The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Strategic Plan Document:
2013/14, 2014/15 & 2015/16

The Robert Jones and Agnes Hunt 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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Date	31st 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)*	Russell Hardy

Signature 

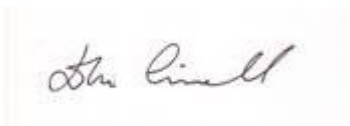
Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	Wendy Farrington Chadd

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	John Grinnell

Signature 

Executive Summary

Our vision & aims

Our strategic intention is to become the leading national specialist orthopaedic Trust in the UK. As a Trust Board we have developed the following Mission Statement:

"To be the leading centre for high quality, sustainable orthopaedic and related care, achieving excellence in both experience and outcomes for our patients"

Strategic aims

We have developed key strategic aims to deliver our vision. These are supported by a robust business planning and performance management regime which identifies clear objectives for each aim, sets measurable targets for delivery and monitors improvements.

Strategic aim 1 - To be the provider of choice for patients through the provision of safe, effective, high quality orthopaedic and related care.

Over the next three years we will achieve the following objectives:

- Improve and streamline access for patients through reduced waiting times
- Receive the very best ratings from our patients
- Patient and staff satisfaction scores in the top 5% of all NHS hospitals
- Improve the quality of care for our patients
- Increase our Market Share in both specialised and general activity through choice
- Meet the requirements of our provider licence.

Strategic aim 2 - To improve outcomes for patients through partnership working with patients, staff and commissioners of services at a local and national level, and through clinical networks with other providers.

During the next three years we will:

- Strengthen clinical networks in line with the development of National Care Standards in specialised services
- Support our local health economy services through hub and spoke models using the RJAH brand to strengthen local services
- Redesign patient pathways to improve access ensuring patients only access the hospital when they need specialist care.
- Increase specialised activity in line with National sub-specialisation and increasing demand.

Strategic aim 3 - To develop a vibrant and viable organisation where people achieve their full potential and success leads to investment in services for patients.

Over the next three years we will achieve the following objectives:

- Reduce the time patients stay in hospital through increased daycase rates and shorter inpatient stays.
- Develop new 23hr ward and day theatre facilities
- Upgrade our main theatre block and co-locate theatre facilities
- Deliver our financial plans and commitments
- Invest in clinical leadership and personal development which promotes the Trust values
- Develop a workforce strategy that supports the role redesign and is underpinned by technology
- Reduce staff sickness absence to 2.9%
- Optimise IM&T to enable improved processes and streamline administration

Strategic position, demographics & market

The current turnover of the Trust is approximately £87 million and the Trust employs 1093 whole time equivalent staff. The net assets of the Trust are valued at approximately £53 million.

Our largest commissioners are Shropshire County Clinical Commissioning Group (CCG) and a growing number of the Trust's services are commissioned through the National Commissioning Board. A primary driver influencing overall demand for our services is the age profile of our population in which 20.7% are aged over 65.

We have undertaken a market assessment which has identified three main components of market change:

- Demographic and age profile
- Developments in sub-specialisation and specialist commissioning
- Patient choice

A key challenge for the Trust in recent years has been in meeting demand for our services. Following our market assessment we have modelled demand scenarios that range from a downside of reducing activity levels, a most likely scenario being a prudent assumption of market drivers and an upside scenario of future market share potential.

Collaboration, Integration & Patient Choice

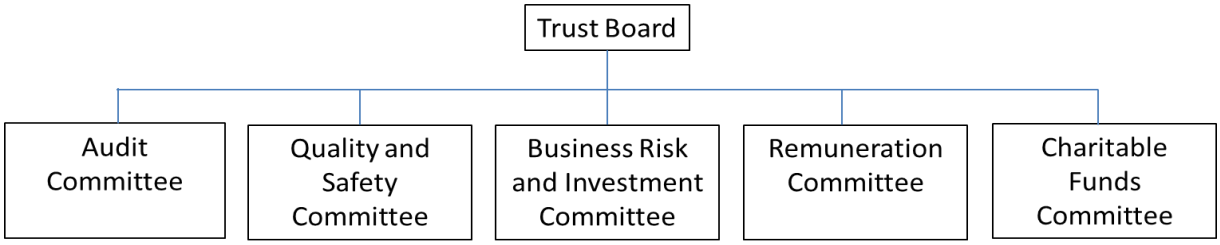
As an organisation, RJAH collaborates with local service providers, as well as regional and national networks to deliver care. Local Partnerships include **Joint Consultant Posts** with Wrexham Maelor & Shrewsbury & Telford NHS Trust, **Outreach Clinics** provided in North Wales, Mid Wales, Cheshire and Shropshire & **Community Rheumatology** services in partnership with Telford Community Trust.

We also have Specialist Partnerships within **Paediatric Orthopaedics** providing outreach service into BCUHB's three District General Hospitals and network links with link to Alder Hey Children's Hospital as part of a paediatric network. Our **Neuromuscular Services** link to a number of specialist centres including both Alder Hey and Birmingham Children's hospital services for multidisciplinary networking and learning purposes and our **Bone Tumour** links with the Greater Manchester and Cheshire Cancer Network to deliver specialist bone tumour care and advice to other Trusts including the Christie NHS Foundation Trust.

Patients are increasingly choosing RJAH as a provider of choice, and with national policy on named consultant choice this has made meeting waiting times an increased challenge for us as a provider of general as well as specialist services where few alternative providers exist, in particular for Spinal Surgery.

Our Approach to governance

The corporate governance structure is set out below.



The Trust Board is responsible for setting the strategic direction for the Trust, for monitoring the performance against its objectives and ensuring the highest quality of patient care is provided. Each committee has a work programme with responsibility for identified corporate risks and CQC regulations.

The Trust uses its governance structure as a basis on which to report to Monitor against the compliance framework targets and to report to other external agencies such as the CQC. The Organisation has no outstanding quality concerns raised by CQC or any other quality monitoring organisations.

Quality Strategy

The Trust has a well embedded Quality Strategy. The strategy draws together our safety, clinical effectiveness and patient experience aims with Monitor's Quality Governance Framework to enhance the quality of care provided to our patients.

Quality & operational risks

The key quality and operational risks to the organisation will be monitored via the Quality and Safety Committee and the Board Assurance Framework during the life of this plan. They include:

- Failure in clinical quality or safety controls
- Sustainable maintenance of Inpatient and Outpatient Referral to Treatment (RTT) targets
- Failure to deliver RTT Open Pathways target
- Impact of NHS restructuring on commissioning arrangements
- Delay in specialised commissioning arrangements being confirmed

Service line management strategy

Our overall approach to service line management in the next three years will be to grow key profitable services whilst reviewing the way forward for services which do not make a positive contribution. We will only retain loss making services if they are essential to the Trusts strategy and direction, and where they do not compromise our overall viability.

Clinical leadership

Within the Trust we have a robust clinical structure which mirrors and complements our service line structure. Our overall clinical strategy is integrally linked to our service line management approach working with individual teams within the Trust to ensure quality and clinical excellence is embedded within each service.

