Royal Berkshire NHS
NHS Foundation Trust

# Forward Plan Strategy Document for 2013-14

# Royal Berkshire NHS Foundation Trust

## Forward plan for y/e 31 March 2014 (and 2015, 2016)

**Approved on behalf of the Board of Directors by:**

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| **Name** *(Chair)* | **Stephen Billingham** |

**Signature**


**Approved on behalf of the Board of Directors by:**

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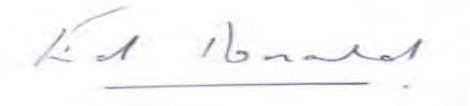
|---|---|
| **Name** *(Chief Executive)* | **Ed Donald** |

**Signature**



**Approved on behalf of the Board of Directors by:**

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| **Name** *(Finance Director)* | **Craig Anderson** |

**Signature**

**Executive Summary**

The Royal Berkshire NHS Foundation (RBFT) has built on its strong district general hospital (DGH) foundations to provide a range of specialist and hyper-acute services. Our strategy remains to provide quality local services for our local population whilst additionally serving a larger population seeking more specialised care.

Our analysis has shown that population growth is leading to increased demands for healthcare. In particular growth in the elderly population, in conjunction with worsening lifestyles coupled with the demand for emergency care and care for long term conditions, is having significant impact on the Trust. Demand for elective care is also likely to grow, but for this more profitable work we face competition from other National Health Service (NHS) providers as well as the private sector. The tariff structure for elective care is such that it acts to offset the substantially lower margin on non-elective care. Therefore our future financial viability is dependent on maintaining an appropriate balance between elective and non-elective work.

We have seen sustained increases in emergency attendances and non-elective (NEL) admissions. Due to the tariff rules around non-elective admissions we only receive 30% tariff for admissions over 2008/2009 activity levels which affects our financial position. We are also caring for increasing numbers of patients who are medically fit for discharge and are awaiting care home places or packages. These represent a risk of some £8.5m for this Trust whereby we treat patients, incur costs, yet are not funded. This is simply not sustainable and we have assumed a resolution will be found which funds the Trust for costs appropriately incurred. With this latter point in mind we need to collectively resolve the financially unsustainable burden placed on acute trusts through the application of NEL threshold and re-admissions penalties.

We have seen our market share of elective surgery decline slightly in recent years. Our key competitive challenges are our waiting times, which are affected by a lack of capacity (including a general reduction in the planned care bed pool due to increasing non-elective admissions) and the quality of areas of our estate.

In summary we are anticipating continued growth in demand for our services. Income for 2012/13 was £333.4m. Activity and drugs income are predicted to grow by about 2.4% in 2013/14, which means, net of the tariff deflator, we are expecting income of about £336.4m in 2013/14.

We want to ensure that patients receive the best possible patient experience and the highest quality care. A key thread throughout our strategy is ensuring that patients receive care from the right person, at the right place and at the right time. This is in line with the newly developed Clinical Services Strategy (CSS) and our Quality, Innovation, Productivity and Prevention (QIPP) agenda which is predicated upon realising efficiencies through focusing on the quality of care.

Our response will be to increase capacity in key areas – emergency department, intensive care, maternity, theatres, endoscopy, inpatient beds and diagnostics. This will be managed and aligned to the capital investment programme and to ensure that the areas most under pressure are addressed first. We will transform our outpatient services, ensuring waiting times are reduced initially to six weeks in 2013/14 and then further reduced to two weeks in 2014/15. We will plan our services around the patient, ensuring a one-stop assessment so that each patient leaves their appointment with a diagnosis and/or a treatment plan. By improving the access and availability of diagnostics at our community sites we will deliver the widest possible portfolio of outpatient appointments closer to home for patients.

We already work in partnership with other local healthcare providers to deliver integrated services, particularly for the frail elderly. We work together on admission avoidance, service navigation and on discharge arrangements and we recognise that further integration and collaboration will be essential over the next five years and beyond.

***District general hospital 'plus'***

We already provide a range of specialist services, beyond those typically expected of a district general hospital including stroke, heart attack, bariatric cares and specialist renal care. Our aim over the next five years is to build on these specialisms and create centres of excellence in key specialities including spinal surgery, urology, intestinal failure and hip arthroscopy. We deliver neonatal, trauma and critical care via a network arrangement with Oxford University Hospitals (OUH) NHS Trust.

We know that the trend to centralise high complexity low volume and rarer conditions will mean that we will lose some work, particular rare cancer work. We will aim to mitigate this loss of activity by repatriating less complex work. By continuing to grow and develop in this way we will ensure that we reach the critical mass of population required to be sustainable.

Our financial vision is to build a strong financial base, maintain financial control, deliver agreed financial targets, contribute to our overall service strategy by developing our Long Term Financial Model (LTFM) and anticipating future financial risks.

The headlines of our three year forward financial strategy are to deliver this vision and

- maintain a risk rating of at least 3;
- achieve Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA) margin of at least 5%;
- achieve small surplus margin and aim to grow this to over 1%;
- make demonstrable progress in upgrading our estate to meet current and future anticipated demand;
- maintain a liquidity ratio of at least 10 days; and
- meet prudential borrowing code ratios, and repay our Foundation Trust Financing Facility loans in line with the schedule of repayment.

