1) Executive Summary

The operational plan is presented here using parameters agreed by Board (with advice from Governors) and designed to deliver long term financial and clinical sustainability with a low-risk profile.

There are four key drivers of the operational plan; financial, clinical (including Research) and workforce sustainability alongside quality of services and patient experience.

1.1) Financial sustainability

The Board has previously functioned on its requirement to remain financially sustainable over a longer period of at least 10 years. This is set out in more detail in the Strategic Plan 2014 – 19 and requires annual operating revenue surplus (at current prices) of at least £20m to deliver its 10 year capital replacement programme and maintain sufficient cash headroom to meet its working capital needs (assumed to be at least £10m at current turnover). In this scenario new investment is funded either through loan or similar facilities based on revenue positive business cases; or where appropriate through charitable grants (for non-core NHS activities).

1.1.1) Revenue

The proposed revenue plan is as follows:

2013/14 Plan £000s		2013/14 Outturn * £000s	2014/15 Plan £000s	2015/16 Plan £000s
184,274	NHS Income	191,200	191,500	192,400
24,565	Research and Development	25,100	17,900	17,300
67,404	Private Patients	68,500	81,000	92,800
42,049	Other Income	48,900	53,700	54,300
318,292	**Total Income**	**333,700**	**344,100**	**356,800**
297,690	Operating Expenditure	317,300	327,600	337,400
4,609	Dividend / Interest	5,200	4,900	5,400
15,993	**Development Reserve**	**11,200**	**11,600**	**14,000**

'*' Forecast at month 11

In the short term, and taking into account the risks outlined below, this 2-year operational plan provides sufficient cash and capital to meet the minimum requirements for sustaining operational performance and service quality; but does not provide the financial headroom required to commit to longer term investments such as new IT solutions and major building and site upgrades.

1.1.2) Capital

The following capital expenditure is affordable within the revenue surplus; further details are contained in section **2.7**:

2013/14 Plan £000s	**Capital Programme**	**2013/14 Outturn £000s**	**2014/15 Plan £000s**	**2015/16 Plan £000s**
10,200	Internal Finance	6,100	11,200	9,400
14,000	Equipment Loan	4,700	15,900	10,000
6,000	Charity Donations	2,900	3,100	2,000
30,200	Total Capital Expenditure	13,700	30,200	21,400
0	Loan Interest and Repayments	0	1,400	2,700
30,200		13,700	31,600	24,100
	Financed By:			
14,000	Loan Finance	6,500	14,100	10,000
6,000	Charity Donations	2,900	3,100	2,000
16,000	Surplus	11,200	11,600	14,000
36,000	**Total Financing**	20,600	28,800	26,000

This shows £20.6m funds available (contingent on delivering the revenue surplus) and a likely loan requirement of £40m over 4-years; starting in 2015 – 16.

1.1.3) Cash

The cash plan set out in the table below; along with a committed working capital facility with Lloyds Bank will ensure a low risk profile is maintained over the period:

Cash Flow	**2013/14 Outturn £000s**	**2014/15 Plan £000s**	**2015/16 Plan £000s**
EBITDA	19,300	19,600	21,400
Movement in working capital	1,100	(5,500)	(800)
Cash from operations	20,400	14,100	20,600
Capital expenditure	(16,700)	(30,200)	(21,400)
Loan Finance (net)	6,500	12,800	7,300
PDC Dividend Paid	(4,700)	(5,000)	(5,000)
PDC Drawn down	200		
Movement in Cash	5,700	(8,300)	1,500
Closing Cash	20,000	11,700	13,200
Continuity of Service Risk Rating COSSR			
Capital Servicing	4	4	4
Liquidity	4	3	3
Overall	4	4	4

1.1.4) Margin for transformation and development

This 2-year operational plan for financial sustainability is built on delivering improved margins through the following key objectives:

i. Service transformation and integration

The Trusts strategy covers a number of transformational initiatives being developed by and between providers. These are summarised in the next sections below and set out in more detail in the 5-year Strategic Plan.

ii. Fair prices for NHS activity

The Royal Marsden has been independently assessed in the highest quartile (best) of NHS providers for the costs of delivering specialist services. But its services to NHS commissioners are paid under tariff at 80% of the cost of providing these services; resulting in a loss of £27m per annum (roughly 20%). Positive margins from providing private care have been used to subsidise this shortfall; but this is no longer appropriate or sustainable other than in the very short term

The Trust will be submitting its case for Local Tariff Modification to Monitor in March; using the process already described and approved. Improvement is expected in services associated with cancer, outpatient services, paediatrics and Critical Care during the next two years but it is too soon to assess the likely impact during this period in advance of testing our case with Monitor.

iii. Improved productivity and expenditure cuts

The Trust is continuing to pursue a Cost Improvement Programme (CIP) based on procurement, outsourcing (such as for drug supply) and scale economies; however the scope for delivering benefits to commissioners (through tariff deflator and QIPP cuts) and to the bottom line through this route is becoming more difficult. Maximum 5% is deliverable over the two years through this route.

iv. Increase in NHS activity and income

Nationally a combination of a growing and ageing population with improved prospect of survival is resulting in increases in both cancer incidence and prevalence. The British Journal of Cancer cites a prevailing trend of +3% growth in cancer prevalence per annum. This data is further supported by the Trust's own referral and activity data which bears out the fact that hospital cancer populations have increased continuously over recent years. Furthermore treatment options for patients have also increased. All of this leads us to safely predict increases in the coming year across most treatment modalities, but most likely in outpatients attendances, chemotherapy, and imaging.

v. Increase in private activity

The Trust plans to increase its private income to at least £100m (from £70m) as quickly as possible. The key factor that drives an increase in PP income is increasing inpatient capacity. The Trust has identified additional PP inpatient capacity for 2014 - 15 and 2015 - 16; however, the £100m target is likely to require the Trust to identify capacity outside the existing hospital sites. The opportunities for this level of expansion will be explored in 2014 - 15.

