West Hertfordshire Hospitals NHS
NHS Trust

Trust Board meeting 24 November 2011

Financial Strategy

This paper sets out the Trust's financial strategy, which underpins its overall strategy, and brings together and expands on the main themes which will be reflected in the next iteration of the Foundation Trust (FT) application. It has been considered by the Finance Committee in September and reflects the Committee's views.

Overall aim
The Trust aims to be a successful FT and to do this it needs to meet the Financial Risk Rating (FRR) requirements of Monitor. In doing this there is a balance to be struck between:

- The level of savings achievable and hence the surpluses that can be generated
- Liquidity and cash holding
- Investment in capital

All three aspects are challenging for the Trust and so overall financial performance planned, as measured by the FRR, is a 3, ie good, rather than excellent.

Financing and Liquidity
The Trust has been successful over the last 4 years in achieving its financial targets after a previous longer period where annual deficits and financial instability were much more common. However, even recent success has been despite a weak balance sheet and poor liquidity and cash levels, reflecting legacy financing issues.

The Trust currently has loans to the value of £24m which were taken out to develop the AAU and to address liquidity. The proposal to the DH to reschedule these loans is a key element of the Trust's strategy to spread loan financing over a longer period of time (reflecting the life of assets financed) and to reduce pressure on budgets at a time when general funding for health, as well as other public services, is particularly challenging.

In the light of these financing pressures the Trust should consider any proposals for further borrowing very carefully and only borrow further if there is a compelling business case that guarantees savings and a rapid pay back of investment.

The IBP and LTFM set out plans to improve liquidity, as measured by the Monitor risk rating, to a level of 3. This equates to marginally negative net current liabilities over the next 5 years.

Cash levels need to improve to a minimum of 10 days as required by the DH, this will be achieved when current loans are rescheduled and maintained at this level.

The surpluses planned over the next 5 years will cover debt repayment and may provide small sums to allow capital investment marginally above depreciation.

Understanding service performance
Service line information needs to be developed to understand relative contributions made by different services, to inform decisions about service strategy and to allow much more transparent consideration of the extent to which the board is willing for some specialties to subsidise other. This needs to be linked to analysis of specialty market position to shape future services.

SLR needs to become an integral part of the way we do business and part of our routine reporting rather than an interesting ad hoc add on. Visibility and use of this information will speed up improvements in data quality and so allow benefits to be achieved from SLR more quickly. The Trust should also move on from SLR to SLM with greater clinical leadership of service lines and a management approach which brings together all aspects of performance within a specialty/service line with clear accountability for performance.

With the current economic climate it is likely that the provision of smaller specialties will need to be rationalised between providers in the local health economy. This will mean that we may gain some services and lose others, enabling service provision to be maintained in a form that is more financially viable.

The Trust's approach to business planning and business case evaluation needs be developed to add more rigour and to enable better informed decisions about the use of scare resources. Benefits realisation must be an integral part of this.

Efficiency, service redesign and cost improvement
Over the next five years required annual efficiency savings are expected to be in the 5-7% range.

Greater clinical involvement in financial management will be key to the Trust's future financial viability. A significant proportion of future savings will need to come from productivity improvements and redesign of the way in which we provide clinical services, as well as cost savings from support functions, estate rationalisation and procurement.

There is extensive benchmarking data available about relative performance and this needs to be used rigorously to inform future savings plans. For example there is evidence that medical staff cost are high (in relation to activity) compared to other hospitals.

Clearly cost and service quality need to be considered together and there is a lot of evidence that reducing costs can often lead to improvement in service.

The Trust needs to develop a culture of continuous improvement and an approach which recognises that more complex changes take longer to implement and

therefore we need to work on short, medium and long term savings in parallel. A stop start short term approach to addressing financial pressures will not be effective in the longer term.

Neither can we trade our way out of financial difficulty because GP commissioners will not have the funds to pay for extra work so the focus has to be on how we can provide high quality care more cost effectively.

We will also have to be prepared to make short term investment available to support implementation of savings schemes, eg investing in technology which will release staff costs.

As workforce costs are 2/3 of total spend, headcount reductions must be achieved to reduce costs. Reducing agency staff spend is essential as an early step and we need to have rigorous processes in place to evaluate new appointments, particularly of consultant staff, as senior medical staff are a big driver of total spend within the Trust.