Our analysis as part of the Integrated Business Plan (IBP) has identified that the following strategic options are available to RBFT:

1. Stand alone as a DGH plus
2. Stand alone (as a DGH plus) but vertically integrate
3. Stand alone (as a DGH plus) and be part of healthcare groups
4. Stand alone (as a DGH plus) but vertically integrate and be part of healthcare groups
5. Full merger

We recognise that any option will take time to be implemented and that we will need to be a stand alone organisation in the short term. We will continue to strengthen our financial position by placing an increasing emphasis on being part of healthcare groups, clinical networks and delivering integrated care with our partners. However, our assessment is that we will reach a point whereby this arrangement will no longer be viable and we anticipate this will probably be within the next three years. Over the next three years, we will assess and evaluate the strategic options available to us. This will need to address system issues such as transitional funding received last year for NEL activity with a formal payment arrangement that pays us for the work that we do.

**In summary we have:**

- undertaken a significant amount of analysis which identifies that demand and need is on the increase, and is likely to rise to unsustainable levels in the long term;
- developed our Clinical Services Strategy to address the challenge of demand;
- developed a draft IBP, which will be shared with all internal staff and also the wider stakeholder community in the local health economy;
- undertaken a detailed evaluation of the long term strategic options;
- committed to maintain a FRR of 3;
- developed a draft financial plan to support our strategic service developments in the longer term;
- considerable challenge around our estate infrastructure and have developed our estate strategy;
- delivered cost improvements of £49m to date and changed our approach to QIPP as outlined in our plan;
- developed plans to address the financial pressures to manage our investments in Electronic Patient Records (EPR) system and Royal Berkshire Bracknell Clinic (RBBC); and
- to collectively resolve the financially unsustainable burden placed on acute trusts through the application of NEL Threshold and Readmissions penalties.

**Strategic context and direction**

In 2005, building on our strong performance financially and against activity targets, we became the first Foundation Trust (FT) in the South Central region. We took advantage of the freedoms that FT status gave us – we had a sense of independence and confidence that we could rise to any challenge and meet it alone.

On reflection, some of the challenges we took on were too big and our ambition to expand too great. We made major investments which distracted us from our key purpose of providing high quality healthcare to our local population. These investments were made at the expense of maintaining and improving our existing estate infrastructure.

Our quality of care remained high throughout this period but our staff experience was poor and morale suffered. We failed to provide best value for money - our productivity was in the lower quartile and our high EBITDA performance hid underlying cash issues and declining margins.

Our ambition and drive to expand and compete damaged our relationship with key commissioners and General Practitioners (GPs) and our market share started to decline.

Our three year forward plan has been considered in the light of the significant levels of change and challenge facing the NHS as a whole, and to address the financial implications of past investments. RBFT serves a core population in West Berkshire of circa 500,000 and a broader population of a further circa 500,000 across Berkshire and its borders. Berkshire is one of the lowest per capita funded health economies and the Trust has the lowest number of beds per 1000 population as well as the lowest number of beds per 1000 population for critical care.

Population growth, particularly in the elderly population, and increasing demand for healthcare (particularly for emergency care and care for long term conditions) are key areas of focus over the next few years. This increasing demand is set against a background of national austerity measures with continuing financial constraint and the need to reduce costs. The coming years are expected to be challenging and a robust strategy is essential to try and cope with these pressures.

To set out our response to the challenging environment we have developed a five year IBP to look at the longer term strategic challenges and pressures which will need to be dealt with, with the aim of future proofing our services. We have already started work to reconfigure some services and make efficiencies so that we move forward as a strong organisation in terms of the services we provide, and our workforce, making the very best use of the skills of our staff. Partnerships with organisations and people who influence the ways in which we design and provide our services are key and we plan to build on the good relationships we currently enjoy with our commissioners and patients. The next stage for the IBP is to engage with the wider stakeholders and staff. Our analysis as part of the IBP has identified the following strategic options that are available to RBFT:

1. Stand alone as a DGH plus
2. Stand alone (as a DGH plus) but vertically integrate
3. Stand alone (as a DGH plus) and be part of healthcare groups
4. Stand alone (as a DGH plus) but vertically integrate and be part of healthcare groups
5. Full merger

Our strategy reflects our continued focus on quality, patient safety and patient experience. It addresses the challenges associated with delivering these priorities as NHS resources become increasingly constrained through a business strategy that builds upon our strengths and the market opportunities we believe we are well placed to exploit.

## The Trust's strategic position within the local health economy

Royal Berkshire NHS Foundation Trust (RBFT) occupies a key strategic position within the local health economy. We serve a core catchment of patients residing in four key Clinical Commissioning Groups (CCGs) areas in Berkshire (South Reading, North and West Reading, Wokingham and Newbury) and the South East locality of Oxfordshire CCG. For these patients we provide a full range of acute medical and surgical services but we also provide specialist and hyper-acute services.

