Royal Brompton & Harefield NHS
NHS Foundation Trust

Operational Plan Document for 2014-16

Royal Brompton & Harefield NHS Foundation Trust

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

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

Name	**Piers McCleery**
Job Title	**Director of Planning & Strategy**
e-mail address	**p.mccleery@rbht.nhs.uk**
Tel. no. for contact	**020 7349 7706**
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;**
- **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)*	**Sir Robert Finch**

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	**Robert J Bell**

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	**Richard O'D Paterson**

Signature

1.2 Operational Plan

1.2.1 Executive Summary

The Trust continues to meet strong demand across both sites and across all specialties for its clinical services. There are operational challenges in terms of scheduling and accommodating increasing quantities of inpatient and daycase episodes and outpatient clinic appointments, but we believe that we will be able to maintain the clinical quality of these services while achieving a financial surplus over the two year period of the operational plan. Our performance over the last year (FY13/14) – for example, low levels of surgical wound infection; high levels of staff engagement within our peer group of providers; the 11th most highly placed Trust in the UK in relation to the 'Friends & Family Test'; and growth in research grant income and in private patient income – gives us confidence that this plan is achievable.

1.2.2 Short-term challenges

1.2.2.1 The local health economy

- Since 2012, health and social care providers and commissioners within North West London have dedicated time and resources to address the key challenges of looking after and caring for a growing and ageing population, of working from inadequate NHS facilities, and of working within an increasingly tight financial envelope. These challenges need to be met, or the quality and financial sustainability of NHS clinical services in NW London will deteriorate. Alongside GPs, hospital doctors, community providers, nurses and wider NHS staff from other Trusts and commissioner bodies, we have since 2012 participated in the 'Shaping a Healthier Future' (SaHF) programme, to determine how best i) care can be delivered closer to people's homes; ii) hospital care can be centralised onto specific, specialist sites; and iii) an excellent patient experience can be delivered through one seamless system of care across all organisations and facilities concerned. Many of the plans within this programme involve significant reconfiguration of services and demand the execution of sizeable capital projects, both of which bring very substantial challenges to our local health ecomony. Implementation of some key workstreams, such as the transfer of services between different hospitals & Trusts, is planned to begin in the middle of 2014.
- Although the SaHF programme office had determined at the outset of the programme that our Trust was not directly affected by this programme, nevertheless we remain wholeheartedly in agreement with the vision that the Shaping a Healthier Future programme has articulated, and we are committed supporters of the need to deliver more integrated and joined-up care across the multiple levels of provision within the health system. To this end we are working with Hillingdon Hospital NHS FT and Hillingdon CCG in developing a community-based diagnostic and rehabilitation cardiology service, and continue to expand our pulmonary rehabilitation services in community locations within the borough of Hillingdon. We also will support the implementation of the programme by continuing to work closely with and in support of two of the six acute Trusts participating in this programme who are our partner Trusts - the Hillingdon Hospitals NHS Foundation Trust and the Chelsea and Westminster NHS Foundation Trust, with whom our Harefield and Royal Brompton hospital sites respectively collaborate

1.2.2.2 National commissioning intentions

- Our roles within the SaHF programme and as a founding member of the Imperial Healthcare Partners Academic Health Science Partnership demonstrate our commitment to take an active and supportive role in our local NW London health economy. However the great majority (c.85%) of our NHS clinical income is commissioned by NHS England Specialised Commissioning Services (NHSESCS), whose strategy and intentions (we understand) are due to be published in draft form for consultation with providers towards the end of April. Briefings from Mr James Palmer (Medical Director for NHSESCS) suggest that a principal tenet of this

strategy will be to encourage the consolidation of the number of specialist service providers within a given service, specialty or group of related specialties, by only paying for services from centres that meet the service standards set by a national Clinical Reference Group. The primary motivation is to improve clinical outcomes by concentrating higher volumes of patients within fewer centres.

