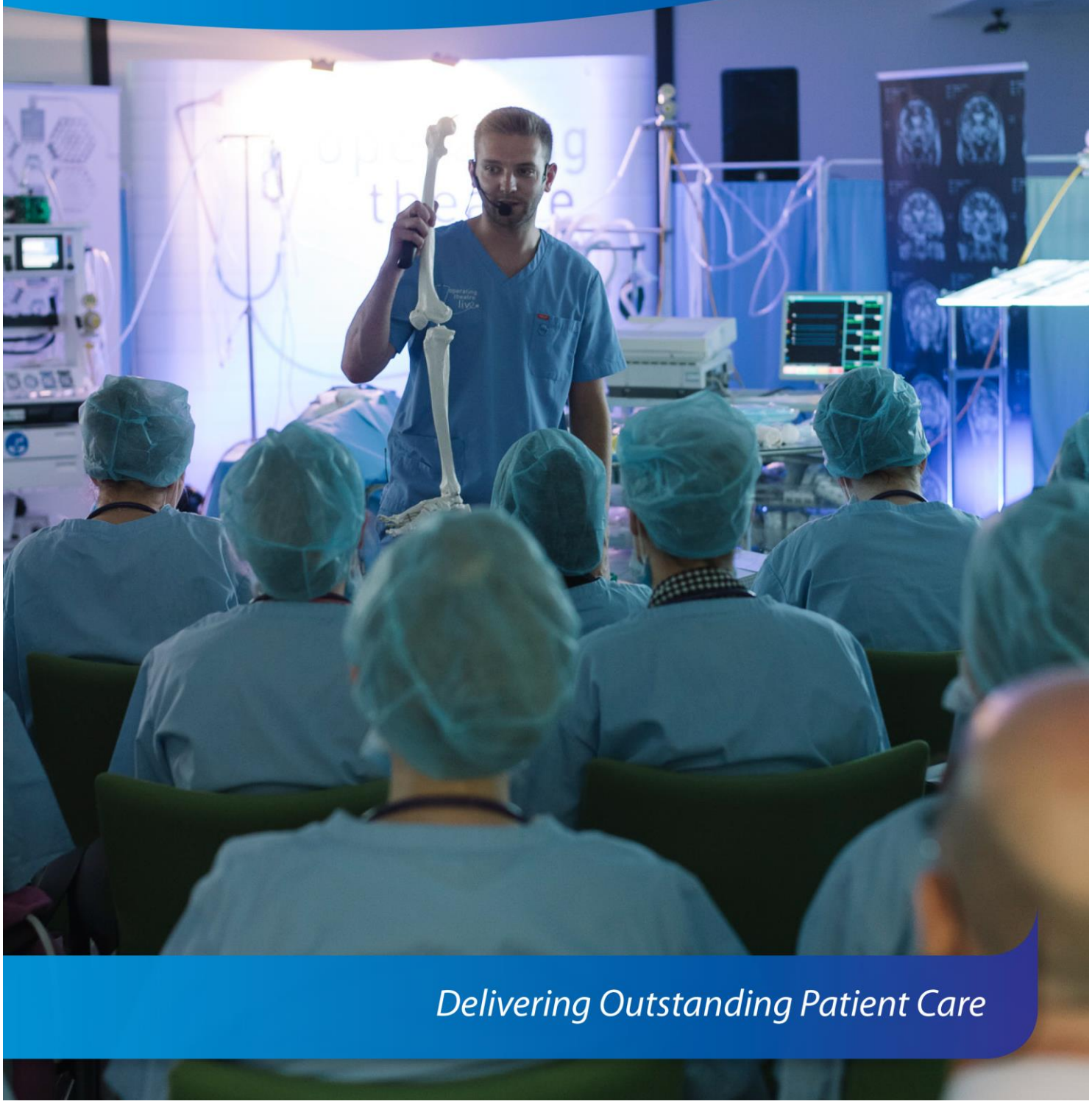
NHS
The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Operational Plan 2017-19



Delivering Outstanding Patient Care

Contents

Operational Plan for y/e 31 March 2019

This document completed by (and NHS Improvements queries to be directed to):

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Date	28th December 2016

The attached Operational Plan is intended to reflect the Trust's business plan over the next two years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- **The Operational Plan is an accurate reflection of the current shared vision of the Trust Board having had regard to the views of the Council of Governors and is underpinned by the strategic plan;**
- **The Operational Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The Operational Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans;**
- **All plans discussed and any numbers quoted in the Operational Plan directly relate to the Trust's financial template submission.**

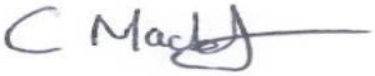
Approved on behalf of the Board of Directors by:

Name ***(Chair)***	Frank Collins
Signature	

Approved on behalf of the Board of Directors by:

Name ***(Chief Executive)***	Mark Brandreth
Signature	

Approved on behalf of the Board of Directors by:

Name ***(Chief Finance Officer)***	Craig Macbeth
Signature	

1 Strategic Context

1.1 Refreshing Our Strategy

Our vision is to be the leading centre for high quality sustainable orthopaedic and related care achieving excellence in both experience and outcomes for our patients.

In summary our strategy is;

1. We will become the local system integrator for MSK services.
2. We will develop a specialist orthopaedic chain.
3. We will deliver operational excellence.

Operational Excellence	Culture and Leadership
• Focus on the operational detail, using good data. • Embed and standardise safe processes. • Define data enabled transformation schemes. • Focus on unwarranted variation and waste, drive efficiency and value to ensure sustainability. • Be as safe as we can be – CQC Outstanding.	• Clinically led organisation. • Rebuilding Relationships. • Structured team development. • Investing in leaders and aspiring leaders. • Focused support for first line managers. • Refine service improvement method and capability.
Specialist Orthopaedic	**Local MSK Services**
• Explore new markets. • Leading work to develop a 'chain' • National voice on our area of expertise. • Maintain and secure our position as an excellent educator.	• Relevant. • Part of the system. • Management of Demand • Underwriter of quality of care in the system. • Long term contractual model. • Long term expert and partner. • MSK and orthopaedic services. • Innovative and creative.

As at writing, this operational plan, the Trust is in breach of licence with NHS Improvement and has been rated as "requires improvement" from the Care Quality Commission, significant priority is to maintain our operational grip, deliver quality services and therefore assure financial sustainability. Whilst achieving this we must simultaneously delivering priorities that protect the services provided for our patients, including supporting our local CCG to manage demand together with

exploring greater partnership working with our orthopaedic specialist partners and as part of the Specialist Orthopaedic Alliance.

Our strategic programme is set in the context of deteriorating financial performance across the NHS. This operational plan looks to incorporate a planned period of stability and a period of transformation to ensure that our services continue to be safe and viable going forward. Achieving the strategic priorities of the Trust requires financial sustainability. Our corporate priorities and therefore our deliverables for 2017/18 are embedded within our capital programme, cost improvement plans (CIP), collaborative working and local health system changes and within our financial assumptions.

1.2 Rebuilding Relationships Programme

During 2016 we conducted a series of wide ranging information gathering exercises with our staff, this was in the form of a diagnostic about our culture. This demonstrated some positive features of the culture;

Patient focused	Team work (within teams)	Friendly
Caring	Loyalty	Capable

It also demonstrated some areas for us to work on to improve our culture. With this in mind the Trust is utilising a culture change methodology which;

- Defines the behavioural standards we expect of everyone.
- Measures people against those standards.
- Gives people the opportunity and means to develop.
- Applies positive and negative consequences for both behaviours and task.

The programme has been designed with three elements with a central focus on rebuilding relationships, the Trust recognises to rebuild relationships with staff we will need to enable our leaders, create an enabling infrastructure and give an active commitment to having frequent, open conversations with all staff, illustrated below;

1.3 Barometer Group

This summary was tested with our barometer group, this cross sectional group of staff work as a group of people that get together regularly. They act as the voice of our staff and consider;

- What do you think of our plans?
- How is implementation going?
- How are people reacting?
- What do we need to adjust in our plans?

2 Activity Planning

2.1 Review of 2016/17 Activity Performance

The Trust enters 2017/18 having forecast a reported surplus of £2m for the previous year in line with its control total. The table below demonstrates the demand expected and planned for in 2016/17 based upon prior activity levels, commissioning intentions and demographic profiling, versus actual seen (for all activity English & Welsh).

