Royal Brompton & Harefield NHS
NHS Foundation Trust

# Strategic Plan Document for 2013-14

# Royal Brompton & Harefield NHS Foundation Trust

# 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:**

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| **Name** *(Chair)* | **Sir Robert Finch** |

**Signature** 

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

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| **Name** *(Chief Executive)* | **Robert J. Bell** |

**Signature** 

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

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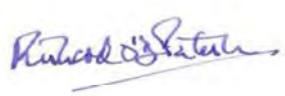
| **Name** *(Finance Director)* | **Richard O'D. Paterson** |

**Signature** 

# RB&HFT - Strategic plan 2013/14

## 1. The Trust's strategic context and direction

### 1.1. Strategic vision

1.1.1. In line with the Annual Forward Plans that we have submitted over the last three years, the strategic vision of the Trust continues to be that which we articulated when we became a Foundation Trust in 2009 – namely for our two hospitals to be the UK's leading specialist centre for heart and lung disease. Our three strategic goals (Service Excellence, Organisational Excellence, Productivity & Investment) also have remained the same.

1.1.2. Previous plans have identified the constraints of the current configuration and condition of physical infrastructure on both sites. Having invested significant time and resources in assessing options to redevelop the Royal Brompton Hospital (RBH) either in the White City area of West London or on the same site in Chelsea, the Trust Board has made the decision to redevelop the hospital on the same site in Chelsea. Notwithstanding the opportunity to be part of a potential cluster of specialist healthcare providers and research bodies, the revenue cost of supporting the development of a new hospital while maintaining operations in the existing hospital would impose very significant financial strain upon the Trust and, in all probability, an unavoidable and wholly unacceptable deterioration in our financial risk rating. Work is now under way to determine i) the optimal mix of activities within a redeveloped RBH on a more concentrated footprint in Chelsea (and potentially in other potential locations with other partner healthcare providers), ii) the maximum envelope of funding available from the full set of sources open to the Trust, in order to fund both the long-term redevelopment of RBH and Harefield and mid-term developments such as the ICU (Intensive Care Unit), HDU (High Dependency Unit) and Level 1 ward provision at Harefield, and an extended AICU (Adult Intensive Care Unit) at RBH.

1.1.3. These redevelopment activities need to be viewed within the wider UK healthcare context. This context is defined by factors such as growing levels of co-morbidities in patients with long-term conditions, the importance of critical mass at sub-specialty levels of a clinical discipline or individual stages of a single disease pathway, and the concomitant requirement for these sub-specialties and process stages to be more richly and reliably linked by technology. These factors do not sit well with the traditional concept of 'bricks and mortar' hospitals and clinics, but rather with a concept of systems of care involving multiple providers in different locations. We envisage our hospitals as existing within one or more of such systems of care, each being a composite part of a multi-specialty environment, created by a physical campus of adjacent or co-located providers' sites, and / or by a set of peer-to-peer clinician relationships networked through common and shared data platforms and systems (eg imaging systems, electronic patient records and data warehouses). While there are already initiatives under way that will start to form systems of care such as these, we will be defining their shape and structure in more detail over the next 6 months. This top-down definition will also

incorporate the 'bottom-up' outputs of a design forum made up of 20+ senior clinicians that has been meeting for the past 12 months, and it will be the strategic blueprint and operating model for our hospitals in the future.

### 1.2. Strategic position in the UK and local health economy

1.2.1. The Trust is a centre that provides a comprehensive range of tertiary and quaternary cardiac and respiratory services to treat paediatric and adult patients across a number of disease cohorts, the majority of whom are referred to our two hospitals from cardiac and respiratory clinicians based in District General Hospitals (DGHs) located not just in North West London, the North West Home Counties, London and the South-East of England, but also from many other regions of the UK. Included within this service portfolio are nationally commissioned services such as our adult Cardiothoracic Transplantation, Pulmonary Hypertension and ECMO (extra-corporeal membrane oxygenation) programmes, and our paediatric Primary Ciliary Dyskinesia and respiratory ECMO services.

1.2.2. Our centre is active within national and regional as well as local health economies, some of whose more influential characteristics are as follows:

1.2.2.1. ONS statistics released in July 2012 reveal that during the decade ending in 2011, the population of children under the age of 5 in London & South East England grew at over 2% per year, significantly higher than previously forecast. In London in particular this has led to sustained high occupancy rates and frequent shortages of paediatric intensive care unit beds, and consequently in FY12/13 our PICU was unable to accommodate nearly 80 requests to transfer in acutely ill patients with cardiac conditions. It has resulted too in steadily increasing pressure on waiting-lists for inpatient assessments for our paediatric cystic fibrosis patients. These capacity pressures are one factor that has driven us to seek collaborations with other providers.

1.2.2.2. We are seeing an increase in the number of acute episodes of illness in our cohorts of patients with long-term chronic conditions such as heart failure, congenital heart disease, cystic fibrosis, asthma and lung cancer. Although these episodes are initially managed via the A&E at patients' local DGHs, more and more patients are referred back to our hospitals for management of this acute episode. There has been a similar increase in the number of patients returning to our hospitals to receive symptom control or palliative care after a previous intervention or therapy. We believe the greater exercise by patients of their right to choose where they are treated is one common factor behind these trends, both of which are placing additional pressure on ward beds. We aim to identify a solution to these issues as part of the strategic blueprint mentioned in section 1.1.3 above.

