A lifetime of specialist care

Royal Brompton & Harefield NHS
NHS Foundation Trust

ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST

Final Operational Plan 2016/17

Principal changes between Draft Operational Plan ('DOP') submitted on 8 February and Final Operational Plan ('FOP') of 18 April 2016 (subsequently resubmitted on 29 June 2016 following agreement of the control total)

The 2016/17 DOP was necessarily issued without sight of the final published tariffs for next year and in advance of any indication from commissioners, in particular NHS England ('NHSE'), of contract proposals. Furthermore, the Trust's internal budgeting process for 2016/17 had only recently commenced.

Although the non-financial elements of the DOP remain substantially unchanged, there has been a significant deterioration in the forecast financial outturn for 2016/17. This has largely been driven by substantially less favourable tariff and related proposals from NHSE relative to earlier expectations. The following table summarises the movements from DOP to FOP:

Item	DOP (£k)	FOP (£k)	Notes to variations
Adjusted 15/16 outturn	**(17,650)**	**(19,528)**	**Vacancy gaps, non-recurring CIPs**
Net tariff movement	(200)	(4,942)	Initial tariff proposals received *
Growth (demographic + SDs)	900	3,962	NHS service developments
Kuwait	3,500	3,500	Unchanged
Wimpole Street	(5)	(462)	Further delay/ payroll costs
S&T Fund (general)	4,800	4,800	S&T funding following agreement of control total
Cost inflation	(8,053)	(8,505)	Marginal net change
Cost pressures	(1,500)	(3,776)	DOP placeholder/ CNST/ other
CIP schemes	9,409	9,401	DOP 2.7% placeholder
Depreciation, PDC, other	0	(534)	Includes contingencies
Subtotal	**(8,800)**	**(16,082)**	Before investment property sale
Investment property sale	10,250	9,250	Gain on sale reduced
Budgeted 2016/17 outturn	**1,450**	**(6,832)**	

For further detail see section 4 and Annex A.

1. Activity planning

1.1 NHS commissioned services

Initial NHSE 2016/17 contract proposals were received on 30 March and agreement with NHS England was reached on 13 May 2016. The FOP reflects costed bottom up activity growth including service developments, in contrast to the DOP which merely assumed 1% demographic growth. Given the delayed NHSE proposals the original deadline of 31 March for the signature of that contract was missed although there had been good progress on the agreement of the principal CCG contracts. Overall NHS activity in 2016/17 is expected to be largely comparable to levels achieved in 2015/16: accordingly, activity changes per se should have few implications for operational and quality performance. The expected impact on (particularly) the RTT 'incomplete pathway' standard for elective activity remains the subject of discussions with NHS England Specialised Commissioning.

1.2 Non-NHS clinical services

In light of the continuing substantial reductions in NHS tariffs, the elimination of Project Diamond, and the further postponement of the introduction of HRG4+ and cardiac and respiratory top ups, the Trust has been obliged to consider other sources of income. These comprise:

1.2.1 Wimpole Street outpatient and diagnostic centre – this facility is under construction and is expected to open for business in June 2016. It will largely (but not solely) be used to generate additional private patient income given the new catchment that it will offer.

1.2.2 Hospital management contract in Kuwait – this is currently under negotiation with the Kuwaiti Ministry of Health and other government bodies in that country. If successful, it should make a positive impact on the Trust's results and cash flow from October 2016.

1.2.3 These initiatives should each in time create additional inpatient demand: the Trust is exploring how best to meet these probable further demands on capacity.

2. Quality planning

2.1. Quality improvement

2.1.1. The Trust's Quality & Safety Strategy

We are committed to ensuring that our clinical services meet national standards of quality and safety mandated by the CQC, and to achieving demonstrable continuous improvement in service quality. To this end, our 2015-18 Quality & Safety strategy sets out our commitment to providing the highest quality of care for all our patients and ensuring that this is provided safely at the right time, in the right way, and by the right people. The over-arching goals of this strategy, which will be delivered by all staff, are to:

- Maintain a culture within the organisation which prioritises patient safety, clinical effectiveness and continuous quality improvement at every level, and ensures that leaders create an appropriate environment and model behaviours which facilitate safe care, motivate staff to be caring and responsive to patient needs and enhance patient experience.
- Ensure transparency so that data on quality and safety is readily available to staff and patients and used to drive change and improvement
- Improve the reliability of care by increasing the capability of staff to undertake safety and quality improvement work through development of appropriate skills and application of best practice.

