Royal Berkshire NHS Foundation Trust

Operational Plan
2017/18 – 2018/19

Version: PUBLIC
Contents

Introducing the Trust ........................................................................................................i
Operational Plan 2017/18 and 2018/19 .................................................................1
1. Activity planning ........................................................................................................1
2. Quality planning .........................................................................................................4
2.1. Our approach to quality improvement .................................................................4
2.2. Our quality improvement plan ...........................................................................6
2.3. Our quality impact assessment process ...............................................................8
3. Workforce planning ..................................................................................................10
4. Financial planning ...................................................................................................14
4.1. Financial forecasts and modelling .................................................................15
4.2. Efficiency savings for 2017/18 to 2018/19 .........................................................16
4.3. Capital planning ...................................................................................................21
5. Sustainability and Transformation Plan ...............................................................23
6. Membership and elections ..................................................................................25
Appendices ....................................................................................................................... xxvi
1. Appendix: Quality Committee Structure ......................................................... xxvi
2. Appendix: Quality Impact Assessment process ........................................... xxvii
Introducing the Trust

The Royal Berkshire NHS Foundation Trust provides high quality acute services to a core population of around 500,000 people living in local communities. The Trust also provides specialist services to a population of one million across Berkshire and its borders. The Trust is a specialist centre for cancer, bariatric care, renal services, heart attack and stroke, with a designated Hyper Acute Stroke Unit. In addition, the Trust provides specialist care as part of a network in neonatology, interventional radiology and trauma. The Trust provides services which may not be found in every hospital including spinal surgery.

The Trust provides its services from six main sites:

- **Royal Berkshire Hospital** is an 725 bed hospital, providing emergency and acute medical care and surgical services, general medicine and some specialist services in Reading
- The **Prince Charles Eye Unit** in Windsor provides eye services to the patients of East Berkshire
- The **Windsor Dialysis Unit** is a dedicated facility providing outpatient haemodialysis and peritoneal dialysis services
- **West Berkshire Community Hospital**, located in Thatcham, provides a day surgery unit and an acute outpatients department
- **Royal Berkshire Bracknell Healthspace** offers a range of services including renal dialysis, cancer care and outpatient clinics
- **Townlands Memorial Hospital** in Henley offers a range of outpatient services

In addition, the Trust provides services from a number of other sites in the community and directly provides some community services. The geographical disbursement of these sites affords the opportunity of the patient to be treated closer to home.

On-Going Challenges

The Trust faces a number of challenges, which albeit fairly typical across the NHS, impact us locally quite significantly. These challenges create operational and financial pressures and increase the overall level of risk which the Trust has to manage.

In summary these are:

- **Delivery of the National A&E Standard, incorporating local demand management schemes and Delayed Transfers of Care**;
  - The Trust is submitting an A&E trajectory which, whilst showing an improving trend and in excess of 93%, does not meet the 95% standard across the year. This is subject to ongoing discussion with Commissioners via the local A&E Delivery Board. The ability of the Trust to meet the standard is impacted by the system’s capability to introduce schemes which significantly reduce demand and reduce delayed transfers of care (DTOC).
  - The Trust has undertaken a bed modelling exercise which indicates a significant bed deficit and the need for further investment to increase bed capacity, which has been included in our capital plans.
National Cost Pressures and requirement for higher CIPP Savings:

The Trust is experiencing national cost pressures resulting from the increased insurance costs via NHS Litigation Authority (NHSLA), increased regulatory fees such as Care Quality Commission (CQC), increased pay costs through the apprentice levy and reduced income arising from a tariff deflator. Together these increase the year on year deficit by £3.5m. These pressures, taken together with the planning assumption that inflationary pressures will be covered by efficiency saving, means that the Trust is planning on cost QIPP (Quality, Innovation, Productivity and Prevention programme) savings of £16.6m in 2017/18 and £14.1m in 2018/19. At 5.0% and 4.2% of activity income respectively these represent a significant financial challenge in excess of the national planning guidance of 2% per annum.

Staffing, retention and agency spend:

Staffing recruitment and retention is impacted by our proximity to London, where others are able to offer London weighting. One impact of these pressures is the ongoing use of agency staff. Whilst the Trust has made significant progress in reducing agency spend, and is planning to make further progress during 2017/18 to reduce agency spend by a further £2.7m, the Trust is submitting an Operating Plan which does not meet the NHS Improvement (NHSI) agency spend cap in 2017/18.

The Trust intends to continue to take action to reduce agency spend, such that spend in 2018/19 will be below the NHSI proposed cap and sooner if at all possible.

Old and space constrained Estate:

The Trust has a challenge to improve some of our ageing estate and to manage the constrained site at the Royal Berkshire Hospital which has little room for significant expansion. This is subject to short term and longer term scrutiny and planning as part of our Estates Strategy.

Competition:

The Trust faces high levels of competition in its immediate locality with three independent sector providers in a number of services. The system has seen high volume routine work transfer out leaving the Trust with the higher acuity complex work and high comparative substantive costs.

Local Health System financial sustainability

The Trust continues to work closely with other health partners within Berkshire West as part of the Accountable Care System (ACS). The financial challenge across the system has been quantified at circa £50m. The ACS is working on projects to mitigate this risk and move to alternative forms of contract which shares risk and seeks to incentivise our performance. This will result in the Trust accepting a degree of shared demand management risk in playing its part towards the financial sustainability of the system.
Our Strategy

Our Trust Strategy sets the direction for 2016-2021 and is based on our vision

“Seamless Excellence in Health Care Delivery and Outcomes”.

Our Operational Plan for 2017/18-2018/19 has been developed to target delivery of our Trust Strategy and underpinning strategic imperatives

- Consistently delivering quality care and healthcare outcomes
- Shaping a fit for purpose core acute service
- Shaping fit for purpose elective service
- Being a good system partner and exercising system leadership for integration
- Developing a fit for purpose hospital estate strategy
- Developing IT and information systems supporting better care
- Being a great place to work (and work wit)
- Achieving financial sustainability

We are committed to strengthen our foundation in recovering the financial position and working together with our partners in the development of the Sustainability and Transformation Plan (STP) and our local Accountable Care System (ACS) (see section 5). We will work in partnership to achieve integrated care models with patient-centred pathways and greater co-ordinated care services for our patients.
Operational Plan 2017/18 and 2018/19

1. Activity planning

In setting the draft 2017-19 activity plan, the Trust and the Clinical Commissioning Groups (CCGs) are following an agreed process to ensure affordability. This analysis forms the basis of the Trust’s growth assumptions.

The Trust continues to build on capacity and demand analysis undertaken in 2016/17, utilising local expertise and the expertise and tools made available through support from the Intensive Support Team (IST). Work continues to assure ourselves of the Trust’s ability to manage demand within the current environment and skill mix, with particular attention being given to efficient utilisation of resource and the challenges arising from the pressure on patient flow and bed availability. The outputs from these models and projected levels of activity continue to be discussed with commissioners in parallel to the 2017-19 contractual and activity negotiations to ensure agreed levels of work are realistic, achievable and support recovery to compliance where applicable.

Growth projection has varied by service and has been built from the Trust’s forecast outturn position including a base level growth due to changes in population size and profile. On comparison to previous years the Trust anticipates a continuation of high growth levels in the Emergency Department and non-elective pathway. However, this is being off-set by lower levels of growth across elective areas. The high level growth figures used within our activity planning can be seen below.