- While we believe that all of our services have the critical mass and prerequisite components to meet these standards, we are concerned that in some specialty practice areas the application of the volume / outcome hypothesis to justify particular volume thresholds (per centre or per practitioner) may be based on too limited an evidence base, and that it may pay insufficient regard to issues such as contingent damage to other linked services as well as patient access and experience. However we look forward to engaging positively with NHSESCS around this strategy and its implementation.

1.2.3 Quality plans

1.2.3.1 Overview of the quality assurance process

- To ensure that the Trust is able to provide the appropriate levels of assurance on effective internal control to the Trust's patients, to its Board of Governors and to its stakeholders, the Risk and Safety Committee (RSC) has been established as a sub-committee of the Board. This committee, with membership of the Trust's Non Executive Directors and attended by the Executive Directors, oversees and scrutinises the systems for internal control, whether financial, clinical or operational, in order to seek assurance that risks are identified and adequately managed. It receives regular performance reports from the Governance and Quality (G&Q) Committee, chaired by the Medical Director and Deputy Chief Executive, which provides management scrutiny of the Trust's risk management issues against an integrated governance and patient safety agenda.
- Review of risk is carried out initially at a local / departmental level, with the facility to escalate relevant risks (through the division and/or department Quality & Safety lead). Every 6 months, the top risks for the trust are reviewed at the G&Q Committee, where representation from each of the clinical and non clinical divisions ensures the Trust is able to share best practice and respond to identified weaknesses. A performance report relating to these risks and their mitigation is then forwarded to the RSC. In turn, a summary of risks then goes on to the Trust Board, presented by the Chair of RSC. This reporting process has undergone significant change and development over the last 12-18 months, in that the report also now details what new risks have been added, any risks which have been upgraded, progress with closing/downgrading existing risks, internal and external, current and future risks to the organisation.
- The Trust has put in place a Risk Management Strategy which assigns responsibility for the ownership and management of risks to all levels and individuals to ensure that risks which cannot be managed locally are escalated through the organisation. This process populates a central Risk Register which constitutes a systematic record of all identified current and strategic / future risks to the organisation. All risks are evaluated against a common grading matrix, based on the NPSA model, to ensure that all risks are considered alike. The control measures, designed to mitigate and minimise the identified risks, are recorded within the register. The Risk Register is continually reviewed by the RSC and by the Board to ensure that these risks are being adequately controlled, and it also informs the collation of regular self assessments against the Quality Governance Framework (QGF).

1.2.3.2 The Trust's current quality performance

- The Trust is registered with the Care Quality Commission (CQC) without any conditions. The CQC's two most recent inspections carried out during the last 12 months – of Harefield Hospital in February 2014 and of Royal Brompton Hospital in August 2013 – resulted in both sites being deemed to be fully compliant.
- The Trust's performance is also assessed by Monitor through its compliance framework of key performance indicators, against which targeted achievement is measured. Currently all but two targets have been met by the Trust in FY13/14: these relate to Clostridium Difficile (C.Diff) and the 62 day wait for 1st treatment for cancer.
- C.Difficile: the Monitor de minimis of 12 was breached in Q4 2013/14. The Risk Assessment Framework, published on 2nd April 2014, states that both avoidable and unavoidable cases will be taken into account. This differs from the Trust's understanding of commissioners intentions for 2014/15 where commissioners have stated an intention to make a determination of whether a case should count against the trajectory, according to the circumstances of the case. It is possible that the Trust may be compliant with the centrally set C difficile objective of 9, should cases where there have been no lapses of infection control standards be deemed non trajectory (unavoidable), while failing the Monitor de minimis through the rolled forward requirement to report both avoidable and unavoidable cases against the Monitor de minimis.

