The Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust

ANNUAL OPERATING PLAN

2011/2012

Final Version
20 April 2011
Mike Court

Delivering Outstanding Patient Care

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Section 1- Chief Executive's summary

This document represents the Trust's Annual Operating Plan. It is a summary of our objectives for 2011/12 that will take us towards the achievement of our vision.

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

The Trust is moving into 2011/12 on a very positive base in terms of our performance as an organisation. The Trust continues to deliver high quality care to its patients as evidenced by the very low rates of infection and achievement of very high levels of patient satisfaction. We continue to focus on enhancing the patient experience by improving the patient pathway. All of this has been achieved at a time when the demand for our services continues to grow. Our financial performance continues to be strong with a current forecast outturn of £1.6m surplus.

We will complete a major development to improve the patient experience with the completion of the new main entrance. Work will also continue on the three key service developments to improve patient pathways; improving access for patients, minimising their stay in hospital and improving admissions and discharge arrangements.

During 2011/12 the Trust will achieve our ambition to become an NHS Foundation Trust, which will grant us the earned autonomy to manage ourselves, to work actively with our members through the Council of Governors in shaping future services for the benefit of our patients.

This plan outlines our main objectives for 2011/12 and the resource assumptions which constitute our financial plans. It also identifies the main risks in terms of delivering the Annual Plan.

Wendy Farrington Chadd
Chief Executive

Section 2 - Review of the past years performance

2.1 Introduction

RJAH Orthopaedic Hospital is one of the UK's five specialist orthopaedic hospitals providing specialist and routine orthopaedic and related care to patients locally, regionally and nationally. In addition the Trust is a specialist centre for complex and revision orthopaedic surgery for adults and children, together with providing a regional spinal injuries service and bone tumour surgery.

Our two largest commissioners are Shropshire County Primary Care Trust (the local host PCT) and Betsi Cadwaladr University Health Board in North Wales. Other commissioners are predominantly located in the North West, Mid and West Wales and the West Midlands. Our spinal injuries services are commissioned regionally through the West Midlands, North West and Wales specialist commissioners.

The demand for our services continues to grow as a result of the excellent service the Trust has provided to its patients during the year, through the continuing focus on quality of care, operational efficiency, the investment in our staff and the environment within which we operate, whilst meeting the requirements of our commissioners all within the agreed financial envelope.

The balanced scorecard report covers the four domains of performance

- Quality – patient safety/clinical effectiveness;
- Quality – patient experience;
- Operational – efficiency;
- Operational – resources (finance, workforce, estates).

The performance of the in each of these areas is given below.

2.2 Quality performance in 2010/11

The Trust is totally committed to providing safe, effective and high quality orthopaedic and related care to all its patients. This is a strategic aim for the Trust and as such drives the annual and overall five year strategy, as given in the Integrated Business Plan.

During the year the Trust has developed a Quality Improvement Strategy for the next five years. This focuses on how to continuously improve the care provided to the patient, and their pathway through the organisation. The document includes annual Quality Development plans for each year of the strategy.

In June 2010 the Trust produced a Quality Account for 2009/10. This report provided details of how the Trust measured its performance related to quality, the Trust's approach to safety, clinical effectiveness and patient experience. It highlighted the very good performance during the year and noted the quality improvements intended for 2010/11.

The Trust's quality performance during 2010/11 has been excellent as measured through the balanced scorecard, which reports on the three elements of quality (safety, clinical effectiveness and patient experience), plus operational, workforce and financial performance.

Notable results regarding quality for 2010/11 are:

- Excellent infection control rates
  - No MRSA bacteraemia
  - Two cases of Clostridium Difficile;
- One serious incident (8 in 09/10);
- Improved management of medicines;
- Achievement of specific CQUIN targets;
- Extremely high level of patient satisfaction (>97%);
- Reduction in complaints whilst treating more patients;
- Patient waiting time targets met for referral to treatment (18 weeks for England and as requested for Welsh commissioners);
- CQC target for number of patients who had their operation cancelled met;
- WM SHA target for number of patients whose discharge was delayed met;
- CQC registration without conditions.

2.2.1 Patient safety

The Trust works in partnership with the National Patient Safety Agency (NPSA) and has implemented the recommended seven steps to patient safety: - build culture, lead staff, integrate risk, promote reporting incidents, involve patients and public, learn lessons, and, implement solution to prevent harm.

The Trust has also successfully implemented the World Health Organisation (WHO) patient safety campaign as part of plans to continuously improve clinical governance. The Patient Safety First campaign focuses on the implementation of five interventions, leadership for safety, reducing harm from deterioration, reducing harm in critical care, reducing harm in perioperative care (included adopting the WHO safe surgery checklist) and reducing harm from high risk medicines.

2.2.2 Clinical Effectiveness

Clinical effectiveness within the Trust continues to be measured through:

- Balanced scorecards from Board to ward;
- Audit, evidence, guidelines and standards to identify and implement best practice based on National standards and recommendations;
- Quality improvement tools, (such as clinical audit, evaluation, rapid cycle improvement) to review and improve treatments and services based on:
  - The views of patients, service users and staff;
  - Evidence from incidents, near-misses, clinical risks and risk analysis;
  - Outcomes from treatments or services;
  - Measurement of performance to assess whether the team/department/organisation is achieving the desired goals;
  - Identification of areas of care that need further research.

2.2.3 Patient Experience

Enhancing the patient experience at the Trust continues to be central to the care the Trust provides irrespective of the stage in the patient journey and pathway of care. To further enhance the experience a number of initiatives have been successfully implemented during the year:

- Involving patients to shape future care delivery within the Trust using patient stories and diaries, which are presented at committee level and fed back to the Quality and Safety Committee;
- Improved patient care pathway: ADOS (admit on day of surgery) and EDD (estimated date of discharge for most patients);
- Enhanced recovery programme: the development of education programmes for patients at 'joint school' including provision of patient DVD's;
- Privacy and Dignity: eliminating mixed sex accommodation and providing same sex bathrooms across all wards;
- Maintaining high standards of cleanliness initial report following the PEAT inspection as excellent.
- Completed pilot of availability of wi fi for patients across the hospital. Full roll out to take place in 2011/12.

2.3 Operational performance in 2010/11

Operational performance this year has been strong meeting local and national performance indicators.

2.3.1 Demand for services

The Trust has seen a growth in referrals to the hospital over the last year. This reflects an increase in the demand for our services. During the year the Trust has appointed additional consultants to spinal disorders, arthroplasty, rheumatology and anaesthetics.

2.3.2 Activity

The Trust has met the contractual plan set by our commissioners. The level of activity compared to last year is shown in the table below

Type	2009/10 Actual	2010/11 Forecast	% difference
First outpatient attendance	23,459	25,225	+7
Follow up outpatient attendance	55,608	57,925	+4
Elective finished consultant episodes	14,912	15,373	+3
Emergency finished consultant episodes	926	824	-11

Excludes spines NCAs, private patients and therapies

2.3.3 Patient access

The referral to treatment waiting times for admitted and non admitted English patients of 18 weeks have been achieved during the year as were waiting times requested for Welsh commissioners.

A number of patients have also been transferred from North Wales to reduce their waiting times.

