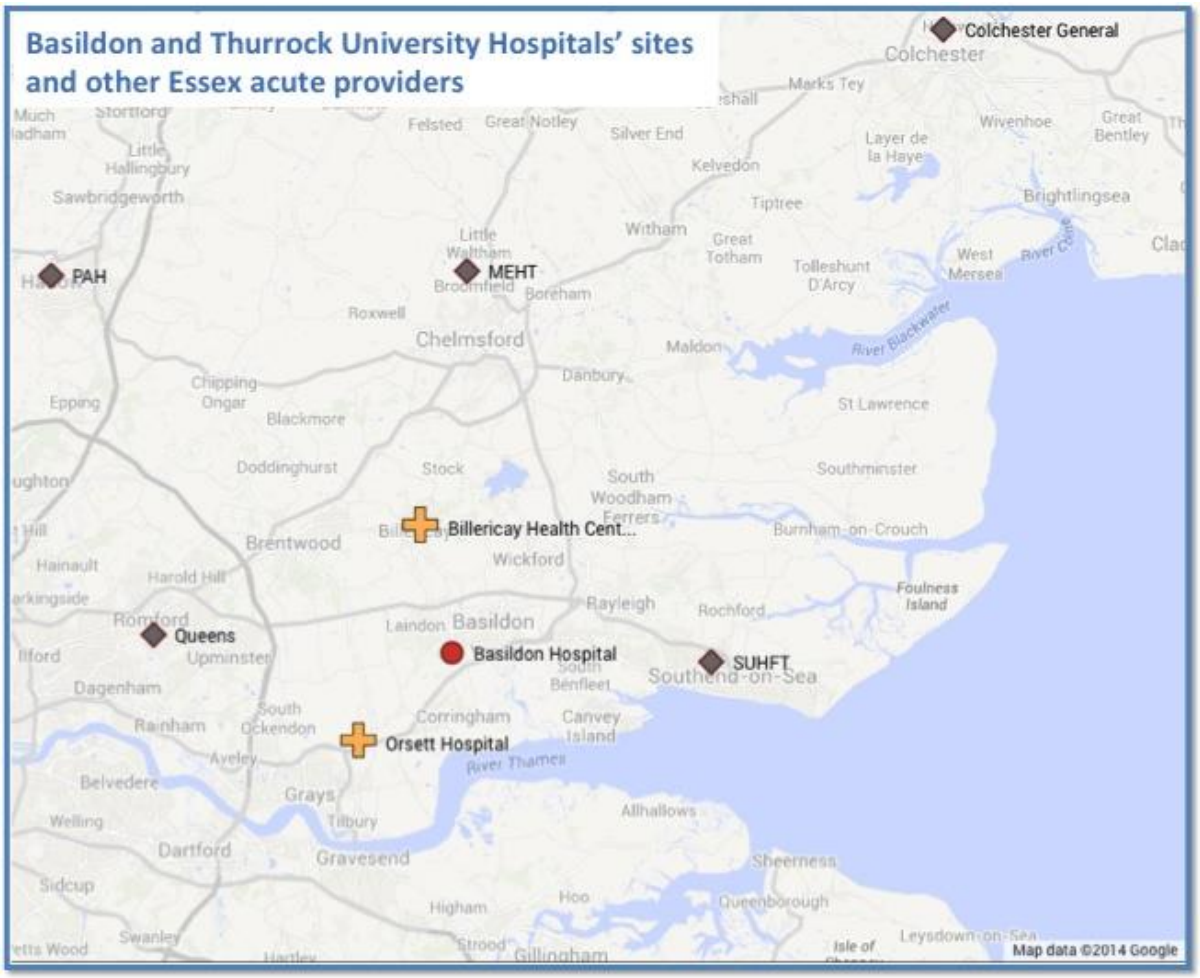
Basildon and Thurrock University Hospitals NHS Foundation Trust Strategic Plan 2014/15 to 2018/19



Our vision for the Trust is to be an excellent hospital providing high quality, safe care for our community.

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1 Declaration on sustainability

1.1 Summary

Our operational plan for 2014/15 to 2015/16 outlined our developments to continue our quality turnaround and deliver cost improvements of over £32m. Despite this level of cost savings, our projection is for a further three years of deficit as we make the necessary investments in quality and change at a time of constrained revenue for NHS providers. We are able to support this level of deficit and continue to make capital investments in our infrastructure due to the strong cash balances the Trust built up during its initial years as a foundation trust. Looking ahead to the period 2016/17 to 2018/19, which is the focus of this strategic plan, there are an increasing number of uncertainties to consider:

- NHS funding levels will be determined in a new political cycle
- The payment and pricing system is subject to change in 2015/16
- Full impact of the Better Care Fund, as well as implementation of primary care strategy
- Designation of emergency centres is expected to have taken place
- More providers are likely to have been declared unsustainable and hence entered the 'failure regime'
- Essex-wide Acute Services Review will have concluded and implementation should be underway

Against this backdrop, we expect that the Trust will be required to deliver a further £30m of cost improvements to be sustainable financially. We anticipate that the Trust's potential for internally generated efficiencies will taper down, particularly given commissioners planned shift in resource from acute to community and primary care and the large internal savings planned for 2014/15 and 2015/16. Our plan is to return to reduce our underlying deficit in 2016/17 and break even or deliver a small surplus in 2017/18 and 2018/19.

It is therefore the assessment of the Board that the Trust is sustainable over this planning period but that risks exist (as outlined above) and therefore the position is highly sensitive as set out in our sensitivity analysis shown in section 4.2.

1.2 Vision and Mission

Our vision for the Trust is to be ***an excellent hospital providing high quality, safe care for our community.***

Our mission as a foundation trust is ***to improve the health of the community we serve.***

We are committed to:

- Providing **harm-free care** to our patients both in and out of hospital
- Providing our patients and their carers with the **best possible experience** while they are using our services and those of our partners
- Delivering **excellent outcomes** for our patients by implementing best practice
- Providing **value for the taxpayer** through high quality care at the lowest possible cost

We can only fulfil our mission by working in partnership with other local health and social care providers and our commissioners. It is imperative for our sustainability that we work together and

whilst the exact shape and nature of our partnerships are not yet defined, we anticipate that fundamental change will be required across the health and social care economy over the next five years.

1.3 Measuring outcomes to drive improvement

Improving outcomes for patients is at the heart of our strategy. At a trust level we have set our quality goals and associated outcome measures for 2014/15 and 2015/16. Our goals and targets for years 3-5 will be set at a level that remains stretching but achievable after we review progress in 2014/15.

