Royal National Hospital for Rheumatic Diseases

NHS Foundation Trust

Strategic Plan Document for 2013-14

Royal National Hospital for Rheumatic Diseases NHS Foundation Trust

Strategic Plan for y/e 31 March 2014 (and 2015, 2016)

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

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Date	**28th May 2013**

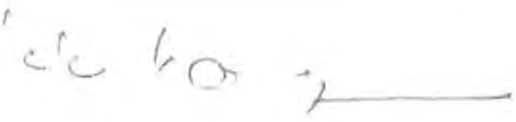
The attached Strategic Plan is intended to reflect the Trust's business plan over the next three years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- The Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;
- The Strategic Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;
- The Strategic Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans;
- All plans discussed and any numbers quoted in the Strategic Plan 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 

1. EXECUTIVE SUMMARY

This Strategic Plan describes how the Board of the RNHRD NHS FT intends to deliver appropriate, high quality services and how it plans to resolve its financial issues that have led to its non-compliance with its licence through the development of a strategic intent by 30th June 2013 and a strategic plan by 30th September 2013. This document describes the challenges the Trust faces in responding to changes in commissioning intentions and in reducing overall expenditure in line with referral patterns and tariff changes within the structure of a small specialist foundation trust operating out of a historic building.
The key elements of the plan are reflected in the description of the corporate objectives for the organisation for 2013/14 as summarised below:-

1.1. Corporate Objectives

Strategic

- To develop a realistic and deliverable strategic plan to describe, within a timescale to be agreed with Monitor, the optimum future for our services
- To develop a sustainable outreach model to take RNHRD services out in to the community
- 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 and implement the recommendations from the Mid-Staffordshire Public Enquiry/Francis Report
- 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 2013/14 and CQUIN targets identified in 2013/14 contract
- To implement the Friends and Family test

Governance

- To meet the Code of Governance
- To meet the measures detailed in the Compliance Framework/Risk Assessment Framework
- To meet the NHS Connecting for Health Information Governance Assessment
- To maintain NHSLA level 1 accreditation
- To comply with the NHS Constitution

Finance & Activity

- To deliver the financial plan for 2013/14, to include:
  - delivering activity plans to maximise income
  - managing cash throughout the year
  - production of timely and accurate forecasting
  - working with commissioners to deliver QIPP
- Increasing productivity and reducing costs in addition to the current QIPP targets

IM&T

- To develop the IM&T strategy to support the organisation in achieving its strategic objectives to include:
  - the further development of the Electronic Patient Record system to improve clinical and cost effectiveness and collection of clinical outcomes data
  - the further development of the Trust scorecard and data warehouse
  - improved use and knowledge of information in order to make informed business decisions and to meet commissioning requirements

Estates

- To develop the Estate Management strategy to support the delivery of high quality patient care in an appropriate environment. This includes:
  - meeting day to day operational issues to ensure mandatory and statutory compliance

1.2. Assessment of Challenges

In describing the challenges the Trust is currently facing it is important to note the enforcement undertakings which have been agreed by the Trust Board. Having regard to its Enforcement Guidance, Monitor accepted from the FT a number of enforcement undertakings pursuant to its powers under section 106 of the Health & Social Care Act 2012. Of particular note is the requirement for the RNHRD to develop and submit to Monitor a statement of strategic intent by 30th June 2013 and by 30th September 2013 a realistic and deliverable strategic plan to address the financial issues that led to the non-compliance with its license.

1.3 Key Financial Data

If the Trust was to continue as a standalone organisation, its financial projections would be as follows:

	Actual		Projected		
	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000
Income & Expenditure Surplus / (Deficit)	(106)	923	(3,589)	(4,300)	(4,802)
Underlying financial position	(1,006)	(2,761)	(3,109)	(4,060)	(4,562)
Financial Risk Rating	2	1	1	1	1

The deteriorating financial position is due predominantly to changes in commissioning and referral patterns, and the impact of reductions to tariff, pay award and inflation.

The financial position will be monitored through the Finance and Activity Committee with remedial actions being agreed and implemented where necessary. The Trust will be working with its partners to obtain external funding to support the cash position.

This plan sets out projections for the Trust as it is presently constituted and discloses significant losses. This plan does not describe any remedial actions to contain losses. However, the Board is in the process of identifying remedial actions which will be described in the strategic intent document to be submitted on 30th June 2013, with detailed strategic planning to follow with a submission date of 30th September 2013.

2. STRATEGIC CONTEXT AND DIRECTION

The 2013/14 financial forecast describes a £3.6m deficit prior to the provision of any non-recurrent support. This does not represent a sustainable financial position. Discussions are underway to agree a financial support package from the Department of Health to fund this forecast deficit position and essential capital expenditure. The Trust Board will agree and submit to Monitor by 30th June 2013 a statement of strategic intent to address those financial issues. Work is underway to engage with the main clinical commissioning groups, specialist commissioning, governors and other key internal and external stakeholders to prepare this intent. Once the statement of strategic intent has been agreed the Trust will develop a strategic plan by 30th September 2012

that includes:-

- An outline of the preferred strategic option
- Appropriate contingency planning
- Dates, milestones and KPIs to achieve the described strategic option
- An outline of the funding requirement for the delivery of the strategic option.