Activity	Original Forecast Total 2016/17 Changes	Current Forecast Total 2016/17 Changes	Shropshire 2016/17 Changes	Telford & Wrekin 2016/17 Changes	Powys 2016/17 Changes	Betsi Cadwaladar 2016/17 Changes	Specialised Commissioning 2016/17 Changes
Outpatient	7%	17%	26%	5%	6%	-4%	3%
Elective Inpatient	2%	2%	3%	-16%	-3%	-9%	4%

A key risk for the Trust in 2017/18 continues to be the levels of activity not aligning with commissioning intentions, together with the ability for the aspiration of Shropshire CCG to deliver at pace a shift in demand to stem the ever increasing growth in orthopaedic activity. The Trust is working closely with Shropshire CCG and the local STP to become the MSK system integrator to enable a more cohesive approach to managing demand and the supply chain.

Assumptions for 2017/19 are based on flat activity and accounting for expected changes;

- Demographic change impact;
    - 2.6% to 2.9% per annum for acute activity.
    - 4.4% per annum for specialist activity.
- Additional waiting list work for England/Wales.
- National tariff changes in line with tariff including an inflator of 0.1%.
- No changes to local prices.
- No winter resilience income has been assumed.

2.2 Sustainability and Transformation Plans (STP) / Local Health System Commissioning

2.2.1 Shropshire CCG

The commissioner intentions set out to;

- Explore the further use of biosimilar and generic alternatives within drugs.
- In the absence of mandated tariffs consider the use of non-mandated tariffs or other alternatives.
- Referral to treatment backlog additional funding is deemed non-recurrent and will not be carried forward.
- Contractual notice received for Oswestry Pain Programme service to be decommissioned.
- Investigate targeted treatments using risk stratification tools.
- Review Shropshire Outreach Orthopaedic Service (SOOS) specification.
- Consideration of withdrawal of MRI direct access to reduce MRI demand.
- Review current dexa scanning arrangements including introduction of risk stratification for preventative and >75 years pathway.

The commissioning intentions also highlight pathway reviews as follows;

Spinal pathway	Arthroscopy	Upper limb (shoulders)
Carpal tunnel	Ganglion	
MSK services	Rheumatology prescribing	

For the forthcoming year, this Trust has considered local commissioning intentions and the ambition and development of the Shropshire, Telford and Wrekin Sustainability and Transformation Plan (STP). Our experience indicates we have to plan our resources in a flexible manner ensuring sufficient escalation capacity to respond to the true changes of increasing activity levels.

During 2017/18, recognising the performance challenges in 2016/17, action plans have been developed to seek to stabilise and continue performance improvements. However, as previously highlighted given the system wide factors impacting on the targets, the Trust performance indicates the need for the local health system to progress at a quicker pace driving the decision making and subsequent delivery in regards to demand management.

Currently unplanned changes in demand arrangements are monitored through the Trust's agreed capacity and demand analysis. Changes in referral rates and demand are highlighted at the monthly contracts meeting with our commissioners.

2.2.2 Specialised Commissioning

The West Midlands specialised commissioning team are forecasting a material deficit for 2016/17, together with £37m QIPP target and headline growth for 2017/18 of 4.8% primarily driven by new NICE approved drugs and nationally commissioned policies. Hence, there is limited scope for new service developments in 2017/18, consideration for those that save money or improve quality at no extra cost will be the focus.

The strategic direction sets out;

- Moving towards place and population based commissioning to support stronger collaborative working.
- Concentration and networking of specialised providers to reduce number of contracts.

The commissioner intentions set out to;

- Expand the pathfinder model within spinal surgery to Staffordshire, Coventry and Warwickshire to mitigate demand for neurosurgical outpatient attendances.
- Introduce a case management function together with enforcing the specification over delayed discharges (14 days) and length of stay (180 days total length of stay) to ensure that the right patient is in the right bed and improve patient flow.
- Increase access for paediatric spinal deformity to reduce waiting times.
- Improve access to spinal services and reduce waiting lists.
- Spinal cord injury service review in progress with a transformational impact in 2017/18.
- Implementing best practice across the spinal surgery pathway.
- Development of non-mandatory prices for spinal cord injury.

Nationally it is recognised that spinal cord services are facing particular challenges including delays in admissions and equity of access which is impacting on patient experience together with impacting on other services such as major trauma and critical care. The review of spinal cord injury services is nearing completion and it is anticipated that during 2017/18 this will identify where there are capacity and demand issues together with an option appraisal of solutions to improve both the level and location of provision in some regions.

2.3 Sustainability and Transformation Plan (STP)

The main area of focus for the Trust in response to the local STP is the review of musculoskeletal services, particularly in response to making the best use of resources, together with the merging of back office functions. The Trust recognises the position of the local health economy and the need for changes in the delivery of healthcare to enable all agencies to meet the demands of our respective populations and patients, within the limits of the available resources.

As predominantly a specialist tertiary provider, the Trust recognises and accepts the STP framework and footprint challenges and that it will not be immune from its effects. Whilst recognising the drive for national STP's, the current focus omits the impact on Welsh patients and on specialised services, two thirds of this Trust's patients come from outside our local system (Wales and nationally), this unique demand profile is yet to be reflected within the STP framework, as

indicated within the Shropshire STP feedback letter, together with nationally driven programmes including the national vanguard in relation to Getting It Right First Time (GIRFT).

At this time, there is significant concern regarding the lack of development within demand management with credible initiatives to better manage growth in demand for secondary services. As highlighted, throughout this operational plan, level of demand has the ability to undermine any financial aspects of both the STP and provider operational plans.

At this time local economy impact is yet to be considered within the development of back office functions, the Trust is very aware of being a main employer within Oswestry and therefore a wealth creator within the local economy; effects of any changes here need careful consideration for the community.

2.3.1 STP Orthopaedic and MSK Review Headline Findings and Recommendations

Overall the review highlighted difficulties in the MSK workstream of the STP for engaging joined up discussions, sharing of information and a common sense of purpose and objectives. Hence, since receiving initial findings of the review this Trust is working closely with Shropshire CCG and the local STP to become the MSK system integrator to enable a more cohesive approach to managing demand and the MSK supply chain.

There has previously been little joined up work across the system on improving referral management, intermediate services and reducing interventions and the pace of the work undertaken needs to accelerate if it is to have an impact on demand. Hence the following recommendations as a system, which are subject to further discussion;

- The impact and application of specialised top-ups will be communicated more clearly for system understanding in order to correct some widely held misconceptions.
- We will be recommending that the STP undertake a programme of joint, clinically led audit work to assess compliance with referral and service restriction policies. Sharing of the outcomes of this work and actions agreed where the policies are not being effectively implemented or require further development.
- We will be recommending that the STP undertake a programme to map the current and proposed pathways including expected/actual patient flow numbers, in order to clarify the current referral routes.
- It is recommended that the proposed independent clinical review of the TeMS services is progressed and the results shared across the system. Similarly, data on referral rates, conversion rates and any evidence of reducing surgical intervention rates I shared by the CCG's to inform the service redesign in the Shropshire system.
- A common set of goals for MSK services will be established, based on an agreed set of assumptions and agreed data about the system. All parties will need to sign up to and engage in the MSK review process and use the data presented in this review.

2.3.2 Right Care Right Value and NWA benchmarking

The evidence from both RightCare and the NWA benchmarking suggests that the most significant variance is associated with hip, knee and shoulder pathways. Reviewing these pathways, thresholds and controls will be a high priority in our wider system work. To ensure a stable system it is recommended that we prioritise work to review the primary and community pathways for conservative management of hips, knees and shoulders in order to provide a different 'default' pathway for these patients.

It is recognised that there appears to have been a number of pre-conceptions and misconceptions regarding costs to the CCG (e.g. the impact of specialist top-ups on RJAH activity) and unfortunately these appear to be driving some of the thinking on solutions to reducing costs in the system.

Both sets of analysis identified significantly lower than expected spend on pain procedures / management, together with Rheumatology as an area of care with significantly below expected activity and cost versus comparators. Hence a review of rheumatology and pain pathways is required as this might impact on other orthopaedic services.

