Sustainable
FOR THE FUTURE

ROBERT JONES AND AGNES HUNT ORTHOPAEDIC AND DISTRICT HOSPITAL NHS TRUST

ANNUAL PLAN 2009/2010

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1.0 INTRODUCTION

1.1 RJAH Orthopaedic Hospital NHS Trust

RJAH Orthopaedic Hospital is the principal provider of adult and children's musculoskeletal services for the people of Shropshire and the Welsh Borders. As a leading specialist trust we provide regional services to the West Midlands, North West England and Central and North Wales, and national services to the whole of England and Wales.

The trust has a long established track record in providing the highest quality, safe and effective hospital care to our patients and in 2007 we were voted 'Best Hospital' in the Healthcare Commission's annual Inpatient Survey.

The trust is on a single site, located on the outskirts of Oswestry adjacent to the Shropshire/Wales border. It has nine inpatient wards, eight operating theatres including a dedicated daycase unit, supported by specialist nursing, diagnostic imaging and therapy services. There are substantial outpatient facilities on site, with additional outreach clinics and treatments held in other hospitals more local to patients.

The organisation provides a full range of musculoskeletal surgical and medical hospital services through a clinical business unit structure. These are:

Surgical Services comprising:

- Orthopaedic surgery for adults and children
- Theatres, Anaesthetics, HDU and TSSU
- Outpatients
- Diagnostics
- Orthotics

Medical Services comprising:

- Rheumatology
- Metabolic Medicine
- Spinal Injuries
- Paediatric Medicine and ORLAU
- Elderly care rehabilitation
- Therapy services
- Pharmacy

Hosted Services

Provided on site by Shropshire County Primary Care Trust:

- Advanced Primary Care Services (APCS)
- Minor Injuries (MIU)
- DAART - older peoples' assessment and rehabilitation

Provided on site by Shrewsbury and Telford Hospitals NHS Trust:

- Maternity services
- Non-orthopaedic outpatient clinics

Partnerships and clinical Networks

We work in partnership with neighbouring provider organisations including Shrewsbury and Telford Hospitals NHS Trust and North East Wales Trust, Wrexham, as well as specialist centres such as University Hospital North Staffordshire, Birmingham Children's Hospital NHS Foundation Trust, Alder Hey Children's NHS Foundation Trust and Christie Hospital Foundation Trust in providing services.

1.2 Mission Statement

Our Trust mission statement provides the foundation for our strategic goals and five year plan. We face some important challenges and an exciting future. Changes in national and local health policy both in England and Wales mean we will need to continue to adapt and evolve our services to ensure we meet the needs of our patients, both now and for the future.

Our strategic intention is to become the leading national specialist Orthopaedic Trust in the UK and the key provider of Choice for local people and beyond, offering high quality, patient centred care. Our unique geographical position, the nature of the services we provide and our leading reputation in patient care, research and education place us in a strong position to develop as an NHS Foundation Trust.

"The leading provider of high quality and sustainable Orthopaedic Services, building on our reputation for excellence".

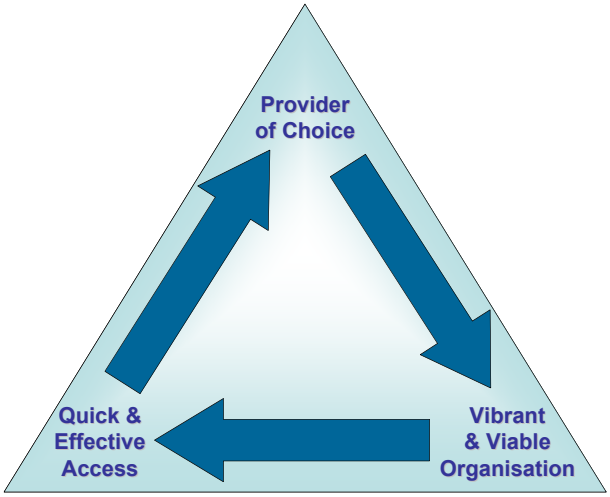
1.3 Trust Principles and Values

Quality of care is the theme that runs through our services and we aspire to the highest international standards for future service provision.

The trust mission statement is underpinned by three strategic aims:

- **To be the provider of choice for patients requiring orthopaedic care through the provision of safe, effective and high quality care.**
- **To develop a vibrant and viable organisation where people achieve their full potential and where, as we move forward and continue to develop as an NHS Foundation Trust, success leads to investment in services for patients.**
- **To improve access to our services and ensure that everyone, no matter where they are from, is seen as quickly and effectively as possible.**

The strategic aims underpinning the corporate objectives are depicted below and it is through the delivery of these aims and objectives that the trust will achieve authorisation as a Foundation Trust.



As a Trust Board we have endorsed the following values:

	VALUE	EVIDENCED BY:
1.	**Quality**	Services are provided to the highest quality standards in terms of patient experience, treatment and environment. We will achieve the highest levels of cleanliness with a zero rate of MRSA in our hospital.
2.	**Excellence**	We aim to exceed the expectations of our patients and customers and we set high standards for our services. Patient satisfaction consistently shows that over 90% of patients report our services as excellent.
3.	**Respect**	We are a caring environment where patients as individuals come first. We treat patients, their carers and our colleagues with respect and dignity.
4.	**Safety**	We will maintain safe surroundings and facilities for our patients, staff and visitors.
5.	**Involvement and Teamwork**	We will foster collaboration and co-operation amongst individuals and teams. We will work together for the organisation as a whole. We are clear about our expectations of staff in their delivery of services. We will involve patients in improving our services
6.	**Leadership**	We will develop a clear direction for the future of our hospital which will be owned at all levels. We will set objectives and monitor ourselves against their delivery.
7.	**Efficiency**	We will operate to the highest level of cost efficiency and effectiveness whilst maintaining high standards. We will successfully manage our resources.
8.	**Partnership**	We will work collectively with stakeholders, within our wider health economy, and with staff in developing our plans for the future.
9.	**Communication**	We commit to communication at all levels within the Trust and externally to our patients and stakeholders.

1.3.1 The Operating Framework for 2009/10

The operating framework sets out the mechanisms for delivery of the national and local priorities and the main messages are;

Quality will be the organising principle of the NHS and spans 3 areas: safety, effectiveness and patient experience. From April 2010 onwards acute trusts will be expected to publish quality performance in the form of an annual 'Quality Account'.

Highest ever focus on securing **value for money** by prioritising the most effective treatments, reducing errors and waste and keeping people healthy and independent for as long as possible. In light of the difficult conditions facing the global economy the challenge is to secure substantial public sector efficiency savings in 2010/11.

The **national performance targets** for England remain the same as they were for 2008/09 with a maximum Referral To Treatment time target of 18 weeks. The waiting time targets for Wales continue to reduce with the target that by 31st December 2009, 100% of patients to be treated within 26 weeks of referral.

The **national tariff** has been revised to make the payment system more clinically relevant. A new set of healthcare resource groupings (HRGs) called HRG4, have been

developed and will take effect from April 2009. The most fundamental changes relate to the market forces factor, procedures delivered in outpatient clinics, a reduction in specialist top-ups and additional income for Commissioning for Quality and Innovation schemes (CQUIN).

The five national priorities identified in the operating framework are:

- Improving cleanliness and reducing HCAIs
- Improving access through achievement of the 18 week referral to treatment target
- Keeping adults and children well, improving their health and reducing health inequalities
- Improving patient experience, staff satisfaction and engagement
- Preparing to respond in a state of emergency, such as an outbreak of pandemic influenza

1.4 Trust Objectives for 2009/2010

The Trust objectives for 2009/2010 have been developed to reflect the national requirements and also the key aims and objectives identified through the ongoing work of staff engaged in the Trust's Sustainable Services Programme. These goals have been aligned with the national and local priorities and translate into the following five key Objectives for RJAH.

2009/2010 Objectives:

- **Quality Improvement** – We will maintain the current low levels of health care associated infections and use the Commissioning for Quality and Innovation (CQUIN) framework to identify and deliver improved quality and innovation measures. We will maintain our excellent ratings for our patients experience.

- **Access –** We will maintain and improve upon the 18 week Referral To Treatment (RTT) targets for England, as well as ensure that for Wales, by December 2009 100% of patients are treated within 26 weeks of being referred by their GP. We will increase our market share as the provider of Choice for local people.

- **Financial Success -** We will deliver an in-year surplus of £1.1 million and invest in improving our environment and facilities for patients.

- **A committed and effective workforce -** We will continue to support our staff in maintaining the highest standards of care.

- **Foundation Trust Status –** We will develop our application to become an NHS Foundation Trust, securing the future for our services

2.0 REVIEW OF PERFORMANCE FOR 2008/09

2.1 Review of the Past Year

2008/09 has been a successful year for the Trust in which we have continued to deliver safe, effective, high quality care and our patients have rated us to the very highest levels of satisfaction.

- We have treated more patients in the hospital than in any previous year and have achieved our waiting list targets for English and Welsh commissioners.
- We have delivered this record level of patient activity and have achieved a financial surplus for the second successive year, reducing our support requirement from the SHA.

In 2008/09 there have been significant changes to our organisational structures and to our workforce which have included;

- Increases in staffing establishment within Theatres to achieve extended hours of service provision through new rotas, planned for introduction in 2009.
- Reduction of the overall ward bed base, achieved through shorter lengths of stay and improved bed utilisation.
- All Consultant Job Plans have been reviewed to ensure maximum utilisation of expertise and clinical sessions in line with service requirements and to ensure consistency.

During the year the Trust also appointed additional consultants specialising in Foot & Ankle, Arthroplasty and Anaesthetics.

The Annual Healthcheck rating from the Healthcare Commission published in October (based on 2007/08 performance) showed an improvement in the Use of Resources component from Weak to Fair overall, but a disappointing reduction from Excellent to Fair for the Quality of Services component. The rating for our 2008/09 performance will not be published until October 2009 but we are aiming to achieve a Quality of Services rating of Excellent, as well as a rating of Good for Use of Resources.

Performance indicators for 2008/09

Performance against the range of national performance indicators relevant to the trust was excellent during 2008/09.