All of our planned service and pathway changes described within this plan will be driven by clinicians from within the relevant service areas.

Clinical workforce strategy & sustainability

The majority of staff work within direct patient care roles within the Trust. The focus of the clinical workforce strategy moving forward is succession planning of key posts; strengthening clinical leadership; activity driven workforce planning to increase productivity and continued assurance of safe staffing levels.

Any workforce changes will be tracked via the Executive Team and reported to the Business Risk and Investment Committee on a regular basis.

Overall, our clinical services are sustainable without any challenges of low consultant cover or single handed practitioners to be addressed and all of our services meet with current Royal College guidance in relation to critical mass; this will continue to be reviewed during the life of this plan.

Productivity

The Trust understands that productivity and efficiency improvements over the coming 3 years are key to the delivery of our overall operational and financial plans. We have assumed in our plans the need to make 4% year on year efficiencies. Through improved operational efficiencies we can continue to improve access. Key areas include daycase rates, length of stay although this is offset somewhat by co-morbidities, and reducing sickness levels. The Key Performance Indicators (KPIs) against which our on-going success will be measured have been agreed with our Board.

Cost improvement plans

The Trust has a strong track record of delivering CIP targets based on a 'bottom up' approach supported by corporate themes. Our CIP for the next 3 years will deliver a 4% efficiency saving. All plans are Quality Impact Assessed.

Financial Strategy

The Trusts financial strategy is:

"To generate sufficient surpluses to help us deliver the highest quality clinical care"

Having modelled our financial plans across the three year period, sufficient surpluses and cash balances are achieved in order to improve our FRR to a level 4 risk rating as set out below. This measure will be updated when Monitor publish their revised financial indicators under the Risk Assessment Framework however our aim is to continue to strengthen our underlying financial position.

Key Financial metrics	2013/14 Plan	2014/15 Plan	2015/16 Plan
Net Surplus	£1 m	£1.6m	£1.7m
Cash Balance	£3.5m	£4.9m	£6.1m
Risk Rating	3	3	4

During 2013/14 our investment priorities will be to operationalise the new Tumour Unit which is the first phase of a wider programme to improve and modernise our theatre and fast track ward capacity. In years 2 and 3 of this plan we will the focus our investments towards ensuring we can meet the demand for our services predicted within scenario 2 (most likely scenario) of our demand modelling in an efficient manner.

Financial Risk

The most material financial risks as detailed in the overall plan are:

- Delivery of 2013/14 CIP/Increased Cost Pressures
- Penalties levied for any target failure
- Commissioners cannot afford assumed growth in demand
- Shortfall on fundraising for Tumour Unit
- Turbulence to Commissioning landscape arising from Specialist Services dataset review
- Tariff Instability

1. Strategic Position

1.1 Our vision & aims

Our strategic intention is to become the leading national specialist orthopaedic Trust in the UK. We want to be the provider of choice for people both locally, and throughout England and Wales when they need high quality, patient centred specialist care. Our unique geographical position, the high quality of services we provide and our excellent reputation in patient care, place us in a strong position to achieve this vision in the new NHS.

As a Trust Board we have developed the following Mission Statement:

"To be the leading centre for high quality, sustainable orthopaedic and related care, achieving excellence in both experience and outcomes for our patients"

Quality remains our defining purpose as a hospital and our collective purpose is to deliver outstanding patient care. Healthcare delivery is changing; the needs of our patients the technology available and ability to deliver care differently provides us with a huge opportunity. Our services need to be ***sustainable*** and ***cost effective*** to be viable both now and in the future. We need to ensure access to our services supports both growth and patient choice.

Increasingly the need to ***work in partnership*** across wider clinical networks will be a feature of service provision as many of our specialist services are part of clinical networks who will increasingly define standards of care. We need to recognise where working in partnership can strengthen our services.

As a Trust we need a 'step change' in the way we ***use technology*** to support healthcare delivery at every level. The use of technology in the future will be critical to our longer term sustainability and continued reputation for innovation and quality.

1.2 Strategic aims

We have developed three key strategic aims to deliver our vision. These are supported by a robust business planning and performance management regime which identifies clear objectives for each aim, sets measurable targets for delivery and monitors improvements.

Every objective we set as a Trust will be assessed against the delivery of these aims through Key Performance Indicators (KPIs) and will need to demonstrate a clear link to QIPP principles, particularly our savings plans for the future. Our Board Assurance Framework provides a quarterly update to the Board on key performance against these objectives.

Our three strategic aims are:

1. *To be the provider of choice for patients through the provision of safe, effective and high quality orthopaedic and related care*

2. *To improve outcomes for patients through partnership working with patients, staff and commissioners of services at a local and national level, and through clinical networks with other providers*

3. *To develop a vibrant and viable organisation where people achieve their full potential and success leads to investment in services for patients.*

1.2.1 Strategic aim 1

To be the provider of choice for patients through the provision of safe, effective, high quality orthopaedic and related care.

The Trust is the provider of choice for our local patient catchment. We have a strong market share within the local health economies of Shropshire, Cheshire and North Wales.

This strategic aim sets out our intention to consolidate and expand our market share through the planned NHS reforms by attracting additional patients from within and beyond our Local Health Economy.

Over the next three years we will achieve the following objectives:

- Improve and streamline access for patients through reduced waiting times
- Receive the very best ratings from our patients
- Patient and staff satisfaction scores in the top 5% of all NHS hospitals
- Improve the quality of care for our patients
- Increase our Market Share in both specialised and general activity through choice
- Meet the requirements of our provider licence.

1.2.2 Strategic aim 2

To improve outcomes for patients through partnership working with patients, staff and commissioners of services at a local and national level, and through clinical networks with other providers.

As a Trust we recognise the need to work collaboratively with partners and with patients to redesign services in a way that supports sub-specialisation. We need to work across networks where these strengthen services and to offer care closer to patient's geographical locations where this suits specialist care, e.g. through hub and spoke models.

During the next three years we will:

- Strengthen clinical networks in line with the development of National Care Standards in specialised services
- Support our local health economy services through hub and spoke models using the RJAH brand to strengthen local services
- Redesign patient pathways to improve access ensuring patients only access the hospital when they need specialist care.
- Increase specialised activity in line with National sub-specialisation and increasing demand.

1.2.3 Strategic aim 3

To develop a vibrant and viable organisation where people achieve their full potential and success leads to investment in services for patients.

This aim relates to our continued development of the organisation as an employer of choice. We have a committed workforce which is key to ensuring a successful and viable future for the Trust as an independent organisation.

As an NHS Foundation Trust, we will invest in services for patients to improve quality further.

