The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Operational Plan
2014/2016

Delivering Outstanding Patient Care

Contents:

Section	Page:

1. Executive Summary

1.1 This operational plan considers in depth the issues we face over the next two years as we work towards achieving our goals and strategic objectives.

1.2 We explore the issues emerging from our Local Health Economy and how they relate to us. Additionally we consider our diverse commissioning environment that covers the Welsh and Specialised services sectors. We describe how we are proactively working to develop long term relationships to ensure we are able to sustain and build on our current position of being a leading provider of specialist orthopaedic care.

1.3 We assess our operational performance and business processes against key quality standards, risks, and objectives. Despite our current strong performance, our plan allows for continual improvement by identifying resources to enable further development and investment in our workforce and to deliver a number of agreed C-QUIN schemes as agreed with Commissioners as part of the 2014/15 contracting process.

1.4 Our capacity for the period has been set at 2013/14 baseline levels. This provides sufficient space for 2014/15 Commissioned demand and provides a small amount of headroom that will allow us opportunities for further growth in our market share ahead of an expected increase in demand generated from a national review of specialised services commissioning.

1.5 We outline our intention to continue progression with the development of care pathways with a particular emphasis on admission on day of surgery and enhanced recovery to ensure the best possible patient experience and most efficient use of our resources.

1.6 We identify our Key Performance Indicator's (KPI's) and set improvement targets in support of the delivery of our fully developed efficiency programme that consists of a mixture of stepped efficiency and transformational CIP schemes as fully outlined at Appendix 2.

1.7 The above considerations have been used to set a financial plan that meets the minimum requirements of our financial strategy and maintains a CoSRR rating of 4 (lowest risk).

1.8 The financial risks we face in delivering this plan have been considered and their unmitigated impact modelled as part of a downside scenario.

1.9 We have subsequently applied a series of Board approved mitigations to the downside model that demonstrates we have a robust and sustainable short term plan ahead of further testing to be undertaken as part of our five year strategic plan.

2. Introduction and scope

2.1 This operational plan has been completed to focus on our business requirements for the next two years. It represents the first stage of our updated strategic planning document that will focus on an extended five year period and will be completed by the end of June in line with this years planning timetable.

2.2 The operational plan will consider in depth:

- The Trust specific challenges and risks we can expect to face over the next two years.
- The challenges of the Local Health Economy from which we operate and how we are working collaboratively to address these.
- How we will ensure that our services to patients remain of the highest quality whilst remaining resilient to the increasing financial pressures of the system from which we operate.
- The expected demand for our services and the capacity required to deliver these within national waiting time requirements.
- The financial assumptions we have made linked to the above and how these have been integrated into the plans of our main Commissioners.
- The cost of delivering our services influenced by both local and national cost pressures and detailed rationale behind any assumptions made.
- How we will continue to deliver our services more efficiently.
- An assessment of our financial performance and testing of our ability to respond to a series of downsides.

3. Strategic objectives

3.1 Our strategic intention is to become the leading national NHS specialist orthopaedic provider as captured by our mission statement:

'To be the leading centre for high quality sustainable orthopaedic and related care achieving excellence in both experience and outcomes for our patients'

3.2 Our aim is supported by three principle strategic objectives that form the foundations of our plan as follows:

To be the provider of choice for patients through the provision of safe, effective and high quality orthopaedic and related care

We aim to consolidate and expand our market share by attracting additional patients from within and beyond our Local Health Economy by:

- Ensuring access for patients through the pro-active maintenance of waiting times at sub specialty level.
- Supporting a culture of continuous improvement, listening to patient's views and in doing so provide the best patient experience that will strengthen our reputation and increase referrals through choice.
- Maintaining patient and staff satisfaction scores in the top 5% of all NHS hospitals.
- Pro-actively seeking to support other local providers and Commissioners with waiting list management issues.

To improve outcomes for patients through partnership working with patients, staff and commissioners of services at a local and national level, and through clinical networks with other providers

We recognise the need to work collaboratively with partners and with patients to support the transformation of care pathways across the whole health and social care system. We aim to achieve this by:

Maintaining strong clinical networks with GP's, Commissioners and other providers.

- Increase our role in the wider health economy in supporting patients with musculoskeletal conditions.
- Supporting our local health economy services through hub and spoke models using the RJAH brand to strengthen local services.

- Redesigning patient pathways ensuring patients only access the hospital when they need specialist care.

- A commitment to continued investment in the delivery of specialist services to ensure on-going compliance with specialised services standards.

- Reducing the time patients stay in hospital through increased day case rates and shorter inpatient stays.

To develop a vibrant and viable organisation where people achieve their full potential and success leads to investment in services for patients.

We will continue to develop the organisation as an employer of choice. We have a committed workforce that is key to ensuring our future success. We will maintain this by:

- Investment in clinical leadership and personal development which promotes the Trust values.

- Support training and development schemes including talent management programmes for our rising stars.

- Development of a workforce strategy that fits the changing way in which we deliver our services.

- Continuing our focus on the wider health and well being of our staff reducing time lost to sickness absence.

We will continue to invest in services for patients to improve quality further. This will be achieved by:

- Robust financial management leading to continued achievement of our financial plans and efficiency programme.

- Investment in first class replacement theatres and ward facilities that support our continuous improvement and improve our patient experience.

- Investment in technology that support new more efficient ways of working and service redesign.

3.3 In delivering these objectives we will continue to meet the standards required of us by our regulator as outlined in our provider license whilst maintaining our financial sustainability

4. Local Health Economy and Commissioner Base

4.1 We continue to focus on a strategy that forecasts continued growth in demand for services driven by:

- Demographic and age related population factors
- Developments in sub-specialisation and specialist commissioning
- Patients choosing our hospital for their treatment

4.2 We are however mindful that we are operating within a climate of unprecedented financial constraint for the NHS which means that if we are to continue to grow and prosper our strategy needs to be ever more aligned to the needs of our commissioners.

