

Royal National Hospital 
for Rheumatic Diseases
NHS Foundation Trust

Forward Plan Strategy Document for 2012-13

Royal National Hospital for Rheumatic Diseases
NHS Foundation Trust

Forward Plan for y/e 31 March 2013 (and 2014, 2015)

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

Name	KIRSTY MATTHEWS
Job Title	CHIEF EXECUTIVE
e-mail address	Kirsty.matthews@rnhrd.nhs.uk
Tel. no. for contact	01225 473448
Date	28 th May 2012

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:

Name (Chair)	PETER FRANKLYN
-----------------	----------------

Signature

Approved on behalf of the Board of Directors by:

Name (Chief Executive)	KIRSTY MATTHEWS
---------------------------	-----------------

Signature

Approved on behalf of the Board of Directors by:

Name (Finance Director)	RACHEL HEPWORTH
----------------------------	-----------------

Signature

Strategy Guidance - Annual Plan Review 2012-13

Section 1: Forward Plan

A. The Trust's vision is summarised as:

Aim

To transform the lives of people affected by complex long term conditions.

Values

The values of the RNHRD describe how the Trust wishes to be viewed by its patients and service users, staff, commissioners and other key stakeholders and are described below:-

- **Success**
To achieve the optimal appropriate patient led outcomes for our patients, relatives and carers
- **Integrity**
To be open, honest and ethical and take responsibility for our actions
- **Learning**
To learn and encourage new ideas, demonstrate evidence based practice, value feedback and continue to strengthen our reputation for expertise
- **Creativity**
To seek new solutions, welcome constructive challenge and be open to new ideas; to drive change and be flexible and bold in our approach to new initiatives
- **Empowerment**
To create and sustain an environment where people can maximise their contribution

Clinical Vision

To facilitate the provision of care closer to home and effect the shift from delivery care away from an inpatient setting to increase day case and outpatient priority. The Trust remains committed to extending its reputation for the provision of nationally recognised specialist services, clinical research, and as a centre of educational excellence.

Quality Vision

To continue to provide high quality, safe care the RNHRD will continue to keep in place effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.

Financial Vision

Deliver financial plans to ensure services are properly resourced.

Corporate Objectives 2012/13

Strategic

- to meet the challenges of the transition of the health economy as a whole
- to develop a sustainable outreach model to take RNHRD services out in to the community
- to identify additional sources of patient referrals in line with the RNHRD's vision and values and develop robust operational plans to secure their delivery
- to identify innovative and effective methods to improve branding and increase awareness of the quality and range of our services to assist patients, carers and commissioners in making the choice to access our services
- to ensure our workforce is fit for purpose and flexible to meet the strategic objectives

Quality of Patient Care

- to continue to provide high quality, safe care by demonstrating compliance with the CQC essential standards of quality and safety
- to develop health outcome measures across all specialties to evidence patient benefit and effectiveness of services in line with Commissioners requirements
- to achieve quality improvement targets for 2012/13 and CQUIN targets identified in 2012/13 contract
- to implement Patient Safety Thermometer audit on inpatient wards to provide snapshot data on number of patients receiving "harm free care"
- to provide written discharge summaries within 24 hours of discharge to GPs

Governance

- to meet the Code of Governance
- to meet the measures detailed in the Compliance Framework
- to meet the NHS Connecting for Health Information Governance Assessment
- to maintain NHSLA level 1 accreditation

Financial & Activity

- to deliver the financial plan for 2012/13, to include:
 - maximising private patient income
 - meeting the cash target throughout the year
 - meeting the QIPP and cost improvement target for the year
 - production of timely forecasting
- increasing productivity and reducing costs in addition to the current QIPP and cost improvement targets

IM&T

- to develop the IM&T strategy to support the organisation in achieving its strategic objectives to include:
 - the migration of all staff from Windows XP to Windows 7
 - the further development of the Electronic Patient Record system to meet clinical needs and minimise excessive use of paper
 - the successful delivery of one single source of information
 - improved use and knowledge of information in order to make informed business decisions

Estates

- to develop the Estate Management strategy to support the delivery of high quality patient care in an appropriate environment. This includes:
 - day to day operational issues in line with mandatory and statutory compliance
 - capital development programme to reflect future clinical intentions and organisational requirements for the site

B. The Trust's strategic position is summarised as:

The local health economy and the Trusts position within it

The Royal National Hospital for Rheumatic Disease (RNHRD) is a specialist hospital in central Bath with an international reputation for research, and expertise in Rheumatology, complex Neuro Rehabilitation, Pain Management and Complex Fatigue Syndrome. The Royal United Hospital, the local District General Hospital in Bath, does not provide these services for the local population. The services of the Trust support both the local population and attract referrals on a regional and national basis.

Summary Demographic Data

- The population of Bath & North East Somerset (B&NES) in 2009 was 177,200 residents
- The structure is similar to the UK in population proportions by 5-year age groups
- B&NES remains less ethnically diverse than the UK as a whole
- Local population growth has been significantly impacted by the increase in the number of students
- ONS project that B&NES population will increase by 12% by 2026, this increase is expected to mainly be experienced in older people, in particular the 80+ population is projected to increase by 40% between 2010 & 2026
- Arthritis and musculoskeletal conditions affect 1 in 5 in the UK, this demographic data can be used as an indicator of anticipated growth in referrals to Rheumatology.

The possible threat posed by competition and its potential impact

- There are two local private providers of Neurorehabilitation services that are taking referrals that previously came in to the RNHRD, this change in referral practice contributed to a 5.7% reduction in occupied bed days from 5,908 in 2010/11 to 5,573 in 2011/12. A further significant reduction in neurorehabilitation referral levels is anticipated in 2012/13 due to increased competition from other specialist independent providers of neurorehabilitation and the independent sectors ability to provide many of the neurorehabilitation services in more appropriate, accessible accommodation
- Establishment of a competitive alternative provider of rheumatology services in the local area.

The possible threats and opportunities from changes in commissioning intentions and service delivery changes

Threats

- The shift to community settings of care for Neuro Rehabilitation and Rheumatology patients has had a significant impact on referral levels in to neuro rehabilitation and length of stay across both services. As the neuro rehabilitation income is generated on an occupied bed day basis the reduction in length of stay, whilst clinically appropriate, has had a significant impact on income
- Changing commissioner referral patterns for endoscopy services to local Independent Treatment Centres
- Challenge of securing funding for complex pain services
- The relatively small size of the RNHRD and the specialist nature of its services makes it difficult for the Trust to engage with the emerging Clinical Commissioning Groups in a meaningful manner
- Establishment of a triage system for musculoskeletal/orthopaedic patients by local commissioners which may impact on the number of new referrals, estimated potential impact of up to 10% of referrals. Triage by practitioners with special interests usually GPs or physiotherapists are being used in other areas as a way to improve the efficiency and appropriateness of the referral process
- Although the actual number of referrals to the Rheumatology service are increasing, the number of admissions to inpatient services are decreasing in line with commissioners requirements which directly affects the income received
- The loss in income across all services is proceeding at a pace faster than the Trust's ability to reduce costs, the Trust faces a disproportionately high overhead cost relative to turnover
- The opportunity to increase significantly levels of activity and income from the Trusts service lines is limited due to pressures on funding available

Opportunities

- Development of further rehabilitation services for cancer survivors building on the success of the MacMillan step up service and the complex regional pain, late effects service
- Strengthening relationships with veterans organisations further to develop links and services to support veterans across our rehabilitation services
- Due to improvements in the clinical management of Rheumatic Diseases, and in line with best practice, to continue to grow outpatient and day case rheumatology activity for biologic therapy
- Engagement in the Strategic Health Authority Trauma pathway forum establishing neuro rehabilitation pathways across the South West
- Increasing the number and type of out patient services and day case packages for neuro rehabilitation patients
- Establishment of the neuro rehabilitation service as a level 1 service, the highest level of complex rehabilitation service provision
- To increase diversity in development of pathways for different diagnostic groups for rehabilitation and/or complex needs
- The Trust is exploring opportunities to increase numbers of clinics in primary care settings
- Increase collaboration with key voluntary sector organisations with interest in Rheumatology issues.

C The Trust's Clinical and Quality strategy over the next three years is:

To facilitate the provision of care closer to home and effect the shift from delivery care away from an inpatient setting to increase day case and outpatient priority. The Trust remains committed to extending its reputation for the provision of nationally recognised specialist services, clinical research, and as a centre of educational excellence. In delivering this clinical vision the RNHRD is seeking to build a sustainable model of care for the future through:-

- Introducing new models of care and maximising new technology to shift clinical activity, where appropriate, from inpatient to day-case and outpatient basis, both on-site and in community settings in line with improvements in the management of conditions and Commissioner intentions
- Investing in services where there is demonstrated scope for growth
- Reshaping services where costs consistently exceed income
- Consolidating and reshaping the estate to release resources to support the developments, primarily for new clinical facilities
- Undertaking the transformation in partnership with commissioners of care and in line with Quality, Innovation, Productivity and Prevention (QIPP) plans
- Strengthening clinical leadership to maximise the contribution of clinical staff to the day to day running of the Trust
- Reshaping the workforce in line with national standards to maximise efficiency and productivity, leading to a reduction in costs, whilst maintaining safe, high quality patient care

Core Objectives for all Services in 2012/13

The Trust has identified core objectives which will be equally applied across all services, they are:

To delivery high quality, safe care:

- Future development plans will include reducing the cost base of the service, where clinically appropriate and in line with the vision and strategy and providing a higher contribution to Trust overheads by:-
 - Continuing to work with veterans organisations to develop links and services to support access to our rehabilitation services
 - Taking opportunities generated by natural wastage to improve productivity and skill mix to reduce cost base of the service. Develop rotational posts with other services to improve flexibility and responsiveness of staff across the Trust to service needs
 - Generating clinically relevant research outcomes for publication and dissemination and inclusion into evidence-based treatments for all services
 - Continuing to deliver evidence based education to GPs and other clinical groups and commissioning as required to improve understanding of our specialist conditions, improve patient management and increase referrals
 - Implementing of digital dictation and streamline administrative processes
 - Maximising private patient income through effective marketing plans.