2.1 Trust's Strategic Position within the Local Health Economy

The RNHRD is a specialist hospital in central Bath which primarily provides specialist rehabilitation for patients with complex long term conditions (LTC). A long term health condition is a condition that lasts a year or longer, impacts on a person's life, and may require on-going care and support. The core patient base of the RNHRD includes people with LTCs such as inflammatory and non-inflammatory rheumatic disease, complex rehabilitation needs, acute and chronic pain conditions, and Chronic Fatigue Syndrome/ME. These services support both the local population and attract referrals on a regional and national basis.

The best way to support people with LTC is to help people to live healthily and to manage their conditions, so that they stay well and are less reliant on medical interventions, including hospital stays. The draft Joint Health & Wellbeing strategy for Bath & North East Somerset (B&NES) describes the provision of improved support for people with long term health conditions as one of its priorities and describes the prevalence of long term conditions as rising (in line with national and regional rates). A significant feature of B&NES Clinical Commissioning Group (CCG) commissioning intentions for 13/14 remains the management of LTCs.

A key priority in the B&NES CCG plan for patients with LTCs is to redesign clinical pathways to improve clinical outcomes; increase & ensure patient satisfaction and deliver care closer to home.

2.1.1 Forecast health, demographic, and demand changes

The RNHRD is geographically located within B&NES. The population of B&NES has increased by 8% since 1981, with a current population of around 176,900, with an increase of 2% in the population of people aged over 80. In line with national trends B&NES has an aging population: current estimates indicate that there will be over two and half as many people aged over 80 by 2026 compared with 1981.

In terms of forecasting demand for the Trust's services:-

- There are around 10 million people in the UK with Arthritis and Musculoskeletal conditions (source ARMA website)
- An estimated 11% of adults and 8% of children suffer severe pain, representing 7.8 million people in the UK. (source national pain audit final report 2010-2012)
- M.E. affects over 200,000 adults and children in England (250,000 across the UK). Around 25,000 are children.
- Referrals in Complex Pain and Chronic Fatigue Syndrome are increasing due to greater awareness and the development of National models and production of National guidelines.

The Trust therefore needs to anticipate an overall increase in need for patients with rheumatological conditions and osteoporosis and for those patients to be presenting with higher complexity due to increased co-morbidities due to age.

RNHRD Referral Base

The table below shows the Trust's in-patient referral activity by CCG* (75% of total activity, remaining 25% from 7 surrounding CCGs) based on RNHRD inpatient referral information.

Clinical Commissioning Group Name	2010/11	2011/12	2012/13	2013/14	Grand Total
NHS BATH AND NORTH EAST SOMERSET CCG	31.95%	34.58%	34.53%	37.69%	33.72%
NHS WILTSHIRE CCG	34.44%	29.69%	29.75%	27.99%	31.34%
NHS SOMERSET CCG	9.77%	12.31%	11.94%	16.42%	11.42%

* CCG is derived from the patient's registered GP Practice (data excluded Neuro Rehabilitation)

The table shows that the in-patient activity is primarily derived from the host CCG and that the main area of growth has been from NHS Somerset CCG.

The table below shows the Trust's out-patient referral activity by CCG* (80% of total activity, remaining 20% from 7 surrounding CCGs) based on RNHRD outpatient referral information.

Clinical Commissioning Group Name	2010/11	2011/12	2012/13	2013/14	Grand Total
NHS BATH AND NORTH EAST SOMERSET CCG	35.60%	35.86%	35.06%	34.20%	35.45%
NHS WILTSHIRE CCG	32.57%	33.72%	34.40%	36.02%	33.57%
NHS SOMERSET CCG	14.62%	14.52%	14.17%	14.59%	14.46%

* CCG is derived from the patient's registered GP Practice (data excluded Neuro Rehabilitation)

The table shows that out-patient referral activity has been relatively constant over the last three years from three main CCGs

The RNHRD has no accident and emergency department and patients are generally referred and admitted on a planned basis. This has a significant impact on the nature of the relationship between the Trust, patients and potential referrers with an increased emphasis on outcomes data, research and development and generating awareness of the Trust and the services it provides.

The small relative value of the contract with the local CCGs influences the depth and nature of the relationship between the CCG and the Trust. The RNHRD has contracts with a number of CCG's within the south-west region, and accepts referrals from across the country.

Despite the RNHRD describing itself as a national specialist service provider 87% of GP referrals across all services are from the three local clinical commissioning groups, less than 5% of the remaining referrals come from outside the south west region.

Specialist commissioned services accounted for 9% of the Trust's total income in 2012/13, with revenue of £2.1m. With the closure of the Neurological Rehabilitation Services but more of the Trust's services coming under the specialist commissioning responsibility of NHS England, income from specialist commissioning is expected to increase to £6.4m, representing 39% of total income.

2.2 Competitive Environment

As a specialist provider of complex rehabilitation services the RNHRD does not have any local key competitors. The competitive challenge is as described below:-

- competition for national referrals for specialist services from other specialist centres
- production of outcomes based evidence to secure funding for referrals to specialist services
- development of appropriate positioning of hospital based complex rehabilitation services for long term conditions versus community based services or community organisation provided services.

