



Royal Berkshire NHS Foundation Trust

Integrated Business Plan
2013 – 2018

Stakeholder Summary: August 2013
(Draft version for discussion purposes)






Executive summary

Introduction

As a foundation trust, the Royal Berkshire NHS Foundation Trust (RBFT) needs to ensure a solid financial base so that we are able to continue to invest in services for our patients, deliver high quality care with the best outcomes and an exemplary patient experience. Our Integrated Business Plan (IBP) sets out our challenges for the next five years, namely: to continue to deliver safe and high quality patient care in tandem with identifying further efficiency challenges.

Quality of care remains our top priority and is at the heart of our strategy, which seeks to build on and continuously improve the quality of our services, clinical outcomes and clinical productivity. Our services are already amongst the safest in the country with low mortality and infection rates an improving patient experience and good operational performance. This is supported by our historically strong financial performance, with earnings before interest, tax, depreciation and amortisation (EBITDA) of above 6% and track record of delivery of Cost Improvement Plans (CIPS). Although some of our estate is modern there is a significant capital programme of £100m over the next 10 years to ensure that all our facilities meet our current and future needs.

Market Assessment

The context in which we operate is changing and will impact significantly on the configuration of our services over the next five years. These changes are likely to see a shift in a large number of outpatient attendances into the community as we harness new technology and also improve the range of diagnostics at our community sites. We have analysed the impact of the growing population (particularly the growing numbers of elderly people) and lifestyle factors for our catchment population over the next five years and have reflected these in our planning. Overall a residual growth rate of approximately 5% and 11% has been assumed for elective and outpatient activity in the most likely growth scenario over the next 5 years.

Strategic and service delivery options

The future organisational form of RBFT is uncertain but the likelihood, and our preferred option is that we will remain as a stand-alone organisation, vertically integrated with community providers to deliver seamless care to patients. We recognise that any option will take time to be implemented and that we will need to be a stand alone organisation in the short term. We will continue to strengthen our position by addressing the cost of financing with increasing emphasis on being part of healthcare groups, clinical networks and delivering integrated care with our partners. However our assessment is that we will reach a point where this arrangement will no longer be viable and we anticipate that this will probably be in the next 3 years. The impact of the anticipated growth in demand alongside the relocation of appropriate activity into the community means that we will need to develop services that can deliver the anticipated requirements of our patients over the next five years, whilst ensuring that our income grows sufficiently to support our plans. The impact of our service developments and the increasing demands have been converted into activity projections.

Financial Plans

We have a track record of significant cost improvement programmes, totalling £49m over the last three years. We need to continue to deliver further savings of between 3-5% over the next five years and we have identified Quality, Innovation, Productivity and Prevention (QIPP) Programme opportunities of £46m over this period. Of major concern to the Trust is the current penalty regime around non elective threshold and readmissions, resulting in lower payments for this unavoidable growth in non elective work which is predicted to grow to £8.4m in 2013/14: the equivalent of treating 4000 patients for free. Based on projected high growth activity assumptions, we have modelled our income growing by £44m to £381m with a surplus of £6.5m. However, this is based on assumptions regarding service development and growth in activity. In our limited growth activity model, we would actually see our income reduce from 2012/13, representing a £49.5m reduction from our high growth model and final year deficit of £1.9m.

Demand management and activity growth

The general trend in activity over the last few years has been of significant growth, particularly in emergency and non-elective care. We are therefore committed to supporting commissioners in the successful implementation of demand management, including shifting activity from day case to outpatient procedures and ensuring reductions in the number of follow up appointments. The Trust continues to be a top performer in day case rates and reductions in outpatient follow up activity, resulting in financial savings and avoidance of unnecessary hospital stays. Our implementation of admission avoidance schemes for non-electives have been successful but are currently not keeping up with the pace of increase of non-elective admissions and there is predicted to be continued growth in referrals year on year which is leading to a growth in our waiting lists.

Limited growth activity models are predicated on the assumption that commissioners plan to introduce effective demand management schemes. If these schemes are fully embedded the medium and high growth in activity we have projected may be avoided. As we have not yet seen significant impact of these schemes in reducing activity, we have set out the required increase in capacity across the health economy to match demand. This increase in capacity may be mitigated by the corresponding success of demand avoidance through reducing lengths of stay, delayed discharges and readmissions in addition to developing alternative and more efficient and effective treatment pathways or locations.

Activity growth projection

We have modelled three scenarios:

- Limited growth – assumes income will remain flat.
- Medium growth – our most likely estimate of future activity.
- High growth - a higher rate of growth based on specific assumptions around market share and service developments.

Both our medium and high growth scenarios are below the historical trends in activity increase that we have seen in recent years

	Medium growth over 5 years	High growth over 5 years
A&E	20%	33%
Outpatients	11%	17%
Day cases	26%	28%
Non Elective	10%	26%
Elective	5%	8%
Direct Access	4%	4%

We therefore expect to see the following shift based on activity between now and 2017/18:

- Potentially 125-196 extra inpatient beds required (based on our medium to high growth analysis and an assumption of 87% occupancy.)
- Shift from Inpatient to day case and outpatient activity, with predicted growth of between 12-17% for outpatient slots.
- Potential increase in Berkshire West market share to 80%.
- Income will increase to circa £360-380m.
- Increase of our usage of community sites.
- Estate reconfiguration and investment of £10m per annum.
- Expansion of specialist centre.

Conclusion

RBFT is a strong acute Trust with a large A&E and maternity unit, a good reputation, excellent clinical performance and a sound operational record. The quality of the services we provide is our top priority. The hospital is valued for its core services and our vision is to strengthen these, continuously improving quality whilst shifting appropriate work out of the hospital and integrating our services across the community.

We are a healthcare provider committed to doing better through teamwork. We recognise that far from being independent we are interdependent, working within a broader health system with an emphasis on lasting relationships with our partners to make a difference for our patients and their families. We pursue continuous improvement with the passion and perseverance to become one of the country's best healthcare providers. It is vital that each aspect of our work in future drives better value by seeking to enhance the outcomes of care and through the redesign of clinical pathways to reduce the costs of those outcomes. We will seek to do this by working together in partnership.

Summary of our strategic vision

Where we are

The Royal Berkshire NHS Foundation Trust

- Large DGH Plus.
- Services to local people across Berkshire and Oxfordshire.
- Hyperacute and specialist services
- Significant emergency pressures crowding out activity.

Clinical operating model – Care groups

- Patient-centred clinical operating model, organised around patient needs: Networked; Urgent; and Planned.

Our estate

- Some facilities not matching the patients' expectations.
- Significant expenditure to maintain at an acceptable level.

Financial position

- Current funding not fully following the patient, therefore required non-recurring funding.
- High costs of historic investments.
- Savings of £49m in last three years.

The challenge

Ensure ***safe, high quality care*** for all, with improving patent experience and operational performance. The population of older people is increasing higher than the national average, increasing admissions, length of stay and pressure on non elective beds.

Matching demand with capacity and skills: Increasing levels of non-elective demand are not fully reimbursed, reducing margins and impacting on elective activity. Capacity constraints continue to increase waiting lists and reduced market share of commissioned activity.

Competition to provide ***healthcare across our entire community:*** responsive to the needs of the patient and the health economy. Independent sector pose a threat to our elective and ambulatory services. The new outpatient and elective markets have grown in recent years with the single largest determinant of competition being waiting times.

Deliver ***financial stability***, ensuring appropriate funding for all the work that we do. Medium growth model delivers financial stability through service development and growth in activity. Downside model would result in a potential deficit and a reduction in cash.

Developing an ***estate that can deliver rationalised and integrated services*** reflecting our clinical services strategy, delivery of high priority maintenance backlog; and those developments of highest priority e.g. ICU Emergency Department.

Our strategic options

Vision

- Vertically integrated DGH Plus.
- Top decile performer for quality, including patient experience and outcomes.

Activity and capacity plan

- Capacity to match growth in population and service developments.
- Additional system capacity to be provided to address forecast 125 extra beds for mid-case scenario.

Estates

- Range of options: Best use of RBH and community facilities to deliver clinical services strategy.

