



Strategic Plan Document for 2013-14

Hampshire Hospitals NHS Foundation Trust

Strategic Plan for y/e 31 March 2014 (and 2015, 2016)

This document completed by (and Monitor queries to be directed to):

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The attached Strategic Plan is intended to reflect the Trust's business plan over the next three years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

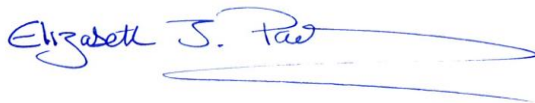
In signing below, the Trust is confirming that:

- The Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;
- The Strategic Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;
- The Strategic Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans;
- All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission.

Approved on behalf of the Board of Directors by:

Name (Chair)	Elizabeth Padmore
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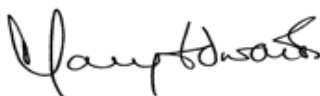
Signature



Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Mary Edwards
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Signature



Approved on behalf of the Board of Directors by:

Name (Finance Director)	David French
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Signature



Strategic Plan for Hampshire Hospitals NHS Foundation Trust (HHFT)

1. Executive Summary and Key Messages

- Clinically led integration of services across the Basingstoke and Winchester sites continues as a priority.
- Future anticipated workforce and clinical sustainability issues have driven a strategic review of the HHFT clinical model which has recommended a reconfiguration of the existing DGH sites and the construction of a new critical treatment hospital. A full business case is under development.
- Excluding impairments and restructuring costs, the FT delivered a surplus in 2012/13 of £4.9m and FRR '4', with a closing cash balance of £36m.
- The FT experienced a challenging winter period causing failures to achieve A&E waiting time targets and impacting RTT waiting times for admitted patients. A&E attendances are significantly higher than the same period last year and this is placing considerable strain on staff and resources.
- Legacy under-funding issues inherited by the emerging CCGs from Hampshire PCT have not been addressed during the budget allocation process for 2013/14. One of the lead local commissioners has affordability issues with current activity levels and has gained approval to draw-down its contingencies at the start of the year. It has ambitious and challenging QIPP schemes to address its financial position which is unlikely to be fully realised.
- Non-reimbursement of activity over-performance on commissioner contracts has historically been absorbed by the FT, but increasing financial pressure is reducing headroom to continue to do this. Clinical engagement in demand management schemes is helping to ensure activity levels more closely match reimbursement.
- The volume of activity being performed above the non-elective threshold at a marginal rate of 30% is increasing and becoming unsustainable from both a financial and capacity perspective
- Significant additional expenditure budget has been allocated to fund increased staffing levels throughout the planning period.
- Significant capital investments to improve patient care, reduce operational expenditure and increase the diversification of income streams are planned or have already been started. These projects will be funded through a combination of utilising the existing surplus cash balance generated by the FT and external loan funding from the FTFF.
- Prudent assumptions regarding the continuation of tariff deflation and CCG affordability concerns mean sustained, increasing financial pressure. The FT anticipates deteriorations in forecast surplus, cash generation and FRR from '4' to '3'.

2. Vision and strategic objectives

HHFT provides a full range of acute services to our local communities and in addition provides a range of specialist/tertiary services. These include specialist, tertiary treatment for specific cancers including pseudomyxoma peritonei (a rare abdominal cancer), colorectal cancer and secondary liver cancer. We also provide a regional haemophilia service which supports patients with this treatable but incurable genetic disease from diagnosis onwards, focused on preventing complications and hospital admissions.

The vision set out by the Board of Directors is:

“We wish to be the focus for healthcare in Hampshire with an excellent reputation for patient care. To achieve this we recognise the need to be an organisation that is innovative and collaborative, working tirelessly to provide outstanding care and treatment to all of our patients.”

The strategic objectives which underpin this vision are:

- Sustaining excellence: provide high quality, readily accessible services delivered by the best quality staff.
- Strategic improvement: provide flexible, modern facilities for our patients and staff.
- Strategic improvement: improve financial performance in order to fund better facilities and services.
- Strategic improvement: exploit technology in order to transform our services and make us more efficient.

3. Demographic and Market Trends

In 2011, the population of Hampshire was estimated to be 1.759 million. This figure includes Southampton and Portsmouth and is a mixture of urban and rural areas. The population of Hampshire is predicted to rise by approximately 2.3% by 2017. This is taken from the government comparison of 2011 census and the Small Area Population Forecast (SAPF) for Hampshire. The overall future population growth for Hampshire is lower than the South Central Strategic Health Authority and England averages. South Central SHA's overall future population growth average is similar to the England average. This is in line with the expected population growth in the Winchester area but the Basingstoke and Andover areas are facing much higher growth rates of 5% and 8.8% respectively.

