Financial Recovery Plan to March 2021: FRP21

January 2019

TAKING PRIDE IN OUR CARE

Barking, Havering and Redbridge University Hospitals NHS Trust

Contents

I. Overview

Patient safety and quality of care remain at the heart of the Trust, however there is a clear understanding that this needs to be delivered in a way which is financially sustainable. This is not a trivial exercise for the Trust or the Integrated Care System (ICS), and this document seeks to answer "what would need to be achieved to breakeven by March 2021?", in line with our Board Undertakings. It will also inform our clinical strategy and five year plans due to be developed in 2019.

BHRUT has a long history of poor financial performance, which is forecast to reach a deficit of around £100m by March 2021 before mitigation (our "do nothing" scenario). Helpfully, our diagnosis shows there are no material "structural" drivers of this deficit which cannot be fixed. We will need to be ambitious with our cure.

Our internal aim needs to target upper quartile Model Hospital cost performance with c.£60m of savings over two years, or 5% per annum, which we estimate will cost £20m to deliver. Recurring themes include the need to reduce our staff vacancy rates and improve our culture as part of a substantial workforce agenda. At the same time we need to improve our core processes to support highly efficient, profitable elective pathways, overhaul the way we look after outpatients and increase the resilience of our A&E performance.

We also need to redesign pathways across our ICS for the benefit of our patients and be one of the first ICS's to deliver financial value. Our Trust and the CCG are serious about working together, demonstrated by an agreement to stop "intercompany squabbling" and pursue "real savings" of £60m, which will then be shared equally to send a clear message that working together is good.

This would bring us to a residual deficit of c.£30m by March 2021 which we expect to be closed through a combination of transformation funding through tariff and reduction in interest costs from the centre.

As always in these plans, risks abound. For BHRUT, these include the need for change in culture and clinical engagement; the inability to recruit; insufficient capital and change in leadership. For the ICS, key risks are ability to redesign pathways with digital support and then delivery of benefits given scarcity of success in other ICS. Other risks include macro assumptions given we have not received planning guidance, and much work needs to be undertaken to turn this document into a programme which is ready to deliver from 1 April 2019. This all leads to the final and probably most significant risk - the reality check that some of this recovery is likely to take longer than two years given the need for deep, enduring change.

II. Financial context and plan to end FY20/21

This FRP21 seeks to show what it would take for BHRUT to breakeven by March 2021, in line with our Board commitments. It will also inform our broader clinical strategy and five year plans, due to be developed in 2019.

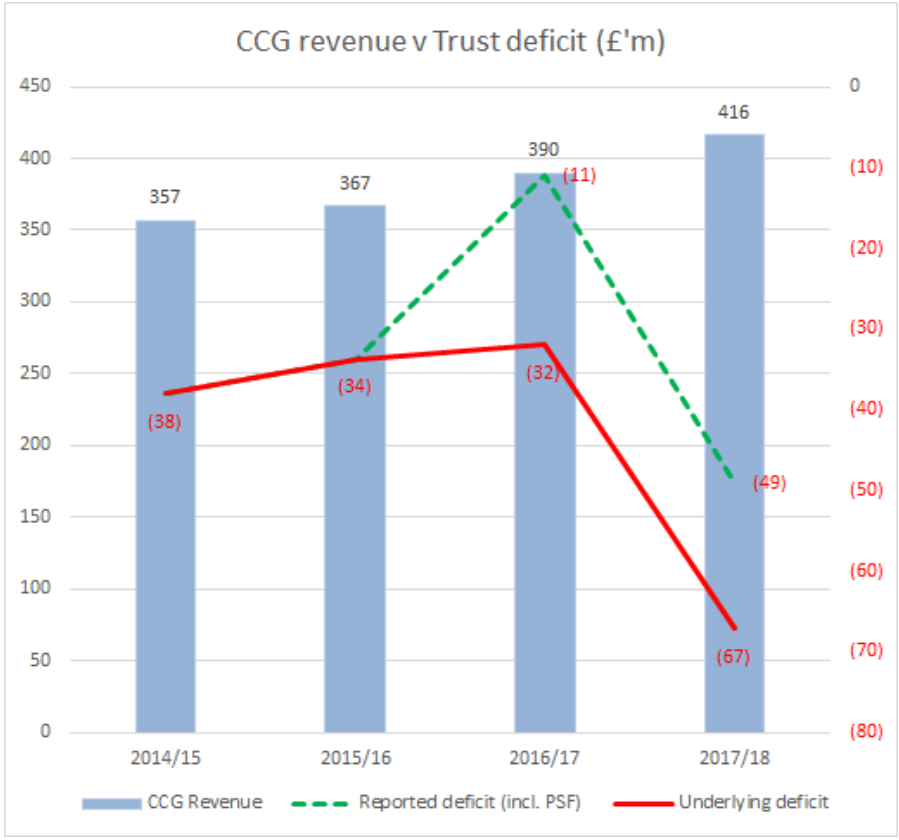
The Trust has reported significant financial deficits for a number of years, as set out in the chart to the right. This culminated in an outturn deficit of £49m post PSF (£67m before PSF). This led to the Trust being placed into Financial Special Measures ("FSM") in February 2018.