Our financial plan

- Financial plan (medium growth) is based on activity below historic trends.
- If limited growth activity scenarios are correct then this will lead to a reduction in income and 'stranded' costs.
- The RBFT will need to be appropriately paid for the activity delivered.

About us

Our services are primarily commissioned by the newly formed Clinical Commissioning Groups (CCGs) in Berkshire. However, our services also draw in patients from neighbouring areas, most significantly South East Oxfordshire. Our catchment population is approximately 500,000 and we provide specialist care, including cancer services, bariatric care and hyperacute stroke and heart attack services to a wider population of approximately one million. We are one of the largest district general hospitals in the country with an annual turnover of circa £320m and we employ nearly 5,000 staff across a wide variety of clinical and non-clinical roles.

Our locations

Our staff deliver a wide range of care and treatment at a range of locations across Berkshire and South Oxfordshire.

Our specialist centre is the Royal Berkshire Hospital in Reading, a large district general hospital with the expertise available to treat patients requiring urgent or hyper-acute care.

Additionally we have a number of community sites where we deliver ambulatory care and diagnostics. A key part of our strategy will be developing the range of services offered in the community to take a greater proportion and range of care nearer to, or at, patient's homes. Our major community sites include:

- West Berkshire Community Hospital (day case surgery also provided);
- Prince Charles Eye Unit (day case surgery also provided);
- Royal Berkshire Bracknell Clinic; and
- Townlands Community Hospital.

Clinical operating model – Care groups

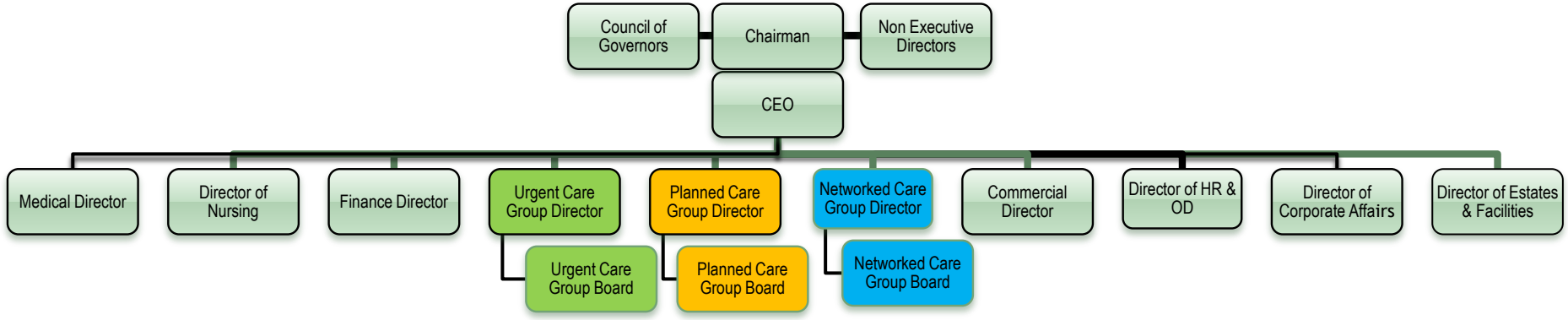
Our clinical operating model puts patients at the centre of everything we do. The Trust's services are organised around patient needs through the establishment of the Networked (long term conditions), Urgent (emergency) and Planned (elective) care groups. Our strategy is to develop zones of care on our sites so that our built environment supports our clinical operating model. We will also deliver a greater volume and range of care closer to patients homes. Clinical teams are at the heart of running the Trust, working in partnership to serve the best interests of patients and our communities.

The concept of the ***Networked*** Care group is driven by the need for new sustainable models of care to accommodate the growing number of patients with long term conditions (LTCs), the ageing population and the growth of the frail elderly in particular. The care group aims to take a whole system approach operating end to end across the health economy with all stakeholders:- patients, carers, general practice, community services, social and voluntary sectors.

The ***Planned*** Care group is the core elective part of the Trust's business. The care group provides high quality seamless care for patients which can be planned in advance in an inpatient or day case environment. Services include a wide range of elective services and cancer care.

The ***Urgent*** Care group is the core emergency part of the Trusts business. A key aspect of high quality urgent and emergency care is bringing the right clinician to the right patient at the right time, first time. Getting the right decisions and diagnosis early in the pathway of care as possible reduces length of stay and errors whilst improving safety and quality of care.

Our structure



Our population and community

A population of around 880,000 people live within approximately 30 minutes of the central Royal Berkshire Hospital site covering most of Berkshire as well as border areas of Oxfordshire, Buckinghamshire and Hampshire. Not all of these are in our core catchment areas. A further population of 85,000 residents within the Newbury CCG (Clinical Commissioning Group) area live within 40 minutes of the Royal Berkshire Hospital site but are much closer to West Berkshire Community Hospital. This gives a total catchment population of approximately one million and provides a strong platform for us to build and consolidate a secure future.

By 2018, the population in our core catchment area is forecast to increase by nearly 25,000 people. However this growth will not be equal across age groups and localities: the growth in the elderly and infant population in Wokingham and West Berkshire being more significant than elsewhere.

The health of our population

Generally the majority of our population is healthier than the England average. However there are significant pockets of deprivation and life expectancy gaps, particularly in Reading and West Berkshire. Each of our key areas has distinct health needs and the health promotion programme 'Staying Healthy' is a key priority across each area.

The table of changes in disease trends demonstrates the upward trend in disease incidence that is predicted as our population grows and becomes older. The rate of increase of disease prevalence is beyond that which can be explained by population growth alone. This suggests that our population is getting unhealthier and is likely to place growing demands on healthcare services.

Disease	2011	2015	2020	Vulnerable population
Coronary heart disease	19,500	20,400	21,345	West Berkshire and Wokingham
Stroke	9000	9500	9900	West Berkshire and Wokingham
Cardio-vascular disease	47,000	49,500	52,000	West Berkshire and Wokingham
Chronic obstructive pulmonary disease	13,700	14,500	15,000	All
Dementia	32,500	34,000	35,500	West Berkshire and Wokingham
HIV	663	687	710	Reading
All cancers (new diagnoses)	1700	1800	1900	All

Source: Joint Strategic Needs Assessment, Berkshire West

Past and current performance

Over the past two years we have consistently performed well against the range of targets we are measured on externally. When benchmarked against trusts in our peer group we perform highly across key targets.

However, like other trusts across England and particularly in the South East we recognise that continuing to meet these targets against a background of increasing patient demand will be very difficult.

Work carried out by both Capita and The Kings Fund suggest that the emergency access target is particularly fragile. When benchmarked against other trusts in our region we find that our admission rates from A&E are lower and our length of stay for non-elective patients are higher reflecting the acuity of the patients we admit. This suggests we are admitting appropriately and our readmission rate is low suggesting we do not discharge prematurely.

We have the lowest bed base per 100,000 population in the country and this leaves us vulnerable to fluctuations in demand and hold-ups in the discharge process.

Benchmarked emergency care metrics

Trust	Length of stay 0-1 days (%)	Readmits (%)	Conversion to admission (%)
Royal Berkshire NHS FT	44.3	12.7	24
Heatherwood and Wexham Park NHS FT	56.0	14.3	29
Hampshire Hospitals NHS FT	54.7	12.4	23
Frimley Park Hospital NHS FT	52.5	14.7	27
Buckinghamshire Healthcare Trust	51.7	12.2	29
Oxford University Hospitals NHS Trust	51.7	14.1	16

Source: The Kings Fund

Past and current financial summary

We have an EBITDA of above 6% and a healthy cash balance of £20m. We do however have historically high costs of financing including impairments of circa £30m in the last two years for major investments made. We have a track record of significant CIP delivery, totalling £49m (both income and cost) over the last three years and will seek to drive this important element through our newly launched QIPP Programme with a focus on quality.

