



The Royal Orthopaedic Hospital
NHS Foundation Trust



Operational Plan Document for 2014-16

**The Royal Orthopaedic Hospital
NHS Foundation Trust**

Operational Plan Guidance – Annual Plan Review 2014-15

The cover sheet and following pages constitute operational plan submission which forms part of Monitor's 2014/15 Annual Plan Review

The operational plan commentary must cover the two year period for 2014/15 and 2015/16. Guidance and detailed requirements on the completion of this section of the template are outlined in section 4 of the APR guidance.

Annual plan review 2014/15 guidance is available [here](#).

Timescales for the two-stage APR process are set out below. These timescales are aligned to those of NHS England and the NHS Trust Development Authority which will enable strategic and operational plans to be aligned within each unit of planning before they are submitted.

Monitor expects that a good two year operational plan commentary should cover (but not necessarily be limited to) the following areas, in separate sections:

1. Executive summary
2. Operational plan
 - a. The short term challenge
 - b. Quality plans
 - c. Operational requirements and capacity
 - d. Productivity, efficiency and CIPs
 - e. Financial plan
3. Appendices (including commercial or other confidential matters)

As a guide, we expect plans to be a maximum of thirty pages in length. Please note that this guidance is not prescriptive and foundation trusts should make their own judgement about the content of each section.

The expected delivery timetable is as follows:

| | |
|--|---------------------|
| Expected that contracts signed by this date | 28 February 2014 |
| Submission of operational plans to Monitor | 4 April 2014 |
| Monitor review of operational plans | April- May 2014 |
| Operational plan feedback date | May 2014 |
| Submission of strategic plans to Monitor (Years one and two of the five year financial plan will be fixed per the final plan submitted on 4 April 2014) | 30 June 2014 |
| Monitor review of strategic plans | July-September 2014 |
| Strategic plan feedback date | October 2014 |

1.1 Operational Plan for y/e 31 March 2015 and 2016

This document completed by (and Monitor queries to be directed to):

| | |
|----------------------|----------------------------|
| Name | Joy Street |
| Job Title | Company Secretary |
| e-mail address | joy.street@nhs.net |
| Tel. no. for contact | 0121 685 4336 |
| Date | 4 th April 2014 |

The attached Operational Plan is intended to reflect the Trust's business plan over the next two years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- The Operational Plan is an accurate reflection of the current shared vision of the Trust Board having had regard to the views of the Council of Governors and is underpinned by the strategic plan;
- The Operational Plan has 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 Operational Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans; and
- All plans discussed and any numbers quoted in the Operational Plan directly relate to the Trust's financial template submission.

Approved on behalf of the Board of Directors by:

| | |
|-----------------|----------|
| Name (Chair) | Tim Pile |
|-----------------|----------|

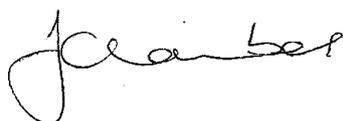
Signature



Approved on behalf of the Board of Directors by:

| | |
|---------------------------|-------------|
| Name (Chief Executive) | Jo Chambers |
|---------------------------|-------------|

Signature



Approved on behalf of the Board of Directors by:

| | |
|--|------------|
| Name <i>(Finance Director)</i> | Paul Athey |
|--|------------|

Signature

A handwritten signature in black ink, appearing to read 'Paul Athey', written in a cursive style.

1.2 Executive Summary

The Royal Orthopaedic Hospital NHS Foundation Trust has prepared this two year plan in the context of its five year strategy.

The five year strategy is still being developed and will be based on robust market research and set in the context of what we know about our strengths and weakness, external pressures and the overall health environment.

We have prepared the ground for our strategy by engaging as many of our staff as possible. Internal briefing sessions have been held; medical, clinical and non-clinical reference groups have been established to consider the future direction of the organisation and a major stakeholder event will be held in April to draw in views of GPs, commissioners, university and research colleagues as well as patients and partner organisations.

The trust has identified some key pillars for the future which we believe underpin excellence and reflect our expertise as a specialist provider:

1. Delivering excellent outcomes and patient experience (clinical and non-clinical)
2. Leading the way in research, innovation and education
3. Developing our approach to collaboration and community engagement
4. Being a great place to work (developing and supporting our staff)

Our PESTLE and SWOT exercises suggest focus on:

1. Productivity and efficiency improvements – supported by investment in IT and standardisation of processes
2. Consideration of the impact of integrated care on our patient pathway
3. Embedded organisation-wide staff engagement and the provision of greater opportunities for clinician to clinician dialogue
4. Leadership development in support of change
5. Targeted communication and marketing techniques suitable for different audiences to boost reputation

The ideas for service development are under development and are subject to wider consultation and detailed assessment, but at present are as illustrated in the tables below. As our commissioners develop their strategic plans we will review and update our own priorities to ensure alignment.

These priorities come from both a top down analysis of demand and need and from a bottom up, service driven desire to develop sub-specialties. Some represent incremental change while others bring a new dimension to the work of the trust in a way which we believe better meets the needs of patients, aligns more closely to national strategy, and is consistent with providing value for commissioners. One of our key strengths is our specialist expertise and by focusing on improving outcomes for patients we will enhance our reputation for doing routine work better than elsewhere and doing activity that no-one else can do.

Short Term Priorities

| Service Development Theme | Reason for prioritisation | Workstreams identified | |
|--|---|---|--|
| Routine Orthopaedics | Needed to deliver and maintain contractual growth targets in operational plan | External <ul style="list-style-type: none"> a) targeting low-referring GP practices b) Supporting urgent care/emergency pressures in other trusts c) Marketing USPs d) Local schemes (virtual opinion clinics/ one stop carpal tunnel clinics etc). | Internal <ul style="list-style-type: none"> a) Productivity improvements b) Review of patient pathways c) Introduction of IT solutions to support efficiency , safety and outcomes |
| Paediatric Surgery | Key pressure point within Trust and Health Economy (demand exceeding supply) | <ul style="list-style-type: none"> a) Reviewing range of services provided and ages catered for b) Relationship with Birmingham Children's Hospital – strengthen collaboration and mutual dependencies c) Neuromuscular Conditions including post-paediatric/ young adult care | |
| Musculo-skeletal Health and Wellbeing | Major theme within plan – to extend clinical service beyond end-stage disease, move into pre and post operative prevention and after-care | <ul style="list-style-type: none"> a) Increasing community presence – pilot year 1 through partnership with Bournville Village Trust b) Expand existing services (outreach, musculo-skeletal medicine, bone infection, heel pain, functional restoration) c) Develop new services – sports injury, adolescent pain d) Wider re-design of pathway in conjunction with primary care | |
| Diagnostics and rehabilitation | Significant cost pressure (outsourcing MRI and West Heath step down facility) | <ul style="list-style-type: none"> a) View alternatives for community rehabilitation beds b) Radiology capacity c) Direct access imaging d) Explore the feasibility of expanding community rehabilitation services provided to acute trusts to include post trauma, fractured neck of femur and bone infection care. | |