An overview of the Trust' key competitors and an assessment of the key areas of strength/threat relative to the key competitors is summarised below:

Threat to RNHRD Services	Strength of RNHRD Services
Establishment of a competitive alternative provider of local rheumatology services in the local area.	Multidisciplinary approach and access to a large number of specialists, covering general and more specialised rheumatic conditions, in one setting.
Referrals directed to one of the other national providers of specialist rheumatology services.	There are a limited number of alternative providers regionally in the Trust's more specialist rheumatology services such as Connective Tissue Disorder (CTD) and AS services. The strength of such services at the RNHRD is the strong clinical reputation, delivery of research based services and profile of the key clinicians. The AS service, in particular, remains one of the few of its kind in the UK and has an international reputation.
Currently in England and Wales there are approximately 136 general pain clinics based in acute Trusts (source national pain audit final report 2010-2012). Other providers offering seemingly similar pain services or those seeking to develop care packages for more complex patients. Additional tertiary centres could be set up as part of the opportunity offered through National Specialist Commissioning.	There are currently less than 5 providers throughout the UK offering tertiary level services for complex pain National Specialist Commissioning provides an opportunity for pain services at the RNHRD to deliver highly specialised services without the constraints of having to apply for prior approval for each case. The RNHRD pain services will ensure that care pathways are followed and correct for access to services, and that the dashboard data set is kept to continue with evidence based practice and ensure that our outcomes will compare favourably with any competition in the future.
Nationally there are approximately 14 other NHS multi-disciplinary services for CFS/ME (source action for ME).	There are currently two other CFS/ME services in our local area, however, they do not offer a comparable service to the RNHRD. The strength of the RNHRD adult CFS/ME service is a focus on working with patients and employers to enable patients to return to or remain in employment. There are no other paediatric CFS/ME services that accept referrals from outside their area and few that provide regional services.

The RNHRD provides a number of niche services which have opportunities for growth such as; BRIRS, CRPS, Paediatric CRPS and chronic pain, Paediatric CFS/ME, and the Macmillan 'Step up' service for Cancer related Fatigue.

In reviewing health, demographic and demand changes and being aware of the competitive environment it is not anticipated that there will be any significant changes in market share or referral activity over the life of this plan apart from those described through the risks from the changes in commissioning intentions.

2.3 Threats & Opportunities

2.3.1 Changes in Local Commissioning Intentions (B&NES CCG)

2013/14 will see the CCG review and streamline clinical pathways, this will pose a number of opportunities and threats for services at the RNHRD which include:

Opportunities	Threats
Rheumatology ▪ Review of pathways for Osteoporosis, Osteoarthritis, Fibromyalgia should ensure appropriate referrals to the RNHRD. ▪ Development of the national specialist commissioning agenda will create a more sustainable platform for referrals in to the very specialist rheumatology services. ▪ Introduction of a protocol to ensure patients can access joint injections by the community.	**Rheumatology** ▪ CCG benchmarking indicates a much higher level of activity in this area in rheumatology against national benchmarks, and are seeking to develop referral and treatment protocols to bring activity in line with these national benchmarks.. ▪ The CCG are reviewing the use of community provided resources as an alternative to accessing services provided by the RNHRD. This includes: - the option to access community IV teams to provide biologic services for rheumatology services - a redistribution of out-patient physiotherapy resources reducing referrals in to the Trust direct access therapy services
Pain ▪ The pain pathway was reviewed in 2012/13 by local commissioners – aim to put in place a service so that patients can be assessed and supported to manage their pain in the community, and then patients with defined complex chronic pain referred to specialist care quickly as appropriate ▪ Development of the national specialist commissioning agenda will create a more sustainable platform for referrals in to the complex pain services.	**Pain** ▪ CCG benchmarking suggests B&NES has a higher level of secondary and tertiary pain activity compared with national benchmarks.

In reviewing these threats and opportunities the Trust has factored these considerations in to its strategy by:-

- Reducing in-patient beds down to 12 for 2013/14 to reflect the move to treating patients on a community, out-patient or day case basis.
- Increasing day case capacity
- Restructuring clinical workforce to adapt in the optimum manner to changing care pathways.
- At this point the Trust has no plans to diversify its income streams further but will actively review opportunities presented by the vacation of space previously allocated to Neuro-rehabilitation.

2.4 Collaboration, Integration and Patient Choice

The detailed plan for the proposed acquisition of the services of the RNHRD by the RUH will be approved by the Boards of the RUH & the RNHRD during the summer of 2013 and submitted to Monitor on 30th September 2013. The patient benefits and opportunities to develop the care pathways in line with commissioning intentions will be explicitly described through this plan

The proposed acquisition of the services of the RNHRD by the Royal United Hospital (RUH) will increase efficiency through:-

- Reduction in back office costs
- Reduction in fixed overhead costs
- Better access to a broader range of support services
- Further clinical integration

The RUH are currently working with the OFT to determine what level of review will be required for the proposed acquisition.
There are currently two key opportunities for collaboration / partnership with other providers:-

- Continuing to develop and strengthen collaborative research and educational links with the Nuffield Department of Orthopaedics, Rheumatology and Musculoskeletal Sciences (NDORMS) at the University of Oxford.
- The outcome of the submission of a full application for an Integrated Pain Management Health Intervention Team (HIT) will be known in autumn 2013. HIT seeks to bring together all of the senior pain clinicians, researchers, health commissioners and clinical services across the Bristol and Bath area to ensure people of all ages receive optimum care for persistent pain across the region to increase flexibility in planning the year's programmes so the unit can respond to the changing referral patterns and meet the needs of the largest group of patients funded at any time.