Going forward surpluses made on this activity should be used to support developments in quality of cancer care, facilities and technology; and not to subsidise NHS tariff.

1.2) Clinical sustainability

This 2-year operational plan for clinical sustainability is built on delivering improvements across key initiatives:

1.2.1) Service Portfolios

Services are managed by tumour type and differentiated according to whether they are provided to NHS patients, private patients or for research; creating portfolios of activity. The service line objective is to achieve a positive contribution across the portfolio. This task is supported by service line reporting and patient level costing systems in order to understand the impact of cancer tariffs and clinical decision making on the underlying service sustainability.

Alongside this there are links to national service specifications will ensure that services continue to comply with the criteria laid down by Clinical Reference Groups (CRGs) on behalf of commissioners. A number of Trust experts are represented on these national bodies.

1.2.2) Access policy

Since the national tariff for cancer funds (on average) only 80% of the costs of all cancer care, and since the Trust as a specialist provider cannot subsidise these losses with surpluses from other NHS services, the Trust has advised its Commissioners that it may seek commissioner support for taking some services outside the NHS contract and tariff regime.

Revision to the access policy will involve realigning capacity and hospital resource allocation to achieve a more clinically sustainable level of service provision. The main areas of focus will be prioritising referrals based on agreed catchment areas for each tumour group, a clinical need which cannot be met at another centre or an opportunity to enter into a clinical trial that is only offered at the Royal Marsden. In addition triage of non-elective admissions to ensure priority is given to those patients requiring the specific and specialist services of the Royal Marsden

1.2.3) Surgery

Surgery accounts for c. £32.5m of Trust income and makes a net loss of £8.2m. Given current tariff pressures this position will worsen if not addressed through transformation in the surgical portfolio. In addition The Trust is facing significant capacity constraints which impact on the ability to deliver other approved strategies (e.g. Private patients and Research and Development)

In the first 2 years addressing utilisation and capacity issues and reversing financial deficits identified which will create the capacity for;

i. Developing a specialty specific surgical portfolio to support the delivery of the private care strategy, the non-surgical portfolio, including research, presented through the financial assessment, market assessment and national trends

ii. Delivery of elements of the surgical portfolio through robust partnership to protect the business against regulatory threat, strengthen surgical research links, address capacity concerns and support strategic growth,

iii. Management of the surgical workforce to ensure a safe, sustainable and affordable portfolio, to support the delivery of the private care and NHS service strategy, including the development of academic surgery.

iv. Investment in estate to expand the Chelsea footprint will enable delivery of private surgical activity and more efficient day surgery.

1.2.4) The London Cancer Alliance

The Royal Marsden was a core founder, and is host of the London Cancer Alliance (LCA). The LCA is the Integrated Cancer System (ICS) for West and South London and provides a quality and accreditation system across 16 provider Trusts; and works collaboratively with two Academic Health Science Networks, primary care and the voluntary sector. The LCA is led by two Clinical Directors one of which is the RM Chief Nurse. The LCA works across patient pathways to improve quality, to reduce unwanted variation, and to improve outcomes and the patient's experience of care. The LCA now has 2, 500 clinicians actively engaged driving clinical standards and innovation so that all Londoners can experience world class cancer care.

Since its inception the LCA has worked with all providers to ensure across South and West London that it has robust data to monitor for improvement. Across all tumour pathways and all treatment modalities, including survivorship and palliative care, the LCA is publishing exemplar pathways to ensure that patient journeys are seamless. For each tumour type clinicians are writing evidence based guidelines to ensure that wherever in London the person is treated they are receiving the best cancer care.

1.2.5) The Royal Marsden School

The Royal Marsden School offers comprehensive cancer and palliative care courses tailored to meet the needs of healthcare professionals from organisations across the UK (and worldwide) and is the UK's only dedicated provider of cancer education. The School provides academic programmes at both Degree and Masters level. In addition, the School offers a wide range of stand-alone modules at Degree and Masters level. A large number of individually planned projects and unaccredited study days are provided to a diverse stakeholder group to meet patient and service requirements in cancer and palliative care.

School activity has progressively increased with numbers of places rising from 373 in the academic year 2003/2004; to 1229 in the academic year 2012/2013. With the School now in its twelfth year and going from strength to strength, future developments will focus on increasing the multi-professional portfolio and providing a flexible cancer education pathway. The School is also working closely with local organisations and education commissioners in developing a range of activities that respond to the rapidly changing demands of clinical service delivery.