Since then, the financial position of the Trust has been stabilised, and we are targeting a reported deficit of £60m and underlying deficit of £65m for FY18/19.

Our financial performance has been compounded by significant and sustained operational performance and other challenges, including:

- RTT - full recovery plan in place with a plan to return to achieving 88% from March 2019 from the current performance of 82%.
- A&E - sustained high attendance figures have impacted on performance. Work is on-going to improve patient flow through initiatives such as Red2Green, and multi-agency discharge events are now embedded practice.
- Diagnostics - following a fire in our Queen's endoscopy suite in May 2018, diagnostic waiting times have lengthened with 87% of patients receiving diagnostic within six week against a target of 99%. We plan to return to compliance from April 2019.
- High levels of employee vacancy - with 16.6% of staff WTE employed on a temporary contract against a target of 8%.
- Cultural conflict, weak clinical engagement and poor system wide relationships.

The system in which the Trust operates is also financially challenged, with Barking and Dagenham, Havering and Redbridge CCGs ("BHR CCGs") currently in FSM and forecasting a "do nothing" deficit of £179.4m by end of FY20/21. Continued financial pressure has led to a historically challenging relationship with our primary commissioner, however, we are working together to find collaborative solutions to the issues faced in our health system as set out in sections 11 - 15.



Our diagnosis of the key drivers of our deficit indicate that there are no material structural drivers, and rather that our deficit represents a combination of internal operational efficiency challenges and strategic health economy issues, all of which can be addressed over time to support our ambition in reaching upper quartile.

We have worked through the causes of our deficit, as set out in the table to the right, which we have considered through three lenses; structural, strategic and operational causes.

Structural deficit

After the rebate of £16m from Department of Health, the net cost of our PFI contract is estimated to be £6m above the reference cost. We also face an annual increase c.£0.8m in PFI costs, due to the underlying complex structure.

Strategic deficit

The key driver of our strategic deficit relates to our local health economy. It is estimated that we undertake c.£30m of work per year which is unaffordable to the system. The system estimates that the Trust delivers c.£60m more activity than would be expected in secondary care in our region.

The Trust incurs £5m of interest costs more than our peers, due to £150m more debt than peers. This relates to the Trust's history, and paying a higher rate of interest on borrowings (6% vs 1.5%).

At this stage, we do not believe there is a material additional cost of operating on two sites (currently it is estimated to be c.£3m). As part of a broader strategic analysis, we will refine the actual value of the additional costs.

Operational deficit

In order to achieve financial sustainability and deliver c.£60m of gross improvements to support our financial recovery, we need to target upper quartile performance. This will address:

- higher than national average clinical negligence costs due to the high value of historical claims;
- under-recovery of overseas visitors income;
- stranded cost pressure due to contractual arrangements with PELC;
- our large temporary staffing costs; and
- various other operational inefficiency.

Deficit driver	£'m
Structural	
Excess PFI v market	6
Strategic	
Historic local health economy infrastructure deficit	30
Financing costs	5
Split / underutilised sites	3
Total strategic	**38**
Operational	
Clinical negligence costs	2
Overseas visitors	1
PELC losses	3
Excess cost of temp staff	11
Other costs	46
Total costs (vs. upper quartile)	**63**
Total drivers	**107**

Our FY18/19 forecast outturn of £64.8m underlying deficit will grow to c.£100m deficit by end FY20/21 in our "do nothing" scenario. This cannot be closed solely through internal efficiency and productivity improvements and will need new system collaboration and savings for BHRUT to successfully deliver this plan.

