The Rotherham NHS Foundation Trust

Forward Plan Strategy Document for 2012-13

The Rotherham NHS Foundation Trust
The attached Forward Plan Strategy Document (the “Forward Plan”) and appendices are intended to reflect the Trust’s main business plan over the subsequent three years. Information included herein should accurately reflect the strategic and operational plans that have been agreed on by the Trust Board.

In signing below, the Trust is confirming that:

- The Forward Plan and appendices are an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the board of governors;
- The Forward Plan and appendices have been subject to at least the same level of Trust Board scrutiny as any of the Trust’s other internal business and strategy plans;
- The Forward Plan and appendices are consistent with the Trust’s internal business plans;
- All plans discussed and any numbers quoted in the Forward Plan and appendices directly relate to the Trust’s financial template submission.

Approved on behalf of the Board of Directors by:

<table>
<thead>
<tr>
<th>Name</th>
<th>Peter Lee</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Chair)</td>
<td></td>
</tr>
</tbody>
</table>

Signature

Approved on behalf of the Board of Directors by:

<table>
<thead>
<tr>
<th>Name</th>
<th>Brian James</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Chief Executive)</td>
<td></td>
</tr>
</tbody>
</table>

Signature

Approved on behalf of the Board of Directors by:

<table>
<thead>
<tr>
<th>Name</th>
<th>John Somers</th>
</tr>
</thead>
</table>

Date: 31 May 2012
(Finance Director)

Signature
Annual Plan Review 2012-13

A. The Trust’s vision

Introduction

2011/12 has been a pivotal year in which the Trust has re-evaluated its future strategy in order to set solid foundations from which to sustain our performance over what will be immensely challenging times ahead, both financially and operationally. The Trust has worked intensely to deliver its financial and strategic plans as set out in the 2011/12 Annual Plan but this has not been without the need for difficult (but absolutely necessary) strategic decision making. We are confident that the work undertaken has placed us in a strong starting position for 2012/13 (and beyond) with the appropriate structures, systems and processes in place to facilitate our future strategy. We are convinced we are well positioned to allow us to be flexible and responsive in meeting the demands of a changing healthcare environment and have the resilience to continue to perform at the highest level.

The Trust actions in 11/12 were directed through the interim strategic direction, (SDS2.5). This approach allowed progress in key priority areas, whilst giving the opportunity to ensure that the future direction was appropriately influenced by the final outcome of the Health and Social Care Bill deliberations. Conclusion of this debate has now allowed Service Development Strategy 3 (SDS3) to be moved toward finalisation following engagement with a range of key stakeholders including staff, commissioners, governors and members. This outlines our key priorities over the next 3 years as follows:

The Vision

To become a best in class health care provider
We will do this by operating within the best 10% in everything we do

The Mission

To improve the health and wellbeing of the population we serve

Values

Our programme is underpinned by enduring values which have been previously set out in detail. These are:

- Respect
- Safe
- Right First time
- Together
- Responsible
- Compassion

Key Priorities

We have identified six major areas of development which need to be taken forward together to secure the future success of the Trust. These are:

- High Quality Care
- Effective Clinical Systems
- Efficient Business Processes
- Productive Partnerships
- Sustainability through Innovation and Diversification and
- Engaged and empowered workforce
High Quality Care: The Trust will develop and introduce a new quality strategy for the organisation that will ensure quality continues to be the key driver of everything that we do.

The new strategy will focus on driving quality improvement in three key areas:

- Safe – Providing safe care by reducing risk of harm
- Caring – own and enhance the patient experience end to end
- Reliable - deliver effective care systematically and consistently

Effective Clinical Systems: This area will focus on the:

- maintaining health and well-being
- elective care
- urgent and emergency care
- patient access and support
- maximising the benefits of integration

Efficient Business Processes: this area will focus on:

- aligning contracts with capacity and workforce
- optimising resource allocation and utilisation
- harnessing and exploiting information technology
- utilising information for performance management and improvement

Productive Partnerships: This area will focus on working with:

- commissioners
- other NHS providers
- voluntary sector
- independent sector
- governors and members
- media and public

Sustainability through Innovation and Diversification: This area will focus on:

- research and development
- innovation and technology adoption
- any qualified provider and other structured procurements
- volume competition
- diversification and complementary business acquisition
- private patients services

Engaged and empowered workforce: This area will focus on:

- future workforce design
- training and education
- leadership development and talent management
- recruitment retention and reward strategy
- efficient and effective deployment
- communications and briefings

These key success factors need to be supported through enabling strategies covering the following areas:

Board Development, Management Structures, Governance and Assurance, Workforce, Estates Management, Programme Management, Service Improvement, Business Intelligence, Brand Development, Marketing and Communications.
In setting our key priorities, we continue to put the patient at the centre of everything we do with the ultimate aim of delivering excellence across all of our service provision and that patients, service users and carers recognise them as being of the highest quality. Upholding our principle aim in a time of financial constraint requires radical thinking and planning to re-shape delivery of our services as is reflected in our key priorities described above. As finances shrink, we need to work even more closely with commissioners and other partners (both public sector and private providers) to ensure our population continues to receive the highest quality services whilst delivering best value for money.

We wish to be viewed by all of our stakeholders as a leader in delivering effective change, with our staff equipped and appropriately incentivised to deliver best quality care and service. It is recognised that at a time of great uncertainty and a requirement for significant reconfiguration, our staff will feel uncomfortable and threatened by the impending changes necessary for the Organisation to thrive in the future but we will do everything within our gift to minimise negative impacts.

Our plans and any action we will take, ultimately circles back to improving the whole experience for those who access any of our services. We must examine, assess and embrace opportunities which assist in driving up quality, from use of technology to forging effective partnerships. We strongly believe that a continued and relentless focus on delivering excellent quality services, driven and embedded through strong clinical and managerial leadership to redesign and re-shape services will reap the financial benefits necessary to protect our future sustainability.

B. The Trust’s strategic position

Introduction
As part of the SDS3 development work, the Board has undertaken both PEST and SWOT analysis to define the current strategic position and clarify both opportunities and threat.

2011/12 was the first year of operation of the new integrated care organisation, encompassing hospital and community services, progressively working closer together and aligning care contributions along agreed pathways. This configuration is the anchor of our strategic position and taking forwards integration to progressively higher and deeper levels will provide us with a unique proposition. The Trust has also worked very closely with strategic partners in both health and social care communities to ensure where possible and appropriate, plans are aligned to ensure focus on commonly agreed priorities and maximum synergy is obtained.

Competition
The key threat and opportunity anticipated is that presented by the fast emerging development of Any Qualified Provider with work now beginning in earnest to take forward this agenda. There are threats in terms of potential loss of services currently provided and henceforth subsequent loss of associated income. The level of impact both from a financial and service aspect will only become clear as specific details of those services to be opened to new market entrants are made available at which point we will assess the position and determine mitigating and or promotive actions as required. Whilst there are significant threats, there may also be potential opportunities for income generation should we decide it appropriate to pursue any rewarding opportunities. We will strategically assess the opportunity as well as the risk of AQP in order to balance any losses by extending activities where economically viable to do so, as set out in the 11/13 Marketing Strategy. Our focus on delivering and sustaining high quality services will be the key driver for our AQP decision making.

Changes in Commissioning Intentions/Service Delivery Changes
As anticipated, commissioning intentions in 2012/13 are based upon both doing less and doing more for less and thereby increasing efficiency and revising spend priorities. Implementation of demand management schemes continues to reduce recurrent income to the Trust and a greater focus has been placed on delivering services in alternative (or lower) level of care settings. We have worked closely with the host commissioner to develop and agree clinical thresholds for demand management. The 12/13 and onward plans have taken into account planned reductions at referral/procedure specific level and this will be monitored closely throughout the year.
It is inevitable that with such significant financial pressures faced by the NHS as a whole, changes in the way services are currently delivered are both unavoidable and necessary. The Trust has worked closely with commissioners to facilitate and develop joint forums through which service changes and their potential impacts (positive and negative) are formally discussed and considered. These forums have both senior manager/clinician engagement from both primary and secondary care facilitating an open debate and views from both perspectives. We confidently anticipate that this clinical engagement will deepen as Clinical Commissioning Groups progressively assume their pivotal roles.

Service delivery changes need to be driven through care pathway re-design, with the patient journey and experience held as the primary focus for the review and final changes proposed/agreed. These forums (one focussing on elective management, one on unscheduled care) embrace this methodology to determine next steps and derive changes which ultimately aim to benefit the patient/user.

The greatest opportunity for us lies in our ability to create positive, effective changes across the whole care pathway as a consequence of being an integrated organisation. Not only do we possess the ability to implement the change but we have the opportunity to re-group, and where necessary, re-skill our staff to deliver high quality, responsive services, irrespective of delivery location.

Through our forward Service Development Strategy 3, joint commissioner/provider groups and direct clinician to clinician engagement, we aim to achieve real, sustainable changes which will revolutionise the way in which health services are delivered and subsequently perceived by patients and carers.

We recognise there are some things we can change, some things we can re-shape and some things we can re-design but there are also things we have no control over. Our strategy focuses our efforts on those things we can change and influence.

**Specialised Commissioning**

Group Commissioning of services across clinical networks and larger populations (including South Yorkshire and Bassetlaw Commissioning plans) will continue to affect the strategic position of the Trust. In the forthcoming year we expect the key impacts will be in the progressive implementation of the plans to deliver major trauma centres for both adults and children.

We also expect that service changes will be required in order to ensure that all trusts meet commissioner service standards for children's services, particularly those for the surgical child. We also anticipate further developments in cardiac, stroke and neonatal care services as set out in the relevant work plans currently sponsored by NORCOM, the North Trent and Bassetlaw Commissioning Consortium.

Cancer services for specialised Upper GI and Head and Neck are currently under review and may result in new pathways for our patients.

**Provider collaboration**

We anticipate the need for service providers to collaborate closely in the provision of services, particularly out of hours services. We also intend to make our contribution to ensuring that the Sheffield city region and beyond works cohesively to ensure a viable research and innovation footprint that will compete effectively at national level and attract the necessary inward investment.
C. The Trust’s Clinical and Quality strategy over the next three years is:

The Trust is working on the development of a new model of healthcare as part of our third service development strategy (see diagram below).

This is a proposed model and is subject to final agreement; however it reflects the move towards an integrated pathway and systems based models. The organisation and structure of the Trust, its departments and services will need to be re-structured/devised to support delivery of corporate objectives, core values and the quality strategy. This includes:

- Different ways of working, ‘systems based thinking’
- Cultural shift from silo working to team-working
- Clear reporting lines (clinical and managerial leadership and supervision)
- Clear accountabilities for teams and individuals
- Decision making as near to the frontline service delivery as possible
- Clear and effective lines of communication and information flows across and within structures and systems and processes
- Systems that are developed around an understanding of human factors
- Moving from a vertical ‘top down structure’ to ‘horizontal structures’

Quality

Our strategy aims to set out where we are trying to get to in the long-term. It guides how we organise our resources either financial, people, estates or equipment, information and technology to ensure that we benefit patients.
Our overarching aim is to:

1. Provide safe care by reducing the risk of harm
2. Own and enhance the patient experience, end to end
3. Deliver effective care systematically and consistently

Working with our key partners to ensure we have productive working relationships will be critical as will be harnessing innovation and diversification. Our clinical systems and business processes all need to be efficient and effective. In order to sustain change we need to engage staff fully in the improvement agenda. We will do this by:

**Developing Leaders**

Executive leadership, with clear accountability for all aspects of the quality agenda will be clarified, supporting matrix working, collaborative approaches and the elimination of silo working. We will further develop our corporate leadership structures, led by the Medical Director and Chief Nurse (CNO) to be streamlined and more transparent with Clinical Directors, with the support of senior nursing staff, taking a clear lead for improving the quality of care within their systems. Effective collaboration between clinicians, patients and others to facilitate shared decision making in every care setting will be the objective of leadership at all levels.

**Introducing new structures and processes**

We have already introduced a quality governance team to support the development and implementation of key policies. An important aspect of ensuring robust quality and performance management will be a root and branch review of our committee structures with the aim of rationalising the numbers and ensure more effective information sharing and monitoring with the added benefit of allowing more time for quality initiatives.

**An Investigation and Learning Unit (ILU)**

Will be introduced to ensure we have high quality, consistent investigations, the learning from which will be shared with clinical leaders to implement rapid change. We will develop clinical processes that provide innovative end to end care by developing integrated pathways. Engagement of clinicians and key stakeholders has, and will continue to be, key to these developments.

