West Hertfordshire Hospitals NHS
NHS Trust

Delivering a healthy future in west Hertfordshire

Phase II

Benefits Realisation Strategy

& Management Plan

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Author		
Author		Esther Moors
Job Title		Head of Service Planning
Department		Planning Department
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0.3	4 Nov 08		

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EXECUTIVE SUMMARY

INTRODUCTION

This document therefore summarises the overall strategy that will underpin WHHT's approach to Benefits Realisation for Phase 2 of the DaHF Programme and provides actions plans to ensure that the required work will be delivered.

1 BENEFITS REALISATION STRATEGY

In measuring the success of DaHF, WHHT needs to ask the following key questions:

1 How well was the change itself effected?
2 How has the way we deliver services changed?
3 Did we realise the strategic benefits anticipated in the Business Case?

The timing of each of these questions will be key to ensuring that it is answered fully and the Benefits Realisation Strategy therefore consists of 3 stages:

Stage	Title	Timing (after completion)	Aim
1	Post-project Evaluation	100 days	To assess how the change itself was effected.
2	Operations Review	12 months	To assess the impact on service delivery.
3	Benefits Realisation	18 - 24 months	To assess achievement of strategic benefits.

2 BENEFITS REALISATION ACTION PLANS

Action plans are included for each stage of the review process outlining required outcomes along with supporting benefit measures, methods and owner. These action plans will now be subject to further review by benefit owners to ensure that the measures included are robust.

INTRODUCTION

The Delivering a Healthy Future Programme (DaHF) represents a significant change in the way that West Hertfordshire NHS Trust (WHHT) delivers services to patients. DaHF consists of three phases:

1. The development of an elective care centre at St Albans City Hospital;
2. The centralisation of emergency care at Watford General Hospital; and
3. The development of a Community General Hospital at Hemel Hempstead.

Phase 1 of DaHF has already completed and is subject to its own benefits realisation process. Phase 2 is currently underway with major investment in capital assets and a profound change in the way that care is provided and is therefore the focus of this document. Phase 3 will commence once Phase 2 has been completed and will be led by the Primary Care Trust.

Given the scale of investment in DaHF, both in terms of finance and staff time, the Trust has a responsibility to review whether anticipated benefits as outlined in the original Business Case have been realised with the minimum disruption to patients and to staff. This document therefore summarises the overall strategy that will underpin WHHT's approach to Benefits Realisation for Phase 2 of the DaHF Programme and provides actions plans to ensure that the required work will be delivered.

1 BENEFITS REALISATION STRATEGY

1.1 Best Practice Requirements

In developing a DaHF Benefits Realisation Strategy for WHHT, several 'best practice' resources have been considered in order to ensure that the Trust fulfils its responsibilities. These are summarised below:

- PRINCE2 (Projects in Controlled Environments) methodology has been used throughout DaHF as the basis for Project Management arrangements and underpins this document.

- The NHS Institute for Innovation and Improvement's guidance for Benefits Realisation has been used to inform this document.

- DaHF is subject to 'Gateway Reviews' carried out by the Department of Health to assess progress at key decision points. All significant NHS reconfiguration programmes are subject to this process and Gateway Review 5 focuses on 'Operations Review and Benefits Realisation.' This review typically occurs 6 – 12 months after a project has delivered its agreed outputs and may be repeated several times over the life of the operational service, dependent on the nature of the project. In addition to this, the Gateway Process also expects that a 'Post Implementation Review' of the project will be completed and that lessons learned have been captured. This document therefore seeks to ensure that all Gateway 5 requirements will be met.

1.2 WHHT Approach

In measuring the success of DaHF, WHHT needs to ask the following key questions:

4 How well was the change itself effected?
5 How has the way we deliver services changed?
6 Did we realise the strategic benefits anticipated in the Business Case?

The timing of each of these questions will be key to ensuring that it is answered fully and the Benefits Realisation Strategy therefore consists of 3 stages:

Stage	Title	Timing (after completion)	Aim
1	Post-project Evaluation	100 days	To assess how the change itself was effected.
2	Operations Review	12 months	To assess the impact on service delivery.
3	Benefits Realisation	18 - 24 months	To assess achievement of strategic benefits.