<table>
<thead>
<tr>
<th>Type</th>
<th>Growth %</th>
<th>Volumes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department Attendance (A&amp;E)</td>
<td>3.5%</td>
<td>4,473</td>
</tr>
<tr>
<td>Outpatient Attendances (incl OPPROCs)</td>
<td>1.3%</td>
<td>6,528</td>
</tr>
<tr>
<td>Non-Elective Activity (incl Obstetrics - NELNE)</td>
<td>2.4%</td>
<td>1,202</td>
</tr>
<tr>
<td>Elective Activity (incl Daycase)</td>
<td>1.0%</td>
<td>511</td>
</tr>
</tbody>
</table>

Activity levels have been agreed with commissioners with a view to efficiently using local resources to deliver activity levels together, utilising local independent sector resources where required. The Trust is currently supported by the independent sector in the delivery of a number of diagnostic modalities including endoscopy, diagnostic breast services and elements of radiology. These agreements have been in place through 2016/17 and the Trust expects to continue in this format into 2017/18 as we continue to work closely with local partners to analyse the system wide capacity and demand on diagnostic pathways. Discussions relating to allocation of capital resource has stressed the need for local investment to meet demand, specifically in the creation of diagnostic capacity through increased access to diagnostic equipment.
as well as a recognised need to increase the number of hospital beds locally.

As part of the Trust-wide development plans we continue to pursue ways of increasing internal efficiency and maximise the use of Trust capacity. Where gaps are identified through capacity analysis, options appraisals are being developed to define sensible and efficient solutions to meet demand within Trust services and in collaboration with primary care and the independent sector.

The Trust has factored in on-going recovery plans where key performance standards are not being met. 2016/17 has seen significant internal and external interrogation of the Trust's emergency access standards (A&E 4 hour standard), resulting in a request to engage assistance from the Emergency Care Intensive Support Team (ECIST), and a 'roundtable' discussion between the Trust, local authorities Berkshire Healthcare and local commissioners. The Trust is working as part of the system wide A&E Delivery Board on the actions identified through the roundtable discussions.

As a result of the sustained levels of increased demand that is being experienced in our A&E during 2016/17 the Trust has escalated that it will be unable to comply with the 2016/17 Sustainability and Transformation Fund (STF) trajectory agreed at the beginning of the year. A trajectory for 2017-19 has been provided as part of the activity planning processes. However, with projected growth continuing to increase demand onto an already pressured service the Trust will strive for improvement but anticipates performance similar to that achieved during 2016/17. The Trust has not relied upon a significant reduction in the number of patients flagged as ‘Fit to Go’ or the formal reporting of Delayed Transfers of Care (DTOC) in its projection and we are in conversation with our partners to address these issues both at the beginning and end of the patient pathway. Sustainable performance within A&E will need to be realised through efficiency gains in patient pathways and greater collaboration with primary and social care providers to support the wider health economy in accessing care within the community setting. This work is being underpinned and informed by an in-depth analysis of patient flow modelling of the Trust’s bed base. In late 2016 the Trust opened an extension to the Trust’s A&E facility to provide a larger area for consultant led assessment for ambulance arrivals to ensure early decision making in the patient pathway. Further efficiency gains are being discussed through the collaborative A&E Delivery Board.

The Trust has successfully turned around its performance against all of the national cancer standards during 2016/17. Development of sustainability plans was a key component in this work and following a Q1 recovery of the Two Week Wait standard and an early recovery of the 62 day standard during Q2, attention remains highly focused on the management and maintenance of the cancer standards. Through 2017-19 the Trust anticipates sustained compliance on a quarter by quarter basis and will continue work to advance processes and efficiencies to best serve patients within these pathways.

The Referral to Treatment (RTT) incomplete standard has been a key area of attention through 2016/17. The Trust has adapted quickly to the national rule changes enabling the Trust to concentrate on its pathways as a whole. A programme of work to streamline the reporting and data capture processes to increase the level of efficiency and visibility of patient pathways across the Trust has been effective. Whilst this work has brought about challenges the Trust has progressed quickly with necessary changes. The Trust has sustained compliance through
2016/17 and expects this to continue through 2017-19 as we progress through to the second phase of planned improvements. A fundamental change to the Trust’s systems for the management of the RTT standard is due to be implemented in early 2017. Whilst the Trust is confident performance against the standard will be maintained post implementation there is an expectation that proactive data quality will be positively impacted.

Through 2017-19 the Trust will continue to work to further improve against all operational standards. However, whilst we strive to remain within the group of top performers both regionally and nationally, maintaining this level of performance, in particular, the A&E four hour standard will be a challenge given the reliance on partner actions. We are again projecting significant levels of growth in demand which is complicated further by onward pressure for availability of beds resulting from being an outlier for DToC. The current projection will present a significant challenge to the Trust should attempts to reduce demand through commissioner Quality, Innovation, Productivity and Prevention plans (QIPPs) prove ineffective. The impact of this pressure is felt throughout the Trust and as such planning for unplanned changes in demand will likely result in a need for additional resource at an increased cost to the Trust and a negative impact on performance.

The Trust will continue to work on its resilience planning and improvements through a combination of a continued drive on internal efficiencies, modernising and transforming patient pathways. This includes the continued development of ambulatory care services and an increased ‘offer’ at the front door to reduce admissions as well as working with partners to reduce attendances and improve DToCs. However, the Trust has identified a significant bed deficit on the Royal Berkshire site and has limited options both from an estates and financial perspective to address this, particularly in the light of the continued high number of beds day taken up by the DToCs. This means that the Trust’s flexible capacity to accommodate winter pressures and resilience decant space is limited. How to address this in the future will be considered as part of the Estates Strategy and future financial planning.
2. Quality planning

2.1. Our approach to quality improvement

Our Trust wide Quality Improvement Strategy is jointly led by the Director of Nursing and the Medical Director and focuses on clinical effectiveness, patient experience, patient safety and culture. Our Quality Strategy is the plan through which we focus on the quality of clinical care and ensure that we continuously improve our services. It ensures that quality drives the overall direction of our work and that the patient is at the centre of all that we do. Quality at the Trust is defined by whether services are safe, effective, caring, responsive and well led.

The Trust has always maintained the quality of patient care at the centre of its values and objectives. Our quality strategy is reviewed annually and is reflected in the Trust strategy. Building on the Trust’s successes in the “Making Every Moment Count” (MEMC) Programme our aim is to continue with structured quality programmes to contribute to the development of a culture of continuous quality improvement. We acknowledge that our staff are central to delivering the strategy and the vision is that staff at all levels will have the confidence to highlight areas of improvement/concern and will be equipped with knowledge, skills and support to implement the required improvements.

The Trust recognises the importance of organisational culture on the successful implementation of the quality improvement programmes; the Trust’s Workforce & Organisational Development Strategy aims to deliver, “The right employees in the right place with the right skills and motivation to deliver patient care as efficiently and effectively as possible”

Organisation-wide improvement approach

The Trust’s improvement approach utilises project management and quality improvement methodologies (see later sections).

There is a clear governance structure in place through the Trust Improvement Programme Board chaired by the Chief Operating Officer and jointly managed with the Director of Finance to ensure that the right balance is achieved between quality and finance. This Programme Board reports into Senior Management Team and Board.

The Trust has developed a Clinical Audit and Quality Improvement annual programme based on an analysis of patient safety and experience data from 2015-16 and aligned to the Trust’s key quality priorities for 2016-17. The completion of this programme will be monitored through the Trust’s Clinical Outcomes and Effectiveness Committee chaired by the Medical Director. Throughout the year additional quality improvement projects may be identified in response to specific quality issues and service needs; these will be evaluated and approved by the clinical leads and managed by the clinical audit and improvement facilitators. Quality improvement training is available to all staff. Our aim is to continue to be a transparent and open organisation, particularly in the way we respond to complaints and incidents, and how this informs service development.

In addition, root cause analysis (RCA) investigations are completed for all identified ‘Serious Incidents Requiring Investigation’ (SIRI) and incidents for which significant learning has been identified. From these investigations robust action plans for improvement are developed and learning shared across the organisation to mitigate any patient safety risks highlighted and improve quality. Regular thematic reporting from SIRIs is submitted to the Trust Quality Assurance and Learning
Committee for oversight and wider dissemination of learning and improvements made.