Quality and Infection

During 2008/09 the trust has maintained its very high standards in relation to hospital acquired infections with:

- No cases of MRSA Bacteraemia for a second successive year
- A total of 7 cases of C Difficile against a target ceiling for the year of just 9
- Amongst the lowest levels of Surgical Site Infection (SSI) rates in the country.

Patient Access

This year has seen a big drive by hospital staff to successfully reduce waiting times for patients and to minimise delays in the patient pathway which is evidenced by:

- Early achievement of the English and Welsh RTT waiting time targets
- No breaches of the stages of treatment waiting time targets for England and Wales
- There have been 0 breaches of the national cancer waiting time targets
- The trust improved its performance on the national cancelled operations target by achieving ≤ 0.8%, including 0 breaches of the 28 day readmission target
- The number of delayed discharges was maintained below the national target threshold of ≤ 3.5%

Patient Experience

For the 2008 National Patient Satisfaction survey a total of 850 patients who had been inpatients at RJAH during 2008 were sent a questionnaire. 600 patients responded, giving a response rate of 71% against an all trusts average of 51.5%.

The chart below indicates how we performed against other trusts surveyed across a total of 80 questions:

Our own continuous assessment of patient satisfaction, based on questionnaires completed by patients following their stay in hospital, looks at four key measures which are important to patients. Throughout the year more than 96% of patients have rated their care at RJAH as either good or excellent.

How Many Patients We Treat

Activity levels were higher than in 2007/08 across all categories, as the table below illustrates;

2008/09 v 2007/8 Activity

Type	2007/08 Actual	2008/09 Actual*	Variance against 2007/08
First OP Attendance	21,644	22,984	6.2%
Total OP Attendances	63,948	67,389	5.4%
Elective FCEs	11,791	12,838	8.9%
Emergency FCEs	833	855	2.6%

* Projected at February 2009

Sustainable Services

In recent years, the Trust's ability to develop a credible and viable business plan for the future has been limited due to poor financial performance and a lack of clarity regarding the underlying causes. We have worked hard to improve this position and fundamental to our success has been our focus on the Sustainable Services Programme.

The Sustainable Services workstreams have included:

- Theatres usage and efficiency
- Bed Utilisation
- Estates rationalisation
- Corporate and Management review
- Medical staffing/job planning review

As a result of this change programme, we have seen huge improvements in performance in the organisation which have enabled us to secure a clearer future, and for 2009/10 have allowed us to develop a set of objectives for improvement based on the patient pathways for services.

During the last 18 months, the Trust has also made significant changes organisationally and operationally which have been key to this improved position. These include:

- Changes at Executive and Non Executive level
- Changes in organisational structure and management
- Changes in the operational running of the Trust to improve efficiency
- Improving the focus on key areas of delivery to:

- Increase activity
- Reduce cost and;
- Maintain quality

At the same time, we have demonstrated a significant increase in activity, an increase in ward occupancy across the Trust and improved utilisation of assets in terms of theatres, outpatients and diagnostics.

Our Staff

During the later part of 08/09 the trust developed a HR/OD strategy, through consultation and discussion at all number of levels, involving clinicians, managers, staff side representatives and staff within the organisation, this has resulted in a document that is meaningful and owned within the organisation. Further details regarding the Key principles and objectives can be found in a later section of this plan, the strategy details a delivery plan for the coming year, an extension of key performance indicators and clarity relating to assurance and monitoring.

During 2008/09 it was recognised that leadership and management development is a key requirement for the sustainability of the organisation for the future, and reference is made to this within the HR/OD strategy regarding the scoping of future requirements to further support the development of leadership and management capability within the Trust in a cohesive and structured way.

Clinical leadership sessions were delivered primarily this involved consultants Clinical Directors and Clinical Leads, the medical leadership competency framework currently under discussion was used as basis for this. Other bespoke sessions regarding management development and leadership were delivered throughout the year.

The Trust has also recently been given the green light for successfully implementing all elements of the national electronic staff record system.

2.2 Summary of Financial Performance

The financial year 2008/09 has been a positive one seeing the delivery of all of the Trusts statutory financial duties. The Trust was able, due to the management of its cost base and through increased productivity, to defer a proportion of the SHA transitional funding it received. This allows the Trust to effectively repay the last instalment of it loan (£1.1m) a year ahead of schedule. The Trust therefore goes into 2009/10 free from historic debt.

A summary of the financial performance is shown in the table below:

	2008/09 Plan	2008/09 Actual Performance (Forecast)	Variance
	£000's	£000s	£000s
Income	71856	72059	203
Pay	-38781	-39060	-279
Non Pay	-27235	-27007	228
EBITDA	5,839	5992	153
Financing & Depreciation	-4705	-4858	-153
Net Surplus before exceptional items	**1134**	**1134**	**0**
Exceptional Items	-250	-250	0
Reported Surplus	**884**	**884**	**0**

The Trust has also been testing its performance against the 5 metrics Monitor use in assessing Foundation Trusts performance. These are detailed below and show the Trust delivering a level 4 risk rating (5 being the best) which puts the organisation in a strong position as it moves forward with its Foundation Trust application.

	2008/09 Annual Forecast	Risk Rating
EBITDA margin	8.32%	3
EBITDA achieved	103%	5
Return on Assets (ROA)	5.21%	4
I&E surplus margin	3.76%	3
Liquidity ratio (Days)	33	4
Overall Risk Rating	**4**	**4**

Other key highlights of the financial year include:

- The delivery of a 4.5% cost improvement programme totalling £3.250m
- The delivery of an additional 9% of activity over the previous year which has driven an increased contribution
- Investing £3.6m on the Trusts assets including a significant development and upgrade to the Trusts private patient ward.
- Completion of the Torch building, a donated asset which enabled centralisation and co-location of a children's service for muscle disorders and rehabilitation, and facilitated the centralisation of research across the trust.

2.3 Organised to deliver

2.3.1 Trust Board – Who and how it works

The Trust Board has overall accountability for the management and performance of the Trust. The board comprises a Chairman, 5 Executive directors and 5 Non-Executive Directors as follows:

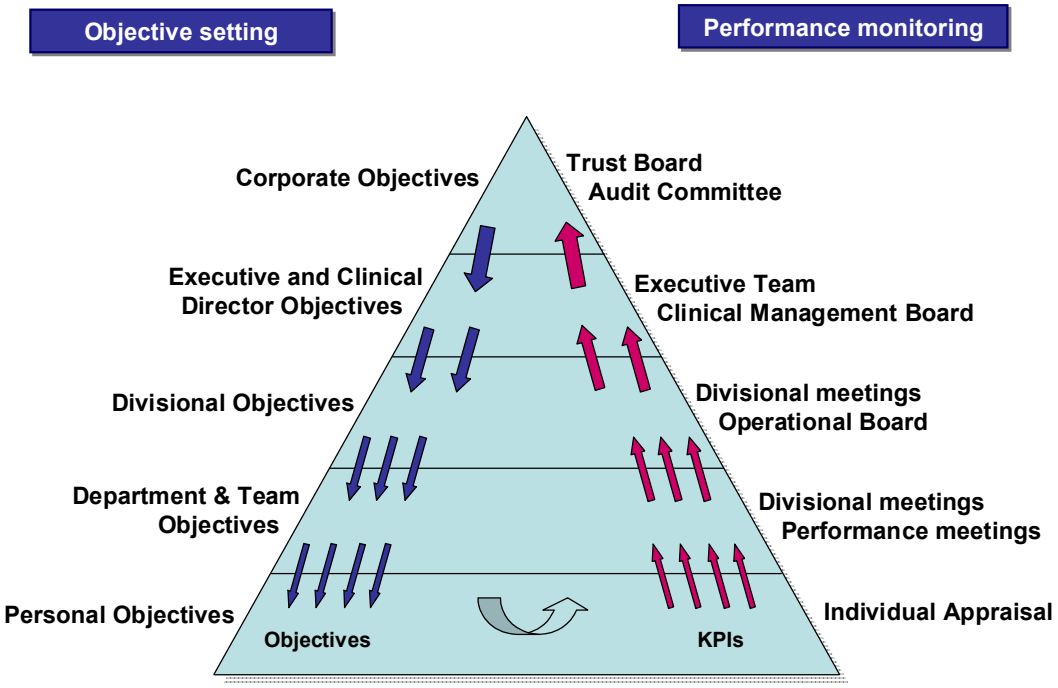
	Name	Position
Executive Directors	Wendy Farrington Chadd	Chief Executive Officer
	David James	Director of Operations and Development
	John Grinnell	Director of Finance, Contracting and Performance
	Vicky Morris	Director of Nursing and Governance
	Professor Iain McCall	Medical Director
Non-Executive Directors	Russell Hardy	Chairman
	James Turner	Vice-Chairman
	Mervyn Dean	Non-Executive Director
	Lynne Lobley	Non-Executive Director
	Peter Jones	Non-Executive Director
	Glen Lawes	Non-Executive Director

How we govern ourselves

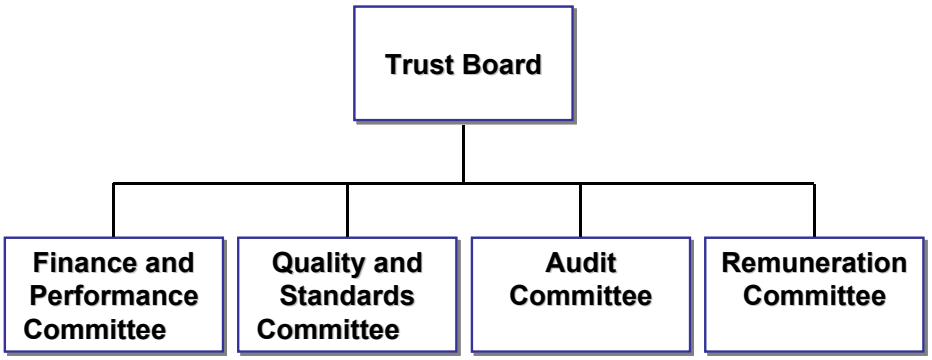
The delivery of the annual plan is monitored in accordance with the Trusts Governance Strategy and objectives through the Assurance Framework. Progress against delivery of the annual plan will be monitored by the Audit Committee, supported by presentation of the

assurance framework and the corporate risk register, with a quarterly exception report provided to the Board.