Specialty Business Plans for 2012/13

The Trust has the following specialist clinical services:

- Rheumatology,
- Neuro Rehabilitation,
- Pain Management,
- Fatigue Management Services for paediatrics and adults and
- Complex Regional Pain services.

Clinical Leads and General Managers have been involved in the development of business plans for each specialty; details by specialty are below.

Rheumatology

Drivers for change in rheumatology include:

Reduction of 12% in national tariff for Rheumatology will result in reduced income despite a predicted increase in activity. Alongside this costs are increasing, therefore services need to be reviewed to ensure they are efficient and productive. New drug therapies and earlier diagnosis continue to transform the treatment of Rheumatological disease; leading to reduced levels of disability, more patients can now be managed in out patient settings by multidisciplinary teams reducing the need for in patient beds. This shift of care from inpatient settings to outpatient, day case and community settings is in line with national policy and requires strengthened relationships at strategic and day to day levels with primary care. To support this the Trust is working with Commissioners and emerging Clinical Commissioning Groups to review referral, admission and out patient follow up criteria and has agreed to maintain for 2012/13 the average length of stay we achieved in 2011/12 of 8 days. The introduction of musculoskeletal triage services within the community during 2012/13 could reduce GP referrals to rheumatology by around 15% but this also presents us with an opportunity to develop direct access services within out patient Physiotherapy and Occupational Therapy as GPs may move from referring musculoskeletal conditions to Rheumatologists and instead will refer direct to therapists.

Objectives for 2012/13

- Reduce rheumatology inpatient beds from 17 to 12 with associated skill mix reductions whilst maintaining length of stay targets set by Commissioners and reducing cost base
- Increase day case activity by 20% and extend day case unit opening from 3 days per week to 5 days to increase the number of non elective patients able to have their assessment, investigations and/or treatment in a day case setting
- Establish a dedicated rheumatology helpline for health professionals to improve access to clinical advice and reduce unnecessary admissions
- Ensure discharge summaries are sent to GPs within 24 hours of discharge
- Ensure that there are no delays in rheumatology follow up appointments by managing demand and developing follow up criteria
- Improve nursing leadership by appointment of a band 6 night Sister working across the hospital and a band 6 Out Patient Sister
- Appoint an additional substantive Consultant specialising in rheumatoid arthritis or connective tissue disease to sustain current levels of activity and reduce reliance on waiting list initiatives and locum appointments. The post will also seek to strengthen academic and research linkages
- Run additional Fibromyalgia and Ankylosing Spondylitis programmes which focus on self management, reduce inpatient admissions and increase income. Pilot the use of community facilities to increase capacity in Ankylosing Spondylitis programmes
- Develop direct access physiotherapy, occupational therapy and Dexa scanning services for GPs to maximise income generation
- Increase endoscopy activity through increased engagement with GPs and improve governance of single handed consultant service by working with other local providers
- Clinical measurement and imaging will increase direct referrals from GPs by implementing electronic referrals and reporting system for bone density scanning; participate in the modernising scientific careers Clinical Scientist training programme.

Neuro-Rehabilitation

Drivers for change in Neuro rehabilitation include:

The demand for in-patient Neuro rehabilitation bed days has steadily declined over the last two years due to a number of factors; 52% improvement in length of stay to an average of 10 weeks, changes in Commissioning and increased competition from local community based NHS services, private and charity sector providers. There are two new private/charitable competitor units opening over the next year in Swindon and Bristol respectively. This has meant that bed occupancy has reduced and is currently forecast for the year 2012/13 at 10 equivalent occupied beds, rather than 17.5 equivalent occupied bed forecast requirement for 2011/12. This reduction in income means that the Unit would have to reduce its direct costs further by around £800K to remain viable, if the lost income was not generated elsewhere. Work to seek alternative admission types has identified patient groups where there is potential for growth, but it is forecast that this will lead to marginal addition demand in the next financial year. To provide some stability for the unit a block contract for 10 beds with a cap and collar arrangement has been agreed with the South West Specialist Commissioners for 2012/13.

Objectives for 2012/13

- To aim for 100% data completion of UKROC dataset to formally establish the service as a level 1 service, the highest level of complex rehabilitation service provision, to meet agreed CQUIN payment.
- To increase diversity in development of pathways for different diagnostic groups for rehabilitation and/or complex needs in particular stroke and multiple sclerosis
- To explore accreditation with Headway as an approved provider of Neuro rehabilitation
- To increase the number of referrals from across the South West peninsula and within the existing South West Specialist Commissioning Group through increased marketing of the unit as a specialist centre of excellence including further development of the internet page and an annual patient outcomes report.
- Review of tariffs and production of service prospectus to provide clear information to all commissioners on level of service provided
- Ensure full inpatient Neuro rehabilitation assessment within 7 days and communication to the commissioning PCT within 14 days as part of CQUIN target
- Develop specialist out patient services within psychology, complex therapy and spasticity management to maximise income
- Appointment of band 7 ward manager and band 6 night sister to strengthen nursing leadership and support clinical practice
- During 2011/12 the Unit had 3 cases of *Clostridium difficile*, in 2012/13 there will be a zero tolerance approach to *Clostridium difficile*
- Develop and improve continence management to reduce rate of catheter acquired infection with subsequent reduction in antibiotic prescribing. Purchase bladder scanner and implement training for staff
- Reduce the number of staffed Neuro rehabilitation inpatient beds from 17.5 to 13 with associated skill mix reductions across all professionals whilst maintaining length of stay targets set by Commissioners and reducing cost base
- Appoint an Associate Specialist/LAT in Neuro rehabilitation medicine to support clinical governance and ensure safe levels of medical staff
- Actively engage with the Bristol and Plymouth Trauma Centres and the regional decision making bodies to ensure that the whole system redesign incorporates the role of specialist rehabilitation.

Pain management

Drivers for change in pain management include:

Pain management programmes were down by 7.9% in 2011/12 due to Commissioners not approving funding for patient treatment in a tight financial climate and this trend looks like continuing in 2012/13. CQUIN targets have been agreed with Commissioners for 2012/13 to establish Pain Management Outcome measurements for example, returns to work, increased attendance at educational establishments. Changes to national specialist commissioning will not come into effect until 2013/14 for pain services but it will be important to network and link with the emerging national team to ensure they have a good understanding of our services.

Objectives for 2012/13

- Increased flexibility in planning the years programmes so the unit can meet the needs of the largest group of patients funded at any time
- To build a strengthened local service profile by developing services for adults and young people that will be delivered via outpatient treatments
- To meet agreed CQUIN targets to establish Pain Management Outcome measurements for example returns to work and increased attendance at educational establishments.
- To further increase by 10% income from research grants
- To attract private patient income of £ 150K for 2012/13
- Developing local services, e.g. CRPS education programmes for GPs and other clinicians, and brief intensive interventions for psychology/physiotherapy treatment for chronic pain delivered in primary care settings
- To develop a Paediatric Pain Clinic increasing our range of services, this is an outpatient service aimed at referrals from the local area
- To develop an opiate reduction service.
- In light of the commissioning climate to work more closely with PCT's and agree pathways to allow a smoother funding process. Network with national specialist commissioning team to develop their understanding of pain services.

Complex Regional Pain

Drivers for change in complex regional pain include:

This is a growing service, last year there was a 27% increase in referrals and conversion from referral to assessment was 88.3% with 115 new patients seen. Inpatient activity was slightly under target at 92. Resource to support inpatient physiotherapy and occupational therapy for CRPS inpatients has been allocated to the therapy department to improve access to specialist therapy for this group of patients. The CRPS team is small with a high proportion of part time staff and capacity to manage increased activity is limited. The launch of the new Late Effects service is an opportunity to expand the team and the appointment of a full time Service Manager will enhance continuity and communication. 2012/13 will be a year of consolidating and maintaining the increased activity within CRPS whilst growing the new national service. Future developments need to include reducing the cost base of the service and providing a higher contribution to Trust overheads.