RightCare have undertaken work to examine the effect of having a specialist centre within a CCG's boundaries in order to assess the impact this has on cost and activity. The results shared with us were in draft format only, but provide useful insight. The results found no clear trend of CCGs hosting a specialist MSK provider having higher than expected MSK Elective spend. However, Shropshire CCG had a higher than expected MSK spend that was statistically significant. Some other CCGs had higher spend than Shropshire relative to their comparators, but others had lower than expected MSK spend.

2.3.3 Getting It Right First Time (GIRFT)

The Trust operational plan considers and puts in place actions for delivering positive response to GIRFT areas of concern;

Problem; Costly (quality of life and £), variation in outcome in adult elective orthopaedics.

Caused by	Solutions	RJAH focus
VARIATION IN PRACTICE OF PRACTITIONERS • Not following evidence on implants • Low volumes of specialist work • Ownership of collecting outcome data and coding • Different approaches to networking, multidisciplinary • team (MDT), joint working and trauma	PROFESSION • Clinical leadership • Follow guidance • Sub-specialise to deliver minimum numbers • Mentoring etc. • Appraisal • Revalidation	STP – MSK services review Transformation sustainability projects.
VARIATION IN PATHWAY AT PROVIDERS • Ring-fenced beds, theatres and staff • Governance • Support for data quality and accuracy of outcome • data and coding	PROVIDERS • Reconfiguration to facilitate critical mass and • minimum volumes in networks • Ring-fenced beds, theatres and staff • Litigation - pre-emptive planning	Transformation sustainability projects.
VARIATION IN MANAGEMENT MODEL • Top-down management combined with poor • clinical engagement • Loss of clinicians morale	MANAGERS • Management model - shoulder to shoulder with clinicians	Rebuilding Relationships programme
VARIATION IN COMMISSIONING • Lack of focus on minimum critical volumes across a region/potential network • Inconsistent and unregulated relationships with AQPs	COMMISSIONERS • Commission collaboration to achieve critical mass • Total collaboration across providers to encourage • critical mass and healthy collaboration /competition with focus on sustainability and quality	STP – MSK services review

In line with RightCare, the GIRFT programme has focussed on the over delivery of rotator cuff repair and sub-acromial decompression as a national issue and is targeting the adoption of more conservative physiotherapy led treatment. Extensive research from Professor Andy Carr details the findings to support this and case studies of shoulder practices successfully delivering lower rates of surgical intervention and high patient satisfaction.

2.4 Demand and Capacity Approach

The Trust's Contracts and Informatics team work with the divisional teams and finance leads to assess demand for the forthcoming year and agree contract baselines. The forecast outturn position for month seven activity is assessed for each sub-specialty, by point of delivery for English, Welsh and specialised activity. Issues such as commissioner intentions, non-recurrent issues, relevant national changes, referral trends, changes in waiting lists, service delivery changes, demographic

movements, and changes in waiting times are all considered as part of the demand assessment and agreement of the contract baselines.

Capacity is assessed by sub-specialty and point of delivery based on current capacity levels, then considering changes in capacity, clinical practice, when bank holidays fall within the year, wait list backlogs, additional activity undertaken in year, patient cancellations and DNA rates. This is then compared with the expected demand and discussions are held with clinical leads where required regarding flexing activity to meet any shortfalls and agreeing plans.

The Trust has in place a Referral to Treatment (RTT) transformation programme. The programme will entail the application of a variety of principles, systems and tools to create a sustainable improvement in the Trust's key performance indicators in relation to RTT. The process involves focusing upon our internal capacity to meet patient's needs, keeping our staff positive and empowered and continually improving the current activities in the organisation. The programme consists of seven projects;

- Pre-operative assessment – review existing pathways to create a standardised process and a patient pool size to fill short notice slots.
- Outpatient transformational group – increase the utilisation of the outpatient department to optimise available capacity.
- Follow-up appointments – demand has been exceeding capacity in this area, this will review clinical protocols to agree seven sub-specialty follow-up and discharge protocols.
- Demand and capacity sub-specialty sustainability – develop a tool for informed decision making for required capacity and flexibility to respond to demand for services.
- Theatre scheduling and theatre extension (Menzies) – review of theatre schedules to facilitate improve in job plan utilisation and more effective use of resources and support services. Through Menzies increase delivery of theatre capacity.
- Main theatre utilisation – to respond to general increased demand and to increase flexibility to respond to peaks of demand from different sub-specialties.
- Access data quality – reduce our error rates in our data collection to utilise resource more effectively rather than validating and correcting retrospectively through data cleansing.

2.5 Capacity Analysis

2.5.1 Beds

The Trust is working to deliver a strategy which provides sufficient beds and staff to deliver the healthcare needs for the demand levels for orthopaedic services from our commissioners, from an estate which promotes the effective use of that capacity. However, changing demographic and financial circumstances, and the intentions of commissioners, mean that staffing and bed numbers continue the need to become more flexible in the future.

To ensure a flexible bed base and maintain stability in bed occupancy at 85% regular bed modelling reviews are taking place. For current activity levels, due to increased referral rates received from Shropshire CCG in the first two quarters of 2016/17, the Trust has a requirement for an additional eight beds which is anticipated to continue into 2017/18 which will be managed through the opening of our Kenyon ward. Further work will continue to ensure we maximise the benefits of our new Baschurch unit in improving patient flow which should offset further bed pressures.

2.5.2 Theatres

2016/17 saw the opening of the Trust's new theatre development, this encompassed four theatres, a replacement HDU with extended admission and recovery facilities. This was based upon original modelling indicating the requirement for a ten theatre model with flexibility for future expansion together with increased admission and recovery facilities for increased day surgery patients that are open between 7am and 10pm improving our admission on day of surgery and reducing pressure on bed requirements.

The Menzies Unit, a standalone modular building housing two operating theatres and a procedures room, originally on lease until September 2016 has been extended with a 10 year contract with a five year break clause at a significantly reduced rate. During 2016/17 phase one will open one of the theatres to provide an additional 10 sessions per week. The opening of the remaining theatres will be subject to assessment of future demand and will be reassessed upon conclusion of the 2017/18 contract negotiations.

This is in line with our Trust strategy aligned to best practice national guidance we are executing a shift in activity from an inpatient elective setting to day case. This ensures that patients will continue to be treated in the most cost effective setting with the opening of our additional day case theatres in 2016/17 allowing the Trust to simultaneously manage demographic growth.

2.5.3 Workforce

The Trust needs to resolve our capacity and demand, currently too many of our operations are delivered outside of our core plan. This is through out of job plan (OJP) arrangements (31% theatres and 19% outpatients 2015/16) and outsourcing (sending patients to private hospitals for their surgery). The Trust recognises that when we do this we reduce the financial contribution (the margin) that this work affords.

The Trust is currently working through a programme with a phased approach reviewing our OJP capacity as follows;

- Phase one; agree volumes of OJP activity in advance and contract on this basis.
- Phase two; agree a series of productivity based improvements to our OJP working arrangements.
- Phase three; agree a reward system based upon performance linked to our refreshed Trust strategy, productivity, values and behaviours.

The Trust completed a capacity and demand review which has indicated the requirement to increase consultant capacity in particular sub-specialties. Recruitment commenced in 2016/17 to a number of new consultant posts creating the additional capacity required for sustainable delivery in 2017/18. Through recruitment the Trust looks to achieve;

- To sustainably achieve the 92% threshold.
- Respond to increased levels of demand.
- Increase flexibility in sub-specialties to respond to peaks of demand.
- Create additional core capacity.
- To make a positive contribution to sub-specialty service lines.
- To provide effective consultant succession planning.
- Work towards a maximum of 20% of core activity undertaken on a flexible basis as OJP.

As highlighted above the opening of the Menzies Unit and Kenyon ward instigates the requirement to substantively recruit in nursing and theatre staffing in response to expanding our clinical workforce and increased activity levels with an agreed baseline activity from our main local commissioner. The Trust have put in place a monitoring tool in regards to activity levels to ensure core resource capacity remains in line going forwards and that OJP working arrangements are only utilised for flexibility purposes.

2.5.4 Independent Sector

The Trust utilises the independent sector in the following circumstances;

- Additional capacity required to meet referral to treatment time standards through increased demand outside of informed commissioning intentions.
- Unforeseen clinical resource shortages i.e. Consultant bereavement leave, specialist skill shortage due to staff turnover.