Asset utilisation and estate rationalisation
From a financial perspective the Trust has to look at rationalising the estate it utilises and concentrate individual services in fewer locations. There is a huge differential in the ratio of fixed estate costs and patient care income generated between our 3 current sites. At Watford and St Albans the income:fixed site cost ratio is approx 15:1, at Hemel it is only 5:1.

We should aim to maximise the proportion of our funds spent on patient care as opposed to running buildings by concentrating services on two main sites, with a third, smaller, location for ambulatory care. Alongside this, extending the working day would not only enable better estate utilisation but also provide better access to services which would be popular with patients. Extending outpatient clinics by 2 hours a day would provide 25% extra capacity and so enable the current workload to be provided in smaller facilities, and a reducing workload in even less space. Space is currently seen as a free good and this has to change.

Rationalisation would reduce estate/hotel services costs, provide capital receipts and reduce operational inefficiencies from running the same services in several locations with senior staff spending considerable time travelling between sites. It will also enable the Trust to concentrate services in fewer buildings and so to reduce the level of backlog maintenance required.

With uncertainties over the future of PFI, and no clear alternative model for major capital investment, the redevelopment of the Watford site is likely to have to be undertaken in an incremental way, partly funded by estate sales. The state of the property market will need to be taken into account in deciding when to sell assets and. We must work with the PCT on the development of a local general hospital at Hemel to reach a solution which optimises benefits for the health economy as a whole and enables the Trust to progress site rationalisation to reduce estate costs. The Watford Health Campus may provide some opportunities to work with private partners on redevelopment, and the Private Patient Unit is a current example of creative working with the private sector.

It will be essential that investment in the estate is driven by service strategy and supported by robust analysis of future demand and trends in healthcare. Increasingly it is clear that investment in IM&T will need to be increased and this may need to be done through managed service arrangements as capital is likely to continue to be very limited.

The Trust currently funds capital investment mainly from depreciation charges and it is not realistic to generate significant further surpluses to reinvest. This is likely to be the case for the next few years of public sector spending restrictions. Because of the high level of backlog maintenance the Trust should as a minimum reinvest depreciation charges into capital each year, supplemented by any land sales and a modest contribution from surpluses where possible.

As an FT the Trust would be able to borrow funds up to its Prudential Borrowing Limit however affordability would be critical. The Tier 1 limit would allow circa £80m of borrowing but the servicing costs would be some £5m pa or 2% of turnover.

Partnership working and external relationships
The quality of relationships with external partners will be another key determinant of our future financial strength. Close relationships with GPs (especially at a clinical level) will help to secure income by enabling the Trust to understand and respond to ‘customer ‘needs and to be seen as a responsive provider of acute care.

We must be active participants in QIPP and work constructively with our partners to ensure the local population can have the best services that can be provided, across organisational boundaries, within funds available.

In the short term relationships with the PCT and SHA will also be important to secure income and undertake joint work to address service and financial issues. Similarly the relationship with HCC is important for social care issues and the transfers of patients out of the hospital, and with Watford Borough Council in relation to the campus and the development plans for west Watford.

Finance function and support for Trust managers
The finance function will be developed to enhance customer focus across all parts of the department and to embed a business partner approach to support the Trust’s divisions. The emphasis will be on maximising value added, streamlining systems and processes, and making best use of financial systems to provide high quality cost effective support. This will require an emphasis on development of finance staff to ensure they have the professional, business and softer skills to do this.

The development of financial management skills across the Trust is vital and needs to be enhanced, the finance team should support and facilitate this so that all managers have the financial management skills as well as the understanding of probity and good financial governance to manage resources and income in their area effectively.

The opportunities for participating in shared financial services will be reviewed regularly to ensure that potential benefits are taken up.

Conclusion
In summary, the Trust needs to be successful financially in order to underpin the provision of high quality patient care. Improving operational efficiency will be vital to provide the financial scope to allow the Trust to borrow to support strategic change. These strategic decisions, which need to include estate rationalisation, need to be made involving clinicians. Borrowing to facilitate change may be needed and should be supported, provided that there is rapid payback on investment and clear plans for benefits realisation.

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