1.2.2.3. The national trend of increased life expectancy within most cohorts of the UK population is but one of several co-morbidities with which an increasing number of our patients present. In 2002-03, less than 6% of the Trust's cardiac surgery

operations were performed on patients aged 80 and above; by 2012-13 this has doubled to more than 12%, despite the development and adoption of newer and less invasive techniques such as PCI and TAVI, both of which are lower risk options for elderly patients not fit enough to undergo surgery. The number of inpatients with diabetes at both our hospitals has been rising and is c.12% at any one time. Within this population, the cohort with the greatest prevalence are those patients admitted for cardiac surgery (22% of whom having diabetes), with higher rates of mortality and surgical site infections than other cardiac surgery patients.

1.2.2.4. One of the objectives of the North West London 'Shaping a Healthier Future' programme is a reduction in the number of A&Es, demanding more management of patients within primary care and at home. We believe we can contribute and support this policy by building on our pulmonary rehabilitation and rapid access heart failure services based around our Harefield site so as to increase the scope and number of such services in communities around both our sites. One such approach (community cardiology) is described in more detail in section 1.3.5 below.

### 1.3. Opportunities – commissioning intentions, diversified income streams and collaborations

1.3.1. Working with commissioners: Around 85% of the Trust's income will be derived from clinical services that are now commissioned by the NHS Commissioning Board (NCB). We have already begun to work with the NCB's teams to develop new services and improve existing ones in order to increase value for money (improvements in outcomes, better use of resources) for their spend. One key aspect of this will be developing more productive relationships with our suppliers of medical technologies, devices and medication, with whom we will collaborate to develop more rigorous business cases that focus on the benefits of a new innovation from a health economic perspective as well as an outcomes perspective. We anticipate too that commissioners will increasingly look i) to set standards that concentrate the provision of a much greater part of a pathway of care for certain complex patient cohorts within 1-2 specialist centres, rather than across several providers, ii) to delegate to the same specialist centre the responsibility for co-ordinating adherence to these standards and for managing the commissioning contract for this pathway. Our Trust is one such centre for adult cystic fibrosis patients: when invited, we will look to contribute to similar arrangements for other patient cohorts.

1.3.2. Safe & Sustainable programme for paediatric cardiac surgical services: there remains a risk that our paediatric cardiac surgical services may be decommissioned as a result of a recommendation last July by the Joint Committee of PCTs that Royal Brompton Hospital should no longer carry out these services. On the face of it, this would create a significant financial (as well as operational) risk for the Trust perhaps in 3-4 years time, as this would remove some £8m of financial contribution, thereby removing the solid financial underpinning for a much wider array of services across the Trust. Recouping this £8m gap through the development of new services or the expansion of existing services would probably take more than one year (perhaps two) to achieve. We believe however that the

recent changes in the commissioning bodies in charge of overseeing specialised services will result in a more balanced view of how provider reconfiguration may or may not contribute to improving long-term outcomes in the UK, in respect of which recent NICOR (National Institute for Cardiovascular Outcomes Research) analysis suggests that we remain one of the leading centres. We still believe that in the light of the demographic changes highlighted in section 1.2.2.1 above, there is a need for 3 centres in London, working collaboratively with one another and with DGHs in London & South East in a networked model of care. We welcome the opportunity offered by the NCB for all providers to redefine pathways of care for congenital cardiac disease (paediatric and adult) together in London, based on all available demographic data and also on a fair and balanced assessment of the international evidence base of clinical outcome analysis in paediatric cardiac surgery.

1.3.3. Attracting and retaining research funding: since 09/10, the Trust has increased its annual research income by >40% to £10.4m. This has been achieved both through increased funding for our Biomedical Research Units (2012-17) and increased project income, primarily from grant funding agencies but also the commercial sector. The Trust intends to continue this upward trajectory, in particular by improving our set-up and delivery of studies in order to develop sustained "preferred" partner relationships with industry and retain existing public sector funding linked to delivery metrics. We will also continue to focus on securing additional grant funding and this will be facilitated by the Trust's research partnerships: i) the Institute of Cardiovascular Medicine and Science, whereby the pooling of resources and expertise with Liverpool Heart and Chest Hospital will provide benefits to RB&HFT research; ii) Imperial Health Partners and the associated Academic Health Sciences Network; iii) other clinical research partnerships with local NHS Trusts whereby research activities are maximised by the pooling of eligible patients with the academic leadership at RB&HFT.

