Royal Surrey County Hospital NHS
NHS Foundation Trust

Strategic Plan Document for 2013-14

Strategic Plan for y/e 31 March 2014 (and 2015, 2016)

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

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Date	**31st May 2013**

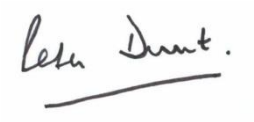
The attached Strategic Plan is intended to reflect the Trust's business plan over the next three years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

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

Approved on behalf of the Board of Directors by:

Name *(Chair)*	Peter Dunt

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Nick Moberly

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Paul Biddle

Signature 

1. Strategic Context and Direction

1.1 RSCH is a district general hospital serving a catchment population of 320k in Guildford and surrounding areas; and the tertiary cancer centre for a broader catchment population of 1-2 million people (depending on the tumour type) in Surrey, West Sussex and Hampshire and beyond.

1.2 Demographics

The population of Surrey is generally more affluent and older than the national average, although there are pockets of deprivation, with a smaller proportion of people from ethnic minorities.

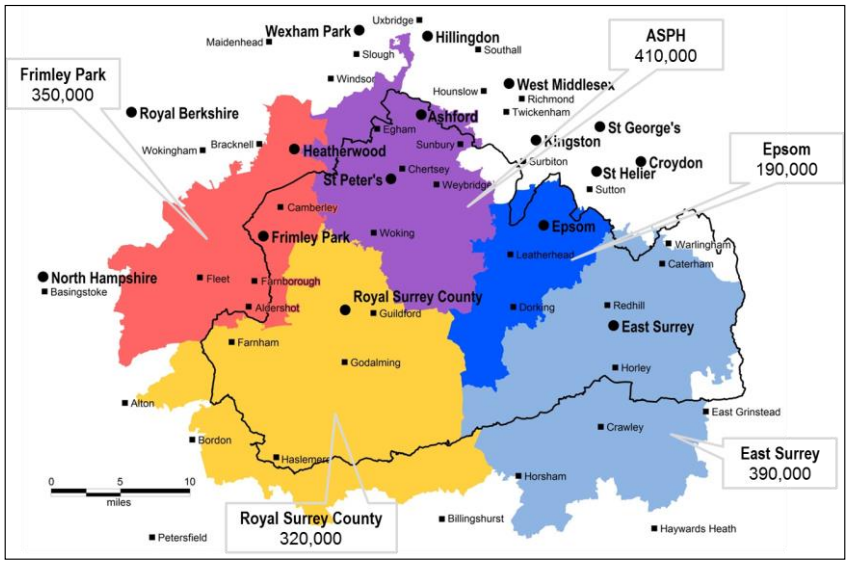
Characteristic	Guildford, Waverley and Woking*	England
Population:		
Estimated % growth	+1.6%	+3.8%
Age Profile %:		
0-15	19.1%	20.2%
16-64	65.0%	64.0%
65+	15.9%	15.9%
Ethnic Group %:		
White	95.2%	90.9%
Other	4.8%	9.1%
Life Expectancy:		
– **Male**	79.7	77.3
– **Female**	83.2	81.6
% with limiting long-term illness	13.3%	17.9%
Qualifications:		
No qualifications	18.7%	28.9%
<5 'O' s (or equiv)	14.2%	16.6%
5+ 'O' s (or equiv)	20.8%	19.4%
2 'A' levels (or equiv)	10.5%	8.3%
First degree or above	30.0%	19.9%
Other	5.9%	6.9%

Like other trusts nationally, over the coming years RSCH expects to face underlying growth in demand for healthcare services as a result of an ageing population, as well as continued steady growth in demand for cancer services.

1.3 General Hospital Services

The pattern of acute provision in Surrey is relatively dispersed, with 5 mid-sized general hospitals providing services across the county.

Surrey Providers and Population



Ashford and St. Peter's Hospitals NHS NHS Foundation Trust

Working together to put **patients first**

Royal Surrey County Hospital NHS NHS Foundation Trust

Of these hospitals:

- 3 are Foundation Trusts (RSCH, ASPH, FPH) with a good track record of clinical, operational and financial performance
- One (SASH) is on a trajectory to FT status, having turned around a historic position of poor clinical and operational performance, although it still has to complete its process of financial stabilisation
- One (Epsom), which is part of the ESUHT, is subject to the London-led Better Services, Better Value review, and may at some point be subject to significant service reconfiguration.

In the main, the hospitals have distinct general hospital catchments, and a good track record of collaboration; and competition for DGH services between the trusts is not intense. The biggest single competitive flashpoint in the county relates to the provision of cardiovascular services, with both ASPH and FPH wanting to establish themselves as significant regional “hyper-acute” providers.