### Overview of RBFT's key competitors

Competition presents a significant risk to the Trust's income. RBFT is exposed to competitive threats from both NHS and private providers. Private sector providers tend to target more profitable elective services such as orthopaedics leaving the Trust to continue providing services that are less profitable. Circle is one of the private providers which has invested heavily and opened a brand new hospital last year with laminar flow theatres and capacity to deliver around 8,000 elective operations per annum.

Our NHS competitors include Frimley Park Hospital (FPH) NHS FT and Heatherwood and Wexham Park (HWWP) NHS FT with whom we compete for patients in the Bracknell and Wokingham areas and Hampshire Hospitals NHS FT and Great Western Hospitals NHS FT with whom we compete for patients in the Newbury area.

Competition is further fuelled by the growing implementation of market development policies by commissioners (e.g. the implementation of Any Qualified Provider (AQP)). In 2012/13 two direct access services - non-obstetric ultrasound and adult hearing services - were subject to AQP, and we anticipate a number of other services to follow this process over the next three years.

We have reviewed AQP opportunities tendered by neighbouring commissioners where we could offer services to populations on, or beyond our current boundaries. An example of this is our Direct Access Adult Hearing Aid service which is treating patients in a range of locations beyond Berkshire including Oxfordshire, Buckingham, Southampton, Portsmouth and London.

The piece-meal and volatile nature of competition through Choose and Book (rather than through competitive tender) makes it very difficult for the Trust to take out cost to offset reductions in income.

### Assessment of strengths and weaknesses relative to key competitors

To meet the challenges associated with competition, we have undertaken marketing assessment as part of our IBP. Specific challenges we face when competing with the private sector include the poorer condition and aesthetic appeal of the elective areas of our estate, and our waiting times which are frequently longer than those available elsewhere.

We have plans to address our waiting times and provide a one-stop assessment within six weeks of referral in 2013/14 with the aim of reducing this further in future years. Our recently completed estates strategy sets out plans to refurbish and expand the areas where our elective patients are cared for.

Our major competitive advantage remains our trusted position within the local community, our range of community sites, the breadth of specialities covered and our proven track record of providing quality care. We do not take this position for granted and we know we need to work closely with CCGs, GPs and patients to understand their

requirements and ensure that we provide the information required to enable patients to make an informed choice for their treatment.

**Forecast demographics, health needs and demand changes**

In recent years, we have seen sustained and consistent increases in demand particularly in non elective admissions, Accident and Emergency (A&E) attendances, cancer treatment and maternity services. We expect this to continue and work undertaken by independent consultants (Capita) commissioned by the CCG has reinforced this view.

Our core catchment population as a whole is forecast to grow by circa 3% to 2016, but growth will not be equal across all age groups with the biggest rise expected in the over 65s. The number of over 85 year olds is forecast to grow significantly by 15% over the three year period. The increased number of elderly patients means a proportionately higher impact on the demand on our services than for some other age bands. Our experience suggests that this will translate to more hospital admissions, longer length of stay and more support required post discharge to ensure that patients are discharged in an appropriate environment with adequate levels of support to avoid unnecessary re-admissions. Therefore, we are working on providing a more integrated service with our colleagues in social, primary and tertiary sectors to ensure we meet this challenge. The birth rate is also expected to remain high across the region, and this will continue to put pressure on maternity and paediatric services.

In addition to the population increases highlighted earlier, we also expect an increase in the certain disease prevalence (diabetes, cancer, stroke, dementia and heart attack) within the population. National screening programmes such as the launch of the flexi-sigmoidoscopy screening programme in 2015/16 will also create additional demand. In 2013/14, we expect to launch our diabetic macular oedema treatment pathway which will increase demand for our ophthalmology outpatient services.

There is a risk that capacity in key areas will not be sufficient to meet long term demand and so the Trust has been evaluating and implementing approaches to manage the demand and need. These include:

- redesign and expansion of the emergency department and intensive care unit;
- redesigning of pathways (for example integration of the frail elderly and ophthalmology);
- increased use of one stop clinics;
- expansion of capacity in theatres and endoscopy;
- better utilisation of our community sites;
- increased use of non face to face appointments and remote monitoring using technology; and
- more integrated working with community providers.

**Impact assessment of market share trends over the life of the plan**

We expect some loss of market share of higher profit procedures to be inevitable in the coming financial year. The impact of AQP and tendering of non-complex services is a key challenge, particularly around how we continue to provide the complex, less cost effective services not covered by the tenders whilst maintaining the financial viability of the affected departments.

Over the full five year period covered by our IBP, we aim to regain some of the market share lost in recent years. This will be achieved by an initial fall in our market share, increase in activity followed by sustained gains in subsequent years following the implementation of a number of service developments, improvement to our estate infrastructure and the maturing of partnership working arrangements.

## Threats and opportunities from changes in local commissioning intentions

### Overview of local commissioning strategy and intentions & QIPP

Our four local CCGs are commissioning services under one umbrella. The key themes that cut across their commissioning intentions are integration, safety, effectiveness, quality, value, accessibility and patient experience. The CCG QIPP objectives for 2013/14 follow on from those in previous years and are based on fewer hospital attendances and admissions, shorter length of stay in hospital and providing care closer to or at home. There is also an emphasis on self care and health promotion. The impact of their QIPP objectives, if achieved successfully, would suggest a reduction in activity and associated income for RBFT. However, with other demand and disease prevalence increasing, coupled with the embryonic organisation development of CCGs and the likely slow impact of demand management intention, we anticipate that there will be an increase in activity.