- 62 day cancer pathway: the Trust provides surgical treatment for patients with lung cancer. The lung cancer pathway is long and complex and patients are often referred to the Trust after day 62. When this happens the Trust seeks reallocation of the breach to the referring Trust. Indeed, Department of Health guidance indicates that reallocation of breaches for referrals made after day 42 may be appropriate. During 2013/14 the Trust sought breach reallocations on this basis, but with a seemingly increasing level of resistance from referring Trusts. At the time of writing it seems likely that the Trust will fail to meet this target in Q4 2013/14. There will continue to be a risk of target failure in 2014/15. The Trust has commissioned a review of lung cancer pathway services with the objective of finding out whether referrals could be made an earlier point in the pathway. The Trust is also talking to NHS England about the desirability of the Department of Health guidance being adopted nationally as an operating standard in order to ensure that breach reallocations can be effected when appropriate.

1.2.3.3 Key quality risks

- Within the Risk Register there are currently two quality risks which score a 'red' rating of ≥20 in terms of their severity. Both these risks relate to the Trust's physical infrastructure – ie buildings and facilities – and in particular to i) the maintenance backlog, ii) the existence of areas that are unsuitable for patients and staff. As highlighted in the last two years' Annual Plans, the age and fabric of many of the Trust's buildings has meant that some of them could potentially pose a risk to the health of patients, staff and visitors. A 3-year accelerated planned preventative maintenance (PPM) programme is now coming to an end, which has been supported by a ring-fenced allocation of capital from the Trust's Capital Working Group, and within which target areas of both hospitals have been classified by the severity of the risk that they posed. The Capital Working Group has approved the allocation of further sums to continue this accelerated programme for one more year during 2014/15, focusing in particular on asbestos removal and fire safety works in the Fulham Road Wing which represent nearly all of the remaining intermediate risks within this building (all high risk items having been addressed in FY12/13 and early FY13/14). All existing maintenance risks in all buildings across both sites continue to be listed and monitored individually on the Risk Register.

1.2.3.4 Quality priorities

- The Trust has six Quality priorities for 2014/15 which are listed below:

i) Quality & Productivity programmes: this is a programme which started at Harefield in Autumn 2012 to look holistically at the cardiac surgery service, identify where there are challenges, to agree the changes to be made and to oversee their implementation. The programme focus has been broad, incorporating clinical leadership and staffing, conduct, waiting list management, plant and building improvements, and quality of care and outcomes in theatres, ITU/HDU and on the wards. It has included all the surgeons and other relevant multidisciplinary clinical leads, clinical and non-clinical directors, managers and other support staff. Notable achievements to date include outcomes having improved for 3rd year in a row (as reported by the SCTS); two new consultant posts have been appointed to; new clinical leadership for and improved staffing for ITU is now in place; there is clear agreement on the plant developments which would be of most benefit, and this is now represented within the capital investment plans for Harefield; and waiting lists have been reduced as a result of the surgeons pooling work within 2 teams.

   In Autumn 2013, the programme has been extended to the cardiac surgery service at Brompton. This programme has identified a different set of challenges, but the principles of the programme and membership are similar. For Brompton the focus is spread over 8 sub-groups – caseload composition, referrals, plant, efficiency in theatres and labs, patient pathway, team working, research education and training, information technology and communications. The stated ambition is for both these programmes to merge in the latter half of 2014-5 to further strengthen the ties between the 2 sites.

ii) Intensive care family satisfaction surveys (RBH AICU & PICU, HH ITU): this is a programme whereby patients, and particularly the families of patients who have stayed in intensive care, are asked to complete a bespoke questionnaire as to their experiences at such a difficult time. It was started in Brompton AICU, but has recently been rolled out to Harefield; and a modified version to PICU. The feedback gained is used to help staff understand the perspective of the family, and identify where and how we can improve and take that more into account - for example, making sure more regular updates are given to families in the waiting room, when the patient is acutely unwell. The palliative care team, who have usually already developed a relationship with the family, have started to take on that role. This year, the aim is to embed the programme fully across all ITU areas, and to look at sharing the learning across the sites, as well as just within each unit.