While growth in the overall Hampshire population is lower than overall England and NHS South of England averages, the age category with greatest growth (65+) creates both opportunities and threats for HHFT; care of the elderly is an HHFT strength, but demand management of non-elective episodes for older people is essential to reducing costs. Life expectancy in Hampshire is also increasing when compared to the national trend and the HHFT catchment areas have a higher life expectancy in comparison to other areas. Along with dementia, fractured neck of femur and stroke, other diseases associated with the elderly population such as bronchitis and other long-term conditions are likely to be higher. The main causes of death in Hampshire are cardiovascular disease (coronary heart disease and stroke) and cancer, which together are responsible for 55% of all deaths.

The approximate population served by HHFT (based on the 2010 population predictions of electoral wards contained in the current constitution) is 587,000. The majority of HHFT's patients live in areas served by North Hampshire and West Hampshire CCGs and hence these CCGs, together with Local Area Team Specialist Commissioning, fund the majority of clinical income. In addition, HHFT has

lower value contracts with the CCGs of North East Hampshire, West Berkshire, and Fareham and Gosport.

GP referral rates and market shares have remained stable since acquisition. Although market share in the south of our catchment area (Winchester and Eastleigh, covered by West Hampshire CCG) is stable, this has remained a concern since the acquisition as the potential loss of business to competitors in the south is a real risk if the preservation or development of local services for that population is not addressed. The risk of losing the Eastleigh population to competitors in the south means that maintaining an appropriate complement of services on the Winchester site is essential. Eastleigh is a particular risk as real choice exists for that population to choose another provider should there be any perception of a loss of services at Winchester.

In addition, the likely future demand of a rapidly growing population in Basingstoke and Andover must also be addressed through careful service planning. The sharp increase in those aged over 65, and in particular those aged 85 and over, across most of HHFT's catchment area add an additional factor to how HHFT should plan services in the future. This also gives further credence to the vision that care should be delivered even closer to home in the medium to longer-term.

Preserving local services and delivering care closer to home are key parts of the vision for HHFT. As such, a purely 'hot and cold' site arrangement between Winchester and Basingstoke hospitals is not a feasible option.

4. Local commissioning arrangements

There was disappointment amongst the local CCGs that the historically poor funding settlement legacy from Hampshire PCT was not addressed in funding allocations for 13/14. In particular, North Hampshire CCG is financially challenged and has been in discussions with NHS England seeking approval to commit its budget contingencies upfront. West Hampshire CCG appears to be less challenged and has agreed a PbR contract with HHFT for 13/14. North Hampshire CCG have also agreed a PbR contract in principle but have made it clear that they have affordability concerns which will impact their ability to pay for above-plan activity levels.

Historically, HHFT has operated commissioning contracts on either a block or 'collar and cap' basis. Our experience has been that these contracts have over-heated, due mainly to ambitious QIPP schemes not delivering in line with expectations and resulting in activity not being reimbursed.

Continued tariff deflation increasing the financial pressure on HHFT, combined with affordability issues in the local health economy, means that QIPP and demand management schemes are increasingly important in 13/14 and beyond. Our senior consultants are particularly focusing on non-elective admissions and orthopaedic surgery volumes. As well as financial benefits from reducing activity paid at 30% tariff, or not at all, delivery on these QIPP objectives will bring benefits to RTT achievement and medical bed pressures, particularly over the winter period.

Financial pressure means that local commissioners are keen to achieve price savings by tendering clinical services which have previously been provided by HHFT. We actively participate in tenders where we wish to retain services but have been under pressure from CCGs to offer staff and facilities to other providers should HHFT not win the tender. We continue to resist this pressure to prevent private sector providers from cherry-picking services without the associated risks of owning facilities and employing staff. In 13/14, we expect to participate in tenders for GP 'direct access' pathology and paediatric therapies.

5. Income Sources

Clinical income from core DGH services to local commissioners represents the majority of HHFT's total

income. Reduced margins and local health economy financial pressures are a threat to this income source which has led to the FT's initiatives to diversify income.