The opening of an eleventh theatre will allow the full repatriation of 450 cases outsourced to the independent sector in 2016/17. Currently the Trust has utilised the independent sector in the following sub-specialities;

Lower limb	Foot and ankle	Dexa scanning
Arthroplasty	Upper limb	Nuclear medicine

The Trust is aware that our commissioners may only agree to support additional capacity on a risk share basis with the expectations within the STP that overall capacity for the expected demand and delivery of waiting time requirements is commissioned across the portfolio of providers in the system. Therefore we would expect that demand will be managed to ensure there is no requirement for any further use of the independent sector.

2.6 Constitution Standards

The Trust planned core constitution standards for 2017/18 cover four areas and are predicated on a number of assumptions as detailed here.

2.6.1 52 weeks

- Plan on zero from England and Wales, however there remains a risk of significant patient delays through enacting their choice rights, jeopardising delivery of this target.

2.6.2 RTT incomplete pathways - 18 weeks (All patients waiting on PTL)

- Demand will stay at the levels indicated within our operational plan and contractually agreed.
- Additional capacity available internally through the opening of additional theatres and at alternative providers (if required).
- Full complement of staff to deliver activity.

2.6.3 Diagnostic 6 weeks standard

- Based on October's baseline.
- Assuming our predicted level of growth.

2.6.4 Cancer 62 day standard

- All cancer services will remain the same in terms of provision.
- Baseline is estimated final year end 16/17 position.

2.7 Key Operational Risks

The key operational risks are identified in the table below.

Source of Risk	Description	Risk Score	Action
High Level RTT Recovery - Sustainable maintenance of RTT pathway target	Lack of capacity in sub specialties together with a failure to follow policies and embed RTT management processes. There is a pressure on a number of subspecialties where demand exceeds capacity. Resource constraints prevent commissioners investing in sufficient activity to sustain waiting times. Position at October 2016 shows that Trust is breaching	20	MBI Demand and capacity modelling identified priority sub-specialty consultant appointments, posts currently out to advert. Additional theatre operational from November 2016, to provide additional 50 cases per month and provide supporting infrastructure for substantive appointments. Two further theatres scheduled to come online April 2017. Recruitment of theatre staffing to support increased theatre capacity ongoing with fastrack recruitment day scheduled for 20th November 2016. Plans to align clinicians to pressure points i.e. theatres and clinics with flexibility of DCC sessions agreed and consultant level proposals January to March 2017 on additional sessions and flexed sessions circulated to Consultants. Shortfall in sessions for theatre to be kept under regular review. New Access Policy in place and training for staff has been rolled out, with bespoke training to appropriate staff groups including clinicians,

	open pathway target and has a number of 52-week waiters.		executives and Trust Board. Meeting structure formalised with clear governance escalation through Chairs reports to next level. RTT Recovery Board established, chaired by non-Exec, which reports in to the Board. Weekly Exec comms cell in place to monitor plan. Recovery trajectories in place delivery of 92% open pathways under 18 weeks by March and clearance of 52 week waiters by December 16. Six transformation workstreams have been identified - PIDs, Action Plans/Timelines and Project Structures have been agreed and groups have begun work. Complete roll out of Consultant training on patient choice based on patient management plan expectations. Increase bank/agency spend to mitigate vacancies to secure additional activity. Administrative resources for consultant appointments to be appointed ahead of clinical appointments to strengthen booking processes. Additional outsourced capacity being secured to mitigate risk to in-house activity. Daily scheduling review to ensure theatre session allocation remains on plan.
High Level RTT Recovery - Financial Risk	Commissioner affordability challenges conflict with recovery plan requirements. Internally expenditure to deliver recovery may exceed plan.	20	Contract with CCG to be agreed by December 2016. Contract will need to include provision for phase 2 sustainability. RJAH will ensure that these are based on current waiting list and growth. Internally monitoring of OJP spend linked to RTT recovery in place. Long term follow up outpatients being reviewed in identified ringfenced clinics. Internal spend on RTT recovery will continue to be monitored through RTT BRIC
High Level RTT Recovery Clinical Acceptance Of New Ways Of Working	A lack of clinical acceptance of new ways of working in developing sustainable solutions to delivering RTT	16	Focus on engagement with the Medical Director and the Clinical leads. Clinical leads involved in demand and capacity work. Regular Sub specialty meets supported by Operational managers now in place. Clinical lead development programme underway. Additional consultant posts identified through capacity and demand work have been advertised. One additional day a week of Medical Director time dedicated to recovery programme. Transformational projects have been identified which will map the patient pathway to optimise efficiency through standardisation of the pathway systems and processes. Discussions are ongoing with all clinical leads to discuss strategy for managing overdue backlog and avoidance of future backlogs. Increased use of practitioners and nurse specialists is key to this. Arthroplasty team have now agreed a Virtual clinic model for Long Term Follow Up - submitted to Commissioners in October who ahve requested a further discussion. Further additional consultant posts appointed to. Follow Up protocols fully implemented.
High Level RTT Recovery - Lack of Operational Capacity	A lack of Consultant, Theatre and Outpatient Room capacity to enable sufficient activity to deliver RTT recovery in multiple sub specialties, in particular spinal	20	Clinical teams are identifying additional availability for theatres and clinics. Operational team are reorganising theatre schedules to create capacity. Use of physio supported clinics being maximised. Increased pooling of patients to make best use of available capacity. Greater use of registrars to increase outpatient capacity.

	disorders.		Issue raised with NHS Improvement and NHS England because of national pressures on spinal services. Working with Commissioners to try and control demand. Private sector capacity at Nuffield and Yale being utilised. Agreement has been reached to try and transfer 20 patients to the Royal National Orthopaedic Hospital in Stanmore. The possibility of some additional spinal theatre lists over Christmas is being explored. Locum spinal consultant now in place. Transformation projects under way looking to increase capacity in theatres and outpatients and maximise utilisation, including recommissioning of Menzies theatre suite. Appoint additional clinical staff in appropriate constrained sub specialties to make best use of theatre space that would be at risk of being lost. Additional consultant posts are being advertised in October/November. Implement new follow up protocols to reduce reliance on consultant staff for routine follow ups. Pilot of 'Virtual follow ups' clinic model for long term arthroplasty patients has been signed off by clinicians.
High Level RTT Recovery - Staffing and Recruitment	The Trust has difficulty recruiting appropriate staff to fully support its RTT Recovery Plans. (This includes theatres therapies and radiology) Once recruited the lead in time for staff to take up post and to be trained appropriately causes delays to recovery plans. There are difficulties in attracting qualified theatre staff due to national shortages, the hospital's location and changes in national training schemes.	15	Operational structure now in place. National advert released in September to help recruit additional theatre staff. Video to support recruitment campaign shared widely on social media. Ongoing reviews of operational team functioning. Failure to recruit sufficient theatre staff will mean increased reliance on Bank staff and overtime which may not be sustainable in the long term.

3 Quality, Safety & Patient Experience Priorities

3.1 Commissioning Priorities

The Trust has recently received commissioning quality priorities as reflected through the commissioning CQUINs as follows;

Goal	Indicator Name	Measurement
1	Improvement of health and wellbeing of NHS Staff.	The Trust has agreed to the staff survey. Baseline per national template.
	Healthy food for NHS staff, visitors and patients.	Baseline per national template.
	Improving the uptake of flu Vaccinations for front line clinical staff.	Baseline per national template.
2	Timely identification of sepsis in emergency departments and acute inpatient settings.	Only in-patient setting, apply for both children and adults Baseline period in Q4 2016/17. Trust to confirmed to the CCG; • The baseline period. • Date when the baseline results will be submitted to quality leads, for review and agreement. Eligibility criteria to be clarified at this time.
	Empiric review of antibiotic prescriptions.	Baseline per national template.
	Reduction in antibiotic consumption per 1000 admissions.	Baseline as per national template.
6	Offering advice and guidance.	Baseline per national template.
7	NHS e- referrals CQUIN.	Baseline per national template.
8	Supporting proactive and safe discharge – Acute Providers.	Baseline per national template.
9	Tobacco screening (2018/19 only).	Baseline per national template.
	Tobacco Brief advice (2018/19 only).	Baseline per national template.
	Tobacco referral and medication offer (2018/19 only).	Baseline per national template.
	Alcohol screening (2018/19 only).	Baseline per national template.
	Alcohol brief advice or referral (2018/190 only).	Baseline per national template.

