Heatherwood and Wexham Park Hospitals NHS
NHS Foundation Trust

2014/15 Operational Plan submission

Heatherwood and Wexham Park NHS Foundation Trust

Strictly confidential

Operational Plan Guidance – Annual Plan Review 2014-15

The cover sheet and following pages constitute operational plan submission which forms part of Monitor's 2014/15 Annual Plan Review

The operational plan commentary must cover the two year period for 2014/15 and 2015/16. Guidance and detailed requirements on the completion of this section of the template are outlined in section 4 of the APR guidance.

Annual plan review 2014/15 guidance is available here.

Timescales for the two-stage APR process are set out below. These timescales are aligned to those of NHS England and the NHS Trust Development Authority which will enable strategic and operational plans to be aligned within each unit of planning before they are submitted.

Monitor expects that a good two year operational plan commentary should cover (but not necessarily be limited to) the following areas, in separate sections:

1. Executive summary
2. Operational plan
    a. The short term challenge
    b. Quality plans
    c. Operational requirements and capacity
    d. Productivity, efficiency and CIPs
    e. Financial plan
3. Appendices (including commercial or other confidential matters)

As a guide, we expect plans to be a maximum of thirty pages in length. Please note that this guidance is not prescriptive and foundation trusts should make their own judgement about the content of each section.

The expected delivery timetable is as follows:

Expected that contracts signed by this date	28 February 2014
Submission of operational plans to Monitor	4 April 2014
Monitor review of operational plans	April- May 2014
Operational plan feedback date	May 2014
Submission of strategic plans to Monitor (Years one and two of the five year financial plan will be fixed per the final plan submitted on 4 April 2014)	30 June 2014
Monitor review of strategic plans	July-September 2014
Strategic plan feedback date	October 2014

1.1 Operational Plan for y/e 31 March 2015 and 2016

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

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Date	**4th April 2014**

The attached Operational Plan is intended to reflect the Trust's business plan over the next two 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 Operational Plan is an accurate reflection of the current shared vision of the Trust Board having had regard to the views of the Council of Governors and is underpinned by the strategic plan NB The Strategic Plan is subject to agreement with FPH;**
- **The Operational 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 Operational 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; and**
- **All plans discussed and any numbers quoted in the Operational Plan directly relate to the Trust's financial template submission.**

Approved on behalf of the Board of Directors by:

Name *(Chair)*	**Mike O'Donovan**

Signature

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	**Grant Macdonald**

Signature

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	**Darren Cattell**

Signature

1.2 Executive summary

- This submission has been developed in the context of the planned acquisition of HWPH ("the Trust") by Frimley Park NHS Foundation Trust (FPH), expected to be effective on 1 August 2014. As such, it focusses on the Trust's plan for 2014/15, with the 2015/16 figures driven by a series of roll-forward assumptions. This approach has been agreed with Monitor. The 2014/15 plan has been developed as if the Trust were to continue as a standalone organisation for the whole year.

- 2013/14 has been a challenging year for the Trust with a number of changes in key executive positions and significant regulatory scrutiny of care quality, as well as ongoing preparatory work for the acquisition by FPH. As such the Trust Board has agreed not to change the existing corporate objectives for 2014/15 but develop a series of measures which are set out in Section 1.3.1.2 and essentially are designed to ensure that the organisation that is taken over by FPH is safe and financially stable.

- Our comprehensive Quality Action Plan addresses the Trust's care quality priorities and responds to the findings of recent CQC inspections. The Action Plan is driven by the Quality Programme Board, chaired by the Chief Executive, and is held to account by the Board via the Healthcare Governance sub-committee. In addition we have strengthened and continue to strengthen, our quality governance systems and processes to improve ward-to-Board visibility and, as such, the Board's ability to hold the Executives to account.

- A key feature of our response to the concerns raised by the CQC, is a significant investment in capacity; principally in A&E and an additional ward, as well as escalation facilities, underpinned by our capacity modelling work. In 2013/14 the Trust has invested £4.2m recurrently in these quality-focussed capacity improvements, and a further £3.5m supporting the quality agenda and safeguarding patients' wellbeing (£2.3m of which is a non-recurrent exceptional spend). In 2014/15, the incremental cost of our quality-focussed capacity improvement is a further investment of £3.2m.

- *Commercially sensitive text moved to Section 1.4.1*

- Our planned deficit and £20.6m capital investment plan mean that the Trust will require £22.8m of cash funding through PDC in 2013/14. Following the planned support, our COSR for the year is 2.

1.3 Operational Plan

1.3.1 The short-term challenge

1.3.1.1 Trust overview

HWPH has been in a form of turnaround since 2009 when it was found to be in significant breach of its terms of Authorisation by Monitor, in particular, condition 2 which required the Trust to exercise its functions "effectively, efficiently and economically." Since then the Trust has delivered the below financial results:

Year	Deficit (excluding impairments)
2009/10	£9.9m
2010/11	£13.2m
2011/12	£13.9m
2012/13	£6.9m
2013/14 (M11 forecast)	£8.2m gross, with the plan showing £4.8m, plus FPH restructuring costs of £1.1m plus £2.3m of CQC and other costs of Quality

Since the beginning of 2013/14, the Trust has also been under closer scrutiny by the Care Quality Commission (CQC). The CQC has visited the Trust on three occasions in the last twelve months. The CQC has identified that the Trust has been failing to meet expected standards in a number of areas, therefore attracting Compliance actions and a number of Warning Notices. The concerns raised by the CQC included a lack of capacity within A&E and the hospital's bed stock, evidence of breaches in infection control, medicines management, privacy and dignity of patients and respecting and involving those who use the Trust's services.

In 2013 the Board of the Trust, supported by wider stakeholders agreed that the Trust was not financially or clinically sustainable in its current form and it was agreed that the case would be explored for an acquisition of the Trust by nearby Providers. It quickly became apparent that the most suitable other Provider was Frimley Park Hospital NHS Foundation Trust (FPH). The Outline Business Case for the acquisition has been approved and work on the Full Business Case is underway. Subject to the final approval process, the current proposed date for the acquisition to be effective is 1 August 2014.

Owing to the imminent acquisition, HWPH has agreed with Monitor that the focus of this submission will be 2014/15. A simple roll-forward exercise has been done for the purposes completion of the submission, and as such the 2015/16 projections are largely theoretical.

1.3.1.2 Corporate aims and objectives

2013/14 effectively represented the 'second year' of the Trust's three-year plan that was submitted to Monitor in 2012/13. As such, the Trust's year three of three overriding vision and corporate objectives for 2014/15 remain unchanged.

The Trust's Vision is:

- To provide safe, effective, high quality acute secondary care
- That patients will remain at the centre of all we do and have a positive experience of all we offer
- That the communities we serve will feel confident in our care and know they can trust us
- That our staff will feel confident in us as an employer and know they will be supported to do their very best
- That all partners see us as simple to work with and feel confident that we will deliver what we say

The Trusts Objectives are:

- To maintain high quality, safe, clinically effective care that ensures a positive patient experience
- To deliver efficient services within the activity and resource levels agreed with our commissioners; improving our clinical effectiveness and productivity
- To be a good employer, improve staff morale and develop a highly skilled and engaged workforce
- To work in collaboration and partnership with all parties to ensure maximum benefit to the population served
- To deliver significant cost improvements and to develop programmes that will achieve recurrent cost improvements of appropriate scale in later years to ensure the overall financial viability of the Trust.

In recognition of the Trust's position and the near-term challenges that it must meet the Board has agreed a number of more granular measures for 2014/15. These are:

- Delivering the CQC action plan in response to CQC and other Regulatory Quality standards
- Commencing the Cultural improvement journey
- Delivering Performance Standards notably Emergency Care Access, despite increasing acuity of Patients when complete new Capacity is available
- Delivering Performance Standards in 18 weeks and cancer services
- Recovering appropriate income levels for services provided from Commissioners or securing transitional support
- Maintaining control over our cost base whilst delivering the operational plan
- Maintaining a "stable transitional" leadership team past the transaction
- Development and delivery of largely transactional CIPs rather than transformational CIPs given the transaction
- Secure sufficient cash from the DH to support the above and the period to and just beyond the transaction to secure and deliver the continued capital investment required
- One year rather than two year planning horizon; year two rolled forward based on assumptions.

1.3.1.3 Local health economy overview

The Berkshire East constituencies served by the Trust vary greatly in level of need. Currently the Trust faces increasing demand for services resulting from a growing population and an aging demographic. In the Trust's core catchment area of Slough, levels of deprivation are high resulting in a higher level of need for associated services such as diabetes and cardio-vascular disease. The commissioning plans of Slough CCG for 2013/14 identified a number of local health economy challenges; the following are still relevant for the Trust:

- Highest birth rate in South Central and fifth highest in England
- Significant ethnic population with diverse health needs
- Ranked 93/326 of Local Authorities on the Index of Multiple Deprivation
- Coronary heart disease is the single most common cause of all premature death
- Diabetes is significantly above national rates
- Obesity in children remains statistically above national rates
- Alcohol admissions are rising in males and females and are the highest In the county
- Domestic violence & child safeguarding
- HIV rates and TB rates above south central average

Furthermore, it is recognised that there is a significant demand for A&E services at the Trust driven by "a vacuum between straight forward everyday care (GP) and life threatening emergencies (999), and the fact that for many

people A&E fills this gap."[1] In terms of Patients presenting to A&E this can be seen in the following graphs with an increasing acuity of Patient being clearly shown. The Trust's decision to invest in excess of £2m in A&E services in order to meet the challenges posed by Patient led demand and capacity and quality constraints as outlined by the CQC appears to be broadly the right response. However, the Trust needs to ensure Patient flow also works in order to achieve the Emergency Care Access Standard.