RSCH has a web of collaborative links for DGH services which bind the trusts together and create a significant incentive for all parties to maintain good relationships – most notably:

- Cardiology – collaboration with FPH. RSCH patients requiring angioplasty are referred to FPH; and RSCH cardiologists participate in the FPH cardiology on call rota
- Vascular – collaboration with FPH. RSCH buys in a vascular service from FPH
- ENT – RSCH is the hub of a network embracing FPH, ASPH, and Epsom Hospital
- OMFS – RSCH is the hub of a network embracing FPH, ASPH, SASH and Hampshire Hospitals
- Stroke – a Surrey-wide telemedicine-enabled on call rota is in place
- Paediatrics – RSCH has a Special Care Baby Unit, and refers babies requiring intensive care to the APSH NICU

Some independent provision is apparent within the county. A number of GP provider businesses have been established on the margins of the Trust's catchment – e.g. PIMS in Woking, EDICS in Epsom and MEDICS in Dorking. BMI Mount Alvernia in Guildford undertakes Choose and Book work. Virgin has established an Any Qualified Provider business in partnership with Ashford and St. Peters which operates in the Trust's core catchment. (Virgin has also taken over the local contract for the provision of community services).

Although an increasing amount of more specialist work is now being undertaken within the county, there are still significant tertiary flows mainly to London in specialties such as cardiology, neurosciences, haematology and renal services. As a general direction of travel, all of the Surrey trusts, with commissioner support, are seeking to repatriate as much work as possible to the county – which in principle would be good for patients, cheaper for commissioners and helpful in maintaining the sustainability of the Surrey providers.

Overall, it is the Trust's intention to maintain market share within its existing catchment, incrementally grow market share at the boundaries of its catchment in areas such as Cobham/Epsom, Dorking, Cranleigh, Horsham, and parts of East Hampshire (e.g. Borden).

1.4 Specialist Cancer Services

RSCH is the specialist Cancer Centre for a 1m+ catchment population in Surrey, West Sussex and Hampshire, receiving referrals from the 3 Surrey DGHs and also (for some other tumour types) from other non-Surrey hospitals such as Brighton and Sussex University Hospitals, Western Sussex Hospitals, Hampshire Hospitals, and Epsom and St Helier University Hospitals. In this role it provides the following specialist cancer services (in addition to locally based cancer services for Breast, Lung, and Colorectal):

- HPB (to a 2 million population, including BSUH
- OG
- Urology (including Basingstoke)
- Gynae-oncology
- Head and Neck/OMFS (including Hampshire Hospitals)
- Level 2 Haemato-oncology (for the RSCH and FPH catchments)
- Radiotherapy and Chemotherapy
- Paediatric, and Teenage and Young Adult, Oncology (in partnership with the Royal Marsden)

RSCH's main competitors in the delivery of specialist cancer services are the specialist Cancer Centres serving adjacent populations, i.e. Royal Marsden, BSUH, Portsmouth, Southampton and Royal Berkshire. In addition, Hampshire Hospitals has indicated its intention to establish its own Radiotherapy service (to sit alongside its existing Chemotherapy service).

With the recent changes to commissioning structures and the absorption/replacement of the cancer networks by the new Strategic Clinical Networks, maintaining specialist cancer catchment is vitally important.

Against this backdrop, RSCH has sought to strengthen and stabilise its catchment by building a £10m radiotherapy outreach facility at SASH's Redhill site (which will open early in FY 2014/15) and by establishing outreach Chemotherapy at Ashford Hospital (part of ASPH). It is also intended to establish outreach Chemotherapy at FPH. It is seeking to ensure that if Hampshire Hospitals establishes its own Radiotherapy service that current referral pathways for specialist cancer surgery are maintained.

Overall, it is the Trust's objective to maintain and incrementally increase its existing catchment, with Epsom and other parts of South West London offering particular opportunities.

1.5 Clinical Support Services

RSCH has had a long standing partnership with FPH in pathology, which has now been extended to create a 3-way partnership with ASPH, known as Surrey Pathology Services.

This is one of the largest NHS-only pathology networks nationally, and continues not only to deliver high quality pathology services at competitive price point, but also to compete effectively for 3rd party business both from the NHS and the private sector. It is the intention of all 3 partners in SPS to continue extending and growing this business.

1.6 Strategic Partnerships – ASPH

During 2012, RSCH has established a "Principal Partnership" with ASPH, which is designed to foster collaboration both on the delivery of clinical services and on the provision of support functions. The vision of both trusts is to establish a "Surrey University Hospitals Partnership", working in close collaboration with the University of Surrey and other academic partners, which will:

- Deliver a joint and complementary Clinical Strategy for Surrey for specialist and core services – improving the clinical outcomes and patient experience for our population.
- Create a Centre of Excellence for Academic and Clinical Research and Training.
- Be an exemplar for the partnership delivery of support and clinical support services that are cost effective, high quality and resilient.