The overall aim of The School is to provide excellence in education that is both relevant to practice and enhances the lives of patients and their loved ones living with and after cancer. Through a sound strategy that promotes a dynamic and changing curriculum and that is increasingly accessible to cancer practitioners both in the UK and overseas, the School can justifiably be recognised as a leading provider of education in cancer and its associated long-term conditions.

In 2013/14 The RM School has diversified to embrace the “Out of Hospital” agenda and include the first course for Nurses new to the Community. This has been well evaluated by the first students and will be the first in a new portfolio of programmes for nurses and bands 1-4 in acute and in the out of hospital setting.

1.2.6) Community Services Integration

The community services division have been working with partners across both health and social care to transform services so that they are fit for purpose in supporting the out of hospital strategy and the Better Care Fund. Services will ensure that care is patient centred, meets their needs in a holistic way, and is available 7 days a week. Services will focus on supporting long term conditions and end of life care, and will provide intensive home support to those that need it; to prevent unnecessary admission to hospital and also to support timely discharge. Care teams in the community will realign themselves so that they relate more closely to primary care; enabling closer working and the ability to identify those most at risk and in need of services. These care teams will work in a more integrated way with social care; providing care that can wrap around the patient.

1.3) Quality of services and patient experience

The Royal Marsden continues to provide an excellent service to its patients and their families by ensuring that cancer services are designed around their holistic needs. The Trust is continually assessing the quality of its service using all the nationally mandated cancer audits, the ISO 9001 framework for quality of its chemotherapy and radiotherapy services and the national patient excellence award (Craig M). To monitor patient's satisfaction with the service and their overall patient experience the Trust uses the following methodologies to gain real time information about the patient experience: Picker hand held frequent feedback service; the meridien survey in the community, and the national inpatient and outpatient picker surveys. In addition the RM patients have placed the Trust in the top 10% of Trusts since the inception of the Friends and Family Test.

There is robust evidence that a necessary precursor for a positive patient experience is staff engagement and a good staff experience (Mabel et al 2012). The national staff survey illustrates that RM staff feel engaged, are proud of their Trust and would recommend it to friends and family.

Healthcare is a staff dependent industry with the major costs to the Trust being staff time. It is therefore essential that the Trust has effective, robust timely recruitment and people management policies. The following areas are those where quality of care and costs can be impacted and therefore the Trust is placing a major focus in these areas:

- Significant reduction in agency staffing – nursing, medical and all corporate areas. Some temporary staff use is inevitable where there are sudden gaps in service provision however it is key to the quality of the service that this is the exception. When agency staff are used to fill gaps in frontline services patients comment on lack of continuity and a reduction in the quality of their care.

- In February 2013 The Trust achieved NHSLA level 3 and with it the reduction in its insurance premium. The Trust Finance Director and Chief Nurse met with the NHSLA CEO and discussed the need to ensure that the Trust's insurance premium in the future appropriately reflects the low risk as compared to other multi-specialty Trusts. In February 2014 the Trust received its latest NHSLA assessment and scored green across all risk areas.

1.4) Clinical Research

The Royal Marsden clinical research strategy will prioritise the research that has been identified as having the most benefit to patients, and ensures that they benefit from the latest advances in cancer treatment. Research ultimately improves treatment options, and there is evidence to show that patients do better in hospitals that conduct research, even if they are not part of a study themselves. There are several elements within the research strategy:

1.4.1) Clinical Research Network (CRN)

The Royal Marsden is leading the South London CRN and is spearheading the rise of clinical research in the NHS, according to a league table from the National Institute

for Health Research (NIHR) Clinical Research Network. The Royal Marsden increased its studies from 159 in 2011/12 to 187 in 2012/13, and it is the top trust in England in the acute specialist trust category for the number of studies it conducted last year.

1.4.2) Biomedical Research Centre for Cancer

The Royal Marsden, together with its academic partner, The Institute of Cancer Research (ICR), is designated as the UK's only Specialist Biomedical Research Centre for Cancer. The specific remit of the BRC is to facilitate rapid and effective translation of scientific findings regarding the genetic and molecular basis of cancer into improved therapeutic strategies that are ultimately tested in large-scale national trials. The award of BRC status is made by the National Institute for Health Research (NIHR) and is done on a five year basis. We have to bid for this funding every five years – the next renewal is due in 2016 (for commencement, if approved, on 1st April 2017).

1.4.3) Investment in Clinical research

i. West Wing Unit

The Royal Marsden's new £2.6 million West Wing clinical research facility at Sutton opened to its first patients in March this year. The facility is a dedicated space for patients participating in clinical trials. The unit will increase the opportunities for translating early-phase studies conducted in the Drug Development Unit into late-phase research.

ii. Centre for Molecular Pathology (CMP)

The NIHR/BRC CMP is a shared building between the Royal Marsden and the opened in 2012 and is now fully functional with both a service and discovery function.

iii. RM Clinical Trials Unit

The Royal Marsden Clinical Trials Unit was formed in early 2014 as a specialist unit with a specific remit to design, conduct, analyse and publish clinical trials and other well-designed studies. Based in Sutton, it will operate cross-site, acting as a co-ordination hub for all Biomedical Research Centre funded activity. The CTU team will work with clinicians and researchers to conduct the highest quality clinical research.