We are mid-construction of a new private patient (PP) centre on the Basingstoke site including an out-patient consulting facility, dedicated theatre capacity and an 22 bed ward. The removal of private patient income restrictions, together with strong engagement from the consultant body, has been helpful in the preparation of the case and our confidence in it. We anticipate construction to complete by June 2013 with financial benefits generated from year 2013/14 onwards.

The FT has also focused on developing services funded by specialist commissioning such as haemophilia where HHFT now coordinates the regional network. We are investing capital funding in a new radiotherapy centre opening in Q4 13/14 on the Basingstoke site so that patients can be treated locally rather than travel daily to Southampton. In addition, HHFT is one of only two centres in the UK which treat the rare cancer, pseudomyxoma peritonei, as well as secondary peritoneal carcinomatosis. As awareness of our success in treating these has increased, we have seen more referrals and treatments being performed.

HHFT's new size and geographic area means that it is in a position to deliver services previously performed at neighbouring or tertiary centres. We have introduced a new service for complex pacemakers and defibrillators which we expect to be a helpful source of income and margin for the future.

Finally, where neighbouring CCGs are less financially challenged we see opportunities for new business on our geographic borders with West Berkshire and Wiltshire. We have assigned a director level individual to focus on developing additional income streams from these CCGs, specialist commissioning and other commercial sources.

6. Clinical strategy and the future clinical model

The acquisition of Winchester and Eastleigh Healthcare NHS Trust in 2012 was driven by concerns about the future clinical sustainability of mid-sized DGHs, in particular whether the population served by the former Basingstoke and North Hampshire NHS FT was sufficient to maintain acute services and the associated clinical workforce.

Since acquisition, the Board has continued to assess the future clinical strategy and has concluded that the preferred option is to reconfigure the two existing DGH sites from around 450 beds to 300 beds each and centralise acute services in a new build facility. A business case for this project is currently under development. This APR submission includes the anticipated project management costs and fees associated with the preparation of this business case, but do not include any capital expenditure for construction and reconfiguration as these figures have not been finalised. The FT will engage with Monitor over the coming months as the business case is finalised and future plans mature.

HHFT's proposed new clinical model is based firmly upon improving quality and safety whilst delivering equitable and accessible care for our population. The clinical model includes some centralisation but this is balanced by delivering care close to home where possible. There is substantial national and international evidence and strategy supporting all three facets of this model.

a. Clinical sustainability and development

It is now well established that, with certain specialist procedures or operations, concentrating activity in one place rather than doing a small number in many places can lead to better outcomes. This is the reasoning behind the centralisation of major trauma, stroke, heart attacks and paediatric cardiac surgery throughout the country. The centralisation of critical treatment is well recognised by the Royal

College of Surgeons and other colleges.

It is also well recognised that, due to changes in medical education pathways, trainee doctors are less experienced. This, together with other evidence, strongly suggests that care is best delivered by consultants and specialists. Recent papers by the NHS Confederation and many of the Royal Colleges emphasise these points.

Care closer to home is also important. Again, there are good models of this care both in this country and abroad. This model is recognised as a major priority by the Department of Health as a solution to the changing demographics nationally. It is also supported by the Clinical Commissioning Groups (CCGs).

In HHFT we provide a range of services: specialised, acute, elective and chronic disease management. The new clinical model has been developed to re-provide these services with the following key principles:

- 1 Providing secondary care at the core
- 2 Improving quality of care
- 3 Being independently viable (sustainable) into the future
- 4 Remaining NHS but not being constrained by its traditions
- 5 Delivering one service however many sites
- 6 Being local where possible, central where necessary

Taking into account the above evidence and drivers, abiding by these six principles and following extensive and detailed feasibility modelling and clinical discussion has led to the decision that building a central Critical Treatment Hospital (CTH) for our sickest patients would be the best option. The preferred option is for any necessary centralization to be on a new site which allows good access for patients in all geographical areas currently served by HHFT. The remainder of our care would be delivered from our general hospitals in Basingstoke and Winchester, the community hospital in Andover or from other local healthcare facilities.