2.1.2. Alignment of this Strategy across all five NHSE domains of quality

SAFE

- Sign up to the NHS England Safety initiative, develop and implement a Safety Improvement Plan (leadership & culture, measurement, building capability and projects) linked to the Trust Strategic Plan
- Actively participate in the ICHP Patient Safety Collaborative and extend our links with local DGHs to optimise patient pathways and transitions between services ensuring continuity of care
- Continue to develop and enhance the Trust Risk Register ensuring prompt recognition, management and mitigation of risks to our services and patient care

EFFECTIVE

- Improve Mandatory Training compliance to at least 80% for all staff groups
- Consolidate our MDT approach to clarify patient selection criteria, improve inter-professional communication, referrals and documentation, and provide patient information and feedback
- Increase reported appraisal rates such that > 80% staff undergo annual appraisal
- Improve patient-pathway management to improve efficiency and cost management of care provided.

CARING

- Improve end of life care planning, DNACPR and access to specialist palliative care
- Improve access to all non-cardiothoracic services
- Improve CQC inpatient and out-patient survey results year on year aiming to be among the top performing 10% of Trusts
- Improve response rates for Patient & Staff FFT aiming to be in top 10% nationally for each question

RESPONSIVE

- Progress plans for 7-Day working in order to support efficient clinical decision-making and streamline patient pathways across a 7 day week optimising admission, transfer and discharge processes
- Work with commissioners to reduce waiting times
- Continue to improve the availability of relevant clinical information for all patient interactions
- Acquire current patient experience feedback on all Trust services
- Develop an information/ contact centre for patients, carers and referrers to access information about the Trust, their own condition, referral processes and services.

WELL-LED

- Ensure the closest possible working partnership between clinical leaders and managers is fostered across the organisation
- Continue the annual Staff Safety Climate Survey to identify areas for improvement in relation to staff experience, training and wellbeing
- Continue to develop and implement Human Factors and Simulation Training programmes for multi-professional staff across the Trust together with education programmes for Duty of Candour, Being Open, Consent to Examination and Treatment, Deprivation of Liberty and Mental Capacity
- Develop IHI Open School membership pan-Trust in year 1 (100 members) and introduce Quality Improvement science training for multi-professional staff groups.

2.1.3.The top risks to quality

Within the Trust's Risk Register, two of the highest risk scores relate to the Trust's physical infrastructure (i.e. buildings and plant). These are: i) the existence of areas that are unsuitable for 21st century patient care and ii) the maintenance backlog. As highlighted in previous annual plans, the age and fabric of many of the Trust's buildings have meant that, if not adequately addressed, they could potentially pose a risk to the health of patients, staff and visitors. A planned preventative maintenance (PPM) programme that has run since 2012/13 will be maintained in 2016/17: this is being supported by a ring-fenced investment plan, in which target areas of both the Trust's hospitals have been classified by the severity of the risk that they pose. These include electrical infrastructure works in the Fulham Road Wing and the modernisation of certain parts of the Harefield campus as part of the Trust's long-term redevelopment plan.

The third top risk in the Risk Register has been identified as a potential failure to comply with external regulations and requirements laid down by bodies such as the CQC and Monitor/ NHS Improvement, which could result in possible loss of income and reputational damage. Among the mitigating controls are: an audit of out of date policies; the development of a CIRIS compliance management system to track updates and compile an evidence base demonstrating compliance with CQC Fundamental Standards; and ongoing review of CQC targets and Monitor/ NHSI Risk Assessment Framework targets.

2.1.4. The Safety Improvement Plan - our response to NHSE's 'Sign up to safety'

As part of our Quality and Safety Strategy, the Trust has joined the NHS England '*Sign up to Safety*' initiative, for which we have submitted and published our five pledges as the first step in re-iterating our commitment to delivering safe and effective care. To deliver these pledges, our Safety Improvement Plan (SIP) aims to reduce avoidable harm by 50% and continuously improve and measure the quality of care we provide over the next three years and beyond. The Executive leads for the SIP are the Director of Nursing and Governance and the Medical Director, while the '*Sign up to Safety*' leads are the Lead Clinicians in Clinical Risk at both our hospitals.

The plan is constructed around the domains of i) leadership, ii) building capacity and capability, and iii) projects with measurable outcomes. Significant progress has been made in the first two domains, and our focus is now on the third. Following review and analysis of our patient safety incidents, complaints, PALS contacts and also local audits, the Trust has identified a number of areas for improvement (the 'Big 6' projects):