Having developed our "do nothing" scenario, it is clear that ongoing internal efficiency improvements (i.e. our "QCIP" programme) activity will not be enough to get us to breakeven by the end of FY20/21. As such, we have worked through the target shape of our cure.

Broadly, our recovery is driven through three areas:

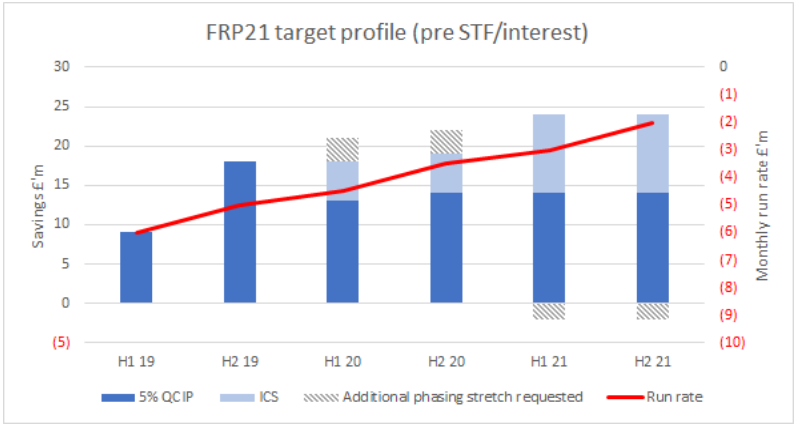
1. Self-help - Ongoing QCIP and productivity improvements, based on sustainable, clinically led change, of c.£36m (5%). This is after £10m per annum for cost of delivery, and includes dedicated resource and a 10% quality and innovation incentive fund (as set out on page 25);
2. Integrated Care System ("ICS") - The Trust and the BHR CCGs are committed to working together to realise £60m of real cash savings and to sharing this equally between them to bring both parties back to break-even whilst ensuring we protect the financial integrity and sustainability of NELFT. Priority areas are better system provision and management of Outpatients, Long Term Conditions and Older People; and
3. National - £30m, with £25m assumed from Provider Sustainability Funding ("PSF") embedded in tariff, and £5m reduction in interest charges.

Financial Plan to FY20/21

The chart to the right sets out our financial plan for the next two years, using our forecast FY18/19 underlying outturn deficit of £64.8m as a base, with a steadily improving run rate through each half year to end FY20/21.

Having set out a high level plan for the next two years, there are a number of next steps for us to now take:

- Detailed work up of the FY19/20 QCIP plan, including monthly financial phasing. In particular, our focus will be on fully worked up, detailed and deliverable plans for the first half of the year;
- Work through detailed a demand and capacity modelling exercise to assure the growth assumptions included in our plan; and
- Bottom up financial planning and agreement of divisional budgets.



Outlook before mitigation actions	FY18/19 £'m	FY19/20 £'m	FY20/21 £'m	H119/20 £'m	H219/20 £'m	H120/21 £'m	H220/21 £'m
Brought forward	(65)	(65)	(81)	(35)	(30)	(27)	(22)
Efficiency requirement (2%)		(11)	(11)	(6)	(6)	(6)	(6)
Annual cost pressures		(5)	(5)	(3)	(3)	(3)	(3)
Deficit before actions	**(65)**	**(81)**	**(97)**				
Cumulative cost savings							
5% QCIP		28	57	14	14	14	14
Cost of delivery		(10)	(20)	(5)	(5)	(5)	(5)
ICS		10	30	5	5	10	10
Add. phasing stretch requested		4	0	2	2	(2)	(2)
Net cost savings		**32**	**67**	**16**	**16**	**17**	**17**
Deficit before PSF/interest improvements	**(65)**	**(49)**	**(30)**	**(27)**	**(22)**	**(18)**	**(13)**
Run rate (H2 for 2019)	(5.0)	(4.1)	(2.5)	(4.5)	(3.6)	(2.9)	(2.1)

III. Key pillars of our financial recovery plan

To date, we have identified key priority themes, supported by a series of enablers. Inevitably, specific workstreams are at different stages of maturity, however we are clear on the detailed next steps which we need to take in each area.

Approach to Trustwide Recovery

Our approach starts with a clear top down Case for Change – we need to save £100m in the next two years, at a broadly linear pace, and there is little which is structural preventing this recovery.