The benefits derived at each of these points need be assessed from several perspectives, as what may be seen as a benefit to one group of stakeholders may be a dis-benefit to others. The following perspectives will therefore be used at each stage:

- Patient
- Staff
- Finance
- Environment
- Performance
- Wider NHS

Wherever possible, WHHT aims to ensure that mechanisms are in place to routinely capture data for all benefits, so that performance can be assessed by the Trust at any point following the implementation of DaHF Phase 2, rather than as a 'one-off' exercise to respond to the needs of a particular review. Existing data sources will therefore be used wherever possible in order to facilitate this exercise. Given that the original Business Case was completed in October 2007, WHHT will also aim to ensure that baseline data is provided from this date wherever possible and appropriate so that any changes in the Trust's performance since the inception of the Business Case can be captured.

Finally, the Trust is also in discussion with the Kings Fund and with an MBA student, to ensure that there is an external review of the clinical impact of the changes in patient pathways delivered as a result of DaHF. Plans for external reviews will be confirmed by the end of December 2008.

1.3 Responsibilities

The responsibilities of key committees and individuals in ensuring that this benefits plan comes to fruition are summarised below:

WHHT Trust Board: Overall responsibility for delivery of benefits, with responsibility delegated to the DaHF Programme Board for the duration of its existence.

DaHF Senior Responsible Owner: Responsible for ensuring that the 'Post-Project Evaluation report is completed.

WHHT Director of Delivery: Responsible for ensuring that the 'Operations Review' report is completed.

WHHT Chief Executive: Responsible for ensuring that the 'Benefits Realisation' Report is completed.

Head of Service Planning: Designated author for all 3 reports.

Benefits Owners: Each benefit has been given a designated 'owner' who will be responsible for ensuring that measures are appropriate, that mechanisms are in place to collect data on an ongoing basis and that baseline data is collected during October 2008. The Benefit Profile Template included as Appendix I is intended to assist in this task.

Service Managers: Responsible for ensuring that the necessary data collection mechanisms are embedded in their service(s) and advising benefits owners as to how to ensure that best use is made of existing data sources.

2 BENEFITS REALISATION ACTION PLANS

2.1 Post-Project Evaluation Plan

ID	Perspective	Required Outcomes	Measurement(s)	Currently Monitored? Y/N	Owner	Measurement Method
P1	Patient Care	Reconfiguration of services does not have any adverse patient impact.	P1.1: No increase in SUIs (outside of natural variation) P1.2: Minimal negative patient feedback. P1.3: No increase in patient care identified risks.	Y Y Y	Director of Nursing	Run-chart of SUI volumes. Patient complaints & compliments (formal and informal). DATIX
S1	Staff	Staff are engaged with the reconfiguration and feel valued throughout the process.	S1.1: Staff turnover rates do not increase through change (outside of natural variation). S1.2: DaHF workforce review survey.	Y N	Director of Workforce	Run-chart of staff turnover rates. Completion of qualitative survey & interviews with key members of staff.

ID	Perspective	Required Outcomes	Measurement(s)	Currently Monitored? Y/N	Owner	Measurement Method
E1	Environment	Capital work completed on time and Watford environment is fit for purpose.	E1.1: AAU building is handed-over and fully functional. E1.2: Schedule of PMOK work required for DaHF is completed on time. E1.3: The new ITU, CED and Front of House areas are handed-over and fully functional. E1.4: Staff and patients able to park their cars on the Watford site.	Y Y Y tbc	Director of Estates	tbc
F1	Finance	Building works are delivered within budget. Transition costs stay within budget.	F1.1: Breakeven. F1.2: Breakeven.	Y Y	Director of Finance	DaHF final financial summary. Transition budget financial summary.

ID	Perspective	Required Outcomes	Measurement(s)	Currently Monitored? Y/N	Owner	Measurement Method
P1	Trust Performance	The Trust maintains performance against its key performance targets.	P1.1: Achievement of A&E 4-hour waiting time target. P1.2: Achievement of 18-week waiting time target. P1.3: No increase in readmission rates. P1.4: Reduction in delayed transfers of care.	Y Y Y Y	Director of Delivery	Chief Executives Weekly Report (Balanced scorecard as of # # #)
N1	Wider NHS	Initial achievements and lessons learnt are captured and disseminated within the wider NHS.	N1.1: Lessons Learnt Log N1.2: Lessons Learnt Staff Survey	Y Y	Senior Responsible Owner (Medical Director)	Lessons Learnt Log Use staff questionnaire developed for SACH review.

