Strategic Plan Document for 2013-14

The Royal Orthopaedic Hospital 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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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)*	Bryan Jackson

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Graham Bragg

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Paul Taylor

Signature

Strategy Guidance - Annual Plan Review 2013-14

Principles underlying the Annual Plan Review (APR) process

1. This document sets out the requirements for the principal published forward plan ("Strategic Plan") for Foundation Trusts. The Strategic Plan should set out how the Trust's Board intends to deliver appropriate, high quality and cost-effective services for its patients on a sustainable basis. It should, therefore, lay out the Trust's assessment of the challenges it faces (both within the organisation and more broadly within its local health economy), its strategy to address those challenges and its implementation plans over the 3 years from 13/14 to 15/16.

2. The Strategic Plan should be consistent with the information submitted in the finance template (being issued on 29th March), and provide context for key figures included in the finance template.

3. It is crucial to recognise that the Annual Plan is not meant to be a simple budgetary exercise, but rather a key governance document which explains how high quality services will be delivered into the future. This will involve analysis of a broad range of issues, which may, for example, include: demographics and health trends; clinical sustainability and the implications of 24/7 consultant rotas; opportunities and threats from reconfiguration; cultural factors and their impact on delivering services which are safe, clinically effective and result in high patient satisfaction; cost benchmarking and the opportunity for transformational CIPs. Clearly, this is not meant to be an exhaustive list and different Trusts will have differing starting positions and face somewhat differing challenges.

4. Monitor has for many years emphasised the importance of robust planning over a multi-year time horizon in maintaining a healthy and sustainable FT sector. Our experience in prior Annual Plan Reviews has shown, however, that FTs on the whole tend to focus on a one-year planning cycle and look less at addressing longer-term strategic issues. The context to the 2013/14 Annual Plan is particularly challenging, with FTs facing rising demand and the need to deliver increased quality and efficiency and an improved experience of healthcare services for patients. Against this background, a short-term planning outlook, particularly one which does not take due consideration of the local health economy or the sustainability of service delivery models, would be inadequate.

5. There is no prescribed format for the published section of the Strategic Plan. However as a guide we would expect plans to be between 10 and 20 pages in length. To support APR analysis there is some specific information, not for publication, that we require from all Trusts and we have therefore included space for these in Appendices 1-4. Where there are commercially sensitive or confidential matters that Trusts do not want to include in the main published section and which cannot be accommodated within Appendices 1-4, these may be included in Appendix 5[1].

[1] Although Monitor does not intend to publish these Appendices, all information provided to Monitor is potentially subject to disclosure under the Freedom of Information Act 2000 (subject to the normal exemptions).

6. Annex A sets out, at a high level, the main stages in the development of the three-year Strategic Plan and the key elements which underpin each.

7. Monitor expects that Strategic Plans would include an Executive Summary outlining key elements of the Strategic Plan, including a summary of key financial data.

8. The main section of the Strategic Plan should normally address the areas set out in the following table, and any other relevant areas.

Strategic Context and Direction	Trust's strategic position within LHE including: • An overview of the Trust's key competitors and an assessment of the Trust's key areas of strength/weakness relative to the key competitors; • Forecast health, demographic, and demand changes; and • Impact assessment of market share trends over the life of the plan.

	Threats and opportunities from changes in local commissioning intentions
	• An overview of the key changes to local commissioning strategy and intentions and their anticipated impact on the Trust, including:
	  ○ QIPP & demand management;
	  ○ Decommissioning;
	  ○ Potential "Any Qualified Provider" Tenders;
	  ○ Shifting care delivery outside of hospitals; and
	  ○ Reconfiguration plans.
	• An explanation of how the Trust has factored these considerations into its strategy;
	• Analysis of how the Trust's demand profile and activity mix has evolved over recent years and what changes are forecast; and
	• Details of how the Trust is diversifying its income streams (e.g. research, private patients, exploiting intellectual property).

