Gloucestershire Hospitals NHS
NHS Foundation Trust

Strategic Plan

2014—2019

BETTER FOR YOU

What is a strategic plan?

As a result of new planning guidance from NHS England, all NHS trusts must now work with commissioners and partners to develop strong, robust and ambitious five-year plans to secure the continuity of sustainable high quality care for all.

The first two years of this plan have been developed at an operating level and can be viewed in our Operating Plan which is available on our website.

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Background and the context in which we are working

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1.1 Purpose of the plan

This plan sets out a comprehensive summary of our strategy to meet our vision, the analysis that underpins it and the plans to implement it. It sets out in detail an assessment of the future challenges facing the health economy and our trust, and the options available to address the identified challenges.

At the end of the document we provide an assessment of the likelihood of the plan ensuring the sustainability of our Trust over the coming five years on a clinical, operational and financial basis.

1.2. About our Trust

The Gloucestershire Hospitals NHS Foundation Trust is one of the largest hospital trusts in the country and provides high quality acute elective and specialist health care for a population of more than 612,000 people. Our hospitals are district general hospitals with a great tradition of providing high quality hospital services; some specialist departments are concentrated at either Cheltenham General or Gloucestershire Royal hospitals, so that we can make the best use of the expertise and specialist equipment needed.

Our Framework for the Future is made up of:

- → Our Mission: Improving health by putting patients at the centre of excellent specialist health care
- → Our Vision: Safe effective and personalised care – every patient, every time, all the time.

Our Goals

Our goals are described in four core areas:

- → Our Services: to improve year on year the safety of our organisation for patients, visitors and staff and the outcomes for our patients
- → Our Patients: to improve year on year the experience of our patients
- → Our Staff: to develop further a highly skilled and motivated and engaged workforce which continually strives to improve patient care and Trust performance
- → Our Business: to ensure our organisation is stable and viable with the resources to deliver its vision.

Our Values

Our Values underpin everything we do and describe, in single words, the way we expect our staff to behave towards our patients, their families and carers, and colleagues. After listening to patients and staff the Trust has identified six core values, described here in the words of patients. These are:

- → Listening

Patients said: "Please acknowledge me, even if you can't help me right now. Show me that you know that I'm here."

- → Helping

Patients said: "Please ask me if everything is alright and if it isn't, be willing to help me."

→ Excelling

Patients said: "Don't just do what you have to, take the next step and go the extra mile."

→ Improving

Patients said: "I expect you to know what you're doing and be good at it."

→ Uniting

Patients said: "Be proud of each other and the care you all provide."

→ Caring

Patients said: "Show me that you care about me as an individual. Talk to me, not about me. Look at me when you talk to me."

1.3 The context in which we are working

Much has improved in health and social care over the past 20 years resulting in:

→ A greater awareness that good physical health is linked to good mental health

→ More people managing their own care at home as monitoring technology evolves

→ More services in or near people's own homes

→ Fewer people needing surgery due to improved imaging techniques, drug treatments and less invasive treatments

→ More people spending less time in hospital due to improved community services and advances in surgical techniques

→ Other professionals doing tasks previously done by doctors

→ Major advances in the treatment of common diseases such as stroke and cancer.

However the scale of the challenges we now face in Gloucestershire and within our Trust specifically, is significant.

1.3.1 Changes in need for our services

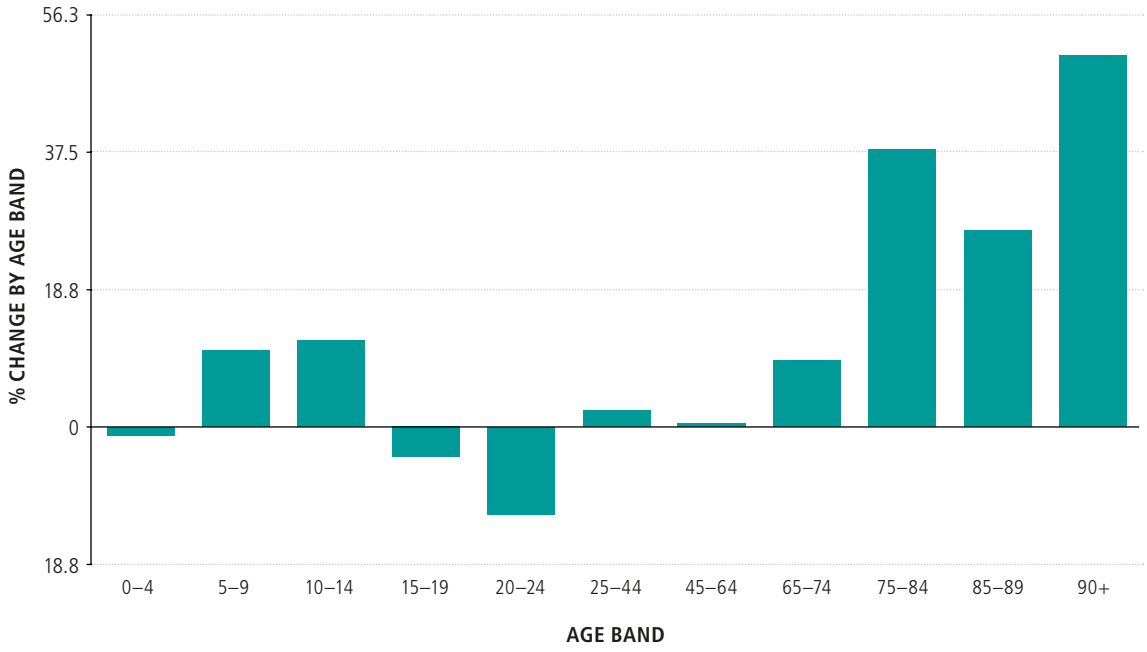
The size of the population we serve is growing. Over the next 10 years the population of Gloucestershire will increase from around 612,000 to 636,400.

The population we serve is also ageing. This is a national phenomenon but Gloucestershire's increase is greater than the national average. The number of people over the age of 65 is estimated to increase by approximately 70% between 2010 and 2035. The number of people over the age of 90 is expected to double over the same time period. The change over the next 10 years is shown graphically in figure 1.

This is consistent with the demographic growth assumptions reflected in Gloucestershire CCGs five year plan.

The risk of all major causes of early death and serious illness increases with age. This means that the number of people living with a long-term illness will rise much more quickly than the growth in the population with an increase in 10% in the next five years alone. Over the next 20 years, those living in Gloucestershire with diabetes and stroke are projected to increase by over 30% and

Figure 1. Projected changes in population for Gloucestershire by age group 2013–2023



coronary heart disease by 50%. Care for people with multiple long-term conditions is often very complex and, as their number grows, so does the impact on demand for services.

Many of the conditions we see are at least partly associated with lifestyle factors such as smoking, alcohol and obesity. If current obesity trends continue the number of obese adults in Gloucestershire will increase to 40% over the next 20 years.

This will result in considerable increase in the demand for health and social care. This is already beginning to manifest itself. Figures 2 and 3 overleaf show the change in age specific admission rates for emergency and elective admissions between 2006/7 and 2013/14.

The graphs show that people over the age of 75 are more likely to be admitted to our Trust now than they were seven years ago. This is particularly marked for emergency admissions over the age of 85.

When these two phenomena are taken together we can model the impact on the demand for our services from demographic changes alone. This is shown in the graphs overleaf which demonstrate an additional 12,000 admissions per annum by 2023.