4.3 This section focuses on the opportunities and challenges arising from each of our Commissioners respective positions.

Commissioning Landscape

4.4 As a leading provider of Specialist services we have a wide and diverse commissioner base as detailed below.

RJAH Commissioner base	
Commissioner	% of Trust total income
Shropshire	33%
BCU	15%
NHS England (Specialised Services)	11%
Powys	8%
Telford & Wrekin	5%
Cheshire West and South	5%
Other England and Wales - contracted	4%
Health Commission Wales (Specialised Services)	2%

Shropshire/Telford and Wrekin CCG

4.5 Our local CCG's are working under increasing financial constraints as a result of specific challenges faced by other local providers coupled with growing demand for health services and the likely resource transfer required as part of the 'Better Care Fund' that will become fully operational from 2015/16.

4.6 In response to this, they have launched a strategic review of acute services known as the 'Future Fit' programme. This review focuses primarily on the split site DGH and community services provided in Shropshire by other local providers who are facing specific operational and financial challenges that require potential wider reconfiguration to address.

4.7 Although our services are outside the scope of this review, we remain committed to supporting the programme as a local provider and stakeholder and are therefore engaged in the redesign discussion to ensure that the most appropriate configuration of services is provided that will deliver sustainable quality services to local patients.

4.8 Whilst we are the main provider of elective orthopaedic care for Shropshire CCG we recognise the potential for increased market share from the larger Telford and Wrekin population that is just 40 minutes away by car.

4.9 The intention of Telford & Wrekin is to put out to tender its full musculoskeletal service during 2014/15 at which point our Board of Directors will give full consideration to the opportunities for RJAH.

QIPP

4.10 As a consequence of their financial constraints, Shropshire CCG are planning on the assumption that a £1m QIPP (Quality, Innovation, Improvement and Prevention) scheme will be delivered against our contract in 2014/15.

4.11 As development of QIPP schemes is still at an early stage we have agreed for a formal review of progress to be built into the contract periodically throughout the year to ensure risk of non delivery is fully assessed and managed.

4.12 Of the total QIPP schemes identified to date we recognise £0.9m relates to viable schemes as follows:

- Pain Pathway – a revised pain pathway has been agreed with SCCG that will see, based on clinical criteria, patients being referred to a community led whole pain service. This will commence from April 2014 and the impact has been built into our capacity plan.

- Advice and guidance – schemes focussed on avoiding unnecessary first outpatient appointments through early advice or diagnostics

- Follow Ups – a review of the requirement for follow ups based on clinically agreed protocols

- Thresholds review – the CCG will be looking to implement further demand management schemes to reduce referrals. Again as part of the contractual agreement this will require formal sign off to ensure any proposals are professionally supported, consistently applied and consistent with national guidance in this area.

4.13 Should there be slippage against these schemes we have agreed formal routes of escalation and risk share arrangements

Welsh Commissioners

4.14 Our largest Welsh commissioner, Betsi Cadwaldr University Health Board (BCU), is both a Commissioner and provider of services. We have in recent times being supporting them with their intention to repatriate their more routine orthopaedic operations 'in house' and our plan recognises a recurrent reduction in activity based on this intention.

4.15 More recently, under new leadership, BCU have begun to discuss opportunities for us to work as a more strategic partnership in delivering services to their patients and provide support with their service delivery pressures.

4.16 In response to this, we have agreed to maintain our orthopaedic capacity for BCU at historic levels and will be committed to increasing this further as a contingency should any future demand management schemes be introduced by our main Commissioners.

4.17 Powys LHB have in recent times made us the primary provider of musculoskeletal services for their patients in North Powys. We see this continuing to grow as we develop further outreach services in their rural communities and look at opportunities for integrating services.

Specialised Services

4.18 The commissioning of Specialised Services has undergone a significant restructure over the last year with the consolidation under NHS England. Much work has been done with the introduction of Clinical Reference Groups to ensure Specialised Services are appropriately defined within prescribed service specifications.

4.19 We have been active in supporting this process both through direct representations and through our membership of the Specialist Orthopaedic Alliance. All of our services purchased through specialist commissioners meet the minimum required service specifications.

4.20 Whilst for 2014/15, our specialist service contracts see a period of stability, the commissioning intentions beyond this could see some more material changes as outlined in a strategy document issued by NHS England "Prescribed Specialised Services Commissioning Intentions 2014/15 – 2015-16"

4.21 For RJAH we anticipate the following issues as being key in the ongoing delivery and development of our specialised services:

- For 2015/16 under revised Identification Rules we expect the range of services we provide and commissioned as specialised services to grow. This will include areas such as Revision Surgery where we foresee opportunities to meet demand from surrounding providers who may not meet service specifications.

- Strategic Clinical Services Review – NHS England currently commissions 143 specialised services and will be developing a commissioning framework for each service to ensure consistency of commissioning. As each review is developed NHS England will decide how best to take forward the procurement of services which could result in re testing the market place.

- Prime Contractor – Commissioners will lead a process to invite proposals for prime contractor delivery where this enables consolidation and networking of specialist provision.

4.22 Whilst a number of these developments may impact on our longer term planning we will use the intervening period to ensure we are well placed in terms of service provision and in developing our networks to support a potential future shift in prime contractor role.

4.23 Whilst there are risks associated with this changing landscape we feel that overall the direction of travel will offer opportunities for us to further consolidate and grow our specialised services in a role that will be pivotal to both regional and national networks.

Other English Commissioners/Providers

4.24 Our current plans remain prudent in only assuming underlying demographic growth in demand. We do however believe that, given the care we deliver, we can grow our market share and have identified Eastern Cheshire and South Staffordshire as target markets. These will be considered further in our longer term strategic plan.

4.25 In addition local providers remain challenged in delivering RTT for orthopaedic services. We have begun to support local hospitals in meeting these challenges and see this as a growing part of our portfolio in the future.