1.7 Commissioning Intentions

Overall, the 2013/14 contracting round has been positive for the Trust, with a number of important proposals (such as proper payment for OP therapy services) being recognised and agreed.

Specialist commissioners also recognised further growth for specialist cancer services.

Guildford and Waverley CCG has however set out an aggressive set of QIPP plans, which would reduce the value of the CCG contract by £7m if successfully implemented. These focus on adult unscheduled care (and in particular the frail elderly pathway), paediatric A&E attendances, and overall levels of OP referrals, as well as other themes. Overall, RSCH is sceptical that these plans will be delivered in full, but is committed to working with the CCG to move these forward. As far as unscheduled care is concerned, RSCH's financial interest is aligned with the CCG's, since - by virtue of the 30% emergency threshold - it loses money on emergency activity above 08/09 levels.

1.8 Overall Assessment Of The Market Environment

RSCH enjoys a reasonably secure position currently within its health system. But the Trust recognises that like other acute trusts nationally, it faces an exceptionally demanding market environment, characterised by:

- A remorseless squeeze on margins, as a result of year-on- year tariff deflation, at a time when the cost base continues to experience inflationary pressures
- An increasingly intense focus on quality, with the promulgation of ever more quality

standards, increasing publication of comparative data on clinical performance, and an intense focus on the more qualitative aspects of experience and care post-Francis

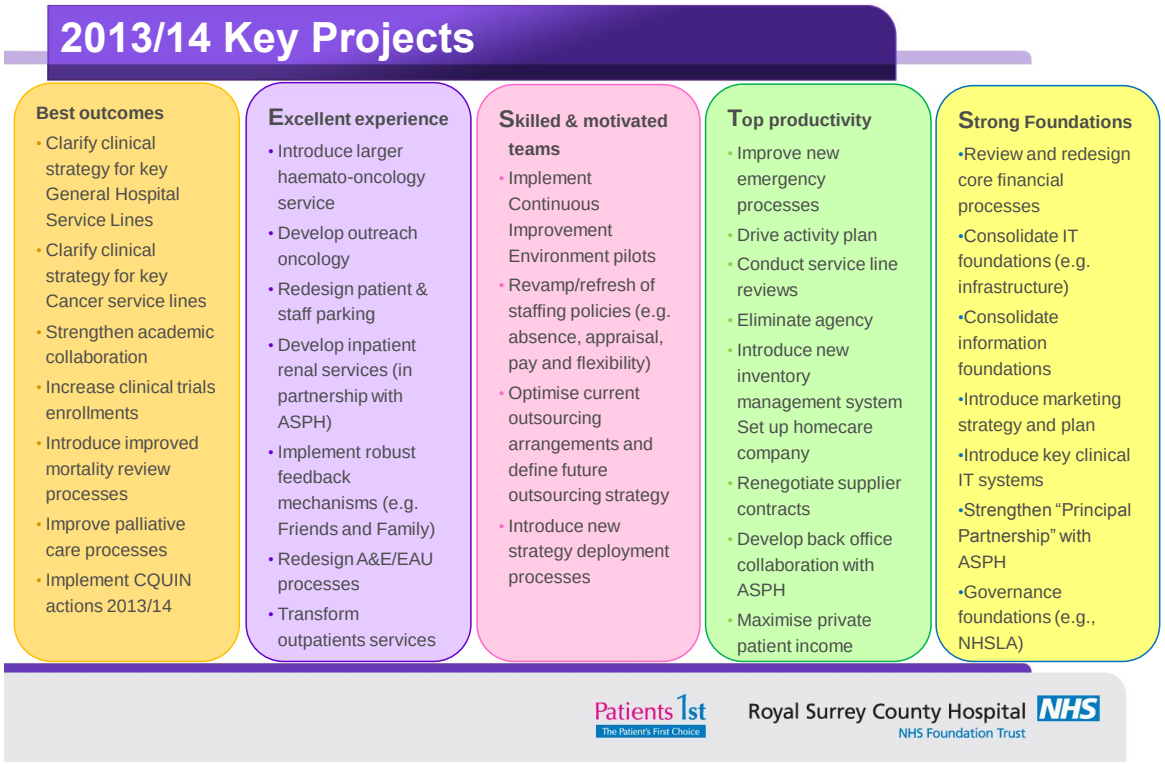
- A continued drive towards shifting more work from an acute to a community setting
- Increasing opportunity for, and evidence of, competition with the advent of Any Qualified Provide and similar initiatives

The Board's conclusion is that to survive and prosper in this challenging environment it will have to "think like a business" – that is be relentless in ensuring that its clinical quality is second to none, and that the all-round experience it offers patients is outstanding; whilst at the same time focusing on ensuring that it makes the best use possible of the scarce financial resources it has available