**Internal peer review process for monitoring compliance with Care Quality Commission (CQC) standards**

One of our goals is to achieve good/outstanding in our CQC rating.

A series of Trust-wide improvement projects, informed by our previous CQC inspections, areas of known risk and a review of the key lines of enquiry that the CQC use, have been established to deliver specific time bound programmes of work.

In addition, the Trust has an established internal review aiming:

- To drive up quality standards by providing assurance and reassurance on the Trust’s performance in relation to specified key lines of enquiry considered good practice and commonly assessed by the CQC at inspection.
- To educate staff about their responsibilities in relation to basic qualitative issues assessed by the CQC

The scheme involves 50 multi-disciplinary staff members visiting wards and departments monthly to provide assurance about the performance of key lines of enquiry used by the CQC within its inspection process. Results are fed back directly to the wards/ departments and are then take forward through the governance system.

The recommendations from the previous CQC inspection are being monitored via an action plan which is reviewed by the Senior Management Team, Trust’s Quality Assurance and Learning Committee (QALC) and externally by our commissioners.

**Quality Committee Structure**

The Quality Assurance & Learning Committee is primary committee for providing assurance to the Board (via the Quality Committee) of clinical quality across the organisation. The Quality structure is outlined in Appendix 1

**Quality improvement capacity and capability to implement and sustain change**

The Trust has a resource to help build improvement capability through support to QIPP. Operational and clinical staff are currently delivering quality improvement projects to improve hospital flow through the Patient Flow programme and there are similar programmes in other areas such as pre-operative assessment.

The Trust is beginning to build capacity and capability to implement and sustain change. The Trust’s Organisational Development Strategy includes a strategic domain on Transformation and Continuous Improvement, which includes increasing improvement capability through improvement methodology training. The Trust is focused on engaging a wider staff group in building the QIPP programme through the development of this capability, and has already invested in building leadership capabilities through the Trust’s Consultant leadership programme.

**Measures of impact of quality improvement**

The QIPP programmes identify key performance indicators, including cost targets, as well as measures of quality improvement such as length of stay reduction, which are monitored to ensure the programme remains on target. The achievement of these key performance indicators are one measure of the investment in the QIPP approach.
The use of Quality Impact Assessments (QIA’s, see section 2.3) are a critical part of our governance in assessing the full impact of our QIPP projects.

### 2.2. Our quality improvement plan

Our quality strategy aims to deliver the highest quality healthcare services to our patients over the next five years through the delivery of the following overarching goals:

- The Trust will, through its management structure and clinical leaders, ensure that quality and safety dominate thinking at all levels of the organisation.
- There will be continuous improvement in service, outcomes, processes and monitoring.
- The Trust will concentrate on the prevention of failure, and if it does occur, ensure learning from it.
- The Trust will celebrate success in the delivery of improvements in quality and safety.
- The Trust is committed to the development of learning from benchmarking its performance.

The Programme Management Office (PMO) and Quality Governance Team will work collectively in order to deliver transformational change.

### Patient Safety

We are committed to striving to achieve harm free care and will focus on reducing harm. The Trust aspires to zero-tolerance of avoidable hospital acquired infections. We will continue to address improvement needs in sepsis, staff training, reducing medication errors and serious incidents.

To address these effectively we will improve our learning from incidents and identification and management of risks.

### Quality Account Priorities Development

The Trust identifies multiple key quality improvement priorities each year around the domains of patient experience, clinical effectiveness and patient safety. These priorities are based on patient and staff feedback, on-going priority work streams, and key national targets. Each priority will have an identified lead and action plan for improvement which will be monitored throughout the year by the QALC. In 16/17 the focus has been on staffing, sepsis, cancer waiting times, medical records, dementia care and exceeding quality aspirations.

### CQUINs

The Trust has a number of national and local Commissioning for Quality and Innovation (CQUINs) for 2016/17 against which it is making and reporting progress. For 2017/18 and 2018/19 the focus will be on the national CQUINs contained within the Commissioner Contracts.

### Mortality Review Process

A Mortality Surveillance Group, established in June 2016, chaired by the Medical Director, has strengthened the mortality review processes in the Trust. A system is in place where every inpatient death is reviewed. If there are any concerns raised at this initial review the case will go have a full mortality review. The Surveillance Group reviews any potentially avoidable deaths and the themes arising from all mortality reviews to ensure that lessons learned are shared across the organisation.
National Clinical Audit

The Trust will participate in all relevant National Clinical Audit and Patient Outcomes Programmes (NCAPOP) and Quality Account National Clinical Audits. This will provide assurance of the clinical effectiveness of our key services and enable the Trust to benchmark its performance, against local and national peers. Over 2017/18 and 2018/19 the Trust will work towards integrating the outcomes of national clinical audits with specialty level quality indicator dashboards to provide benchmarked clinical effectiveness and quality measures which will be used as a driver for local quality improvement projects where indicated.

Clinical Outcomes

In line with the Carter Report, departmental clinical outcomes are presented to the Trust Board on a monthly basis. This will be supported, in early 2017, by a dashboard being developed from Dr Foster data. The Clinical Outcomes and Effectiveness Committee review all aspects of clinical effectiveness, including mortality, compliance with National guidance (such as NICE, NCEPOD, audits) and clinical concerns from the Data Quality Group.

Safe Staffing

Good quality and adequately supported front-line staff are essential for quality improvement. We recognise the most powerful tool that an organisation has in achieving its goals and objectives is its staff. We will ensure that our workforce will be competent, well trained and resourced to provide high quality care across the organisation, underpinned by a culture of caring. We acknowledge we have challenges in recruiting to, and retaining substantive nursing midwifery and medical vacancies. This is captured on our Corporate Risk Register and our recruitment strategy.

The Trust complete strategic staffing reviews of nursing levels, using a triangulated approach (utilising evidence based tools, professional judgment and peer comparison); with public Board level discussion to ratify and agree nurse staffing levels. We continue to monitor the new approach to provide a single consistent way of recording and reporting deployment of staff working on inpatient wards/units. When national data is available we will benchmark ourselves against other providers.

Seven day hospital services

The Trust has a Service Improvement and Delivery Plan with the Berkshire West CCGs, which monitors compliance against the four priority clinical standards. The Trust participates in the six monthly NHSI audits of seven day services and shares the results with the Operational staff and the Executive teams. The results of the audits are analysed and an action plan is being developed based on the last audit published. A seven day project will be part of the SAFER patient flow programme in the next two years, aiming to reduce the length of stay of patients throughout the hospital.

The Trust is performing well overall, and our workforce planning will contribute to achieving full compliance by 2020.

The results of the audit are shared with the CCG and any actions to improve compliance are discussed and agreed. The most recent audit was undertaken in September 2016. The Trust is also progressing on the other clinical standards with progress being monitored through the seven day project and the CCG notes progress against these standards.
The on-going review of consultant job plans and rotas will assist in identifying the current gaps in the organisation’s ability to deliver seven day senior medical cover and the Trust aspires to have all medical wards with 7 day senior medical cover from January 2017. The Trust is committed to working as a system partner in ensuring seven days services, subject to budgetary constraints. Any gaps in provision will need to be filled either by reorganisation of the workforce and patterns of work or by agreement with the CCG.

Getting it Right First Time (GIRFT)

The Trust is fully involved in the implementation plans for GIRFT. Several specialties (Orthopaedics, Vascular Surgery and Urology) have already been reviewed with a further speciality for review in December.