Over the next three years we will achieve the following objectives:

- Reduce the time patients stay in hospital through increased daycase rates and shorter inpatient stays.
- Develop new 23hr ward and day theatre facilities
- Upgrade our main theatre block and co-locate theatre facilities
- Deliver our financial plans and commitments
- Invest in clinical leadership and personal development which promotes the Trust values
- Develop a workforce strategy that supports the role redesign and is underpinned by technology
- Reduce staff sickness absence to 2.9%
- Optimise IM&T to enable improved processes and streamline administration

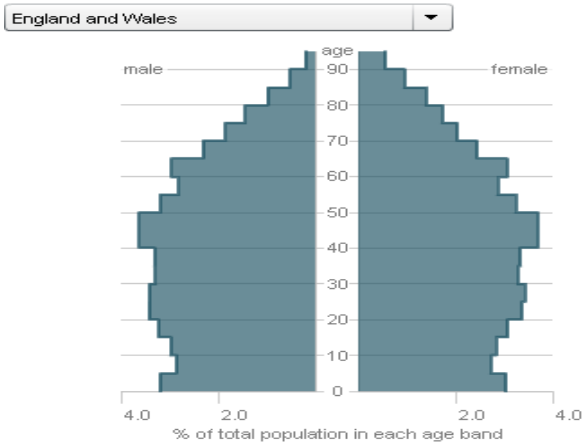
1.3 Strategic position, demographics & market

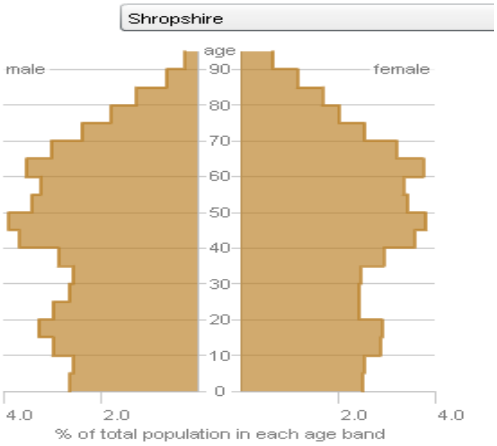
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) has been an NHS Foundation Trust since August 2011. Our geographic location and specialist nature give a complex commissioning portfolio across the English Welsh Border and nationally for some services. The current turnover of the Trust is approximately £87 million and the Trust employs 1093 whole time equivalent staff. The net assets of the Trust are valued at approximately £53 million.

The Trust is one of the UK's five specialist orthopaedic hospitals providing specialist, routine orthopaedic and related care to patients locally, regionally and nationally. The hospital is an elective surgical centre for routine orthopaedics, and in addition, a specialist centre for complex orthopaedic surgery for both adults and children, a regional spinal injuries centre, and a national centre for bone tumour surgery.

Our largest commissioners are Shropshire County Clinical Commissioning Group (CCG) accounting for 37% of our contracted activity and Betsi Cadwaladr University Health Board in North Wales, 19% of contracted activity. A growing number of the Trust's services are commissioned through the National Commissioning Board. Other commissioners are predominantly located in the North West, Mid and West Wales and the West Midlands.

A primary driver influencing overall demand for our services is the age profile of our population. Shropshire County has a median age of 44 compared to the English and Welsh Median of 39 and 20.7% of its population are aged over 65 compare to an average of 16.4% which is a proven driver of demand for orthopaedic services. A similar pattern is reflected in all of our main commissioner areas with the exception of Telford and Wrekin which has a slightly younger demographic profile (National census data 2011).The diagram overleaf shows Shropshire's population pyramid in comparison the overall England and Wales pyramid, highlighting the older age group of our local population.





The nearest local acute Trusts providing non specialist orthopaedic services similar to our self in England are;

- Shropshire and Telford NHS Trust (with sites in Shrewsbury and Telford)
- The Countess of Chester Hospital NHS Foundation Trust, and
- Mid Cheshire Hospitals NHS Trust in Crewe.

Within North Wales, Wrexham Maelor Hospital, part of Betsi Cadwaladr University Health Board (BCUHB) is our nearest neighbour.

Our key areas of strength relative to our competitors are our long standing reputation for delivering quality clinical care highlighted by low infection rates, high rates of patient satisfaction and the support of our both local commissioners and population. Our challenges come from high demand for services where access is limited elsewhere in our health economy and the complex and specialist nature of the care we provide in some service lines e.g. spinal surgery.

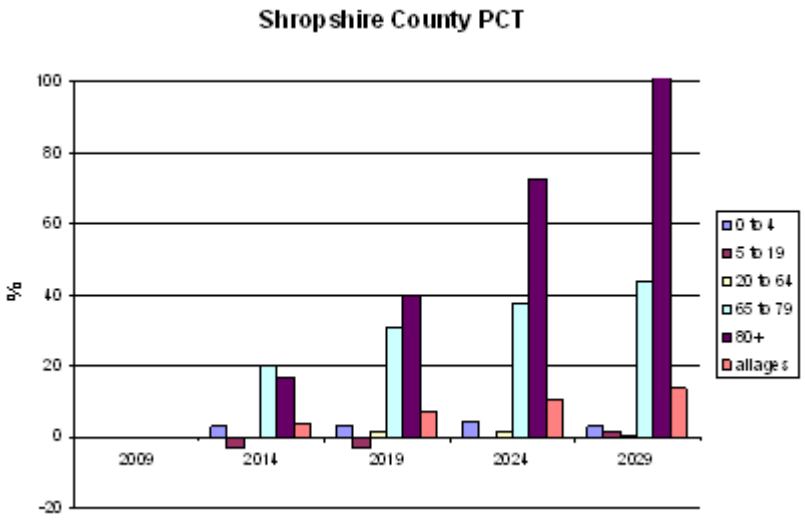
1.4 Market assessment

This market assessment has three main components:

1.4.1 Demographic and age profile

- **Age profile of the population** – There is much evidence to show that the increase in the proportion of elderly and older people is placing increased demand on orthopaedic services and that this will continue to rise in the next 10 to 20 years. Our commissioners estimate that the annual growth in demand will be approximately **2% per annum** prior to offsetting demand management schemes. This is potentially understated as the pool of patients with existing replacement joints requiring revision increases. The growth in our local population aged over 65 is also significant.

  These factors are demonstrated in the graph overleaf which shows a dramatic growth in ages 65 and over in the next 15 years. Based on historic trends and these future projections we predict that underlying demand nearer a 6% increase per annum. We recognise that this brings affordability challenges and therefore the need to implement demand management programmes working with our commissioners; we do need to recognise the pressure this creates in terms of waiting times.



- **Demand management** – We have a strong track record of working with our commissioners to reduce the growth in underlying demand for our services. This has included a number of initiatives around Procedures of Limited Clinical Value (PLCV) and the introduction of referral thresholds for joint surgery. Moving forward we will work with commissioners to deliver a more programmed approach to demand management. This will include delivering the PLCV, improved referral pathways including fully utilising the Referral Assessment Centre and optimising the Advanced Primary Care Service for musculoskeletal conditions. This service front end will be managed by RJAH from 2013/14.

  Our estimate for 2013/14 is that this will remove **approximately 1% to 2%** of our demand moving forward and form a key strand of our commissioners QIPP. On that basis commissioners are estimating that the residual demand growth, having taken into account demand management schemes, would be 1% to 2% per annum. **Our assessment is that residual demand will be nearer 4%.** We have accounted for this range in assumptions as part of our scenario planning.

