

2016/17 OPERATIONAL PLAN

1. Background

- 1.1. The 2014/19 five year strategic plan set out clearly the Trust's strategic aim and objectives for the five year period. The Trust has reviewed this strategy and is recommitting to this overall direction, which sets the context for the submission of the 2016/17 one year plan.
- 1.2. The Trust's strategic aim is to remain as a standalone organisation whilst also exploring potential opportunities for collaboration with other acute providers in the local health economy, and in particular exploiting the opportunities provided by the local acute trust collaborative "Working Together Programme" and Acute Care Collaboration Vanguard; both programmes constituting a collaborative of seven hospital trusts in South Yorkshire, Mid Yorkshire, North Nottinghamshire and North Derbyshire.
- 1.3. Further, the progress that the Trust has already made in the last two years in terms of clinical sustainability and transformation of services will increasingly need to be viewed in the context of the national planning guidance requiring 'local' health economies to create Sustainability and Transformation Plans (STPs) at a pan-regional level. The Trust has been identified within the South Yorkshire and Bassetlaw STP footprint covering a population base of 1.6m with the intention to plan on a population basis. The 'footprint' system leader has now been confirmed and the Trust is actively participating in the development of the STP.
- 1.4. In parallel, the Five Year Forward View (5YFV) guidance for Acute Providers makes clear the challenge; the need to deliver high quality patient care, NHS constitutional access standards and financial balance, eliminating unwarranted variation across all these areas, while also making the transformation that is needed to ensure long-term sustainability and in doing so reduce the health and wellbeing, quality and finance gaps. Based on this guidance the Trust will continue to review its current performance against each of the domains in order to identify the gap to delivery and further actions necessary.
- 1.5. As an acute and community services provider opportunities to further progress local integration will be central to delivering our objective to sustain high quality services.

2. Approach to activity planning

Key Points:

- Small decline in A&E attendances (less 1.5% - 2016/17 plan compared with 2015/16 plan)

- Continuing increase in emergency (non-elective) admissions, despite community based transformation initiatives (4% increase – 2016/17 plan compared with 2015/16 plan)
- Trust intention to contract at the projected 2015/16 forecast outturn levels for emergency admissions (without additional growth) on the basis of the potential opportunity to be realised from further integration of acute and community services in 2016/17.
- Reductions in day cases and elective activity compared to 2015/16 plan and an increase in outpatient procedures, which is commensurate with the direction of travel.
- Demand and capacity planning confirms capacity to deliver activity plans and to deliver the RTT, cancer and diagnostic waiting times.
- Supported through on-going activity planning and review with each commissioner.

2.1. Robust activity plans are essential to secure the most effective use of available financial resources across the local health economy. As a provider of both hospital and community based services, the Trust has worked collaboratively with each of its commissioners to agree plans that set realistic baselines across the full range of services delivered. Our joint responsibility to effectively plan across these services links closely with the need to ensure clinical pathways are appropriate, fit-for-purpose and support the right service, delivered by the right people at the right time, in the right place. The current commissioning arrangements provide for triangulation of plans not only between commissioner and provider but at commissioner to commissioner level to ensure the implications of any independent commissioning decisions are transparent and fully understood across all parties.

2.2. At key activity lines the Trust has reviewed 2015/16 activity plans and mapped the year-end position to support modelling of 2016/17 activity plans. The outcome of this is shown below:

POD	2015/16 Plan	2015/16 Forecast	2016/17 Plan	Variance (%)	
				To Plan	To FOT
AandE	78,167	77,147	76,995	(1.5)	(0.2)
DC	35,453	35,011	35,065	(1.1)	0.2
EL	5,983	5,368	5,657	(5.4)	5.4
NEL	25,481	26,439	26,530	4.1	0.3
OPFA (inc proc)	93,485	91,246	91,306	(2.3)	0.1
OPFUP (incl proc)	203,274	208,353	198,104	(2.5)	(4.9)

The key assumptions driving 2016/17 activity plans are as follows:

- A significant increase in Non Elective cases above 15/16 planned levels which accounts for year-on-year growth
 - Overall outpatient first attendances (including procedures) will remain in line with the trends experienced in 2015/16.
 - Decreases in Outpatient follow-up activity (including procedures) to reflect progress towards new:follow peer group ratios.
- 2.3.** The Trust has based its 2016/17 plan for emergency admissions on the 2015/16 forecast position and therefore includes in-year activity growth experienced above 2015/16 planned levels (plus a small net increase).
- 2.4.** The rationale for the decision not to include emergency growth over and above the forecast outturn position is based on the premise that the range of schemes introduced during 2015/16 (funded through additional investment for Community Transformation) will be operating at optimum potential in 2016/17. The expectation is that these investments support the health economy strategic intention to reduce the level of emergency admissions, provide a better patient experience and promote self-management where appropriate. Already with the support of the local commissioner the Trust has developed and enhanced its community services whilst ensuring integration with acute services. This has delivered a number of service improvements including Discharge to Assess facilities, a 24/7 Care Co-ordination Centre, a restructure of the district nurses into locality teams with new locality leaders, and an integrated falls and bone pathway amongst others.
- 2.5.** The findings of the Joint Strategic Needs Assessment (JSNA) and health needs projections detailed within the Rotherham Public Health analysis project a continued rise in emergency admissions linked to an ageing population and the social deprivation of the local community. It is evident there will be lower levels of NHS funding available to support further increases in activity. The Trust has and will continue to actively pursue all opportunities to review current working models to embrace improvements whilst exploring and developing new ways of working which support safe management of patients in their own homes to avoid the need for admission to hospital. In particular, the Trust will pursue the potential opportunities to be realised through closer integration of not only our acute and community services, but also with partners across primary care, mental health, social care and the voluntary sector. A scheme to pilot such a model will be a focus during 2016/17. This will facilitate a review of the required capacity to manage demand to deliver efficiency savings.
- 2.6.** During 2016/17 the Trust will further enhance analysis of activity to support financial planning and forecasting.
- 2.7.** Continuation in moving from elective inpatient admissions to day case and outpatient procedures are in line with the national direction of travel to provide procedures which are more cost effective, whilst maintaining equivalent quality of services.