2.3.4 Patient experience and operational efficiency

The Trust has been working to improve the patient experience. Some key operational achievements during the year are

- Increased the number of patients treated as day cases;
- Introduced phased admission to overcome long waits for patients once they are admitted;
- Reduced the number of patients who have been cancelled on the day of their surgery;
- Reduced the length of stay (includes elective inpatients and day cases) as a result of the introduction of enhanced recovery, improved patient education and seven day working of support services. The average length of stay for hips and knees has reduced from 6.5 to 5.4 days;
- Overall length of stay (elective inpatients and day cases) reduced from 2.8 to 2.6 days (annual averages for 2009/10 and 2010/11 respectively).

2.3.5 Readmission rates

The Trust continues to provide successful clinical outcomes as measured by the extent of readmissions to the hospital (on average approximately 1%).

2.4 Workforce performance in 2010/11

2.4.1 The Trust undertook a considerable amount of work relating to improving communication, engagement and involvement of staff within the Trust, including the completion of an externally funded project to improve partnership working within the Trust. This resulted in the principles of staff partnership being agreed; a management of change policy, toolkit and training; and a communication focus group. During the year HR management and staff side representatives have worked in partnership to review the HR policy framework.

2.4.2 The 5 year workforce plan is revised annually, and this year it has been closely aligned to planned/predicted activity and service change through the business planning process. The specific issue of succession planning was formally addressed in relation to critical posts, and this now forms an annual process which is being cascaded into all areas of the Trust.

2.4.3 The Trust continues to undertake leadership and management development based on individual assessment and need, for example: Aspirant Directors Programme, Lean Master Class.

2.4.4 Throughout 2010/11 the HR department has been working with the Trust to reduce sickness absence from 4 to 3.5% which led to the introduction of a fast track physiotherapy service for staff and the launch of a staff health and wellbeing strategy, Health Horizons.

2.4.5 The development of the Enhanced Recovery programme provided the opportunity for the establishment of the new role of therapy support workers. Workers of the future have been supported through the Trust's apprenticeship and work experience programmes.

2.4.6 The HR department has been working closely with managers to reduce escalating bank and agency costs through the HR productivity meetings established later in the year.

2.4.7 HR performance against key performance indicators have been regularly reported to the BRIC committee and the Trust Board. The HR department has increased the extent of reporting and activity tracking to ensure compliance with key legislative and NHS requirements, particularly relating to pre-employment checks.

2.5 Financial performance in 2010/11

2.5.1 The Trust's financial performance for the year was excellent:

- A forecast £1.6m (pre impairment) surplus against a target of £1.3m;
- the achievement against Monitors Compliance Framework of a level 4 Financial Risk Rating (5 being the best);
- A £2.8m efficiency programme against a target of £2.8m;
- Cash balances of £3.9m against a plan of £3.1m;
- An investment in our assets of £3m;
- Timely payment of our suppliers with 95% paid within 30 days.

2.5.2 The table below highlights our key financial performance metrics:

	Annual Plan	Forecast	Variance %
Income	79.43	81.72	2.9%
Expenditure	-74.04	-76.01	2.7%
EBITDA*	5.4	5.71	5.7%
Financing Costs	-4.10	-4.09	-0.2%
Net Surplus	***1.30***	***1.62***	***24.6%***
CIP	2.84	2.84	-
Financial Risk Rating	4	4	-
Capital Expenditure	4.0	3.06	-25.0%
Cash	3.12	3.90	25.0%
Better Payments Practice Code	95%	95%	-

*Earnings before Interest Tax Depreciation and Amortisation

This performance is particularly pleasing given the challenging financial environment public sector bodies are operating within. Some key highlights are detailed below.

2.5.3 Income

The Trust has treated more patients than ever before as the demand for its services grow. In addition the complexity of the cases we treat has also increased recognising the demand for some of our more specialist work. From this the Trust earns additional income from our commissioners. We have seen the Trust over performing against most of our contracts driving additional income levels. We have worked closely with our commissioners to ensure the activity levels we have delivered are affordable and our relationships in the local health economy are strong.

The Trust also treats a number of private patients which also saw an increase during 2010/11 supporting our overall financial performance.

2.5.4 Expenditure

In delivering additional and more complex activity the Trust incurred additional pay and non pay costs. In particular we invested in a number of services to improve the patient experience and further improving the safety of our patients. These include:

- Expanded critical care facilities to include an additional bed;
- The development of a patient outcome centre;
- Additional Consultant Surgeons, physicians and anaesthetists;
- Upgraded key IT systems including a new theatre system.

The successful delivery of our cost improvement programme has also supported our overall financial performance. We have been particularly focussed on ensuring that our cost improvements do not diminish the quality of our services and where we can improve. Some of the key schemes delivered in 2010/11 include:

- Delivering activity on the RJAH site previously carried out at other hospitals;
- Ensuring more of our activity is delivered in core hours;
- Reduced reliance on external agency and consultancy staff;
- Improved procurement arrangements, particularly for our expenditure on expensive implants;
- Improved leasing arrangements for medical equipment.

2.5.5 Capital

The cash we generate from delivering surpluses supports our investment programme in our assets. Whilst we planned to spend £4m on our Estate and Equipment we actually spent nearer £3m. This was due to the re-phasing of our most material capital scheme which is Redesigning the Hospital. The money we have not spent in 2010/11 has been held so that it can be invested in 2011/12.
During 2010/11 we have invested in the following:

- The start of the Hospital Redesign project which has included the total redevelopment of our outpatient area improving the patient environment and creating additional capacity;
- Supported generously by the League of Friends the Trust has commissioned a high specification 3T MRI scanner keeping us at the forefront of healthcare technology;
- Replaced medical equipment;
- Upgraded many parts of the hospital;
- IT systems to improve patient care.

2.5.6 Cash

Our cash balances have grown through the year driven by our increased surpluses and the re profiling of our capital expenditure plans. We plan in future years to continue to deliver surpluses allowing us to ensure we have cash balances that maintain our viability and allow us importantly to reinvest in our services.

The overall financial performance of 2010/11 has ensured we have met our objectives and importantly give us a sound base for delivering our future plans.

Section 3 - Business plan for 2011/12

3.1 Strategic aims and objectives for 2010 - 2015

3.1.1 Vision

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 leading 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"

Our mission is ambitious, however as a NHS Foundation Trust we will build on our strong local public and patient support, utilising the benefits of NHS Foundation Trust status to engage fully locally, regionally and in Wales, reinvesting in services to improve the quality of care we provide to patients. Becoming a membership organisation fits our ethos as a hospital with a strong patient and volunteer following, and a track record of working with our local communities who continue to support the hospital.

3.1.2 Strategic Aims

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 redesign the patient pathway to facilitate improved patient outcomes and increased productivity.
3. To develop a vibrant and viable organisation where people achieve their full potential and success leads to investment in services for patients.

3.2 Strategic context for 2011/12

The Trust's plan for 2011/12 has taken into account both national and local strategy, as detailed below.

3.2.1 National context

(i) Equity and Excellence: Liberating the NHS

The coalition Government published their ambitious plans for the NHS in a White Paper in July 2010. The plan had a simple aim: to deliver health outcomes for patients who are among the best in the world, harnessing the knowledge, innovation and creativity of patients, communities and frontline staff in order to do so.