**Embedding Strategies and Policies**

We will ensure that all of our policies (supported by the newly developed quality governance team) and strategies are aligned to the quality agenda, the key strategies being: Patient Experience, Patient Safety, Clinical Audit and Effectiveness, Business Intelligence and Data Quality, Health and Safety.

**Workforce Development**

We will ensure we recruit staff with the right attributes and behaviours and ensure a reward system reflects the value we place on this. Training and education of staff in systematic application of known safe working practices with the aim of creating and embedding a safety culture within the Organisation will be developed. The training will include team working, human factors and encouraging more open and transparent reporting of incidents. Staff will be provided training in customer care to make sure every interaction is positive for patients. Continuing Professional Development (CPD) will be supported by providing time to allocated quality improvement activities as part of re-validation and clinical excellence awards. Nursing and Midwifery reviews will include consideration of staffing levels to allow these staff time to engage in the quality improvement agenda.
**Improving Patient Access**

We will make it easier for patients to navigate the healthcare system and to get information they need through the introduction of a Single Point of Access. Ensuring that the Equality and Diversity System action plan is implemented across all our activity will ensure appropriate, timely and equitable access to all patients.

**Information and Technology Development**

We will continue to develop Electronic Patient Record (EPR) and SystmOne, (our activity and clinical recording systems) and similar information technology to support clinicians in making better decisions and delivering safer services (through patient monitoring, risk scoring, triggers/alerts and decision support tools. The Datix web based risk management system will be more effectively utilised to capture incidents and potential risks, and sharing information by the development of safety dashboards, with clinical directors held to account for remedial action. Better and faster systems to provide feedback will be facilitated through the establishment of a new *Business Intelligence Unit*.

**Improving Measurement and Performance Management**

All operational quality objectives will align to our strategic quality objectives so that we have information to support a total quality management approach. This will be supported by the development of benchmarks and dashboards, with clinical directorates and specialities developing their own quality improvement strategies with clear, measurable objectives and targets to manage performance within their services accordingly. The implementation of revalidation will extend this to individual clinicians.

The sub strategies that need to be in place to support our overall quality strategy are:

- Patient Safety Strategy
- Patient Experience Strategy
- Clinical Effectiveness Strategy
- Human Resources including training and development
- Business Intelligence Strategy
- Informatics Strategy
D. Clinical and Quality priorities and milestones over the next three years are:

<table>
<thead>
<tr>
<th>Topic</th>
<th>New or On-going</th>
<th>Objectives : 2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAFE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never Events</td>
<td>On-going</td>
<td>Zero Never Events</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>On-going, expanded</td>
<td>Increase in compliance with safe and secure medicines management from April 2012 baseline.</td>
</tr>
<tr>
<td>NHS Safety Thermometer</td>
<td>New</td>
<td>Introduce and improve data collection in relation to falls, pressure ulcers, Urinary Tract Infections and Venous Thromboembolism (VTE) assessments in acute and community setting from April 2012 baseline.</td>
</tr>
<tr>
<td>Communication</td>
<td>On-going</td>
<td>Improve quality and timeliness of referral and discharge letters from April 2012 baseline.</td>
</tr>
<tr>
<td>CARING</td>
<td></td>
<td></td>
</tr>
<tr>
<td>End of Life care Governor Indicator</td>
<td>On-going Expanded</td>
<td>Increasing compliance by 95% of 5 key measures on the Liverpool Care of the Dying Pathway (LCP) by April 2013 Reducing the number of inappropriate Fast Track discharges to Community Health Care</td>
</tr>
<tr>
<td>Patient Responsiveness</td>
<td>On-going</td>
<td>Increasing our responsiveness to our patients needs using a composite indicator of care from April 2012 baseline</td>
</tr>
<tr>
<td>Dementia</td>
<td>New</td>
<td>To deliver the locally agreed improvement targets for early identification of patients with dementia – Find, Assess and Refer (FAR) - in relation to all admitted patients aged 75 years and older by April 2013</td>
</tr>
<tr>
<td>RELIABLE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NICE Quality Standards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Assessments for Looked after Children</td>
<td>New</td>
<td>Increase the number of health assessments carried out for looked after children and young people from the April 2012 baseline.</td>
</tr>
<tr>
<td>CQUIN</td>
<td>2012/13 programmes</td>
<td>Delivery against programmes</td>
</tr>
</tbody>
</table>
### Priorities for 2013/14 and 2014/15

<table>
<thead>
<tr>
<th>Topic</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SAFE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reducing mortality</td>
<td>Plan for 24/7 working &lt;75 SHMI trust wide and specialty specific Top 15% lowest</td>
<td>Implement 24/7 working &lt;70 SHMI trust wide and specialty specific Top 10% lowest</td>
</tr>
<tr>
<td>Never Events</td>
<td>On-going</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>Full compliance Medicine Code Reduction in medication errors</td>
<td>Year on year reduction in medication errors</td>
</tr>
<tr>
<td>NHS Safety Thermometer</td>
<td>85% harm free patients Patient Safety Strategy implemented</td>
<td>95% harm free patients Lowest 10% nationally falls, VTE,UTIs, Pressure Ulcers</td>
</tr>
<tr>
<td>Communication</td>
<td>Roll out pilot electronic handover Technology programmes planned</td>
<td>Implement EPR handover assessments Innovative Technology solutions implemented</td>
</tr>
<tr>
<td><strong>CARING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>End of Life (EOL) care</td>
<td>On-going</td>
<td>All patients on EOL provided high level of care in appropriate setting</td>
</tr>
<tr>
<td>Governor Indicator</td>
<td>100% compliance CQUINs</td>
<td></td>
</tr>
<tr>
<td>Patient Responsiveness</td>
<td>Full implementation of Patient Experience Strategy</td>
<td>Top 10% questions patient survey E4E targets met Equality and Diversity System actions complete</td>
</tr>
<tr>
<td>Dementia</td>
<td>Implementation of strategy</td>
<td>All patients with Dementia referred and cared for appropriately</td>
</tr>
<tr>
<td><strong>RELIABLE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NICE Quality Standards</td>
<td>100% compliance NICE Standards Implementation of Clinical Effectiveness strategy</td>
<td>100% compliance NICE Standards</td>
</tr>
<tr>
<td>5 Long Term Conditions Pathways</td>
<td>85% reliability</td>
<td>95% reliability</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Targets met</td>
<td>Targets met</td>
</tr>
</tbody>
</table>
The key milestones relating to all programmes of work will be monitored regularly via monthly, quarterly reporting and ‘real-time dashboards via:

- Performance reports
- Quality Account reports
- Patient and Staff Safety and Experience report
- Quality Risk Profile CQC
- Monthly SI updates
- Complaints reports
- Risk Registers

External reviews are currently under way for maternity and colorectal services. On completion of the reviews and in receipt of the final report, an action plan will be developed to address all identified deficiencies. These action plans will be monitored closely by Corporate Safety and Experience Committee (CSEC) and the Board.

During 2011/12 we had a Never Event for the first time in 3 years. We will continue to monitor all Never Events closely via the Datix system and also run a series of task and finish groups to ensure that all National Patient Safety Agency alerts, including all Never Events, are fully embedded and that any non-compliance identified, is resolved immediately.

Falls continue to be our highest safety incident category, as is the case nationally. Following our falls collaborative we saw a significant reduction in falls, however during the year our rates have increased slightly, although still below the national average. We will continue to focus on falls via our NHS Safety Thermometer programme that will also include Venous Thromboembolism assessments, Urinary Tract Infections and Pressure Ulcers.

Infrastructure issues i.e. lack of trained staff, skill mix and staffing levels have been raised via Datix incident reporting. The Chief Nurse will be reviewing nursing and midwifery staffing levels to include consideration of the acuity of patients and advising the Board accordingly.

Our annual audit of safe and secure medicines highlighted some deficiencies in our controls. We have therefore initiated a major programme of work to replace all non-compliant drug cupboards. In addition we have re-designed our audit tools and conduct quarterly audits of practice across the Trust in all relevant areas. Feedback from these audits will be monitored closely by Corporate Safety and Experience Committee and the Board.

The Trust’s Risk Management Strategy sets out a robust process for ensuring that risks are reported, managed and reviewed via our Datix web based system. This includes incidents, claims and complaints and risk registers.

All QIPP, CIP programmes are utilising this system to monitor risk to delivery of quality and efficiency programmes. Any risks to quality and safety more generally will be monitored as set out in the risk management strategy at community services and CSU level, corporately and to the Board.
E. The Trust’s financial strategy and goals over the next three years:

Executive Summary

The plan is the result of a well-defined business planning process which has involved clinical and non-clinical input. Given the current financial levers / constraints outlined in the NHS Operating Framework for 2012/13 the focus of the plan is on cost reduction. The Trust set out its assessment of the funding gap (£14.5m) in October 2011 which determined the requirement for a 7% Cost Improvement Plan (CIP) target. Individual Clinical / Operational Service Unit (CSU / OSU) CIP plans have been reviewed as part of the Strategic Service Reviews (SSR’s) and base budget setting meetings held in January 2012 and subsequently by the Executive Team and Corporate Business Planning and Investment Committee (CBPIC).

The plan for 2012/13 and subsequent years reflects the 1 year contractual agreement reached with NHSR / Associates, in conjunction with the longer term financial framework agreement. The plan sets out the base budgets plus cost pressures associated with delivering those commissioning intentions. This indicates a surplus of £37k in 2012/13 which includes a £1.35m contingency and a surplus of £240k in 2013/14 which includes a £2.1m contingency.

There is a significant amount of non-recurrent / deferred income underpinning the financial plan in 2012/13 (£8.0m) and the Trust is also benefitting from the decision to re-invest the funding associated with emergency re-admissions (£2.2m) which are subject to a non-payment rule under current PbR guidance. This funding is underpinning the Trust’s position and is mainly aimed at improving the non-elective pathway. The Trust will need to utilise this transitional support in order to reduce activity in line with the QIPP reductions to 2014/15 set out in the 2012/13 Heads of Agreement. This will allow the Trust to “right size” the Organisation in terms of its cost base against those commissioning intentions and to seize those opportunities identified in recent benchmarking reports undertaken on the Trust’s workforce.

The Trust plans for an increased level of surplus in future years, which is necessary to support the site development programme, EPR implementation, workforce re-structuring and other enabling schemes that will ultimately result in improvements in patient quality.

Key Outcomes 2012/13

- A strong Monitor Financial Risk Rating score of 3
- 0.1% increase in overall income year-on-year, excluding the effect of deferred income in both years and 0.2% decrease taking account of the deferred impact
- Underlying patient income is up 2.1% (£4.3m) mainly due to £2.0m non-recurrent community investment and £0.6m contract increase from 2011/12
- Underlying non-patient income is down 21.5% (£4.7m) mainly due to £1.3m reduction in community services, non-recurrent support and £1.2m lost contracts (RDASH, MMH residences and Post Graduate Medical Education Centre).
- 0.7% decrease in overall operating costs year-on-year, excluding the effect of deferred income on expenditure and 0.2% increase taking account of the deferred impact / inflation
- Surplus of £3.2m before re-structuring costs and impairment
- £15.4m CIP’s

Activity / Income Assumptions

The overall income for 2012/13 is planned to be £225.4m which is a 0.2% reduction from 2011/12 plans and which has taken account of the tariff adjustment of -1.8% and other changes set out in The Operating Framework 2012/13 that:

- Incentivises more procedures being performed in a less acute setting
• Incentivises same-day emergency treatments where clinically appropriate
• Increase the payment differential between standard and best practice care for fragility hip fracture care and stroke
• Promotes the use of interventional radiology procedures

The finance plan reflects the outcome of recently concluded contract negotiations with NHS Rotherham and discussions with other PCT’s. Clinical income has been aligned to specialty level plans which are based on forecast outturn plus growth where appropriate less reductions for the Quality, Innovation, Productivity and Prevention (QIPP) agenda. Higher levels of growth have been included for Sleep Studies to account for anticipated increases in outpatient numbers and reduced levels of growth have been agreed in Orthopaedics to reflect the loss of joint injections now carried out in primary / community care.

**Income Bridge**
The £7.3m overall reduction between 2011/12 forecast outturn and 2012/13 income budgets is largely due to the fall in other operating income includes £2m receipt of non-recurrent funding to support the mortuary project in 2011/12 and other issues that include:

<table>
<thead>
<tr>
<th>£m</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>232.7</td>
<td>2011/12 outturn</td>
</tr>
<tr>
<td>(4.9)</td>
<td>Other income (mortuary, N/R CV's)</td>
</tr>
<tr>
<td>(2.0)</td>
<td>Clinical income</td>
</tr>
<tr>
<td>(0.4)</td>
<td>Other (R&amp;D, education &amp; training)</td>
</tr>
</tbody>
</table>

**225.4** | 2012/13 budget

**Expenditure Plans 2012/13**
Total operating and non-operating costs reduce from £217.5m in 2011/12 outturn to £211.4m in 2012/13.