The plans, summarised on page 11, start with a recognition in section 1 that we need to embed cultural change, making the most of the Virginia Mason based PrideWay to help avoid the failed delivery attempts in the past.

We have then built up a recovery plan (summarised on page 11) based on:

- Plans for each division (detailed in sections 1 to 6). These are led by the divisional triumvirate and a senior finance manager sponsor, through a process of diagnosing the root cause behind current performance, with a particular focus on loss making service lines and Model Hospital benchmarking.
- This use of evidence rather than eloquence should result in a more robust basis for our financial cure. That in turn is then based on a "what would it take" ambition, rather than a "what do we feel safe committing to" approach to establish a set of initiatives which will turn these specialties around. Each initiative is RAG rated based on Opportunity, Deliverability and Resource (What, How and Who).
- We have then focused on corporate areas (section 7) and Trust wide initiatives (section 8) including non-divisional, non-pay, estates and workforce schemes.
- Following this we have summarised the cost of delivery and Trust enablers (digital strategy, PMO and Finance) (section 9). Cost of delivery is currently estimated at £10m pa and consists of £4m for dedicated resource, £2m contingency for headcount changes and £4m pa for a quality and innovation fund. In addition to this, the capital cost of digital is estimated at £10m over two years. We have not yet refined other capital costs of delivery but these are estimated at £10m pa. This total of £30m capital over two years compares to a Capital Resource Limit of £10m (£5m pa).
- Income opportunities (section 10) seek to both grow certain specialist services and private patient activity, and reduce low acuity work. These are in addition to the £100m of cost savings, in effect rewarding "cure" rather than encouraging an attempt to "grow out of trouble".
- Finally we have considered system savings (Sections 11-15) to show the potential opportunity collaboration with our system partners presents across the two year recovery.