(ii) The Health and Social Care Bill 2011

The government published the bill in mid January 2011. The Bill covers a number of key areas including:

- powers and duties of GP commissioning consortia, the NHS Commissioning Board, local authorities and the Secretary of State;
- abolition of PCTs and SHAs;
- the new public health service;
- changes to the pricing system;
- establishing information systems;
- economic regulation of health and social care services;
- a failure regime for providers;
- greater freedoms for Foundation Trusts;
- creation of HealthWatch England and health and well-being boards;
- changes to the function of NICE.

(iii) The Operating Framework for the NHS in England 2011/12

The Department for Health published the Operating Framework in mid December 2010. The overarching goal is to build strong foundations for the new system by: maintaining and improving quality; keeping tight financial control; delivering on the quality and productivity challenge; and creating energy and momentum for transition and reform.

As the NHS moves towards this new system, there is a need to meet rising demand while also continuing to improve performance and outcomes for patients. To achieve this, the NHS is being asked to cut waste, reduce bureaucracy and simplify NHS structures.

The key points of the Operating Framework are;

- NHS organisations have an extra year to achieve the efficiency savings target of £20 billion;
- £89 billion will be allocated to PCTs next year – an increase of £2.6 billion;
- PCTs will remain statutorily accountable in 2011/12 and 2012/13, but more clusters of PCTs will form next year;
- Some PCT staff will be allocated to emerging GP consortia;
- Alterations in tariff and non-tariff prices for providers are outlined;
- SHAs will hold back 2 per cent of PCTs' allocations to ensure funds are available to meet the costs of change;
- An outcomes framework has been published containing outcome goals to help focus on health improvements achieved.

The key priorities in the operating framework for 2011/12 include:

- continuing to reduce healthcare associated infections;
- reducing the emergency admission rate;
- eliminating mixed-sex accommodation;
- ensuring good and timely cancer screening services;
- being prepared to respond in a state of emergency, such as a pandemic flu outbreak;
- maintaining quality in public health;
- improving healthcare for people with a learning disability;
- paying greater attention to the physical and mental health needs of children and young people;
- ensuring good services for people with diabetes;
- addressing violence against women and girls;
- delivering good respiratory disease services;
- increasing access to psychological therapies;
- commissioning improvements in dentistry services;
- improving mental health services;
- improving stroke outcomes;
- ensuring good end-of-life care.

(iv) The NHS Outcomes Framework 2011/12

The Department of Health published the Outcomes Framework at the end of December 2010. Its purpose is threefold:

- to provide a national level overview of how well the NHS is performing, wherever possible in an international context;
- to provide an accountability mechanism between the Secretary of State for Health and the NHS Commissioning Board; and
- to act as a catalyst for driving quality improvement and outcome measurement throughout the NHS by encouraging a change in culture and behaviour, including a renewed focus on tackling inequalities in outcomes.

The NHS Outcomes Framework sets out the national outcome goals that the Secretary of State for Health will use to monitor the progress of the NHS Commissioning Board. The framework sets the direction of travel for improving quality and encourages a change in culture and behaviour, with a renewed focus on tackling inequalities in outcomes in five domains, (i) Preventing people from dying prematurely, (ii) Enhancing the quality of life for people with long term conditions, (iii) Helping people to recover from episodes of ill health or following injury, (iv) Ensuring that people have a positive experience of care; and (v) Ensuring people are treated in a safe environment and protecting them from avoidable harm.

3.2.2 Local context

As a result of the proposed Government plans for the NHS our major commissioner Shropshire County PCT has joined Telford PCT, Herefordshire PCT and Worcestershire PCT to form a cluster PCT.

GP commissioning groups continue to be formed within the boundaries of our current commissioners. Within Shropshire a single consortium has been formed which represent all bar one GP practice. Single consortiums have also been formed in Telford and West Cheshire, whereas three consortia have been formed in Central and Eastern Cheshire PCT region.

3.3 Key objectives for 2011/12

All the key objectives that the Trust intends to achieve during 2011/12 are given in the Trust Business Plan (see appendix 1). Each objective in the Trust Business Plan clearly states who the executive/clinical/managerial lead is, what the target/measure is, which quarter it will be achieved by, and the risk to the Trust should the objective not be achieved.

All the objectives that each division intends to achieve during 2011/12 are given in the relevant Divisional Business Plans which are structured in exactly the same manner as the Trust Business plan.

The objectives given in the Trust Business Plan have been obtained by selecting the key objectives from within each of the Divisional Business Plans.

The key corporate objectives for 2011/12 are summarised below

Strategic aim 1

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

- Maintain CQC registration;
- Deliver very low rates of infection
  - MRSA bacteraemia 0 cases
  - C Diff <2 cases;
- Ensure patient satisfaction is very high (> 95%);
- Ensure commissioner requirements are fully met;
- Implement model of customer care;
- Maintain privacy and dignity;
- Maintain referral to treatment waiting times.

Strategic aim 2

To redesign the patient pathway to facilitate improved patient outcomes and increased productivity.

- Service development: Patient Access
  - Continue the drive to develop one stop diagnostic tests;
  - Role out community rheumatology service across Shropshire PCT area, as agreed with commissioners;
  - Redesign outpatients and develop outreach clinics in the community;
  - Ensure commissioners requirements are met;
  - Full roll out of expanded outpatient facility and integrated outpatient and anaesthetic led pre-operative assessment "one-stop shop".
  - Continue the hospital redesign project with completion of the main entrance improving the patient environment and access to the hospital.
- Service development: Surgery pathway
  - Maximise use of the new theatre information system to deliver theatre quality and productivities;
  - Improve the patient pathway for day care surgery maximising the use of the Menzies Unit

- Service development: Inpatient stay pathway
  - Continue roll out of the enhanced recovery programme, consistently applying the principles and pathways to all patients;
  - Initiate the co horting of other patient groups such as Spines and short stay patients into one area and day cases into the Menzies unit to reduce length of stay;
  - Develop uniform admission on day of surgery practices across all subspecialties and teams;
  - Continued drive towards improved discharge arrangements and partnership working with social care;
  - Develop common routes back into the service for patients experiencing issues post discharge.

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.

- Become a Foundation Trust;
- Ensure staff satisfaction is improved;
- Reduce sickness absence (< 3%);
- Maintain staff turnover (< 10%);
- Review skill mix in specific departments eg radiology, therapies;
- Continue staff training programme eg customer care;
- Complete the new main entrance to enable more efficient access to services;
- Implement Sustainability strategy;
- Expand the volunteers base and their scope;
- Successfully deliver the financial plan, including
  - Meet CIP targets
  - Roll out PLICS and embed in strategic decision making.

The patient experience will be improved by the increased availability of day surgery in Menzies and a reduction in the length of stay for patients. In addition completion of the new main entrance will improve the patient experience providing good access and excellent facilities in a friendly environment.

3.4 Operating resources

3.4.1 Workforce plan

Workforce planning has been strongly aligned to planned service provision and changes and long term financial management in order to accurately identify the workforce demand in the coming years.

Our planning assumptions provide for activity growth of 1.2%; however delivery of efficiencies will enable growth to be achieved without a comparable growth of the workforce. Overall, the workforce demand assumes a 7% reduction in workforce over a 5 year period, without compromising ability to deliver the planning assumptions for growth.

