

**Putting Patients First**



# Annual Plan 2012/13





The Shrewsbury and Telford Hospital **NHS**  
NHS Trust

## Putting Patients First

**Section 1: Introduction**

**Section 2: Trust Profile**

**Section 3: Commentary on the Previous Year and Delivery of Plans**

**Section 4: Strategy**

**Section 5: Alignment to Commissioner Plans**

**Section 6: Key Risks**

**Section 7: Improving Quality and Safety**

**Section 8: Delivering Contractual and National Targets**

**Section 9: Financial Plans**

**Section 10: Workforce Plans**

**Section 11: Sustainability**

**Section 12: Delivering a successful NHS Foundation Trust**

**Section 13: Declarations**

The Shrewsbury and Telford Hospital **NHS**  
NHS Trust

**Putting Patients First**

## **Section 1: Introduction**



Our vision and mission as an organisation is to make healthcare fully joined up for the community we serve, delivering services that are safe and well organised, rated very well by patients and staff alike.

In working towards our vision and mission we will continue to focus the Trust around one organising value and principle—“**Putting Patients First**”. Our expectation is that this simple phrase should guide every decision we make in our hospitals, making us think about what really matters so that we use our time, skills and other resources to the best of our ability so that we can afford to do more for patients. This means delivering:

- **Safe Care:** Putting Patients First by ensuring that we deliver the highest standards of patient safety and patient experience.
- **Timely Care:** Putting Patients First by making sure that we achieve and maintain waiting time standards in A&E, outpatient, inpatient, day case and cancer care
- **Affordable Care:** Putting Patients First by making sure that we live within our means, do not spend more than the resources available to us and are able to invest in quality for the future.

This must be achieved in the context of the major challenge that is the amount of money hospitals receive for everything they do will continue to decline in real terms. We are not immune from this responsibility—in fact we actively want to build a future where we can afford the kind of quality of service that we all aspire to. It is our view that in order to face up and respond to this financial challenge over the next 5 years, the Shropshire health economy requires an at scale transformation. Our future assumptions incorporate reducing reliance upon institutional care, less reliance upon acute care and one that supports and sustains people in their own homes.

This Annual Plan therefore sets out how the organisation will develop, enhance and change in the context of the challenges facing the Trust to ensure that we deliver services for which we can all be truly proud of.

## Putting Patients First



## Section 2: Profile

- 2.1 Overview
- 2.2 Range of Services
- 2.3 Activity



## 2.1 Trust Overview

The Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford & Wrekin and mid Wales. We were established in 2003 following the merger of The Princess Royal Hospital NHS Trust and the Royal Shrewsbury Hospitals NHS Trust.

### 2.1.1 Our main service locations

Our main service locations are the Princess Royal Hospital in Telford and the Royal Shrewsbury Hospital in Shrewsbury, which together provide 99% of our activity. We also provide community and outreach services such as:

- Consultant-led outreach clinics at Wrekin Community Clinic in Telford, Robert Jones and Agnes Hunt Orthopaedic and District Hospital (RJA), Bishops Castle, Bridgnorth, Ludlow, Whitchurch, Newtown and Welshpool community hospitals.
- Midwife-led units at Ludlow, Bridgnorth and Robert Jones and Agnes Hunt Orthopaedic and District Hospital (RJA).
- Community midwifery services across Shropshire and Telford & Wrekin.

Information about our main service locations is set out in Table 2.1a. Further information about our services and activity is provided in Section 2.2 and 2.3.

Table 2.1a Our main acute sites and midwife-led units <sup>i</sup>		
<b>Princess Royal Hospital (PRH)</b>	Adult Inpatient (overnight) beds	275
	Children's inpatient and assessment beds	24
	Surgical day case beds	24
	Renal dialysis stations	20
	Chemotherapy/haematology day centre	10
	Intensive care / high dependency	11
	Midwifery-Led Unit beds	13
	PRH provides A&E, inpatient, outpatient and day case facilities for general and acute medicine, cardiology, general surgery, upper gastro-intestinal and breast surgery, urology, critical care, trauma and orthopaedic services, paediatric services, midwife-led maternity, emergency treatment and renal dialysis. A range of other specialities are provided as outpatient and daycase. PRH has a 10-bedded private patient facility and private outpatient service.	
	In future the PRH will be our main centre for inpatient women's and children's services.	
	<b>Royal Shrewsbury Hospital (RSH)</b>	Adult Inpatient (overnight) beds
Children's inpatient and assessment beds		23
Surgical day case beds		24
Renal dialysis stations		24
Chemotherapy/haematology day centre		16
Intensive care / high dependency		9
Consultant maternity beds		41
Midwifery-Led Unit beds		13
Neonatal Intensive Care Unit beds		6
Special care baby unit beds		16
RSH provides A&E, inpatient, outpatient and day case facilities for general and acute medicine, cardiology, general surgery, colorectal surgery, vascular surgery, urology, gynaecology, critical care, trauma and orthopaedic services, paediatric services (including oncology and head & neck), emergency treatment, oncology & haematology, renal, ophthalmology, oral & maxillofacial surgery and ENT, consultant and midwife-led maternity services (with co-located neonatal intensive care). In future the RSH will be our main centre for acute surgery.		
<b>Bridgnorth</b>	Midwifery-Led Unit beds	4
<b>Ludlow</b>	Midwifery-Led Unit beds	7
<b>Oswestry</b>	Midwifery-Led Unit beds	6

## 2.1.2 Our Workforce

We employ approximately 5300 staff, and benefit from the support of hundreds of volunteers working directly for the Trust and for our main voluntary partners (including Leagues of Friends at our two main hospitals, WRVS and the Lingen Davies Cancer Appeal). The total number of staff employed on permanent and fixed-term contracts at 29<sup>th</sup> February was 5362. Given that many of our staff work part-time this represents 4497 whole-time equivalent (wte). There are currently from 522 volunteers active in the Trust and from our main charitable partners. Expenditure on staff accounts for approximately 68% of our expenditure.

Our workforce at 29<sup>th</sup> included:

- 507 wte doctors and dentists (11.4%)
- 1370 wte nursing and midwifery staff (30.5%)
- 569 wte scientific, technical and therapies staff (12.6%)
- 1,221 other clinical staff (27.1%)
- 830 non-clinical staff (14.4%)

More information about our workforce is available in Section 9.

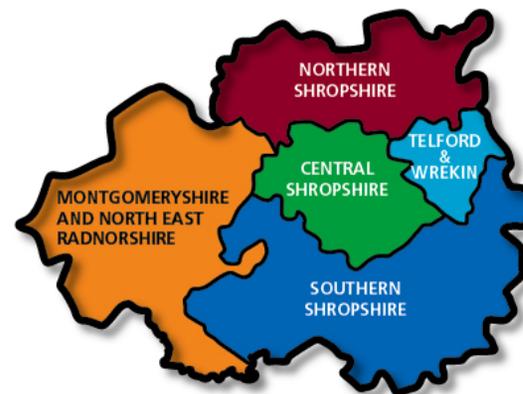
## 2.1.3 Our Communities

Over 99% of our services are provided to patients from Shropshire, Telford & Wrekin and northern and eastern areas in Powys. Whilst most of Shropshire and Telford & Wrekin would see our hospitals as their main local acute hospital, our catchment in Wales includes around 60,000 people in Montgomeryshire and north east Radnorshire (of an overall Powys population of 131,300).

This area, encompassing around half a million people, extends from the sparsely populated Powys in the west, through rural Shropshire to urban Telford. The main population centres are Shrewsbury and the new town of Telford. Alongside these major towns the area contains numerous smaller market towns including Bridgnorth, Ludlow, Market Drayton, Newtown, Oswestry, Welshpool, Wem and Whitchurch.

The map and table on the right (Table 2.1b) summarise our catchment for our main hospital services.

Some of our specialist services, such as the Shropshire and Mid Wales Fertility Centre, attract patients from a larger catchment but this represents less than 1% of our overall activity.



Area	Powys	Shropshire	Telford & Wrekin
<b>Population<sup>ii</sup></b>	131,300	293,400	162,600
<b>Area</b>	5,179	3,199	291
<b>Population Density</b>	25	92	556
<b>Overview</b>	Powys is the most sparsely populated county in England and Wales and there are no acute hospitals in the county. Around 60,000 people from north and east Powys (eastern Montgomeryshire and north east Radnorshire) look to us as their main provider of acute hospital care.	Shropshire is a predominantly rural county with a varied landscape. It is one of the most sparsely populated counties in England with a mix of the county town (Shrewsbury, which is home to the Royal Shrewsbury Hospital), small market towns and rural areas.	Telford & Wrekin is a small unitary authority dominated by the large new town of Telford (home to the Princess Royal Hospital), which is the largest population centre in our catchment and nearly twice the size of nearby Shrewsbury.
<b>Key towns</b>	Y Drenewydd (Newtown) and Y Trallwng (Welshpool)	Shrewsbury, Oswestry, Bridgnorth, Market Drayton, Ludlow, Whitchurch, Wem	Telford, Newport

## 2.1.4 Our turnover and income

Our annual turnover is in excess of £296m.

The majority of our income (90%) is for clinical services and is primarily derived from our three main commissioners, namely Shropshire County Primary Care Trust, Telford & Wrekin Primary Care Trust and Powys Teaching Health Board. Our contracts represent the majority of acute services expenditure for Shropshire County (59%) and Telford & Wrekin (70%), but a significantly smaller proportion for Powys (9%) which is served by a ring of acute hospitals outside the county.

The remainder of our clinical income comes from small levels of activity from other commissioners, specialist service income (e.g. renal and neonatal services commissioned via West Midlands Specialised Commissioning and Health Commission Wales) as well as other clinical income (e.g. private and overseas patients, NHS Injury Cost Recovery Scheme).

The balance of our income (10%) is for non-clinical services such as Education.

**Table 2.1c Income 2009/10 to 2011/12**

Commissioner	2009/10 £000s	2010/11 £000s	2011/12 £000s
<b>Clinical Income:</b>			
<b>Shropshire County PCT</b>	115,186	121,449	130,505
<b>Telford &amp; Wrekin PCT</b>	80,527	87,756	91,200
<b>Powys Teaching Health Board</b>	21,163	21,446	21,461
<b>Other Clinical Income</b>	22,040	21,240	23,468
<b>Total Clinical Income</b>	238,916	251,891	266,634
<b>Non-Clinical Income:</b>	23,967	21,089	30,161
<b>Total Non-Clinical Income</b>	23,967	21,089	30,161
<b>Total Income</b>	262,883	272,980	296,795

## 2.1.5 Our expenditure

Our annual expenditure for 2011/12 is expected to be in the region of £297m

**Table 2.1d Expenditure 2011/12**

	Plan	Forecast	Variance
	£m	£m	£m
Pay Costs	(199.2)	(199.5)	(0.3)
Non Pay Costs	(76.8)	(82.6)	(5.8)
<b>Sub Total</b>	<b>(276.0)</b>	<b>(282.1)</b>	<b>(6.1)</b>
Depreciation and Dividends	(14.7)	(14.7)	-
<b>Total Expenditure</b>	<b>(290.7)</b>	<b>(296.8)</b>	<b>(6.1)</b>

The costs of pay and non pay exceeded the Trust plan by £6.1m, these additional costs have been funded through the additional income received. This is the result of several factors including:-

The reduction of the over 18 week backlog has required the Trust to put into place increased capacity within the two hospital sites and also to purchase external capacity, particularly in respect of Orthopaedic activity, from local external providers. This has led to an increase in pay costs to Clinical and Non Clinical staff. In addition to ensure the safe delivery of particularly Unscheduled Care the Trust has been required to put in place temporary staffing. Such staff attract a significant pay premium.

The increased usage of High Cost Drugs, particularly in the treatment of Cancer and Ophthalmology patients, has exceeded levels as specified within the local Health Economy. Such increased costs are recovered from the local commissioners. The actions taken to reduce waiting times has also increased non pay costs as the Trust has purchased substantial levels of additional theatre capacity from the local Nuffield Hospital.

## 2.1.5 Our organisational structure

We have a clinically led management structure with our clinical services delivered in 11 Clinical Centres, each led by a Consultant or other specialist (e.g. Pharmacist, Therapist). Alongside our Centres, we have four cross-cutting programmes, or Value Streams, to support improved patient care across the Trust and with our external partners. These cover cancer care, scheduled care, telehealthcare and unscheduled care and are each led by a Consultant. The Clinical Centres and Value Streams are summarised in Table 2.1d.

Our Clinical Centres are supported by corporate functions led by our corporate directors:

- Chief Nurse / Director of Quality and Safety
- Communications Director
- Director of Business and Enterprise
- Director of Compliance and Risk Management
- Director of Operations
- Finance Director
- Medical Director
- Workforce Director

The main management decision-making body in the Trust is the Hospital Executive Committee, which is chaired by the Chief Executive and is a sub-committee of the Trust Board. The Hospital Executive Committee drives performance and delivery throughout the Trust and comprises the Centre Chiefs, Chief Executive and corporate directors.

Decisions in the Trust are made through **devolution** to frontline clinical services in the Clinical Centres and **cooperation** across the Trust to ensure a co-ordinated approach to quality and delivery. Centres have devolved accountability for managing their Centre budget, and mutual accountability for the Trust budget through the Hospital Executive Committee and other financial accountability and governance processes. .

## 2.2 Range of Services

The Trust offers a comprehensive range of acute services including:

- **Diagnostics (Diag)**, including: Pathology (Haematology; Blood Transfusion; Phlebotomy; Clinical Biochemistry; Microbiology; Histology; Cytology; Mortuary Service) and Radiology (Plain film; Ultrasound; CT; MRI; Nuclear Medicine).
- **Emergency and Critical Care (ECC)**, including: Accident and Emergency; Medical Assessment Units & Medical Admissions Ward / Acute Admissions; Intensive Therapy Unit and High Dependency Unit including Critical Care Outreach Team; Hospital at Night Nurse Practitioner Team; Clinical Site Management Team; Major Incident and Emergency Planning.
- **Head and Neck (H&N)**, including: Audiology; Ear, Nose and Throat (ENT) services; oral and maxillo-facial surgery; Orthodontics, restorative dentistry.
- **Medicine (Med)**, including: General Medicine; Geriatric Medicine; Respiratory; Diabetes & Endocrinology; Neurology; Dermatology; Stroke Medicine; Cardiology, Coronary Care Unit, Cardiorespiratory and Cardiac Rehabilitation; Renal.
- **Musculoskeletal (MSK)**, including: Trauma and Orthopaedics; Rheumatology; Osteoporosis; Pain Management.
- **Oncology (Onc)**, including: Clinical and medical oncology (including chemotherapy and radiotherapy); Palliative Care; Clinical haematology.
- **Ophthalmology and Patient Access (Oph)**, including: Ophthalmology and Orthoptics; Outpatients; Booking and Scheduling; Medical Records.
- **Pharmacy (Pharm)**, including Dispensing and Distribution; Medicines Management; Medicines Information and Utilisation; Aseptic Suite and Medicines Production.
- **Surgery (Surg)**, including: General surgery; Urology; Colorectal and Upper Gastrointestinal surgery; Gastroenterology; Vascular surgery; Breast Surgery; Paediatric Surgery; Anaesthesia (excluding critical care); Endoscopy; Theatres; Day case surgery; Apley Private Practice Unit; Pre-operative assessment; Sterile Services

- **Therapy (Ther)**, including: Physiotherapy; Occupational Therapy; Speech and Language Therapy; Dietetics.
- **Women's and Children's (W&C)**, including: Obstetrics and Midwifery; Paediatrics; Neonatology and special care baby services; Fertility Services; Gynaecology.

These services form the core of the mandatory services list which we will be submitted during the Monitor assessment phase.

During 2011/12 we saw:

- 56,052 elective and day case episodes (a 3.25%% decrease on 2010/11).
- 41,884 non-elective inpatient episodes (a 2.55% increase on 2010/11).
- 345,723 consultant-led outpatient appointments (a 7.36% increase on 2010/11).
- 110,079 accident and emergency attendances (a 3.53% increase on 2010/11).
- 6,749 maternity episodes (a 0.10% increase on 2010/11).

During the course of the year there was a transfer of activity from day case episodes to consultant-led outpatient appointments (procedures). This was in line with changes in national definitions and rules.

More information about Trust-level activity can be found in Section 2.3. A breakdown of patient activity in our main patient specialities is set out below in Tables 2.2a and 2.2b

Table 2.2a Consultant-Led Patient Activity by Speciality				
Consultant-Led Patient Activity by Speciality				
Speciality	Inpatient/Daycase		Outpatient	
	2010/11	2011/12	2010/11	2011/12
<b>ECC:</b> A&E Outpatient	8	18	3,413	3,486
<b>H&amp;N:</b> ENT	3,130	3,354	17,641	19,744
Oral and Maxillofacial	1,883	2,111	10,570	11,572
Orthodontics		0	11,150	10,288
Audiological Medicine		0	1,221	2,690
<b>Med:</b> Cardiology	1,824	2,127	11,998	18,232
Dermatology	15	37	12,992	16,223
General Medicine*	21,500	22,328	30,715	34,223
Neurology	220	316	8,341	8,455
<b>MSK:</b> Trauma and Orthopaedics	7,130	7,150	53,321	55,999
Pain Management	1,001	1,045	2,334	3,219
Rheumatology		0	1,860	1,217
<b>Onc:</b> Oncology	8,269	8,678	11,475	12,818
Haematology	4,786	5,520	9,184	10,330
<b>Oph:</b> Ophthalmology	7,971	4,086	35,180	50,449
<b>Surg:</b> Anaesthetics		0	767	900
Gastroenterology	13,510	14,576	8,977	10,085
General Surgery**	11,164	11,561	31,182	34,405
Neurosurgery		0	192	174
Urology	5,792	4,432	12,995	15,436
<b>W&amp;C:</b> Gynaecology	3,935	3,996	17,589	22,659
Obstetrics / Maternity	6,792	6,790	11,620	38,520
Paediatrics	6,590	6,563	16,733	17,549
Psychotherapy		0	15	22
<b>Diag:</b> Chemical Pathology		0	567	642
<b>Total</b>	<b>105,520</b>	<b>104,686</b>	<b>322,032</b>	<b>399,337</b>

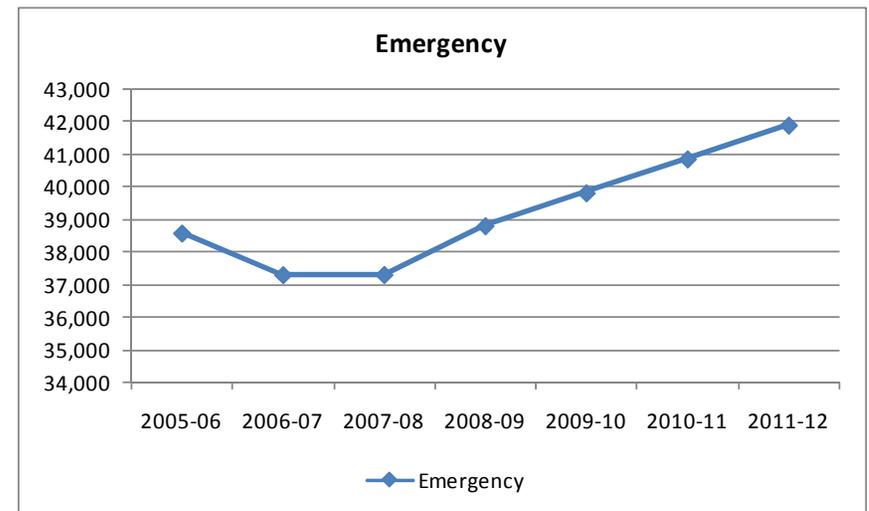
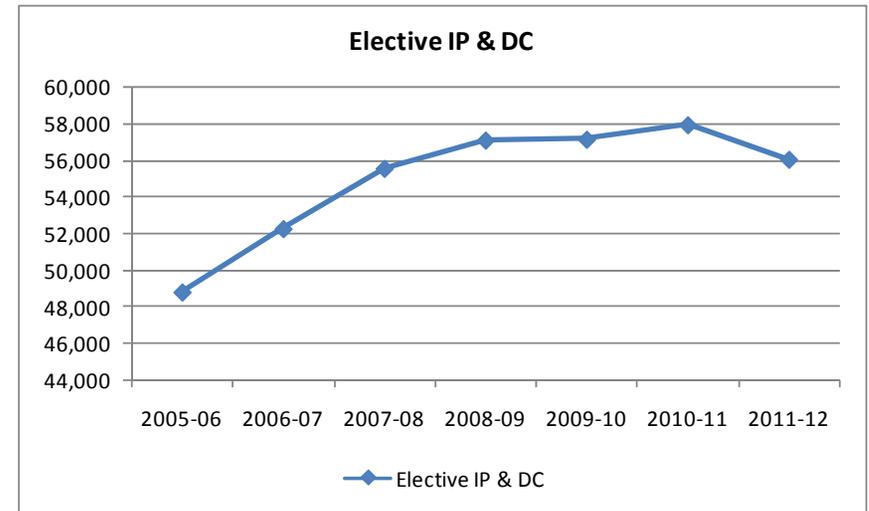
\*Includes General Medicine, Renal Medicine (Nephrology), Diabetic Medicine, Endocrinology, Geriatric Medicine

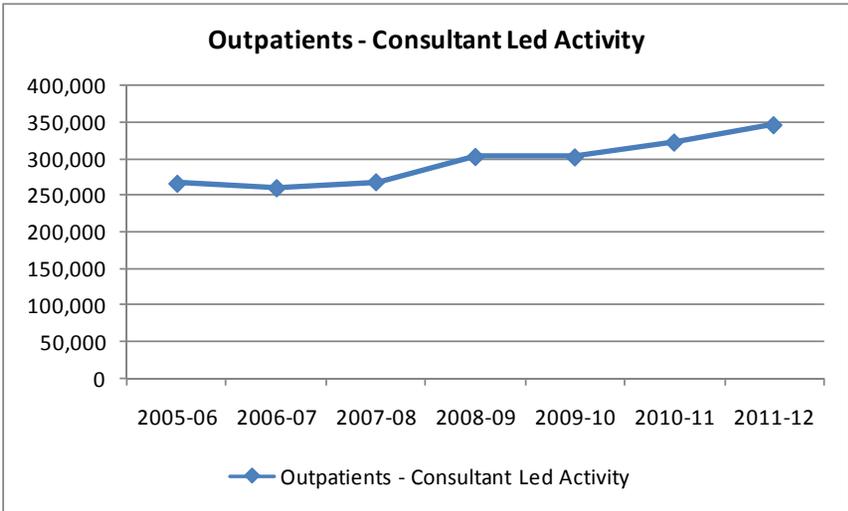
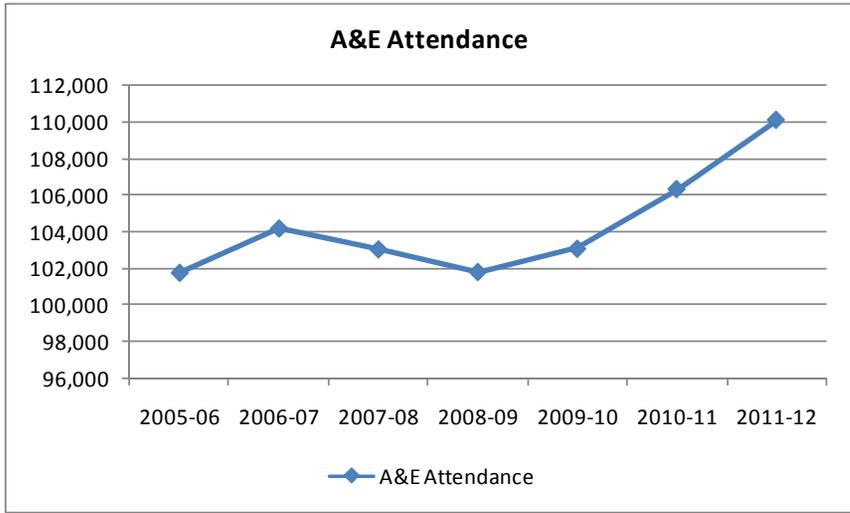
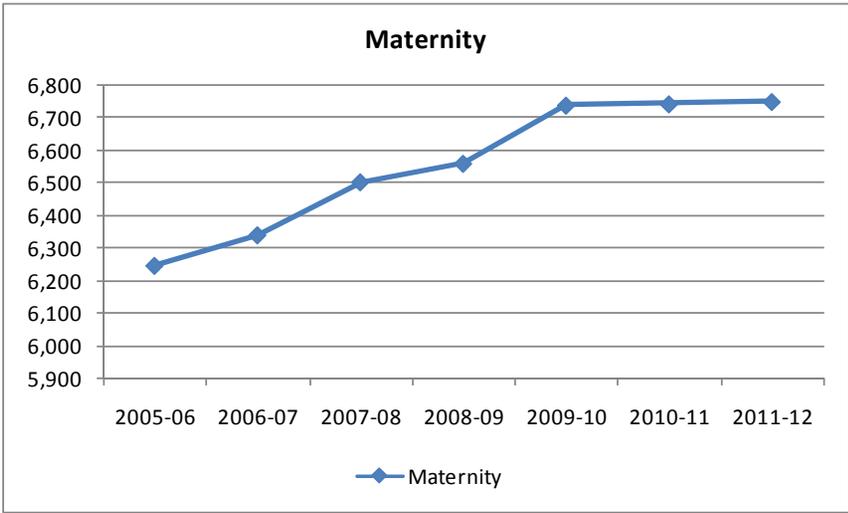
\*\* Includes General Surgery, Vascular Surgery, Upper GI Surgery, Colorectal Surgery, Breast Surgery

Table 2.2 Other Patient Activity by Specialty				
Specialty	Inpatient		Outpatient	
	2010/11	2011/12	2010/11	2011/12
ECC: Non Consultant			1	0
H&N: Non Consultant			5,774	7,119
Med: Non Consultant			52,039	55,697
MSK: Non Consultant			3,072	4,093
Onc: Non Consultant			21,706	23,923
Oph: Non Consultant			9,192	7,553
Surg: Non Consultant			8,785	10,127
Ther: Dietetics			4,431	7,075
Occupational Therapy			6,895	7,218
Physiotherapy			62,128	58,413
Speech and Language			5,475	6,202
W&C: Non Consultant	5,504	5,533	32,290	34,554
Midwife Episode			65,401	65,006

## 2.3 Activity

The graphs below show the trends in activity since 2005-06. Please note 2011/12 saw a significant movement of Daycase, Outpatient First and Outpatient Follow Up activity into the Outpatient Procedure activity type as per national rules.