2.2 Operations Review Plan

ID	Perspective	Anticipated Benefits	Measurement(s)	Currently Monitored? Y/N	Owner	Measurement Method
P2	Patient Care	There are real changes delivered to patients' pathways: ▪ Quicker diagnosis and decision regarding care plan. ▪ Shorter length of stay. ▪ Senior Decision Making at the start of the patient journey. ▪ Care pathways are developed for more integrated care approaches.	As per individual service Quality Indicators outlined in operational policies. Given the number of indicators, current plans are shown as Appendix II. It is also hoped that work planned with the Kings Fund or with an MBA student will ensure that clinical quality indicators are as meaningful as possible. The Trust will also be working to ensure that quality indices / care pathway developed for use within the AAU.	Some – further work to be done to gain assurances for all.	Director of Delivery	Individual Service Managers to ensure data routinely collated.

ID	Perspective	Anticipated Benefits	Measurement(s)	Currently Monitored? Y/N	Owner	Measurement Method
S2	Staff	Staff confident that service is running smoothing and that 'teething' problems have been resolved. Staff levels appropriate for service delivery.	S2.1: Staff turnover rates do not increase through change (outside of natural variation). S2.2: Reduction in use (and cost) of bank and agency staff and overtime. S2.3: Compliance with EWTD. S2.3: Improvement in annual NHS Staff survey re morale / motivation	Y Y Y Y	Director of Workforce	Run-chart of staff turnover rates. Run-chart of costs. Graph of % compliance. NHS Staff Survey Results

ID	Perspective	Anticipated Benefits	Measurement(s)	Currently Monitored? Y/N	Owner	Measurement Method
E2	Environment	Improvement in the environment at WGH.	E2.1: PEAT scores? E2.2: Reduction in immediate capital budget spending on infrastructure? E2.3: Availability of 'backfill' higher quality equipment? E2.4: Utilisation rates of new items of major equipment?	Y Y Y Y	Director of Planning	tbc
F2	Finance	AAU 'breaking even' against its budget. Workforce costs ???	F2.1: Comparison of AAU expenditure against income, based on tariff agreed with PCT. F2.2: Reduction in staff costs as outlined in Business Case?	N Y	Director of Finance	AAU budget report. Trust finance report?

ID	Perspective	Anticipated Benefits	Measurement(s)	Currently Monitored? Y/N	Owner	Measurement Method
P2	Trust Performance	The Trust maintains performance against its key performance targets.	P2.1: Achievement of A&E 4-hour waiting time target. P2.2: Achievement of 18-week waiting time target. P2.3: No increase in readmission rates. P2.4: Reduced average length of stay for emergency patients. P2.5: Reduction in delayed transfers of care.	Y Y Y Y Y	Director of Delivery	Chief Executives Weekly Report (Balanced scorecard / DOH Quality matrix due for release late 08)
N2	Wider NHS	Service benefits (& disbenefits) captured above are disseminated within wider NHS.	N2.1: Service outcomes captured and reported in clinical and managerial journals, along with relevant lessons learnt. N2.2: WHHT service nominated for good practice awards.	N	Director of Delivery	AAU manager and other relevant Trust staff to have time designated for completing submissions.

2.3 Strategic Benefits Realisation Plan

The plan below uses the benefits outlined in the original Business Case wherever possible and identifies measurements that will enable the Trust to assess whether that particular benefit has been derived.

ID	Perspective	Business Case Benefit	Measurement(s)	Currently Monitored? Y/N	Owner	Measurement Method
P3	Patient Care	▪ To improve the effectiveness of the clinical services in order to meet national performance and quality targets.	P3.1: Reduction in LOS for emergency patients. P3.2: No increase in readmission rates. P3.3: Improved national patient survey results.	Y	Director of Delivery	Chief Executive's Report.
S3	Staff	▪ To reduce staff costs by facilitating significant service redesign by 2007-08 (now 08-09).	S3.1: Reduction in staff costs against 06-07 baseline.	Y	Director of Finance	Finance Report.