Improving Patient Safety – Providing harm-free care to our patients both in and out of hospital

Goal: to reduce patient harm events

Outcome measures	*Year 2*
Percentage of patients with harm free care	Above average by end of Q4
Harm from injurious falls	20% on year 1 outturn by end of Q4
Pressure ulcer incidence	0.19 per 1,000 bed days by end of Q4
Reduction in Never Events	Zero
Reduction in avoidable VTE events	20% reduction based on year 1 outturn by end of Q4

Improving the Quality and Reliability of Care - Delivering excellent outcomes for our patients by implementing best practice

Goal: Reducing harm from deterioration

Outcome measure	*Year 2*
Reduction in cardiac arrests	Best quartile
HSMR	Below 90
SHMI	< 1.00

We will also measure progress against our new processes:

- Daily review by senior clinician,
- Reviewed by a senior clinician within 12 hours of admission
- Use of the sepsis care bundle

Improving Patient and Staff Experience - Providing our patients and their carers with the best possible experience while they are using our services and those of our partners

Goal: to go above and beyond the Friends and Family test.

Outcome measure	*Year 2*
Patient Friends and Family test	Upper third
Staff Friends and Family test	Median or better
National patient survey: Responsiveness to inpatient needs	Upper third
Patient Reported Outcome Measures	Median or better
Cancer survey	Upper third

2 Market analysis and context

Trust overview

We provide an extensive range of acute healthcare services at Basildon and Orsett hospitals, plus x-ray and blood testing facilities at the St Andrew's Centre in Billericay. We primarily serve the 405,800 population of South-West Essex covering Basildon and Thurrock, together with parts of Brentwood and Castle Point. We also provide dermatology services across the South Essex area from seven sites. The Essex Cardiothoracic Centre (CTC) is also part of the Trust and provides a full range of specialist cardiothoracic services for the whole county and further afield.

2.1 Healthcare needs assessment

Population growth

The latest ONS population projections[1] based on 2012 estimates show that the Trust's catchment population (defined for the projection as NHS Basildon & Brentwood and NHS Thurrock) is expected to grow slightly faster than the national projection. This is reflected across almost all 5-year age bands.

	ONS Population estimates for BTUH catchment, 000s			Projected growth 2014-2019		Projected CAGR 2014-2019	
Age band	2012 estimate	2014 projected	2019 projected	BTUH Catchment	National	BTUH Catchment	National
0 to 4	28.0	28.2	28.7	2%	1%	0%	0%
5 to 9	25.9	27.5	29.0	5%	6%	1%	1%
10 to 14	24.8	24.6	27.8	13%	11%	2%	2%
15 to 19	25.5	24.9	23.5	-6%	-7%	-1%	-1%
20 to 24	23.5	23.5	22.4	-5%	-5%	-1%	-1%
25 to 29	26.3	27.1	28.2	4%	4%	1%	1%
30 to 34	27.9	28.1	29.5	5%	3%	1%	1%
35 to 39	28.1	28.0	29.5	5%	10%	1%	2%
40 to 44	30.9	29.8	28.3	-5%	-9%	-1%	-2%
45 to 49	31.4	31.7	29.8	-6%	-6%	-1%	-1%
50 to 54	27.2	28.7	31.2	9%	4%	2%	1%
55 to 59	23.0	24.0	27.8	16%	15%	3%	3%
60 to 64	22.3	21.4	22.8	7%	6%	1%	1%
65 to 69	20.3	21.8	20.0	-8%	-6%	-2%	-1%
70 to 74	14.3	15.1	20.0	32%	27%	6%	5%
75 to 79	12.4	12.8	13.5	5%	10%	1%	2%
80 to 84	9.5	9.7	10.5	8%	12%	2%	2%
85 to 89	5.6	5.8	6.7	16%	15%	3%	3%
90 and over	3.0	3.3	4.2	27%	22%	5%	4%
Total	**409.9**	**416.0**	**433.4**	**4.2%**	**3.6%**	**0.8%**	**0.7%**

We are also aware of two potentially significant housing developments, which could lead to a greater population increase than projected by ONS analysis of historic trends. Around 40,000 homes at Purfleet form part of the Thurrock local plan, whilst 20,000 homes are planned to the east of Basildon.

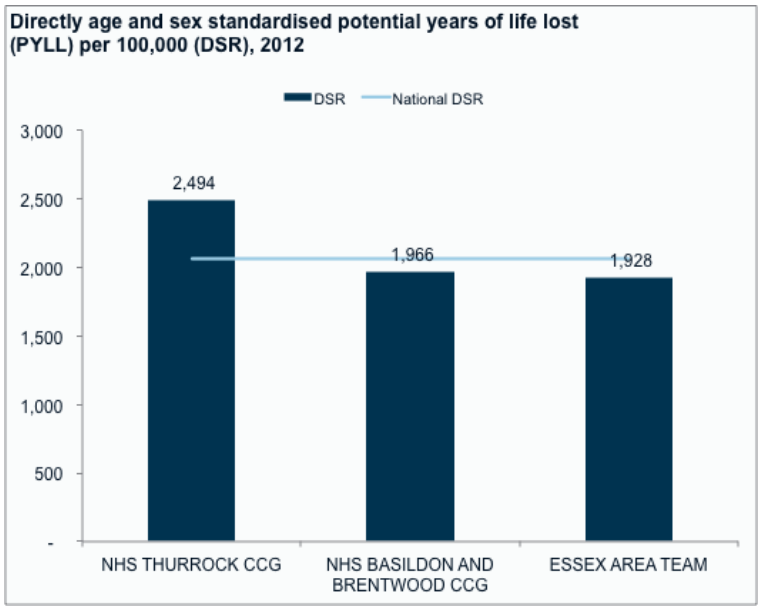
Commissioner growth assumptions are for between 1-1.5% per annum increases due to demographic changes and 1.5-2% per annum increases due to non-demographic factors. These are then offset by QIPP initiatives.

Health profile

The 2013 Health Profiles provided the following commentary about the three main local authorities within the catchment area. Generally, outcomes and determinants of health are worst in Thurrock and significantly better in Brentwood. Basildon has worse deprivation on average but this masks a wider variation than the England average with more than 20% of people living in the second most

[1] *Source: Population Projections Unit, ONS. Crown copyright 2014*

deprived quintile *and* the least deprived quintile. Obesity and smoking are priority issues in Thurrock and Basildon and all areas have low levels of breast-feeding.