3. DELIVERY OF HIGH QUALITY SERVICES

3.1 Approach taken to Quality

- The RNHRD NHS FT Board approves the overall strategy for quality which included Trust-wide quality goals covering safety, clinical effectiveness and patient experience which incorporate national and local priorities. The local priorities are identified by our patients, members, governors and, commissioners and staff.
- The Board declared full compliance with the CQC Essential Standards of Quality and Safety throughout 2012/13.
- There are no existing quality concerns (from the CQC or other parties).
- The Care Quality Commission completed an unannounced inspection visit at the RNHRD on 02.08.12. as part of the CQC's routine schedule of planned reviews. The CQC concluded that the trust was meeting all the standards inspected.

3.2 The Key Quality Risks Inherent in the Plan

- A Risk Register is maintained and reported on for regular review by the Executive, the Board and Audit Committee.
- The principal quality risks facing the Trust and mitigating actions are summarised below.

	Principal risks and uncertainties	Mitigating actions
1	Loss of key personnel leading to a business continuity risk	Business continuity plan.
2	Delay in rheumatology follow ups	Medical Director and Director of Operations to review demand and capacity for outpatient activity. Rheumatology Consultant capacity to be reviewed in May 2013. Outstanding rheumatology follow ups monitored monthly by the Finance and Activity Committee and Board to reduce maximum wait to 6 weeks over stated follow up.
3	Single handed consultant within Endoscopy:	Consultant attends training sessions with gastro-enterology team at RUH Bath. Locum cover to be arranged if Consultant unavailable and there is sufficient demand.
4	Failure to achieve local *C.difficile* trajectory of 6 cases in 6 separate patients for 2013/14	Infection prevention and control policies and procedures in place. Root cause analysis completed on all cases and any resulting action plans are reviewed by Infection Prevention and Control Committee and Clinical Risk Committee, IGQAC and Board. External assessments by host commissioner.

- Success in mitigating these risks will be dependent on the delivery of the strategic plan for 2013/14.

3.3 How the Board derives Assurance on the Quality of its Services and Safeguards Patient Safety

The steps which have been put in place to assure the Board on the quality of its services and safeguards patient safety are:

Governance & Leadership

- The Board will review progress against the recommendations for providers from the Mid-Staffordshire public Inquiry
- There are Board meetings in public which are attended by Governors
- Quality is the first Board key standing agenda item

- The Board reviews performance against national quality goals every month and the local quality goals each quarter
- The Board quality governance structure has an established Board sub-committee; the Integrated Governance and Quality Assurance Committee (IGQAC) chaired by the Chief Executive with a Non-Executive Director (NED) and Executive Director Membership and a representative from the host commissioners is invited to attend. The IGQAC committee receives reports on a range of quality issues and provides assurance to the Board on quality performance throughout the Trust including; compliance with CQC essential standards of quality and safety, clinical risks, patient safety, patient experience, complaints, Patient Advice and Liaison Service (PALs), National CQC Survey of adult inpatients in the NHS results for the RNHRD, clinical effectiveness including national guidance such as National Institute for Health and Clinical Excellence (NICE), and training reports
- The Board is advised of any risks to clinical quality through an up to date risk register report which covers all Trust services and is presented to each quarterly meeting of IGQAC and the Audit Committee. Each risk has a designated lead Director
- There is a process in place for capturing front-line staff concerns, including a whistle blowing policy.
- The Trust has in place a bespoke audit system, Vital Aspects of Care (VACs), which provides early warning indicators for patient safety. The Board receives a report on the VACs outcomes each month
- To ensure the Quality Report presents a balanced view a draft version was approved by the IGQAC committee prior to presentation to the Audit Committee and Board.

Policies

- The organisation structure ensures clear responsibilities for delivering quality performance
- The Trust has policies in place that comply with NHSLA standards regarding quality
- There are clear rules within Trust policies to cover escalation of serious untoward incidents and complaints
- A statement regarding occurrences of any serious untoward incidents and complaints is included in the monthly quality performance report to the Board.
- Action plans to address quality performance issues are reviewed at IGQAC to ensure that actions are completed and lessons are learned
- There is a continuous rolling programme of clinical (national and local) and internal audit in relation to quality governance, which includes action plans competed from the audit and a programme of re-audits are undertaken to assess improvement. This process is reviewed at IGQAC and the Audit Committee.

Systems and Processes

- Quality outcomes are made public through Board meetings in public, presentation and feedback at Council of Governor meetings, Annual Members Day and posting information on the Trust web site
- Patient feedback is reviewed by the Board through the monthly patient walk rounds and surveys including the friends and family test and the quarterly quality reports which include feedback through complaints, PALs, feedback to Governors, National CQC Survey of Adult inpatients in the NHS results for RNHRD
- The Board actively engages other stakeholders on quality through;
  - Quarterly quality reporting at the IGQAC meeting attended by a representative of the host commissioner
  - Meeting and sharing quality reports with the host commissioner and
- Governors are invited to attend open Board meetings.

Data Use and Reporting

- The Board receives a monthly dashboard on national priority indicators and regulatory requirements and local performance measures, including Monitor's Risk Ratings and adverse event reporting. These include performance against targets in conjunction with a Red/Amber/Green (R/A/G) rating and historic own performance and benchmarking where available
- Granular reports are reviewed by IGQAC
- The reports cover all the Trust's services and are challenged at the individual service level
- There were no compliance or improvement actions following the outcome of the Care Quality Commission unannounced inspection visit during 2012/13
- There are no major concerns with coding accuracy performance.
- As part of the internal audit plan for 2013/14, an audit of the Assurance Framework will be undertaken.