1.4 Changes in demand for our services

The demand for our services is primarily influenced by changes in demography by national and local policy and

Figure 2. Change in non elective admission rates per 1000 population 2006 to 2013

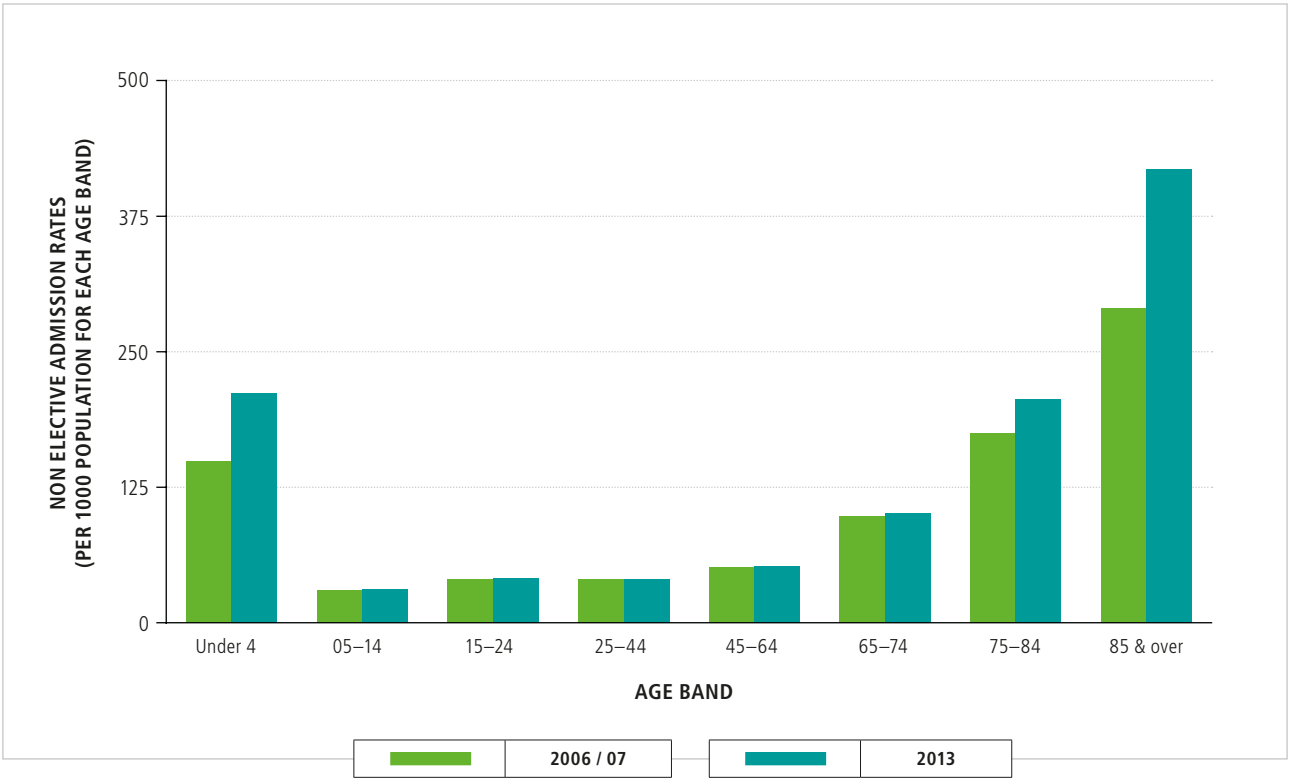


Figure 3. Change in elective admission rates per 1000 population 2006–2013

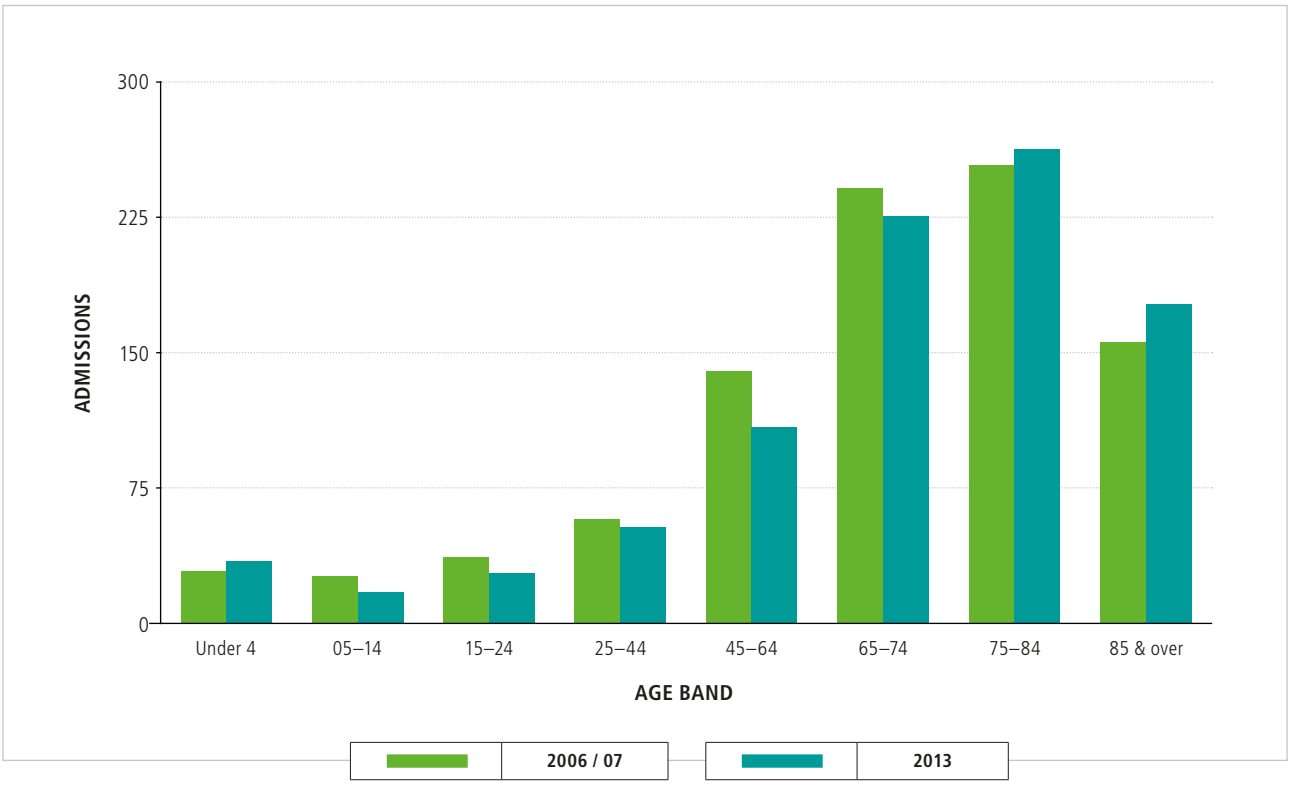


Figure 4. Projected change in non elective admissions 2013–2023

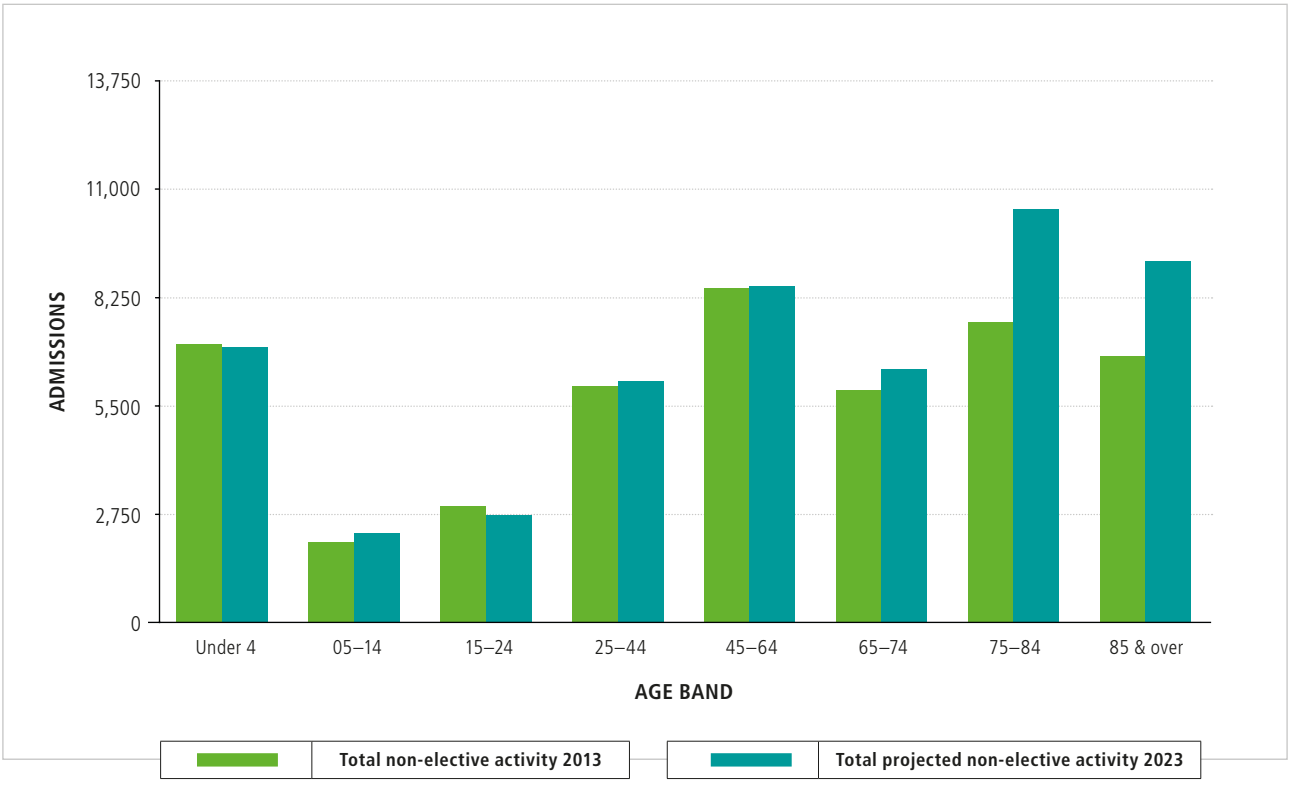
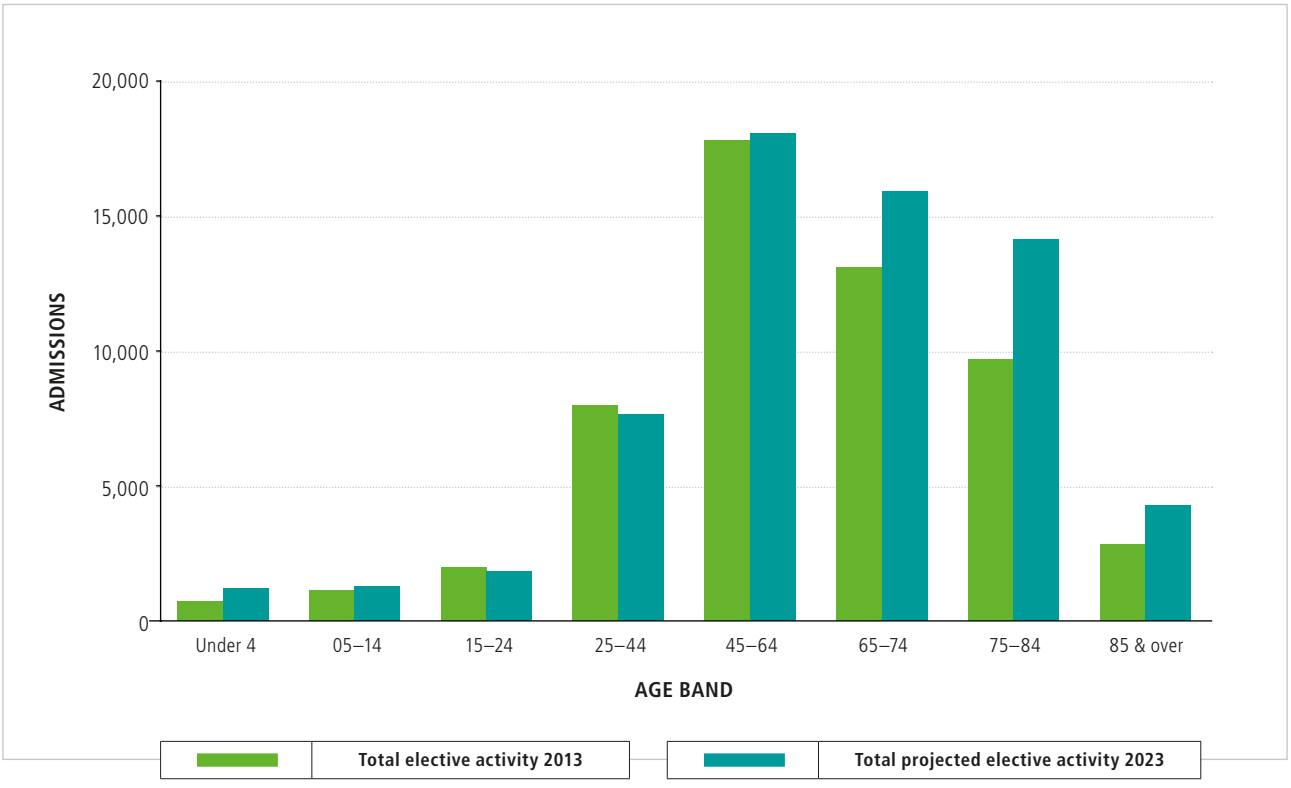


Figure 5. Projected change in elective admissions 2013–2023



commissioning intentions also play a part.

1.4.1 National policy

The most recent national planning guidance, Everyone Counts, reinforces the five "offers" to the public that will be delivered through the commissioning arrangements:

- → NHS services, seven days a week
- → More transparency, greater choice
- → Listening to patients and increasing their participation
- → Better data, informed commissioning, driving improved outcomes
- → Higher standards, safer care.

A number of these "offers" have been given additional impetus this year. The Urgent and Emergency Care Review outlines transformational changes that will be required over the next three to five years to build a stronger, more sustainable urgent and emergency care system for everyone. Whilst the recent reconfiguration of our emergency departments goes some way to achieving the vision set out in the document, the detail behind the vision is yet to be published.

We are working on the assumption that we will be a provider of a Major Emergency Care Centre. We anticipate that we will need to do more work with partners both within and beyond Gloucestershire to ensure we have a resilient service that is compliant with the standards for a Major Emergency Centre as they emerge. Failure to be recognised as a Major Emergency Centre would have a profound impact on the scope of services we are able to maintain and as a consequence threaten our clinical and operational sustainability.

Similarly the publication of the First Report of the Seven Day Working Forum has set out 10 clinical standards, primarily for acute hospitals. Achievement of these standards in the next 12 to 24 months will require both changes to the working practices of our clinicians and a significant financial investment; provisionally £2 million has been earmarked for development in the financial plan for 2015/16, including the impact of Seven Day Working. Meeting the requirements of seven day working will also require us to reconfigure our services between our two sites to ensure we can deliver consistently high consultant-led care to the sickest patients.

The Francis Report, in response to the Mid Staffordshire Inquiry, with its 290 recommendations and the government's response The Hard Truths; the Journey to Putting Patients First, has already had a profound impact on the operation of our Trust. Additional investment in nursing staff in 2013/14 exceeded £1m and responding to the emerging standards in an open and transparent way is likely to incur further additional cost over the period of this plan; a further £0.9 million has been set aside in the financial plan for 2014/15.

A key additional challenge over the period of this plan is the Better Care Fund (previously referred to as the Integration Transformation Fund), which was announced as part of the 2013 Spending Round. It is intended to provide an opportunity to transform local services so that people are provided with better integrated care and support. It is