At CCG level, the improved outcomes for the population of Brentwood offset the poorer outcomes for the Basildon population so that the Basildon & Brentwood CCG appears very similar to the Essex average (which is better than the England average). Thurrock had a particularly high level of potential years of life lost (PYLL) in 2012 when it was over 25% higher than the national average. In both CCGs, PYLL have been increasing due to neoplasms (cancer) and cerebrovascular diseases whilst reducing for ischaemic heart disease and respiratory diseases.

Priorities for commissioners

A wide range of requirements and priorities were set out in the NHS England planning guidance for CCGs. From these, our main CCG commissioners have identified the following system objectives:

NHS Basildon & Brentwood (264,000 population across 44 GP Practice members):

- System objective 1: To achieve excellence in primary care service delivery
- System objective 2: Patients to have a named clinical lead as part of a wider integrated team
- System objective 3: To develop specialist pathways of care and improve outcomes
- System objective 4: To reduce reliance on urgent/unplanned use of hospital services by 15% by 2018

NHS Thurrock (166,000 population across 34 GP practices):

- System objective 1: Reduce the number of people requiring a service response
- System objective 2: Empower communities to take responsibility for their own health and well-being
- System objective 3: Build a whole person approach to the health and care system
- System objective 4: Bring health and care closer to home
- System objective 5: Ensure people are able to live as independently as possible for as long as possible

NHS England (East Anglia Area Team): Prescribed Specialised services, screening & dental

The Trust's 2014/15 contract value for specialised services is £47.8m, with a further £3.2m for Screening & Dental. As such, NHS England is a significant commissioner of the Trust's services. NHS England set out their commissioning intentions for 2014/15 and 2015/16 in October 2013 and intends to undertake a public consultation on a draft five-year strategy for specialised services in July 2014. The likely direction of travel is to continue to leverage the benefits of having a single national

commissioner to drive consistency in access, service delivery, quality and cost, with potential for further consolidation of low volume, highly specialised services

2.2 Funding analysis

Overview

The last 12 months have seen a sharp reversal in financial positions between provider and commissioners. Both local CCGs are reporting year-end surpluses for 2013/14 (NHS Basildon & Brentwood £0.3m, NHS Thurrock £1.6m) compared to the Trust's deficit of £9m. CCG plans are to increase the size of in year surpluses to over 1% of allocation through the planning period. Both CCGs have identified changes to allocation formulae and speed of transition to 'target allocations' as a risk. Basildon & Brentwood is further from target and so faces a greater risk.

Better Care Fund

NHS Basildon & Brentwood are planning for a £20m fund by year 2, £5m of which is existing social care funds which will flow through the CCG whilst £15m of which is currently in contracts with the local community and mental health providers. No acute contracts have been included in years 1 and 2.

NHS Thurrock expects the value of their fund to be £10.5m in 2015/16 of which £9.7m is identified currently as NHS money.

Potential liabilities arising from the Care Bill and the lifetime cap on social care costs is a future challenge that commissioners have identified.

Provider assumptions

In line with both the Operational Plan and the latest Monitor guidance the Strategic Plan assumes that there will be no major change to the national tariff or the underlying assumptions detailed below:

1. National tariff will include an efficiency reduction of 4% each year
2. National pay awards are no greater than 1%
3. Increases in employers' contribution to Superannuation will be funded via the tariff

The Tariff assumption is fairly flat at -0.02% in 2016/17, however, in 2017/18 & 2018/19 the overall tariff deflator is forecast to be -1.62%. In order to achieve financial break even across the Strategic Planning period the Trust will have a shortfall of £29.5m plus debt servicing of £4.5m, that is, £34m in total.

Our strategic cost improvement programme is a core part of the Trust's overall financial strategy and is covered under priority 6 (Provide value for the taxpayer by continuously improving productivity). System wide 'transformational' changes are also expected from the Essex wide review of acute services, integrated commissioning as part of Better Care Fund and other joint working across the local health economy.

2.3 Competitor analysis

The Trust is the largest of three main acute providers in south and mid Essex alongside Southend University Hospitals NHS Foundation Trust (SUHT) and Mid Essex Hospital Services NHS Trust (MEHT). All three have revenue of £270-290m but with a different mix of sub-regional and regional services. BTUH is skewed towards medical specialties, particularly acute & geriatric medicine, and women's & children's services. SUHT is the main provider of Cancer (Oncology and the majority of cancer related surgery) services and has the largest combined Trauma & Orthopaedics, Rheumatology and Pain Management (MSK) service. MEHT is the only non-foundation trust and hosts the regional burns care and plastic surgery services.

In addition to the three providers described above, other NHS acute hospitals in Essex include Queen's Hospital, Romford (part of Barking Havering & Redbridge University Hospitals NHS Trust), Colchester and The Princess Alexandra Hospital in Harlow. The table below provides a snapshot across all five Essex Acute trusts plus aggregate data for BHRUT for a number of different measures of size and performance based on publicly available data. Colour formatting has been used to highlight differences between the trusts. All trusts were in deficit in 2013/14, with the non-foundation trusts having the greatest financial challenge. BTUH, Mid Essex and BHRT have highest levels of occupancy and lower scores for inpatient family & friends test BTUH and Mid Essex also have lower levels of harm free care, although both were showing stronger 18 week admitted patient performance than the other Essex trusts. BTUH had the strongest A&E performance across Essex in the fourth quarter of 2013/14.

Neighbouring Cardiothoracic centres are Papworth to the north and Barts Health to the west. Cardiothoracic surgery at Barts Health is currently of a comparable scale to BTUH, however, plans to move cardiac services from the Heart Hospital (UCLH) to Barts Health would effectively double the size of the Barts Health service. This would bring it closer to the scale of Papworth, which is also in the process of relocating to the Cambridge Biomedical Campus.