- Reducing acute kidney injury, particularly in diabetic patients – our aim is to reduce the incidence of avoidable new onset AKI by 50% by 2018 from current levels
- Reducing sepsis, including surgical site infection – our aim is to achieve > 95% compliance with the SEPSIS 6 System for the identification and management of sepsis in adult and paediatric patients, and by 2018 to reduce all wound infections to a rate of < 2% across the Trust
- Improving detection and management of the deteriorating patient – our aim is to achieve by 2018 > 95% compliance with NEWS/ PEWS for all relevant patients, and with > 95% accuracy in scoring, documented escalation and management plans
- Reducing the incidence of pressure ulcers – we are aiming for zero new grade 3 or 4 pressure ulcers and 95% compliance with the SSKIN care bundle for relevant patients
- Reducing inpatient falls in elderly patients to improve the care and experience of elderly patients (and their carers/ families) by reducing falls, ensuring by 2018 95% compliance with agreed tools for management of dementia/ delirium and frailty
- Improving medication and device safety – our aim is to improve the Trust medication incident reporting rate > 7.5 / 100 admissions, improve content of

incident reports for devices and medication ensure > 95 % medication and devices incident reports meet reporting timescales, zero red & amber events.

2.2. Seven day services

2.2.1. We are confident that we are now compliant with all requirements for consultant cover and timely review of patients across all wards throughout the whole week, with improved access to all diagnostic modalities (echo, lung function, MRI, CT, X-ray, etc). We are also participating in a NAO (National Audit Office) national review of discharge arrangements for elderly patients, so as to ensure that discharge happens at the most appropriate times during the week (i.e. not just Monday to Friday).

2.3. Quality impact assessment process

2.3.1. Each proposed scheme within the Financial Stability Plan (FSP) 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 are presented to the Medical and Nursing Directors before being reported to the Board's Risk & Safety Committee.

2.3.2. 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.

2.4 Clinical target trajectories

2.4.1 Trajectories for both the 18 week incomplete pathway RTT target and the 62 day urgent GP referral for suspected cancer have been uploaded to the NHS Improvement Portal as required.

2.4.2 The trajectory for the 18 week incomplete pathway RTT target shows non-compliance for months 1-11 with achievement of the target in M12 (March 2017).

2.4.3 The trajectory for the 62 day urgent GP referral for suspected cancer shows performance of 50% for Q1, 55% for Q2, 60% for Q3 and 65% for Q4 2016/17. It should be noted that this trajectory is contingent on diagnostics being completed and referrals being made by referring centres at an earlier point in the pathway. The latest guidance on breach allocation was received on 24 March 2016 and the Trust is currently reviewing the impact of the proposed changes to measurement.

2.4.4 NHS England continues to monitor the Trust's performance against these targets through the Clinical Quality Review Group. NHSE is currently engaged in reviewing the Trust's action plan with regards to the 18 week incomplete pathway RTT target following which a recovery trajectory will be agreed.

3. Workforce planning

3.1.1 Workforce planning is undertaken primarily through the annual budgeting cycle that is carried out by the Trust's divisional directors and general managers, Chief Operating Officer and their business partners from the Finance department.

3.1.2 During this process all departments and related pay costs are reviewed to ensure that they reflect both service requirements and the wider demands of the Financial Stability Plan – this includes regular application of the Safer Nursing Care Tool to ensure that ward nursing establishments remain safe and appropriate for evolving patient volumes and dependency. We are continuing to match staffing patterns better with service requirements (e.g. catheter labs at Harefield to better accommodate the PPCI/acute cardiology service; introduction of a shift-system to pathology laboratory blood science services).

3.1.3 We are further developing our existing collaborations with our neighbouring Foundation Trusts – Hillingdon Hospital, The Royal Marsden Hospital and Chelsea & Westminster Hospital (C&W) – on better integrating certain clinical and clinical support services, most recently gastroenterology services with C&W and haematology with Hillingdon (and Imperial College Healthcare Trust).

3.1.4 We are also reviewing our current reliance on junior medical posts to provide 24/7 cover and EWTD-compliant rotas, expanding the scope and no. of 'advanced practitioner' nursing and AHP roles so that, over the next two years, the skills and expertise available across the 24-hr period provide more effective cover.

