery of the control total set for the year.

The Financial Plan starts from recurrent run rate deficit baseline projection of £65m. The key run rate challenges that have faced the Trust over the preceding 6 months are:

- The impact of CPE from both the cost of screening and use of cohort wards and the impact on activity performance from reduced ward capacity
- Urgent care system – the excess cost of providing safe and effective capacity and patient flow
- The excess costs of consultant and non-consultant medical staff cover
- The excess costs of using agency nurses arising predominantly from the shortage of nurses nationally, available to recruit
- Prescribing cost overspends
- Underperformance against planned activity
- The impact of the national funding and pricing settlement in 2015/16.

In addition to the run rate challenge, the 2016/17 efficiency and funding challenge adds an additional £25m of financial challenge, comprising:

- Pay settlements and pension changes - £14.4m including the 1% basic pay uplift, cost of increments and employers' pension costs
- Clinical, facilities and estate cost inflation - £9.7m
- Reduced underlying prices for NHS clinical services of £8.4m, being the deferred impact of the 2015/16 ETO tariff package not accepted in 2015/16
- Further reduced funding for training and education – a cumulative reduction to the Trust of £8m since 2013
- partially offset by resumed access to CQUIN funding (as long as there are no cost consequences to achievability) and some generic and CNST specific uplifts to national tariffs.

Based upon the assessment of underlying run-rate performance combined with the net efficiency requirement for 2016/17, and offset by the £20.2m from the Sustainability and Transformation Fund, the Trust has an overall operational financial delivery challenge for 2016/17 of £70m, to deliver the 2016/17 control total.

Once items such as “cost pass-throughs”, education infrastructure and “recharges to other trusts” have been removed from the Trust's planned 16/17 income of £1bn, this £70m challenge equates to delivering **9%** savings in the year across £800m of our continuing activities.

Activity and Contract Income

The Trust's activity planning model is deployed at Divisional level.

For planned activity the model starts with the forecast activity for the current year and then adjusts for the following:

- local and national performance standards e.g. RTT, cancer and diagnostic waiting times
- achievement of NHS constitution standards
- underlying population and demographic trends, recognising the comparatively poor health outcomes of the trust's catchment area.

For unplanned activity the model starts with the forecast activity for the current year and then adjusts for:

- recent trends in terms of growth
- achievement of A&E standards
- projected impact of service redesign

Any anticipated changes, forecast through commissioner's commissioning intentions that will impact on referrals or patient flows are considered and, if sufficiently evidenced, are incorporated into the demand model.

The 2016/17 plans include:

- decommissioning or transfer to another provider, for a small number of Community services
- the impact on CMFT of a small number of developments following the contract expiry for the Greater Manchester CAT services
- some minor alterations to models of care (i.e. moves into outpatient-type service areas and expansion of telephone contacts)

For 2016/17 the output of the process has resulted in planned activity levels that are broadly 1-2% above 2015/16 plan in terms of value and activity, except where more specific details vary from this – specific examples include:

- expansion in Renal transplants due to further organ availability resulting from the live donor programme
- a step change in Paediatric Stem Cell transplants due to growing demand and clinical need
- an additional CAMHS Tier 4 bed and significant step up in Neonatal cot capacity, both to meet growing demand and ensure compliance with recommended occupancy levels
- further increases in Macular care to comply with the recommended frequency of intervals between treatment
- assumptions made about managing and mitigating the impact of CPE, to support increased levels of activity in the Heart Centre (Cardiology and Cardiac surgery)
- some marginal growth in birth numbers
- additional Adult critical care beds in the main unit and in the Heart Centre

The actual income projections also include:

- realisation of appropriate levels of reimbursement for unbundled or separated activity areas (e.g. Cancer MDTs and Associated Healthcare Professionals) and screening programmes (New Born Blood Spot screening) Some of these proposals are still under discussion with relevant commissioners, despite clear advance notification being given in September 2015.
- cost inflation on capacity based services (e.g. community services and paediatric and neonatal intensive care), in line with contract agreements reached in previous years

- significant further increases in drug and device expenditure associated with general growth as well as the recurrent impact of new NICE and Commissioning policy decisions (e.g. Hepatitis C drug therapy) and increases in activity associated with high cost excluded devices (e.g. TAVI)
- successful tender award for the delivery of cytology screening services to Greater Manchester (in addition to existing Lancashire and Cumbria provision)