### Demand management

The Trust continues to face capacity pressures in the short and medium term as a consequence of the significant demand for healthcare services. The Trust has experienced a 7% increase in non-elective admissions and a 6% increase in A&E attendances in 2012/13. As highlighted earlier, the Trust is working with the primary and community partners to reduce emergency demand and increase capacity in social and community healthcare settings. However, there is a risk that this despite these efforts, the Trust will be exposed to the risk on breaching the two week cancer and A&E four hour target.

The Trust is implementing a number of service developments (detailed in **Appendix 1)** to address the current pressures outlined above and to meet the increasing demand on healthcare from the growing population. The Trust also recognises that the capacity in the Trust will take time to expand as detailed work needs to be undertaken to ensure additional capacity addresses not only the short term, but more importantly the long term. In addition, the Trust is also lobbying to reverse the non-elective threshold and readmission penalties as the impact of this is not sustainable given the levels of non- elective demand being experienced locally and across the region. In 2012/13 under the tariff rules for non-elective we treated 2800 patients (spells/FCEs) above the 2008/09 levels equating to £8.5m in revenue.

### Diversification of income streams

The Trust will also aim to increase income from private patients. In 2012/13 we appointed a dedicated manager for the Private Patients Service who will drive forward our plan to increase income. The Trust has no dedicated private facilities and therefore a mix and match approach, using the expertise of contracting with the large insurer market players to direct private patients within the catchment area to RBFT as first point of call, rather than our competitors, will be utilised. Other areas targeted will be the use of RBBC for radiotherapy and out-patients; growing ophthalmology in West Berkshire, and utilising under resourced areas, such as therapies, radiology, and pathology laboratory work. Training of staff to capture data correctly is paramount to this success, as is ensuring that for daycase and inpatients the pathway is smooth for both patients and consultants.

## Collaboration, integration and patient choice

We know that over the next three years we will need to work with our partners to deliver more care in an integrated way. We are already providing integrated services for patients with diabetes and long term neurological conditions and in 2013/14 we will also provide an integrated ophthalmology service.

We provide many of our services for the frail elderly in an integrated way, working with partner organisations to avoid admissions, minimise delays in care and ensuring that patients are discharged safely and appropriately at the right time. We will build on this over the next three years with the goal of providing a fully integrated pathway for frail elderly patients that transcends organisational boundaries. We recognise that this approach may lead to a decrease in income and are investigating different methods of funding. We collaborate with other providers and our commissioners on a range of initiatives.

There is a great deal of work underway with GP colleagues on admission avoidance and on referral pathways. We have recently worked on a joint project with our CCG colleagues on referral pathways for orthopaedics. This aims to ensure that patients are treated appropriately and that surgery is not the first option.

## Approach taken to quality

The priorities for improvement in 2013/14 have been developed with a view to ensuring that the priorities meet the Trust's objectives, and address areas that could benefit from improvement such as those which align with Commissioning for Quality and Innovation (CQUIN).

### *Priority 1: Patient experience: Improve staff attitude and communication*

Our first priority is to further improve the positive experience for our patients and reduce the number of complaints received from patients. This will be achieved through the introduction of two courses. The Positive Patient Experience course and the Successful Communication workshop will develop effective communication, understanding human behaviour and checking understanding by stepping into patients' shoes. This will be supplemented by the dedicated Patient Experience Committee looking at different ways of improving the patient experience across the Trust.

### *Priority 2: Patient safety: Reduce the number of pressure ulcers*

As part of a CQUIN target in 2013, we will be aiming to reduce the number of pressure ulcers acquired after admission to hospital. There is an integrated approach with our partners to increase patient and public awareness alongside educational programmes for health care professionals to achieve a reduction.

### *Priority 3: Effectiveness of Care: Improve the appointments system*

The first instalment of the EPR system was deployed in 2012 to provide accurate patient-related information directly to clinicians, and to administration staff for ease of appointment bookings and admissions. This is the first part of the process for the Trust in its move towards an entirely electronic system that will ultimately replace paper records.

There have been initial difficulties in the first part of the implementation which led to inappropriate clinic appointments being made for patients. The Trust is committed to make significant improvements.

## Clinical strategy

### The Trust's overall clinical strategy over the next three years

We have recently refreshed our five year Clinical Services Strategy (CSS) covering the period 2013/14 – 2017/18. Taking into consideration our corporate objectives and our organisational vision, work undertaken to develop our CSS has identified a number of areas of development on services which will require investment both in strategy and estate facilities.

Our focus in 2013/14 will be on resolving some of our key operational issues through the submission of business cases for the service developments outlined in **Appendix 1**, notably patient flow, through the urgent care pathway.

We will also begin the process of transforming our outpatient services with the aim of providing a one stop assessment within six weeks of referral. In order to do this we will increase the utilisation of our community sites both in terms of volume and breadth of specialities and appointment types. In future years our aim is to reduce the length of wait further.