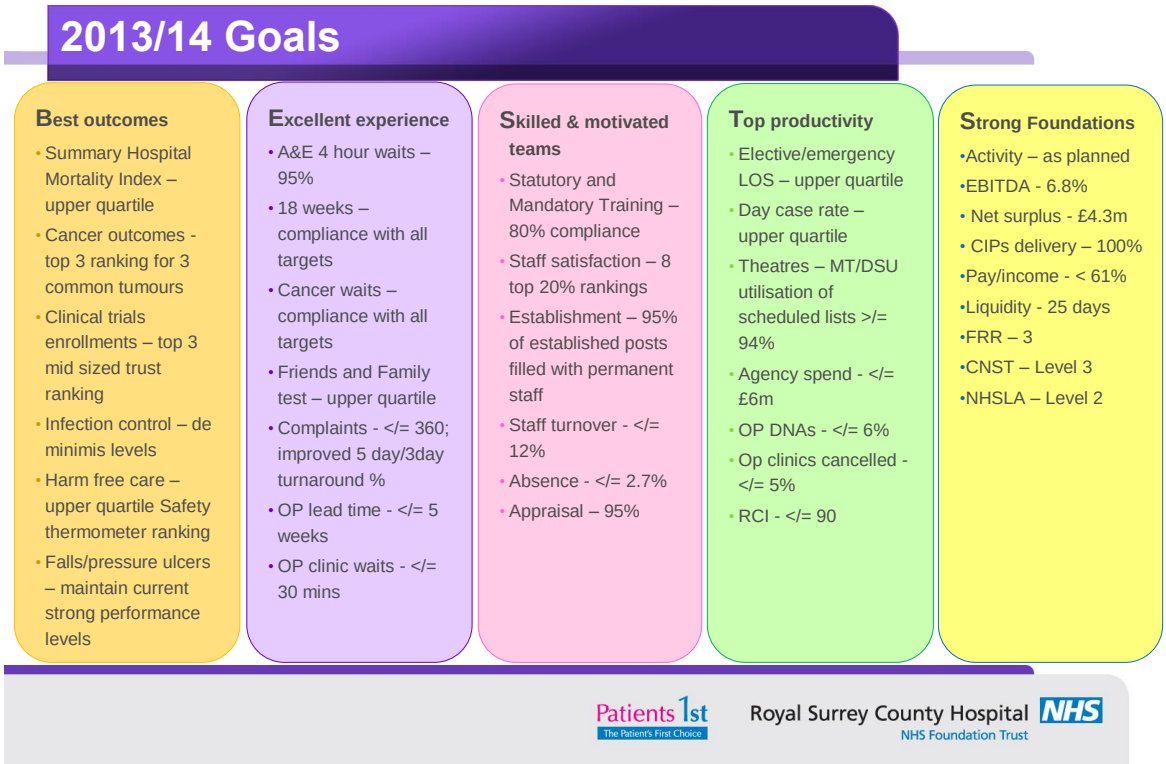
1.9 Trust Strategy – Best Care

Given this backdrop, the Trust's strategy remains to pursue a dual mission as a cancer centre and a DGH, focusing on delivering outstanding quality and superior levels of productivity. This strategy can be summarised as delivering BEST Care:

This overall strategy is supported by a portfolio of major projects to be delivered in 2013/14:



The specific goals which the Trust aims to deliver over the coming 12-18 months are as follows:



2. Approach taken to Quality

2.1 Key priorities

The Trust's quality improvement priorities for 2013/14 are outlined below under the traditional quality domains.

- **Best Outcomes - Clinical Effectiveness**
  - Increase clinical trials activity
  - Improve the mortality review process
  - Improve Palliative Care process
- **Best Outcomes - Patient Safety**
  - Maintain minimal infection rates
  - Promote and improve harm free care
  - Reduce inpatient fall rates
- **Excellent Experience**
  - Implement friends and family survey
  - Implement new emergency processes
  - Improve outpatient experience

3. Clinical Strategy

3.1 As outlined in the Trust's overall BEST Care strategy, RSCH's clinical strategy focuses on continuing its dual mission as a District General Hospital for a 320k catchment in Guildford, Waverley and beyond, and as a specialist Cancer Centre serving a population of 1-2 million in Surrey, West Sussex and Hampshire.