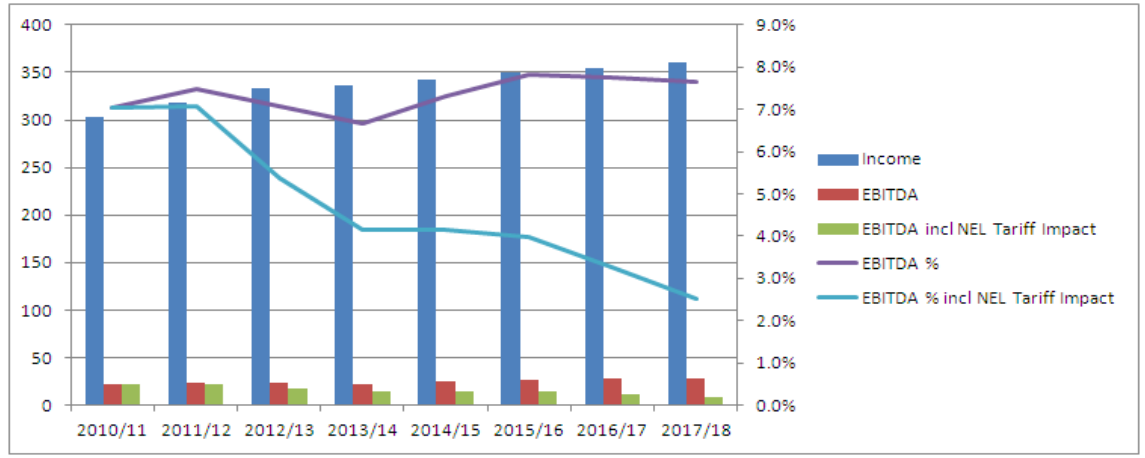
However our expenditure growth has outstripped income growth leading to weakening overall margins. This is a result of a combination of factors which include the impact of the cost of historical investments and lower payments for unavoidable growth in non-elective work.

Of major concern to the Trust is the current penalty regime around non-elective threshold and readmissions. Given current growth rates in non-elective admissions this penalty has the potential to grow to £8.4m in 2013/14, which is the equivalent of treating 4,000 patients for free.

Income and Expenditure £m	2010/11	2011/12	2012/13
Total income	303.1	317.4	333.4
Pay costs	(180.7)	(183.6)	(190.0)
Other direct costs	(101.1)	(110.1)	(119.8)
Total direct costs	(281.8)	(293.7)	(309.8)
EBITDA	21.3	23.7	23.6
EBITDA Margin	7.0%	7.5%	7.1%
Depreciation	(12.2)	(13.6)	(16.5)
PDC	(6.5)	(6.1)	(5.2)
Other	(0.6)	(2.8)	(1.4)
Surplus/ (Deficit)	2.0	1.2	0.5

Source: Royal Berkshire NHS Foundation Trust

Income and EBITDA Trends (incl NEL Tariff Impact & Readmission Penalties)



Source: Royal Berkshire NHS Foundation Trust

Past and current activity levels

There have been changes in the way we code and count activity over recent years but the general trend has been for growth, particularly in emergency and non-elective care where increases in activity have been consistent and sustained.

We are committed to providing 'Better Value Better Care' for our patients and commissioners and therefore there has been a shift in activity from day case to outpatient procedures and reductions in the number of follow up appointments. The Trust is a top decile performer for day case rates and for reductions in outpatient follow up activity. The reduction in follow up appointments achieved since 2010/11 translates into cash savings of circa £8.4m to our commissioners. The high day case rate benefits both our commissioners and our patients who avoid an unnecessary hospital stay.

We have also implemented admission avoidance schemes for non-electives which have generated significant savings for our commissioners (£10m-£14m). However the number of non-elective admissions continues to grow at an unrelenting pace. Despite commissioner demand management schemes we are still seeing a growth in referrals year on year which is leading to a growth in our waiting lists. The increasing demand for non-elective care is having an impact on our ability to deliver elective targets.

'More of the same' is not enough and we must take an innovative approach in delivering care in the future. Our ethos is to work differently to ensure we provide quality care to all our patients.

Demand management - working together to keep well and out of hospital

Our future activity projections are broadly aligned with a review of future demand commissioned by NHS Berkshire West. It is clear that over the next five years there will be a growth in demand across all types of activity but with particular pressures on emergency attendances and non-elective admissions of children and people aged over 65 years.

No single element of the health economy can deal with this increased demand alone. We already work with our partners including local GPs, Berkshire Healthcare NHS Foundation Trust, South Central Ambulance Service NHS Foundation Trust, local authorities and the third sector to manage demand. We need to continue to work in an integrated way with our health and social care partners to ensure that there are appropriate and effective demand management schemes to ensure that admission is avoided where possible and that patients are cared for at the right time, in the right place by the right person. We have a strong foundation of integrated working on which to build upon.

Our approach to demand management recognises reducing demand and increasing capacity. We have been successful in reducing demand through a number of admission avoidance schemes, which have realised significant savings for the health economy. However, we know that to avoid increases in activity over the next five years, additional demand reduction initiatives are required if the health economy is to avoid the additional costs of increased bed capacity.

Initiatives already in place

Frail elderly admission avoidance

Over recent years we have worked closely with partners to set up working parties to look at the pathways of care for frail elderly patients and how these might be improved. These working parties include the Long Term Conditions Board, the Clinical Summit and the Capacity Planning Group and it is through these means that we will continue to work collaboratively to drive through improvements for this vulnerable patient group. We employ Community Geriatricians who work across community hospitals, nursing homes and in patients own homes to ensure that patients can receive the right level of care and the appropriate care packages outside of an acute hospital setting. Working together in this way has prevented between 240 and 360 admissions per month saving the commissioner circa £7.7m-£11.6m over an 18 month period.

Paediatric admission avoidance

We have worked with GPs in Reading to develop pathways for common reasons children attend the emergency department. These protocol based pathways aim to give GPs and parents the confidence to manage these common conditions in the community and explain when it is appropriate to seek secondary care help.

Demand management for elective care

Our Orthopaedic team have worked collaboratively with commissioners to develop referral pathways for Orthopaedics. These pathways set out the steps that GPs need to take before referring a patient and ensures that surgery is not considered as the first treatment option. We have seen an increase in our conversion rate for Orthopaedic new appointments to surgery which suggests that this approach is effective. We have worked with our commissioners to ensure that procedures of low clinical value are not carried out without special permission.

Demand management initiatives in place and delivering savings	Benefit
Frail elderly admission avoidance 240 – 360 p.c.m. (per annum savings over 18 mths)	£7.7-11.6m
Excess bed days (per annum savings over last 2 years)	£1.1m
New to follow up ratio (reduction in 0.79 FU over 3 years – average)	c.£6m

Source: Royal Berkshire NHS Foundation Trust

Market assessment

To inform our integrated business plan we carried out a detailed assessment of:

- predicated changes in population size;
- predicted changes in population structure;
- local health needs;
- changes in disease prevalence, particularly long term conditions;
- the needs of our commissioners;
- our competitors and the threat they pose; and
- our own internal strengths and weaknesses as well as the external opportunities and threats.

Our findings and our response to those findings are detailed below :

Population growth

Growth is predicated across all sections of the population and this will lead to an increase in demand. In response, we are planning to increase our theatre, endoscopy, ICU and emergency department capacity as well as increasing both the elective and non-elective bed base. We will refurbish our maternity unit to ensure we have sufficient capacity to deal with the sustained high birth rate and to ensure we are well positioned to respond should there be the need for a high volume birth centre in our region.

Demand for care closer to home

Our commissioners and our patients both wish to have more services provided closer to home. We plan to maximise the use of our community sites by increasing the range and volume of services we provide at these sites. Key to this will be ensuring that appropriate diagnostics are provided so that patients can have a one-stop assessment and do not have to travel to the RBH site for diagnostics.

Growth in the elderly population and increasing long term conditions

The increased demand from the >65's and particularly the >85's will require a health and social network approach. Existing admission avoidance schemes will be built upon in order to keep people well enough to be cared for at home. We will also work with partners to improve the discharge process, particularly for patients who will require on-going care. We are already working in an integrated way in some specialities e.g. diabetes and rheumatology and we will build on this.