- **Waiting list pressures –** Orthopaedics is the most challenged service nationally in terms of waiting times. 41% of Trusts Nationally (66 hospitals) are not currently meeting the 92% open pathway for orthopaedic services. A number of the Trusts which are challenged in meeting this target are local to RJAH. Over recent years to support orthopaedic service delivery there has been a general growth in use of the private sector. Once we are in a sustainable position with our own waiting times we will offer non recurrent capacity to other commissioners. We estimate this could be in the region of **1% to 2% per annum** of our current throughput from 2014/15 onwards. This allows us to focus in 2013/14 on our RTT sustainability and then look to more active marketing from 2014/15 onwards.

- **Specific commissioner intentions** - Our Welsh Commissioners at BCUHB (North Wales) have plans in 2013/14 to repatriate 50% of their non-specialist activity from RJAH. This equates to an overall **3% reduction in demand** this has been built into our plans. Over the life of this plan, somewhat offsetting this, Powys LHB is looking to reduce waiting times back to the Welsh national targets, and refer further activity to RJAH. Again this is built into our projections.

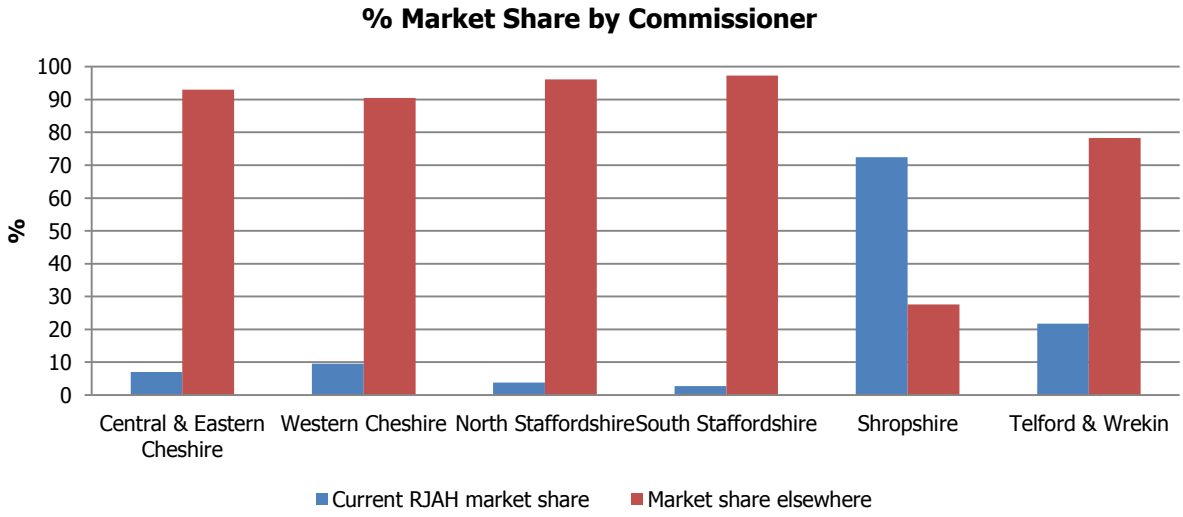
1.4.2 Developments in sub-specialisation and specialist commissioning

- **Specialist Services realignment –** Under the leadership of the National Commissioning Board the direction of travel is that more of our services will be contracted through specialised commissioners using specialist definition sets. In all likelihood the standards required for delivering specialised services e.g. critical mass, will mean activity currently met at district general hospitals will need to be redirected to specialised units.

Whilst this programme will become clearer over the next planning period we have done an initial assessment of the implications for RJAH. Of the 240 revisions undertaken per annum by our neighbouring Trusts, based on the geographical location of the patients around 60% would be expected to transfer to RJAH. It should be recognised that over the coming years this will apply to a growing number of services.

1.4.3 Patient choice

- **Patient Choice** – Patients are increasingly choosing RJAH as a provider of choice. With national policy on named consultant choice this has made meeting waiting times an increased challenge for us as a provider of general as well as specialist services where few alternatives providers exist, in particular for Spinal Surgery. We have seen an increase in the number of patients positively choosing RJAH and with improved access to capacity; we expect patients will continue to choose the RJAH for treatment based on our excellent services and outcomes. We believe that, with a more active marketing programme and a targeted expansion of our outreach services, we can gain market share. The graph below shows our current market share which evidences that for our surrounding commissioners there is opportunity for further growth. A prudent assessment of this is that through a more active programme we could attract growth of at least **1% per annum.**



1.4.4 Any qualified provider tenders

- Within the Local Health Community there are currently no 'any qualified provider' tenders planned which will affect our market share or service profile.

1.5 Implications of Commissioner & marketing intentions

A key challenge for the Trust in recent years has been in meeting demand for our services. Following our market assessment we have modelled demand scenarios that range from a downside of reducing activity levels, a most likely scenario being a prudent assumption of market drivers and an upside scenario of future market share potential.. The impacts of these are detailed further below:

- **Scenario 1 - The downside scenario.** This assumes that as a Trust we develop pathways to sustainably deliver the national referral to treatment waiting times and builds in the impact of demand management initiatives, but does not allow for any growth in specialised work, patient choice or undertaking any additional waiting list work on behalf of commissioners.

- **Scenario 2 - The most likely case.** This scenario again assumes the sustainable delivery of referral to treatment targets and demand management but also builds in an element of growth in specialised work in line with national trends, patient choice and additional waiting list work on behalf of commissioners.

- **Scenario 3 - The upside scenario.** This scenario again assumes the sustainable delivery of referral to treatment targets and demand management alongside an element of additional waiting list work on behalf of our commissioners. It then also builds greater growth in specialised work and increased patient choice.

Scenario 1 = Downside Case	2013/14 Surgical inpatients	2014/15 Surgical inpatients	2015/16 Surgical inpatients
Opening position	11,300	10,700	10,650
Baseline Contract Adjustments	-1,050		
Demand Management/PLCV	-250		
Demographic Growth @1%	100	100	100
RTT Investment	600	-150	-450
Closing Position	10,700	10,650	10,300

Scenario 2 = Most Likely Case	2013/14 Surgical inpatients	2014/15 Surgical inpatients	2015/16 Surgical inpatients
Opening position	11,300	10,800	11,250
Baseline Contract Adjustments	-1,050		
Demand Management/PLCV	-250		
Demographic Growth @2%	200	200	200
RTT Investment	600	-150	-450
Market Share Adjustments			
Patient Choice		100	200
Commissioner Waiting List Pressures		200	200
Shift of Specialised Activity		100	50
Closing Position	10,800	11,250	11,450

Scenario 3 = Upside Case	2013/14 Surgical inpatients	2014/15 Surgical inpatients	2015/16 Surgical inpatients
Opening position	11,300	11,000	11,800
Baseline Contract Adjustments	-1,050		
Demand Management/PLCV	-250		
Demographic Growth @4%	400	400	400
RTT Investment	600	-150	-450
Market Share Adjustments			
Patient Choice		200	200
Commissioner Waiting List Pressures		200	200
Shift of Specialised Activity		150	0
Closing Position	11,000	11,800	12,150

We have used the most likely case, as part of the financial plans that are detailed later in this plan.