For general hospital services, this implies that:

- The Trust will continue to offer a comprehensive portfolio of general hospital services from its primary location in Guildford
- It will however pursue a proactive strategy of establishing outreach Outpatient clinics in key locations at the borders of its current catchment, to extend market share
- It already offers some community based services (for example, outreach services for COPD; community nursing services for Diabetes; supported discharge services) and it intends over time to grow its presence in the community
- It will look for opportunities to align its clinical strategy with its Principal Partner, ASPH, whilst continuing to support its collaborative relationships with other trusts. This may involve working together closely, or even integrating/reconfiguring specific services where appropriate, as well as working together on a "JV" basis to repatriate significant tertiary services such as Renal back into Surrey

For cancer services, this implies:

- Continuing to bed in key recent service transfers such as Urological cancer
- Working to extend our specialist Haemato-oncology service to embrace ASPH and SASH, and over time moving towards the delivering of a Level 3a service
- Continuing to implement a proactive outreach strategy, in particular, launching outreach Radiotherapy at SASH, launching outreach chemotherapy at SASH, Ashford and FPH, and looking for opportunities to extend our cancer catchment into the outer fringes of South West London in particular

For clinical support services, this implies:

- Working with FPH and ASPH to continue developing and extending our Surrey Pathology Services partnership
- Assessing options to set up a Pharmacy Homecare business
- Assessing options to extend and set up on a commercial footing our current supported discharge activities, potentially collaborating with ASPH
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3.2 **Clinical Workforce Strategy**

Key strategic objectives in the triangle above for the Trust are to have a skilled and motivated workforce whilst at the same time delivering high levels of productivity. This means having the right numbers of people, with the right skills, right motivation, right engagement, and at the right time to ensure patient care and safety, whilst at the same time to ensure effective management of the Trust's pay bill in relation to income and activity.

In the last quarter if FY2012-13 the Trust embarked on a realignment of workforce numbers resulting in the removal of 100 posts across all staff groups. Following employee consultation, this is being achieved by the removal of vacancies, natural wastage, restructuring of departments, and redeployment of staff. All the changes have also been subject to risk assesment and those designated as having a higher risk have been further reviewed by the Clinical Governance and Quality Committee and Board to ensure there is no adverse impact on patient care. Unfortunately, there will be up to 20 redundancies mainly affecting corporate support staff, specialist nursing and matron positions that will affected during H1.

The Trust will also continue to ensure the ongoing development of its Medical workforce. Work began last year to review job plans of all consultants and this will continue with the aim of achieveing an average 8:2 PA split across the Trust. Appraisal systems have been redesigned to support the Revalidation process which is now fully underway. The Trust will develop and implement a new Resourcing and Retention strategy to minimise reliance on expensive agency resource. Work undertaken thus far has shown that a number of departments such as A&E have too great a reliance on locums so steps are being taken to increase the permanent establishment. Gaps in the rotas, with resulting reliance on temporary staff, for junior doctors caused by insufficient deanery allocation are also being reviewed to ensure better cover for the next rotation due in August. This will further assist in the working hours of junior doctors to ensure satisfactory diary carding and compliance with the European Working Time Directive.

Nursing levels across the hospital have also been reviewed as part of the workforce changes above and in anticipation of the Frances report. There have been no reductions in nursing levels on wards but there has been a removal of HCA posts where this can be achieved without impacting on patient care. A few specialist nursing and matron roles have also been removed. However, nursing staff numbers are now being increased on a number of wards, and in ITU, Maternity, and A&E to reduce dependency on agency staff which will both reduce costs and improve patient care. No further reductions to nursing and HCA staffing are anticipated in

the year ahead except if this can be achieved by reducing length of stay and bed capacity so existing staff ratios will be maintained.

Professional and other clinical staff numbers are expected to remain the same over the next year.

In addtion to staff numbers other key parts of the workforce strategy are:

- Continuation of high employee satisfaction and engagement
- A review of Statutory and Mandatory Training to ensure 80% compliance
- Further review of Appraisal processes both to ensure 100% completion and better linkage with the AfC increment and the Medical Revalidation processes.
- Reduction in absence both long term and short term to 2.7%

4. Productivity and Efficiency

4.1 Potential Productivity Improvements

The Patients First 2013/14 programme plan, which incorporates the governance of major IT and Trust projects, has been developed with rigour and attention to the Trust's strategy and priorities. Resource has been allocated to key transformation themes in Medicine, Surgery and Oncology, in addition to important functions such as Information, Procurement and Materials Management.

Many of our portfolio of major projects for 2013/14 have a productivity aspect. The following in particular are worth highlighting

- **Redesign of A&E/EAU processes** - this project will focus on improving A&E and EAU pathways and performance through the introduction of streamlined and standardised processes for emergency patients. This will not only reduce waiting times and help to improve patient experience; it will also reduce pressure to use expensive escalation resource
- **Outpatients transformation** – primarily focusing on improving patient experience, this major transformation project will also contribute to greater efficiency by reducing DNAs and improving clinic utilisation

- **Reduced Length of Stay** – this project will focus on making further improvements in emergency and elective LOS through improved discharge planning and processes, implementation of an improved Frail Elderly pathway, better management of surgical patients (e.g. introduction of a new acute abdomen pathway) and better management of elective surgical patients (e.g. enhanced recovery)

- **Eliminating Agency, Attendance, Pay and Flexibility, Efficient Medical Workforce and Zero Based Reviews** – a portfolio of workforce-related projects are designed to reduce the Trust's reliance on expensive agency resource
- **Inventory Management** – installation of OmniceII will bring reductions in non clinical supplies usage, and also reduce stock levels

4.2 **CIP Governance**

The Trust has a solid and improving record of CIP delivery - 85% in 2010/11, 93% 2011/12 and 99% in 2012/13.