2.4 SWOT[2] analysis

Geographic position

- Good sized and growing catchment population with above average health needs – should be sustainable in terms of required volumes for core services
- Largely inelastic demand for core (Basildon & Thurrock) catchment but more competitive situation in surrounding towns, particularly to the north (Billericay, Brentwood) – opportunities to gain (and threat of loss of) market share, particularly for planned care
- Proximity to London provides access to a large pool of potential staff, however absence of London weighting allowance, teaching hospital status (and smaller private patient market) reduces attractiveness

Portfolio of services

- Provide a number of tertiary and regional services, particularly through the Essex Cardiothoracic Centre, with good reputation and outcomes, and also Renal, Bowel screening and Dermatology – potential to build further through vascular, interventional radiology and hyper-acute stroke services

[2] Strengths, Weaknesses, Opportunities and Threats

- Largest provider of Women's & Children's services within Essex
- Bowel screening centre with strong gastroenterology medical and gastrointestinal surgical teams plus modern JAG accredited endoscopy unit
- Portfolio skewed to acute medicine (in terms of admissions, beds, resources) with a number of potentially sub-scale surgical specialties
- Limited community based services – Musculoskeletal (MSK) service development provides opportunity for the Trust to demonstrate its potential

Performance

- Trust has achieved improvements in hospital mortality measures and, after being placed in 'special measures' by Monitor in July 2013, has been given a service rating of 'Good' by the CQC and subsequently removed from special measures in June 2014
- Improvements to A&E 4 hour wait throughout 2013/14 with attainment of 95% target

People

- Broadening clinical engagement and leadership but still a number of services which lack strong leaders and innovators
- Large number of new appointments at divisional level or above over the last 18 months, but there remains a significant organisational development programme to implement
- In line with similar organisations, there are gaps in middle grade doctor rotas in key services (A&E, Paediatrics, Acute Medicine) but addressing these issues through redesigned consultant job plans and development of advanced care practitioner roles
- Successful nursing recruitment to revised ward establishments leading to better care and lower temporary staff costs

Financial position

- After years of delivering surpluses, the Trust reported a deficit for 2013/14 reflecting its investments in improved patient care despite the challenging financial environment
- Service line analysis shows that the operating margins vary with EBITDA[3] as a % of income ranging from around +25% to -25% across the major services
- Two year £32m Cost Improvement Programme is underway, during years 3-5, the Trust will become more dependent on the success of wider transformations in the local health economy
- In 2012/13 the Trust had a Reference Cost Index (RCI) of 92. However, this was before the investment in additional staffing during 2013/14 and the expected RCI will increase

Partners in Local Health Economy (LHE)

- Good relationships with local CCGs (NHS Basildon & Brentwood and NHS Thurrock)
- Acute services Review provides opportunity for whole health economy solutions to sustainability challenges to be developed but very early days in the process
- Quality of primary care is variable as identified in "Transforming Primary Care in Essex"
- The Trust actively engages with community, social care and mental health providers and commissioners as part of strategic and operational fora
- As part of the Anglia Ruskin Health Partnership (ARHP) the Trust regularly engages with other providers across Essex and as part of the UCLPartners (UCLP) network

[3] Earnings Before Interest Tax Depreciation & Amortisation (a measure of operating margin)

2.5 Forecast Activity and Revenue

NHS Clinical income and activity

The Trust is planning on clinical income remaining at or below 2013/14 level compared to around 2.6% annual growth between 2010/11 and 2013/14. This assumes reducing prices are offset by growth of approximately 1% a year (lower than demographic weighted growth). The Trust has not tried to project the exact mix by point of delivery (POD) – but the expectation is that if the Trust and local health partners are successful at reducing demand for emergency care below planned levels then this would free up resource to deliver more planned care and vice versa. All assumptions are based on the current pricing regime, which is known to be subject to change in 2015/16, and therefore the most important assumption is the overall level of clinical income, which is expected to be commissioned.

Non-clinical and non-NHS income

Our plan includes growth in other income of 5% per annum from 2013/14 outturn to 2018/19; this is equivalent to £7.3m. It is predominantly driven by three growth areas that are explained in more detail in section 4:

- Pathology Joint Venture
- Re-basing and expansion of the Private Patient contract with Ramsay Health Care
- Increase in facilities income

For all other areas we have assumed growth through price inflation for relevant service (e.g., Education & Training uplifted by 1.5% per annum, Research and Development uplifted by 2.1% per annum). The assumption is that the national re-basing of the Education and Training levies are neutral to the Trust.

2.6 Capacity analysis

Estate

The Trust's activity is delivered across three sites.

- **Basildon Hospital** site is by far the largest and most significant in terms of service delivery. It provides a full range of services including Accident & Emergency, main outpatients and the CTC. It has a footprint of 124,425m^2 and includes circa 840 inpatient beds, 17 theatres, including day theatres plus procedure rooms, and 2,400 car parking spaces. It is also the main site for clinical and non-clinical support services, trust headquarters, the education department and laundry services. Other users of the site include social services, NELFT, SEPT and the laundry. The quality of infrastructure is mixed ranging from the original building through to the new additions, planned developments include projects for Women's and Children's, Radiology, Endoscopy and winter capacity works. Similar to many large hospital sites, access to and from the location is problematic during peak hours in the morning and evening. There is frequent queuing for car parking which impacts negatively on patient and visitor experience and staff travel plans.
- **Orsett Hospital** is around seven miles from Basildon Hospital. The site has a footprint of 10,900m^2 gross internal area (GIA) and includes a surgical day unit, outpatient clinics and radiology. Other users include Southend Hospital and NELFT. The infrastructure is fairly poor

overall and is in need of investment. Improving use of Orsett is a strategic priority over the next two years to enable a strategic assessment of the long-term viability of the site to be undertaken.

- **St. Andrew's centre, Billericay** is around six miles from Basildon Hospital and has a footprint of 357m^2 GIA. There are two buildings on the site, both Trust owned, one is shared by the Trust and North East London NHS Foundation Trust to provide community based therapy services, the other is a community health centre providing primary services (GP's, dentistry and others). BTUH delivers phlebotomy and radiology services.

Beds

Based on the activity and case mix assumptions, planned reductions in average length of stay and occupancy, future demand for beds is projected to reduce by 8% (or around 50 beds) between the 2013/14 average requirement and 2018/19. As with the emergency admissions activity assumptions which drive much of this reduction, this represents an extremely challenging plan given the ageing population and the correlation between average age at admission and length of stay. Hence under a 'do nothing' scenario, bed demand would increase faster than demographic weighted activity growth.