created from the transfer of resources from the NHS to adult social care. In 2014/15 this equates to £1.1bn nationally rising to £3.8bn in 2015/16. In Gloucestershire this equates to £xx in 2014/15 and £xx in 2015/16.

Safe implementation of this fund relies on transformational change in local service provision to ensure that investments in adult social care deliver real reductions in the requirement on existing services. In Gloucestershire the degree of transformation will need to be at a scale, which not only reduces existing demand but also addresses the modelled impact of demographic change.

Increasingly rapid scientific progress brings the prospect of new prevention and care possibilities. A growing scientific understanding of the role that genes play in the development and progress of diseases will have an enormous influence on healthcare especially in terms of diagnosis and prognosis.

The role of the patient in health care is changing. Patients are acting more and more as consumers. Better education enables people to play a more active role in the management of their own healthcare.

This transition from patient to consumer has important consequences for the interaction at the point of service delivery and services will need to adapt to meet these expectations.

1.4.2 Local policy

Gloucestershire is well positioned to develop collaborative working for health and social care.

There is a single Clinical Commissioning Group, responsible for social care, a single, coterminous local authority, a single foundation trust main provider of acute services, a single foundation trust main provider of mental health services and a single community trust provider of community services.

The health and social care organisations in Gloucestershire are well aligned and have worked together to develop a shared vision for the next five years.

Key principles in the vision include:

→ A person centred approach

→ Developing assets within each local community

→ Adopting a “one system, one budget” approach

→ Designing efficient and effective services through the development of care pathways and a systematic approach to delivering transformational change.

We are confident that the assumptions reflected in this plan are broadly consistent with the assumptions reflected in the plans of partners in the local health economy.

The drive is to deliver services closer to people's homes, whenever it is safe and efficient to do so. We continue to look for opportunities to develop community services, either by delivering them in

communities ourselves or supporting others to do so but the pace of change and transformation in these schemes is slow.

1.5 How well are we positioned in the market?

1.5.1 Market share

The income sources for the Trust over the past four years are shown in Table 6.

The Trust continues to be the market leader for the provision of acute health services in Gloucestershire. In 2013/14 the Trust secured around 85% (£356 million) of the local available acute funding from Gloucestershire Clinical Commissioning Group and the South West Specialised Commissioning Group. The projected trend over the next five years is that this will continue, with a marginal transfer of some activity and income to other providers. The market share trend is expected overall to remain static.

The percentage reduction in income from our main CCG commissioners is a consequence of the increased scope of specialised services. The reduction in private patient income is a consequence of both a reduction in the fee paying market and a policy decision to prioritise beds previously ring fenced for private patients, for NHS use.