	Collaboration, Integration and Patient Choice • Plans to integrate services to provide better care and/or increase efficiency; • Development of partnerships and collaborations with other providers; and • Consideration of impact of proposals in relation to competition rules (CCP etc.) and patient choice, where applicable.
Approach taken to quality (including patient safety, clinical effectiveness and patient experience)	• An outline of existing quality concerns (CQC or other parties) and plans to address them; • The key quality risks inherent in the plan and how these will be managed; and • An overview of how the Board derives assurance on the quality of its services and safeguards patient safety. (Trusts may find Monitor's Quality Governance framework helpful in appraising quality arrangements).
Clinical Strategy (Consistent with	Service Line Management Strategy: • The Trust's overall clinical strategy over the next three years;

information contained within the Trust's published Quality Account).	• The Trust's service line strategy over the next three years; and • The inputs the Trust used to develop this strategy (e.g. SLM, benchmarking etc).
	Clinical Workforce Strategy • An overview of the clinical workforce strategy (covering doctors, nurses and other key clinical groups); • Key workforce pressures and plans to address them; • The impact of the Workforce Strategy on costs (short-term and long-term); and • Findings of benchmarking or other assessment (eg using the DH Workforce Health Tool).
	• Clinical Sustainability • Identification of which of the Trust's services could potentially lack critical mass (defined by Royal Colleges etc.); • Identification of which services have consultant cover below those recommended by Royal Colleges etc. (link to financial template); and • Innovations in care delivery developed at the Trust or in conjunction with partner organisations.
Productivity & Efficiency	An overview of potential productivity and efficiency gains built into plans, including financial impact of projected gains, in areas such as: o Length of stay; o Bank and agency spend; o Bed occupancy o Theatre productivity; and o Emergency readmission rates.
	CIP governance • An assessment of historic performance, including main drivers, and necessary further action to ensure future delivery; and • An overview of PMO, leadership and assurance arrangements for the life of the Strategic Plan.
	CIP profile • Key CIP schemes including risk ratings for individual schemes (see Appendix 2); and • An outline of transformational /service redesign CIP schemes which represent step changes in processes rather than incremental changes and a brief explanation of how this change will be achieved.
	CIP enablers • The extent of clinical leadership and engagement in identifying and delivering CIPs; • The requirement for enabling investment in infrastructure (external support, IT, project delivery resources, etc.)

	Quality Impact of CIPs • The mechanism by which the Trust ensures that its CIP plans won't adversely affect quality of services; • The measures of quality which will be used to inform this assurance and how the Trust monitors quality impact of CIPs on an on-going basis.
Financial & Investment Strategy	An assessment of the Trust's current financial position.
	Key financial priorities and investments and how these link to the Trust's overall strategy.
	Key risks to achieving the financial strategy and mitigations.

Strategic Plan

Strategic Context and Direction

The Royal Orthopaedic Hospital NHSFT (ROH) provides routine and specialist elective orthopaedic services to patients from the West Midlands and beyond. Situated in Birmingham, its main competitors are the two large acute trusts UHB and HEFT and those acute trusts in the wider conurbation such as City Sandwell, Wolverhampton, Walsall and Worcester. The two Birmingham-based private hospitals also provide orthopaedic services and it is anticipated that Circle may enact its plans to develop an orthopaedic facility within 2 miles of the ROH site within the next 5 years. With the reduction in waiting times at ROH the attraction of the private sector to patients is increasingly focused on hotel services and choice of timing rather than as a result of long waits. ROH does not offer trauma services but does offer emergency surgery by tertiary referral. The market for orthopaedics continues to grow and current activity levels, although reduced compared to previous years, are now at the baseline ready to absorb the increases in demands as part of demographic change following the effect of reducing waiting times over the last four years. A conservative figure of 4% per annum has been used (lower than the latest report "Getting It Right First Time" suggests) and this takes account of both residual decline as a result of waiting times and the growth in the elderly population in the area. The Trust is also focusing on the development of key specialist services where there is limited capacity currently available, both locally or nationally. Spinal Deformity continues to be a significant pressure point in the NHS, and the Trust is looking to support the delivery of this service in the region through the appointment of two new Spinal Deformity surgeons who will both start work during 2013. We are also developing our Young Adult Hip Service, which is a developing market with limited competition in the West Midlands. Demand for this service was previously driving Birmingham patients outside of the local area to receive treatment, and the Trust is confident that there is significant scope for expansion in this service in the coming years with commissioners' support. The development has again been supported through the appointment of a new consultant specialising in this field. In addition to these service developments, we are confident of achieving growth in routine orthopaedic services, utilising our performance on waiting times and outcomes to attract new patients to the ROH.