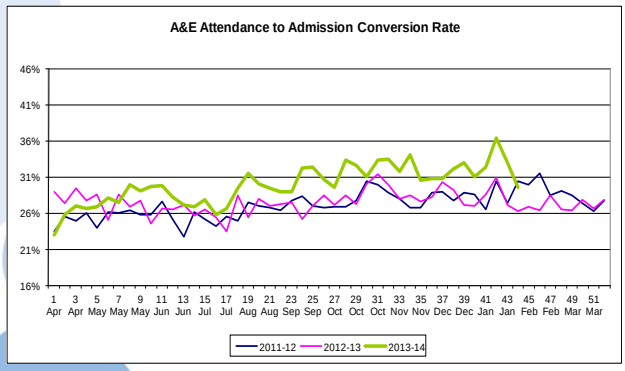
A&E Activity and Admissions

Heatherwood and Wexham Park Hospitals NHS Foundation Trust

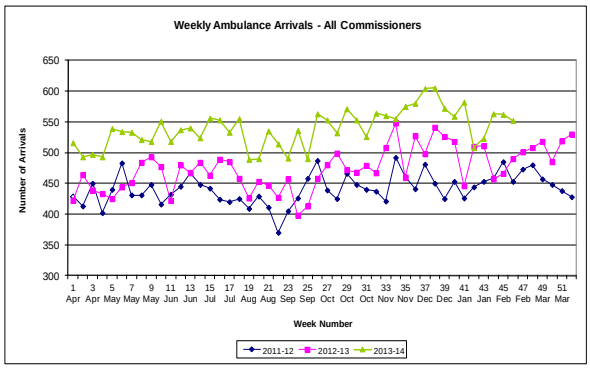
Wexham Park A & E Attendances

HRG Code	HRG Description	Activity 2011-12	Activity 2012-13	Activity 2013-14	% Change
VB01Z	Any investigation with category 5 treatment	74	87	98	12.6%
VB02Z	Category 3 investigation with category 4 treatment	510	698	1,137	62.9%
VB03Z	Category 3 investigation with category 1-3 treatment	2,034	2,460	3,717	51.1%
VB04Z	Category 2 investigation with category 4 treatment	4,766	5,596	7,437	32.9%
VB05Z	Category 2 investigation with category 3 treatment	2,011	1,977	2,764	39.8%
VB06Z	Category 1 investigation with category 3-4 treatment	2,378	2,452	3,507	43.0%
VB07Z	Category 2 investigation with category 2 treatment	12,500	15,180	15,470	1.9%
VB08Z	Category 2 investigation with category 1 treatment	20,279	19,919	21,798	9.4%
VB09Z	Category 1 investigation with category 1-2 treatment	37,437	41,094	34,873	-15.1%
VB10Z	Dental Care	35	2	2	0.0%
VB11Z	No investigation with no significant treatment	6,101	3,145	7,601	141.7%
	Total	**88,125**	**92,610**	**98,404**	**6.3%**
	Year on Year Change		**5.1%**	**6.3%**	

A&E attendances have increased year on year by 5.1% in 2012/13 and 6.3% in 2013/14. This year has also seen a marked increase in acuity in terms of HRGs



The admission rate increased to over 30% during mid August and continues to be high compared with previous years.



Ambulance arrivals in total grew 7.5% between 2011/12 and 2012/13 with a further significant increase of 14.7% in 2013/14.

Figure 1: A&E activity and admissions analysis

1.3.1.4 The Local health economy challenge

There are undeniably are some tensions between the Trust and its main commissioners relating to the financial pressures on the local health economy (LHE) and how they impact on the Trust through Commissioner contracts. Nevertheless, in recent years where we have collaborated, this collaboration with our LHE partners has been broadly successful. For instance a consensus was reached on a number of service reconfigurations under the *Shaping the Future* programme. This Programme was led by the Berkshire Primary Care Trust cluster, and supported by HWPH and the CCGs (in shadow form at the time of approval). The Trust wishes to continue with this collaborative approach to improve care for Patients and to bridge the looming system affordability gap.

The proposal for the Trust to be acquired by FPH has also been developed in a collaborative manner, with the Trust working hard to safeguard the future of services for local people and staff. The Board had previously recognised

[1]Citation from an independent report into local patient and healthcare professional perceptions of urgent care across the Berkshire East region on behalf of the CCGs. *Urgent and unplanned care in east Berkshire*, 2013; p. 2.

that the Trust was too small to be viable on a long-term basis, particularly given that it operates across two sites, and has actively pursued the acquisition of the Trust by FPH. The Trust continues to engage with local key stakeholders in order to develop the strategic direction of the new larger organisation and, as part of this, clinical pathways that will be both sustainable and deliver excellent quality of care.

Further examples of close working between the Trust and its commissioners are afforded by the work being done to review a range of pathways to improve patient experience and drive out efficiencies, for instance in Gynaecology and Urology (Haematuria). Many of these solutions involve collaborative efforts between the Trust and other partner organisations. A further example is where the Trust is likely to place ENT specialists into community clinical and other primary care settings. An elective demand forecasting tool is also under development that will improve the Trust's ability to flex capacity in response to the commissioners' ability to flex demand, such that the Trust should be able to plan better its services and control its expenditure responsively rather than reactively. These areas of work are still developmental and therefore are not reflected in the current financial plan.

While commissioners are supportive of the plan for HWPH to be acquired by FPH, and despite the above examples of collaboration with commissioners, there is not as yet a shared view of the financial challenges across the LHE or within the Trust, the reasons for these, and what more may be done collaboratively to address them.

Efforts to address these issues through means of radical transformation are not as yet being discussed openly and particularly in light of the FPH transaction. The areas of collaboration over pathway redesign remain relatively narrowly focussed. In recent months, our CCG partners have been working with Local Authorities on further plans to reshape services locally, in the context of the Better Care Fund (BCF) initiative. The Trust has now been invited to meet with our partners to discuss the approach to the detailed development and implementation of related plans, including agreement of the likely impact of the plans on existing services and models of care. Discussions at this stage are still embryonic.

1.3.1.5 The Local health economy financials

NHS England	2013/14	2014/15	2014/15	2014/15	2015/16	2015/16	2015/16	2015/16	2015/16
Total CCG Programme Budget Allocations 2014/15 & 2015/16	CCG Programme Budget Baseline	CCG Programme Buget Allocation	Growth on Prior Year	Total Growth on Prior year	CCG Programme Buget Allocation	Growth on Prior Year	Total Growth on Prior year	Better Care Fund Additional Allocation	Total Allocation
CCG	£000	£000	£000	%	£000	£000	%	£000	£000
NHS Slough CCG	146,980	153,041	6,061	4.12%	158,789	5,748	3.76%	2,362	161,151
NHS Windsor Ascot & Maidenhead C	141,109	146,475	5,366	3.80%	151,655	5,180	3.54%	2,093	153,748
NHS Bracknell & Ascot CCG	129,942	134,040	4,098	3.92%	139,913	5,873	3.61%	1,905	141,818
NHS Chiltern CCG	298,514	308,250	9,736	3.26%	317,433	9,183	2.98%	4,683	322,116
Local CCGs Allocations	**716,545**	**741,806**	**25,261**	**3.53%**	**767,790**	**25,984**	**3.50%**	**11,043**	**778,833**
National Allocation to CCGS	**62,743,712**	**64,336,427**	**1,592,715**	**2.54%**	**65,680,146**	**1,343,719**	**2.09%**	**1,100,000**	**66,780,146**

Figure 2: CCG allocations 2013/14 to 2015/16 projected

Historically the East Berkshire region has been below target in terms of funding. This in turn has had a significant impact on the Trust; this is discussed further below. Figure 2 illustrates that in 2014/15 and 2015/16 local CCGs[2] collectively will receive an uplift of 3.5% in each year (before the impact of the BCF). NHS Slough CCG in particular will receive 4.1% and 3.8% respectively. This means that more than £50m of additional funding will be injected into local CCG allocations over 2014/15 and 2015/16. A further c. £11m of BCF funding is expected to be directed into the local health economy in 2015/16, meaning that total growth in CCG allocations over the 2-year period will be c. £62m.

However, the QIPP agenda and the impact of the BCF agenda will see commissioners continuing to divert funding away from the Trust. In 2014/15 commissioners have signalled their intensions to deliver QIPP plans that will, at

[2]NHS Slough CCG; NHS Windsor, Ascot & Maidenhead CCG; NHS Bracknell & Ascot CCG; and NHS Chiltern CCG.

some point from 2014/15, reduce the Trust's income by £6.8m[3] (although detailed plans have not yet been shared and no figure has been shared in respect of 15/16). This gap is in addition to the c. £12m historical contracting underfunding identified by the Trust that the Trust hopes to make some inroads into within the 2014-15 contracting round.

In terms of the BCF, our calculations suggest a transfer from local CCGs to the BCF of c. £43m across all providers by 2015/16 (c. 3% of their 2 year allocation). The vast majority of this will be in 2015/16 (c. £41m). Early signals from local CCGs suggest that they do not intend to use their growth in allocation as a source of funds for the BCF and instead intend to reduce contract baselines with traditional NHS providers. However no specific plans or financial values have been shared as yet. As such it is not possible to model the potential impact of the redirection of this funding.

For planning purposes we have assumed that reasonable transitional arrangements will be put in place to support the Trust as it right-sizes its cost base following any material changes in models of care and following the Trusts acquisition by FPH.

1.3.1.6 The Trust's financial challenge

The sustainability challenges faced by smaller DGH trusts are well known. Typically there is a greater degree of operational gearing from corporate overhead and smaller DGH trusts are vulnerable to competitive pressure from specialist and community providers and find it harder to attract and retain higher calibre staff, particularly so close to London owing to the disparity in remuneration and lifestyle differences.

Income

HWPH is no exception in this regard and has suffered in particular due to the historical underfunding within the local health economy described above.

The Trust is impacted by the 30% marginal tariff for emergency activity in excess of the marginal rate threshold. Currently the Trust is bound by the 30% marginal rate calculation over and above the 2010/11 agreed baseline for calculations, the impact of this in 2014/15 is expected to be £2.7m.

In July 2013 the Foundation Trust Network carried out a review of the marginal rate for emergency admissions above the 2008/09 baseline[4], and found that "96% of survey respondents said the marginal rate policy is not effective in reducing emergency admissions to hospital", and found indications that "the marginal cost of these admissions is over 50%, rather than 30%."