**The Trust's service line strategy over the next three years**

During 2012/13 the Trust has migrated from using Service Line Management (SLM) to Patient Level Costing (PLC). Use of PLC is in its infancy and has not been used as a substantial input into this plan. However, actions underway which will enable much greater use of this tool in future plans:

(i) each care group has identified three specialties where PLC would suggest improvements in financial performance could be delivered

(ii) the Trust has joined Albatross benchmarking organisation which has also informed (i) above

(iii) the Trust is actively engaged in Monitor's work on unit costs and looks forward to this being used to guide future service line management strategies.

**The inputs the Trust used to develop this strategy (e.g. SLM, benchmarking etc.)**

The realisation of our clinical ambitions and ambitious goals will be underpinned by the clinical care groups which will focus on work streams to improve and maximise utilisation of our estate; increasing our productivity and efficiency; developing our workforce; improving information and business processes; strengthening organisational development and sustaining financial health through use of PLC.

As per above the Trust has not made extensive use of service line management or patient level costing in developing this plan but recognises this is a key area for added value in planning in future years.

**Clinical workforce strategy**

**An overview of the clinical workforce strategy (covering doctors, nurses and other key clinical groups)**

The Trust has made a number of service and skill mix changes in the past year. In the next one to two years the Trust will continue to make changes to workforce and service provision in order to enhance patient care, improve access to our services and increase productivity. This will be achieved through working collaboratively across care groups and with external healthcare providers.

Examples of some of the planned changes include:

- implementation of new working patterns and a move towards six and seven days working for some services e.g. Therapies, Pharmacy and Theatres
- expanding and extending facilities e.g. critical care facilities and Theatres
- restructure of clinical and support functions e.g. Renal and Finance.

The workforce priorities section **Appendix 1** provides further details of our workforce plans.

## Clinical sustainability

In 2013/14 head and neck cancer surgery will be centralised to Oxford though we will still provide follow-up care and oncological services to these patients. We have concerns about the future of our oral surgery service following the loss of a minor oral surgery tender in 2012/13; in the medium term we are using the existing oral surgery capacity to reduce our waiting lists which are subject to a performance notice from our commissioner and we also plan on repatriating some work from Oxford University Hospitals.

Ear Nose and Throat (ENT) already runs a combined rota with HWWP and there is the possibility of a pan Berkshire service.

We have sufficient obstetrician cover for up to 6000 births. We anticipate more than 6000 births in 13/14 and will need to increase staffing accordingly.

## Productivity and efficiency

### Change of approach

The Trust has delivered efficiencies of nearly £49m over the past three years (both cost and income). Over the past few months it has been acknowledged that the on going challenge of delivering major efficiency savings whilst delivering key service targets and coping with operational pressures means that it is becoming increasing difficult to identify savings without impacting on the quality of patient care. The Trust believes that the emphasis now needs to shift to medium/long term large scale change to deliver top decile efficiency and quality, which evidence both nationally and internationally demonstrates will also reduce waste and deliver cost efficiencies.

With full support from both the Trust Board and all three care groups, we have developed a QIPP programme under the four work streams of Quality, Innovation, Productivity and Prevention (Safety). A dedicated Quality Improvement team, led by a senior medical consultant, has been created to work with operational staff using a range of quality and service improvement tools to improve the patient experience, safety, efficiency and productivity of patient care which will deliver efficiencies. Whilst supported by the new team, there is an expectation that the delivery of individual projects is at care group and corporate team level and changes have been made to budgets accordingly to reflect the level of planned savings.

The QIPP target set by the Trust for 2013/14 is £10m, and further details on the programme are provided in **Appendix 2**.

### QIPP governance

The Trust Project Management Office (PMO) function coordinates all QIPP projects across the Trust both financial and non financial. The team ensure that each project has a suite of project documentation completed including milestones, risks, measurement of financial savings, quality impact assessments signed off by the lead executive director.

All projects are detailed on a Trust-wide QIPP database, and projects are rated green, amber or red status depending on the level of risk of delivery and the value of savings is risk rated accordingly. The database is updated

weekly and formal summary reports are produced for discussion at each QIPP Programme Board and as part of the monthly Executive Trust Board report

**QIPP profile**

In addition to the above programme, there are also £600k of cost savings which have been carried forward from projects that were implemented in 2012/13. Key projects from the programme include:

- **Prevention -** Harm free care and safety underline this programme as the key area of improvement for the Trust QIPP going forwards and will focus on improving quality of care and clinical outcomes in at least seven areas trust wide over the next three years.
- **Talented teams** – to include a review of our recruitment strategy and ability to retain good staff, an improvement in our management of sickness absence, a Trust-wide review of skill mix by ward/area, expanding certain services towards six and seven day working and a Trust-wide review of every consultant job plan.
- **Pathways** – a number of pathways are being reviewed and redesigned across the Trust; this includes our frail elderly pathway, the emergency care pathway, a focus on the Enhanced Recovery Programme and a Trust-wide plan to reduce length of stay.
- **Clinical networks** – one of the key projects within this programme is the consolidation of pathology services. Discussions have progressed to include Heatherwood & Wexham Park Hospital and the Surrey Pathology Partnership (Frimley Park, Ashford & St Peters and the Royal Surrey hospitals) to review the potential for a five-trust model.
- **Utilisation of services** – to drive up improvement in productivity, projects to improve the utilisation of our services both on the main Trust site and at our community facilities are underway. This includes a Trust wide review of all outpatient clinics to drive up efficiency within clinic sessions, reduce DNAs and improve waiting times, a review of theatre utilisation and plans to increase capacity particularly for elective work.
- **Procurement** – We have again set ourselves a challenging target of £3m for 2013/14 which will be driven by care groups supported by the central team. Plans for savings have been identified to date totalling £2m, with another £1m to be developed over the next few weeks.
- **Quality through commissioning** – the Trust will be driving improvement in the quality of services we offer and will ensure maximum benefit is realised through commissioning incentives such as Best Practice Tariffs and CQUINs.
- **Pharmacy and drug spend** – challenge set Trust-wide for specialties to reduce drug spend by 15%. Other initiatives include plans to bring aseptic service back in-house.

To ensure contingency is built into the QIPP programme this year, the Trust is driving achievement of c£15m in year cost savings against the requirement for £10m, recognising that some projects are likely to slip during the year, and some will no longer become feasible. In addition, income QIPP projects will also be targeted.

**QIPP enablers**

To support staff across the organisation, we have implemented a Quality Improvement team with dedicated resources, led by one of the Trust's medical consultants and supported initially by Newton Europe, an external consultancy experienced in process redesign. The team will be working with operational staff using a range of quality and service improvement tools to improve the quality, safety, efficiency and productivity of patient care which will deliver efficiencies. The new approach was launched to staff Trust wide during May, and a series of in house tools

developed to provide staff with robust methodology to support delivery of their projects addressing areas often forgotten, such as changing behaviours and sustainability.

**Quality impact of QIPP**

Recognising the need to ensure quality remains at the forefront of everything we do, every individual QIPP project is subject to a Quality Impact Assessment (QIA) reviewed by the medical and nurse directors with those reaching the scoring threshold escalated to the Trust QIPP Programme Board for discussion and final agreement on whether or not the project should continue. Following completion of a project, the QIA will be reviewed again to re-assess for any impact on quality that was not identified at the commencement

## Financial and Investment Strategy

Our financial vision is to build a strong financial base, maintain financial control, deliver agreed financial targets, contribute to our overall service strategy Long Term Financial Model and anticipate future financial risks.

The headlines of our three year financial strategy are to deliver this vision and:

- maintain a risk rating of at least three
- achieve EBITDA (earnings before interest, tax, depreciation and amortisation) margin of at least 5%
- achieve small surplus margin and aim to grow this to over 1%
- make demonstrable progress in upgrading our estate to meet current and future anticipated demand
- maintain a liquidity ratio of at least 10 days
- meet prudential borrowing code ratios, and repay our Foundation Trust Financing Facility loans in line with the schedule of repayments.

This will be achieved by a focus on:

- being sized to meet the current demand projections
- growing market share within a 15 minute travel time and increasing to 30 minutes
- resolving the financially unsustainable penalty regime around NEL Threshold and Readmissions.
- cost control
- being in the upper quartile for clinical efficiency with an ambition to be in the top decile
- payment for quality, including achievement of CQUIN
- reduction in overhead costs
- best value in procurement
- disposing of surplus assets
- securing expanded sources of fund to invest in the estate.

The underlying operating business remains reasonably healthy however the Trust has had to cover the cost of its two main historic investments. In 2012/13 the Trust's EBITDA, surplus pre impairments and cash flow were negatively impacted by these historic investments as summarised in the table below.

| £m | EBITDA | Surplus | Cash |
|---|---|---|---|
| **Bracknell** | **(1.37)** | **(3.02)** | **(3.79)** |
| **EPR** | **(5.50)** | **(6.70)** | **(11.66)** |
| **Total** | **(6.87)** | **(9.72)** | **(15.45)** |

In relation to Bracknell (RBBC) the Trust has worked with local commissioners and other healthcare providers to develop a rental model for Bracknell which, when accompanied by Trust actions to grow activity, along with rescheduling of debt, is expected to reduce the on-going negative cash impact to approx. £1.5m per annum.

In relation to the EPR, the Trust has experienced a number of operational issues with the system, which stem from the design and the complexity in the configuration of the system.

We have undertaken significant activity to ensure the system remains safe for patients, and allows us to maintain data integrity. However, as a consequence of these issues, the Trust has faced significant operating costs. We are continuously reviewing our approach to minimise the costs with the system and a number of these actions have helped significantly to reduce the monthly operating costs. Typically, in most industries, operating costs of IT are circa 4% of total income. In the environment which we operate it is widely benchmarked that clinical IT systems should represent less than 1% of income. The Trust is planning to minimise its annual operating cost to £3m.

Looking towards the next five years, we are in the process of developing our detailed plans to support our IM&T strategy towards the delivery of an Electronic Patient Record by 2018.