1.5.1 Private Patient Activity

Over the last two years we have improved our private patient pricing which has meant an improved trading position for this work. Going forward we will improve our capacity for amenity accommodation but within the on-going economic climate we have assumed private patient activity will not increase significantly.

1.5.2 Research

As a specialist Orthopaedic Trust we have a clear focus on research. We have dedicated research laboratories and longstanding research links with Keele University and our Comprehensive Local Research Network (CLRN). Any research undertaken at RJAH has to demonstrate benefits to patients and meet clear governance criteria determined Nationally.

As of the 1st of April 2013 the Trust had 65 on-going research projects. We have exceeded our CLRN recruitment targets by 12% in 2012/13 and have an aggressive business plan to recruit 450 more patients next year. It is our intention, wherever possible, to enhance our income by contributing to commercial trials to ensure our research service continue to make a positive contribution.

2. Collaboration, Integration & Patient Choice

As an organisation, RJAH has both a local and national service profile and so collaborates with local service providers, as well as regional and national networks to deliver care.

2.1 Local Partnerships

- **Joint Consultant Posts** - We have a number of joint consultant posts in place with both Wrexham Maelor Hospital, part of BCUHB in North Wales, and the Royal Shrewsbury Hospital (Shrewsbury and Telford NHS Trust). These posts enable RJAH to support neighbouring Trust's to provide a comprehensive trauma service and enable direct links for patients into specialist orthopaedic services. We intend to continue this model of care at current levels over the next three years.

- **Outreach Clinics –** We have historically provided a limited number of community outpatient services in North Wales, Mid Wales, Cheshire and Shropshire enabling patients to be seen within their geographic location. In line with our marketing strategy we will be developing this model in the next three years in areas where we have a growing market share through choice or specialist service realignment.

- **Rheumatology -** We provide community Rheumatology services in partnership with Telford Community Trust to the population of Telford and Wrekin. In 2013/14 we will support the patient service provided at SaTH on a hub and spoke model basis.

2.2 Specialist Partnerships

- **Paediatric Orthopaedics -** Our Paediatric Orthopaedic Consultants provide a specialist outreach service into BCUHB's three District General Hospitals. This provides access to specialist inpatient and outpatient orthopaedic services to patients across North Wales. The team also link to Alder Hey Children's Hospital as part of a paediatric network. The further development of a hub and spoke arrangement will be reviewed over the period of the plan.

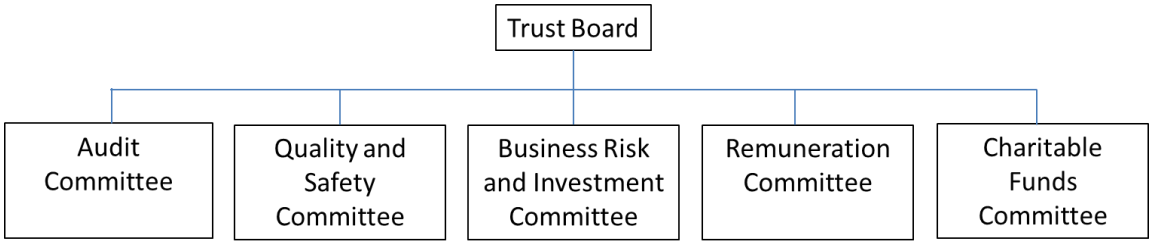
- **Neuromuscular Services -** Our Paediatric Neuromuscular services links to a number of specialist centres including both Alder Hey and Birmingham Children's Hospital services for multidisciplinary networking and learning purposes.

- **Bone Tumour –** RJAH is a specialist Bone Tumour Centre and links into the Greater Manchester and Cheshire Cancer Network to deliver specialist bone tumour care and advice to other Trusts including the Christie NHS Foundation Trust. During 2013/14 we will be completing a new Tumour Unit build which we see a dedicated specialist bone tumour unit on the hospital site. Operationally this will enable us to maintain our specialist registration and maximise quality and service efficiency in 2014/15 and 2015/16.

3. Quality

3.1 Approach to governance

The corporate governance structure is set out below.



The Trust Board is responsible for setting the strategic direction for the Trust, for monitoring the performance against its objectives and ensuring the highest quality of patient care is provided. The Audit Committee on behalf of the Board is responsible for ensuring overall governance, risk management and internal control is effective and evidenced. The Quality and Safety and the Business Risk and Investment Committees are able to oversee matters within their areas of responsibility and have clear terms of reference.

Each committee has a work programme with responsibility for identified corporate risks and CQC regulations.

3.1.1 Trust Board

The Board has approved formal terms of reference and an annual business programme, together with a formal board development agenda. The Board consists of a Non-Executive Chairman, five Non-Executive Directors and five Executive Directors.

3.1.2 Performance Reporting

It is important that the Trust Board receives concise, timely and informative reports on how the organisation is delivering against its objectives. The Trust's performance reporting processes enable the setting and monitoring of objectives, agreement of performance indicators and ensure that the Board has a good understanding of the whole performance of the organisation and is able to recognise and address performance problems. The details are set out in the Trust's Performance Management Strategy and Accountability Framework.

Data used in performance reporting is drawn from a number of information sources including internal data systems, NHS choices, and Benchmarking data sources.

Board reporting consists of a single balanced scorecard centred on the delivery of the Trust's objectives. The metrics in this scorecard take a more rounded view of the organisation's performance by including:

- Clinical effectiveness and patient safety
- Patient experience
- Operational efficiency and demand for services
- Financial perspective
- An assessment of performance against areas on which the Trust is assessed externally.

The scorecard is complemented by:

- Run charts for the key performance indicators. These charts provide an understanding of historical and current performance against the relevant performance target. This information enables a predictive view of performance

- An exception report that provides relevant details of the underperformance and what action is being taken to resolve this.

The key performance indicators included within the scorecard are quality assured via internal audit processes led by our information department and reported to our Audit Committee. In addition our internal auditor KPMG reviews a numbers of key metrics each year.