4. APPROACH TAKEN TO QUALITY

- Quality governance is subject to rigorous challenge, including full NED engagement and review through participation in Audit Committee and IGQAC
- The capabilities required in relation to delivering good quality governance are reflected in the make-up of the Board
- The Audit Committee has conducted self-assessments during the year against the Code of Governance.
- The Board members have taken a proactive approach to improving quality through a monthly walk rounds to identify areas for improvement, the outcome of the walk rounds are reported to the Board. The resulting

action plans are presented to the Board. The Board will be adopting the 15 Steps approach to these walk rounds in 2013/14.
- The Board receives training including quality issues prior to each Board meeting
- Staff throughout the Trust are involved in national patient safety initiatives
- The Chief Executive Briefing sessions for all staff include items on quality.

5. CLINICAL STRATEGY

Clinical teams at the RNHRD will continue to develop and maintain relationships with other key clinical and non-clinical stakeholders to address local and national priorities for service user benefit and improve delivery of services across the south west region. All RNHRD services will continue to provide cost effective, patient centred evidence based care aligned to the NHS outcome framework and other national and local drivers, and will continue to embed and prioritise research and clinical audit to inform clinical developments. Specialty specific plans for 13/14 include:

5.1 Rheumatology

For 2013/14 the planned income shows a reduction of circa £388k consistent with the commissioning intentions of the service' main commissioners. The income plan is driven by the clinical plans as below:-

- A reduction in new outpatient appointments by 10%, allowing for the transfer of joint injections to the community in line with commissioner intentions.
- A new follow-up ratio for outpatient appointments of 1:4.8 to reflect the increasing complex nature of the long term conditions being supported
- Inpatient activity based on 6 beds to continue to reflect strengthened day case provision and commissioning intentions. This is a further reduction on 2012/13, when beds were reduced to 8 by September 2012.
- Reduction in in-patient beds will be achieved by:
  - Extending provision of Day Case unit to five days a week to allow emergency/urgent patients to be assessed quickly and to avoid, where appropriate, in-patient admission.
  - Working with B&NES CCG to agree discharge criteria. This will ensure that those patients that can be managed appropriately can be discharged more quickly to primary care.
- Increase in services provided in the community by:
  - Embedding in the local health community the newly established GP helpline, and to audit the calls to inform development of GP education programmes
- Strengthen evidence base for effectiveness of treatment by:
  - Development of systems and processes to collect Patient reported outcome measures that assess the patient experience, disease activity and function in patients with rheumatic disorders. These will be collected on a regular basis and published on the Trust website.

5.2 Pain Management

The service expects to deliver an overall increase in income despite the reduction in tariff. The key area of growth is in individual admissions (complex patient – bed days). This reflects recent trends for an increase in referrals as complex inpatients rather than to group programmes.

Pain Management is also planning to achieve an increase in private patient income from £93k 2012/13 to £130k in 2013/14. This takes into account recent growth in this area, and the development of referral routes with solicitors and Case Management Services.
Plans for 2013/14 across the Trusts specialist pain services include:

- Develop and deliver an outpatient Paediatric Pain Clinic. There is currently no local provision for young people who require a specialist outpatient service.
- Continue to develop the complex individual admissions interventions
- Explore extension of pain services for older adults at a regional and national level. The regional level will include outpatient clinics and interventions and national provision for highly complex cases can be made within our existing individual treatment service.

5.3 Chronic Fatigue Syndrome (CFS) Adults

Activity plans are based on 2012/13 out-turn, therefore the reduction in PCT income year on year reflects the change in tariff.

Plans for 2013/14 include:

- To further strengthen relationships with referring CCGs for the Macmillan 'Step Up' service to ensure GP referrals continue once Macmillan funding ceases at the end of the current contract.
- To continue to review other significant causes of chronic fatigue in other long term conditions and extend the clinical delivery model to include this patient group
- To work collaboratively with the RUH cancer services and other stakeholders on the survivorship agenda, providing a clear pathway that is understood by service users and clinicians in relation to the support available through the Macmillan Step Up Service for cancer survivors.

5.4 CFS Paediatrics

Activity plans assume 10% growth.

Plans for 2013/14 include:

- New research to commence, looking at the aetiology of CFS/ME using the ALSPAC cohort. This will raise awareness of CFS/ME nationally and internationally, and drive a further increase in referrals.
- Group therapy under development for patients where individual therapy has not been successful
- In process of applying for a grant to support development of an international collaboration (17 countries) to collate patient data. The grant will enable us to apply for very large programme grants for further research and will recruit adults from most services in the UK.
- Seek to expand into South Bristol to improve access to services

5.5 Complex Regional Pain Syndrome (CRPS)

The service expects to deliver an overall increase in income despite the reduction in tariff. The service has a waiting list and with increased capacity, particularly in therapy and psychology, will be able to increase inpatient admissions.

The CRPS service includes the nationally commissioned Breast Radiation Injury Rehabilitation Service (BRIRS) which commenced in September 2012. The service is partly delivered by The Christie NHS Foundation Trust in Manchester and Barts Health NHS Trust in London and SLAs were developed during 2012/13 with these organisations.