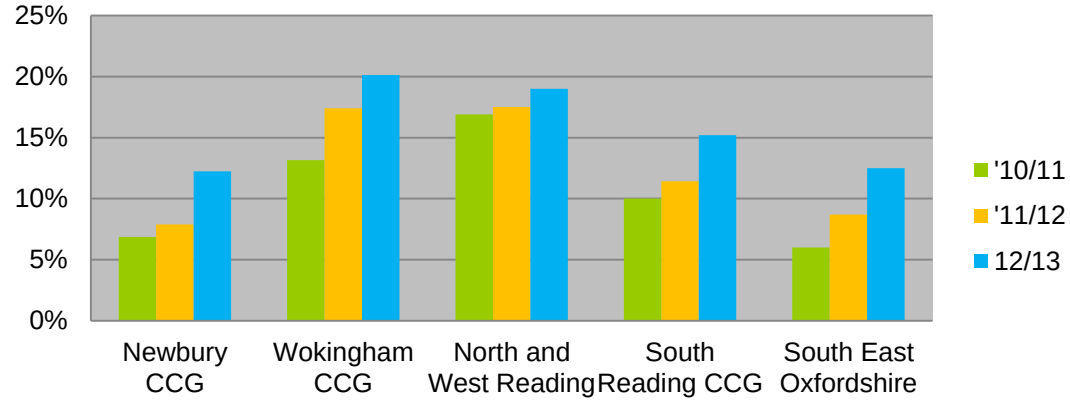
Harnessing our strengths

We have identified key areas where we have proven strength and we aim to develop these services and promote them to increase our market share at our boundaries and win back lost market share from within our key catchment area. We will develop to be centres of excellence for a range of specialities or procedures e.g. cardiology, oncology (brachytherapy and IMRT) and elective surgery (particularly spinal surgery).

Competition

We face increased competition from both NHS and independent sector providers. Our competitive strengths lie in our trusted position in the local community, our ability to manage the most acute patients and the breadth of services provided. Our weaknesses are the comparatively poor condition of parts of our estate and our waiting times which are longer than those of our competitors. A detailed market assessment plan has been developed which will address the competitive threat we face. Key facets of our response to competition include reducing waiting times for outpatient appointments to less than 6 weeks and improving our estate, including the creation of an elective orthopaedic centre and refurbishment of planned care wards.

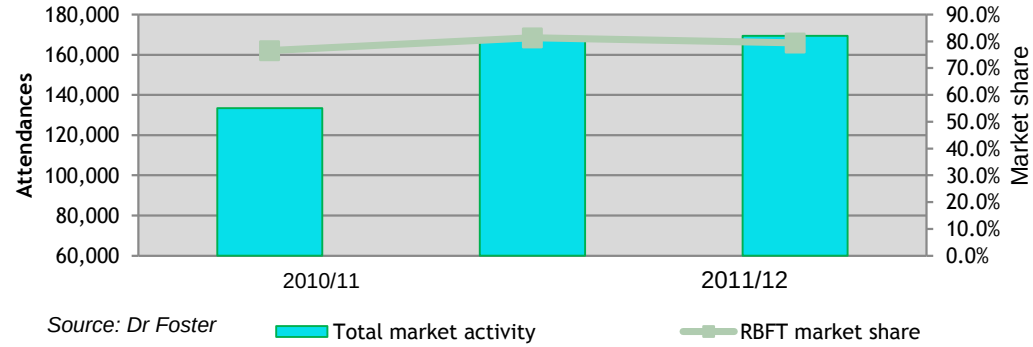
Private Providers Share of Orthopaedic Elective Activity



Source: Dr Foster

New outpatient appointment activity has risen significantly since 2010/11. This is partly due to shift in activity from day case to outpatient. RBFT has maintained overall market share over this period although has lost its share in some key areas.

Market Trends for New Outpatient Appointments



Source: Dr Foster

Service developments

Each of the Care Groups has reviewed its market share and has assessed its own strengths and weaknesses. They have identified key service developments that they will focus on during the next five years to ensure that they continue to provide high quality safe care and an exemplary patient experience.

Key quality priorities driving service developments:

- **Improve outcomes for patients**
- **Improve patient safety**
- **Improve the patient experience**

Networked Care

- Further development of integrated services with our partners. This will require the development of new funding models which are yet to be formalised but may include pooled budgets or programmed budgets for some services.
- Providing care closer to home for patients using innovative techniques.
- Integrated frail elderly care: the Care Group is actively working with the CCGs, Berkshire Health Care FT, Unitary Authorities and the voluntary sector to re-engineer the frail elderly pathway. The focus will be on re-ablement, case coordination/management, prevention and support. In doing so there is a recognition that services need to be brought together.
- Consolidation of pathology services.

Planned Care

- Improve the outcomes following complex surgery by creating a surgical High Dependency Unit.
- Become a Centre of Excellence for spinal surgery, hip arthroscopy and urology and develop a benign upper GI centre.
- Establishment of a dedicated and fully integrated elective orthopaedic centre.
- Deliver radiotherapy and chemotherapy using innovative techniques.
- Provision of dedicated planned care beds with adequate capacity co-located with pre-operative assessment and the admissions suite in line with the estates zoning strategy.
- One-stop outpatient appointments with short waiting times.
- Develop an integrated eye service.

Urgent Care

- Development of Urgent care floor with capacity to provide seamless patient flow in ED, ICU and CDU.
- Establishment of further teams to provide 24/7 specialist services.
- Development of a maternity service to meet the increasing demand and growth in population and birth rates.
- Working with our community partners on supporting patients being cared for in the most appropriate environment either through admission avoidance or effective discharge schemes.
- Ensure our equipment is fit to meet the future developments in delivery of care in all specialties.
- Hyperacute centre for cardiology and stroke.

Activity projections

The impact of our service developments and the increasing demands we face from the growing population and increasing disease prevalence have been converted into high level activity projections as detailed below.

Activity type	2012/13 activity	Projected activity change from 2012/13 to 2017/18					
		Medium		High		Limited	
		2017/18 activity	Change	2017/18 activity	Change	2017/18 activity	Change
Elective inpatient	8,148	8,656	508	8,952	804	8502	354
Day case	32,348	40,917	8,569	41,697	9,349	34,734	2,386
New outpatient	163,523	181,916	18,393	188,043	24,520	179,369	15,839
Follow-up outpatient	305,139	340,546	35,407	363,059	57,920	327,794	22,665
Outpatient procedure	27,300	30,903	3,603	31,621	4,321	30,330	3,030
Other outpatient	19, 904	22,327	2,423	22,393	2,489	20,794	890
Non-elective	45,870	50,232	4,362	57,787	11,917	49,031	3,161
Direct access	3,020,490	3,063,629	43,139	3,236,974	216,484	3,025,260	4,568
A&E attendances	101,642	122,181	20,539	134,908	33,266	112,137	10,495
Chemotherapy /Radiotherapy	22,692	33,121	10,429	33,485	10,793	29,764	7,072
Renal attendances	75,131	94,288	19,157	94,288	19,157	78,492	3,361

Source: Royal Berkshire NHS Foundation Trust

Limited growth

- assumes income will remain flat
- Modelled on the assumption of limited growth in all areas except non-elective. Application of the tariff deflator (modelled at 1.1%) results in flat income growth
- Note that this scenario does not include key service developments in haematology and audiology that reduce activity (included in high and medium growth scenarios)

Our key assumptions are as follows:

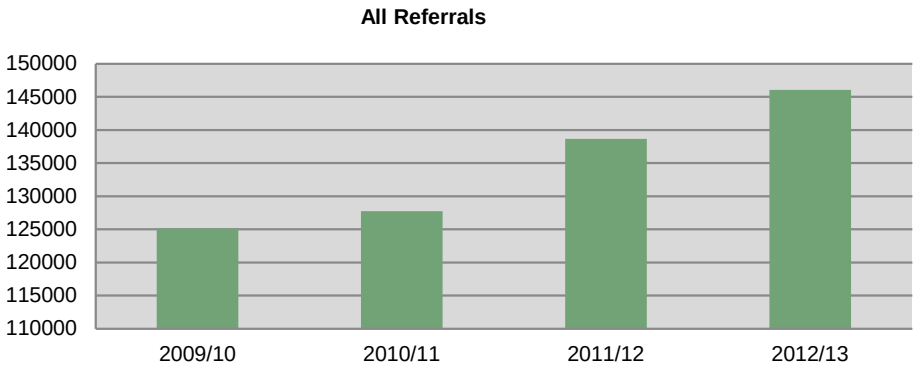
Medium growth

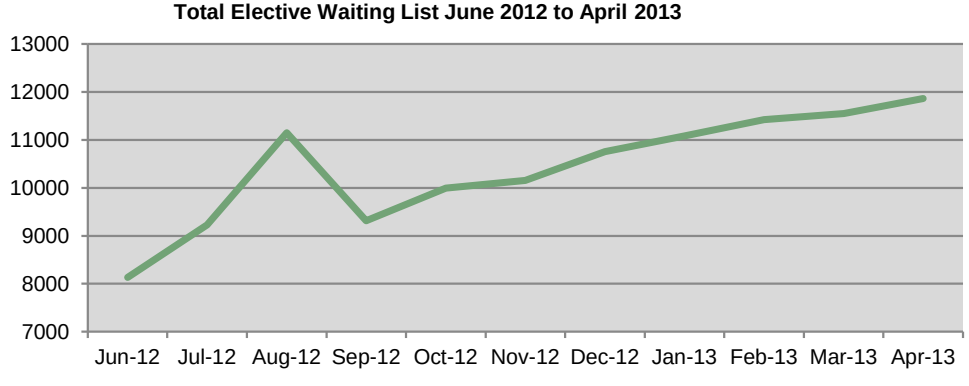
- Our most likely estimate of future activity
- Impact of growing population as per ONS estimates (all years)
- Market share growth as per 2013/14 activity plan (in year 1: 2013/14)
- Launch of haematology DAWN service (year 2)
- Additional market share growth in orthopaedics, general surgery and plastic surgery of 2% over years 2-5 related to the elective orthopaedic centre service development
- Increase in endoscopy demand as per DoH estimate (years 2-5)
- Flexible sigmoidoscopy screening programme (years 4-5)
- Increase in IMRT (from year 2)
- Lucentis treatment for diabetic macular oedema (from year 2)
- Reduction in outpatient waiting times to 6 weeks (in year 1)
- 4% Growth in adult A&E attendances and 8% growth in paediatric A&E attendance (years 2-5)
- ICNARC predictions for ICU bed need (year 2-5)
- Growth in birth rate beyond ONS predictions (years 2-5) – impact on both maternity and paediatrics

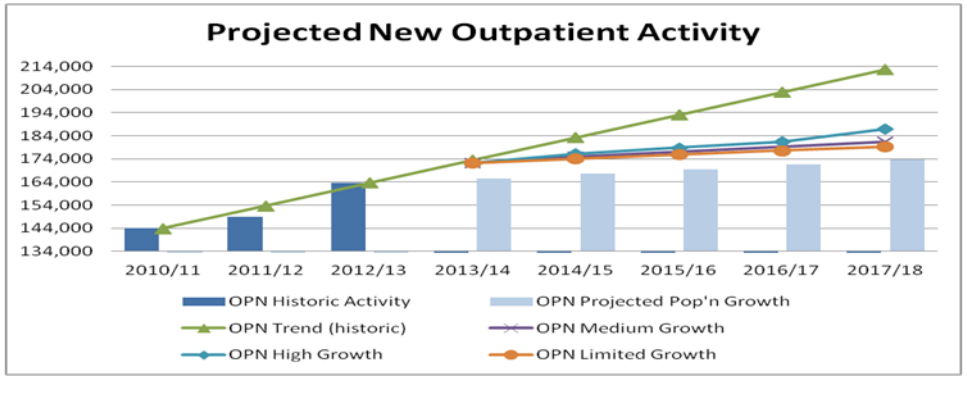
High growth

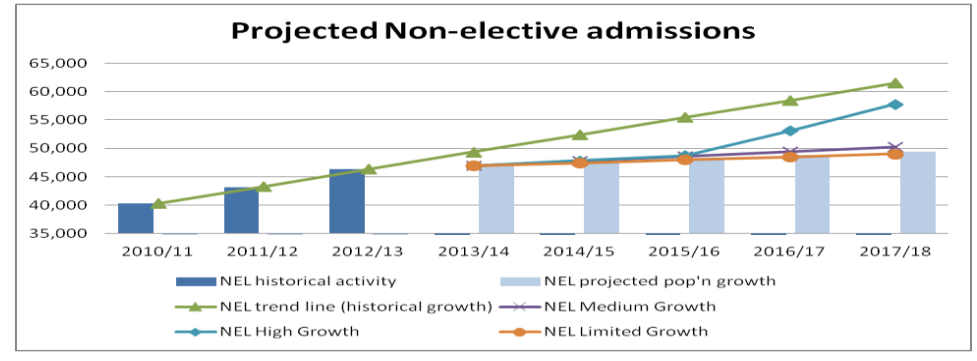
- a higher growth based on specific assumptions around market share and service developments
- Includes the assumptions in the medium growth model, with additional growth
- Growth in renal activity
- Increase in obesity referrals for NICE guidelines
- Additional market share growth in orthopaedics, general surgery and plastic surgery of 7% over years 2-5 related to the elective orthopaedic centre service development
- Additional market share growth 2% over years 2-5 in ENT, gynaecology, oncology, ophthalmology, rheumatology, haematology, paediatrics, cardiology and respiratory
- Impact of 8000 birth centre on gynaecology activity (year 5)
- 8% growth in adult A&E attendances
- Designation as an 8000 birth unit (year 5) – impact on both maternity and paediatrics
- Designation as a paediatric inpatient centre for Berkshire

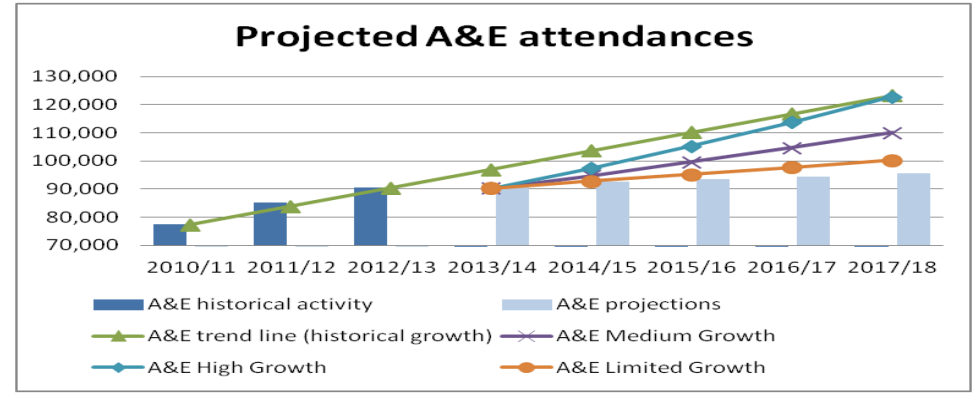
Past, current and forecast demand











Cumulative activity growth projection

	Medium growth over 5 years	High growth over 5 years
A&E	20%	33%
Outpatients	11%	17%
Day cases	26%	28%
Non Elective	10%	26%
Elective	5%	8%
Direct Access	4%	4%

All data source: Joint Strategic Needs Assessment Berkshire West; Royal Berkshire NHS Foundation Trust

Impact of service developments: Capacity analysis

The table below details the additional bed requirement across the whole health economy based on our bed base (as at Q4 2012/13) and the bed base that would be required to deliver our medium and higher growth scenarios, assuming our model of care delivery remains the same. It is recognised that a reasonable proportion of this capacity would be provided by RBFT.

- A 93% bed occupancy rate is considered a realistic estimate of current utilisation. The corresponding bed requirement is matched by our capital investment programme which includes funded plans for the Heygroves SHDU (8 beds 2013/14), the Redland Orthopaedic Centre (11 beds 2013/14) and the Pre-operative Assessment Unit (28 beds 2014/15). Our work with Newton on analysis of length of stay has identified expected savings enabling a reduction in the bed base of approximately 28 beds from 2013/14 which, combined with the additional bed capacity, would ensure adequate capacity if this level of occupancy were to continue.
- A bed occupancy rate of 85% is considered to be an optimum level to offer a high quality service without compromising safety and patient experience. Although our quality performance and careful management of activity demonstrates that we have never compromised safety, the current occupancy rate of 93% is not ideal in the long term.
- Ideally we would be seeking to achieve 87% occupancy rate over time and the attainment of this reduced occupancy rate will put additional pressure on capacity.
- If capacity can be released through innovations in caring for non-elective patients, availability of beds in the community and effective demand management, such as, reducing length of stay and delayed discharges this will reduce the number of beds predicted. In the absence of significant impact of these schemes in reducing activity, the following analysis represents the required increase in capacity offered by the local health economy to match activity.