4.26 We consider that the scope for further growth from this area of our Commissioning base offers further contingency to the risks posed from additional demand management constraints that may be imposed by our larger Commissioners in future years.

Alignment with Commissioner Plans

4.27 As stated we are operating within an environment of unprecedented economic challenge. Our plans are developed against this context with a focus on:

- Supporting commissioners in reducing growth in demand by actively working with them on identifying further QIPP schemes.
- Agreement of a long term strategic relationship with BCU to support their capacity pressures.
- Reducing our reliance on local commissioners by increasing our market share across a wider commissioner base.
- Supporting providers who are struggling to meet RTT for orthopaedic services.
- Continue to meet and exceed specialised services definition requirements, play an active role in the formation of the future strategy of specialised services and where there is potential consolidation of provision ensure we are well placed to benefit.

5. Quality Planning

Quality objectives

5.1 Quality is at the core of all we do as we aim to continue delivering outstanding patient care to every patient every day.

5.2 We have a number of measurable goals as defined by our Quality Strategy and reported in our Quality accounts as follows:

- To deliver safe, harm free care
- To deliver effective, reliable care
- To improve the patient and staff experience

5.3 As a hospital our overriding objective is to deliver outstanding patient care and we pride ourselves in the standards we achieve and in the feedback from our patients on the quality of our services.

5.4 There is always opportunity to improve and we have considered the Francis report and its related publications and are committed to take forward any actions that help improve care for our patients.

Current position and future developments

5.5 The Trust receives regular spot checks by the Care Quality Commission to ensure the standard of care provided meets expected requirements. The last review undertaken was in the Autumn of 2013 and provided the Trust with a positive report that was shared with our Board of Directors and Quality and Safety Committee.

5.6 In line with the recent recommendations made following the failings in care at other Trusts and the subsequent extensive reviews of Sir Robert Francis, Don Berwick and Sir Bruce Keogh, we have re-assessed our nursing establishment against the latest recommended levels in a report that has been considered by our Board of Directors.

5.7 As part of this we have agreed additional investment in nursing staff that will be introduced during 2014/15 to ensure we can maintain the highest quality of care across our entire operations.

5.8 On-going monitoring of staffing levels and ratios will be undertaken utilising the safer nursing toolkit. This will report ward establishment levels to our Board and to the public via our website.

5.9 All future changes to our service delivery model occurring through service developments or the commissioning of new services, will continue to routinely assess the impact on our care requirements as part of the business case review process.

Quality links to our Commissioned services

5.10 The quality of the services we provide to patients is routinely reviewed by our Commissioners as part of monthly performance reviews that consider summary dashboard reporting on Trust wide quality issues. These provide opportunity for any areas of concern to be discussed and reviewed.

5.11 In addition to this, each year we agree improvement goals to the way our services are delivered as part of the C-QUIN **(**Commissioning for Quality and Innovation) framework.

5.12 Working in partnership with our commissioners, each year we agree a series of improvement targets based on threshold performance levels linked to both national and local quality initiatives.

5.13 For 2014/15 the CQUIN plans agreed include:

National (mandatory) schemes:

- Implementation of the Staff Friends and Family Test
- implementation of the Friends and Family Test within outpatients

- Increase response rate of the Friends and Family test across the all wards and Day case services
- Decreasing negative Friends and Family Test response rates
- Continued collection of the Safety Thermometer data including increase days between falls
- Dementia assessment, support, clinical leadership and training

Local schemes:

- Implementation of the Medicines Management Safety Thermometer
- Further roll out of the 'STAR' (Sustaining quality Through Assessment and Review) nursing care assessment process
- Provision of DVT prevention information on discharge
- Early infection identification through intra-operative temperature measurement
- Dementia assessment in Pre-operative assessment clinics

5.14 Performance is tracked throughout the year at monthly performance review meets.

5.15 Future C-QUIN targets from 2015/16 onwards are expected to include further implementation and roll out of many of the quality initiatives already identified:

Managing quality risks

5.16 Quality risks are identified from the trust's risk management processes and are monitored, managed and mitigated at local, Divisional and Corporate levels.

5.17 Each risk is clearly defined and includes clear action plans to control and mitigate the risk.

5.18 All cost improvement programme schemes proposed are reviewed and signed off by both the Director of Nursing and Medical Director to ensure no detrimental impact on quality ahead of implementation.

5.19 The corporate risk register and Board Assurance Framework are reviewed quarterly by the Board of Directors and identify the key quality risks for the organisation with clear mitigating actions and action plans.

5.20 Key quality risks identified are:

- Failure to innovate and achieve efficiencies.
- Failure of Trust key systems in the event of a major incident.
- Reputational risk due to poor regulatory performance (CQC)
- Failure to deliver C-QUIN initiatives.
- Failure in data quality
- Failure in clinical quality or safety controls

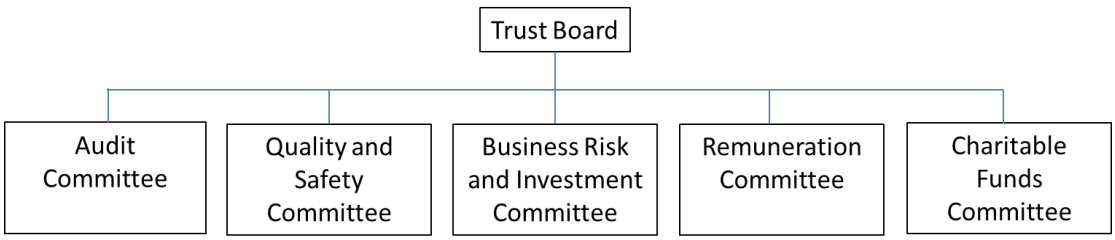
5.21 Our governance framework supports the regular review and escalation of quality risks identified through a number of designated assurance committees including:

- Risk and Governance Committee
- Clinical Effectiveness Committee
- Health and Safety Committee
- Clinical Audit Committee

Board Assurance - Quality Governance Framework

5.22 A comprehensive dashboard of quality and performance indicators is reviewed monthly by the Board of Directors that includes quality data from ward to board. This information is cascaded throughout the organisation, is shared with our Commissioners at performance meets and is available on the Trust's website for public scrutiny.