The impact of the planned activity and service development on the next 2 years can be seen in the table below.

Workforce	2011/12	2012/13
Consultants	69.5	70.1
Junior Medical	37	37
Nursing & Health support staff	263.3	252.4
Scientific, therapeutic & technical	155.2	156.2
Other clinical	270.8	260.9
Non clinical	262.3	255
Total Workforce	**1058.1**	**1031.6**

3.4.2 Finance plan

This section sets out in detail our financial plan for 2011/12 which is fully aligned to our five year Long Term Financial Model (LTFM) that has also been updated as part of the Trust's Integrated Business Plan (IBP).

In setting this plan, the principles of our financial strategy have been followed, namely to continue to plan for surpluses that can be used to:

- 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 future exposure to adverse events (downside risks).

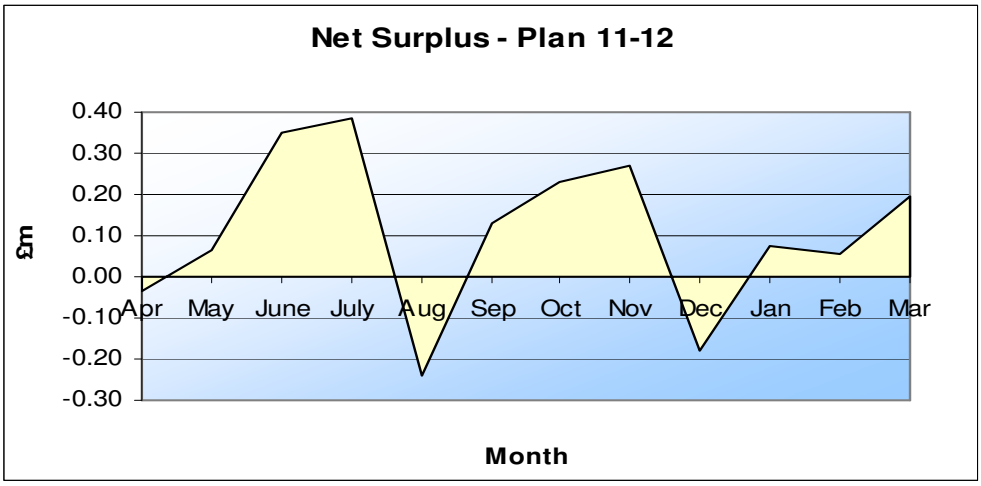
The table below sets out the key financial metrics planned for the year and compares these with the expected out-turn for 2010/11:

	Unit	Forecast 2010/11	Plan 2011/12	Movement	Movement %
Clinical Income - NHS	£m	72.00	72.30	0.30	0.4%
Clinical Income - Non NHS	£m	3.60	3.75	0.15	4.2%
Non Clinical Income	£m	6.12	5.76	-0.36	-5.9%
Expenditure - Pay *	£m	-45.28	-45.24	0.04	-0.1%
Expenditure - Non-pay *	£m	-30.73	-31.00	-0.27	0.9%
EBITDA	£m	5.71	5.57	-0.14	-2.5%
Finance Costs	£m	-4.09	-4.27	-0.18	4.4%
Net Surplus	**£m**	**1.62**	**1.30**	**-0.32**	**-19.8%**
CIP	£m	2.84	3.00	0.16	5.6%
Capital Expenditure	£m	3.06	5.29	2.23	72.9%
Cash	£m	3.90	3.00	-0.90	-23.1%

* net of CIP Plan

Robust in year performance monitoring will be key to the delivery of the plan and will follow the Trust's performance management framework.

Phasing of in year delivery is equally key. Detailed assessments have been made for clinical income and high cost areas of non pay as well as the expected call on inflation and development and pressure reserves. After considering these factors, a monthly delivery trajectory has been agreed as set out in the chart below:



This shows that we expect to deliver an overall net surplus in all months except for April, August and December when activity will be lower than normal due to the holiday season.

The key assumptions used in determining the above are set our below:

Clinical Income from NHS Contracts

We have set a clinical income target of £72.3m to cover the income we expect to achieve from our contracts with Commissioners. This is an increase of £0.3m from 2010/11 expected out-turn. The key points that underpin this are detailed below:

- National Tariff – The final impact of the grouper and tariff changes is a loss of £1.2m (2.5% of our total tariff income). This is inclusive of the national tariff deflation requirement of 1.5%;
- Local Tariffs - These have been deflated by 1.5% in line with the Operating Framework. However, we have successfully negotiated increases to a number of our local prices for Spinal Surgery and HDU having used our Service Line Reporting and Patient Level Costing data to support our position. Overall income from locally set tariffs has increased by £0.45m from 2010/11 levels equating to a 2.7% increase;

- Specialist Commissioners – Tariffs have been deflated by 1.5% but overall income levels are being maintained at 2010/11 levels due to a combination of an increased bed day tariff for Spinal injuries agreed with West Midlands Specialist Commissioners and retrospective funding for increased activity across our North West and Welsh Spinal contracts;
- Our overall tariff movement is a loss of £0.75m inclusive of deflation which equates to around 1% of our total NHS clinical income. This compares favourably against the national tariff efficiency which was set at 1.5% in the Operating Framework;
- Activity – We have agreed further growth of c400 elective cases across our English Commissioner base. This more than mitigates the loss of 150 cases from Betsi Cadwaladr as this commissioner continues to repatriate its more simple work in house. The assumption for Powys is currently based on 2010/11 out-turn, however we have been approached to offer a proposal to undertake additional cases which is currently being worked through. The net growth in activity is therefore 250 cases equating to an additional £0.85m of income;
- Orthotics transfer – The full year effect of the transfer of the Orthotics service from SaTH amounting to £0.3m. This income had previously been classified as non clinical;
- CQUIN – The schemes proposed for 2011/12 are as follows:

Goal	Description	Weighting
VTE	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	15.00%
Patient Experience	Improve responsiveness to personal needs of patients	10.00%
Medicines Management	Improvements in Medicines Management linked to the DoH provider checklist for safer more cost effective prescribing (3 indicators)	15.00%
Expected Date of Discharge	Improved recording of EDD in patient records and on the Hospital PAS, linked to patient engagement in agreeing EDD (2 indicators)	15.00%
Out patient rescheduling and communication	An improvement in the administration of outpatient appointments, to reduce re scheduling and improve patient communication	15.00%
Management of the Deteriorating Patient	Implementation of a modified trigger tool based on the national Alert Project	15.00%
Productive theatre - pre op waiting and post op pain management	Reduction in waiting times in pre-operative anaesthetic area prior to operation and improving post operative acute pain management (2 indicators)	15.00%

An additional CQUIN has been agreed regarding

Goal	Description	Weighting
Improving specialist rehabilitation services	Education on how SCI complications can be avoided pre and post rehab	80%

The level of income attached to these remains at 1.5% of contract values (£0.6m) CQUIN does not apply to Welsh contracts. A reserve of 10% of the total value of our CQUINs has been built into our expenditure plans to support delivery.