1.5.2 How well do we perform?

Table 7 sets out our performance against a selected set of metrics compared to the national average. This suggests that our performance is broadly comparable to the national average, with the exception of the 62-day wait target for cancer where we have action plans in place, and is therefore felt unlikely to be a significant influence on patient choice.

1.5.3 Who are our competitors?

Our positioning as the only major provider of NHS acute care in Gloucestershire means that we have very little competition for the non-elective services we offer.

The definition of a much wider range of services as specialised and the transfer for commissioning of these services to NHS England provides opportunities for some services to be moved from tertiary centres to hospitals like ours. However, the requirement to meet new more rigorous national specifications standards does present a potential threat for some of our existing services. It is important for us to ensure we meet the national specifications for these services and increase our profile by ensuring we are represented at national clinical reference groups and at regional networks.

The independent and third sector in Gloucestershire is providing increasing levels of NHS-funded treatment, although the level of provision (as a proportion of commissioning spend) remains small. To date we have not experienced any major threats to our services as a result of the market opening up to new providers. Where services have been put out to tender we have been successful in retaining our existing services and in acquiring some new services.

Due to our geographical position and reputation, we are in a strong position in

Table 6. Income by Commissioner

Commissioner	Outturn 2010/11 £'000	% Income	Outturn 2011/12 £'000	% Income	Outturn 2012/13 £'000	% Income	Outturn 2013/14 £'000	% Income
Gloucestershire	321,283	85.6%	328,217	85.7%	328,971	84.8%	282,283	70.5%
Worcestershire	19,573	5.2%	18,785	4.9%	15,394	4.0%	11,489	2.9%
Herefordshire	8,110	2.2%	8,463	2.2%	7,303	1.9%	3,319	0.8%
Wales	3,060	0.8%	3,179	0.8%	2,997	0.8%	3,046	0.8%
Other CCG's including non contracted activity	6,642	1.8%	7,261	1.9%	7,071	1.8%	22,803	5.7%
Specialised Services	12,712	3.4%	13,711	3.6%	23,132	5.9%	73,854	18.5%
Private Patients	3,885	1.0%	3,376	0.9%	3,156	0.8%	3,212	0.8%
TOTAL	375,265	100.0%	382,992	100.0%	388,024	100.0%	400,006	100.0%
Annual Change (%)	–	–	2.1%	–	1.3%	–	3.1%	–

Table 7. Gloucestershire Hospitals Performance against a selected set of metrics compared to the national average 2013/14

Performance Measure	GHNHSFT	National Average
Accident and emergency: percentage of patients seen within 4 hours	93.8%	93.5%
Cancer percentages within 2 week wait for referral (excluding breast symptomatic)	93.9%	95.3%
Cancer patients within 31 Days from Diagnosis to First Treatment	99.7%	98.3%
Cancer patients within 62 Days to Treatment (excluding Rare Cancers)	81.0%	86.0%
< 1% 6 weeks from Request to Diagnostic Test	0.6%	1.3%
% admitted patients referral to treatment within 18 weeks	92.3%	90.5%
% non admitted patients referral to treatment within 18 weeks	97.3%	96.7%
Standardised Hospital Mortality Indicator (SHMI)	1.0458	1.0000
Rate of patient safety incidents per 100 admissions	5.66	6.99
Rate of patient safety incidents resulting in severe harm or death per 100 admissions	0.10	0.04
Rate of C diff per 100,000 bed days	20.6	17.3
Percentage of patients risk assessed for VTE	94.6%	95.4%
Percentage of patients (0 to 15) readmitted within 28 days of discharge	10.25%	9.28%
Percentage of patients (16 and over) readmitted within 28 days of discharge	11.45%	10.52%
Responsiveness to inpatient needs*	77.2	76.9
Friends and Family test net promoter score	70	64

* This is based on a national dataset collated from local patient surveys

relation to patient choice. Overall we are a net 'importer' of patient referrals and patient choice. This is in part a consequence of our role as the main provider of specialist cancer services for Gloucestershire, South Worcestershire and Herefordshire.

Key strengths include our positive reputation and strong clinical relationships across the healthcare community. Pathways are stable and major shifts are not anticipated. The opening of the Worcestershire Radiotherapy Unit will reduce the flow of patients from South Worcestershire for specialist cancer services, but this has been planned with Worcestershire Acute Trust and is already reflected in our activity assumptions.

There has been a small transfer of NHS choice activity to private providers, including elective orthopaedic activity. This change has not been all negative as it has helped the Trust meet some access targets.

1.6. Funding and activity analysis

Recent projections from the Nuffield Trust and NHS England suggest that, assuming the health budget remains protected in real terms and we continue with the current model of care, the national funding gap could grow to £30 billion by 2021. These trends in funding and demand will expose all providers to a very high level of financial risk. The impact of demographic change would mean that real age-adjusted per capita spending on the NHS would be 9.1 per cent lower in 2018/19 that in 2010/11.

Monitor, the NHS Trust Development Authority and NHS England share a view of the total affordability challenge facing the NHS over the next five years, as shown in the Table 10 below.

The increase in challenge from 2015/16 reflects changes in both the revaluation of public sector pension contributions and reforms to state pension along with the impact of the Better Care Fund. The impact of the pension changes are also reflected in the forecast increase on input cost inflation over the same period (this will be covered later in relation to the organisation's financial modelling assumptions underpinning the five year financial plan).

The analysis of market share has already identified our Trust accounts for 85% of the local available acute funding from NHS Gloucestershire, which represents in excess of 70% of total healthcare-related contract income for our Trust. NHS England published two year allocations for CCGs in December 2013 (2014/15 and 2015/16) based on a revised allocation formula which considered each CCG's position in relation to a 'fair share' allocation of national funding.

Allocations are based on 'distance from target' (DFT) positions but with a minimum guaranteed uplift of 2.14% for 2014/15 and 1.7% for 2015/16. NHS Gloucestershire are currently 'under target' by less than 3% and received the minimum guaranteed uplift for the two year allocation period. NHS England planning guidance (Everyone Counts: Planning for Patients 2014/15 to 2018/19, December 2013) published CCG planning growth assumptions for 2016/17 to 2018/19 and these are shown in Table 11 along with the first two-year allocations and the DFT position for NHS Gloucestershire and the assumed funding allocation levels over the total five year period.

Whilst the commissioning landscape has changed considerably over the last 15 months, the total quantum of trust healthcare-related contract income has

Table 10. NHS Affordability Challenge 2014/15–2018/19

	2014/15	2015/16	2016/17	2017/18	2018/19
Affordability challenge for the NHS as a % of current commissioning budgets	3.1%	6.6%	5.5%	4.7%	4.6%
Assumption on input cost inflation	2.6%	2.9%	4.4%	3.4%	3.3%

Table 11. NHS Gloucestershire: Income Growth Assumptions and DFT 2014/15 –2018/19

	2014/15	2015/16	2016/17	2017/18	2018/19
Income Growth Allocation/Uplift Assumptions	2.14%	1.7%	1.8%	1.7%	1.7%
CCG Budget Allocation	£667.52m	£678.87m	£691.09m	£702.84m	£714.79m
Distance from Target (DFT)	-2.5%	-2.78%	–	–	–

Table 12. NHS Gloucestershire CCG: five year plan assumptions 2014/15–2018/19

	2014/15	2015/16	2016/17	2017/18	2018/19
Headroom fund for non-recurrent costs including cost of change	2.5%	1%	1%	1%	1%
Surplus requirement	1%	1%	1%	1%	1%
Operational/Contingency reserve	1%	1%	1%	1%	1%
Provision for above assumptions (approximate)	£30.0m	£20.4m	£20.7m	£21.1m	£21.4m
Commissioner QIPP based on inclusion of the above assumptions and demographic and underlying growth	£18.0m	£21.0m	£17.0m	£15.0m	£15.0m

increased year on year by an average of 2.2% over the last three years; this gives some indication of the work undertaken by the Trust against assumed contract levels.

The NHS Gloucestershire CCG five year plan is based on the assumptions detailed in Table 12.

The local CCG has developed a plan which appropriately aligns with the NHS England planning guidance and includes (with the exception of 2015/16 where there is a marginal difference) provisions for headroom, surplus and contingency which exceed the level of commissioner QIPP requirement in each year. This provides potential non-

recurrent investment to support change and transformation whilst some flexibility against delivery of the QIPP assumptions.

Commissioning for specialised services is led locally by the Bristol, North Somerset, Somerset and South Gloucestershire local area team of NHS England which geographically covers the whole South West patch. Nationally, over the last year, specialised services have experienced annual growth in excess of 6% and to support the position for 2014/15, £400 million will be drawn down from prior years' surpluses.