Medium /Long term Priorities

| Service Development Theme | Reason for prioritisation | Workstreams identified |
|--|--|---|
| Private Patients | Stagnant service – should it grow or contract? | Option appraisals: a) a) Grow service (services/markets/ commercial partnership/international) b) b) Restructure internal service/free up resources c) c) Close service and redirect resources to NHS market |
| Specialist Growth | Key priority, but highly dependent upon national strategy outcomes | a) a) Current focus on influencing NHS England consultation b) b) TBC – to be informed by national strategy outcomes |
| Bone Infection | Will be impacted by national policy direction on regional bone infection centres | a) a)Expand existing Bone Infection Unit for ROH patients and other providers b) Develop long bone service c) Consider regional centre status |
| Trauma | Service currently limited – undertake feasibility study | a) Expand trauma service to provide full Trauma &Orthopaedic offering b) Maintain market share c) Pull out of trauma market |
| Emerging Surgical Treatments | Needs wider engagement - can be supported on an ad-hoc basis | a) Young adult hip expansion b) Large joints opportunities – patella femoral/ complex shoulder service |
| Research, Development, Education, Teaching and Innovation | Significant area of stagnant provision next to area of rapid growth – need to be brought together, have investment and be marketed | a) Develop capital bid to accommodate multi-function facility b) Restructure organisation to deliver |

The Trust believes that, taken together, this emerging strategy - built on firm foundations but rapidly modernising – will secure the future of excellent orthopaedics in the greater Birmingham area and beyond that for the really specialist services.

The Trust has already thrown a challenge to its clinical staff to think differently and become thought leaders in terms of what this should look like. A key area of work to be started as part of the five year strategy, but unlikely to be completed until the end of 2014, is to consider and define what great orthopaedic care will look like in ten years' time and then work towards that. Given the nature of this trust and the significant expertise of its clinical staff, this is an exciting prospect that

will lead to transformation.

The trust will want to identify global best practice and adopt this as well as partnering others to develop innovations through research and clinical trials. These matters are not short-term and cannot be confined to the skills of a small trust in Birmingham, but the ambition is to seek out excellence and apply it as soon as possible for our patients. By adopting new standards, based on the very best practice, we will be able to deliver a clinical service that is second to none.

In order to deliver a step-change in the nature and quality of our clinical service, the trust recognises that it will need to restructure in a way that gives more weight and prominence to clinical leadership; our transformational initiatives will incorporate clinical leadership development. We envisage the active involvement of doctors in service leadership roles, supported by nurses and managers to deliver best quality care. This, we recognise is a challenge in many trusts. However, we feel that as at least half of our consultants have been engaged in the thinking challenge and evolving this plan, they will be keen to deliver the service change needed in the interest of their patients.

This Annual Plan reflects our self-assessment of our state of readiness to meet the ambitions expressed above and is the key building block phase necessary to make deliver a reality.

The first two years are dedicated to building a strong foundation for the future by investing in enabling transformational initiatives; including clinical leadership development and change management capabilities. The trust, as a recognised specialist provider operating in close proximity to a very large acute facility, recognises the need to identify itself as a niche provider in the changing NHS landscape. We see ourselves as a provider achieving better outcomes than others and as having the capacity and capability to undertake complex and specialist work not done elsewhere. This requires us to concentrate on basic modernisation in support of an enhanced patient journey – ***rectifying hitherto slow-paced and under-resourced investment in technology and building robust partnerships that underpin service development*** rather than trying to achieve everything independently ourselves. Within the longer term this will cement the standing of the trust as a self-evident leader in orthopaedic care, looking beyond surgical intervention towards ***health promotion and preventative activity*** and also ensuring that the trust is both ***innovative and an early adopter of best practice innovations*** in its field.

The 2 year plan therefore moves the trust away from generating surpluses for later re-investment, into the here and now of investing when the need arises. The Board identified capital investment in IT as a clear priority in 2012/13 and began a procurement process to provide the infrastructure necessary to support modern information systems. This plan accelerates investment still further by beginning the procurement of integrated IT services and clinical systems. This will increase quality and provide much more robust assurance than has been possible with the multiplicity of systems currently in use. Much of this work will be done in partnership and allow us to learn from others who are more advanced.

In addition we intend to invest in an area of growing clinical pressure – imaging. Not only do ***we intend replacing our current MRI scanner, we intend adding a second***. This will enable us to repatriate work currently undertaken on our behalf elsewhere and reduce waiting times for our patients. We recognise it may also stimulate still more demand, but it may also offer an extra facility in the local health economy which already experiences demand pressures in this area.

These investments have necessitated a review of risk since our previous capital plan would have been to develop new theatre capacity in light of the need to mitigate the risk of theatre plant failure and potential loss of utilisation of three theatres. The trust has assessed this risk and identified an alternative mitigation that facilitates the erection of temporary theatre space coupled with planned changes to working practice.

In terms of elective activity commissioned by our CCGs, the trust has secured a **6% growth in contract value (against 2013/14 baseline) for the first year of this plan**. Activity profiles take account of the changes in **case mix which follows the international trend away from inpatient stays, towards day case**. At the same time we have taken account of growth in the elderly population of up to 2% per annum.

Specialist activity has maintained its year on year position and the trust has benefited from a small contract to deliver a sarcoma pathway from an additional CCG, thus meeting the needs of patients and enhancing our reputation and geographical coverage for specialist work.

Changes in working practice to accommodate enhanced weekend cover, **operating over 6 days a week and additional physiotherapy to enhance outcomes** have also been factored into these plans.

The trust has been cautious about generating additional income by significant growth in patient activity as improvements in operational efficiency need to be made to support this potential. Once the refocusing and efficiency gains of the next two years is underway, there will be evidence on which to base our marketing as a centre of undisputed excellence. Patient and GP choice will be automatically directed towards our provision because its better outcomes will provide clear differentiation in the market place. The trust intends taking a radical approach to the development of its patient benefit by considering opportunities for service change beyond the incremental – for example a **radical reduction in waiting time**. This will be evolved in line with the infrastructure changes identified within the IT and informatics strategies. The trust will (in consultations with partners) also **consider major expansion of its broader musculo-skeletal services** using its partnership with Bournville Village Trust to pilot an innovative approach.

New developments in the first two years will include **baseline work to completely overhaul the trust's learning, research and innovation capability** and this will be done in line with the Academic Health Science Network and partner universities as well as the deanery. This will allow much greater focus on the training of doctors and our own staff and will encourage high calibre staff to join and stay with the organisation. The facility will take a multi-disciplinary approach and will encourage the involvement of local GPs and other clinical staff who may benefit from courses offered. It is anticipated that this will require capital and charitable investment.

The trust's quality agenda remains a top priority and this has been signalled by a refresh of the role of the Board's own Clinical Governance Committee and the infrastructure beneath. The trust will receive a Care Quality Commission inspection in June 2014 and believes that its existing good practice, coupled with the additional interventions as a result of much internal work on the Francis recommendations, will maintain its strong reputation for quality.

A **nursing skill mix review** is scheduled for the early period of this plan and this will further ensure that quality and quantity of staff remains right for the new patient profile. The Trust believes that **improving staff engagement** will be a key enabler to achieving a successful and

sustainable organisation and is committed to engagement, particularly with the medical workforce, as a means to support the ambition to be 'a great place to work'.