As depicted below, business objectives are embedded within all levels of the organisation right through from the overarching corporate objectives, through Executive and Divisional Objectives, to team and individual objectives.



The trust's governance arrangements for 2009/10 are as depicted in the board and formal sub-committee structure diagram shown below:



External reporting to the SHA is required monthly and the new Care Quality Commission will also review performance on a quarterly basis.

3.0 FUTURE BUSINESS PLANS

3.1 Strategic overview

3.1.1 Strategic Context

National and local context

The NHS Next Stage Review Final Report 'High Quality Care for All' describes the changes facing society and healthcare systems around the world and sets out how the NHS in the 21st century faces a particular set of challenges. These are summarised as rising expectations; demand driven by demographics; the continuing development of the 'information society'; advances in treatments; the changing nature of disease; and changing expectations of the health workplace. The vision the report sets out is of an NHS that gives patients and the public more information and choice, works in partnership and has quality of care at its heart – quality defined as clinically effective, personal and safe.

In May and June 2008 each Strategic Health Authority published a report describing their locally-developed visions for improving health and healthcare over the next decade. "Investing for Health" forms the strategic framework developed by NHS West Midlands to identify and address the challenges facing health services across the region. The report describes seven challenges which need to be addressed:

- Inequalities
- Insufficient investment in prevention
- Variability in quality
- Unaffordable cost of 'doing more of the same'
- Lack of public confidence in the NHS
- Better alternatives
- Understanding services

In addition a local strategy has been developed called 'Health and Health Care Strategy for Shropshire, Telford and Wrekin'. The strategy provides a framework for improving health and providing health services over the next five years until 2012/13 to set out:

- how patients will be treated
- what developments and improvements are needed
- the implications for staff including recruitment, development and training
- the financial plan.

The strategy will also develop a vision to '2020' which will outline the main developments and improvements that will be needed over the next 12 years. Three criteria have been identified to support the work with communities in shaping future health services:

Making Sense Clinically	Health, Well Being and Equity
	Quality, Safety And Effectiveness
	Supporting and Developing the Workforce
Making Sense to the Communities We Serve	Involving People in Making Decisions about their future Health Services
	Affordable, Sustainable, Fit for Purpose
	Personalised Services and Access to Care, Closer to Home

The three main objectives of the local strategy for Shropshire, Telford and Wrekin are:

- Preventing Disease and Promoting Healthy Lifestyles
- Providing Services at Home or as Close to Home as Possible
- Providing Sustainable and Accessible Acute Hospital Services

Its development is overseen by the Clinical Leaders Forum which includes senior medical and nursing staff and the directors of commissioning from the two Primary Care Trusts and the two Acute Trusts in Shropshire, Telford and Wrekin. Much of the development is being driven by eight Pathway Development Groups, each led by a senior clinician and using Map

of Medicine as a key enabler. The Planned Care group is chaired by Dr Debbie Short, Rehabilitation Consultant at RJAH.

3.1.2 Payment for Quality

The 2009/10 Operating Framework, through payment of 0.5% of our income based on achievement, formalises the development, monitoring and reporting of clinical quality measures via a Clinical QUality and INnovation scheme CQUIN). These are in addition to any national and local mandatory targets and are focused around four key themes:

- Safety
- Effectiveness
- Innovation
- User Experience

Our CQUINS scheme for 2009/10 has been finalised with our co-ordinating commissioner and is made up of the following 5 indicators:

- Score for patients who reported they received copies of letters sent between hospital and GP. 1st year Discharge letters, 2nd year outpatient letters
- Hip Patient Reported Outcome Measure
- Knee Patient Reported Outcome Measure
- Medicines management – acute trusts compliant with safety standards
- Documented evidence that an agreed % of patients/carers have had an explanation about their treatment and follow up care and have understood the information prior to their admission

3.1.3 Contracting and Influencing Strategies with Stakeholders

Shropshire/Cheshire

With an estimated 289,100 residents, Shropshire has the smallest population of any of the shire counties and is one of the most sparsely populated counties in England. Key Facts:

- Its population is increasing faster than England as a whole due to inward migration of older people
- There is a corresponding fall in the 20 – 65 age group.
- The highest population growth is in the over 65 age group which is projected to increase from 1 in 5 to 1 in 4
- the over 75 age group will increase to almost a quarter of the total population by 2013.

Shropshire PCT are the co-ordinating commissioner for RJAH and as such oversee commissioning arrangements with the trust on behalf of all English PCTs. Shropshire PCT has one of the highest access rates and the highest spend for musculoskeletal services in England. The PCT are therefore seeking to develop different ways of delivering musculoskeletal services within Shropshire. Having invested in orthopaedics during 2008/09 in order to deliver the 18 week RTT targets, the PCT are looking to a reduction in spend for 2009/10. However activity and demand modelling is showing rising demand, illustrated by increased activity levels during 2008/09 with no corresponding reduction in waiting list size. Shropshire County PCT face a difficult position financially during 2009/10 and the trust will be working closely to support the PCT.

The Trust will need to be proactive in marketing terms to retain referrals from Cheshire, particularly if travel costs become an increasing consideration for both patients as a result of the 'credit crunch' and commissioners a result of the transfer of responsibility for bearing patient transport costs.

Wales

North Wales has one of the highest access rates for orthopaedics in the UK. Powys covers a quarter of Wales and is the most sparsely populated county in England and Wales. Key facts:

- A high percentage of the North and Mid Wales population is over retirement age (20% – 30%)

- the highest population growth is in the over 65 age group
- The proportion of people aged 75 and over in Powys has increased from 8.8% to 10.2% over the past 10 years
- Inward migration of older people and outward migration of younger people is commonly cited as the cause for the growth of the aging population percentage in Wales.

A major reconfiguration of Welsh health services is in progress which will see the development of an NHS Wales Delivery Board which will operationally oversee seven new NHS Local Bodies. The seven new LHBs will be integrated health organisations and will take over all the roles and responsibilities of Wales' current 22 LHBs and seven NHS trusts. They will be established in shadow form from June 2009, with a view to them becoming fully operational from October 2009. It is hoped that the national proposals to move Wales to English PbR tariff arrangements will simplify commissioning relationships and cross border patient flows.

Specialised Services Commissioning

In 2006 the Review of Specialised Services Commissioning arrangements led by Lord Carter recommended that 'Specialised Commissioning Groups' (SCG) should formally designate specific providers to provide specific specialised services. Designation would be based on a nationally agreed set of patient-centred, clinical, service, quality and financial criteria and be reassessed every five years. Designation is not an isolated activity and will be part of the commissioning process to ensure fair access to clinically effective, high quality, cost effective specialised services. Activity at undesignated providers should not be funded by commissioners. The designation process will comprise several stages:

- needs assessment
- service specification
- quality review
- financial assessment
- strategic plan
- procurement and designation decision
- commissioning and monitoring.

RJAH recently completed a high level analysis of all the services which met some or all the criteria outlined in each of the relevant Specialised Services National Datasets of which there are currently 35. This exercise highlighted a number of services within the trust which meet the criteria for specialised commissioning but are currently commissioned at a local level. The West Midlands SCG are in the process of reviewing this list and have already identified 3 areas which they would like to progress further:

- Orthopaedic and Research Locomotor Assessment Unit
- Complex rehabilitation
- Spinal Surgery

In Addition the National Commissioning Group (NCG) are working with organisations who provide very specialised services to identify those which would benefit from National Designation. These are organisations who are one of only 4-5 centres who undertake very specialised activity for less than 1000 patients from the whole of England. The bone tumour services at RJAH are already nationally commissioned a further two services are currently through to the second round of assessment which would lead to National Designation for 2010/11. The two services are:

- Diagnosis and treatment of patients with McArdle's disease
- Children requiring Selective Dorsal Rhizotomy for cerebral palsy diplegia.

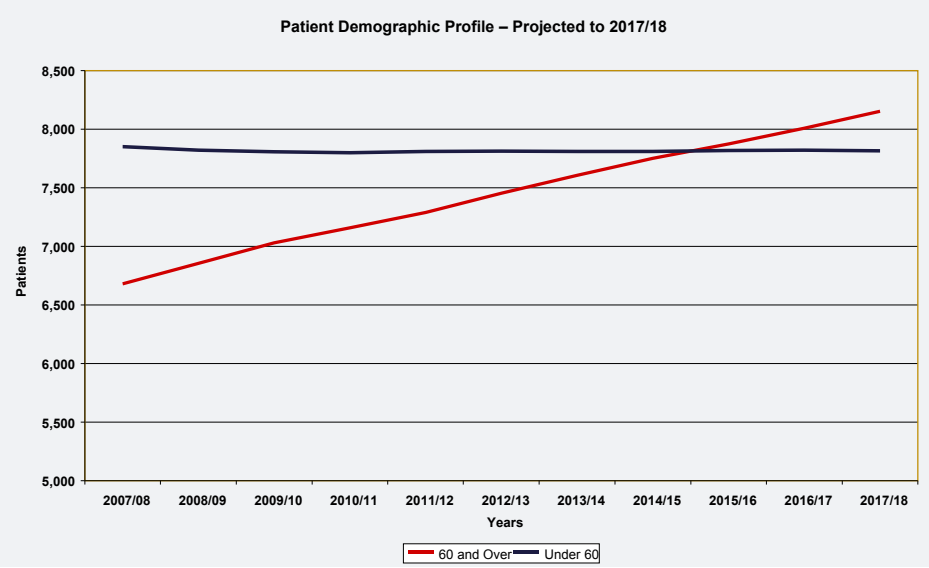
It is still unclear how the reconfiguration within Wales will affect future arrangements for Specialised Services Commissioning within Wales. Health Commission Wales may continue to commission specialist services on behalf of the whole of Wales, or this may be devolved to Local Health Boards with HCW undertaking more of an advisory role.