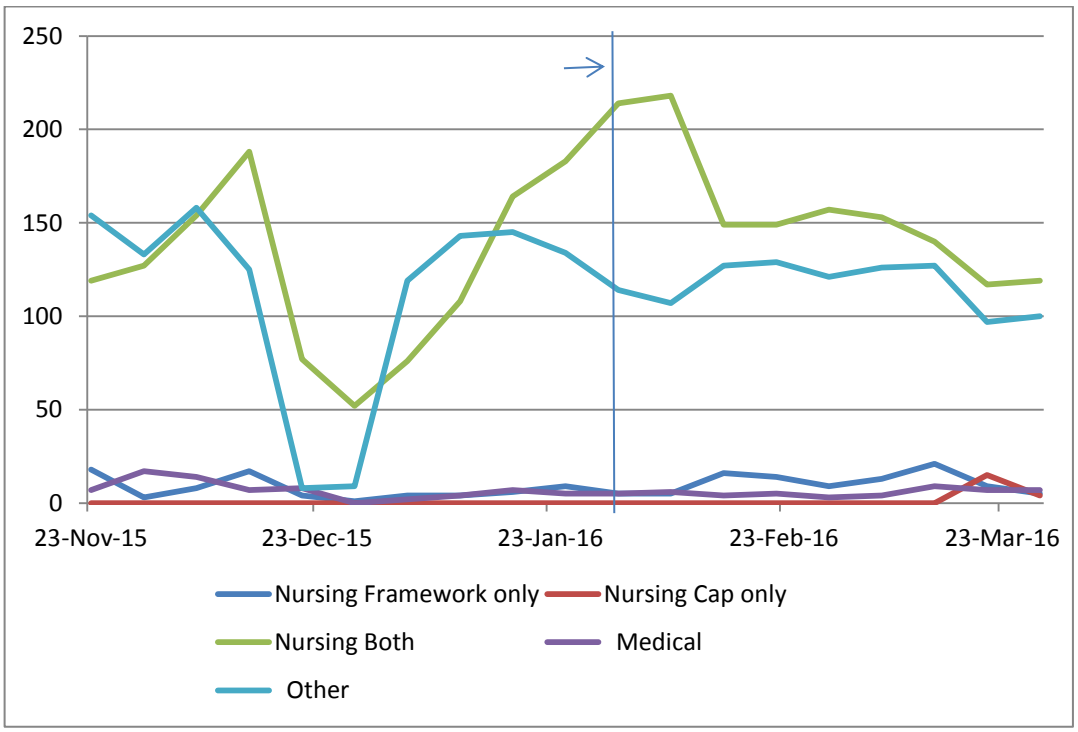
3.1.5 In addition, the extension of our 'Hospital to Home' platform (for managing the discharge of patients with complex care needs) to some of the patient cohorts treated by our adult intensive care unit will, if scaled up, require the development of a different workforce model for rehabilitation and therapy provision in patients' homes in conjunction with our hospital-based intensive care teams.

3.2 Agency and consultancy workforce

3.2.1 In line with national initiatives, the Trust has been making efforts to reduce reliance on temporary (especially agency) staff costs. The principal challenges we face are in specialist nursing – notably paediatric and adult critical care; also in I&T as part of delivering investment in our Digital Care Transformation Programme (which will reduce during Q2 and Q3 2016/17).

3.2.2 In critical care nursing, the Trust is drawing from a small pool of appropriately-qualified staff who are rarely available via 'framework' agencies. The Trust has therefore yet to see material financial benefit from this initiative, but is committed to bearing down on these costs through ongoing permanent recruitment efforts planned into 2016/17; incentives to current staff for additional shifts (bank and overtime); and continuing negotiations with key agencies. The table below shows the no. of shifts in

the Trust exceeding relevant thresholds, with evidence of progress made in the final months of 2015/16:



4. Financial planning

4.1. Summary income & expenditure forecast

The Trust's provisional 2016/17 forecast, together with the expected outturn and original plan for 2015/16, may be summarised as follows (£m):

	2016/17 Provisional budget	2015/16 Expected outturn	2015/16 Original plan
Income			
NHS clinical	302.2	289.4	287.3
Non-NHS clinical	63.3	38.7	39.1
Non-clinical	27.6	29.7	28.1
Total income	393.1	357.8	354.6
Expenditure			
Pay	(226.9)	(206.4)	(202.9)
Non-pay	(164.0)	(145.8)	(142.5)
Total expenditure	(390.9)	(352.2)	(345.4)
EBITDA	2.2	5.6	9.2
EBITDA margin	0.6%	1.6%	2.6%
Central costs, incl. depreciation	(11.6)	(8.8)	(12.7)
Gain on sale	9.3	-	-
PDC dividend	(6.7)	(6.5)	(6.5)
Net surplus/ (deficit)	(6.8)	(9.7)	(10.0)

4.1.1 The provisional budget for 2016/17 reflects the following items:

- Although a headline tariff uplift of 1.1% (which would represent some £3m for this Trust) has been announced, the NHSE contract proposals, if implemented, will result in at least a £4.9m reduction in NHS clinical income (£5.7m reduction less a CNST-related uplift of £0.8m) as reflected above. The underlying elements of this reduction include:
  - Overall tariff deflator of £2.5m
  - NHSE local prices (including those for critical care) not uplifted by 1.1%, being £0.8m
  - CQUIN added back in full (not available in 2015/16 under DTR) offset by a contingency of £2.1m (one third of the full value) representing the estimated cost of delivering CQUIN targets and/ or failure to achieve them as well as the recently announced intention of NHSE only to pay CQUIN at 2.0% rather than 2.4%
  - £0.4m impact of marginal rate of emergency admissions
  - The progressive elimination over the final six months of 2016/17 of margin earned on certain high cost devices currently at local prices

- Given the level of stress in the budget £2m central contingencies have been included for both pay and non-pay expenditure.