Planning for specialised services is proving extremely challenging and at this stage, the generic expectation is that growth could range between 0%–2% over the five year plan period against the trusts current baseline contract in the region of £73 million. This is considered in the section under the risks to financial sustainability.

Next section: Risk to sustainability and strategic options 

2

Risk to sustainability and strategic options

Risk to sustainability and strategic options

2.1 Corporate risks to sustainability

We have considered the likely impact of these external challenges on each of our clinical services and the organisation as a whole. This review has engaged our Board, our Governors and our clinical teams. The section below sets out our analysis of the risks to our future clinical, operational and financial sustainability.

2.2 Clinical sustainability

2.2.1 Delivering consistent care 24 hours a day

Public expectation of services designed for customer convenience has resulted in routine seven day services in many industries – but not healthcare. This is a missed opportunity, because extending the service would improve clinical outcomes by providing consistent clinical care irrespective of the time of day, with the added benefit of providing a much more patient-focussed service.

To achieve this will require a significant change in working practices, including patterns and schedules of working, multidisciplinary team working with development of new clinical roles, and reviewing the configuration of services. The risks are the limited availability of the workforce in traditional roles (particularly doctors), the limited flexibility of the nationally negotiated employment contracts, and the resources required to meet the standards.

2.2.2 Retention of critical clinical services

We are fortunate that the scope and scale of our clinical services are sufficient to ensure that we can maintain the critical clinical linkages between services to deliver high quality care. In considering the likely implications of the Review of Urgent and Emergency Care we have made the assumption that there will be one Major Emergency Care Centre in Gloucestershire. To meet the standards required is likely to require further reconfiguration of our emergency care pathways and additional resource to secure the level of specialist care required. However, not securing Major Emergency Care Centre status would have a much more far reaching impact on the clinical sustainability of our services due to the loss of key clinical linkages. There are some clinical pathways where our catchment population is too small to generate sufficient activity to cost effectively maintain standards.

2.2.3 Choice for elective services

Increasingly people are being encouraged to exercise choice around their health care, particularly in relation to planned care. A number of our competitors focus entirely on planned care. This enables them to ensure that the pathways and facilities they provide are responsive to the needs of individuals. Our current practice means that the same clinical teams and facilities are utilized for both planned and emergency care. Peaks in our emergency activity are understandably given priority, often to the detriment of planned care.

2.3 Operational sustainability

2.3.1 Increasing demand

The demographic changes and the increasing likelihood of admission with increasing age, in the absence of radically different models of service delivery will result in an increasing demand for our services. Modelling suggests that this equates to an added pressure of approximately 113 urgent care beds (across acute and community) and 35 elective beds across our entire system over the next five years. At present commissioning plans acknowledge this but assume that the impact on the acute health sector will be mitigated by Quality, Improvement, Productivity and Prevention (QIPP) initiatives that will provide health services in settings in the community, close to and in people's homes, resulting in reduction in reliance on hospital based services.

The risks of this are:

- → Our collective ability with partners within the health system to develop these alternatives at a scale and pace which really impacts on demand is limited

- → If the QIPP schemes are successful then the income to our organisation reduces and we will need to ensure we proactively take out costs as activity diminishes to maintain financial balance

- → As these schemes are established it is likely that the case mix within our hospitals changes with those people admitted having more complex problems requiring longer stays in hospital. The costs of more complex treatment may not be fully recoverable through tariffs, increasing our financial risk.

2.3.2 Capacity and quality of the physical estate

We are currently utilising all of our available estate. Although we do have some empty ward areas these are nightingale wards where the quality of the patient experience is difficult to maintain. This risk will be compounded if we see an increase in demand for our services.

We have similar pressures on our theatre and outpatient capacity. Although we have made a significant commitment to improving the environment through our capital programme it will not deliver sufficient additional capacity to accommodate the increase in demands for our services if the shift to care closer to home is not realised.

2.3.3 Workforce availability

The demographic changes illustrated in section 1, mean that the population of working age adults is decreasing, resulting in the recruitment challenges we are now experiencing across a range of healthcare roles, but most significantly nursing. The shift in gender balance in the medical workforce brings with it an associated increase in part-time and flexible working.

Indefinite wage restraint is not sustainable. In a crowded employer market this will result in recruitment challenges across the wage bands of the NHS. The possible imposition of nurse staffing ratios will increase these challenges.

National medical workforce training strategies are shifting the emphasis towards more training in general practice, with a consequent reduction in the availability of doctors in training in hospital based specialties.

The nature of healthcare work is changing and the skills of the current workforce are not always well matched to future needs

2.3.4 Two site working

The fact that we operate from two main hospital sites presents both an opportunity and a challenge in moving forward. The two sites offer local access to the two largest centres of population in the county and engender a significant degree of local ownership. However providing services on two sites inevitably leads to duplication of services. The desire and the expectation to offer equitable services around the clock leads to a demand for increased numbers of health care workers with specialist skills which is either unaffordable or cannot be matched by the supply. This represents the most significant risk to our operational sustainability.

There is a clinical and managerial consensus that the quality and efficiency of our services would improve if we were able to concentrate all services requiring specialist, staff, facilities and equipment on a single site. We have considered both the Greenfield option of vacating both existing sites and building a new facility elsewhere and the Brownfield option of providing all services from one of the existing sites. Both options have been rejected on the basis that:

- → The cost of building a new hospital is unaffordable in both capital and revenue terms. (capital £600m: revenue £50m based on a PFI model)

- → The greater part of the current assets at Cheltenham and Gloucester (£191m of a total asset value of £228m) would in effect be written off

- → Concentration of all acute services in one place – whether Greenfield or Brownfield – would create major planning problems particularly in relation to public access and traffic management.

- → Neither of the existing sites are large enough to accommodate the current or predicted demand for services.

As a consequence we are committed to developing both existing sites with appropriate clinical specialisation on each. This commitment is reflected in a balanced portfolio of investment on both of the hospital sites, including a state of the art interventional radiology theatre to support the specialist vascular service at CGH, investment in a surgical robot to support the specialist urology service at CGH and refurbishment of the theatres on the CGH site..

2.4 Financial sustainability

2.4.1 Five year financial plan 2014/15 -2018/19

The financial plan covering the period 2014/15 – 2018/19 is shown in Table 13 overleaf.

We plan to achieve an operating surplus in each and every year, which ranges between 0.9% and 1.3% of total income and maintaining a minimum Continuity of Service (CoS) Risk Rating of 3. The plan is based on us maintaining financial strength in the support of clinical and operationally viable and sustainable services

The financial plan will generate cash to invest in the capital programme and clinical services whilst ensuring we do not move in to a deficit position or deteriorate our CoS Risk Rating. Improvements to the cash position through effective treasury management will also help in moving the organisation towards a CoS rating of 4.

The first two years 2014/15 and 2015/16 align with the two year operational plan submitted

to Monitor on 4 April 2014, the assumptions underpinning the three outer years (2016/17 – 2018/19) are summarised in Table 14.

The issue of alignment with commissioners is important and we are working actively within the local health economy to shape the future direction of health and social care provision. In constructing our plan, we have carefully considered both the track record and status of current thinking regarding commissioning intentions and delivering transformational change to inform our base assumptions; the following factors have informed our plan assumptions regarding change to activity related healthcare contract income:

- → Income has grown year on year and by an average of 2.2% per annum over the last three years
- → Gloucestershire CCG overall growth assumptions (demographic and underlying growth) range between 1.6% and 2.7% each year across the relevant service types (Outpatient, Daycase, Non Elective, Elective, etc) with the majority above 2.2%
- → Gloucestershire CCG QIPP impact assumptions range between 0.4% and 4% each year across the relevant service types, with the average around 2 – 2.5%
- → The specialised services commissioner expects net growth on contract income to range between 0% - 2% each year.

We have assumed an overall 'flat cash' contract scenario for the three years 2016/17 – 2018/19 i.e. growth of 1.5% offset by the tariff deflator of -1.5%. In effect, the growth assumption of 1.5% already assumes commissioner QIPP of around 0.7% based on the generic assumptions applied by the main commissioner, Gloucestershire CCG. Our assumption is at the bottom of the range expected by the specialised services commissioner.

In overall terms, the financial plan is based on a prudent set of reasonable assumptions.

2.4.2 Activity related healthcare income and risks

The main risk relating to healthcare contract income is commissioners achieving a greater level of QIPP than currently assumed within our plan assumptions. The 1.5% net growth currently assumed in the plan for the three outer years assumes inherent QIPP delivery of around 0.7% against the average main commissioner QIPP assumption; the downside scenario assumes a further 1% which is detailed below.

Our plan assumes continuation of the current emergency cap policy. Current activity exceeds the 2008/09 baseline with a financial impact (loss of income) approaching £5 million per year. This is a prudent assumption, but is an area subject to review with commissioners.