Objectives for 2012/13

- To increase referral rates and inpatient programme numbers year on year by 15%
- To deliver evidence based CRPS education via a National CRPS conference, educational seminars and to RNHRD in patient staff to improve the understanding of CRPS and improve patient experience and increase patient referrals
- Launch Breast Radiotherapy Injury Rehabilitation Service, (Late Effects) with the RNHRD as national lead and working with partner hospitals of Barts and the London, London, the Christie, Manchester and the RUH, Bath
- Relocate team to larger office space to accommodate additional staff for Late Effects service
- To generate £20K income from overseas patients and private patients in 2012/13

Adult Fatigue Management Services

Drivers for change in fatigue management include:

The Adult Fatigue Management service has seen activity increase by 6.2% but due to tariff reductions and higher mix of contract to non contract patients their income was £24K below plan last year. Referrals more recently have increased for young adult population and as such a young adult programme has become established. 2012/13 is a year of expansion for the team due to the launch of the new Macmillan "Step Up" service. The service will provide care to cancer survivors initially from BaNES and Wiltshire to manage symptoms of fatigue. Commissioners need to be engaged in the progress with this service with a view to providing mainstream funding in 3 years time. The adult service continues to be a QIPP exemplar on NHS evidence for its use of alternative media to support people with CFS/ME. Similar to other specialist teams in the Trust the adult fatigue team is small with a high proportion of part time staff and capacity to manage further increases in activity will be limited.

Objectives for 2012/13

- To increase referral rates by 10% and deliver overall increase in activity
- Establish Macmillan "Step Up" Service and attend Commissioning College to take forward future commissioning agenda
- To generate £10K income from private patients and legal reports in 2012/13

Paediatric Fatigue Management Services

Drivers for change in paediatric fatigue management include:

The Paediatric Fatigue Management is a rapidly growing service which has seen activity increase by 29.9 % their income was £132K above plan in 2011/12 and they have continued to build on their reputations for high quality treatment. The team recruited additional admin, psychology and physiotherapy staff during last year to cope with the increased demand and have recently appointed a GP with Specialist Interest, (2 sessions per week) to enhance medical staffing. 3.5 sessions of a paediatric Consultant will be recruited to in collaboration with North Bristol Trust during 2012/13. Satellite paediatric CFS/ME clinics, managed by the RNHRD continue successfully. 2012/13 will be a year of steady growth but also one of consolidation for new staff to bed into the service. Similar to other specialist teams in the Trust the paediatric fatigue team is small with a high proportion of part time staff and capacity to manage further increases in activity will be limited.

Objectives for 2012/13

- To increase 2011/12 referral rates and deliver overall increase in activity
- Improving equity of access for local children by increasing service provision within the region.
- Increasing the provision of specialist physiotherapy for children with CFS/ME.

Quality Strategy

Introduction

The RNHRD is committed to providing high quality and safe care. The board has reviewed the requirements detailed in Monitor's Quality Governance Framework and during 2011/12 certified;

The board is satisfied that, to the best of its knowledge and using its own processes and having regard to Monitor's Quality Governance Framework (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), its NHS foundation trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.

Purpose

The purpose of this strategy is to describe the trust key aims for quality, including safety, clinical effectiveness and patient experience for 2012-15 and the key actions, milestones, plans to address any concerns and risks to delivery. The trust will agree any additional priorities for improvement each year following feedback from patients, staff, Council of Governors, members, commissioners, the local Overview and Scrutiny Committee and local LINK.

Duties within the Organisation

The Board will ensure that there is a Quality Governance Framework in place.

Quality Governance is the combination of structures and processes at and below board level to lead on trust-wide quality performance including:

- Ensuring required standards are achieved;
- Investigation and taking action on sub-standard performance;
- Planning and driving continuous improvement;
- Identifying, sharing and ensuring delivery of best-practice; and
- Identifying and managing risks to quality of care.

The Directors have operational responsibility for delivering high quality, safe care.

All staff have responsibility for delivery of high quality safe care, adhering to trust policies, attending training, reporting incidents and risks and managing risks.

Monitoring and Audit

Compliance with the strategy will be monitored through monthly reports to the Board and the assurance the board receives from the quarterly IGQAC meeting minutes.

References

Monitor Compliance Framework 2012/13
Monitor Quality Governance Framework 2010
NHS Constitution 2012
NHSLA Risk Management Standards 2012
NHS Standard Contract Acute Trusts 2012

D Clinical and Quality priorities and milestones over the next three years are:

Quality Goal	Key actions required to deliver the goal	Key milestones the Trust Board will use to evaluate progress towards the goals	Plans in place to address any existing concerns about quality	Risks to delivery and how these will be managed
2012/13				
Safety				
Meet the CQC essential standards of quality and safety and maintain registration without conditions	Continuous assessment against the CQC essential standards of quality and safety	Quarterly CQC essential standards compliance declarations by Directors presented to Board	No concerns identified	No risks to delivery identified
Meet the applicable indicators detailed in Monitor's Compliance Framework 2012/13	Meeting the MRSA, C. Difficile and maximum time of 18 weeks from point of referral to treatment and certification against compliance requirements regarding access to healthcare for people with a learning disability	Quarterly performance declarations presented to the Board	C Difficile target further improvements to infection prevention and control by accelerating sink replacement programme to	Introduction of more sensitive C Difficile screening may result in detection of more cases than the de minimis threshold of 12 cases detailed in the Compliance Framework 12/13
Meet all the safety requirements within the 2012/13 contract with host commissioner	Continuous assessment against the safety requirements, participation in National Patient Safety Programme.	Quarterly performance reports to host commissioner, minutes of meetings reported to IGQAC.	C Difficile target further improvements to infection prevention and control by accelerating sink replacement programme to	Introduction of more sensitive C Difficile screening may result in more cases than the local target of 6 cases in 6 separate patients
Clinical Effectiveness				
Meet NICE guidance published in 2012/13	Review of NICE guidance	Quarterly reports to IGQAC on NICE guidance and results of clinical audit	No concerns identified	No risks to delivery identified
Establish a dedicated rheumatology helpline for health professionals	Introduce new process of ward based Registrars taking calls from GPs	Quarterly performance reports to host commissioner, minutes of meetings reported to IGQAC.	No concerns identified	No risks to delivery identified
Ensure discharge summaries are sent to GPs within 24 hours of discharge	Medical director to agree with medical staff technology solution to generate discharge summaries and managing process when medical staff change.	Quarterly performance reports to host commissioner, minutes of meetings reported to IGQAC.	Internal audits during 2012/13 to review performance and identify any areas for improvement	No risks to delivery identified
Patient Experience				
Meet the pledges set out in the NHS Constitution	6 monthly assessment against the pledges	6 monthly report to IGQAC	No concerns identified	No risks to delivery identified
Improve performance in any areas where the trust scored in the lowest 20% for the 2011 national patient surveys published in 2012.	Review of results of patient survey to identify any areas where the trust scored in the lowest 20% and develop action plan to improve performance	Reports to IGQAC and Board on outcome of national surveys and resulting action plans	Improve information to patients who have a delay in the start of their outpatient appointment	No risks to delivery identified

2012/13				
Patient Experience (continued)				
Ensure that there are no delays in rheumatology follow up appointments	Monthly review of clinic capacity and demand for new and follow up appointments	Monthly operational reports to trust Board	Recruitment of additional Consultant Rheumatologist to create additional clinic capacity to meet demand for follow up appointments	Failure to appoint due to lack of suitable candidate if this occurs, waiting list initiative clinics to continue.
Continue to improve telephone access to the appointments department	Monthly review of complaints with appointment team	Reports to IGQAC and Board on outcome of national surveys and resulting action plans	Redesigning roles within the appointments office to improve productivity and utilise available technology	Ability of staff to cope with change required may slow down improvement
2013/14				
Safety				
Meet the CQC essential standards of quality and safety and maintain registration without conditions	Continuous assessment against the CQC essential standards of quality and safety	Quarterly CQC essential compliance declarations by Directors	No concerns identified	No risks to delivery identified
Meet the applicable indicators detailed in Monitor's Compliance Framework 2013/14	Meeting the MRSA, C. Difficile and maximum time of 18 weeks from point of referral to treatment and certification against compliance requirements regarding access to healthcare for people with a learning disability – subject to any changes to the indicators detailed in the 2013/14 Compliance Framework	Quarterly performance declarations presented to the Board	No concerns identified	No risks to delivery identified
Meet the safety requirements within the contract with host commissioner	Continuous assessment against the safety requirements, participation in National Patient Safety Programme.	Quarterly performance reports to host commissioner, minutes of meetings reported to IGQAC.	No concerns identified	No risks to delivery identified
Achieve NHSLA Level 1 Assessment	Review of trust policies against NHSLA assessment criteria	Reports from IGQAC Committee on progress against NHSLA Level 1 action plan and outcome of NHSLA informal assessments	No concerns identified	No risks to delivery identified
Clinical Effectiveness				
Meet NICE guidance published in 2013/14	Review of NICE guidance	Quarterly reports to IGQAC on NICE guidance and results of clinical audit	No concerns identified	No risks to delivery identified
Patient Experience				
The trust will meet the pledges set out in the NHS Constitution	6 monthly assessment against the pledges	6 monthly report to IGQAC	No concerns identified	No risks to delivery identified
Improve performance in any areas where the trust scored in the lowest 20% for the 2012 national patient surveys published in 2013.	Review of results of patient survey to identify any areas where the trust scored in the lowest 20% and develop action plan to improve performance	Reports to IGQAC and Board on outcome of national surveys and resulting action plans	No concerns identified	No risks to delivery identified