2.3. Our quality impact assessment process

Quality Impact Assessments (QIA) are completed for all QIPP projects, by the project lead or quality improvement lead, supported by the Programme Management Office (PMO) lead. When a programme or project is created the QIA is completed by the programme lead and signed off by the Executive lead. The escalated QIAs are discussed by the Medical Director and Director of Nursing and an action is decided whether to proceed with mitigations or not to proceed if the quality impact is too great.

There is a clear process and governance structure for Quality Impact Assessments for all QIPP projects in place. This process is outlined in Appendix 2.

The areas of quality that are addressed and scored for impact and likelihood include; patient experience; patient safety; staff safety; education; clinical effectiveness; prevention; productivity and innovation. The Medical Director and Director of Nursing are informed of all QIAs that have been submitted. Any escalated QIAs are reviewed (those scoring eight or above) and there are four possible outcomes including accepting/not accepting scoring and agreeing to proceed at risk or not. Escalated QIAs are reviewed by the Trust Improvement Programme Board and the Project Lead is informed of how to proceed, with the risk rating being adjusted accordingly. Post-project QIAs are completed for any projects with escalated QIAs and approved by the Trust Improvement Programme Board, within six months of the implementation of the project. The Quality Committee also reviews the QIAs for QIPPs and post-project QIAs are used to communicate lessons learnt to the Senior Management Team.

Triangulation of quality with workforce and finance

The Board receive an integrated performance report monthly covering safety, experience, clinical effectiveness, access, workforce and finance, supported by a suite of exception reports as required. Performance issues are identified and appropriate actions to be taken are recorded. These action points are developed and Board sub-committees, with members including clinicians and non-clinicians, are used to further explore key issues and help achieve resolution. Issues submitted by the Board to its sub-committee are followed up in subsequent Board meetings until resolved. A comprehensive governance process, including a risk management, assurance and escalation framework exists to support the Board underpinned by a hierarchy of committees. The Care Groups get a similar report for their areas which is then monitored each month with the Executive Team.
Identifying Managing Key Risks to Quality

The Trust has a systematic approach to risk management that ensures the identification and escalation of both operational and strategic risks. The Board Assurance Framework (BAF) identifies the key risks that may disrupt the Trust from achieving its strategic goals, quality goals and objectives. The BAF and the Corporate Risk Register identify the significant risks, which potentially may affect the delivery of the Trust’s objectives. Lack of bed capacity, staffing issues and failing to meet the emergency access target have all been identified as key issues which potentially may affect our ability to meet our quality strategy. These are being closely monitored and all have a description of the risk, the current risk, the main controls and risk owner. These elements are picked up throughout this document.
3. Workforce planning

Workforce and Organisational Development Strategy

The Trust’s Workforce Strategy aims to deliver ‘The right employees in the right place with the right skills and motivation to deliver patient care as efficiently and effectively as possible’. The strategy details five main themes: Model Employer, Model Career, Staff Engagement, Workforce Productivity and (Human Resources Management) HRM Development, with a five year action plan. The plan focuses on developing a modernised workforce adapted to the changes that will need to be made in the delivery of healthcare.

The Trust’s new Organisational Development (OD) strategy identifies key domains where the Trust will make organisational improvements over the next three years including developing an organisational culture, leadership, management and board development, operating in partnership, promotion of workforce development, employee engagement and positive culture.

Both the workforce and OD strategy are linked to the Trust and Clinical Services Strategy.

Approach to Workforce Planning

There are a number of workforce challenges faced across the Trust, including on-going recruitment, employee turnover and skills gaps. Some vacancies are noticeably harder to fill in the Trust than others.

Workforce planning within the Trust has been approached on an integrated basis with activity and financial planning. To ensure ownership of the plan, workforce changes have been driven via the Care Group and Corporate Services structures. The service managers and clinicians are working together within specialties to identify QIPP efficiencies and developments in line with the organisational objectives.

A workforce planning template was utilised to enable each service to consider service planning, supply and demand; workforce gaps and surpluses; actions needed; risks, monitoring and quarterly review assessing performance in year against plan.

Productivity and efficiency

Workforce productivity is a key work stream within our QIPP plans including work streams covering recruitment and retention, temporary staffing and demand and capacity.

The Trust utilises an electronic rostering programme that directly interfaces with the NHSP platform. The majority of Trust staff in all specialties, other than medical, are on the e-rostering system which interfaces directly with the Electronic Staff Record (ESR) and payroll. This removes the necessity for double entry of shifts where cover is required. Control processes are in place that ensure that senior management sign off is required for multiple shift cover or agency fill of vacant shifts. The Trust plans to move to e-rostering for the remaining medical workforce in the next financial year.

As an example of the efficient use of the system; a senior nursing meeting takes place three times daily, fed with real-time data from the e-rostering system, in which nursing cover across all services is reviewed and when necessary staff are moved to areas of high activity. This process ensures safe care and avoids unnecessary backfill.

There is a separate programme to deliver QIPPs in the medical workforce. This group is focussing on a review of job plans and the
alignment of medical planned activities to the Trust’s activity plan. In addition, new software has been implemented that gives greater visibility of senior medical staff leave to the teams who carry out the clinic and theatre bookings.

In line with the recommendations of the Lord Carter Review, the Trust is carrying out the reconciliation of ESR with the financial ledger. The ESR will facilitate the control process and assist managers for staffing budgets. Any review of service budgets will be aligned to safe staffing levels assigned to wards, which are based on nationally recognised acuity tools.

A benchmarking review against other medium and large acute Trusts has shown that the Trust is not an outlier on any band in regard to the skill mix.

Services in the Trust are actively reviewing their skill mix and new roles are being introduced, for instance, nursing assistant practitioner, nursing associate, ICU-dedicated pharmacist, physician’s assistant, that will improve service capability and deliver savings.

**Recruitment**

One of the Trust’s workforce challenges is on-going recruitment. The reasons behind these difficulties may include a skills gap at national or local level, insufficient quality of supply or the high cost of living in the area.

In September 2016 the Trust recorded a vacancy rate of 8.6%. Vacancies are highest in the qualified scientific and support staff groups and allied health professionals. The Trust is addressing the gap by changing the way we recruit to match a competitive market. For example, we recognise that filling nursing and midwifery vacancies remain a challenge for the Trust and have developed retention and recruitment plans to address this.

The Trust is adopting a proactive candidate-focused recruiting approach. We are increasing the sourcing methods, (to include proactive social media campaigns, headhunting, international recruitment, graduate and internal training schemes, working in partnership with other Trusts through BOB) to provide sufficient candidates to fill the vacancies.

**Retention**

Retention is another workforce challenge. A retention framework has been developed with actions covering engagement, education, training and development, pay and retention initiatives, healthy safe workplace and staff recognition. In addition The Trust has established a (recruitment) and retention working group to focus on these challenges.

In October 2016 the Trust had a number of areas reporting turnover levels higher than the Trust target of 14%. All hotspot areas have been identified and targeted actions plans are being developed.

**Organisational development**

The Trust recognises our people as our most important asset and the OD strategy places people at its heart. In order to be known for excellent care, the Trust recognises that it must develop a skilled, well-led and engaged workforce.

The introduction of the Apprenticeship Levy in May 2017 heralds an opportunity to invest in career development programmes for our existing staff in key areas such as Healthcare Support Roles, Healthcare Science and Leadership and Management Development as well as
offering opportunities for new ways of working through converting existing establishment positions into apprenticeship opportunities. Our strategy plans to link apprenticeships to career pathways. Our target is to convert fifty substantive establishment positions into apprentice roles. The Trust also plans to deliver 200 apprenticeship qualifications across our current workforce.

From an equalities perspective, we will continue to take action to enhance the experience and opportunities for BME staff at the RBFT – including engaging with National Leadership programmes, developing a network of BME coaches and taking positive action to ensure our BME staff are represented in our local talent management and leadership development programmes.