1.4.4) Commercial Research Income

The Royal Marsden has a strong track record of delivering commercial studies with long standing relationships with pharma and technology; in 2012-13 commercial income was £10.8m and in 2013-14 is forecast to be £7.3m. The investment in research capability described above will ensure the Royal Marsden continues to grow income form commercial research.

1.5) Workforce

The Royal Marsden's workforce is the Trust's most valuable asset and is essential to support us in continuing to achieve our vision of providing excellent care delivered by expert and caring staff and enable our achievements in cancer research, treatment and education. The Trust attracts and retains a high concentration of clinical academics in conjunction with our academic partner the Institute of Cancer Research; as a result Royal Marsden / ICR are the fourth most cited cancer institutions internationally

The Royal Marsden is committed to developing and sharing knowledge of cancer both for existing staff and in the wider NHS and beyond. For example, the Royal Marsden School offers comprehensive cancer and palliative care courses tailored to meet the needs of healthcare professionals from organisations across the UK as well as internationally. The Trust is the UK's only dedicated provider of cancer education. In the last academic year it offered 756 module places, 193 study days, 280 other types of activity. This unique facility, with lecturers who are also regularly engaged in clinical practice, enables us to develop our workforce to rapidly respond to changing requirements through high quality education bespoke programmes.

The Royal Marsden's medical education is highly rated by our trainees and in Speciality School visits. In a joint initiative with The Royal Brompton NHS Foundation Trust, we have developed a state-of-the-art Education and Clinical Skills and Simulation Centre dedicated to deliver a range of high fidelity full immersion, clinical situational awareness and clinical skills based teaching activities for the benefit of staff in both Trusts and geographically in the wider NHS, particularly on medical education programmes.

Levels of staff engagement are consistently rated highly through the annual NHS staff survey. The support given by Royal Marsden line managers is rated particularly well and there is a clear commitment of staff to deliver high quality and safe care to patients.

In delivering the operational plan over the next two years, there is a need to maintain and build on these strengths and ensure the Royal Marsden is in a position to respond to the levels of transformational change that are needed and the focus is on the following key initiatives:

1.5.1) Strengthening clinical leadership

The Royal Marsden is further strengthening clinical leadership at all levels in the organisation to support service line management and ensure that clinical intelligence informs business decisions. This will be enabled by creating Clinical Business Units to ensure that this is achieved within the Divisions and multi-professional leadership development will maintain a focus on delivering a high performance culture that delivers results through engendering staff accountability and engagement and developing service improvement skills and those to support transformational change.

1.5.2) Pay and Remuneration

There are a number of key initiatives around pay and remuneration over the next two years which will support a high performance culture; the national changes in terms

and conditions will be implemented and a review of consultant and junior doctor contracts to reward and incentivise good performance will be conducted. There is a commitment to reduce temporary staff spend (both bank and agency);bank pay rates will be reviewed so these are aligned to market conditions, can be flexed according to supply and demand and support the Trust's financial strategy.

1.5.3) Recruitment and retention

Recruitment and retention of high quality staff underpins excellence and will directly support the Trust's business strategy; the 'employee brand' will be promoted to continue to attract the highest quality staff. Hard to recruit areas will be targeted through a range of initiatives including developing new attraction strategies, recruitment pipelines and talent pools, assessment centres and international recruitment, where appropriate. Local solutions will be developed to respond to areas of high turnover.

1.5.4) Maximising potential through productivity and efficiency

There are a number of components of the operational plan for the next two years to support staff in working to their optimum and delivering on the quality and efficiency agenda. High quality workforce information and systems are critical to monitoring progress and focusing effort related to improving workforce productivity and efficiency. Workforce expenditure controls will be developed to appropriately control costs and drive efficiencies whilst maintaining quality. A particular focus will be the further reductions in temporary staff spend.