iii) Lung cancer review programme: this is a review of the whole lung cancer pathway at Harefield and is partly in response to the challenges of being a tertiary centre only involved at the end of the 18 week wait pathway. However the review is looking more widely at the whole service, including surgical and non-surgical support, as well as taking account of input from key partners outside of the Trust, the relationship with referrers and primary care /community services. The programme has just started in 2014, but is anticipated to develop along similar lines to the Quality & Productivity programmes in cardiac surgery.

iv) 7 day working: NHS England require all trusts to have defined what 7-day

working means for them, and to have put in place the necessary changes to deliver it by April 2017. The High-intensity Specialist Led Acute Care (HiSLAC) project is a national research programme which we have volunteered to be involved in. Funded by the NIHR-HSDR programme, the project is designed to evaluate the efficacy and cost-effectiveness of that component of seven day services which focuses on increasing specialist (consultant) input to the care of acutely ill medical admissions at weekends. This project is just recruiting trusts to be involved now, so details are a little thin as to the nature of the project at this point, but will become clearer as the year progresses.

v) Theatre cancellations for non-clinical reasons: this is a known challenge for both sets of our theatres, and will be similar in other Trusts. The programme is now looking to develop further by looking at longer term trends, to identify and implement multiple small changes which should make the process more efficient and effective, and reduce the number of cancellations occurring. It is anticipated that this programme will be started in 2014-15, but implementing all the improvements and then giving time for these to take effect is likely to take longer than 12 months.

vi) Medication errors for children's services: medication errors are one of the main categories of incidents reported nationally and within the Trust. Most are 'near-miss' events, and result in minor or no harm to the patient. There is already a strong improvement programme in this area overseen by the Medicines Safety group, and the Trust has a good record of medicine safety. In 2014-15 there will be particular focus specifically on Children's Services, to look at all aspects of medication errors from prescribing to calculation to administration to drug interactions, and to identify and implement multiple small changes across all these areas, which should lead to there being more efficient and effective processes in place. The absolute number of incidents reported will be tracked, but may actually increase, if the raised awareness means more may be reported. As a result, the success of the project will be assessed more holistically.

1.2.3.5 Response to the Francis report

- Following the publication last year of the final report of the public inquiry by Robert Francis QC into care at Mid-Staffordshire NHS Foundation Trust, the Trust has prepared a plan that addresses the particular concerns which the Secretary of State of Health drew from this report. This plan has four main attributes:

  i) Focus on the patient, culture and standards: over the last 6 months 'Barbara's Story' has been shown to over 500 staff and the Trust Board. This is a fictional film of a patient's story of coming to hospital and is used to stimulate discussion and awareness of patients' perceptions and of dementia. It will continue to be shown during 2014 and is included in general induction. Staff and patient workshops also have been reconstituted so as to be more focused around a specific area or service in a division, and will occur at least twice a year. Feedback from the different sources relating to this area / service / division (e.g. national survey, Friends and Family test, complaints, PALS, social media and NHS choices) will be collated before each workshop and will be used to stimulate discussion. The aim is to identify and make improvements that patients view as important.

  ii) Strengthening the patient voice: involving patients and staff together in a process

of experience based co-design was the subject of an NIHR research project in which this Trust was involved (ICU at Harefield and lung cancer at Royal Brompton), and following completion of the study the process has been used again in lung cancer at Harefield. Fifteen patients and relatives were involved with another 30 wanting to be copied into outcome information of the project. The key areas were discharge (and in particular looking at improving the discharge lounge facility) and chest drains (since patients go home with these in place, and have noted that these were 'alien' to them and their partner/relative. Other projects involving co-design have been carried out in AICU and the respiratory service at Harefield. The Trust started using the Friends and Family Test (FFT) in December 2012 and has exceeded the15% response rate. The Net Promoter Score was introduced in February 2013 and our Net Promoter Score (NPS) has been between 80 and 90, the 3rd highest of all Trusts in London and 11th highest nationally.