## Putting Patients First



## Section 3: Commentary

- 3.1 Clinical Quality Improvements
- 3.2 Service Developments
- 3.3 Delivering the Financial Plan
- 3.4 Performance against Key Targets and Standards
- 3.5 Commissioner relations and contract delivery
- 3.6 Board Development
- 3.7 Progress with the Foundation Trust Application

## Putting Patients First

### 3.1 Clinical Quality Improvements

Please see Section 7.

### 3.2 Service Developments

The key service developments within 2011/12 were:

#### 3.2.1 Service Configuration

Completion of an outline business case for the reconfiguration of hospital services including the development of a new women's and children's centre at the Princess Royal Hospital. The full business case will be complete by April 2012 and if supported by the Strategic Health Authority will mean capital works will commence in 2012/13 for completion in 2014/15

#### 3.2.2 Unscheduled care

As part of the Trust's drive to improve patient flow through its unscheduled care service a number of service changes were introduced in 2011/12:

- An acute medical short stay facility at the Princess Royal hospital site within the medical assessment unit.
- Increase in the use of ambulatory emergency care pathways at both the RSH and PRH sites.
- Introduction of the Bed Bundle to act as an improvement approach to facilitate earlier transfers from MAUs and discharge from the hospital
- Case management and discharge planning - A rapid improvement program that supported better multidisciplinary

working and timely discharge lead to the development of the integrated case management team to support wards where the post hospital needs of the patient are complex.

- Frail Elder project introduced the concept of a frail elder team to facilitate, where clinically appropriate, the discharge of patients within the first 72 hours of their hospital stay.
- The development and implementation of an electronic referral form to initiate a social care assessment, thereby reducing the time taken versus a paper system.

#### 3.2.3. Trauma Unit designation

As part of the national drive to deliver best practice in trauma care and to meet commissioning intentions, the Trust submitted its bid for the RSH site to be its designated Trauma Unit and to work alongside University Hospitals North Staffordshire as one of three Trauma Centres across the West Midlands. This bid was accepted and from March the new network arrangements came into effect.

#### 3.2.4 Orthopaedic pre-operative assessment

The Trust introduced in 2011/12 improved pre-assessment for Orthopaedic elective surgery to more effectively manage clinical risk of anaesthesia, optimise theatre and bed utilisation, and provide adequate and appropriate procedure and rehabilitation assessment to enable informed decision making and informed consent for the patient.

#### 3.2.5 Capital Developments

- **Second Emergency Obstetric Theatre**

## Putting Patients First

The Trust allocated £714,000 for the conversion of a labour room into second emergency obstetric theatre. By doing this reduced the risks associated with timely access to theatre for emergency obstetric cases.

- **Cancer and Haematology Centre Development**  
Together with the Lingen Davies Cancer Fund who donated £3.2 million the Trust made substantial progress in 2011/12 on the completion of the new Cancer and Haematology centre at RSH at a cost of £4.8 million.
- **Replacement Linear Accelerator** The Trust approved the replacement of one of its two linear accelerators in 2012/13 at a cost of over £2.5 million.

### 3.2.6 Whole Trust change projects

- **Electronic request and results**  
The Trust began work on the development of a comprehensive electronic request & results reporting system to deliver improved safety and timely in the request and management of diagnostic results.
- **Patient Nutrition**  
In February 2012 the Trust introduced protected meal times for all patients as part of its programme to improve inpatient care. This initiative recognises the vital part that nutrition plays.
- **Non-medical e-rostering**  
The roll-out of a non-medical e-rostering system began in 2011/12 to improve workforce management, focusing initially on ward areas.
- **Tele-health**  
A trial of state of the art Video-conferencing equipment began in quarter 4 of 2011/12 to link up the Trust's two hospital sites for

education and training events and for cross site meeting purposes. This development marks the start of phase one of the roll out of tele-health technology into clinical practice within the Trust.

- **Patient/hospital status at a glance**  
In order to develop greater patient visibility at a ward and hospital level work began on the introduction of patient/hospital at a glance screens to be sited in each ward across the Trust. The project will deliver a system that is both linked to the Trust's patient administration and the VitalPac patient early warning system.
- **Comfort Rounds/intentional rounding**  
Hourly/2 hourly comfort rounds were introduced midway through 2011/12 to ensure that patients were supported on a regular basis for hydration, pain management and toileting. This process has been evaluated well by patients.

### 3.3 Delivering the Financial Plan

#### 2011/12 financial year

A detailed review of the underlying financial position of the Trust by the newly appointed Finance Director, subsequently validated by PricewaterhouseCoopers, identified that a recurrent deficit had been brought forward into the 2011/12 financial year, amounting to £14.4 million. Given the scale of this deficit, despite the actions being taken to deliver cost savings by the Trust in the 2011/12 year, it was recognised that in order for a balanced Income and Expenditure position to be achieved it would be necessary for the Trust to receive external non recurrent financial support from the West Mercia Cluster amounting to £6.5 million.

In setting a plan for the Trust the principal objectives have been to:

## Putting Patients First

- address the recurrent financial deficit and establish plan to deliver financial savings for the period 2012/13 to 2015/16 that enable the Trust to maintain a sustainable recurrent financial position, whilst at the same time ensure delivery of a balanced Income and Expenditure position in the 2011/12 year; and begin the process of improving the liquidity position of the Trust.

In delivering to this financial plan the Trust has however also been required to respond to a series of significant operational performance issues, most notably:

- addressing a significant waiting list backlog and a “hidden” backlog arising from the existence of a suspended waiting list,
- establishing new working practices to improve operational flow through the two hospital sites so as to enable the A and E attendances to be delivered with the 95 per cent target, enable cancer waiting time targets to be achieved and ensure that a sustainable waiting list position is able to be delivered; and
- Improving the quality of care provided by the Trust, with the stated aim of reducing the number of deaths within the two hospitals and improving the HSMR rate.

### Income and Expenditure position 2011/12

Performance within the 2011/12 year is summarised as follows:  
Planned v Forecast I&E 2011/12

	Plan	Forecast	Variance
	£m	£m	£m
NHS Clinical Income	260.8	269.9	9.1
Other income	22.3	22.4	0.1
Financial support	6.5	6.5	-
<b>TOTAL INCOME</b>	<b>289.6</b>	<b>298.8</b>	<b>9.2</b>
Pay Costs	(198.6)	(199.3)	(0.7)
Non Pay Costs	(76.3)	(85.1)	(8.8)
<b>TOTAL EXPENDITURE</b>	<b>(274.9)</b>	<b>(284.4)</b>	<b>(9.5)</b>
<b>EBITDA</b>	<b>14.7</b>	<b>14.4</b>	<b>(0.3)</b>
Depreciation and Dividends	(14.7)	(14.4)	0.3
<b>SURPLUS/(DEFICIT)</b>	<b>-</b>	<b>-</b>	<b>-</b>
<b>EBITDA Margin %</b>	<b>5.1%</b>	<b>4.8%</b>	<b>(0.3)%</b>

The level of Income generated by the Trust within the year has exceeded budget by £7.3 million. This achievement has arisen because of:

- a significant change within the case mix of patients treated within the hospital has led to over performance within contracts;
- activity associated with addressing the over 18 week backlog; and
- increased charges relating to High Cost Drugs

Reduction of the over 18 week backlog has required the Trust to put into place increased capacity within the two hospital sites and also to

## Putting Patients First

purchase external capacity, particularly in respect of Orthopaedic activity, from local external providers. This has led to an increase in pay costs to Clinical and Non Clinical staff. In addition to ensure the safe delivery of particularly Unscheduled Care the Trust has been required to put in place temporary staffing. Such staff attract a significant pay premium.

The increased usage of High Cost Drugs, particularly in the treatment of Cancer and Ophthalmology patients, has exceeded levels as specified within the local Health Economy. Such increased costs are recovered from the local commissioners. The actions taken to reduce waiting times has also increased non pay costs as the Trust has purchased substantial levels of additional theatre capacity from the local Nuffield Hospital.

The delivery of the Income and Expenditure plan has required the Trust to take forward a Cost Improvement Programme delivering savings in the year amounting to £6.9 million. The Trust expects to deliver savings in the year amounting to £7.2 million with a full year effect of £13.1 million.

### 3.4 Performance against Key Targets and Standards

The Trust's anticipated end of year performance against key national targets for 2011/12, based on actual end of February performance, is as follows:-

Performance Indicator	Performing	Under-performing	Forecast 2011/12 Performance (Based Feb YTD Position)
Four-hour maximum wait in A&E from arrival to admission, transfer or discharge <sup>1</sup>	95%	94%	94.30%
MRSA bacteraemia	0	>1SD*	1
C Diff	0	>1SD	39
RTT - admitted - 95th percentile <sup>®</sup>	<=23	>27.7	43.08 Weeks
RTT - non-admitted - 95th percentile <sup>®</sup>	<=18.3		29.01 Weeks
RTT - incomplete - 95th percentile	<=28	>36	33.84 Weeks
RTT - admitted - 90% in 18 weeks	90%	85%	67.51%
RTT - non-admitted - 95% in 18 weeks	95%	90%	86.61%
2 week GP referral to 1st outpatient	93%	88%	97.72%
2 week GP referral to 1st outpatient - breast symptoms	93%	88%	98.09%
31 day second or subsequent treatment - surgery	94%	89%	94.67%
31 day second or subsequent treatment - drug	98%	93%	98.68%
31 day diagnosis to treatment for all cancers	96%	91%	97.49%
Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy treatments)	94%	89%	98.67%
62 day referral to treatment from screening	90%	85%	92.94%
62 day referral to treatment from hospital specialist	85%	80%	92.30%
62 days urgent GP referral to treatment of all cancers	85%	80%	85.35%
Patients that have spent more than 90% of their stay in hospital on a stroke unit	80%	60%	87.70%
Delayed transfers of care	3.5%	5.0%	4.70%

## Putting Patients First

The assessments used in the table above are as per the Department of Health's Performance Assessment Framework.

The Trust has been unable to deliver and sustain performance against the A&E 4-hour 95% target during the year. Improving patient flow remains a key priority, with a number of workstreams being introduced in-year. The Trust is working closely with its commissioners and health & social care partners in this regard.

The Trust has not achieved its 18-week referral-to-treatment (RTT) targets for either admitted or non-admitted patients for 2011/12. The Trust began the year with a significant backlog of patients (ie patients already waiting over 18 weeks), rising to a figure in excess of 5000 patients at the end of May. This represented 25% of the total number of people waiting (open clocks), compared to a regional average of 6-7%. Through a combination of improved processes and additional non-recurring activity the backlog is now 5-6% and the Trust expects to be delivering the overall RTT targets for admitted and non-admitted patients from April 2012 onwards.

The Trust is anticipating that it will achieve all its cancer targets once final March figures are available. In-year, the area of greatest concern has been the overall 62-day target which was below target for each of the first 4 months of the year. However, performance has been above target for each subsequent month and the Trust achieved 'year-to-date' delivery in January and has sustained this.

The Strategic Health Authority introduced a revised Provider Management Regime in January 2012 (beginning with and reporting December performance). In shadow form until April 2012, the process includes the Trust formally signing off completed performance templates at Trust Board before submitting them on a monthly basis. The templates are discussed further in Section 8 and are included in the appendices to this document for information.

### 3.5 Commissioner relations and contract delivery

The Trust has worked closely with its 2 local commissioners (Shropshire County PCT and NHS Telford & Wrekin) and Healthcare Commissioning Services (HCS) during the course of 2011/12. There have been regular performance and quality review meetings and issues that have arisen in-year have been discussed and progressed within an appropriately challenging and constructive 'what can we do to help' environment.

Both commissioners have been supportive across a range of issues during the year. With regard to 18-week RTT performance, for example, additional non-recurring support has been provided to help clear the backlog, the commissioners have worked with the Trust to place or redirect patients to alternate Providers for 'challenged' specialties and both commissioners have contributed positively as members of the Trust's RTT Delivery group that meets on a weekly basis.

It is expected that the final outturn position on these contracts will be in line with the jointly recognised and agreed expectations.

There have been a number of problematic issues to manage with regard to the Trust's 3<sup>rd</sup> largest contract – that with Powys LHB (worth approximately 8% of the Trust's income). The most significant is a disagreement as to when and how the LHB's referral management process for routine referrals became operational. This has however been resolved moving forwards. It is likely that this contract will marginally underperform at the end of 2011/12.

In general, discussions with Powys LHB have focussed on the fact that, due to financial challenges, the LHB are looking to engage clinically with the Trust to implement a range of admission avoidance, pathway redesign and 'care closer to home' (ie in Powys) initiatives to reduce activity and therefore contract spend at the Trust. The Trust is committed to working with the LHB on such schemes, but with the recognition that the LHB must fund appropriately the activity that the Trust ultimately undertakes on its behalf.

## Putting Patients First

### 3.6 Board Development

In order to progress the Trust's FT application, SaTH have implemented a Board Development programme that addresses the key components of a high-performing Board and will satisfy Monitor's requirements. The development plan covers Monitor's seven domains:-

- Board capability and capacity
- Understanding the business
  - Quality
  - resilience & safety
  - legally constituted,
  - good business strategy
  - financially viable
- Sound governance – compliance with statutory requirements, service performance, local health economy issues

These are delivered as a full day programme, off-site.

The sessions were divided into three main stages;

Stage 1 - Board capability and capacity (June – October 2011)

Stage 2 – Understanding the business (Oct 2011- March 2013)

Stage 3 – Compliance requirements (March 2013 to authorisation)

#### **STAGE 1 BOARD CAPABILITY AND CAPACITY (June 2011 – October 2011)**

This work was led by Chantry Vellacott (CV) following a mini-tender process to identify the most appropriate supplier. The key elements are:

- Critical Review of Board Papers
- Board capacity & capability assessment

- Board workshop – Handling tough times ahead

#### **Overview of Board capability and capacity programme**

##### **(i) Critical Review of Board Papers**

The assessment report on each Board report reviewed. A summary report scheduling findings, with improvement recommendations. A feedback meeting- to CEO, or wider audience if required.

##### **(ii) Board Capability and Capacity Assessment**

Using an approach of structured questionnaires and interviews with each Board Director, CV applied a proven Board development diagnostic framework, which in conjunction with Board observation and a high level review of key governance systems and processes provided an opinion upon the following dimensions:-

- Board skills and experience
- Organisational understanding of Board Directors
- Operation of the Board
- Overall Board capability

Each of the Directors will completed a concise questionnaire covering the four dimensions and were individually interviewed. The findings were triangulated and a report produced which made recommendations for specific development action by NED's , ED's and overall views.

##### **(iii) FT Board Development Workshop and Action Plan**

A session entitled 'FT Authorisation – Handling Tough Times Ahead', was held using downside mock Board papers and discussion as a role play exercise

The ensuing debate and actions agreed were analysed collectively using CV's experience of Monitor's expectations, and their observations and research on the Board and its governance arrangements /culture.

## Putting Patients First

### STAGE 2 UNDERSTANDING THE BUSINESS (Oct 2011- March 2013)

This work has been delivered largely by Trust staff. The programme covered the key elements of the Trust's strategy, business planning and governance framework. Each of the leads presented an overview of their area to the Board along with a short summary of the key issues. These form the basis of the Trust's Integrated Business Plan (IBP) and Long-Term Financial Model (LTFM). The key areas to cover are:-

- Formulating Strategy
- Financial Governance
- Quality & Safety Strategy
- External Relationships
- Governance

### STAGE 3 COMPLIANCE REQUIREMENTS (March 2013 to authorisation)

This is the final part of the process and will occur from March 2013 onwards as the final part of the trust's application process. Currently this section will focus on:-

- FT Board certification and statements
- FT Compliance Framework
- Final preparation for Monitor Board2Board

## 3.7 Progress with the Foundation Trust Application

The Trust is committed to improving the quality of acute services across Shropshire and Mid-Wales and views the application for and achievement of FT status as a key 'vehicle' to facilitate this end. In particular, becoming an FT will:

- Enable the Trust to be more explicitly and effectively accountable to its local communities via a robust and thriving membership.
- Give the Trust greater freedom to innovate and develop in a way suited to its populations and location.
- Ensure that the Trust maximises opportunities to provide integrated services for patients.
- Allow the Trust to create and retain planned financial surpluses, giving it more freedom to invest in and develop services that meet the needs of the community.
- Enable the Trust to focus on its efficiency and productivity, resulting in a better understanding of the Trust's 'business' and helping to ensure that resources are used more effectively.
- Allow us to develop a workforce strategy that is bold for the future, recognising outstanding contributions and success, and rewarding excellent performance appropriately.

There is a robust programme structure in place with SMART outputs. Thus far the Trust has achieved all the required milestones.

## Putting Patients First



## Section 4: Strategy and Service Developments

- 4.1 Strategic Context – the Local Health Economy
- 4.2 Commissioning Arrangements
- 4.3 Developing our Strategy and Long Term Organisational Objectives
- 4.4 Supporting Strategies
- 4.5 Key Service Developments

## Putting Patients First

### 4.1 Strategic Context – the local health economy

Over 99% of our services are provided to patients from Shropshire, Telford & Wrekin and northern and eastern areas in Powys. Whilst most of Shropshire and Telford & Wrekin would see our hospitals as their main local acute hospital, our catchment within Wales only includes approximately half of the overall population in Powys.

Our catchment area, encompassing around half a million people, extends from the sparsely populated Powys in the west, through rural Shropshire to urban Telford. The main population centres are Shrewsbury and the new town of Telford. Alongside these major towns the area contains numerous smaller market towns including Bridgnorth, Ludlow, Market Drayton, Newport, Newtown, Oswestry, Welshpool, Wem and Whitchurch.

Within the local catchment area there are 3 distinct populations:-

#### Telford & Wrekin

- Telford & Wrekin is comparatively younger and less affluent than Shropshire, with 24% of its population living in deprivation quintile 1
- Telford & Wrekin is predominantly urban and has a higher proportion of residents from a Black & Minority Ethnic (BME) group, compared with Shropshire

#### Shropshire

- Shropshire is an aging and affluent population with a large proportion of its residents living in a rural geography
- The majority of the population are of white origin

#### Powys

- Powys, similarly to Shropshire, consists of an aging and affluent population
- Powys has the highest proportion of residents living in a rural setting

The population in Shropshire and Powys is considerably older than the national average with 22% and 24% of the population over 65 respectively, compared with 17% nationally

The ageing demographic will increase demand for acute services over the next 5 years and beyond. As the proportion of over 65s is expected to grow by 2020, the increased prevalence of long-term conditions will put further pressure on services

As part of our externally commissioned market assessment exercise we assessed the epidemiological needs of our population. This assessment told us that within our local population there is a high prevalence of heart related conditions and diabetes, and high growth is predicted in dementia. Within Powys there is also a higher recorded incidence of cancer and COPD, however, this may be due to better screening and diagnosis in the area.

The local demographics and health needs projections have shaped the development of our future strategies.

### 4.2 Commissioning arrangements

Shropshire County PCT published its Strategic Plan for 2009-2014 in February 2010 detailing its vision to improve the health and wellbeing of people in Shropshire through partnership working to provide high quality and safe and responsive services in the most appropriate setting.

The strategy is based on 6 key themes:

- Tackling health inequalities
- Support for healthy lifestyle choices and managing long term conditions
- Promoting mental health and well being
- Developing care closer to home
- Developing vibrant community hospitals
- Developing modern health care

NHS Telford and Wrekin, in partnership with Telford and Wrekin Council, published its Health and Well Being Strategy, the objectives defined as:

## Putting Patients First

Improve the health and wellbeing of the population of Telford and Wrekin by:

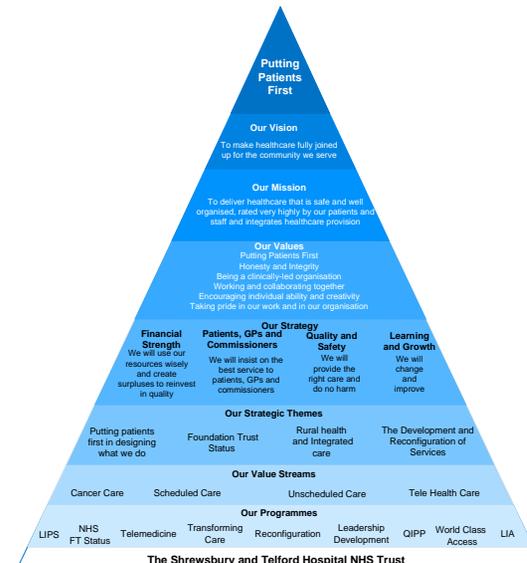
- Reducing health inequalities
- Providing access to a range of quality services to meet health needs
- To ensure delivery of key national and local targets including financial balance
- To support the development of good quality providers of health services
- To engage with the whole community with regard to future services

NHS Wales published its 'Together for Health' strategy for 2011-16 detailing the need for service transformation, identifying 7 major areas for change as follows:

- Improving health as well as treating sickness
- One system for health – integrated NHS bodies
- Hospitals for the 21<sup>st</sup> century as part of a well designed fully integrated network of care
- Aiming at excellence everywhere
- Absolute transparency on performance
- A new partnership with the public
- Making every penny count

### 4.3 Developing our strategy and long term organisational objectives

Our strategy framework is detailed within our Management System (pyramid) which brings together our mission and vision and identifies the programmes that will enable us to deliver our organisational objectives.



Our strategy has been developed within 4 domains (adapted from Kaplan and Norton): Quality and Safety; Patient, GP and Commissioner; Learning and Growth and Financial Strength.

Developing a strategy that is balanced between these four domains will ensure that we:

- Focus on what internal processes we must excel at if we are to improve the **quality and safety** of our care.
- Focus on what we have to do to meet the needs of **our patients, GPs and commissioners**.
- Focus on the **learning and growth** that will prepare us for the future through developing our staff, the technology we use and the innovation we create.

## Putting Patients First

- Focus on what it will take to create the **financial strength** to enable us to invest in the quality of our service.

‘**Putting Patients First**’ is our top priority, our highest value, and at the heart of all of our strategic intentions and forms one of the *four strategic themes* that support the rationale for our FT application.

Our organisational objectives have been developed through a process of stakeholder needs analysis and an understanding of the gap of where we are and where we want to be.

To communicate our strategy within the organisation we have produced a Strategy Map, a “plan on a page” which represents the most important elements of our strategy. This plan on a page will help everyone to understand what we must do to deliver our strategy and achieve our vision of the future.

Our objectives for 2012/13 are shown in Appendix A we anticipate these objectives being relevant at least over a five year period, but we will continually review and refresh our strategy on a quarterly basis.

The key themes that run through our strategy are

- Putting Patients First – designing what we do for our patients
- A Foundation Trust – a clear purpose
- Rural Health and Integrated Care – an expert role
- The Development and Reconfiguration of Services – developing safe, high quality and sustainable services

### 4.4 Supporting strategies

In order to deliver our overarching strategy we have identified our priority initiatives. These are **projects, programmes, foundations or supporting strategies** that will help us to achieve our overarching strategy, accomplish change, improve our processes, create capacity or improve our performance.

#### 4.4.1 Putting Patients First

Our business is primarily driven by the outcomes we want to achieve for our patients. *Putting Patients First* means giving the best patient experience we can, doing so safely and using the evidence of what works best to inform our practice. This theme underpins our whole strategy and service development plan.

#### 4.4.2 Foundation Trust Status

The organisational rigour that *becoming an FT* demands is something we aspire to and which will allow us to make the right decisions and secure the widest possible range of specialist care for the people that we serve.

Whilst we are ambitious to develop the quality, range and reach of local services, we also recognise we need to demonstrate our financial health. Our short term strategy therefore is about building a solid foundation which can be used as a platform for future growth. We have therefore assessed each of our core services for clinical sustainability, profitability and growth potential and prioritised our development plans and which services we might divest ourselves of accordingly.