3.2 Quality Goals

The Trust choices for improvement are based upon reviews of our quality and safety performance and service areas of development together with a triangulation of commissioning priorities, service user feedback and incident reporting.

Hence, our three key domains of quality are as follows;

- Patient Safety – keeping patients as safe as possible.
- Patient Experience – understanding patient satisfaction through experiences.
- Effectiveness – clinical and cost effective treatments and care.

Through our domains of quality the Trust will identify our key priorities for 2017/18 together with our aims, rationale and measurement for each in line with the quality accounts guidance timetable ensuring stakeholder engagement as standard.

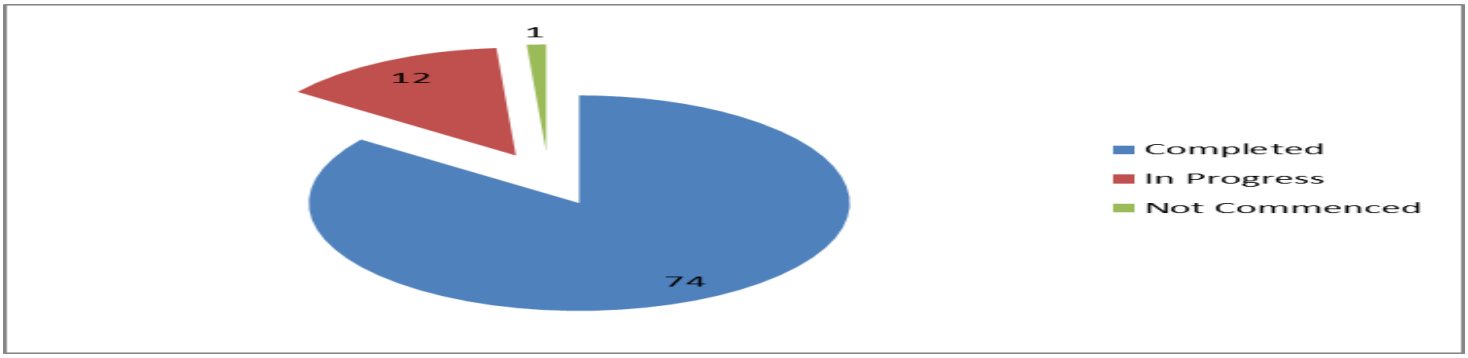
3.3 Current Quality Concerns & Key Quality Risks

The Trust is required to register with the Care Quality Commission (CQC). The first CQC quality report for the Trust was published on 3 March 2016. The Trust has been rated as “Requires Improvement”. In response to the findings contained within the report, the Trust has produced an action plan to address every point raised.

The Trust will continue to monitor the action plan that we have in place supported by the campaign work from 'Sign up to Safety' which the Trust has joined to support the reduction of patient harm.

3.4 CQC Action Plan

The final CQC report was received by the Board of Directors on 26th February 2016 together with the action plan. The Trust continues to make good progress with good engagement across the organisation in the actions required to improve. An overview of completed actions are;



We are on track for completion by 31st March 2017. The action plan below highlights the areas which are currently indicated as amber and are the areas of focus for completion.

Area identified as requiring improvement	Action	RAG Rating	Evidence of compliance	Evidence of compliance received/ Progress to date
Major incident training	Ensure that full major incident training is provided to relevant staff		Training records Review of systems and processes planned for the 1st March 2016	Full review of core standards for EPRR undertaken and peer reviewed. Work to be undertaken in relation to the policy update and also training and compliance. Plan agreed with NHS England implementation to be completed by March 2017. EPRR Update an agenda item for Q&S Nov 2016.
Safeguarding Children	Developing links with SaTH to be able to access data on Shropshire and Telford children		Access developed. Information on children on a CPP.	IT are currently supporting the sharing of information processes. Interim process in place, waiting for health economy system implementation.
Imaging requests	Develop electronic requesting to reduce errors on requests and risks associated with illegible requests. Develop extended scope for MDT requesting of specific diagnostic tests.		System in place. Initial scoping or work to be undertaken.	System in place within EPR to enable electronic generation of Imaging Requests. Requires upgrade of EPR to become active
Outpatients	Review space to ensure sufficient space for patients in wheelchairs to manoeuvre.		Outpatients task and finish group minutes. Engagement with Estates regarding outpatient environment.	Outpatient redesign group in place. Progress is being made regarding the review and upgrading of this area. Bookwise licence now expanded and agreed to monitor and book clinics available.
	Review whether specialist		Engagement with	Outpatient redesign group in place.

	seating could be provided in waiting area.		Estates regarding outpatient environment.	Progress is being made regarding the review and upgrading of this area.
	Storage in imaging and outpatients review options for alternative storage.		Outpatients task and finish group minutes.	
Patient Experience	Develop a campaign to encourage patients to share their experiences both positive and negative.		Campaign in place. Support from the Comms team.	Progress being made in the development of a Patient Experience Strategy. Patient experience collaborative launched with implementation plan and evidence of action in place.
Performance Management Processes	Review current processes regarding performance management.		Meeting booked to discuss performance framework process.	Work is being completed on the proposed integrated performance management meetings for the Divisions.
	Implement new structures and processes to ensure efficient and effective performance management processes are in place.		Plan in place to implement new processes.	Work is being completed on the proposed integrated performance management meetings for the Divisions.
	Clear tripartite arrangements in place for the divisions regarding Medical, Nursing and Managerial leads.		Plan in place to implement new processes.	Work is being completed on the proposed integrated performance management meetings for the Divisions.
	Formalise role of Clinical Leads, including expectations of modelling key behaviours.		Clear roles and responsibilities in place.	
Board Visibility	A full programme of patient safety walk about will be established to include NED and Governor involvement.		Evidence of visits. Programme in place.	A draft programme of safety walkabouts is to be developed from discussion and agreement with the Executive Team and will involve patient Panel members and Governors.

3.5 Quality Improvement Methodology, Governance and Sign up to Safety Priorities

The Trust's Quality Improvement Strategy 2014 - 17 outlines the commitment to delivering consistently safe care and to taking action to reduce harm to patients in our care, and moving in our goal to achieve excellence in all we do. By participating in NHS England's Sign Up to Safety initiative, and the overarching goal of reducing avoidable harm, the Trust is developing a Safety Improvement Plan – the basis of which is the analysis of our local incident and claims data. This analysis has identified work streams that, it is expected, will significantly reduce harm, these are;

1. Improve team effectiveness and safety culture in the operating theatres.
2. Reduce the number of grade two pressure ulcers within the organisation, with focus upon medical device associated pressure ulcers.
3. Reduce the number of patient falls.

The Safety Improvement Plan is aimed at improving the health outcomes and effectiveness of our care; it aims to reduce avoidable harm thereby improving the patient experience. Further development of the Trust's 'safety culture' is essential so that the delivery of safe and evidenced-based care becomes embedded in the day-to-day practices of all Trust staff.

Within the three domains of effectiveness, safety and patient experience, the Trust has identified a number of overarching quality commitments. Our commitments will remain consistent to 2019. Underneath each commitment there are specific quality indicators we focus on as a priority. Our performance is reported against these indicators via the Quality and Safety Committee to ensure that our goals are achieved to make a positive difference.

The Trust will look to launch training in 2017/18 for service quality champions to embed the focus upon improving quality, reducing variation and identifying and removing waste. Through this programme the trust will look to launch a programme with cross-cutting themes focused upon theatres, outpatients, flow and processes supplementary to our traditional CIP approach. Strong clinical leadership will be the cornerstone to success of these programmes.

Creating four work streams cut across our organisation and our patient pathways, they are the elements that patients and staff interact with daily. They also align with the ten high impact changes which still hold strong today with the ever continuing environmental change. The principles that will be applied to these work streams are; quality & cost, variation, remedial cost of poor quality and efficiency & productivity. The Trust recognises that long term sustainable changes are the key to delivering financial benefits; hence this programme will focus upon the medium to long term solutions, numerous changes are needed to create a step change in cost base that can only be delivered in this way. This programme will encapsulate and engage our organisation, engaging with clinicians and staff at all different points in the Trust.