The Trust has just completed a refresh of its strategy which involved staff, patients and governors which has reaffirmed our intention to continue as a stand-alone orthopaedic centre of excellence working in partnership with other providers to deliver the optimal level of care for our patients.

Changes in the commissioning landscape have strengthened the Trust's ability to work strategically with commissioning partners to develop our services. Around 30% of our activity is now commissioned by the Birmingham and Black County Area Team, incorporating specialist activity in spinal and oncology services. This portfolio is expected to grow to over one third of our activity in 2014/15 with the inclusion of specialist orthopaedics. The Trust has already been working closely with these commissioners over the last 12 months to support our spinal deformity service, and has now built up key relationships that will support the development of specialist services in the future. The Trust also continues to work closely with our new CCG commissioners, hosting a monthly Joint Clinical Commissioning Group meeting which allows consultants and GP colleagues to jointly drive forward improvements in services and patient care.

Commissioning intentions have been based on assumptions of current performance as the baseline, with specialist commissioners reviewing the pressures on spinal deformity lists in particular in recognition of the national supply and demand issues in this area. No services have been decommissioned and the trust is not subject to 'Any Qualified Provider Tenders' at this point. No reconfiguration plans affect the trust though there is a recognition that if a neighbouring trust disposes of a local hospital to UHB there may be scope for them to compete strongly for routine elective work. This is factored into our assumptions as far as is possible at this stage with mitigation based on brand, performance and strong marketing. We continue to play our part in the local economy and meet with groups including all local health and local authority services on a monthly basis to take forward issues on an economy wide basis.

Trust income streams are diversifying with research income growing tenfold and set on a trajectory of continued increase due to excellent comparative performance within the region. The exploitation of intellectual property is being pro-actively managed and should deliver a modest yield during the life of this plan. Taken together with private patient work, this income should deliver a contribution to turnover of c£1.2 million annually.

Collaboration with other trusts continues to evolve on the basis of service delivery models – for example with Birmingham Children's Hospital with regard to paediatric services and we maintain joint appointments with several trusts as well as outreach in some localities. The trust has considered the benefits and opportunities of working more closely with UHB as part of its Health Campus and through academic and research collaborations will evolve clinical pathways as appropriate.

Approach taken to Quality

As an elective provider, quality is the key factor underpinning patient choice and our success. In broad terms the trust's quality indicators have remained strong but this has not led to complacency. Recent CQC and CCG visits have not raised major concerns but have nonetheless found areas for improvement which we are tackling. In addition we have invited external review of areas where our own internal quality measurement systems have highlighted areas requiring further scrutiny.

Our plans to improve quality are informed by both internal and external information and stakeholders and are identified in our Quality Account. Key areas of focus include learning from serious incidents, improving our medicines management processes, reducing our surgical site infections, improving our administration systems and increasing our target for VTE assessment to > 95%.

Key quality risks include the increasingly complex co-morbidities that our patients present with. We have taken steps to manage this by increasing our consultant physician input, establishing a service level agreement with our local mental health trust and employing an advanced nurse practitioner with a background in medicine to complement the surgical skills and expertise of our current workforce. All patient transfers out of the hospitals and emergency admissions to HDU are reviewed and presented at monthly audit meetings to identify trends and areas for learning and improvement.

Our current admission process, the pathway from the outpatient appointment where a decision for surgery is undertaken to the day of surgery, is another key area of risk which we are focussing on to improve our processes for informed consent, clerking of patients and prescribing of medicines. The

new pathway will be in place in the summer prior to the opening of the new admissions and daycase unit.