<table>
<thead>
<tr>
<th>£m</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>217.5</td>
<td>2011/12 outturn</td>
</tr>
<tr>
<td>(15.4)</td>
<td>CIP</td>
</tr>
<tr>
<td>2.7</td>
<td>Base budgets (vacancies, new posts)</td>
</tr>
<tr>
<td>1.7</td>
<td>EPR</td>
</tr>
<tr>
<td>0.5</td>
<td>NI/£250 “flat rate” increase for lower bands</td>
</tr>
<tr>
<td>2.2</td>
<td>Incremental drift</td>
</tr>
<tr>
<td>1.0</td>
<td>Non pay inflation</td>
</tr>
<tr>
<td>1.2</td>
<td>Other cost pressures</td>
</tr>
</tbody>
</table>

**211.4** | 2012/13 budget
Key Risks / Actions to Support Delivery of the Financial Plan

1. Effective performance management of the £15.4m CIP delivery via Programme Management Office (PMO), including regular monitoring by exception of CSU / OSU and cross cutting Corporate schemes at Corporate Programme Board.

2. Escalation of CSU / OSU adverse financial performance against plan to CMB on a monthly basis with the intervention of an executive team where appropriate to put in place recovery plans.

3. Executive lead responsibility for CQUIN schemes and £4.7m associated funding which will fall under PMO and be subject to regular monitoring by exception and action plans where delivery is at risk.

4. In year development of plan B CIP’s to offset slippage / non-delivery of schemes. This will be linked to an incentives strategy that aims to encourage clinical / non clinical areas to generate favourable variances to plan. This will involve the creation of funding set aside for good performance and increased freedom in respect of certain expenditure.

5. Regular review of activity against contract conditions to ensure that the Trust is not liable to sanctions and is earning full tariff for activity based on elective caps and the NEL threshold (CBPIC, CSU Performance meetings).

6. Additional expenditure over plan linked to approved business cases (CBPIC, CMB, ETM).
F. The Trust’s approach to ensuring effective leadership and adequate management processes and structures over the next three years is:

Guiding Principle
SDS3, our forward strategy, identifies the desire to review the appropriateness of extending our portfolio of services into new areas (e.g. Nursing Homes) with the driver not only of generating new streams of income to the Organisation but to provide even greater leverage in managing the extended care pathway. It is expected that this will assist in delivering the efficiencies required through allowing us to be in a position to shrink acute services. This will be facilitated through improving intermediate/long term care provision by transferring tried and tested systems and processes aimed at driving up quality into these new areas of work. Demonstrable quality improvements generally promote greater confidence in service provision and increasing the confidence of referrers from both primary and secondary care into these alternative levels of care will encourage more effective utilisation.

As we explore these potential opportunities, subject to individual business cases, we will reconfigure our management capacity to deliver high quality, efficient and effective services relevant to the business opportunity being pursued. We are confident that we have existing capability to support this strategic direction of travel.

Trust Board Effectiveness
The Board will look to review its effectiveness across its 3 year strategic development strategy by applying an approach that is relevant to the circumstances, strategic focus and stage of development of the Trust in accordance with SDS3 milestones. The general principles we will apply will extend to include a focus on the ‘right’ structure, people, culture, tasks, information processes and follow-through. As Board begin 12/13 with a revised membership, our efforts will undoubtedly focus in the early months on Board dynamics, as a significant element on which to concentrate effort in order to build appropriate levels of trust between board colleagues, a high level of constructive challenge by both non executives and executives and high levels of engagement in and out of board meetings.

The Board reviewed its effectiveness during 2011 which included an assessment of the failings at Mid Staffordshire and other high profile failures (in and out of the NHS) to ensure the Board did not lack the same focus on the ‘business’ nor did it have confused systems of governance. The Board plans to capture enhanced learning once the next Francis Report is issued in October.

External support is being investigated in order to ensure that we assess our effectiveness and develop as a Board, by holding together the diversity of talents necessary for organisational success in accordance with SDS3 priorities. The annual review of Chair, Non-Executive and Executive performance evaluation will continue in accordance with the requirements of the Code of Governance. The Board will continue its annual programme of Committee Effectiveness Reviews and True for Us assessments that measure our compliance with best practice corporate governance.

The Board is clear that it needs to mobilise its senior leaders to provide an efficient and effective service by as far as possible shifting to a prevention service. This will be delivered through better understanding the needs of its patients and its service users and as such, clinical leadership thinking beyond immediate professional and organisation interests will be a priority in order that quality genuinely is our organising principle.

We are also conscious that the visibility of board effectiveness or otherwise will be heightened by the move to public board meetings and we plan to review board agenda setting to ensure maximum visibility and transparency of the Board decision making processes, within the limits set in relevant statute and regulation.
Furthermore, The Council of Governors is an essential part of the Trust’s structure and we plan to help it to effectively discharge the new responsibilities outlined in the Health and Social Care Act. The Trust wishes to support the Council to be comfortable and confident with the responsibilities and to continue to contribute to the affairs of the Trust in a positive way, as a “critical friend” which retains and displays all of the required qualities of that status. Managed well, this development can improve the performance, nature and function of the Council of Governors and ensure it retains its fundamental characteristics. The over-arching objective is to embrace the Council of Governors and ensure that at all times a sound relationship exists between the Board and Council.

Effective Senior Leadership
During 2011/12 in-year service reconfiguration led to a review of the Senior Management structure and this was successfully completed. Our approach is predicated on the basis that to deliver our aims and objectives we need the right people, with the right skills, in the right place, at the right time. We are confident we have this combination in place within our senior structure to take forward our revised strategy and to deliver the initiatives agreed with our commissioners for 2012/13.

As the strategic direction of the Trust is re-defined and changes to key executive and non-executive members (both leavers and starters) take place, opportunities arise to review leadership and management arrangements which will re-assign lead executive responsibilities. A gap analysis has already been undertaken following the imminent departure of the Chief of Strategic Development and implementation of SDS3 outlines how roles and responsibilities will be allocated to provide coverage across all areas.

Our Board composition has recently been reviewed following a number of non-executive officer appointments coming to an end. As a consequence, we have already taken the opportunity to re-examine the categories of knowledge and experience required to assist in delivering our revised forward strategy, and subsequently have been able to close most of the gaps identified.

The next 3 years will see the creation and maintenance of a skills and development programme for the Board of Directors reflecting the need for them to be able to not only discharge their legal and regulatory responsibilities but to function inclusively with a clear understanding of the Trust's functions, understand the skills and knowledge they possess and the abilities they need to operate as a successful board, and develop and maintain supportive relationships.

Strong board leadership, supported by strong senior and operational leadership is key to delivering our mission, vision, values and forward strategy. As described earlier we have already reviewed our senior management structures and are confident we have the most effective team and processes in place to meet the currently known challenges ahead. Whilst we have examined the current external impacts, we know that steady state will not prevail, and as such we will continue to review our structures to make certain the skill sets currently in place at the most senior levels remain appropriate and effective.

The areas of specific focus for delivery in this financial year are those relating to:
- Unscheduled care (including A&E)
- Aspects of Planned Care
- Continued focus on integration of acute/community services
- Care closer to home initiatives

Commissioning Impacts
We are acutely aware of the external developments across the region, for example development of the Major Trauma Centre, elements of specialised services to be commissioned directly via Specialised Commissioning Group, further developments in Cancer services and reconfiguration of Paediatric Cardiology to name but a few.
We have configured our management structure to ensure we have senior level representation on external boards to allow us to understand, assess and advise upon the potential future impacts on our services.

We know there are more financial challenges yet to come and commissioners will continue to drive savings through increasing QIPP. In 2012/13, we have worked collaboratively with commissioners to establish and agree QIPP schemes which are recognised across all parties as deliverable and achievable. This is an important underpinning principle as the Trust must be able to take real costs out of the system in order to deliver efficiencies; otherwise the exercise becomes one of ‘cost shifting’ rather than ‘cost saving’.

All of the schemes agreed in 2012/13 have been adjusted within the contract activity plan therefore taking account of the financial implications. Whilst plans have been adjusted and we are comfortable with the schemes, it will only be through close monitoring of the specific detail of each scheme, and performance managing through to delivery, that the savings will be achieved. We have reviewed our systems and processes, reporting mechanisms and escalation procedures internally to ensure they remain robust to provide consistent reporting of the current position.

We are mindful that a level of non-recurrent support is available to us at present but will cease in the future. Each opportunity to re-design our services, making them as efficient and effective as possible, without impacting quality, must be grasped and our forward strategy defines how we plan to progress this.

Introduction of Any Qualified Provider is running at pace and we perceive this a both a threat and a potential opportunity but until specific details are made available it is difficult to assess the impact – it is our knowledge of the potential threat/opportunity that is most important factor, meaning we will be keen to keep abreast of AQP activity across the region.

Any financial savings required will eventually impact on operational service delivery and this is why it is essential that we further develop patient level costing to provide us with the necessary information to make informed decisions relating to operational services as the challenges increase.

**People and Organisational Development**

We have a very clear vision of our aims and objectives and how we want to be perceived, but the only way of delivering this is through ensuring our departmental strategies share that common goal and interlink to work alongside other strategies as appropriate in support of SDS3.

One of the key underpinning strategies of any organisation is that relating to People and Organisational Development (POD), but nevermore could there be a time when managing its delivery will be essential. Everything we are required to do will involve change for staff on all levels throughout the Trust. Whilst recognising the scale of the challenge, we will be proactive in our approach to secure the least possible impact on our staff with the POD strategy at the heart of this. Our approach is to:
• Develop organisational design principles to deliver SDS 3
• Further enhance the talent management approach including training needs analysis, attraction and retention programmes, identifying “rising stars” through succession planning, business performance management and effective PDR processes
• Identify gaps between current and future structures, including roles and responsibilities to meet the SDS3 requirements, by re-aligning Clinical Service Unit structures and flattening organisational hierarchies;
• Further develop and embed the Performance Management System by ensuring greater visibility between performance and reward and pay progression
• To provide and develop a range of leadership and management programmes for all levels of staff
• Assess the viability of establishing academic partnerships and scope an approach to an ‘in-house’ academy model with the express intention of delivering key business objectives
• To measure the effectiveness of programmes through a balanced score card approach
• Work across national and international networks to ensure the Trust links in to wider leadership talent pools including private and public sectors
• Provide a support mechanism for staff throughout the transition period
• Take opportunities afforded to us through natural wastage to review roles and responsibilities, becoming leaner and efficient whilst remaining effective
• To be fully engaged in and dynamically support departments to realise their efficiency programmes through active and robust monitoring of performance
• Provide a professional expert advice service to aid our Senior Management Team and enhance organisational performance
• Review a range of management and leadership roles as part of its workforce planning for the next 3 years. This process will identify key individuals who the Trust intends to support with short-term and medium term development programmes. This cadre of staff will be key to ensuring that the Trust delivers its strategic development strategy.
• Re-shape the workforce in order to deliver a different model of healthcare and supporting managers in delivering the organisational change programme necessary to embed these models
• Keep a close eye on the basics of sickness / absence management and mandatory and statutory training to maximise the availability of fully trained staff that are compliant with our contractual obligations.

As referenced throughout this document, we are at present in a time of major change; the NHS nationally as a whole from a financial perspective; locally with revision to commissioning arrangements, and internally with the need to review and revise our strategic direction to make us fit-for-purpose.

We are confident we have reviewed the current position thoroughly and taken account of the major strategic focus as included in SDS3 but key to our future success will be the ability to quickly examine, assess, prepare and adapt to meet future strategic challenges.
G. The Trust’s other strategic and operational plans over the next three years:

Strategic Service Reviews have been held across both acute and community services with each area asked to outline their service development plans over the coming 3 years. At this review, services are requested in advance to align plans to the Organisational strategic direction and therefore the majority of schemes are already directly linked into our overall strategic aims as defined at the outset of this document. This approach aims to make sure that all development priorities map accordingly to deliver the desired objectives. All services key aims include:

- Review of care pathways (acute/community)
- Review of use of alternative levels of care
- Administrative & Clerical Review
- Ward, community and specialist nursing review
- Outpatient Review
- Reducing non-elective admissions
- Reducing Length of Stay
- Extending physician presence (New Model Hospital)
- Opportunities to transfer services into the community
- Workforce re-design
- Fostering partnerships/increasing clinical engagement with Commissioners

There are however, two unique areas within our service provision which we will look to maximise any opportunities that may arise. These are outlined below:

**Photopheresis**
TRFT is one of a handful of designated specialist service providers of this service and already has an outstanding reputation both nationally and internationally. In 2012/13 we are looking to deliver outreach Photopheresis to inpatients admitted at Sheffield Teaching Hospitals who are identified as benefiting from treatment. We will monitor the impact of this as it is introduced and evaluate the service. Subject to the outcome of that review, TRFT may seek to capitalise further on this. The service is also currently looking to extend the research aspects.