Our performance reporting balanced scorecard is shown below:

Balanced Scorecard Trust Board
2013 / 2014 Month - xx

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Patient Safety

Overall Performance

Period	Key Metric	Actual	Year to date	Change	Forecast
	Infection Control				
	Serious Incidents				
	Never Events				
	Unexpected Deaths				
	Clinical Quality				
	Medication Errors as % of activity				
	Pressure Ulcer Assessments				
	30 day Readmission Rates to RJAH for all specialties				
	CQUIN				

Patient Experience

Overall Performance

Period	Key Metric	Actual	Year to date	Change	Year End Position
	Patient Satisfaction - Net Promoter Question				
	Number of Complaints				
	Theatre Cancellations				
	Delayed Discharges				
	Access to Bone Tumour Services				
	Access to Services				

VISION

To be the leading centre for high quality, sustainable Orthopaedic and related care, achieving excellence in both experience and outcomes for our patients

Resources

Overall Performance

Period	Key Metric	Actual	Year to date	Change	Year End Position
	EBITDA				
	Net Surplus				
	CIP Delivery				
	Capital Expenditure				
	PSPP				
	Cash Balance				
	Sickness Absence				
	Staff Turnover				
	Staff Appraisal				

Efficiency

Overall Performance

Period	Key Metric	Actual	Year to date	Change	Year End Position
	Demand for Services				
	Activity - Surgery				
	Activity - Medicine				
	New to Follow Up Ratio (Consultant Led Activity)				
	BADS Activity				
	Admission on Day of Surgery				
	Theatre Efficiency				
	Average Length of Stay - Elective Including Daycase				
	Enhanced Recovery				
	Bed Occupancy - Adult Orthopaedic Wards				

External Perception

Overall Performance

Period	Key Metric	Actual	Year to date	Change	Year End Position
	Monitor Risk Rating - Finance				
	Monitor Risk Rating - Quality Governance				

At a Divisional, Team and Ward level, progress against this plan as part of our governance and quality structure is monitored via an integrated Ward to Board scorecard systems and robust monthly and quarterly monitoring arrangements of local risk registers and risk assessments. During 2013/14 the Nursing Assessment and Accreditation System will also be introduced to provide further assurance.

Board effectiveness was reviewed internally in 2012/13. The outcomes of this evaluation have been used to develop the on-going Board development programme.

During 2012/13 we increased our membership to 4,590 in line with our membership strategy. Our Council of Governors are integral to our planning processes as representatives of our members and have been consulted throughout the development of this plan. The Council of Governors will continue to develop a representative voice for their constituencies through increased membership engagement over the next three years. As part of the public membership strategy, Governors will be instrumental in receiving feedback from members through focus groups, on-line surveys and secret shopper initiatives, in order to represent members more fully.

The Trust uses its governance structure as a basis on which to report to Monitor against the compliance framework targets and to other external agencies such as the CQC.

The Organisation has no outstanding quality concerns raised by the CQC or any other quality monitoring organisations.

3.2 Quality Strategy

The Trust has a well embedded Quality Strategy. The strategy draws together our safety, clinical effectiveness and patient experience aims with Monitor's Quality Governance Framework to enhance the quality of care provided to our patients.

This Quality Strategy will be reviewed in 2013/14 to ensure alignment with the recommendations of the Francis Report the 6 Cs nursing vision and strategy and internal workforce changes.

3.3 Quality & operational risks

The key quality and operational risks to the organisation which could potentially impact on the delivery of the three year business plan have been identified through our risk register and the Board Assurance Framework; they will be monitored via the Quality and Safety Committee and the Board Assurance Framework during the life of this plan.

The tables below highlight the main quality & operational risks to the organisation:

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
Internal Risk	**Failure in clinical quality or safety controls**	Breaches in quality/safety targets. Adverse impact on patient experience. Adverse effect on the delivery of high quality patient care.	Controls are in place which include monitoring systems		KPIs are part of monthly Board and ward performance reports All serious incidents are reported to the Board via the Quality and Safety Committee. National & Local patient surveys.
Internal Risk	**Sustainable maintenance of Inpatient and Outpatient Referral to Treatment (RTT) targets**	Impact on patient experience and clinical outcomes. Breach of contracts & key target leads to penalties. Damage to reputation. Additional costs incurred in delivery of RTT.	Capacity has been increased and more rigorous activity planning introduced. Detailed Sub specialty demand & capacity model in place	This will remain a challenging target to maintain.	Quality and Safety Committee review patient experience, clinical effectiveness & safety. Quarterly scrutiny by the BRIC. Inclusion in monthly performance report to the Trust Board. Monthly PCT and SHA meetings.
Internal Risk	**Failure to deliver Open Pathways target, including "52 week waits"**	Breach of contracts & key target. Damage to reputation Contract penalties.	Study of patients pathway has been commissioned On-going discussions with Commissioners re demand management	National Shortage of capacity for spinal surgery will remain a pressure for the Trust.	Monthly performance report

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
External risk	**Impact of NHS restructuring on commissioning arrangements** **Delay in specialised commissioning arrangements being confirmed**	Delay in contract agreements leading to uncertainty over income levels. Could delay improvements to patients pathway	New relationships being forged with Shropshire CCG SOA working with DH to introduce proposed changes Trust acting as interface between CCG's and Specialist Commissioners in ensuring consistent assumptions taken for contract plans	Confirmation of specialised commissioning arrangements	Monthly updates to Trust Board

4. Service line management strategy

4.1 Our approach to service line management

The Trust manages itself through three Clinical Divisions and a Corporate Division, within which individual services are managed at a service line level.

A corner stone of our service line management strategy is having appropriate internal information which we have developed through a patient level costing system. This programme is available directly to 30 clinicians. This is used to understand the drivers behind the service lines business performance. We have examples of turning around the performance of service lines through this approach which has included using the information to influence national tariff and local pricing solutions. It also underpins our QIPP and has been pivotal in gaining clinical engagement in business and service planning.

4.2 Potential areas of growth or contraction

Using our service line performance system we have identified, potential areas of growth or contraction in the next three years and the subsequent service line objectives which are highlighted below:

- **Arthroplasty / Lower Limb –** This forms our largest subspecialty. Our market share in this area is expected to grow in the next three years through targeted outreach/marketing and a shift in revision surgery to specialist centres.
- **Metabolic Medicine** – This service is facing a repatriation risk from North Wales and peripheral English commissioners. We will continue to ensure the service is highly efficient to meet local requirements.
- **Paediatric Medicine** – There is a growing demand for muscle services evidencing the need for permanent increase in consultant capacity. The service is being consolidated to meet national specialist service definition requirements.
- **Paediatric Surgery** – We will continue to grow our market share through our outreach strategy, developing further networks around Staffordshire and Wolverhampton area.
- **Pain Management** – The service is affected by the Procedures of Limited Value (PLCV) QIPP. The Trust will work with CCG colleagues on integrating a wider pain management service, ensuring costs are reduced to meet revised service turnover.
- **Rheumatology** – Shropshire CCG and Powys LHB are looking to RJAH to deliver increased service provision. There is a working group with local commissioners looking to invest to ensure service

meets NICE guidance although capacity released from BCU repatriating activity will offset the need for significant changes to our workforce.

- **Spinal Surgery** – A service review is underway to ensure the financial viability with sustainability of waiting times. The review will refer to National Spinal Taskforce recommendations, shift to specialist commissioners and improved local referral pathways. Likely expansion in Consultant base required to meet growing demand.

- **Upper Limb** – We will work with new APCS to redesign upper limb services to reduce waiting times. There has been a recent increase in Consultant Capacity to support improved RTT position in the future. In the medium term we will develop our outreach strategy for this area.

4.3 Delivery of Compliance Targets

As a Trust we are required by Monitor to deliver a number of compliance standards across our service lines including referral to treatment waiting times, quality standards including infection control and financial targets on an annual basis.

As essentially a single specialty provider (Orthopaedics) we face unique challenges in meeting our RTT waiting times however the delivery of all of the compliance targets is integral to all of our service line management plans and will be monitored via the Integrated Balanced Scorecard at a Board level.