Learning from serious incidents, as evidenced by the implementation and then auditing of action plans, is a risk that we have identified and new systems for doing this have been introduced. Our incident reporting systems Ulysses is now used to track the completion of action plans with reports provided monthly to directorates to enable them to take the necessary action. This will be monitored via the directorate performance meetings.

The Board derives assurance on quality issues from a number of sources - the monthly dashboard on corporate performance which includes patient safety indicators; the monthly report from the Director of Nursing and Governance providing narrative on a number of quality issues; the work of the Board's Integrated Governance Committee which receives regular sub-committee reports; exception reports; peer review and inspection reports and the quarterly quality report. All Board members participate in monthly CQC outcome workshops that include visiting areas of the business to assess compliance. Two Board workshops were held last year, one to undertake a detailed self assessment against the quality governance framework (quarterly self assessments are undertaken by the Integrated Governance Committee on behalf of the Board), and the second to hear from colleagues within and outside of healthcare and how they have tackled quality issues including safety and customer experience. Patients and their carers also attended to tell their story directly to the Board and patients storied have continued at the Board meetings.

The Board is committed to learning from external reports and as such the Director of Nursing and Governance is leading work on the Francis report. The approach being taken is that of including frontline staff, patient and public representatives and commissioners through existing forums as well as newly established task and finish groups. Key findings, recommendations, learning for the organisation and actions that are required will be identified and implemented by the end of November 2013

Clinical Strategy

The trust has now embedded a new clinical directorate structure and service line management which is supported through a bi-monthly trust business and learning day (TBALD) which allows time for clinical staff to engage with managers and focus on business requirements. This is further supported by a project management office (PMO) which ensures that service redesign is undertaken by multi-disciplinary groups of staff at all levels who can design the service they work in through active collaboration. The trust has used external advisors to develop its lean methodologies and regularly benchmarks performance in terms of evidence based outcomes.

In order to ensure the whole workforce is fit to deliver the overall trust strategy a number of operational and strategic actions will be taken:

Staff Engagement: In broad terms the Trust's level of staff engagement needs improving. The effects of this have been seen during 2012/13 in a number of areas from the staff survey, concerns expressed by some staff groups, in levels of absence and staff turnover. This will be the key workforce priority during the term of this plan with the immediate areas of focus being communication, feedback and engagement of staff in clinical incident action planning and learning. Management and leadership are recognised as key and the Trust will build on its recent approach of greater visibility and accessibility as well as encouraging middle managers to lead culture change by example. The key risk is that improvements in staff engagement will take too long to be realized

to improve operational performance. This risk will be mitigated through the sustained focus of the executive team in this area.

Reducing Expenditure on Agency Staffing: In order to both reduce unplanned agency expenditure and ensure continued delivery of high quality care, we plan to continue to recruit to existing funded vacancies within our workforce, particularly in the ward and theatre areas as well as in the junior doctor staff group. It is expected that current levels of expenditure on agency staff in these areas will reduce as a result of this additional workforce.

Measured management of small-scale workforce reductions: There are no plans for significant workforce reductions to meet the levels of efficiency and CIP required. There will be some small-scale workforce reductions arising from the service reconfiguration of a new Admissions and Day Case Unit and merger of two clinical areas. These reductions will be achieved through natural wastage, removal of existing vacancies and redeployment. At this stage there are no plans for redundancies. All service changes, clinical and non-clinical are risk assessed to ensure there is no detrimental effect on delivery of safe care for patients. A formal skill-mix review of the nursing workforce is also planned during 2013/14.

Flexibility of working to achieve activity growth: During 2013/14 we will be undertaking a systematic review of consultant job plans to both recognize the unique contribution of consultants and ensure alignment of individual working to the service objectives. This will then become an annual process as the Trust evolves its strategy. It is envisaged that the planned growth in hip and knee operations can be achieved within the existing workforce capacity. The Trust has invested in additional consultant workforce in the key areas where there was insufficient workforce capacity, namely in spinal deformity and young adult hip. These additional people join the Trust during 2013/14.