ID	Perspective	Business Case Benefit	Measurement(s)	Currently Monitored? Y/N	Owner	Measurement Method
E3	Environment	▪ To provide a robust platform to enable the Trust to secure the development of an affordable new acute hospital by 2014 for West Hertfordshire	E3.1: All new AAU areas and major equipment items being fully utilised. E3.2: Trust has achieved Foundation Status. E3.3: Business Case for new acute hospital in progress.	N Y Y	Director of Planning	Board Papers
F3	Finance	▪ To improve efficiency and productivity of all clinical and non-clinical services to reduce unit cost to at or below tariff. ▪ To facilitate a significant reduction in the cost base of the Trust, enabling the Trust to provide high quality services to its patients at tariff.	F3.1: Trust performance against tariff (reference costs). F3.2: Financial improvement as outlined in original Business Case and included as Appendix III	Y Y	Director of Finance	Standard financial reporting & monitor rating. Standard financial reporting.

ID	Perspective	Business Case Benefit	Measurement(s)	Currently Monitored? Y/N	Owner	Measurement Method
P3	Trust Performance	▪ To ensure the Trust can meet its statutory obligations no later than 2008/09	P3.1: The Trust maintains performance against its key performance targets. P3.2: Monitor rating.	Y Y	Chief Executive	Balanced Scorecard

APPENDIX I – BENEFIT PROFILE

BENEFIT DESCRIPTION	
Benefits Realisation Stage:	Post-Project Evaluation / Operations Review / Strategic Benefits
Benefit ID & Title:	*Give ID eg P1, S2 etc and Title as per plan above*
Outcome Description:	*Give description of desired outcome as per plan above*
Benefit Owner:	*Give name & title*
MEASUREMENT PLANS	
Measurement 1	
Description:	Give description of measure as per plan above
Type:	*State if Financial / Qualitative / Quantitative*
Measurement Method & Frequency:	*State how data wil be collected ie CHKS data, via PAS etc. Whether data will be collected daily, weekly, monthly etc*
Reporting Format:	*State how the data will e presented eg SPC chart etc NB: Give example wherever possible.*
Already Reported to:	*State if the measurement is already regularly reported and if so, where and how often.*
Baseline Value & Date:	*Give date of baseline data NB: Give Oct 07 and Oct 08 values wherever possible.*
Target Value & Date:	*State if there is a agreed target value and the date by which this should be achieved.*
Data Collector:	*Give the name of the person who will collate the data and present it in required format.*
Resource Requirement:	*State any ADDITIONAL resources needed to collate required data*
Measurement 2	
Description:	Give description of measure as per plan above
Type:	*State if Financial / Qualitative / Quantitative*
Measurement Method & Frequency:	*State how data wil be collected ie CHKS data, via PAS etc. Whether data will be collected daily, weekly, monthly etc*
Reporting Format:	*State how the data will e presented eg SPC chart etc NB: Give example wherever possible.*
Already Reported to:	*State if the measurement is already regularly reported and if so, where and how often.*
Baseline Value & Date:	*Give date of baseline data NB: Give Oct 07 and Oct 08 values wherever possible.*
Target Value & Date:	*State if there is a agreed target value and the date by which this should be achieved.*
Data Collector:	*Give the name of the person who will collate the data and present it in required format.*
Resource Requirement:	*State any ADDITIONAL resources needed to collate required data*
Repeat for all further measures as required.	
CONCLUSION	
Benefit Delivered:	Yes or No
Comment:	*Comment if required to support conclusion*
Further Work:	*Outline any further/ongoing work required*

APPENDIX II – INDIVIDUAL SERVICE QUALITY INDICATORS

The service quality indicators included here are those that individual services have identified within their operational policies. However, it is hoped that work with the Kings Fund will enable the Trust to ensure it has a robust means of measuring the impact of DaHF on the quality of patient care.