5.23 The Board Governance structure consists of a number of assurance committees chaired by Non-Executive members of the Board of Directors as illustrated below:



5.24 The Quality and Safety Committee reviews and monitors the systems and processes required to ensure the effectiveness of the care provided, clinical risk issues and the patient Experience

5.25 The Business Risk and Investment Committee provides assurance to the Board in relation to the operational performance, financial and risk management structures and processes required for the delivery of the services.

5.26 The Audit Committee supports the formal and transparent arrangements for considering how the Board applies the corporate reporting, risk management and internal control principles which are reported through the annual governance statement within the annual report. The Audit committee is also responsible for maintaining working relationships with the Trust's internal and external auditors

5.27 Each year the Trust undertakes a rigorous review of its own performance and that of its sub committees which assure on the quality of care provided through a self-assessment against Monitor's Quality Governance Framework.

5.28 Additionally we are accountable to a Council of Governors who have a statutory duty to hold our non-executive directors to account for the performance of the board and represent the interests of our members

Workforce and quality

5.29 We recognise that a highly motivated and skilled workforce is an essential component in delivering quality services.

5.30 Development of our staff in leadership, identifying talent in our workforce, understanding quality improvement methodologies including measurement and clearly identifying improvement as it happens are key to our success in ensuring quality is at the heart of our business.

5.31 Engaging staff in describing and supporting the kind of environment they want to work in and striving to achieve this are hallmarks of our strategy:

- We will always introduce and identify ourselves-'Hello my name is…'
- We will strive to meet the needs of others
- We will always think from the patient's perspective not our own
- We will pride ourselves on our appearance both personally and within our environment
- We will challenge poor behaviour
- We will keep our discussions within confidential areas

6. Operational planning

6.1 A number of areas have been considered in planning the delivery of our services over the next two years as follows:

Waiting time requirements

6.2 Whilst the parameters for these are variable across our Commissioner base, we expect them to remain constant throughout the planning period as follows:

- England – 18 weeks
- Wales (except BCU) – 26 weeks
- Wales (BCU) – 36 weeks

6.3 We continue to utilise the capacity modelling tool recommended by the IST (Intensive Support Team) in ensuring that we have sufficient capacity at a sub specialty level to sustain achievement of waiting time targets at each defined milestone. This has been used to support our Commissioning discussions for 2014/15.

Theatre Capacity

6.4 We delivered 11,400 surgical procedures from our 10 theatres during 2013/14 and this is recognised as our baseline capacity.

6.5 In the event of further demand for our services, we recognise there is scope to flex up our surgical capacity by a further 10%. This would be achieved by increasing our extended working hours provision across our entire theatre base.

6.6 Continued improvements to productivity and efficiency are planned to offset an increase in case-mix complexity driven by the replacement of pain injection theatre lists with surgical cases. This will be achieved by scheduling improvements.

Clinical Capacity

6.7 We have recruited an additional spinal surgeon due to commence in April 2014 that will provide additional capacity to continue progression with reducing our waiting times for Spinal surgery.

6.8 We will continue to utilise our surgeon base flexibly in ensuring we continue to achieve waiting time requirements at a sub specialty level. As in previous years, this will include supplementing regular job plans with additional clinical sessions ‘out of job plan’ as required.

6.9 The scale of ‘out of job plan working’ will reduce from 2013/14 levels as the focus has switched from hitting waiting time targets and backlog clearance to sustaining them.

Demand for Surgical services

6.10 Our activity plan for the next two years has been derived from the capacity provided under our current operating model of staffing 116 theatre lists per week.

6.11 After adjusting the 2013/14 out-turn for cases delivered in the private sector (our plan does not allow for further use of these agreements) our internal delivery capacity is set at 11,400 cases per annum.

6.12 We have assessed this will be commissioned as per the following table:

Demand Assessment - theatre cases	2014/15	2015/16
Prior Year out-turn*	11,600	11,400
Less non recurrent activity:		
Waiting list work (other providers)	- 150	- 415
QUIPP:		
Shropshire Pain Service repatriation	- 250	- 200
BCU demand management	- 415	115
Add:		
Growth commissioned from England	100	100
Waiting List work - Spinal surgery	100	
Waiting List work - BCU	272	
Balance - flexible capacity to be commissioned	143	400
Baseline Capacity	**11,400**	**11,400**

** 2014/15 prior year out-turn includes 200 cases delivered in the private sector.*

6.13 This reconciles with the formally commissioned position for 2014/15 that is shown at Appendix 2 and includes the following assumptions:

- Annual growth arising from an aging population that is driving increases in demand for orthopaedic surgery.
- Additional waiting list work as we continue to make progress in clearing a waiting list backlog of spinal surgery patients
- Repatriation of the Shropshire pain management service to an external provider as part of an agreed QIPP scheme.

- A recurrent reduction of 300 routine referrals from BCU (North Wales). For 2014/15 this has been offset by additional capacity support agreed as part of a new strategic working relationship between our organisations whereby we will offer any spare capacity to support achievement of their orthopaedic waiting targets.

- Flexible capacity that will be offered to support other providers in maintaining their orthopaedic waiting lists and/or by growing our market share with other Commissioners. For 2014/15 the balance remaining has been reserved for BCU (at their request) pending work up of a final agreement. From 2015/16 this capacity will be important to allow for the potential increase in Specialist Commissioning.

- Any further demand management schemes agreed during the planning period will be offset by an increase in the flexible capacity we have to offer others.