- Re-admissions – The Operating framework for 2011/12 contains a new ruling that Trust's are responsible for the costs of related re-admissions to NHS care within 30 days of discharge. This ruling that only applies to English patients will be transacted as an in year penalty adjustment against actual contract performance. An appropriately sized reserve based on an assessment by the West Midlands Contract Support Agency has been included within our overall income target to cover the potential consequences.

Non NHS Clinical Income

Private Patients

The plan assumes that the improved private patient activity experienced for the latter half of 2010/11 following a successful marketing campaign will continue throughout 2011/12. A small increase in prices has also been assumed as we begin to renegotiate our contracts with insurance companies. Overall income from private activities is expected to achieve £3.3m.

Injury Cost Recovery

With the additional provisions made in 2010/11 to cover future claim withdrawals we believe we can at least achieve 2010/11 out-turn. The plan for 2011/12 has been set on this basis.

Non Clinical Income

The plan expects levels of non clinical income to fall from 2010/11 levels by £0.36m. This is largely driven by a reclassification of the Orthotics service provided at SaTH that occurred mid way through 2010/11 and reduced recharges to other Trusts expected to occur during the year.

Pay

Overall pay budgets have been funded at broadly 2010/11 forecast out-turn after the application of a £1.5m CIP programme for pay. Pre CIP this equates to an increase of 3% on 2010/11 out-turn. This is inclusive of reserves for new developments and pressures. Highlighted below are some of the key drivers for the increase:

- Inflation - Only employees earning less than £21k to receive a pay award. This is expected to amount to £0.1m;

- Incremental pay progression as per agenda for change and the consultant contract terms and conditions totalling £0.3m;
- An increase in Employer's National insurance Contributions amounting to £0.2m;
- The appointment of additional consultant posts to support the delivery of the increased activity and to reduce Out of Job Plan payment; £0.3m;
- A new development reserve of £0.3m;
- Full year effect of 2010/11 appointments equalling £0.3m.

Non Pay

Overall our non pay budgets and reserves have been funded at £0.27m more than 2010/11 forecast out-turn after the application of a £1.5m CIP programme. Pre CIP the increase is £1.77m, a 5.8% increase on 2010/11 out-turn based on the following:

- Reserves set aside to cover likely in year inflationary pressures. Set at 2.5% of current non pay spend with additional sums set aside for energy and drugs; £0.65m;
- Additional reserve for the ongoing impact of the VAT increase, £0.3m;
- Marginal cost reserve of £0.3m to cover the costs of performing the additional activity contained within the plan;
- Full year effect of the new leased MRI scanner;
- Reserve to ensure costs of delivering CQUIN schemes.

Finance Costs

We expect our financing costs to rise by £0.22m mostly associated with increased capital charges associated with the new capital developments.

Cost Improvement Plan

The Cost Improvement target for the year is £3m which equates to 4% of our operating expenditure and has been set at the level recommended in the Operating Framework.

Schemes have been identified totalling £3.27m thus offering some protection from non achievement in year. The split between pay and non pay is broadly equal with the table below illustrating how the programme is expected to be delivered.

2011/12 CIP Plan	
Theme	Plan £m
Improve Operational Efficiency	0.96
Realsing benefits of technologyTechnology	0.16
Improved Contributions	0.07
Workforce productivity	0.97
Back office	0.41
Estates rationalisation	0.14
Tactical/Miscellaneous	0.56
Total of schemes identified	3.27
Target	3.00
Over Identified	0.27

The themes detailed above are fully aligned to the principles of QIPP and are further defined below:

- Improving operational efficiency – linked to target improvements in KPI's with a particular emphasis around theatre efficiency and reduced length of stay;
- Realising the benefits of technology – Investment in new technology and the implementation of new information systems;
- Improving contributions – Reviewing our trading arrangements with other organisations;
- Workforce productivity – Targeting a reduction in bank and agency spend linked to improved sickness and absence management. Additionally optimising skill mix across all areas;
- Back office function productivity – A reduction in the cost of delivering our non core services enabled through benchmarking and market testing;
- Estates rationalisation/sustainability – Benefits derived from the planned upgrades and rationalisation of the Trust's estate linked to capital investment plans.

All of the identified schemes have been signed off by nominated operational and executive leads. As part of the sign off process, a quality impact assessment has been completed to ensure no adverse impact on patient care.

Capital Programme

The capital plan for the year has been agreed by the Capital Planning Group and is detailed in the table below:

Future Capital Programme	2010/11 Forecast £m	2011/12 Plan £m
Rolling Investment Programme		
Backlog maintenance/Medical Equipment	1.35	0.90
Information Technology	0.20	0.20
Recurrent capitalisations	0.11	0.15
Sub-Total Rolling Investments	**1.66**	**1.25**
Strategic developments		
Hospital redesign/patient flow	0.86	3.38
MRI Scanner enabling works	0.40	-
Outpatients redesign	0.14	0.11
Orthotics Manufacturing upgrade	-	0.20
Movement Centre extension	-	0.07
Admissions and Discharge Unit (ADU)	-	0.08
X-ray Dept refurbishment	-	0.20
Sub-Total Strategic Developments	**1.40**	**4.04**
Total Capital Programme	**3.06**	**5.29**
Funded By:		
Depreciation	2.47	2.59
League of Friends (MRI scanner)	0.40	
Cash generated from surpluses	0.19	2.10
Trust Funds (main entrance)	-	0.60
Total Funding	**3.06**	**5.29**

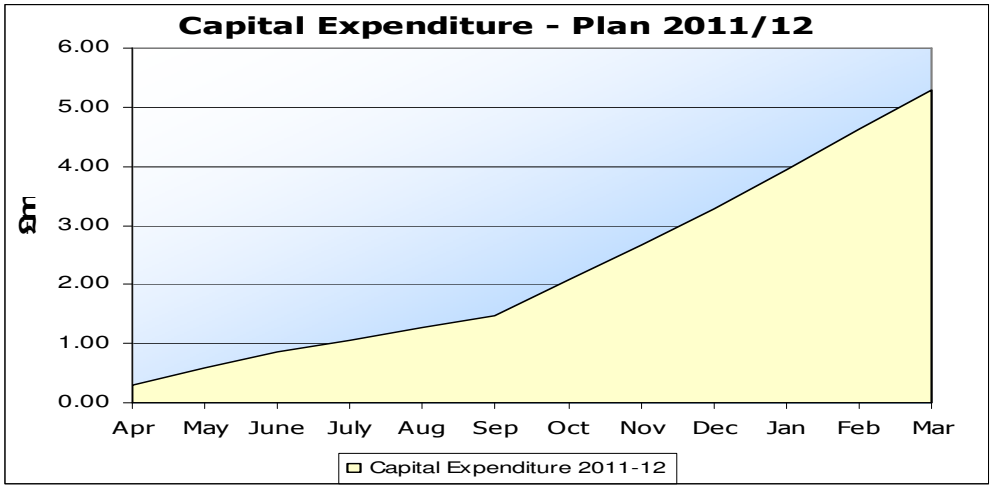
Included in 2011/12 capital plan are:

- Backlog maintenance – this covers the cost of backlog building maintenance and equipment refresh. The spend of £0.9m represents the standard £1.05m annual allocation less £0.15m spent ahead of schedule in 2010/11 as part of the revised capital plan. This allocation will be prioritised through the Capital Planning Group;
- Information Technology – to support the delivery of our IM & T Strategy;
- Hospital redesign scheme– the completion of the scheme including the relocation of the nurses' home accommodation updated parking arrangements and the building of the new main entrance;
- The relocation of the Orthotics Manufacturing unit which was originally scheduled to take place in 2010/11;
- The relocation of the Movement Centre which is subject to separate lease agreements;

- Admissions and Discharge Unit – a scheme to co-locate patients being admitted and discharged to and from the hospital to aid our plans to reduce length of stay;
- The beginning of a scheme to improve the patient facilities in the Imaging Department. This will ensure a consistent high standard of facilities through from the redesigned out patient through to X-ray. This scheme continues into 2012/13.