We seek operational efficiencies to ensure ongoing financial viability, meeting and exceeding quality and performance targets and ensuring future clinical viability of what we believe are our core services.

#### 4.4.3 Rural Health and Integrated care

##### (i) Telemedicine

We believe, through telemedicine, that there is huge scope to improve local access to care for patients at local level, make care more consistent and reliable, improve access to expert decision makers, improve patient flow and lower costs for organisations including ourselves.

## Putting Patients First

We envisage a system that following a careful analysis of risks and benefits would progressively offer patients, and their carers to benefit from these services. We will develop the partnerships we need to build this capability.

We have agreed that the Ontario Telehealth Network (the world's largest T Health provider) will work as a learning partner in support of developing this strategy.

### (ii) An integrated healthcare system

There are challenges faced in delivering *rural healthcare* in particular the distances patients have to travel to access care. We must promote the sustainable use of resources across the health economy and will therefore offer leadership to the development of an *integrated healthcare system*. We expect this will help to improve the quality of service our partners and we can provide.

This model of delivering care should improve resilience and reliability of our services and at the same time control and lower the cost of provision. We therefore aim to act as a "service integrator" and establish a series of integrated pathways of care for our population. The evidence base for this approach has been tested in developing our plans.

It is our view that in order to face up and respond to the financial challenge over the next 5 years, the Shropshire health economy requires an at scale transformation. Our future assumptions will need to incorporate reducing reliance on institutional care, less reliance on acute care and one that supports and sustains people in their own homes. The Trust is therefore developing its plans through 6 service areas or pathways that are likely to form the basis of any radical re-working of a health care system;

- End of Life Care
- Long term Conditions Management
- Frailty and Older Person Care
- Dementia Care
- Hospital at Home

- Front ended Acute Service

The unifying characteristic of these 6 areas is that they all could radically reduce the need for in-patient hospital based health care, all of which relate to a more integrated model of delivery and a much smaller inpatient bed base for our Trust:

### 4.4.4 The Development and Reconfiguration of Services

During 2010 we developed and consulted on a strategy called '**Keeping it in the County**'. This was a proposal to re-shape services that faced particular safety or sustainability challenges. The services affected include:

- Inpatient paediatrics
- Consultant obstetric and midwife led maternity care
- Acute surgery (upper and lower gastrointestinal surgery and vascular surgery)
- Head and Neck surgery (ENT and maxillofacial surgery) and urology.

Following extensive consultation we have secured approval of an outline business case to re-shape these services. This includes the development of a women and children centre at Princess Royal Hospital and an acute surgical and trauma unit at the Royal Shrewsbury Hospital.

### 4.5 Key Service Developments

The key drivers for our service development plan are articulated within our IBP (Chapter 3; Strategy) and (Chapter 4: Market Assessment). There are a number of desired outcomes that have shaped our service development plans, these include:

- Improving the income and expenditure balance of our services

## Putting Patients First

- Delivering services in a rural setting by seeking the means through which, where practical, service integration can be achieved.
- Developing services that deliver growth for the Trust but in a cost neutral manner for commissioners through repatriation of patient flows to improve the service choice for the population..
- Reconfiguration of services to ensure that they are clinically safe and sustainable in the future

### 4.5.1 Improving the income and expenditure of some services

In order to deliver improved quality of service it is essential the organisation is financially sound. Establishing a core service offering in key specialties must form the basis of the Trust's stabilisation and growth strategy. The Clinical Centres and their associated specialties have been evaluated according to specialty growth and profitability. We have segmented specialties into four strategies based on individual specialty growth and profitability.

### 4.5.2 Delivering services in a rural setting

Once our solid foundation has been built, we will look to expand our core services through a number of strategic initiatives including localising services of low clinical dependency that will be strategically located to attract market share from the competition For example Ludlow and Bridgnorth community hospitals.

In our service transformation plans we will boost local confidence in us as an organisation and fully involve the GP community and other local providers in any future changes made to services. We will also pursue some opportunities that this approach will bring to extend our traditional core services into community based care through a more integrated care model of delivery detailed later in this section

### 4.5.3 Developing services that deliver growth

Our Service development plans can be organised into the consolidation and growth of existing services:-

- Repatriation of Market Share
- Expansion of Women's & Children's and paediatric surgery
- Cancer services development
- Right sizing diagnostics
- Growth in CSSD customer base

And the development of new service Developments:-

- Cardiology
- Private Practice Joint Venture

Within cardiology the Trust wishes to develop a local elective PCI service and a devices service. This proposal has been selected based on that it offers improved access to the population of Shropshire, Telford and Wrekin and Mid Wales; it builds on an existing strength to establish credibility and a competitive advantage and it ensures service sustainability and service capacity into the future

The Trust is also looking to explore the private patient market as an enabler of profitable growth, which will then be reinvested back into NHS services. Alongside the upside revenue potential, there are a number of advantages associated with increasing private patient care that this strategy will deliver, including:

- Optimising the use of NHS facilities and maximising operating efficiencies within SaTH
- Facilitating easier and more convenient consultant visits between NHS and private patients

## Putting Patients First

### 4.5.4 Reconfiguration of services

Developing the options and the appraisal process for reconfiguring women's, children's and surgery has been a clinically led process. The total capital cost of this reconfiguration programme which is a mix of new build and refurbishment, is £35million and will be funded through PDC. The majority of this is for the new build element at PRH (£28m). Details of the economic analysis and affordability can be found in full in the FBC.

The reconfiguration principles set out by commissioners NHST&W and SCPCT at the beginning of the programme were:

- Keeping two vibrant, well balanced, successful hospitals in the county
- A commitment to having an Accident and Emergency Department on both sites
- Access to acute surgery from both sites

These principles were underpinned by two essential requirements; making services safer now and in the future and making services sustainable now and in the future and were considered in the context of a wide range of current and future issues and challenges:

## Putting Patients First



## Section 5: Alignment to Commissioner Plans



## Putting Patients First

### 5.1 Shropshire County PCT and NHS Telford & Wrekin

Contract discussions have taken place jointly with our 2 local commissioners to ensure, as far as possible, a consistent approach to negotiations for 2012/13. Contract offers have been made and accepted and detailed activity and finance schedules, together with the general contract documentation, will be completed as per national requirements and timescales.

Activity baselines have been set based on an agreed view of 2011/12 forecast outturn, less non-recurring activity associated with reducing the Trust's 18-week backlog (see section 3.5).

A review of actual outturn will be undertaken once the final position is known to determine whether there is any risk associated with the contracted activity levels.

Further reductions to the baseline activity have been made to allow for the transfer of commissioning responsibility for some services to Specialised Commissioning (eg radiotherapy) – this will be neutral in overall contracting terms – and in relation to the health economy-wide QIPP initiatives (see 5.2). The commissioners have not allowed for any activity growth for demographic changes within the contracted activity levels.

During the course of 2011/12 the Trust identified and raised a series of 'coding and counting' issues that it requested funding for in subsequent years. Agreement has been reached on a number of these, equating to approximately £4million of additional funding for 2012/13 (approximately £1.5million of this represents the final transition year of issues raised and agreed in previous years, eg the tariff for community midwifery contacts). As part of the agreement to fund these, the commissioners have indicated that they wish to undertake a number of service reviews in-year to better understand, and if appropriate change, the associated patient pathways. The Trust is fully committed to working with the commissioners in these reviews.

### 5.2 Local QIPP Schemes

The reduction in planned activity reflected in the contract numbers, due to the delivery of QIPP initiatives during 2012/13, equates to approximately £5.3million (£8.8million on a full-year basis) across both commissioners. The Trust is committed to playing its part, working alongside commissioners and its other health and social care partners, to ensure delivery on these initiatives and is involved in clinically-led discussions with commissioners in how to take these forward (see below). The basis of the contract agreement however, is that any 'overperformance' due either to delays in implementation of a scheme or the impact of a scheme on activity being less than anticipated, will be charged for.

For unscheduled care the Trust plays an active role within the local Urgent Care Network. There are a range of schemes either being discussed or already agreed that are designed to redirect admissions to alternative community-based services, shift activity away from admissions to ambulatory care and reduce the length of stay for patients that do need to be admitted. Examples include changes to working practices, based on an ambulatory care model, being introduced alongside (acute) physician-led Acute Medical Units and a 'frail and vulnerable patient' team has been established to focus on improving and streamlining clinical pathways for this specific cohort of patients.

For planned care, the commissioners have enhanced their 'procedures of low clinical value' policy and, following clinical engagement, the Trust has agreed to the proposed changes. A number of pilots agreed with commissioners and initiated during 2011/12 to replace consultant outpatient appointments with either telephone contacts (eg endocrinology) or 'straight to test' (eg cardiology) are being rolled out in 2012/13. A 'consultant-to-consultant' referral policy has been agreed and is in place. The Trust has agreed to work with commissioners to better understand the cohort of patient activity that is discharged after the first outpatient appointment (quite high in some specialties) to see if alternative pathways may be more appropriate and during February the Trust hosted a workshop for consultants and GPs to discuss ways of making better use of Choose & Book, with particular emphasis on the

## Putting Patients First

use of Advice and Guidance to reduce the need for outpatient attendances.

### 5.3 Powys LHB

As highlighted in section 3.5, financial challenges mean that the LHB is seeking ways to reduce the level of demand it places on the Trust. The LHB does, however, recognise that it needs to fund activity that is either admitted to, or seen, at the Trust at national tariff where applicable or at the same locally agreed tariff as our main commissioners where national tariff does not apply.

At the time of writing this Plan there is no formal contract agreement in place with the LHB for 2012/13. Proposals to-date from the Trust have centred around a contract value based broadly on outturn activity (plus coding and coding issues as described in section 5.1) but with an agreed form of wording that confirms the Trust's willingness to work with the LHB on admission avoidance and pathway redesign. The LHB has not discounted this but its stated intention would be to underperform on such a contract and the Trust will need to assess the level of risk associated with this. If agreement is not reached by the end of April then this will be escalated through the appropriate processes to reach a resolution.

### 5.4 Specialised Commissioning

Activity to the value of approximately £4.5million has been transferred from our local commissioners to Specialised Commissioning as part of the change in commissioning responsibilities, bringing the total contract value to approximately £14million. This contract has been agreed.

The main service elements of this contract are renal dialysis and neonatal care. The largest element that has now transferred relates to radiotherapy.

### 5.5 Other Commissioners

The Trust has a number of contracts with other commissioners (eg Welsh specialised Services). In total these represent approximately 2-3% of the Trust's total contract income. Contracts have been agreed that are broadly consistent with forecast outturn activity levels.

### 5.6 Draft Activity Plans

Indicative activity plans, at point of delivery, are as follows :-

SLA Activity Type	11/12 Forecast Outturn	12/13 Annual Plan	Variance	Variance %
Elective IP	8,542	8,100	-442	-5.17%
Elective DC	47,511	44,670	-2,841	-5.98%
Emergency	41,882	40,515	-1,367	-3.26%
Maternity	6,749	7,190	441	6.53%
A&E Attendances	110,076	108,875	-1,201	-1.09%
Consultant Led/Responsible First Attendance	104,459	100,362	-4,097	-3.92%
Consultant Led/Responsible Follow Up Attendance	178,599	167,085	-11,514	-6.45%
Consultant Led/Responsible Outpatient Procedure	62,665	59,608	-3,057	-4.88%
<b>Total:</b>	<b>560,481</b>	<b>536,404</b>	<b>-24,078</b>	<b>-4.30%</b>

Planned activity reductions for 2012-13 are related to the following:-

- Non-recurring activity undertaken in 2011-12 associated with reducing the 18-week backlog patients
- The part year impact of QIPP schemes being implemented within the health economy in 2012-13.

## Putting Patients First



## Section 6: Key Risks

- 6.1 Background
- 6.2 Risk structure
- 6.3 Training and education
- 6.4 Key risks
- 6.5 FT risks



## Putting Patients First

### 6.1 Background

The Shrewsbury and Telford Hospital NHS Trust is committed to changing healthcare for the better and believes that our role as individuals, and as an organisation, is to provide the safest possible care at the highest level of quality we can afford using the best evidence of what provides the greatest benefit to patients.

The Trust Board recognises that to achieve this highest level of quality, it is essential that effective risk management should be part of the Trust's culture and strategic direction.

The Board is committed to an open and honest approach in all matters. It expects all staff to acknowledge that risks within the Trust can be identified and managed if everyone adopts an attitude of openness and honesty. The overall approach expected within the organisation is one of help and support rather than blame and recrimination.

The effective management of risk is central to providing the safest possible care at the highest level of quality we can afford whilst allowing the Trust to make the most of opportunities, and minimising the risks taken. Boards need to be able to demonstrate that they have been informed about all risks not just financial and that they arrived at their conclusions on the totality of risk based on all the evidence presented to them.

The purpose of the Risk Management Strategy is to detail the Trust's framework for setting objectives, providing assurance and managing risk to enable:

- The Trust to maintain a corporate risk register, that details those risks that could prevent the achievement of Trust strategic and operational objectives as stated within the Trust's business plan.

- The resulting risk register to be reported through the Trust Risk Management Executive to the Trust Board. The Risk Management Executive is the overarching risk management committee in the Trust.
- The Trust to develop an Assurance Framework that informs the Board of the effectiveness of key controls that seek to mitigate or manage principal identified risks to the Trust's stated objectives.
- The resulting Assurance Framework to be scrutinised by the Audit Committee.

The Trust aims to manage risk in an integrated way; considering all aspects of risk including clinical, non-clinical, financial, operational, business and strategic with the aim of minimising its exposure to risk.

The maternity service has a complementary approved risk management strategy which describes the processes in place in the Women's and Children's Centre for managing risk in this high risk environment as required by the CNST standards published by the NHSLA.

### 6.2 Risk structure

The Trust will maintain its structured approach to risk management. It is not possible to manage risks until they have been identified. Risk identification is the process of identifying what can happen or has happened and why. The first step is to review business plan objectives, identifying the Principle Risks (Hazards) that may impact upon the ability of the Trust or Centre to achieve its objectives. The Trust has produced a document 'Guide for ongoing Risk Assessment' to assist line managers.

The approach to risk identification includes:

- A "pro-active approach" to the identification and management of Principle Risks that may threaten the achievement of Strategic and operational objectives as identified within the Trust Business Plan.

## Putting Patients First

- A “reactive approach” to the identification and management of risks that may threaten the achievement of the Trust Risk Management workstreams as indicated in Section 13.0 of this strategy.

### 6.3 Training and education

Training and education are key elements in establishing and maintaining the “risk management culture”. They provide staff with the necessary knowledge and skills to work safely and to minimise risks at all levels.

The Trust will undertake to provide training in all areas for staff and other agencies working within Trust sites to ensure the development of a risk management culture.

This process will start at induction. All staff are required to attend a corporate induction programme on joining the Trust and this will include an introduction to the risk management culture within the Trust. The session will also encourage staff to self-assess their personal responsibilities and development needs in relation to risk management and the task they will be undertaking.

Action will be taken to ensure that accurate and consistent training records are maintained and that appropriate follow-up action is taken when staff do not attend mandatory or statutory training courses.

All Trust staff are required to attend certain mandatory risk management training courses. In addition certain staff groups are required to attend additional courses or undertake e-learning / distance learning

programmes as appropriate, which are mandatory for their specific work groups, these are detailed in the relevant policies.

Staff health, safety and welfare programmes will be developed across the Trust. Specific consideration will be given to statutory requirements, violence in the workplace initiatives and stress reduction.

Each and every employee will have personal objectives linked to the corporate objectives, including training reviewed annually at time of staff appraisal in line with Trust policy. Where appropriate personal objective and development plans will directly link to identified risks.

Board members, Executive and Non-Executive Directors and other identified Senior Managers will be appropriately trained and skilled in risk management for their role as Board member or members of the Senior Management Team. They will be provided with bespoke Risk Awareness Training for Senior Managers to ensure that they have a clear understanding of their role and responsibilities for risk management throughout the organisation. Attendance will be recorded and forwarded to the Chief Compliance Officer. This will be reported in the Risk Management Annual Report to the Risk Management Executive.

### 6.4 Key risks

The board is currently reviewing its key risks and will be holding a facilitated workshop in April to agree the key risks, controls and assurances for 2012/13 which will be reported through the Board

Assurance Framework. All the current risks identified by the Board are summarised in Table 1 and the summary action plan in Table 2.



## Putting Patients First

**Table 2 – Summary action plan**

Principle Risks	Planned Action to cover gaps	Progress against identified gaps
Failure to deliver recurrent I&E position	<ul style="list-style-type: none"> <li>Develop formalized finance and performance review mechanism at Centre level</li> </ul>	Senior finance officers assigned to Centres
	<ul style="list-style-type: none"> <li>Reduce reliance on agency spend</li> </ul>	<ul style="list-style-type: none"> <li>Reduction in agency spend</li> </ul>
	<ul style="list-style-type: none"> <li>Implement service line reporting</li> </ul>	<ul style="list-style-type: none"> <li>Service Line Reports constructed on monthly basis for review at Centre level.</li> <li>Establish SLR Project Board (Jan 12)</li> </ul>
	<ul style="list-style-type: none"> <li>Develop formalised finance &amp; performance review mechanism at centre level</li> </ul>	<ul style="list-style-type: none"> <li>Senior finance officers assigned to Centres.</li> <li>Service Line Reports constructed</li> </ul>
Failure to deliver CIP resulting in trust not being a viable service provider	<ul style="list-style-type: none"> <li>Put in place appropriate project management resources to deliver programme</li> </ul>	<ul style="list-style-type: none"> <li>Team established and supporting non-recurrent reserves in place.</li> <li>Comprehensive reporting processes constructed and presented to HEC and F &amp; P Committee</li> </ul>
Failure to deliver key milestones in Future Configuration of Hospital Services (FCHS) resulting in unsustainable service delivery	<ul style="list-style-type: none"> <li>Put in place appropriate project management resources to deliver programme</li> </ul>	<ul style="list-style-type: none"> <li>Programme resource agreed</li> </ul>
Failure to deliver national performance targets resulting in poor quality of service	<ul style="list-style-type: none"> <li>Development and implementation of Health economy wide action plan with robust governance arrangements</li> </ul>	<ul style="list-style-type: none"> <li>Health economy wide action plan agreed to eliminate 18 week backlog by February 2012 and identifies the additional resources required to ensure sustainability</li> <li>On target to achieve by end of March</li> </ul>
	<ul style="list-style-type: none"> <li>Deliver agreed trajectories for cancer</li> </ul>	<ul style="list-style-type: none"> <li>On target</li> </ul>
	<ul style="list-style-type: none"> <li>Deliver performance plans for A&amp;E</li> </ul>	<ul style="list-style-type: none"> <li>Likely to underachieve target</li> </ul>
Failure to deliver FT milestones	<ul style="list-style-type: none"> <li>Work up detailed plans</li> </ul>	<ul style="list-style-type: none"> <li>Plans for 2012/13 in place</li> </ul>
	<ul style="list-style-type: none"> <li>Complete FBC by March</li> </ul>	<ul style="list-style-type: none"> <li>Plans in place to complete</li> </ul>
Mismatch between capacity and demand for 18 weeks and follow up outpatient appointments	<ul style="list-style-type: none"> <li>LHE discussions</li> </ul>	<ul style="list-style-type: none"> <li>Plans being drawn up to manage</li> </ul>
Delayed Transfers of Care (DTC) impacting on patient flow & patient safety	<ul style="list-style-type: none"> <li>Develop agreed DTC action plan with all partners</li> </ul>	<ul style="list-style-type: none"> <li>DTC action plan is part of the recently agreed unscheduled care programme plan monitored by PMO</li> <li></li> </ul>

## Putting Patients First

Principle Risks	Planned Action to cover gaps	Progress against identified gaps
Inpatient outliers resulting in inefficient & unsafe care	<ul style="list-style-type: none"> <li>Develop agreed project plan</li> </ul>	<ul style="list-style-type: none"> <li>Unscheduled care action plan agreed &amp; monitored by PMO</li> </ul>
Poor response /supervision of junior medical staff resulting in suboptimal treatment	<ul style="list-style-type: none"> <li>Recruit to identified posts</li> <li>Conversion of waiting list initiative and locum spend to substantive posts</li> </ul>	<ul style="list-style-type: none"> <li>Consultant and medical appointments in progress for hard pressed specialties</li> <li>Obstetric anaesthetic posts filled</li> </ul>
	<ul style="list-style-type: none"> <li>Appointment of Physician's Assistants</li> </ul>	<ul style="list-style-type: none"> <li>Interviews held but funding not agreed</li> </ul>
Poor standards of care provision on wards resulting in unsatisfactory patient experience	<ul style="list-style-type: none"> <li>Continue Quality Assurance reviews by Senior Nursing team with a review of at least 10 sets of case notes</li> </ul>	<ul style="list-style-type: none"> <li>Monthly report to Q&amp;S and TB</li> </ul>
	<ul style="list-style-type: none"> <li>Refine patient sensitive and staff sensitive Indicators to gain ward to Board overview of ward to Board indicators</li> </ul>	<ul style="list-style-type: none"> <li>Monthly report to Q&amp;S and TB</li> </ul>
	<ul style="list-style-type: none"> <li>Implement identified software solution (Health Assure) to enable 'Ward to Board' assurance at a glance</li> </ul>	<ul style="list-style-type: none"> <li>Project plan developed – implementation Spring 2012</li> </ul>
	<ul style="list-style-type: none"> <li>Implement action plan</li> <li>Roll out revised documentation in February</li> </ul>	
Poor management of significant patient test results resulting in missed / late treatment	<ul style="list-style-type: none"> <li>Investigate electronic system - Task &amp; Finish Group to be established led by Associate Medical Director</li> </ul>	<ul style="list-style-type: none"> <li>Task and finish group established</li> </ul>
	<ul style="list-style-type: none"> <li>Clinical audit to be carried out to test</li> </ul>	<ul style="list-style-type: none"> <li>Some evidence that changes are working</li> </ul>
Inadequate management capacity and capability / Lack of clinical leadership resulting in failure to engage clinical staff in change	<ul style="list-style-type: none"> <li>Organisational development programme for Centre Chiefs and managers</li> </ul>	<ul style="list-style-type: none"> <li>OD programme ongoing for clinicians and managers</li> </ul>
Inadequate / inefficient clinical skill mix impacting on ability to deliver safe & effective care	<ul style="list-style-type: none"> <li>Reduce reliance on Junior Doctors</li> <li>Introduce tighter controls on nurse / bank / agency spend</li> </ul>	<ul style="list-style-type: none"> <li>Trust grade doctors being appointed</li> <li>Task and finish group established on agency and locums</li> <li></li> </ul>
	<ul style="list-style-type: none"> <li>Centralised medical staffing</li> </ul>	<ul style="list-style-type: none"> <li>Team expanded to cover agency &amp; locum</li> </ul>
Inadequate network resilience arrangements	<ul style="list-style-type: none"> <li>Commission consultancy to scope the solutions &amp; their costs</li> </ul>	<ul style="list-style-type: none"> <li>Information to be presented external supplier with a view to contract specification being developed to enable procurement process to commence.</li> </ul>

## Putting Patients First

Principle Risks	Planned Action to cover gaps	Progress against identified gaps
Poor information systems & processes	Implement IA action plans Focussing on prioritised list of actions	<ul style="list-style-type: none"> <li>Data Quality Group established with approved KPIs to review progress in the improvement of key data items.</li> </ul>
	Review Trust PAS	<ul style="list-style-type: none"> <li>Finnamore and PricewaterhouseCoopers reviews of PAS completed.</li> <li>Task Group convened to take forward recommendations from the review. (led by Director of Service Transformation)</li> </ul>
	Separate IT and Information functions	<ul style="list-style-type: none"> <li>Chief Information Officer post approved and to be advertised.</li> </ul>

## Putting Patients First

### 6.5 FT risks

Risk description	Mitigating action taken	LxC*	Residual score	Status
Failure to deliver reconfiguration of services	Full public consultation and ongoing engagement with patients and clinicians and clear project management arrangements and plan in place.	2x5	 10	OPEN
Failure to deliver improved financial position – including working capital and CIPs	SLR introduced aligned to new Centre structure with monitoring of performance. CIP plans identified to deliver savings to achieve operating surpluses. Dedicated Programme Management Office established to track performance of CIP delivery.	3x5	 15	OPEN
Failure to deliver improvements to quality and safety	Quality Improvement Strategy being drawn up with clear action plan monitored through Quality & Safety Committee. Additional focus on improving patient safety and patient experience. Embedding LIPS across organisation.	3x5	 15	OPEN
Failure to deliver service performance improvements	Full Improvement plan agreed with commissioners and monitored by Board and PMO.	3x5	 15	OPEN
Capacity to manage the impact of consolidation of financial management and operational performance whilst starting the FT pipeline	Project approach with robust measurable programmes in place and creation of Programme Management Office to ensure deadlines are delivered. Management and clinical restructure completed. Additional senior staff in post.	3x5	 15	OPEN

## Putting Patients First

# Section 7: Improving Quality and Safety



## Putting Patients First

### 7.1 Background

During 2011/12 the Trust Board has focused on the essential improvements required to provide a baseline for Quality Improvement. With the implementation of a major strategy (Devolution and Cooperation) Clinicians are now in key leadership roles and the Board therefore in a position where they can be confident that the Clinical Centres led by their Centre Chiefs can lead the Quality Improvements that are needed. Our Strategic Plan describes the longer term strategic planning framework for the Trust. It describes how we will operate and sets out our priorities. It reinforces that putting patients first is our highest priority and is our organising principle that will underpin all of our developing clinical strategies and operational plans.