- 2.8.** Divisional teams and service leads have been instrumental in setting and agreeing the 2016/17 activity plans, allowing a full capacity review to support in-year delivery. This has included review of theatre, outpatient, bed and workforce capacity to better align capacity to demand. Further work is needed to better align consultant job plans and capacity to meet the demands on services, building on the progress made in 2015/16 to support clinical teams to align demand and capacity. The Trusts ability to operate flexibly to meet demands will be paramount.
- 2.9.** In light of the outcome of the capacity and demand planning, currently the Trust does not anticipate a need to access the independent sector to deliver its activity plan. Should this need arise in-year as a consequence of unforeseen circumstances, appropriate procurement regulations will be applied to secure any additional capacity deemed necessary. Any proposals to utilise the independent sector will be raised with commissioners.
- 2.10.** In setting elective and outpatient activity plans the Trust has taken into account increases in referrals and previous trends at individual specialty level and, assuming all things remain as planned, expect the planned activity levels will deliver the RTT, cancer and diagnostic waiting times. Any significant variances from planned levels generate a review and remedial action. The Trust is already taking remedial action in relation to the operational standards it is not currently meeting and for which it has also set recovery trajectories.
- 2.11.** Whilst there have been fewer numbers of A&E attendances compared with planned attendances in 2015/16, patients presenting are often more complex requiring greater input in terms of staffing resource and immediate care. This is evidenced by the increased number of emergency admissions. In addition, the Trust continues to face significant staff shortages within the Emergency Department team and is progressing steps to address the situation.
- 2.12.** Construction work is continuing on development of the new Emergency Centre on the Rotherham Hospital site. Importantly, this development is also providing the Trust with the need and opportunity to revise the patient pathway and the supporting staffing model, commensurate with the national strategy on urgent and emergency care. Opening in 2017, it will deal with emergency attendances and admissions, following the closure of the walk-in-centre.
- 2.13.** As part of on-going planning the Trust continues to work closely with all commissioners to review trends and track compliance against activity plans at individual specialty/point of delivery. This provides all parties with early sight of significant variances (positive or negative) and enables early agreement of remedial action.
- 2.14.** Winter planning is critical to support surges in demand. The Trust is an active member of the monthly Rotherham Systems Resilience Group. This group brings together providers of health and social care providers from across the health economy to facilitate a multi-disciplinary approach facilitating a whole-system review to emergency planning. Also, in accordance with good practice, a full review will be undertaken following the winter pressures which will be

widened to encompass the recent poor performance experienced at the end of 2015/16 to identify learning and further mitigation to improve systems resilience for the future.

- 2.15. Having had the opportunity to further progress contract negotiations with regards activity setting with our commissioners the Trust does not have any residual significant variances.

3. **Quality**

Key Points:

- 2016/17 Quality Priorities agreed, following consultation process and taking into account CQC feedback, as part of Trust's Quality Account.
- Risks to delivery identified and included within Trust Board Assurance Framework and Corporate Risk Register.
- Delivery monitored through set of robust governance arrangements, including Board Quality Assurance Committee and Clinical Governance Committee, with further strengthening of clinical governance and leadership arrangements from ward to board through 2016/17.
- Delivering high quality services is a primary strategic objective and one of the Trust's core values for which all staff are responsible. Executive responsibility for quality planning and improvement lies with the Chief Nurse, supported by the Medical Director and Chief Operating Officer.
- The Trust has continued to make progress towards implementing Seven Day services with further action planned.
- All Cost Improvement Plans are subject to a robust Quality Impact Assessment.
- The Trust Board is able to triangulate performance in quality, finance and workforce through the monthly Integrated Performance Report, and its board committee have been set up to provide additional assurance.

Approach to Quality Planning and Quality Improvement

- 3.1. In the 2015/16 Quality Account the Trust identified four quality ambitions and seven quality improvements, and set out plans for their achievement. These included:

- Mortality – reduction in HSMR
- Harm Free Care – achievement of 96%
- Friends and Family Test – improvement in response rates
- National targets – achievement of all targets

Progress has been made in relation to each of these with still more to do in 2016/17.

3.2. As part of the Trust's clinical governance arrangements, consultation has taken place within the Trust with agreement that the 2015/16 ambitions be retained for 2016/17. In addition to the consultation process, priorities for the coming year have been developed by triangulating data from complaints, concerns, patient feedback mechanisms, patient safety incidents and nursing metric indicators. The planning process for this year also takes into account the Trust's action plan following a CQC inspection in February 2015, and the quality improvements that have taken place throughout the year to support the development of the quality planning process.

3.3. The Quality Priorities agreed in the Trust's Quality Account 2016/17 (including priorities from the 'Sign up to safety campaign') are:

- Improve admission to discharge management
- Improve responsiveness to complaints
- Reduce the incidence of medication errors
- Prevent missed or delayed diagnosis
- Improve recognition and management of the deteriorating sick patient
- Improve rates of harm free care and expand use of the safety thermometer
- Improve mortality rates (reduce HSMR and SHMI)
- Improve patient experience of the Trust's clinical administration systems, e.g. outpatient booking system
- Improve our engagement with patients and families and use feedback to support service transformation
- Reduce non-clinical ward moves

The intention is that through implementation of the key quality priorities and in consultation with patients it will be possible for the Trust to adopt and publish a set of patient commitments. For example, as a patient I will be; protected from avoidable harm, infection and falls, know who my named consultant and nurse are.

3.4. As part of the process of setting out the Trust's quality priorities for 2016/17 the top three risks to deliver and mitigation have been identified as follows:

- Failure to meet targets in the Quality Account

Mitigation: Leadership development and clear lines of accountability and responsibility

- Reduction in the need for agency staff

Mitigation: Continued focus on substantive recruitment to vacancies to reduce reliance on agency staff supported by implementation of e-rostering.