Diagnostics

- **Imaging modalities** – we are expecting to see continued growth of MRI and CT scans ahead of underlying activity growth with shift from plain film and increased imaging intervention rates. Our current demand requires 20 consultant radiologists. We anticipate that through implementing 7 day and extended day services we will have sufficient physical/equipment capacity but that we may need to invest in more staff.
- **Catheter laboratories** – We currently operate four catheter laboratories and a business case is being considered for the fitting out of the additional laboratory completed as a shell within the original development. If taken forward this is likely to be in partnership with a commercial partner.
- **Endoscopy** – we are investing £1.5m in a new endoscopy suite. Through a combination of expanded facilities, 7 day working and shifting simpler activity to outpatient procedure rooms (e.g., cystoscopies) we will be able to meet the expected 61% increase in activity
- **Pathology** – many of our future pathology services will be provided by the joint venture with SUHT and Integrated Pathology Partnerships. The new organisation will have sufficient capacity to meet the needs of both organisations as well as additional customers

Operating Rooms

- **Day surgery** – The Trust has two day surgery units, one at Orsett (two theatres) and one at Basildon (three theatres)
- **Main theatres** – located on the Basildon site and include 7 theatres
- **Maternity** – the maternity unit includes two dedicated theatres
- **CTC** – has three dedicated theatres and a hybrid theatre, opened in 2013 and used for cardiology, interventional radiology and vascular surgery work

Workforce

The Trust currently employs around 4,500 WTE. During the past year we have made significant progress in recruiting new staff to reduce the number of vacancies and bring new skills into the

organisation. Whilst over the planning period we are projecting a reduction in overall staff numbers reflecting the ongoing efficiency requirement with little or no growth in revenue, staying on top of inevitable turnover of staff and ensuring we have a pipeline of high quality candidates will remain a vital 'business as usual' activity. Our workforce capacity plans include:

- Supporting effective deployment for 7/7 services
- Developing new knowledge and skills
- Developing alternative strategies in hard to recruit to specialties
- Managing the workforce impact of our strategic change programme

2.7 Extent of alignment with LHE partners

We have met with both of our local CCGs as part of our planning process. We have also received feedback on our draft strategy from NHS Basildon & Brentwood, and have reviewed information related to CCG five-year strategic plans, and the emerging Essex Primary care strategy. Through this process, we identified four areas where our strategic plan required further development:

- How to make the Trust a 'provider of choice' to enable gains in market share and help us to win the confidence of commissioners to take forward service developments
- Ensure we reflect plans for shift of resource from acute to community settings
- Show clearer alignment with national and commissioner agendas, particularly in terms of mental and physical health parity
- Be bolder on 3-5 year opportunities of 7 day working and use of technology

Where our plans are not aligned with those of the CCGs we will continue to work together to increase the level of alignment.

3 Risks to sustainability and strategic options

3.1 Service line risks to sustainability

We have identified six broad risks to sustainability, which may apply at the individual service line level or at trust level, these are:

1. Sub-scale clinical services without sufficient cross-cover and/or volumes to maintain competence (and financial viability)
2. Unable to recruit and retain sufficiently skilled and motivated workforce to ensure delivery of high quality services
3. Demand for services (e.g., emergency care) exceeds available capacity leading to extended waiting times, delivery of sub-standard service in inappropriate setting or loss of market share
4. Externally imposed reconfiguration of services or decommissioning of specialised services
5. Unable to respond sufficiently to increased competition, new pathways of care or shrinking overall market which challenge 'traditional' revenue streams
6. Unable to respond sufficiently to financial challenges leading to reduced liquidity or unsafe cost reduction initiatives

We have risk assessed our main service lines against these challenges and will use these assessments to shape our future plans for clinical services.

3.2 Strategic priorities

We have defined six strategic priorities through the strategic planning process, which have been used to help evaluate options and shape our strategic work programme. We have not considered major structural change across the health economy (e.g., merger or wholesale reconfiguration) as we are fully engaged with the Acute Services Review which provides an Essex (including Thurrock) process for considering the best service configuration and then recommending (or laying the foundations for) any changes in organisational form. Further details of timings associated with this process are outlined in 4.1

1. Deliver high quality care whenever needed. Our plan is to be fully compliant with the Keogh standards of urgent and emergency care all patients should expect seven days a week by 2015/16 at latest and so this is not considered as part of our 3-5 year strategic plan. Our intention is to be in a position to be designated as a Major Emergency Centre, although we expect designation decisions to form part of the output of the Acute Services Review.

2. Provide more services out of hospital. Our two initiatives relevant to this strategic plan are: development of MSK service and the Frailty/Elderly care pathway. These are both significant in their own right but are also likely to provide the shape of future specialist pathway and integrated care commissioning.

3. Shift the mix of our services from emergency to elective. Our initiatives for this priority are: provider of choice amongst patients and commissioners (and thereby increase our likelihood of increasing our share of planned care referrals), and Cardiothoracic Centre development.

4. Collaborate with others in care networks. In addition to MSK and Frailty pathway initiatives which will be underpinned by collaboration with partners, this priority is also supported by our Pathology Joint Venture and Acute Services Review which has specific workstreams on sub-scale specialties and cancer pathways.

5. Recruit and develop excellent staff. Strategic recruitment of clinical leaders (including use of joint appointments with tertiary centres) and our organisational transformation programme are our key initiatives.

6. Provide value for the taxpayer by continuously improving productivity. In addition to our strategic CIP programme which we will continue to develop over the planning period, our key initiatives also include technology enabled transformation and the strategic development of our estate, both of which we anticipate will be shaped by recommendations and decisions from the Acute services Review.

4 Strategic Plans

4.1 Key initiatives

Implementation of our two-year, £30m+ strategic cost improvement programme is already underway. This will be a core part of our strategic plans for sustainability and will continue to evolve over the planning period. We anticipate that the Trust's potential for internally generated efficiencies will taper down from 2015/16 and we will therefore be increasingly dependent on health

economy wide transformational changes to remain viable and financially sustainable. Outlined below are the key initiatives that we expect to have, or enable, large scale impact over the medium term.

Acute Services Review

It is recognised across the Essex system that the status quo in terms of current configuration of acute services is unsustainable. The variable quality of clinical care and financial pressures mean that the issues being faced can only be remedied by whole system transformational change. The seven CCGs and five acute trusts have embarked on a planning process with the intention of tendering for consultancy support for an Acute Services Review (ASR) in September 2014. This phase has been overseen by a steering group and supported by Talking Health/Tricordant. In parallel the five acute trusts are also considering a back and middle office review to test alternative solutions and to drive quality and cost efficiency. This is in the early stage of planning and has also been supported by Talking Health/Tricordant.

The review will not result in the closure of an existing hospital site and a range of clinical services will continue to be provided across the five hospital sites.

The scope of the ASR has been derived from:

- The need to determine an appropriate emergency care configuration based on the Keogh Urgent and Emergency Care Review
- A review of specialties that are considered by trusts and CCGs to be an operational priority (difficult to staff/currently under pressure/sub-scale or considered unsustainable)
- Specialties where there is currently significant non-compliance with guidance eg IOG
- Specialties where current or forthcoming national guidance may prompt reconfiguration

It is the intention to consult on any changes with the public in late 2015/early 2016.