1.3.4. Private patients: The Trust's strategic plan is to increase the size of the Private Patient business across both sites, thus increasing the level of support to the Trust's NHS clinical activity, by focusing on complex, high-value activities across cardiothoracic surgery, cardiology and respiratory medicine in the UK and internationally. Within the UK the business is looking to increase the number of outpatient locations to gain market share in areas where traditionally we have received very few referrals. The Middle East continues to be a focus internationally; however the business is looking at developing new referral patterns, and a small number of referrals have already been received from China and Russia. This year the Royal Brompton Inpatient ward will be redecorated and the patient and families facilities improved. A new private reception will be built on the Sydney Wing ground floor.

1.3.5. Community cardiology: Liverpool Heart & Chest Hospital, our joint venture partner in our Institute of Cardiovascular Medicine and Science collaboration, has been operating a community cardiovascular service for the past 2-3 years. The service involves both the diagnosis of all types of heart conditions in patients referred to weekly clinics by GPs and also longer-term management of these conditions, and has generated a broad range of uniformly positive outcomes including reduced admissions at local A&Es. We believe that there are several areas of North West London and the surrounding Home Counties where

this (or a similar) service could generate similar such benefits. We are working with LHCH to understand how it should best be operated: we will be then look to engage with North West London's CCGs to determine how this model of care best fits with their commissioning plans.

## 2. The Trust's approach to quality

### 2.1. Overview of the quality assurance process

2.1.1. To ensure that the Trust is able to provide the appropriate levels of assurance on effective internal control to the Trust's patients, to its Board of Governors and to its stakeholders, the Risk and Safety Committee (RSC) has been established as a sub-committee of the Board. This committee, with membership of the Trust's Non Executive Directors and attended by the Executive Directors, oversees and scrutinises the systems for internal control, whether financial, clinical or operational, in order to seek assurance that risks are identified and adequately managed. It receives regular performance reports from the Governance and Quality (G&Q) Committee, chaired by the Medical Director and Deputy Chief Executive, which provides management scrutiny of the Trust's risk management issues against an integrated governance and patient safety agenda.

2.1.2. Review of risk is carried out initially at a local / departmental level, with the facility to escalate relevant risks (through the division and/or department Quality & Safety lead). Every 6 months, the top risks for the trust are reviewed at the G&Q Committee, where representation from each of the clinical and non clinical divisions ensures the Trust is able to share best practice and respond to identified weaknesses. A performance report relating to these risks and their mitigation is then forwarded to the RSC. In turn, a summary of risks then goes on to the Trust Board, presented by the Chair of RSC. This reporting process has undergone significant change and development over the last 12-18 months, in that the report also now details what new risks have been added, any risks which have been upgraded, progress with closing/downgrading existing risks, internal and external, current and future risks to the organisation.

2.1.3. The Trust has put in place a Risk Management Strategy which assigns responsibility for the ownership and management of risks to all levels and individuals to ensure that risks which cannot be managed locally are escalated through the organisation. This process populates a central Risk Register which constitutes a systematic record of all identified current and strategic / future risks to the organisation. All risks are evaluated against a common grading matrix, based on the NPSA model, to ensure that all risks are considered alike. The control measures, designed to mitigate and minimise the identified risks, are recorded within the register. The Risk Register is continually reviewed by the RSC and by the Board to ensure that these risks are being adequately controlled, and it also informs the collation of regular self assessments against the Quality Governance Framework (QGF).

**2.2. The Trust's current quality performance**

2.2.1. The Trust is registered with the Care Quality Commission (CQC) without any conditions. The CQC's two most recent inspections carried out during the last 12 months – of Harefield Hospital in June 2012 and of Royal Brompton Hospital in January 2013 – resulted in both sites being deemed to be fully compliant.

2.2.2. The Trust's performance is also assessed by Monitor through its compliance framework of key performance indicators, against which targeted achievement is measured. Currently all but three targets have been met by the Trust in FY12/13: these three relate to Clostridium Difficile (C.Diff), 18 week wait, and the 62 day wait for 1st treatment for cancer.

2.2.2.1. C.Diff: during FY12/13, the Trust breached both the Department of Health and Monitor targets (7 cases and 12 cases respectively) for the number of C.Diff cases reported and attributable to the Trust, reporting 18 such cases. The Trust has been disputing these targets since the beginning of FY11/12 as being unrealistic and unachievable, and we have proposed a target for FY13/14 of 14 cases which is in line with the longer-term downward trajectory of cases that the Trust has been achieving. The Trust adopts a zero tolerance approach to healthcare acquired infection and all steps are being taken in order to ensure that the incidence of C. Diff infection is kept to the absolute minimum. In line with this approach, during the second half of FY12/13 we reported only 5 cases, a significant reduction from the 13 cases in the first half of the year. We are currently discussing the target with the London office of the NHS Commissioning Board, and we understand that ours is not the only dispute in relation to C.Diff targets.

2.2.2.2. 18 week wait: during several months of FY12/13, the Trust failed by c.5-7% at both its hospitals to meet a target of 90% of patients to be admitted for treatment within 18 weeks of referral from their GP. During Q3 and Q4, the Trust operated an arrangement with the Wellington Hospital (HCA) under which selected patients referred to Harefield Hospital for surgery were offered admission to the Wellington for surgery by Harefield surgical teams, with post-operative care carried out by the Wellington teams but under the oversight of Harefield intensivists. This provision of additional capacity ensured that the cumulative gap between performance and the 90% target threshold narrowed substantially during Q3 & Q4, such that during April 2013 the threshold was exceeded (92.1%) and will continue to be met throughout the rest of this year and beyond.