iii) Application of the Francis report's particular recommendations: Eighty-one recommendations were identified as having at least some immediate application to hospital Trusts, and with a few additions and deletions following the Government's response the Trust has actions to implement. An internal audit review by KPMG of these actions has concluded that the recommendations should be RAG rated to identify the progress we are making in addressing them. The aim is to complete all actions possible in 6 months; following this implementation, recommendations by other bodies may lead to additional actions being applicable within the Trust over the next year.

iv) Schwartz Rounds: The national implementation and recognition of the Schwartz Round programme continues to increase, and its positive impact was specifically identified by Robert Francis, who along with another member of his panel attended a Round at the Trust. Rounds allow staff to get together once a month on alternate sites to reflect on the stresses and dilemmas that they have faced while caring for patients. Research pilot sites in America and England show staff who attended Schwartz Centre Rounds feel they communicate better with their patients and colleagues; are less isolated and more supported; feel better able to cope with the emotional pressures of their work; and understand better how their colleagues think. The Rounds have also enabled teams collectively to share the conflicts and the challenges of letting go when there are no treatment options left for their patients; and provide a space for colleagues to hear each others' stories often for the first time. This sharing enhances team working and provides a glimpse of the person in the professional.

1.2.4 Operational requirements and capacity

- The current commissioning environment is characterised by aggressive QIPP agendas and tariff deflation. The Trust's Financial Stability Plan therefore for the last 3-4 years has been characterised by an equal split between cost reduction/efficiency initiatives and new service developments generating margin, but delivered from more or less the same physical infrastructure. Although there have been some capital investments that have added capacity (e.g. 2 sleep labs at RBH; Acorn Ward and a 4th cath lab at HH), this capacity has readily been filled. On both sites and across all specialities - cardiac surgery, thoracic surgery, transplantation, cardiology, imaging and respiratory medicine – strong demand for the Trust's clinical services has not slackened: and where the pace of growth

has slowed – eg in paediatric inpatient activity – the limiting factor has been capacity rather than a withdrawal of demand.

- To maintain the clinical quality of our services and also a financial surplus position in this environment, our operational plans must be able to accommodate continued growth in the volume of activity, both to respond to demand and to reduce unit costs. While significant capacity expansion at RBH will be linked to the Chelsea campus redevelopment, which may start on site in 2018, short-to-medium term expansion is possible at Harefield, which will not only address current capacity pressures but also make possible longer-term redevelopment ambitions when resources permit.
- The current capacity planning assumptions that have been originated by the operational management teams and approved by the Trust's Capital Working Group are laid out below, and apply to the 5-year period to 2018:
    i) RBH:
        - Redevelopment work will not start on-site before mid-2018 (planning and design costs will be incurred throughout the period)
        - Fulham Wing will continue to accommodate services largely as now – with material implications for ongoing backlog and other infrastructure investments
        - Paediatric inpatient capacity will remain on-site – the joint venture with Chelsea & Westminster NHS Foundation Trust is in a planning phase. In the interim period, there will be a full year benefit from the addition of four more PHDU beds.
        - Additional outpatient clinic space will be created on Level 1 of the Sydney Wing adjacent to the cardiovascular BRU in order to accommodate growth in the inherited cardiac conditions services.
        - Off-site outpatient (in the vicinity of Harley Street) and inpatient capacity will have been commissioned for private practice.
    ii) HH:
        - Although long-term redevelopment will be in the planning phase only, over the next six months we will be assembling and testing a viable development and funding plan to create a Graduated Care Graduated Care and Imaging Centre. This building would consolidate all level 2 & 3 beds and also major scanning modalities within a single, purpose-built facility.
        - Over the next 18 months, we will address short-term capacity constraints by installing a modular-built extension to the Level 3 ITU that incorporates 6 additional beds. A modular-built scanning centre will be installed to house a fixed MRI scanner (to replace current sub-optimal mobile provision) and a second (and high-end) CT scanner. We will also be adding a further 18 Level 1 beds in the form of a 2nd floor for Acorn Ward.
        - There will also be an opportunity for greater shared use of accommodation in Phases 1 and 2 of the Heart Science Centre between the Trust and Magdi Yacoub Institute, for research and administrative purposes.
        - Towards the end of 2014/15 we will begin to convert the former thoracic theatre suite in order to bring it back into clinical use as an endoscopy facility, with additional daycase / short stay beds for respiratory as well as cardiac patients, and some additional transplant inpatient beds.