Summary of key pillars of recovery

	Target	Plan	RAG rated plans	OVERVIEW OF FINANCIAL RECOVERY PLAN FRP21 — Planned H1 20	H2 20	2020	H1 21	H2 21	2021	Total	Gap H1 20	H2 20	2020	H1 21	H2 21	2021	Total	Target H1 20	H2 20	2020	H1 21	H2 21	2021	Total
BHRUT - self help																								
1 **Culture change**																								
2 Acute Medicine	14.0	13.0		1.2	1.5	2.7	4.8	5.5	10.3	13.0	2.3	2.0	4.3	(1.3)	(2.0)	(3.3)	1.0	3.5	3.5	7.0	3.5	3.5	7.0	14.0
3 Surgery & Anesthetics	20.0	18.4		2.2	2.2	4.5	7.0	7.0	14.0	18.4	2.8	2.8	5.5	(2.0)	(2.0)	(4.0)	1.6	5.0	5.0	10.0	5.0	5.0	10.0	20.0
4 Women's and Child Health	10.0	3.7		1.6	1.9	3.6	0.1	0.1	0.2	3.7	0.9	0.6	1.5	2.4	2.4	4.8	6.3	2.5	2.5	5.0	2.5	2.5	5.0	10.0
5 Specialist Medicine	4.7	4.0		1.0	1.2	2.2	0.9	1.0	1.9	4.0	0.2	0.1	0.3	0.3	0.1	0.4	0.7	1.2	1.2	2.4	1.2	1.1	2.3	4.7
6 Cancer & Clinical Support	5.0	3.9		0.8	0.8	1.5	1.2	1.2	2.3	3.9	0.5	0.5	1.0	0.1	0.1	0.2	1.1	1.3	1.3	2.5	1.3	1.3	2.5	5.0
7 Corporate Services	5.0	4.3		0.9	0.9	1.9	1.2	1.3	2.5	4.3	0.3	0.3	0.6	0.0	0.0	0.0	0.7	1.3	1.3	2.5	1.3	1.3	2.5	5.0
8 Other savings *(Notes 1 and 2)*	0.0	14.6		3.5	3.9	7.4	3.4	3.8	7.2	14.6	(3.5)	(3.9)	(7.4)	(3.4)	(3.8)	(7.2)	(14.6)			0.0			0.0	0.0
Other risks	(2.0)	(2.0)		(0.5)	(0.5)	(1.0)	(0.5)	(0.5)	(1.0)	(2.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.5)	(0.5)	(1.0)	(0.5)	(0.5)	(1.0)	(2.0)
Gross savings	**56.7**	**60.0**		**10.8**	**11.9**	**22.7**	**18.1**	**19.2**	**37.3**	**60.0**	**3.4**	**2.3**	**5.7**	**(3.9)**	**(5.1)**	**(9.0)**	**(3.3)**	**14.2**	**14.2**	**28.4**	**14.2**	**14.1**	**28.3**	**56.7**
9 Cost of delivery																								
Contingency	(4.0)	(4.0)		(1.0)	(1.0)	(2.0)	(1.0)	(1.0)	(2.0)	(4.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(1.0)	(1.0)	(2.0)	(1.0)	(1.0)	(2.0)	(4.0)
Dedicated resource	(8.0)	(8.0)		(2.0)	(2.0)	(4.0)	(2.0)	(2.0)	(4.0)	(8.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(2.0)	(2.0)	(4.0)	(2.0)	(2.0)	(4.0)	(8.0)
Quality and innovation	(8.0)	(8.0)		(2.0)	(2.0)	(4.0)	(2.0)	(2.0)	(4.0)	(8.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(2.0)	(2.0)	(4.0)	(2.0)	(2.0)	(4.0)	(8.0)
Total cost of delivery	**(20.0)**	**(20.0)**		**(5.0)**	**(5.0)**	**(10.0)**	**(5.0)**	**(5.0)**	**(10.0)**	**(20.0)**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**(5.0)**	**(5.0)**	**(10.0)**	**(5.0)**	**(5.0)**	**(10.0)**	**(20.0)**
Net benefit	**36.7**	**40.0**		**5.8**	**6.9**	**12.7**	**13.1**	**14.2**	**27.3**	**40.0**	**3.4**	**2.3**	**5.7**	**(3.9)**	**(5.1)**	**(9.0)**	**(3.3)**	**9.2**	**9.2**	**18.4**	**9.2**	**9.1**	**18.3**	**36.7**
10 Income / portfolio	5.0	14.6		1.8	2.6	4.3	5.6	4.8	10.3	14.6	(0.5)	(1.3)	(1.8)	(4.3)	(3.5)	(7.8)	(9.6)	1.3	1.3	2.5	1.3	1.3	2.5	5.0
INTEGRATED CARE SYSTEM																								
11 Older People	10.0	1.5		0.1	0.5	0.6	0.5	0.5	0.9	1.5	1.6	1.2	2.8	2.9	2.9	5.7	8.5	1.7	1.7	3.3	3.3	3.3	6.7	10.0
12 Long Term Conditions	10.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.7	1.7	3.3	3.3	3.3	6.7	10.0	1.7	1.7	3.3	3.3	3.3	6.7	10.0
13 Outpatients	10.0	7.3		0.1	2.7	2.8	1.8	2.8	4.6	7.3	1.6	(1.0)	0.6	1.6	0.5	2.1	2.7	1.7	1.7	3.3	3.3	3.3	6.7	10.0
14 Other system wide initatives	0.0	1.9		0.2	0.5	0.7	0.6	0.6	1.2	1.9	(0.2)	(0.5)	(0.7)	(0.6)	(0.6)	(1.2)	(1.9)							
15 Repatriation of activity	0.0	8.3		0.6	1.9	2.5	2.9	3.0	5.9	8.3	(0.6)	(1.9)	(2.5)	(2.9)	(3.0)	(5.9)	(8.3)							
	30.0	**19.0**		**1.0**	**5.5**	**6.5**	**5.7**	**6.8**	**12.5**	**19.0**	**4.0**	**(0.5)**	**3.5**	**4.3**	**3.2**	**7.5**	**11.0**	**5.0**	**5.0**	**10.0**	**10.0**	**10.0**	**20.0**	**30.0**
Total (before PSF, Int. and income schemes)	**66.7**	**59.0**		**6.8**	**12.3**	**19.2**	**18.8**	**21.0**	**39.8**	**59.0**	**7.4**	**1.9**	**9.2**	**0.4**	**(1.9)**	**(1.5)**	**7.7**	**14.2**	**14.2**	**28.4**	**19.2**	**19.1**	**38.3**	**66.7**
Income upside	*5.0*	*14.6*		*1.8*	*2.6*	*4.3*	*5.6*	*4.8*	*10.3*	*14.6*	*(0.5)*	*(1.3)*	*(1.8)*	*(4.3)*	*(3.5)*	*(7.8)*	*(9.6)*	*1.3*	*1.3*	*2.5*	*1.3*	*1.3*	*2.5*	*5.0*
NATIONAL																								
PSF	25.0	25.0																						25.0
Interest	5.0	5.0																						5.0
Net benefit (excl. income)	**96.7**	**89.0**																						**96.7**
Plus income upside	5.0	14.6																						5.0