Quality Goal	Key actions required to deliver the goal	Key milestones the Trust Board will use to evaluate progress towards the goals	Plans in place to address any existing concerns about quality	Risks to delivery and how these will be managed
2014/15				
Patient Experience				
Meet the safety requirements within the 2014/15 contract with host commissioner	Continuous assessment against the safety requirements, participation in National Patient Safety Programme.	Quarterly performance reports to host commissioner, minutes of meetings reported to IGQAC.	No concerns identified	No risks to delivery identified
Safety				
Meet the CQC essential standards of quality and safety and maintain registration without conditions	Continuous assessment against the CQC essential standards of quality and safety	Quarterly CQC essential compliance declarations by Directors	No concerns identified	No risks to delivery identified
Meet the indicators detailed in Monitor's Compliance Framework 2014/15	Meeting the MRSA, C. Difficile and maximum time of 18 weeks from point of referral to treatment and certification against compliance requirements regarding access to healthcare for people with a learning disability – subject to any changes to the indicators detailed in the 2014/15 Compliance Framework	Quarterly performance declarations presented to the Board	No concerns identified	No risks to delivery identified
Meet the safety requirements within the 2014/15 contract with host commissioner	Continuous assessment against the safety requirements, participation in National Patient Safety Programme.	Quarterly performance reports to host commissioner, minutes of meetings reported to IGQAC.	No concerns identified	No risks to delivery identified
Clinical Effectiveness				
Meet NICE guidance published in 2014/15	Review of NICE guidance	Quarterly reports to IGQAC on NICE guidance and results of clinical audit	No concerns identified	No risks to delivery identified
Patient Experience				
The trust will meet the pledges set out in the NHS Constitution	6 monthly assessment against the pledges	6 monthly report to IGQAC	No concerns identified	No risks to delivery identified
Improve performance in any areas where the trust scored in the lowest 20% for the 2013 national patient surveys published in 2014.	Review of results of patient survey to identify any areas where the trust scored in the lowest 20% and develop action plan to improve performance	Reports to IGQAC and Board on outcome of national surveys and resulting action plans	No concerns identified	No risks to delivery identified

Financial Strategy

E The Trust's financial strategy and goals over the next three years:

The RNHRD's financial objectives for the 2012/13 year are:

- To deliver the financial plan for 2012/13, to include:
 - Maximising private patient income
 - Meeting the cash target throughout the year
 - Meeting the QIPP and cost improvement target for the year
 - Production of timely forecasting
- Increasing productivity and reducing costs in addition to the current QIPP and cost improvement targets.

The RNHRD's financial strategy for 2012/13 and beyond is to obtain the financial resources required to ensure the continued and safe delivery of services. This is to be achieved through:

- Maximising income by working closely with commissioners and GP's to attract referrals and by promoting our services
- Reducing costs and increasing efficiency through a cost improvement programme, vacancy control and scrutiny of expenditure forecasts.
- Seeking external support where it is in the best interests of the services and local health economy to do so.

The key assumptions underpinning the Trust's income and expenditure plans are:

- A general reduction in activity, particularly in Neuro Rehabilitation although there are some growth opportunities, such as in Chronic Regional Pain Syndrome and Chronic Fatigue services. Activity plans were developed with regard to historical trends, commissioner intentions and local knowledge and costed based on national tariff changes and agreed local tariffs.
- Demand management initiatives within the PCT's are likely to impact on demand for high cost drugs for which the Trust is reimbursed based on expenditure.
- Inflationary pressures have been specifically identified per expenditure type. No pay award other than for incremental rises has been assumed for staff remuneration.
- Capital expenditure is planned to exceed depreciation value, where external funding has been received for specific projects.
- The Trust benefited from a prepayment in cash equivalent to one month's contract value, amounting to £730k. Further income for 2012/13 and 2013/14 is being sought from the commissioners to enable the delivery of a robust and achievable plan for the chosen strategic option.

The main risks to delivering the financial strategy are that:

- The activity plans may not be delivered thus reducing the income envelope further.
- The Trust, as a small organisation, carries a large proportion of overheads and fixed costs limiting the scope for cost reduction plans.
- Sufficient income to produce a balanced financial plan is not confirmed at the time of writing. If additional funding is not available the Trust will run out of cash during 2012/13.
- The Trust remains financially fragile and vulnerable to changes to its working capital.

Leadership and Organisational Development

F The Trust's approach to ensuring effective leadership and adequate management processes and structures over the next three years is:

The Trust Boards approach to ensuring effective leadership and adequate management processes and structures over the next three years will need to take in to account:-

- The planned merger or transfer of services during 2012/13
- Business continuity risks
- Director of Operations and Clinical practice return from maternity leave in August 2012
- Engagement of external management consultant to facilitate Board seminars
- Single handed consultant in endoscopy
- Recruitment of additional Rheumatological consultant

The Trust Board, mindful that the next three years will be ones of transition towards more effective integration with other service providers, places the highest priority on maintaining effective leadership and management processes during this period. In order to set a benchmark and to reassure the Board that effective governance is in place, and being maintained, the Internal Auditors were tasked this year with evaluating performance against Monitor's Code of Governance. This included assessing the active engagement of the Board and Council of Governors. Their report rated Governance as Green, providing reassurance that the concepts and practical application of good governance are understood and implemented at the Trust.

Forward plans for merger or alternatively the orderly transfer of services do however present a risk to business continuity, as does the potential loss of key personnel. These risks are recognised and remain under review.

Meanwhile external advice regarding forward plans and how the transition process can best be managed has been contracted. This follows extensive use of professional consultancy in developing those plans.

There are no current or future known gaps in Board skills and composition. The Board has a Non Executive Director with specific skills in the area of merger. As the process of transition unfolds a project manager will be in post to provide oversight, co-ordination and continuity in the provision of services.

Other Strategic and Operational plans

The Board of the RNHRD has, for the last few years recognised that the organisation is vulnerable as an independent FT, principally because of its size.

In 2009 the Board expressed its strategic intent to merge with the Royal United Hospital, Bath (RUH). The opportunities to explore and potentially implement this option have been limited for a number of reasons including in particular the delay experienced by the RUH in becoming an FT itself. The underlying trend for the financial year 2012/13 shows a recurring annual deficit of approximately £2m. All financial indications now show that the Foundation Trust is not sustainable in the short to medium term as described below:-

- Loss of income, due to changing referral patterns, lower levels of in patient activity and downward pressure on tariffs
- The overhead costs of being an FT and the overhead costs associated with running an old hospital building which is not fit for purpose
- The loss of income is proceeding at a pace faster than the FTs ability to reduce costs and/or increase income, which has resulted in the Trust facing a disproportionately high overhead cost relative to turnover
- There is concern that the necessary level of cost reduction can not be achieved within the current infrastructure without prejudicing the quality and continuity of services to patients.

Therefore in April 2012 the RNHRD NHS FT Board agreed that given the unavoidable inherent lack of certainty at this stage about the timing of the necessary milestones in the RUH's FT authorisation application and a weak forecast 2012/13 financial position, the Trust would need to commence a process of exploring strategic options to address its financial viability concerns.

A programme management structure has been agreed by the Trust Board to effect this strategic decision; key timelines are as described below:

- Options appraisal document to assess the options against agreed criteria to be produced by mid June
- Agreement of strategic option with key stakeholders by 22nd June
- Board seminar 28th June to agree the process to effect the strategic option
- Implementation programme to commence July 2012

Key Risks

- Competition concerns raised by the CCP or other regulatory bodies
- Timescales of when relevant provision in the Health & Social Care Act 2012 becomes effective and developing a framework for the process accordingly

Mitigation

- Application of relevant public consultation, corporate & restructuring and competition law
- Ongoing management of relationships with stakeholders
- Robust project management structure
- Engagement of legal advice

Regard to the views of Trust Governors

H The Trust has had regard to the views of Trust Governors by:

The Trust is well supported by an experienced and committed Council of Governors. Internal Audit has confirmed that the structure at Council and sub committee level allows proper engagement between Directors, Non Executive Directors and Governors. During the past year the latter have, through the medium of an Annual Members Day, Newsletters, informal and formal briefings been able to act as a catalyst for communication with members. At times the pace of events surrounding the acceleration of long term strategic intent has been such that it has been more difficult to manage this process, but every effort has been made through the Lead Governor and Chairs of Council sub committees to keep Governors informed. Two Governors are routinely in attendance at Board meetings and two Governors sit in attendance at Audit Committee meetings.

The Chief Executive presented the developments in clinical services and plans for 2012/13 at the March 2012 Council of Governors meeting. The Chief Executive presented the outline strategic intent for 2012/13 at an extraordinary Council of Governors meeting on 30th April 2012 and the detail of the Annual Plan for 2012/13 was made available at the May 2012 Council of Governors meeting. Finally Governors have been engaged in a process of consolidating their views on the future of the Trust. After consultation with members, and taking into account the views of service users, this took the form of a paper presented to the April 2012 Board and recognised as a welcome input to strategic developments at the Trust.