2.2.2.3. 62 day cancer pathway: the waiting time target for patients urgently referred by their GP for suspected cancer is 62 days (two months) from referral to first treatment, including time spent waiting for diagnostic tests at other hospitals before being referred to our Trust. Where the Trust receives patients referred by other trusts late in their pathway, these patients are treated quickly: and if administrative delay at the referring trust has been a factor, breaches are repatriated to the referring trust where agreement can be reached. Although the

Trust exceeded the adjusted threshold (79%) for this target in FY12/13, this level of performance was reliant on a number of ad-hoc negotiations between the Trust and referring hospitals to repatriate breaches. To improve this performance, our cancer team are planning two initiatives. The first is a joint 'back to basics' review, between the cancer executive team and lead clinicians at each of our referring hospitals and our cancer team, of the lung cancer pathway in order to identify where the majority of referral delays occur – eg obtaining timely access to PET scans. The second is to look at making formal individual agreements between our Trust and our referrers in relation to the amount of elapsed time before a breach will be repatriated. This would follow a precedent set by several London Cancer Alliance (LCA) Trusts, of which we are one, who have made individual agreements with referring hospitals about setting a standard for days since referral, in which the stipulated number days vary from day 42 to day 52, and where any referrals sent after this number of days are automatically assigned as a breach back to the referring Trust.

2.2.3. In terms of its performance against the Commissioning for Quality and Innovation (CQUIN) measures, during the first three quarters of 2012/13 the Trust has achieved all of the measures. The final position for 2012/13 is dependent upon agreement of quarter 4 figures with commissioners.

**2.3. Key quality risks**

2.3.1. Within the Risk Register there are currently three quality risks which score a 'red' rating of ≥20 in terms of their severity. These risks and the Trust's plans for managing them are described below.

2.3.2. Decommissioning of paediatric cardiac surgical services: as we have outlined above, the crystallising of this risk would have a significant impact on the Trust, not only destabilising the Trust financially in the immediate aftermath but also causing us to abandon our vertically integrated model of care and to recast our strategic Mission. Our approach to managing this risk has been to engage constructively with the Safe & Sustainable programme team that proposed this decommissioning in July last year, in order to point out the resulting disproportionate amount of damage to a wide range of existing high-quality services. This conclusion was endorsed by a report produced by an independent panel of expert clinicians led by Professor Peter Hutton. While we believe the attitude of the Safe & Sustainable programme teams may recently have shifted with regard to decommissioning these services at our centre, a number of key issues at present remain unresolved (eg the legal challenge to the Safe & Sustainable programme's reconfiguration proposals by a charity linked to the Leeds Royal Infirmary; the conclusions of the report on the Safe & Sustainable programme by the Independent Reconfiguration Panel, and the view taken of this report by the Secretary of State for Health). Until these issues are resolved definitively, this will continue to be evaluated as the most severe risk for our Trust.

2.3.3. Estates – maintenance backlog / areas unsuitable for patients and staff: as mentioned in last year's Annual Plan, the age and fabric of many of the Trust's buildings has meant that

some of them could potentially pose a risk to the health of patients, staff and visitors. An accelerated planned preventative maintenance (PPM) programme has been implemented throughout the past 12 months, with target areas of both hospitals being classified by the severity of the risk that they posed. As of the end of FY12/13, c.95% of the high risk (ie most severe) maintenance backlog and safety issues had been eradicated. This programme will continue during FY13/14, focusing on the eradication of the majority of the significant risk (ie of medium severity) backlog and safety issues, and it will be supported by a ring-fenced allocation of capital from the Trust's Capital Working Group.

2.3.4. Information Technology capability failing to meet clinical needs: this risk definition covers a number of smaller risks relating to issues with both IT infrastructure (eg a lack of a single real-time point of access to all clinical information relating to a patient) and applications (eg a lack of patient databases for congenital heart disease patients and for implanted cardiac devices). A Chief Information Officer has been appointed in January 2012, who has begun to investigate external vendors / solutions in order to determine the optimal application architecture for Trust. Approval has been given by the Trust's Management Committee for a substantial investment in a Corporate Data Warehouse and supporting analytics' package which will underpin this architecture. A new devices database has gone live in March, while the congenital heart disease database is under implementation.

# 3. Clinical strategy

### 3.1. Evolution of the Trust's overall clinical strategy

3.1.1. The Trust's clinical strategy has for the last five years been based around 12 clinical care groups, encompassing both cardiac and respiratory services for both adult and paediatric patients. Where these services relate to congenital diseases such as cystic fibrosis or congenital heart disease, service delivery is structured as a continuum of care, from foetal medicine to palliative care or to treatments for end-stage lung and heart failure.