Frailty pathway

Both of our main CCG commissioners have identified the Frailty pathway as a priority service model for transformation. Basildon & Brentwood are exploring two options for change: collaborative development with existing providers or a competitive dialogue similar to the procurement underway in Cambridgeshire & Peterborough. Two issues which will determine the approach are: the re-ablement contract due for renewal in Nov 2015 and the current landscape of service providers across south Essex, with two competing community service providers operating along the same pathway. Whilst our Geriatricians are providing (and are seen to be providing) system clinical leadership, we are aware that our commissioners are concerned about BTUH's capacity and capability to take the lead on the service model. They have encouraged us to consider potential partnerships to build this capacity and this will be an area of focus over the next 18 months. As with the Acute Services Review, the potential consequences of change will play out during 2016/17 and beyond.

MSK pathway

The two local CCGs have commissioned the Trust to provide an integrated MSK service across community and secondary care. Following an OJEU procurement process, the Trust will award a contract for a community service that will provide a triage, assessment and treatment service that is

primarily delivered by Physiotherapy and Extended Scope Practitioner. The size of the community contract will be in the region of £2.5 - £3m per annum and will be awarded initially for a period of three years commencing from 1 April 2015. The aim of the service will be to ensure patients are treated in the most appropriate setting within a financially sustainable model that drives efficiency and delivers lower cost. This will support an improved market share position with the repatriation of local patients as capacity is released from activity shifting from secondary care to community provision. The Trust effectively demonstrating that it can deliver an innovative integrated model of care, will strengthen its position and relationship with the commissioners and could enable this commissioning arrangement to be extended to other services. The work is being led by an experienced Orthopaedic Surgeon.

Provider of choice amongst patients and commissioners

Whilst the Trust has made significant progress over the last year to win back the trust and confidence of patients and the local population, we still have a long way to go to ensure we are the provider of choice amongst patients and commissioners. We know from analysis of referrals from Basildon & Brentwood that across a number of key surgical specialties our market share has declined during 2013 compared to 2012 and this share is now further below our share of almost 90% of obstetric referrals. Our plan is to reverse this decline over the coming years through redesigning inefficient processes that delay care for patients, streamline our pathways to ensure patients receive high quality care with the minimum inconvenience and waiting, and ensure we are achieving the best possible outcomes for our patients. Involving GPs, patients and carers as well as our staff will be essential and, where appropriate, we will partner with other organisations that can bring additional skills and experience to our proposition. An example of this is our work on MSK pathways, whilst on a day to day basis we are constantly making it easier for patients and carers to give us feedback on their experiences at all levels of the organisation.

As we develop our plans for attracting more patients to choose the Trust for their planned care, we will also consider how we can use our estate (and other NHS facilities such as Brentwood Community Hospital) to deliver care closer to patients where it is clinically safe and operationally efficient to do so.

Development of the Essex Cardiothoracic Centre

Opened in July 2007, The CTC boasts some of the most modern cardiothoracic (heart and lung) treatment facilities in the county. The Essex CTC was purpose-built to accommodate the highly equipped operating theatres and cardiology treatment rooms needed to provide world-class treatment and care. Unlike a standalone cardiothoracic unit, the centre is able to treat a greater range of patients by having direct access to renal support therapy, vascular surgery and surgical trauma teams.

It also provides an important financial contribution to the Trust as well as distinctive strength to the clinical portfolio. However, after years of growth there are an increasing number of challenges that the Centre must address including: reducing demand for coronary revascularisation, increasing competition from neighbouring centres, increasing efficiency requirement, and needing to keep pace with clinical developments.

The vision for the Essex CTC is that it will maintain its position as a tertiary cardiac centre over the next five years, with a changing focus on structural cardiology as well as coronary services in line with developments in the specialty and with future expansion in Electrophysiology and devices.

Pathology Joint Venture

We expect our Pathology Joint Venture to be operational on 1 August 2014, or shortly thereafter. BTUH and SUHT have selected Integrated Pathology Partnerships (iPP) as the third partner in the JV. No profit is planned from Basildon and Southend work, but third party growth would generate profit, which would be shared between the partners of the JV. We anticipate that by 2018/19 this will generate an important income stream for the Trust in the form of dividends based on the identification of realistic opportunities for growth exist via new customers across the East of England and East London. The building of a new state-of-the-art hub is critical in the delivery of any new growth in volumes. Moreover, by adopting a dual contract approach, the joint ventures, and therefore the trusts, can exploit further opportunities for disaster recovery, equipment maintenance and facilities management.

All investment requirements and the contracted responsibility for delivering pathology testing to the agreed service level (and associated risk) are transferred to iPP. Within our contract price, iPP will make a significant investment into the pathology service delivered by the trusts:

Organisational development

Our organisational development work has three main strands: embedding values; leadership development; and organisational structures and design.

Embedding values. We will build on our work to embed our values into the way that we work every day. New joiners will be "recruited for values" and this will be reinforced through our induction processes. Alongside this, we are implementing a range of initiatives to support existing staff to work in ways that strengthen our values and address behaviours that undermine them.

Leadership development. Our leaders at every level are vital for us to build a critical mass of change makers. Our development programmes will provide targeted support relevant to the individual but with a focus on developing competencies in change management and continuous improvement. We will continue to bring in a range of expertise from other organisations and whilst we are confident these programmes will enhance the quality of clinical leadership, we expect that further external recruitment to key posts will be required. In addition a number of posts will be aligned to tertiary and academic institutions to improve attractiveness and increase the calibre of applicants.

Organisational structures and design. Further development of our service line management will include: developing the clinical leadership structure, including supporting Clinical Service Units to gain greater autonomy; strengthening the performance framework that provides the assurance that CSUs are meeting the Trust's aims and objectives; engaging senior clinicians in the organisation, management and development of their services; and ensuring individual, team, and service objectives are aligned to Board strategy.

Technology enabled transformation

There are three key themes to our IM&T requirements to support our strategic priorities: development of an integrated electronic patient record (EPR); provide electronic information flows

to enable more integrated working with other partners; and develop our business intelligence system and associated skills to maximise the benefits of information driven performance improvement. As the foundation for this, in February 2014 following a procurement exercise, the Trust placed a 10-year contract with System C for an integrated EPR and all future IT requirements. The contract allows the Trust to call off all EPR modules and new services as and when required. The core modules including business intelligence went live in November 2013, with order communications set for implementation in 2014. The objective is to be in the top quartile of the Clinical Digital Maturity Index[4] from April 2016.