The total programme to be delivered amounts to £5.29m and will be funded from a combination of depreciation, surplus generated in year and opening cash reserves.

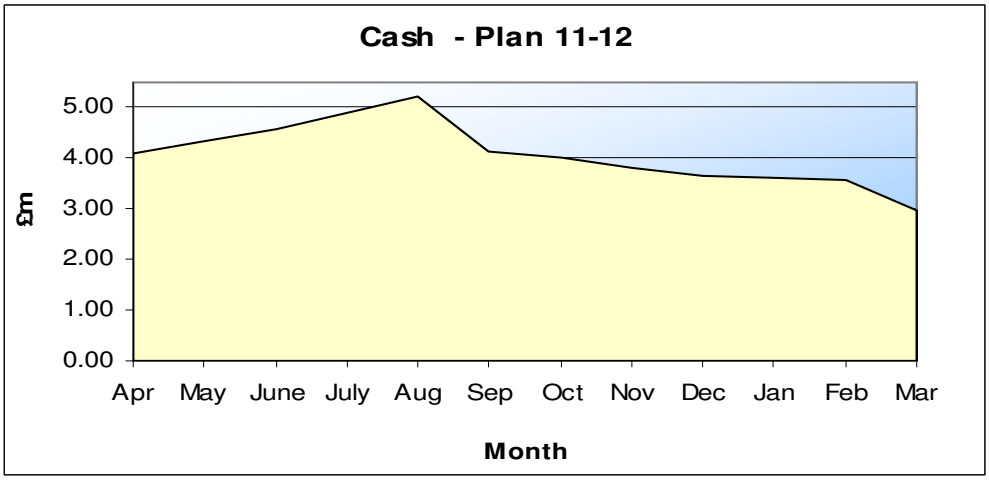
The phasing of the programme is detailed in the chart below:



Cash flow

Cash flow is expected to remain strong throughout the year with no loans or overdrafts planned against the working capital facility of £6m that will become live upon authorisation as a Foundation Trust.

The table below shows the monthly plan of cash balance after taking into account expected phasing of income, expenditure, financing charges, and capital expenditure.



As can be seen from this, we expect to end the year with £3m cash. Surplus cash balances will be invested throughout the year in line with the Treasury Management policy.

Risk Rating

The table below shows how the Trust's plan maintains an overall risk score of 4 (with 5 being the best) under Monitor's code of compliance:

Risk Rating	2010/11 Forecast £m	2011/12 Forecast £m
EBITDA margin	7.0%	6.8%
EBITDA, % achieved	106.4%	100.0%
ROA	6.3%	5.1%
I&E surplus margin	2.0%	1.6%
Liquid ratio	24.9	32.2
Risk Rating	**4**	**4**

Section 4 – Key risks

4.1 Risk management arrangements

As part of the annual planning process the Trust identifies its key corporate risks. These risks are then reviewed on a monthly basis through the Executive Team and quarterly through the Board sub-committees and Board Assurance Framework.

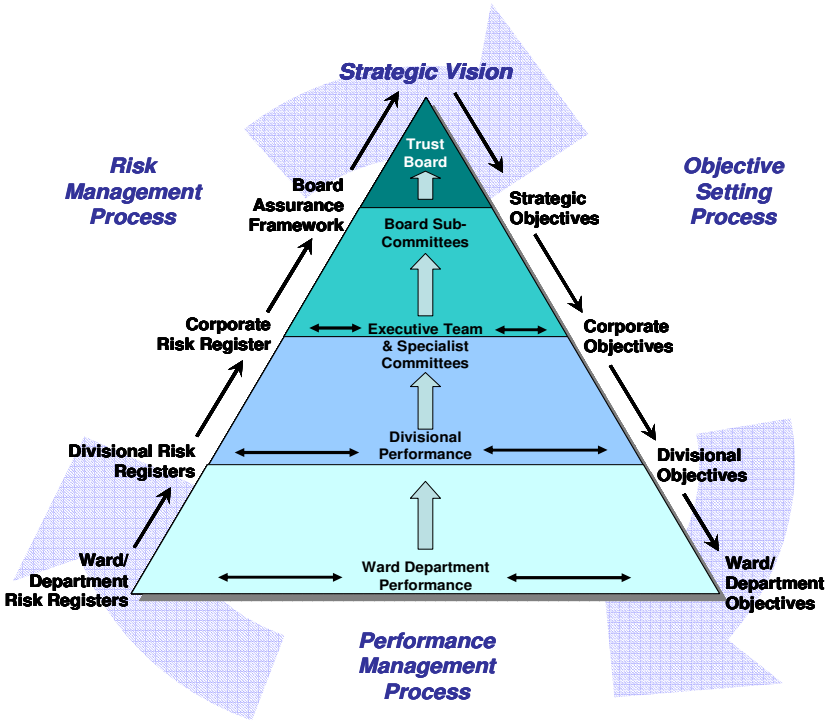
The Trust utilises an electronic risk management system '4Risk' to manage and maintain its organisational risk registers. The Corporate risk register is made up of key risks to the delivery of the long term strategic objectives, risks to the delivery of the Annual Plan objectives and high risks escalated from the operational/clinical risk registers.

The Corporate risk register, together with the high level operational/clinical risks, is reviewed monthly by the Executive Team and any new risks identified are assigned a responsible Director/Manager as risk owner. On a quarterly basis the formal sub-Committees of the Board review the corporate risks within their domain to assess progress on actions, controls and assurances. Any additional risks identified are assigned a responsible Director/Manager as risk owner and entered onto the relevant risk register.

The Trust Board receives the Board Assurance Framework on a quarterly basis. Additional risks identified are discussed and a responsible Director assigned as the risk owner.

Clinical Teams and departments set out their team and individual objectives, develop key performance indicators and identify key risks to the delivery of those objectives. All risks are recorded and managed via 4Risk. Delivery of objectives, management of risks and identification of assurances are managed and monitored through the Trust's performance framework.

Our risk management and performance framework is outlined in the diagram below:



In line with the Board Assurance Framework Strategy, all identified risks are scored using the matrix below. Clinical or operational risks which remain high, with a residual risk score of 15 or above, after mitigation are automatically escalated to the corporate risk register.