1.2.5 Productivity, efficiency & CIPS

1.2.5.1 Financial Stability Plan (FSP) - introduction

- The Trust's FSP brings together all measures designed to improve financial viability – saving and cost improvement plans; service developments delivering additional financial contributions; and cost-pressures managed or mitigated to avoid additional cost. For 2014/5, the FSP aims to deliver c£9m and for 2015/16 c£12m. In terms of oversight arrangements, delivery of the FSP is the responsibility of the Chief Operating Officer. Progress is monitored via monthly Operational Management Team meetings, and individual review with key budget-holders. In addition, quarterly reviews provide a forum for wider executive review of progress against plan, and for broader discussion of risks and further remedial action where necessary.

1.2.5.2 FSP profile and enablers

- The 2014/15 FSP comprises £3.9m of service development contribution and £5.1m of cost reductions. Service developments are centred around new private patient services led by a new outpatient facility in the Harley Street area, growing demand for services at Harefield and critical care services on both sites. Pay savings total £1.9m and these include job-plan changes amongst senior medical staff; further material reductions (>£0.5m) in usage of junior medical agency staff; similar levels of reduction in reliance on agency nursing (although the sums identified for 2014/5 are less ambitious than in 2013/4 and take account of the challenging recruitment and vacancy position the Trust faces in, for example, critical care areas). Non-pay savings total £2.0m and focus on changes to maintenance contracts and equivalent arrangements, and improvements in procurement and stock control/inventory management. Savings are achieved both through obtaining best possible unit prices from key suppliers (facilitated by the uniquely high volume of many procedures undertaken in the Trust), and increasingly by rationalising the number of suppliers with whom the Trust contracts. The Trust has been exploring longer-term relationships with its major suppliers in order to derive the maximum advantage in terms of access to technology, 'pipeline' developments and current products (without compromising procurement regulations).
- The 2015/16 FSP comprises £7.0m of service development contribution and £4.9m of cost reductions. Service developments are centred around the second year of the new private patient outpatient facility (and resulting inpatient flow) and the activity flow from the short-term expansion of Harefield facilities. Cost savings are anticipated to be delivered in similar proportion to 2014/15.

1.2.5.3 Quality impact of FSP

- Each proposed FSP scheme is assessed by the local (divisional/ directorate) management team (including lead clinicians) for its implications for service quality and safety. Once schemes are agreed and included in the draft budget proposals, a summary of the schemes, their relative and/ or potential risks is presented to the Medical and Nursing Directors before being considered by the Board alongside the Annual Plan (and reported to the Risk & Safety Committee).
- During the year, the Trust's quality and safety processes (routine audits, incident reporting and review) are used to identify any potential, unforeseen consequences of FSP schemes. During Q2, a specific review is undertaken of each FSP scheme and its operation and impact, and reported via the Governance & Quality Committee to the Board's Risk & Safety Committee.