Bed Capacity

6.14 The further development of care pathways using enhanced recovery principles coupled with improvements to our admit on day of surgery performance and a continued increase in the proportion of activity we undertake as day surgery will continue to reduce the number of inpatient beds we require.

6.15 Linked to our KPI metrics (section 7.4) we expect to require 14 fewer inpatient beds over the next two years as further efficiency improvements to working practices become embedded.

Workforce Plan

6.16 Our workforce plan for the period is based on an agreed workforce strategy which has considered specific challenges and how we need to respond to them as well as our operational delivery and efficiency plans. The table below summarises the planned changes:

Staff Type	2013-14	2014-15	2015-16
	Baseline WTE	Plan WTE	Plan WTE
Medical staffing (including Junior medical staffing)	119	121	121
Nursing	274	289	287
All scientific, therapeutic & technical staff	201	204	202
Healthcare assistants	136	125	125
Admin & clerical	408	408	397
Total	1138	1148	1132

6.17 A major area of focus will be upon increasing the nursing workforce in line with our commitment to the Francis report recommendations ahead of aligning our nursing, recovery and theatre workforce to the introduction of a new standardised pathway of care upon the opening of a new Admissions, Recovery and Day Case Unit (ADCU) from 2016/17. The Management of Change process in order to support this service development has already begun.

6.18 Our 2014/15 workforce plan includes the transfer of the Shrewsbury and Oswestry APCS services and associated staff under TUPE arrangements.

6.19 Workforce efficiency and productivity improvements will be supported by investment in IM&T. This will result in an administrative headcount reduction from the 2013/14 baseline of 11 WTE (3%) by 2016.

6.20 A local policy for the application of incremental progression linked to an individual's achievement of specific objectives has also been agreed and will be implemented from April 2014.

Service Improvement

6.21 We are committed to continuously improving the quality of care for our patients and will ensure the continued development of modern high quality care pathways. Our operational plans therefore incorporate the following:

Enhanced Recovery development

6.22 We will build on the successful introduction of enhanced recovery pathways for hip and knee surgery by rolling out the principles to our entire surgical base so that enhanced recovery is considered as standard practice for most patients undergoing orthopaedic surgery.

6.23 This will continue to improve the patient experience by getting patients better sooner and will allow us use our resources more efficiently.

6.24 There are a number of critical steps that have been incorporated into our Enhanced Recovery pathways as set out in full at Appendix 1.

Outpatient pathway development

6.25 We will introduce new outpatient pathways for hip and knee referrals that will bring forward the diagnostics stage of the pathway.

6.26 This follows on from an equivalent development successfully introduced for our spinal pathway that reduced the overall number of outpatient visits required to be undertaken by a patient and therefore supports shorter access times to our services.

Seven day services provision

6.27 Whilst the national work stream considering the provision of 7 day services is largely centred around maintaining consistent access to emergency admissions, our operational plans are aligned to the principles of 7 day service provision.

6.28 We operate as a 24/7 service for our inpatient admissions and currently use a 6 day working model for our elective and outpatient services that is flexed according to demand.

6.29 Should future demand for our services require it, we remain receptive to extending our elective and outpatient services across 7 days on the proviso that doing such could meet the requirements of a full economic appraisal.

Investments made in Technology

6.30 We plan to modernise a number of our support services from pharmacy to bookings supported by a significant capital investment in new systems and technology.

6.31 This will include the introduction of an electronic patient records system, e-prescribing system, and electronic recording systems for patient care vital signs monitoring on our wards that will enable us to operate more efficiently.

6.32 Additionally we will implement a digital pre-operative screening system to enable low risk patients to undertake their pre-operative assessment remotely without the need to attend in person.

Tumour Unit service development

6.33 New outpatient facilities and an integrated ten bedded ward will be provided as part of an agreed investment in the provision of new facilities for our Tumour service.

6.34 The new facilities will provide a number of single and dual occupancy rooms to be allocated based on individual patient need and preference.

6.35 Upon the opening of the new unit in 2015/16, six rooms on our private inpatient ward that have been accommodating tumour patients in the interim, will return to our private patient room base and will therefore support an increase in activity and income for this area of our business.

APCS

6.36 We will take over operational responsibility for the running of the Shrewsbury and Oswestry APCS (Advanced Primary Care Service) for orthopaedic referrals from April 2014. This will allow us to improve existing pre referral pathways and assist us with the reduction of overall waiting times.

6.37 The existing clinical staff will transfer across to RJAH to ensure business continuity and we have identified a service manager and administration staff to support the day to day running of the service.

Key operational risks

6.38 As part of our plans, we have reviewed the operational risks we expect to face.

6.39 These have been captured in both our Corporate Risk Register and Board Assurance Framework and are summarised as follows:

- Sustainable maintenance of inpatient and outpatient waiting times in line with prescribed referral to treatment time targets.
- Failure to implement new ways of working to realise benefits from investment in technology and new facilities
- A workforce that is unresponsive to change and blocks innovative ways of working.
- Failure to manage causes of staff sickness leading to an increase in absence.
- The impact of an increasingly complex case mix of work arising from a national review of specialist commissioning arrangements.

6.40 As part of our Board Assurance Framework, these risks will be monitored and tracked throughout the year by the Board of Directors and the Business Risk and Investment Committee.

7. Productivity and Efficiency plans

Productivity measures (Key Performance Indicator's)

7.1 We are committed to delivering our services in the most efficient way and recognise the importance of this as an enabler to delivering high quality services within an agreed financial plan.

7.2 We have recently agreed a business case that will change the shape of how we deliver our surgical services and further support our productivity agenda as part of the opening of new admission, theatre and recovery facilities from 2016/17.

7.3 In the interim, we will continue to build on the improvements made in recent years and strive for further improvements supported by those service improvements referenced in the operational planning section.