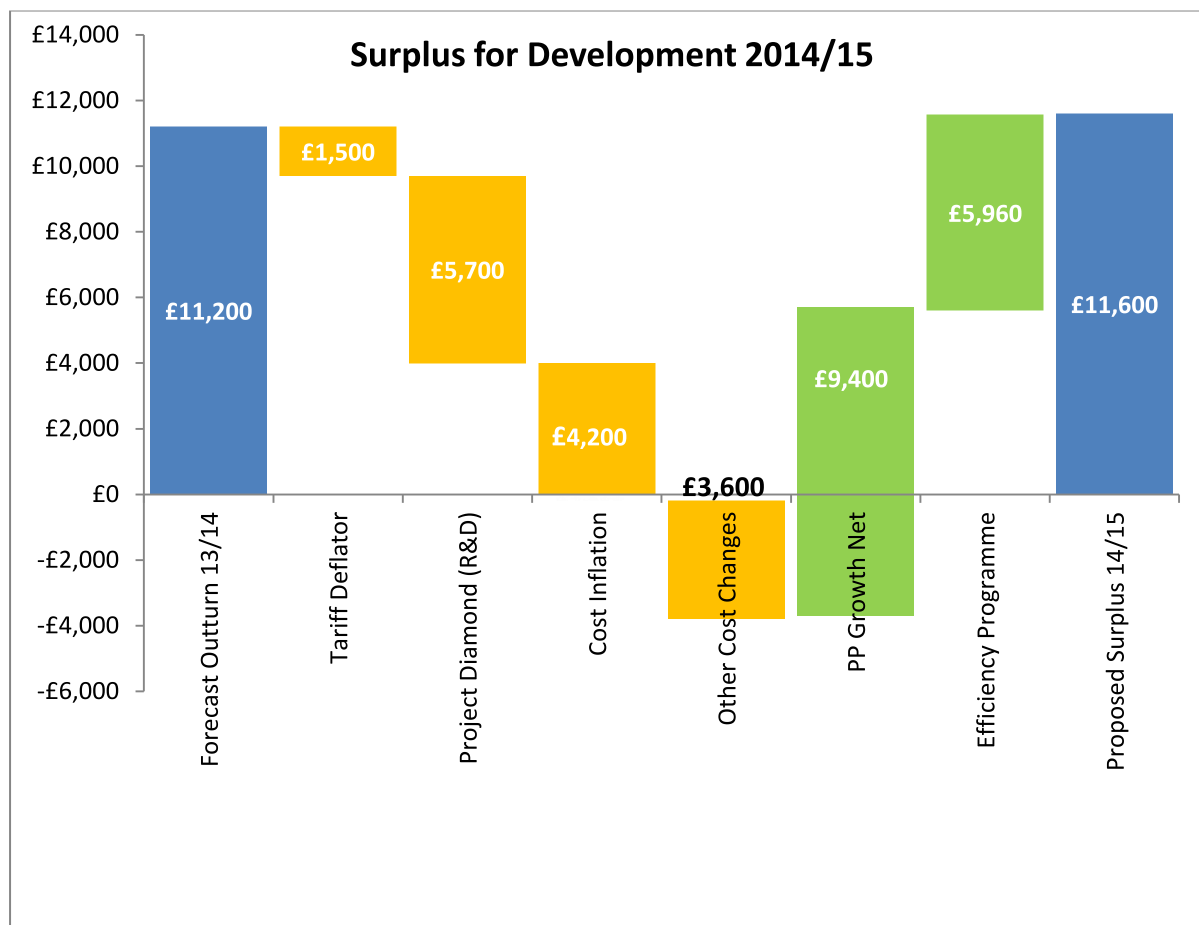
The aim is to ensure staff are working as efficiently and effectively as possible and performance is positively managed, reducing overall unit costs through workforce productivity and staff performance management improvements to optimise quality patient care and minimise the requirement for more formal action. Structures and ways of working will be reviewed to ensure that appropriate skill mix and working processes are in place and that staff are working at an appropriate level.

Internal communication strategies and mechanisms to support and engage with staff will be developed; in particular this will include implementing further ways to involve staff in the development of strategies and planning, for example, continuing with open meetings with senior staff.

2) Operational Plan

2.1) The short term challenge

The short term financial challenge is demonstrated, in headline terms, by the waterfall diagram below.



A combination of the tariff deflator, cost pressures within Divisions, inflation and loss of Project Diamond funding was factored into the efficiency assumptions agreed by the Board. Improvements for private care and efficiency are sufficient to meet the surplus required to fund the minimum cash and capital programme requirements set out elsewhere in this plan; with possible improvement to come from on-going negotiations over Project Diamond funding and over local tariff modification.

Key short term challenges have been identified as follows:

2.1.1) Commissioner Engagement

Meaningful engagement with NHSE has, to date, been very limited and it has not been possible to secure contract heads of terms at the time of submitting this plan; in particular for discussing service and financial strategies as part of the NHSE, Monitor and TDA joint initiative in strategic planning for the next two and the following three years.

Contract for Cancer Services

The Trust does not have any contract or contract heads in place with NHSE and the Trusts request for escalation in line with the national timetable has not been agreed by NHSE. In addition NHSE has not, so far, been prepared to discuss the Trusts 6-month notice letter (see Appendix 1). This letter contains important plans for activity management and tariff modification, among other things, which may potentially delay their implementation.

Contract for community services

The Trust has a contract in place with CCGs, London Boroughs but not with NHSE. The Trust has already provided commissioners' with legal advice to the effect that the existing contract cannot be rolled over past 31st March.

The Trust has notified commissioners that it is not prepared to take any financial risk on this one-year only contract and that, potentially, a new arrangement will be required from 1st April. The operational plan has been prepared on this basis for 2014 - 15.

2.1.2) Fair pricing

Local tariff modification and 2015 tariff

The Trust has been working with commissioners for some years to address problems with cancer tariff, paediatric top-ups and specialist service provision. A very thorough case for modification to the tariff will be presented to Monitor; covering the entire period 2014 – 16. This is not yet included in the income assumptions for either year.

In addition the Trust has been informed that Project Diamond funding will not be provided from NHS Research and Development resources in future. PD Trusts have been directed to NHSE (as part of contract negotiations) and Monitor (as part of local price modifications) to recover these funds. Continuation of this funding for at least a further year until tariffs can be addressed remains justifiable.

Cancer tariff working group

This group is led by the Royal Marsden NHSFT and University College London Hospital NHSFT; with support from Ernst and Young. These two Foundation Trusts have extensive knowledge of cancer care and have highly developed patient level costing and benchmarking systems. They are actively involved in leading roles within the two London Integrated Cancer Systems, three London AHSNs and in Project Diamond and the Shelford Group (UCLH only).