Within this plan we described our intention to develop a Quality Improvement Strategy which has now been developed and will be approved by the Board on the 29<sup>th</sup> March 2012. This strategy describes our priorities for the improvements in patient safety, the improvements in patient experience and the improvements in patient outcomes that we are seeking. It will also make these improvements measurable so that we can track progress.

The Trust is clearly committed to continuous Quality Improvement and has worked with staff and patients to outline the areas for Quality Improvement for 2012 and beyond. The Board and the Clinical leaders across the organization will promote innovative ways to support clinical outcomes whilst focusing on promoting and maintaining health and well being as well as prevention. A high intensity “Leading improvements in patient safety”(LIPS) commissioned by the Trust Board in 2011 was and remains one of the key vehicles for change.

We have received significant support from our Commissioning and GP colleagues in the last year to refine clinical pathways. “Keeping it in the County” public consultation principles and the progress to a final business case for those services are focused on making services safe and sustainable. Working with Clinical Commissioning groups and the Local health economy will be core to ensuring care is delivered in the

best interests of the patients whether that is in their home or within the specialist clinical centre within the hospital. In essence providing the right care in the right place and by the right professional will be key to our success.

The performance of Quality has been monitored closely by the Board with detailed, monthly reviews part of the role of the formal Quality and Safety Committee of the Trust. In an important transition to the Clinical Centres, the Centre Chiefs will now be core to monitoring Quality Improvement. The Centres went live in October 2011 and the Trust has worked with Clinical staff to establish key performance Indicators to monitor Quality from the ward to the Board. This provides a basis for collective ownership and a continuous improvement drive.

The Quality Improvement Strategy provides a five year framework from which the Trust can be held to account for the annual improvements it aspires to deliver. The annual improvement outcomes from this Strategy will be published through the Quality account each year. The Strategy document itself will need to be an evolving and iterative document being influenced by national policy and local requirements, however the core to this document are the improvements that staff and patients feel passionate about and we have a desire and an obligation to meet those improvements.

### 7.2 Bringing Clarity to Quality

Our quality improvement strategy (QIS) is supported by explicit year on year objectives across these 3 domains to ensure that quality is everyone’s business in our organization (Trust web site). We also know that being open with the public we serve is also essential if we are to build the confidence in our services. As an illustration of our ambition and of the public facing nature of the challenge we are setting we have agreed a goal of reducing the level of in-hospital mortality over the 5 year QIS by 25% (from the 2011 baseline). We believe this safety goal is a powerful and simple statement of intent. Over many years our HSMR has been higher than the national average. HSMR and overall mortality are now both declining. We began to implement the first stage of our strategy during 2011/12 and in that year we have seen a reduction of

## Putting Patients First

over 9% in crude death rates and we expect to see a continuing fall in both these measure over the lifetime of the Strategy and of the Integrated Business Plan.

We are seeing reductions in the number of falls and pressure ulcers but our ambitions will be to eradicate grade 4 pressure ulcers in 2012 and grade 3's in 2013, with year on year reductions in falls. We have achieved England's best five-year mortality for colorectal cancer surgery and have a reputation for delivering the most patient friendly maternity service in the West Midlands, with the lowest intervention rates and a highly distributed service model.

Continuing to use national guidelines and best practice tools, we will develop and enhance the care delivery at the Shrewsbury and Telford NHS Hospital Trust and we will monitor not only the clinical outcomes but a range of patient experience feedback methods developed as a framework of best practice in caring for patients. Patients and staff have identified clear priorities for inclusion within this Strategy and we will continue to work with them to ensure that the annual quality Improvement plan and Quality Accounts produced each year support us to become a leading national Trust on quality patient care with optimum outcomes.

The LIPs (Leading Improvements in Patient Safety) Programme which we run in partnership with the Institute for Health Care Innovation and Improvement is a key part of this quality improvement strategy. We have developed with our partner the first Trust level LIPs implementation with more than 100 key clinical staff participating in our groundbreaking launch in 2011. We expect that a further 500 of our key front line staff will have been trained in safety management over the next four years.

We believe that by working together we can redefine the reputation we have for the provision of excellent, safe and high quality health care. We will define our brand in these terms and monitor and measure its validity and strength.

### 7.3 Ensuring that Quality Drives our Agenda

We have through a number of discussions across the Trust and with partners outlined that we want to provide service delivery which is patient focused, with patients at the centre of everything we do. In essence, care delivered in the right place at the right time by the right individuals. We will deliver care in a variety of settings with our partners, most notably primary care practitioners.

We are clear however, that Quality drives our agenda and in doing so have asked the following question:

“What would it take for all patients to make very positive comments about our hospital and recommend us to their friends and family?”

### 7.4 How will we improve and how much by

We predict that through the development and implementation of the Quality Improvement Strategy, and by identifying ambitious annual Clinical Centre Quality Development Plans, we will achieve further improvements in clinical quality and patient safety over the next five years. This Strategy does not however, stand alone and fits with the Trust's overarching integrated business plan. The Integrated Business Plan will be supported by the following Strategies.

- Quality Improvement Strategy
- Workforce Strategy
- Organisational Development Strategy
- Information and technology Strategy
- Estates Strategy
- Risk Management Strategy

## Putting Patients First

The Trust is confident that the five year Quality Improvement Strategy will deliver the following high level improvement and performance goals by 2017.

Achieving high levels of patient safety by 2017 evidenced by a reduced in patient mortality rate and demonstrated by:-

- 25% reduction in crude death rate from baseline in June 2011.
- In the top 10% of hospitals with the lowest Hospital Standardised Mortality rate being below 100.
- Supported and underpinned by:-
- Elimination of “avoidable” hospital acquired pressure ulcers at grade 3&4 by 2013
- 80% reduction of inpatient falls resulting in harm by 2017
- Hospital acquired infections reduced year on year across 4 mandatory reporting criterion.
- 100% compliance of WHO safer surgery checklists (2012/13) and 100% compliance on procedural check lists (2013)
- 100% compliance to required medication systems and processes with outcomes in NRLS reporting in top 10% performance nationally.
- 95% reliable standardised care in high risk and volume conditions and clinical process

Achieving ongoing improvements in patient experience with the aim of getting it ‘right first time, every time’ for all outpatients and inpatients.

Underpinned and supported by:-

- Real time patient feedback being in top 80% performance with clear actions demonstrated on the 20% where experience is not optimal & to make those improvements whilst patients are still in our care.
- Excellent environment ratings PEAT (Patient environment action teams) inspections in all hospital wards and departments
- 95% of patients recommending our hospital to family or friends
- 90% of Outpatients rate their care as ‘excellent’ overall
- 95% of Inpatients rate their care as “excellent” overall
- Patient and Carer information leaflets provided for 100% planned procedures
- 100% Inpatient and Outpatient care delivery will be able to demonstrate carer and patient involvement in decisions and care delivery.

Being able to demonstrate clinically effectiveness through improved patient outcomes by 2017.

Underpinned and supported by:-

- Achieve comparable national best practice clinical outcomes consistently across all services
- Ensure 100% of all patients achieve their required constitutional rights on national waiting and access times

Improve the effectiveness of patients requiring unscheduled care by:-

- Increase the number of elderly frail patients who can be effectively supported and discharged within 72 hrs to 80%.

## Putting Patients First

- Reduce emergency surgical admissions by 5%.
- In A&E ,being reviewed by a specialist within 1 hr of request and
- If decision to admit then admission to a bed within 4hrs
- Increase % day case rates on elective basket of procedures to 80% by 2016.
- Reduction in Staff sickness to 3.5%
- Annual delivery of the Trusts CIP and LTFM

### 7.5 The Board & Centre Clinical teams being sufficiently aware of potential risks to Quality

Over the last year, the Trust Board have recognised that the Trust has been a poor performer across a range of clinical and operational indicators. This situation is now rapidly improving with significant cultural change being supported through the LIPS programme, the development of Clinical Centres and Clinical leadership and staff engagement programmes like Listening into Action (LiA).

This increased awareness of Quality and Safety is demonstrated through the development of a balanced score card approach from the ward and Departments to the Trust Board, raising expectations of clinical managers and leaders, for example making falls and pressure ulcers unacceptable rather than inevitable. Regrettably the Trust has had 6 “Never” event serious Incidents reported in 2011/12 and robust governance arrangements have been effected to ensure these are never repeated.

The profile of these very serious incidents are as follows:-

- 4 within Ophthalmology based on the insertion of wrong size lens.
- One within Urology and
- 1 within Maternity (retained vaginal swab).

There has been a significant increase in reporting of serious incidents (195%) which in part is felt to reflect the positive reporting culture that has been built up over the last year

The joint working between the Executive team and Centre Chiefs through core committees (Hospital Executive Committee and Risk Management Executive) has enabled a high level view of any emerging risks. At all levels within the organisation there is a recognition that we want to build on this work to ensure that our performance monitoring of care provision is robust to ensure consistently safe and effective care.

### 7.6 Maintaining and measuring national minimum quality standards

While the primary focus of the QIS strategy is a five year improvement agenda to identify, develop and deliver best practice and innovation, it is equally important that the Trust achieves and maintains excellent performance against minimum national standards such as Care Quality Commission (CQC) essential standards, and national performance targets. The Trust has achieved level 2 CNST accreditation in 2012 in Maternity standards and level 1 for NHSLA Risk Management Standards. Patient sensitive Indicators are monitored closely through a ward to Board process “Test your care” with a complementary process called the Health Assure system introduced into the Trust in late 2011 which provides an ability to demonstrate compliance with CQC standards, involving clinical teams. The Trust is working closely with CQC relating to a moderate concern from their annual review process and progress made in the action plan for improvements.

## Putting Patients First

### 7.7 Building on our current Quality performance

We will focus on addressing the known issues that are a cause of concern for our patients as part of our commitment to continuous improvements in Quality as follows:-

- Getting it right first time/ first contact in patient pathways.
- Consistent and effective Communication- Care and compassion
- Providing information at each stage of the pathway
- Consistent clinical standards and practice- safe care
- Strong performance management of care that falls below the required standard
- Way finding (sign posts to wards and Departments)
- Access and booking
- Cancelled operations
- Patient transport

Staff and patient representatives contributing to QIS Strategy have outlined their concerns about the approach and communication from staff on the front line which they feel has led to a lack of consistency in care delivery. They have outlined that

- Verbal and written communication must be a priority for improvement so that the individual needs of the patient are core to how we professionally communicate as individuals and within clinical teams.

- They have emphasised the importance of the role of the ward manager and Matron in supervising care delivery but importantly to be a strong and visible leader with whom patients and carers can easily discuss any concerns and improvements made where required.
- However, they have identified a need for greater focus on all the interlinking dimensions to Quality through clinical leadership and performance management.

### 7.8 Actively engaging patients, staff and other key stakeholders on Quality

We recognise that our staff survey as well as our inpatient and Outpatient survey indicates the improvements required. In response to these concerns and in order that we agree ambitious improvement targets, public, patient and staff engagement commenced in 2011 with significant engagement and contribution to the development of the QIS strategy. This includes a “Listening into action” programme (LiA), LIPS (Leading Improvements in Patient safety) programme and quality improvement workshops. In these engagement processes we asked patients and staff what was important to them in ensuring high quality services for all. Many of the aspects of their views have been integrated into the quality improvement strategy. A summary of the key themes which emerged from that engagement can be accessed on our web site under Quality Improvement.

The Quality Improvement Strategy makes a commitment and signals an even higher level of engagement and involvement with patients, community partners and stakeholders in supporting the redesign and transformation of services. This will be achieved by integration of quality improvements with ongoing development and implementation of the Trust’s Patient experience and involvement Panel work programme (PEIP). The work programme will cover Outpatient areas, A&E, Theatres, Maternity and Inpatient areas.

## Putting Patients First

Detailed Quality Improvement objectives for patient experience, clinically effective and efficient care, and patient safety will be further developed with input from the Trust's Centre Chiefs, value Stream leads, clinical leads and audit and Outcomes team.

The Trust will continue to enhance the partnership work that it has built up over the last year with the Patients panel and with the Telford and Wrekin LiNKs, Shropshire LiNKs (CHIG), and Montgomeryshire Community Health Council so that patients and patient and carer representatives are consistently involved in service redesign and are actively involved in the metrics approach to gaining patient experience from Outpatient areas, Departments and wards. The Trust will build on the methods of feedback and enhance the triangulation of themes and trends arising from those approaches.

As part of implementing the Quality Improvement Strategy we will investigate these themes further, using agreed patient feedback methodology including "Real Time" Monitoring to ask a high numbers of Outpatients and Inpatients about their immediate experience of care and services. If patients say they would recommend us to others we will ask why and for those who would not, we will also ask why and use the information to give feedback to staff and target our improvement efforts. The use of the Net promoter will be key to measuring confidence in the care we provide.

### 7.9 Metrics approach to care delivery – The Trust approach to putting patients first

The Trust Board recognizes that Quality and Safety are core aspects of the Boards agenda and that at least 25% of the agenda at the Board is focused on those aspects of the Trusts agenda. In the principles of putting patients first (one of the organizing principles of the Trust) a patient story is read out at the beginning of the private Board, Quality and Safety Committee and Hospital Executive committee. This process ensures that the emotions of this story resonate whilst the core business continues. The following methods to reviewing care will provide a

metrics approach for Departments/ wards/ centres and corporate Committee's to evaluate Quality care provision and performance.

### 7.10 Observations of Care

Observing care delivery in a ward and or Departments in teams of 2. Involves: - Board members, Corporate nursing team, senior managers/Matrons, members of the Patients panel and Commissioners. Direct feedback of positive aspects of care as well as any issues which may need to be addressed will be given to the ward manager or nurse in charge with written feedback to the relevant clinical centre as well as a high level summary to the Quality and Safety Committee.

### 7.11 Patient Stories and Patient Diaries

Recruiting patients at the beginning of their patient pathway either in Outpatients or as an inpatient to share their story with us or use a Diary to record all aspects of their care, will be a core part of our improvement programme. Both processes will be used to evaluate and improve care delivery. This involves, Patient experience and involvement panel members (PEIP) who have received training on these principles; PAL's, Patient services team, Corporate Nursing team, Matrons, LiNKs, CHC and Commissioners. The themes from these stories will be triangulated with complaints and PALs/ real time patient feedback and fed back to wards/Depts within each relevant clinical centre and corporately collated so that emerging trends and themes for improvement are clear.

### 7.12 Themed patient panel reviews

When trends or themes appear the Trust will establish comprehensive panel reviews into those issues resulting in an internal report for consideration by the Hospital Executive Committee, Quality and Safety Committee and Board consideration when required. This will involve, Patient experience and involvement panel members (PEIP), LiNKs,

## Putting Patients First

CHC, Corporate Nursing team, Clinical Matrons and Commissioners/ Education providers.

### 7.13 Real time patient feedback

Through an agreed template which has been designed to ask core open questions from patients during their Inpatient stay or in Outpatients/A&E and Maternity. This will illicit real time feed back and enable prospective improvements to be made monthly this will reflect the progress being made on areas of improvement from the annual patient survey but also the top themes of concern from complaints and real time patient feedback as well as the “net promoter” questions on discharge. Ward managers, service area clinical matrons, PEIP members, Patient services team, corporate nursing team and Commissioners will be involved.

### 7.14 Ward to Board review

Core clinical (patient sensitive) Indicators have been agreed for ongoing review as indicators of the effectiveness of care delivery, this provides ward/Dept/ A&E/ Maternity level as well as Centre and Board level information to identify trends and themes. The information will be gathered by ward managers/ Matrons/ Senior nurses and supported by PEIP members with the information gathered from this process being shared publically on each ward.

### 7.15 Quality Performance reviews

The Clinical Centres' will all have a Quality performance review of these Indicators as part of their core Governance performance meetings. To maintain an overview of the overall and individual centre performance the Deputy Chief Nurse and Director of Finance will lead a monthly review of quality measures that demonstrate active performance towards quality improvement. This has a clear escalation process to the Chief Nurse when improvements are not made within agreed timescales and active performance management.

### 7.16 Patient environment action teams (PEAT) Inspections

A monthly review of Patient environments to ensure that cleanliness, estate and facility issues are picked up and improved. This involves:- Patient panel members, Corporate nursing team, facilities, Infection Control team and Estates.

### 7.17 Patient Safety First reviews

The NPSA advocate “*Patient Safety first*” reviews of ward/ Dept areas. A tool is available which enables Executive Directors and Non Executive Directors meeting with staff teams to discuss care delivery, the concerns about care delivery and support to progress. These will always be announced and a summary of discussions and agreed actions will be fed back to the Depts, Executive team and Quality and Safety Committee.

### 7.18 Unannounced ward and Department reviews

Through our active monitoring and triangulation of key performance Indicators per ward and Department, we are now able to identify clinical areas which are cause for concern. In these circumstances we have over the last year undertaken detailed reviews of wards, some resulting in formal investigations into the concerns, remedial action plans or assurance provided. This process will now include patient or carer representation and commissioners/ Education providers and will progress onto a planned annual programme of review which will encompass all clinical areas and highlight the positive progress being made by clinical areas as well as picking up areas for improvement where these have been evidenced through the review.

### 7.19 Quality and Safety Committee

## Putting Patients First

Is a formal committee established by the Board to review all quality and Safety issues in relation to performance. The Committee will identify trends and themes of issues with care delivery and raise any concerns with the Board. As part of this assurance process a 1 hour visit to a clinical area prior to the formal Committee business commencing is a formal part of the agenda with any issues from the visit being minuted.

### 7.20 Executive Directors- Clinical profile and support roles

The Executive Directors who are clinicians will be expected to undertake Clinical time with front line teams and ensure clear clinical leadership as well as clinical credibility. The Corporate nursing and Medical teams will also support this approach with all having 4 clinical sessions built into their job planning. Non Clinical Executive Directors will support a wider profile in clinical areas and also support a “ Non Executive” Director style support to Centre Chiefs and their teams.

Current examples of clinical performance are outlined below to support the quality improvement ambitions that we have set out.

#### Patient Experience

	Sep 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012
How clean is this ward (including toilets)?	95%	94%	91%	92%	97%	95%
As far as you know do the staff wash or clean their hands between touching patients?	91%	92%	92%	91%	95%	93%
Do you feel informed about potential medication side effects?	72%	58%	65%	71%	60%	67%
Do you feel you have enough privacy when discussing your condition or treatment with staff?	91%	87%	82%	85%	86%	92%

Do you feel that you have been treated with respect and dignity while you are on this ward?	97%	96%	96%	90%	95%	97%
Do you feel involved in decisions about your treatment and care?	68%	77%	82%	80%	83%	82%
Have hospital staff been available to talk about any worries or concerns you have?	84%	86%	90%	81%	90%	89%
Do you get enough help from staff to eat your meals?	83%	86%	92%	83%	90%	90%
Whilst you have been on this ward have you ever shared a sleeping area with a member of the opposite sex?	100%	99%	100%	97%	99%	98%
Do you think hospital staff do everything they can to help control your pain?	96%	88%	90%	82%	90%	91%
When you use the call buzzer is it answered?	77%	81%	90%	82%	83%	85%
Have staff talked to you about your discharge from hospital?	32%	50%	61%	52%	55%	55%
Total	82%	83%	86%	82%	85%	86%

#### Nursing Care Metrics

	Feb 2012
Medication Storage and Administration	89%
Infection Control and Privacy & Dignity	89%

## Putting Patients First

Patient Observations	↑	81%
Pain Management	↑	72%
Tissue Viability	↑	74%
Nutrition	↑	82%
Fluid Management	↑	64%
Falls assessment	↑	92%
Contenance	↑	81%
Total	↑	81%

### 7.21 Current Status – HSMR

At the end of November the Dr Foster Hospital guide 2011 was published with additional coverage given in the Daily Telegraph. In this report SaTH was highlighted as an outlier with an HSMR of 115 for the year 2010/11.

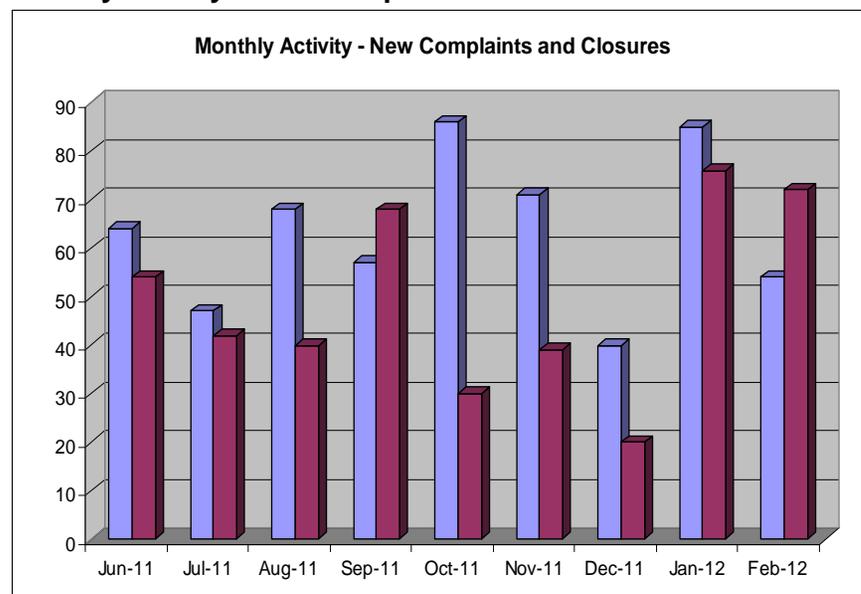
Since November 2010 there has been a solid downward trend in the HSMR with the current rates being (Rebased):-

- HSMR for last 12 months – 102
- Year to date (Apr – Dec) – 99

In Aug 2011 there was the first sign of a reduction in the crude rate of deaths, especially in Medicine. This trend has continued with there now

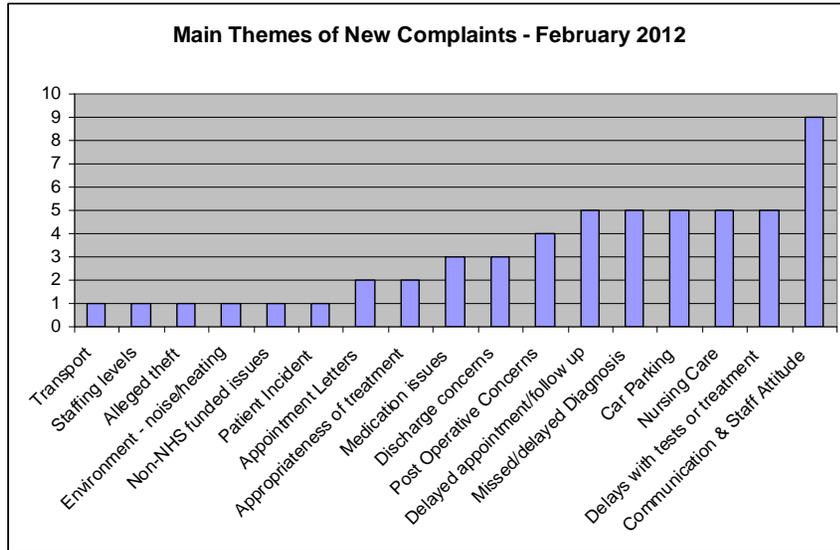
being 174 less deaths year to date than the same period last year. This represents an 11.76% reduction in in-hospital deaths against last year

### Monthly activity – new complaints and closures



# Putting Patients First

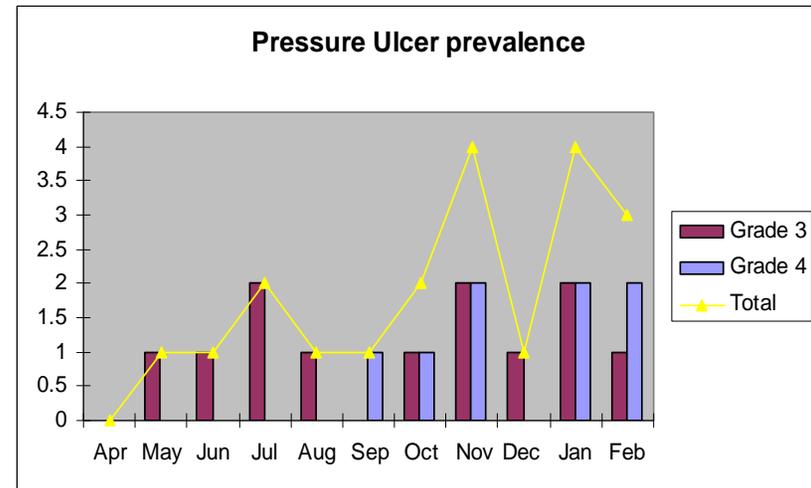
## Main Themes of New Complaints – February 2012