Note 1: "Other Savings" consist of procurement (£5.5m), estates (£3.8m), CNST, training, overseas patients and EPR savings (together £2.1m), and the unallocated balance of workforce schemes (£2.73m), all of which sit outside divisions.

Note 2:Through our Trustwide analysis of Workforce, we have identified opportunities of £5.48m. We have worked through the makeup of these savings with divisions, (i.e. items 2-7 above), and of the £5.48m, £2.74m fall within these divisional lines above. Of the remaining £2.73m, we have held this within "Other Savings", whilst we work through the detail with the divisions. We have and will continue this Trustwide focus on workforce, as an enabler for divisional delivery as well as to further stretch ourselves and achieve our ambition for workforce improvement.

IV. Integrated care system (“ICS”)

System collaboration is essential to improve patient outcomes, and is also essential to our achievement of a break-even position by end FY20/21.

We have been focused on working with our system partners as part of the ICS to deliver sustainable pathway redesign and system change, in the interest of better patient care and outcomes as well as benefiting the Trust's financial position by c.£30m by FY20/21 (as assumed in our financial modelling).

System drivers of deficit

We now better understand the key drivers behind our system deficit, which at a high level comprise of:

- Underfunding of our system historically, of over £40m when considering primary care co-commissioning budgets and CCG allocations;
- Primary care capacity constraints, specifically FTE GPs and nurses at low levels. We have consistently had the highest number of referrals (per 1000) into secondary care of the 12 CCGs in NCEL; and
- A significant cohort of the population from Eastern Europe who do not historically utilise primary care and present at acute hospital.

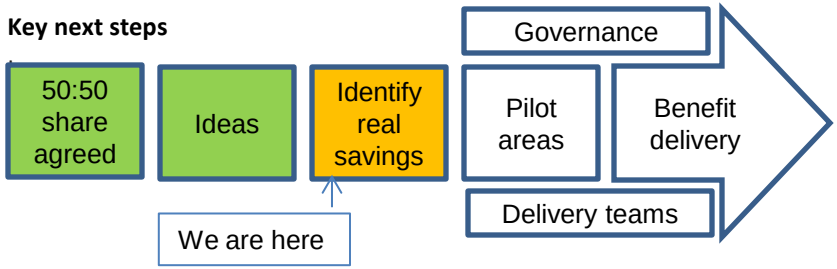
Our joint ambition

Through our work, we have agreed with our CCG to speak with one voice on our approach to the system challenge, along the lines of the following joint statement:

"BHRUT and the BHR CCGs are committed to working together to realise £60m of real cash savings and to sharing this equally between them to bring both parties back to break-even. The scope of the savings will be all areas of joint spend (i.e. where both parties have income/expenditure) and will need the parties to work together on both how the savings are realised and how the rewards are shared between them through contractual mechanisms. This programme of work will be achieved whilst ensuring we protect the financial integrity and sustainability of NELFT."

Our ambition is to be amongst the first ICS's to deliver real cash savings nationally

Key next steps



To date, we have:

- Agreed a joint intent to pursue c£60m of real savings to be shared equally between CCG and BHRUT
- Developed a series of ideas across Older People, Long term conditions and Outpatients with clinical and systems wide involvement
- Started to try to quantify the real savings possible in these three areas plus repatriation opportunities, looking at external cost savings net of estimated cost of alternative pathways. This is still at an early stage off development and is constrained by current data quality issues
- To date, we have identified initiatives with estimated net savings or just over half the £60m target (£33m)

Next steps:

- Work to date is intended to form the basis of selecting two or three areas to pilot and prove concept, process and resource. The aim is to then replicate this across other areas.
- Governance will need to support this new way of joint working
- Delivery teams will need to be properly resourced
- Our aim remains to start delivering benefit from 1 April 2019