EY has led the recent work, among other things, with Project Diamond Trusts and has evaluated comparative cost and PBR data. The Christie Hospital and Guys and St.

Thomas' NHS Foundation Trusts have also lent their support to this work. Appendix 2 provides a more detailed summary of this work.

2.1.3) Cash Management

NHS commissioners have been particularly poor payers in 2013 – 14; with more than £10m outstanding for long periods. Significant cash pressures are expected in at least Q1 of 2014 and a fully committed working capital facility is in place. The cash plan assumes similar trends in future years.

2.2) Quality Plans

The quality framework uses key national and international metrics to assess and monitor patient safety, the effectiveness of patient care and patient and staff experience these include the following (although this should not be regarded as an exclusive list):

2.2.1) Patient Safety

i. The prevention and control of Health Care Associated Infections (HCAI). People with cancer are vulnerable to infection because they are immuno – compromised, receive complex multi-modality treatment and inpatient care and require multiple courses of anti-microbials. The Trust therefore takes concerted positive action to prevent and control infection utilising the best international evidence to guide its infection prevention and control programme.

ii. The use of the WHO Surgical Safety Checklist to ensure the safety of patients and staff in theatre. The use of the checklist is prospectively audited to ensure compliance and that any lessons learnt are shared.

iii. The use of the Patient Safety First initiatives for high risk drugs, patient vital signs monitoring and leadership for safety.

iv. Procurement and maintenance of medical equipment throughout the Trust that is coordinated and maintained centrally and through medical device passports in each clinical area.

v. ISO 9001 for chemotherapy and radiotherapy attained again in 2013/14.

vi. JACIE accreditation for the quality and safety of Blood and Marrow transplant attained again in 2013/14.

vii. The use of the National Modified Early Warning Score (MEWS) and Situation Background Assessment Recommendation (SBAR) throughout all clinical areas to ensure that any clinical deterioration is monitored and acted upon rapidly.

viii. Modern and well maintained resuscitation equipment in all areas of the Trust including non-ward areas.

ix. A comprehensive and well-designed mandatory training programme for all clinical staff on patient safety. The Royal Marsden leads an excellent simulation programme for multi-professional teams in the acute or emergency scenario in patient care. This

facilitates clinical staff to be experienced at working together in a time critical emergency setting.

x. The Executive Medications group that is multi-professional and works to continuously improve medicines safety at all points of care.

xi. Falls monitoring and audits to constantly improve the environment and care of people who are at risk of falls.

2.2.2) Effectiveness of care

In cancer care the key issues that are essential are:

i. Early and effective access to definitive treatment: The Royal Marsden has strategies in place to ensure that all referrals are managed effectively through the system in a timely and effective way. One of the most difficult issues for a tertiary cancer centre is when referrals arrive late from another Trust this is being proactively addressed at CEO level locally and centrally. The Trust is a core member of The London Cancer Alliance and is working with all other providers in West and South London to improve clinical pathways and best practice patient navigation at provider Trusts that feed into the RM.

ii. The right treatment given by the right person in the right place: The Royal Marsden meets all the essential Peer Review components of the core members of the MDT. The cancer patient experience survey (CPES) also revealed that patients thought there were the right number and skill mix of nurses on duty. The 2013 CQC unannounced inspection also assessed staffing levels and skill mix and found no concerns.

iii. Reducing length of stay whilst ensuring that there are no avoidable readmissions: The RM has been actively working on reducing length of stay and has an active Enhanced Recovery Programme (ERP) and 23 hour Breast surgery programme. There is however more work to do around a small group of patients who have a prolonged length of stay. Various initiatives are currently being designed and will be instituted and evaluated this year. These initiatives include reducing non elective admissions by ensuring Consultant evaluation prior to admission, developing the out of hospital transitions into the community, ensuring that all inpatients are evaluated daily and have active care plans.

iv. Therapeutic cancer care that is evidence based and continuously evaluated: The Royal Marsden is a research rich organisation and at ay one time is leading over 500 clinical trials. This means that the patient has access to key cancer therapeutics. The Royal Marsden also has an excellent Health Services Research structure which ensures that all clinical professionals are enabled to be involved in research that examines systems and care as well as therapeutics.

v. Cancer Education and Training: The Royal Marsden has the only dedicated training School for Cancer Nursing and Allied Health professionals and provides most of the postgraduate cancer training for nurses in England. In 2013 / 14 fior the third consecutive year the School was awarded the highest quality indicator in London by the NHS Health Education England.

vi. Clinical Audit: The RM completes all mandatory national cancer audits and then has a comprehensive programme of clinical audit responsive to patient and strategic requirements.

vii. Access Policy: ensuring that those patients that require care at the Royal Marsden are able to access services when needed through matching demand to available capacity. Initiatives to reduce demand include reviewing each service to define the referral catchment area. Patient referrals should then only be accepted from the defined catchment area for each condition or where there is a clinical or research need to attend the Royal Marsden rather than the patient's local Trust. It is also essential that capacity is used as effectively as possible by only admitting non-elective patients who require specialist cancer care at the Royal Marsden and reducing length of stay.