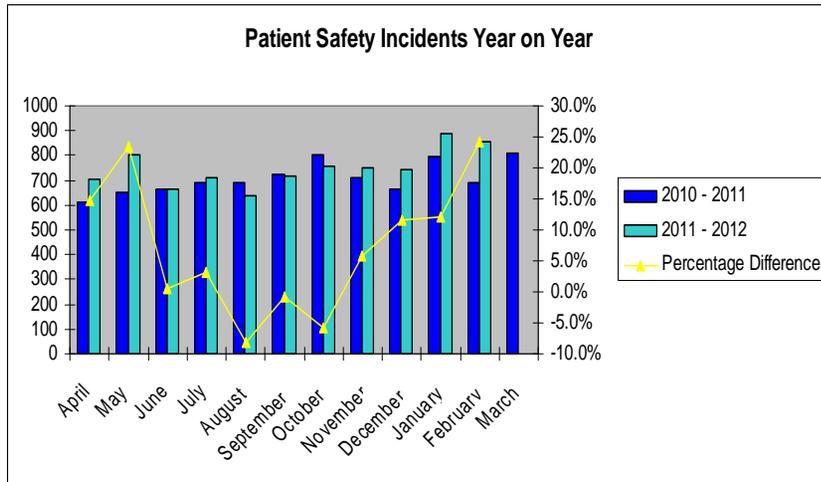
## Falls comparisons Apr 2011- February 2012

Falls COUIN 11/12	April	May	June	01	July	Aug	Sept	02	Oct	Nov	Dec	03	Jan	Feb	Mar	04	Year
2011/2012 inpatient falls on Datix	132	143	132	407	129	130	134	393	134	135	147	416	151	121		272	1488
2010/2011 inpatient falls on Datix	147	180	131	438	126	132	157	415	167	147	139	453	152	133	146	431	1737
Baseline (Q3 & Q4 rebased year)	152	166	136	454	130	137	163	430	167	147	139	453	152	133	146	431	1768
Baseline -1.25%	150	164	134	448	128	135	161	425	165	145	137	447	150	131	144	426	1746
Baseline -2.5%					127	134	159	419	163	143	136	442	148	130	142	420	
Baseline -3.75%									161	141	134	436	146	128	141	415	
Baseline -5%												430	144	126	139	409	1680

## Total number of grade 3 & 4 pressure ulcers



## Patient Safety Incidents Year on Year

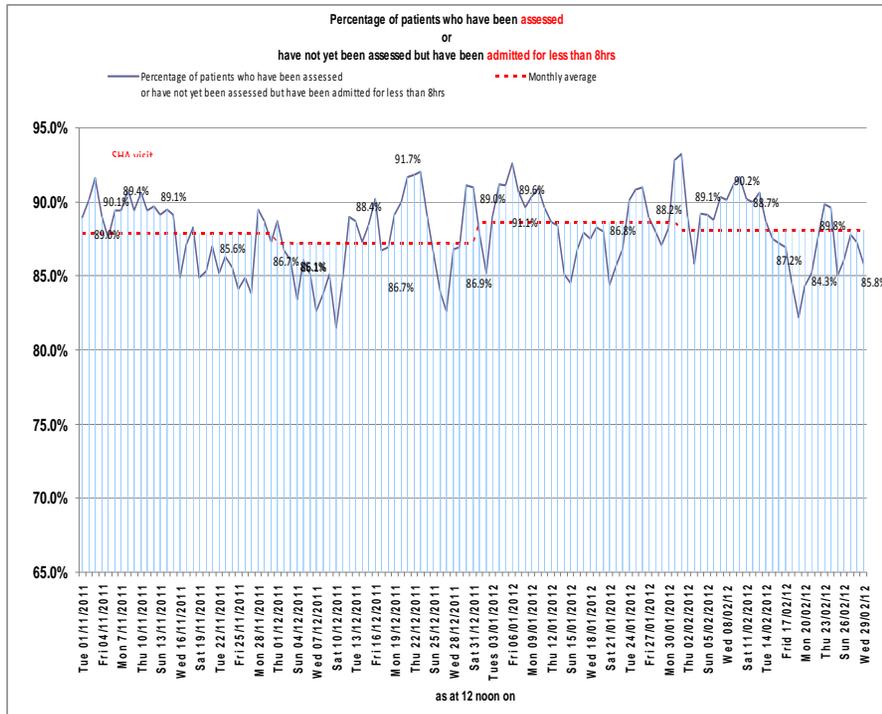


## 7.21.1 VTE: Current Status

The rate of reported VTE assessments across the Trust for January 2012 is **91.58%**. The draft figure for February is not yet known and the final figure will not be available until the 20<sup>th</sup> working day of March. The Vitalpac average for February is

# Putting Patients First

slightly down on last month but we expect to continue to achieve the 90% target.



The Shrewsbury and Telford Hospital **NHS**  
NHS Trust

## Putting Patients First



## Putting Patients First



## Section 8: Delivering Contractual and National Targets



## Putting Patients First

### 8.1 Local Commissioners

Contracts have been agreed with our main commissioners with the exception of Powys LHB (see section 5.3 above). The contracts identify the detailed activity numbers that have been commissioned, including :-

- Elective inpatient and daycase spells (by HRG)
- Emergency and maternity spells (HRG)
- Consultant new, follow-up and procedure outpatient attendances (specialty)
- A&E attendances
- Direct access activity (eg radiology, physiotherapy)
- Other non-consultant led activity (eg nurse led, community midwifery).

The contracts also incorporate a set of schedules detailing both nationally mandated and locally agreed quality and performance targets, together with contractual consequences/penalties if these are not achieved. There are a range of these contained within the contract, including :-

- Nationally mandated 'never' events (non-payment)
- Nationally mandated infection control, cancer, 18-week and A&E targets (financial penalties)
- SHA mandated targets including reduction in pressure sores (range of penalties from improvement notices to financial)
- Locally agreed measures including a number of Stroke targets (failure to improve performance may result in withholding of payment)
- Screening programme targets such as bowel screening (possible improvement notices and withholding of payment)

Both formal performance review and clinical quality review meetings are held with our 2 local commissioners on a monthly basis. Where necessary, specific 1-off meetings or 'task and finish' groups are arranged with representatives from the commissioners and the Trust's clinical centres to discuss areas of concern and/or where performance is

below target, to agree and monitor corrective action plans. These are fed back into the formal review meetings as appropriate. As previously indicated, both local commissioners are also represented on the Trust's RTT delivery group, which meets on a weekly basis.

### 8.2 Other Commissioners

Monthly contract review meetings are held with Powys LHB. On an ad-hoc basis (2-3 times per year) there are also clinical service meetings with the LHB. For these, representatives from the LHB attend the Trust on an 'all day' basis and meet with representatives from the Trust's clinical centres to discuss specialty-specific issues.

Regular contract review meetings are held with the Trust's other commissioners, eg Specialised Services. Clinical centre representatives attend these as required.

### 8.3 Reconciliation Process

The contract agreement places a requirement on both our commissioners and the Trust to ensure a monthly activity and financial reconciliation takes place. There is an agreed timetable (contained within the contract documentation) for data submissions, queries to be raised and responded to, data to be resubmitted and month-end figures to be signed-off or escalated for resolution.

### 8.4 Internal Performance Management Arrangements

During the course of 2011/12 the Trust undertook a major management restructuring, creating 11 Clinical Centres and putting clinical leadership at the heart of decision making (each Centre is represented by its Centre Chief – a clinician – on the Trust's Hospital Executive Committee).

## Putting Patients First

As the Centres mature the Trust is in the process of reviewing and strengthening its performance management processes. A key part of this will be the development of 'performance and accountability' agreements for each of the centres. These will detail both the expectations that the organisation requires of each centre and also the support the centres can expect from the corporate departments. These expectations placed on the centres will cover a range of issues but will include delivering planned activity levels, living within the resources available and delivering against national and locally agreed performance targets. The intention is that the centres formally sign-off the agreements.

Alongside this, the Trust has instigated monthly review meetings with each of the Centres (they began in January 2012, initially in 'shadow' form going 'live' in April 2012. These are chaired by the Director of Operations and from a corporate perspective are also attended by the Finance and Workforce Directors. Other Directors may also attend. The Centres are represented by the Centre Chief and Manager, supported by their respective finance and workforce colleagues. Review packs containing key performance measures across finance, workforce, quality and national targets are produced prior to the meetings and form the basis for the discussions. The review packs will be refined during the first quarter of 2012/13 following review and to reflect feedback received from the centres.

### 8.5 Provider Management Regime

Since the beginning of January 2012 the Trust, as per SHA requirements, has been completing the Provider Management Regime (PMR) template issued by the SHA. The PMR has 7 sections, namely:-

- Governance Declaration
- Governance Risk Rating
- Financial Risk Rating
- Financial Risk Triggers
- Contractual Risk Rating
- Quality
- Board Statements

The PMR provides a formal RAG Rating for the Governance Risk Rating, Financial Risk Rating and Contractual Risk Rating. A summary of these scores for the templates submitted during 2011/12 is as follows:-

	Dec 2011	Jan 2012	Feb 2012
Financial Risk Rating	Green	Green	Amber
Governance Risk Rating	Red	Red	Red
Contractual Risk Rating	Green	Green	Green

A summary of the Board Statements is included within Section 13 (Declarations)

The full PMR templates are included as appendices B and this includes a breakdown of those areas contributing to the Red rating for Governance.

A summary of performance against key national targets during 2011/12 is included at section 3.1

The Trust has been unable to deliver and sustain performance against the A&E 4-hour 95% target during the year. Improving patient flow remains a key priority, with a number of workstreams being introduced in-year. The Trust is working closely with its commissioners and health & social care partners in this regard.

The Trust has not achieved its 18-week referral-to-treatment (RTT) targets for either admitted or non-admitted patients for 2011/12. The Trust began 2011/12 with a significant backlog of patients (ie patients already waiting over 18 weeks), rising to a figure in excess of 5000 patients at the end of May. This represented 25% of the total number of people waiting (open clocks), compared to a regional average of 6 - 7%. Through a combination of improved processes and additional non-recurring activity the backlog is now 5-6% and the Trust expects to be delivering the overall RTT targets for admitted and non-admitted patients from April 2012 onwards.

## Putting Patients First

The Trust is anticipating that it will achieve all its cancer targets for 2011/12 once final March figures are available. In-year, the area of greatest concern has been the overall 62-day target which was below target for each of the first 4 months of the year. However, performance has been above target for each subsequent month and the Trust achieved 'year-to-date' delivery in January for the first time and has subsequently and has sustained this.

## Putting Patients First

# Section 9: Financial Plans



## Putting Patients First

The 2012/13 financial year is challenging for the Trust. Significant reductions in Income combined with a requirement to absorb internally all cost inflation in respect of Pay and Non Pay expenditures, result in the Trust having to deliver an ambitious Cost Improvement Programme in order to achieve the statutory duty to achieve an Income and Expenditure Balanced position at the end of the year.

In this context this paper provides a description of the 2012/13 budget, and describes the construction of the:

- Income budgets, in particular describing the changes that have led to the Income budget for the year,
- Pay Expenditure – the assumptions adopted in the creation of the Pay budgets,
- Non Pay Expenditure – the assumptions adopted in the development of the Non Pay Budgets,
- Reserves – the level of funds being held within Trust reserves to underpin the 2012/13 budget; and
- Cost Improvement Programme – the activities being taken forward to deliver Cost reductions in the year.

The paper then progresses to consider how the Plan progresses on a monthly basis through the year and then concludes by considering the impact upon the Medium Term Financial Plan of the Trust.

### Overall Income and Expenditure Budget.

The Income and Expenditure budget for the 2012/13 year is presented in the table below

	Recurrent £000's	Non Recurrent £000's	Total £000's	Forecast Outturn 2011/12	% change
Income	297,194	5,326	302,520	298,844	+1.23
<b>Expenditure</b>					
Pay	(199,701)	(620)	(200,321)	(199,338)	+0.49
Non Pay	(95,064)	226	(94,838)	(85,098)	+11.45
Reserves		(6,382)	(6,382)		
Cost Improvement Programme	27,145	(13,559)	13,586		
Total Expenditure	267,620	(19,665)	(287,995)	(284,272)	+1.90
Earnings before Interest, Tax, Dividends and Amortisation (EBITDA)	29,574	(15,009)	14,565	14,408	
Dividends and Amortisation	(14,408)	-	(14,408)	(14,408)	
<i>Surplus / (deficit)</i>	<i>15,166</i>	<i>(15,009)</i>	<i>157</i>	-	

As can be seen the Income and Expenditure budgets as constructed enable the Trust to take forward into the 2013/14 year a surplus amounting to £15.166 million, however in the year because of slippage in the achievement of the CIP programme, a surplus amounting to £157,000 is recorded.

#### Key messages – Overall Income and Expenditure Position

- Trust to deliver surplus in the year amounting to £157,000
- Required to deliver a Cost Improvement Programme that generates recurrent cost savings amounting to £27.145 million,

## Putting Patients First

- In year savings from the Cost Improvement Programme amount to £13.586 million
- The Trust carries forward into the 2013/14 a recurrent surplus of £15.166 million.

### Income Budget

The Changes within the Income budget are presented in the table below:

	Recurrent £000's	Non recurrent £000's	Total £000's
2011/12 Forecast Outturn	290,700	5,444	296,144
Baseline b fwd into 2012/13	290,700		290,700
Income Reductions			
Negative Tariff	(2,731)		(2,731)
Readmissions Adjustment	(2,414)		(2,414)
Accident and Emergency Adjustment	(863)		(863)
Local Commissioners QIPP	(5,288)		(5,288)
	(11,296)		(11,296)
Income Increases			
Agreed Coding Changes	3,505		3,505
2012/13 High Cost Drugs growth	2,761		2,761
CQUIN 1% growth	2,221		2,221
Transitional Funds		4,900	4,900
Demographic growth	3,432		3,432
Department of Health Initiatives	694		694
	12,502	4,900	17,402
Local Commissioners QIPP schemes reversed	5,288		5,288
<b>Income Budget 2012/13</b>	<b>297,194</b>	<b>4,900</b>	<b>302,094</b>

### Income Reductions

- Negative Tariff – The Trust has in collaboration with the Local Commissioners computed the impact of the 2012/13 National Tariff upon the forecast Recurrent Outturn Activity. Doing so reduces the level of Income to be payable to the Trust by £2.731 million.
- Readmissions Adjustment – The 2012/13 Operating Framework requires an adjustment to be applied to Trust Income arising from Elective and Non Elective readmissions. Applying the new rules relating to this activity reduces the Trust Income by £2.414 million.
- Accident and Emergency Activity Adjustment – In the 2011/12 year the level of contractual over performance associated with Accident and Emergency was overstated. In recognition of this situation, the level of funding for the over performance has been rescaled based upon average performance across the North and East Midlands Strategic Health Authority Cluster. This has the effect of reducing Income by £863,000.
- Local QIPP Programme – In February 2012 the Trust was notified by the two Local Commissioners, Shropshire County PCT and Telford and Wrekin PCT, of an intention to reduce activity provided by the Trust amounting to £5.288 million. Discussions with the Local Commissioners have indicated that this sum represents the part year effect of their QIPP schemes. The Trust is awaiting information describing fully the areas where precisely activity is to be reduced and also the Full year effect.

### Income Increases

- Coding Changes – Throughout the 2011/12 year the Trust has provided Local Commissioners with performance data, for activities where it believed that a correct application of PBR rules would lead require Commissioners to pay for the work completed. Following negotiations with Commissioners the Trust has secured additional Income from these activities in the 2012/13

## Putting Patients First

year. This is estimated to increase Income in the 2012/13 year by £3.505 million.

- 2012/13 High Cost Drugs growth – The costs attributable to a range of High Cost Drugs are presently excluded from the Tariff and instead passed directly to Commissioners. A review of the level of growth associated with these drugs has been undertaken and it is estimated that this will increase charges to Commissioners by £2.761 million.
- CQUIN – The 2012/13 Operating Framework increased the level of Income associated with specific quality improvements from 1.5%, as in the 2011/12 year to 2.5% for 2012/13. The precise details associated with the CQUIN Income are being finalised. Achieving the additional 1% increases Income to the Trust by £2.221 million.
- Transitional Funds – When presented with the contract offer from the Local Commissioners, the West Mercia PCT Cluster requested information describing the impact of the offer upon the Trusts finances for the 2012/13 year. An estimate of the impact, assuming a requirement to deliver a surplus in the 2012/13 year of £2.5 million was that the contract offer would result in a financial imbalance to the Trust of £7.4 million. In recommending a sum to be made payable to the Trust from Transitional funds held by the Strategic Health Authority Cluster, the PCT Cluster concluded that the sum available to the Trust should be restricted to a level consistent with ensuring that the Trust achieved a break even position in the 2012/13 year. Accordingly a request has been made to the Strategic Health Authority Cluster to provide non recurrent transitional funding for a sum amounting to £4.9 million.
- Demographic growth – As part of the contract negotiations the Trust had been informed by the two Local Commissioners of an expectation that the effect of demography could be expected to increase activity in the 2012/13 year by approximately 1.3 per cent. In establishing a contract figure for the 2012/13 year both

of the Local Commissioners removed growth funding from their contract sum. In setting a budget for the 2012/13 year it has been decided to budget for increased Income associated with Demographic growth. Doing so increase the Income available to the Trust by £3.432 million.

- Department of Health Initiatives – A series of Department of Health Initiatives are being taken forward within the Shropshire health economy in the 2012/13 year supported by earmarked Department of Health funding. These initiatives increase the Income of the Trust by £694,000.

### Local Commissioner QIPP schemes reversed

The late presentation of the QIPP programme by Local Commissioners and also the limited level of specific data associated with the programme has meant that it is not possible to plan with certainty the effect the Local QIPP programme will have upon the Trusts Income and the levels of activity to be performed. That said, it is clear from both Local Commissioners that there now exists a commitment to reducing significantly Income flowing to the Trust. For these reasons it has been decided that in setting a budget for the 2012/13 year, at this stage it is appropriate to avoid estimating the impact upon activity and Income levels until improved information is made available by the Local Commissioners. Instead it has been decided to recognise the financial impact through the establishment of a negative Income reserve, as greater clarity emerges the activity and income associated with the activity will then be adjusted accordingly.

Key Messages - Income
<ul style="list-style-type: none"> <li>- Total Income for the year - £302.094 million</li> <li>- Income reduced by comparison with the previous year by £11.296 million</li> <li>- Income growth in the year - £12.502 million</li> <li>- Trust to receive non recurrent Transitional Funds - £4.9 million</li> <li>- Local Commissioners QIPP Programme - £5.288 million.</li> </ul>

## Putting Patients First

### Expenditure Budgets

#### Pay Expenditure

Pay spending in the 2011/12 year has been complicated, as the Trust has sought to:

- introduce additional posts to address recognised quality deficiencies; and
- respond to the requirement to address a serious problem in respect of waiting times performance.

This has meant that consistently throughout the year, the level of Pay spending has increased.

	April £000's	May £000's	June £000's	July £000's	Aug £000's	Sept £000's	Oct £000's	Nov £000's	Dec £000's	Jan £000's
Monthly Pay spend	16,244	16,478	16,575	16,261	16,363	16,709	16,699	16,752	16,675	16,993
WTE	4765.40	4733.46	4783.86	4759.51	4739.95	4788.91	4829.68	4861.18	4846.81	4862.82

Presented with these issues, it has been decided to reconstruct Pay Budgets for the Trust, based upon the recorded level of Pay spending occurring in the month of January 2012. A decision supported at both the Hospital Executive Committee and Operational Delivery Group meetings in February 2012.

In the month of January 2012, the Trust spent £16.993 million. This month is however distorted by non recurrent spending associated with Arrears repayments (£80,000) and costs incurred in accelerating performance in respect of waiting times. (£127,000).

Adjusting for these two items, the monthly pay spend then amounts to £16.786 million. The annual budget is then computed as follows:

	Monthly January Pay spending £000's	Annualised based on January Pay spend £000's
January Pay spend	16786	201,428
Bank Holidays Adjustment		(1,000)
Pay Awards and Increments		2,000
Bed Closure Programme Phase 1 and 2		(3,815)
Agency Doctor Contract – 20 per cent rate reduction		(1,000)
Department of Health Initiatives		694
<i>Total Budget</i>		<i>198,307</i>

Since constructing this budget the Trust has received notification of spending in the month of February. In this month Pay spending increased to £17.056 million. After adjusting for costs associated with waiting list performance Pay spending then amounted to £16,929 million. When compared with the January this represents an increase of £143,000 in the month. Given the scale of this change, in constructing the budget for the 2012/13 year it has been decided to increase the total budget by £1.72 million to a revised spending level for the year of £200.027 million.

In setting this budget, revised practices are also being introduced to enable the budgets for the 2012/13 year to be more closely managed, these controls being:

- Agency Spending – the “premium” costs associated with staff employed as Agency staff, has been removed from the budgets held by Budgetholders and instead is held centrally. Availability of the budget being approved through a panel comprising the Medical Director and Finance Director. This practice ensures that :

## Putting Patients First

- (a) Budgetholders are not able to utilise premium costs to increase employed staffing levels within their departments / Centres; and
  - (b) In applying for ongoing access to Agency premium costs, Budgetholders are required to actively satisfy a central panel of the “need” for Agency costs and the actions being taken to avoid such costs into future months.
- Waiting List Initiative – All budgets associated with Waiting List Initiative payments, has been removed from the Budgets held by Budgetholders, and instead is held centrally. Availability of the budget being approved through a panel comprising the Medical Director and Finance Director. This practice ensures that :
- (a) Decisions over the availability of funds to support Waiting list Initiatives are clearly linked to waiting list performance and allows for scrutiny of activity levels performed within “core” work time; and
  - (b) Budgetholders are not able to utilise waiting list funding to support a growth in staffing levels without clearly validated of impact upon waiting times performance.

In setting a budget for the 2012/13 year it had been decided to base the construction of the budget upon the three month moving average associated with the period November 2012 to January 2012. The highest level within the year.

### Non Pay Budgets

As with Pay spending, the 2011/12 year has been characterised by consistent increases in the level of monthly Non Pay expenditure.

The variability of spending across non pay areas is such that, in order to obtain a satisfactory view of the level of non pay spending it is necessary to smooth out random variation by applying a moving average to the monthly spending levels. Applying a three month moving average provided the following results.

	April – June £000s	May – July £000s	June – Aug £000s	July – Sept £000s	Aug – Oct £000s	Sept – Nov £000s	Oct – Dec £000s	Nov – Jan £000s	Dec – Feb £000's
Average monthly spending	6,491	6,730	6,966	7,074	6,980	7,159	7,322	7,598	7,731
Movement	-	231	236	38	(94)	179	173	276	184

## Putting Patients First

	3 month moving average – Nov to January £000's	Annualised based on 3 month average spend £000's
3 month moving average – Nov to Non Recurrent monthly spend in the period	7,598	
Professional Advisors	(145)	
Waiting times performance – Nuffield Hospital	(134)	
Revised Moving average – excluding excess payments	7,319	87,828
Remove seasonality – associated with Utility costs		(786)
Revised 3 month Moving average Annualised budget		87,042
Total Budget High Cost Drugs growth – estimated 2012/13		2,761
Inflation – at 4.5 per cent		3,805
Capitalisation of revenue costs		(226)
		93,881

Since constructing this budget, the Trust received notification of Non pay spending levels in the month of February. In February Non Pay spending in the month amounted to £7.929 million. As a consequence the moving average monthly spend for the period December through to February increased to £7.731 million. Adjusting for the non recurrent excess payment to professional advisors and achievement of waiting list performance reduces the monthly moving average to £7.44 million.

Given the scale of this change, it has been decided to adjust the budget to reflect the increased spending in February. Doing so increases non pay budgets in total by £1.35 million, to a revised level of £94.706 million.

### **April – Continuation of Waiting Times Performance Programme.**

Given the position of the Trust in respect of it's waiting list performance, it has been agreed that the activities being undertaken to improve the performance

should be extended by a further month into April. Doing so will mean that the Trust will incur additional Pay costs, beyond the levels described above, amounting to £294,000 and Non Pay costs amounting to £132,000. Undertaking such levels of activity will result in an over performance as compared with the contracted Income. Prudently it has been assumed that the increased Income will equate to the increased Pay and Non Pay costs.

### **Reserves**

In recognition of the risks facing the Trust in the 2012/13 year, the Trust has established contingency reserves amounting to £6.382 million. These reserves are being held to cover:

- Lost Income – from Local Commissioners as they implement their QIPP programme and enforce contractual penalties – sum £5.288 million; and
- Demography – Unachieved Income growth as a consequence of demographic changes – sum £1.094 million.

### **Key Messages - Expenditure budgets and Reserves**

- Pay Budgets set based upon Month 10 level of spending - £198.307 million, increased by further £1.72 million as a consequence of spending level in February
- Non Pay set based upon a 3 month moving average covering the period November to Jan - £93.881 million – increased to £94.706 million as a consequence of increased spending recorded in February.
- Contingency reserves – held to cover lost Income associated with QIPP and Demographic growth amounting to £6.382 million.

## Putting Patients First

### Cost Improvement Programme

The Trust has set an ambitious cost improvement programme for delivery in the 2012/13 year as presented in the table below.