Plans for 2013/14 include:

- To move the service to national commissioning by April 2014
- To host the international CRPS conference in November 2013 in collaboration with the International Association for the Study of Pain Special Interest Group for CRPS

Plans for 2013/14 (BRIRS) include:

- To submit first research project application to NIHR
- To work closely with Macmillan Cancer Care to consider options for second late effects service and submit funding application Spring 2014
- To build relationship with new National commissioners to ensure longevity of service

5.6 Clinical Measurement

The clinical measurement service provides bone density scans and certain other imaging and diagnostic services. Its customers are GP's, for which the Trust receives explicit payment, and internal referrals.

Plans for 2013/14 include:

- To extend ICE electronic requesting system to direct access BMD service (in-line with GP feedback)
- To monitor and audit new radiology requesting system
- To engage with CCG to ensure implementation of agreed osteoporosis pathways
- To pursue research opportunities/fulfilment of research strategy, including submission of two research grant applications:
  - Remedi: electrical exercise stimulation for stroke patients
  - Raynaud's and Scleroderma Association: scleroderma study

5.7 Neuro Rehabilitation

The Neurological Rehabilitation service closed on 31st March 2013. It is expected that any costs not yet paid at 31st March 2013 will be accrued in financial year 2012/13 as a constructive obligation. No budget is being set for future costs or income for the service. An element of reserve, however, has been set as contingency in case of residual costs arising during 2013/14 that had not been anticipated during the production of the 2012/13 annual accounts.

5.8 Research & Development

The RNHRD NHS FT is a small specialist trust with a strong research track record of excellent experienced senior staff, R&D staff and facilities to support researchers. The Trust currently co-hosts three NIHR funded clinicians, Professor Candy McCabe who holds a Career Development Fellowship with UWE, Dr Jenny Lewis awarded a Clinical Lectureship with UWE and Dr Esther Crawley, Paediatric Chronic Fatigue Syndrome expert who holds a Clinician Scientist Award with the University of Bristol. In addition there is a NIHR funded academic clinical fellow and three externally funded full-time clinical research fellows

The embedded research culture is supported by the Board who recognise the importance of research in the development of quality services and improvements to NHS patient care. Our research strategy identifies the strong collaboration with its academic partners with representation from Bath, Bristol and UWE Universities and the Bath Institute for Rheumatic Diseases on the Research & Development committee.

The RNHRD R&D office have many years of experience of supporting researchers through all stages of the complex research processes from grant application, gaining research ethics and NHS Trust permissions and providing on-going support throughout the project lifetime. Research Governance (RG) procedures are embedded in the hospital systems and many standard procedures and policies are in place to ensure projects adhere to all RG Framework requirements. The R&D manager has experience with RfPB, i4i and a significant number of medical charity and pharmaceutical funding systems and awards. Trust staff were successful in being granted £446,087 in new external funding in the 2012/13 financial year, as either the main or co-applicant, with further applications pending decisions.

The Trust has exceeded its target (600) for recruitment of patients to NIHR portfolio registered study for 2012-2013 by recruiting 709 patients (an increase of 275 from 2011-12) and increased the number of active Portfolio studies to 29. As a consequence the existing level of funding support from the Western Comprehensive Local Research Network (WCLRN) has been maintained for 2013-14, with the addition of funding for an extra research nurse. The WCLRN has funded the licenses for a comprehensive web based software system (EDGE) to enable real time collection of recruitment data for projects whilst also providing an efficient stem for clinical teams to share diaries, book patients and access research documents. Recognition of the secured infrastructure for an increased portfolio of both commercial and non-commercial funded research has led to the establishment of a clinical research hub with dedicated space in the Trust

6. Clinical Workforce Strategy

6.1 An overview of the clinical workforce strategy (covering doctors, nurses and other key clinical groups)

The specialist nature of the rehabilitation undertaken at the RNHRD has led to the development of a multi-disciplinary approach to treatment with a non-medical led model of care.

The Trust is now entering its fifth year as a significantly financially challenged organisation. The impact on morale of staff in continuing to operate within a significant level of organisational uncertainty should not be underestimated. To date staff turnover has not been significantly impacted running at 13% for 2011/12 and 15% for 2012/13 against a target of 11%. However the closure of the neuro-rehabilitation unit and the further delay to the date of acquisition by the Royal United Hospital (RUH) creates an increased risk to staff turnover and business continuity. Of particular note is the position with regard to the Non-Executive Directors all of whom reach the end of their current term of office between August and December 2013.

The Trust has always prided itself in the quality of its research which is reflected in the level of published papers in high impact journals. The Trust strongly supports and encourages staff to study for higher degrees, particularly allied health professionals as the Trust values the importance of expanding the evidence base for rehabilitation. Staff are encouraged to network with local universities and other research active NHS organisations to progress high quality collaborative research.

The Trust employs 225.6 whole time equivalents (wte), with 118.5 wte in clinical roles, the table below demonstrates numbers within each professional group.