**Management of Enteral Feeding Contracts**
Our Dietetic service has for some considerable time managed the enteral feeding budget on behalf of the host commissioner. The input of expert knowledge and advice has resulted in significant savings. We may seek to market this over a wider catchment to explore any potential opportunities to extend the service, providing income generation to the Trust and significant cost savings to commissioners.
H. The Trust has had regard to the views of Trust Governors by:

Engaging our governors in relation to the Strategic Direction of the organisation is extremely important and provides an opportunity to seek views of those representing the public we serve.

It is extremely important that our Governors are provided with the necessary information to equip them for their decision making, particularly in the current climate within which the NHS is working. To this end, our Governors have been provided an overview of the challenges faced by the NHS and a brief of how the organisation might look to position itself to meet those challenges (presented by the Chief Executive).

In order to gain maximum input from Governors, six generic scenarios were posed to the audience, with background information provided and potential positive/negative impacts. Following facilitated group discussion Governors were asked to vote anonymously against each of the scenarios posed as to how comfortable they felt with the statements made.

The issues were presented as scenarios, but designed to encapsulate many of the real issues we will be facing over the coming 3 years. The session provoked a good debate amongst governors with Executives facilitating sessions and was well received.

The outputs of the session indicated that in the majority of cases, governors were ‘comfortable’ with exploring the use of technology and moving services into community settings where appropriate, both of which are key strands of our strategic direction but understandably less comfortable with reducing workforce but also recognised external factors as being the drivers for this.

We actively seek and encourage governor participation, value their contribution and work with them to develop and embrace reasonable requests. Governors were consulted in the development of our Quality Accounts, the outcome of which resulted in approval of the proposed programme and the inclusion of a specific governor quality account indicator and strong influence on the Quality Strategy, approved in March 2012, which in turn drives the quality objectives contained within this plan.

The Council of Governors have been fully involved in the formal SDS3 engagement process, the outcome of which will finalise the strategic aims of the Trust which this annual plan operationalises for the first year of the strategy period.

We wholly recognise the expanding role of our Board of Governors and look forward to working even more closely with them over the coming period.
## Appendix 1: Key risks (NOT INTENDED FOR PUBLICATION)

### Financial Risks

<table>
<thead>
<tr>
<th>Category of risk</th>
<th>Description of risk (including timing)</th>
<th>Potential impact</th>
<th>Mitigating actions / contingency plans in place</th>
<th>Residual concerns</th>
<th>How Trust Board will monitor residual concerns</th>
</tr>
</thead>
</table>
| Achievement of CIP                            | The risk is that planned CIPs are not delivered within the pre-defined timeframe or delayed              | 1 Impact on financial ratings  
2 Impact on delivery of financial plan                                                                                                                 | CIP delivery will be monitored via Programme Management Office (PMO) with deviations from plan escalated as appropriate with residual actions agreed to recover the position | 1 Actions agreed to mitigate the risks are insufficient to recover the position  
2 New risks are identified which require alternative courses of action to be taken                           | Trust Board will monitor material variances via monthly financial reporting                                                                          |
| Achievement of CQUIN                         | The risk is that agreed milestones against CQUIN indicators (both national and local) are not delivered | 1 Impact on financial ratings  
2 Impact on delivery of financial plan  
3 Impact on delivery of quality improvements                                                                                                                                                                   | Executive sponsors have been allocated to each indicator and delivery will be monitored via Programme Management Office (PMO) with deviations from plan escalated as appropriate with residual actions agreed to recover the position | 1 Actions agreed to mitigate the risks are insufficient to recover the position  
2 New risks are identified which require alternative courses of action to be taken                           | Trust Board will monitor material variances via monthly reporting specific to CQUIN                                                                       |
| Contract Performance                         | The risk is that contractual/financial penalties are incurred as a consequence of variance to activity and quality plans | 1 Impact on financial ratings  
2 Impact on delivery of financial plan  
3 Impact on quality improvements                                                                                                                      | Close scrutiny of contract performance across all areas to identify variances from plan with deviations escalated as appropriate and actions agreed to recover the position | 1 Agreed demand management schemes are ineffective  
2 Actions agreed to mitigate the risks are insufficient to recover the position  
3 New risks are identified which require alternative courses of action to be taken                           | Trust Board will monitor material variances via monthly financial reporting                                                                          |
<table>
<thead>
<tr>
<th>Category of risk</th>
<th>Description of risk (including timing)</th>
<th>Potential impact</th>
<th>Mitigating actions / contingency plans in place</th>
<th>Residual concerns</th>
<th>How Trust Board will monitor residual concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management of Expenditure</td>
<td>The risk is that expenditure goes beyond that set out in the plan</td>
<td>1 Impact on financial ratings 2 Impact on delivery of financial plan</td>
<td>Departmental expenditure will be closely monitored with Clinical and Business service leads held accountable. Corporate plans will also be monitored and scrutinised against agreed business proposals. Any deviations from plan will be escalated as appropriate with residual actions agreed to recover the position</td>
<td>1 Actions agreed to mitigate the risks are insufficient to recover the position 2 New risks are identified which require alternative courses of action to be taken</td>
<td>Trust Board will monitor material variances via monthly financial reporting</td>
</tr>
<tr>
<td>Category of risk</td>
<td>Description of risk (including timing)</td>
<td>Potential impact</td>
<td>Mitigating actions / contingency plans in place</td>
<td>Residual concerns</td>
<td>How Trust Board will monitor residual concerns</td>
</tr>
<tr>
<td>------------------</td>
<td>----------------------------------------</td>
<td>------------------</td>
<td>-----------------------------------------------</td>
<td>------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Achievement of Clostridium difficile Target</td>
<td>The risk is that actual number of C.diff infections will exceed the trajectory by year end. The trajectory is taken from a “best case” reference period.</td>
<td>1 Impact on Governance ratings 2 Contract compliance and consequent financial penalties 3 Patient Impact</td>
<td>External expert review of Control of Infection approach, commissioned, reported in 11/12 and resultant actions underway Agreement reached with Coordinating Commissioner on a protocol defining the circumstances under which a target breach would be confirmed and subsequent reinvestment of any financial penalties Increased focus on length of stay as an avoidable risk factor</td>
<td>1 Residual concerns relate to the seasonal and other disease conditions which are variable and outside the Trusts control and which previous experiences and external evidence have shown to impact on the incidence of C.diff</td>
<td>Monitoring completion of action plan arising from external expert review Regular monitoring of length of stay, generically at Trust and Speciality level and specifically as a key risk factor in individual and cluster incident analysis</td>
</tr>
</tbody>
</table>
| Achievement of MRSA Target | The risk is that a zero baseline will not be maintained | 1 Impact on Governance ratings 2 Contract compliance and consequent financial penalties 3 Patient Impact | TRFT has an excellent track record of low incidence of infection rates with zero MRSA achieved for 23 consecutive months. TRFT will continue to undertake full root cause analysis of all cases. | 1 Actions agreed to mitigate the risks are insufficient to recover the position 2 New risks are identified which require alternative courses of action to be taken | Monthly performance reporting  
Due to the timing of this submission, Board are aware that the target has already breached by one |
<p>| Achievement of 62 day cancer target | The risk is that the outsourcing of rectal cancer surgery, necessary to prevent possible operative harm to patients, will result in longer overall pathways, putting pressure on 62 Day performance | 1 Impact on Governance ratings 2 Patient Impacts | The Trust has prepared a plan to handle the period of time whilst surgery is outsourced. This plan contains both permanent and temporary changes to aspects of the diagnostic processes. The further mitigation available | 1 Residual concerns relate to the ability of the Trust to sustain a challenging handover target to the external provider of 28 days for the required duration | Monthly performance reporting |</p>
<table>
<thead>
<tr>
<th>Achievement of A&amp;E four hour target</th>
<th>The risk is that actions taken to date and additional schemes agreed for 2012/13 do not deliver the planned outcomes. Additionally, where agreed demand management schemes are ineffective or demand on A&amp;E services unexpectedly increases, this will adversely impact upon our ability to deliver the target</th>
<th>1 Impact on Governance ratings 2 Patient Impacts</th>
<th>A&amp;E performance will continue to be monitored on a daily basis and remains a key priority of the Trust. A range of schemes aimed at increasing clinical capacity within A&amp;E are agreed for 2012/13. Variances from plan will be escalated as appropriate and further actions agreed to recover the position.</th>
<th>1 Recruitment is delayed and/or demand increases beyond expected levels. 2 Actions agreed to mitigate the risks are insufficient to recover the position 3 New risks are identified which require alternative courses of action to be taken</th>
<th>Monthly performance monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness of Human Resource Plans</td>
<td>The risk is that the HR approach is unable to deliver the plans and/or that plans are delayed or deferred</td>
<td>1 Impact on delivering efficiency programmes 2 Impact on Finance ratings 3 Impact on delivering financial plan 4 Impact on delivering organisational strategy 5 Impacts on Quality</td>
<td>The Trust has agreed a robust HR plan and is reviewing existing HR capacity to assist delivery of efficiency programmes. Performance will be monitored via Programme Management Office (PMO). Deviations from plan will be escalated as appropriate with residual actions agreed to recover the position</td>
<td>1 Actions agreed to mitigate the risks are insufficient to recover the position 2 New risks are identified which require alternative courses of action to be taken 3 Lack of integration between individual CIP projects and corporate actions including required statutory consultations</td>
<td>Monthly performance monitoring and challenge on integrity, scale and pace of corporate programme.</td>
</tr>
<tr>
<td>Category of risk</td>
<td>Description of risk (including timing)</td>
<td>Potential impact</td>
<td>Mitigating actions / contingency plans in place</td>
<td>Residual concerns</td>
<td>How Trust Board will monitor residual concerns</td>
</tr>
<tr>
<td>-----------------</td>
<td>----------------------------------------</td>
<td>------------------</td>
<td>-----------------------------------------------</td>
<td>------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>EPR Implementation</td>
<td>The risk is that the processes and EPR functionality defined for use within those processes will not be adequately executed by end users</td>
<td>1 Impact on financial ratings 2 Impact on delivering financial plan 3 Contract compliance 4 Impacts on Quality 5 Impact on delivering organisational strategy</td>
<td>1 Weekly reporting of position statement to Executive Team 2 Clearly defined and detailed action plan with delivery timelines leading up to go live, during switch over period and immediately post ‘go-live’ 3 Post ‘go-live’ daily CDS and data quality checks 4 Enhanced resources available post go-live to identify, review and rectify or resolve any identified variances in functionality 5 Extensive training programme pre EPR implementation across all affected staff 6 On-hand training resource available during and post go-live in all affected areas 7 Continue extensive testing of systems and functions consistently up to switch over 8 Extensive risk register reviewed on a weekly basis 9 Continued engagement with Connecting for Health 10 Connecting for Health representative on Patient Safety Group</td>
<td>1 Actions agreed to mitigate the risks are insufficient to recover the position 2 New risks are identified which require alternative courses of action to be taken</td>
<td>Monthly performance monitoring</td>
</tr>
</tbody>
</table>
Risks to Quality

Rectal Cancer Surgery

A clinical audit of aspects of morbidity and mortality relating to rectal cancer surgery was completed in January 2011. The outcomes of this audit demonstrated that there was a clinically significant variation in a particular surgical complication, compared to that expected. Detailed clinical discussions were unable to adequately explain this variation, nor recommend a course of internal remediation that could be pursued with sufficient confidence to guarantee patient safety. For this reason, the Trust has decided to restrict this resection surgery until such times as it can be safely recommenced. To create the conditions for a safe recommencement, the Trust has activated the invited review mechanism of the Royal College of Surgeons and sought advice from the National Clinical Advisory Service, the body set up to help clinicians and managers how to understand, prevent and manage clinical performance concerns. Currently, the surgical resections are being conducted within another cancer network hospital until the above conditions are satisfied.

Obstetrics and Gynaecology Services

The Trust has been developing its approach to usage of triangulation of different information sources to identify where there may be systemic issues affecting quality and efficiency. A “cluster” of Serious Incidents (SIs) associated with the provision of maternity services have been observed and triangulated with other issues demonstrating challenges in delivering these services. Whilst most of these issues are not explicitly linked, the Trust has nevertheless decided to seek an external independent review of the systems and processes used to deliver these services, to provide assurance that these are sound and effective and to identify any areas where further improvement is needed or possible. This review will be conducted in May 2012 and be reported in June 2012. In the meantime, an enhanced framework of support has been provided to maternity services.