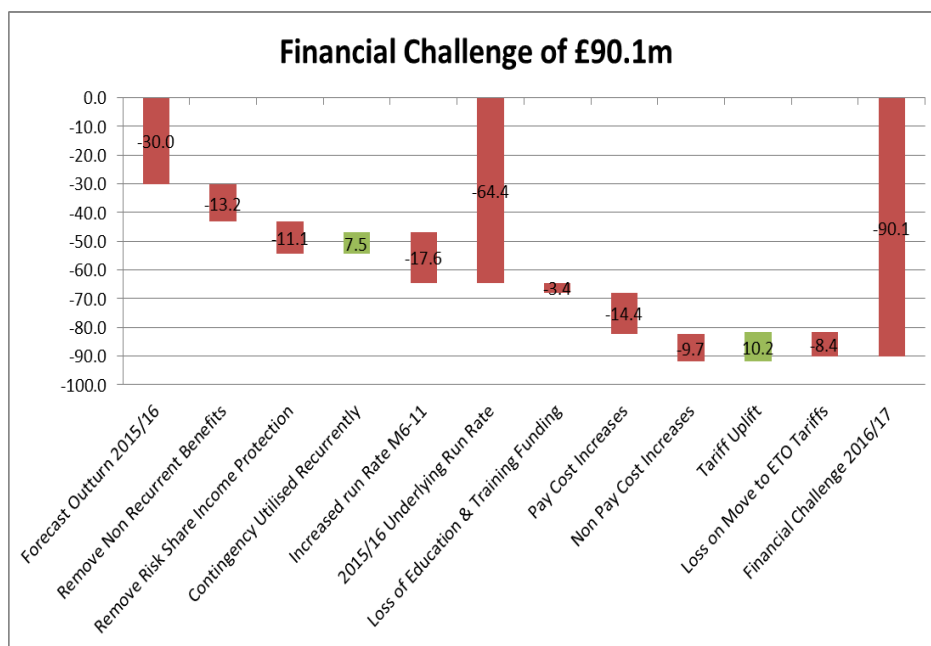
CMFT was a DTR provider in 2015/16 therefore the shift in income also reflects:

- 2014/15 to 2015/16 *and* then 2016/17 National Tariffs
- Reintroduction of CQUIN – albeit the CQUIN proposals for Specialised Commissioning, only shared in mid March 2016, place significant aspects of this CQUIN (£6.6m) in jeopardy due to requirements to incur significant implementation costs or accept a wholesale transfer of budgetary risk on significant cost items.

More information on these changes is provided in the Clinical Income bridge workings.

5.2 Efficiency Savings for 2016/17

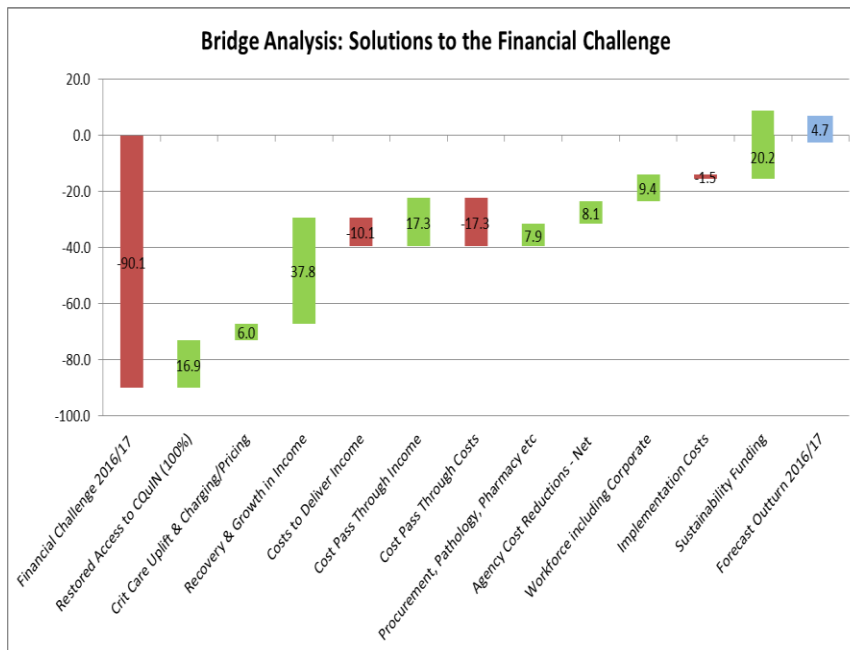
The aggregate financial challenge for 2016/17 is £90m combining the £65m run rate challenge and the £25m efficiency and funding challenge as shown below:



The Trust has established a dedicated PMO function which has also incorporated the work of the previously established Transformation team. It has Director level leadership with direct input from Programme and Divisional Finance Director roles to support and drive the overall programme. The overall virtual Turnaround team comprises nearly 20 individuals for whom a significant element of their role is the achievement of the work stream improvements and delivery of the concomitant financial benefits. This capacity and structure supports a set of identified, accountable lead Executive Director roles for each key work stream. This internal Turnaround Programme is driving and supporting delivery through 5 main programmes of work:

- Recovery of run rate issues from 2015/16
A key driver in developing the cost reduction elements of the programme has been the imperative to substantially reverse the main run rate expenditure pressures experienced during 2015/16. Key areas include:
 - Full delivery of elective programmes, at least to 2015/16 planned levels
 - Containing the excess costs of resilient urgent care delivery
 - Reducing the continuing costs of safe and effective management of CPE
 - Reducing the excess costs of medical staff and agency nurse staffing
 - Tacking prescribing cost overruns
- Cross cutting work streams
These work streams focus on improving productivity and efficiency and support the recovery of activity underperformance. Examples include:
 - Theatre improvement and elective delivery programmes
 - Improving patient flow and reducing length of stay
 - Continuing follow-through on delivering outpatient transformation
 - Medical workforce contribution
 - Administrative effectiveness
 - Medicine optimisation
 - Effective use of Diagnostic resources
 - Continuing leading-edge procurement programmes
- Review of loss making services - is a process of strategic review of those clinical services which incur continuing substantial operating losses. The Board is committed to taking active decisions on selective loss-making service lines during 2016/17. Due to the timelines for implementation after completion of these reviews, no reliance is placed on achieving financial savings from this work stream in 2016/17.
- Management Controls - Whilst the Trust considers the above approaches will develop a full set of sustainable solutions to the current financial challenges, it is also recognised that lead-in times for full delivery will place delivery of the overall financial plan at risk through 2016/17 and has therefore progressively implemented increased management controls through the fourth quarter of 2015/16. These include vacancy control processes across all Divisions (for all non-front-line-nursing roles), and non-pay spend controls to further reduce discretionary (non-clinical) spend.
- Accelerated Corporate Savings and Workforce – Savings targets initially set based on 20% of pay budgets for all Corporate functions, will be delivered from a wide range of measures including both pay and non-pay savings and a small element of income generation. These measures will deliver £3m of savings from April 2016, moving to a full-year impact of £4.5m before April 2017. With a similar approach adopted across many clinical Divisions, plans link into a review of administrative / support functions where effective use of increased IT capabilities will be a key enabler of clinical and administrative efficiency. Other workforce cost savings include further reducing agency premium costs across other staff groups including Pharmacy, AHPs and Laboratory Medicine. Work continues to improve the consistent management of sickness absence and to consolidate progress made during 2015/16 with implementing electronic rostering.

A summary of the expected impact of the identified solutions to the 2016/17 financial challenge is shown in the bridge below.



Risks and Key Dependencies

The Trust needs to deliver savings of 9% in the year to achieve its required control total. This requires the Trust to recover its elective activity; grow in certain areas of activity; contain its overspends and reduce its overall cost base simultaneously.

The Trust provided a schedule of key assumptions, dependencies and system-related delivery risks as an attachment to its acceptance letter regarding the Sustainability and Transformation Fund. A short summary of these is provided below:

- full access to CQUIN at 100% from both CCGs and Specialised Commissioning without the need for additional expenditure
- continued support across the surrounding CCGs for Urgent Care Resilience funding at 2015/16 levels
- zero losses on contract deductions / penalties
- the retention of existing gain share agreements on drug price savings
- flat cash on HEE / NIHR income streams
- no extra in year cost impacts from national policy developments e.g. 7 day working, junior doctors contract, or loss of income from industrial action
- no negative impact of land and building indices on valuation of the estate
- existing patterns of patient flows in Urgent Care are maintained
- CPE containment strategies continue to be increasingly effective