7.4 Progress will be measured by tracking against a series of key performance indicators as shown below:

Productivity KPI's			
Metric	**Baseline**	**2014/15**	**2015/16**
Admission on day of surgery	87%	90.0%	95.0%
Overall daycase rate	49%	51%	53%
BADS daycase rate	80%	85%	90%
Average length of stay (excluding daycases)	4.3 days	4 days	3.5 days
Readmissions within 28 days	1%	1%	1%
Bed Occupancy	87%	87%	87%
Inpatient beds	187	179	173
Utilisation of theatre sessions	95%	95%	95%
Theatres Cases per Session	2.2	2.2	2.2
Outpatients per session	8.4	9.2	10.0
Outpatient DNA	6.6%	6.3%	6%
Outpatient New to Follow up ratio	1 : 2.2	1 : 2.1	1 : 2.0
Staff turnover ceiling	10%	10%	10%
Staff sickness rate	2.9%	2.7%	2.5%

7.5 Improvements in efficiency have been targeted in the following areas:

- Admit on Day of Surgery –We will continue to push towards a 95% objective and where necessary work with our clinicians to introduce new working practices.

- BADS/Overall Day case rate - We will continue to maximise opportunities to admit patients as day cases and are working toward 90% compliance against the BADS (Basket of procedures suitable to be undertaken as day cases) target.

- Average Length of Stay/Bed requirement – This will be achieved by improved Admit on Day of Surgery performance, and from the further development of pathways of care utilising enhanced recovery principles.

- Theatre cases per session – Whilst this metric is required to hold at current performance this will require increased productivity to be realised given an increasingly complex case mix of activity included within the plan.

- Outpatient clinic productivity – This is a new area of focus from 2014/15 and will track productivity of our outpatient clinics to ensure continued improvements in utilisation.

- Outpatient DNA –We are targeting a 10% improvement in DNA rates year on year by reviewing our booking processes and supported by appointment reminder technology.

- Outpatient new to follow up ratio – In line with Commissioning intentions we will work to reduce the number of follow up outpatient attendances as a proportion of our overall first outpatient referrals. This will be supported by the new outpatient pathways planned for hip and knee referrals.

- Staff sickness – Continued improvement targets are set as we foster a culture of workforce productivity and robust sickness management.

7.6 Performance against these metrics will be measured as part of routine monthly reporting to the Board of Directors through a balanced scorecard

7.7 Our clinical divisions will be supported in addressing any barriers to delivery via the Trust's performance framework.

Efficiency Programme

7.8 In order to deliver our financial objectives we will be required to deliver further annual efficiencies of 4% annually for the duration of the planning period.

7.9 Our CIP's have been formed around the following themes:

- **Stepped Operational efficiency** (productivity improvements linked to KPI's)
- **Service redesign / use of Technology** (This theme captures our transformational CIP's)
- **Improved service line performance** (focus on how to improve performance of our loss making service lines)
- **Commercial/Trading opportunities** (growing business of our trading areas including Private Patients, Residential Pain Management , Orthotics Manufacturing and Diagnostics)
- **Corporate Functions** (including strategic procurement opportunities)

7.10 The majority of CIP's identified for the period will arise from incremental improvements to efficiency.

7.11 We believe there are still opportunities in this respect given the focus of our operations in recent times has been on clearing waiting list backlog and therefore our efficiency programme has been supported by additional contribution as opposed to efficiencies in delivery.

7.12 We have identified transformation CIP's totalling £0.6m over the two years that will be recognised from the introduction of new technology to support a more efficient administration model for appointments, bookings and prescribing.

7.13 An Executive chaired Programme Board has been created to oversee the introduction of the new systems and will ensure the full benefits from the investments are realised.

7.14 Beyond this two year planning period, Our future CIP programme will be supported by a recently agreed Business Case to transform the delivery of our surgical services supported by a major investment in the provision of a new ADCU (Admission, Day Case and Recovery Unit).

7.15 This will provide increased recovery capacity integrated to our existing main theatres and allow a single pathway of care to be introduced for our day case and inpatient admissions.

7.16 A full list of CIP schemes has been identified. For both years the total schemes identified are in excess of the £3m target so as to ensure there is contingency in built to manage slippage.

7.17 The detailed list of schemes identified is reported at Appendix 3.

CIP Governance

7.18 Our successful track record of CIP delivery has been underpinned by robust CIP Governance arrangements that include the following steps:

- Each scheme is proposed by operational divisional managers and tested for corporate fit before being signed off at divisional level by the Clinical Director.

- Each scheme put forward includes full description, workforce implications, Quality impact assessment, risks to delivery and an action plan with key milestones to achievement.

- These are then scrutinised for quality impact by the Medical and Nurse Director ahead of a further review by the Business Risk and Investment Committee to ensure there are no residual concerns.

- Any key KPIs that are required to track schemes are built into the Trust Board's balanced scorecard whilst the overall Trust Balanced Scorecard provides assurance that quality is not affected by the cumulative effect of the CIPs.

- The overall CIP delivery programme is overseen by the Executive Team who periodically review progress and their quality impact.

- Additionally progress is tracked though the Clinical Management Board and Divisional Performance Reviews.

- Further assurance is added through oversight from the Business Risk and Investment Committee and the Trust Board. Delivery of CIPs is a key risk tracked on our Board Assurance Framework.

8. Financial Plans

Financial Strategy

8.1 Our financial strategy is to generate sufficient surpluses to help us deliver the highest quality clinical care. To achieve this we have identified the following key financial objectives:

- To generate annual surpluses to enable a re-investment in both our facilities and operational model to continuously improve the quality of our services and patient experience.
- To support the delivery of the productivity agenda maximising 'invest to save' opportunities.
- To maintain sufficient cash balances that give the Trust sufficient risk coverage against downside risks.

8.2 In delivering against this strategy we aim to generate a surplus from operational activities of at least £1m each year and maintain cash balances of at least £3m (equivalent to two weeks of operating expenditure).