In terms of Leadership and Management Development (LMD), three programmes will be created to support the development of leaders and managers working in all professions. Each programme comprises of 3 core themes (1) Managing Self (2) Managing Others (3) Managing the Trust.

Accompanying the core programme will be a range of specialist and leadership topics which will be available to develop specific skill sets in areas such as lean; systems thinking; organisational design. Programmes will be linked to the Trust’s core values and behavioural framework and will be based on a blended learning approach supported by a resource library.

2017/18 will see the establishment of the first cohort under the Talent Management framework. The framework is designed to encourage talent at all levels to be identified. A range of learning and development opportunities will be available to support people in their roles and also to identify career pathways. Work will begin also on a Trust wide succession plan to identify critical roles and those best able to undertake a competitive process to fill them.

A new set of Trust values has been consulted upon and introduced. Care, Aspiration, Resourceful, Excellence. Early in 2017 we will launch the Behavioural Framework which underpins the values. This work is being consulted on widely and the final framework will be embedded in recruitment, induction, appraisal and talent management.

**Working with system partners in STP and ACS**

The Trust is working closely with system partners in developing new models of care via the ACS and STP. Our vision is to improve health outcomes and add value by working together and in doing so close the health and wellbeing, care and quality and financial gaps. The delivery of the STP requires a multi-professional workforce with the right skill mix and capacity. Both the STP and the ACS provide opportunities for the integration of workforce and organisational development across organisations.

The footprint in the area west of London has unique workforce challenges, which impact the entire system; the high cost of living locally means recruiting and retaining the workforce is a big issue, and turnover rates are higher than the national average. Working in partnership across the system will improve recruitment, aid staff retention, address skills shortages and manage the market more effectively to remove reliance on an agency workforce.

One of the main objectives of the STP Workforce Programme is to develop a clear understanding of the needs of the local population and the number and skills of the workforce required to deliver the services in the years ahead.
The STP is placing significant emphasis on joint education, training and development across the system. The Trust will contribute to the delivery of inter-professional and cross-service and -sector education and training. This includes the development of a clear understanding of the needs of the local population. Subsequently, the number and skills of the workforce required to deliver the services in the years ahead shall be derived and the training needs will be scoped. The programme shall define which education provider is best placed to deliver the education and training needs. The programme seeks new combined roles across sectors, taking advantage of the different sectors’ abilities to attract and retain staff.

The establishment of a common regional platform will allow the more effective utilisation and deployment of the region’s healthcare workforce and achieve quality and financial improvements.

A shared workforce plan will increase opportunities for staff, including specialist doctors, to rotate across organisations and in doing so gain greater experience and deliver better care.

If all these ideas were put into place, the plan submitted by the BOB STP suggests savings would be realised across the footprint over the five year lifespan of the plan, and would result in increased workforce numbers.
4. Financial planning

Overview

The Board of the Royal Berkshire NHS Foundation Trust, at its Board Meeting on the 20th December 2016 approved the Final Operating Plan which returns a £4.39m deficit pre STF monies (and donated assets) for 2017/18 and a £0.51m surplus for 2018/19 both of which are in-line with proposed control totals. Accordingly Sustainability and Transformation Fund (STF) monies of £9.01m have been included in each year. The Trust has submitted trajectories compliant with National Standards for cancer and RTT but has submitted a non-compliant trajectory for the National A&E standard. It is assumed that agreement will be reached with regards to the A&E standard trajectory such that STF monies will still be payable in full.

The Trust has included a cost QIPP of £16.6m for 2017/18. Equating to 5.0% of activity income this is 3.0% (£8.28m) more than the planning guidance. Cost QIPP of £14.14m is included for 2018/19, equating to 4.2% of activity income, which is 2.2% (£7.34m) more than the planning guidance.

Cost QIPP at this level has been necessary to cover a number of cost pressures included in the plan such as CNST costs, Junior Doctors contract and a tariff deflator equating to £1m income reduction in 2017/18.

In line with the contracts which have been agreed in principle with Commissioners we have not included any activity reductions relating to Commissioner QIPPs as history tells us that, notwithstanding the success of such schemes, the net growth in activity has always been at least 2.5% for the Trust. Similarly the risks and opportunities from the ACS and STP are not currently reflected within the plan, but work remains on-going within the ACS and STP.

The Trust has agreed in principle a variant on the standard PbR contract with Berkshire West CCGs which reinforces the aim to move to a contract for the whole ACS system during 2017/18 which provides for greater risk share in demand management and delivery of cost efficiencies across the whole of the ACS. This arrangement includes identifying projects which, once agreed, all parties in the system will collectively accept with revised risk share mechanisms which give gain/pain share across all partners.

As a step towards this, in exchange for a committed reinvestment of non-elective marginal rate monies the Trust has accepted moving to a gain/pain share based on a marginal rate payment mechanism for elements of the A&E and elective activity above the contract activity levels. ACS partners have agreed to work with the Trust so that was can collectively mitigate through specific actions to be identified in the event

<table>
<thead>
<tr>
<th>£m</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q2F</td>
<td>Final Oper. Plan</td>
<td>Control Total</td>
</tr>
<tr>
<td>STF Monies</td>
<td>0.00</td>
<td>9.90</td>
<td>9.01</td>
</tr>
<tr>
<td>Control Total pre STF Monies</td>
<td>5.12</td>
<td>[5.10]</td>
<td>(4.39)</td>
</tr>
</tbody>
</table>

Note: Additional income from donated assets excluded from above 1.50 1.00
that activity exceeds planned levels presenting a risk to the Commissioner and the Trust.

The Trust will continue traditional contracting relationships with other Commissioners with income being based on the national PbR contract.

The table below provides a summary of the Final Operating Plan Income Statement for 2016/17 to 2018/19.

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity Income</td>
<td>330.31</td>
<td>(9.82)</td>
<td>320.49</td>
<td>333.09</td>
<td>336.56</td>
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<tr>
<td>Drugs Income</td>
<td>39.18</td>
<td>39.18</td>
<td>42.23</td>
<td>45.53</td>
<td></td>
</tr>
<tr>
<td>Other Income (incl devices)</td>
<td>31.52</td>
<td>(0.21)</td>
<td>31.31</td>
<td>34.12</td>
<td>34.19</td>
</tr>
<tr>
<td>Total Income</td>
<td>401.01</td>
<td>(10.03)</td>
<td>390.98</td>
<td>409.44</td>
<td>416.28</td>
</tr>
<tr>
<td>Pay Costs</td>
<td>(227.45)</td>
<td>(0.59)</td>
<td>(228.04)</td>
<td>(230.14)</td>
<td>(228.46)</td>
</tr>
<tr>
<td>Pay %age income (excl drugs)</td>
<td>62.9%</td>
<td>64.8%</td>
<td>62.7%</td>
<td>61.6%</td>
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<tr>
<td>Drugs</td>
<td>47.19</td>
<td>0.04</td>
<td>(47.15)</td>
<td>(50.99)</td>
<td>(55.14)</td>
</tr>
<tr>
<td>Drugs income % cost</td>
<td>83.0%</td>
<td>83.1%</td>
<td>82.8%</td>
<td>82.6%</td>
<td></td>
</tr>
<tr>
<td>Non Pay Costs</td>
<td>(116.88)</td>
<td>(0.84)</td>
<td>(117.72)</td>
<td>(116.76)</td>
<td>(116.88)</td>
</tr>
<tr>
<td>Non Pay % income (excl drugs)</td>
<td>32.3%</td>
<td>33.5%</td>
<td>31.8%</td>
<td>31.5%</td>
<td></td>
</tr>
<tr>
<td>Other Costs</td>
<td>(5.61)</td>
<td>(5.61)</td>
<td>(5.43)</td>
<td>(5.28)</td>
<td></td>
</tr>
<tr>
<td>Surplus / (Deficit)</td>
<td>3.88</td>
<td>(11.42)</td>
<td>(7.54)</td>
<td>6.12</td>
<td>10.52</td>
</tr>
</tbody>
</table>

Note: Surplus / (Deficit) excl. donated assets 4.62 9.52

4.1. Financial forecasts and modelling

Key Assumptions inherent in the 2017/18 and 2018/19 Final Operating Plan are detailed below:

Income

Income is based on the national PbR (Payment by Result) for all contracts except Berkshire West CCGs.