Service	Service Element to be monitored	Method of measurability	Frequency of Monitoring	Responsibility
AAU	Quicker Diagnosis: ▪ 2 hour turnaround from admission to completion of initial diagnostic tests. ▪ 6 hour turnaround from admission to treatment pathway decision by senior clinician. ▪ Care pathways in place for high volume conditions. Improved infection control: ▪ Isolation of all infectious patients. Rapid discharge of patients: ▪ Discharge of 55% of patients within 48 hours. Activity levels: ▪ The AAU will admit approximately 24,000 patients each year and the anticipated daily admission rate will be between 65 and 90 patients.	tbc (PAS or BMS?) tbc (PAS or BMS?) Protocols in place. PAS data? PAS data PAS data	All to be routinely reported on a monthly basis	AAU Manager

Service	Service Element to be monitored	Method of measurability	Frequency of Monitoring	Responsibility
Cardiology / Cath Labs	▪ Reduced time to procedure. ▪ All AAU cardiac diagnosis patients seen by cardiologist within 24 hours. ▪ All cardiac inpatients seen in cath lab within 78 hours and with a median of 48 hours. ▪ Reduction in average LOS patients with a cardiac diagnosis ▪ Repatriation of cardiac procedures that would previously have been referred to tertiary centres.	tbc PAS data? PAS data PAS data PAS activity data	All to be routinely reported on a monthly basis.	Cardiology Service Manager
Pathology	Diagnostic testing and Consultant advisory service will be provided on selected tests with a rapid turn around of two hours for blood tests for the AAU, seven days a week and 24 hours a day. User satisfaction questionnaire.	Sampling protocols will be in place. Investigation of alerted outliers. Issue questionnaire	3 monthly As they occur Annually	Pathology Service Manager
Pharmacy	1. Audit of TTA waiting times (Target- 2 hours from receipt to ready) 2. Drug histories for patients admitted taken by pharmacy and entered onto Infloflex (Target-90% entered)	Audit undertaken by pharmacy staff Audit undertaken by pharmacy staff	Every 3 months Every 3 months	Chief Pharmacist.

Service	Service Element to be monitored	Method of measurability	Frequency of Monitoring	Responsibility
Radiology	Audit of patient waiting times for CT, Ultrasound and General Imaging in AAU. 90% of all requests accepted during normal working hours (0800 – 2000 Monday to Friday) will be performed within two hours and 100% within six hours of the patient being available for Imaging (to allow for patients being stabilised, having other tests etc.)	Request forms entered onto CRIS on requested list – indicating time of receipt. Compare to examination time on CRIS.	Every 3 months	Radiology Service Manager.
	Report turnaround times – measured in hours that Clinicians wait for a report post Imaging procedure. In 90% of cases, during normal working hours, a report will be available post Imaging examination within three hours. In 100% of cases, during normal working hours a report will be issued within 6 hours – assuming voice recognition software available. Images will be available immediately post procedure on PACS.	Examination time on CRIS. Compare to time typed onto CRIS.	Every 3 months	
	Patient satisfaction questionnaire.	Issue questionnaire.	Every 6 months	
	User satisfaction questionnaire.	Issue questionnaire.	Every 6 months	

NB: OTHER SERVICE KPIS TO BE ADDED – STANDARD SET OF WARD QUALITY INDICATORS CURRENTLY BEING DEVELOPED BY CORPORATE NURSING TEAM

APPENDIX III – DaHF BUSINESS CASE FINANCIAL ASSUMPTIONS

Taken from 'DaHF Benefits Realisation II' Document, by T Pearce, January 2007.

Trust has identified a gross amount of savings of £21 million against a Do Nothing option. Some of these savings are driven by a reduction in activity, giving a net reduction in costs against a Do Nothing of £11 million. Of the £11 million £4.5 million is a cost avoidance against Do Nothing for implementation of European Working Time Directorate and a further £600,000 additional cost of provision of CT scanning etc. as result working on two acute sites. The reduction in income of £9.7 million is offset against a reduction in clinical pay costs of £5.3 million

The Trust is assuming an overall reduction in income between 2007/8 and 2010/11 of £23 million as a result of the move to Watford and PCT commissioning intentions

This can be summarised as follows:

2007/8 to 2010/11			
	Total £m	PCT Commissioning intentions £m	Watford £m
Loss of income	27.0	17.0	10.0
UCC Recharge	-2.8	-2.8	
Transitional Charge	-1.6	-1.6	
Net Loss of income	22.6	12.6	10.0

Of the total loss of income £2.8 million is assumed to be recharged to the PCT for the UCC accommodation at Watford and the staffing of the Watford UCC.