In addition, an assessment of the high level risks that could impact upon the delivery of the plan have been grouped into 5 themes:

- key dependences in income plans
 - achievement of the Sustainability and Transformation Fund
 - achievement of CQUIN
- operational delivery of both income and productivity improvements
- turnaround delivery in terms of capacity, focus and pace
- the containment of cost overruns
- contract framework risks
 - pricing

- clinical coding
- resilience funding

As a result of the emerging run rate challenges in late autumn, the Trust put itself into internal Turnaround in December 2015 and has strengthened both its management and government processes accordingly. In light of the level of challenge that the delivery of the 2016/17 plan creates, the Trust has now also decided to engage additional external support into the Turnaround process through the NHS Improvement procurement process.

It is recognised that a challenge of this magnitude will only be successful if the whole organisation engages in its delivery and so in addition to the turnaround team and external support, the Trust is also undertaking and will continue to develop, throughout the year, a whole range of staff engagement events “Ideas into Action” to ensure that staff feel fully engaged and able to contribute their ideas. (So far 200 staff have attended one of these events)

The Sustainability and Transformation Fund

This plan for 2016/17 underpins acceptance of the requirements set out in the letter to CMFT of January 15th 2016. £20.2m of Sustainability funding has accordingly been incorporated as income within CMFT financial plans and cash flow forecasts.

2016/17 Financial Sustainability Risk Rating

Is forecast to remain at a “2”, in all foreseeable scenarios.

Sensitivity Analysis

CMFT has undertaken high-level initial risk assessment across key aspects of this draft plan, resulting in the downside risk assessment originally outlined as an attachment to the acceptance letter. In particular, this assessment of risks continues to actively consider:

- a) Risk assessment of the cost reduction and revenue generation work streams including an assessment of the impact of any slippage / failure of a proportion of the schemes on cash flow and liquidity
- b) Assessment of the inflation assumptions included in the financial plans against the nationally indicated assumptions and also against the inflation assumptions identified by other local providers.

At this stage the plan has a significant range of material risks which continue to require active management and mitigation through driving internal delivery using the full rigour and pace of the internal Turnaround programme established.

Risk reduction in relation to delivery of this plan is a daily priority across CMFT’s leadership team.

Lord Carter’s Provider Productivity Work Programme

The Trust’s overall efficiency programme (see above section on efficiency savings for 2016/17) encompasses plans to address opportunities for improvements within Pharmacy, Laboratory Services, Medical, Nursing, Corporate and Administrative Workforces. Additional work streams have dedicated focus on length of stay, outpatients and theatres efficiencies.

Additionally the Trust is actively engaged with the Pan Greater Manchester review of Pathology services which is underway and a similar Devolution Manchester review of Radiology services. Other areas identified as part of delivering the Devolution Manchester agenda are Back Office functions and Estates utilisation.

We look forward to further development of the Productivity and Efficiency Portal to facilitate the use of the information to enable clinical engagement.

5.3 Capital commentary

The Trust has an identified capital programme for the 2016/17 financial year with a total value of £39m, of which:

- £22m is from internally generated funding including planned slippage from 2015/16;
- £7m relates to continuing commitments to life-cycling programmes as part of the 38-year PFI contract;
- £5m relates to continuing (and largely pre-committed) strategic investments in information technology and systems, supported by a discrete loan facility with ITFF; and
- £5m to continue programmes maintaining statutory compliance

The expenditure plans for the year encompass a number of individual schemes, which collectively encompass the delivery of £23m on the renewal of existing estate and compliance with updated standards, and a further £16m of efficiency generating schemes across IM&T equipment and estates.