2.4.3 Cost improvement programme and risks to delivery

Over the last three financial years, we have delivered between £14.1 million and £18.3 million cost improvement per year. Whilst planned levels were higher, these were mitigated by increased levels of contract income and associated contribution which supported delivery of the surplus targets.

The increasing gap between funding for the

Table 13. Financial plan 2014/15–2018/19

	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000
Protected Clinical Income	403,856	411,933	411,933	411,933	411,933
Non Protected Clinical Income	5,661	5,774	5,890	6,007	6,128
Other Operating Income	53,830	53,720	54,794	55,891	57,008
Total Income	463,347	471,427	472,617	473,831	475,069
Pay Expenditure	(280,603)	(283,822)	(281,970)	(280,128)	(278,292)
Non Pay Expenditure	(151,970)	(153,521)	(156,037)	(158,613)	(161,254)
Total Expenditure	(432,573)	(437,343)	(438,007)	(438,741)	(439,546)
EBITDA	30,774	34,084	34,610	35,090	35,523
Depreciation	(15,524)	(16,828)	(17,501)	(18,201)	(18,929)
Other Financing Expenditure	(11,298)	(11,300)	(11,561)	(11,834)	(12,118)
Other Financing Income	48	48	48	48	48
Operating Surplus	4,000	6,004	5,596	5,103	4,524
Continuity of Service Risk Rating	3	3	3	3	3

Table 14. Financial plan assumptions 2014/15–2018/19

	2016/17 £000	2017/18 £000	2018/19 £000
Tariff Growth	**2.5%**	**2.5%**	**2.5%**
Efficiency Factor	**-4.0%**	**-4.0%**	**-4.0%**
Tariff Deflator	**-1.5%**	**-1.5%**	**-1.5%**
Clinical Activity Related Growth	**1.5%**	**1.5%**	**1.5%**
Operating Income	**2.0%**	**2.0%**	**2.0%**
Pay Inflation	**1.0%**	**1.0%**	**1.0%**
Drug Inflation	**5.0%**	**5.0%**	**5.0%**
Other Non-Pay Inflation	**2.5%**	**2.5%**	**2.5%**
Internal Cost Pressures	**1.5%**	**1.5%**	**1.5%**
Capital Charge Inflation	**4.0%**	**4.0%**	**4.0%**

health system and the rise in demand is making it increasingly difficult to sustain high levels of recurrent cost improvement without more radical change. Over the next five years, the trust has set ambitious cost improvement targets which are set out in Table 15.

The annual CIP targets have been set at higher levels in the first two years (2014/15 and 2015/16) to stretch the ambition to around 5.3% of the cost base. However, acknowledging the scale of this challenge, a contingency has been set aside which results in a net target of 4% which aligns with the three outer years (2016/17 – 2108/19) of the plan.

Over recent years, we have facilitated CIP delivery through a dedicated CIP Project Director and we are currently in the process of making a new appointment which gives an opportunity to review programme arrangements and ensure 'fitness for purpose' for the current and future years.

There is a very fine balance between reducing costs (often involving bed reductions) and dealing with growth, which is a very real challenge for the local health and social care economy, particularly in relation to the older population. Therefore, we are focused on reducing the internal cost base but are actively engaged in planning for the rise in the population and seeking community wide solutions based on the shared local vision.

Sensitivity has been modelled around 10% non-delivery of the CIP target each year which is considered in the following downside scenario and mitigation section below.

2.4.4 Downside scenario and mitigating factors

Table 15. Cost Improvement Targets 2014/15 – 2018/19

	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000
Annual target	23,500	23,100	17,500	17,500	17,600
Contingency	(6,300)	(4,900)	–	–	–
Annual Net Target	7,200	18,200	17,500	17,500	17,600

We have considered the potential range of issues which could present a financial risk and impact on the five year financial plan; whilst not exhaustive, this includes the following:

- → CIP programme – failure to deliver plan
- → Commissioner QIPP delivery exceeding current Trust plan assumptions
- → Reduction in tariff income through explicit policy or implied through funding changes (which do not fully cover costs e.g. pension changes)
- → Better Care Fund – funding and activity not aligned resulting in operational and financial consequences;
- → Impact of known national policy exceeding current investment provisions (e.g. seven day working and impact of Francis and Keogh) and new policy
- → Reduction in other income e.g. changes to education and training funding
- → Other inflationary and cost pressures
- → Transformational changes to care and service pathways impacting on income and cost base.

Many of the factors are either unknown or require greater clarity in order to model the impact with greater certainty (e.g. changes to care and service pathways), nevertheless, the following sensitivities have been modelled and considered prior to mitigating factors:

- → CIP – 10% delivery shortfall each and every year of the plan;
- → QIPP – additional 1% each and every year of the plan.

Table 16 provides a summary of the following for each year of the financial plan:

- → Operating Surplus/(Deficit) Base Case (Financial Plan);
- → Operating Surplus/(Deficit) with CIP Sensitivity;
- → Operating Surplus/(Deficit) with QIPP Sensitivity
- → Operating Surplus/(Deficit) with Combined Sensitivity.

In isolation, each sensitivity would result in an in year deficit from 2017/18 and the combined effect would move the Trust into deficit from 2015/16.

There are a number of actions/mitigating factors that we would consider against the downside scenario and indeed these will be progressed irrespective of the emergence of the outlined risks.

Table 17 shows the net impact of mitigating factors on the combined downside scenario and includes the financial plan base case figures.

The mitigated downside scenario shows an operating surplus over each year of the plan which grows then stabilises from 2016/17 onwards. This scenario could be considered prudent as the downside factors are modelled from 2014/15 (with agreed contracts) whereas the mitigations have been modelled based on realistic timescales for delivery which mainly start from 2015/16 and 2016/17.

Table 16. Financial Plan: Operating Surplus and Sensitivities

	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000
Operating Surplus/ (Deficit): Base Case	4,000	6,004	5,596	5,103	4,524
Operating Surplus/ (Deficit): CIP Sensitivity	2,280	2,429	279	(1,954)	(4,272)
Operating Surplus/ (Deficit): QIPP Sensitivity	2,405	2,810	824	(1,209)	(3,293)
Operating Surplus/ (Deficit): Combined Sensitivity	685	(765)	(4,473)	(8,217)	(12,000)

Table 17. Financial Plan: Operating Surplus with Mitigated Downside

	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000
Operating Surplus/ (Deficit): Base Case	4,000	6,004	5,596	5,103	4,524
Operating Surplus/ (Deficit): Combined Sensitivity	685	(765)	(4,473)	(8,217)	(12,000)
Operating Surplus/ (Deficit): Mitigated Downside	1,185	1,495	3,827	3,820	3,660

Note: Above excludes the impact of Exceptional Items

3

Strategic Plans

Strategic Plans

The risks set out in earlier sections present a considerable challenge but we believe that our size, the scope of our clinical services and our performance means that we should be well placed to be a sustainable organisation into the future.

In terms of our strategic direction we believe that the scale of our organisation will be stable over the period of the plan. The scope of our services will change as activity that can be delivered closer to home shifts to other settings, providing us with an opportunity to consolidate our existing specialist services and where appropriate develop others.

Our strategic plans bring together the initiatives that will enable us to mitigate the risks to our sustainability. These include:

- → Improving our internal efficiency
- → Continuing to align our services between our sites to ensure we can deliver consistent quality of care
- → Future proofing our services through clinical collaborations
- → Improving our physical estate
- → Harnessing the benefits of information technology to improve the quality of care
- → Exploiting the opportunities for new markets
- → Care Closer to Home
- → Developing Leadership across the system
- → Workforce redesign.

3.1 Improving our internal efficiency

Our financial sustainability is predicated on an ambitious cost improvement programme. The key workstreams of our Cost Improvement Programme include:

- → Reducing variation
- → Demand based bed allocation
- → Improving utilization of theatres, outpatients and diagnostics
- → Transport and logistics
- → Reducing duplication, including a review of space and site utilisation
- → Workforce review
- → Supplier engagement and procurement
- → Business development.

The outcome of these initiatives must be to deliver a reduction in length of stay firstly to reduce costs, but also to free up existing capacity to accommodate any growth in demand.

3.2 Continuing to align our services between our sites to ensure we can deliver consistent quality of care

The drive is to deliver services closer to people's homes, whenever it is safe and efficient to do so. This means that we will continue to look for opportunities to develop community services, either by delivering them in communities ourselves or supporting others to do so.

For those services that rely on very specialised staff or equipment it is not possible to replicate these in multiple locations and maintain the quality and safety of those services.