- Failure to deliver contractual national quality requirements (in particular, A&E 4 hour target, waiting times including cancer and diagnostics)

Mitigation:

Sustained focus on delivering identified actions to improve and sustain performance against the A&E target;

- Continued focus on substantive recruitment to reduce reliance on locum cover in A&E
- Delivery against the A&E improvement action plan
- Embedding service improvement methodology
- Development of the Emergency Centre.
- Review and management of performance against waiting times.

3.5. Delivery of the Trust's Quality Account and Plans relies upon and is monitored through a governance framework. This includes the Board Quality Assurance Committee which meets monthly and which is supported by a number of themed groups. Following review of the Trust's quality governance arrangements a Clinical Governance Committee will shortly be established with a remit to cover a number of patient safety matters previously overseen by a range of committees, with the intention of ensuring wider oversight across all CQC domains and the quality framework themes. Its establishment will also enable a number of groups to be disestablished. Progress against delivery of the Quality Account and Plan will be monitored through a Quality Improvement action plan with oversight by the Trust Board.

3.6. Delivering high quality services is a primary strategic objective and one of our core values for which all staff have a responsibility. Executive responsibility for Quality Planning and Quality Improvement lies with the Chief Nurse, supported primarily by the Medical Director and Chief Operating Officer.

3.7. The Trust engages a number of organisation-wide improvement methodologies and in particular has introduced the "Listening into Action" programme throughout the Trust with the aim of empowering staff to make a difference in their own areas of work. Listening into Action is now a part of the way we work and continues to be embedded.

3.8. The Trust, through the Chairman and Chief Executive, are engaging with colleagues via "Moving Forward Together" sessions, supported by a revised communication and engagement strategy.

Seven Day Services

3.9. The Trust assessed itself against the 10 clinical standards contained in the NHS England guidance, NHS Services Seven Days a Week, in July 2014 and used this baseline assessment to work with Rotherham CCG to agree and prioritise

investment for the remainder of 2014/15 and recurrent investment for 2015/16, in order to work towards achieving the ten clinical standards.

3.10. In terms of the requirement to focus on five (of the ten) clinical standards in 2015/16, the following standards were agreed for investment in 2015/16 and are being monitored contractually through a CQUIN process. Significant progress continues to be made in implementing the standards and progress is reviewed through a detailed action plan which includes an assessment for each of the ten clinical standards, together with detailed update on those priority standards agreed contractually with the CCG.

3.11. Progress during 2015/16 to deliver against the 7 day working standards:

Standard Reference	Standard Description	Local Solution to Deliver the Standard	Current Progress
Standard 2	Time to First Consultant Review	Enhanced Medical Capacity	New way of working agreed on AMU. Standard Operating Procedure in place. Emergency Department rotas reviewed with recruitment to ED Consultant posts ongoing. Ward reconfiguration supports the improved pathways for emergency care. Implementation of new roles for both nursing and medical colleagues
Standard 3	Improved MDT Review	Advanced Nurse Practitioners	Delivery of this clinical standard is through implementation of the SAFER care bundle. This is monitored through audit of performance against the SAFER care bundle metrics.
Standard 4	Shift Handover	Site Management Team	Medicine electronic handover system is fully operational. Recruitment to and implementation of Site Management Team to provide 7-day, 24 hours site management is fully implemented. Hospital at Night supported in development with Site Management Team
Standards 5 & 6	Diagnostics and Access to Interventional Services	Investment in Diagnostic & Therapy Services	Radiology – increased capacity across a number of modalities on Saturday and Sunday. Therapy – Enhance weekend provision in place Pharmacy – improved medicines reconciliation

3.12. The three year transition to seven day services as outlined in the NHS England Planning Guidance fits with the current 2-3 Year Unscheduled Care Transformation Programme work and is included in the Trust's Transformation Programme as a key enabler to achieving many of the change objectives within the programme.

3.13. Despite significant progress, there remain some key risks to full implementation including:

- Recruitment – medical and advance nurse practitioners
- Introducing new work patterns for clinical staff to provide 7-day services
- The need for other key partners to provide 7-day services, i.e. social care, primary care

3.14. Progress in relation to developing seven day services is reported at Trust management committees and includes assessment against all ten clinical standards, together with a detailed update on those priority standards agreed contractually with the CCG for 2015/16.

3.15. Whilst it is recognised there remain challenges and that further investment will be required to fully implement a structure that can deliver seven day services, nevertheless the Trust continues to make good progress in a number of areas in relation to seven day services. In 2016/17 progress will continue to be driven through the Transformation Programme. Whilst the Trust has self-assessed its position against four of the clinical standards using the NHS England 7-day services 7DSAT tool, the plan is to assess the remaining standards. The SAT tool will then be able to provide both a dashboard specific to the Trust and it is anticipated that once all Trusts participate in using the tool, then a national dashboard and benchmark data will be available to support continued development and share best practice.

Quality impact assessment process

3.16. All Cost Improvement Plan (CIP) proposals are initially formally risk assessed from a finance perspective to review feasibility for delivery and identify any areas of concern. Clinicians are an integral part of managing budgets within the Trust and hence are intrinsically involved in both the budget review meetings and the formulation of CIP proposals. This initial financial assessment allows cross-reference between service and corporate schemes for identification of any overlapping of schemes. Schemes are rejected at this stage if they do not provide the necessary financial assurance.

3.17. All CIP proposals deemed financially viable undergo a quality impact assessment. On submission of schemes service leads are required to provide their risk rating and are asked to clearly document any known or perceived impacts affecting patient safety, clinical outcomes, patient experience and staff experience. All CIP schemes are reviewed by a multi-disciplinary team consisting of representative from corporate functions, with nursing, clinical and managerial leads from across the five Divisions. This approach provides the opportunity for 'challenge and confirm'. In addition, the Chief Nurse, Medical Director, Chief Operating Officer and Director of Finance are involved in the process. Further information may be requested at this stage to assist in providing further assurance.

3.18. All CIP schemes approved through the processes described above are then re-reviewed by the Chief Nurse and Medical Director to seek final assurance with regard to continuity of quality services. The Chief Nurse and Medical Director

write jointly to the CCG confirming the outcome of their review. An approved risk rating methodology is applied consistently at all stages of the process.