Other options were considered including centralising on the present Winchester or Basingstoke site. To support the analysis of these options, work was carried out in the following areas to develop, inform and gauge support for the clinical model:

- Medical leads and specialty teams reviewed in detail where they provided their care at present, to whom it is provided, and what staff and facilities they have available. They then developed a detailed plan as to where the services should be provided in the new model.
- The local ambulance service was consulted for opinion and advice. Data were reviewed regarding response times, location and clustering of calls, and the feasibility of detailed clinical triage. The possibility of co-locating an ambulance centre on the CTH site has been explored.
- Work with specialist hospital architects developed examples of hospital builds which reflect the proposed clinical model for the CTH
- Multiple meetings with local GPs in all catchment areas were carried out by senior medical staff.
- Local CCG leaders and Boards were engaged

- The model has been shared with the Local Authorities and the Health Overview and Scrutiny Committee.
- Presentations of the model were made at local public meetings.

Only patients with serious conditions requiring urgent care will be taken to the critical treatment hospital, and will be transferred to their nearest general hospital or discharged home once their condition is improving. A new state-of-the-art cancer centre will be on the same site and will provide essential radiotherapy services to residents in north Hampshire, alongside other therapies, including complementary therapies.

The two general hospitals in Basingstoke and Winchester will continue to run outpatient clinics, and to be where the vast majority of elderly care, rehabilitation and elective surgery take place, particularly day-case and short stay procedures. Patients who are unwell and require time in hospital to be assessed and stabilised are likely to be treated on these sites. Women and children will be able to access facilities locally and in our general hospitals but may choose to go to the central site for their care, where our obstetric-led maternity service and in-patient paediatric service will be located.

The reprovion of care as detailed in this clinical model will allow HHFT to reconfigure its services in a novel and exciting way that follows best practice and is equitable to its population. It offers us the opportunity to be at the forefront of clinical practice in the UK.

b. Workforce sustainability

In common with all acute hospitals, HHFT faces a number of challenges in the changing nature of its medical workforce:

- Reduction in availability and available service commitment in all training grades
- Increasing specialisation of the consultant workforce
- Need for 24/7 cover of clinical specialities
- Increasing consultant delivered care

The clinical strategy aims to reduce service dependency on doctors in training and to centralise the provision of rotas that require 24/7 specialist consultant availability.

Our workforce must change to accommodate medical training changes, seven day working and national standards regardless of an additional site. The new site offers a more innovative opportunity to organise our services and the staff supporting them differently. Opportunities include: efficiencies in providing more complex, urgent work in one place; efficiencies around deployment of scheduled/unscheduled workforce skills on general sites; development of a generalist medical role; new and extended roles for non-medical staff; recruitment/retention opportunities.

Details of the workforce model will become clearer as the service areas have thoroughly considered the opportunities the clinical model presents and the improvements they can make to their services and how they are delivered. A workforce plan and skills analysis is in development to identify early training needs and any piloting schemes that are required in advance of the CTH being built.

c. Financial sustainability

The current projections for secondary care income suggest increasing downward pressure year on

year. Controlling costs and improving efficiencies continue to be required in all areas of the Foundation Trust's operations. Running the two district general hospital estates in their current states may become unaffordable. Consolidating services where appropriate allows economies of scale and more significant service redesign opportunities to improve efficiencies.

The organisation will continue to need to achieve efficiencies over the coming years, but there are some opportunities provided by the future clinical model that provide additional opportunities for efficiencies. These include: increased theatre productivity through cohorting and single emergency/overnight theatre provision; single rotas for 24/7 activities co-located on central site; improved length of stay due to rapid consultant-led assessment, diagnosis and treatment of sickest patients; controlled bed capacity against rising activity pressures due to cohorted patient management models; reduced duplication in centralised services; energy efficiency benefits of new site and estate management efficiencies by optimised use of assets on existing sites.

The clinical strategy continues to be evolved and developed by clinical leads across the organisation and the wider system, including governance and risk analysis and benefits realisation proposals.

7. Approach to Quality

HHFT is focused on improving quality and safety that is patient centred. HHFT has a single integrated approach to the governance of clinical quality, performance and finance. This is widely visible across the organisation and is a fundamental aspect of organisational structure. Accountability for all three elements lies with the Divisional Medical Directors (senior consultants) who are supported by Divisional Operations Directors.

Clinical quality is not reported separately from the other aspects of performance but is reviewed alongside them; as such, quality governance is inherent in the day to day running of the organisation. This approach ensures that all aspects of governance and management are given the same weight and are discussed, reviewed and improved on a daily basis.