Both Gloucestershire Royal and Cheltenham General are vibrant general hospitals. The strategic intention of the organisation for the past 12 years has been to preserve for both hospitals an identity as the local acute hospital whilst implementing a programme of centralisation of the most specialised services. Figure 18 shows the current distribution of services between our sites.

All clinical teams are encouraged to continually review the sustainability of the services they deliver, taking into account the changing context in which they operate, and generating ideas for improvements in quality. A key influence on these discussions will be the outcome of the next stage of the national Urgent and Emergency Care Review.

If the Trust is to continue to operate on two sites and to maintain specialist services within its portfolio then it is inevitable that further reconfiguration of services will be required.

3.3 Future proofing our services through clinical collaborations

We will continue to work with partners beyond Gloucestershire to build on existing and developing clinical networks, to ensure that we are providing clinical services to a large enough population to maintain clinical competence and deliver high quality care that meets national standards consistently seven days a week. Our key partners for clinical collaborations are Wye Valley Trust, Great Western Hospital NHS Foundation Trust, North Bristol NHS Trust and University Hospitals Bristol NHS Foundation Trust.

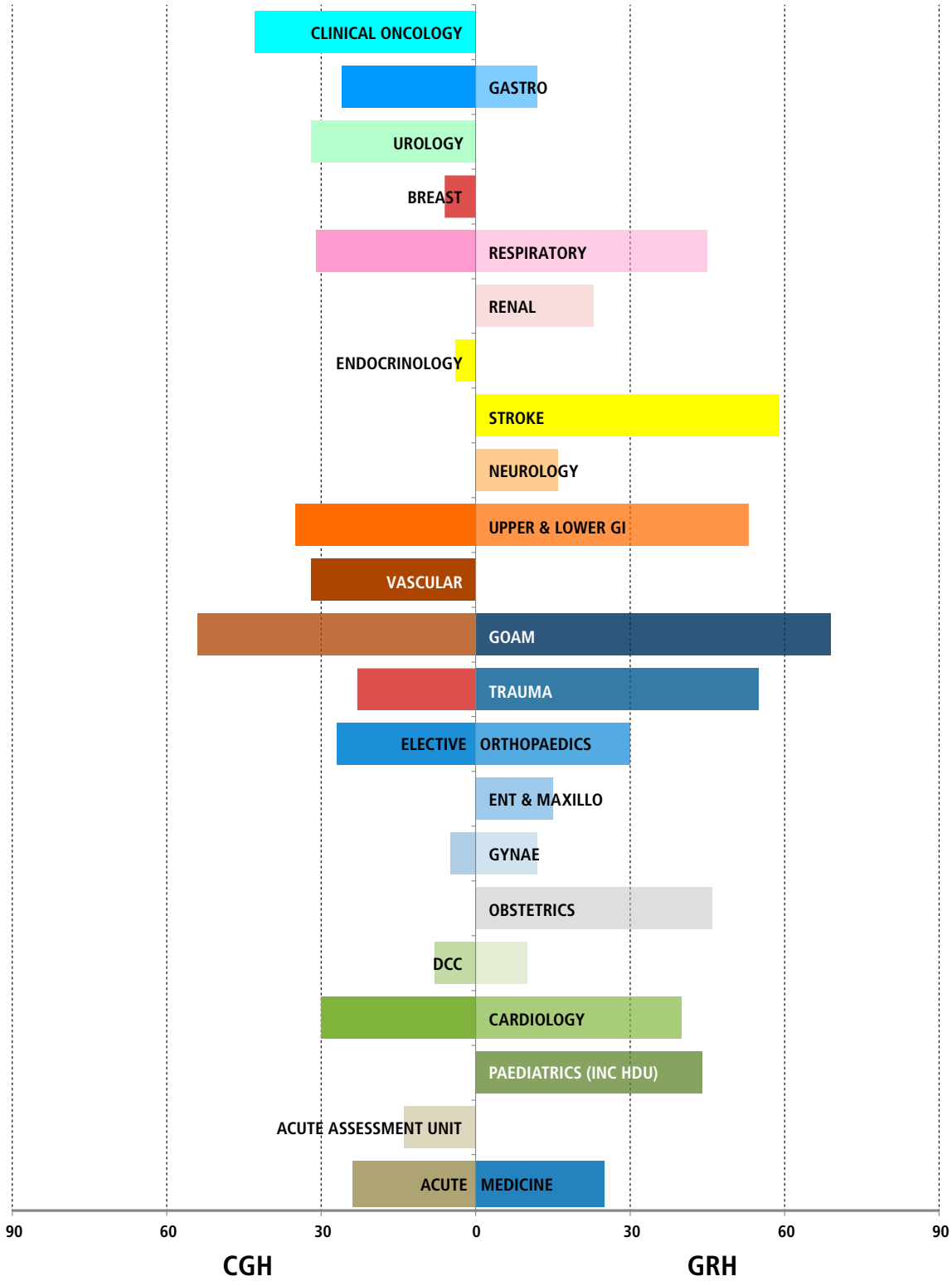
In developing these networks our intention would be to deliver services as close to peoples' homes as it is safe and efficient to do so. Our clinical networks with the two providers in Bristol will be primarily related to specialised services. In these networks, they are likely to be the lead provider subcontracting to us for elements of the patient pathway for Gloucestershire residents.

We will continue to develop the specialist aspects of our services, to ensure we maintain our compliance with the standards for those specialised services that we already provide but also to take on additional specialised services where it is appropriate and feasible to do so.

3.4 Improving our physical estate

The quality of some of our clinical environments on both of our sites, but primarily at Cheltenham General, is impacting on the sustainability of some of our services. Priorities for our capital programme over the next five years include investment to improve the environment initially at Cheltenham General and then Gloucestershire Royal.

Figure 18. Bed Allocation by specialty size of bar indicates bed allocation as at Feb 2014



Investments will enable us to match the quality of environments provided by other providers of elective care. We will also review the way in which we deliver these services to ensure they are responsive to the preferences of individuals for access in the evening and at weekends. We will seek to improve the reliability of our services, and reduce waiting times and cancellations, by providing dedicated facilities and teams for elective care.

We have worked with architects to help us generate plans to develop both of our sites. The total cost of these plans would be around £200m. Whilst this sum is clearly significant it is considerably less than the £600m required for a new hospital site. The plans also allow for a phased development of both sites which will enable us to begin to make progress with allocations from our capital programme.

The Trust is also considering options in relation to fundraising and commercial development activity which will support the overall level of investment funding.

3.5 Harnessing the benefits of information technology to improve the quality of care

Our Information and Technology Strategy aims to unlock the value of our information and unleash the power of technology to provide safe, effective, personalized care - every patient, every time, all the time. The strategy has six themes:

→ Digital care records

→ Lean care support

→ Digital patient services

→ A knowledgeable workforce

→ Valuing Information

→ Enabling technology.

Our most significant commitment in this area is to introduce a clinical information system. We have called this our "SmartCare Programme" in recognition of the transformational impact it will have on the quality of care we deliver. It will enable rapid communication of accurate information between staff and potentially with patients, it will reduce clinical risks and it will provide us with up to date information on the process and outcome of the care we deliver.

In order to reduce the costs of such a system we are working in partnership with two other hospitals who have similar requirements to us, Northern Devon Healthcare Trust and Yeovil NHSFT. We have just completed the procurement process and have selected TrakCare from Intersystems. The full business case for this programme includes a benefits realisation plan and the anticipated return on investment is reflected in our financial forecasts; cash releasing benefits in excess of £12 million are included over the life of this plan (benefits accrue over a longer period of eight years) in addition to significant non-cash releasing benefits

It is important to ensure that our technology platform is fit for the future. Our "technology blueprint" provides us with a three year plan to upgrade our technology. Resources to enable us to progress this are reflected in our capital programme.

Ensuring the right clinical information is available to health professionals at the point of care improves the quality of care

provided. We will continue to work with other health and social care organisations in Gloucestershire in the Interopeorability Project to enable the appropriate, timely sharing of information to support patient care.

3.6 Exploiting the opportunities for new markets

3.6.1 Private patient market

We are currently engaging with an external partner to review strategy and business in this area, which will also involve a review of policies and processes. This is a focused piece of work which will set a new direction for the Trust in this market and reverse the gradual decline in private patient income over the last three years.

3.6.2 Research and Innovation

Our research portfolio is already significant given the size and scope of our organization. In 2014/15 research income from a combination of support funding, grant income and income from commercial trials was nearly £3m. We will seek to ensure that all patients are given the opportunity to participate in appropriate available trials by expanding the portfolio of trials available and supporting the recruitment of patients into trials.