4.1.2 The anticipated introductions of both HRG4+, which recognises the higher costs of complex care, and top ups for cardiac and respiratory services, all intended to take effect from 1 April 2016, have again been deferred. Their proposed new introduction date is 1 April 2017. These had been expected to make up most or all the income shortfall resulting from the withdrawal of Project Diamond funding from 1 April 2015 which, in 2014/15, had amounted to £13m.

4.1.3 The substantial planned increase in non-NHS income relates to the Trust's initiatives in Wimpole Street, London, and Kuwait. If these are successful they are expected to partially subsidise the Trust's loss-making NHS activities.

4.1.4 Pay increases reflect a 1% across the board uplift; additional pension and NI costs; and additional staff costs associated with the expanded private patient activities. The 2015/16 charge benefited from the release of a £1.5m PAYE provision.

4.1.5 Non-pay increases reflect an £800k increase in the Trust's CNST contribution; non-pay costs of PP initiatives; and higher establishment costs of new premises, including Wimpole Street.

4.1.6 Central costs for 2016/17 are net of: £2.6m of capital donations (vs. £2.7m for 2015/16) and an investment property revaluation gain of £3.0m (2015/16 £3.0m). For 2015/16 there is an impairment write-back of £1.0m (nil for 2016/17). An additional depreciation charge is budgeted for 2016/17 following a professional revaluation of operational buildings at 31 March 2016.

4.1.7 The gain on sale of investment property is struck at an estimated sale value of £20m.

4.1.8 The uplift in PDC charge derives from the revaluation of operational properties.

4.2. Bridge between adjusted outturn for 2015/16 and provisional forecast for 2016/17

4.2.1 This is set out in Annex A. It assumes that all the Trust's private patient service developments are introduced as planned and on schedule. The major contribution expected from our proposed Kuwait hospital management contract is susceptible to political and other uncertainties; this initiative therefore carries the risk of non- or sub-optimal performance.

4.2.2 The individual columns in Annex A comprise:

- *2016/17 normalised baseline* – this represents the expected outturn for 2015/16 as adjusted to exclude any items, whether of income or of cost, not expected to recur in 2016/17. Examples are the release of a £1.5m PAYE provision; the write back of previously impaired consultancy costs in relation to the Trust's intended redevelopment; and the cost benefit of non-recurrent savings in 2015/16.

- *Net tariff movement* – this represents the current best estimate of the impact of, in particular, NHS England's tariff proposals for 2016/17 per paragraph 4.1.1.
- *NHS growth/ service developments* – this represents the estimated additional income on a bottom up basis to be earned in 2016/17 from service developments, certain of which commenced in 2015/16 but were effectively unpaid for under the block contract arrangements.
- *Kuwait* – this represents 50% of the estimated annual income and related costs of a proposed three year hospital management contract in Kuwait based on detailed figures shared with the Trust Board and summarised in the proposal to the Kuwait Ministry of Health. This assumes that the contract commences on 1 October 2016. Until the contract is signed there remains a risk that this initiative does not proceed but the Trust's view on a 'more likely than not' basis is that it will do so.
- *Wimpole Street* – this private patient outpatient and diagnostic initiative is now expected to start operations from June 2016. The detailed budget and related investment case has been previously approved by the Board. In its early stages this initiative will be ramping up so costs are expected to exceed revenues over 2016/17.
- *FSP cost improvement plans* – these represent the outcome of line by line budget reviews with, and challenges to, all budget holders over the past two months.
- *Cost pressures* – as part of those same budget reviews, all cost pressures not captured in the normalised outcome for 2015/16 were identified and initially classified into unavoidable, mid-case and mitigatable. Only those deemed after rigorous scrutiny to be unavoidable have been retained but, as noted above, contingencies have been established intended to cover any cost leakage.
- *S&T Fund (general)* –the Trust was offered general S&T funding of £4.8m for 2016/17: this was conditional on achieving: (i) a control total deficit of £2.3m, subsequently revised to £3.7m and then further revised to £7.5m at which point is was accepted, (ii) certain performance targets, for example 62 day cancer and 18 week RTT, and (iii) an agency spend cap.
- *S&T funding (targeted)* –the Trust has received no indication that it might qualify for targeted S&T funding.
- *Inflation of pay and non-pay costs* – this reflects guidance from Monitor in relation, for example, to across the board pay rises and increments, as well as additional employers' pension and NI costs. It also reflects a 1.7% general increase for non-pay items.
- *Other* – this principally comprises £2m each of pay and non-pay contingencies together with the increase in depreciation and PDC charges as a result of the property valuation commissioned by the Trust as at 31 March 2016.
- *Sale of 151 Sydney Street* – the gain of £9.25m reflects the excess over book value of the property (following an estimate of the valuation uplift at 31 March 2016) against the estimated proceeds of £20m.