The central Planning and Performance Team, reporting to the Director of Finance, are responsible for co-ordinating the development of CIP schemes, assessment of financial impact, translation into targets and budgets, monitoring of achievement and reporting progress to the Executive and the Board. This team sets the overall framework for the task and designs the tools and templates to establish and track the schemes.

The Planning and Performance Team begins the process in November when, using the Strategic Plan as a framework, the Portfolios and support functions formulate CIP and development ideas. These strategic sessions involve each SBU's Leadership Team: Clinical Directors, Deputy Directors of Operations, Service Managers and Matrons and are facilitated by the Planning and Performance Team through the Business Finance Managers.

CIP scheme ideas are then presented to the Executive for challenge and approval. All schemes are then RAG-rated for deliverability and risk factors, and the financial targets are revised where necessary to take into account these risks (e.g. timing of achievement, likelihood of success etc.). These "risk-adjusted" targets are what are included in the 2013/14 plan, ensuring a realistic yet challenging basis for budgets.

As the shape of the CIP Programme develops it is reported monthly to the Finance and Investment Committee and the Board for challenge and review.

When the programme is agreed and the CIP targets fed into budgets, the Planning and Performance Team establish the CIP monitoring templates which become the responsibility of the relevant SBUs to complete as they implement the CIPs. Progress is reviewed at the monthly SBU performance meeting where CIP achievement forms part of the SBU's Performance Scorecard.

Progress against the Trust-wide CIP target is presented monthly to the Finance and Investment Committee where the in-month and forecast year-end position is reviewed.

4.3 **CIP profile**

The key cost efficiency CIP schemes for the period 2013/14 – 2015/16 are:

Zero-Based Reviews (£7.3m) – risk rating Amber

RSCH has embarked on a multi-phase, bottom up review of all specialties, departments and activities to identify strategic fit, delivery options and productivity improvements. For 2013/14 this primarily involved a comprehensive review of departmental management structures, ward nursing and support function staffing and the resulting workforce reduction programme is being implemented. Moving beyond these first gains, the Trust will undertake a series of data-driven reviews of specialties and clinical support functions to identify; areas the Trust strategically wishes to retain or grow, what the optimum delivery model is, (e.g. joint review of Clinical Strategy with ASPH) and the productivity gains resulting.

Procurement (£5.1m) - risk rating Green

This CIP is a combination of a centrally-driven continuous improvement programme of supplier rationalisation, spend consolidation and price negotiation, as well as local SBU schemes of

product substitution, reduced usage and reduced wastage. It covers clinical and non-clinical supplies and services.

Pharmacy (£1.8m) - risk rating Green

In 2013/14 RSCH's Pharmacy leadership have completed a review of upcoming off-patent drugs, Non-PBR drugs and have 'horizon-scanned' for drug developments in the coming year. As a result a target for reducing drug spend in the coming year has been set (some of the savings from which are assumed to be shared with CCGs). In addition, RSCH is currently in the process of the establishment of an Outpatient prescribing and Homecare delivery subsidiary company in order to address current operational performance shortcomings with the existing providers and improve patient experience (e.g. wait times) and efficiency. This business case will also realise cost savings in Pharmacy over the Strategic Plan period.

Efficient Medical Workforce (£1.1m) - risk rating Amber

This CIP represents savings in the re-alignment of PAs following a planned comprehensive review of doctor job plans. In 2013/14 there are some nominal savings from reductions in PAs. The exercise of collating job plans has been completed; these will be reviewed this year and the changes planned implemented in 2014/15.

Contract renegotiation (£0.7m) - risk rating Green

The Trust is currently reviewing its estates, facilities and IT outsourcing arrangements and investigating further consolidation of outsourcing opportunities. As individual major facilities and support contracts approach expiry dates over the next five years (e.g. catering, patient information systems) the Trust has negotiated discounts for extending these contracts, and plans further negotiations in 2014/15 and 2015/16.