There are recognised challenges to this approach. For example groups that operate across divisions on trust-wide themes such as safety or experience need clear mechanisms of accountability and engagement with processes to ensure specific trust-wide actions as appropriate. There is therefore a dedicated corporate governance team led by senior clinical staff with full time non-clinical managerial support and leadership. The Chief Medical Officer is executive lead for this function and for trustwide clinical quality. There are specific trust wide groups reporting directly to the Executive Committee through to the Board. These include Patient Safety, Clinical Effectiveness, Patient Experience, and an integrated approach to risk management. This approach is also supported by the Clinical Quality and Safety Committee where trust-wide quality and clinical governance initiatives are reviewed, monitored and analysed in detail to provide additional assurance. The membership of this group includes executive and non-executive directors.

HHFT is located on three main sites (Basingstoke, Winchester and Andover) and this split in geography means that there is potential for additional risks to occur in areas that might be affected by the move of staff between sites. In response to this challenge, links have been established with the clinical divisions through their Governance Leads and the Associate Medical Directors for Governance each attend a Divisional Governance Board.

The three separate sites also present challenges in interpreting data, as the organisation must be assured that good performance at one site is not masking less good performance at another with the

overall numbers for the organisation equalling out. Data reviewed at the Board therefore includes data by site, as well as trust-wide.

The monthly review of governance performed by the Board of Directors includes detailed analysis of SIRIs, patient complaints and thank-you letters, scores and feedback from NHS Choices and Friends & Family. As with clinical metrics, analysis is presented by clinical division and by hospital site .

Specific Quality sub-strategies have been identified to address specific challenges identified. These include:

- **A clear vision and expectation of quality governance:** There is visibility of those charged with delivering the governance agenda including robust clinical champions and quality champions at each site
- **A clear governance reporting structure:** this effectively articulates the systems and processes in place for quality governance
- **Clear identification of the strategy and priorities:** developed in the divisions, integrated by the Governance team and approved by the Board
- **Visibility:** Ensure visibility of executives and the governance team in all areas and sites
- **Feedback:** Those involved in providing information for quality and performance management are kept informed of feedback
- **Senior staffing:** senior staff are responsible for promoting a culture of clinical quality being of equal importance to performance and finance.
- **Involvement:** patients, Governors and staff are all involved in developing priorities for quality improvement
- **Improved data quality:** Assessment of the success of the quality strategy requires an accurate understanding of the quality of data available to HHFT; this is a high corporate priority.

a. CQC Visit January 2013

A Trust action plan has been developed in response to the findings of the CQC unannounced visit to the Royal Hampshire County Hospital (Winchester) site in Jan 2013 which triggered a minor concern around staffing. The action plan incorporates actions associated with staffing and other comments in the report, for example inconsistent infection control information displayed across the hospital sites. Recruitment of additional nursing staff has been initiated and funding for these posts has been included in expenditure budgets for 2013/14. The Associate Director of Governance has met with action owners to determine the progress of the actions and the overall action plan is reviewed monthly and progress reported at the Executive Committee.

8. Productivity and Efficiency

CIP performance in year 2012/13 was driven by realising the synergies from acquisition. The back-office functions of HR, Finance, Procurement, IT, Governance, Legal and Communications were integrated soon after acquisition with aligned management processes and systems. This led to expenditure savings of £3.5m per year and a headcount reduction of 100 WTE. Over the second half of the year, CIP delivery was hindered by significant over-performance on commissioner contracts combined with a challenging winter period which required additional medical beds to be opened which in turn reduced surgical bed capacity causing deterioration in productivity measures such as theatre utilisation.

The winter months of 2012/13 were challenging for the entire organisation with intense pressure on short-term bed management and compliance targets such as ED 4 hours and RTT diverting resources

from longer-term strategic objectives including CIP delivery.

Having stabilised operational activities following the acquisition, clinically led integration of services is continuing, albeit at different speeds in different specialties, and this integration is a driver of increased productivity and efficiency for 2013/14 and beyond. Data showing discrepancies of performance between HHFT sites, clinical specialties and individual clinical practice has been flagged to divisional leadership and the Associate Medical Directors and this forms a significant part of the CIP programme for 2013/14. In years 2014/15 and 2015/16, the clinical teams have been challenged to improve performance so that HHFT is a top-quartile Trust for length of stay, non-elective admissions etc.