4.3. Efficiency savings for 2016/17

4.3.1. Lord Carter's provider productivity programme

As a specialist Trust we have not been directly engaged in Lord Carter's initiative nor have we been asked to supply prices for our 100 most common non-pay items. The Trust is nonetheless assessing Lord Carter's procurement recommendations and has already adopted the NHS Standards of Procurement: it has achieved Level 1 and is actively working toward Level 2.

Work is also underway to adopt GS1 product classification and to respond to other e-procurement initiatives recommended by Carter.

4.3.2. Agency rules

NHS Improvement has allocated an agency expenditure ceiling of £9.04m for 2016/17, compared to projected full-year expenditure in 2015/6 of c£12m – a 25% reduction. Trust actions under the umbrella of the national initiative will make progress towards this target – but the imperative to provide safe care in the areas of greatest agency pressure (acute demand for cardio-respiratory critical care) may lead the Trust to breach this target. Please also refer to section 3 (Workforce Planning).

4.3.3. Procurement

We have obtained substantial price reductions during 2015/16, in part as a result of the new, national cardiothoracic devices procurement framework introduced part way through the year. Unfortunately, the benefit of these favourable price variances has been largely negated by the impact of an adverse volume variance: the number of devices implanted in patients has been running ahead of plan. Because this Trust has been on a block contract with NHS England the cost of these excess devices (c. £15k each) had a direct impact on our financial result. However, we may benefit in 2016/17 from reverting to a cost and volume arrangement with NHSE.

We have been signed up for many years with LPP and we use NHS Supply Chain and procure collaboratively via approved buying frameworks wherever possible.

The FOP reflects a challenging procurement target for 2016/17.

4.3.4. Capital planning

The Trust's estate is outdated and in parts unsuitable for the provision of modern healthcare. As a result, each year we incur backlog maintenance expenditure as well as needing to replace obsolete plant and equipment. As a result, internal bids for capital expenditure each year far exceed the Trust's capacity to finance and manage such investments. Indeed, we have been highly selective in determining the projects that are presented for Board approval of the annual investment plan.

The Trust is currently engaged in capital programmes that will enhance its revenue-generating capacity and improve patient care for both NHS and private patients. These programmes include:

- Improving and expanding critical care and imaging facilities on the Trust's Harefield campus; these will come on stream in 2017

- Establishing an outpatient and diagnostic centre in Wimpole Street, London, scheduled to open in June 2016
- In 2014/15 the Trust adopted a three year plan to upgrade its I&T infrastructure after years of underinvestment: this programme should be completed in 2016/17. This has been essential as much Trust hardware and systems, including clinical I&T, were inadequate and in some cases about to become unsupported.

All these initiatives are important and well advanced such that it would be counter-productive to halt them now even if we wished to do so. However, the Trust intends in 2016/17 to scale back its capital spend as this investment 'bulge' comes to an end and cash constraints restrict future expenditure. This reduced level of spend is reflected in the forecast.

We are seeking to finance part of the Trust's continuing capital programme through the sale in 2016/17 of a (non-clinical) investment property. We are also seeking residential and retail planning permission to redevelop another investment property: we intend to sell that property in 2017/18 and use the proceeds to construct on the Royal Brompton campus both a new wing to rehouse respiratory inpatients from unsatisfactory premises and a new imaging centre.

Finally, we have recently signed leasing contracts for three replacement MRI scanners on seven year operating (i.e. non-capitalised) leases to avoid a further borrowing requirement. The replaced scanners were between seven and 13 years old and at or near the end of their respective useful lives.

4.3.5. Link to the 5 Year Sustainability & Transformation Plan to 2020/21

NHS England commissions more than 80% of our NHS services and we have only limited interactions with primary and community care providers.

At the date of writing how specialist Trusts should determine their footprint for S&TP purposes has yet to be determined although we have had informal guidance that, together with a handful of other specialist Trusts, we will be included in a specialist S&TP footprint to be led by NHS England. However, as the Trust is located geographically within the NW London footprint we will also attend planning meetings of that health community to provide input on local initiatives in which we are engaged.