Board Monitoring

The Board monitors risks to quality and safety through the following reporting mechanisms:

- Performance reports
- Quality Account reports
- Patient and Staff Safety and Experience report
- Quality Risk Profile CQC
- Monthly SI updates
- Complaints reports
- Risk Registers

The detailed contents of these reports are defined by the relevant trust strategies including quality accounts and risk management strategy and by external agencies where noted (e.g. CQC).
Use of external assurance (including internal audit)

**Internal Audit (PricewaterhouseCoopers - PwC)**
In line with the Internal Audit Work Plan full scope audits of the adequacy and effectiveness of the control framework in place are underway for the following areas for the year 2011/12.

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>Assurance rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core Financial Systems</strong></td>
<td></td>
</tr>
<tr>
<td>Income and Debtors</td>
<td>High Assurance</td>
</tr>
<tr>
<td>Cash and Bank</td>
<td>High Assurance</td>
</tr>
<tr>
<td>Cost Improvement Plans</td>
<td>Limited Assurance</td>
</tr>
<tr>
<td><strong>Operational Areas</strong></td>
<td></td>
</tr>
<tr>
<td>Stock Control : Community Health</td>
<td>Moderate Assurance</td>
</tr>
<tr>
<td>Lone Working: Community Health</td>
<td>Moderate Assurance</td>
</tr>
<tr>
<td>Integration and Control: CHS</td>
<td>Moderate Assurance</td>
</tr>
<tr>
<td>Discharging / Bed Management</td>
<td></td>
</tr>
<tr>
<td><strong>Information Management and Technology</strong></td>
<td></td>
</tr>
<tr>
<td>Registration Authority</td>
<td></td>
</tr>
<tr>
<td>IT Asset Management</td>
<td></td>
</tr>
<tr>
<td>Business Continuity / Disaster Recovery (Trust-wide)</td>
<td></td>
</tr>
<tr>
<td><strong>Risk and Governance</strong></td>
<td></td>
</tr>
<tr>
<td>Assurance Framework / Risk Management</td>
<td></td>
</tr>
<tr>
<td>Quality Governance</td>
<td></td>
</tr>
<tr>
<td>Clinical Negligence Claims Handling</td>
<td>Moderate Assurance</td>
</tr>
<tr>
<td>Care Quality Commission</td>
<td>Moderate Assurance</td>
</tr>
</tbody>
</table>

None of the recommendations made by Internal Audit in these reports highlighted material issues.

Recommendations made for all the above audits are either followed up by the Assurance Unit or by Internal Audit to ensure that all recommendations are sustainably implemented within the organisation. Internal audit reports are followed up twice by the Assurance Unit, at six-monthly intervals. Following the second review, any remaining unimplemented recommendations were escalated to the appropriate Executive Lead at the Audit and Assurance Committee to provide an update.

**External Audit (KPMG)**
External Audit will carry out the required audit of the 2011/12 annual report and accounts.

In addition to use of internal/external auditors, we have also engaged with a range of other professionals during 2011/12 to provide assurance e.g. Professor Brian Wilcox reviewed our processes for managing C.Diff.

In 2012/13 (and beyond) we will continue to engage a range of external sources to provide assurance in relation to the effectiveness of our systems and processes. Representatives from both internal and external audit are included as members of the monthly Audit and Assurance Committee attended by both Executive and non-Executive Board members.
Appendix 2: CIPs and efficiency (NOT INTENDED FOR PUBLICATION)

Cost Improvement Plans (CIPs) in the Forward Plan period

CIP Design

How have schemes been identified and developed?

The size of the challenge facing the NHS in general, and Provider Organisations in particular, over the next three years is immense (the £20Bn efficiency requirement). Progress by Directorates and Departments in delivering 2011/12 CIPs has been positive and whilst there remain challenges to delivering the full quantum of savings this year (11/12), the Trust is on track to deliver its plans.

However, the fact is that the Trust has only really harvested the low-hanging fruit. The challenge over the next three years will become more and more difficult as the financial pressures force the Trust to improve efficiency through much more radical solutions.

Fortunately there are a number of opportunities. The merger with community services opens up new channels for service delivery though integration; which will enable new efficiencies to be found; EPR, along with SystmOne in the Community, will over time substantially reduce the huge cost of maintaining, handling and transporting paper records; and contractual agreements with the PCT will protect the Trust by establishing a longer term financial envelope to ensure the sustainability of Rotherham’s health economy over the next 2 years so that it can use that income to redesign and reshape services more innovatively and without concern that income will be lost in doing so.

The CIP for the Trust in 2012/13 forms part of the £30m assessment of the savings required over the 3 year period from 1 April 2012. This was derived from estimates of reductions in contract income for acute and community services and tariff depreciation set alongside expenditure cost pressures, particularly the impact of pay (increments) and non-pay inflation etc.

In 2011/12 NHS Rotherham agreed to re-invest the 70% Non-Elective levy above 2008/09 activity levels as well as the savings that NHS Rotherham would accrue for not paying for re-admissions. This non-recurrent support is available and will allow us to reinvest in redesigning services that will be sustainable with lower income levels, but this non-recurrent support falls away to nil as part of the longer term approach that the parties have agreed. The £4.8m associated with this non recurrent re-investment enables the Trust to deliver a balanced financial position whilst providing time for it to right size to the financial envelope available in a safe manner that will ensure that there are no adverse impacts upon the quality of our services.

Given the longer term uncertainty around non recurrent support (due to the structural changes taking place in the NHS which might affect future levels of funding available to commissioners and new commissioners having different priorities), it is prudent to front-load recurrent saving plans into 2012/13 to offset this risk and strive towards the delivery of a recurrent position in 2012/13 that provides a solid platform for sustainability going forward. The overall financial assumptions to underpin the baseline position for 2012/13 therefore appear as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base savings target</td>
<td>10.0</td>
</tr>
<tr>
<td>Front loaded adjustment re non recurrent support</td>
<td>4.5</td>
</tr>
<tr>
<td>Total</td>
<td>14.5</td>
</tr>
<tr>
<td>CIP % as a proportion of relevant expenditure</td>
<td>7.0%</td>
</tr>
</tbody>
</table>
## CIP Focus - Top 5 CIP Schemes

<table>
<thead>
<tr>
<th>Ref</th>
<th>Scheme</th>
<th>Scheme description including how Forward Plan will reduce costs</th>
<th>Underpinning IT / information or management systems</th>
<th>Total savings £m</th>
<th>Phasing over three year period (%)</th>
<th>WTE Reduction</th>
<th>Subject to a quality impact assessment (Y/N)</th>
<th>Who is responsible for signing off on the quality impact assessment</th>
<th>Key measure of quality for plan</th>
<th>Lead</th>
<th>Scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Inverto procurement project</td>
<td>Systematic review of Trust supplier contracts to ensure best value</td>
<td>Agresso</td>
<td>1.35</td>
<td>0.71</td>
<td>0.64</td>
<td>Y</td>
<td>End user / procurement</td>
<td>End user satisfaction (evaluation)</td>
<td>Chief Financial Officer</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Outpatient capacity</td>
<td>Reduction in outpatient capacity linked to referral management scheme</td>
<td>Hospital episodes data</td>
<td>2.9</td>
<td>1.6</td>
<td>1.3</td>
<td>50 - 60</td>
<td>Y</td>
<td>Clinical CIP team</td>
<td>Staff /Patient satisfaction survey</td>
<td>Chief of Hospital</td>
</tr>
<tr>
<td>3</td>
<td>Closure of ALOC</td>
<td>Removal of a nurse led ward in line with patient flow to the community</td>
<td>Hospital episodes data InterQual</td>
<td>0.93</td>
<td>0.70</td>
<td>0.23</td>
<td>15 - 25</td>
<td>Y</td>
<td>Clinical CIP team</td>
<td>Staff /Patient satisfaction survey Bed Utilisation</td>
<td>Chief Nurse</td>
</tr>
<tr>
<td>4</td>
<td>Administration &amp; Clerical Review</td>
<td>Reduction in A&amp;C staff as a consequence of streamlining A&amp;C processes, further Voluntary &amp; Compulsory Redundancy and improved functionality of new patient data system</td>
<td>ESR</td>
<td>1.34</td>
<td>0.70</td>
<td>0.64</td>
<td>10 - 20</td>
<td>Y</td>
<td>Clinical CIP team</td>
<td>Staff /Patient satisfaction survey</td>
<td>Chief Human Resource Officer</td>
</tr>
<tr>
<td>5</td>
<td>Consultant PA’s</td>
<td>Reduction in Consultant PA’s as a result of job planning process</td>
<td>ESR</td>
<td>0.50</td>
<td>0.50</td>
<td></td>
<td></td>
<td>Y</td>
<td>Clinical CIP team</td>
<td>PDR Contract Compliance</td>
<td>Chief of Hospital</td>
</tr>
</tbody>
</table>
CSU’s and corporate departments have been expected to make a minimum contribution equating to 7% of their relevant budget for 2011/12 which will allow the Trust to present a balanced financial plan.

It is also appropriate to recognise that there will be other cost pressures that will materialise in the system or that may affect the Trust in 2012/13. These include reduced levels of income due to further reductions in activity associated with changing referral rates and unforeseen circumstances such as extreme weather conditions, losses against activity funded at marginal rates, increasing inflationary pressure on non-pay spend and the requirement to pick up any recurrent costs incurred in delivering pump primed schemes aimed at reducing emergency / non elective demand. It is worth noting that the Executive have developed strategic plans that are expected to result in a significant reduction in non-elective demand that is supported by non-recurrent funding.

A range of Corporate led schemes have been developed and these schemes are focussed on CSU’s that have under-performed against plan in the current year or in areas where it has been recognised that opportunities exist for increased efficiency that will lead to cost reduction. This approach has created a framework that has produced differential CIP’s (with a minimum 7% baseline) based on underlying efficiency. It has been guided by work undertaken by PricewaterhouseCoopers as part of their workforce review which has benchmarked Trust costs and skill mix against a peer group, assessed position against tariff and been cognisant of the consequences of changes to demand or capacity that has been evidenced by in year performance.

There are a number of areas that the Executive Team recommended CSU’s and corporate departments consider as part of their CIP planning for 2012/13 which are set out below. The list is not exhaustive but is based on those areas where opportunities exist for some traction in the short to medium term:

- Downsizing outpatients in response to:
  - reducing rates of referrals
  - substantial reduction in DNAs (following the extension of partial booking to all OP clinics and introduction of new reminder technology) and
  - revised booking rules
  The Trust estimates that in excess of 30%, and some instances 50% of current OP clinics slots are wasted – these will be rationalised into fewer, fuller clinics
- Reduced variation in follow up care; our follow-up rates are generally in excess of our peers, and there are a number of areas which are already following up patients by telephone rather than bringing them back to the hospital; creating greater scope to rationalise OP Clinics
- Integrated pathway development across acute and community services, which opens up new opportunities to streamline patient flow, shift the focus of care, deploy staff in different ways, reduce duplication of effort and to reduce referrals, admission and readmission rates, and reduce lengths of stay
- Seizing opportunities to prevent avoidable admissions and reducing lengths of stay by better team working between Hospital and Community services
- Listing patients for day surgery as the default (when bed pressures occur, more patients listed for Inpatient admission are treated as day cases, which clearly indicates that they could have been listed as day cases in the first place)
- Outsourcing
- Reduce locum and agency spend
- Reduction in overtime and in the use of Waiting List Initiatives (by bringing such work within existing contracted sessions)
- Procurement
- EPR benefits realisation
CIP Process

The Chief Financial Officer reviewed the level of CIPs required in 2012/13 taking a high level view of both income and expenditure assumptions and compared this with the outline target developed as part of the previous year’s business plan for consistency. An initial target across the Trust was set at 7% of existing budgets, initially equating to over £14 million. The Executive Team recognised that such a target would be challenging for the Trust and therefore, at the same time, also tasked itself with producing corporate schemes that would span different parts of the Organisation and would be developed in a more holistic approach. The Trust had pre-empted this challenge by commissioning some preparatory work around the configuration and profilling of its workforce to identify areas of potential savings.