	Bed type (Occupancy Rate)	2013/14 Net growth	2014/15 Net growth	2015/16 Net growth	2016/17 Net growth	2017/18 Net growth	Five year: cumulative growth
Medium growth scenario	Inpatient beds (87%)	+68	+12	+15	+15	+15	**+125**
	Inpatient beds (93%)	*+32*	*+12*	*+13*	*+15*	*+14*	***+87***
	Day beds (87%)	-	-	-	+13	+6	**+19**
	Day beds (93%)	-	-	-	*+4*	*+5*	***+9***
High growth scenario	Inpatient beds (87%)	+68	+14	+16	+52	+46	**+196**
	Inpatient beds (93%)	*+32*	*+13*	*+15*	*+50*	*+45*	***+155***
	Day beds (87%)	-	-	-	+15	+6	**+21**
	Day beds (93%)	-	-	-	*+5*	*+6*	***+11***

The table on the right details the increase in outpatient activity projected across the 5 year period and the projected percentage increase in slot capacity that will be required to meet this. As well as traditional outpatient clinics part of this increase in capacity may be met by other innovative ways of delivering outpatient care such as virtual clinics and the harnessing of telemedicine.

	Outpatient activity	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Medium growth scenario	Projected activity	515,988	540,200	549,786	558,644	566,923	575,839
	% change in required slots from 2012/13		5%	7%	8%	10%	12%
High growth scenario	Projected activity	515,988	540,200	556,675	566,867	576,481	605,263
	% change in required slots from 2012/13		5%	8%	10%	12%	17%

Key strategic investments

Royal Berkshire Bracknell Clinic

We opened the Royal Berkshire Bracknell Clinic, our £28m 'state of the art' renal and cancer clinic in July 2011. The clinic offers the most advanced radiotherapy cancer treatment available in a community setting. For the first time local patients needing chemotherapy and renal patient requiring dialysis are able to receive their treatment in a modern setting close to where they live.

As income has grown from renal, cancer and general outpatient activity, the Bracknell Clinic realised an operating surplus in 2012/13. Incremental cash receipts from Primary Care Trusts in March 2013 enabled us to reduce loans by £7.5m.

Discussions with other healthcare providers have identified some potential rental activity but this provides a lower return than an activity model. Increasing outpatient activity can deliver breakeven by 2014/15 and reverse the cash outflow by 2017/18. This will require an increase of 8,200 and 19,600 appointments, representing 15-30% of patients currently seen at the Royal Berkshire Hospital from Bracknell and Wokingham. The second floor remains available for future development.

Electronic Patient Record

As a Trust we are committed to delivering an Electronic Patient Record (EPR) and our investment into the Cerner Millennium system in 2012, was our first step towards delivering the Electronic Patient Record by 2018. Since the implementation, the Trust has experienced a number of operational issues with the system, which stem from the design and the complexity in the configuration of the system.

We have undertaken significant activity to ensure the system remains safe for patients, and allows us to maintain data integrity. However, as a consequence of these issues the Trust has faced significant operating costs. We are continuously reviewing our approach to minimise the costs with the system and a number of these actions have helped significantly to reduce the monthly operating costs. Typically in most industries operating costs of IT is circa four per cent of total income. In our environment clinical systems should represent less than one per cent of income.

The Trust and Cerner (the supplier of the system) are committed to rectifying the operational issues faced with the system. Both organisations remain committed to delivering an Electronic Patient Record and we strongly believe we will have the operational issues addressed

Looking towards the next 5 years, we are in the process of developing our detailed plans to support our IM&T strategy towards the delivery the Electronic Patient Record by 2018. These actions will involve a number of activities: strong EHR foundation; health information exchange; data management and analytics; care management and patient engagement. We also have to be mindful to have a strategy which is adaptive and one which will operate in different organisational configurations that may materialise to allow us to be financially viable in the long term.

Our estate and facilities

Our real estates strategy has been developed to support the clinical services strategy and help to meet our clinical objectives to be a local healthcare provider of choice providing safe and clinical effective services. The Trust has considered in detail the clinical services priorities and the condition of its real estate portfolio, and reviewed the available options and their affordability. A transformational approach and a new build on a green field site were both considered to be financially unviable whilst doing nothing is unviable from both a clinical perspective and a patient experience perspective. Our preferred option therefore is to adopt a 'make best use approach' where the cost of developments is phased over 10 years and zones of care are created to support our clinical operating model. There is a key decision required around the future use and retention or reinvestment for the North Block. Mobilising this Real Estate Strategy will still require significant investment by the Trust, and this is anticipated to be some £100m over 10 years, based on current day costings. The disposal of Craven Road properties, Battle site and other underused buildings reduces our backlog expenses.

Emerging strategic options - next five years

Having considered the challenges and pressures on rising demand, the opportunities identified in the Capita report, decreasing margins and increasing capital investment requirements, we recognise that our organisational form may need to change to ensure our long term future. In our view there are a number of strategic configurations that RBFT could adopt, or play a part in, going forward in order to remain clinically and financially viable. Given the challenging and uncertain wider NHS environment it is difficult to predict our exact organisational form in five years time.

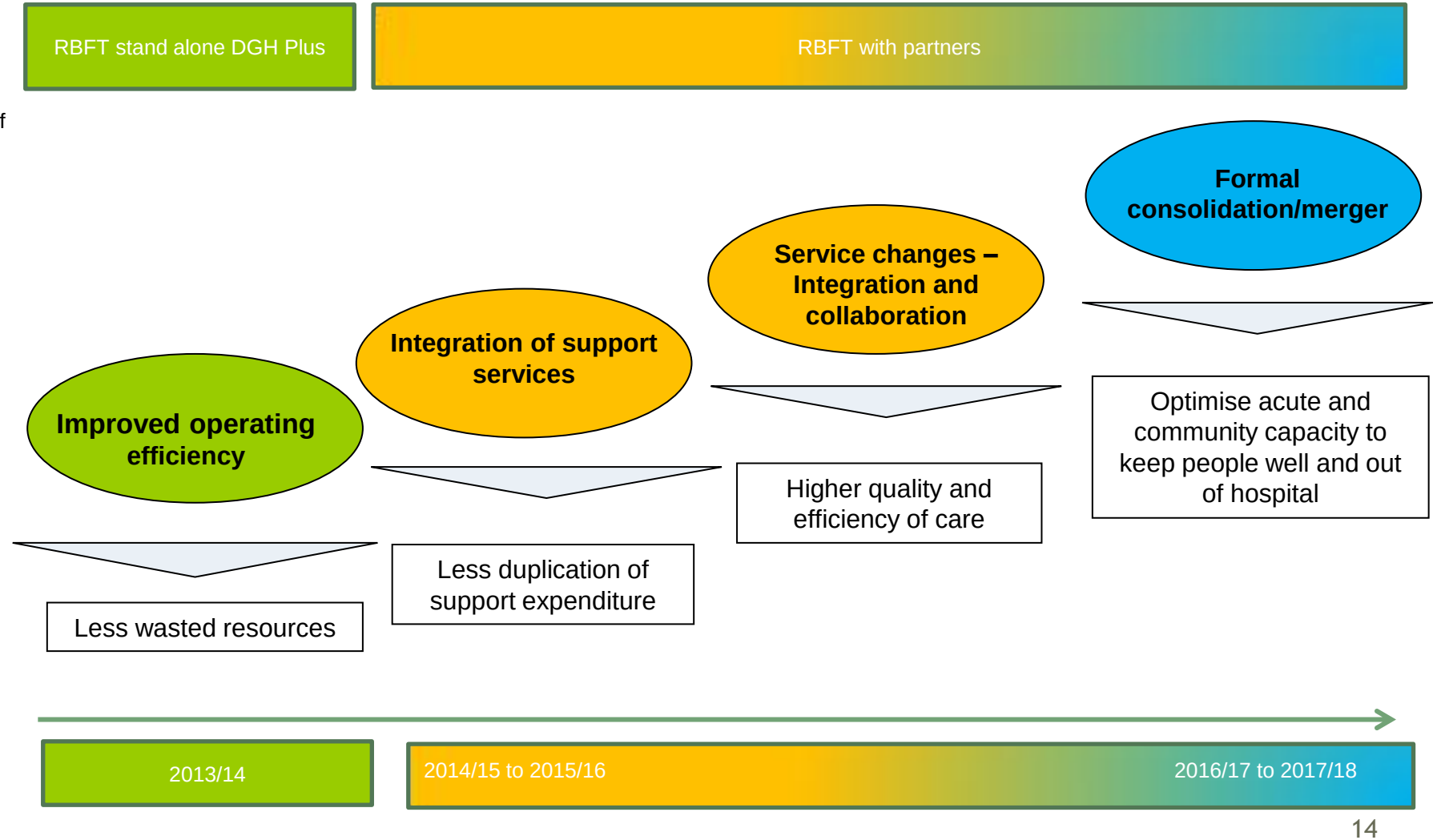
We recognise that any option will take time to be implemented and we will need to be a stand alone organisation in the short term. We will continue to strengthen our services by addressing the cost of financing with increasing emphasis on healthcare groups (clinical networks) and delivering integrated care with our partners. However our assessment is that we will reach a point whereby these arrangements are no longer viable. We anticipate this will probably be by 2016/17 and during the intervening period we will continue to assess and evaluate the strategic options available to us. As our strategy develops the preferred strategic configuration that is necessary will become clearer.