CIP Plan	REC	NREC	TOTAL
Medical Consultants	3500	-2500	1000
WLI Payments	1000		1000
Nursing	1600	-700	900
Bed Reductions	3500	-2625	875
Theatres	1000	-833	167
Admin and outpatients	1700	-1558	142
Pathology reconfiguration	1300	-1300	0
Allied Health Professionals	700	-583	117
On Call Payments	1000	-500	500
Estates and Corporate services	800	-400	400
Temporary staff reduction	5040	-740	4300
Diagnostic tests	600	-450	150
Coding alterations	1000		1000
Procurement	2000	-1000	1000
Centre identified Non Pay savings	1080		1080
VAT Changes - Locum Doctors		300	300
Reduce Non Pay to Month 10 level	1325		1325
<b>Total</b>	<b>27145</b>	<b>-12889</b>	<b>14256</b>

In order for the Trust to successfully deliver its budget for the 2012/13 year, it is critical for these levels of costs savings to be released. As can be seen from the above table, whilst the Trust delivers recurrent savings from this programme amounting to £27.145 million, after allowing for the implementation dates for each of these respective schemes the level of savings released in the year reduces to £14.256 million. The timing of the savings programme is illustrated in the table below.

Revised CIP Plan	April	May	June	July	August	September	October	November	December	January	February	March	Total
Medical Consultants									125	292	292	292	1000
WLI Payments	43	43	91	91	91	91	91	91	91	91	91	91	1000
Nursing	25	25	25	25	25	25	125	125	125	125	125	125	900
Bed Reductions										292	292	292	875
Theatres											83	83	167
Admin and outpatients												142	142
Pathology reconfiguration													0
Allied Health Professionals											59	59	117
On Call Payments	6	13	19	26	32	38	45	51	58	64	71	77	500
Estates and Corporate services							67	67	67	67	67	67	400
Temporary staff reduction	0	100	420	420	420	420	420	420	420	420	420	420	4300
Diagnostic tests	2	4	6	8	10	12	13	15	17	19	21	23	150
Coding alterations	0	0	18	36	55	73	91	109	127	145	164	182	1000
Procurement	13	26	38	51	64	77	90	103	115	128	141	154	1000
Centre identified Non Pay savings			108	108	108	108	108	108	108	108	108	108	1080
VAT Changes - Locum Doctors			30	30	30	30	30	30	30	30	30	30	300
Reduce Non Pay to Month 10 level	110	110	110	110	110	110	110	110	110	110	110	110	1325
<b>Total</b>	<b>200</b>	<b>321</b>	<b>866</b>	<b>906</b>	<b>945</b>	<b>984</b>	<b>1190</b>	<b>1230</b>	<b>1394</b>	<b>1892</b>	<b>2073</b>	<b>2254</b>	<b>14256</b>

In addition to these sums the Trust is also required to deliver savings that commenced in the 2011/12 year in full within the 2012/13 year these schemes being:

	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total	Plan Saving	Var
Phase 1 and 2 Bed Closures	107	187	266	292	318	318	318	318	318	318	318	318	3395	3815	(420)
Locum Doctor Agency savings	42	42	67	67	67	67	67	67	67	67	67	67	750	1000	(250)
<b>Total</b>	<b>149</b>	<b>229</b>	<b>343</b>	<b>359</b>	<b>395</b>	<b>4145</b>	<b>4815</b>	<b>(670)</b>							

The total level of savings being delivered in the 2012/13 year amount to £13.586 million.

## Putting Patients First

### Status of the Cost Improvement Programme

Confidence in the delivery of an ambitious Cost Improvement Programme depends upon the stage of implementation of each element of the Programme. The table below provides a description of the “status” of each element and a corresponding Risk Rating.

From the above analysis:

- Savings planned for delivery from the 2011/12 programme are all classified as Green
- The 2012/13 programme is categorised as follows :

	Director / Centre Chief Lead	Status	Savings "in year" £000s	Risk Rating
<b>2011/12 schemes</b>				
Bed Closure Programme Phase 1 and 2	Director of Operations	Phase 1 beds closed by 31 <sup>st</sup> March, Phase 2 in April – Associated Bank staff reduction to be confirmed	3,395	Green
Agency Doctors – Rate Reduction	Medical Director	Agreed decision that all Medical Doctors to be sourced from four contracted Agencies, where not possible sourced through existing staff based on NHS contract terms	750	Green
<b>2012/13 schemes</b>				
Medical staffing reduction	Medical Director/ Centre Chief (Women & Children)	All Centre Chiefs to be provided with savings to be delivered in year within their centres by 30 <sup>th</sup> March. Centre Chiefs to construct plan for approval by 14 <sup>th</sup> April.	1000	Amber
Waiting List Initiative Payments	Medical Director	Waiting List Initiative monies centralised from 1 <sup>st</sup> April. Approval Panel established in April.	1000	Amber
Nursing Review	Director of Quality & Safety/ Chief Nurse	Revised Ward Management arrangements introduced 1 <sup>st</sup> April 2012, Revised Handover arrangements to commence in September following completion of staff consultation	900	Amber
Phase 3 Bed Reduction	Director of Operations	No plan constructed	875	Red
Theatre savings	Centre Chief (Surgical)	Review of Theatre savings completed and being implemented	167	Green
Administration and Outpatients	Director of Transformation	Group to review and implement changes now operational	142	Green
Allied Health Professionals	Director of Operations	External review commissioned – no plans established	117	Red
On call payments	Workforce Director	No plan constructed	500	Red
Estates and Corporate services	Finance Director	Plans to achieve reduction finalised	400	Green
Temporary staff reduction – Medical staff	Medical Director	Actions taken to reduce temporary staff from May	1100	Green
Temporary staff reduction – Non Medical and Nursing	Workforce Director	Review of temporary, bank and agency staff	3200	Green
Diagnostic Tests	Centre Chief (Diagnostics)	Diagnostic centres to develop plans with Centres to reduce activity – no plan constructed	150	Red
Coding alterations	Finance Director	Areas for coding improvements identified within Ophthalmology and Head and Neck Centres – need to address Clinical coders work space area at RSH.	1000	Amber
Procurement	Finance Director	Centre savings plans issued on the 23 <sup>rd</sup> March.	1000	Amber
Centre identified Cost savings	Centre Chiefs (Surgical, Therapies, Diagnostics)	Changing practices in respect of Orthopaedic implants (550k), Revised funding arrangements in respect of Hospice Care (160k), Remove expenditure relating to High/Low Bed Rentals (115k), Professional fees (ASH Consultancy) (100k), Maintenance arrangements within Radiology (80k), other savings 75k	1080	Amber
VAT Savings – Locum Doctors	Medical Director/ Workforce Director	Introduce new working practices with PricewaterhouseCoopers to ensure savings from VAT IN May 2012	300	Red
Reduce Non pay to Month 11 levels	All Centres	Non pay budgets based upon Month 10 spending – new Performance arrangements in respect of Budgetholders implemented from 1 <sup>st</sup> April 2012	1325	Amber

## Putting Patients First

	£000s
Green – in place	4,009
Amber – to be finalised	8,305
Red – to be constructed	1,942
Total savings from 2012/13 schemes	14,256

Key Messages – Cost Improvement Programme	
-	New schemes introduced in the 2012/13 year generate recurrent costs savings amounting to £27.145 million, and “in year” £14.256 million
-	Slippage on schemes carried forward from the 2011/12 year reduces the total level of savings by £670,000 to £13.586 million.
-	£11.1 million of the £14.256 million savings are delivered in the last six months of the 2012/13 financial year.
-	£4.0 million of the savings in 2012/13 classified as green ( in place), £8.3 million (to be finalised) and £1.9 million as Red (no plan constructed)

### Income and Expenditure Account over the 2012/13 year on a monthly basis

The Income and Expenditure Account over the twelve months April 2012 to March 2013 is presented in the table below.

	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Planned Surplus / (deficit) £000's	(1528)	(533)	1029	661	(194)	359	389	156	(533)	(302)	(764)	1417
Cumulative surplus / (deficit) £000's	(1528)	(2061)	(1033)	(372)	(566)	(207)	182	338	(194)	(496)	(1260)	157

As can be seen the Trust expects to record a deficit in the month of April amounting to £1.528 million and complete the first quarter of the year with a cumulative deficit amounting to £1.033 million. By the end of the second quarter the cumulative overspend is planned to reduce to £207,000 and by Quarter 3 the planned deficit amounts to £194,000.

During the period a negative run rate is recorded in the months of April and May, followed by positive run rates in five of the months between June and December.

Significantly over this period the Pay spend per month declines from £17.052 million in April to £14.98 million in March 2013. In order to achieve this level of reduction, the numbers of staff employed within the Trust (either as substantive or temporary staff members) has to reduce substantially.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Pay Cost £000s	17052	16641	16202	16163	16124	16111	15915	15902	15764	15293	15139	14984

Key Messages – Monthly Income and Expenditure Plan	
-	Trust suffers a deficit in the first month of the year amounting to £1.528 million,
-	End of Quarter 1 cumulative deficit 31.033 million, by quarter end of quarter 2 cumulative deficit £207,000 and by quarter 3 cumulative deficit £194,000.
-	To achieve plan total Pay spend has to decline from £17.052 million in April 2012 to £14.984 million by March 2013.

### Risks associated with the 2012/13 Plan

Income – Demographic growth – In setting the Plan it has been assumed that the Trust will increase Income as a consequence of demographic growth by 1.3%, and in doing so generate Income

## Putting Patients First

amounting to £3.432 million. A contingency reserve has been established to partially cover this risk amounting to £1.094 million.

Local QIPP – Local Commissioners have indicated that local QIPP schemes will reduce Income by 5.288 million; little detail exists in respect of the activities being introduced to reduce the Income.

Discussions with Commissioners suggest that the full year effect of their plans will reduce the Income to the Trust by £8.0 million. A contingency reserve has been established to cover lost Income from QIPP schemes amounting to £5.288 million.

Commissioning intention of Powys Health Board – No information has been provided to the Trust by the Trust that details the commissioning intentions of the Powys Local Health Board.

Pay Spending – As described in the above the Trust is required to substantially reduce spending. Doing so is dependant upon the delivery of CIP schemes and controlling expenditures in respect of Waiting List Initiatives and Agency Costs. No contingency reserve exists to cover this risk.

Non pay spending – As with Pay spending the underlying level of Non Pay spending (excluding Inflation and growth in High Cost Drugs) is expected to reduce in the year as a consequence of the delivery of Cost Improvement Targets. No contingency reserve exists to cover this risk.

Cost Improvement Programmes – The Target for the 2012/13 is to deliver a recurrent CIP plan of £27.145 million, and after allowing for slippage savings in year amounting to £14.256 million. In achieving this sum, the Trust is required to deliver the savings to specific deadlines. Delay in the delivery of the programme by one month will reduce the scale of savings by £2.3 million; delay of the programme reduces the scale of saving by £6.3 million. No contingency reserves exist to cover this risk.

### Key Messages – Risks and Contingencies

- Contingency reserves exist to cover the impact of Local QIPP schemes and Demographic growth upon Income

- No contingency reserves exist to cover the failure to deliver the 2012/13 CIP Programme.
- Delay in the delivery of the 2012/13 CIP programme creates a cost pressure of £2.3 million; delay by three months creates a cost pressure of £6.3 million.

### Impact upon the Medium Term Financial Plan

In setting the medium term financial plan for the Trust, a series of assumptions have been applied, notably:

- Negative Tariff – Applies across the years 2012/13 to 2016/17. In the years 2013/14 to 2016/17 at the rate of 1.8 per cent.
- Demographic growth – Increases Income each year by 1.3 per cent.
- QIPP schemes – Over the two years 2012/13 and 2013/14 Income reduces as a result of QIPP schemes recurrently by £8 million.
- Pay Costs – Rise in each year by 2 per cent; and
- Non Pay costs – Rise in each year by 4.5 per cent.

Given these assumptions, the successful delivery of the Cost Improvement Plan in the 2012/13 financial year, is critical if the Trust is to progress sustainably over the period 2012/13 to 2016/17 as illustrated in the table below. More specifically, by delivering the 2012/13 CIP Plan, the Trust is then able to carry forward into the 2013/14 year a recurrent surplus amounting to £15.0 million. Doing so ensures that the Trust is required to generate savings of £4.3 million in the 2013/14 year in order to deliver a surplus consistent with the requirements as presented by Monitor. In future years the levels of savings to be achieved amount to £6.8 million to £7.6 million per year.

## Putting Patients First

	Recurrent £million's	Non Recurrent £million's	Total £million's	New Recurrent CIP £million's	Savings achieved " in year" £millions	% "in year" CIP as compared with turnover
2012/13	15.0	(14.8)	0.2	27.1	14.3	4.7%
2013/14	2.5	(0.3)	2.2	4.3	17.1	5.9%
2014/15	2.1	-	2.1	6.8	6.8	2.4%
2015/16	2.1	-	2.1	7.5	7.5	2.6%
2016/17	2.0	-	2.0	7.6	7.6	2.6%

### Key Messages – Medium Term Financial Plan

- 2012/13 CIP – Successful delivery of the 2012/13 Plan critical for the Medium Term Financial sustainability of the Trust, achieving this sum enables the Trust to achieve its CIP requirements in the 2013/14 year.

### Financial Risk Rating 2012/13

The financial ratios used as part of the Monitor process to determine a risk rating are presented in the table below. The planned performance in the 2012/123 financial year produces an overall risk rating score of 3 for the year.

	2012/13 Plan	Risk score	Weighted risk score
EBITDA margin	4.9%	2	0.50
EBITDA, % achieved	100.0%	5	0.50
ROA	3.4%	3	0.6
I&E surplus margin	0.1%	2	0.40
Liquid ratio	16.27	3	0.75
<b>Overall Risk Rating</b>		<b>3.0</b>	<b>2.75</b>

### 2012/13 Capital Programme

The planned capital expenditure below reflects the amounts within the Trust's Capital Resource Limit including the additional, nationally funded, capital of £33m for the Trust's reconfiguration plans.

The profile of spend over the reconfiguration project's overall timescales are yet to be finalised.

## Putting Patients First

2012/13 Capital Programme	Plan
	£000s
Backlog Maintenance	2,470
Bed Reconfiguration	1,856
Medical Equipment Replacement Programme	2,722
Patient Monitoring	300
IT Replacement Programme	466
VitalPAC	126
Cancer Centre	5,200
Charitable Funded Medical Equipment	1,000
Reconfiguration of services - Keeping it in the County	33,000
Aggregate	510
<b>Total Gross Expenditure by Project</b>	<b>47,650</b>

### **Statement of Financial Position**

The statement below reflects the planned movement in Total Assets employed between March 2012 and March 2013. The movement in Non Current Assets illustrates the capital programme as described above and therefore includes the nationally funded capital of £33m for the Trust's reconfiguration plans

	March 12 £000	March 13 £000
<b>Total Non Current Assets</b>	<b>159,166</b>	<b>196,071</b>
Inventories	5,402	4,902
Current Trade and Other Receivables	10,557	10,557
Cash and Cash Equivalents	1,200	2,200
<b>Total Current Assets</b>	<b>17,159</b>	<b>17,659</b>
<b>Current Trade and Other Payables</b>	<b>(25,342)</b>	<b>(25,135)</b>
Finance Lease		
PDC dividend Payable accrual		
Provisions	(213)	(214)
<b>Total Current Liabilities</b>	<b>(25,555)</b>	<b>(25,349)</b>
<b>Net Current Liabilities</b>	<b>(8,396)</b>	<b>(7,690)</b>
<b>Total Assets less Current Liabilities</b>	<b>150,770</b>	<b>188,381</b>
Provisions	(408)	(325)
<b>Total Assets Employed</b>	<b>150,362</b>	<b>188,056</b>
<b>Total Taxpayers' Equity</b>	<b>150,362</b>	<b>188,056</b>

### **Service Line Reporting**

The Trust is, through the use of its Patient Level Costing system, now able to provide Income and Expenditure positions for each of the Clinical Centres. The table below produces a Clinical Centre financial position reconciled to the financial position as presented at Month 10, 2011/12

## Putting Patients First

M10 YTD SLR position by Centre

Metrics	Surgical	Musculo-skeletal	Head and Neck	Ophthalmology	Women and Childrens	Emergency and Critical Care Centre	Medicine	Oncology	Total
Total Income	£47,320	£24,850	£11,520	£9,633	£39,284	£18,035	£65,943	£23,390	£239,976
Direct Costs									
Direct Pay Costs									
Nursing	£4,935	£2,252	£507	£263	£12,470	£5,747	£15,523	£1,452	£43,149
Consultants	£5,282	£2,779	£2,251	£1,341	£3,159	£1,360	£4,360	£1,102	£21,634
Other Clinical	£5,824	£3,860	£2,918	£1,887	£5,598	£3,378	£9,909	£1,560	£34,935
Non-clinical	£1,401	£458	£338	£470	£1,479	£1,199	£2,370	£897	£8,613
<b>Total: Direct Pay Costs</b>	<b>£17,442</b>	<b>£9,350</b>	<b>£6,015</b>	<b>£3,961</b>	<b>£22,706</b>	<b>£11,684</b>	<b>£32,163</b>	<b>£5,011</b>	<b>£108,331</b>
Direct Non Pay Costs									
Drug Costs	£2,648	£335	£174	£1,352	£1,183	£678	£4,033	£8,037	£18,439
Supplies	£740	£409	£929	£237	£1,268	£932	£2,427	£729	£7,670
Other Direct Costs	£529	£807	£108	£224	£519	£485	£972	£132	£3,776
<b>Total: Direct Non Pay Costs</b>	<b>£3,917</b>	<b>£1,550</b>	<b>£1,212</b>	<b>£1,813</b>	<b>£2,970</b>	<b>£2,095</b>	<b>£7,432</b>	<b>£8,897</b>	<b>£29,886</b>
<b>Total: Direct Costs</b>	<b>£21,359</b>	<b>£10,900</b>	<b>£7,227</b>	<b>£5,773</b>	<b>£25,676</b>	<b>£13,779</b>	<b>£39,595</b>	<b>£13,908</b>	<b>£138,218</b>
Indirect Costs									
Allied Healthcare Professionals	£870	£451	£387	£355	£479	£493	£1,533	£1,064	£5,633
Radiology	£1,672	£1,842	£451	£294	£632	£2,904	£2,366	£427	£10,589
Pathology	£2,892	£914	£692	£436	£1,637	£1,312	£2,909	£854	£11,644
Theatre	£4,840	£3,940	£1,673	£1,100	£1,121	£1	£139	£18	£12,832
Other Services	£4,142	£1,400	£926	£991	£1,305	£756	£2,363	£592	£12,475
Prosthetics	£52	£1,196	£9	£157	£37	£15	£49	£1	£1,516
Hotel Services	£15	£9	£4	£3	£10	£5	£27	£5	£78
Pharmacy	£658	£156	£60	£182	£291	£18	£1,173	£1,023	£3,562
Other Costs	£0	£0	£0	£0	£0	£0	£0	£0	£0
<b>Total: Indirect Costs</b>	<b>£15,142</b>	<b>£9,908</b>	<b>£4,200</b>	<b>£3,519</b>	<b>£5,513</b>	<b>£5,505</b>	<b>£10,559</b>	<b>£3,985</b>	<b>£58,330</b>
<b>Total: Total Direct/Indirect Cost</b>	<b>£36,501</b>	<b>£20,808</b>	<b>£11,427</b>	<b>£9,292</b>	<b>£31,188</b>	<b>£19,284</b>	<b>£50,154</b>	<b>£17,893</b>	<b>£196,547</b>
Contribution	£10,819	£4,042	£93	£341	£8,096	£-1,249	£15,790	£5,496	£43,429
Contribution %	23%	16%	1%	4%	21%	-7%	24%	23%	18%
Overhead Costs									
Site Costs	£2,436	£1,266	£725	£723	£2,127	£1,151	£3,751	£1,093	£13,272
Corporate Costs	£3,024	£1,622	£991	£748	£3,276	£1,731	£4,414	£1,689	£17,495
CNST Contribution	£492	£446	£74	£61	£3,518	£234	£92	£18	£4,934
<b>Total: Overhead Costs</b>	<b>£5,952</b>	<b>£3,334</b>	<b>£1,790</b>	<b>£1,531</b>	<b>£8,921</b>	<b>£3,117</b>	<b>£8,256</b>	<b>£2,800</b>	<b>£35,701</b>
EBITDA	4,867	709	(1,698)	(1,190)	(825)	(4,365)	7,534	2,696	7,728
Finance Costs	2,158	1,299	545	534	1,788	1,480	3,079	1,305	12,188
<b>Total Profit</b>	<b>2,709</b>	<b>(590)</b>	<b>(2,243)</b>	<b>(1,724)</b>	<b>(2,613)</b>	<b>(5,845)</b>	<b>4,455</b>	<b>1,391</b>	<b>(4,460)</b>
Profitability	5.72%	-2.37%	-19.47%	-17.89%	-6.65%	-32.41%	6.76%	5.95%	-1.86%
SHA Support									4,583
Trust Surplus/(Deficit)									123

The Shrewsbury and Telford Hospital **NHS**  
NHS Trust

## Putting Patients First



## Putting Patients First

# Section 10: Workforce Plans



## Putting Patients First

### 10.1 Background

We are ambitious to ensure that our organisation is a great place to work. We aim for our workforce to be our strongest ambassadors, they will be proud to work for our organisation for the care we will deliver.

We are developing a Workforce Strategy to ensure a planned yet visionary approach to the leadership of our Workforce.

The focus for the year ahead will be to improve the employment experience, the measure of our success will be significant improvement in our staff survey results.

### 10.2 Workforce Profile

We employ approximately 5300 staff, and benefit from the support of hundreds of volunteers working directly for the Trust. Our main voluntary partners (including Leagues of Friends at our two main hospitals, WRVS and the Lingen Davies Cancer Appeal). The total number of staff employed on permanent and fixed-term contracts at 27 March 2012 was 5362. Given that many of our staff work part-time this represents 4497 whole-time equivalent (wte). There are currently 522 volunteers active in the Trust and from our main charitable partners. Expenditure on staff accounts for approximately 68% of our expenditure.

Our workforce at 27 March 2012 included:-

- 507 wte doctors and dentists (11.4%)
- 1370 wte nursing and midwifery staff (30.5%)
- 569 wte scientific, technical and therapies staff (12.6%)
- 1,221 other clinical staff (27.1%)
- 830 non-clinical staff (14.4%)

More information about our workforce is available in Section 9.

### 10.3 Workforce Strategy

The Trust is developing a Workforce and an Organisational Development Strategy that will enable the organisation to achieve its vision – putting patients first.

The strategy foundation is to embed our values throughout the employment life cycle, to ensure we consistently live our values through our employment decisions.

- Putting patients first – service to the patient above all else
- Honesty and integrity – dealing with the facts
- Being a clinically led organisation
- Working and collaborating together
- Encouraging individuality, ability and creativity
- Taking pride in our work and in our organisation

The Strategies focus on the planning and development of a Workforce that is fit for purpose both now and for the future challenges the organisation will face.

### 10.4 Health and Wellbeing

The health and well-being of staff is imperative to ensure the delivery of safe and quality services to our patients. This means that as an organisation, we support staff to assess and take responsibility for their own health, as well as promoting healthy options and providing preventative services to our Workforce.

Informed by the 2009 Boorman Report we have developed an approach to Health and Wellbeing. We are proactive about the Health and Wellbeing of our Workforce, a wide range of initiatives have been implemented with a strong focus on engagement, recognition and empowerment. The benefits being:-

## Putting Patients First

### Organisation Benefits:-

- Help achieve our objectives and key performance indicators
- Provide independent support for staff through a time of significant organisational change
- Improve attendance at work, with an additional benefit of a reduced demand for Bank and Agency staff
- Reduction in sickness absence percentage
- Improved staff retention, reducing the cost of turnover and retaining skilled and experienced workers

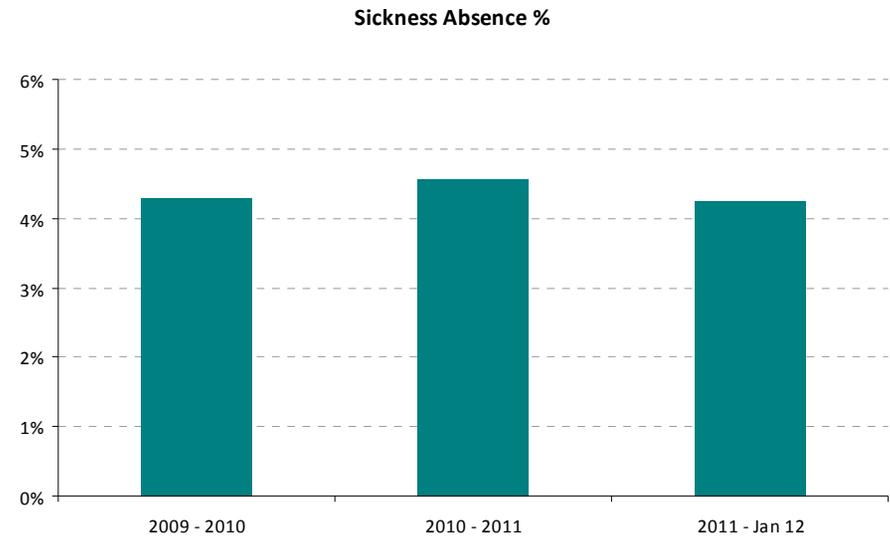
### Employee Benefits:-

- Staff feeling that they are involved in decisions that affect them, both individually and through representatives.
- Increased morale and engagement with work
- Supporting staff in dealing with stressful situations more positively and effectively
- Reduced levels of stress and absence and improved health and wellbeing
- Through good communications support staff to understand and adapt to change easily
- Access to support to help staff keep themselves healthy and safe
- Promote a positive self image

Our Health and Wellbeing objectives are included in our Workforce strategy, and include that we will:-

- Implement the recommendations of the Boorman review
- Embed a culture of staff feeling that the organisation actively promotes health and well-being.