3.1.4 Future Activity Projections

In order to consider the future demand profile for the Trust and to support the development of a range of planning assumptions for 2009/10 and beyond, the trust has worked closely with Tribal Consulting. This work has looked at the current market and potential for growth/retraction, the RJAH share of the market along with the potential to grow this market share and the infrastructure required to support the projected market share. This has enabled the development of a range of planning assumptions, which following impact testing have allowed robust baseline, best case and worst case scenarios to be developed.

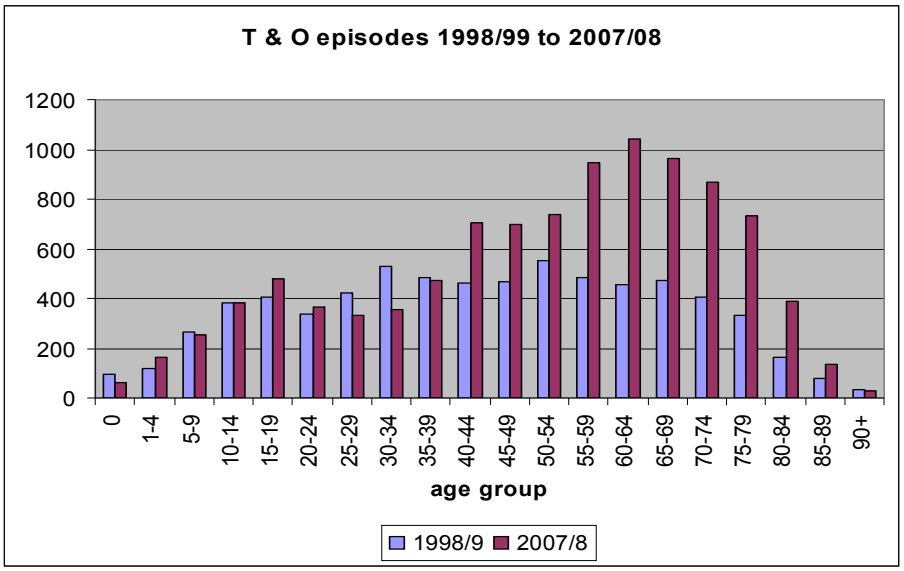
These planning assumptions and scenarios have been modelled using a combination of historic demand and activity profiles and population demographic information. The capacity planning modelling has been supported by detailed benchmarking against a selected peer group of 13 trusts including specialist trusts and major teaching hospital/university trusts.

The following graph illustrates the potential patient demographic profile for RJAH Orthopaedic Hospital, looking ahead to 2017/18 based on projected demographic growth for the hospital's catchment.



This illustrates a continued growth in the over 60 age group which will generate increased demand for orthopaedics generally, and specifically for RJAH offers the opportunity for increased volumes in orthopaedics.

The graph below clearly illustrates the shift in the age profile of patients treated at RJAH comparing 1998/99 to 2007/08.



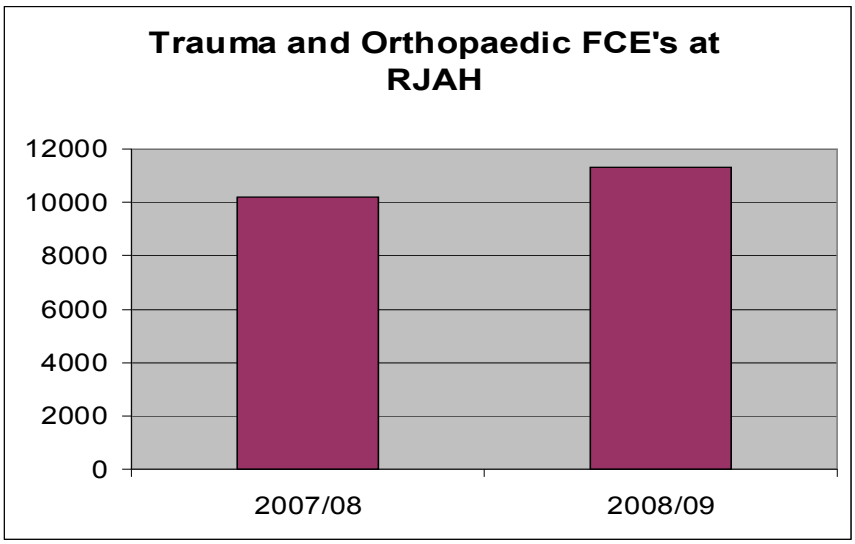
Strategic Scenario Planning

The development and impact assessment of best and worst case scenarios will be part of the full IBP development process.

The Best Case scenarios reflect an increase in market share assumptions, looking at the total activity undertaken within a given area and the proportion of this activity which is currently undertaken within other providers. An assumption has then been made that within a given distance (measured by travelling time) from RJAH the opportunity exists through patient choice and marketing to increase RJAH Orthopaedic Hospital's proportion of that market share.

The worst case from the base model assumes a repatriation of some Welsh activity and a shift to primary care locally for some Ambulatory activity.

Historically, the trust has seen continued year on year activity growth, with an almost doubling in admitted patient activity in the past 12 years. The chart below focuses on the 11.2% increase in activity for Trauma and Orthopaedics over the last 12 months which is projected to be sustained through 2009/10.



3.1.5 Marketing of Trust Services

RJAH will be developing its marketing strategy during the course of 2009/10 as part of the Integrated Business Plan development for its Foundation Trust Application.

In moving forward, the Trust will need to develop its marketing capacity to ensure the maintenance of its existing referral base and to develop the potential for increased referrals through the patient Choice mechanism.

To protect our existing Welsh market, as choice does not operate in Wales, we may need to consider different mechanisms. The introduction of English PbR tariffs for cross border activity would suppress the current 'pricing' competition amongst English providers and support commissioning decisions based on quality and outcomes. RJAH is well placed to ensure it meets the needs of its Welsh patients in this respect.

The trust already has a strong presence as a provider of choice for English patients from further afield than the local Shropshire and South Cheshire populations. In 2009/10 the focus of the trust will be to establish a position of demand and capacity 'equilibrium'. This position will then enable the trust to explore opportunities to further penetrate existing markets for core, profitable service lines and evaluate potential for new market developments.

The use of Choose and Book and the information provided on both the NHS Choices website and our own RJAH website will be paramount in attracting patients from further afield. Developing strategic partnerships with other organisations will also help penetrate existing markets and take RJAH branding further into England and Wales.

3.1.6 Development of Commercial opportunities

Areas in which the trust is looking to further develop opportunities are:

- The Trust is enhancing its private patient and amenity facilities to maintain and increase income opportunities
- The Trust is exploring potential joint ventures or long term arrangements with local private hospitals
- The Trust is looking to redefine its relationship with the Institute of Orthopaedics

3.1.7 Financial Projections

The financial context within which the Trust will operate in the future can be summarised as follows:

- To continue to deliver the highest quality clinical care without non recurring financial support;
- To create a surplus equivalent to at least 1% of turnover (equivalent to a level 3 risk rating under Monitors compliance code) as a contingency against downside risk but importantly to increase cash balances to:
    - Invest in service delivery and continuous improvements in patient quality and safety;
    - Invest in the Trusts infrastructure with a focus on maintaining and modernising the estate
- Ensure efficiencies are delivered year on year in a planned way that focuses on service redesign and meets as a minimum the efficiency targets assumed nationally as part of the national tariff uplift.

With this context the Trust has developed a 5 year financial plan from 2009/10 to 2013/14 to support the delivery of the service strategy. This plan is made up of a number of assumptions that are detailed in the following sections. The assumptions form a base case

scenario which has taken into account risks and opportunities and the likelihood of occurrence. The Trust has further tested some up and downside risks particularly relating to demand projections in the future.

3.1.8 Activity and Income Forecasts

Activity assumptions for 2009/10

The Trust is predicting in its base case scenario the need to deliver growth in demand of 7% in 2009/10, 4% in 2010/11 and 2011/12 and 1% population growth thereafter. As detailed in Section 4.6 this assumption has been developed taking into account the following key demand predictions:

- A rising demand for our services which has been evidenced in 2008/09. This plateaus in the latter part of the plan.
- Continued delivery of waiting time targets for our English and Welsh patients
- Expanding our market share through the NHS Choice system and via spot work for other Trusts
- Increased underlying demand driven by our ageing population and elasticity of demand given shorter waiting times

	NHS T&O FCE's					
	Year					
	08/09 FOT	09/10	10/11	11/12	12/13	13/14
England	7512	8195	8536	8900	9060	9223
Wales	3242	3419	3487	3456	3517	3580
Total	10754	11614	12023	12356	12577	12803

Income Assumptions

The basis for setting income plans has been the forecast out turn position for 2008/09. This has been adjusted for a number of known changes as follows:

- The income plan assumes non recurrent financial support from the SHA of £2.2m in 2008/09 and £1.3m in 2009/10 to reflect the profile of savings generated from the sustainable services project.
- The most significant change to how the Trust will be funded in 2009/10 is the update to the national tariff and the groupings of clinical procedures under HRG 4 (the previous version being HRG 3.5). The Trust is concluding discussions with our English Commissioners regarding the implementation of this new pricing structure. Whilst HRG 4 is structured very differently to the previous tariff in global terms the Trusts gains circa 10% on its English PbR income over 2008/09.
- An area of uncertainty is whether our Welsh commissioners also introduce HRG 4 prices. The Welsh do not currently operate under the payment by results policy. Given some of the historic price agreements with our Welsh commissioners the Trust faces a financial risk of c. £1m if HRG 4 is introduced. The Trust is trying to establish the likelihood of this being implemented in 2009/10. If this decision is deferred this remains a risk to the Trust that will need to be recognised in any long term planning. This downside has been included in the financial plan.
- Following initial work with Ernst and Young the Trust has been working with its host commissioner Shropshire PCT to ensure we are paid appropriately for the work the Trust delivers where not covered by the scope of the PbR tariff. Examples include pre-operative assessment, physiotherapy attendances, clinical orthotics and outpatient procedures. The total of these changes are in excess of £1m. Given the affordability

issues faced by our commissioners in purchasing this activity and with the impact of HRG 4 the Trust has agreed to phase payment for some of these services over a 2 year period.