4.4 **CIP Enablers**

The key CIP enablers for 2013/14 and the two subsequent years of the strategic plan are:

Clinical leadership and engagement

The clinical leadership of the organisation, including matrons, clinical directors, the Director of Medicine and the Director of Nursing and Patient Experience have been directly involved in the formulation and assessment of the CIPs included in the 2013/14 programme. For example, Ward establishment reviews were conducted by Matrons together with Business Finance Managers to ensure that a robust and safe establishment was maintained. Clinicians are directly involved in monthly performance management and CIP review meetings.

Programme management and project delivery

The central Planning and Performance team is responsible for the overall coordination, monitoring and reporting of the CIP Programme. The SBUs are responsible for the implementation and risk-management of the individual schemes. In the case of cross-functional or cross-Portfolio schemes (e.g. establishment of outreach Outpatient clinics or Length of Stay improvement) specific project teams are established with dedicated monitoring and reporting.

In addition, significant and priority transformative CIPs are incorporated into the Trust's

Strategy Deployment process, supported by Patients First.

4.5 Quality Impact of CIPs

In formulating the 2013/14 detailed CIP programme, quality assessments were made at the strategic identification sessions in late 2012. As the CIPs were reviewed by the Executive for approval for implementation, quality impacts were identified and challenged.

The headcount reduction programme, the largest element of the 2013/14 CIP Programme, was subject to an additional quality and risk assessment process. The responsible Deputy Directors of Operations risk-assessed each post affected, scoring in terms of clinical, operational, reputational, financial and strategic risk. These scores and resulting RAG ratings were then reviewed by the Director of Medicine and the Director of Nursing and Patient Experience. The resulting assessment was then presented at the February Board meeting and each were reviewed and challenged by the Board, which resulted in a quality assessment of critical posts including plans to continue to fulfil essential functions performed by posts identified at risk.

For the CIP Programme as a whole on an on-going basis, the monthly monitoring process that is undertaken with the responsible CIP owner includes a section on quality assessment and quality KPIs to ensure that any quality risk resulting from the implementation of the CIP is identified and mitigation put in place.

KPIs to monitor clinical quality and patient experience are part of the Trust's regular metric dashboards and monthly reporting cycle. The SBU monthly performance scorecards include metrics on patient experience and clinical quality outcomes, for example:

- Patient survey results on quality of care, food etc.
- Complaints
- Mortality indices
- MRSA/C. difficile incidences
- Handwashing and hygiene compliance
- Staff sickness rates and trends
- Readmission rates
- Falls

The monthly Trust Performance Report to the Board also includes a Trust-wide aggregated summary of the SBU quality outcomes.

5. Financial and Investment Strategy

5.1 Current Financial Position

The Trust ended 2012-13 with a surplus of £2.7m representing an EBITDA of £17.6m this is £2.5m behind the original plan submission but £1.4m favourable to the re submission during Q3, and gave the Trust a FRR of 4. The trust saw its surplus margin eroded during the year partly due to the need to employ high levels of agency staff to deliver activity, and partly due to casemix being weaker than planned, in addition some one-off events, both favourable and unfavourable, affected the bottom line. The most significant of these were the impairment of the Pathology building, provisions for HMRC and redundancy, offset by release of deferred

income relating to Bowel screening, overall a net impact of £0.5m benefit. Underlying surplus therefore at £2.2m.

Capital spend of £11.1m saw the Endoscopy project brought into use, the start of Outreach Radiotherapy building at SASH – for which a £7.5m loan has been agreed with the FTFF during 2013-14 - and the start of the ICU expansion, in addition £2.3m investment in clinical and IT equipment.

Cash held at year end was £15.6m

The Trust had a challenging CIP target of £16.8m of which it was 99% achieved, this was a good result and stands the trust in good stead for the coming year

5.2 **Planning Assumptions**

The plan for 2013/14 has been built up as part of the Trusts Business Planning Cycle, which commences in the autumn with Business units presenting their strategy for the coming 3 years. The planning process includes activity and finance forecasting and budget setting, CIP development, capacity planning, quality and operational performance measurement planning, capital and cash plans. This year has seen the introduction of detailed consultant level activity plans accounting for scheduled theatre sessions, planned annual leave, Holiday periods such as Christmas and Easter etc

The Trust has set a plan with minimal demographic growth included over and above the 2012/13 levels ie 2% for growth in cancer related activity and chemotherapy/radiotherapy. Where there is the potential for catchment growth through outreach outpatient clinics leading to additional Elective activity these have been included under Revenue Generation, in addition targeted growth in specific areas such as HpB and ENT where demand is such that additional capacity is required.

The Trust has signed formal SLA documents with Surrey CCGs and NHS England; prior to this, an interim arrangement to agree cash payments for all commissioners for April and May had been in place, it is expected that agreement with remaining CCGs will be reached shortly.