Financial Assessment

Departmental budget review meetings were initially held with all budget holders within the Trust at which outline CIP proposals were discussed before being formally submitted to the Chief Financial Officer. These submissions were then formally risk assessed from a finance perspective in terms of feasibility for delivery and any areas of concern or shortfalls in proposals submitted were fed back accordingly. Clinicians are an integral part of managing budgets within the Trust and hence were intrinsically involved in both the budget review meetings and the formulation of CIP proposals. Where proposals need resourcing to help deliver plans, these must be funded from the gross savings identified from each proposal i.e. self-funding. The assessment also ensured that CSU CIPs were not double counted against corporate schemes.

Quality Impact Assessment

After a further updated submission these proposals were then assessed to identify any possible quality impact risk and from a quality perspective by a multi-disciplinary executive level team including medical, nursing and quality governance perspectives. Further clarity was sought where concerns were raised.

The finalised departmental proposals were then reviewed collectively by the executive team, together with the corporately led proposals, at which point certain schemes were either amended and/or rejected. Where quality was clearly going to be compromised as part of CIP proposals, then the schemes were simply rejected and hence, the Trust has put together CIP plans that will deliver financially with minimal impact upon quality.

CIPs will be performance managed both via a programme management function headed up by executive directors as well as part of the overall financial management of the Trust via its normal reporting procedures up to the Board of Directors.

Clinical Engagement

The CIP component of the Strategic Service Review process focuses accountability for speciality clinically related CIP delivery through the Clinical Director. These reviews have tested the engagement of relevant professionals in plans that affect their services and also the co relation of schemes whereby the actions takes place in one directorate and the savings fall in another. Corporate schemes that affect all clinicians (for example outpatient efficiency improvement and follow up reduction) have speciality and individual clinicians engaged in all aspects of the programme, with a corporate communications approach involving generic and clinician targeted communications to ensure clarity of the approach, report on progress and next steps, and ensure any barriers or difficulties are known and understood in time to be overcome.
CIP Management

How has the Trust gained assurance that its CIP target will be achieved over the next three years?

To manage our major transformation programme, we have reconfigured the ‘Healthcare of Tomorrow’ Board (HoTB) to oversee and deliver this agenda. The Executive Team has formed the core of the HoT Board which is chaired by the Chief Executive, and is being supported by a Corporate Programme Management Office (CPMO) with responsibility for driving the planning, design and implementation of agreed changes approved by the HoT Board.

Not everything will be monitored directly through the CPMO as a governance process has been developed which includes:

- Local CIP targets identified and agreed through the budget setting process, will be delivered by the relevant senior manager and delivery of the CIP target assessed at monthly performance review meetings
- A pre assessment process being undertaken to determine if a cross cutting or complex initiative requires either:
  - A policy decision – The Chief Executive will agree an executive sponsor and include within their performance management objectives, the outcome to be delivered, together with resources required and timescales. A policy lead will then be assigned by the Executive Director who will be responsible for developing a mini Project Initiation Document (PID) and work with the PMO to review on delivery of the policy change or;
  - A light touch (local CIPs, personal objectives) approach is required. The Chief Executive will agree an executive sponsor and include within their performance management objectives, the outcomes to be delivered, together with resources required and timescales. The Executive sponsor will assign a project lead who will develop a mini Project initiation document and work with the PMO to agree templates and reporting processes to be followed or;
  - A programme approach, as a number of projects are involved and therefore, the CPMO has developed a Gateway review process which includes the HoTB undertaking a review at:
    - Gateway 1 – The identified opportunity to be scoped for a CIP and then;
    - Gateway 2 – Assessing the validation of the idea including the review of CIPs targets to be set, options appraisals and risk and impact assessment and then;
    - Gateway 3 – Agreeing the implementation plan which will then be passed over to a programme lead to implement.

The key measures of successful progress will be based on the HoT Board:

- Appointing a programme executive for each programme
- Appointing a programme lead for each programme
- Programme mandates have been agreed for each programme
- Project Initiation Documents have been drafted for each project or cluster of projects
- Actual delivery of milestones is as per plan within tolerance levels
- Actual financial savings are being delivered as per plan within tolerance levels
- Monthly reporting on CIP delivery will be undertaken and risks and mitigating factors captured on Datix
- Performance review meetings will be used to assess the delivery of local CIPs and issues requiring escalation to the board will be identified
- Projects (or clusters of projects) are delivered on time, cost and quality as identified in PIDs
The Trust has an overall savings target of £15.4m for 2012/13 which has resulted in a minimum 7% CIP requirement for CSU’s / OSU’s to deliver across the Trust. This was communicated to the organisation in October 2011 via a letter from the CEO / CFO which outlined the scale of the financial challenge, identified areas of efficiency that were cross cutting and set out the business planning timetable.

The business planning process resulted in 2nd cut CIP’s that were scrutinised as part of the SSR / budget setting process and which had been further reviewed as part of Executive Team Meeting on 6th February 2012. Schemes that were not rated Green from a finance and quality perspective were then individually assessed by the Executive on 27th February 2012 to agree a final position on whether the scheme should be included in the CIP 2012/13. Adjustments were made where appropriate to reflect delays in implementation or revised expectations in relation to savings. The most significant movement was in respect of the permanent closure of ALOC which was previously denoted as an Amber scheme from a finance and quality perspective. This has been re-classified as Green on both finance and quality with savings deemed as achievable by the end of Q1 2012/13.

Further CIP’s have been recently added for car parking income (£250k) to reflect the withdrawal of the 1st hour free rule, international recruitment of middle grade doctors to reduce the need for locum spend (£500k) and savings related to EPR (£702k) which relate to savings on administrative and clerical posts due to enhanced functionality of the new system and savings on systems related to the pre-EPR situation (PAS etc).

In respect of delivery of CIP’s, the forecast outturn position for 2011/12 indicates a shortfall in CIP delivery of £2.0m with £1.7m due to in year slippage and £0.9m non-delivery which is mitigated by £0.6m of CSU plan B’s. This provides a delivery % on the original savings target of 78% in 2011/12 and a delivery potential % of 92% for 2011/12 schemes.

£m
11.7 original savings target 2011/12
(1.7) slippage
(0.9) non-delivery
0.6 plan B’s
9.7 forecast outturn 2011/12

As well as plan B’s brought forward by CSU’s a number of additional schemes over and above the original £11.7m target were developed in year in order to compensate for the shortfall in delivery against the original schemes. These include MARS, salary sacrifice schemes and integration plans for Community Services.

The Trust is planning to utilise Programme Management Office (PMO) to ensure the delivery of CIP savings across the planning period. It is anticipated that CSU / OSU schemes will be performance managed at the monthly operational performance meetings and reported to PMB on an exception basis whilst cross cutting schemes will be thoroughly reviewed at PMB with execute sponsorship. This will result in the need for corrective action and / or a recovery plan where appropriate and significant deviation from plan will be reported to Audit & Assurance and Board.
Appendix 3a: Financial commentary: income (NOT INTENDED FOR PUBLICATION)

This commentary should be consistent with the Trust’s associated financial template.

The Trust has agreed a one year contract for 2012/13 with its main commissioners and the heads of agreement include the financial framework within which NHSR and TRFT have agreed to work towards to 2014/15 to ensure delivery of the QIPP agenda.

The key points to note are:

- **Income maintained non-recurrently in 2012/13 (£1.4m)** at levels agreed in 2011/12 heads of agreement (not incl. +1% CQUIN) to provide transitional financial support against loss of income resulting from QIPP reductions and in order to provide sufficient time to “right size” in line with this reduced activity
- **Re-investment of savings (£2.2m)** in 2012/13 that NHSR will accrue for not paying for re-admissions in line with the Payment by Results rules and associated guidance
- **Investment available (£2m)** in 2012/13 non-recurrently to support the Trust in reducing acute activity and where appropriate, move it into a community setting
- **CQUIN schemes (£4.1m)** have been agreed for the acute and community elements of the contract in 2012/13, the largest part of which is aimed at improving the non-elective care pathway (£1.1m)

- The total contract value for acute services in 2012/13 is £137.9m (including CQUIN but excluding Specialised Services) and is made up as follows:
  - £49.6m in urgent care
  - £64.3m in planned care
  - £3.2m funded under block arrangements
  - £3.4m for CQUIN
  - £3.6m for non-recurrent investments
  - £13.8m for exceptions (those areas of non-PbR which carry greater financial risk)
- The total contract value for community services in 2012/13 is £29.4m (including CQUIN and in year contract variations)
- The parties have agreed to the programme of work aimed at delivering Rotherham’s QIPP programmes to 2014/15. An absolute reduction of 6.25% on 2011/12 emergency admissions is required by 2014/15. This is achievable by maintaining 2012/13 activity levels for 2013/14 and 2014/15 following the recent change to the non-elective pathway to enable patients to be assessed in a non-admitted setting
- The new “assessment tariff” associated with the change to the non-elective pathway is variable across the surgical, medical, children’s and early pregnancy assessment areas but averages at 65% of the non-elective admission tariff
- Planned care activity has been forecasted as part of the QIPP agenda and it is anticipated that the following changes to 2014/15 will apply and be driven forward by the joint Clinical Referrals Management Committee (CRMC):
  - 2.4% increase in outpatients firsts
  - 0.26% increase in electives
  - 12.8% decrease in follow ups
- The NHS Standard Contract sets out the financial adjustments for performance in reducing Clostridium Difficile that will be applied by commissioners. The financial consequences are significant and breach of target plus tolerance by 4 cases in 2012/13 would cost the Trust £828k

The Heads of Agreement applicable to the 2012/13 contract provide mitigation against this financial consequence in that any financial adjustment is to be re-invested in full based on an audit of avoidable / unavoidable cases linked to an action plan to address the deficiencies identified as part of the root cause analysis.
A high level income bridge analysis between 2011/12 forecast outturn and 2012/13 income budgets shows that the £4.3m overall reduction is largely due to the fall in other operating income which is £4.5m less than forecast outturn, mainly due to the £2m receipt of non-recurrent funding to support the mortuary project in 2011/12 and other issues that include:

- Reduction in deferred income brought into plan in 2012/13 (£0.9m)
- Reduction in threshold adjustment (£2.2m) funded non-recurrently in 2011/12 but now part of baseline (funded via outturn)
- Reduction in re-admissions non-recurrent funding (£0.7m) in line with introduction of new assessment tariff
- Reduction in patient income due to tariff efficiency (£3.6m)
- Increase in CQUIN (£3.1m) on forecast outturn
- Increase in non-recurrent support (community £2.0m, acute £1.4m)
- Increase in income CIP’s relating to contract (£0.9m)

Approximately 85% of the Trusts income for 2012/13 is secured contractually which provides reasonable certainty. The contract with the coordinating commissioner was signed in line with the Operating Framework timetable. In 2011/12 the overall income at M12 was £6.9m favourable to plan YTD. Clinical income was up £2.3m along with £0.8m additional NHSR funding to support re-structuring costs plus £0.8m to fund a number of contract variations to support the Trust’s operational position and the £2.0m donated asset adjustment. The clinical income YTD position at M12 was mainly made up of over performance in Medicine, particularly General Medicine (£0.7m) and Community Services (£1.1m).

It is planned that 2012/13 activity will be contained within contracted levels to ensure no loss of margin as a result of the 30% threshold on non-elective activity greater than 2008/09 levels. This will be as a result of implementing a range of schemes aimed at reducing emergency admissions and expediting discharges. The risks associated with non-receipt of CQUIN funding which adversely affected the Trust in 2011/12 will be mitigated by using PMO to ensure delivery of the criteria set out against each indicator.

Whilst contract negotiations were successfully completed within a tight timeframe, there remain a number of risks within the commissioning intentions. Key issues are outlined below:

**CQUIN**

2012/13 sees a 1% increase in CQUIN related income representing £4.7m of our lead commissioner contract. Delivery of the agreed schemes is essential to sustain our overall financial performance. To this end, Executive leads have been formally allocated responsibility for each individual scheme and performance will be monitored and managed through our Project Management Office with Executives held accountable for delivery against the quarterly and monthly milestones.

We anticipate that the level of income earned directly from CQUIN will increase year on year and therefore are further strengthening our internal mechanisms to ensure our systems and processes relating to delivery of CQUIN remain robust.

**Non-Elective**

Demand for non-elective services continues to prove difficult to predict with peaks and troughs experienced at times throughout the year when it may have been least expected, with extremes in weather conditions giving rise to much of the variation.
The planned levels for 2012/13 predict activity will be maintained at or below 2008/09 levels therefore not incurring financial implications associated with threshold adjustments (i.e. only receiving 30% of the tariff for levels over and above 08/09 levels). It will be crucial that performance against non-elective plans is closely scrutinised and monitored to ensure we do not incur unplanned financial pressures. A number of routes have been identified for monitoring and managing performance as described below:

**External**
A joint (commissioner and provider(s)) Unscheduled Care Group has been established. This group has agreed the key areas of focus for 2012/13 and reflects commissioners QIPP requirements as may have been adjusted through the contract. Performance against implementation of jointly agreed non-elective demand initiatives will be monitored through this group with reports back to the Strategic Commissioning Group. In addition, the joint Contract Performance Group will monitor performance at individual specialty line to understand any variations from plan and agree any necessary actions/escalation.