Staff have been engaged in developing a **strong strategic narrative** which describes the Trust's vision and purpose. Once completed this will be shared widely in order for the whole workforce to understand the aims of the organisation and their personal role in achieving this. Significant non-recurrent funding is planned **for investment in organisational development** which will include **leadership and management development** to enhance the ability of line managers to engage effectively with staff. The Trust intends to improve the opportunities staff have to make improvements in their work and feel empowered. In order to ensure these improvements are viewed as credible by staff, we will also be further **embedding trust values** into the day-to-day work of the Trust.

Leadership development will be prioritised at many levels and this will be tailored to the needs of the individual and their contribution to the annual and the five year strategic plan, with staff being absolutely clear about their roles. **The highly constructive engagement of our medical workforce will continue** and will form the basis of our new model of clinical leadership. It is likely that, in the early stages of this plan, the trust will undertake some internal restructuring to better align clinical teams and resources to the needs of the strategy.

In support of improved performance, the trust will **move emphasis from 'targets' to 'standards of patient care'**. This will allow the organisation to explain its rationale for performance objectives in patient benefit terms. Our clinicians welcome this and it will help us establish standardised ways of working at best practice level and ensure we focus on developing KPIs that we believe are best for those we treat. We believe this fits much better with the ethos of the Francis report and speaks more directly to our staff. If the trust is seen to be getting it right for patients rather than trying to meet externally set targets, we feel it more likely that we will secure buy-in from the whole organisation. This also signals the benefits of adopting best practice and helps mitigate risk in situations where a huge variety of different approaches are taken to the same issue. At the same time, the trust will endeavour to retain the flexibility needed to meet the demands of individual patients rather than simply pushing them through a treatment process.

In summary, this plan sets out an ambitious vision of renewal and transformation to ensure a positive and sustainable future for our services, for the benefit of our population and patients. The Board and Executive Team are forming following a period of high turnover and this signals the start of a new phase in the Trust's development. For the first time, the Trust will use its financial strength to invest in enabling initiatives to secure sustainable high-quality services.

We are investing in our staff and in particular, clinical leadership, to support culture change and transformational capabilities.

We are investing in diagnostic capacity, clinical and managerial information systems and we are developing our collaborative approaches to improve our ability to meet patients' needs, develop new innovations and train our future workforce.

These initiatives will strengthen our position as a specialist provider of choice and support better outcomes and overall patient experience.

Financial information and activity summary

The table below shows the summary I&E plan for 2014/15 – 2015/16:

| | 2013/14 Forecast Outturn (£m) | 2014/15 Plan (£m) | 2015/16 Plan (£m) |
|--|-------------------------------------|----------------------|----------------------|
| Clinical Revenue | 69.1 | 71.0 | 73.6 |
| Other Operating Revenue | 5.0 | 4.4 | 4.7 |
| Total Operating Revenue | 74.1 | 75.4 | 78.3 |
| | | | |
| Pay | 40.7 | 42.1 | 43.5 |
| Clinical Supplies | 20.6 | 20.8 | 21.1 |
| Non Clinical Supplies | 3.9 | 4.7 | 4.9 |
| Other expenses | 3.4 | 3.5 | 3.7 |
| Total Operating Expense | 68.6 | 71.1 | 73.2 |
| | | | |
| EBITDA | 5.5 | 4.3 | 5.1 |
| | | | |
| Non-Operating Revenue & Expenses | 3.5 | 3.8 | 4.6 |
| | | | |
| Surplus before Impairments | 2.0 | 0.5 | 0.5 |
| | | | |
| Impairments taken to I&E | (2.3) | (1.0) | (0.5) |
| | | | |
| Surplus/(deficit) after impairments | (0.3) | (0.5) | - |
| | | | |
| Impairments taken to revaluation reserve | - | (0.2) | (0.2) |

| | | | |
|--|--------------|--------------|--------------|
| | | | |
| Total comprehensive expenditure | (0.3) | (0.7) | (0.2) |

The activity plan for 2014-15 and 2015-16, taking into account all the factors mentioned above, is shown below.

| | 13/14 F/cast Outturn | 14/15 Activity Plan | Growth % |
|--------------------------|-------------------------------------|------------------------------------|---------------------|
| Day Cases | 7,293 | 7,578 | 3.9% |
| Electives | 6,726 | 6,988 | 3.9% |
| Non Electives | 390 | 392 | 0.5% |
| TOTAL | 14,409 | 14,958 | 3.8% |

| | 14/15 Activity Plan | 15/16 Activity Plan | Growth % |
|--------------------------|------------------------------------|------------------------------------|---------------------|
| Day Cases | 7,578 | 7,881 | 4% |
| Electives | 6,988 | 7,268 | 4% |
| Non Electives | 392 | 392 | 0% |
| TOTAL | 14,958 | 15,541 | 3.9% |

1.3 Operational Plan

2 Operational Plan

2.1. The short term challenge

2.1.1 During the early phases of this plan, the trust faces some key internal challenges:

- The need to return to consistent delivery of the 18 week RTT targets despite changing case mix and increased demand
- The need to maintain high standards of data integrity and administration during transition to better IT systems and processes
- The need to maintain financial performance such that the planned outturn is delivered despite increased levels of committed spend set in initial budgets
- The need to develop, in parallel, the five year vision with the full engagement of staff
- The need to build from scratch, many of the partnership relationships that will be essential going forward and to maintain within those relationships a position of independence and strength when many will be much larger and more powerful than ourselves
- The need to develop business plans that take account of emerging best practice and to pilot new approaches without unnecessary disruption
- The need to recognise the need for change and find ways of making it less painful but more beneficial
- The need to evidence our competence within the organisation by delivering on promises
- The need to engage key people, identify champions and to welcome, accommodate and acknowledge staff who only wish to follow rather than lead, but nonetheless play a key role
- The need to develop standards of practice throughout the organisation that are focused on patient benefit
- The need to take tough decisions on the range of clinical services offered and to ensure these fit within the context of the health economy
- **The need to develop a critical mass of leaders and managers who have the resolve and ambition to deliver the trust strategy through engaging effectively with staff and delivering results within a framework of responsibilities**
- The need to embed Trust values, rewarding behaviours that deliver these and acting on those that do not

2.1.2 The external environmental challenges include:

- Uncertainty over designation as a specialist centre
- Uncertainty over the national hub proposals for commissioning
- Orthopaedic services not being one of the key commissioner priorities
- The potential impact of the Better Care Fund on commissioner resources available for investment

The trust aims to achieve Continuity of Service Rating of 4 in the short term and for the period of the plan. However, there will be a number of short term financial challenges to ensure we meet this target;

- Increasing activity, whilst ensuring RTT times are met. The trust recognises that this

will incur additional spend, and will therefore need to ensure that these costs are closely monitored, in particular, by managing the use of ADHs, bank and agency staff.

- In light of the increasing challenge in finding cost improvement efficiencies, the trust recognises the short term challenge of ensuring CIP plans are robustly developed, in order that they are deliverable, whilst also maintaining or improving quality of care.
- The trust is going through a period of significant investment in order to improve both clinical and non-clinical efficiency and improve patient care. In particular the trust is focussing on the development of IMT infrastructure and increasing internal imaging capacity. It will be important to track this spend closely, and monitor any financial or operational risks arising as a result of the developments.