3.1.2. We outlined in section 1.1.3 above the priority over the next six months to define a new strategic blueprint and related operating model relating to our two hospitals' positions within an integrated system of care. Both the clinical care group structure and our vertically integrated model of care for congenital patients will remain wholly integral to these positions. However we see this structure continuing to evolve in the following ways (some of which we first outlined briefly in our FY12/13 annual plan):

3.1.2.1. The increasing confluence of cardiac and vascular practice in the UK, as typified by interventional practice to treat aneurysm and dissections within the aorta, demands that our clinical practice in this area must become more cardiovascular than merely cardiac. Fuller integration of cardiac and vascular intervention services in our hospitals will create better patient pathways, better co-ordinated services and increased opportunities for research. We are preparing to build a thoracic vascular interventionist practice of our own, most likely in collaboration with another tertiary centre, by making a series of interventionist and physician

appointments and by the development of a hybrid theatre at each of our hospitals, for which the Trust's Charity has initiated a fund-raising campaign.

3.1.2.2. Development of a multi-specialty environment (I): the increasing number and complexity of co-morbidities of our cardiac and thoracic interventionist patients require that both our hospitals improve the on-site availability of adjacent clinical services. For example in renal medicine, our intensivists and theatre teams are well-able to manage renal failure caused by an underlying cardiac or respiratory disease or post-operatively by cardiac shock. We do not however have a sufficient on-site presence of a specialist renal physician familiar with discrete diseases of the kidneys and intrinsic renal failure. Joint appointments of such a physician with a partner Trust, such that he/she was on-site for a dedicated 2-3 days per week, would result in better optimisation of patients with renal failure pre-operatively and shorter lengths of stay post-operatively. Another example would be in our management of diabetes which could become more comprehensive if the scope and remit of our current diabetology service was expanded by bringing it 'in-house' and based fully in our hospitals with the appointment of one or more full-time consultants and 2-3 full-time nurse specialists. Similarly, an enhanced on-site presence (ie 1 day per week) of a consultant gastroenterologist will improve the quality of care we provide both to our cardiac and respiratory patients – for example in terms of the management of liver failure and bleeding in the upper gastrointestinal tract in pre- and post-operative patients, or the endoscopic placement of a nasojejunal tube within intensive care patients.

3.1.2.3. Development of a multi-specialty environment (II): our clinical strategy is underpinned by a robust IT strategy. We envisage the deployment of an IT application architecture that makes available a full set of patient- and cohort-level data for administrative, clinical, research and commercial purposes to all clinicians involved in the care of our patients and our referring partners' patients, not just those belonging to our Trust. There are clearly efficiency benefits that will flow from this architecture, as well as the more obvious and important clinical quality benefits. We envisage too that the infrastructure / hardware underpinning this architecture must be able to support telemedicine links through which outpatient clinics and MDT meetings can be conducted with a wide array of DGH partners. We are also making a significant investment in a corporate data warehouse and analytics system which not only will make a step change in cohort assembly for research purposes and cohort tracking for clinical audit purposes, but will also provide clinical decision-making support.

## 3.2. **Service line management strategy**

3.2.1. The current clinical care group structure will continue to be the basis within which nearly all of our portfolio of cardiac and respiratory services are refined and expanded. After 2-3 years of development we believe we now have a service line reporting capability that can provide timely, accurate and meaningful information to care group chairs, such that they

can (inter alia) make more informed decisions about the allocation of resources within their teams. We are currently planning how to roll this out across all the Trust's clinical care groups.

3.2.2. Our annual service development programme, which is integrated with the Trust's broader financial budget cycle, is the principal means by which individual services within the clinical care group structure are strengthened or expanded and by which gaps or niches within the Trust's service portfolio are identified and filled. Examples of this are as follows:

3.2.2.1. New service development: our respiratory division will introduce this year a streamlined multidisciplinary service for the evaluation of patients presenting with upper airway symptoms, in order to improve the differential diagnosis between asthma patients and an exercise-induced laryngeal obstruction (EILO), and to provide therapy services for EILO patients. Elsewhere in our respiratory division, a new type of anti-fibrotic agent (perfenidone) has recently been approved by NICE for the management of idiopathic pulmonary fibrosis (IPF), which slows the disease progression and the decline in lung function, and is the first new treatment for IPF for many decades. Treatment with this drug therapy is only available via designated specialist centres, of which RBH is one.

3.2.2.2. Expansion of existing services: while the draft standards of care emerging from the national paediatric intensive care Clinical Reference Group stipulate occupancy levels at or around 80%, our Paediatric Intensive Care Unit, like its counterparts elsewhere in London, continually runs at a 95-100% occupancy level. We are looking to add staffing for four high dependency / Level 2 beds which will expand the current 'step-down' capacity, thereby freeing up the existing 16 Level 3 beds to handle more new patients. In a similar vein, we are looking to double the size of our Cardio-Oncology daycase service, which we operate to support oncologists and other medical or surgical teams at the Royal Marsden Hospital and other cancer centres. This service treats cancer patients either with existing cardiac co-morbidities or who develop cardiac complications as result of medication taken to treat the cancer.