3.6 Cost Improvement Plans Assessment

Cost improvement plans all encompass a Quality Impact Assessment (QIA). The project is assessed against whether it has any potential impact on patient care, safety or experience. Projects that will require a Project Initiation Document (PID) which encompasses a Quality Impact Assessment (QIA) are defined by the following criteria;

- If there is a change in clinical practice.
- If there is procurement of a different clinical product.
- Changes to service delivery (including staffing).
- Changes in income that may have a contractual impact.

The QIA is reviewed by the Medical Director and Director of Nursing for authorisation. A scheme cannot be implemented until this approval has been completed. If a QIA has not been completed adequately or requires additional information, this will be routed back for rework prior to resubmission or rejection in full.

If the project is deemed to have an unacceptable level of risk, a review meeting will be initiated with the division to discuss further detail before the project is implemented. If a project is not deemed to have a positive or neutral impact on quality it will be withdrawn.

In 2017/18 the Trust will set up a Quality Value Delivery Working Group to provide formal governance arrangements to manage the trust projects and CIP programme, the purpose of the meeting will be to provide assurance and oversight to the project and CIP process, seek status reports as to the stage of delivery for each scheme, together with approving & ratifying schemes. The meeting will assess and manage risks associated with project delivery at a Divisional/Departmental level and RAG rate schemes for likelihood of delivery.

Meetings will take place weekly for one hour chaired by the Associate Director, Strategy and Planning. The standing agenda will be;

- Weekly review for PID and QIA approvals (5 minutes).

- Monthly status presentation by Divisions/Departments where schemes to meet savings target have not been defined or where there is slippage in delivery. Rolling weekly programme of attendees (20 minutes).
- Monthly status presentation by Trust wide scheme project leads updating on status and impact (20 minutes).
- Monthly investment case review and presentation of post implementation reviews (15 minutes).

The group will provide assurance and oversight of the quality impact of the CIP programme with a regular monthly report to the Finance and Planning Committee, a sub-committee of the Board.

3.7 Triangulation

The Trust's integrated performance report triangulates quality, workforce and financial indicators. This report is produced and reviewed monthly, with the metrics of the report structured across three domains and is in keeping with Carter's recommendations.

Caring for Patients	Caring for Staff	Caring for Finances
Serious incidents	Sickness absence	% theatre utilisation
Never events	Staff stability index	Theatre cases per session
Patient falls	Staff appraisal	Average length of stay
Safety thermometer	Mandatory training	Bed occupancy
28 days emergency readmissions	Staff turnover	Outpatient DNA rate
Friends & Family	Total WTE	Inpatient activity
Complaints	Registered nurse vacancy rate	Day case rate
Cancellations not rebooked within 28 days	Unregistered nurse vacancy rate	Outpatient activity
% delayed discharge	Nurse turnover rate	% of inpatients admitted on day of surgery
18 weeks RTT	Proportion of registered nurses	BADS activity
Patients waiting over 52 weeks	Doctors hours per patient day (on implementation of e-rostering)	Referrals received for consultant led services
MRSA	Nursing hours per patient day (on implementation of e-rostering)	Financial control total
C-Diff	Caring hours per patient day (on implementation of e-rostering)	Clinical income
Unexpected deaths	Grievances	Private patients income
VTE	Disciplinary	Other income
Hospital acquired pressure ulcers	% actions completed from staff survey	Pay
Medication errors	Pulse check (on implementation)	Non-pay
% reportable cancellations	Safe staffing	Financing
Cancer two week wait		Agency control total
31 days first treatment (tumour)		Cash balance
31 days subsequent treatment (tumour)		Capital expenditure
6 weeks wait for diagnostics		
% enhanced recovery		
New to follow up ratio		

4 Workforce Planning

4.1 Workforce Profile

The Trust has begun to undertake skill-mix and service reviews together with more joined up planning for our workforce and pay bill, producing detailed monthly reports to the Board. The Trust continues to undertake detailed analysis of our workforce demographics to enable us to plan better. The Trust has analysed our workforce information to identify potential hotspot areas where there is a shortage of skilled clinicians and where there are age clusters, that could potentially cause shortages in the near future.

The Trust continues to work closely and meet regularly with, our health system partners to understand the workforce planning requirements for an integrated health system and to identify opportunities for collaboration.

4.2 Workforce Planning with Clinical Engagement

The greatest operational risk remains to be constrained middle grade and junior doctor numbers. The Trust will continue to collaborate with our partners to mitigate this risk, together with continuing to develop advanced practitioner roles to support doctors and delivery of patient care.

Focus will remain on our identified hotspots with internal training pathways for hard to fill posts. The challenge remains within the nursing workforce of nationally decreasing numbers. Therefore through the Trusts partnership working with the universities to ensure involvement in the training and recruitment of our nurses of our future.

4.3 Clinical Strategy and Local Health Economy Integration

The Trust aims to further collaborate with our partners in the local health system to produce more sophisticated workforce plans, across the wider health system where possible to respond more effectively to changes in our community facilitating secondary care clinicians working with primary care outside of the hospital setting.

4.4 Workforce Transformation and Productivity

At 56% of total spend, people represent a huge investment for Trusts, however ‘workforce’ can often be regarded as a cost to be controlled rather than a creative and productive asset to be harnessed. There is a wealth of talent in the Trust, that are engaged to solve the efficiency and productivity issues the Trust currently faces.

Within our Rebuilding Relationships programme, a project specifically focused upon performance, culture and management, is determining our approach to driving a performance culture. Commencing with defining the behaviours that the Trust requires by fully engaging our people in this definition process. The Trust will seek to build a performance management system that allows us to;

- Measure behavioural performance via a bespoke 360 tool.
- Apply positive and negative consequences for behavioural performance.
- Provide a fully bespoke set of development options to enable our people to fully embed and embody our required behaviours.
- Reflect and respect our multi-professional workforce that has different accountabilities to different central professional bodies.
- Link to systems that provide key management information to inform decisions about talent management, tackling absenteeism and team performance issues.

4.4.1 E-rostering

The Trust has recently purchased an e-rostering system. The aim is to establish a flexible workforce operational plan that aligns the needs of our patients, in respect of acuity and dependency in real time (IPAMS), with the appropriate number and skilled staff, deploying staff to meet patient needs in the most cost effective way possible. This will support safe staffing allocation by ensuring that the balance is achieved between national guidance, patient dependency and

professional judgement, supporting an environment where the planning of staffing is based on the care needs of the patients predicted and then in situ, providing care as required in real time.

To deliver this we will need to utilise technology available including electronic rostering together with our current system to assess real time acuity indicators. There will be a number of key changes from the implementation of this business case and the delivery of the e-rostering workforce project. By utilising technology, methodology and experience we will be able to organise and predict through scheduling our workforce requirements both in real time and forecasting the future, predicting our specific needs. Through this process we will define our care standards and configurable acuity and dependency, optimising the use of our workforce.

Managers will plan and manage staffing with greater ease, consistency and accuracy based on multiple considerations important to care. This system will support a standardised approach to rostering staff. Subsequently this will enable our nurses to release time to care and provide quality bedside care. Ward managers can be assisted through the implementation of this system to maintain a stable nursing workforce, improve patient and nursing satisfaction scores, and avoid incidental overtime or agency costs. Importantly, the reliable data and reporting provided will also build a "bridge" with financial leaders less familiar with clinical care. This undoubtedly will result in more effective utilisation and allocation of our workforce. In addition staff will provide improved levels of service through maintaining the highest standards of care whilst ensuring safe skill mix in a transparent way adds to the Trust's commitment to ensuring the improvements of the safety of patients.

4.4.2 Agency Staff

The Trust recognises that there is now a cap on the amount of money that can be paid per hour for agency staff which came into force late November 2015 affecting all staff groups within the Trust. It is recognised that from February the price caps were reduced further and that all agency staff will be procured through an approved framework agreement which should have rates at or below the cap. As a Trust we intend and already do operate predominantly within these rates, except on occasion in areas such as;

- Junior doctors.
- Specialist Consultants.
- Theatre scrub.
- Radiographers.

The Trust is actively recruiting into vacancies which will reduce the requirement for agency. The Trust also recognise that there is a ceiling for agency expenditure of £1.6m, our current performance is forecast to fall below the ceiling.