- 3.19. Where any threat or compromise to quality is indicated, schemes are rejected. The robust controls in place for reviewing CIP proposals provide assurance to the Trust Board that it is able to deliver financially with minimal impact upon quality.
- 3.20. CIPs are performance managed both via a programme management function headed up by executive directors as well as part of the overall financial management of the Trust via its normal reporting procedures up to the Trust Board.
- 3.21. The CIP component of the Strategic Service Review process focuses accountability for specialty clinically related CIP delivery through the Clinical Director. These reviews have tested the engagement of relevant professionals in plans that affect their services and also the co relation of schemes whereby the actions takes place in one directorate and the savings fall in another.

Triangulation of indicators

- 3.22. The Trust has approached triangulation of quality, workforce and financial indicators through its specifically developed Integrated Performance Report (IPR) which provides detailed analysis of Trust performance for each of the key indicators – quality, workforce and finance. The indicators measured include a mixture of national and local requirements and are purposefully selected and presented in a way that allows direct comparisons and correlations to be identified.
- 3.23. This system of reporting allows performance against quality indicators to be linked to other factors which may be impacting on delivery. The Integrated Performance Report is reviewed monthly by the Trust Board and at other key Trust committees, as well as at all monthly Divisional Performance meetings. It also forms the basis of discussions with commissioners at monthly contract quality meetings.

4. Our Approach to Workforce Planning

Key Points:

- The Trust has adopted nationally recommended approach to workforce planning.
- The Trust is implementing innovative approaches to workforce re-design in the face of major demand and supply issues for clinical staff. For example, the proposed redesign of Emergency Care Centre staffing arrangements.
- The Trust is implementing three of the e-rostering modules in 2016/17.
- Plans are in place and initiatives are being pursued to ensure compliance with the agency cap, with review of breaches to identify further mitigating actions to

reduce risk where possible.

- Workforce planning remains a key area of focus for 2016/17 and beyond, with a need to strengthen our approach and effectiveness to support transformation and sustainability of services. This will include workforce profiling, benchmarking, service improvement and new roles.
- Strategic Workforce Committee provides oversight, governance and assurance for the strategic workforce agenda.

4.1. The Trust has adopted the nationally recommended Six Steps approach to workforce planning – Defining the plan, Mapping service change, Defining the required workforce, Understanding workforce availability, Developing an action plan, Implement monitor and refresh.

Governance Process

4.2. A robust Workforce Plan is critical to the Trust's strategy as it enables the Trust to plan for and recruit the workforce required for successful service delivery and ensuring the operational and clinical sustainability of the organisation. In support of the Trust's approach to workforce planning the Trust has:

- introduced a new workforce report at Trust Board with agreed KPIs/metrics to ensure that the Trust Board has regular visibility of the workforce plan, issues and risks to delivery. Through this approach there is also triangulation with quality and financial performance metrics.
- reviewed and updated the terms of reference of the Strategic Workforce Committee (a Trust Board Committee) as part of the Trust's improved governance arrangements.
- workforce plan/issues are reviewed at monthly Divisional performance meetings.
- developed a workforce planning and diversity assessment tool to provide a high level overview at organisational level.

Links to Clinical Strategy, Local Health and Care System Strategies

4.3. The integration of acute and community services and pathways across the Trust which will ensure that patients are treated in the most appropriate environment, at the right time, with access to the relevant skilled professional(s) will inevitably require existing medical, nursing and Allied Health Practitioner (AHP) roles to change as new services and technologies are embraced and there is a more multi-disciplinary focus to patient care closer to home.

4.4. The Trust is fully committed to integrated working with partner organisations and for 2016/17, the acute and community transformation programme has initiated a

pilot scheme to develop a fully integrated locality team, based around the district nursing footprint and which will see acute and community teams working with primary care, social care, mental health and voluntary sector colleagues and a shared patient caseload.

- 4.5.** Another very practical example of workforce change and engagement relates to the development of the new Emergency Centre on the Rotherham Hospital site. Clinicians from the CCG, the Trust and Care UK are working to develop an integrated urgent care model that will improve the quality of service for patients, joining up the skills of primary care – GPs and nurses – with the skills of staff in our Accident & Emergency department. As part of this process the Trust will continue to work with internal and external stakeholders to identify and recruit the workforce required to operate this new model successfully. Key to this will be the development of the new Emergency Nurse Practitioner / Advance Clinical Practitioner roles to go some way to address the issue of the national shortage of middle grade doctors and to enhance the roles of the already skilled emergency care nurses. The Trust will work with Yorkshire & Humber Health Education England (Y&HHEE), local universities and colleges to support and grow this new workforce model in two phases; (i) ENP/ACP's upskilled to deliver the service by April 2017 (ii) full workforce in place by March 2019.
- 4.6.** Increasing the nursing workforce remains a key objective of the Trust. Similar to many Trusts, we have experienced nurse demand outstripping supply. The Trust has undertaken large scale recruitment events for both nurses and Health Care Assistants (HCA) with further similar initiatives planned. The Trust continues to consider options such as overseas/international recruitment (appointed c100 nurses), offering more flexible work patterns (10.00 – 16.00 shifts), and redesigning the internal bank/flexi staffing service in partnership with the managed agency service provider.
- 4.7.** Similar challenges exist with the current medical establishment where there are recognised national shortages, particularly in relation to Emergency Medicine, General Internal Medicine and GP's. The Trust's response to the gaps has been through the appointment of locums which is costly and not sustainable as a long term solution. A number of initiatives to address this on-going issue are underway within the Trust, e.g. continuing to reduce reliance on hospital provision and increase the number of community practitioners and Advanced Nurse Practitioners, development of services that can be delivered without doctors, delivering against the 10 clinical standards over the next 2 years.
- 4.8.** During 2016/17 the Trust will continue to build on the review of all clinical service units undertaken previously; all will be subject to scrutiny of their costs, performance outcomes, future developments and benchmarks to enable the Trust to make an objective decision about future viability or sustainability. This will be key in determining the Trust's service and workforce strategy for the next 3-5 years.
- 4.9.** The Trust is working with other neighbouring Trusts to identify mutually agreed ways of working which will deliver safe, sustainable, high quality clinical services within the region - part of the Working Together Programme (WTP). The main driver for this work has been looking at collaborative working around clinical

pathways. This work was recognised with the successful Vanguard application in October 2015 and the Trust is currently involved with the WTP team in developing the 'value propositions' to be considered during 2016/17. Understandably, given the financial challenges facing every NHS organisation, discussions have also taken place regarding any potential efficiency in relation to support office functions, procurement costs and locum expenditure in order to ensure that we achieve maximum efficiency for the public purse.