	2012		2013	
	WTE	Headcount	WTE	Headcount
Consultant	8.7	10	7.75	8
Associate Specialist	1.2	2	0.2	1
Registrars/Clinical Fellow	9.2	10	9.6	10
Nurse	43.35	67	29.78	35
Psychologist	8.74	10	9.7	11
Occupational Therapist	12.25	24	11.06	14
Physio	23.35	39	19.75	28
S&LT	3.63	5	1.63	2
Music Therapist	0.2	1	0	0
Radiographers	2.13	8	1.74	4
Medical/Biomedical Scientist	3.72	4	2.81	3
Clinical Support	47.45	98	24.49	33
Total Clinical	**163.92**	**278**	**118.51**	**149**
Administrative & Clerical	81.92	98	74.54	88
Estates	36.27	52	32.56	40
Total Non-Clinical	118.19	150	107.1	128
Total Trust	**282.11**	**428**	**225.61**	**277**

N.B these figures are a snapshot of numbers of staff in post on 31st May for 2012 and 2013, the table does not reflect current and planned recruitment activity being undertaken in line with budget plans for 2013

The significant reduction in headcount from 2012 to 2013 is due to:-

- The closure of the neuro-rehabilitation in-patient and out-patient service on 31st March 2013 this accounted for the reduction of 60 clinical staff.
- The reduction in in-patient beds for rheumatology in 2012 and the corresponding ward reconfiguration the majority of the impact of this was through healthcare assistants retiring and their posts not being filled.
- High levels of Maternity leave.

Due to the discontinued neuro-rehabilitation service and changes in commissioning intentions the bed base of the hospital will be reduced to 12 beds. In order to maintain patient safety levels particularly out-of-hours and at the weekend this has required an increase in trained nurses and a reduction in Health care assistants in the rheumatology in-patient ward.

Due to the reduction in inpatients beds training is being implemented to create more effective cross cover arrangements for trained nurses in terms of the ward, day case unit, infusion service, endoscopy unit and outpatients.

6.2 Key pressures for 2013-14 include the following

- Loss of Associate specialist in Rheumatology
- Single handed consultant in endoscopy
- For some professions it has been necessary to advertise several times to appoint an appropriately skilled individual, however with effective forward planning risks to services are minimised. The retention of highly specialised employees will continue to be the focus of the HR action plan 13-14.

6.3 The impact of the Workforce Strategy on costs (short-term and long-term)

The increase in skill mix will increase cost by circa £92k per annum in rheumatology. Recruitment of locum consultant/s costs identified in reserves will be offset by contribution to income. Recruitment of ad-hoc endoscopists allowed for in budget will offset by contribution to income.

6.4 Findings of benchmarking or other assessment (e.g. using the DH Workforce Health Tool)

The RNHRD NHS FT will be working closely with NHS Employers regarding the implementation of the '5 high impact tool' to improve employee health and well-being.

6.5 Clinical Sustainability Identification of which of the Trust's services could potentially lack critical mass (defined by Royal Colleges etc.)

The endoscopy service is vulnerable as a single handed consultant specialty, in order to mitigate the risks the following has been put in place;

- Attendance at the Upper GI MDT at the Royal United Hospital Bath (RUHB)
- Supervised training by the Consultant Gastroenterologists at RUHB
- The unit does not receive referrals as part of the local Cancer Pathway

6.6 Identification of which services have consultant cover below those recommended by Royal Colleges etc. (link to financial template)

As above

6.7 Innovations in care delivery developed at the Trust or in conjunction with partner organisations.

- The Trust secured funding in 2012 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 Breast Radiation Injury Rehabilitation Service is in 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.
- The Chronic fatigue service for adults has, in conjunction with MacMillan, developed an additional strand of fatigue management, branded the Macmillan Step Up Service to support cancer related patients experiencing significant fatigue.
- Dr Sengupta has won two awards at the prestigious PM Society Digital Media awards for 'Talking AS' an innovative online assessment tool designed to improve how AS patients are monitored and treated. This was developed in partnership with an external partner.
- Interactive patient centred iphone app to assist patients with CFS/ME to keep track of their activity levels and monitor their energy usage on day-to-day activities to help them maintain balance and avoid 'boom and bust' energy cycles. This won the 'Innovation in Technology' category at the NHS Innovations North Bright Ideas awards ceremony
- Extension of satellite service model facilitating the delivery of services in the patient's home or local community using a hub and spoke model to allow access to specialist expertise at the RNHRD and provision of high quality services within a robust governance structure. Currently this model is used for paediatric CFS where local clinicians are appointed and trained by the RNHRD to deliver a local service following initial assessment and diagnosis by the lead consultant.
- The Trust will continue to take an innovative approach to marketing its specialist services in line with specialist and local commissioning intentions.

6.8 Clinical sustainability and the implication of 24/7 consultant rotas

No implications for this organisation because the only 24/7 service we provide is Rheumatology emergency admission service which is comprehensively covered by a consultant rota and supported by a junior doctor rota, both rotas are non-resident.

6.9 Cost benchmarking and the opportunity for transformational CIPs

The opportunity for significant and transformational cost improvement plans will be realised once the Trust is able to proceed with its strategic intent to be acquired by RUH Bath, as a result of this pending acquisition

there are limitations to the extent that the Trust can consider transformational CIPs at this time, due to economies of scale.

Cost improvements that are planned and are in the process of being facilitated include a major reconfiguration of the hospital site to potentially include the sale of the office accommodation building and the vacation of rented space with potential full year effect savings of circa £75k. The Trust is evaluating the proposals to procure back office functions via an SLA rather than in-house which may prove more cost effective by benefiting from another organisation's ability to achieve economies of scale.

7. PRODUCTIVITY AND EFFICIENCY

7.1 Overview

The Trust is assuming that the length of stay for Rheumatology inpatients will remain at approximately 7 days, as achieved during 2012/13, this will be monitored by our consultant medical staff going forward. The Trust already has low levels of bank and agency spend and any requests for agency requires direct authorisation by the Director of Operations and Clinical Practice. Bed occupancy is not expected to change in the immediate future although steps are being taken to improve this longer term, historically this has been difficult to record due to a flexible bed base. The RNHRD does not have surgical theatres and negligible emergency readmission rates (within 28 days). These are monitored as adverse events and subject to root cause analysis if they occur.