**Assumptions underpinning income and expenditure**

Our strategic objectives identify the priority to meet the healthcare expectations of our patients in a safe and efficient environment giving the best possible patient care and experience.

External reports, supported by our own experience, have shown ongoing growth in demand for our services arising form both demographic changes and an ageing population.

We are mindful that we need to work with other stakeholders in the health economy to manage this growth to ensure ongoing affordability but we are equally mindful of ensuring that we are appropriately funded for the work that we do.

With this latter point in mind we need to collectively resolve the financially unsustainable burden placed on acute trusts through the application of NEL threshold and re-admissions penalties. These represent a risk of some £8.5m for this Trust whereby we treat patients, incur costs, yet are not funded. This is simply not sustainable and we have assumed a resolution will be found which funds the Trust for costs appropriately incurred and in our budget we have assumed these penalties will not be applied.

In 2012/13, we experienced growth in income along with non recurrent funding from the PCT which enabled delivery of an operating surplus of £0.5m for the year. Whilst the tariff rules drive a reduction in income for the same activity, and commissioners may wish to go further and actually reduce activity through QIPP, we have seen net historic growth in income and we are predicting this continuing giving a net 2.5% growth in income per annum.

We have taken a prudent approach to cost increases through including appropriate inflation assumptions, differentiating between pay, drugs and non pay and have also included a 0.5% (£1.8m) contingency for the first time.

We acknowledge the need to drive ongoing cost efficiencies and have planned on delivering 3% per annum. We have moved away from a traditional “Cost Improvement Plan” approach to driving cost efficiency to one which is much more quality focussed through a multiple year QIPP Programme. We are confident that through driving quality cost efficiency will come, along with better patient care. The latter two do not need to be mutually exclusive.

**Our financial strategy and the actions we will take to support delivery**

We expect the environment will remain challenging for the life of this plan; however it is vital we maintain a degree of financial stability. We define this as maintaining a Monitor FRR of 3 or better through:

- delivering an EBITDA of at least 5% coupled with a small surplus
- delivering sustainable cost efficiencies of at least 3% of income through our QIPP Programme and
- maintaining a cash balance of at least £20m to maintain cash liquidity of at least 15 days.

**Delivering an EBITDA of at least 5% and a small surplus**

In 2013/14 our plan predicts income of £336.4m, EBITDA of £22.4m (being 6.7%) and a surplus of £0.5m. (Versus income of £334.5m, EBITDA of £23.5m (7.1%) and a surplus of £0.5m for the year ended March 2013.)

The income figure is challenging, with a current assessed net risk of £13.2m against it, and, excluding drugs, is essentially flat versus the prior year (assuming a level of on-going non recurrent funding or the resolution of NEL Threshold and readmissions penalties such that the Trust is fully funded). The income remains higher than Commissioners initially were looking for but reflects our view of anticipated growth supported by external analysis. Using the standard PBR Contract means that demand risk sits with the commissioners and not the Trust. However, as per above, we have not allowed for contract penalties, particularly NEL Threshold and readmissions as these are unsustainable and are subject to on-going negotiation with commissioners. It should not be the case that commissioners are able, due to their own financial pressures, to enforce unsustainable contract penalties to pay for legitimate contract growth.

**Maintaining a cash balance of £20m**

Allowing for depreciation and the payment of PDC dividend and loan interest we expect to generate cash of £20.0m of which £3.7m is needed to repay the loans attributable to the Royal Berkshire Bracknell Clinic and the Electronic Patient Record. The current budget proposes that we invest £21.2m in capital equipment of which £14.1m will be financed from cash and £7m via leases. Our capital expenditure will be carefully managed to enable us to maintain our cash balance of £20m at the end of the year.

**Analysis**

The table below sets out our SoCI and for the five years ending 2017/18. They are included for information. On submission they will appear as part of the financial model. The attached cash flow shows a £15m capital expenditure spend for 2013/14 versus our budget of £14m. It is expected that the extra £1m of capital expenditure will be funded by incremental non recurrent income from the CCG which is the subject of on-going discussion.