2.2.3) Patient Experience

The patient experience is monitored through using Picker hand held devices in all clinical areas and outpatients to gain the individual patient experience, with these results fed directly back to Ward Sisters, Matrons and up through the Executive Directors to the Board. From 1st May 2013 all inpatient wards (except children's) also had the Friends and Family Test applied. The majority of comments have been extremely positive but where there have been suggestions for improvement these have been systematically fed back to clinical areas for action. Since the inception of the FFT the RM has constantly been in the top 10% of high performing Trusts.

All the national patient surveys are also conducted and where there is anything other than an excellent score an action plan with key deliverables is agreed. One of the important deliverables going forward is to ensure that the patient / and or their family are not overburdened with questionnaires. The Royal Marsden is a research rich environment which means that many of our patients are on clinical trials and therefore undertake associated quality of life questionnaire or patient diaries. It is essential therefore to monitor the volume of questionnaires that patients are subjected to and this will be closely monitored with the Patient Experience group in 2014 onwards.

All Matrons, through to Directors read complaints and praise letters and themes for learning and improvement from these are fed into improvement plans across the Trust. At the Board Quality Assurance and Risk (QAR) committee the Chairman and Non-Executive Directors all see complaints and discuss the response and any remedial actions with the Executive Directors. Following the Francis report and its recommendations the Trust has made some improvements to its complaints policy and practice. More complainant meetings are being provided at an early stage with positive feedback. The PALS team has also been conducting weekly ward rounds to ensure that inpatients have a route to raise concerns easily that can be actioned immediately.

Members of the senior Medical, nursing and AHP teams are leading or members of the new national Clinical Reference Groups, The Trust is also represented on the London Children's Strategic Clinical Network, The London Cancer Strategic Clinical Network and the London SCN Oversight group. Professional clinical leads continue to lead other cancer tumour specific national and international advisory boards for cancer or their profession and this knowledge is also therefore available to the Trust.

2.2.4) Quality priorities and targets for 2014-16

The following priorities and targets are updated for 2014 – 15.

Safe Care

i. Reduction in Healthcare Associated Infections (MRSA bacteraemia and Clostridium Difficile infections). Applies to Acute beds @ RM and patients of Sutton and Merton Community Services (SMCS) Less than 1 MRSA bacteraemia

    a. Less than 16 C Difficile infections (target for 14/15)
    b. (Report in Quality Account the number of C. Difficile infections per 100,000 bed days)

ii. Rate of patient safety incidents and percentage resulting in severe harm or death

    a. (In 2012-13 the number of deaths from serious incidents per 100 admissions was 0; the number of severe harms from incidents per 100 admissions was 0.012) Acute beds and SMCS
    b. Reduction in the rate of patient safety incidents per 100 admissions and the proportion that have resulted in severe harm or death

iii. Percentage of admitted patients risk assessed for Venous Thrombo-embolism. Maintain above 95% the number of patients who have a completed VTE risk assessment

Effective Care

iv. Reduction in community acquired grade 3 and 4 pressure ulcers: SMCS Reduce the incidence of severe community acquired pressure ulcers (Grade 3 & 4)

v. Increase the number of patients that die in their preferred place of death (The National Primary Care Snapshot Audit in End of Life Care (2009) found that the number of patients achieving their preferred place of death is 42 %.). Acute and SMCS achieve more than 42% of patients dying in their preferred place of death.

vi. Increase the numbers of patients who have an Holistic Needs Assessment. Increase in the number of designated patients will be offered a Holistic Needs Assessment by the end of 2013-14

vii. Emergency re-admissions to hospital within 28 days of discharge. Reduction in the number of avoidable re-admissions to hospital within 28 days of discharge

viii. The RM acute service is on track to achieve 100% of its CQUIN payments in 2013/14 and the SMCS division is currently achieving

Patient Experience

ix. Reduction in chemotherapy waiting times and improvement in patient experience related to waiting times. Reduction in chemotherapy waiting times at Sutton and Chelsea and improvement in the patient experience related to waiting times.

x. Ensure that we are responding to in-patients' personal needs improvement in responses to 5 questions (in the CQC national survey described above) as monitored through the Inpatient Frequent Feedback Surveys

xi. Percentage of staff who would recommend The Royal Marsden to friends or family needing care.

    a. Patient Experience survey introduced into SMCS in December 2013. To achieve a baseline measurement and if possible benchmark with other community services.

xii. Improve communication, particularly when patients arrive for first appointments. Increase or maintain the high percentage of positive comments in dedicated patient feedback.

xiii. Reduce the length of time a patient waits for medicines or equipment at the point of discharge. Increase or maintain the high percentage of positive comments in dedicated patient feedback.

Children's services

xiv. The uptake of immunisation working in partnership with primary care. Increase the percentage of children receiving pre-school immunisations in partnership with GPs.

2.3) Activity Plan

The following table shows the current projected activity volumes for 2013 - 14, with the anticipated values for 2014 - 17. These predictions are based on prevailing activity trends and include both NHS and Private Patient activity.