2.2 Quality plans

Our quality plans build on the diverse programmes of staff engagement during 2013/14. Many multi-disciplinary and multi-level groups were established to consider how best to embed quality and this approach will continue in parallel to the robust governance processes of committees. The introduction of expected standards of practice, supported by well-managed audit, will help staff understand their role in patient safety.

- Implementing Berwick, Keogh and Francis Report Recommendations.

The organisation (through workshops with board, governors, staff and stakeholders) has identified the areas requiring focus and development.

Examples of underpinning work in 2014-2016 include :- supervisory practice for the senior sisters creating ward clinical environments that are conducive to healing and an excellent patient experience; developing greater awareness of the duty of candour, leading to an organisational wide culture of openness and transparency; ensuring complaints and incidents are reviewed at local level and lessons shared and disseminated widely. This links to our approach towards standard setting and adherence.

- Patient Safety Culture

A staff survey will be completed in year one to explore staff members' understanding and perception of the organisational culture of patient safety. This important initiative will inform the Board, allowing the appropriate and relevant steps to be taken to ensure staff members are aided in ensuring patient safety in an organisation that is supportive and welcoming of incident reporting or the escalation of concerns through other routes, such as whistle blowing.

- Maintaining the standards of existing quality measures

Maintaining and promoting standards will be a priority for year one and two as part of our setting of strong foundations. In year one the C. Difficile target of zero cases will be a challenge, however we welcome the national guidance for identifying avoidable/unavoidable cases. ROH has been undertaking root cause analysis of C. Difficile for some time as standard good practice; we shall share our experiences with colleagues regionally and nationally in the coming year. Pressure damage prevention has been a significantly successful quality improvement programme in recent years and we anticipate that in 2014-16 there will be a slower rate of reduction of the number of reported ulcers. This indicates that ROH is fast approaching the lowest level of

achievable and avoidable damage and this will continue to be evidenced through robust and transparent root cause analysis.

Previous quality schemes, not specifically CQUINs, have been incorporated into the contract for 2014/15 and we anticipate achievement of these business as usual standards for our patients benefit.

- IT investment supporting enhanced quality

Quality standards, as measured by CQUIN schemes and local CCG contractual requirements, are currently heavily reliant on staff members to deliver processes and paper based recording systems. By nature this is cumbersome and poses certain risks to safety. The IMT strategy will bring technological solutions to the quality agenda. For example we anticipate clinical systems will support decision-making and the introduction of e-prescribing will help reduce avoidable drug errors; recording of Friends and Family data (including free text comments) will be via hand-held devices allowing for real-time review and action; clinical information on individual patients will be shared through data warehousing affording less opportunity for data error and patient harm; real time reporting is anticipated for pressure damage and patient falls.

The ability to review quality initiatives promptly will enable the wider organisation to share practice at increased speed, helping to prevent further harm/potential harm to other patients.

- Externalisation

The historical organisational record of excellent delivery against quality standards will be shared to a greater extent with the aim of educating our external stakeholders of the standards to be expected when referring their patients or commissioning services. This aligns to the two year strategy of a strong foundation from which to develop new services from years three to five. It is recognised that this highly relevant patient related knowledge has not been celebrated or shared sufficiently across the local health economy and will be vital in positioning the ROH in the West Midlands conurbation.

- Special needs of the elderly patient

The specific reference within the year one activity plan to the growing elderly population will be recognised through the detailed consideration and resulting actions taken from the Francis report recommendations for elderly care. This will include a review of the provision of physician care and continued development of safeguarding and dementia screening activity.

- New CQUIN scheme

Following sample patient pathways enables learning and awareness of the whole patient journey across our existing organisation. This will provide valuable details and inform the organisation of areas of strength and further development. Whilst the scheme has a prescribed number of patient journeys we anticipate undertaking further reviews in years one and two.

- 6C's

The Compassion in Practice document (6C's) will be used to focus on behaviours appropriate to great care. At the same time we will be looking for new opportunities, for example to receive formalised feedback on our community based service, which will give us quality standards for expanding this type of work.

- Board Awareness

The review of the internal governance structure and processes undertaken in 2013/14 will be further embedded in year one. Following the announced Care Quality Commission (CQC) visit in June 2014 an action plan held at board level will oversee the implementation of any recommendations made. It is anticipated that the new inspection regime may identify aspects of our organisation's quality of care and the patient experience which have hitherto been less well scrutinised. The board welcomes the new inspection regime and the enhanced involvement in inspection by CCGs and aims to work in partnership so as to make the most positive response to any necessary changes.

- Board Assurance

The Board Assurance Framework and corporate risk register were also reviewed in 2013/14 and will be enhanced throughout year one of the new strategy. This is highly relevant to ensure quality of care is supported throughout the next two years as the organisation sets its foundation for years three to five.

- Challenges.

- The introduction of IT based solutions across the nursing workforce has risks associated with implementation. This is an area that has previously been neglected across the organisation and so the wider nursing workforce are less familiar with the practical use of IT within patient care. These risks will be managed through sensitive and pragmatic support of the nursing teams.
- Maintaining the historical achievements in quality standards will be a challenge as the portfolio of contractual and CQUIN schemes increases and the short term risks of running existing paper based processes.
- Supporting staff to educate and empower on behalf of quality of care needs time and attention, but will be ameliorated by introduction of a fourth matron post, implementation of supervisory time and the introduction of a supernumerary bleep holder role.
- Developing the nursing workforce in areas such as 6C's and Care Makers given the relative age profile and stability of the workforce in some areas and consequent lack of exposure to practices which are often well embedded in larger multi-speciality hospitals..
- Proposed structure changes will affect matron portfolios on the introduction of a fourth matron post and handovers and balance will require careful attention.
- Building quality assessment and evaluation into diverse new business proposals and maintaining standards during transitional periods.
- The engagement of the clinical workforce to work together across professional boundaries to deliver improvements in clinical care and necessary efficiencies.

3 Operational requirements and capacity

3.1 Context & Challenges

3.1.1 Increased referrals → need to treat additional patients

Overall in 2013/14 our referral rates increased by more than 10% following a previous trend in reducing referrals over a couple of years. The growth has been seen predominantly for procedures such as injections and surgery on hands and feet. As an elective centre we believe that we can offer certainty to patients, in that their operation will be less likely to be cancelled due to the emergency pathway than that of our neighbours and reduced risks of infections as we are an elective centre. Key challenges include:

- Understanding our referral pattern and then identifying how to proactively manage any changes in demand and capacity along the whole patient pathway – OP/Imaging/Theatre/Bed.
- The established 16% increase in demand for MRI will be addressed in the short / medium term with a mobile unit that will be situated on the ROH site from Quarter 2, 2014.
- Actively promoting the Trust as the centre for orthopaedic excellence amongst the GP community, other referring centres and commissioners and most importantly amongst the public.
- Increasing working at weekends to make Saturdays a normal part of the working week – this commenced in 2013/14 with theatres now working a minimum 2 weekends per month. Increased opening hours in pharmacy, imaging and therapies at weekends were also implemented in 2013/14 and this will extend further to include standardised outpatient clinics at weekends and further therapy support in 2014/15

3.1.2 Case mix changes → need to treat a different mix of patients

The trust saw a switch in case mix in 2013/14 from elective to day case procedures with a 12% increase in Day Case procedures but a 6% reduction in elective work. This reduction in length of stay (LOS) and switch to day case is reflective of a changing health delivery model. ROH will therefore:

- Model the impact of the case mix change and increase ADCU (admissions and day-case unit) capacity accordingly (working later into the evening)
- Examine type of surgery that currently goes through main theatres and look to re-provide this in other settings – either in ADCU/ Injection Suite or in outpatients (OPD) for small joint procedures in particular.