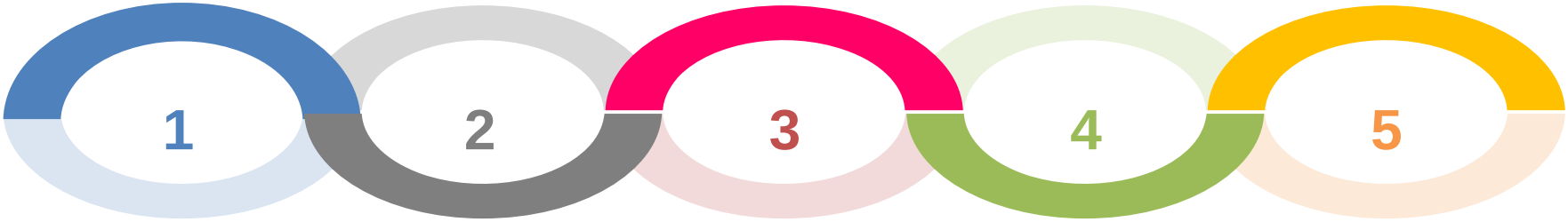
V. Risks and next steps

We have identified a number of risks to our financial recovery and are taking steps to mitigate these

	Risk	Mitigation	Impact (after mitigation)	Likelihood (after mitigation)
1	Cultural change and clinical engagement	Continued work with PrideWay, early engagement of clinicians throughout transformation schemes	High	Med
2	Inability to recruit, given national shortages	Intelligent recruitment, good process and develop reasons to join BHRUT	High	Med
3	Insufficient capital	Will need to agree best approach with NHSI/E	Med	High
4	Change in leadership	FRP based on evidence and widespread buy-in, with board and NHSI/E support	Med	High
5	Inability to design and embed new processes and supporting systems and information across the Trust and ICS	PrideWay, dedicated resource, expert IM&T	High	Med
6	Benefit delivery in ICS (given little precedent elsewhere)	Clear intent, good co-operation; needs to be supported by governance and delivery teams	High	High
7	Change in macro assumptions / tariff etc	Outside ICS control	Med	Med
8	Insufficient capacity or capability	Will need to convert these plans into fully costed and resourced programmes	Med	Med
9	In sufficient mental health provision to allow parity of esteem in the system	Need NELFT as core ICS partner and link to drive wider system support	Med	Med
10	Time to deliver, particularly need to embed cultural change and lead times to change areas such as primary care	Dedicated resource and PMO, proven VMI quality improvement	High	High

Next steps

We are committed to delivering this strategic financial plan



We need to deliver c.£100m savings by FY20/21 to achieve financial sustainability.

Based on the Trust's financial model and the advised inflation rates, known and estimated unknown cost pressures, we forecast a deficit challenge of c.£100m if no further action is taken.

Based on our work to date, and after taking into account of investments required to deliver savings, consider that we need c.£40m Trust savings, c.£30m system savings, and achieve £30m PSF and national funding.

This plan maps out our progress to date and areas of saving that we are focusing on to deliver savings within our control.

We have performed detailed diagnostics across our organisation, both in clinical divisions as well as corporate functions, to identify financial opportunities which we can deliver ourselves.

These indicate that we can deliver c.£40m of net benefit across the next two years, with further work to be done in Q4 FY18/19 to make them deliverable.

We need to continue to work with our system partners to improve patient outcomes and support our financial recovery.

We recognise that traditional QCIP within our four walls will not be sufficient to close our financial gap.

We have invested significant time and resource to work closer with our system partners, and build strong relationships which historically have not existed.

This has resulted in three key pathways to be focused upon, namely; outpatients, long term conditions and frail & elderly.

To successfully deliver this ambitious plan, we have and continue to address several enablers.

Additional resource: the level of resource available to deliver our plan is insufficient. We will continue to strategically invest.

Governance framework: we will need a best in class PMO, which will support the Trust to deliver this FRP.

Operational engagement: we need engaged clinical and operational leads throughout the development of this plan.

System change needs to take place to release significant savings from system collaborations

We will continue to work with our system partners to develop a clear system vision and governance structure to continue to focus on pathway redesign and to coordinate regulatory messages.

We would like to work closely with our system partners to rapidly develop a shared system view and coordinated delivery structure to deliver the system schemes, align clinical models and act together in the interest of the system.