In addition to integrated EPR developments, there is also a significant requirement to replace out of contract and obsolete systems, including PACS, RIS, Maternity, Theatres and Telephony. PACS and Theatres replacement would need to take priority for funding over new systems such as e-prescribing, as they will stop working at the end of the Connecting for Health contract in 2016.

Estate strategy

Our estate strategy requirements are a mix of providing capacity aligned with new pathways of care; ensuring effective use of space for the future; and ensuring our estate is maintained in an optimum condition. These include specific initiatives such as:

- Provide Paediatric Assessment Unit facility that this is adequate to deliver high quality urgent care 24/7
- Delivery of a day unit to support ambulatory care and free up capacity in theatres and ward areas
- Delivery of the women and children's build project
- Support and enable the development and utilisation of Orsett
- Deliver a fit for purpose and compliant endoscopy unit
- Provision of space for new ambulatory pathways of care e.g. urology procedure room to enable move from theatres
- Deliver improved site access/egress and parking provision

We will also engage with LHE partners to consider opportunities to improve utilisation of the LHE estate.

4.2 Financial plan

Overview and key assumptions

The Board agreed planned deficits for 2014/15 and 2015/16 as part of the operational plan submitted in April 2014, following the anticipated £6.8m deficit in 2013/14, which included a late non-recurrent Maternity Work in progress adjustment of £1.4m. The actual deficit was £9m but has not been adjusted in the plan. The Trust's plans overall for years 3-5 are to return to a breakeven position, continuing the improvement trajectory from 2014/15 and 2015/16. Given the challenging financial conditions expected, and the uncertainty around future income levels and system wide reform, the Strategic Plan includes the following key assumptions:

[4] Published by EHI Intelligence

- No net growth in NHS Clinical income between 2015/16 and 2018/19 – with an assumed low level of underlying activity growth (c. 1%) offset by tariff deflator over the period
- There is no material impact on the Trust of any change to tariff structure
- There is no other material impact of the Better Care Fund
- Delivery of CIP requirement of £60m over the five years, with savings front-loaded into the first two years (£33m)
- Employer's pension increases in 2015/16 and 2016/17 are funded via national tariff
- Risks to clinical income through fines, penalties and EPR activity recording risks are managed with no material reduction in income
- Quality can be maintained or improved whilst achieving required levels of cost reduction
- The Trust generates enough internal cash to deliver the capital programme, including achieving and maintaining improved working capital position of around £12.5m, no further borrowing is assumed in the plan
- Manpower reductions projected are assumed to be managed through natural wastage, turnover or TUPE arrangements to minimise redundancy costs
- Given that consultation following the Acute Services Review will not commence before January 2016, there will no material impact until the end of this planning period
- Financial performance will be sufficient to generate a Continuity of Service Risk Rating of 3 for the end of 2014/15 and 2 in all other years

Whilst the strategic financial plan allows for little operational headroom, the Trust has chosen to be cautious about the level of internally generated CIPs that can be achieved in the outer years following our large-scale programme in 2014/15 and 2015/16. Increasing the outer years CIP plans to 4% would generate a further £10m of cash as well as improved EBITDA and surplus margin.

The Trust has also taken the decision to fund the capital programme without borrowing. This provides an option should the situation require it but would also increase the level of savings required in the long run.

Sensitivity testing, of downside risks, has been performed and is set out later in the document.

Income & Expenditure

We have agreed a financial improvement plan to return to surplus in 2017/18. This requires a doubling of EBITDA from 2013/14 outturn with limited scope for income increases. As such, delivery of our Cost Improvement Programme, recurrently, each year, is essential. As set out in 2.5, our plan assumes a reduction in NHS clinical income over the planning period, which we aim to offset by growth in other sources of income (principally a moderate increase in private patient income and profits from our Pathology Joint venture).

The summary I&E is shown below, followed by further detail of the changes in cost base.

£m	2013/14 Outturn	2014/15 Plan	2015/16 Plan	2016/17 Plan	2017/18 Plan	2018/19 Plan
NHS Clinical income	261.3	258.3	258.5	261.0	259.4	257.8
Non-mandatory clinical income	2.9	2.9	2.9	3.5	4.1	4.6
Other operating income	23.5	25.1	25.7	26.6	27.7	29.0
Total Income	**287.7**	**286.3**	**287.1**	**291.1**	**291.1**	**291.5**
Non-pay	(93.0)	(91.8)	(94.0)	(95.6)	(98.7)	(102.0)
Pay costs	(185.8)	(182.9)	(179.7)	(179.2)	(175.2)	(172.8)
EBITDA	**8.9**	**11.5**	**13.4**	**16.2**	**17.3**	**16.7**
Depreciation & Amortisation	(8.6)	(10.9)	(10.5)	(10.5)	(10.5)	(10.5)
Operating surplus	**0.3**	**0.7**	**3.0**	**5.8**	**6.8**	**6.2**
Net financing costs	(7.1)	(7.2)	(7.0)	(6.3)	(6.3)	(6.2)
Surplus (Deficit)	**(6.8)**	**(6.5)**	**(4.0)**	**(0.5)**	**0.5**	**0.0**
EBITDA margin, %	*3%*	*4%*	*5%*	*6%*	*6%*	*6%*

Changes in non-pay expense – we are projecting a £9m increase in non-pay costs between 2013/14 outturn and 2018/19. The main drivers of this are price inflation of £15m (around half of which is due to drugs inflation) and service changes (net impact of service charge associated with outsourcing pathology services to the Pathology JV), offset by a CIP of £22m, front loaded to 2014/15 and 2015/16. We have a contingency of £1.5m per annum during years 3-5 of the planning period.

Changes in pay expense – we are projecting a £13m decrease in pay costs between 2013/14 outturn and 2018/19. The main drivers of this are a CIP and service change impact of Pathology JV with a combined impact of over £40m savings. The vast majority of this is CIP with over £18m in the first two years and a similar amount across the outer three years. We are projecting the unit pay costs to increase by around £20m over the period through pay awards and pension changes, with an additional £2.1m to support the c. 1% per annum of additional activity.

Capital plan

The plan includes £61.4m of capital expenditure over the five-year period, which is around £8m higher than projected depreciation. The largest single development is the proposed Women's & Children's services redevelopment. The Full Business Case is currently under development and a decision will be made in the second half of 2014/15. The plan also includes almost £12m of investment in clinical equipment, both replacement and new equipment. This includes investment in cardiothoracic developments. There are two refurbishment schemes taking place over the next two years covering endoscopy and radiology and around £10m of investment in IT infrastructure and electronic patient record. The investment profile is front-loaded and the expenditure implications of this are set out in the section below. For the outer two years, expenditure is planned at equivalent level to depreciation.