### 10.5 Absence Data

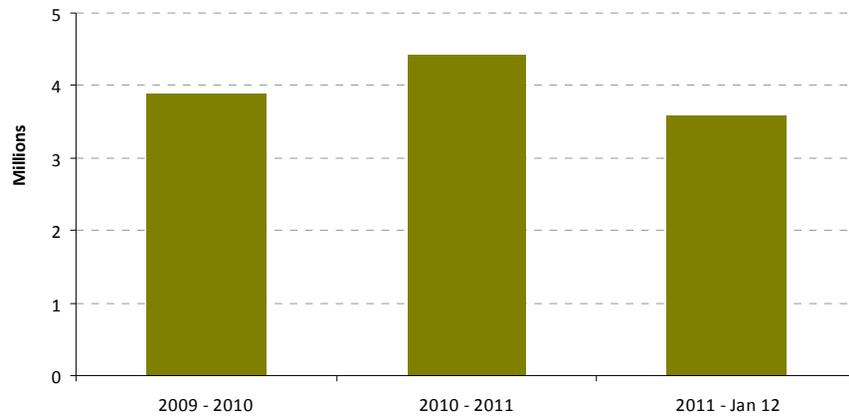


The Trust's sickness absence rate for the year to January 2012 is 4.24%.

The impact of absence for the Trust is greater than quality; Agenda for Change terms and conditions provide favourable payments. Absence creates a cost impact for the organisation average annual costs to date and projected costs are illustrated below (calculated as salary costs for actual employees with absence – on-costs and backfill costs not included). Therefore a strategic approach to Health and Wellbeing will deliver an increase in staff satisfaction and a decrease in costs.

## Putting Patients First

Cost of Sickness Absence

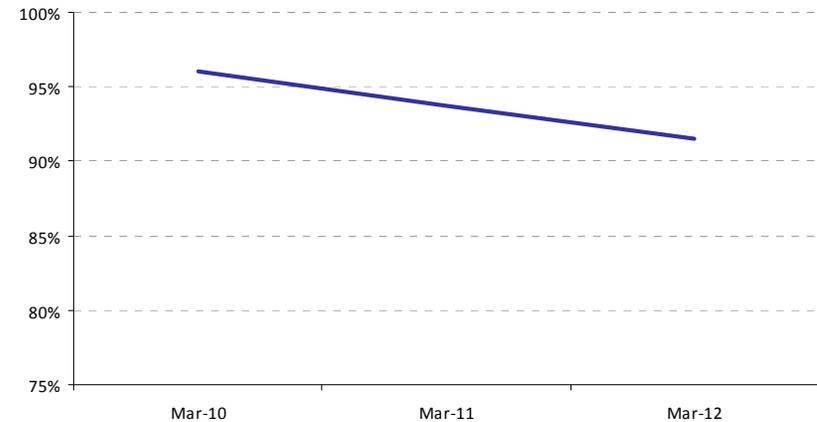


Turnover has been at a steady rate over the last three years, whilst this can be seen in a positive light, in a scenario of required pay reductions it does limit the opportunity to maximise natural wastage.

### 10.6 Vacancy Rate

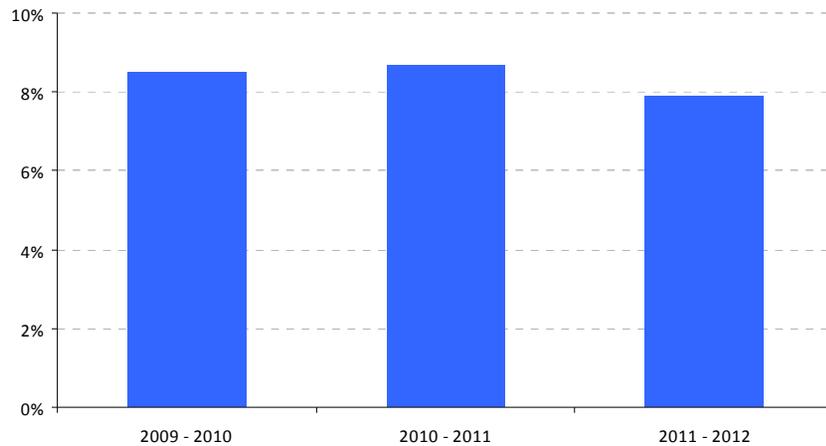
The vacancy rate within the Trust has been variable over the last twelve months, a recent decrease is as a direct result of the Trust holding vacancies to support a recent bed reduction programme. Over the next twelve months we will aim to reach full establishment.

Vacancy Rate



### Turnover

Turnover %



### 10.6 Recruitment Hotspots

The Trust like any other acute provider struggles to recruit in certain specialities due to national challenges. In addition the rural location of

## Putting Patients First

the organisation can also present a challenge within some professional groups.

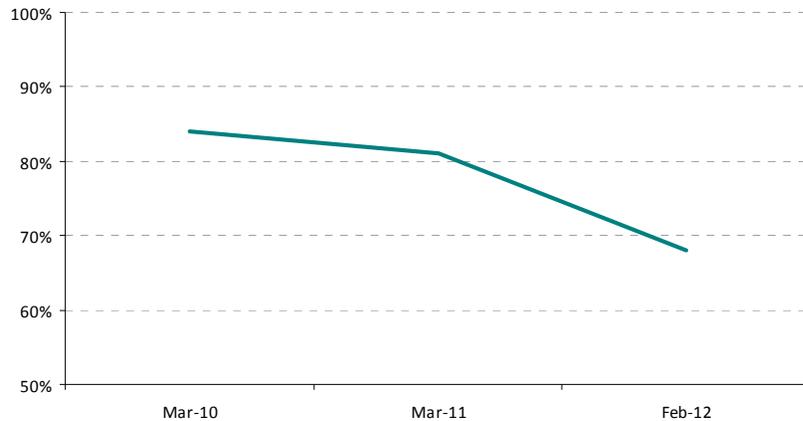
Table Recruitment Hotspot		
Role and Specialty	Timeline	Action Plan
<p><b>Trainee &amp; Middle Grade Medical Staff</b></p> <p>In particular</p> <ul style="list-style-type: none"> <li>Specialist Registrars in general medical specialties,</li> <li>FY2 in Trauma &amp; Orthopaedics</li> <li>Middle Grade in Accident &amp; Emergency, Trauma &amp; Orthopaedics, Anaesthetics</li> </ul>	Immediate	Various strategies considered, including offer of clinical fellowships, but without success.
<p><b>Consultant Haematologist</b></p> <ul style="list-style-type: none"> <li>Potential retirement of 2 consultants presents a major risk to our quality of service, performance and income.</li> <li>Difficult to recruit individuals with Cytology skills as this is no longer a mandatory requirement</li> <li>Issue nationally but struggling at SaTH to attract</li> </ul>	2014	<p>Options regarding Cytology being considered including development of Advanced Practitioner role and recruitment of Biomedical Scientists</p> <p>No plans to readvertise currently employing one locum Consultant Haematologist</p>
<p><b>Consultant Radiologist (Breast)</b></p>	Immediate	Training Advanced Practitioners to undertake biopsies and film reading. Plans to train Consultant Radiographer (4 year programme)
<p><b>Medical Staff – Anaesthetics</b></p> <p>Difficult to attract trainee and middle grade medical staff</p>	Immediate	International recruitment Flexible working options
<p><b>Senior Pharmacists</b></p>	Immediate	Developing relationships

<p>Unattractive career progression – giving up specialty to undertake management role – very little perceived benefits due to AfC. 80-90% of graduate pharmacists are female. Current career model does not support good work/life balance (10-15 years experience required to attain senior role). Competition from community Pharmacy due to pay anomalies</p>		with universities, schools of pharmacy and medical schools, including funded teacher practitioner links.
<p><b>Fertility Scientists</b></p> <p>Unable to appoint fully qualified staff</p>	Immediate	Appointment of trainees
<p><b>Advanced Nurse Practitioners (Neonatal and Paediatrics)</b></p> <p>Unable to appoint fully qualified staff</p>	Immediate	Appointment of trainees
<p><b>Women's Services Assistants</b></p> <p>Difficulties in retention</p>	Immediate	Development of comprehensive training package
<p><b>Sonographers</b></p> <p><b>Planned training programme is successful in recruitment but impacts on ability to deliver services</b></p>	Immediate	Two year in-house training programme developed. Utilise learning beyond registration.

## Putting Patients First

### 10.7 Appraisals

Appraisal Completion



Appraisal rates have recently decreased this is an area that the organisation is keen to see improvement, the target is 80%. Last month saw a dramatic reduction this is being addressed.

Performance Reviews are held monthly with each clinical centre, allowing ongoing monitoring against all workforce metrics. Centres are challenged regarding their performance and clear agreement between executives and centre teams is reached regarding improvement.

In the year ahead we are developing our appraisals framework with the aim of ensuring meaningful appraisals. We will also translate our values into competencies to begin to embed our values as behaviours that we all sign up to.

### 10.8 Staff Survey

Our Staff Survey results do not represent the employment experience we want our Workforce to have. Against the national benchmark we

feature in the bottom 20% for 24 key findings. Moving forward we will focus on what needs to take place to ensure our organisation is a great place to work and ensuring our staff deliver excellent patient care.

Our focus will be to ensure a positive employment experience, through a focused improvement in two areas; staff recommending the Trust as a place to receive care and to work. We aim to improve our results in this area by 10% each year for the next 5 years. Staff Conversations are being planned to better understand 'what would make SaTH a great place to work?' Centres will then focus on improving employment experience. The Board is committed to change and through the Workforce Strategy believes improvement can be achieved.

### 10.9 Workforce Planning

The Trust is currently developing a more sophisticated approach to Workforce Planning the appointment of a Workforce Planning and Transformation Manager (joins April 2012) work will focus on planning our Workforce into the future concentrating on how care will be delivered against the supply pipeline. The Trust plans to start home growing its talent for a variety of posts through widening participation. In terms of succession planning a need in a number of specialties is pressing. Our approach will be to identify business critical roles and understand who the potential successors are to those posts and to identify the support needed to support progression. A key development this year will be the development of our OD Strategy will be talent identification, development and planning.

### 10.10 Workforce Plans to support Cost Improvement Programme (CIP)

The Trust faces significant financial challenges next year which will impact significantly on our Workforce in a variety of ways, including a headcount reduction. Potential Workforce impact is illustrated below, in some areas plans are still being finalised

## Putting Patients First

Cost Improvement Programme	Staff Group	Impact WTE	Impact Saving 12/13	Measure to minimise risk
Nursing Review	Nurses	54	900	Redeployment into posts covered by bank/agency.
Medical Staff	Consultants and SAS	10	1000	Savings achieved through job planning
Bed Reduction Programme	Nurses HCA	128 WTE 64 Nurses 64 HCA	3500	Potential Redeployment
AHP Review	Physiotherapists Occupational Therapists	20	117	Potential Redeployment
Estates & Corporate	Estates Personnel Managers	16 10 – Estates 6 Corporate	800	Potential Redeployment
Temporary staff reduction	Various Administration Management Nurses Medical Records	160	4030	End of fixed term contract.
Booking and Scheduling	Booking clerks Administrators	39	142	Potential Redeployment
<b>Total Impact</b>		<b>427</b>		

Plans will all be Quality Impact assessed to ensure that safety and quality of services are not compromised, this will be led by Chief Nurse.

### 10.11 Workforce Transformation

Over the forthcoming year the Trust will deliver a number of transformation programmes all of which have Workforce implications. The Future Configuration of Hospital services will present its Full Business Case in the year ahead; a Workforce Transformation plan supports this business case through describing our approach. A number of elements of the Workforce Plan will begin this year to ensure effective Workforce planning and management. In addition this year will see the reconfiguration of services such as general surgery which also require a Workforce Transformation Programme.

In addition the organisation will also develop its approach to new ways of working such as Telehealth to support the implementation and to ensure the benefits are realised a Workforce Development programme will need to be developed to support staff with this change.

### 10.12 Workforce and Organisational Development

As we move forward as an organisation we are clear on the direction we wish to take. In order to truly understand our organisation we are this year completing an Organisational Cultural Assessment<sup>1</sup>, utilising the Cameron and Quinn Competing Values Tool. We aspire to have a culture centred on our patients in which our staff feel engaged, enabled and empowered.

The development of our Organisational Development Strategy will further develop our Leadership Development. It will set our approach for Talent Identification and development to support our organisation but also the wider NHS as we will be an organisation that nurtures talent and allows growth.

<sup>1</sup> Cameron & Quinn, 2009

## Putting Patients First

Our OD Strategy will ensure that we address our organisation as a whole to ensure that focus is given equally to behaviours, processes and structures.

Through a Learning Needs Analysis a need to develop business acumen has been identified, this has begun with the newly appointed Trust Leadership Team (Devolution and Co-operation). The Leadership Academy entered a partnership with Warwick Business School to begin to develop our senior clinical leaders. The programme is designed for Centre Chiefs and their teams and includes the key areas of:

- strategic leadership
- leadership behaviours
- culture change
- leading teams
- engaging staff and stakeholders

The programme, which offers 50 places to Senior Leaders, will be robustly evaluated, and uses the Competing Cultures Model (Cameron & Quinn) as an underpinning framework.

Recognising the significant impact of effective leadership at every level of the organisation, the Leadership Academy will deliver enhanced leadership skills and behaviours. Key early priorities are:

- Senior Clinical Leader Development (with Warwick Business School)
- Coaching Skills for Leadership (Level 7 accredited programme)
- Ward Manager Leadership Development (including accountability, leadership behaviours and coaching skills)
- Management Development (accredited programmes at team leader and supervisor levels).

### 10.13 Developing our devolved structure

The Trust has since the inception of Devolution and Co-operation invested in the development of its Centre Chiefs (who are responsible for leading their centre as business units)

A regular Trust Leadership Team facilitated workshop has covered the following key topics

- Telehealth
- Development of clinical leadership teams
- Strategy
- Financial Challenge
- Quality Improvement Strategy
- The relationship between centre's and corporate teams.

The programme for 2012/13 will include

- Leadership Development
- Professional Standards
- Reconfiguration of Services
- Organisational Development
- Strategic Development
- QIPP

The OD strategy is clear in its commitment to develop centres to ensure organisational success.

### 10.14 Staff Engagement

Staff Engagement is an important element of our Workforce Strategy based on the overwhelming evidence on the difference it can make to key indicators such as HSMR and Absence<sup>2</sup>.

---

<sup>2</sup> NHS Employers 2011

## Putting Patients First

The Trust has recently adopted 'Listening into Action' a developed Staff Engagement Model which has been successful in a number of NHS organisations. The Trust held staff conversation with over 400 staff to better understand what it is like to work here. Since the launch of this programme – Making Change Happen over 80 staff have begun to work on enabling projects to start to empower staff to make changes for the benefit of patients, their colleagues and the organization.

To date ten projects have been identified as early enablers, including Women and Children's Centre who are engaging a wide range of internal and external stakeholders in improving their labour induction.

### 10.15 Sharing our Annual Plan with our staff

Once approved by board the plan will be shared with centre teams, much of our thinking within this document is informed by the centre teams, reconfiguration and Telehealth being good examples.

The Annual Plan is shared with centres who have used the strategic focus of the organisation to develop their annual plan and objectives. Centres then share this plan within a range of centre meetings. Objectives will also inform individual objectives.

## Putting Patients First



## Section 11: Sustainability

- 11.1 Sustainable Development
- 11.2 Good corporate citizen
- 11.3 Carbon Reduction Commitment
- 11.4 Carbon Emissions.
- 11.5 Examples of good practice



## Putting Patients First

### 11.1 Sustainable Development

The Trust has made good progress in many areas of the plan during the past 12 months. We are accurately measuring and recording our building energy usage and using this to identify when usage deviates from the norm. A similar approach is being taken to water usage.

New buildings are considered for sustainability from the outset. Examples include the new RSH Cancer Centre which will incorporate a 'light well' to introduce natural light and ventilation into the core of the building. There will be user-adjustable natural ventilation to the perimeter of the building and the lighting will incorporate efficient T5 fluorescent fittings with light and movement detection.

The new building proposed for Telford is being considered for renewable energy such as solar and biomass (wood-fuel), with possible integration of services to the existing building so as to give a more widespread improvement in energy efficiency. We are aiming for a BREEAM 'Excellent' rating for the new building.

In terms of educating our staff about environmental issues, we have produced some Green Pages on the intranet and are presently developing an e-learning package using bespoke examples of good practice around our hospital.

We have made a 'car-sharing' scheme available to staff and also have discounted bike offers for staff to use at local shops; hence creating a link with supporting the local economy.

In terms of reducing the carbon footprint of the products that we purchase, we have recently purchased a software system to identify our carbon hotspots. This will enable us to target these areas so as to manage our carbon footprint. The software has been developed in conjunction with the NHS SDU.

Future aspirations for Sustainability will be around a further reduction in our carbon footprint arising from buildings (and occupation thereof), transport and procurement.

The trust has also agreed with Shropshire Healthcare Procurement Service to adopt a partnership approach to sustainable purchasing, beginning with a system to take our procurement data and run it through an artificial intelligence spend analysis robot developed by Reading University and Goldsmiths College London to identify the controlled & uncontrolled spend. Where there is purchase order line item detail, this will enable the calculation of the carbon footprint of each individual item by combining purchasing data with the Centre for Sustainable Accounting's carbon intensity figures. By gaining understanding of where our carbon hotspots lie in terms of product, supplier and category, we should be able to start to look for alternative products and identify worst offending suppliers in terms of carbon footprint, and use our purchasing power to encourage more sustainable corporate behaviours.

### 11.2 Good corporate citizen

The Shrewsbury and Telford Hospital is one of the largest employers in the county and a large user of resources. As such it can play a key role in the local community.

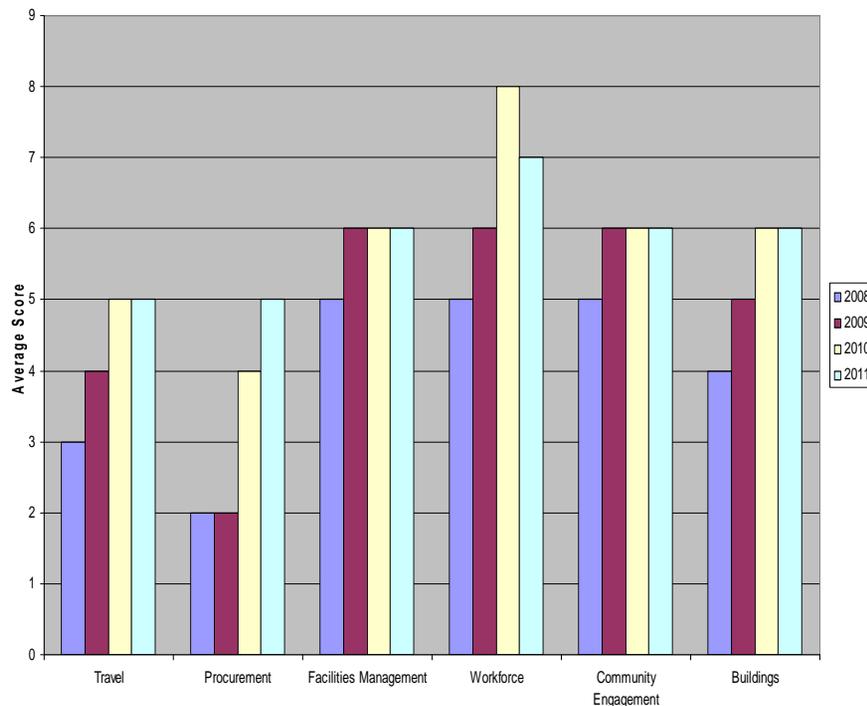
At SaTH the *NHS Good Corporate Citizenship Assessment Model*<sup>3</sup> is central to achieving sustainable development. It is a web-based tool ([www.corporatecitizenship.nhs.uk](http://www.corporatecitizenship.nhs.uk)) designed to help NHS organisations assess and improve their contribution to sustainable development. The trust has been registered since 2008 and has seen steady progress. The Board receives an annual update on progress and agrees the priorities for the coming year.

---

<sup>3</sup> Taking Action on Climate change – Faculty of Public Health, NHS Confederation & NHS Sustainable Development Unit – August 2009

## Putting Patients First

Chart 1: NHS Good Corporate Citizen assessment 2008-2011



The priorities for the coming 12 months are:

1. Estates and Transport –
  - a. active travel (cycling, walking, public transport, car sharing etc) ,
  - b. business travel (alternatives so as to reduce need for vehicle movements between sites for meetings) and
  - c. minimising usage of hazardous substances in Trust activities.

2. Procurement –
  - a. re-write Procurement Strategy to include sustainability,
  - b. promote sustainability to end-users,
  - c. review possibility of making some sustainability criteria compulsory and
  - d. look at enhancing Supplier engagement.
3. Workforce and Engagement –
  - a. Promote the work of the GCC
  - b. Develop an awareness-raising / training package regarding environmental and energy issues.

The full action plan will continue to be monitored through the Corporate Citizen Steering Group which meets quarterly and is available through the Director of Compliance & Risk Management

### 11.3 Carbon Reduction Commitment – Energy Efficiency Scheme.

The Trust submitted its report to the Environment Agency for carbon emissions in 2010/11. Total emissions for reportable purposes, amounted to 16,206 tonnes CO<sub>2</sub>. This is reduced to 10,127 tonnes, as a direct result of producing our own electricity and utilising the waste heat via the combined Heat and Power (CHP) plants at each site.

At the time of writing this report, total figures for 2011/12 are not known but are being closely monitored and will be reported in time for the annual submission in 2012. Approximate costs based upon 2010/11 emissions are £121k.

The Trust has very accurate figures for the carbon emissions resulting from building energy usage (heating, lighting and ventilating of buildings using electricity, gas and oil) for the period 2007 onwards. Typically across the NHS, buildings-related CO<sub>2</sub> emissions account for 24% of total emissions.

## Putting Patients First

SaTH has already undertaken significant work to reduce the energy demand and carbon footprint of its buildings – heating, ventilation and cooling controls have been upgraded, and new lighting and less carbon-intensive cooling systems have been installed. Combined heat and power plants have been installed at both sites, which use gas to generate electricity and then utilise the ‘waste’ heat to provide heating and - through an absorption process - cooling for the buildings. This is also reflected in the Trust’s position in the Carbon Reduction Commitment (CRC) Performance League Table. The Trust achieved a 17% reduction – again attributable to the new controls and CHP at PRH.

### 11.4 Carbon Emissions.

Carbon emissions in 2010/11 increased by approximately 500 tonnes (3%) compared against 2009/10, but the winter was approximately 4% colder. The opening of the new equipment sterilisation unit at Queensway has also brought about an increase in carbon emissions – it is an energy intensive process. The new CHP at PRH will help to reduce this for 2011/12 (full year’s data not yet available). Modifications have recently been made to the CHP at PRH and these will bring about further savings. A full year’s data is not yet available for 2011/12.

The domestic waste contract includes a clause to require recycling and it is very pleasing to report that approximately 75% of the Trust’s domestic waste is now recycled. Work is on-going to adopt new ways to recycle other waste streams such as food and glass and these are schemes that will be adopted in 2012/13

Collection and disposal of clinical waste is currently undergoing a tender exercise and again, we will be looking to increase the recycled component. Technology is now available to recycle ‘offensive waste’ – and we will be looking to work in partnership with the new Contractor to develop ways of segregating this waste which will also reduce disposal costs.

Table 2 CO<sub>2</sub> emissions SaTH buildings 2007-2010:

Year	Tonnes of CO <sub>2</sub> emitted	DD-corrected (to 2007)
2007	15,831	15,831
2008	16,187	14,793
2009	16,209	14,914
2010	15,715	13,023

The full Sustainability and Carbon Management Strategy and the Action Plan were approved by the Board in November 2011

### 11.5 Examples of good practice

There are many examples of good practice across the Trust, including:-

- combined heat and power,
- new energy controls at PRH,
- energy efficient lighting,
- new windows at RSH ward block,
- car-sharing software for staff,
- additional cycle storage,
- tax-friendly cycle purchase,
- partnership working with Shropshire Council to promote cycling,
- excellent public transport links to the main sites,
- recycling of domestic waste,
- plans to recycle some clinical waste and also food waste from kitchens and League of Friends
- adoption of low-energy lighting and ventilation strategies in the new Cancer Centre, and
- consideration of renewable energy technologies for the new building at PRH.