The FT has recruited a senior director to lead the procurement function through a step-change in performance. The Executive Committee have also approved the recruitment of two additional procurement managers to increase both the capacity and capability of the team. In order to increase control on non-pay expenditure, purchase orders are mandated and a policy of non-payment of invoices received without a PO number has been introduced. A programme of clinical engagement has been successful in aligning the behaviour of the organisation with its corporate procurement objectives. In trauma and orthopaedics, for example, the Clinical Director has engaged his consultant colleagues to agree to use a single supplier of orthopaedic prosthesis. This is allowing the procurement team to tender a volume commitment to the market which has responded with significantly lower prices. We are working with like-minded Trusts to combine volumes of these high cost items to leverage further price reductions.

The FT is nearing completion of its programme to integrate clinical IT systems across the two legacy organisations. Selection of a single PACS/RIS supplier will result in cost savings of £0.5m in 13/14. In-house development of an electronic patient record (ePR) is ongoing and will facilitate the decommissioning of Cerner Millennium at Winchester and the PAS system at Basingstoke, resulting in licensing savings in 2014/15.

Capital expenditure in 13/14 and 14/15 is earmarked for the development of a single pathology hub to replace the current duplication of pathology services on both sites. This is a £6.5m capital investment which will drive major expenditure savings in 14/15 through reduced staffing savings and process efficiencies.

Capital funding in 14/15 is also reserved for a programme to create efficiencies in pharmacy, either through a centralised pharmacy hub or by introducing automation innovations such as pick/pack robotics.

a. CIP enablers and governance

The identification and development of CIPs in the divisions has been a combination of central guidance and locally defined initiatives, for example, how pathology services across the three sites should be reconfigured.

Where organisation-wide cost saving opportunities exist, for example procurement, they have been identified by the relevant functional area, scoped in conjunction with the clinical divisions and captured in the relevant expenditure budget.

Clinical divisions and corporate support functions were each given a 'control target' for 13/14 expenditure based on out-turn expenditure for the prior year. This out-turn expenditure was normalised to capture part-year effects and exclude non-recurrent events. CIP schemes were prepared by each division and function to achieve this control target and these plans were then

reviewed by a Committee including the Chief Nursing Officer, Chief Medical Officer and the Divisional Medical Directors of each clinical division. This review was to assess the achievability and quality impact of each scheme. Several schemes were rejected following this review. Divisional control targets were amended to ensure that the accepted CIP schemes were equitable and realistic, with accountability for delivery owned at a divisional level. In light of the importance of staffing levels, vacancy factor assumptions and non-allocated CIP requirements were reduced and centrally held planning contingency was released to fund this. Our assessment is that no CIP schemes included in this submission are detrimental to patient safety or clinical quality.

As a clinically led organisation, the clinical divisions are all led by a senior consultant, supported by an Operations Director and Clinical Directors (also senior consultants) for each specialty. Clinical divisions have responsibility for the delivery of all quality (patient safety and experience), performance (achievement of Monitor, CQC and contractual targets) and finance (income and expenditure at least in line with Plan) objectives. Quality, performance and finance are described internally as the three-legged stool, acknowledging that all three areas are equally essential for the ongoing sustainability of the organisation. Monthly reviews within divisions, at Divisional Performance Reviews, Executive Committee and Trust Board are all conducted on this basis allowing for discussion of CIP schemes and finance within the context of clinical performance and quality, and vice versa.

Each CIP scheme has a named owner with agreed savings phased over the planning period. Ownership for CIP delivery rests with the divisional or functional area as part of the finance element of the three-legged stool described above.

The Commercial Manager provides a consolidated, trust-wide monthly overview of performance to scheme owners, divisional boards, the Executive Committee and ultimately the Trust Board to track progress so that issues and shortfalls are identified early. In addition, the Commercial Manager works closely with the Business Intelligence team to highlight any productivity discrepancies across the FT to the leadership of the clinical divisions.

We commissioned a review of the CIP process from the FT's internal auditors (KPMG) in 12/13 and have incorporated their recommendations including increased scheme granularity, more detailed Board reporting and increased focus on significant service reconfiguration into CIP plans for this planning period.

9. Financial and Investment Strategy

Excluding the effects of asset impairments and restructuring associated with the acquisition, HHFT delivered a surplus of £4.9m in 2012/13 with year-end cash of £36m and an FRR of 4. Financial performance in the second half of the year deteriorated, due mainly to winter pressures causing additional bed stock to be opened with associated staffing costs from both increased substantive employees and bank staff use. This was exacerbated by over-performance on clinical income contracts resulting in approximately £9m of activity being performed above the contract cap and hence not reimbursed.