Expenditure

Arguably, the controls that the Trust put in place in the years before the response to the CQC Quality challenges to meet the financial challenge have been effective. In 2012/13 the Trust reduced its deficit from £13.9m the previous year to £6.9m.

For 2013/14 the Trust planned for a deficit of £4.8m. However, following the identification by the CQC of a number of material quality of care issues, discussed below, the Trust Board took the decision to authorise a significant part-recurrent increase in spending to ensure that these failings were addressed as quickly as possible.

Investments in quality have been significant. The opening of additional ward capacity, and escalation areas, as well as improvements to A&E required an investment of £4.2m in 2013/14, this is expected to increase with the full year effect being £7.4m recurrent cost in 2014/15. In 2013/14, this was largely covered by Winter Pressures funding

[3] In respect of Berkshire East commissioners.
[4] *Emergency admissions marginal rate review: call for evidence*, The Foundation trust Network, July 2013.

received of £3.9m but with only £4.8m non recurrent Winter Pressures funding expected in 2014/15 this leaves the Trust with a like-for-like cost shortfall of £2.6m. In simple terms this is largely the difference between the deficit identified in the FPH OBC of £4.2m and the planned deficit for 2014-15 of £6.9m before exceptional items.

Before the recent CQC reports, the Trust's spend on agency and expensive short-term staffing was already high. The ongoing turnaround efforts of the Trust and uncertainty regarding the Trust's near and long-term future has had a detrimental impact on staff morale and the Trust's ability to attract and retain staff. Staff turnover is currently running at c. 12%, c. 16% amongst nurses. As well as the resultant reliance on premium clinical and nursing staff, many of the Trust's senior managerial staff are contracted on an interim basis. This dynamic has exacerbated both the Trust's deficit and the sense of instability that has in turn impacted staff further.

Furthermore, the speed of the Capacity and Quality response that the Trust has mounted has inevitably resulted in the Trust incurring additional premium staffing costs. In the four months 7 to 10 of 2013/14 the Trust spent £3.6m on the premium cost (i.e. the element of cost over and above substantive budgets) of agency staffing, compared with £2.2m in the first five months of the year. In terms of the 2014-15 financial plan agency spend is expected to remain high for the first three months of the 2014/15 financial year only with reductions seen through recruitment and retention CIPs thereafter. This is a risk to the Trusts financial plan.

The Trust's current forecast deficit for 2013/14 is £8.2m, including an in-year exceptional investment in quality of £2.3m and costs of the FPH transaction of £1.1m, compared with a planned deficit of £4.8m. The forecast deficit is also driven in part by non-delivery of CIPs which are £1.4m (11%) behind target at month 11.

The persistent deficits have impacted the Trust's cash position. The Trust has agreed with Monitor and the DH a receipt of £17.2m of cash funding through PDC in 2013/14.

The short term challenge and priority for the organisation going into 2014/15 is to stabilise control of the cost base, whilst maintaining momentum around the quality agenda and to secure appropriate income levels under agreed contracts for the services provided to Commissioners.

1.3.1.7 The Trust's quality challenge

In May 2013, the CQC identified that the Trust was failing to meet expected standards of care in a number of areas, therefore attracting Compliance actions, and a major failing in monitoring systems that attracted a Warning Notice. The concerns raised by the CQC included lapses in care caused by a lack of capacity within A&E and the bed stock , evidence of breaches in infection control, medicines management, privacy and dignity of patients and respecting and involving those who use services.

The Trust developed plans to address the issues and shared these with Monitor, CCGs, and other stakeholders, including the Local Authority Overview and Scrutiny Committees. The Trust established a weekly Quality Programme Board, chaired by the Chief Executive, reporting into the Healthcare Governance Committee (a Board sub-committee) to oversee and drive forward delivery of the plans. A number of these actions have been completed and an ongoing assurance mechanism is in place to ensure that they are embedded into the Trust's systems and processes.

The Trust has also taken positive steps to address capacity issues, developing a bed capacity modelling tool, which is resulting in the opening of 2 additional wards (Ward 17 in 2013/14, and Ward 10 in 2014/15), and investing in A&E capacity.

In October 2013, the CQC visited the Trust for a second time. The report was received in January 2014. This report highlighted a number of improvements, particularly in the previous lapses found related to capacity and found those areas "significantly improved". They also found positive improvements in "a number of wards" and found these areas were "well led and well managed". Previous shortcomings in medicines management had been corrected and the Trust now meets the required standards. However, although there is improvement, the

inspection continued to find lapses in care in some specific areas, identified some new issues, and continued to identify failings in matters where the Trust had not yet completed work in response to the initial May 2013 findings. The CQC served the Trust with 7 warning notices. It found failures to meet the following 8 essential standards:

- Outcome 1 - respecting and involving people who use services;
- Outcome 4 - the care and welfare of those who use services;
- Outcome 8 - cleanliness and infection control;
- Outcome 10 - safety and suitability of premises;
- Outcome 11 - safety, availability and suitability of equipment;
- Outcome 14 – staffing;
- Outcome 16 - assessing and monitoring the quality of service provision ; and
- Outcome 21 - records.

Of the failures to meet essential standards, 4 were judged by CQC to have a major impact on patients and 4 were judged to have a moderate impact.

The CQC inspected the Trust for a third time in February 2014. The Trust is awaiting a draft copy of the report but initial feedback has been provided that improvements have been made in a number of areas. The Trust recognises that there is more work to do to improve the overall quality of care that we provide to our patients and is continuing to implement and monitor the Quality Action Plan. This is discussed further in Section 1.3.2 below.

1.3.2 The quality plan

1.3.2.1 Governance arrangements

The Trust's high-level quality governance arrangements are reflected in its corporate meeting structure:

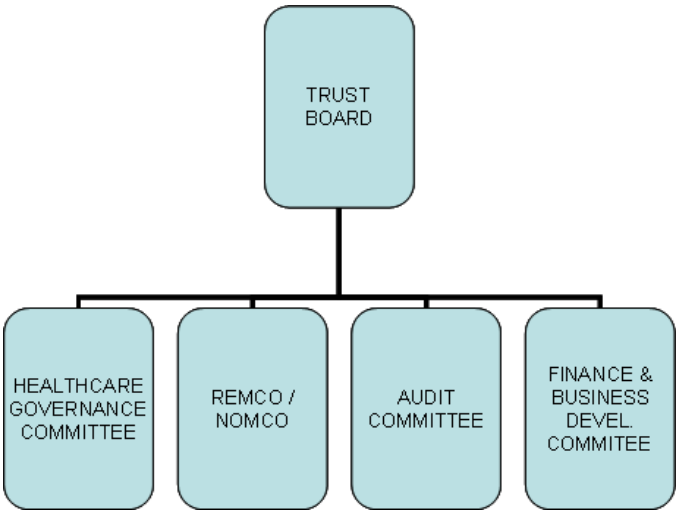


Figure 3: Trust formal corporate meeting structure

Safety and Quality are discussed at every meeting of the Trust Board. The Board receives the following reports at each meeting:

- Patient Safety & Quality Report;
- Serious Incident Report.

The Patient Safety & Quality Report provides a Trust-wide overview on Trust performance against a number of quality objectives, falling under each of the three core headings of Patient Safety, Patient Experience and Clinical Effectiveness:

Patient Safety, including:

- Mortality;
- Incident reporting;
- Patient Falls;
- Safety Thermometer;
- Medication Errors
- Claims

Patient Experience, including:

- Complaints & Compliments;
- Friends & Family Test;
- Patient Survey feedback

Clinical Effectiveness, including:

- CQUINs;
- Stroke Care;
- Maternity Performance

This allows the Board to have a sound general oversight of the quality and safety issues affecting the Trust and informs Non-Executive challenge of the Executive team.

Below the Board, the Healthcare Governance Committee (HCG) provides a dedicated safety and quality-focused Committee of the Board (chaired by a Non-Executive Director) and meets on a monthly basis. In addition to routinely reviewing a set of agreed quality/safety KPIs, the Committee is able to 'delve deeper' into key safety/experience issues and to provide assurance/raise concerns to the Board through doing this.

The HCG receives reports from Executive-led sub-groups as part of a detailed sub-structure which ensures that there is an 'escalation route' for the full range of safety/quality issues, including Patient Safety, Patient Experience and Clinical Effectiveness; as well as Groups specifically covering Infection Control and Health & Safety matters:

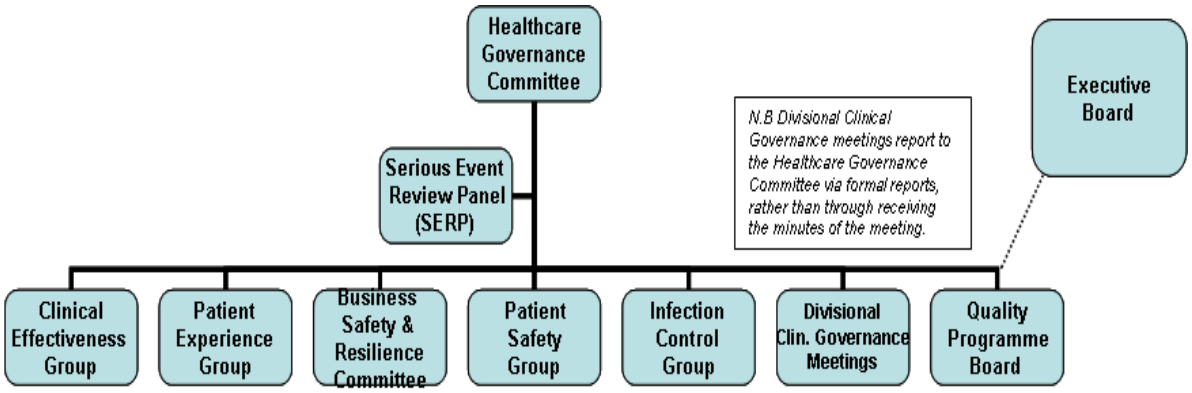


Figure 4: Healthcare Governance substructure

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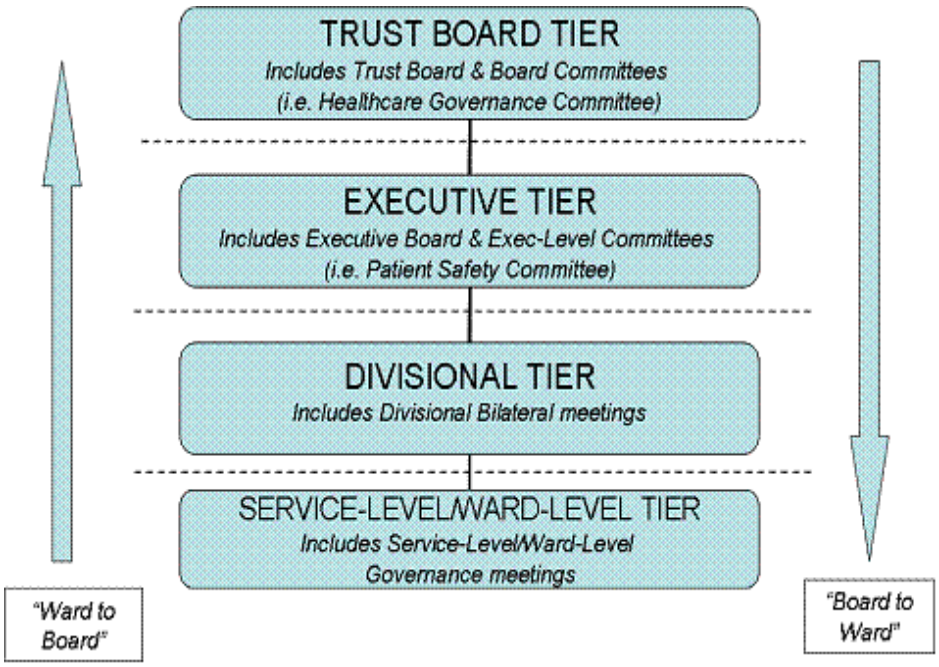
Finally, the HCG also receives reports from each clinical Division on a cyclical basis; this is to provide assurance that each Division has sufficient localised governance arrangements in place (through the Divisional Clinical Governance meetings) to manage all risk to patients identified and to improve care through positive action. The reports are based upon the key outcomes arising from each Division's Clinical Governance meeting. Below the Divisional Clinical Governance meetings, each Division has a distinct and bespoke clinical governance sub-structure, the details of which will be provided separately.

However, notwithstanding the above, the Trust recognises that ward to Board reporting has not been as effective as it should have been. To this end, the Board have recently commissioned a 'Governance Plan', a multi-faceted approach to improving quality governance:

- In the first instance, the Trust is developing a revised structural map of the organisation to simplify the arrangements in place and to ensure that there is sufficient information flow between each 'tier' of the organisation as represented by the diagram below:



- A Standard Operating Procedure has been drafted to standardise the operation of the committees operating within each tier of the structural map;

- As referenced above, the Trust has developed a Ward Dashboard;

- The Trust has developed a Standard Operating Procedure for its system of clinical compliance rounds that aims to revise, define and bring absolute clarity and certainty to the functioning, reporting requirements and framework within which the clinical compliance rounds take place;

- In addition, to further service/division-level awareness of clinical governance best practice, a governance workshop has been held with divisional teams to reiterate the importance of having an effective mechanism to review and challenge qualitative information. This workshop included discussion of the Monitor Quality Governance Framework and how the Trust is performing against this.

Each aspect of the Governance Plan will be externally validated by the Good Governance Institute, initially through a desktop review of all requisite paperwork; followed by a comprehensive audit of the effectiveness of the Trust's implementation of the Plan over a four-month period.

1.3.2.2 Response to the CQC

In 2013, the **Quality Programme Board (QPB)** was established as an Executive forum meeting on a weekly basis, to oversee the practical implementation of a series of quality-improving actions identified throughout the year. This is the key forum for driving forward the Trust's operational response to the issues identified by the CQC.

The QPB, chaired by the Chief Executive, reports through to the Executive Board and to the HCG to ensure that the Trust Board has sufficient oversight of its progress.

A comprehensive Quality Action Plan, developed by the QPB, was approved by the Trust Board in March 2014. The key themes that this plan is addressing are set out below. In addition to these actions the Trust has also agreed with Monitor to commission KPMG to undertake a Medical Governance Review. This is not shown below explicitly but is within the culture circle and will have a direct impact on Doctors culture:

Figure 5: Quality Action Plan schematic

The Trust has recognised that the timescales for implementation of the actions stemming from the CQC's findings are challenging and has brought in additional resource to help implement the Plan. A number of experienced project managers are in post to support members of the Executive Team and progress is monitored by a programme management office lead who reports directly to the Chief Executive, and QPB on a weekly basis.

The Trust has made good progress in improving the quality of care for our patients. A number of actions have been completed, including reinforcing Trust standards around maintaining the privacy and dignity of patients, providing our staff with appropriate equipment and improving cleanliness of all areas. The Trust is establishing an ongoing mechanism to monitor compliance with these actions and to continue to drive improvements and the embedding of good practice within the organisation.

The Trust has a number of longer term plans in place to address quality concerns. A key area of focus is to improve the cultural issues within the organisation and address concerns relating to bullying and harassment. The Trust has joined the pioneering Listening into Action programme to listen and respond to staff feedback. A series of events are scheduled to take place over a twelve month period and progress will be measured by regular pulse surveys. Patient feedback is also instrumental in measuring the Trust's progress. The Trust has implemented a patient

experience tracker whereby volunteers meet with a sample of patients on a daily basis to obtain feedback on aspects of their care.

In addition to the above, significant investment in the Trust's estate is scheduled to take place in the coming years. This investment is targeted at areas identified in a six facet survey and will go a considerable way to improving the physical environment for our patients.

Other projects will continue to progress, including the development of electronic patient records and consultant job planning, updating the medical governance structure, improving discharge planning and working with domestic staff to maintain the cleanliness of the hospitals.

The Trust has developed a ward dashboard to facilitate ongoing monitoring of quality at a ward level. The monthly dashboard includes indicators around falls, infection control, staffing levels and patient satisfaction (complaints and compliments). This will be reported to the QPB and HCG on a monthly basis to facilitate Board understanding of quality.

1.3.3 Operational requirements and capacity

1.3.3.1 Expected demand

Commercially sensitive text moved to Section 1.4.2

1.3.3.2 Capacity planning

A critical failure of the Trust during 2013/14 has been not achieving the Emergency Care Access Standard in each of the four quarters. As previously stated this was largely due to bed capacity and Patient flow issues.

The Trust has taken positive steps towards addressing its capacity issues.

The Trust has developed a statistical bed capacity model and on this basis has identified the need to open an additional 24 bedded medical ward. The beds will open in April 2014 and the additional capacity will ensure that the Trust is well placed to meet demand for the unscheduled care beds for, on average, 98% of the time.

Over and above this the Trust is opening a medical decant ward that will facilitate a rolling programme of refurbishment for the Trust's core wards. Should the need arise, the refurbishment programme may be put on hold allowing the capacity to be used as an overflow ward if required.

The Trust also experienced challenges in delivering the elective performance standard of 18 weeks in 2013/14. In 2013/14 the Trust will spend c. £1.0m in outsourcing costs (primarily surgical waiting lists and gastroenterology), and a further £2.5m on additional overtime session payments to medical staff. An exercise is underway to identify the capacity required to deliver the anticipated demand, including bringing into line the Trust's 18 weeks backlog, through a recruitment drive during the first 6 months of the year. The backlog in 18 weeks will be addressed during the first quarter of 2014/15.

In 2014/15 surgical premium costs have been budgeted at 2013/14 run-rates for the first three months of the year, thus allowing the Trust to take the planned reduction in spend from increased in-house capacity as a CIP in-year.

Over-and-above this, the Trust is also ensuring Consultant capacity is matched to anticipated Patient demand. This work is advanced but not yet sufficiently robust to form part of the Trust's baseline budgets. Nevertheless it is anticipated that this will deliver c. £2.0m of CIP in year (£3.4m full year-effect). The current CIP plan target of £13.5m includes only c. £0.4m of this expected benefit.

1.3.4 Productivity, efficiency, and CIPs

1.3.4.1 CIP Governance

The Trust has identified the need for a robust project management office (PMO), together with regular divisional and executive challenge. The proposed structure outlined below is currently being recruited to temporarily due to potential duplication after the FPH transaction and whilst there will always be a strong interface between operational delivery and the PMO, this structure provides the necessary degree of separation to ensure that there is sufficient independent scrutiny and rigorous reporting of progress. Each work stream under development or implementation has a nominated executive sponsor with overall responsibility for the delivery of the scheme. The executive sponsor is supported by a project manager and named team members.