6. Link to Emerging Sustainability and Transformation Plan

6.1 Greater Manchester STP

In February 2015, the 37 NHS organisations and local authorities in Greater Manchester signed a landmark devolution agreement to take charge of health and social care spending and decisions across the city region. The Devolution vision is **‘to deliver the fastest and greatest improvement in the health and wellbeing’** creating a strong, safe and sustainable health and care system that is fit for the future. To do this change will be delivered in two critical areas that reflect the direction set out in the five year forward view:

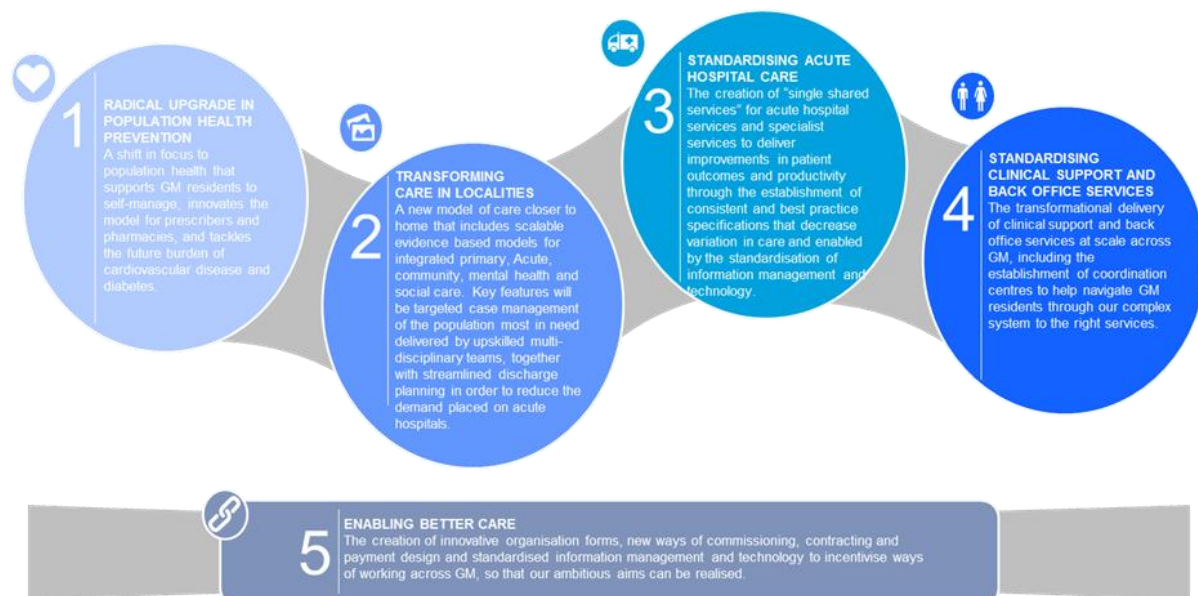
1. Reaching a ‘new deal’ with the public - public services will be responsible for their localities. For example they will take responsibility for ensuring easy, timely access to good quality seven day a week primary care and supporting families to bring up their children to have the best start in life. At the same time the people of GM must take greater charge of, and responsibility for, their own health and wellbeing by, for example, keeping active and moving at whatever stage of life, registering with a GP and going for regular check-ups, drinking and eating sensibly, not smoking and encouraging their children to do the same.

2. Creating a new health and care system - the devolution agreement affords us the opportunity to think differently and promote service and system change so that we prioritise the improvement in outcomes for the people of GM, above individual organisational interest.

The sustainability and transformation plans for GM are set out in the Strategic Plan. The Strategic Plan has been built from ten plans created by the local authorities and NHS in each part of Greater Manchester, as well as the hospitals and other providers of NHS services. It also includes Greater Manchester wide plans, in particular it sets out the five transformation changes that, if implemented across the system, will make a significant contribution to the achievement of long-term clinical and financial sustainability.

System Transformation

Five areas for transformational change are set out below.



6.2 What this means for CMFT

Transforming community based care and support

We are working with the other community service providers across Manchester, Manchester City Council and primary care to develop new place based models of care. This will be based on newly established multidisciplinary health and social care neighbourhood teams – an initiative known as One-Team.

The neighbourhood teams will be based on geographical areas as opposed to organisation. There will be 12 teams across Manchester and each team will focus on the place and people that they serve, centred around the ethos that care should be closer to home rather than delivered within a hospital or care home. Working in this way, One Team will shift the focus from organisations and services to place and progressive upstream investment.

These services will be brought together into a single Local Care Organisations (LCO) which will expand over time to include community, social care, acute, mental health services, third sector providers

Standardising acute and specialist care

Single Hospital Service - Manchester is unique in having three acute hospitals within one city. This leads to inefficiencies and inequalities in standards and outcomes for patients. An independent review is being undertaken led by Sir Jonathan Michael. It will cover North Manchester General Hospital, Wythenshawe Hospital and Withington Community Hospital and CMFT (excluding Trafford). The Review will be structured around two phases:

1. December 2015 to March 2016 - assessment of the potential benefits of a fully aligned hospital service model.
2. March to June 2016 - detailed appraisal of the most appropriate and effective governance and organisational arrangements to deliver the identified benefits.