- 4.10.** The Trust has made an annual workforce submission to the Yorkshire & Humber Local Education and Training Board providing details of workforce statistics, and challenges and risks in support of overall regional and national workforce planning.

e-Rostering and Reduction in Agency Staffing

- 4.11.** The Trust is implementing e-Rostering during 2016/17, to replace paper based rostering on wards. This will be rolled out across the Trust. The Trust has appointed a Programme Director and put in place the supporting governance arrangements for the project. The Trust has procured three modules (HealthRoster, BankStaff and SafeCare) which it will implement as Phase 1, for nursing, AHPs, A&C staff and community staff in 2016/17. The intention is that the medical workforce will form part of the Phase 2 implementation in 2017/18.
- 4.12.** The Trust will re-design its staff bank service to fully realise the benefits from the upgraded software. This is a key enabler to increasing bank usage and reducing the reliance on agency staff. This will be implemented in the first quarter of 2016/17 alongside strengthening the bank arrangements overall.
- 4.13.** The Trust recognises the impact that the continued engagement of agency staff has on its financial performance and is currently planning how it will comply with the agency caps and maximum wage rates when procuring staff from 1 July 2016 as this will form part of the criteria for releasing funding from the Sustainability and Transformation Fund. In endeavouring to achieve this objective it will be critical that the Trust continues to ensure that patient safety is not compromised.

New Workforce Initiatives Agreed with Partners involving Workforce redesign

- 4.14.** As outlined, there is a £12.0m capital development underway for the provision of a new Emergency Care facility involving a number of key providers. The vision is to transform how patients receive urgent and emergency care in Rotherham by integrating the services provided by the A&E department, walk-in centre and GP out of hours services into a single emergency centre where patients who need urgent treatment will receive it from the most appropriate clinician first time, 24 hours a day, 7 days a week. It is envisaged that the new centre will act as a hub around which a new joined up healthcare system can be developed for the whole of the Rotherham health care economy.
- 4.15.** The redesign of emergency and urgent care services has been a clinically led process with the clinical benefits for patients at the forefront of discussions. The new service model for the new Emergency Centre is built upon front-end

decision making by senior clinicians to stream patients to the most appropriate clinician. As part of the service model, mental health pathways (adult, older people, CAMHS) are being redesigned to ensure early response times which involve working together to develop agreed protocols that cross organisations, and manage demand appropriately across the health and social economy.

4.16. The aim is to build an integrated and flexible workforce able to meet the needs of the patients at all levels of acuity. The new EC workforce model has been designed to flex capacity to where the demand is most acute, improving the patient flow thereby reduce waiting times and has been predicated on a multi-professional workforce with mid-level non doctor clinicians such as Advanced Clinical Practitioners, developed through a training programme with Nottingham University / SHU, to address the middle grade doctor shortage and reflect the changing nature of unscheduled care needs.

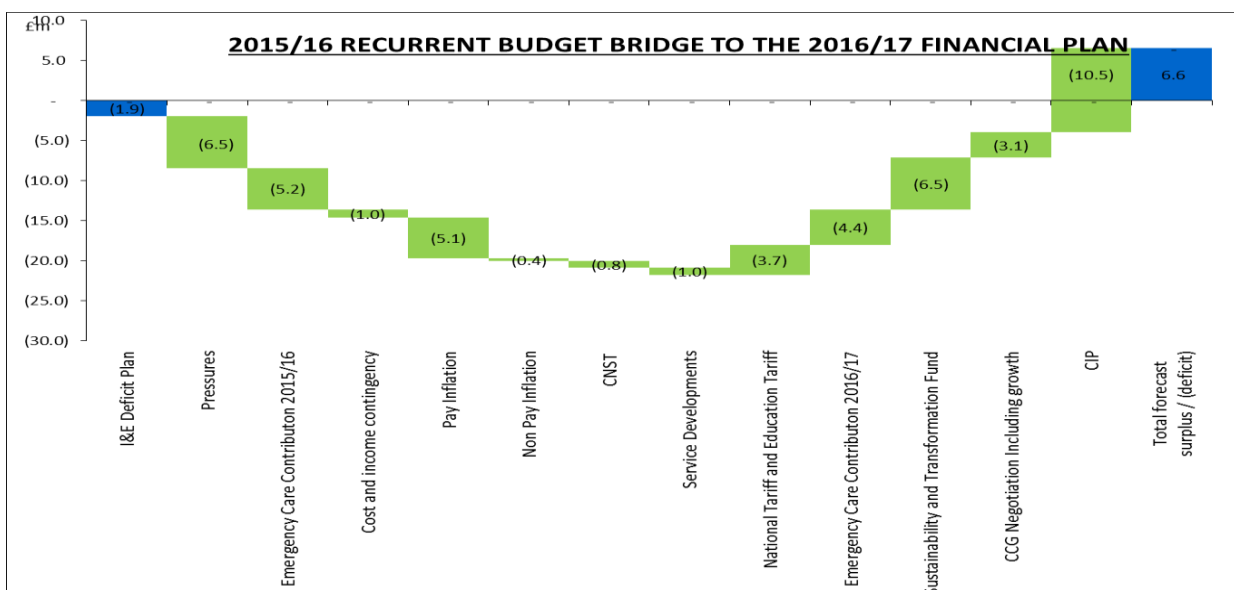
5. Financial forecasts and modelling

Key Points:

- £6.6m surplus plan in line with the control total
- CIP target of £10.5m, 5.5% of controllable costs
- £11.6m capital programme
- A downside scenario of £1.25m deficit

5.1. The 2016/17 financial plan has been produced via a “bottom up” approach from the Trust’s Clinical Service Units, Divisions and Corporate Directorates in terms of activity, workforce and the financial consequences. This “bottom up” approach has been reconciled with a “top down” approach using the key assumptions with the Five Year Forward View and the planning guidance.