Financial Projections

8.3 A summary of the Income and Expenditure projections for the next two years is shown in the table below:

Summary Income & Expenditure	2013-14 Forecast outturn	2014-15 Plan	2015-16 Plan
	£'m	£'m	£'m
Clinical Income	79.4	79.8	79.8
Private Patient Income	3.8	4.0	4.1
Other Income	6.5	6.1	6.5
Total Income	**89.7**	**89.9**	**90.4**
Pay expenditure	-49.8	-50.9	-50.7
Non pay expenditure	-35.0	-34.1	-34.4
EBITDA	**4.9**	**4.9**	**5.2**
Finance costs	-3.9	-3.9	-4.3
Net surplus	**1.0**	**1.0**	**1.0**
COSRR	**4**	**4**	**4**
Donated Income	0.0	0.5	1.0
Inpairments	0.0	0.0	0.0
Reported Surplus	**1.0**	**1.5**	**2.0**

8.4 This shows that we are planning to deliver an operating surplus of £1m for each of the next two years by maintaining our income base at current levels and by generating efficiencies to offset against local and national cost pressures.

Key drivers to the financial projections (bridge)

8.5 The most material factors that influence our financial position have been identified by the creation of a bridge that details the drivers for the movements from one financial year to the next. This is shown in detail at Appendix 4. Further detail behind each driver is as follows:

Income

- Tariff deflation of 1.1% applied in both years. This is a confirmed position for 2014/15 and we anticipate additional support will be provided through tariff in 2015/16 to meet the increased costs we have assumed as part of latest set of pension reforms.

- Local tariff adjustments have been built into the plan that include an improved tariff for our nerve conduction service and spinal outpatients. These have been agreed in contract baselines for 2014/15.

- C-QUIN is assumed at 2.5% for all of English Commissioned income excluding 'pass through' elements such as high cost drugs. Based on an assessment of previous year's performance we have assumed this will be received in full. The costs of delivering C-QUIN schemes where applicable have been incorporated into our plans.

- Volume – We have allowed for an overall reduction in activity of 200 cases per annum based on our 2013/14 out-turn which included 200 cases delivered in the private sector to support waiting list clearance.

- Case mix – We anticipate a richer case mix will be delivered as capacity for 250 injections that are to be repatriated will be utilised instead for delivering orthopaedic surgery at a typical average case mix. The additional implant and consumable costs associated with this shift have been built into our cost plan.

- A reduction to our training and education income from 2014/15 as part of a national reform to funding methodologies. Our 2015/16 plan shows that half of this will be recovered by reviewing our training provision within the confines of our reduced funding.

Service Developments

- The income and costs associated with us taking over operational responsibility for the Shrewsbury and Oswestry APCS service have been built into our plans.

- Additionally the Shrewsbury based Rheumatology service will be commissioned directly from us from 2014/15 as opposed to the local District Hospital. The income and costs associated with this change are also included.

National Pressures

- Pay awards aligned to national policy have been incorporated. This will allow for standard incremental progression or an inflationary pay award of 1% for both years.

- Investment in additional qualified nurses will be made in 2014/15 aligned to the recommendations of the Francis report.

- An increase in our litigation premiums as notified by CNST has been factored into our cost base.

- Additional pension costs from 2015/16 linked to national reform of the NHS pension scheme.

- Linked to historical performance, Inflation assumptions made are as follows for both years:

    - Energy – 10% year on year increases
    - Non Pay – 1% year on year increases.

Local Pressures

- Our plan has incorporated the following local cost pressures:

    - The aggregated full year impact of investments made in 2013/14.
    - Increases to the costs of locally provided Service Level Agreements.
    - The project costs associated with delivering our technology transformation programme.
    - A Climate reduction Control levy based on historical energy consumption.
    - Further investments in delivering our IT strategy.
    - Financing costs associated with the delivery of a major business case for the redesign of our surgical services
    - A general contingency equivalent to 0.5% of operating expenditure to cover unforeseen cost pressures.

Continuity of Services Risk Rating (CoSRR)

8.6 We have assessed our financial plan against the Continuity of Services Risk Rating (CoSRR) and this has confirmed that we will remain at a level 4 (lowest risk) throughout the planning period.

Capital Investment Plans

8.7 We have refreshed our 5 year Estates Strategy aligned to these plans. As part of this process we have updated the six facet survey which advises us of our backlog maintenance requirements.

8.8 Over recent years our strategy has been focused on reducing areas of the Estate that have poor functionality or carry significant costs to maintain. Our latest assessment shows an overall backlog risk of £3.5m of which £2.8m is low risk and when risk adjusted equates to just £0.5m of investment required. This much reduced level allows our future investments to be more focused on strategic developments.

8.9 Our plans do not include any disposal of assets or sale of surplus land.

8.10 The table below outlines that over the next 2 years we are planning an investment of £20m.

Capital Plan	2014/15 £m	2015/16 £m	Total £m
Backlog Estates maintenance	0.7	0.7	1.4
Equipment replacement	0.5	0.4	0.9
IT	0.4	0.2	0.6
Theatres/Ward refurbishment programme		0.5	0.5
Contingency	0.3	0.3	0.6
Sub-Total Maintenance	**1.9**	**2.1**	**4.0**
Outpatients and Pre-op	0.3		0.3
Technology	1.3		1.3
Tumour Business Case	2.1		2.1
Surgical Services Business Case	4.0	8.3	12.3
Sub-Total Developmental Investments	**7.7**	**8.3**	**16.0**
Total Capital Programme	**9.6**	**10.4**	**20.0**
Funded By:			
Donated Income Received	0.5	1.0	1.5
Depreciation	2.5	2.8	5.3
Loan Funding	4.0	6.0	10.0
IT Government Scheme	1.4	0.0	1.4
Investment by the trust	1.2	0.6	1.8
Total Funding	**9.6**	**10.4**	**20.0**

8.11 The rationale for our main investments are:

Maintenance Investments

- Backlog Estates Maintenance – as per our risk adjusted requirements.