The Trust has accepted principle a contract with Berkshire West CCGs as outlined above.

Growth in non-elective admissions has resulted in income at 70% of tariff, whereas the cost of delivering the growth is historically circa 100% of tariff. Whilst Berkshire West CCGs have agreed to reinvest monies back into the Trust this places an extra £2m cost pressure to the Trust in 2017/18 rising to £3m in 2018/19. The Trust remains of the view that this mechanism is no longer fit for purpose in that it neither recompenses trusts for the cost of delivering activity nor has it incentivised the Commissioners sufficiently to reduce demand.

The above activity has been run through the latest HRG4+ and has produced a 0.3% tariff deflator for 2017/18, versus Planning Guidance of a 0.1% tariff inflator, before CNST costs. This has placed an extra £1.00m financial pressure on the Trust in 2017/18.

Pay

Pay reflects the planning guidance from NHSI and includes a 1.8% inflation increase in 2017/18 and a 2.0% inflation increase in 2018/19 to cover an assumed annual pay award along with changes to employer pension and NI contributions. Collectively these add circa £4.1m and £4.3m to the pay cost of the Trust in each year.

In addition we have included an increase of £4.46m and £4.47m in 2017/18 and 2018/19 respectively to support the delivery of the incremental activity growth.
Reducing the pay costs is an assumed saving in cost QIPPs of £9.96m in 2017/18 (with £2.00m restructuring cost assumed) and £9.77m in 2018/19 (with an assumed restructuring cost of £1.33m). Further detail on in year cost QIPPs is provided below.

**Drugs Cost**

Drugs cost has been assumed to increase at a rate of 7.8% per annum, increasing costs by £3.68m, and £3.98m in line with the NHSI Planning guidance. This cost increase is largely offset by an increase in drugs income.

**Non Pay Cost (excluding drugs cost)**

Non pay inflation has been assumed at 1.8% per annum, equating to £1.4m increased costs, in line with NHSI Planning Guidance.

Activity growth is expected to drive a further increase in non-pay cost of circa £1.19m in 2017/18 and £1.14m in 2018/19.

CNST costs are planned to increase by £1.47m as per our latest quoted premiums for 2017/18 with a further £2.89m increased cost in 2018/10, in line with NHSLA guidance.

Reducing the non-pay costs is an assumed saving in cost QIPPs of £6.64m in 2017/18 and £4.38m in 2018/19 (with assumed restructuring costs of £0.67m). Further detail on in year cost QIPPs is provided below.

**Risks and Opportunities and Contingency**

The largest risk within the control of the Trust relates to the delivery of cost QIPPs, in particular such QIPPs being delivered non-recurrently and requiring an amount of restructuring costs to deliver them. This risk is currently assessed at £2.5m for 2017/18.

The Trust continues to work with all Commissioners in identifying areas for demand management and further cost efficiencies in delivery. The Trust recognises that this is needed to mitigate the system wide risk that exists and to deliver the Five Year Forward View aim of partners working together to deliver financial sustainability.

**Cash Management**

The Final Operating Plan shows a low cash position of £14.48m in 2017/18.

Capital spend has been allocated totalling £25.5m in 2017/18 and £24m in 2018/19.

For cash planning purposes the Trust aims to maintain year end cash balances of circa £14.5m.

**4.2. Efficiency savings for 2017/18 to 2018/19**

**QIPP process**

The Trust is adopting a sustainable approach to efficiency savings in 2017/18, by differentiating between Cost Improvement Programmes which are focussed on taking cost out in year, and QIPPs which are about transforming clinical and non-clinical services to provide quality and cost improvements over multiple years. This will enable the Trust to develop a longer term programme of efficiency savings rather than incremental departmental cost reductions.

Cost Improvement schemes are identified by the Care Groups or Corporate Department. Some of the Cost Improvement Programmes are aligned to cross-cutting themes such as procurement, medicines management and removal of temporary staffing. Other Cost
Improvement Projects are relevant to only one directorate, for example reviewing or consolidating services.

The Trust QIPP schemes are aimed at addressing the larger challenges facing the Trust that will require significant changes. The programmes include outpatients, SAFER patient flow and reducing administration and corporate costs in line with the Carter challenge.

The Trust efficiency savings are identified through a series of workshops and meetings with the Care Groups and corporate functions, which include representation from clinical and non-clinical staff. The programmes are also based on national directives, external reviews and benchmarking. These programmes will be aligned to the Trust’s strategic imperatives as detailed in the Trust Strategy. The Trust efficiency programme is signed off by the Trust Improvement Programme Board, Finance and Resources Committee, Senior Management Team and then the Board.

All schemes have been identified for 17/18 but there remains a gap of approximately £6m for 18/19 which have yet to be aligned to particular pay CIPs. However, as the above figure demonstrates we have identified a range of opportunities upon which to draw. Further work is being undertaken to develop and validate these opportunities ready for implementation.

Each programme will have a senior management lead, a programme lead and a named PMO support lead. All large programmes have scoping briefs and Project Initiation Documents with programme plans. The scoping briefs detail the phasing of the savings, the key milestones and baselines to monitor delivery and are signed off at the Trust Improvement Board. A project lead is then assigned who continues to work through the scoping brief and establish the metrics and baselines to measure delivery.
The delivery of the cost QIPPs are overseen by the Chief Operating Officer, working with the Director of Finance. All programmes are monitored through the monthly Trust Improvement Board with senior management leads in attendance and achievement is tracked through the PMO’s database. The Executive Team has a weekly briefing on the cost QIPP programme and the Finance and Resources Committee and Board has monthly reports on progress and exception reporting where appropriate. There is a clear risk rating for each of the programmes.

The Trust baselines data on cost and performance, if appropriate, before implementing QIPP programmes. In order to capture seasonal variation, the data would be looked at over an appropriate period. For example the Trust has developed a bed model whereby the historic trend is based on the last 3 years of data.

**Approach and Methodology**

RBFT is developing a multi-year approach to the QIPP savings, starting from a review of the 2016/17 efficiency savings and programme structure to identify lessons for success or failure against target to apply to the development of plans for 2017-2019. In addition the Trust now monitors “pipeline programmes” through the Trust Improvement Board and is developing service improvement programmes that will deliver cost improvements later (in subsequent months or years).

As part of the ACS, RBFT is involved in the development of the CCG QIPP plans for 2017/18 and therefore alignment between the reduction in income and the Trust’s QIPP plans can take place. Part of this alignment will need to be a risk assessment of the proposed CCG schemes in terms of the impact on RBFT.

Specific transformational QIPP programmes will commence in the Trust to improve efficiency and then expand into the system through the ACS for instance the Outpatients programme which seeks to modernise and improve the efficiency of services along the patient pathway.

**Transformation**

During 2017/18 the Trust will develop its transformational approach to QIPPS and service improvement, re-modelling and skilling up the PMO function to develop its transformational support to the organisation. An agreed methodology is being developed (likely an enhancement of the previous service improvement methodology used in the Trust) to underpin all service improvement and QIPP work on both large and small scale projects, and to build and expand our continuous improvement approach across the Trust. This work will link across with similar or overlapping programmes through the ACS, and the methodology used will be consistent. The Trust is looking to develop staff with a transformation toolbox by introducing training in lean, six sigma and project management.