5.2. The key movements from the 2015/16 recurrent budgets are shown in the table below;



- Starting point is the £1.9m deficit plan
- Adjustment for the non-recurrent money received in 2015/16 as a contribution to the Emergency Centre Capital build (2016/17 contribution is shown later in the bridge)
- Cost and income contingency
- Inflationary pressures of both pay and non-pay (excluding CNST). The pay pressures include both the pay award and incremental drift, with non-pay covering pure inflationary price increases. Both elements have been modelled on the national assumptions.
- Clinical Negligence Scheme for Trusts (CNST) – the Trust has seen an increase of £0.8M in the premiums in 2016/17.
- Unavoidable cost pressures – these are cost pressures being incurred by the Divisions and Directorates to deliver the contracted level of activity, and predominately reflect the impact of workforce pressures (vacancies and the need to use non contracted workforce). This value is lower than the costs incurred in 2015/16 reflecting progress in year to reduce reliance on premium pay and the expected impact of the reducing agency caps.
- Tariff changes, both patient care activity (Payment by Results) and Education and Training (transitional impact of changes to MADEL and SIFT).
- CCG Negotiation – the Trust is planning to set the 2016/17 contractual levels of activity based on a realistic view of demand and activity. This is mainly relating to setting the contract for non-elective / emergency activity at the 2015/16 forecast out-turn levels plus any known specific adjustments.
- £6.5m Sustainability & Transformation Fund allocation received
- CIP, £10.5M (5.5% of controllable costs)

5.3. The Trust continues to face the challenge of eliminating the underlying deficit. This has been further reviewed at the end of 15/16, indicating positive improvement over recent years from approximately £9m in 13/14 to £7.7m in 14/15. The plan for 16/17 aims to erode this further to achieve a reduced underlying deficit of between £4.4m and £6.5m. At this level of CIP it is expected that the Trust could achieve sustainability with the STP period with a view to accelerating this based on STP planning through collaboration and strong locality working.

5.4. The sensitivities within the 2016/17 plan, including the downside scenario, are reflected in the detailed financial appendices but in summary include;

- Final contractual value with our lead commissioner
- Confirmation of the pay settlement and the ability to reduce premium pay costs
- Final 2015/16 year end position
- Risks and potential mitigations as described in section 6.

Efficiency savings for 2016/17

5.5. The Trust Board is committed to managing its financial resources prudently and effectively, to ensure continued provision of high quality services. Whilst recognising the pressure on NHS resources and the need to make efficiencies, the

such as standardisation and rationalisation of ranges which supported by major partners (NOECPC and NHS SC) will deliver leveraged savings totalling over £1.1m upon completion of the 13 schemes.

- The Procurement team has supplied data relating to the entire spend of December 2015 for all “non pay spend” to the team working as part of the Carter review.
- Collaborative working with the six partners within the Working Together Programme.

6. Risks to delivery of the financial plan in 2016/17

6.1. The acceptance of and the delivery of a control total of £6.6M surplus for 2016/17 is predicated on, and intrinsically linked, to a number of inter-related factors and deliverables, as follows:

- Access to the Sustainability and Transformation Fund with delivery of its conditions, including delivery of each of the remedial trajectory key performance targets;
- Delivery of the CIP for 2016/17
- Delivery of the clinical activity contract including full receipt of CQUIN funding
- Ability to reduce reliance on premium pay spend including agency cap through effective recruitment to key substantive roles and workforce re-design
- Successful partnership working through acute care collaboration Vanguard and increased resilience to support introduction of new models of care
- Implication of the junior doctors contract
- Capital programme
- Acute and community integration, locality working models including multi agency working
- Further transformation across emergency and elective pathways to support delivery of activity and CQUIN

6.2. In accepting the control total of £6.6M surplus for 2016/17, the Trust has had to be especially mindful of the associated inherent risks which accompany its acceptance as a result of the conditions to which it is linked as described above. As part of its consideration the Trust has reviewed the risks in detail and identified mitigation where possible and which are described below. Through mitigating controls the Trust will be seeking to eliminate the risks. Inevitably though, it may not be possible to eliminate each of the risks entirely.

Risks to delivery of Financial Plan

Factor	Risk	Mitigation	Downside Financial Risk £000s
I&E/Cash	<p>Failure to access Sustainability & Transformation Fund as a result of missing remedial trajectory performance targets (£1.625m per quarter):</p> <ul style="list-style-type: none"> • A&E 4 Hour waits • 52 week waits • Cancer • Diagnostic waits 	Realistic trajectories submitted as part of the plan with clear actions plans to support delivery.	<p>████████</p> <p>██████████</p> <p>██████████</p> <p>████████</p>
I&E/Cash	Failure to delivery 2016/17 CIP	Despite the efficiency rate within tariff being 2% we have set a very stretching CIP target for 2016/17 of 5.5%, approximately £10.5m. This stretch, we believe, is realistic and is supported by the high level outputs from the Carter Review.	████████
I&E/Cash	Failure to manage cost pressures including the agency cap target (35% reduction) within budgets/ contingency	A contingency of £1m within the plan, which may not be sufficient to cover all pressures	████████
I&E/Cash	Junior Doctors contract implications	A 1% increase in costs has been provided for. Anything above this level will be a financial pressure to the Trust	
I&E/Cash	CQUIN schemes	Full delivery of the CQUIN schemes is assumed. Each scheme has an Executive lead with a senior manager operationally	████████

		responsible.	
I&E/Cash	Community Contract – there is a block contract for 2016/17 with a risk, that as patients are appropriately transferred into the community setting from an acute setting, the income doesn't follow	Monthly performance and activity meetings with the lead CCG to monitor activity and financial consequences.	■■■■
Capital/Cash	Capital Programme	Ability to slow down/re-prioritise schemes across years to support organisational pressures and cash flow.	
I&E/Cash	Workforce pressures in key areas (Emergency Department, Acute Medicine, Clinical Coding)	The Trust has budgeted for current levels of spend (mix of substantive and agency) There is a risk of further reliance on non substantive costs due to increased vacancies.	■■■■
		TOTAL	£7,750

6.3. The cash consequences of any of the above risks not being mitigated would result in the Trust requiring temporary cash support.