**Internal**
Performance is reported through a series of meetings including Corporate Business Planning and Investment Committee and Contract Compliance Group both held monthly. In addition to this, services will be held to account through executively led monthly performance meetings.

Where performance is significantly adverse to plan, we have agreed an extra-ordinary meeting with commissioners to scrutinise the position in detail and agree next steps/actions/escalations.

**Elective/Outpatient Activity and Delivery of QIPP**
The plan is predicated on delivering within an overall financial envelope bringing with it no guarantee of income for over performance. It is imperative that performance against each individual specialty is closely monitored and scrutinised to deliver the overall bottom line.

QIPP adjustments have been accounted for within the final activity plan and we will need to closely monitor delivery against each indicator as this will determine our ability to deliver within the financial envelope agreed.

Elective, outpatient and QIPP delivery will be managed and monitored in line with the principles set out above both externally and internally with the joint external monitoring forum being the Clinical Referrals Management Committee, responsible for all areas of elective/outpatient demand management initiatives.

**Non-Recurrent Support**
We have agreed a 3 year financial framework with our coordinating commissioner which ultimately gets both organisations to the recurrent lower level financial envelope available in the future.

We have agreed appropriate schemes with our commissioners which aim to deliver a lower recurrent financial baseline and will work closely with them to implement them. The Trust recognises this is a pivotal year for ensuring non-recurrent monies is effectively utilised to re-design services to provide future sustainability.

Whilst all of the above risks are associated with delivering our 2012/13 agreed financial plan, further risks are just around the corner. Introduction of Any Qualified Provider will commence in earnest during the year with some early indications already made by the South Yorkshire and Bassetlaw Cluster. Our ability to quickly identify potential opportunities/threats and respond accordingly will be key. We have existing processes for strategically assessing potential opportunities and have embedded systems for responding to tenders. However, we know that other local NHS and private providers will be at least as well equipped to respond as we are. We will examine each opportunity in line with our organisational strategic direction as it arises.
Appendix 3b: Financial commentary: Service Developments (excluding transactions) (NOT INTENDED FOR PUBLICATION)

This section should not detail any planned transactions, which should be included in Appendix 3c.

This commentary should be consistent with the Trust’s associated financial template.

Each of the priorities below should be categorised as either:

1. organic or innovation (i.e. delivered internally by the Trust or through co-operation); or
2. transferring out / discontinuing an activity (in agreement with commissioners).

**Electronic Patient Record**

The Trust’s major service development in 2012/13 is the implementation and go live of Phase One of a new electronic patient record (EPR) system, which will not only replace the current Patient Administration System (PAS), but will also replace other IT systems in the short and medium term. The system will bring major changes to the way that patient information is recorded and stored as well as revolutionising the actual day-to-day interaction between clinicians, service departments and patients.

Whilst there is still significant capital investment required in year to bring this development to fruition, with a planned go live date of June 2012, there are significant revenue consequences of £1.7M in year. There is a further non-recurrent investment of £0.4M in staff training which is essential to ensure staff are fully engaged and understand how to use the system in order to facilitate a smooth transition. Given the critical nature of the system, it essential that it is supported appropriately and an investment of £0.3M (12 WTEs) has been included to provide technical and help desk support in addition to the existing IT staff infrastructure within the Trust. In total there will be approximately 20 additional WTE staff directly employed supporting the system.

Clearly, there are risks associated with implementing such a system, but the Board are confident with the significant amount of non-recurrent investment that has been made in recent years to develop the system and with the continuing capital and revenue support being made available in year, as directed by careful risk assessment that “go live” will be achieved successfully. The Board has made a long term commitment to the system and the fundamental change that it brings to the Organisation and therefore, has been absolutely clear throughout the project that the system can only be implemented when it is fit for purpose and hence has already delayed the go live date until those conditions are met.

Not only will the EPR system bring about fundamental clinical process change and improvement, there are also expected to be significant financial benefits. The Trust has been prudent in its approach as far as recognising these benefits in its financial plan for 2012/13. Only the direct IT system savings of £0.2M together with a further £0.5M savings from staff and process reconfiguration have been assumed to be delivered, although the Trust expects significantly more cash releasing benefits in subsequent financial years.

**Site Rationalisation**

The Trust plans to rationalise the buildings on its main hospital site and consolidate activities within the main hospital building and move further administrative support to its dedicated off-site facility. As a consequence, the capital programme has set aside resources for the demolition of 4 major properties, which will then be utilised to provide additional car parking spaces and thereby increase income generation from this source. The Trust is thereby reducing the lives of these assets and accelerating their depreciation to ensure that the assets are fully depreciated when they are demolished. This will incur non-recurrent costs in 2012/13 of £3.2M and reduce the Trust’s capital charges by £0.3M recurrently.
Reducing Non-Elective Admissions
With the transfer of Rotherham community services to the Trust at the start of 2011/12 there is a real sense of expectation from both the Trust and its commissioners that significant progress can be made on stemming the increase in non-elective acute admissions. Whilst 2011/12 has been mainly a year of consolidation as far as these services are concerned, significant progress has already been made in redesigning care pathways and the interface between the acute and community sectors. The Trust is planning to invest a further £0.8M in this area to change the way it interacts with its patients and break down some of the barriers, both perceived and real, to redesign its services to be more responsive to patients’ requirements and prevent unnecessary admissions. Just one example is the planned appointment of two community based consultant geriatricians.

It should be noted, however, that the local Joint Strategic Needs Assessment (JSNA) indicates that demand will naturally increase through demographic changes and the impact of conditions associated with lifestyle and improved survivorship from what previously have been life limiting conditions, including some forms of cancer. Therefore the task is not only to reduce admission against a steady state condition but absorb genuine increases in demand.

The PCT and CCG are intending to rapidly review the entire structure of out of hours and emergency service provision shortly and the Trust will support any move to ensure the structure in Rotherham is optimised in line with the emerging evidence base.
Appendix 3c: Financial commentary: Transactions (NOT INTENDED FOR PUBLICATION)

This commentary should be consistent with the Trust’s associated financial template.

Not applicable
PFI’s and Material or Significant Investments:

This commentary should be consistent with the Trust’s associated financial template.

Capital Expenditure

The Trust has developed a prudent capital programme for 2012/13 which is planned to be managed from within its internally generated resources for depreciation and cash slippage on capital expenditure from 2011/12. This is in stark contrast to the significant capital investment the Trust has made in recent years, which has involved gross borrowing of £30M. The Trust does not see any justification for further borrowing and is mindful of protecting its cash and overall working capital balances to maintain an appropriate liquidity risk rating.

The Trust’s most significant investments are associated with its two main areas of service development i.e. the electronic patient record system (£5.7M) and site rationalisation (£1.6M). The former will bring to a conclusion the initial phase of a 3½ year project to not only replace the current ageing patient administration system and eliminate the risk to business continuity that system represents, but more importantly will bring major changes to the way that patient information is recorded and stored as well as revolutionising the actual day-to-day interaction between clinicians and patients. The latter will see the demolition of four buildings on site and the consolidation of services into existing buildings and a more fit for purpose environments.

In addition the Trust will also be setting aside monies for maintaining the Trust’s infrastructure and estate in terms of £1.0M for new and replacement medical equipment and a further £2.7M for backlog maintenance and related issues associated with the main hospital site. A contingency of £1.0M has also been provided for as it is inevitable that other capital issues will arise in year.
Appendix 3d: Financial commentary: Activity (NOT INTENDED FOR PUBLICATION)

This commentary should be consistent with the Trust’s associated financial template.

As would be expected in times of financial constraint, all commissioners have sought to reduce levels of activity in the acute setting. As a consequence of successful commissioner demand management schemes across the region, we have experienced a decline in out of area referrals over the past 2 years and expect this trend will continue as the level of efficiencies to be delivered increases. Although, with the highest impact areas already addressed, the future activity reductions may not be as considerable as in previous years.

The activity spread across commissioners for 2012/13 is outlined below:

<table>
<thead>
<tr>
<th>Commissioner</th>
<th>% of Total Contract Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rotherham</td>
<td>83.8%</td>
</tr>
<tr>
<td>Barnsley</td>
<td>6.8%</td>
</tr>
<tr>
<td>Sheffield</td>
<td>3.6%</td>
</tr>
<tr>
<td>Doncaster</td>
<td>3.3%</td>
</tr>
<tr>
<td>SCG</td>
<td>0.6%</td>
</tr>
<tr>
<td>NCA</td>
<td>0.6%</td>
</tr>
<tr>
<td>Derby County</td>
<td>0.5%</td>
</tr>
<tr>
<td>Bassetlaw</td>
<td>0.4%</td>
</tr>
<tr>
<td>Wakefield</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

As demonstrated above there is a significant differential between the host and associate activity with NHS Rotherham increasing its percentage of the overall income plan. Of the associates, NHS Barnsley shows a higher proportion due to us managing the Ophthalmology services provided at BHNFT, whilst the remaining associates in the immediate locality (Sheffield and Doncaster) align similarly in making up our overall activity plan.

The location of The Rotherham NHS Foundation Trust, situated more or less in the middle of other local providers, affords it greater opportunities for cross border referrals with the travelling distances being of more or less equal proportions. Whilst we have described earlier that reductions in cross border referrals are being experienced, we must, and will, work hard to sustain current levels. Patient choice continues to remain high on the NHS strategic agenda and with the forthcoming nationally mandated publication of acute provider performance indicators it is essential we retain a good and positive reputation. Our mission is simple – ‘to become a best in class healthcare provider’ - and our journey toward delivery is brought to life through Service Development Strategy 3 and implementation of the key priorities (outlined in section A) during 2012/13 will mark start of that journey.

Our workforce will need to be appropriately aligned to deliver our forward strategy and to this end a fundamental root and branch review of the entire workforce commencing with Administrative and Clerical functions, and a review of Nursing and Midwifery with a particular focus on nurse leadership structures and Specialist Nurse roles is underway.
Appendix 3e: Financial commentary: Workforce (NOT INTENDED FOR PUBLICATION)

This commentary should be consistent with the Trust’s associated financial template.

As described in section F, managing workforce priorities is an essential element in delivering the financial efficiencies required to sustain our future.

Our first priority will be to ensure we have sufficient capacity to deliver and to this end we will restructure the People and Organisational Development (POD) Directorate to provide the level of support required to drive organisational transformation. This will be delivered through close partnership working with clinical leads and business managers to ensure an effective balance between robust disinvestment activities which do not impact the quality of the service provided. Performance monitoring through the Project Management Office will ensure a cohesive, all-encompassing workforce plan is developed ensuring a consistent approach is implemented across the organisation therefore avoiding fragmentation and allowing an overall workforce status to be defined at any one time.

There is an expectation that because of the economic climate and associated re-structuring the required reduction in headcount in headcount over the next three years will be in the region of 1000. To facilitate this we will continue to deliver planned workforce reduction programmes including redeployment/outplacement support, re-training programmes, a Mutually Agreed Redundancy Scheme (MARS) and voluntary redundancy schemes, with compulsory redundancy being the last resort. Clearly we will need to mitigate against the loss of talent, skills and knowledge in order to ensure that we continue to provide seamless high quality care and clinical safety during an extended period of transformational change. To this end, all of these schemes need to be considered collectively to sustain an appropriately skilled and re-configured workforce.

We will look to increase the use of technology as an enabler to delivering efficiencies and their potential to reduce resourcing requirements across the Organisation. For example, the introduction of E-Rostering, enhancing Electronic Staff Record functions, Electronic Patient Records and SystmOne are steps towards the ultimate aim of streamlining processes and systems.