Clinically Sustainable Medical Workforce: We recognize the medical workforce model for out-of-hours care is not fit for the future and is currently sustained by long-term expenditure on junior doctors. Work is currently underway to identify a clinically appropriate model resourced from a sustainable workforce. The Trust has identified options for further evaluation and has already appointed a post-holder with additional expertise. The work will impact on anaesthetists and wards and needs to be developed in line with the changing patient profile of greater co-morbidity and complexity. It is likely that additional cover, at consultant or senior level, will be required and financial provision has been made for the likely level of investment required which is expected to come into effect in late 2013/14 and into 2014/15.

The key risks to implementation of both a new workforce model and increased flexibility is strained employee relations, as both individual and cultural norms that do not align to the organisation's objectives are addressed. These have potential for both delay in implementation and reduced effectiveness. These risks will be mitigated by training of medical leaders together with open engagement of and communication with both the staff affected and the broader workforce to aide acceptance of the need for change to deliver organizational sustainability and safe care for patients.

We intend to realize the benefits of the new national agreement for staff on agenda for change, linking individual contribution to incremental progression. We expect to have implemented any necessary changes by the end of 2013/14. It is our intention to also consider during 2013/14, implementing fixed point salaries for more senior staff.

Productivity and efficiency

Productivity gains have been on the agenda for three years through the Project Management Office (PMO). Length of stay has reduced by around half a day in 12/13 and through the life of this plan will reduce still further through both expansion of the Bone Infection Unit (which allows patients to be treated at home for what otherwise would be a long inpatient spell), pathway changes and further roll out of Enhanced Recovery.

Work is underway to improve pre-operative processes, from initial receipt of referral letter, to rapid pre-operative assessment and direct booking of date for surgery at 1st outpatient appointment, through to admission on the day of surgery and increasing our day case rate by opening our new Admissions and Day Case Unit for longer hours. The impact of these changes and improvements in efficiencies is expected to result in a further 0.5 reduction in length of stay to <4 days in 13/14 and a reduction in patients cancelled on the day or the day before their surgery as well as an overall reduction in "waste" in terms of workarounds which are in place due to poor and inconsistent processes.

Bank and agency spend will reduce in 2013/14 as a result of recruitment in the second half of 2012/13 which has addressed key skills shortages within the theatres department where agency nursing had previously been required to address these needs. Further work is on-going through the 2013/14 CIP programme to resolve the longstanding requirement for locum junior doctors, and the Trust is planning to reduce spend in this area by £200,000 in the financial year.

Bed occupancy is also being managed through the Cost Improvement Programme (CIP) in order to maintain optimum efficiency levels of 85% occupancy. Theatre productivity will continue to improve through the introduction of more flexible working arrangements among clinicians expected to be achieved through a Trust wide job plan review which will commence in June 2013. By increasing theatre utilisation to 90% we are confident that we can create enough capacity to deliver the growth in activity modelled within the life of this plan. By reducing the number of patients cancelled on the day, or the day before their planned surgery by 50%, we have identified that additional out of hours sessions, currently required to maintain activity levels and achieve 18 week RTT, will no longer be required which should create a saving of around £100k per month.

As part of our development of a Service Line Management model, the Trust's full cost improvement target has been devolved to Directorates from 2013/14. Work has been on-going to support Directorates in the process of developing these schemes and this support is continued through the PMO office, with appropriate scrutiny applied by key Executive Directors. All relevant CIP schemes are subject to a Quality Impact Assessment, which is signed off local by Clinical Directors and Matrons, and corporately by the Director of Nursing and Governance and the Medical Director.