3.2.2.3. Strengthening existing services: during FY13/14 our Harefield clinical teams will begin a stepped process to broaden the scope of the intensivist model of care currently at the core of the Intensive Care Unit to include all high dependency care wards. By incrementally deepening all medical and nursing rotas in these areas, we expect to manage the growing pressures of a diverse mix of emergency (transplant, primary PCI, aortic dissection) and elective cases more consistently throughout peaks of demand and weekends as well as weekdays. We have also made significant investments in our transplant programme in terms of personnel (including the recruitment of a second cardiologist with an interest in end-stage heart failure and a further cardiothoracic surgeon specialising in heart transplantation) and in terms of equipment (we are now using the Organ Care System to maximise the quality of the donor organ for around half of the donor heart retrievals that we make).

3.2.3. In one particular area we may potentially seek to innovate outside (rather than within) the existing clinical care group structure. The genetics team from the Trust's cardiovascular BRU (Biomedical Research Unit) has successfully applied for a £1.8m HICF (Health Innovation Challenge Fund) grant to develop a clinical genetics service, to be operated in a laboratory adjacent to the existing genetics research laboratory. Although the clinical laboratory is unlikely to be accredited before the end of 2014, we are currently mapping out a three year plan as to how this service will be developed, in particular determining its position in the Trust in relation to the clinical services it will serve and to the Trust's other laboratory services.

### 3.3. Clinical workforce strategy

3.3.1. Nurses: The Trust has skilled, registered nurses with cardiac and respiratory experience in all wards and units who are supported by some healthcare assistants and managed by senior nurses/matrons. A major priority is to continue implementing the nursing strategy which is being amended to reflect the requirements of the national strategy for nursing, midwifery and care staff in England: Compassion in Practice. A range of key performance indicators are monitored including the safety thermometer and infection prevention practice with the aim of reducing avoidable harm to patients. Nurse recruitment both in the UK and beyond will continue with the aim of reducing the reliance on agency nurses. Education is provided in the Trust and in association with universities, and student nurses gain experience here. There is an advanced nursing team, and research nurses, who will continue to undertake a range of clinical roles that are important to patients and that help ensure a positive experience for them.

3.3.2. Medics: The immediate priority areas for strengthening existing medical rotas or initiating new services are covered in the service line strategy section above. Beyond these there are three broader strategic objectives for the management of the medical workforce.

3.3.2.1. Recruiting top talent: The recruitment & retention of highly experienced and skilled medical (as well as nursing) staff not only reduces locum costs but also ensures that the Trust remains at the leading edge of clinical innovation in our specialty fields. The clinical care group structure has enabled us to identify more proactively where resource needs and opportunities exist, although given that we have to compete on a global basis for talent in our specialist fields of treatment of heart and lung disease, there is always a risk that we will be unable to attracting UK and international interest of sufficient calibre in new consultant positions.

3.3.2.2. Creating a performance-driven culture: all consultant staff now undergo annual 360° multi-source feedback, and we have introduced electronic systems for storing the relevant appraisal material and for job planning. The rationale behind this priority is not merely to meet the revalidation requirements set by GMC, but also to improve leadership strength amongst consultants, assist in succession planning, and to help drive the adoption of a performance culture.

3.3.2.3. Leadership: The Trust runs a number of accredited Leadership Programmes and has recently added to its learning portfolio through collaboration with the Advisory Board, an international consultancy offering tailored programmes to organisations to support the progression of senior leadership talent. The programme content covers topics such as Leading Change, Developing Leaders, Effective Problem-Solving, Managing Conflict and facilitating Teamwork, Productivity (optimising throughput and staffing) and Finance (cost discipline and capital investment). The programme is run on a multi disciplinary basis and the current cohort includes a number of senior medical consultants who have been identified as having significant leadership potential.

3.3.3. Therapy and Psycho-social services: The Trust has a range of expert practitioners in therapy services, which are integrated into Therapy teams to complement the divisional structure of the Trust. These services are developing service level agreements in order to streamline and enhance their responsiveness to the changing needs of the patient demographic, and ensure an appropriate skill mix is utilised. Psycho-social and Palliative Care services continue to be developed in line with the Trusts desire to provide a holistic service to patients, and also to meet national strategic requirements. With all services, the emphasis is on best practice, with a high level of engagement with research and educational attainment.

### 3.4. Clinical sustainability

3.4.1. As service standards begin to emerge from the c.75 Clinical Reference Groups working under the auspices of NHS England, both our hospitals must ensure that they meet these standards in terms of outcomes, case volumes and resourcing. To do this the Trust will maintain critical mass, innovate and invest at the sub-specialty level (eg aortic surgery) rather than the specialty level (ie cardiac surgery). By setting the sub-specialty level as our strategic focal point we intend to be a more convenient and accessible referral partner for our DGH-based cardiologist and respiratory physician colleagues.