4.4 Clinical leadership

Within the Trust we have a robust clinical structure which mirrors and complements our service line structure. Each of the 3 Clinical Divisions have a Clinical Director, Divisional Manager and Matron who report through to the Executive Team. Clear clinical lead structures then cascade through our service lines providing a strong Ward to Board clinical focus to all of our decision making processes. We have a Leadership development programme specifically tailored to develop our future clinical leaders.

Our overall clinical strategy is integrally linked to our service line management approach working with individual teams within the Trust to ensure quality and clinical excellence is embedded within each service. Any changes to service design are influenced through this SLR approach with clinical engagement being the key feature. In line with national revalidation guidance we will embed our new revalidation processes using national benchmarking data from the HED system in 2013/14. We also have in place robust accreditation processes for all Nursing and Allied Health Professional staff and during 2013/14 will introduce the Nursing Assessment and Accreditation process within our wards; a quality driven measurement process supported by national standards and the compassion in care process.

5. Our clinical workforce

5.1 Clinical workforce strategy

The majority of staff work within direct patient care roles within the Trust, with 10.5% Consultants & Medical Staff, 24% nursing staff, 25% Health Care Assistants and 14.5% Allied Health Professions/Scientists. Across all clinical groups, turnover has been stable at 5% or below over the previous year, therefore the focus of the clinical workforce strategy moving forward is succession planning of key posts; strengthening clinical leadership; activity driven workforce planning to increase productivity and continued assurance of safe staffing levels.

As a specialist elective hospital, it is inappropriate to compare staffing ratios with general acute Trusts; therefore the Trust uses comparators with other specialist orthopaedic hospitals. These show we have above average nurse: bed, nurse: medic, AHP: medic and qualified nurse: HCA staffing ratios.

Building on the successful recruitment of eight Consultants in 2012/13 we will continue to align consultant workload with activity forecasts through flexible job plans and address planned medical retirements over the coming year through existing strong succession planning. The Trust will ensure on-going compliance through its clinical workforce strategy with the European Working Time Directive.

The clinical workforce strategy is integrated into the Trust's financial plans. Costs of pay awards and progressions are incorporated as well as the costs of any additional posts identified in service and workforce plans. The CIP/QIPP fully integrates with our clinical workforce plans and there are no planned material costs of implementation.

What is paramount to the strategy is that we are able to meet the demands for our services in a cost effective manner. This is particularly the case where we will have opportunity to flex our capacity to meet demands for our service. Our clinical workforce plans need to support us to do this without incurring excessive premium costs. We already operate over the weekend and see this continuing.

Any clinical workforce changes will be tracked via the Executive Team and reported to the Business Risk and Investment Committee on a regular basis.

5.2 Clinical sustainability

Overall, clinical services are sustainable without any challenges of low consultant cover or single handed practitioners to be addressed. The Trust has long established partnerships for Paediatric services, working with both Alder Hey Children's Hospital and Birmingham Children's Hospital which provide mutually beneficial networking across the professional groups. In a similar manner, the Tumour Service provision links directly into the Cancer network. All of our services meet with current Royal College guidance in relation to critical mass; this will continue to be reviewed during the life of this plan.

5.3 Extended working

Overall agency usage for clinical staff within the Trust is low and the Trust has already established 6 day working within some support areas including theatres and pharmacy, and will roll out 7 day working where required to support service delivery within areas including x-ray and Therapies.

6. Productivity

6.1 Productivity measures

Within the current financial and political climate the Trust understands that productivity and efficiency improvements over the coming 3 years are key to the delivery of our overall operational and financial plans.

We have assumed in our plans the need to make 4% year on year efficiencies and improving our productivity levels further to meet an expected growth in demand. This will ensure contributions are maintained. The Board do not underestimate these challenges and have developed a series of key business metrics that will support delivery. They are not exhaustive however do reflect the main elements of the patient's pathway.

The Key Performance Indicators (KPIs) against which our on-going success will be measured include those detailed in the table overleaf:

Metric	Year end target			
	2012/13 outturn	2013/14	2014/15	2015/16
Overall daycase rate	50%	50%	53%	55%
BADS daycase rate	78.63%	86%	88%	90%
Admission on day of surgery	87.25%	90%	92.5%	95%
Average length of stay (including daycases)*	2.09 days	2.0 days	2.0 days	2.0 days
Hip and Knee average length of stay	Hips – 4.63 days Knees – 4.95 days	Hips – 4.5 days Knees - 4.75 days	Hips – 4.25 days Knees - 4.5 days	Hips – 4 days Knees - 4.5 days
Bed Occupancy	83.59%	85%	85%	85%
Number of Beds**	184	174	180	180
Available theatre sessions utilised	96.08%	95%	95%	95%
New to Follow up ratio	1: 2.2	1:2.1	1:2.0	1:1.9
Staff turnover ceiling	4.18%	8%	8%	8%
Staff sickness rate	3.6%	2.9%	2.7%	2.5%
Readmission rate to RJAH	0.82%	1.05%	1%	1%

* The overall average length of stay remains at 2.0 days throughout the plan despite improving admission of day of surgery and BADS rates to reflect the expected increase in complexity of the cases we will be treating.

**note we plan to reassess the bed requirements of the Trust as part of our option appraisal of future capacity requirements and in line with our tumour unit developments.

These measures link through to the Division's service plans and progress against these measures will be monitored using our robust Ward to Board scorecard system and formally reported to Board on a monthly basis via the Integrated Balanced Scorecard.

7. Cost improvement plans

7.1 Cost Improvement Plan governance

The Trust has a strong track record of delivering CIP targets. The success has been based on a 'bottom up' approach reinforced by corporate themes. Supported through robust governance arrangements, our focus has been on improving the efficiency of our core clinical processes. Our reduced length of stay and high theatre throughput are testament to this programme. Whilst we continue to strive to increase our productivity further our plans are focused on utilising leaner processes and technology to streamline our support functions.

To drive the redesign of our support services we have introduced a Project Management Office (PMO) to oversee this key strand of the overall financial programme. In addition we have strengthened the project management arrangements of our new IM&T strategy which is an enabler to this project. This includes an Executive led IM&T programme Board with responsibility for ensuring the IM&T strategy is delivered. Appropriate resources are included in the plan to deliver the strategy.

Our track record has been underpinned by robust CIP Governance arrangements that include:

- This is the fourth year of quality impact assessments (QIA) being carried out by the Trust with sign off from Clinical Leads, Nurse Director and Medical Director
- Each year we plan to identify 10% to 15% more CIP than is required to recognise the risk of scheme failure or slippage
- Each scheme is generated by clinical leads and tested for corporate fit. They are all signed off by Divisional Managers and Clinical Directors

- Each scheme includes full description, workforce implications, QIA, risk assessment and action plan. Each QIA includes areas of potential risk and KPIs that would be utilised in tracking to ensure there are no unintended consequences of the change. Once signed off by the Divisions (incorporating clinical Director Sign off) all plans are scrutinised and signed off by the Medical and Nurse Director. The BRIC and Board then review the profile of CIPs to ensure there are no residual concerns.