Tariff deflation and affordability issues for local CCGs are adding pressure to financial sustainability in 13/14 and beyond. The FT has responded by making significant capital investment decisions to diversify income including the building of a new radiotherapy centre and a private patient centre. Capital investment is also focused on expenditure reduction schemes such as the new pathology hub, integrated IT systems and consolidated medical records storage.

The current, substantial cash balance is being used to fund these significant capital investments and

hence the cash balance of the FT is forecast to reduce significantly in 2013/14. This represents a challenge to the FT given the strategic objective of building a new critical treatment hospital for which cash liquidity is also required. In the short-term, we plan to approach FTFF for a loan to fund several capital projects in 2013/14.

Having built a strong cash balance over recent years, we have chosen to invest in a combination of capital projects to increase income and reduce expenditure. Absent significantly higher profitability levels or further loan funding in the future, these capital projects represent a one-off investment opportunity and will exhaust our surplus cash reserves. Whilst creating increased margins to feed the year-on-year 4% savings requirement in the short term, they are insufficient to deliver 4% savings indefinitely.

Year on year tariff deflation, CCG affordability issues, pay inflation and a national spotlight on staffing levels which represent nearly two-thirds of our expenditure together with significant increases in non-pay expenditure such as CNST all combine to intensify financial pressure on HHFT.

We anticipate that we will be unable to maintain FRR '4' and we forecast FRR '3' for all three years of this planning period.

a. Financial Risks and Mitigations

Although not yet signed, PbR contracts have been agreed in principle with all commissioners including specialist commissioning. North Hampshire CCG however has stated they have affordability issues if activity continues at current rates, which we believe is a credible concern. We will monitor the performance of this contract closely through the year to ensure that non-reimbursed activity is minimised. A likely area of over-performance is orthopaedics and the consultant body has accepted the challenge to reduce surgical interventions in line with what the commissioner is able to fund.

As part of recent commissioning contract arrangements, the FT has been protected from the financial impact of failure to achieve contractual and CQUIN targets. Under a PbR contract environment however, penalties become payable if targets are not achieved. Reporting of performance in these areas has been strengthened so that issues are identified and rectified quickly.

CIP targets for 13/14 represent £12m or 3.7% of total income which is believed to be a realistic and achievable target. In later years, the risk of the CIP programme increases as the scale and complexity of the schemes increases. Successful delivery of the schemes in 13/14 will clearly benefit the financial position in 13/14 and future years. Strong governance will be in place to ensure this.

The income position for the 13/14 plan is in line with agreed contract values with commissioners. On balance, we expect total income in 13/14 to be higher than plan, with this benefit rolling forward to future years. This is likely to be caused by higher than plan activity levels which in turn will be partially offset by higher than plan expenditures. Although additional expenditure budget has been included for additional staffing in the wake of the Francis report, there is uncertainty about whether further expenditure will be incurred should there be any nationally mandated changes to staffing levels.

Recognising the financial risks in the 13/14 plan, a contingency of £5m is held centrally to mitigate the risks. As the financial environment tightens in years 14/15 and 15/16, the ability to hold this level of contingency diminishes.

Additional Comments associated with the Corporate Governance Statement

The A&E target at the beginning of 2013/14 has continued to be affected by winter pressures, with high demand for non-elective activity beyond commissioned activity levels and a sustained higher acuity of patients than expected. These pressures continued throughout April and the A&E target was missed for the month overall.

We have continued with the actions previously identified and communicated to Monitor and have also strengthened managerial capacity in this area. However, the recent introduction of the new '111' service is placing additional pressure on A&E services locally and has potentially contributed to the double-digit increases in A&E attendances seen versus the same period last year. Performance in the early part of May has improved and is currently meeting the 95% target. The Board anticipates that this improved performance will be sustained moving forward, but is not assured that the target will be reached for the Q1 target overall.

RTT for admitted patients was not achieved at the aggregate level in Q4 2012/13, driven by orthopaedics which is currently performing significantly above contracted levels. Extra cases were delivered internally and through spot-purchasing in the private sector, but this was partially offset by increased cancellations of scheduled cases due to the pressure on beds from emergency admissions. We have agreed ring-fenced funding from the CCG to deal with long-waiting orthopaedic patients and are working closely with local CCGs to reduce orthopaedic demand to an 'affordable' level within the local health community. However, the Board is not assured that aggregate RTT performance will achieve the target in each month of Q1 and Q2.