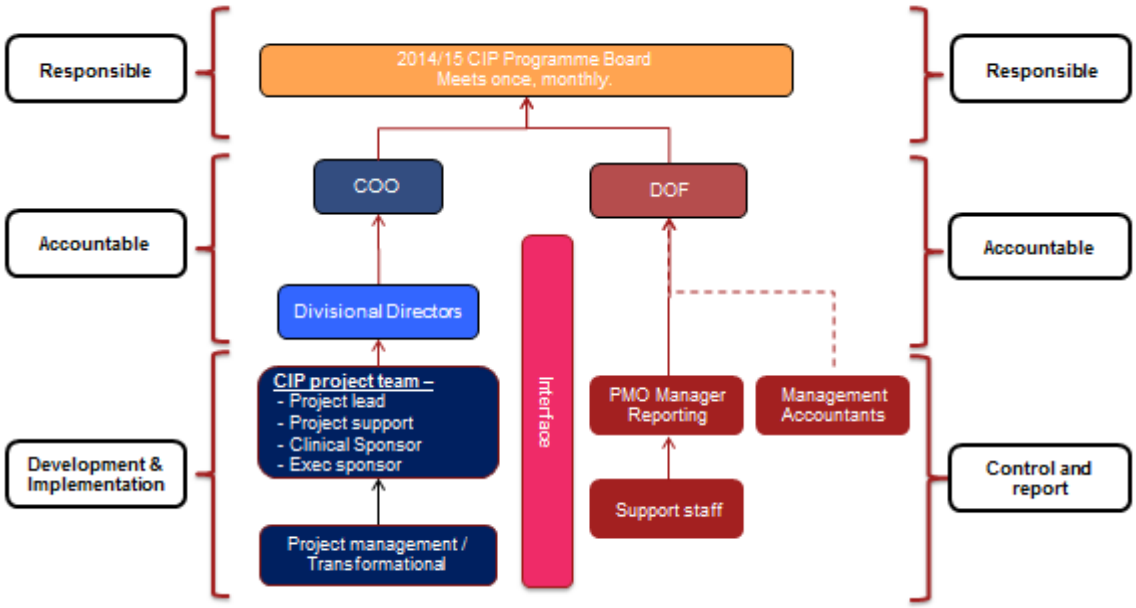


Figure 6: CIP governance structure

The documentation used to plan the detailed steps for delivery of approved schemes is fully compliant with Monitor's guidance and includes a quality impact assessment, milestone plan, financial benefit assessment, key performance indicators, risk register and stakeholder map. All plans are subject to formal sign-off by the Medical Director and Director of Nursing (where relevant).

1.3.4.2 CIP Challenge

The Trust has set a challenging internal CIP requirement in 2014/15 of £15.5m, c.5.7% of the pre-CIP cost base (excluding exceptional items). This has been risk adjusted to £13.5m (c. 5.0%). Within this target are £2.6m of actions expected to be delivered through income generation schemes. The impact of the risk adjustment falls on the balance thus the Trust has a pure internal CIP target of £12.9m (4.5%) which has been risk adjusted in the plan to £10.9m (3.9%).

£m	Internal target	Plan target
Income	2.6	2.6
Cost	12.9	10.9
Total	15.5	13.5

Figure 7: 2014/15 CIP target summary

The Trust as a whole is slightly behind where it would like to be in the development of CIP for 2014/15 owing to the impact on the organisation of mounting a sizable and rapid response to the recent CQC inspections. Nevertheless, the Trust has recognised this and is responding urgently. The Operational teams are now engaged and good progress is being made. A number of firms are providing external support and expertise, such as Newton, PwC and EY.

The Trust has RAG rated the current status of each CIP scheme across a number of standard criteria which provides a view on the robustness of the scheme and the likelihood of its delivering savings from the planned start date. The table below shows a summary:

RAG Rating	In year CIP	Risk adjustment	Risk adjusted in year CIP
Green	9.2	100%	9.2
Amber	5.5	75%	4.1
Red	0.7	25%	0.2
Total	15.5	87%	13.5

Figure 8: 2014/15 CIP target summary

The current status shows there is a significant challenge for the Trust to deliver.

1.3.4.3 Transactional versus transformational CIPs

The Trust's CIP programme is for 2014/15 is a combination of largely transactional and smaller by value transformational projects. The Trust's ability to plan and implement a truly radical programme of service redesign is significantly reduced by the lack of strategic clarity, both in terms of the impact on services of the acquisition by FPH and future commissioning intentions, as well as internal issues such as low staff morale and high turnover. Nevertheless, at least 8% (of the £13.5m) or c. £1.1m of the Trust's CIPs are classed as transformational. These can be grouped under 3 interrelated themes:

- Demand and capacity
- Patient flow
- Productivity and efficiency

Demand and capacity

The capacity planning work discussed in Section 1.3.3.2 has provided a number of CIP opportunities. The Trust has developed a model that has initially targeted theatres and outpatient clinics and, once refined, will be applied to other areas. Furthermore the model seeks to benchmark against other Providers including FPH to help identify underperforming specialities and target them more closely for improvements.

The output of the model will enable the Trust to:

- Right-size capacity (aligning activity plan with funded capacity), supporting Divisions to recruit the correct level of substantive staff;
- Identify any ongoing requirement for outsourcing or opportunities to bring activity in-house;
- Identify efficiencies available through improved theatre utilisation;
- Identify efficiencies available through improved clinic utilisation; and
- Identify opportunities from meeting top decile new outpatient appointment to follow-up ratios.

The right-sizing of our capacity will support a reduction in bank and agency spend. In order to avoid delays in delivering this CIP, the Trust has already commenced an organisation-wide project to focus on improved recruitment and retention, which will involve a number of recruitment drives in foreign territories which the Trust has not previously visited.

Patient flow

The Trust has a number of other organisation-wide schemes including improvements to Patient Flow which will encompass the following:

- Improvements to diagnostic waits enabling faster decision-making (underpinned by the Newton work in radiology discussed below);
- Improvements resulting from service model changes e.g. Ambulatory Care, PACE team, improved effectiveness of discharge team; and
- Improvements resulting from time shift in discharge associated with "Home for lunch" CQUIN project.

The programmes of work described above are expected to significantly reduce the current length of stay which will lead to further savings:

- Improvements from improved efficiency of medical teams once bed base is right-sized and outliers/escalation are minimised;
- Improvements from implementation of 7 day working and specialty rotas in medical sub-specialties;
- Improvements from implementing King's Fund recommendations around daily Consultant ward rounds; and
- Improvements associated with embedding use of Realtime (patient registration and discharge planning).

Productivity and efficiency

As well as the capacity planning informed projects, the Trust has been working with management consultancy firm, Newton, since 2012 on a programme of productivity and efficiency. In 2014/15 we will continue to focus on a number of areas with their support.

- **Length of stay leading to Bed reductions (expected savings in 2014/15 £1.1m)** – This is reducing bed capacity during the summer months with the closure of the GP Unit and one medical ward for the summer months.

- **Theatre productivity (expected savings in 2014/15 £1.0m) –** This project was initially implemented in November 2012 and while it has been broadly successful the targeted savings have not yet been achieved across all areas. Specifically in 2014/15 we will be seeking to address issues across plastics, gynaecology, and ENT relating to a number of factors, although these savings have only partly been included (£0.5m) in the current CIP programme.

- **Outpatients (expected savings in 2014/15 £1.0m)** – This project has identified productivity opportunities that may be achieved within additional sessions. However there are challenges in respect of clinical engagement and managerial capacity which mean that the project requires a re-launch in 2014/15. As such, these anticipated savings have not yet been included in the CIP programme.

- **Radiology (expected savings in 2014/15 Break-even in-year)** – This is a complex project which must combine the productivity gain that the Trust has identified through its work with Newton, with the need to deliver increased through-put to meet shortened access time requirements. The net in year saving is reduced by the costs of delivery and recurrent savings are expected to be significantly higher.
- **Endoscopy (expected savings in 2014/15 – Break-even in-year)** – A project to deliver increased productivity in endoscopy through improving start times, and managing bookings more effectively has been on hold while the service was going through the implementation of electronic clinical records and scheduling, and an external accreditation exercise. This will now be implemented in 2014/15. Although the savings will not be realised until 2015/16, owing to the investment required in monitoring tools.

As well as the transformational schemes highlighted above which are expected to generate savings through implementing new ways of working, the Trust has also identified a larger number of more transactional schemes. A table setting out the broad categories of schemes is set out in Figure 9 below.

	Full year effect	In year 2014/15	% of total 2014/15 CIP
Transactional CIPs and one off reductions	1.9	3.8	28%
Premium staffing reductions	3.7	2.7	20%
Non-pay cost improvements	2.5	2.8	21%
Additional income	2.3	2.3	17%
Transformational / length of stay reductions	1.4	1.1	8%
Full year effect of prior year schemes	0.5	0.5	3%
Other	0.3	0.3	2%
Total	**12.6**	**13.5**	**100%**

Figure 9: Summary table of identified schemes

Owing to the challenging timeline for CIP development and implementation noted above, the monthly savings from the identified schemes will increase throughout the year as the schemes start to come online. Figure 10 sets out the planned phasing for 2014/15 schemes.

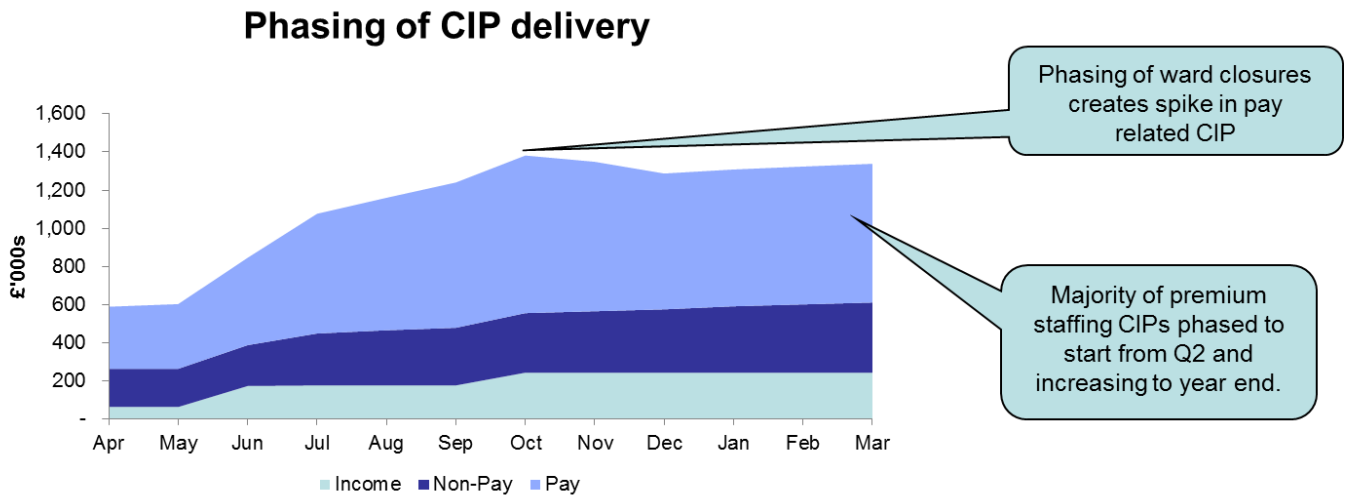


Figure 10: Planned phasing of CIPs 2014/15

The Trust has primarily focussed on the development of 2014/15 CIP plans owing to the proximity of the transaction with FPH. FPH have now engaged EY to support the development of joint CIP plans given the date and nature of the 1st August transaction. A further update will be available in due course, but will not duplicate the FBC proposed "synergy savings", instead it will be based on each current Trusts potential but will in essence be a joint CIP plan, starting part way through 2014/15 and into 2015/16.