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The risk evaluation matrix used by the Trust is given below

LIKELIHOOD	IMPACT				
	1	2	3	4	5
	INSIGNIFICANT	MINOR	SERIOUS	MAJOR	CATASTROPHIC
5 - ALMOST CERTAIN	5 Low	10 Moderate	15 High	20 High	25 High
4 - LIKELY	4 Low	8 Low	12 Moderate	16 High	20 High
3 - OCCASIONALLY	3 Very low	6 Low	9 Low	12 Moderate	15 High
2 - UNLIKELY	2 Very low	4 Low	6 Low	8 Low	10 Moderate
1 - RARE	1 Very low	2 Very low	3 Very low	4 Low	5 Low

To ensure consistency in scoring of risks across the Trust, we have also developed a framework to indicate the consequences of risk from a number of perspectives.

This framework is detailed in the following table:

Impact type	1 Almost None	2 Minor	3 Moderate	4 Major	5 Catastrophic
Non-Financial impact	Insignificant increase in cost or slippage Budgetary slippage retrievable within 1 month Negligible impact on Performance rating Negligible change in quality No obvious harm to a person or persons	Targets/plans slip by 1-4 weeks > 5% over budget - retrievable within 1-3 months Failure of 1 performance rating indicator Minor change in quality No permanent harm (recovery within month) to a person or persons	Targets/plans slip by 2-4 months 5-10% over budget - retrievable within 3-6 months Overall performance rating reduced Service quality notably impacted Short term adverse impact on reputation Semi-permanent harm to a person or persons (recovery takes longer than 1 month but no more than 1 year)	Targets/plans slip by 4-6 months 10-25% over budget irretrievable in year Performance fundamentally compromised Service sustainablity at risk Permanent harm not resulting in death or severe disability to a person or persons and/or start of a national investigation into the Trust Medium term adverse impact on reputation	Service unavailable for longer than 7 days Loss of service/ buildings Death or permanent severe disability to a person or persons Long term adverse impact on reputation
Financial margin	Up to £50k	£50k - £100k	£100k - £250k	£250k - £0.75m	£0.75m+

The Assurance Framework includes:

- Clearly defined *principal objectives* together with clear lines of responsibility and accountability;
- Clearly defined *principal risks* together with an assessment of their potential impact, likelihood and mitigations;
- Key *controls* by which these risks can be managed;
- Internal and independent *assurances* that the risks are being managed;
- Board *reports* identifying that risks are being reasonably managed and objectives being met, together with any identified gaps in assurances and gaps in risk control.

4.2 Key risks, mitigation and ratings

The Trust's top three strategic risks have been identified as:

- Governance risk
- Clinical and operational risk
- Financial risk

The key risks for each of these areas are given on the next pages.

Governance risks

Description of risk	Cause and Effect	Risk rating	Mitigation	Residual risk	Strategic aim	Lead Executive
Business continuity – LHE incident planning	**Cause:** Occurrence of a major incident such as pandemic influenza or bed capacity problems **Effect:** Requirement for increased capacity for affected patients especially critical care facilities	**I = 5** **L = 4** **20**	Trust level continuity plans in place and regularly tested. LHE business continuity plans in place and regularly tested. Regional business continuity plans Identified Trust executive lead for major incident and pandemic emergency planning	**I = 5** **L = 2** **10**	**3**	**Director of Nursing and Governance**
New North Wales Health Board repatriate activity	**Cause:** potential that N Wales repatriate less complex work **Effect:** Loss of simple case mix to welsh providers	**I = 4** **L = 4** **16**	Base case assumes loss of activity through repatriation despite major capacity constraints and no limited capital available to develop further. N Wales Trust's requiring RJAH capacity to meet RTT	**I = 4** **L = 3** **12**	**3**	**Director of Finance**

Clinical and Operational risks

Description of risk	Cause and Effect	Risk rating	Mitigation	Residual risk	Strategic aim	Lead Executive
Revised patient pathways/length of stay reduction	**Cause:** Failure of internal process; failure to recruit appropriately skilled staff. Failure to meet demand requirements. Failure to deliver CIP **Effect:** Quality and safety breaches. Reliance on key individuals with specialist skills. Risk of business continuity. Threat to delivery of some key services. Unable to deliver demand requirements	**I = 4** **L= 4** **16**	Monitoring of patient safety measures Formal process for introducing new procedures HR strategy and succession plans Training and development strategy Internal key principles to pathway improvements agreed and project group formed Steering group to lead implementation Working operational group	**I = 4** **L = 2** **8**	**2**	**Director of Operations**
Staff sickness absence	**Cause:** Failure to manage absence and avoid causes of absence **Effect:** Increased expenditure on agency/overtime/out of job plan spend; reliance on key individuals with specialist skills; threat to service delivery; impact on quality and performance	**I = 4** **L = 4** **16**	Sickness absence management strategy Sickness trigger points set and monitored monthly HR performance management and support to Trust OH service provision Health and wellbeing strategy	**I = 4** **L = 2** **8**	**3**	**Associate Director of HR**