3.1.3 RTT failure → need to smooth flow, reduce waits & improve performance management

In 2013/14 we saw a 20% increase in outpatient referrals. As a result of this increase in demand, the trust failed to meet the RTT target for Admitted Care in Q3 and Q4. Work with the Intensive Support Team, internal audit of the RTT process along with National Audit Office recommendations in January 2014 have encouraged the trust to consider different ways of managing the waiting list. We will undertake full patient and process mapping in 2014/15 along with continuation of capacity and demand exercises in key specialties and in diagnostic services.

We are also examining our current policies with regard to leave arrangements for consultants as good discipline in this area, coupled with effective job plan reviews will allow us to better manage efficiency and build a base for delivering much reduced waiting times in the life of the overall strategic plan. This will complement work on 6 day working and flexible working patterns.

We will refocus management of waiting lists under 1 team and provide a more centralised approach, whilst still giving surgeons the discretion to choose which patients they will operate on according to clinical need. To secure maximum efficiency in process while maintaining the highest quality outcome for patients we will:

- Examine all aspects of the patient process from referral to discharge and implement Lean methodology.
- Work with CCG partners to provide a single point of access for referrals into the Trust either via choose and book or directly to the appointments office to reduce initial delays
- Get demand and capacity right in our key stretched specialties (spinal / spinal deformity and paediatrics), recruiting to additional consultant posts if required following robust cross team job planning.
- Undertake training needs analysis and ensure that our staff are trained and supported to deliver to an agreed standard which is supported by standard operating procedures and policies.
- Complete the job planning exercise for all consultants commenced in 13/14 and to be finalised in Q2 of 14/15. This exercise will ultimately help us to provide a more flexible service for patients
- Examination of current Annual Leave/ Study Leave/ Professional Leave policies to ensure that they not only ensure patient safety but also that patients wait as short a time as possible for their surgery

3.2 Response to the challenges

3.2.1 Ensuring Appropriate Capacity and Improving Patient Flow

In 2013/14 a programme of work commenced under a Clinical Programme Board (CPB). The CPB takes a project management approach working with key clinicians and managers in the organisation to address some of our most difficult issues, including:

3.2.2 Cancellation of surgery

At commencement of the project >5% of patients were being cancelled on the day of their surgery, some for unavoidable reasons such as illness but others for avoidable reasons such as running out of theatre time. Following detailed analysis and changing and improving processes, after 4 months this has reduced to 2% with an aim to reduce this further to 1% by the end of Q1 and sustain this position

3.2.3 Enhanced Recovery

Our targeted length of stay for hip and knee replacements is 2.5 and 3.5 days respectively due to consistently admitting patients on the day of their surgery and using the Royal Orthopaedic Community (ROCs) team to support patients in early discharge. However we aim to reduce this further and introduce a standardised approach to anaesthetics along with increased

physiotherapy for patients including ensuring that patients are mobilised within 6 hours of their surgery. This “First Up” programme will be delivered by nursing teams who will undergo a training programme in spring 2014.

3.2.4 6/7 Day Working

Standardised theatre sessions now take place on at least 2 Saturdays per month however in 2014/15 and by working in partnership with the Trust Consultative Committee, we aim to amend current and new staff terms and conditions to provide a more flexible workforce that can assist in delivery of services over a 6/7 day period as a standard. Clinical Standards will be developed in conjunction with medical colleagues to ensure that all patients are seen before and after their surgery and are reviewed by a consultant at weekends.

3.2.5 Pre-operative and outpatient pathway

Since September 2013, no routine elective patient is admitted to ROH without being pre-assessed and clerked before the day of their admission. (Some patients, especially those with spinal or oncological conditions continue to be assessed on the day of their operation for clinical reasons.) An anaesthetic clinic has been introduced alongside a rapid assessment Pre Operative Assessment Clinic (POAC) which ensures patients are assessed and optimised before surgery. Additional improvements are required to continue to smooth out the processes that our patients go through. Wait times on the day of clinic for imaging are sometimes elongated due to demand and capacity restrictions in imaging. In 2014/15 all of our imaging equipment is being replaced with faster technology that will allow 2-3 patients to be imaged in the time it currently takes to image 1 patient and our ability to image whole spines will triple, thus reducing waits and improve patients experiences.

3.2.6 Direct Booking

The ability for patients to have certainty of the date of their surgery is really important to them and to us. The Direct Booking service was introduced in 2013/14 with 70% of our consultants now using this to book their patients on the day the decision is made for their surgery in the Outpatient Clinic. In 2014/15 we will roll out this service further and aim to increase this to 90%

3.2.7 Electronic Document Transfer (EDT) :

In October 2013 we launched the EDT pilot ensuring that GPs received an electronic discharge letter regarding their patient on the day that they were discharged home. Previously this was sent in the post and the information included was hand written and in an inconsistent format. By April 2014, working in conjunction with our CCGs colleagues and our staff, we will have rolled out EDT for all correspondence going to GPs in our local commissioning area – Birmingham Cross City – for both discharge letters and outpatient letters. We will continue to work with commissioners across a wider Birmingham / West Midlands area to roll this out further in 2014.

3.2.8 Admissions and Day Case Unit (ADCU)

This new facility opened in September 2013 and is supported by new ways of working and managing patients. Following feedback from patients we now stagger admission times. This prevent them waiting excess time in hospital on the day of their surgery. Our aim to ensure that no patient waits longer than 3 hours from the time they arrive to the time they go to theatre. We will continue to embed this is 2014/15.

3.2.9 Improving our Estate

We are currently undertaking **improvements to the Children's Ward**, some of which were suggested by the Care Quality Commission. This **includes additional side wards, a play room (in part funded from the Project Playroom fundraising campaign) increased privacy and dignity and better facilities overall for patients, their families and staff**. The new facility will open in July 2014.

- An options appraisal for the relocation of our pathology service (which is currently off site) will be undertaken
- The business case for additional MRI capacity and potential partnerships with others to provide cohesive scanning within an imaging suite
- Completion of the final phase of medical records relocation
- Demolition of part of the old estate and provision of a pad which can accommodate a temporary theatre, to allow mitigation in case of increased/alternative theatre capacity being needed
- Feasibility plans for the redevelopment of the Research and Teaching centre to develop a modern multi-disciplinary learning hub for medical school students, post-graduates and trust staff.

4 Finance and operations

4.1 Efficiency plan

As highlighted in previous years, the Trust continues to believe that there is a need for cost improvement plans which deliver cash releasing expenditure savings. In order to ensure we run as an efficient and effective hospital, such savings must be balanced against the continued need for investment in the quality of our patient care and experience. The trust plans for growth in income, supported by its commissioners and this will also fund the capital investment needed to ensure a sustainable service.