1.3.4.4 Operational performance standards

Our capacity planning and programme of transformation CIPs are intended to support us to deliver an improved performance against operational performance standards as well as care quality, patient experience and financial results.

During the 2013/14 the Trust has consistently struggled to deliver against the 4hr standard for A&E, and has also underperformed against the 18 week standard and 62 day cancer. It is our expectation that the investments we are making in terms of increased capacity and improved patient flow will contribute to material improvements in these standards. Nevertheless we have formally declared a risk against the below indicators:

Indicator	Plan to address
A&E Clinical Quality – Total time in A&E under four hours	1. Additional capacity investments 2. Ambulatory care facility has now been opened and we are extending the range of conditions that can addressed through the unit 3. Redesign of the front end of the urgent care pathway and how patients flow through 4. Changes in medical ways of working and improved discharging under the "home by lunch" initiative
Referral to treatment time, 18 weeks in aggregate, admitted patients	1. Reduction in outpatient waits to under 6 weeks for all specialties. 2. Improvements in the way elective procedures are managed, for instance: a. Maximising our baseline capacity b. Additional sessions c. Outsourcing to the private sector to bring waiting lists into balance 3. Improved validation of patient lists through a 12 weeks extensive validation process of inpatient and outpatient PTLs
Compliance with requirements regarding access to healthcare for people with a learning disability	A comprehensive strategy to address requirements around access to healthcare for people with a learning disability is under development. As a matter of urgent action the Trust is developing a programme of training for staff. The requirement to improve the Trust's performance in this area is being monitored as a risk on the Trust's Board Assurance Framework and the Quality Action Plan.

We note that the financial template requires us, where declaring a risk, to either say that plans to address are:

- Not required
- Not provided
- Or are provided in our strategic plan.

At this stage we have provide an outline in this document and trust that this is sufficient for the purposes of this submission. Details of our strategy to address non-compliance CQC requirement are also detail in the Quality Plan section of this document.

1.3.5 The Financial plan

1.3.5.1 Overview

	2013/14 forecast outturn	2014/15 plan	Variance	% change
NHS patient income	229.5	237.4	7.9	3.4%
Other operating income	20.8	16.3	(4.5)	(21.6%)
Total income	**250.3**	**253.7**	**3.4**	**1.4%**
Pay	(164.5)	(166.1)	(1.6)	1.0%
Non-pay	(79.2)	(80.9)	(1.7)	2.1%
Total operating expenditure	**(243.7)**	**(247.0)**	**(3.3)**	**1.4%**
EBITDA	**6.6**	**6.7**	**0.1**	**1.5%**
Non-operating income/expenditure	(11.4)	(13.6)	(2.2)	19.3%
Planned surplus/(deficit)	**(4.8)**	**(6.9)**	**(2.1)**	**43.8%**
Exceptionals	(3.4)	(2.3)	1.1	(32.4%)
Total surplus/(deficit)	**(8.2)**	**(9.2)**	**(1.0)**	**12.2%**

Figure 11: Summary I&E

2013/14

During the course of 2013/14 the Trust experienced a significant increase in income and expenditure. Figure 12 sets out the key drivers of the Trust's variation from its original plan.

While a large part of the variation was due to over-performance, it was also necessary for the Trust to take steps to respond to concerns raised by the CQC regarding capacity and thus opened an additional ward (ward 17), and opened additional A&E capacity as well as escalation areas. Further investments in quality were made in the form of increased clinical staffing, primarily at premium costs.

While much of the cost of £4.2m of additional capacity was funded externally, primarily through £3.9m of winter monies, much of the other investments in quality totalling £3.5m were not specifically funded from Commissioner income. The Trust has been able to generate additional income to offset c. £1.2m of this with the balance (£2.3m) classified as exceptional and recorded "below the line", along with another £1.1m of transaction costs.

Most of the £3.4m of the exceptional expenditure below the line, is non-recurrent. However, the Trust is predicting to incur a further £2.3m of non-recurrent, exceptional items in 2014/15.

As such the Trust is forecasting a year-end deficit of £8.2m for 2013/14, although it will deliver its planned figure of £4.8m before exceptional items.

		£m Income	£m Costs	£m Net
FY14 Plan		**234.4**	**239.2**	**(4.8)**
	Overperformance / quality	5.9	4.5	1.4
	Premium staffing element	0.0	3.5	(3.5)
	18 Weeks	1.8	1.8	0.0
	PbR Drugs	1.6	1.6	0.0
	Capacity / Quality	3.9	4.2	(0.3)
	Maternity tariff change	1.5	0.0	1.5
	Paeds 0LOS tariff change	1.2	0.0	1.2
	Exceptionals	0.0	3.5	(3.5)
	Other	0.0	0.2	(0.2)
FY14 Actual		**250.3**	**258.5**	**(8.2)**
	Increase	15.9	19.3	(3.4)

Activity overperformance delivered at a loss of £2.9m due mainly to premium costs a function of vacancy problems

18 week backlog money received in advance matched to costs – additional costs e.g. outsourcing and additional sessions are matched to over performance / quality

Figure 12: Key drivers of 2013/14 variance to original plan

2014/15

In developing the plan for 2014/15, the Trust has assumed that its expenditure run-rate in the latter part of 2013/14 will continue into 2014/15, and that the additional capacity that has been installed on quality grounds (£4.2m) will be a recurrent element of the Trust's cost base. The full-year impact of this is will add £3.2m to the cost base (before CIP) compared with 2013/14 forecast outturn. The cost base is further increased by number of anticipated corporate cost pressures (£3.4m), and inflation (£3.8m). The Trust has also built £3.0m of contingency into the position. These items will be offset through the delivery of the Trust's programme of cost CIPs £10.9m, and as such it is anticipated that the Trust's total expenditure for the year (after exceptional items) will be c. £262.9m, which is c. £4.4m greater than 2013/14 forecast outturn of £258.5m (after exceptional items).

Commercially sensitive text moved to Section 1.4.3

1.3.5.2 Income plan 2014/15

Commercially sensitive text moved to Section 1.4.4

1.3.5.3 Expenditure plan 2014/15

The Trust's expenditure plan for 2014/15 is shaped by three main features, all of which are closely interrelated:

- **2013/14 exit run-rate** – As noted above, in the second half of 2013/14 the Trust took urgent steps to address the shortcomings in care quality identified by the CQC during a number of visits. The resultant increase in expenditure, particularly in respect of maintenance costs, premium staffing, and external support, has resulted in an exit run rate deficit in month 11 of £21.3m. This compares favourably with the planned level of £22.0m at month 1, including inflation, before any CIP programme takes effect.

- **Capacity and Quality investments** – As well as the above mentioned factors contributing to a high expenditure run-rate in the early months of the plan, there are a number of investments (£3.2m incremental investment) that the Trust is making on a recurrent basis to improve quality of care (before CIP).

Investments in capacity and quality (previously "winter")	Within 2013/14 forecast outturn	Incremental in 2014/15	Total 2014/15 plan
A&E	1.3	0.9	2.2
Ward 17	1.2	0.5	1.7
Ward 10	0	1.7	1.7
GP Unit	0.2	0.2	0.4
Christiansen unit	0.3	0.3	0.6
Other	1.2	-0.4	0.8
Total	**4.2**	**3.2**	**7.4**

Figure 13: investments in capacity and quality 2013/14 and 2015/16 (before CIP)

As can be seen from Figure 13, primarily these relate to additional bed capacity, through the opening of the additional wards, and the investment in A&E. The Trust recognises that urgent action must be taken to address this higher cost base. However, the Trust is also realistic regarding the speed with which this can been achieved given the need to ensure that care quality is maintained. As such in setting its plan for 2014/15 the Trust has accepted that the monthly run-rate at the start of the year will necessarily be higher than is felt to be the Trust's natural "baseline" of expenditure.

- **Productivity and efficiency** – The high opening run-rate and investments in capacity and quality mean that the Trust CIP requirement is significant. As noted in Section 1.3.4.2, the Trust must deliver CIPs of c. 5.0% of its cost base in order to bring the run-rate back to the natural baseline position. The Trust recognises the scale of this challenge and the steps it is taking to address this have been explored in Sections 1.3.3.2 and 1.3.4.3.

1.3.5.4 Capex and Liquidity 2014/15

Capex spend in 2013/14 is driven primarily by our programme of investment and renewal in our estate. This is a key feature of our Quality Action Plan. Figure 14 sets out the main areas of the investment programme. Next year it is currently planned that c. £3.0m will be spent in ward improvements and the patient environment and a further c. £3.0m will be spent ensuring that we are fully compliant with all requirements and accreditations. Another key feature of the programme is the £1.9m investment in our additional catheter laboratory facility, which will support our cardiology service development.