3.4.2. In assessing our patient cohorts at this sub-specialty level – for example, our 900 cystic fibrosis patients; our 2,000 strong bronchiectasis cohort; 300 primary ciliary dyskinesia (PCD) patients; 1,430 patients with cardiomyopathy; and our 6,000 patients with adult congenital heart disease – we are keenly aware of the need to maintain sufficient clinical resources (not just consultants, but in particular clinical nurse specialists and therapists) to provide treatment for these sizeable cohorts. We believe there are currently no services operated in our Trust where the levels of clinical resourcing are below those recommended by the Royal Colleges or stipulated by any existing or emerging clinical standards, although there are areas where this resourcing can be deepened (see section 3.2.2.3 above).

3.4.3. Instead, we regard the principle challenge to the continued development of our clinical services as being not so much our workforce but rather the location, capacity, configuration and condition of our Trust's buildings and physical asset base. We have therefore set up several major capital programmes under the oversight of the Trust's Capital Working Group, which are now at various stages of the up-front planning process.

Over a medium-term (3-5 years) horizon these programmes will upgrade, modernise and expand core areas (as mentioned earlier in section 1.1.3) in both our hospitals, while also constituting the first steps of the wholescale redevelopment of first the Royal Brompton and then Harefield hospitals.

# 4. Productivity & efficiency

### 4.1 Overview of productivity and efficiency potential

The Trust is targeting improved productivity in the following areas:

- Increased spell volumes, by means of length of stay reductions and improved discharge processes. A series of initiatives across the clinical divisions aims to deliver a minimum 1% increase in spell volumes.
- Theatre and catheter lab productivity, using dashboards developed in 2012/3 to highlight bottlenecks and target improvements in patient scheduling and coordination of theatre and critical care capacity. The Trust will engage third-party support in these projects.
- Wider use of pre-admission clinics to optimise patient pathways and avoid unnecessary delays in treatment and inefficient use of bed capacity.
- Further progress in reducing reliance on temporary – especially agency – staff by sustaining progress made in 2012/3 with permanent recruitment, and by ensuring authority for committing these resources is retained by senior staff.

### 4.2 Financial Stability Plan (FSP)

The Trust's FSP brings together all measures designed to improve financial viability – saving and cost improvement plans; service developments delivering additional financial contributions; and cost-pressures managed or mitigated to avoid additional cost. The Trust has a good recent record in delivering its FSP – achieving >85% of plan between 2008 and 2012. Delivery of the plan fell to c.70% in 2012/3, but this was mitigated by substitute schemes which helped ensure delivery of the Trust's overall financial plan for the year. For 2013/4, the FSP aims to deliver c£11.5m, in addition to c£1.5m of identified cost-pressures which are not funded and will have to be managed within existing budgets.

#### 4.2.1 Oversight arrangements

Delivery of the FSP is the responsibility of the Chief Operating Officer. Progress is monitored via monthly Operational Management Team meetings, and individual review with key budget-holders. In addition, quarterly reviews provide a forum for wider executive review of progress against plan, and for broader discussion of risks and further remedial action where necessary.

4.2.2 FSP profile and enablers

The FSP comprises £3.9m of service development contribution and £7.6m of cost reductions (in addition to £1.5m of identified but unfunded cost-pressures). Service developments are responding to growing demand for asthma, sleep and ventilation services; critical care for acute respiratory failure; complex heart assessment; and cardiac services (especially at Harefield). Pay savings account for £5.2m of the £11.5m FSP and approx 3% of the 2013/4 pay budget. This is made up of a £3m reduction in temporary staffing costs (in nursing and junior medical staff budgets in particular), and a series of detailed establishment changes across the Trust, facilitated in part by a Mutually Agreed Resignation Scheme run in February and March 2013. Non-pay savings focus on procurement and inventory management (the latter facilitated by improved materials management and product tracking systems, which are reducing stock wastage). There is also a reduction in maintenance costs, as a consequence of the remedial investment made since 2010 in the trust's ageing plant and estate.

The Trust is also reviewing further major changes to its laboratory medicine services. Microbiology and Histopathology disciplines have undergone consolidation in 2012/3, and blood sciences services will follow suit in 2013/4. We are evaluating a joint service with the Royal Marsden NHSFT and a comparator North-West London service. No financial benefit is assumed in 2013/4, but savings of up to 10% are anticipated for 2014 onwards.

4.2.3 Quality impact of FSP

Each proposed FSP scheme is assessed by the local (divisional/directorate) management team (including lead clinicians) for its implications for service quality and safety. Once schemes are agreed and included in the draft budget proposals, a summary of the schemes, their relative and/or potential risks is presented for explicit endorsement by the Medical and Nursing Directors before being considered by the Board alongside the Annual Plan (and reported to the Risk & Safety Committee).

During the year, the Trust's quality and safety processes (routine audits, incident reporting and review) are used to identify any potential, unforeseen consequences of FSP schemes. During Q2, a specific review is undertaken of each FSP scheme and its operation and impact, and reported via the Governance & Quality Committee to the Board's Risk & Safety Committee.

# 5. Financial & investment strategy

## 5.1. Assessment of the Trust's current financial position

5.1.1. The Trust finished the financial year 2012/13 with net assets of £216.7m, cash resources totalling £18.8m and borrowings of just £1.2m. Liquidity was also satisfactory. However, looking ahead the Trust faces a number of headwinds:

5.1.1.1. First, reductions in tariff and continuing cost inflation mean that achieving budget for 2013/14 will be demanding, following hard on the heels of three years of CIPs and service developments. 2014/15 and subsequent years are expected to require substantial further cost saving measures as the pressures on both income and costs are expected to continue.