Financial and Investment Strategy

The Trust aims to continue to achieve a financial risk rating of at least 4 (or its equivalent under the Risk Assessment Framework) for the period of this plan and therefore continue to maintain a strong financial position within a difficult local and health sector financial environment. We will achieve this by:

- Continuing to pursue our lean based organisational change programme "Excellent Health" which continues to enable front line staff to redesign key processes with a patient focus eliminating unnecessary waste and therefore costs. This programme has released in excess of £8.5m of cost to date. The renewed focus for 2013-14 onwards is on "patient centred care" where the patient pathway is the focus of the redesign effort in order to

improve the patient experience and enhance the Trust's reputation as the orthopaedic hospital of choice for patients and their GP advocates;

- Investing in enabling IMT solutions to increase clinical quality and efficiency. A significant investment is planned in 2013-14 with a wholesale refresh of the Trust's core systems to allow better integration of core systems and the information provided by them
- Continued investment in the fabric of the estate – with the opening of the new Admissions and Day Case Unit in 2013, and the start of the new Theatre development in 2014.;
- To work in partnership with the local health organisations and support the local QIPP agenda through the Birmingham and Solihull compact;
- To work with local GP commissioners and patient groups to design service delivery models that place the patient at the centre of service delivery
- To grow our young adult hip; spinal deformity and revision of hip services
- Setting aside 1% of turnover to fund developments and new initiatives to ensure that the Trust continues to develop and achieves its strategic aim of being the first choice for orthopaedic patients, carers and commissioners
- Achieving at least 4.0% in cost improvement each year

In modelling to achieve our targets we expect to see costs rise during the period as follows:

- Pay inflation will be 1% in each of years 2 and 3, with similar increases relating to incremental drift, Non pay inflation for general expenditure will be 2.4% in year 2 and 2.1% in year 3 with drugs being 2.5% and specific provision made for increased insurance costs (NHSLA), depreciation and public dividend capital;
- We anticipate a material one-off cost when the new admission and day case unit development is completed in 2013. In addition we plan to commence a new £5m development in 2014 to replace the oldest theatre block and provide new paediatric accommodation.

The key actions to ensure that the trust achieves the financial strategy are:

- Continued executive commitment to the Programme Management Office and the Excellent Health Programme along with a continued Trust Board focus on ensuring that all new schemes and efficiencies do not adversely affect the quality of trust's services;
- To develop greater clinical engagement and accountability through a revised clinical management structure within the organisation;
- To manage the delivery of the capital programme through specific project boards and ensure that the programme is delivered to plan financially whilst delivering the agreed outcomes;
- To continue to devolve financial accountability through the organisation.

The key risks facing the organisation are:

- The change of commissioners from 1st April 2013, and the uncertainty about which aspects of the contract portfolio are “specialised”. This had the potential to disrupt previously productive relationships with commissioners and introduce financial tensions previously not there The Trust is working closely with commissioners through the Birmingham and Solihull compact and with the new CCGs and the Area Team to ensure new relationships and Trust are built and early signs are encouraging;

- There is a continued risk that the national tariff does not recognise the specialist nature of work completed within a specialist unit increasing losses suffered on specialist procedures and specialist cases within standard procedures. The trust is working with the Specialist Orthopaedic Alliance and the national PbR team and more recently with Monitor to inform the debate on specialist orthopaedic services;

- There is a potential loss of quality in services where efficiency schemes have been completed. The trust has a robust process for measuring the outcome of an efficiency initiative and is ensuring that front-line staff are involved in delivering solutions. The Audit Committee regularly reviews all schemes and assures the Trust Board that quality is not affected by efficiency schemes. The Trust has adopted a policy of quality assurance for all cost improvement schemes which results in the medical Director and Nurse Director giving positive assurance on each scheme at a detailed level following review by Clinical Directors and Matrons

- There is a potential for a reduction of referrals through patient choice or any qualified provider initiatives. The trust is ensuring that patients receive good care and a positive patient experience and is committed to publishing outcomes of procedures to demonstrate good care; and

- If the Trust fails to achieve all of the contractual KPIs or CQUINs it will receive a financial fine. This is particularly key in the area of waiting time fines in 2013-14 as the Trust has a number of long-waiters in the spinal deformity service The trust is managing all KPIs and CQUINs through a robust project management structure, and working with commissioners and other providers to increase capacity in all areas where unacceptably long waiting time still exist