- The late release of the new national tariff has meant discussions with our commissioners are not as progressed as in previous years. The mechanism for calculating the income owed under the new tariff, known as the grouper, is yet to be released. The Trust has had to estimate how the new grouper will operate which carries inherent risk. Given this risk and the affordability issues local commissioners face the Trust has included an income risk reserve in its planning assumptions.
- The Operating Framework dictates that for 2009/10 the Trust will receive 2.2% inflation and estimates 2010/11 income will be inflated by 1.7%. Monitor has issued a view on likely future growth beyond this period at 1.2% reflecting the current economic climate and the perceived tightening of public sector spending allocations.
- These inflationary uplifts include 0.5% that will be paid to the Trust upon delivery of certain improvement metrics via the CQUIN process.

Expenditure Assumptions

Again the baseline for the expenditure plan has been the forecast 2008/09 out turn. Key assumptions are as follows:

Pay

Approximately 60% of the Trusts operating costs relate to the workforce. The main increases in pay costs are due to:

- Inflation - pay awards of 2.4% in 2009/10 and 2.3% in 2010/11 have been assumed in line with the national agreement. Following this a rate of 2.3% has been assumed.
- Incremental pay progression as per agenda for change and the consultant contract terms and conditions;
- Implications of the European Working Time Directive (EWTD)

Non Pay

- General non pay has been inflated by 2.5%. Additional costs have been assumed for:
    - Energy inflation to recognise the volatility of the utility market assumed at 20% year on year price increases
    - Drugs inflation which includes a reserve for implementing any prevailing NICE guidance.
- A contingency has been created to cover any indexation linked cost of capital. In early 2009/10 the district valuer is reassessing the asset values and lives which will allow a more comprehensive assessment.
- The Trust will receive a non recurrent benefit from the reduced VAT rate (17.5% to 15%) until December 2009. This has been incorporated in the plan.
- We have been notified of a significant increase in CNST premiums of circa 129%. This is a national issue relating to an undersizing of the pooling funds required and an increasing trend in successful claims. The Trust has maintained its level 2 risk rating which gives a 20% premium reduction. The plan includes an estimated uplift to CNST premiums each year.
- The plan includes anticipated savings on activity delivered at premium rates in other hospitals. This is aligned to the increased capacity created by the introduction of the new theatre development.

Other Key assumptions

- The plan includes the new theatre development approved at the March Board. This includes associated staffing costs, lease payments and efficiency savings.
- For 2009/10 the Trust has included a recurrent 1% contingency reserve against any downside risks. In addition to specific identified cost pressures from 2010/11 the Trust has included 1.5% of operating costs as a reserve to cover future cost pressures.

- Monitors assessment of the future economic climate assumes lower growth levels and an increasing need for efficiency savings. These have been factored into the model. With this context in the latter part of the plan a further contingency is included. This contingency gives the Trust some risk coverage against further dampening of the national tariff and potential unfunded pressures the Trust may face such as pay awards.
- £250k has been included in the plan to cover the cost of the FT application.

Cost Improvement

The initial assessment made by E & Y was that the Trust would need to make savings in excess of 5% in 2009/10 following the withdrawal of non recurring SHA support. The Trust has made significant inroads to that requirement in 2008/09 through the control of its cost base whilst increasing patient throughput. In addition to this the Trust is benefitting from the introduction of HRG 4 and has reached satisfactory conclusions on getting paid for work not covered by the national tariff. This improved position means the Trust can enter 2009/10 with a requirement to deliver CIP's of 3% which is aligned to national tariff assumptions. As per Monitors assessment of future efficiency requirements the plan includes CIP's of 3.5% in 2010/11 and 4% thereafter.

These efficiencies are being delivered through key programmes that are focussing on the surgical patient pathway aligned to the new theatres development and on redesigning our medical specialties to meet the requirements of our local PCT.

The plan is summarised below:

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Sustainable services savings	1,646	1,409	2,787	3,323	3,423	3,505
Tactical savings	1,604	951				
Total savings target	3,250	2,360				

Service line Reporting

The Trust has been developing its understanding of the financial performance of its service lines reporting this quarterly to the Trust Board. The performance across its service lines has improved significantly from 2007/08 to 2008/09. The Trust has assessed efficiency opportunities to further improve individual service lines profitability.

Whilst the Service Line Reports have given clinicians and managers useful information as to where their services make a contribution what they do not allow is to drill into variations at a patient level. The Executive Team have approved a project to implement patient level costing that will be developed during 2009/10. The successful introduction of patient level costing is essential if the Trust are to deliver the efficiency levels predicted in the future.

Financing and working capital strategy

The Trust aims to improve its liquidity over the period through the delivery of planned surpluses. Working capital assumptions include:

- A working capital facility of £5.5m to cover 30 days operational expense (as per Monitor requirement).
- An improvement in debt management performance.
- The repayment in 2009/10 of the final year of the Trust's working capital loan (£1.1m).

3.1.8 Summary of key financial assumptions

The table below summarises the key outputs from the financial model. As detailed the Trust is planning to stay in surplus throughout the life of the model which is largely driven by the delivery of CIP's and some marginal growth in activity levels. The full I & E, Balance Sheet and Cashflow for the 5 year period are included as Appendices (Section 6).

Cash balances continue to grow reflecting the impact of making I & E surpluses. The assumption on capital expenditure is that the Trust reinvests cash generated from the depreciation charge. It is likely that the Estates strategy will demonstrate the need for further investment in the Trusts fixed assets. It is important that the Trust has sufficient cash balances to support this strategy.

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
	£000s	£000s	£000s	£000s	£000s	£000s
Income	72,059	78,857	80,757	83,206	84,589	85,608
Pay	-39,060	-42,718	-43,292	-43,970	-44,450	-44,896
Non Pay	-27,007	-30,012	-31,295	-32,159	-32,749	-33,225
EBITDA	**5,992**	**6,126**	**6,170**	**7,077**	**7,389**	**7,487**
Financing & Depreciation	-5,108	-4,995	-5,134	-5,290	-5,466	-5,537
Net Surplus	**884**	**1,131**	**1,036**	**1,787**	**1,923**	**1,950**
CIP Value	3250	2,360	2,787	3,323	3,423	3,505
CIP % (on Total costs before EBITDA)	4.5%	-3.1%	-3.6%	-4.2%	-4.2%	-4.3%
Capex	2796	3,633	3,024	3,116	3,213	3,234
Cash	3,864	2,364	3,448	5,287	7,260	9,260
Monitor Risk Rating	4	4	4	4	4	4

Note: *EBITDA – Earnings Before Interest Depreciation and Amortisation*
This is the financial operating performance of the organisation prior to financing costs.

The financial model shows the Trust maintaining a level 4 risk rating throughout the life of the model (1 being the worse and 5 being the best).

3.2 Service Development Plans

3.2.1 Elective Orthopaedic Surgery Plans

This is the mainstream business of the trust and therefore it is essential that it is sustainable and makes a profitable contribution. Service Line Reporting (SLR) performance from 2009/10 onwards indicates this is deliverable. However as outlined above, changes are required to improve the patient pathway and experience, which will also deliver a more effective and efficient service. Specifically, these include:

1. Streamline and standardise the patient pathway from referral to outpatients and the onward pathway to diagnostics, pre operative assessment, admissions and surgical treatment.

2. During 08/09 the Trust has increased the use of the theatre facilities but some patients are still being treated by our surgeons in other hospitals. In addition, extra 'out of hours' work is also been undertaken by clinicians at the RJAH. There is a need to increase the theatre capacity, reducing the out of hours activity and treat all patients at the hospital. The development of 2 additional theatres during 2009/10 will increase the capacity of the hospital to meet these needs. The additional theatres will be matched by the recruitment of additional consultants and other clinical support

staff. The new facility will enable the more efficient delivery of short stay patients and increase the number of patients treated as day cases.

3. The trust must consider increasing the critical care support provided at the trust from the current level 2 to a level 3, given the increasing dependency levels of patients and significant co-morbidities associated with an ageing population. The trust must look to satisfy accreditation requirements for centres wishing to be awarded designation status for services such as Spinal Injuries and spinal surgery and mitigate the clinical risks and patient safety considerations posed by increasing dependency.

4. Over the last two years the Trust has developed the bone tumour service in partnership with Manchester forming the Greater Manchester and Oswestry Sarcoma Service (GMOSS). A gradual increase in referrals has been witnessed and the Trust will be developing the service through the appointment of an additional surgeon.

3.2.2 Musculoskeletal Medicine Service Plans

To be responsive to the factors which influence choice, especially travel times, the trust will need to develop opportunities to take services as close to patients as possible.
Examples for musculoskeletal medicine include:

- Review of outreach clinics to take services into community locations where the maximum number of patients will benefit.
- Expansion of the Metabolic Medicine Mobile service to Cheshire and North Wales areas.
- Potential development of mobile services for patients with Rheumatological conditions.
- Development of a mobile Bone Density Scanning Service to improve access for patients and reduce the incidence of osteoporotic fractures.

Paediatric Medicine

Paediatric medical cover is core to the provision of Paediatric Surgery. The trust is developing the McArdle's Paediatric Muscle Service through national specialised services commissioning arrangements.

Rheumatology and Metabolic Medicine

A review of rheumatology and osteoporosis services across Shropshire, Telford and Wrekin has been undertaken which proposes; a hub and spoke model where APCS would be developed to form a comprehensive musculoskeletal triage service; integrated osteoporosis service model; provision of care closer to home. SCPCT intend to develop a service specification and go out to tender for provision of these services during 2009/10, with a view to new services commencing 2010/11.

The Spinal Injuries service has long been established and has been successful in attracting further support from the Specialist Commission for Urology and Baclofen pumps.