NHS & PP Activity	2013/14 Projected Outturn	*2014/15*	*2015/16*	*2015/16*
Inpatient admissions	10,124	10,209	10,296	10,383
BMTs	211	214	218	222
Day case admissions	11,942	12,025	12,108	12,192
Chemotherapy Attends	46,739	50,135	53,779	57,688
Consultant Outpatients	164,287	170,23	176,996	183,714
Ward Attends	24,448	25,671	26,954	28,302
Radiotherapy Attends	74,402	75,414	76,440	77,480

2.4) Operational requirements and capacity

Despite the pressure on NHS commissioner budgets there is no evidence of any reduction in demand for specialist cancer services and new referrals continue to increase. The table below shows the 1 year and 3 year growth in referrals between 2010/11 and 2013/14.

New Referrals

					%age Growth over	
	2010/11	**2011/12**	**2012/13**	**2013/14***	**1 year**	**3 years**
NHS Patients	15,574	16,000	16,426	18,087	10.1%	16.1%
Private Patients	2,940	3,047	3,018	3,458	14.6%	17.6%
All Patients	18,514	19,047	19,444	21,545	10.8%	16.4%

**forecast from 11 months data*

There are no plans to cut the total number beds, theatres and other patient care facilities (in broad terms) in the next two years; however the operational plan has identified a number of services where no funding is provided by any commissioner; or where funding is significantly less than the 80% average seen across the NHS portfolio. Since it is unlikely that new tariffs will be agreed by commissioners these services will be reviewed against clinical and patient safety criteria for early decision; or alternative, non-NHS funding.

2.5) Productivity, efficiency and CIPs

The financial planning process is now nearly complete and Divisional budgets have been scrutinised by the Trusts Medical Director and Chief Nurse to assess any potential impact of these plans on the quality and experience of care provided by the Trust. This work has been carried out under a number of key themes:

- Reducing new cost pressures (cost not being incurred today) in the first cut plan by at least 50%.
- Implementing the new access policy; coupled with key aspects of the surgery strategy.
- Assessing all unfunded services to NHS patients.
- Reviewing all charges received from, and charges to, 3rd parties.
- Increasing private patient activity.

In addition the management team is considering the implications for deferring all capital schemes not funded by loan or charity for 6 months in order to preserve cash.

2.6) Financial Assumptions

2.6.1) Financial planning assumptions

The Board agreed a set of high level planning assumptions for 2013 / 14 and the subsequent two financial years when it approved the Annual Plan in May. These have been updated for changes to the tariff deflator (£0.5m) and for the new pension arrangements (£1m) in the table below:

Year ended 31st March All figs in £'000's	2015	2016	2017
Efficiency required (2014 plan)	16,200	14,000	14,000
Additional efficiency for:			
Increase in tariff deflator	500		
Pension arrangements	1,000		
Revised target for 2015	17,700	14,000	14,000

This table shows that a programme of efficiency savings of between £14 - 18m per year is required to deliver a sustainable surplus available for development of between £18 – 20m; the level at which financial sustainability can be demonstrated. Annual improvements to liquidity (£18m over 10 years) will also be delivered.

2.6.2) Efficiency Requirement

The efficiency requirement comprises the following:

Year ended 31st March All figs in £'000's	2015	2016	2017
Efficiency requirement			
External factors (incl. tariff cut)	5,700	5,000	5,000
Cost inflation	5,000	5,000	5,000
Increase surplus	1,000	1,000	1,000
Other (*incl. possible loss of Project Diamond*)	*6,000*	3,000	3,000
Total Efficiency Required	17,700	14,000	14,000

The efficiency requirement represents a required improvement equivalent to approximately 5% of the current cost base and is in line with estimates elsewhere across the NHS.

2.7) Capital Programme

The first two years of capital programme has been revised to fit within a reduced surplus for development and ensures that existing schemes in progress (most notably for the PACS replacement in IT) can be completed. As in previous years a small allocation for essential minor works and backlog maintenance is allocated to the Director of Projects and Chief Operating Officer; with the remaining funds set aside for the schemes that will be required to deliver the capacity upgrades required for private care.

The equipment replacement loan will fund the remaining short term requirements for essential medical equipment.

2013/14 Plan £000s	Capital Programme	2013/14 Outturn £000s	2014/15 Plan £000s	2015/16 Plan £000s
	Internally Financed			
500	Medical Equipment & Infrastructure	400	500	0
6,000	IT Schemes	2,800	5,800	5,000
3,000	Backlog & Minor Works	1,900	1,800	2,000
	Private Patients Chelsea & Sutton	100	2,500	2,200
700	Other	900	600	200
10,200	**Total**	6,100	11,200	9,400
	Loan Financed			
14,000	Equipment Loan (Current)	4,700	15,900	0
	Equipment Loan (Proposed)	0	0	10,000
14,000	**Total**	4,700	15,900	10,000
	Donated Assets			
2,500	West Wing	2,500	0	0
0	Gamma Camera (Legacy)	0	600	0
3,500	Other	400	400	2,000
0	Robot	0	2,100	0
6,000	**Total**	2,900	3,100	2,000
30,200	**Total Capital Programme**	13,700	30,200	21,400

Requirements for major investment in the following schemes will be addressed as part of business cases still to come to Board and will be addressed in more detail as part of the 5-year Strategic Plan.

- New build in Sutton; including land purchase and upgrade of accommodation.
- Replacement of the Trusts Electronic Patient record and associated IT schemes.
- Purchase of the Fulham Wing of the Royal Brompton Hospital