7.2 CIP Governance

The Trust has a successful track record of delivery on its CIP targets. CIP schemes are approved through Trust Board as part of budget setting. Delivery of CIP is monitored through the Finance and Activity Committee.

7.3 CIP Profile

The Trust does not envisage any transformational CIPs as it focuses on its strategic intention to be acquired. It is expected that any significant transformational CIPs will be delivered through integration at the point of acquisition.

7.4 CIP Enablers

None of the CIP schemes are dependent on significant investment. The appropriate people, including clinicians, have been involved in the development and implementation of CIP schemes where relevant.

7.5 Quality Impact

The CIP schemes were assessed for quality impact by the Director of Nursing and the Medical Director and a risk assessment produced for the Integrated Governance and Quality Committee and commissioners.

8. FINANCIAL AND INVESTMENT STRATEGY

8.1 Current Financial Position

A summary of the income and expenditure plans for 2013/14 and the following two financial years is provided in the table below, together with the financial position for 2012/13 and previous year. This confirms an expected deficit of £(3,589k) in 2013/14.

	Actual		Planned		
	2011/12	2012/13	2013/14	2014/15	2015/16
	£000	£000	£000	£000	£000
INCOME					
CCG & NHS England patient related income	12,840	11,045	8,500	7,889	7,786
Private Patients	164	159	181	180	180
PbR excluded drugs	5,077	5,836	5,500	5,500	5,500
Other patient income*	227	309	873	874	874
sub-total	**18,308**	**17,349**	**15,054**	**14,443**	**14,340**

Non-recurrent non-SLA income or Additional Funding	900	4,648	0	0	0
Other income					
R&D	1,137	1,160	1,058	1,058	1,058
Education & Training	351	338	303	311	321
Charitable contributions	34	123	24	24	24
Other income	294	130	58	58	58
sub-total	**1,816**	**1,751**	**1,443**	**1,451**	**1,461**
TOTAL INCOME	**21,024**	**23,748**	**16,497**	**15,894**	**15,801**
EXPENDITURE					
Pay expenditure	(11,530)	(11,130)	(9,955)	(9,863)	(10,065)
Non-pay expenditure	(3,815)	(4,078)	(3,778)	(3,979)	(4,187)
PbR excluded drugs	(5,077)	(5,836)	(5,500)	(5,500)	(5,500)
Restructuring costs	0	(1,176)	(240)	(240)	(240)
TOTAL EXPENDITURE	**(20,422)**	**(22,220)**	**(19,473)**	**(19,582)**	**(19,992)**
EBITDA	**602**	**1,528**	**(2,975)**	**(3,688)**	**(4,191)**
Interest receivable	3	5	0	0	0
PDC Dividend	(199)	(182)	(192)	(192)	(192)
Depreciation	(512)	(429)	(422)	(420)	(420)
TOTAL SURPLUS / (DEFICIT)	**(106)**	**922**	**(3,589)**	**(4,300)**	**(4,802)**

* No income related to donated assets is being assumed.

The Trust has experienced a deteriorating financial position, which was supported in 2011/12 and 2012/13 by non-recurrent funding from Bath and North East Somerset Primary Care Trust. The two key drivers behind the Trust's position are:

- Declining activity levels, due to changes in referrals and advancements in healthcare (for example, in drug treatments).
- The size of the Trust, which through an inability to achieve economies of scale until the strategic plan can be implemented means the infrastructure and overhead costs are disproportionately high.

This deterioration is expected to continue until the Trust is able to deliver on its strategic plan and transfer the services into a sustainable organisational form.

8.2 Key Financial Priorities and Investment

Each clinical service line is projected to make a positive contribution to overheads of 20%-30% for 2013/14. The Trust will need to work with Clinical Commissioning Groups to understand and contribute to the development of commissioning intentions and evolve services to ensure they meet future demand. Simultaneously, the Trust believes substantial financial savings can be achieved by working with the acquirer of the services, once determined, to expedite the benefits that can be achieved through integration and restructuring.

The Trust's key financial priorities are therefore to:

- Ensure the clinical services continue to maintain a contribution to overheads that would be acceptable to most other NHS organisations.
- Ensure sufficient project resource is available to support the delivery of the strategic plan.
- Ensure there is sufficient capital investment to maintain a safe and secure environment appropriate for the delivery of clinical services.
- Ensure revenue and capital expenditure is appropriate to the delivery of the strategic plan.
- Manage cash flows to ensure the above priorities can be met.

8.3 Financial Risks

The RNHRD is operating in an uncertain environment, and faces several risks to achieving long term financial sustainability for its services. The specific financial risks identified by the Trust are as follows:

Risk	Mitigating Action
Failure to achieve activity and cost levels underpinning the financial plan in 2013/14.	Monitoring of Financial plan presented to April 2013 Board. Forecasting, monitoring and reporting monthly to Finance and Activity Committee, Board and Monitor.
Failure to meet cash targets and/or obtain funding required to meet the cash shortfalls forecast for 2013/14.	Forecasting monitoring and reporting cash daily by the finance team and monthly reports to the Finance and Activity Committee and Board. Negotiations ongoing regarding financial support for 2013/14