3.2.3 Community/District Services

The proposal to create an Oswestry Health Village has commenced with the development of a new GP practice for Oswestry. The view of the PCT is that this will develop over time into a health village. It is intended that the following services, currently either hosted at RJAH or provided by the trust itself, will ultimately relocate to the Health Village:

- Minor Injuries Unit (MIU) – *hosted service*
- Diagnostic Assessment And Rehabilitation Team (DAART) – *hosted service*
- GP medical beds (Sheldon Ward) – *provided by RJAH*
- Maternity services – *hosted service*

We continue to work closely with our colleagues in Shropshire County PCT to ensure that these local services are convenient for patients, economically viable and meet the needs of the population.

3.2.4 Therapy and Diagnostic Imaging Plans

Therapies at the Trust include physiotherapy, occupational therapy and orthotics. All services support both admitted and non-admitted patient pathways. Improving the patient pathway will necessitate changes to the deployment of all of these therapies to better inform the patients of their planned care and reduce the length of stay. The Trust will work with the PCTs to provide a service that is aligned to the patients' expectations and to avoid repeat visits to hospital.

The introduction of unbundling of diagnostics within HRG4 provides both an opportunity and a threat to the Trust. If the current service models and patient pathways remain unchanged, the commissioners may seek to separately procure the diagnostic element of outpatient pathways from locations closer to patients' homes. To mitigate this threat the trust needs to review its existing pathways and models of care with a view to increasing the number of one-stop clinics to include diagnostics as part of a single visit. In addition we should look to provide mobile diagnostic services where possible, seek opportunities for partnership working with community providers and maximise the use of available technology and IT solutions.

3.3 Enabling Strategies

3.3.1 Estates Plans

RJAH has a varied estate with accommodation of different ages and conditions. The site covers 13.2 hectares with a gross internal floor area of 41,500 m^2 and a total building asset value of £33.5 million.

The Trust currently has an Estates Strategy which has been refreshed further to provide a more robust framework for planning. It is also in the process completing a 5 year Development Control Plan aligned to the Trusts service strategy and following completion of a '6 facet' survey.

The six facet survey will look at the following aspects of the site accommodation:

- Physical condition
- Fire and Health & Safety compliance
- Functional suitability
- Space utilisation
- Quality
- Environmental management

The outcome of the survey will inform the development of robust strategies auditable to Monitor and a site development plan linked to the Foundation Trust IBP and LTFM. The strategy has focussed on meeting the objectives agreed through the Sustainable Services Project which are:

- To reduce backlog maintenance.
- Reduce the footprint of the site.
- Increase the % of the site dedicated to direct patient care.
- Consolidate non patient facing areas.
- Reduce the carbon footprint.

During 09/10 The Trust will implement Phase 2 of the Development Control Plan which will include:

- Construction of a new Helipad & covered walkway facilities (donated asset)
- The construction of new additional theatres
- Improvement of clinical facilities to ensure compliance with privacy and dignity standards
- Creation of a new Medical Equipment store and TSSU facility

- The development of a business case to reprovide the orthotics manufacturing service either on or off site
- Development of a business case, building on the review of clinical pathways, to provide a new main entrance for the hospital providing modern high class facilities for receiving patients and visitors to the hospital.
- The development of a business case for the replacement of one of the trusts MRI scanners.

The table below summarises the capital plan.

Type of Investment	2008/09 £000's	2009/10 £000's	2010/11 £000's	2011/12 £000's	2012/13 £000's	2013/14 £000's	Total £000's
Backlog maintenance reduction rolling Investment programme	980	1,000	1,000	1,000	1,000	1,000	**5,980**
Medical Equipment replacement programme	436	150	250	250	250	250	**1,586**
Theatres refurbishment					400	400	**800**
Privacy & Dignity		344					**344**
Recurrent capitalisations	200	200	200	200	200	200	**1,200**
Information Technology	283	117	200	200	200	500	**1,500**
Invest to save Demolition & relocation programme	300	150	225	300	410	330	**1,715**
TORCH Development (part of £3.5m scheme)	716	0	0	0	0	0	**716**
Helipad and covered walk way	100	280	0	0	0	0	**380**
Upgrade/expand private patients unit	250	250	0	0	0	0	**500**
Theatre Cooling System	282						**282**
6 Facet Survey	65	0	0	0	0	0	**65**
Fast track theatre enabling and equipment	0	900	0	0	0	0	**900**
Satellite TSSU		300					**300**
Total Capital Programme	**3,612**	**3,691**	**1,875**	**1,950**	**2,460**	**2,680**	**16,268**
Funded By							
Depreciation	2,801	2,953	3,024	3,116	3,213	3,234	**18,341**
Planned underspend in 08/09	-400	400					**0**
Privacy & Dignity SHA funding		344					
Energy grant	395						**395**
Donations/Appeals	816	280	0	0	0	0	**1,096**
Total Funding	**3,612**	**3,977**	**3,024**	**3,116**	**3,213**	**3,234**	**19,832**
Balance of resources (spend to be determined)	**0**	**286**	**1,149**	**1,166**	**753**	**554**	**3,908**

The financial plan assumes that as a minimum the Trust re-invests its depreciation charge. In 2009/10 the spend includes an additional £400k deferred from our 2008/09 programme. The detail of the future programme will be developed further following conclusion of the 6 facet survey and the Estates strategy. Any areas of significant investment will require individual business cases that will need to meet the Trusts investment policy.

3.3.2 IM&T Service Plans

In 2008 the trust experienced high levels of staff turnover in both the IT and Information departments. The support of an external consultant was secured in order to stabilise the departments and ensure a number of key projects were delivered as planned. The priority for 2009/10 is to review and set out the IM&T Strategy for the next 3 to 5 years and ensure the trust can provide appropriate resources to implement approved IM&T projects.

Areas for particular focus will be:

- Robust and sustainable information governance arrangements.
- Resilient and effective business continuity measures.
- The trust's clinical and business information systems are appropriately supported, resilient and fit for purpose.
- Excellent programme management and thereby delivery of planned projects.

The Connecting for Health programme is overseen locally by a Local Health Economy Programme Board chaired by the Senior Responsible Officer (SRO), SCPCT Chief Executive. RJAH plans feed into a Shropshire-wide Operational Implementation Plan (OIP) and the trust

and SCPCT have a 'shared instance' agreement for any national Connecting for Health deployments that are part of the Lorenzo solution.

3.3.3 Organisation Development and Workforce Plans

The Trust has made considerable progress in the last 18 months in terms of performance and significant changes have been made. We do need to recognise that some of these changes have been difficult and in some areas the resistance to change has been high. The Trust is progressing with an Organisational Development (OD) and HR Strategy and the Board have spent time debating some of the areas that will form part of this Strategy. The strategy aims to establish a culture of working which will help us to achieve sustainability through our staff to assist the organisation to be the leading orthopaedic service provider.

Five key aims of the strategy are: -

- Attracting and retaining high calibre staff (employing the right staff to meet our patients' needs).
- Supporting and developing staff (to deliver high quality service for our patients).
- Facilitating the establishment of new ways of working (which meet the needs of patients).
- To continue to foster a culture which thrives on excellence
- To retain our Investors In People (IIP) accreditation

The strategy for the next 5 years is structured into the following areas :-

- Values, Beliefs and Culture
- Leadership
- Developing the workforce (re-design)
- Organisational capacity, capability and functionality
- Engagement, communication & partnership
- Governance, learning and development
- HR practice and policy

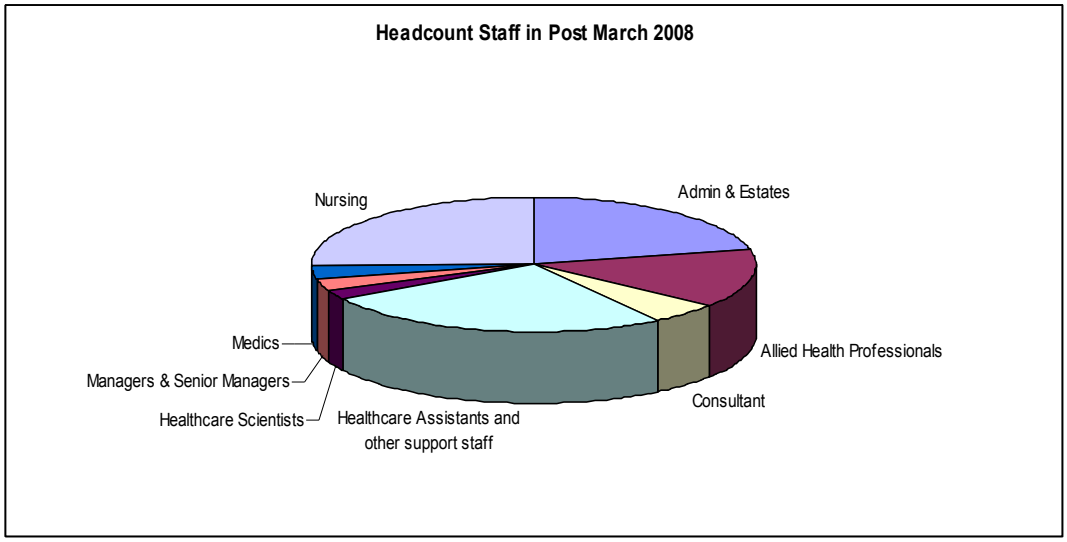
The key objectives outlined in the strategy 'Sustainability Through Our Staff' are:-

- To develop as an effective and efficient organisation with the appropriate capacity and capability to deliver services as a provider of choice
- To build on the vision and values set out within the Annual Plan
- To ensure that all staff have the appropriate knowledge, skills and expertise to perform effectively within their job roles. To ensure that staff development is linked to service and workforce development
- To ensure that Leadership and Management capacity at all levels across the Trust is maximised and that leaders are equipped with the appropriate skills and tools. To ensure clinical leadership is at the forefront of service improvement
- To fully embed the use of technology in working practices to ensure that the Trust clinical and management staff utilise IM&T in order to provide services as efficiently and effectively as possible.
- To plan and develop our workforce proactively, responding to service demands and requirements. To develop appropriate succession planning models for the future
- To continually review refine and develop recruitment and retention across the Trust to ensure that we have the right people with the right skills and that as a model employer we are an employer of choice. To address the risks in this area in the future
- To involve, engage, work in partnership and communicate with our staff to maximise their contribution to the Trust.
- To ensure that the workplace environment is healthy, safe and fit for purpose and that risks are assessed and dealt with in a timely and effective manner.
- To develop and employ flexible working practices, which meet the local requirements of our patients and achieve legislative and national initiative requirements.