The findings will be presented to the Manchester Health and Wellbeing Board and the Board, which includes representation from the city council, the three trusts and the Manchester CCGs, will determine the actions that need to be taken, both by the Trusts and by the Manchester Commissioners, to achieve the future vision described by Sir Jonathan.

Healthier Together - Healthier Together is the commissioner led major change programme, one element of which has been to develop a new model for the provision of acute services based on 'specialist hospitals' which will provide a comprehensive A&E service with surgical back-up 24/7, working in a 'single service' with a number of 'local hospitals' which will continue to provide high quality acute hospital care, but will not have an A&E service with full surgical back up available 24/7.

CMFT has been designated a 'specialist hospital' working in a single service with UHSM as a local hospital. During 2016/17, further work will be undertaken to plan implementation.

Specialist service chains - we plan to develop specialist services chains, taking a lead provider role across GM, for a number of our specialist services such as paediatric surgery and specialist ophthalmology.

GM has been successful in securing £450 million transformation funding over 5 years. The fund will be used to support the five transformation themes set out in GM's strategic plan (see above).

7. Membership and Elections

7.1 Governor Elections in previous year (2015) and plans for the coming 12 months

The majority of our Governors (25 out of 35) are elected from and by our members. All qualifying members aged 16 years or over are able to nominate themselves to stand for election as a Governor. Elections are held each year for those Governor posts whose term of office is ending or where a Governor has resigned. All qualifying members are issued with ballot papers to vote for the candidate(s) that they wish to be elected to our Council of Governors.

During 2015, ten Governor seats (Public and Staff) were open for election. 40 members requested nomination forms, from which 30 candidates went on to stand for election. The ratio of candidates standing for election (per seats open for election) was sustained at the 2014 level of c.1:3. The election process was successful with all seats open for election filled. During 2016, currently, 9 seats will be up for election. Plans are being progressed to undertake a further Governor Election Campaign around July 2016 in order to encourage members to stand.

7.2 Governor recruitment, training and development and engagement

At the start of the election process an invitation letter, from our Chairman, is sent out to all qualifying members. Personalised letters are also sent to members that have previously expressed an interest in the role of Governor/Standing for Election. Elections are promoted via

- Membership Newsletter and our Governor Election Webpage
- Trust intranet and staff briefing
- Election pack/poster to highlight the election process to their patients/visitors and staff
- Social media channels (Trust's Twitter and Facebook accounts) under the slogan "*Be the Elected Voice of our Members, Representing their Interests and Views*".

Each year a bespoke Candidate Information Pack is produced which includes a list of FAQs.

Training and development for Governors includes:

- Induction Training for all new Governors including bespoke Governors' Resource Pack and support arrangements
- Chairman led Governor Development Sessions which include matters that impact on Trust/Governor role, review of the Trust's Operational Plan, Quality Report and Annual Report & Accounts.

Our Governor Development Programme is developed and informed by finding from our Annual Governor Questionnaire, Governor Group Assessments and Governor Skill Mix Matrix.

The Trust recognises that it can be difficult for Governors to engage with their members. We support and facilitate governor/public engagement through:

- Membership and Public Engagement Pack
- Holding major engagement events: a Young People's Open Day and Annual Members' Meeting with questionnaires and engagement information packs issued to Governors to facilitate direct face-to-face engagement with attendees.
- Monthly Chairman's briefings are issued which provide Trust and NHS key information that Governors are encouraged to share with members.

- Governors are also issued with a yearly Operational Plan Overview (includes FAQs) and a Forward Plan Engagement Information Pack (includes questionnaire, poster and newsletter) in order to help them to canvass the views and opinion of members/public.

7.3 Membership Strategy

The Trust's total membership is c. 28,000 (c. public 14,700 and c. staff 13,800). In keeping with our Membership Strategy, we aim to ensure our public membership is representative of the communities that we serve and that a majority of public members is sustained by addressing any natural attrition and membership profile short-falls. This is facilitated each year by holding an annual public member recruitment campaign.