	£'000				
	Q1	Q2	Q3	Q4	Total
Estates Total					
A&E	160	40	10	10	**220**
Maternity	92	220	10	10	**332**
Paediatric HDU	70	200	230		**500**
Ward 10 & 11 Conversion	750				**750**
Statutory and compliance	415	405	405	735	**1,960**
Patient Environment	292	292	292	292	**1,168**
Cath Lab	50	150	450	120	**770**
JAG accreditation - Wexham	20	10	60	910	**1,000**
Ward Refurbishment	50	200	900	600	**1,750**
Other	400	300	200	150	**1,050**
	2,299	**1,817**	**2,557**	**2,827**	**9,500**
Medical Equipment					
Ultrasound machines	252				**252**
Arthroscopic complete system		176			**176**
Mobile X-ray Machine		240			**240**
General X-Ray Rooms x2			432		**432**
Cath Lab			533	533	**1,065**
Lancer Automated Endoscope Reprocessing Machine			308		**308**
CT Scanner				960	**960**
Fluoroscopy Room				486	**486**
Other	848	509	495	229	**2,081**
	1,100	**925**	**1,768**	**2,208**	**6,000**
IM&T	1,200	1,200	1,200	1,200	**4,800**
Contingency	75	75	75	75	**300**
Grand Total	**4,674**	**4,017**	**5,600**	**6,310**	**20,600**

Figure 14: Capex plan 2014/15

As set out in Figure 15, the extensive capital investment programme is the main driver of the Trust's cash funding requirement in 2014/15. Cash outflows from working capital movements are primarily driven by the expectation that accruals will fall to a more natural level following unusually high level of accruals in 2013/14, and an decrease in deferred income from CCG payments on account in 2013/14. Owing to the fact that the Trust has not yet agreed a year-end settlement with commissioners there is an expectation that that both trade debtors and creditors will fall compared with the 2013/14 year-end position.

The Trust is planning to receive £22.8m of PDC funding in 2014/15. £2.7m of this will be used to pay our PDC dividend and £1.8m of it will be used to repay our DH loan.

Deficit	**(9.2)**
Add-back non-cash items	13.6
Working capital movements	(1.3)
Capex	(20.6)
Financing	17.9
Net cash flows	**0.4**
Opening cash balance	**3.0**
Closing cash balance	**3.4**

Figure 15: Summary cash flow

1.3.5.5 Downsides and mitigations 2014/15

Risks	Impact (£m)
1) 50% Non-achievement of expected growth	£(3.1m)
2) Commissioner QIPP is successful	£(1.9m)
3) 80% achievement of planned CIP requirement	£(2.7m)
Total downside risk	**£(7.7m)**
Mitigations	
4) Release contingency	£3.0m
5) Marginal cost impact of QIPP activity lost (assume 52%)	£1.0m
6) Marginal cost impact of 50% growth shortfall	£2.0m
7) Use additional capacity to reduce waiting lists	£ 1.0m
Total mitigations	**£7.0m**

Figure 16: Downsides and mitigations

Figure 16 sets out the downside risks and mitigations that we have identified as part of our planning exercise for 2014/15. While there are a number of further risks that may impact the plan under an extreme scenario, we consider the above to be a representation of the downside risk that have a reasonable possibility of occurring in-year. Under these circumstances we have identified a number of mitigations that we expect would reduce the Trust's exposure to c. £0.7m. This residual impact would need to be managed both in I&E and cash terms either through further support or through additional opportunistic mitigations.

1.4 Appendix 1: Commercially sensitive text

1.4.1 Executive summary

The recurrent investment in quality along with the impact of identified corporate cost pressures of £3.4m, a reduction in non-NHS patient income of £2.0m, and the impact of tariff deflation and cost inflation (£4.8m) are the material factors increasing the Trust's deficit compared with 2013/14. These are offset by increased income from a rebasing of our block contract with commissioners (£2.2m), growth in activity identified through our activity planning work (£4.9m), and CIP of £13.5m (c. 5.1% of our cost base). We will also require c. £4.8m of commissioner support (Winter Pressures funding) in 2014/15 to deliver our planned deficit of £6.9m (before £2.3m of exceptional items). We are anticipating that this funding will be provided as part of the usual winter support mechanism.

1.4.2 Expected demand

The Trust's approach to planning for 2014/15 is underpinned by our expected levels of demand. Our 2014/15 activity plan which predicts our demand has been developed based the Trust's activity forecast outturn for 2013/14 adjusted in accordance with our 2014/15 planning assumptions. Appendix 2 sets out all our planning assumptions for 2014/15 and 2015/16

Given the planned acquisition of HWPH by FPH, currently expected to take place on the 1 August 2014, and a lack of clarity from commissioners regarding immediate significant changes impacting the Trust, particularly in respect of QIPP and BCF, the Trust is not planning for any sizable changes in the portfolio of services it offers within the timeframe covered by the opening year of this plan.

That said, there are some material predominantly positive variations in the Trust's income and activity plan for 2014/15 compared with the previous year. The material variations from the previous years in activity terms are set out below.

- A 1.5% uplift from demographic growth of £2.2m
- A c. £2.0m total benefit from demand led Patient volume upward trend projections across non-elective, outpatients and A&E attendances.
- A number of minor service developments and income generation schemes that have been identified by the clinical divisions. These have been included in the plan on a prudent basis i.e. only where sufficient evidence has been put forward by the divisions to support the developments assumptions.
- Planned reductions in activity from Commissioner service divestments totalling £2.4m. £1.4m of this relates to the closure of the MIU at Heatherwood Hospital under the *Shaping the Future* programme. A further £0.8m of income will be lost owing to the Trust being unsuccessful in retaining the Direct Access Physiotherapy services for Bracknell where Commissioners are transferring these services into the Community.

The expected variations in activity that underpin the Trust's plan, grouped by major point of delivery are summarised in the below table.

Activity - Acute & Specialist		13-14	14-15	% Change	Main driver
Elective inpatients	Spells	6,608	6,802	3%	Demographic growth + 18 week backlog
Elective day case patients (Same	Cases	22,745	24,447	7%	Demographic growth + 18 week backlog + service development for complex echos
Non-Elective	Spells	39,889	40,206	1%	Demographic growth
Outpatients - first attendance	Attendance	66,684	69,113	4%	Demographic growth + activity / capacity review
Outpatients - follow up	Attendance	170,221	172,346	1%	Demographic growth
Outpatients - procedures	Procedures	18,316	18,727	2%	Demographic growth
A&E	Attendance	120,396	105,745	-12%	Demographic growth less closure of HW MIU
Other NHS activity		81,266	86,147	6%	Demographic growth plus reclassification of Echos from OPFU
Other		2,483,455	2,485,048	0%	Largely block contract - Direct Access Pathology, Rehab etc

Figure 17: Key drivers of variances in activity 2014/15 to 2013/14 forecast outturn

1.4.3 The Financial Plan - overview

The Trust has a planned deficit for 2014/15 of £9.2m (£6.9m excluding exceptional items) and is therefore assuming that only £1.0m of this additional expenditure falls to the bottom line. The additional income that is expected to support this expenditure is primarily growth driven. 2013/14 trend analysis suggests that an incremental £2.0m full-year effect will be recurrent, and a further £3.6m of income is either expected to come from demographic growth (£2.2m), or increased productivity resulting from increased capacity (£1.4m). There are also £2.3m of income generation schemes (income CIPs) that are expected to support the position. Crucially the Trust is also assuming that c £4.8m of winter funding will also be made available to the Trust and that any surge in activity over winter can be delivered through the existing capacity.

The key movements between the 2013/14 forecast outturn and the 2014/15 plan are set out in Figure 18 below and a deficit bridge analysis for the full period is at appendix 3.

	£m Income	£m Costs	£m Net
FY14 Actual	250.3	258.5	(8.2)
Exceptionals		(3.4)	3.4
	250.3	**255.1**	**(4.8)**
Normalisation adjustments	(4.8)	(0.7)	(4.1)
Cardiology investment	1.2	0.4	0.8
MSK / MIU divestment	(2.4)	(0.8)	(1.6)
BHFT Rents / PP Income	(2.0)	0.0	(2.0)
Contingency	0.0	3.0	(3.0)
18 Weeks	0.6	0.6	0.0
Inflation	(1.1)	3.8	(4.9)
Rebasing block contract	2.3	0.0	2.3
Growth	6.1	1.3	4.8
FYE Capacity / Quality	0.9	3.2	(2.3)
Corporate Cost Pressures		3.4	(3.4)
CIPs	2.6	(10.9)	13.5
Financing	0.0	2.2	(2.2)
FY15 Plan before exceptionals	**253.7**	**260.6**	**(6.9)**
Exceptionals	0.0	2.3	(2.3)
FY15 Plan	**253.7**	**262.9**	**(9.2)**
Increase	3.4	4.3	(0.9)

Figure 18: Key drivers of 2014/15 variance to 2013/14 forecast outturn

1.4.4 The Financial Plan - income

As discussed above in the Section on activity and capacity, the Trust's income projection for 2014/15 is underpinned by our activity plan. As well as these activity-driven assumptions, there are a number of adjustments to our income projections that are not activity related. These adjustments impact directly on the Trust's deficit position as there is no offsetting marginal cost implication. Of primary benefit will be the Trust's anticipated CQUIN performance; for 2014/15 the Trust is assuming that it will receive £5.2m of CQUIN related income. The Trust is also planning for a £2.2m benefit from the rebasing of its block contract with Berkshire East CCG over-and-above what the CCG currently recognises, and £4.8m of "winter pressure support" as non-recurrent income. (It should be noted that this funds the recurrent cost of additional capacity and quality investment). In addition the Trust expects to receive c. £2.4m worth of previous price discounts funded by Commissioners within the 2014-15 contract.

However, there are also a number of factors that are likely to impact negatively on the Trust's income position. For instance the Trust is anticipating a £2.7m loss of income as a result of the 30% marginal rate emergency threshold (MRET). The Trust has assumed that a further £1.2m will be lost as a result of local commissioner fines and penalties and £0.6m from commissioner Activity Planning Assumptions (APAs), such as A&E attendance to admission ratios and outpatient first to follow-up ratios.

In addition to the above there are a number of further factors that could negatively impact the Trust's income during the year that have not been reflected in the plan. For instance in the period 2014/16 local commissioners[5] are planning to divert £6.8m of their spend with the Trust through QIPP initiatives. The Trust has not yet been provided with any information or detailed plans to support these schemes and has therefore assumed that these will not be successful in planning terms for this submission.