- Equipment replacement - aligned to the age profile and condition of our equipment across the Trust. We have a well embedded risk based approach to equipment replacement prioritis ation which is supported by an external professional maintenance service.

- Information Technology – aligned to the maintenance requirements highlighted in our IM & T strategy.

- Theatres/Ward refurbishment – We will commence a refurbishment programme that will lead to the upgrade of our inpatient Wards and Theatres to compliment the investment in new facilities being made as part of our strategic investment programme.

- Contingency – We have built in a contingency of £0.3m per annum into our plan to ensure business continuity in the event of unexpected failure of key plant and equipment.

Developmental Investments

- Outpatients/Pre-operative rooms – refurbishment and expansion of our current outpatient and preoperative service. The latter is an enabling scheme for the surgical services business case development.

- Technology – Supported by government backed funding we will implement an enhanced Electronic Record, E prescribing solution and Digital preoperative service. These schemes form a key strand of our IM & T strategy and support our wider transformation programmes.

- Tumour Business Case –This investment will provide new upgraded dedicated inpatient and outpatient facilities that will be integrated to the new surgical services development.

- Surgical Services Business Case– This investment will replace existing leased facilities and reduce backlog maintenance requirements and provide increased admission and recovery capacity to support our aim of reducing length of stay.

Funding Streams

8.12 The programme will be funded as follows:

- Depreciation – our financial strategy outlines that we expect as a minimum to reinvest our depreciation charge each year.

- Re-investment of surpluses/cash balances – We will re-invest the surpluses earned during the period in supporting the delivery of our capital plans.

- Donations –We have a dedicated appeal to raise £0.5 for the new Tumour unit and a further £0.15m pledged by the Hospital's League of Friends. Additionally we will spend £1m of our charitable fund balances in support of the delivery of the Surgical Services Business Case.

- Loan Funding – We have agreed a £10m loan from the Foundation Trust Financing Facility to be repaid over 10 years at an interest rate of 2%. The repayments and interest charges are built into our plans.

Cash

8.13 An assessment of our cash balances throughout the planning period has been undertaken as follows:

Summary Cashflow forecast	2014-15 Plan	2015-16 Plan
	£'m	£'m
Opening Cash balance	4.6	5.4
2013/14 Contract over performance	1.2	
Surplus generated from I&E	1.0	1.0
Commitment to Capital Programme	-1.2	-0.6
Loan repayment	-0.2	-0.8
Forecast cash balances	**5.4**	**5.0**

9. Financial risks and downside modelling

9.1 In producing this plan we have considered the financial risks to delivery as captured in our Corporate Risk Register and Board Assurance Framework. These will be reviewed and tracked throughout the year as per established internal governance processes.

9.2 Additionally, we have modelled the impact of our financial risks as a series of downside scenarios.

9.3 The table below details our financial risks, and in the final column an assessment of the risk value to be modelled as a downside.

Key Financial Risk	Risk Value	Mitigations for the base case	Downside scenario to be run
Under delivery of planned CIP	0.5% underperformance valued at £0.4m.	CIP plans overset to manage slippage Strong tracking in place to pro-actively identify problems	slippage non recurrently each year of £0.4m
Affordability challenges of Local Health Economy	Risk share of unidentified Shropshire Health Economy QIPP amounting to £650k.	Continue to work collaboratively to deliver further QIPP schemes.	50% risk share for unidentified value = £325k
Higher cost of delivery than planned	Sub specialty pressures lead to higher than planned premium cost working - OJP, Private sector etc…	Demand & Capacity model at sub specialty level Workforce strategies to maximise flexibility of the workforce	Additional premium costs each year of £0.25m
Tariff Instability	Review of PbR tariff in progress - potential impact from 2015/16. Estimated risk at £0.5m per annum	Strong engagement through Specialist Orthopaedic Alliance and Monitor	Loss on national tariff for 2015/16 of £0.5m

9.4 We have assessed the cumulative impact of these risks as a downside to our financial plan prior to the application of mitigating actions.

9.5 By the end of 2015/16, they would generate a £0.8m operating deficit, our cash balances would reduce to £2.4m (£0.6m below the minimum level prescribed in our financial strategy) and our CoSRR would fall to a level 3.

9.6 However, in practice we are well equipped to manage unplanned challenges to our financial position and would implement a series of mitigating actions as follows:

- Release of contingency sum built into plan - £0.4m
- Bring forward future CIP schemes planned by up to 0.5% per annum.
- Defer £1m of our planned capital investments for 2015/16 that includes a £0.3m contingency.

9.7 In taking such actions, by the end of 2015/16 our operating position would improve to a £0.8m surplus and our cash balances would be £4.8m. Our CoSRR would return to a level 4.

9.8 The impact of the potential downsides and mitigations is illustrated in the following table:

Income & Expenditure - Downside Model	2014-15 Plan	2015-16 Plan
	£'m	£'m
Base case operating surplus	1.0	0.0
Downside 1 - Under achieved CIP (non recurrent)	-0.4	
Downside 2 - Risk share unachieved QIPP	-0.3	
Downside 3 - Increased premium costs of delivery	-0.3	-0.3
Downside 4 - Loss from National Tariff		-0.5
Revised Surplus/ (Deficit)	**0.0**	**-0.8**
Cash balance	**4.4**	**2.2**
CoSRR	**4**	**3**
Mitigation 1 - Release of contingency built into plan	0.4	0.4
Mitigation 2 - Bring forward CIP 0.5%	0.4	0.4
Mitigation 3 - Defer cap investments by £1m in 15/16		
Mitigated Surplus/ (Deficit)	**0.8**	**0.8**
Cash balance	**5.2**	**4.8**
CoSRR	**4**	**4**

9.9 We believe that the downside tests applied provide assurance that we are well equipped to navigate through the short term financial challenges that lie ahead. These will be tested further as part of the completion of our five year strategic plan.