A clear work plan for 2009/2010 is appended to the HR/OD strategy detailing how these objectives will be actioned. The development of the OD Strategy is key to the next stages of taking forward the organisation, however there are key areas in terms of leadership capacity where focus is required.
The Trust will develop a workforce development plan for the coming five years during 2009/10, in line with service strategy and the Long term financial model for the future. Workforce plans in year will reflect a direct response to the key objectives of the Trust in terms of increasing throughput, particularly for the workforce aligned to delivery of major orthopaedic elective activity. Workforce planning will focus up ensuring that that the workforce supports efficient pathways and enables the organisation to achieve the required level of activity within its own capacity.

The Trust will need to increase its workforce numbers, particularly in relation to additional Theatre capacity, but in addition will need review development of therapy and diagnostic services to enable extended provision. There will be development of roles and competencies that support the patient pathway, particularly in within Bands 1 – 4, focussed upon minimising patient length of stay. The organisation will continue to progress its Hospital at Night/24/7 plans, which concentrate upon developing our nursing/critical care workforce, to ensure the Trust has in place safe and appropriate care out of hours.

The Trust at the end of March 2009 employed 954 staff, 60.5% of these work in direct patient care areas. 9.84% of staff left and 8.94% new staff joined the Trust during the year.



3.3.4 Research & Development Plans

Research and Development was in deficit at the start of 2008/09 due to the removal of Culyer central funding. The Trust is clear that core services cannot support research activities and as with other areas, research must provide a contribution to the Trust. For 2009/10 research at RJAH Orthopaedic Hospital will cover all its costs through income generated and the trust will ensure that as a general rule research activity contributes positively to patient care.

4.0 RISK ANALYSIS

4.1 Operational service risk

As a Foundation Trust the licence to operate granted by Monitor will include those mandatory services the Trust must offer. Any material reduction in these services will require approval from Monitor following appropriate local consultation. Whilst this is not relevant to an NHS Trust this section describes the key risks to operational service delivery over the next 12 months.

Rheumatology

The Trust currently delivers specialist and routine Rheumatology services for Shropshire and Welsh residents. This is delivered by two Consultants who operate outpatient clinics at both RJAH and on behalf of local hospitals, most substantially Shrewsbury and Telford hospitals NHS Trust. One consultant will be leaving the trust in April to take up at new post at another trust and the second consultant has indicated plans to retire within the next 18 months or so. A locum consultant will be appointed during 2009/10 to ensure continuity of services in the short term.

In the longer term, Shropshire PCT has instigated a service review of Rheumatology which will culminate in a tender for the service during 2009/10 which will be awarded in 2010/11. The Trust is supportive of this approach and will be working closely with SPCT in developing options for service delivery.

Metabolic Medicine (Osteoporosis)

The Trust currently delivers inpatient, outpatient and a mobile Metabolic Medicine services across Shropshire, Cheshire and Mid/North Wales. The clinical lead that has developed this service is planning to retire in the next 12 months. It is acknowledged that a direct replacement for this role will be difficult. The Trust views Metabolic Medicine as a service it would want to continue offering and is reviewing how this may be delivered in the future. Aligned to the Rheumatology review there may be an option to develop a more integrated service.

Theatre capacity

The Theatre unit is now at capacity and in order to deliver patient access times additional capacity is required through additional theatres and consultants supported by the relevant theatre professional and support staff. This development presents a risk regarding the operational use of additional theatres and the recruitment of additional staff. To mitigate this risk the recruitment and training will commence in March and the additional theatres are of modular construction reducing the lead in time for this expansion.

Clinical Capacity

The trust is currently very reliant on consultants undertaking activity outside of their routine job plan sessions, in order to meet waiting times and increasing demand. This work is completely voluntary and there is a significant risk to clinical capacity and maintenance of waiting time targets should the clinicians elect not to undertake additional out of job plan activity at any point. To mitigate this risk the trust is looking to appoint to additional consultant posts during 2009/10.

4.2 Financial risk

4.2.1 Commentary on financial risk rating

The Trust is self assessing itself against the financial risk rating used by Monitor in rating Foundation Trusts. As previously described five weighted financial ratios are used to assign a

risk rating of 1 to 5 with 5 being the best. Below is how the Trusts 2009/10 financial plan measures against these ratios.

Metric	2008/09 Rating	2009/10 Rating	2010/11 Rating	2011/12 Rating	2012/13 Rating	2013/14 Rating
EBITDA margin	3	3	3	3	3	3
EBITDA, % achieved	5	5	5	5	5	5
ROA	4	3	3	3	4	4
I&E surplus margin	5	5	5	5	5	5
Liquid ratio	4	4	5	5	5	5
Weighted Average	4	4	4	4	4	4

As can be seen the Trust maintains a level 4 risk rating throughout the life of the financial plan with improved liquidity levels being a key factor.

4.2.2 Significant financial risks

In developing the 5 year plan a balance of risk has been taken into account. Key financial risks highlighted are:

- **Commissioner affordability** – as described the Trust is benefitting from the introduction of HRG 4 and from getting paid for the work it does outside of the scope of the national tariff. In England this equates to c. £4m additional income a large proportion of which falls to Shropshire PCT to fund. Whilst the Trust has agreed a financial value for its contract that incorporates these uplifts this has resulted in the PCT having affordability problems. The Trust has agreed to work collaboratively with SCPCT to review certain services to ensure they offer value for money. Inevitably the Trust will carry some risk that these reviews may result in a reduced service requirement from the PCT's. The Trust will need to ensure it can adapt its service to meet these demands so as not to offer levels of service that commissioners are not willing to pay for.

- **Price** – There remains uncertainty as to whether HRG 4 will be introduced by our Welsh commissioners. Our base case assessment assumes its introduction with a loss of c. £1m. If this is not the case the Board need to recognise this a risk the Trust carries in the future. If HRG 4 is introduced by the Welsh this may offer an opportunity to the Trust to repatriate work lost from Powys over recent years as price will be consistent with other English providers. A further longer term risk is that HRG 4 prices will need to stabilise after this its first year in operation. It is difficult to scope the size of this risk.

- **Commissioner intentions** – As previously highlighted demand growth remains strong. There are however areas of uncertainty the Trust has assessed that may reduce or re-direct demand for services at the Trust as summarised below:
  - Shropshire PCT are looking to reduce its overall spend in Musculoskeletal services. The Trust is supportive in working with the PCT to further understand how this objective will be delivered. This is not perceived as a risk in the short to medium term as demand for services are in many specialties in excess of our capacity. The Trust has also not seen any tangible plans to reduce the demand for our services. The Trust plans to take an active part in any discussions with our host commissioner on this matter.
  - Wales – Given the reconfiguration of the Welsh NHS which removes the commissioner provider split, there is a risk that the new body looks to repatriate orthopaedic work. This is unlikely for the more complex work the Trust delivers for Wales as they have no other providers able to offer this work. There is a risk that

some of the simple work is repatriated although this is perceived as a more medium to long term risk as there is a shortage of capacity in the Welsh hospitals.

- **CIP delivery** – The five year plan assumes an increased CIP requirement in the future that reflects the current economic climate. Whilst challenging these efficiency levels are aligned with national tariff assumptions and with those delivered by the Trust in the recent past. Securing sufficient internal capacity will underpin delivery of the saving initiatives planned. The Board recognises that in a climate of reduced NHS funding the delivery of these efficiency programmes is essential to not only sustain financial health but also to reinvest in the development of services.

- **Estate** – The current plan assumes the reinvestment of depreciation in the Estate. It is anticipated that the Estates strategy will evidence the need for further investment. It is therefore essential that the Trust increases it s cash balances to facilitate this.

For 2009/10 the Trust is well placed to manage these downside risks as demand for services is high and there are plans in place to control the Trusts cost base. In addition the financial plan for 2009/10 includes a 1% contingency for downside risk and a further contingency relating to local PCT affordability constraints. The Trust does face longer term risk and as part of developing its 5 year Integrated Business Plan will explore mitigating actions further.

4.2.3 Longer Term Downside Sensitivities

The Board have considered the key financial risk to the long term plan. The two risks that remain consistent are:

- whether the Trusts anticipated income levels are realised. The threat being a reduction in demand, action taken by the PCT due to affordability constraints, or a dampening of the national tariff;
- the impact the economic climate will have on future spending allocations to the NHS.

Both of these risks have been considered in further detail. As referred to in section 3.1.3 the Trust has made an assessment of what the lost demand would be of a shift of our simple cases to primary care settings and similarly that our more simple casemix for Wales is repatriated. Monitor have issued downside scenarios to reflect future growth reflecting the economic climate. These assumptions predict growth to be as low as 0.7% in future years and CIPs to be required at 4.5%.

Both these downside risks have been modelled the results on the 5 year financial plan are shown below:

5 Year Income and Expenditure - Downside Version

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
	£000s	£000s	£000s	£000s	£000s	£000s
Income	72,059	78,857	80,143	81,272	81,370	81,727
Pay	-39,060	-42,718	-43,176	-43,388	-43,402	-43,708
Non Pay	-27,007	-30,012	-30,876	-31,387	-31,698	-31,943
EBITDA	**5,992**	**6,126**	**6,092**	**6,497**	**6,269**	**6,075**
Financing & Depreciation	-5,108	-4,995	-5,134	-5,290	-5,466	-5,537
Net Surplus	**884**	**1,131**	**958**	**1,207**	**803**	**538**
CIP Value	3250	2,360	3,206	3,657	3,662	3,678
CIP % (on Total costs before EBITDA)	4.5%	-3.1%	-4.1%	-4.7%	-4.6%	-4.6%
Capex	2796	3,633	3,024	3,116	3,213	3,234
Cash	3,864	2,364	3,370	4,627	5,480	6,069
Monitor Risk Rating	4	4	4	4	4	4

As can be seen, despite these downside scenarios the trust stays in surplus and has a risk rating of 4.