Commissioner contract gap

Contractual negotiations with commissioners are on-going. Figure 19, below, sets out the key differences between the Trust's income plan and the current contractual offer from commissioners. The current total difference on the Berkshire East contract is £7.6m.

	HWPH	East Berks	Gap
Negotiation start-point (based on M7 2013/14)	**149.9**	**149.9**	-
Add-back Paeds zLos	1.2	-	(1.2)
Add-back MRET	0.4	0.4	-
Add-backs other	1.2	-	(1.2)
Tariff deflator	(1.7)	(1.8)	(0.1)
Adjustments to block contract	6.5	4.3	(2.2)
Demographic growth and activity review	2.7	1.1	(1.6)
Service developments	0.2	-	(0.2)
Service divestments	(2.1)	(2.2)	(0.1)
18 weeks	0.6	0.6	-
Transfer to NHS England	(5.3)	(5.3)	-
CQUIN	(0.1)	0.1	0.2
NLFUP /Other	0.1	(1.1)	(1.2)
Trust contractual proposal (BE CCG)	**153.6**	**146.0**	**(7.6)**
BE MRET reduction	(0.9)	(0.9)	-
Comparable contractual positions	**152.7**	**145.1**	**(7.6)**

Paeds zero LoS and MRET pricing adjustments in 2013/14

Mainly F:FU pricing adjustment add-back not recognised by commissioners

Pricing adjustment to block contract not fully recognised by commissioners.

Figure 19: Contractual gap between HWPH and Berkshire East CCG

The further adjustments that the Trust has assumed in arriving at the income plan are set out in Figure 20, below.

[5] In this instance Berkshire East commissioners

Comparable contractual position for HWPH	**152.7**
Value of proposals in respect of other CCGs	73.4
Value of anticipated non-contracted activity	5.4
Total contractual position proposed by HWPH	**231.5**
Further planning adjustments	
Service developments	0.7
MSS coding	-
Commissioner QIPP	-
Further MRET	(2.2)
APAs	(0.6)
Fines and penalties	(1.2)
Winter pressures	4.8
Best practice tariffs	0.2
High cost drug inflation	0.6
Capacity driven growth	1.4
Rounding	(0.1)
Total Trust NHS income plan (before income CIPs)	**235.1**
Income CIPs	2.3
Total Trust NHS income plan (after income CIPs)	**237.4**

Assumed winter pressure funding to support capacity and quality agenda

Figure 20: Further adjustments to income plan

Nevertheless, the Trust is expecting to receive appropriate levels of income for the services it provides to Commissioners. As stated above the Trust has analysed the shortfall in income and estimates this to be in the order of £12m lower than it should have been over the last four years. The Trust has planned for a significant part of this income to come in to the Trust either within the contract or as transitional funding.

1.5 Appendix 2: Assumptions table

		Planning assumptions	
Activity		2014/15	2015/16
	Baseline	2013/14 month 7 forecast outturn (month 7 x 12/7)	2014/15 plan
	Demographic growth	1.5% increase in activity above baseline (£2,215k)	1.0% increase in activity above baseline
	18 weeks	£1.6m	No incremental change
	Trend analysis - NEL	2.4% increase in activity above baseline (718 units) (£1,344k)	No incremental change
	Trend analysis - OPD first	2.4% increase in activity above baseline (1613 units) (£307k)	No incremental change
	Trend analysis - A&E	2.5% increase in activity above baseline (400 units) (£365k)	No incremental change
	Productivity from addional capacity	£1.4m	No incremental change until FPH plan
	Service developments - Cardiology	£1.2m	£1.8m full year effect
	Service divestments - MIU	Reduction of 21,397 attendances (£1,424k)	No incremental change
	Service divestments - DA Physio	All Berkshire East activity removed (4,622 units, £795k)	No incremental change
	Service divestments - Urological cancer	Reduction of 31 units, £199k	No incremental change
	Revenue generation (income CIPs)	£2.6m	nil
	Commissioner QIPP	No financial impact recognised at this time - subject to Commissioner providing detailed plans	No financial impact recognised at this time - subject to Commissioner providing detailed plans
	Better Care Fund	Any redirection of funding will be offset by transitional support	Any redirection of funding will be offset by transitional support
NHS Patient Income			
	Tariff deflator (PbR activity only)	c. -£1.7m	-1.2%
	Non-tariff deflation	-1.5%	-1.5%
	Non-clinical income inflation	0.0%	0.0%
	Other income inflation	0.0%	0.0%
	CQUIN delivery	£5.2m	No incremental change
	Emergency readmissions within 30 days	-£2.4m	No incremental change

Marginal rate emergency threshold	-£2.6m	No incremental change
Commissioner Annual Planning Assumptions (APA)	-£0.5m	No incremental change
Commissioner fines and penalties	-£1.2m	No incremental change
Winter pressures funding	£4.8m	No incremental change (i.e. a similar level of funding would be received in 2015/16)
Revenue generation (income CIPs)	£2.6	£2.6

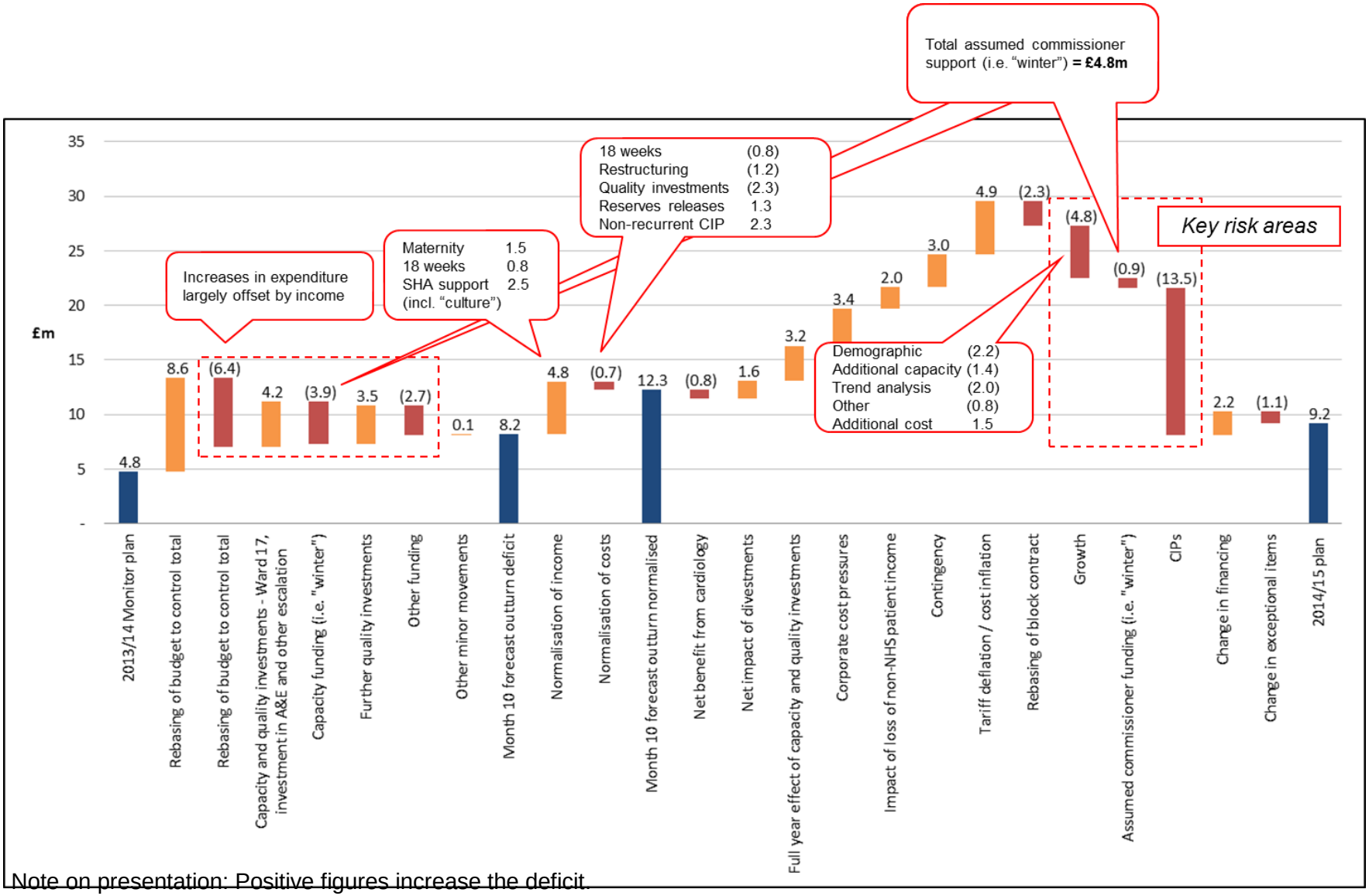
Expenditure

Baseline	Initial M6 Forecast x6 + Outturn Adjs	2014/15 plan
18 weeks	1.6 (£1.0m rolled forward from 2013/14)	No incremental change
Winter pressures	Delivered from new cost base post investments in capacity	Delivered from existing cost base
Pay inflation	0.75%	1.50%
Drug inflation	5.0%	5.0%
Clinical supplies inflation	3.0%	3.0%
Other cost inflation	3.0%	3.0%
Division D management team	£0.6m	No incremental change
Service developments - Cardiac cath lab	c. £400k	c. £1.2m FYE
Service divestments	c. £800k in aggregate	c. £800k in aggregate
Trust recurrent CIP	£10.9m	£12.1m
Trust non-recurrent CIP	£2.4m	£0.0m
FYE investment in capacity and quality (pre CIP)	£3.2m	No incremental change
Restructuring and other exceptional	£2.3m	None assumed. Will depend on FPH acquisition process
Contingency	£3.0m	No incremental change

Balance sheet

Cash	£3.4m	£0.6m
Working capital	£1.3m decrease	£2.1m
Capex	£20.6m	£31.5m
PDC support	£22.8m	£22.5m

1.6 Appendix 3: Deficit bridge analysis



Note on presentation: Positive figures increase the deficit.

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