The FBC assumes this reduction in income will be met in the following way:

	Total £m	PCT Commissioning intentions £m	Watford £m
Reduction in Staff costs - Activity/Performance	14.3	8.6	5.7
Reduction in Staff Costs - Site Rationalisation	4.0		4.0
Reduction in non pay - Activity	5.8	3.7	2.1
Reduction in Hemel A&E Costs (Recharge to PCT?)	2.6	1.7	0.9
FYE of Turnaround	4.3	4.3	
Additional Cost Pressures (inc Backlog Maintenance)	-5.9	-3.5	-2.4
Additional Estate Savings	5.9	0.0	5.9
Additional Estate and activity Costs	-6.3	-4.0	-2.3
Total	24.7	10.7	14.0

This breakdown reflects the impact of the PCT commissioning intentions on the income the Trust receives and the potential scope for cost improvements. n The cost reductions have been offset by the following:

Allowance for additional costs to offset the increase income related to non pbr outpatients activity assumed £2.9 million in 2010/11 increasing to £5.6 million in 2013/14.
Off set of estates savings as a result of the Trust owning outreach activity done at St Albans and Hemel Hempstead. £3.4 million offsets the £8.8 million savings.
Hemel A&E staff costs are assumed to be recharged to the PCT
Additional cost pressures, such as the revenue consequences of backlog maintenance and an assumed .5% of income of cost pressure not funded through tariff. These costs, which may not occur or may be funded through Tariff are assumed to be £5.9 million in 2010/11 growing by £2 million per annum.

Savings are based on current average costs but do not reflect recent changes in workforce establishments (identified by Shared Solutions) This reflects a risk from 2 perspectives, the savings per bed will reduce as the cost base is lower (Sylvette to confirm if this was allowed for) The opportunity for further savings beyond bed reductions on nursing workforce will be limited to benefits from consolidating services on one site and better clinical adjacencies

Summary of Financial Savings

Benefit	Savings £000	Comment	Potential Downside £'000	Potential Upside £'000	Strategy for management	Key Personnel
Medical staff savings	1500	Assumed savings of 33 non training grades and 24 training grades. Potential saving of circa £2.5 million plus Confirmation required from Director of Clinical Education to be fed through into financial management teams. CF changes for Orthopaedics for St Albans. (nb the savings at St Albans e.g. Orthopaedics were always part of the overall DAHF savings) Issue re need to maintain junior doctors re EWTD needs to be resolved	1,000. Based on extra consultant requirements in AAU	2,800 based on reduction in 33 non training grades @£70,000 and 24 training grades @£20,000	Confirm position with Director of clinical education/ review phasing of savings review in the context of reductions in workforce as a result of reduction in activity	Ian Barrison/ Graham Ramsay. Medical Workforce Planning Lead
Nurse and clinical staff savings	1500	Assumed savings based on a percentage of savings identified by Shared solutions. In setting new establishments, the added benefit of delivering all acute services on one site including management of absence and cover of absence. Bigger pools of staff to cover absence . Need to examine the initial work Shared solutions developed and what can not be achieved as a result of current site configuration. In addition to this Therapist support needs to be examined in the context of current performance targets. i.e the reductions in lengths of stay were identified as a result of site consolidation not be putting more demands on the therapy staff.. ditto pharmacy Need to clarify skill mix assumptions If requirements for staff are greater than	500	1,500	£1,500,000 was based on 50% of the savings identified by shared solutions in its initial work. Need to confirm what has already been achieved. Review requirements from directorates re AAU etc. Review latest work from Shared solutions and compare with original work. Need to then agree implementation with Directorates	Sarah Childerstone/ Gary Etheridge/ Divisional Managers Nurse Heads