Appendix 1: Key risks (NOT INTENDED FOR PUBLICATION)

Financial Risks

Category of risk	Description of risk (including timing)	Potential impact	Mitigating actions / contingency plans in place	Residual concerns	How Trust Board will monitor residual concerns
<i>External risk.</i>	Uncertainty presented by the changes and transition to the new structure of the NHS introduced by the Health and Social Care Act 2012, particularly the need to develop working relationships with new and developing commissioners.	Reduced referrals as new commissioners engage in the process. Potential disruption to plans for transfer or merger or services as PCTs and SHA's themselves undergo structural change.	The Trust has worked during the year to engage General Practitioners and promote its services. It has worked closely with the Primary Care Trusts and developing Clinical Commissioning Groups to ensure services are understood and valued.	CCGs may have alternative priorities for commissioning that continue to impact on the Trust	Through formal Board reporting and review of the risk register at Audit Committee
<i>Income risk</i>	Changes to funding levels as a consequence of tariff reductions.	Reduction to income and increased deficit.	The Trust has reviewed its cost base to improve efficient delivery of services.	The scope of cost reduction is limited by the Trust's small size and high proportion of fixed overheads. A deficit and cash difficulties are still likely despite efficiencies achieved.	Through formal Board reporting and accountability of the Programme Board (iro strategic options) to the Board.
<i>Income risk</i>	Reduced levels of activity as a consequence of competition and the movement towards more care being provided in the community.	Reduction to income and increased deficit.	The 2012/13 activity plans reflect anticipated reduction in demand. Activity against plan is monitored weekly to facilitate early warning of deteriorating performance and implementation of appropriate recovery plans. The Trust continues to work with the commissioners to ensure a safe and	Income generated from activity is still likely to lead to a deficit and cash difficulties.	Through formal Board reporting and accountability of the Programme Board (iro strategic options) to the Board.

			effective service is provided that meets patient's needs. It will continue to evolve its services to ensure care is delivered in the best way and in the most appropriate setting.		
<i>Liquidity risk</i>	The Trust may run out of cash in February 2013 or earlier if it does not receive external financial support.	Inability to pay staff or suppliers.	The Trust continues to closely manage the cash balance, debtors and creditors. The working capital facility secured in August 2011 was withdrawn in February 2012, however, a commercial loan secured on property may be available as an alternative. Additionally, the Trust continues to work with the PCT and SHA to secure an advanced contract payment which was received in April 2012 and to obtain further transitional funding.	Additional funding may still not be received from the PCT, or may not be received before the Trust runs out of cash.	Through formal Board reporting and accountability of the Programme Board (iro strategic options) to the Board.

Non-Financial Risks (including quality)

Category of risk	Description of risk (including timing)	Potential impact	Mitigating actions / contingency plans in place	Residual concerns	How Trust Board will monitor residual concern
Clinical	X-ray equipment reached end of support date. Manufacturer can no longer guarantee maintaining the equipment due to age.	Loss of X-ray service	Purchase of new machine included in 2012/12 Capital Plan	None	N/A
Clinical	Risk of Legionnaires Disease from trust water systems	Legionella infection	Trust has completed a detailed action plan to minimise the risk. awaiting final visit by HSE in June 2012 for review of completed actions.	Review of completed action plan by HSE in June 2012	Presentation of risk to Audit Committee and Board
Clinical	Delay in rheumatology Follow ups	Waiting times for rheumatology follow ups may exceed stated interval e.g. 3 or 6 months between appointments due to increase in demand or decrease in capacity	Medical Director and director of Operations to review demand and capacity for out patient activity. Additional Rheumatology Consultant post advertised May 2012.	Lack of suitable applicant for the post requiring further waiting list initiative clinics.	Monitoring of follow up appointments by Finance and Activity Committee and Board.
Clinical	Single Consultant Specialty	Failure to ensure service meets demand.	Alternative provision to be arranged if Consultant unavailable and there is sufficient demand.	None	N/A
Clinical	Failure to achieve local C.Difficile trajectory of 6 cases in 6 separate patients for 2011/12	Failure to meet local trajectory	Infection prevention and control policies and procedures. Root cause analysis completed on all cases and any resulting action plan reviewed by Infection prevention and control committee. External assessments by host commissioner Sink replacements during 2012/13. Cleaning schedules and staff training updated and enhanced cleaning solution in use.	New testing to be introduced during 2012/13 which is more sensitive and may increase rate of detection and therefore number of cases.	Monthly quality reports to Board from Director of Operations and Clinical Practice. Quarterly declarations to Monitor

Workforce	Loss of key personnel leading to a business continuity risk as a result of uncertainty over the organisation's future	Risk to delivery against the activity plans to effectively lead the organisation through a period of change	Establishment of a Programme Management Board with a work stream to review business continuity. Review of risk through the Board sub committees and the Programme Management Board	To be identified through the Programme Management Board	Programme Management Board to provide regular reports to the Trust Board
-----------	---	---	--	---	--

Risks to Quality

PLEASE HIGHLIGHT IN YELLOW ANY INFORMATION WHICH THE TRUST CONSIDERS TO BE COMMERCIALY SENSITIVE, CONFIDENTIAL OR OTHERWISE UNSUITABLE FOR DISCLOSURE

Capacity to handle risk

Leadership is given to the risk management process through

- the Audit Committee and Board developing and agreeing the Assurance Framework
- the board sub committees structures which are now well embedded to strengthen risk management. The Integrated Governance and Quality Assurance Committee meets quarterly and reports to the Audit Committee and Board
- the Integrated Governance and Quality Assurance Committee considers risks associated with clinical quality and governance
- the Audit Committee reviews all risks on the risk register rated moderate and above and ensures that appropriate controls are in place to minimise risks
- the Clinical Risk Committee reviews all clinical risks rated moderate and above and receives reports on complaints, claims and reviews reports from the following committees; health and safety, infection prevention and control, medical devices, drugs and therapeutics, safeguarding and reports from the National Patient Safety Agency and reports to the Integrated Governance and Quality Assurance Committee
- the Director of Governance led the NHSLA assessment against the Clinical Negligence Scheme for Trusts during 2011 with achievement of level 1 and plans for reassessment at level 1 in November 2013
- staff are trained or equipped to manage risk in a way appropriate to their authority and duties
- all staff receive training at induction on risk management policy and process and staff responsibilities and duties
- the Trust seeks to learn from good practice through; membership of local safeguarding committees and the Strategic Health Authority Patient Safety Campaign and implementation of a range of patient safety initiatives
- regular briefs for the Senior Managers at Executive Management Group

The risk and control framework

The objective of the Risk Management Strategy is to ensure that the Trust will conduct its business to the best possible standard and provide the highest quality of care in a safe environment, through identifying, prioritising and managing all aspects of risk.

The Trust Risk Management Strategy aims to achieve the key objective above and ensure:

- management processes are in place to minimise risks
- high patient safety standards are maintained
- the cost of risk is reduced
- safe practices exist
- safe systems exist
- safe premises
- awareness of dangers and liabilities.

The strategy harnesses the knowledge and expertise of individuals within the organisation and translates it with their help into positive action, to help the Trust to achieve its objectives.

The board reviewed the requirements detailed in Monitor's Quality Governance Framework and during 2011/12 certified;

The board is satisfied that, to the best of its knowledge and using its own processes and having regard to Monitor's Quality Governance Framework (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints and including any further metrics it chooses to adopt), its NHS foundation trust has, and will keep in place, effective arrangements for the purpose of monitoring and

The board receives assurance regarding effective arrangements for the purpose of monitoring and continually improving quality of care through quality metrics including those applicable to the Trust in Monitor's Compliance Framework and reporting from the IGQAC committee on a range of measures e.g. those detailed in the host commissioner contract and local measures regarding; patient safety, clinical risk, clinical effectiveness, patient experience and any external visits, information governance, human resources and a 6 monthly review of compliance against the NHS Constitution. Assurance is obtained routinely on CQC registration requirements through quarterly declarations to the Board by the Directors with responsibility for each key standard and a review of the evidence to support the declarations and review of the CQC Quality and Risk Profiles at the IGQAC meeting which reports to the Board.

Risk management is embedded in the activity of the organisation through risk management policies and monitoring against these at various committees. All staff receive training at induction on the management of risk and reporting of incidents. The results of the 2011 staff survey demonstrate that the trust is better than average regarding staff reporting errors, near misses or incidents.

Risk appetites are determined by the review of all risks on the risk register, rated moderate and above, at each Audit Committee meeting which then reports to the Board. The Audit Committee and Board also review the Assurance Framework on a 6 monthly basis.