6.4. The Trust is seeking to move to a different model of contracting for community services in recognition of activity shifts from acute to community and improved integration. Development of a locality model for Rotherham is key the Trust has agreed to review the current block arrangements during 2015/16 with a view to moving to a cost per case contract in 2017/18.

Capital Planning

6.5. The 2016/17 capital plan (£11.6m) will continue to progress schemes from the 2015/16 programme, invest in new schemes linked to clinical and efficiency strategies and start to plan for the 2017/18 period following the development and Board approval of a new Estates Strategy in 2016. The main scheme headlines are as follows:

- **Emergency Centre** – Commenced construction in March 2015 and is due to complete in May 2017 and be operational by July 2017. The scheme

involves the refurbishment of the existing A&E Department and the construction of a two storey building to the side of the existing facility. This development will also see the closure of the walk-in centre, currently located within the Community Health Centre, and the co-location of primary care, GP out-of-hours services, social workers and mental health teams within a single facility.

- **Pharmacy Aseptic Suite** – Commenced construction in September 2015 and is due to complete in June 2016, the £1.02M scheme involves the refurbishment of the existing Aseptic Suite, provision of new dedicated air handling plant to meet the guidelines for such facilities along with the re-provision of separate heating and cooling facilities for the remainder of the department. When complete the unit will meet all the standards necessary to maintain Aseptic Manufacturing accreditation.
- **Endoscopy Decontamination Unit** – Construction of a new circa £1.8M facility to support Endoscopy services within the Trust. The current facility is small and cramped with the existing machines requiring replacement if the Unit is to continue to maintain its JAG accreditation. The scheme is currently in design and is due to be complete by March 2017.
- **Estates Strategy** - The review and development of the Estate Strategy will facilitate the enablement of strategic plans to deliver current and future aspirations of the Trust. The estates review will provide a detailed analysis of what it needs to do over the next 5 years. It will also build on previous strategies to provide an Estates Strategy that supports the Trust's delivery of high quality, safe and effective care pathways.

The updated strategy will allow the Trust to have an estate that is fit for purpose and is integrated with the needs of clinical services, service plans and the core business of the Trust that will provide changes to the retained estate to give, improved space utilisation, reduction in backlog maintenance issues, greater functionality and quality of the retained estate, reduced costs.

Backlog Maintenance

There is an extensive backlog maintenance programme in place in 2016/17 including:

- Electrical site wide infrastructure planned replacements;
- Replacement air conditioning plant to Theatre 11.
- Fire Safety improvements to ensure ongoing compliance with Firecode,
- Legionella prevention measures including removal of dead legs, unnecessary thermostatic mixing valves and high risk issues from risk assessments.
- Disability Discrimination Act schemes to meet compliance dealing with high risks from audit.
- [REDACTED]
- Environmental improvements to patient areas including upgrade of ward kitchens, ceiling replacements in ward bays and other in year patient environment issues arising from PLACE and CQC inspections.

- External and Site Security improvements including replacement lighting, CCTV cameras, access control to ward areas, perimeter fencing to offsite properties
- Lift Replacement programme

7. **Link to the emerging ‘Sustainability and Transformation Plan’ (STP)**

Key Points:

- The Trust has made some significant progress in transforming services, e.g. the delivery of a locality based model of adult community nursing.
- Clinical, operational and financial sustainability remains challenging for the Trust as it does for many acute providers.
- There remain opportunities and the need for the Trust to exploit the potential of collaborative working offered by the Acute Provider Collaborative “Working Together” Programme and Vanguard.
- The Trust acknowledges that the size of the challenge means that realistic planning for the future needs to be on the pan-regional scale offered by the emerging STPs.

- 7.1.** The Trust’s strategic aim, as a result of a strategic options appraisal in 2013/14 and as indicated in the Trust’s Five Year Strategic Plan 2014/19 is to remain as a ‘standalone’ organisation whilst exploring potential opportunities for collaboration with other acute providers in the Local Health Economy, and in particular through the opportunities provided by the local acute trust collaborative “Working Together” Programme, a collaborative of seven acute hospitals in South Yorkshire, Mid Yorkshire and North Derbyshire. This approach is also consistent with national guidance which continues to support the place of smaller/medium sized acute providers with appropriate change. The strategic aim was underpinned by detailed assessments of the Trust’s financial and clinical sustainability.
- 7.2.** Whilst the underlying position improved slightly in 2014/15 with the achievement in full of a £10.9M cost improvement plan, cost pressures in 2015/16, resulting in the requirement for a further ambitious cost improvement plan of £12.9M. Taken together, both the outturn of the Trust’s 2015/16 financial performance and the result of the NHS Comprehensive Spending Review have resulted in the need for the Trust to review the assumptions within its current financial plans to assess the level of financial risk to achieving long term financial sustainability.
- 7.3.** A review of the Trust’s clinical services in 2014/15 confirmed the potential clinical sustainability of ‘core’ clinical services, recognising that some non-core services faced a number of operational challenges which needed to be addressed to ensure future clinical sustainability and that some services would benefit from the

exploration of collaborative working. Importantly, the review acknowledged that the clinical services which demonstrated a greater degree of clinical sustainability were those that were working collaboratively across Trusts. Since then further progress has been made in leveraging the advantages of collaborative working afforded by the local health economy footprint of the “Working Together” Programme, e.g. establishment of weekend GI bleed rotas and support in delivery of the Gastroenterology Service at Rotherham, with Doncaster & Bassetlaw NHS Foundation Trust; and the proposed establishment of a paediatric services clinical network.