As regards possible transformational projects, we applied for Vanguard status for three initiatives (developing a shared critical care service with Chelsea & Westminster Hospital; expanding and enhancing a congenital heart disease network with 25+ referring hospitals; and applying our Hospital to Home platform for managing complex patient discharges to COPD patients prior to and beyond discharge from our partner Hillingdon Hospital) Our bids were turned down, although we have more recently joined the RMH (Royal Marsden Hospital) Partners cancer Vanguard programme.

We have a number of other transformation plans afoot, some touched on above:

- hospital management contract in Kuwait
- new, private outpatient and diagnostic facility in Wimpole Street London
- home ventilation service

- National cystic fibrosis service
- outreach services.

4.4. Cash, liquidity and financial risk rating

4.4.1 Based on the I&E and capital budgets referred to above and the following assumptions:

- NHSE debtor growth of £10m accruing evenly over the year
- PP debtor growth of £2.5m accruing evenly over the year
- Stock reduction of £2.5m accruing evenly over the second half as new procurement arrangements are introduced
- Kuwait receipts in October 2016 and January 2017
- Proceeds of sale of 151 Sydney Street received in September 2016
- £4m CAPEX slippage into 2017/18
- Scheduled drawdowns and repayment of ITFF and Barclays loans
- S&T funding received quarterly in arrears.

The minimum cash position is expected to be £8.1m in August 2016, slightly less than ten days of OPEX. By the end of 2016/17 the balance will be c. £15.7m.

4.4.2 Liquidity should therefore be adequate throughout 2016/17. However, from mid-2017 when ITFF loan repayments will commence, absent significant improvements in NHS and PP clinical income, the Trust's liquidity is likely to deteriorate quickly.

4.4.3 Based on the provisional forecast set out in Annex A and its expected cash profile the Trust will attract a financial risk rating of 2 throughout 2016/17.

5. Membership and elections

5.1 In accordance with the Trust's Constitution, elections for Governors are not held at the same time so that not all Governors' terms of office expire simultaneously. The Trust held two rounds of substantive elections in 2015 plus a recent by-election (January 2016) caused by the resignation of a Staff Governor and an unfilled Public Governor vacancy.

5.2 In Spring 2015 elections were held for Public Governors (2), Patient/Patient-Carer Governors (3) and Staff (4). In the Autumn, elections were held for Public Governors (3), Patient (1) and Staff (1). In 2015, for the first time, the Trust successfully ran electronic (on-line) voting while retaining the option for a postal ballot for those without internet access. There are elections planned four position in Autumn 2016 as terms of office come to an end.

5.3 Currently all elected positions are filled - Public, Patient (and Patient-Carer) and Staff. This is partly as a result of an effective Governor recruitment strategy with publicity and promotion across several platforms including our intranet, internet and print. The Trust is in discussion with a specialist consultancy about a possible multi-media platform to promote the elections.

5.4 All Governors are invited to attend the GovernWell national training programme run by NHS Providers. This programme is intended to support them throughout their term of office with courses covering core skills, NHS finance, recruitment (Governor role in NED appointments). Our Governors are regular attendees whose attendance we record. Each year at least two Governors attend the annual national conference (Governor focus) organised by NHS Providers which provides networking opportunities and information exchange. Governors have also attended briefings organised by our external auditor on topical issues and the Trust Quality Report. During 2016/17 all of these events are scheduled to be repeated and Governors have already been alerted to dates and subjects. A skills audit/survey of Governor training requirements will be completed within the next 12 months.

5.5 The Trust's strategic plans are published in the members' newsletter. Members are asked to comment on these plans to their Governors via the membership office. Consultations on significant plans to develop the Trust's facilities have been held and members were given the opportunity to comment. All members are invited to the Members' Annual Meeting where the Trust's Annual Report and Accounts are presented. The membership strategy, approved by the full Council of Governors, was updated in 2015 and is focused on recruitment and engagement. The present membership is 11,040. In 2014 membership was analysed and areas identified which needed to be targeted: recruitment drives were then held in two constituencies with the goal of 'representative membership'. Approximately 600 members aged 17 – 49 were recruited in the black and ethnic minority groups. A series of member events is held each year. These include tours of the hospital and talks given by medical staff on

their work and research. Further member events are planned for 2016 including a tour of the new hybrid theatre at Royal Brompton Hospital, a tour of the Primary Ciliary Dyskinesia Unit and a talk on heart diseases.