As such, the Trust is planning to deliver £1m of additional contribution through activity growth in each of the 2 years of the operational plan. In addition to this, £2.0m (2.7%) of expenditure savings will be generated in 2014/15, with a further £2.5m (3.4%) of expenditure savings planned for 2015/16.

100% of schemes have been identified for 2014/15, with delivery of the schemes managed through the CIP Programme Board. The Board will also ensure that Quality Impact Assessments are developed, scrutinised and approved.

The majority of the expenditure schemes identified for 2014/15 are traditional in nature, with a significant emphasis on the opportunity for increased efficiency across the Trust. Projects are already underway to look at reducing cancellations in theatres, improving theatre utilisation through greater upfront planning and challenge of theatre lists and reducing reliance on outsourcing of clinical work to other providers.

The longer term focus for CIPs is firmly on transformational projects; a range of which have

begun or are in the planning stage for delivery in the back end of 2014/15 and on into 2015/16. These include reviewing innovative ways to provide step-down rehabilitation services currently provided through the use of community hospital beds, targeting the review and management of surgical site infections to reduce infection rates, thereby reducing the cost of treating such infections, and expanding our successful Bone Infection Unit into a more commercial offering. This model is currently being provided in pilot form to a local NHS Trust.

The Trust is also reviewing a range of options aimed at radically reducing our spend on orthopaedic implants. Following a major piece of work in 2011/12, savings totalling £1m were generated through the reduction of our implant prices, however these costs continue to make up over 10% of our total cost base. We need to consider innovative approaches to making further savings in this area, and are currently working alongside other Trusts within the Specialist Orthopaedic Alliance to scope out a pilot project with the Department of Health and NHS Supply Chain. This will target ways to take costs out of the supply chain that will benefit both Trusts and suppliers. In addition to this work, we have also met with our high volume implant suppliers to discuss other options for greater partnership working, which will form part of a full option appraisal paper aimed at setting out a 5 year procurement plan for orthopaedic implants. We have set ourselves a target of achieving £1m (approximately 15%) savings over this 5 year period.

In addition to the schemes outlined above, the Trust have also set out a range of service transformation schemes that, whilst not directly linked to CIP delivery, will clearly have a long term impact on the efficiency and effectiveness of the hospital.

4.2 Service Transformation themes:

- Investment in technology – hardware to accommodate contemporary programmes such as e-prescribing, electronic patient records, PAS replacement, data warehousing, health informatics upgrades and an outcomes data platform.
- Building robust partnerships that underpin service development. This includes working in tandem with GPs, community providers and rehabilitation teams as well as agreeing major plans for paediatric orthopaedic provision with Birmingham Children's Hospital.
- Health promotion and preventative activity will be developed to ensure increasingly appropriate referrals from GPs.
- Ensuring that the trust is both innovative and an early adopter of best practice innovations in its field, by looking outwards to the activity of other orthopaedic practitioners and actively considering the benefits of changing practice.
- Replacing our current MRI scanner and adding a second in anticipation of incipient growth in demand and potential offer to the Local Health Economy. This will also support commissioner desire to have consultant triage before referral to outpatient clinics, and to develop more advice and guidance services based on triage and early diagnosis.
- Taking account of, and understanding the changes in case mix which follow the international trend away from inpatient stays, towards day case.
- Operating over 6 days a week in order to build in efficiencies through changed contracts and ensuring effective weekend cover
- Offering additional physiotherapy to targeted patients to enhance outcomes
- Working towards a radical reduction in waiting time in order to deliver best service to

patients and inherent efficiency.

- The trust will (in consultations with partners) also consider major expansion of its broader musculo-skeletal health and well-being services in support of the broader integration agenda, as well as extended pain management services. This is in recognition that patients seek support from GPs at an early stage but may not seek surgical intervention appropriately. The trust will aim to oversee the whole pathway from pain through surgery to aftercare.
- In order to develop a learning organisation the trust will undertake baseline work to completely overhaul the trusts' learning, research and innovation capability
- A nursing skill mix review is scheduled for the early period of this plan and this will further ensure that quality and quantity of staff remains right for the new patient profile. Other disciplines may be subject to a similar review as the plan evolves and the balance of skill mix changes in line with whole pathway needs.
- Leadership development will be prioritised at many levels and this will be tailored to the needs of this annual and the five year strategic plan, with staff being absolutely clear about their roles. The engagement of the medical workforce continues to evolve.
- The trust will move emphasis from 'targets' (perceived as externally imposed) to 'standards of patient care'. This will increase standardisation of best practice but still allow variation and development of better practice within a controlled and more efficient and effective environment.

5 Financial Plan

5.1 Introduction and Strategic Context

As previously outlined in this plan, the Trust is embarking on a clear operational plan for 2014-16, with key themes linked to sharpening our internal processes and standards, and starting to build relationships and partnerships across the wider health and social care sector.

In order to fully resource these plans, the Board have agreed to take advantage of the Trust's strong balance sheet and liquidity built up from several years of above average surpluses. £1m has been set aside in 2014/15, £0.5m of which can be invested recurrently, to ensure that we are able to make major, sustainable change to key areas such as our IM&T capabilities and leadership development. The £0.5m non recurrent enabling budget will also remain in 2015/16, as it is recognised that a longer term approach will be needed to fully release the benefits from these key enablers.

In addition to this investment in revenue funds, our 5 year capital plan has also been reviewed to ensure that capital resources are invested appropriately to support our key operational and strategic aims with significant investments in years 1 & 2 on IM&T and radiology equipment.

The table below shows the summary I&E plan for 2014/15 and 2015/16:

| | 2013/14 Forecast Outturn (£m) | 2014/15 Plan (£m) | 2015/16 Plan (£m) |
|--|--|------------------------------|------------------------------|
| Clinical Revenue | 69.1 | 71.0 | 73.6 |
| Other Operating Revenue | 5.0 | 4.4 | 4.7 |
| Total Operating Revenue | 74.1 | 75.4 | 78.3 |
| | | | |
| Pay | 40.7 | 42.1 | 43.5 |
| Clinical Supplies | 20.6 | 20.8 | 21.1 |
| Non Clinical Supplies | 3.9 | 4.7 | 4.9 |
| Other expenses | 3.4 | 3.5 | 3.7 |
| Total Operating Expense | 68.6 | 71.1 | 73.2 |
| | | | |
| EBITDA | 5.5 | 4.3 | 5.1 |
| | | | |
| Non-Operating Revenue & Expenses | 3.5 | 3.8 | 4.6 |
| | | | |
| Surplus before Impairments | 2.0 | 0.5 | 0.5 |
| | | | |
| Impairments taken to I&E | (2.3) | (1.0) | (0.5) |
| | | | |
| Surplus/(deficit) after impairments | (0.3) | (0.5) | - |
| | | | |
| Impairments taken to revaluation reserve | - | (0.2) | (0.2) |
| | | | |
| Total comprehensive expenditure | (0.3) | (0.7) | (0.2) |

Note: Impairments have been included in the current year based on the draft figures from the Trust's external valuation specialist. Impairment figures for 2014/15 and 2015/16 have been estimated by reviewing the capital plans for these years and estimating the likely impact of a revised valuation based on the element of spend used to improve an existing asset of the Trust rather than construct a new one. It is the experience of the Trust that such assets are more likely to be impaired.