First phase

- Stand alone DGH Plus
- Clinical network, rationalisation of cancer surgery, low volume elective, children and maternity services
- Vertical integration of healthcare through partnership

Second phase

- West Berkshire Integrated Care Organisation



Our vision and strategic objectives

We have developed our strategy in response to our assessment of the likely needs of our population over the next five years and a detailed assessment of the market in which we operate. In developing our strategy we have taken into account the views of our staff and our patients. We have also examined our internal strengths and weaknesses and the external opportunities and threats. A summary of our vision and strategic objectives is shown below.

"Providing the best healthcare in the UK for our patients in our community"

Patients first choice of provider of quality healthcare	• Healthcare provider serving our local population (Berkshire West, Bracknell & South East Oxfordshire). • >90% of the local market within a 30 minute drive time of RBFT by providing care closer to home. • A robust approach to quality of care aimed at improving patient safety, clinical outcomes and a first class patient experience. • Diversified income streams.
Financially viable and sustainable in the long term through the delivery of economic, efficient and effective services	• Develop a robust QIPP programme and deliver cash savings of £40m. • Maintain a liquidity ratio of at least 15 days. Maintain an FRR of 3. • Achieve optimal economic utilisation of our estates. • Increase our revenue streams. • Receive full payment for activity delivered.
Hyperacute and specialist centre of excellence	• Continuous review of performance indicators. • Status as hyperacute centre. • Training and education budget increasing by £1m over 5 years.
Key partner in the development and delivery of integrated health and social care	• Develop and maintain health, social and clinical networks across stakeholders. • Ensure collaborative working and leveraging our network to bring to benefit our staff and patients today and tomorrow.
Excellence in education, innovation, research and development	• Develop our research and development facilities. • Achieve a 100% recommendation rate from staff as a place to work and a place where their friends and family would be treated.

Long term financial model scenarios

We have seen consistent growth in activity over the last few years and a key challenge will be to work with commissioners to both manage this growth and affordability whilst ensuring we have the necessary capacity to meet this demand. A key challenge for us is ensuring that we are appropriately funded for all the work that we do and in this context the current penalty regime on non-elective tariffs, which sees potential unfunded cost of some £8.5m and growing, is simply not financially sustainable.

The Trust remains focussed on driving plans which mitigate the cost of historical investments.

£m	2013/14 (Budget)	2014/15 (Medium growth scenario)	2017/18 (Medium growth scenario)		2014/15 (High growth scenario)	2017/18 (High growth scenario)		2014/15 (Limited growth scenario)	2017/18 (Limited growth scenario)
Income	336.4	342.9	359.8		345.2	380.9		335.8	331.4
EBITDA	22.4	25.1	27.5		25.2	29.2		23.6	20.8
EBITDA Margin %	6.7%	7.3%	7.6%		7.3%	7.7%		7.0%	6.3%
Surplus	0.5	2.4	4.8		2.5	6.5		0.9	(1.9)
Surplus Margin %	0.1%	0.7%	1.3%		0.7%	1.7%		0.3%	-0.6%
Closing Cash	20.1	19.1	22.5		19.3	27.0		17.7	8.8

NB; All scenarios assume that the non-elective penalties are zero. If not all scenarios would show significant deficit and FRR of 2 in all years.

We have run scenarios around income with a "high growth scenario" of 3.0% growth per annum and "limited growth scenario" with minimal change to activity with tariff deflator resulting in reduced income.

The "high growth scenario" has income growing to £381m, EBITDA to 7.7%, surpluses to £6.5m and an ending cash balance of £27.0m.

Our "limited growth scenario" has income reducing to £331m, EBITDA falling to 6.3%, a final year deficit of £1.9m, and an ending cash balance of £8.8m and would result in an FRR of 2, most likely in the early years.

This scenario would require significant further cost reductions to return us to financial stability.

Quality, Innovation, Productivity and Prevention (QIPP) Programme

The Trust has delivered efficiencies of nearly £49m over the past 3 years (both cost and income). However, the on going challenge of delivering major efficiency savings whilst delivering key service targets and coping with operational pressures means that it is becoming increasingly difficult to identify savings without impacting on the quality of patient care. The Trust believes that the emphasis now needs to change to medium / long term large scale change to deliver top decile efficiency and quality, which both national and international evidence demonstrates will also reduce waste and deliver cost efficiencies.
With full support from both the Trust Board and Care Groups, we have developed a QIPP Programme under the 4 work streams of Quality, Innovation, Productivity and Prevention (Safety). A dedicated Quality Improvement team, led by a senior medical consultant, has been created to work with operational staff using a range of quality and service improvement tools to improve the patient experience, safety, efficiency and productivity of patient care which will deliver ongoing financial and non financial efficiencies.

Key risks to delivery

Our integrated business plan sets out our ambition to deliver high quality care that meets the needs of patients and commissioners and is affordable for the local health economy. There are inherent risks to the realisation of the IBP and to the continued viability of the Trust. These risks, and the mitigating actions we will take are summarised below.