Annex A – Bridge from normalised 2015/16 outturn/ 2016/17 baseline to 2016/17 budget

				Financial Stability Plan											
	16/17 Normalised Baseline		Net Tariff Movement	NHS Growth/ Devs	Kuwait (6 months)	Wimpole St (10 months)	FSP CIPs (low, medium & high risk)	Cost Pressures (unavoidable , mid-case & mitigatable)	S&T Fund (General)	S&T Fund (Targeted)	Inflation (Pay - 3.3% Non Pay - 1.7%)	Other	16/17 Budget (pre gain on sale)	Sale of 151 Sydney St	16/17 Budget
NHS CLINICAL INCOME															
NHS ENGLAND	225,920		0	5,570	0	0	0	7,109	0	0	0	(13,354)	225,245	0	225,245
NHSE BLOCK ADJ	(0)		0	0	0	0	0	0	0	0	0	0	(0)	0	(0)
CCG /OTHER NHS COMMISSIONED	65,386		(4,942)	120	0	0	(1,801)	25	4,800	0	0	13,354	76,943	0	76,943
NHS CLINICAL INCOME	**291,305**		**(4,942)**	**5,690**	**0**	**0**	**(1,801)**	**7,134**	**4,800**	**0**	**0**	**0**	**302,187**	**0**	**302,187**
PRIVATE PATIENT INCOME	**38,347**		**0**	**1,163**	**16,329**	**7,501**	**20**	**0**	**0**	**0**	**0**	**0**	**63,360**	**0**	**63,360**
NON CLINICAL INCOME	**26,349**		**0**	**304**	**0**	**0**	**461**	**715**	**0**	**0**	**0**	**94**	**27,923**	**(350)**	**27,573**
TOTAL INCOME	**356,001**		**(4,942)**	**7,157**	**16,329**	**7,501**	**(1,320)**	**7,849**	**4,800**	**0**	**0**	**94**	**393,470**	**(350)**	**393,120**
PAY															
PAY COSTS	(209,128)		0	(1,713)	(5,263)	(3,142)	3,127	(1,914)	0	0	(6,719)	(108)	(224,860)	0	(224,860)
PAY CONTINGENCY	0		0	0	0	0	0	0	0	0	0	(2,000)	(2,000)	0	(2,000)
PAY	**(209,128)**		**0**	**(1,713)**	**(5,263)**	**(3,142)**	**3,127**	**(1,914)**	**0**	**0**	**(6,719)**	**(2,108)**	**(226,860)**	**0**	**(226,860)**
NON PAY															
DRUGS	(38,648)		0	(55)	0	(424)	2,370	(8,108)	0	0	0	(101)	(44,966)	0	(44,966)
CLINICAL SUPPLIES	(66,126)		0	(1,129)	0	(159)	3,919	(233)	0	0	(1,118)	92	(64,754)	0	(64,754)
OTHER NON PAY EXPENDITURE	(40,403)		0	(298)	(7,565)	(3,400)	1,305	(1,370)	0	0	(667)	73	(52,326)	0	(52,326)
NON-PAY CONTINGENCY	0		0	0	0	0	0	0	0	0	0	(2,000)	(2,000)	0	(2,000)
NON PAY	**(145,177)**		**0**	**(1,482)**	**(7,565)**	**(3,983)**	**7,594**	**(9,711)**	**0**	**0**	**(1,786)**	**(1,936)**	**(164,045)**	**0**	**(164,045)**
TOTAL EXPENDITURE	**(354,305)**		**0**	**(3,195)**	**(12,828)**	**(7,125)**	**10,721**	**(11,626)**	**0**	**0**	**(8,505)**	**(4,044)**	**(390,906)**	**0**	**(390,906)**
EBITDA	**1,696**		**(4,942)**	**3,962**	**3,501**	**376**	**9,401**	**(3,776)**	**4,800**	**0**	**(8,505)**	**(3,949)**	**2,565**	**(350)**	**2,215**
CENTRAL COSTS	**(21,224)**		**0**	**0**	**0**	**(838)**	**0**	**0**	**0**	**0**	**0**	**3,415**	**(18,647)**	**9,600**	**(9,047)**
CURRENT BUDGET 31.03.16	**(19,528)**		**(4,942)**	**3,962**	**3,501**	**(462)**	**9,401**	**(3,776)**	**4,800**	**0**	**(8,505)**	**(534)**	**(16,082)**	**9,250**	**(6,832)**
				4.6%									Net adjustment for donated depn & capital donations		(668)
													Control Total		**(7,500)**
DRAFT BUDGET 08.02.16	**(17,650)**		**(200)**	**900**	**3,500**	**(5)**	**9,409**	**(1,500)**	**4,800**	**0**	**(8,053)**	**0**	**(8,800)**	**10,250**	**1,450**
MOVEMENT FROM DRAFT PLAN	**(1,878)**		**(4,742)**	**3,062**	**1**	**(457)**	**(8)**	**(2,276)**	**0**	**0**	**(451)**	**(534)**	**(7,282)**	**(1,000)**	**(8,282)**