**Shared services**

The Trust will continue to drive efficiencies in back office and clinical functions internally but in addition the multi-year QIPP plans will need to build in partnership opportunities to consolidate further primarily, but not exclusively, through the ACS and STP footprint. The ACS has established a group to understand the opportunities that shared services could provide the partners. This group are currently looking to identify the key projects to go forward.
The Trust is a founder member of the Berkshire and Surrey Pathology Service (BSPS), a joint venture with four other NHS Trusts. The initiative consolidates laboratories into networks to improve efficiency and quality at an appropriate scale across a number of providers, which was highlighted as an example of good practice in the Lord Carter Report. The BSPS partnership is well progressed and a governance structure is in place. Changes to services, workflows, logistics, equipment and infrastructure are currently taking place. The QIPP programme is monitoring the savings from this scheme.

Commercial income
The Trust seeks to increase its commercial income and secured additional income from our commercial estate in 2016/17. In 2017/18 we should see an increase in revenues from commercial sources.

Estates
The Trust has recently reviewed its Estate strategy which has confirmed a number of actions for disposal of surplus land, which are in progress. The Trust is looking to driver further estate opportunities through benchmarking, implementation of a revised strategy in relation to retail space and the creation of incentives to maximise clinical use of the space we have. There is work underway with our system partners in the ACS and STP to explore opportunities to get the best use of the public estate to provide good access and high quality services.

Lord Carter’s productivity work programme
The Trust is committed to delivering the recommendations in the Carter Review and as a result has set up a programme with an executive sponsor and a programme lead from the PMO. The aim of the programme is to identify opportunities to feed into existing QIPP and CIP programme structures or identify new opportunities. The Trust monitors progress against the Lord Carter action plan through the Trust Improvement Board, and quarterly reports to the Finance and Investment Committee. Specific opportunities or plans will be reviewed by the Board, as appropriate.

For 2017/18-2018/19 the Trust is developing efficiency savings plans in line with the Lord Carter work. Teams are developing Procurement Transformation Plans and Hospital Pharmacy Transformation Programme Plans, which will help to identify and deliver Trust-wide efficiency savings. As data is released the Trust is using the Model Hospital to support the identification of possible areas for efficiency savings to develop into Cost Improvement Programmes. The Trust also participates in different benchmarking networks and uses Service Line Reporting to benchmark our own costs against.

In line with the Carter recommendations, the Trust is in the process of identifying the top ten specialities where the biggest efficiency gains may be made. These will be included in QIPP schemes for 2017/18 and beyond. The Trust will also be looking at reducing sickness as part of the approach to reducing agency spend, as per the data provided by the Model Hospital.

Agency rules
The Trust continues to work to bring down our use of agency workers through a range of initiatives detailed below. The plan shows a considerable reduction in the use of agency but still at a level in excess of the agency ceiling in 2017/18. This was felt to be both prudent and achievable in the circumstances. However, the Trust will continue to
identify opportunities to further reduce this both through its own efforts and in concert with partners. Progress against the action plan and updates on expenditure will be presented to the Trust’s Finance and Investment Committee each month. The committee includes non-executive directors as members.

At this point none of the cost pay QIPPs for 2018/19 have been allocated against agency spend with the result that Trust Final Operating Plan shows agency spend in 2018/19 of £11.41m, £1.09m above the NHSI proposed cap. The Trust intends to continue to take action to reduce agency spend such that spend in 2018/19 will be below the NHSI proposed cap, and sooner if at all possible.

The Trust has successfully reduced the expenditure on agency staff in this financial year from 7.9% of the total staff cost in April to 5% in November. This has been achieved through collaboration with our main provider, NHS Professionals (NHSP), to implement the price caps for most staff groups. The Trust continues to breach agency price caps for some IT management staff and for medical staff. The availability of appropriately qualified medical staff in the specialties required has resulted in higher than price cap rates being agreed.

The Trust has developed an action plan for agency use that includes moving away from specialised rates for managerial staff, which will result in a small increase of backfill staff at the price cap rates; the proposal to implement a ban on clerical agency staff; and the migration of medical agency staff to a bank with enhanced rates that are within the February price cap.

The Trust’s workforce programmes – reduction in agency spend and sustainable medical workforce – focus on driving down the cost of agency using the agency caps introduced through NHSI. The Trust is using the recommendations of the Carter review, and feedback from externally commissioned reviews in Q3 of 2017-17, to drive quality and cost improvements for instance through the development of clinical dashboards and the implementation of robust job planning, aligning activity to capacity.

Nursing staff have been part of the NHS Professionals (NHSP) framework since 2011 and therapists, administrative and some medical staff have also moved onto the framework. In 2016 the Trust agreed new bank staff pay rates with NHSP to incentivise staff to move on to the platform and from non-framework agencies which charge higher rates. Improvements in the level of backfill cover provided by the NHSP service have delivered savings. Work continues to monitor Trust compliance with NHSI agency caps and further controls have been introduced, which include medical agency rates above a threshold to be signed off by the CEO. These initiatives will continue in 2017-18.

The plan is to focus in areas of high cost in terms of agency spend in 2017/18 and beyond, to identify further actions to reduce spend such as reviewing the skill mix of the workforce against the needs of the patients in key areas.

The Trust continues to seek to improve recruitment and retention which will reduce our agency use.

Hospital Pharmacy and Medicines Optimisation

The Trust has developed an overall Hospital Pharmacy Transformation Plan. (HPTP). The Trust has already met 9 out of the 16 parameter specified in the categories of HPTP planning and governance, clinical pharmacy and infrastructure services, EPMA, accurate coding of medicines, drug saving opportunities. We will continue to achieve the
Carter recommendations and model hospital benchmarks, and as such will deliver the transformation. As part of the ACS the Trust believes there may be opportunities for collaborative working across the system.

**Procurement**

Procurement has delivered significant savings to the Trust over the years. The Trust is currently using, implementing and reviewing systems to support its procurement function including electronic catalogue and Atticus Electronic Inventory Management System. The Trust’s procurement programme in 2017/18 is targeting a challenging reduction of 5% of addressable spend.

The Trust has been engaged on the development and implementation of universal use of products and looks forward to being able to realise associate savings. The initial tranche of universal products has been issued and rolled out with the next tranche following after completion.

RBFT maintains several partnerships such as the London Procurement partnership which affords wide access to frameworks and savings, or the Southern Collaborative, which deals with orthopaedic implants. RBFT links with other Trusts to establish key procurement relationships which will support joint working on tenders.

There is on-going work with NHS Supply chain to ensure that the Trust is competitively procuring all lines that are consumed by the Trust. All consumer items are reviewed that are not procured via NHS Supply chain to ensure competitive costs are being achieved.

### 4.3. Capital planning

The Trust has allocated £25.5m capital spend for 2017/18 and £24m for 2018/19

As in previous years the “bids” for capital spend from the departments within the Trust greatly exceeds the cash available.

Whilst an overarching principle for capital allocation to projects is fit with the Trust Strategy and Clinical Services Strategy the Trust will further prioritise capital projects according to:

- Statutory compliance and patient safety;
- Contractually committed;
- Meeting national standards;
- Maintaining planned activity levels;
- Delivering efficiency ranked by rate of return.

Whilst the table below shows the current view of how capital spend will be allocated, the above exercise has not yet been completed and hence the allocations are subject to further review and change.
The Trust has an active programme of disposals including the disposal of the Battle site in conjunction with SCAS. This process is well underway. Further disposals under review may result in incremental cash receipts within the life of the Operating Plan. This may be supplemented by work on-going within the ACS and STP to further rationalise the use of estates.
5. Sustainability and Transformation Plan

**BOB STP**

The Trust is a member of the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Sustainability and Transformation Plan (STP) area which has a population of 1.8 million, 7 CCGs, 6 provider Trusts and 14 local authorities. The organisations recognise the opportunities of working together at scale to improve quality and realise financial benefits across the wider system.