Actions Taken to Mitigate Risks to Quality in 2011/12

Following feedback from patients through the National CQC Survey of Adult Inpatients in the NHS 2011 results for RNHRD, complaints and PALs and patient feedback to the Council of Governors, feedback from the wider public through the Annual Members Day, LINKs, feedback from commissioning PCTs through the CQUIN and feedback from staff through the national patient safety programme and review of the risk register the following quality improvements were agreed by the Board and outcomes for 2011/12 are noted in the table below;

2011/12 Priorities for improvement	Date Source	2011/12 Outcomes
Patient Experience		
<p>In the National CQC Survey of Adult Inpatients in the NHS 2010 results for the RNHRD the Trust scored 74% for the question;</p> <p>Did you ever use the same bathroom or shower area as patients of the opposite sex?</p> <p>There are no multiple use mixed sex bathrooms on the wards, therefore the Trust will hold focus groups with patients to highlight how we can improve the Trust's performance in this area.*</p>	<p>National CQC Survey of Adult Inpatients in the NHS 2011 results for the RNHRD presented to Board and host PCT on publication by Care Quality Commission (Spring/Summer 2012).</p> <p>2011/12 Quality Report</p>	<p>In the National CQC Survey of Adult Inpatients in the NHS 2011 results for the RNHRD the Trust scored 7.5 (compared with a score of 74% for 2010. The scoring has changed from a % in 2010 to a score out of 10 in 2011) for the question;</p> <p>Did you ever use the same bathroom or shower area as patients of the opposite sex?</p>

2011/12 Priorities for improvement	Date Source	2011/12 Outcomes
Patient Experience		
<p>The Council of Governors and the National CQC Survey of Adult Inpatients in the NHS 2010 results for the RNHRD have both highlighted a need to improve communication with patients on leaving the hospital. The areas for improvement highlighted by the National CQC Survey of Adult Inpatients in the NHS 2010 results for the RNHRD were:</p> <p>1. Were you given clear information about your medicines*</p> <p>2. Did a member of staff explain the risks and benefits of the operation or procedure*</p>	<p>National CQC Survey of Adult Inpatients in the NHS 2011 results for the RNHRD presented to Board and host PCT on publication by Care Quality Commission (Spring/Summer 2012). 2011/12 Quality Report</p>	<p>In the National CQC Survey of Adult Inpatients 2011 results are presented as a score out of ten, the Trust scored 8.8 for the question</p> <p>1. Were you given clear information about your medicines?*</p> <p>This was an improvement on the 2010 National CQC Adult Inpatients survey score of 71%.</p> <p>In 2011 the Trust scored 85 for the question 2. Did a member of staff explain the risks and benefits of the operation or procedure?*</p> <p>This was an improvement on the 2010 National CQC Adult Inpatients survey score of 83%.</p> <p>We extended our local inpatient survey to include questions about patient's understanding of the medicines they receive.</p>
<p>Reduce number of delayed follow-ups in Rheumatology.* & ***</p>	<p>Monthly report to Board on number of delayed follow ups. Complaints and PALs reported quarterly to IGQAC. IGQAC and Quarterly Quality Report to Board. Quarterly quality report to host PCT. Annual Quality Report</p>	<p>The delayed rheumatology follow up appointments were managed successfully in 2011/12</p>

Actions taken to mitigate risks to quality in 2012/13

The priorities have been identified through:-

- Feedback from patients through the National CQC Survey of Adult Inpatients and Outpatients in the NHS 2011 results for RNHRD, complaints and PALs*
- Feedback from the Council of Governors.**
- Feedback from commissioning PCTs through the CQUIN***
- Feedback from staff through the national patient safety programme and review of the risk register and staff survey.****

Priorities for improvement 2012/13	Monitoring	Measurement	Reporting
Patient Safety			
<i>C. difficile</i> to improve performance against local agreed target of 6 cases for 2012/13*** 2011/12 performance = 4 cases of <i>C.difficile</i>	Report actual number of cases	Number of patients acquiring <i>C. difficile</i> infection at the RNHRD each month	Monthly reporting to Board, quarterly reporting to IGQAC, host PCT and Monitor and Annual Quality Report
Maintain achievement of key patient safety training targets throughout 2012/13** Safeguarding (80% for level 2), fire (80%), fire marshall (100%), infection control patient and non-patient contact (80%), manual handling patient and non-patient contact (80%), life support basic and life support intermediate (100%).	Monitor percentage actual against targets each month	Achievement against targets	Monthly reports to Board and Quarterly reports to IGQAC and PCT and Annual Quality Report
Clinical Effectiveness			
Discharge summaries to be received by GPs within 24hrs of discharge***	Monthly score card Six monthly audit on a minimum of 25 clinical records to confirm compliance	Percentage of discharge summaries received within 24 hrs to be 95% or greater.	Quarterly reports to IGQAC and host PCT and Annual Quality Report
Patient Experience			
Improve information to patients who have a delay in the start of their outpatient appointment* & ** 2011/12 performance = 8 PALs/complaints	Complaints regarding failure to advise patient of delay in start of their out patient appointment	Number of complaints regarding failure to advise patient of delay in start of their outpatient appointment.	Quarterly reports to IGQAC and Annual Quality Report
To introduce additional measures relating to the management of staff experiencing work related stress. In the 2011 NHS National Staff survey 37% of staff reported they suffered work-related stress in the last 12 months.****	Sickness absence reporting, number of completed stress audits received, NHS National Staff survey Results 2012, audit of work related stress conversations held between managers and staff who are not absent with work related stress	Number of staff absent. Number of staff reporting they suffer work related stress in the 2012 NHS Staff Survey	Staff absence reporting monthly to managers and EMG. Annual stress audit results to Health and Safety Committee. HR key indicators to Board quarterly and Annual Quality Report
Improve access to the appointments department* & ** 2011/12 performance = 85 PALs/complaints about access to the appointments department	Complaints regarding access to appointments department	Number of complaints regarding access to appointments department	Quarterly report to IGQAC, PCT and Board and Annual Report

Use of external assurance (including internal audit)

The Trust Board gained external assurance from four sources during 2011/12:

External Consultants (Rob Gittins): An external consultant was commissioned by the Trust as part of the development of its cost improvement programme to identify potential new income streams in neurorehabilitation. The outcome of this work was that the options being considered were not viable due to a lack of commissioner support.

Internal Audit: As part of the internal audit plan, investigations were made and reports presented on GP engagement and market position, CQC registration, the assurance framework and compliance with Monitor's code of governance, as well as a number of financial systems and processes. Action plans have been initiated to address the recommendations arising from these audits, which did not identify any material issues.

External Audit: As part of their external audit of the annual accounts, the Trust's external auditors were engaged to review the production of month end management accounts, including the year-end forecast position. This followed the marked deterioration in financial position reported to the Trust Board in January 2012 compared to the previous months. The review found that many areas of the production of the management accounts work well, although there were three key areas where improvements could be made relating to out-of-ledger adjustments, audit trail of adjustments and accountability and involvement of budget holders in forecasting. A number of improvements were made following the commencement of a new Director of Finance and Finance Manager with a further programme of improvement and development scheduled. The recommendations of the auditors have been agreed with actions in place to address them.

External Consultants (Finnamore Ltd): The Trust recognises that it is not financially viable as a small NHS Foundation Trust and its plans have reflected the strategic intent to merge with the Royal United Hospital, Bath. In previous years, the Trust has managed to deliver small surplus, but in 2011/12 received additional financial support and delivered a £106k deficit. The financial forecasts for 2012/13, developed in January 2012, indicated that the Trust would be in deficit without plans in place to significantly increase income and/or reduce costs. External Consultants were commissioned to aid the Trust Board in developing its strategy for 2012/13.

External Review of Infection Control

The Trust has quarterly review meetings with the Lead infection Control Nurse from B&NES PCT which includes a walk round of clinical areas and review of root cause analysis relating to notifiable infections e.g. Clostridium difficile cases, written reports are provided and action plans agreed and developed where areas of improvement are identified

External Review of Quality

The B&NES PCT Quality Lead attends quarterly Integrated Governance, Quality Assurance Committee meetings and conducts unannounced quality visits to the Trust, these are documented and resulting actions are monitored through to completion at bi monthly Quality Review meetings with the PCT.

PLEASE HIGHLIGHT IN YELLOW ANY INFORMATION WHICH THE TRUST CONSIDERS TO BE COMMERCIALY SENSITIVE, CONFIDENTIAL OR OTHERWISE UNSUITABLE FOR DISCLOSURE

Cost Improvement Plans (CIPs) in the Forward Plan period

CIP Design

How have schemes been identified and developed?

The RNHRD has a successful record of delivering recurring CIP schemes, achieving recurring savings of £0.9m in 2011/12. The Trust's financial difficulties have continued to accrue as a small organisation with a high level of fixed overheads and volatile activity levels. This makes financial planning difficult and the Trust required non-recurrent support in 2011/12 to deliver a deficit of £0.1m.

The RNHRD's current major CIP schemes were developed during 2011/12 for implementation during early 2012/13. The themes arose through two key pieces of work that were completed with assistance from external consultants: (1) an exercise to identify potential new income streams undertaken in December 2011 – January 2012, and (2) a further exercise to develop service line reporting and cost up a number of options put forward by the Board.

The first exercise was successful in raising the Trust's profile, particularly in the field of veterans healthcare, and did result in an increase in activity in this area. However, new activities that could deliver significant income were not identified.

As a consequence, external consultants were engaged to provide financial analysis of the main service lines (rheumatology, neuro rehabilitation, pain services and complex fatigue syndrome) to determine profitability at service line level, and to cost a number of options for service reconfiguration. These included closing the Neuro Rehabilitation service, converting the hospital to an outpatient only facility, and ward reconfiguration. The outcome of this work showed that all services made a contribution to overheads during 2011/12, although the % contribution varied. The value of income from inpatient services made conversion to an outpatient only facility financially unviable and likewise, the contribution to overheads from Neuro Rehabilitation based on 2011/12 activity levels also indicated it would not be financially advantageous to close the services. Ward reconfiguration – reducing the number of beds per ward and associated changes to establishment – was shown to deliver savings of circa £350k.