5.2 Healthcare Income & Activity

5.2.1 2014/15 Contract Negotiations

Contract negotiations with Birmingham Cross City CCG, (acting as host commissioner for the 22 West Midlands CCGs, and with the NHS England Area Team with regards to Specialist Commissioning) have now concluded and contracts have been agreed.

Financial discussions with Birmingham Cross City CCG focused on the growth in referrals experienced during 2013/14 and how this would impact on 2014/15 activity levels. The CCG agreed that, in order for the ROH to return our waiting list back to April 2013 levels and enable us to achieve our 18 week waiting time targets in a sustainable manner, 6% growth in day case and inpatient activity would be required and this was built into the majority of individual CCG contracts. In addition to this, CCGs also agreed to fund a 12.5% growth in outpatient physiotherapy and orthotics plans to address the rising waiting times in these areas. Negotiations with our Specialist Commissioners ensured that our 2014/15 activity plan was maintained at 2013/14 contract levels.

Contract agreement is still outstanding with the Welsh Health Boards with regards to both specialist and Primary Malignant Bone Tumour (PMBTS) contracts. Wales has instigated demand management schemes in the last 12 months aimed at ensuring that all Welsh patients are treated in Wales wherever possible. This has caused our specialist contract to underperform by over £100,000 in 2013/14, and this trend in activity repatriation is built into our financial plans moving forward.

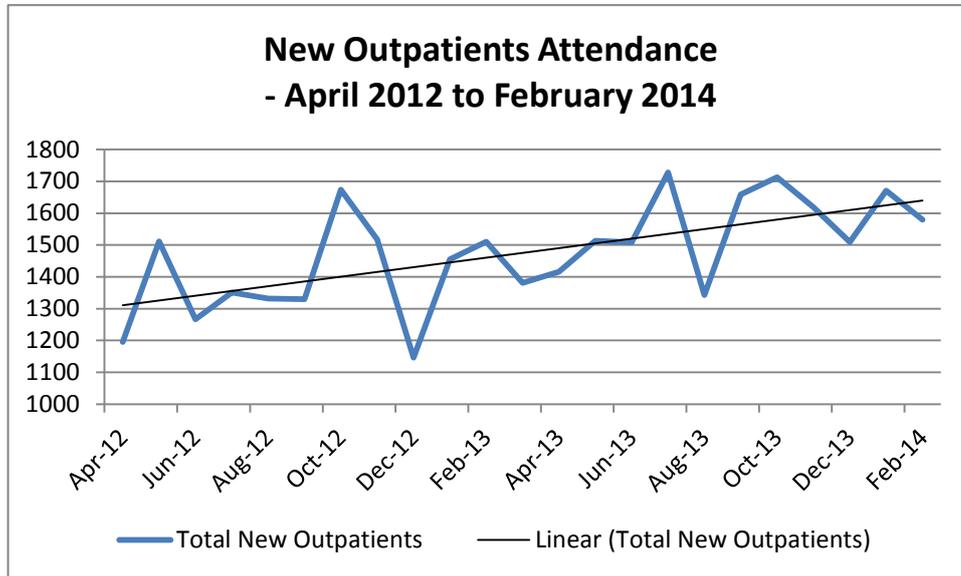
All 2014/15 contracts are based upon a tariff deflator of -1.5% which consists of inflation and cost pressure funding of 2.5% less 4% efficiency requirement. The financial planning for 2015/16 assumes a tariff deflator of -1.8%, adjusted to -1.63% assuming an element of tariff uplift relating to the change in pension contributions for employers.

5.2.2 Additional planned growth

As a small single-speciality Trust, we recognise there is a need to find an appropriate balance between internal efficiency and cost savings and the need to grow, to ensure the cost structure required to develop as a high quality institution can be supported.

The Trust expects income to grow by £3m in 2014/15, after the impact of the tariff deflator.

£1.9m of this growth is already contracted by CCGs, and is designated to deliver appropriate waiting times for our patients. Further demographic growth is not included in contracts, however there is clear evidence of the increasing national demand for orthopaedic surgery. The Trust feels it is realistic to plan for a continuation of the growth seen in 2013/14 (see the graph below), and have therefore included 2% activity growth in its plans for 2014/15 and 2015/16 to address this.



In addition to this demographic growth in general orthopaedics, there are specific pressure points that the Trust is working up plans to address over the coming 12 months that will impact upon activity levels in 2015/16. A new adult spinal surgeon will be appointed during 2014 to support the growing demand for spinal services, and will be picking up a full workload by the start of 2015/16.

In addition to this, there is a constant demand for additional paediatric work across the Birmingham area and the Trust are currently working up plans for how support can be offered in this area over the next 2 years. The ROH is particularly interested in how young adults can be supported in their move from paediatric to adult services, and our market analysis has identified a clear gap in services for this cohort of patients. Further work is ongoing to consider how this service can be developed, which we expect to result in service growth during 2015/16. Our modelling suggests this specific growth is expected to account for a further 2% growth in activity and income during 2015/16.

5.2.3 Activity Plan

The activity plan for 2014/15 and 2015/16, taking into account all the factors mentioned above, is shown below.

| | 13/14 F/cast Outturn | 14/15 Activity Plan | Growth % |
|------------------|----------------------------|---------------------------|-------------|
| Day Cases | 7,293 | 7,578 | 3.9% |
| Electives | 6,726 | 6,988 | 3.9% |
| Non | 390 | 392 | 0.5% |

| | 14/15 Activity Plan | 15/16 Activity Plan | Growth % |
|----------------------|---------------------------|---------------------------|-------------|
| Day Cases | 7,578 | 7,881 | 4% |
| Electives | 6,988 | 7,268 | 4% |
| Non Electives | 392 | 392 | 0% |

| | | | | | | | |
|--------------|---------------|---------------|-------------|--------------|---------------|---------------|-------------|
| Electives | | | | | | | |
| TOTAL | 14,409 | 14,958 | 3.8% | TOTAL | 14,958 | 15,541 | 3.9% |

5.3 Expenditure Budgets

5.3.1 Cost Pressures

A number of key cost pressures have been built into the financial plans for 2014/15 and 2015/16 as highlighted below:

- Pay awards and incremental drift (14/15 - £437k & 15/16 - £424k) – Pay inflation has been costed in line with the government’s announcement on 13th March.
- Interim Junior Doctor Pay (14/15 - £500k & 15-16 £500k) – Whilst the Trust’s medical staffing review is being undertaken, there will be a continued reliance on locum junior doctors to support the safe provision of on-site and on-call medical services. This reliance will reduce in Year 2, but it is anticipated that these costs will be required to address the substantive cost of a new medical model.
- MRI Outsourcing (14/15 - £400k & 15/16 - £300k) – The Trust is currently outsourcing significant MRI work to the private sector due to the excess of demand over capacity. An additional MRI scanner is planned to be completed towards the end of 2015/16, so it is anticipated that these costs will continue until this point.
- CNST contribution (14/15 - £300k & 15/16 - £279k) – Trauma & Orthopaedics continues to see a significant year on year increase in the insurance claims, the impact of which is built into our long term financial planning.
- Increased cost of community rehabilitation (£14/15 - £135k & 15/16 - £80k) – The cost of community rehabilitation care provided by Birmingham Community Health Trust has increased to match the income received for rehabilitation care. This cost increase is phased over a 2 year period.
- Other local cost pressures (14/15 - £850k & 15/16 - £515k) – A range of smaller cost pressures specific to each Directorate has also been funded as part of the local budget setting process.