| Summary SOCI (£m) | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | 2012/13 ACT | 2013/14 Budget | 2014/15 IBP | 2015/16 IBP | 2016/17 IBP | 2017/18 IBP |
| **Income** | | | | | | | | |
| | PCT Activity | | 286.6 | 289.1 | 292.7 | 296.1 | 297.6 | 297.9 |
| | Drugs | | 23.0 | 25.9 | 29.2 | 32.8 | 36.9 | 41.4 |
| | Other | | 23.8 | 21.4 | 21.4 | 21.4 | 21.4 | 21.4 |
| | Total Income | | **333.4** | **336.40** | **343.26** | **350.3** | **355.9** | **360.7** |
| | | | | | | | | |
| Pay | | | (190.0) | (194.5) | (195.8) | (196.9) | (198.2) | (198.8) |
| Drugs | | | (31.1) | (34.4) | (37.3) | (40.9) | (45.1) | (49.6) |
| Clinical Supplies | | | (38.2) | (38.5) | (38.5) | (38.4) | (38.4) | (38.1) |
| Non Clinical Supplies | | | (6.5) | (7.2) | (7.3) | (7.3) | (7.3) | (7.3) |
| Other Operating Exps | | | (44.0) | (39.4) | (39.3) | (39.3) | (39.4) | (39.2) |
| **Total Costs** | | | **(309.8)** | **(314.0)** | **(318.1)** | **(322.9)** | **(328.3)** | **(333.2)** |
| | | | | | | | | |
| **EBITDA** | | | **23.6** | **22.4** | **25.1** | **27.4** | **27.6** | **27.6** |
| | | | | | | | | |
| Depreciation | | | (16.488) | (15.7) | (16.5) | (16.5) | (16.5) | (16.5) |
| PDC | | | (5.166) | (4.9) | (4.9) | (4.9) | (4.9) | (4.9) |
| Interest | | | (1.400) | (1.3) | (1.3) | (1.3) | (1.3) | (1.3) |
| **Surplus (pre impairment)** | | | **0.539** | **0.5** | **2.4** | **4.7** | **4.9** | **4.9** |
| | | | | | | | | |
| Impairment | | | (27.3) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Revaluation | | | 0.564 | | | | | |
| **Surplus (post impairment)** | | | **(26.201)** | **0.5** | **2.4** | **4.7** | **4.9** | **4.9** |
| | | | | | | | | |
| Pay as % of Income | | | 57.0% | 57.8% | 57.0% | 56.2% | 55.7% | 55.1% |
| Non pay (excl drugs and depn) as % of Income | | | 13.2% | 11.7% | 11.5% | 11.2% | 11.1% | 10.9% |
| EBITDA margin | | | 7.1% | 6.7% | 7.3% | 7.8% | 7.8% | 7.6% |
| Surplus margin (pre impairment) | | | 0.2% | 0.1% | 0.7% | 1.4% | 1.4% | 1.4% |
| Drugs Income% Cost | | | 74.0% | 75.3% | 78.2% | 80.1% | 81.8% | 83.5% |

## Summary cash Flow

| | 2012/13 Act | 2013/14 Budget | 2014/15 IBP | 2015/16 IBP | 2016/17 IBP | 2017/18 IBP |
|---|---|---|---|---|---|---|
| **Net Surplus pre impairment** | **0.5** | **0.5** | **2.4** | **4.7** | **5.0** | **3.4** |
| Depreciation | 16.5 | 15.723 | 16.5 | 16.5 | 16.5 | 16.5 |
| PDC and interest | 6.6 | 4.9 | 4.9 | 4.9 | 4.9 | 4.9 |
| Impairment losses/(reversals) | (0.6) | | | | | |
| Working capital | 9.7 | (13.6) | | | | |
| **Cash generated from operations** | **32.7** | **7.5** | **23.9** | **26.2** | **26.4** | **24.8** |
| | 27.2 | | | | | |
| **Net cash inflow/(outflow() from investing activities** | | | | | | |
| **Capital Purchases:** | | | | | | |
| EPR | (5.2) | 0.0 | (1.5) | (1.5) | (1.5) | (1.5) |
| CSC | (1.5) | (1.9) | 0.0 | (0.5) | 0.0 | 0.0 |
| Bracknell | | | | | | |
| major Projects and Estates | (4.1) | (10.6) | (12.0) | (10.5) | (11.0) | (11.0) |
| Medical | (1.7) | (2.5) | (2.5) | (2.5) | (2.5) | (2.5) |
| Intangible Assets | (5.8) | | | | | |
| Increase/(decrease) in capital creditors | (4.0) | | | | | |
| Other | 0.8 | | | | | |
| | **(21.4)** | **(15.0)** | **(15.0)** | **(15.0)** | **(15.0)** | **(15.0)** |
| **Other:** | | | | | | |
| Proceeds on disposal of property, plant and equipment | 0.5 | 4.7 | | | | |
| Purchase of investments & deposits made | (1.5) | | | | | |
| Other | (0.4) | | | | | |
| **Total Cash from Investing Activities** | **(22.8)** | **(10.3)** | **(15.0)** | **(15.0)** | **(15.0)** | **(15.0)** |
| | | | | | | |
| **Net cash inflow/(outflow) from financing activities** | | | | | | |
| PDC | (5.5) | (4.9) | (4.9) | (4.9) | (4.9) | (4.9) |
| Interest | (1.5) | (1.3) | (1.3) | (1.3) | (1.3) | (1.3) |
| Loan draw downs | 2.0 | | | | | |
| Loan repayments (incl.interest) | (2.9) | (11.2) | (3.7) | (3.7) | (3.7) | (3.0) |
| Other | (0.0) | | | | | |
| **Cash generated from financing** | **(7.9)** | **(17.3)** | **(9.8)** | **(9.8)** | **(9.8)** | **(9.2)** |
| **Exclude movement in short term investment per internal cashflow** | **1.5** | | | | | |
| **Net Cash (out)/in** | **3.5** | **(20.2)** | **(1.0)** | **1.3** | **1.5** | **0.6** |
| **Brought Forward Cash** | **36.8** | **40.3** | **20.2** | **19.2** | **20.5** | **22.0** |
| **Carried Forward Cash** | **40.3** | **20.2** | **19.2** | **20.5** | **22.0** | **22.7** |