We will continue to explore the opportunities for commercialisation of novel innovations developed within the Trust for the benefits of patients and the wider NHS. To do this we will draw on support from NHS Innovations South West and the West of England Academic Health Science Network.

3.7 Care closer to home

The response to growing demand will need to include recognition, mobilisation and utilisation of individual and community assets, with health at the heart of local integrated planning and services.

We will continue to work with partners in the health community to transform pathways of care, to enhance the range of services that can safely be delivered in a community setting, preserving hospital based care for those pathways that are dependent on highly specialised equipment or teams. For these pathways to deliver the scale of change required to reduce the demand on hospital based services we are going to have to challenge some now outmoded assumptions about how best to support patients both in and out of hospital.

New ways of working will include:

- → Specialist hospital teams working with general practitioners to provide feedback on referral and reduce demand
- → Specialist teams working in settings outside hospitals in partnership with primary, community and social care, developing competence and capacity
- → Creation of clear clinical governance frameworks to support specialist care away from hospital sites.

The delivery of the QIPP programme across the health community is key to delivering this transformational shift in models of care. The Better Care Fund must be focused on facilitating this shift not just maintaining existing services in the community.

3.8 Developing leadership across the system

In order to redesign services, commissioners and providers across health, care and other preventative and public health services will need to forge strong, equal partnerships with each other. Health and wellbeing boards have an important role to play in the shared leadership that is needed and we will lobby for providers to be represented on our local Health and Wellbeing Board.

We will play our part in system-wide leadership, utilising common approaches to change management and project management to ensure we reap the benefits of "one system, one budget".

We are committed to clinical leadership and the development of Service Line management to ensure that decisions that impact on clinical services are informed by people delivering those services. We will continue to encourage our clinicians to participate in the commissioners Clinical Programme Approach, aimed at providing a transparent framework for defining the best clinical outcomes possible for the population, within the resources available and then commissioning services to deliver these outcomes.

3.9 Workforce redesign

We will develop our workforce plans, re-shaping the workforce where necessary, and ensuring that our future workforce is fit for purpose, and fully aligned to our future requirements.

3.9.1 Workforce reductions

A significant proportion of our expenditure is on pay. If we are to meet our challenging savings targets then we will need to reduce our pay as well as our non-pay expenditure.

Balancing the right number of substantive staff with agency staff, with a view to eliminating expensive agency deployment in all but unplanned situations is crucial. E-rostering will help to fully realise this benefit. In order to protect the quality of our clinical services we will not seek to reduce the number of staff delivering clinical care over the period of this plan. The area in which we expect to see our workforce reduce overall is non-clinical staff.

3.9.2 Proactive recruitment and retention

We will develop a more strategic and proactive approach to workforce planning to help us to predict and pre-empt problems with workforce supply, and to develop appropriate solutions in advance, as opposed to responding to crises.

We have a significant programme of work in place looking at future medical workforce supply in response to the requirements for seven day working and the shift in emphasis for doctors in training to spend a greater proportion of their time in community settings. We will need to increase the number of advanced nurse practitioners and explore the role of associate physicians within our workforce to address this challenge.

This more proactive approach is particularly crucial in the context of our nursing workforce. We have developed a comprehensive nurse recruitment strategy which moves us from being responsive and ad-hoc in our approach

to nurse recruitment, to being forward-looking and anticipatory in bringing nursing talent into the Trust on an ongoing basis.

This strategy will enable us to attract and recruit a range of nurses both overseas and from within the UK; newly qualified and experienced. This approach should enable us to reduce spend on temporary staffing through having a more sustainable substantive workforce supply.

We will establish a joint working party with Staff Side colleagues to look at the issues of recruitment and retention across a range of staff groups.

We will develop a Reward Strategy which focuses on the totality of the employment package and will be testing whether this is "fit for purpose" on a regular basis with both joiners and leavers.

We are committed to supporting the employment and training of young people, and as a result of this are developing an apprenticeship strategy setting out our goals in terms of apprenticeship placements within our Trust.

We are already employing a significant number of apprentices as Health Care Assistants; in coming years we will be seeking to supplement this with apprentice posts in a wide range of clinical and non-clinical areas.

4

Approach to monitoring the plan and risk assessment

Approach to monitoring the plan and risk assessment

Our approach to monitoring the initiatives and the level of risk to delivering these initiatives in the plan is set out below.

Initiative	Risk level	Monitoring
Improving our internal efficiency	High	Efficiency and Service Improvement Board Finance and Performance Committee Main Board
Continuing to align our services between our sites to ensure we can deliver consistent quality of care	High	Divisional Boards The Futures Group Main Board
Future proofing our services through clinical collaborations	Medium	Divisional Boards The Futures Group Main Board
Improving our physical estate	High	Divisional Boards The Futures Group Finance and Performance Committee Main Board
Harnessing the benefits of information technology to improve the quality of care	Low	Information Management and Technology Board Smartcare Programme Board Main Board
Exploiting the opportunities for new markets.	Low	Business Development Group Research and innovation Forum Innovation Panel Main Board
Care Closer to Home	High	Unscheduled Care Board Planned Care Board Finance and Performance Committee Main Board
Developing Leadership across the system	low	Workforce Review Group Main Board
Workforce redesign	Medium	Workforce Review Board Main Board

5

Conclusion and declaration of sustainability

Conclusion and declaration of sustainability

This plan has set out a comprehensive summary of our strategy to meet our vision.

It sets out the case that the context in which we are operating is becoming increasingly challenging as a consequence of:

- changes in the populaton which we serve which will increase the demand for health and social care servcies overall
- national policy directives, quite rightly aimed at improving the quality, consistency and accessibility of our services
- rising patient expectations
- trends in funding and demand which expose all providers to a very high level of financial risk.

It argues that we are reasonably well placed to rise to these challenges as:

- the size of population we serve and the range and scope of clinical services we offer provides us with a solid foundation to maintain key clinical services
- our performance is comparable to the national average across a broad range of indicators
- our positioning as the only major provider of acute care in Gloucestershire means we have little competition for our emergency services.

However, we have identified the following risks to our sustainability:

Clinical:

- the challenges of delivering consistent care 24 hours a day
- our ability to retain some of our clinical services where the catchment population is too small to generate sufficient activity to maintain standards or if the outcome of the Urgent and Emergency Care Review does not support a Major Emergency Centre in Gloucestershire
- our ability to remain a provider of choice for elective services.

Operational:

- managing increasing demand within our existing capacity
- the quality of our estate
- the availability of skilled and motivated workforce
- the challenges of operating from two sites.

Financial:

- the expectation of delivering a 4% cost improvement programme each year over the period of the plan
- the expectations of commissioners to achieve 2-2.5% savings each year from Quality Improvement, Productivity and Prevention initiatives.

We have identified a number of critical schemes upon which we will rely to ensure the sustainability of our services. Thes include:

- → improving our internal efficiency
- → continuing to align our services between our sites to ensure we can deliver consistent quality of care
- → future proofing our services through clinical collaborations
- → improving our physical estate
- → harnessing the benefits of information technology to improve quality of care
- → exploiting the opportunities for new markets
- → care closer to home
- → developing leadership across the system
- → workforce redesign

If these are achieved then Gloucestershire Hospitals NHS Foundation Trust should be sustainable over the period of the plan. However there is a high level of risk associated with the delivery of the plan which poses a significant threat to our sustainability overall and our financial sustainability beyond year three of the plan.

6

Glossary

Better Care Fund	Fund to support transformation and integration of health and social care
COS	Continuity of Service
CCG	Clinical Commissioning Group
CGH	Cheltenham General Hospital
CIP	Cost Improvement Programme
Commissioners	From April 1, 2013, our commissioners became the Gloucestershire Clinical Commissioning Group. Commissioning is the process of assessing the needs of a local population and putting in place services to meet those needs. Commissioners are those who do this and who agree service level agreements with service providers for a range of services.
Governors	Members can become more involved by standing for election as a governor and representing their fellow members' views on the Council of Governors. Governors play an important role in the governance of the Trust. They represent the views of patients, carers and patients.
GHNHSFT	Gloucestershire Hospitals NHS Foundation Trust
GRH	Gloucestershire Royal Hospital
Major Emergency Care Centres	Large units capable of assessing and initiating treatment for all patients and providing a range of highly specialist services
Nightingale Ward	One large ward without sub-divisions
QIPP	Quality, Innovation, Productivity and Prevention approach to making the NHS more efficient
Waterlow Scoring System	The Waterlow score (or Waterlow scale) gives an estimated risk for the development of a pressure sore in a given patient. The tool was developed in 1985 by clinical nurse teacher Judy Waterlow.

Our Strategic Plan forms part of a larger range of Trust documents for 2013/14.

To read any of these documents visit www.gloshospitals.nhs.uk