- Any key KPIs that are required to track schemes are built into the Trust Board's balanced scorecard whilst the overall Trust Balanced Scorecard provides assurance that quality is not affected by the cumulative effect of the CIPs.

The overall CIP is overseen by the Executive Team who periodically reviews CIP progress and their quality impact as a transformational Board. CIP progress is tracked though the Clinical Management Board, through Divisional Performance Reviews (monthly and quarterly). Assurance is added through oversight from the Business Risk and Investment Committee and the Trust Board. Delivery of CIPs is a key risk tracked on our Board Assurance Framework.

7.2 3 year Cost Improvement Plan profile

Our 3 year CIP is detailed in appendix 2. Our main CIP themes for the coming three years are:

- Operational efficiency
- Maximising the benefits of Technology
- Improved contributions from service lines
- Workforce productivity, and
- Estates redesign and rationalisation

8. Financial Strategy

8.1 Current financial position

During 2012/13, the Trust delivered a surplus of £1.2m (pre impairment) and maintained a FRR of level 3.

Cash balances average over £4m and we have invested in our Estates to reduce backlog requirements and in supporting service redesign. Whilst the Trust has faced challenges in managing its cost base as we progress on improving our RTT performance, we maintain an underlying recurrent surplus and believe, with strong demand for our services, we can continue to maintain this level of financial sustainability.

8.2 Financial forward strategy

The Trust's financial strategy is:

"To generate sufficient surpluses to help us deliver the highest quality clinical care"

To achieve this strategy our four key financial objectives are:

- *Invest in service delivery to continuously improve the quality of our services*
- *Support our productivity agenda maximising 'invest to save' opportunities*
- *Invest in our facilities with a focus on maintaining and modernising the Estate and in doing so improving the patient experience*
- *Generate cash balances that give the Trust sufficient risk coverage against downside risks*

8.3 Key drivers to the financial plan

In meeting this strategy, the Trust is conscious that we continue to operate in a financially challenging environment. The Board have been aware of this environment in developing this strategy and the financial plan. Recognising the current environment our financial strategy has modelled potential downside scenarios as well as a 'most likely' scenario. Our underlying demand and capacity assumptions have also been subject to scenario testing (see section 1.4) and the 'most likely' scenario has been used as a the base case for our financial plans.

Whilst there is a detailed financial model supporting the strategy at a summary level, the material assumptions made in our plan are outlined below. For 2013/14, the plan represents the signed off budgets whereas the future years represent our planning assumptions.

The plans include a level of growth outlined in section 1.4 that follows the market assessment.

- Delivering a year on year efficiency of 4% per annum
- That tariff continues to be deflated at 1.3% per annum
- A recognition of potential contract penalties
- Inflationary pressures (pay awards, incremental drift and non pay inflation)
- The need to carry a 0.5% contingency for unforeseen pressures
- Meeting demand for our services in a cost effective manner
- As part of the capital plan, an investment which is yet to be tested as a business case is to develop theatre capacity once the Menzies Unit lease expires.

8.4 Investment priorities

During 2013/14, we aim to operationalise the new Tumour Unit which is the first phase of a wider programme to improve and modernise our theatre and fast track ward capacity.

In years 2 and 3 of this plan we will the focus our investments towards ensuring we can meet the demand for our services predicted within scenario 2 (most likely scenario) of our demand modelling in an efficient manner.

8.5 Financial risk

Through Monitor's consultation on its new Licence arrangements, it is likely that the financial measures which we will be assessed against will change to a continuity of service measure. This is a liquidity/debt gearing based assessment. Given that this is likely to be introduced part year, we have tested this plan against the current Finance Risk rating (FRR) measures as required in the Compliance Framework and the new Risk Assessment Framework (RAF) measures.

This financial plan maintains our FRR of 3 and sees us rated at the lowest risk level against the continuity of services tests that form part of the proposed RAF. This will need to be tested further as more guidance is published from Monitor regarding the final RAF arrangements.

The most material financial risks as detailed in the overall plan are outlined overleaf:

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
Internal Risk	**Delivery of 2013/14 CIP/Increased Cost Pressures**	Failure to achieve planned financial outturn. Detrimental Effect on quality	All CIPs have "clinical sign off" to ensure that there is no adverse effect on quality CIP delivery included in divisional performance framework. Additional plans in place in excess of target to mitigate the impact of shortfall in delivery. 0.5% Contingency included in the plan for unforeseen cost pressures	CIPs will become increasingly challenging. Costs of delivering RTT above those incorporated into the plan	Summarised CIP reporting in monthly performance report. In depth review of progress/issues by BRIC
Local Risk	**Penalties levied for any target failure**	RTT penalties for 90%, 95% & 92% target. Material risk of £5k per month fine for any patient waiting 52 weeks + at the end of any month.	Negotiated 5 month period of grace for spinal 52 week breaches. Revised 92% delivery trajectory linked to spinal long waits to be agreed with commissioners. Any failure of other measures will incur initial Remedial Action Plan (RAP) during which time penalties will not be levied. Demand and capacity plan evidences ability to meet RTT targets during the year for all sub specialties bar spinal. £0.2m risk reserve included in plan	Spinal Surgery capacity not sufficient to meet current demand.	Tracked in detail by BRIC and through monthly Board updates.
Local Risk	**Commissioners cannot afford assumed growth in demand**	Income not recovered to meet cost of delivery	Early engagement with commissioners to size the issue and to include in agreements. If not forthcoming Board recognise may need to reduce access to RJAH services for a period	Patient choice makes reduction in demand for services difficult to enact	Update monthly through Trust Board. Risk will be fully scoped in final annual plan submission.
Local Risk	**Shortfall on fundraising for tumour unit**	Reduced cash balances	Professional fundraiser employed with strong track record. Fundraising programme under way. Ability to reprioritise capex programme fundraising levels fall short of the plan	More challenging fundraising climate due to wider economic pressures	Fundraising will be progressed through the CF Committee and tracked in terms of the business risk through BRIC.

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
Local/National Risk	**Turbulence to Commissioning landscape arising from Specialist Services dataset review**	Confusion as to responsible Commissioner for some Trust services in 2013/14 due to poorly coordinated introduction of new national definition dataset that does not match funding allocations Could delay planned improvements to pathways	Specialist Orthopaedic Alliance working closely with DH to introduce proposed changes. Trust acting as interface between CCG's and Specialist Commissioners in ensuring consistent assumptions taken for contract plans	Impact on CCG budgets may restrict scope for further investment in waiting list clearance	Updates via Performance Report and BRIC
Internal Risk	**Tariff Instability**	Trust may not be fully reimbursed for its activity, which would result in a financial deficit	2013/14 tariff does not raise major concerns, but risk remains for the future. Work with PBR team at DH, supported by SLR/PLICs information. Plan to engage with Monitor re new pricing regime	Risk is compounded by the specialist nature of the Trust.	"Road testing" of tariff reported to Trust Board