5.1.1.2. Secondly, the Trust must maintain and renew its ageing infrastructure assets on both its campuses: this will inevitably represent a drain on cash resources.

5.1.1.3. Finally, the Trust must invest in new and improved facilities to meet growing demand for its services, free up service bottlenecks, and create a legacy for future generations of patients, consistent with its brand as a national and international leader in the treatment of heart and lung disease. This will represent a further drain on liquidity.

### 5.2. Key financial priorities and investments

5.2.1. The Trust's principal financial target, over the financial year as a whole, is to maintain a Risk Rating of a minimum of 3 under Monitor's compliance regime. The FRR assessment process draws on elements of both income statement performance and balance sheet liquidity. The headwinds referred to above will stretch the Trust's financial management and resources. It is to be noted that from Q3 of 2013/14 Monitor has proposed changing its financial compliance regime to a 'continuity of services' basis: this would focus on liquidity and ability to service debt.

5.2.2. In March 2013 the Trust Board approved a recommendation to rebuild/ renew its two hospitals within the constraints of affordability. The intention is to raise the necessary funds through sales of Trust property both in Chelsea and at Harefield that is not required for the operational purposes of either hospital. It is the Trust's intention to obtain approval for a masterplan for each campus consisting primarily of hospital and residential usages. This strategy was formally endorsed by the Trust's Council of Governors on 20th May. It is expected that the Trust will engage with all stakeholders (eg local residents, planning authorities, and others) on an open book basis to determine the nature of any rebuilding proposals, in the context of producing a sustainable development programme within the resources of the Trust.

5.2.3. Although it is unlikely that major hospital construction activities will commence within the next three years, the Trust will necessarily incur substantive planning and design fees over that period, in addition to its other capital expenditures. It is therefore probable that external funding will be necessary, from commercial lenders and/or from the Foundation Trust Financing Facility. In the longer term, bridging finance may be required to pay for construction costs until the proceeds of real estate sales become available. This will depend on the timing of real estate transactions.

5.2.4. The need to renew ageing infrastructure will also require substantial financial resource as will the requirement to free up bottlenecks, in particular in the Intensive Care Units (ICUs) at both hospital sites. ICU investment is likely to precede the main rebuilding works although it will necessarily be fully integrated with them to avoid wasted investment.

### 5.3. Key risks to achieving the financial strategy and mitigations

The key risks to the Trust are these:

5.3.1. Income statement performance – the financial pressures over the next three years will require innovative approaches to increasing income through service developments and improved work flows as well as maintaining vigilance over the cost base, for example through tighter controls over agency staff spending. The Trust has recently developed improved service line reporting (SLR): this will be deployed in improving financial performance through developing those service lines with stronger contribution. SLR aside, further service developments will be identified to bridge the gap between tariff deflation and cost inflation on the one hand and CIPs on the other. Cost-cutting alone will not achieve a balanced budget in any of the three years covered by the APR.

5.3.2. Liquidity – with major capital requirements and little prospect of additional internally generated funding, the Trust will be obliged to look to external funding sources. As the Trust benefits from the ownership of surplus real estate, particularly in Chelsea, it should be well placed to negotiate borrowing facilities on reasonable terms. Indicative discussions with potential lenders, both commercial and the FT Financing Facility, have already started: when an outline business plan is available the Trust will enter into formal discussions with one or more of these parties. A related requirement is to maximise liquidity through improved working capital management, including tight control over planning and design fees for the redevelopment of the Trust's campuses and for the long-term financial modelling of the redevelopment programme to identify the quantum and timing of funding requirements.

5.3.3. Threat to the Trust's paediatric services – as noted elsewhere in this Annual Plan, the 2010 decision by the JCPCT, in effect, to decommission these services would have a serious adverse impact on finances as they together represent some 15% of the Trust's clinical income and c.£8m of contribution. However, subsequent developments mean that we are cautiously optimistic that the Trust will not see the implementation of this decision in London. Even if implementation were to proceed, owing to the delays caused by legal actions and, separately, by an independent review of the JCPCT decision by the Independent Reconfiguration Panel, this issue will not have a significant impact on the Trust's finances in 2013/14 and is unlikely to do so before 1 April 2015. If ultimately this proved necessary, the Trust would seek additional adult patient referrals to utilise freed up capacity, as well as convert the PICU at RBH to an adult facility. This transition would have a significant adverse impact on financial performance over an estimated 18 to 24 months. Given the contingent nature of this outcome, however, it has not been reflected in the financial forecasts forming part of this Annual Plan.

5.3.4. Although not seen as a key risk, it is notable that since 1 April NHS England commissions some 85% of the Trust's NHS clinical services. It will also be the conduit for Project Diamond funding which recognises the complex nature of many of the Trust's services: in 2012/13 this amounted to £9.2m, critical to achieving the Trust's Plan for that year.