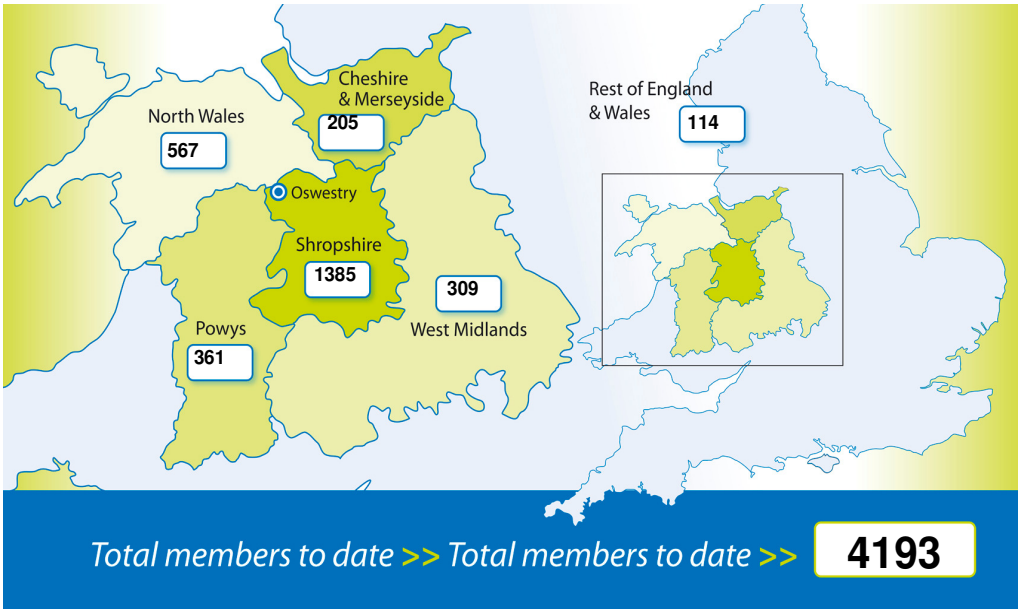
Financial risks

Description of risk	Cause and Effect	Risk rating	Mitigation	Residual risk	Strategic aim	Lead Executive
Economic climate pressures/local commissioner financial pressures	**Cause:** Comprehensive spending review details NHS needing to make 15 to 20 billion in savings. Financial pressures faced by local commissioners as a result **Effect:** inability to purchase growth in activity or more aggressive demand management schemes. Reduced central funding streams eg training and education. National inflation levels run higher that those identified by government	**I = 4** **L = 4** **16**	Base case already assumes material demand management schemes. Activity plans have been shared with commissioners. Opportunities to increase market share for other commissioners to mitigate any loss in activity. Lead commissioner sign up to Trust projections. Options for training and education funding shared with the Trust with range of impact. Prudent inflation levels in base case	**I = 4** **L = 3** **12**	**3**	**Director of Finance**
National tariff volatility	**Cause:** national changes to national tariff may adversely effect RJAH given single specialty eg less risk coverage through portfolio of service **Effect:** reduced payments for same activity	**I = 4** **L = 4** **16**	Orthopaedic: expert working group supports tariff discussions. SOA provide formal feedback on sense check tariff. Lobbying capability of SOA has proved track record. SLR/PLICs allows detailed understanding of cost and income interrelationships. 2011/12 sense check exercise of ability to influence final tariff	**I = 4** **L = 3** **12**	**3**	**Director of Finance**
Undershoot on CIP	**Cause:** Given the size of the CIP the Trust fails to fully deliver on the programme **Effect:** Financial slippage against CIPs would cause an increased financial pressure on the organisation	**I = 4** **L = 4** **16**	Strong track record of delivering similar levels of CIP. Robust plans in pace for initial planning period with key themes in place for the latter part of the model. Programmes supported by QIPP programme. Board with executive and clinical leadership. Supported by enhanced information through SLR/PLICs. Programmes based on transformational change rather than salami sliced. Progress closely tracked by executives/Board. The Board are sighted through the balanced scorecard on key risk areas and react to potential reputational risk accordingly	**I = 4** **L = 3** **12**	**3**	**Director of Finance**

Section 5 – Membership

5.1 Membership profile

Formal membership recruitment commenced during the public consultation process for Foundation Trust status in 2009/10. The Trust currently has 4,095 members (as at 1st March 2011). Of the members 1,264 are staff, 557 are volunteers and 2,274 public. The number of members exceeds our planned target of 3,990 by then end of 2010/11.



In line with our Foundation Trust membership strategy, our members are local people, patients, carers, volunteers and our staff; our membership is reflective of the communities we serve in both England and Wales. Our membership is divided into two different constituencies, Staff and Public.

- Staff members: to be a staff member someone will have to be employed on a permanent contract or have been employed at the Trust for a year;
- Public members: public members will have to be aged 14 years or over and live within the electoral areas of Shropshire, North Wales, Cheshire and Merseyside, Powys or the West Midlands. There is also a constituency for the 'Rest of England'.

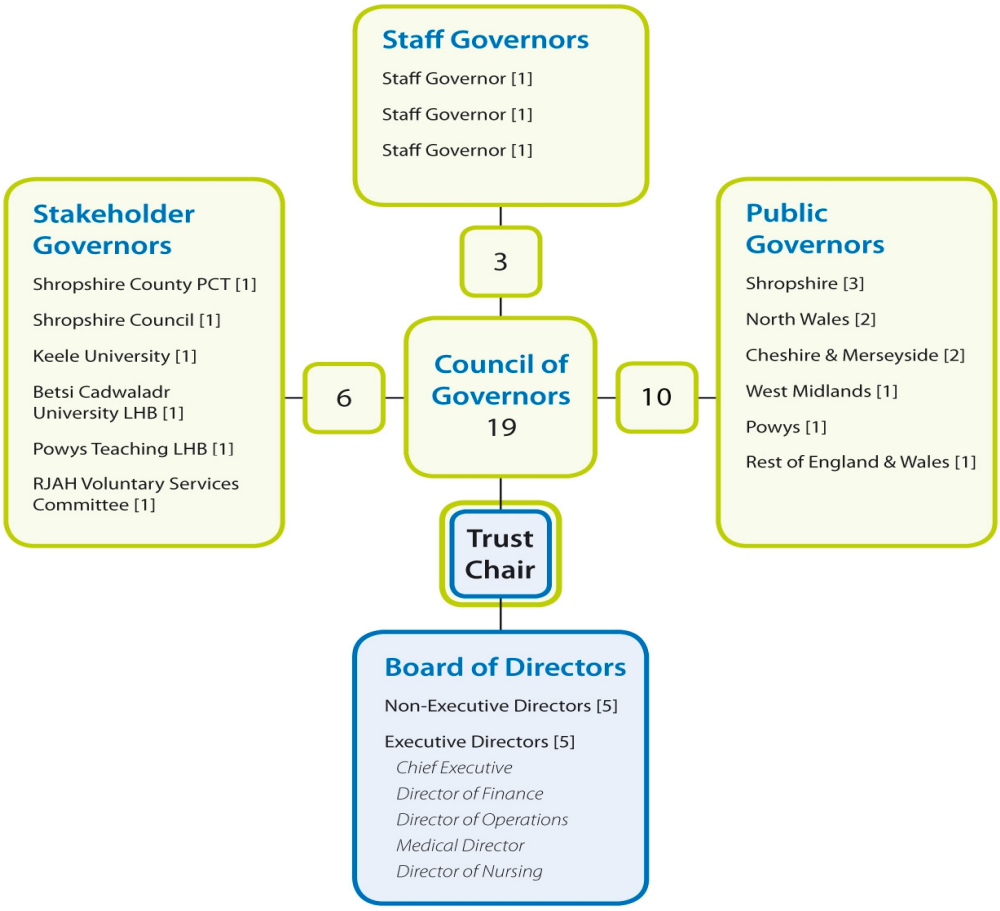
5.2 Membership plans

In line with our Foundation Trust membership strategy, it is planned to increase our overall membership to 4,290 during 2011/12. This will be achieved through a continued recruitment drive including promoting membership when patients visit the hospital, through routine correspondence, during public meetings and though the Trust website.

5.3 Election results

A key element of Foundation Trust status has been the establishment of a Council of Governors. Elections took place during the autumn of 2010 and our shadow Council is now in place and will remain so until the Trust is authorised. The Council of Governors will be the primary route for members to influence the future direction of the Trust. It will strengthen the corporate governance framework of the Trust and enable closer working with stakeholders, the local public, independent and voluntary organisations. The Council of Governors will also lead in membership recruitment, member involvement and be responsible for the membership strategy.

The Council of Governors will link to the Trust Board as detailed below:



All meetings of the Council of Governors will be chaired by the Trust Chairman, be open to the public and will form the key face of public accountability for the Board. Our elected and appointed Governors are detailed below:

Constituency	Governor
Public Governors	
Shropshire	Revd Adrian Bailey Mrs June Middleton Dr Tim Lyttle
North Wales	Mr Gareth Pritchard Mrs Jan Greasley
Cheshire and Merseyside	Mr Kenneth Croft Vacancy
West Midlands	Mr Russell Luckock
Powys	Mr Ron Pugh
Rest of England & Wales	Ms Kate Monaghan
Staff Governors	
	Mr Dave Adams
	Mrs Alex Radford
	Ms Martine Williams
Stakeholder Governors	
Shropshire County PCT	Dr Caron Morton
Shropshire Council	Mr Simon P Jones
Keele University	Dr Nikki Kuiper
Betsi Cadwaladr University HB	tbc
Powys Teaching LHB	Mrs Chrissie Hayes
RJAH Voluntary Services Committee	Mr George Whittingham