The ward reconfiguration option was developed during the budget-setting process and staff consultations are in progress. It is intended to implement the ward changes without redundancy costs through natural wastage, redeployment (facilitated through the service developments) and increasing cross-service working, particularly in therapies and nursing which will have the added benefit of reducing bank and agency usage.

Benchmarking of the Trust's Neuro Rehabilitation tariff against competitors and with newly developed Stokes-Turner methodology has shown the RNHRD's unit costs to be high. The ward reconfiguration and establishment reduction should reduce the unit costs, however, future activity levels are proving vulnerable and therefore the viability of the service is under constant review. As part of the Trust's future plans, it may be necessary to give priority to transferring this service ahead of the other areas of the Trust if activity levels continue to decline.

Work is underway during 2012/13 to further improve service line reporting, paying particular attention to overheads. Parallel to this work, a review of non-pay expenditure is being undertaken, with specific attention to purchase contracts. Recommendations from Internal Audits have implied that contracts are overdue a review and with new staff within the Trust, further opportunities have been identified.

PLEASE HIGHLIGHT IN YELLOW ANY INFORMATION WHICH THE TRUST CONSIDERS TO BE COMMERCIALY SENSITIVE, CONFIDENTIAL OR OTHERWISE UNSUITABLE FOR DISCLOSURE

CIP Focus - Top 5 CIP Schemes

Ref	Scheme	Scheme description including how Forward Plan will reduce costs	Underpinning IT / information or management systems	Total savings £m	Phasing over three year period (%)			WTE Reduction	Has the Forward Plan been subject to a quality impact assessment (Y/N)	Who is responsible for signing off on the quality impact assessment	Key measure of quality for plan	Scheme Lead
					Yr. 1	Yr. 2	Yr. 3					
1	Ward re-configuration – Neuro Rehabilitation	Reduction in bed numbers and review of establishment	N/A	0.4	100	0	0	5.4	Y	Director of Clinical Practice & Operations	Scores in local survey of patient experience and national in patient survey , PEAT inspection	Director of Clinical Practice & Operations
2	Ward re-configuration – Rheumatology	Reduction in bed numbers and review of establishment	N/A	0.2	100	0	0	7.8	Y	Director of Clinical Practice & Operations	Scores in local survey of patient experience and national in patient survey , PEAT inspection	Director of Clinical Practice & Operations
3	Review of non-pay expenditure	Review of non-pay expenditure and purchase contracts	N/A	0.2	100	0	0	0	N	Directors	Changes made to internal controls. Improved management and monitoring of non pay budgets	Directors

CIP Process

Each service has a clinical lead who has worked with the service general manager to develop the required CIP.

The Medical Director is present at Directors/Board meetings and has the opportunity to engage in all discussions and decisions regarding CIP. The Chief Executive and Medical Director then brief the medical staff and consultants via meetings held once a month.

As a minimum twice a year joint meetings are held with all medical staff and senior managers to discuss CIP plans.

Forward CIP's will be developed and approved as part of the process for developing the Trust's future strategic plans. In the meantime, savings opportunities are being identified as the Trust's income and expenditure is being scrutinised in detail to be explored further. Plans are currently resourced from within internal means.

The current CIP plans, in particular the ward reconfiguration were developed for the purpose of meeting service need in an efficient manner. Risks to quality were identified in this manner and the plans adjusted accordingly.

**PLEASE HIGHLIGHT IN YELLOW ANY INFORMATION WHICH THE TRUST CONSIDERS TO BE
COMMERCIALY SENSITIVE, CONFIDENTIAL OR OTHERWISE UNSUITABLE FOR
DISCLOSURE**

CIP Management

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

The key CIP delivery metric is performance against budget (including activity plans and budgeted establishment). The two main CIP schemes relating to ward reconfiguration have been actioned in budgets, and therefore there is clarity at cost centre and budget holder level as to the financial envelope and establishment available within which to deliver the services.

Budgetary performance management is instigated through:

- Monthly meetings between management accountants and budget holders
- Monthly finance meetings between Directors and the General Managers
- Monthly reporting to the Finance and Activity Committee, through which the Trust's financial position and plans receives close scrutiny and challenge.
- Monthly reporting to the Trust Board

Bi-monthly reporting to the Council of Governors.

The performance management process is assisted through:

- The production and review of activity information on a weekly basis, with corrective actions put in place where necessary
- A weekly vacancy panel attended by the Chief Executive and Director of Finance.

Savings in non-pay expenditure, the third CIP scheme, have also been actioned in budgets where they have been explicitly identified and subject to the process identified above. The review of purchase contracts is the subject of internal audit recommendations and consequently there is accountability to the Audit Committee.

Risk to CIP delivery is identified through regular meetings with the budget holders and through the forecasting process. It is mitigated through the process of accountability and alternative plans in place such as vacancy control and pending review of contracts.

The Trust has historically delivered successfully on its CIP plans, achieving savings of £669k of its planned £651k CIP in 2011/12 on a recurrent basis. In 2010/11, it achieved £854k of the £810k plan.

PLEASE HIGHLIGHT IN YELLOW ANY INFORMATION WHICH THE TRUST CONSIDERS TO BE COMMERCIALY SENSITIVE, CONFIDENTIAL OR OTHERWISE UNSUITABLE FOR DISCLOSURE

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

The principal drivers of income in the 2012/13 financial plans are forecast activity and tariff.

Rheumatology services are subject to the national tariff. The national tariff on average has seen deflation of 1.5% compared to 2011/12. The actual change in tariff for each specific procedure, however, varies significantly and the rheumatology services provided by the RNHRD have been impacted by approximately 12%. The remainder of the Trust's services are on local tariffs, to which a 1.8% deflator is expected by the commissioners in line with the 2012/13 Operating Framework and has been applied.

Heads of terms have been agreed with the Trust's main commissioners. Contracts are on a cost and volume basis, although a cap and collar agreement has been made with the South West Specialist Commissioning Group to provide some stability for the Neuro Rehabilitation service.

A reduction in research and development (R&D) income is assumed for 2012/13 as the WCRLN allocation has been confirmed and is less than total allocation received in 2011/12. To mitigate this, a Clinical Trials Manager has been appointed to develop award applications and attract new R&D income. As it takes time for funding to be received for successful applications, no new income has been assumed for 2012/13 although it would be expected to have a number of projects in the pipeline by the end of the year.

Private patient income has been assumed at slightly above the 2011/12 out-turn. There is room to increase private patient income without breaching the cap before it is lifted. Promotional activities are underway, such as the production of service brochures.

Growth is assumed in PbR excluded drugs income, with equivalent growth in expenditure. This is effectively a pass-through cost and is cost neutral to the Trust.

Two service developments, Late Effects and the MacMillan Step-Up Service, will generate additional income for the Trust. Recruitment of an R&D Co-ordinator increases the Trust's capacity to develop funding applications which will, where successful, generate additional R&D income for the Trust. There are no revenue generation initiatives included in the CIP programme.

There are some areas of uncertainty or risk in respect of Trust income:

- Activity levels may be below forecast.
- The Trust will require non-recurrent income during 2012/13 in order to pay staff and suppliers to the end of the year. Discussions are underway with the SHA and PCT but funding not yet agreed.
- The Trust does not have the resources to fund the project or transitional resources needed to effect a merger or transfer of services. Again, discussions are underway with the SHA and PCT but funding not yet agreed.
- A change in accounting treatment for donated assets implemented in 2011/12 means such donations should be recognised in full as income unless there are specific conditions attached. Due to the sporadic nature of donations, this is difficult to include in financial planning, but could potentially lead to material values of income being recognised should the trust be the beneficiary of large donations during the year.

Income materially diverged from plan in 2011/12, particularly in respect of Neuro Rehabilitation. The original plans were based on average occupancy of 17 beds, but actual activity averaged 15 beds. This is largely due to changes in commissioner behaviour and certain PCT's referring into alternative providers in the region. To provide some mitigation, a cap and collar contract has been agreed with the South West Specialised Commissioning Group and income budgets for 2012/13 are based on this contract. There continues, however, to be financial risk associated with this service line as activity levels continue to decline.

PLEASE HIGHLIGHT IN YELLOW ANY INFORMATION WHICH THE TRUST CONSIDERS TO BE COMMERCIALY SENSITIVE, CONFIDENTIAL OR OTHERWISE UNSUITABLE FOR DISCLOSURE

The Trust has secured funding from MacMillan and the National Specialised Commissioning Team to commence two new services relating to chronic fatigue in cancer survivors and late effects of cancer treatment. Both schemes are innovative and the Trust is currently the only provider in the country.

The late effects service is expected to make a contribution to overheads of 0.1m, with income and direct costs of £0.4m and £0.3m respectively. This is a collaboration with Christie's in Manchester and the Barts in London to provide this specialist service across several regions. The RNHRD is the lead provider and will also be delivering training to the other services. Implementation of the service is underway with recruitment in progress. **The key risk to delivery is its dependence on the retention of key staff who are specialists in this field.**

The MacMillan service is unlikely to make a financial contribution to overheads, with income secured to fund the direct costs (£0.1m). The new service, however, together with the late effects scheme offers redeployment opportunities to existing staff impacted by the ward reconfiguration and cross-service working, which aids the implementation of the Trust's CIP schemes. Implementation of the service is underway with redeployment and recruitment in progress. As part of the contract, the charity has agreed to fund refurbishment of the facilities from which the service will be delivered. This forms part of the capital programme.