7.4. The Trust continues to make significant progress in transforming services. The emergency care pathway is subject to significant redesign with the co-location of urgent care “walk-in” services and a physical re-design of emergency services due to come on stream in 2017. In community services, a transformation programme resulted in the delivery of a locality based model of adult community nursing and the establishment of pathways of care to support admission prevention and discharge. Other transformation programmes have involved a more integrated approach to urgent care and community transformation with the central focus being on the management of frail older people.

7.5. This will require transitional funding to support progress which the Trust will seek to pursue through the STP. Learning is available for Vanguard, and the Trust will seek to work more closely with these to share and gain learning. To achieve sustainability by the end of the STP period the Trust will focus on transformation across pathways via delivery of multi provider locality models in Rotherham, and acute care collaboration.

7.6. Whilst the Trust has made significant progress in sustaining and transforming its services, it is clear that the Five Year Forward Plan and the results of the NHS Comprehensive Spending Review demand that our plans go even further and faster in support of the triple aim – better health, transformed quality of care delivery, and sustainable finances. The intention is, therefore, to maximise and leverage the opportunity afforded by the “Working Together” Programme and Acute Care Collaboration Vanguard. For the Trust this means:

- Leveraging the opportunities provided through the programme to work with partners to fix mutual service issues;
- Building on the transformation and integration of services that has already been undertaken;
- Based on the outcome of the clinical service reviews and subsequent knowledge and developments, develop service models with partners for those services that continue to have sustainability issues;
- Ensuring that our plans are completely aligned with the planning intentions of commissioners and local authorities where we provide services.

7.7. The progress that the Trust has already made in the last two years in terms of clinical sustainability and transformation of services will increasingly need to be viewed in the context of the national planning guidance requiring ‘local’ health

economies to create Sustainability and Transformation Plans (STPs). The Trust has been included within the South Yorkshire and Bassetlaw STP footprint covering a planning population base of 1.6M. The intention is that each STP footprint will be convened by a local system leader, recognising that footprints are not representative of statutory boundaries but rather vehicles for collaboration. Nevertheless, the intention is that planning should be on the basis of populations, not institutions or organisational form. The precise arrangements for the South Yorkshire and Bassetlaw STP footprint continue to be developed with the system leader recently having been confirmed. The footprint is largely commensurate with the Sheffield City Region, which provides further opportunity for alignment to progress wider scale public sector reform.

7.8. In parallel, the Five Year Forward View (5YFV) guidance for Acute Providers (Implementing the Forward View: Supporting providers to deliver) makes clear the challenge for Acute Providers and provides a roadmap. Providers need to deliver high quality patient care, NHS constitutional access standards and financial balance, eliminating unwarranted variation across all these areas, while also making the transformation that is needed to ensure long-term sustainability and in doing so reduce the three gaps – health and wellbeing, quality and finance. The guidance sets out the vision and roadmap against five key domains:

- Quality: Success will represent a CQC rating of ‘good’ or better.
- Finance/use of resources: Success will represent delivering the 2016/17 control totals, reducing use of agency staffing, delivering required efficiency savings and productivity gains by responding to the Carter Review, maximising use of estate and realising value from surplus estate.
- Operational performance: Success will include delivering performance targets – A&E waiting times, referral to treatment times, cancer treatment times, and progress on implementation of seven-day service.
- Workforce and Leadership: Build on existing governance tools like the well-led framework to set out a single, shared system view on what good leadership looks like. Developing workforce strategies.
- Strategic change: assess how well Trusts are delivering the strategic changes set out in the 5YFV based on STPs.

7.9. Based on the guidance contained within the 5YFV for Acute Providers the Trust will review its current performance against each of the domains in order to identify the gap to delivery and further actions needed.

8. Membership and elections

Key Points:

- The Trust has continued to recruit to Governor vacancies and the Trust continues to be supported by an active Council of Governors.
- Governors are supported through a training programme and actively

participate in ensuring the quality of patient services provided through such mechanisms as 'walkabouts'.

- Through a series of Governor Surgeries, Governors are able to obtain direct patient feedback enabling the Trust to take any necessary remedial action.
- In 2016/17, Governors will be holding a series of meetings in the community where, in addition to promoting the work of the Trust, they will be able to promote the work of the 'Rotherham Together Partnership'.

- 8.1.** Governor elections have been relatively successful at the Trust in previous years, with few vacancies at any given time. However, the Trust is currently engaged with its 2016 election process, and will take on a new cohort of circa 11 Governors on 1st June 2016.
- 8.2.** The Trust has in place a Governor Training Plan, with subjects as diverse as NHS finances, Trust and regulatory governance, strategic planning, the role of the Governor in CQC inspections, etc. The plan is currently being reviewed with Governors. In addition, quality and safety 'walkabouts' are provided in a number of areas for Governors, who participate together with Non-Executive Directors. Both of these initiatives provide the tools to increase Governors' knowledge of the Trust and the NHS system in general and also helps to ensure they have the skills and knowledge to undertake their role, as well as providing activities in which they have the opportunity to work closely with the Non-Executive Directors.
- 8.3.** The Trust has facilitated 'Governor Surgeries' at the hospital and at its community-centre setting so that Governors can engage directly with patients, trust members, and the public. The excellent feedback from these sessions provides a valuable source of patient and public views, which the Trust can learn from to improve its services. The Trust also receives some excellent feedback from patients/their families who have received treatment at the Trust; we value our colleagues and being able to provide them with such feedback is an important element of our staff engagement strategy.
- 8.4.** For 2016/17, we are seeking to strengthen Governor links directly into areas of the community which the Trust serves by holding advertised meetings that will be led by our Governors. Trust members and all members of the public will be invited to attend. This was trialled during 2015/16 with some success, but we are currently revamping the process. To date, meetings have been held in community meeting rooms, but we are looking to eventually extend the meetings into areas of hard-to-reach groups and areas. This work will also support the work of the 'Rotherham Together Partnership', which seeks to provide governance and leadership in pursuing partners' shared priorities (health, safety, business, economy and the voluntary and community sector) for the borough.
- 8.5.** As part of a collaborative Working Together Partnership, the Trust is working with six local NHS organisations, with a view to collaborative working and is currently considering initiatives that would allow Governors from the various organisations

to meet and work together on Governor based activities, which we hope to establish during 2016/17.