4.4.3 Rebuilding Relationships Programme

The Trust, like many similar organisations, faces financial challenges. More than 65 cost reduction programmes have been initiated throughout the hospital, along with several other enabling programmes. Without rigorous implementation support, these well-intentioned initiatives risk becoming resource-intensive and piecemeal, making it very difficult for the Trust to succeed in delivering the necessary savings.

Analysis of main issues for the Rebuilding Relationships programme to address

This work has been used to underpin a strategic analysis by the Trust to identify the main problems the hospital is facing;

- Strengthening accountability of staff and the responsiveness of our services by being patient centred.
- Improving the financial control of the Trust by developing our clinical leadership, creating clarity between bringing together responsibilities for clinical decisions with the financial consequences of those decisions.
- Improving the utilisation of both our staff and resources, whilst making this Trust a better place to work.
- Tackling stagnation and delay in change and development together with the slowness of decision making.
- Eliminating issues that reduce the ability of our staff to do their job in an efficient manner.

- Expand the transparency and use of operational information in decision making.
- Match the acuity and dependency of our patients with the staff skills required to provide appropriate care throughout a patient's stay.
- Increasing involvement of patients and staff in improving their services.
- Improving the way in which we manage our contracts.
- Ensuring there is clinical leadership and improved quality across the Trust.
- Streamline the Trust to work more effectively, reduce overheads so that resources can be diverted to front line services.
- Strengthening our collaboration with partners to create sustainable clinical services.

Improving quality and productivity is inextricably linked with implementing the Rebuilding Relationships programme, through bringing together responsibility for clinical decisions with the financial consequences of those decisions. The Trust will therefore realign the entire hospital to make functions more efficient and will consider which back office services it could more efficiently provide in partnership.

4.5 Key Workforce Risks

Source of Risk	Description	Risk Score	Action
Consultant Rheumatologist	Difficulty in recruiting to this sub-specialty.	16	Continuous advertising and working with recruitment agencies.
Pressures of activity on Trust staff and ability to manage pressures		16	Launch of Rebuilding Relationships programme. Partnership working / Engagement with Unions. Review Staff survey and SFFT results / Staff engagement experience programme.
Theatre recruitment	Recruitment of scrubs, ODPs and leg holders.	9	Theatre centred focused recruitment and retention programme.

5 Financial Planning

5.1 Overview

- The Trust's financial plans for 2017/18 and 2018/19 set out a control total surplus of £1.1m and £1.9m respectively.
- The plan achieves a UoR rating of a 2 and assumes CIP of £3.6m (3.6%) in 2017/18 and £3.0m (3.0%) for 2018/19.
- Losses from the introduction of HRG4+ tariff included in the above stand at £1.4m, net of assumed mitigations for specialist top ups and exclusions.
- Tariff losses have been mitigated through agreement of local pricing on orthopaedics.
- The plan includes capital investment of £2.5m in 2017/18 and £2.5m in 2018/19 following an assessment of minimum investment requirements to support delivery of safe and effective services.
- Cash balances are projected to drop to £3.5m in 2017/18 and increase to £4.1m in 2018/19 following receipt of STF monies to be held to improve liquidity.

The table below summarises the forecast financial performance for 2016/17 and planned performance for 2017/18 and 2018/19.

	2016/17 Outturn £'m	2017/18 Plan £'m	Variance £'m	2018/19 Plan £'m	2017/18 CIP £'m
Clinical income	89.2	90.5	1.3	90.5	0.2
Private patient income	4.4	4.8	0.4	4.8	0.4
Other income (exc. donations)	6.4	6.5	0.1	6.5	0.3
Sub total income	**100.0**	**101.8**	**1.8**	**101.8**	**0.9**
Pay expenditure	(55.6)	(58.3)	(2.7)	(57.9)	0.4
Non pay expenditure	(39.1)	(38.6)	0.5	(38.2)	2.3
Sub total expenditure	**(94.7)**	**(96.9)**	**(2.2)**	**(96.1)**	**2.7**
EBITDA	**5.3**	**4.9**	**(0.4)**	**5.7**	**3.6**
EBITDA %	**5.3%**	**4.8%**	**(0.5%)**	**5.6%**	
Finance Costs	(3.9)	(4.4)	(0.5)	(4.4)	
Donations	1.2	0.2	(1.0)	0.2	
Net surplus/(deficit)	**2.6**	**0.7**	**(1.9)**	**1.5**	
Donated Income	(1.2)	(0.2)	1.0	(0.2)	
Depreciation on donated assets	0.6	0.6	0.0	0.6	
Control total*	**2.0**	**1.1**	**(0.9)**	**1.9**	
STF**	(0.5)	(0.6)	(0.1)	(0.6)	
Control total exc. STF	**1.5**	**0.5**	**(1.0)**	**1.3**	
UOR	**1**	**2**		**2**	

*Control total targets set for 2017/18 and 2018/19 are £1.105m and £1.917m respectively.
** STF available for 2017/18 and 2018/19 is £0.592m each year.

5.2 Financial Forecasts and Modelling

The plan has been built up from the recurrent forecast outturn position (for 2016/17), adjusted to reflect any known activity and cost pressures (including inflation), any known service changes, and with an internal stretch efficiency target in 2017/18 (circa 3.5%).

5.2.1 Roll forward position

The 2016/17 forecast is based on the Month 7 NHSI submission (as required by the planning guidance) which assumes the year end control total surplus is achieved in full. Any subsequent shortfall in out-turn for 2016/17 will increase the efficiency requirement going forward by an equivalent value.

This has been adjusted for non-recurrent cost pressures and the full year impact of investments committed in 2016/17 to provide an opening baseline position as illustrated in the table below. These investments facilitated the opening of our new theatres development and bolstered our governance and management arrangements in response to regulatory reviews.

	2017/18 £'m
2016/17 control total*	2.0
Less STF in above*	(0.5)
Less non recurrent pressures 16/17	(0.6)
Rollover I&E before commitments	**0.9**
New theatres build	(0.2)
2016/17 structure investments	(0.4)
PAS contract extension	(0.1)
Rollover I&E net of commitments	**0.2**

* Assumes full delivery of 2016/17 control total.

There are a number of key movements for 2017/18 compared to our 2016/17 planned outturn. The main areas are;

- Tariff losses of £2.5m under HRG4+ as modelled from the consultation tariff and £1.1m of this assumed to be mitigated.
- Tariff inflation of 0.1% plus CNST direct uplifts to procedure level.
- A reduction in education and training income of £0.1m from 2016/17 levels.
- National pay award of 1% and incremental progression - £0.8m.
- Apprenticeship levy of £0.2m.
- Increased CNST premiums of 10% £0.2m.
- Non pay inflation of £0.3m.

5.2.2 Assumptions and Drivers

There have been a number of assumptions made for the submission of this plan. As well as the key movements highlighted in section 5.2.1 above the following assumptions have been made;

- The start point for commissioners contract is forecast outturn for 2016/17.
- No fines or penalties have been included as per guidance.
- CQUIN has not been included for Welsh commissioners.
- Agency expenditure as per our control total.

5.2.3 Local Investment in services

The plan allows for £0.7m discretionary investment in local services. Whilst the exact detail is still to be confirmed this is expected to include;

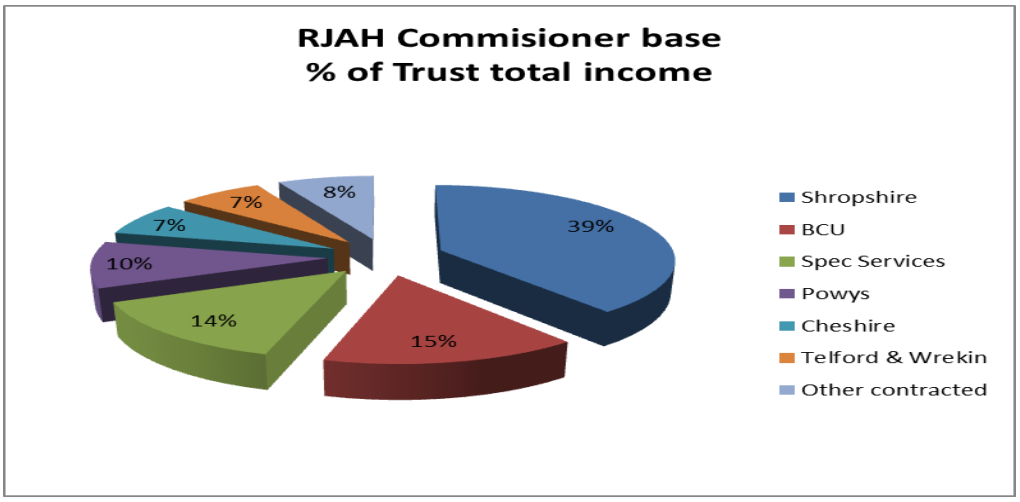
- Replacement of CT scanner (lease agreement).
- Review of nursing establishments at night.
- Further external support to our cultural reform programme.
- Transformational project management.