PLEASE HIGHLIGHT IN YELLOW ANY INFORMATION WHICH THE TRUST CONSIDERS TO BE COMMERCIALY SENSITIVE, CONFIDENTIAL OR OTHERWISE UNSUITABLE FOR DISCLOSURE

Appendix 3c: Financial commentary: Transactions (NOT INTENDED FOR PUBLICATION)

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

It has been the stated strategic intent of the RNHRD and RUH for the last three years to merge once the RUH has achieved foundation trust status. The increasing financial fragility of the RNHRD has increased the urgency with which a new business model must be implemented and consequently the RNHRD is exploring all options. The significant transaction for the RNHRD over the next 12 – 24 months is the transfer of services to another provider or providers or merger with the RUH and the disestablishment of the Foundation Trust.

Discussions are underway with the SHA and commissioners as to how an accelerated merger or transfer can be effected, and for additional financial support to ensure the services are properly resourced during the interim period. The RNHRD will also need transitional relief to fund the project management costs that will be incurred if this significant change is to be successfully achieved. A project management and governance structure has been agreed in principle with the commissioners.

A full understanding of the impact of the Health and Social Care Act 2012 is needed and the Trust is working with Monitor and its legal advisors in this regard.

Appropriate disclosures have been agreed with the Trust's external auditors in relation to the going concern assumption. These relate to uncertainties of the transitional funding, and the future of the hospital building, and therefore the impact on liabilities and asset value.

PLEASE HIGHLIGHT IN YELLOW ANY INFORMATION WHICH THE TRUST CONSIDERS TO BE COMMERCIALY SENSITIVE, CONFIDENTIAL OR OTHERWISE UNSUITABLE FOR DISCLOSURE

PFI's and Material or Significant Investments:

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

N/A

Appendix 3d: Financial commentary: Activity (NOT INTENDED FOR PUBLICATION)

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

The activity assumptions take into account trends in referral rates, commissioners intentions, service developments and local knowledge.

The key risk is in Neuro Rehabilitation where income and the contract with the South West Specialised Commissioning Group assumes an average of 10 occupied beds. This compares to an average of 15 in 2011/12, and 12 in March 2012. Referrals and activity in this service, however, is showing decline and a reduction to 8 beds would seriously impact on the Trust's ability to meet its financial targets, **even with transitional funding**. The service is pro-actively engaging with commissioners and promoting its services, however, it is affected by improvements in community provision for this group of patients and the presence of other providers within the general region. A key milestone for the service is average occupancy of at least 9 South West Specialised Commissioning Group commissioned beds.

Potential opportunities for growth that are being explored include expansion of the late effects services (which is currently commissioned to treat a very specific cohort of patients) and provision of an opiate reduction service within pain management services.

Changes in resource are outlined in the Service Development and CIP sections.

**PLEASE HIGHLIGHT IN YELLOW ANY INFORMATION WHICH THE TRUST CONSIDERS TO BE
COMMERCIALY SENSITIVE, CONFIDENTIAL OR OTHERWISE UNSUITABLE FOR
DISCLOSURE**

Appendix 3e: Financial commentary: Workforce (NOT INTENDED FOR PUBLICATION)

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

Enter text

PLEASE HIGHLIGHT IN YELLOW ANY INFORMATION WHICH THE TRUST CONSIDERS TO BE COMMERCIALY SENSITIVE, CONFIDENTIAL OR OTHERWISE UNSUITABLE FOR DISCLOSURE

Workforce for 2012/13	Priorities	Actions	Key risks	Trust Assurance	Board
	To develop new ways of working and reshape the workforce to improve productivity, reduce costs and effectively meet the needs of our service, patients and employees	Reduction in bed numbers and review of establishment in Neuro rehabilitation and rheumatology Expansion of day case unit to shift care from inpatient to day case setting This will be managed within existing resources and ward layouts will be reconfigured to maximise efficiency and effectiveness of staffing resources.	Financial risk of surplus ward staff will be managed via natural wastage and redeployment of staff to areas of service development e.g. Late Effects, MacMillan and day case expansion. Agreement with local health community to be developed re ring fencing vacancies to allow redeployment.	Monthly workforce report to Trust Board, review of clinical risk via Clinical Risk Committee and Integrated Quality & Governance Committee (IGQAC) which is a sub committee to the Board. Monthly report to Board on clinical practice via Vital Aspects of Nursing Care Audit	
	To introduce additional measures relating to the management of staff experiencing work related stress. In the 2011 NHS National Staff survey 37% of staff reported they suffered work-related stress in the last 12 months	Sickness absence reporting, number of completed stress audits received, NHS National Staff survey Results 2012, audit of work related stress conversations held between managers and staff who are not absent with work related stress	No risks to delivery identified	Staff absence reporting monthly to managers and EMG. Annual stress audit results to Health and Safety Committee. HR key indicators to Board quarterly and Annual Quality Report	
	To work closely with merger/transfer partners to ensure a smooth transition to a successfully merged organisation or transfer of service.	Programme Board in place led by Project Manager. Head of Communications seconded from PCT	Lack of project management skills within the organisation has been mitigated by securing external project management and Communications support from PCT Loss of key personnel leading to a business continuity risk	Project management structure provides monthly reporting to Board and review of risks	

PLEASE HIGHLIGHT IN YELLOW ANY INFORMATION WHICH THE TRUST CONSIDERS TO BE COMMERCIALY SENSITIVE, CONFIDENTIAL OR OTHERWISE UNSUITABLE FOR DISCLOSURE

Workforce Priorities for 2012/13	Actions	Key risks	Trust Assurance	Board
Involving and engaging people – to work together to create a culture of genuine involvement, joint responsibility and effectiveness through training of our staff representatives and change management training for managers/supervisors	TUPE and employee engagement courses booked with ACAS from end of June onwards. Managing change including 'Having difficult conversations' training booked for managers and supervisors at the beginning of July 2012.	No risks to delivery identified	HR key indicators to Board quarterly and Annual Quality Report	

The capital programme for 2012/13 is limited to essential schemes, in view of the Trust's difficult cash position and uncertainty over future plans. The main schemes are as follows:

Building and estate:

- Funded through depreciation
 - Completion of the roof repairs that commenced during 2011/12
 - Contingency for a water treatment plant, if required as part of the Health & Safety plan in respect of legionella prevention.
- Funded through charitable donations
 - Refurbishment of the outpatients department or to improve outpatient facilities, funded through the Refresh campaign.
 - Refurbishment of a ward, funded by MacMillan

Information Technology:

- Funded through depreciation
- Replacement of aging PCT's to maintain functionality
- Complete implementation of the business information system piloted during 2011/12, to make activity information more readily available and aid capacity and performance management.

Equipment:

- Funded through depreciation
- Endoscopy equipment requiring replacement in June 2012. Finance leases expire then and equipment is essential to service provision.
- Ultrasound bladder scanner for the benefit of infection control

PLEASE HIGHLIGHT IN YELLOW ANY INFORMATION WHICH THE TRUST CONSIDERS TO BE COMMERCIALY SENSITIVE, CONFIDENTIAL OR OTHERWISE UNSUITABLE FOR DISCLOSURE

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

The main cost assumptions are as follows:

Pay Expenditure:

Posts are costed at the actual pay point of the current incumbants, thus allowing for incremental drift where appropriate. In fact, many staff have worked for the RNHRD for a long time and already at the top of their pay band. **Incremental drift is relatively low, therefore, but this has consequences for redundancy costs and potential service change.** No pay award has been assumed.

An overall increase in pay expenditure of £0.1m is the net effect of incremental drift, service developments, the ward reconfigurations and the full-year effect of a management restructure implemented during 2011/12.

Non-Pay Expenditure:

This is essentially the 2011/12 rollover budget, adjusted for known cost saving opportunities and service developments. Most non-pay expenditure areas within the Trust are not vulnerable to inflation, the drugs bill outside of PbR excluded drugs is low. Review of all non-pay expenditure and purchase contracts during the first four months of 2012/13 is target to deliver 5% savings on 2011/12 out-turn. **However, care is needed to ensure any new contracts entered into will not compromise the Trust's future plans for service transfer or merger, or limit the opportunities for a new provider to achieve efficiency through synergy.**

Overheads:

Overheads represent approximately 40% of turnover and are predominantly fixed costs. This is one of the drivers behind the Trust's financial difficulties and are an inherent part of being a small Foundation Trust with a Board and governance requirements and operating from an historic, grade 2* listed building. Some aspects of overheads will be covered by the non-pay and contracts review.

PbR excluded drugs:

Some growth compared to the 2011/12 out-turn is assumed, although there may be some impact from local PCT QIPP schemes. E-prescribing is being explored which may reduce expenditure. However, as PbR excluded drugs are recharged to the PCT, this would be a benefit to the local health economy but be cost neutral to RNHRD.

PLEASE HIGHLIGHT IN YELLOW ANY INFORMATION WHICH THE TRUST CONSIDERS TO BE COMMERCIALY SENSITIVE, CONFIDENTIAL OR OTHERWISE UNSUITABLE FOR DISCLOSURE