Benefit	Savings £000	Comment	Potential Downside £'000	Potential Upside £'000	Strategy for management	Key Personnel
		in the financial model, need to review performance assumptions, as current assumptions could be argued not to be particularly aggressive Nb Radiology and Pharmacy costs currently incurred will reduce on opening of AAU (had to be increased for St Albans)				
Management costs	1000	Trust's management costs are significantly greater than average even accounting for multi site trusts. The consolidation of services will enable the savings of management and administration costs: Site management costs (pre and post Hemel) Directorate and corporate structure Risk management Medical Secretaries; Admissions/ Waiting list staff £1 million represents a reduction down to 4% still higher than average	500	2,000	Based on the post delivery of DAHF Trust is a new organisation. Therefore dependent on new management structure to support new ways of delivery. Needs to reflect a reorganisation post DAHF	Chief Exec/ Nick Chatten
Site Rationalisation						
Capital charges Hemel Hempstead	3,800	As result of getting off Hemel Site off set by recharge for use of some of Hemel Site. Dependent to a large extent on resolution of Hemel site issues but a chunk of capital charge savings can be realised early and this needs to be reconciled to impairment finding agrees/applied for.	0	4,000	Based on saving all Hemel capital charges off set against costs of Pathology rental etc. May be higher die to Pathology etc requirement and indexation	Ross Dunworth/Tony Bettridge
FM Costs	800	Medirest contract needs to be	400	1,600	May be some penalties	Paul Mosley

Benefit	Savings £000	Comment	Potential Downside £'000	Potential Upside £'000	Strategy for management	Key Personnel
		reviewed in relation to the service still to be provided at Hemel and the uplifted service at Watford. Also need to review Hard FM costs. FM costs were reduced to reflect the marginal savings from reducing the estate at Hemel			for contract change. However the amount of saving may be higher. Subject to medirest discussions	
Capital charges St Albans	1700	This relates to non elective care centre estates charges assumed to be picked up by the PCT. This is offset in the financial plan by payment to the PCT for the estates costs and as a result of maintaining responsibility for the activity. This needs to be clarified and reviewed.	1,000	1,700	Review income expectation from PCT. Review alternative uses of St Albans long term.	Nick Chatten/ Ross Dunworth
Utilities	1400	Net reduction as a result of the closure of Hemel increased slightly by AAU. Need to review	500	1,400	Dependent on utilities rates also includes rates etc.	Paul Mosley
Capital Charges AAU/ Watford	(2200)	Based on a 40 year life of the AAU. Need to review with DV real value. Also includes £4 million of equipment at 10 year life,	(4,000)	0	Dependent on DV valuation. PDC issue offset by higher than expected interest rate	Ross Dunworth
Other Assumptions in the Financial Plan						
Revenue implications of Backlog maintenanc e	£1,000 in 2008/9 increasing by £1,000 every year	This needs to be reviewed on a regular basis and can be used as a reserve against non achievement of savings elsewhere	(1,000) increasing by £1,000k per year	0		Paul Mosley
Non recurrent costs	£5,000,000 over 3 years				Need to review non recurrent costs: Transitional costs (some allowance in the capex) Double running – extra costs during transition (e.g. potential Helen	Ross Dunworth/ Sarah Childersone

Benefit	Savings £000	Comment	Potential Downside £'000	Potential Upside £'000	Strategy for management	Key Personnel
					Donald costs) Redundancies – review age profiles etc, Equipment write off may be funded through NHS Bank funding. TP also drafting letter to SHA re PDC/IBD issue and will include request for transitional funding	
Other unfunded cost pressures	Circa additional £1m per annum	This needs to be reviewed on a regular basis and can be used as a reserve against non achievement of savings elsewhere	(1,000) increasing by £1,000k per year	0		
Tariff issues		Currently assumed tariff is adjusted for inflation but addresses cost pressures (apart for the .5% provision above) Issues such as EWTD may be funded and therefore give the Trust a gain. The proposed changes to Tariff will also potentially benefit the Trust				

Any savings not achieved against the financial plan will need to be offset against the provision for extra cost pressures. This also needs to be reviewed against:

- Uplifted activity and income assumptions (2006/7 activity, new tariffs may increase income position but need to assume 3% CRES);
- Latest position on Cost Improvement/ Turnaround programme;
- Provision for Transitional costs

The above table should be used as a monitoring tool to review and manage the financial consequences of DAHF. To be reviewed at Financial Working Group.