1.2.6 Financial Plan

1.2.6.1 Assessment of the Trust's current financial position

- The Trust anticipates finishing the financial year 2013/14 with net assets of c£225m, cash resources totalling c£15m and no borrowings. Liquidity was also satisfactory. Looking ahead the Trust faces a number of headwinds:
    - i) First, reductions in tariff and continuing cost inflation mean that achieving budget for 2014/15 will be demanding, following hard on the heels of four years of CIPs and service developments.
    - ii) Secondly, the Trust must maintain and renew its ageing infrastructure assets on both its sites: this will inevitably represent a drain on cash resources.
    - iii) Finally, the Trust must invest in new and improved facilities to meet growing demand for its services, free up service bottlenecks, and create a legacy for future generations of patients, consistent with its brand as a national and international leader in the treatment of heart and lung disease. This will represent a further drain on liquidity.
- The Income and Expenditure plan for 2014/15 shows a budgeted surplus of £2.3m on income totalling £350m and for 2015/16 the current plan is to achieve break-even.

1.2.6.2 Income

- The principal driver of income is existing capacity supplemented by expansion noted above. Confidence is founded on the three main sources of activity - additions to the waiting list, new OP referrals and inter-hospital transfers, all of which remain strong. We have no current or expected risks to planned income, no activity management plans and no inimical commissioning intentions.
- We have assumed as in prior years that the Trust will receive its allocation of Project Diamond monies (c£10m) in each year covered by the plan. Monitor have flagged that they intend to address tariffs for complex and specialised services early in their review of PbR, and it is possible that over the plan period Project Diamond funding will be integrated into tariffs. We have assumed net tariff deflation of 1.5% (gross 4.0% efficiency plus 2.5% uplift for inflation) in both 2014/15 and 2015/16.
- Total income is budgeted to grow from c£335m in 2013/14 to c£350m in 2014/15 and then to c£360m in 2015/16.

1.2.6.3 Costs

- The Trust's recurrent cost base is rising by a net c£20m in 2014/15. Contained within this amount is £2.4m of contingency funding to mitigate against any unexpected costs and/ or shortfalls in the FSP. The impact of pay/ non-pay inflation and incremental pay drift has been assessed at £3.4m in 2014/15 (this amounts to a 0.8% & 1.3% overall uplift to pay and non-pay costs respectively). The costs associated with generating the service development income and contribution are £7.5m in 2014/15. The gross cost reduction element of the FSP programme is £3.9m, split £1.9m to pay as outlined above and £2.0m to non-pay where procurement savings again feature within the budget. A fuller explanation of the FSP is outlined in the sections under 1.2.4 above. Of the c£9m balance of cost increases, £3m is driven by increased/ new usage of PbR excluded drugs and therefore neutral to overall I&E. The full year effect of these uplifts is reflected in year 2 of the forward plan.

1.2.6.4 Key financial priorities and investments

- The Trust's principal financial target, over the two financial years as a whole, is to maintain a Continuity of Services Risk Rating of a minimum of 3 under Monitor's compliance

regime. The headwinds referred to above will stretch the Trust's financial management and resources.

- In March 2013 the Trust Board approved a recommendation to rebuild/ renew its two hospitals within the constraints of affordability, and progress has continued through 2013/14. With regard to Royal Brompton in particular, the intention is to raise the necessary funds for rebuilding through sales of Trust property in Chelsea that is not required for the operational purposes. It is the Trust's intention to obtain approval for a masterplan for each campus consisting primarily of hospital and residential usages.
- Major hospital construction activities at Royal Brompton will not commence within the next two years, however the Trust will necessarily incur substantial planning and design fees over that period. In the longer term, bridging finance may be required to pay for construction costs until the proceeds of real estate sales become available. This will depend on the timing of real estate transactions.
- The capital investment programme of approximately £70m over two years is unprecedented in the Trust's history (annual investment has hitherto rarely exceeded £20m, and will be £23.5m in 2013/4). Major components of the programme include: investment of at least £16m to support the Information &Technology strategy (infrastructure and applications), major imaging investment (CT and CMR modalities at both sites), increasing bed capacity at Harefield, a hybrid theatre at Royal Brompton and redevelopment fees noted above. To support this increased level of investment, external funding is being secured from the Independent Trust Financing Facility totalling £30m over the three years (starting 2014/15 at £10m per annum).