Demand management through the PCT QIPP programme has only been included where schemes are jointly developed eg Frail Elderly Pathway redesign. Other QIPP schemes for Surrey CCGs total £6.9m, these have been deducted from the SLA value, but not included within the Trust Plan, as the Trust does not believe that the CCGs plans are sufficiently developed to impact on the Trusts activity in 2013/14. Modest amounts are included within the forward years' plans to reflect joint working programmes.

The inflation assumptions within the plan are as follows; reduction of tariff income by 0.6% (combined PbR tariff and local prices) increase in non PCT income streams at 1.5%, inflationary increase for employee expense of 1% and a further allowance for incremental drift of an additional 1%, non pay increases of 3%, apart from drugs where 8% has been allowed to cover price increases and new non tariff drugs being implemented. Where there are known cost pressures specific budgets have been uplifted to allow for increases over and above general inflation for example CNST contributions where the Trust has only obtained level 1 in 2013/14, and utilities where the Trust has seen large price increases during the previous year.

The plan has been set to achieve an EBITDA of 6.1% and surplus margin of 1%,(before donations) this is reduced from the plan submitted in 2012-13 and reflects a more prudent approach to the financial environment the Trust finds itself in.

5.3 **Key Financial Priorities and Investments**

The key requirements for the Trust to deliver the plan are:

Maintain the EBITDA and surplus required to deliver a risk rating of 3 – through the measures

outlined below and required to deliver sufficient funding for the Capital programme of £21.9m in 2013-14

Achievement of CIP programmes - the Trust has a £14.8m programme which has been built bottom up – details are given in previous sections. The Trust has a robust programme but risks from outside partners around transformational programmes cannot be ignored.

Increase budgetary responsibility for managers – budget holders have been set realistic budgets including some allowance for temporary staff cover, the trust is determined to control costs and hold managers to account for any overspending areas.

Reduce Agency spend on temporary staff,- the Trust has this as a major focus area and has implemented increased controls to reduce expenditure, as above, managers will be held to account if agency spend does not track to the planned reducing profile.

Deliver the Outreach Radiotherapy Build at SASH requiring capital investment of £9.5m, - this project consolidates the cancer strategy of increasing catchment and delivering care closer to home for patients. The £7.5m loan will be drawn down within the first quarter of the year and repayments will commence in 2014-15. The first patient will be treated in April 2014

Deliver the expansion of ITU project requiring capital investment of £2.9m,- this gives the Trust the required capacity to allow for the increasingly complex surgery carried out as a tertiary cancer centre and for the increase in emergency admissions seen in recent times.

Investment in the Ophthalmology Outpatient area of £1.0m to deliver increased patient experience for this busy service which has seen demand rise over the past years.

Transfer of the Bowel Cancer Screening Service from University of Surrey accommodation to a fit for purpose single site on the Surrey Research Park, this will allow for expansion of the service in line with the national rollout of the age extension and introduction of scoping for age group of 55 years.

Ensure the Trust IT infrastructure is robust by investing £2.2m in replacement equipment and enhanced systems including PACS.

The management of receivables and payables continues to be an area of focus, to ensure working capital is at optimal levels, the Trust has not had to make use of the working capital facility since becoming a Foundation Trust and does not envisage having to do so for the foreseeable future. Cash levels will be maintained at levels between £13m-£16m over the 3 year period.

5.4 **Key Risks and Mitigations**

The Key financial risks for the Trust are as follows:

Year on year tariff deflation in the face of increasing pay/cost inflation, - this poses a major issue to the Trust as to remain a viable organisation the Trust must live within the income it generates by managing its cost base. In mitigation the Trust has a strong track record of CIP development and delivery and has a robust programme in place for 2013-14 with monthly monitoring of progress at Finance & Investment Committee

Move to CCG and NHS England Commissioning structure, - this complex organisational change requires the Trust to engage with many more commissioners than present with the risk that activity is not attributed to the correct commissioner within the time frames available resulting in lost income. In addition more detailed scrutiny of activity is expected from GPs with a direct incentive to reduce payment, and hence increase deductions /challenges over the level seen in previous years. In mitigation the Trust has developed good working relationships with new commissioning bodies and has seen some deductions - for N:FUP Outpatient ratios for example – drop out of the NHS England portfolio. The Trust will need to strengthen it’s

coding and reporting functions to enable the monitoring of income and SLAs – this is in process.

Currently the Trust does not have signed SLAs with minor CCG commissioners – this is a risk to cash flow and payment for activity, in mitigation the Trust is actively engaging with commissioners to close down the SLAs

Payments for CQUIN amount to £4.6m in 2013-14 and represent a significant risk if targets are not met, in mitigation the Trust has set up a sound methodology for the identifying of gaps in CQUIN target achievement and monitoring of progress towards these.

In summary, the Trust faces the next 3 years in a sound position with robust plans in place, which deliver a FRR of 3.35 which rounds to a 3 and gives the Trust a solid base from which to develop its strategy.