The STP has 3 core functions:

- Delivery of BOB wide programmes that need to work across the footprint to deliver maximum benefit. Digital transformation is an example of this.
- Establishment of an STP wide planning and commissioning function for services such as cancer, stroke, ambulance and 111 through a joint CCG Commissioning Executive.
- Spread of innovative practice.

The STP has identified 8 key priorities:

- Shifting the focus of care from treatment to prevention.
- Access to the highest quality primary, community and urgent care.
- Acute trust collaboration to deliver equality and efficiency.
- Mental Health development to improve the overall value of care provided.
- Maximise value and patient outcomes from specialised commissioning.
- Establish a flexible collaborative approach to workforce.
- Digital interoperability to improve information flow and efficiency.
- Primary care at scale.

However delivery of the STP plan will take place at the local health economy level which for the Trust means with colleagues in the ACS and Berkshire West 10 (a partnership of four CCGs, three local authorities, RBFT, Berkshire Healthcare Foundation Trust (BHFT) and South Central Ambulance Service (SCAS) Foundation Trust).

Berkshire West has applied to be recognised as a formal sub system of the STP and applied with a system control total.

**ACS Berkshire West**

The ACS is a local arrangement established to facilitate RBFT, BHFT, and the West Berkshire Clinical Commissioning Groups working together. This will help partners hold each other collectively to account for delivering the necessary transformation of services and in getting the best value for money. At the heart of the ACS will be a group of partners empowered to work together across the local health economy to design clinical pathways that best meet the needs of their patients.

The ACS seeks to see a transformation in how healthcare will be delivered, how the partners will work with each other and how they will be rewarded. The ACS will be the local vehicle for some of the changes envisioned by the STP. The ACS has a Memorandum of Understanding agreed between the partners and appropriate governance arrangements have been established to support the development of the work, and an independent Chair has been appointed.
Work has been undertaken to better understand demands that are being placed on the system to inform discussions about finding better ways in which we can serve patients. The clinical reference group has met to identify and prioritise areas for further work which may deliver new ways of working. Alongside work to identify new models of care, work has been started to identify different business models to allow partners to be appropriately rewarded and share risk.

In line with the STP and the Trust strategy, an ACS workstream looks to establish opportunities around the delivery of support services. Work is underway to establish the areas of biggest opportunity.

RBFT’s Trust Strategy is in accordance, and dependent upon, the successful implementation of the ACS and STP.

RBFT Plans
As an integral member of both the STP and the ACS the Trust is working with colleagues to facilitate this transformative change, including:

• Working to develop the opportunities around digital interoperability which will improve the patient experience.
• Establishing opportunities for an increase in shared services to secure good services within a smaller financial envelope.
• Participating in the workplace wellbeing agenda that is part of the Trust’s OD strategy.
• RBFT have been engaged in the procurement of an enhanced 111 service, with an enhanced clinical hub.

• The Trust is working with ACS partners to seek ways where patients can be managed out of the hospital setting.
• The Trust, as outlined above, continues to work with partners to develop an enhanced seven day service.
• The Trust’s OD and Workforce Strategies seek to see the development of our staff, the reduction in the cost of agency and enhancing leadership development. The Trust is committed to closer working on regional workforce initiatives
• The Trust will look to support the ACS and STP in developing the prevention and mental health agendas. The Trust’s clinical services strategy highlights the support for the prevention agenda and we will work with partners to advance the work to reduce the level and the impact of disease in our communities in part by providing health advice as appropriate.
• The Trust will work with other acute providers in the STP to identify areas of joint working, for instances radiology reporting and medical rota.
6. Membership and elections

The Trust has public governors representing five local geographic areas, as well as volunteer, staff and partner governors. The Trust has recruited five new governors during 2016/17. The Trust currently has seven vacancies on the Council of Governors and elections will be held during November 2016 in order to fill these seats. In order to facilitate this process the Trust and its governors have been raising their profile with the membership through a number of methods including having a session for people to meet their governors at all membership events. A feature article was included in the Trust’s membership magazine, Pulse, where a profile for each governor was included. In addition, further attempts to engage staff members have been undertaken in order to promote the role of staff governors. Proposed dates for events between the membership and the governors have been circulated to the governors. The Trust held its first Open Day in September 2016 which was well attended by public and staff members and which will now become an annual event.

In 2016/17 the membership events have all been oversubscribed and these events have been used as an opportunity to encourage people to develop their relationship with the Trust by encouraging them to become members and apply to become a governor. In addition the Trust seeks to encourage people to stand for governor through the Trust’s Pulse magazine. Where there has been an under-representation of the population, the Trust has sought to work with Governors to help address this issue and has identified possible alternative ways of recruitment, for instance the Trust is currently assessing the opportunity to engage with university students.

To help governors fulfil their role the Trust has strengthened its induction programme and sought to develop them through the committees with which they engage. In addition, governors are provided with regular updates via the NHS Providers newsletters. A governor training and development programme was introduced during 2016/17 and includes sessions on NHS finance, commissioning, quality and patient experience. The training and development programme for 2017/18 is due to be agreed by the Council in early 2017.

The Trust is committed to meaningful engagement with its members. The Trust currently has 8,500 members. The membership strategy for the next 12-24 months will focus on ensuring that the Trust’s membership is representative of the population served. Members aged between 16-29 years are currently underrepresented and a focus will be on developing ways to attract younger members, for example by strengthening links with local organisations, colleges and universities.
Appendices

1. Appendix: Quality Committee Structure
2. Appendix: Quality Impact Assessment process

QIA Process Flow including Post-Project

QIA Process Flow including Post-Project

QIAs are completed for all QIPP projects.

PMO lead completes QIA with project lead.

PMO lead saves copy of QIA in project folder and emails copy to project lead (if necessary) and to Junior Project Support Officer.

Junior Project Support Officer updates QIA spreadsheet.

Project Governance Manager sends weekly email to MD, DoN, and Deputy Head of PMO with a list of all completed QIAs for that week.

MD & DoN meet monthly, if applicable, with Project Lead & Deputy Head of PMO to review QIAs with scores of 8 or more per line to make one of the following recommendations:

1. Score agreed, do not proceed with project in current form – project high risk to quality.
2. Score disputed and project re-scored at meeting with MD & DoN. QIPP board approval to proceed.
3. Score agreed, project high risk to quality – proceed with caution and monitor monthly (undertake post-project QIA).
4. Score agreed but project lead required to re-scope project and resubmit QIA – for approval by MD and DoN.

Deputy Head of PMO produces QIA status report (only of escalated QIAs) with MD & DoN recommendations and circulates report to monthly Improvement Steering Group.

Improvement Steering Group reviews QIAs and makes 1 of the 4 agreed recommendations.

Deputy Head of PMO informs Project & PMO leads of QIA outcome:

1. Score agreed, do not proceed with project in current form – project high risk to quality.
2. Score disputed and project re-scored at meeting with MD & DoN. Improvement Steering Group approval to proceed.
3. Score agreed, project high risk to quality – proceed with caution and monitor monthly (undertake post-project QIA).
4. Score agreed but project lead required to re-scope project and resubmit QIA – for approval by MD and DoN.

If outcome is 4, then Project lead issues DoN, MD & DoN, PMO with re-scoped project for written approval to proceed.

Project Lead and PMO Lead complete Post-Project QIA for projects which were escalated and approved by Improvement Steering Group, 6 quarters after implementation.

Deputy Head of PMO updates QIA status report to close escalated QIAs.

PMO Lead submits QIA status report to QIPP Board.