5.4 Operational Business Developments

The Trust’s financial plan for 2014/15 includes the provision of £400,000 to fund operational business developments aimed at improving patient care and experience. A similar budget has been set aside for such developments in 2015/16.

For 2014/15, this includes addressing the recommendations of the Francis report. As part of the Trust’s detailed business planning process, all Directorates were asked to submit expressions of interest in bids that would improve patient care and service delivery. These bids were shortlisted by a group of clinical representatives, and are now being developed into business cases for consideration by the Executive Management Team in April. Shortlisted bids include:

- Supervisory Senior Sisters
- Additional Matron role
- Surgical Site Infection surveillance
- IM&T development

- Organisational Development interventions

5.5 Strategic Business Developments

In addition to the operational business development reserve mentioned above, the Trust has utilised some of our cash balances built up through the delivery of our surplus targets over a number of years to put aside a £1m development fund, of which £500,000 is recurrent. This will facilitate the delivery of key enablers required to support the service transformation themes outlined earlier in this plan.

6 Capital Plan

The Trust's previous capital plan has been reviewed in light of the key elements of our 2 year operational plan, and a number of initiatives originally planned in the period 2016/17 to 2018/19 have been brought forward.

Over the next 2 years, the Trust anticipates spending £8m on IT and Informatics systems and enablers to revolutionise the working environment for our staff and provide a safer and more streamlined service to our patients. This will include the roll-out of a new IT infrastructure across the Trust, provision of an electronic prescribing and pharmacy system, and improved informatics support in the shape of a data warehouse and trust-wide outcomes system.

In addition to this, £6m is being set aside to address radiology capacity and replace aging imaging equipment to tackle a key bottleneck in our existing services. A new MRI scanner will be added on site to address the £400,000 per year cost of outsourcing scans currently being incurred and to provide the long term resilience to support growth over the 5 year period of our strategic plan. In addition to this and following on from the replacement of our CT scanner in 2013/14, a range of imaging equipment will be updated to provide a modern and efficient radiology service to our patients. A summary of the 2 year plan is shown below:

| | 2014/15 | 2015/16 |
|-----------------|--------------|---------------|
| | £000s | £000s |
| IM&T | 3,563 | 4,806 |
| Radiology | 1,480 | 4,420 |
| Estate | 1,761 | 470 |
| Other Equipment | 497 | 506 |
| Total | 7,301 | 10,202 |

An assessment of the likely capital charge implications is included in the financial plan.

7 Liquidity

The Trust has historically held a very high cash balance, with liquidity ratings significantly exceeding the levels required to score the lowest risk rating within the Continuity of Services risk rating.

However, the Board have made the decision that investment in key enabling areas such as IT infrastructure, imaging and organisational development are an important requirement to ensure

services for our patients remain fit for purpose into the future. As a result, this will impact on the cash balances of the Trust, as shown below.

| | 2013/14 FOT £m | Capital spend | Other cash movements** | 2014/15 Plan £m | Capital spend | Other cash movements** | 2015/16 Plan £m |
|------|----------------------|------------------|---------------------------|-----------------------|------------------|---------------------------|-----------------------|
| Cash | 19.4 | (9.2)* | 3.2 | 13.4 | (10.2) | 4.3 | 7.5 |

***Note the difference between the £7.3m capital plan balance previously seen by the Board and the value here represents £1.5m of infrastructure spend for 2013/14, where goods are planned to be received on 31/3/14, but as a result of the timing of the year end the cash is unlikely to come out of Trust bank balances until 2014/15, in addition to other small capital creditors, including £0.4m relating to imaging.**

**Other cash movements represent areas such as the Trust's profit and working capital movements, which would have an impact on the cash balance.

8 Risk Ratings

Historic healthy surpluses and cash balances have previously resulted in the Trust having significant headroom against the capital servicing capacity and liquidity ratios.

The table below shows that the Trust is aiming to continue to achieve a COSSR rating of at least 4 for the period of this plan and therefore continue to maintain a strong financial position within a difficult local and health sector financial environment.

Due to the significant strategic investments being made over the coming period in areas such as IT infrastructure and imaging capacity, cash and surplus balances will be necessarily lower, resulting in lower headroom over the ratings.

| | 2013/14 | | 2014/15 | | 2015/16 | |
|----------------------------|----------|--------|----------|--------|----------|--------|
| | Forecast | Rating | Forecast | Rating | Forecast | Rating |
| Capital Servicing Capacity | 3.45 | 4.00 | 2.77 | 4.00 | 3.02 | 4.00 |
| Liquidity Ratio | 68.1 | 4.00 | 54.8 | 4.00 | 28.5 | 4.00 |
| Overall Rating | | 4.00 | | 4.00 | | 4.00 |

In light of the lower headroom, the Trust has performed some sensitivity analysis to show how much cash and profit would need to decline in order for a rating of 4 to not be achieved (assuming all other variables remain constant).

8.1 Profit

| | 2014/15 £m | | 2015/16 £m | |
|--|------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| | Sensitivity to achieve rating of 4 | Sensitivity to achieve rating of 3 | Sensitivity to achieve rating of 4 | Sensitivity to achieve rating of 3 |
| Drop in profit to achieve lower rating (weakest quarter) | 0.005 | 0.32 | 0.77 | 2.11 |
| Drop in profit to achieve lower rating (strongest quarter) | 0.22 | 1.47 | 0.77 | 2.11 |

8.2 Cash

| | 2014/15 £m | | 2015/16 £m | |
|--|------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| | Sensitivity to achieve rating of 4 | Sensitivity to achieve rating of 3 | Sensitivity to achieve rating of 4 | Sensitivity to achieve rating of 3 |
| Drop in cash to achieve lower rating (weakest quarter) | 8.2 | 9.6 | 1.1 | 2.7 |
| Drop in cash to achieve lower rating (strongest quarter) | 8.2 | 9.7 | 2.0 | 2.8 |

8.3 Risk Management and Mitigation

An active risk register is reviewed regularly at the most appropriate level of the organisation including Trust Board, Executive Management Team and Directorate. The Audit Committee oversees the process of risk management and is assured that risks are regularly reviewed and mitigating actions taken.

In the circumstances that the Trust needed to mitigate the impact of an unexpected overspend in cash or profit terms, it has considered a number of potential options.

Firstly, as previously discussed, the Trust is currently holding reserves for operational and strategic business developments. In the circumstances where unforeseen costs or poor performance were identified, these reserves could be used to mitigate the risk to the Trust's finances.

In particular, the Trust has a capital plan in place for the next five years, but this plan could be reduced, staggered, or delayed to future years in these exceptional circumstances.

In addition, the Trust has also considered its ability to reduce spending in other ways, for example implementing measures such as vacancy controls and headcount reduction. Also reductions in discretionary spend could be implemented.

The Trust estimates that it could raise an additional £2m using these methods should the circumstances arise where cost pressures of this magnitude were faced.

1.4 Appendices: commercial or other confidential matters

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