Balance sheet and cash flow

Total assets employed are projected to reduce by over £10m over the period as a result of funding the projected deficits in 2014/15 and 2015/16 by reducing cash holdings. In addition to our capital investments, we will also be repaying £7.5m of loans over the period, paying around £28m of PDC

dividends and around £5m in net interest. The cash balance at the end of the period is projected to be £5.2m

Summary Balance Sheet 2013/14 to 2018/19

£m	2013/14 Outturn	2014/15 Plan	2015/16 Plan	2016/17 Plan	2017/18 Plan	2018/19 Plan
Total Non-Current Assets	225.7	226.9	231.7	234.8	234.8	234.4
Current Assets	36.1	38.8	29.1	25.0	24.3	23.3
Current Liabilities	(30.4)	(39.2)	(41.0)	(42.2)	(42.4)	(42.9)
Total Non-Current Liabilities	(26.2)	(27.8)	(25.2)	(23.5)	(21.8)	(20.1)
Total Assets Employed	**205.1**	**198.6**	**194.6**	**194.1**	**194.6**	**194.6**
Public Dividend Capital	114.2	114.2	114.2	114.2	114.2	114.2
Revaluation Reserve	62.7	63.5	64.4	65.1	66.0	66.8
Retained Earnings	28.2	20.9	16.1	14.8	14.4	13.6
Total Taxpayers Equity	**205.1**	**198.6**	**194.6**	**194.1**	**194.6**	**194.6**

Summary cash flow 2013/14 to 2018/19

£m	2013/14 Outturn	2014/15 Plan	2015/16 Plan	2016/17 Plan	2017/18 Plan	2018/19 Plan
Opening cash balance	**34.4**	**15.5**	**20.6**	**10.8**	**6.9**	**6.1**
Cash flow from operations	10.3	11.4	13.3	16.1	17.2	16.6
Movement in working capital	(5.4)	10.7	1.7	1.8	0.4	0.7
Movement in non-current provisions	(0.1)	1.1	(1.1)	(0.1)	(0.1)	(0.1)
Capital and other investments	(20.1)	(11.8)	(15.4)	(14.0)	(10.5)	(10.3)
Financing activities	(3.7)	(6.3)	(8.4)	(7.8)	(7.8)	(7.8)
Net increase (decrease) in cash	**(18.9)**	**5.1**	**(9.9)**	**(3.9)**	**(0.8)**	**(0.9)**
Closing cash balance	**15.5**	**20.6**	**10.8**	**6.9**	**6.1**	**5.2**

Downside risks and mitigations

The Trust has modelled five downside scenarios set out below. These scenarios are high-level indications for local strategic planning and not absolutes (tariff marginal rates not factored in or marginal cost changes).

Scenario 1: 1% reduction in activity, applied to each individual year. This has approximately £2.6m impact each year and assumes that there is no scaling of marginal costs. Without mitigation, it therefore reduces cash holdings by £7.8m by 2018/19.

Scenario 2: 1% reduction in activity, compounded each year. This has approximately £2.6m impact each year which when compounded results in an EBITDA of £7.8m by 2018/19. Again, it assumes no scaling of marginal costs and without mitigation the impact on cash holdings is £15.5m by 2018/19.

Scenario 3: 1% pay pressure; compounded each year. This has an annual impact on costs of around £1.7m, which by 2018/19 compounds to a £5.2m reduction in EBITDA and an unmitigated impact on cash holdings of £10.5m.

Scenario 4: 30% CIP failure; applied to each individual year. This assumes in year slippage of 30% and so has a differential impact depending on the planned size of CIPs. In 2016/17 it reduces EBITDA by £3.4m, reducing to £2.4m in 17/18 and £2.3m in 18/19. It assumes that the slippage is recovered the following year but has an unmitigated impact on cash holdings of £8.1m.

This cash deficit would be mitigated via the Trust's conservative assessments on the following:

- Increase in elective market share;
- The base case including only 50% of the expected Pathology JV surplus;
- Conservative estimate of underlying activity growth

The base case and the scenarios above has been actively challenged and discussed at the Finance and Resources Committee and at the full Board of Directors, and the financial challenges and risks included in the Strategic Plan are fully understood.

4.3 Monitoring and managing delivery

Self-assessment of strategic planning and delivery

In February 2014, the board and other senior leaders from the Trust undertook a self-assessment of our strategic planning approach using the hallmarks of a good strategic planning process set out in the Monitor planning guidance. The board considered the outputs from this survey and this has been used to guide the planning process and approach to managing delivery. Overall the Trust benefits from having a challenging set of Non-Executive directors with considerable experience in strategic planning and delivery. The benefits of having a clinical service led approach to strategic planning are reflected in the higher scores from those closer to 'the front line'. However, all groups are aligned that the Trust has greatest progress to make in plan delivery.

Approach to delivery

Our strategic plan will guide our decisions and behaviours over the coming years and will involve significant change across the Trust and beyond. Our approach to implementation includes the following:

- Embedded in our business planning cycle and delivered through service line management
- Focused support through a strategic change programme and executive level initiatives
- Improved patient engagement
- Partnering with others and only doing what we do well
- Measuring our progress and impact
- Continuing to assess the clinical and financial sustainability of our services

Risks to delivery - strategic

The following is a summary of internal and external risks to our strategy:

- Our capacity and capability to deliver the scope and scale of change required
- Variable clinical leadership

- Risks of future funding changes (tariff and Better Care Fund)
- Capability of primary care to manage demand
- Lack of informatics and analytic capacity
- Diversion of medical training resource from acute
- Rising patient expectations

Risks to delivery - quality

Key risks linked to the proposed quality goals that are already identified and addressed in the Trust Board Assurance Framework and Corporate Risk Register include:

- Capacity and capability to provide appropriate care to acutely unwell and deteriorating patients
- Potential for errors in care delivery as a result of inadequate training, supervision or non-compliance with Trust policy
- The ability to maintain efficient inpatient flow throughout the hospital and safe discharge processes
- Successful recruitment, retention and development of highly skilled staff
- Capability to systematically develop and monitor Trust policies, procedures and protocols
- Capacity and infrastructure to ensure results of diagnostic tests are followed up in a timely manner, due to staff and system delays

For each identified risk there are robust controls and action plans in place to mitigate the potential for possible error and harm from any of the highlighted areas. These are discussed and reviewed on a monthly basis both at Senior Management Group and Board.