To deliver our SDS3 objectives we will review the resource requirements to achieve the workforce objectives and this will include:

• Effectively managing the pace of change required to deliver strategic objectives within the timeframes
• Recruitment and retention programmes designed to provide more generic roles to increase flexibility of our workforce
• Developing a workforce that can meet the fluctuating demands of service provision both during the transition and in the future
• Consider the impact of an ageing workforce and secure succession planning
• Re-designing roles and define spans of control
• Enhancing our workforce analysis systems and processes
• Developing effective and consistent tracking measures including a range of workforce key performance indicators (KPIs) and use of benchmarking tools alongside other sources of workforce and labour market intelligence
• Regular and consistent workforce reporting to Board and other appropriate committees
• Ensuring our approach to industrial relations and consultation demonstrates best practice so that we work effectively with trades unions and other staff representative bodies.
We will require dynamic recruitment and retention initiatives together with effective training programmes to sustain our position. We will further enhance our existing programmes to align them to our future needs so as to:

- Focus on, embrace and attract behaviours that we wish to foster and effectively manage those which we do not
- Use HR processes to further embed our mission, vision and core values with a real focus on patient centred skills (putting the patient at the centre of everything we do)
- Link the above to the performance management system
- Review the learning and development strategy, ensuring the appropriate links to SDS3 and other key organisational strategies with a focus on organisational needs analysis
- Ensure revised systems and processes are fit for purpose and future proof (as far as can be determined)

As part of our emerging workforce strategy we recognise that there is an imperative to establish and exploit natural and strategic alliances and partnerships with other employers across the public, private and third sectors. We will explore the advantages of developing further the use of multi-agency teams in the delivery of care across different service, for example intermediate care and managing discharge/length of stay of patients and service users.

In addition to the above, we will review pay, recognition and other remuneration initiatives and work in partnership with trade unions to further develop this concept whilst recognising the cultural challenge facing employees in changing pay and reward systems. We will also consider a range of non-pay reward arrangements which may be attractive for employees.

This full review of HR and OD is a significant challenge in itself but one that cannot, and must not, be avoided if we are to deliver (within the available resource) our organisational strategy and continue to deliver the highest quality care to those who access our services.
Each of the capital expenditure priorities should be shown under the following main headings:

1. **Development** – this includes building of new capacity (through whatever funding source) or significant reconfiguration or upgrade of existing facilities.
2. **Maintenance or replacement capex** – this includes planned or urgent maintenance capital expenditure or expenditure to replace existing facilities including backlog maintenance.
3. **Other capital expenditure** – this includes purchases of equipment, technology, intellectual property and significant IT expenditure etc.
4. **Other estates strategy** – this includes net proceeds or expenditure on estates reorganisation or other estates strategy to either use the existing estate more efficiently or to release proceeds from surplus or unused assets.

### Development

1. Relocation of Child Health Out Patient Department (OPD) into main area of Child Health accommodation to allow current OPD accommodation to be used for services that are currently in a building designated for demolition, cost estimated at £100K and due to be complete in Q2. Current risks around delivery are scheme affordability and user expectations, mitigating actions are around regular meetings with users and trying to design a cost affordable scheme. Delay in completion would result in services continuing to be provided in an unsatisfactory setting.

2. Redevelop old Mortuary to provide a decontamination facility to allow closure of Central Treatment Room (CTR) and provide appropriate bed and mattress storage across the Trust, cost estimated at £100K and due to be complete in Q1. Current risks around delivery are completion of decommissioning of existing area, asbestos removal and scheme affordability. Mitigating actions are around ensuring decommissioning and asbestos works are progressed prior to tender and completing the design within the cost envelope. Delay in completion would see services remaining fragmented and bed and mattress storage being undertaken in an ad hoc manner with no central coordination.

3. Relocation of Dietetics department to allow current accommodation to be closed and partial demolition of areas to take place and make the service more accessible from within the hospital, cost estimated at £50K and due to be completed in Q2. Current risk is around scheme affordability but this is mitigated by having an agreed layout with the users in place. Delay in completion would see services continued to be provided in an unsatisfactory setting.

4. Transfer Child Development Centre services to community to provide services in a more appropriate clinical setting, due to be complete in Q1, cost estimated to be £100K. Current risk around delivery is outcome of consultation with affected staff and access issues with proposed location, mitigating actions are around HR involvement with staff and on-going discussions with the landlord over access issues. Delay in completion would be around providing services appropriately in a community setting alongside other related children’s services and the Trusts ability to re-provide nursery accommodation that currently is within an unsatisfactory setting.

5. Relocation of Tissue Viability Services to allow closure of Central Treatment Room following service redesign, due to be complete in Q4 at a cost of £50K. No risks envisaged as detailed work has already taken place, any delay will not impact on service provision.
6 Transfer of Physio specialist services to provide services in a more appropriate clinical setting, due to complete in Q3 at a cost of £100K. No risks envisaged as detailed work has taken place and the work is due to be carried out over the summer months. Delay in completion will be on service provision being provided within a more appropriate community setting.

7 Reuse of OCRM building, final use to be determined, due to commence in Q4 at a cost of £200K. No risks can be identified at this stage until a final decision on use is agreed and therefore the impact of any delays is unknown at this time.

8 Environmental improvements to patient areas including upgrade of A&E toilets, replacement seating, and ensuite toilet provision in the ante-natal ward and other in year patient environment issues. Budget set at £100K. All work completed by end of Q4. No risks envisaged, any delays will be mitigated through detailed planning and project management to ensure spend profile remains on target.

All of the above will be funded by the Trust’s capital allocation.

**Maintenance or replacement capex**

1 Site wide infrastructure planned replacements to electrical and mechanical installations, budget set at £200K, electrical work involves replacement of high voltage switchgear, removal of changeover contactors, rebalancing of transformers and provision of Litton connectors to substation A to provide additional business resilience contingency. Mechanical works are around replacement of specialised valves within the boiler house. All work to be completed by the end of Q4. Known risks are around access and availability of materials; these are being mitigated through detailed planning and preparing work packages in a timely manner. Some schemes will have an impact if delayed as some of them require to be done through the summer months to reduce the risk of loss of service provision if undertaken later in the year.

2 Replacement air conditioning plant to Delivery Suite, budget set at £250K. All work to be completed by end of Q3. Known risks are around access and availability of materials, these are being mitigated through detailed planning and preparing the work packages in a timely manner. Any delay will result in the scheme being commissioned in the winter period which may affect service provision.

3 Fire Safety improvements to ensure compliance with Firecode, budget set at £125K, works to include fire door replacement, compartmentation, fire panel reconfiguration and installation. All work to be completed by end of Q4. No risks envisaged, any delays will be mitigated through detailed planning and project management to ensure spend profile remains on target.

4 Legionella prevention measures including reline water tanks, removal of dead legs and high risk issues from risk assessments, budget set at £75K. All work to be completed by end of Q4. No risks envisaged, any delays will be mitigated through detailed planning and project management to ensure spend profile remains on target.

5 Disability Discrimination Act schemes to meet compliance dealing with high risks from audit, budget set at £20K. All work to be completed by end of Q4. No risks envisaged, any delays will be mitigated through detailed planning and project management to ensure spend profile remains on target.

6 Phased replacement programme for electrical distribution boards to meet 17th edition Electrical Regulations, budget set at £50K. All work to be completed by end of Q4, known risks are around access issues which will be mitigated through detailed planning and project management to ensure spend profile remains on target.
7 Replacement of A level loading bay doors to increase security and minimise health and safety risks within the loading bay area, all work to be completed within Q2, budget set at £8K. Known risks are around access and availability of materials; these are being mitigated through detailed planning and preparing the work packages in a timely manner. Any delay will result in the scheme being commissioned in the winter period which may impact on maintaining a safe and secure environment.

8 Replacement of ageing internal bleep system, all work to be completed within Q2, budget set at £47K. Failure of existing system is the current risk therefore detailed business continuity plans are in place in the event of failure. Continued delay presents a risk of failure of the existing system becoming more likely.

9 Replacement of ID badge system, all work to be completed within Q1, budget set at £5K. Failure of existing system is the current risk therefore detailed business continuity plans are in place in the event of failure to ensure staff security is maintained. Continued delay presents a risk of failure of the existing system becoming more likely.

10 Replace theatre power packs and emergency lighting to seven theatre suites, all work to be completed by end of Q3, budget set at £25K. Failure of existing system and access to complete the work are the current risks therefore detailed business continuity plans are in place in the event of failure. Continued delay presents a risk of failure of the existing systems becoming more likely.

11 Boiler house chimney repairs, all work to be completed within Q2, budget set at £13K. Known risks are around access and availability of materials; these are being mitigated through detailed planning and preparing the work packages in a timely manner. Any delay will result in the scheme being carried out at a time when there is a high risk of inclement weather.

12 Replace obsolete controller to pneumatic tube system, all work to be completed within Q1, budget set at £16K. Failure of existing system is the current risk therefore detailed business continuity plans are in place in the event of failure to ensure service is maintained. Continued delay presents a risk of failure of the existing system becoming more likely.

13 Alterations to A level entrance to reduce current health and safety issues, all work to be completed within Q2, budget set at £30K. Known risks are around access and availability of materials; these are being mitigated through detailed planning and preparing the work packages in a timely manner. Any delay will result in the scheme being completed in the winter period which may impact on maintaining a safe and secure environment.

All of the above is funded through the Trust’s capital programme.

Other Capital Expenditure

1 As previously noted, a £1m allocation has been provided for new and replacement medical equipment. Based on previous experience, it is expected that the majority of this will be for replacement equipment.
Other Estates Strategy

1  Demolition of Mental Health block forms part of year 1 of the Estates strategy to reduce its cost base. The building was previously occupied by a local mental health Trust prior to them commissioning a new facility for its patients, as the current accommodation was declared not fit for purpose. The cost of demolition is estimated at £590K and will be completed at the beginning of Q3. Current known risks are access, asbestos and affordability but this is being managed through detailed programming and timely release of work packages. Any delay in starting the demolition will result in deferment of planned savings.

2  Demolition of Greenoaks block forms part of year 1 of the Estates strategy to reduce its cost base. The building is currently occupied by Maternity services as an outpatient facility and the current accommodation has been declared not fit for purpose due to the age, layout and location within the hospital site. The cost of demolition is estimated at £72K and will be completed at the beginning of Q4. Current known risks are relocation of current service, asbestos and affordability but this is being managed through detailed programming and timely release of work packages. Any delay in starting the demolition will result in deferment of planned savings.

3  Demolition of Nursery block forms part of year 1 of the Estates strategy to reduce its cost base. The building is currently occupied by a private provider who has stated that the current accommodation is not fit for purpose due to the age and condition and is not a property that they wish to remain in for the foreseeable future as it impacts on their ability to generate income. The cost of demolition is estimated at £72K and will be completed at the beginning of Q4. Current known risks are relocation of current service, asbestos and affordability but this is being managed through detailed programming and timely release of work packages. Any delay in starting the demolition will result in deferment of planned savings and potential loss of nursery provision should the private provider decide to relocate away from the hospital.

4  Demolition of Oakwood Annexe forms part of year 1 of the Estates strategy to reduce its cost base. The building is currently occupied by non-clinical staff, the current accommodation is not fit for purpose due to the age, condition and layout. The cost of demolition is estimated at £70K and will be completed at the beginning of Q4. Current known risks are relocation of current service, asbestos and affordability but this is being managed through detailed programming and timely release of work packages. Any delay in starting the demolition will result in deferment of planned savings.

5  Demolition of Oakwood Hall (part) forms part of year 1 of the Estates strategy to reduce its cost base. The building is currently occupied by clinical staff, the current accommodation is not fit for purpose due to the age, condition and layout. The building is a grade 2 listed and therefore it is proposed to demolish annexes that have been added to the original building that do not form part of the listing. The cost of demolition is estimated at £100K and will be completed at the beginning of Q3. Current known risks are relocation of current service, asbestos and affordability but this is being managed through detailed programming and timely release of work packages. Any delay in starting the demolition will result in deferment of planned savings.

All of the above is being undertaken through the trusts capital allocation.
Appendix 3g: Financial commentary: Costs (NOT INTENDED FOR PUBLICATION)

This commentary should be consistent with the Trust’s associated financial template.

In the contract we have signed for 2012/13 we have marginal cost arrangements for areas of non PbR where the activity can be volatile so as to guarantee a level of income that protects the service in question. Areas included in this are critical care for adults and children, GP direct access for diagnostic tests and therapy services. The marginal rates are paid on any under and over performance so as to protect both us and the commissioners. The rates agreed are 30% for under and over performance on Critical Care and Direct Access with the exception of Pathology which is paid at 45% to reflect the high marginal costs associated with the tests.

Where we may undertake any additional activity over and above the planned levels for traditional PbR work there are agreements in place to deal with this. Where the activity would fall under the threshold rules (non elective) we will abide by these and receive the standard threshold payment of 30%. For any planned work there is an expectation that if activity is in excess of the planned levels that the waiting times will be extended unless this impacts on meeting the 18 week waiting time as defined in the NHS constitution. The activity will be monitored closely and any financial implications will be agreed to ensure this does not become an issue.

Other areas which sit outside of the tariff including excluded drugs and appliances will be paid for at full cost regardless of the levels of activity set in the plan.