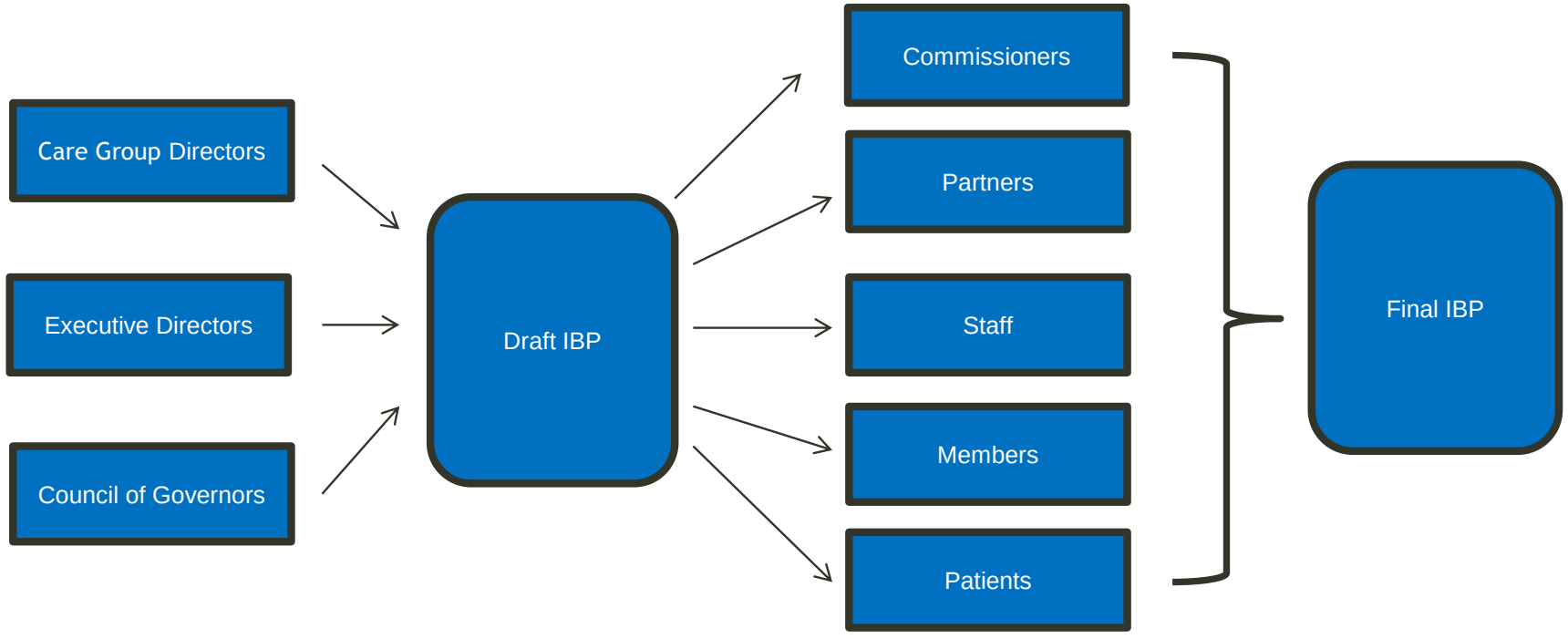
Strategic Risk	Principal Indicators	Mitigations
Failure to maintain quality of patient services	Patient experience indicators show a decline in quality. Potential breach of Care Quality Commission (CQC) regulations. Trust Quality Strategy goals are not met. Quality aspects of contracts with Clinical Commissioning Groups (CCGs) are not met. CIPs impact on patient safety or unacceptably impact on service quality. Failure to meet NHS constitution standards.	Focus on patient safety, outcomes and patient experience through delivery of Quality Strategy and Trust Values. Staff engagement and awareness of required standards. Strengthened quality governance. Use of benchmarks to inform analysis of progress. On-going quality impact review of CIP schemes. Close liaison with NHSLA and CQC.
Failure to maintain financial sustainability	Required levels of QIPP not delivered. Pay costs not adequately controlled. Expected levels of income exceed CCGs affordability. Commercial opportunities not exploited. Lack of capital resources to meet investment requirements. Escalation of EPR implementation costs.	Rolling cost improvement programme with contingencies. Care Group ownership. Estates strategy. EPR stabilisation programme.
Expected increase in demand not funded by commissioners	Activity levels unaffordable for health economy. Lack of robust plans across the healthcare system. Inability to respond to requirements to flex capacity.	Internal performance controls. Effective liaison with commissioners. Strengthened links with commissioners through new partnerships.
Loss of share of current and potential market	Loss of existing market share. Failure to gain share of new markets. Lack of support for business cases or tenders.	Strategy developed with commissioners. Agree assumptions and financial approach with key commissioners. Maintain ability to be nimble in flexing capacity. Contingency plans for withdrawal from services.

Our workforce vision and plan

As a Trust, we recognise our staff as our most valuable asset and as such, our workforce and its leadership and management is at the heart of the successful delivery of our strategic objectives over the next 5 years. Our workforce vision is to be the best place to work, learn and train. This workforce vision lends itself to a 'high commitment' based workforce strategy, a strategy based on developing the commitment of staff so that efficiency and quality of performance is driven by motivated and engaged employees who are committed to the delivery of outstanding patient care.

Staff Group	WTE Staff in Post as at 31/3/13	WTE Staff in Post as at 31/3/14	WTE Staff in Post as at 31/3/15	WTE Staff in Post as at 31/3/16	WTE Staff in Post as at 31/3/17	WTE Staff in Post as at 31/3/18
Medical and Dental (Previous)		579.10	599.36	597.33	594.64	592.53
Medical and Dental Staff (Activity/Business Cases)	579.10	20.26	15.89	15.15	15.67	13.77
Medical and Dental Staff (QIPP 3%)	0.00	0.00	(17.92)	(17.84)	(17.78)	(17.66)
Medical and Dental Staff Total	**579.10**	**599.36**	**597.33**	**594.64**	**592.53**	**588.64**
Registered Nursing and Midwifery Staff (Previous)		1465.64	1676.78	1671.12	1663.57	1657.68
Registered Nursing and Midwifery Staff (Activity)	1465.64	211.14	44.47	42.36	43.84	38.52
Registered Nursing and Midwifery Staff (QIPP 3%)	0.00	0.00	(50.13)	(49.91)	(49.73)	(49.40)
Registered Nursing and Midwifery Staff Total	**1465.64**	**1676.78**	**1671.12**	**1663.57**	**1657.68**	**1646.80**
All Scientific, Therapeutic and Technical Staff (Previous)		517.00	542.10	539.70	536.40	533.80
All Scientific, Therapeutic and Technical Staff (Activity)	517.00	25.10	13.79	12.79	13.41	11.17
All Scientific, Therapeutic and Technical Staff (QIPP 3%)	0.00	0.00	(16.19)	(16.09)	(16.01)	(15.87)
All Scientific, Therapeutic and Technical Staff Total	**517.00**	**542.10**	**539.70**	**536.40**	**533.80**	**529.10**
Support to Clinical Staff (Previous)		1213.07	1271.93	1266.17	1258.50	1252.52
Support to Clinical Staff (Activity)	1213.07	58.86	32.23	30.09	31.60	26.20
Support to Clinical Staff (QIPP 3%)	0.00	0.00	(37.99)	(37.76)	(37.58)	(37.24)
Support to Clinical Staff Total	**1213.07**	**1271.93**	**1266.17**	**1258.50**	**1252.52**	**1241.48**
Infrastructure Staff (Previous)		612.86	614.86	614.86	614.86	614.86
Infrastructure Staff (Activity)	612.86	2.00	18.45	18.45	18.45	18.45
Infrastructure Staff (QIPP 3%)	0.00	0.00	(18.45)	(18.45)	(18.45)	(18.45)
Infrastructure Staff Total	**612.86**	**614.86**	**614.86**	**614.86**	**614.86**	**614.86**
Total Staff (Previous)		4387.67	4705.03	4689.18	4667.97	4651.39
Total Staff (Activity)	4387.67	317.36	124.83	118.83	122.96	108.12
Total Staff (QIPP 3%)	0.00	0.00	(140.68)	(140.04)	(139.54)	(138.63)
Total Staff Total	**4387.67**	**4705.03**	**4689.18**	**4667.97**	**4651.39**	**4620.88**

Engagement process



The IBP has been developed collaboratively between the care groups and corporate directorates and throughout the process the views of the Board and the Council of Governors have been taken into account. Our draft IBP will now be shared with stakeholders including our commissioners, partner organisations, staff and patients. We have a detailed engagement plan to ensure that stakeholder feedback is taken on board before our final IBP is presented to the Trust Board in November 2013.

The engagement exercise identifies different groups of stakeholders who have different perspectives of the needs and aspirations of the local populations. The groups range from the staff who provide the services and the partners who support us, the patients who receive the services and the commissioners who pay for the services. Our engagement approach will maximise the opportunity to encourage 'conversations' amongst stakeholders and to ensure that all views are heard.

The feedback from the various cohorts of stakeholders in the engagement process will be taken into account in developing the final iteration of the IBP.
The Trust will revise the draft IBP by incorporating elements of the feedback that have the potential to enhance the quality and efficiency of the care that it provides, are consistent with commissioners' intentions and affordable. All stakeholder feedback will be responded to directly prior to finalisation of the IBP.

Review process

The IBP will be reviewed on an annual basis as part of the Monitor Forward Planning process. It will form part of the Trust's on-going performance management cycle, with Care Group annual plans and monitoring being aligned to the IBP and updated based on actual activity levels. Subsequent IBPs will be updated on the same basis.