5.2.4 Contingency

The plan contains an undesignated contingency for unforeseen cost pressures of £0.5m (0.5%). This is aligned to historical levels of contingency requirement.

5.3 Alignment to Commissioner Plans

We provide services to a broad mix of commissioners across England and Wales. The proportion of activity and income received from each during 2016/17 is illustrated below;



5.3.1 England

We have reached agreement in respect of contracted activity and prices with all of our English commissioners. The plan reflects these agreed positions and will require us to deliver the same activity as undertaken during 2016/17.

We have a challenging QIPP of £1.2m to deliver for our host commissioner, Shropshire CCG. This will require much focus ahead of 2017/18 to prevent a material over performance accruing.

All of our contracts are on the basis of full PbR and no contract sanctions have been assumed in the plan.

In line with national guidance, we are planning for 0.5% of CQUIN income to be held in reserve.

5.3.2 Specialised Services

We have reached an understanding with our Specialised Commissioners regarding future contracted activity and values including investment in service developments and enhanced staffing for our spinal injuries ward. At the point of this submission, there is one material area requiring resolution; this relates to the application of national tariff to a specific high cost tumour procedure which we had been led to understand from discussions during the tariff consultation period would be locally priced based on cost.

Linked to the agreement in new investment is a commitment for us to deliver QIPP schemes associated with improving delayed discharges

CQUIN remains at 2% with local schemes still to be agreed.

5.3.3 Wales

Wales is not operating to the same planning timetable as England so we will not be in a position to confirm contracted levels within the NHS England planning timetable set.

The Trust is assuming no changes to waiting times for either of our Welsh commissioners from 2016/17 expectations.

5.4 Operational Delivery Plan

We are planning to deliver 11,580 operations in 2017/18 which is 100 cases higher than in 2016/17.

The Trust will utilise the additional theatre capacity from the opening of an eleventh theatre to repatriate all work outsourced to the independent sector during 2016/17 and additionally hold resilience for any unplanned increase in referrals.

5.5 Capital

Our five year strategy assumed a capital resource based on a re-investment of our annual depreciation net of capital loan repayment and a re-investment of annual income and expenditure surpluses.

Given the financial challenges as yet unresolved, we have pulled back our capital investment aspirations as included in our five year strategy to cover essential replacement and maintenance only. Having undertaken a detailed assessment of our essential expenditure requirements, the plan allows for £2.5m for each of the next two years. Funding for this will be a challenge requiring us to contribute from cash reserves as indicated in the table below.

	2017/18 Current Assumption £'m	2018/19 Current Assumption £'m
Internally generated cash from depreciation	2.2	2.2
Internally generated cash from I&E	0.5	1.3
Cash investment	0.8	0.0
Loan repayment	(1.2)	(1.2)
Charitable donations	0.2	0.2
Projected Capital Resource	**2.5**	**2.5**

5.6 Cash

Our cash balances have been assessed as per the table below and are dependent upon the achievement of the 2016/17 control total and clarification in respect of potential additional STF or relief for tariff loss.

These levels are the minimum required to maintain a healthy level of liquidity throughout the year (15 days operating expenditure).

	2017/18 Current Assumption £'m	2018/19 Current Assumption £'m
Forecast Opening cash balance	4.2	3.5
Cash investment in capital programme	(1.3)	0.0
STF	0.6	0.6
Closing cash balance	**3.5**	**4.1**

5.7 Efficiency

Excluding the impact of HRG4+ we have assessed the need to deliver an efficiency programme of 3.6% (£3.6m). We recognise this will be highly stretching and will come off the back of a similarly sized programme for 2016/17.

Whilst schemes to deliver a programme of this size remain under development, we anticipate it will be delivered through a combination of repatriation, service transformation, procurement savings and productivity improvements. Additionally we will look to secure opportunities within our capital programme to prioritise invest to save schemes.

Whilst as a Specialist Trust we are outside the scope of the Lord Carter work we are actively working to embrace the principles and through our STP are reviewing back office functions, pathology services and estates utilisation.

With regard to procurement, we are seeking to improve our prices using recently received benchmark data and will also look to restrict product usage and variation where clinically appropriate and to enable further saving opportunities to be realised.

We will continue to reduce our premium workforce costs through the recruitment of additional consultants and clinical staff aligned to our demand and capacity requirements.

Our transformation projects will focus on improvements to all aspects of the patient pathway and include outpatients, pre-operative assessment, theatres throughput, length of stay and post discharges follow up.

Additionally, through the opening of an eleventh theatre we will be able to repatriate activity outsourced to the independent sector during 2016/17.

Based on historical performance we recognise the need to make allowances for slippage into CIP plans and will therefore aim to identify schemes to a value of circa 20% over and above the target set. This methodology has been effective in consistently delivering our savings programme in full.

Development of the programme remains ongoing and will require full sign off by the Medical Director and Nursing Director as part of an established Quality Impact Assessment process.

5.8 Key Financial Risks

The key financial risks are summarised in the table below and factored into the sensitivity analysis;

Risk	Rating	Action / Opportunity
Delivery of 2016/17 financial plan deteriorating 2017/18 roll forward position.	Medium	Would require increased CIP delivery.
Failure to deliver the Cost Improvement and QIPP programmes.	Medium	There are a number of actions underway to support delivery: • Ensuring project support is resourced and structured to strongly programme manage. • Review of service lines to identify those requiring redesign or identify those which are no longer financially viable.
Workforce pressures impede the ability to deliver the plan within the resources allocated.	Medium	Recruitment and retention programme ongoing.
Ability to maintain the required working capital.	High	Cash flow modelling has taken place concluding that the cash position will not be sufficient for 2017/18 with a potential need for distress funding in 2018/19.

6 Membership & Elections

The Trust and our Council of Governors have governor recruitment and elections as a continuing priority, some of the initiatives are in use and ongoing.

When a Governor has been elected, an induction is held with the Chairman, Lead Governor and Trust Secretary. The induction outlines the current Trust performance, statutory responsibilities and the important role Governors can play in the life of the Trust.

The Council of Governors have regular training and continued professional development in a range of subjects including Quality, the role of the CQC, dementia, effective challenging and questioning and accountability.

Governors have been involved in the appointment of;

- The Chief Executive.
- A non-executive director.
- The re-appointment of an existing non-executive director for a further term of office.

Governors are also an integral part of Trust business with representatives on Committees including the Trust's rebuilding relationships programme barometer group, and patient panel.

The Council of Governors hold quarterly surgeries in the main entrance of the Trust which gives members of the public opportunity to give feedback in real time whilst at the hospital. This has proved a valued opportunity for Governors and has resulted in patients after communicating with the Governors joining the patient panel and undertaking voluntary work with the League of Friends.

Engagement with members and the public is a priority for Governors and the Governors have developed a Membership Strategy which will focus on further engagement opportunities with members and the public and aim to increase membership by 5% per annum. Governors will continue to move forward with Outreach events which give a wider opportunity to meet and engage with members and the public.

The Trust proactively communicates at least three times a year directly with the membership via the Connect publication which features different articles on activities within the Trust and Governor activity.

The Trust and the Council of Governors will continue with the well laid foundations detailed above for engagement with members and the public through 2017/18 and proactively reach out to local interest groups to encourage further engagement and feedback from a diverse range of groups across all constituencies.

During 2016/17 Governor elections took place where new Governors were elected for Powys, Shropshire and Staff. Further elections will be taking place during 2017/18 for Public and Staff Governors.