5.0 FOUNDATION TRUST

5.1 Foundation Trust Application

During 2009/10 the trust will be working with the West Midlands SHA to progress its formal Foundation Trust application with a view to being authorised during 2010. The FT application process will assess the trust's ability to satisfy the seven domains of assurance which correspond to Monitor's three key assessment criteria:

- Legally constituted
- Financially Viable
- Well Governed

The key stages and timescales for trusts progressing through the FT Application process are summarised below:

Stage	Timescale	Brief summary
FT Diagnostic	2 months	The SHA will commission a diagnostic that will review structures, governance and the first draft of an IBP and LTFM. The diagnostic will result in an agreed action plan for the trust and a clear timeline for the application.
SHA Assurance	3 months	Completion of a critical success factors action plan and evidence of delivery of all elements of this is required. The SHA will provide a review the first draft of the LTFM and IBP and ensure that the trust has sufficient evidence to demonstrate that their LTFM is robust. There will be a formal review of financial reporting procedures undertaken by reporting accountants approx 3 months prior to the planned date of the DH applications committee.
Consultation	12 weeks	The trust must submit plans for consultation to the SHA for approval and formal agreement for commencement of the 12 week consultation period. During the consultation period the trust will continue to develop its IBP and LTFM and finalise these with the SHA. The SHA will complete the assurance form for DH that will provide assurance around the seven domains required for FT status.
Historical Due Diligence	4 weeks	This is undertaken when the IBP and LTFM are finalised (i.e. after consultation). TheTrust will need to be able to demonstrate on-going achievement of CIPs. The reporting accountants require at least 1 years audited accounts demonstrating turnaround.
SHA / DH approval	2 – 3 months	This can only take place after the Historical Due Diligence has been completed. The SHA prepare a report for the SHA Board. The DH Applications Committee will then pass the application to the Secretary of State who will ask Monitor to assess the Trust. Monitor will batch and start the assessment.
Monitor Assessment	3 months minimum	A Trust with a history of financial difficulty and turnaround may require a more intensive assessment from Monitor which can take up to 6 months.

6.0 APPENDICES

6.1 Income & expenditure

5 year Income and Expenditure

	2008/09 Closing Total	2009/10 Total	2010/11 Total	2011/12 Total	2012/13 Total	2013/14 Total
Income						
NHS Clinical Income	61,854	68,478	70,801	73,116	74,413	75,306
Total	**61,854**	**68,478**	**70,801**	**73,116**	**74,413**	**75,306**
Non NHS Clinical Income						
Private patient income	3,125	3,194	3,248	3,287	3,310	3,346
Other non-protected clinical income	493	504	512	519	522	528
Total	**3,618**	**3,698**	**3,760**	**3,806**	**3,832**	**3,874**
Other income						
Research and Development	789	487	496	502	505	511
Education and Training	151	154	157	159	160	162
Other income*	5,647	6,040	5,542	5,623	5,678	5,755
Total	**6,587**	**6,681**	**6,195**	**6,284**	**6,343**	**6,428**
Total income	**72,059**	**78,857**	**80,757**	**83,206**	**84,589**	**85,608**
Expenditure						
Pay Costs	-39,060	-42,718	-43,292	-43,970	-44,450	-44,896
Drug Costs	-3,159	-4,596	-4,813	-5,036	-5,265	-5,499
Clinical supplies & services	-15,207	-14,484	-16,067	-18,835	-21,457	-24,076
Other Costs (excl. depreciation)	-8,641	-10,932	-10,414	-8,287	-6,028	-3,650
Total costs	**-66,067**	**-72,731**	**-74,586**	**-76,129**	**-77,199**	**-78,121**
EBITDA	**5,992**	**6,126**	**6,170**	**7,077**	**7,389**	**7,487**
Profit / loss on asset disposals	0	0	0	0	0	0
Exceptional Income/ Costs**	-257	0	0	0	0	0
Total Depreciation	-3,325	-3,395	-3,477	-3,584	-3,696	-3,732
Total interest receivable	181	44	64	84	104	124
Total interest payable on Loans and leases	-130	-75	-24	-21	-18	-15
Total interest payable on WC Facility	0	0	0	0	0	0
PDC Dividend	-1,577	-1,569	-1,697	-1,769	-1,856	-1,914
Taxation payable	0	0	0	0	0	0
Net Surplus/(deficit)	**884**	**1,131**	**1,036**	**1,787**	**1,923**	**1,950**

6.2 Balance Sheet

5 Year Balance Sheet

	2008/09 Total £'000	2009/10 Total £'000	2010/11 Total £'000	2011/12 Total £'000	20012/13 Total £'000	2013/14 Total £'000
Balance Sheet						
Fixed Assets						
Purchased Assets	46,845	49,827	51,612	54,063	56,704	57,432
Donated Assets	8,857	9,079	8,897	8,782	8,669	8,249
Govt Granted Assets	0	0	0	0	0	0
Total Fixed Assets	**55,702**	**58,906**	**60,509**	**62,845**	**65,373**	**65,681**
Current Assets						
Stocks & Work in Progress	1,465	1,465	1,465	1,465	1,465	1,465
NHS Trade Debtors	963	913	863	813	763	713
Non NHS Trade Debtors	40	40	40	40	40	40
Other Debtors	815	765	715	665	615	565
Accrued Income	2,042	2,042	2,042	2,042	2,042	2,042
Prepayments	408	408	408	408	408	408
Cash at bank and in hand	3,864	2,364	3,448	5,287	7,260	9,260
Total Current Assets	**9,597**	**7,997**	**8,981**	**10,720**	**12,593**	**14,493**
Current Liabilities (amounts due in less than one year)						
Bank Overdraft	0	0	0	0	0	0
Trade Creditors	-1,014	-1,014	-1,014	-1,014	-1,014	-1,014
Other Creditors	-2,198	-1,066	-1,066	-1,066	-1,066	-1,066
PDC dividend creditor	0	0	0	0	0	0
Capital Creditors	-796	-796	-796	-796	-796	-796
Interest payable creditor	0	0	0	0	0	0
Payments on Account	0	0	0	0	0	0
Accruals	-3,822	-3,822	-3,822	-3,822	-3,822	-3,822
Deferred Income	-1,902	-602	-602	-602	-602	-602
Total Current Liabilities	**-9,732**	**-7,300**	**-7,300**	**-7,300**	**-7,300**	**-7,300**
NET CURRENT ASSETS (LIABILITIES)	**-135**	**697**	**1,681**	**3,420**	**5,293**	**7,193**
Long term Debtors	530	530	530	530	530	530
TOTAL ASSETS LESS CURRENT LIABILITIES	56,097	60,133	62,721	66,795	71,196	73,404
Creditors: Amounts falling due after more than one year	-375	-325	-275	-225	-175	-125
Finance leases	0	0	0	0	0	0
Provisions for liabilities and charges	-960	-760	-760	-760	-760	-760
					0	0
TOTAL ASSETS EMPLOYED	**54,762**	**59,048**	**61,686**	**65,810**	**70,261**	**72,519**
Taxpayers Equity						
Public dividend capital	30,870	31,220	31,220	31,220	31,220	31,220
Income and expenditure reserve	-3,694	-2,562	-1,527	261	2,184	4,134
Revaluation reserve	18,729	21,311	23,096	25,547	28,188	28,916
Donated asset reserve	8,857	9,079	8,897	8,782	8,669	8,249
Other Reserves (Government grant reserve etc)	0	0	0	0		0
TOTAL TAXPAYERS EQUITY	**54,762**	**59,048**	**61,686**	**65,810**	**70,261**	**72,519**
TOTAL FUNDS EMPLOYED	**54,762**	**59,048**	**61,686**	**65,810**	**70,261**	**72,519**

6.3 Cashflow

5 year Cashflow

	2009/10 Total	2010/11 Total	2011/12 Total	2012/13 Total	2013/14 Total
Cash Flow					
EBITDA after exceptionals	6,126	6,170	7,077	7,389	7,487
Excluding donated depreciation	-442	-453	-468	-483	-498
Movement in working capital:					
Stocks & Work in Progress	0	0	0	0	0
NHS Trade Debtors	50	50	50	50	50
Non NHS Trade Debtors	0	0	0	0	0
Other Debtors	50	50	50	50	50
Accrued Income	0	0	0	0	0
Prepayments	0	0	0	0	0
Trade Creditors	0	0	0	0	0
Other Creditors	-1,132	0	0	0	0
Payments on Account	0	0	0	0	0
Accruals	0	0	0	0	0
Deferred Income	-1,300	0	0	0	0
Provisions & Liabilities	-200	0	0	0	0
CF from Operations	3,152	5,817	6,709	7,006	7,089
Capital Expenditure					
Non Maintenance Capex	-3,353	-3,024	-3,116	-3,213	-3,234
Maintenance Capex	0	0	0	0	0
Cash receipt from asset sales	0	0	0	0	0
Taxation paid	0	0	0	0	0
CF before Financing	-201	2,793	3,593	3,793	3,855
Movement in LT debtors	0	0	0	0	0
Movement in LT Creditors	-50	-50	-50	-50	-50
Interest					
Interest (paid) on loans and leases	-75	-24	-21	-18	-15
Interest (paid)/ received on cash balance & WC facility	44	64	84	104	124
Other					
Public Dividend Capital received	350	0	0	0	0
Public Dividend Capital repaid	0	0	0	0	0
Movement in Other grants/Capital received	0	0	0	0	0
Dividends paid	-1,569	-1,696	-1,768	-1,856	-1,914
Net cash inflow/(outflow)	-1,501	1,087	1,838	1,973	2,000
Opening Cash Balance	3,864	2,363	3,451	5,289	7,262
Net cash inflow/(outflow)	-1,501	1,087	1,838	1,973	2,000
Closing Cash Balance	**2,363**	**3,451**	**5,289**	**7,262**	**9,262**