In early 2016, a review of the Membership profile was undertaken and presented to the Governors' Membership Group (January 2016) from which a targeted public member recruitment campaign was held in February 2016 and successfully completed in March 2016. As part of this campaign around 600 new public members were recruited, resulting in positive outcomes being achieved across each targeted profile group, namely: Young people (11 – 16 years), 40 – 59 year age groups, Males, White Ethnic Groups including Gypsy or Irish Traveller and Other, Mixed Ethnic Group i.e. White and Black, Arab Ethnic Group and Chinese Ethnic Group.

Board Assurance Report - Indicators

<p>Finance Continuity of Services Rating Delivery of Financial Plan – All Divisions</p> <p>Patient Experience Clostridium Difficile - Lapse of Care Complaint Volumes Complaint Volumes - Reopened Complaints - Outstanding Complaints - Outstanding Beyond 40 Days Complaints Resolved Within 25 Days Complaints Unresolved Within 40 Days Compliments FFT % Extremely Likely FFT A&E % Extremely Likely FFT A&E Response Rate FFT Inpatient % Extremely Likely FFT Ward Response Rate Food and Nutrition Nursing Workforce – Plan Compliance Nursing Workforce Day Hours – Plan Compliance Nursing Workforce Night Hours – Plan Compliance Pain Management PALS - Concern</p> <p>Patient Safety Actual Harm Incidents: Level 4-5 Clostridium Difficile - Incidents CPE New Positives CPE Percentage Screened Positive Crude Mortality Crude Mortality - Elective Crude Mortality - Non Elective EWS Alert Response Rate GMC Trainee Survey – Number of low scoring outliers GMC Trainee Survey – Specialties meeting national average Harm: Catheter Associated Urinary Tract Infection Harm: Patient Falls Harm: Pressure Ulcers Harm: VTE HSMR Incidents: Patient Falls: Level 4-5 Incidents: Pressure Ulcers: Grade 3-4 Medication Errors: Level 4-5 Methicillin-resistant Staphylococcus Aureus Never Events Participation of Mandatory National Clinical Audits SHMI</p> <p>Regulatory Framework Community Activity Data Completeness Community Referral Completeness Community RTT Completeness Continuity of Services Rating CQC Rating Governance Risk Rating - Trust</p>	<p>Performance 18 Weeks Specialty Performance - Admitted 18 Weeks Specialty Performance - Incomplete 18 Weeks Specialty Performance - Non Admitted A&E - 4 Hours Arrival to Departure Average Inpatient LOS Days (Excl. Assessment Units) Cancelled Operations 28 day Breaches Cancer 31 Days First Treatment Cancer 31 Days Sub Chemo Treatment Cancer 31 Days Sub Surgical Treatment Cancer 62 Days RTT Cancer 62 Days Screening RTT Cancer Urgent 2 Week Wait Referrals Diagnostic Performance DNA Rate: Follow-up Appointments DNA Rate: New Appointments Elective Actual vs Plan Emergency Admissions - Short Stay Emergency Admissions - Avg. LOS Internal Governance Risk Rating – All Divisions Outpatient Actual vs Plan Percentage of Cancelled Operations RTT - 18 Weeks(Admitted Patients) RTT - 18 Weeks(Incomplete Pathways) RTT - 18 Weeks(Non-Admitted Patients)</p> <p>Ward View Ward: Clinical Mandatory Training Ward: Complaint Volumes Ward: FFT Inpatient % Extremely Likely Ward: Food and Nutrition Ward: Incidents: Patient Falls: Level 4-5 Ward: Incidents: Pressure Ulcers: Grade 3-4 Ward: Medication Errors: Level 4-5 Ward: Nursing Workforce Non-RN Day Hours – Plan Compliance Ward: Nursing Workforce Non-RN Night Hours – Plan</p> <p>Compliance Ward: Nursing Workforce RN Day Hours – Plan Compliance Ward: Nursing Workforce RN Night Hours – Plan Compliance Ward: Pain Management Ward: Sickness Absence Ward: Turnover</p> <p>Human Resources Admin and Clerical Agency Spend Appraisals BME Staff Retention Clinical Mandatory Training Qualified Nursing & Midwifery Vacancies Sickness Absence Staff Retention Time to Fill Vacancy Time to Fill Vacancy - 3mth rolling Turnover Turnover - 3mth rolling</p>
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