## Putting Patients First



# Section 12: Delivering a Successful NHS Foundation Trust

- 12.1 Agreeing our trajectory to authorisation
- 12.2 The next steps
- 12.3 Our FT membership



## Putting Patients First

### 12.1 Agreeing our trajectory to authorisation

At the start of the **2011/12** financial year, the Trust began work to re-energise its NHS Foundation Trust (FT) application. The success of the organisational changes undertaken in the drive for clinically led services which had in turn fuelled the argument for service reconfiguration, were contingent on the Trust gaining authorisation as an FT by the Government's deadline of April 2014. The Chairman and CEO had already met with the Strategic Health Authority (SHA) during March to formalise agreement between the Trust, SHA and Department of Health to this end. Draft milestones and key activities within the planned FT trajectory were detailed in a '**Tripartite Formal Agreement**' (TFA) and are outlined in the table below: **Table 1 – TFA milestones for 2011/12**

Date	Milestone
Mar 2011	Approved reconfiguration of services proposal approved March Trust Board
June 2011	CIP for 2011/12-2013/14 outline in place. Formal review of the Trust's financial position and Cost Improvement Programme
June 2011	Draft OBC for reconfiguration of services produced and approved by Trust Board
Sep 2011	Board Development Plan agreed and approved by Trust Board
Sep 2011	Monthly profile run rate achieved
Dec 2011	3-5 year rolling recurrent CIP agreed
Jan 2012	Improved Performance position achieved
Mar 2012	Quality Improvement Strategy completed
Mar/April 2012	First draft Integrated Business Plan (IBP) and Long Term Financial Model (LTFM) completed
Mar/April 2012	Full Business Case (FBC) for Reconfiguration of Services

These have been updated by the recently issued Single Operating Model which sets out a clear timetable for the Trust's authorisation journey.

### 12.2 The next steps

At the start of **2012/13**, the Trust is on course to become authorised as an FT by December 2013. Chaired by the Trust Chairman, the FT Programme Board was established in January; at the same time, monthly performance monitoring to the SHA via the Provider Management Regime (PMR) commenced and a detailed project plan encompassing TFA and key FT milestones was developed which supported the assumptions for our proposed FT trajectory.

The initial development of the **Integrated Business Plan (IBP)** is now well underway together with the **Long Term Financial Model (LTFM)**; the first draft iterations will be submitted to the SHA in April. Current focus is particularly on further development of the IBP, along with ensuring the delivery of TFA milestones which are: acquiring approval for the full business case (FBC) for the reconfiguration of hospital services and; the production of final **Quality Improvement Strategy** and **Quality Governance Framework** for Board approval during March.

We originally concluded a consultation exercise with the local population about our plans to become an FT back in 2008, and we do not believe our assumptions and aspirations have materially changed since. In the interim period, we have communicated widely, ensuring that all stakeholding groups have been kept informed of when and how we intend to push towards FT authorisation. We also held a refresh 'mini-consultation' in 2009/10 and are currently giving the public to offer their views through a number of different medium. There has always been overwhelming support for the FT process by staff and the public. This coupled with the fact that last summer there was an extensive and ongoing public consultation on our service strategy as part of our Future configuration of Hospital Services Consultation. However we will be seeking advice from the Health Overview & Scrutiny Committee as to

## Putting Patients First

Public Constituency	Status
---------------------	--------

Gender	Male	Broadly representative
	Female	Broadly representative

Age (Years)	0 – 16	Under representative
	17 - 21	Under representative
	22+	Broadly representative

Ethnicity	White	Broadly representative
	Mixed	Under representative
	Asian or Asian British	Over representative
	Black or Black British	Over representative
	Other	Under representative

Socio-Economic Grouping	ABC1	Over representative
	C2	Over representative
	D	Under representative
	E	Under representative

whether another **formal public consultation** is required, and if so we plan to undertake this in June 2012. Outcomes of any consultation relating to our strategy or governance arrangements will be acted upon, with amendment being made to our FT Constitution where appropriate.

We are also preparing for the emerging Single Operating Model (SOM) for provider development; a process which constitutes a 12 month SHA-led Trust development phase of the FT application, for which we'll be self assessing our Board's state of FT readiness through the **Board Governance Assurance Framework** (April-June), and analysing the state the of organisation's current and historic financial health through a process of independently assessed **historic due-diligence** (June).

An independent assessment of **Quality Governance** arrangements will commence over the summer of 2012 before the SHA undertakes a readiness progress review of the Trust and holds a 'Board-to-Board' meeting to rigorously test members of our Board. Assessment and challenge our IBP/LTFM is ongoing from our first submission to the SHA, and work to develop plans will continue before final submission to the DH in March 2013.

### 12.3 Our FT membership

Over recent years the Trust has built up a strong public and staff membership base, with now over 12,000 members. The **Foundation Trust membership office** continues to develop ways for members to become involved with the Trust via an ongoing programme of engagement activities for Foundation Trust members. We are also actively recruiting new members, particularly in under-represented areas.

#### Table 2 – Public membership representativeness

*Source: Capita Membership Services (Feb 2012)*

As part of the key documentation under development in support of our FT application, a formal **Membership Strategy** is due to be finalised by June 2012. Whilst our current public membership exceeds our target (1% of our catchment area which is currently c.525,000), we aspire to maintain a future membership base in excess of 10,000. This will ensure greater involvement of our local community in the work of the Trust. An identified gap in our Foundation Trust membership is the under representation of young people aged between 16-21 years old. The membership office continues to work with local colleges and schools to look at ways to engage young people with the work of the Trust, the most popular of which have been behind the scenes tours aimed at young people and recruiting young people to volunteer opportunities

#### 12.3.1 Engaging with our members

## Putting Patients First

The Trust currently produces and sends a quarterly newsletter to all of its Foundation Trust membership. **A Healthier Future** newsletter contains information about developments and services provided by the Trust and also ways that members can become involved or attend Member events such as health lectures. Within recent editions of the magazine we have also had an insert of 'Looking to the Future' which gives an update on the Trust reconfiguration of services, and ways that members can become involved, including, joining focus groups/workshops and attending public briefing sessions. We feel that regular and ongoing information will encourage active members to come forward when we look to establish a **Council of Governors** next year.

The trust is also establishing a Stakeholder forum in April/May chaired by the Trust Chairman to consider the different aspects of our application

<b>Application Process Milestones - Status Date</b>	<b>Shrewsbury and Telford Hospitals NHS Trust</b>
<b>FT Diagnostic / Readiness -</b> 1) Introductory meeting with Trust 2) Initial Board interviews 3) initial Board observation 4) Initial commissioner interviews	April 2012
<b>HDD Phase 1 starts</b>	May/June 2012
<b>Submission of draft IBP/LTFM</b> linked to responsive review	24 April 2012
<b>Review of Trust submissions &amp; preparation of readiness review pack</b>	May 2012
<b>Further submissions of IBP and LTFM and key documents (includes Action plans)</b>	June 2012
<b>Assess &amp; challenge IBP/LTFM</b>	July 2012
<b>Consultation Starts - Launch public consultation - if required in light of FCHS and refresh (can be launched post initial interviews)</b>	June 2012

<b>External BGAF review</b>	July - Aug 2012
<b>Third Party review of Quality Governance Framework (QGF)</b>	Jul - Aug 2012
Consultation Ends	September 2012
<b>SHA Consultation sign-off 1st B2B</b> Readiness progress review	Oct 2012
<b>HDD Phase 2 starts</b>	Sep/Oct 2012 (must be by November 12)
<b>Observation of Trust Board and other Committees</b>	Sep/October 2012
Interview with HDD partner	October 2012
<b>Finalise IBP/LTFM</b> Final assurance submissions	November 2012
SHA Approval/Review of IBP/LTFM & Commissioner Support	Nov 2012
FT Quality and Safety Assessment <i>Format to be confirmed</i>	Nov 2012
Interviews with Commissioners	Nov 2012
Interview with CQC	Nov 2012
<b>SHA Recommend to Exec Bd - 2nd B2B</b>	early Feb 2013
<b>Submission of papers to DH - Presentation to DH</b>	01-Mar-13
Technical Committee	<i>tbc</i>
DH Application Committee / Recommend to SoS	<i>tbc</i>
SoS Pass to Monitor	<i>tbc</i>
Monitor Assessment	<i>tbc</i>
Expected Final Authorisation	<i>tbc</i>

## Putting Patients First



## Section 13: Declarations



## Putting Patients First

### 13.1 Provider Management Regime

As highlighted in section 8, the NHS Midlands and East Strategic Health Authority (SHA) introduced a Provider Management Regime (PMR) in January 2012 (i.e. beginning with December's performance). As well as completion of the templates for governance, finance, contractual risk and quality, there is a requirement for Board sign-off of a number of assurance statements. The sign-off for the period December 2011 to February 2012 – i.e. the formal board-approved position – is as follows :-

For each statement, the Board is asked to confirm the following:		Dec-11	Jan-12	Feb-12
	<b>For CLINICAL QUALITY, that:</b>	<b>Response</b>	<b>Response</b>	<b>Response</b>
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the SHA's Provider Management Regime (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), its NHS trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	✓	✓	✓
If the Trust Board is unable to make the above statement, the Board must:				
2	Be satisfied that, to the best of its knowledge and using its own processes (supported by CQC information and including any further metrics it chooses to adopt), its Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.			
3	Be satisfied that, to the best of its knowledge and using its own processes, plans in place are sufficient to ensure ongoing compliance with the CQC's registration requirements			
4	Certify it is satisfied that processes and procedures are in place to ensure that all medical practitioners providing care on behalf of the NHS foundation trust have met the relevant registration and revalidation requirements.			
5	Be satisfied that the Trust is embedding patient experience into the service design, improvement and delivery cycle.			
	<b>For SERVICE PERFORMANCE, that:</b>	<b>Response</b>	<b>Response</b>	<b>Response</b>
6	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds), and compliance with all targets due to come into effect during 2011/12.	✓	✓	✓
	<b>For RISK MANAGEMENT PROCESSES, that:</b>	<b>Response</b>	<b>Response</b>	<b>Response</b>
7	Issues and concerns raised by external audit and external assessment groups (including reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner	✓	✓	✓
8	All recommendations to the board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned	✓	✓	✓
9	The necessary planning, performance management and risk management processes are in place to deliver the annual plan	✓	✓	✓
10	A Statement of Internal Control ("SIC") is in place, and the trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to the most up to date guidance from HM Treasury (see <a href="http://www.hm-treasury.gov.uk">http://www.hm-treasury.gov.uk</a> )	✓	✓	✓
11	The trust has achieved a minimum of Level 2 performance against the key requirements of the Department of Health's Information Governance Toolkit	✓	✓	✓
	<b>For COMPLIANCE WITH THE NHS CONSTITUTION, that:</b>	<b>Response</b>	<b>Response</b>	<b>Response</b>
12	The Board is assured that the trust will, at all times, have regard to the NHS constitution	✓	✓	✓
	<b>For BOARD, ROLES, STRUCTURES AND CAPACITY, that:</b>	<b>Response</b>	<b>Response</b>	<b>Response</b>
13	The Board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the Board	✓	✓	✓
14	The Board is satisfied that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability	✓	✓	✓
15	The selection process and training programmes in place ensure that the non-executive directors have appropriate experience and skills	✓	✓	✓
16	The management team have the capability and experience necessary to deliver the annual plan	✓	✓	✓
17	The management structure in place is adequate to deliver the annual plan objectives for the next three years.	✓	✓	✓

## Putting Patients First

For the period highlighted, the Board has confirmed compliance with the necessary assurance statements and expects to continue doing so throughout 2012/13. If an assessment of compliance is made for any of the statements in-year, detailed plans to address this will be provided to the SHA – and monitored by the Trust's Board – at that time.

Monitor has published a revised (and draft) set of assurance statements for Foundation Trusts. These are similar to those contained with the PMR, other than those that relate specifically to issues regarding compliance with Authorisation. The Trust will consider if both sets of assurance statements need to be completed and approved by the Board on a regular basis and, if so, will ensure systems are in place to do so.

The Monitor assurance statements are attached at Appendix D

The Shrewsbury and Telford Hospital **NHS**  
NHS Trust

**Putting Patients First**

## Notes and Appendices



## Putting Patients First

All figures included in this report that refer to March 2011/12 are projections based on the latest information available at the end of Feb 2012.

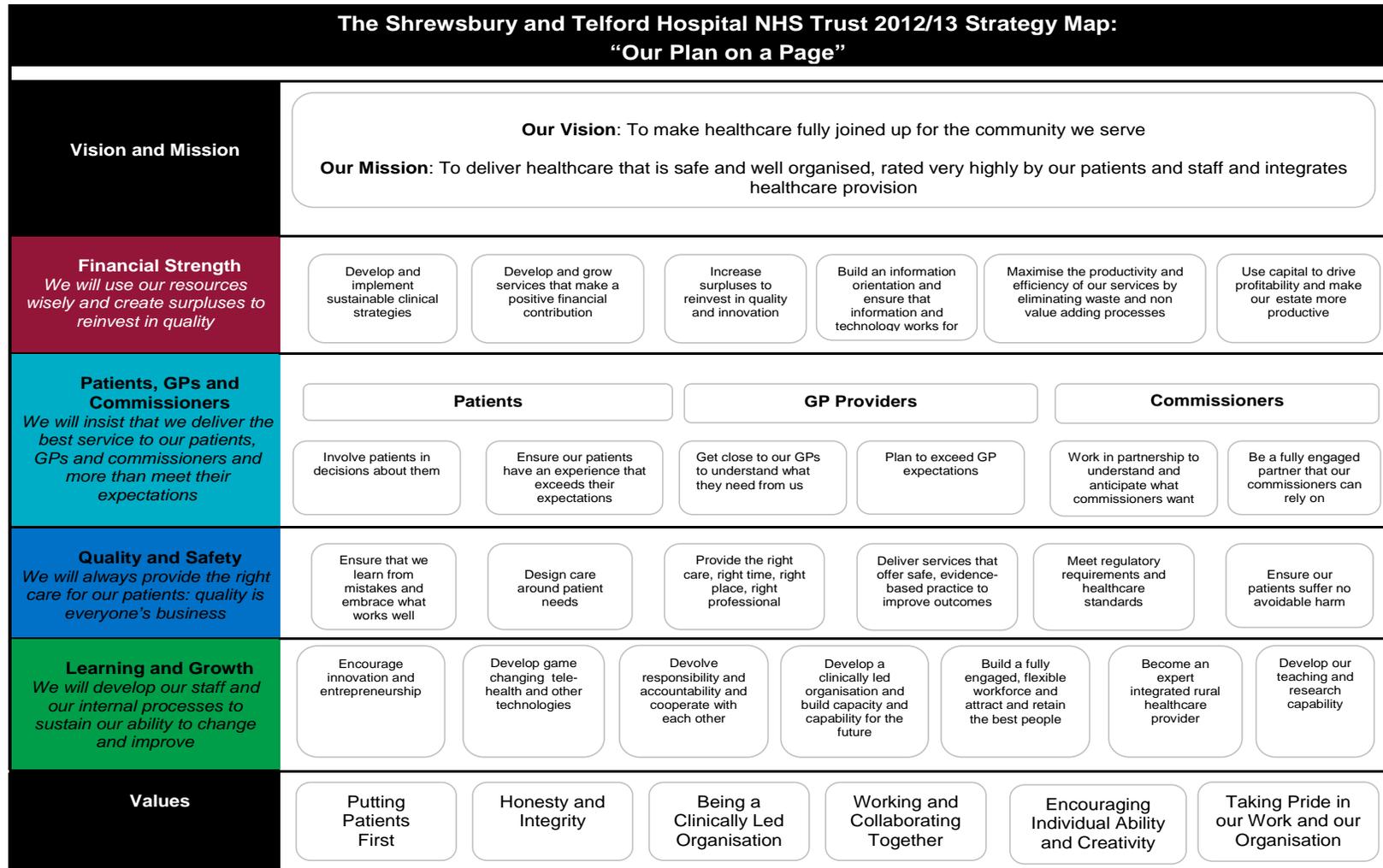
<sup>1</sup> Bed census as at 29<sup>th</sup> Feb 2012.

<sup>1</sup> Population estimates based on ONS 2011

<sup>1</sup> 2011/12 data is projected full-year based on M11 outturn.

# Putting Patients First

## Appendix A



## Putting Patients First

---

**SELF-CERTIFICATION RETURNS**

**Organisation Name:**

**The Shrewsbury and Telford Hospital NHS Trust**

**Monitoring Period:**

**Feb 2012**

**NHS Midlands & East  
Provider Management Regime  
2011/12**

**Returns to  
provider.development@westmidlands.nhs.uk by  
the last working day of each month**

**Appendices B**

## NHS Trust Governance Declarations : 2011/12 In-Year Reporting

<b>Name of Organisation:</b>	<b>The Shrewsbury and Telford Hospital NHS Trust</b>	<b>Period:</b>	<b>Feb 2012</b>
------------------------------	--	----------------	-----------------

### Organisational risk rating

Each organisation is required to calculate their risk score and RAG rate their current performance as per the 2011/12 Provider Management Regime, in addition to providing comment with regard to any contractual issues and compliance with CQC essential standards:

Key Area for rating / comment by Provider	Score / RAG rating*
<b>Governance Risk Rating</b> (RAG as per NHS Midlands and East PMR guidance)	R
<b>Financial Risk Rating</b> (Assign number as per NHS Midlands and East PMR guidance)	A
<b>Contractual Position</b> (RAG as per NHS Midlands and East PMR guidance)	G

\* Please type in R, A or G

### Governance Declarations

NHS Midlands and East organisations, subject to the Provider Management Regime, must ensure that plans in place are sufficient to ensure compliance in relation to all national targets and including ongoing compliance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections, CQC Essential standards and declare any contractual issues.

#### Supporting detail is required where compliance cannot be confirmed.

Please complete sign **one** of the two declarations below. If you sign declaration 2, provide supporting detail using the form below. Signature may be either hand written or electronic, you are required to print your name.

Governance declaration 1			
The Board is satisfied that plans in place <b>are sufficient</b> to ensure continuing compliance with all existing targets (after the application of thresholds), and with all known targets going forward. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections (including the Hygiene Code) and CQC Essential standards. The board also confirms that there are no material contractual disputes.			
Signed by:		Print Name:	
on behalf of the Trust Board	Acting in capacity as:		
Signed by:		Print Name:	
on behalf of the Trust Board	Acting in capacity as:		

Governance declaration 2			
For one or some of the following declarations Governance, Finance, Service Provision, Quality and Safety, CQC essential standards or the Code of Practice for the Prevention and Control of Healthcare Associated Infections the Board cannot make Declaration 1 and has provided relevant details below.			
The board is suggesting that at the current time there is <b>insufficient assurance available</b> to ensure continuing compliance with all existing targets (after the application of thresholds) and/or that it may have material contractual disputes.			
Signed by :		Print Name :	
on behalf of the Trust Board	Acting in capacity as:		
Signed by :		Print Name :	
on behalf of the Trust Board	Acting in capacity as:		

#### If Declaration 2 has been signed:

Please identify which targets have led to the Board being unable to sign declaration 1. For each area such as Governance, Finance, Contractual, CQC Essential Standards, where the board is declaring insufficient assurance please state the reason for being unable to sign the declaration, and explain briefly what steps are being taken to resolve the issue. Please provide an appropriate level of detail.

<b>Target/Standard:</b>	
<b>The Issue :</b>	
<b>Action :</b>	
<b>Target/Standard:</b>	
<b>The Issue :</b>	
<b>Action :</b>	

Ref	Area	Indicator	Sub Sections	Thresh- old	Weight- ing	April 2011	May 2011	Jun 2011	July 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Comments where target not achieved in month?
1	Safety	Clostridium Difficile	Are you below the ceiling for your monthly trajectory	Contract with PCT	1.0									Yes	YES	Yes		
2	Safety	MRSA	Are you below the ceiling for your monthly trajectory	Contract with PCT	1.0									Yes	YES	No		1 MRSA case in Feb (first of the year) remained below YTD trajectory
3	Quality	All cancers: 31-day wait for second or subsequent treatment, comprising either:	Surgery	94%	1.0									NO	NO	No		31 day second or subsequent treatment - surgery failed (92.00% against a target of 94%) Ytd remains green. 31 day second or subsequent treatment - chemotherapy failed (97.40% against a target of 98%) Ytd remains green
			Anti cancer drug treatments	98%														
			Radiotherapy	94%														
4	Quality	All cancers: 62-day wait for first treatment, comprising either:	From urgent GP RTT From consultant screening service referral	85% 90%	1.0									YES	YES	No		62 day treatment targets – screening failed (89.47% against a target of 90%) Ytd remains green
5a	Patient Experience	RTT waiting times – admitted	95th percentile	23 wks	1.0									NO	NO	No		SaTH 95th Percentile for admitted patients was 31.98 weeks in February
5b	Patient Experience	RTT waiting times – non-admitted	95th percentile	18.3 wks	1.0									NO	NO	No		SaTH 95th Percentile for non admitted patients was 21.26 weeks in February
6	Quality	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5									YES	YES	Yes		
7	Quality	Cancer: 2 week wait from referral to date first seen, comprising either:	all cancers for symptomatic breast patients (cancer not initially suspected)	93%	0.5									YES	YES	Yes		
				93%														
8a	Quality	A&E: Total time in A&E	Total time in A&E (95%)	≤ 4 hrs	1.0									YES	no	No		91.77% in February and 94.30% YTD based on submitted Sitreps data
8b	Quality	A&E: NB Please record the areas not being met in the comments sheet	Total time in A&E (95th percentile)	≤4 hrs	No weighting									NO	NO	No		SaTH 95th percentile for Initial Assessment time was 33 minutes in February and 95th percentile Total Time in A&E was 330 min (Both based on unvalidated Mede Data)
			Time to initial assessment (95th percentile)	≤15 mins														
			Time to treatment decision (median)	≤60 mins														
			Unplanned re-attendance rate	≤5%														
		Left without being seen	≤5%															
17	Patient experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5									NO	NO	No		SaTH is currently in the process of signing up to the Learning Disability Charter and is co-ordinating its submission via the Learning Disability Steering Group
<b>CQC Registration</b>																		
A	Safety	CQC Registration	Are there any compliance conditions on registration outstanding	0	1.0									NO	NO	No		Confirmed by Chief Compliance Officer
B	Safety	CQC Registration	Are there any restrictive compliance conditions on registration outstanding	0	2.0									NO	NO	No		Confirmed by Chief Compliance Officer
C	Safety	Moderate CQC concerns regarding the safety of healthcare provision		0	1.0									YES	YES	Yes		Confirmed by Chief Compliance Officer
D	Safety	Major CQC concerns regarding the safety of healthcare provision		0	2.0									NO	NO	No		Confirmed by Chief Compliance Officer
E	Safety	Formal CQC Regulatory Action resulting in Compliance Action		0	2.0									NO	NO	No		Confirmed by Chief Compliance Officer
F	Safety	Formal CQC Regulatory Action resulting in Enforcement Action		0	4.0									NO	NO	No		Confirmed by Chief Compliance Officer
G	Safety	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	2.0									NO	NO	No		Confirmed by Chief Compliance Officer
<b>TOTAL</b>						<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>4.5</b>	<b>5.5</b>	<b>7.5</b>	<b>0.0</b>	

**FINANCIAL RISK RATING 2011/12**

**The Shrewsbury and Telford Hospital NHS Trust**

			Risk Ratings					Insert the Score (1-5) Achieved for each Criteria Per Month												Comments on Performance in Month		
Criteria	Indicator	Weight	5	4	3	2	1	Annual Plan 2011/12	Apr 2011	May 2011	June 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012		Mar 2012	
Underlying performance	EBITDA margin %	25%	11	9	5	1	<1	3	1	1	2	2	2	2	2	2	3	3	3			
Achievement of plan	EBITDA achieved %	10%	100	85	70	50	<50	5	1	1	3	3	4	4	5	4	5	5	5			
Financial efficiency	Return on assets %	20%	6	5	3	-2	<-2	3	2	2	2	2	2	2	2	2	3	3	3			
	I&E surplus margin %	20%	3	2	1	-2	<-2	2	1	1	1	2	2	2	2	2	2	2	2			
Liquidity	Liquid ratio days	25%	60	25	15	10	<10	2	1	2	2	2	2	2	2	2	3	2	2			
<b>Average</b>	<b>Weighted Average</b>	<b>100%</b>						<b>2.8</b>	<b>1.2</b>	<b>1.5</b>	<b>1.9</b>	<b>2.1</b>	<b>2.2</b>	<b>2.2</b>	<b>2.3</b>	<b>2.2</b>	<b>3.0</b>	<b>2.8</b>	<b>2.8</b>	<b>0.0</b>		
Overriding rules	Overriding rules																					
Overall rating	Final Overall rating							<b>2.8</b>	<b>1.2</b>	<b>1.5</b>	<b>1.9</b>	<b>2.1</b>	<b>2.2</b>	<b>2.2</b>	<b>2.3</b>	<b>2.2</b>	<b>3.0</b>	<b>2.8</b>	<b>2.8</b>	<b>0.0</b>		

Month 11 review of the financial position illustrates that the

**Overriding Rules :**

Max Rating	Rule
3	Plan not submitted on time
3	Plan not submitted complete and correct
2	PDC dividend not paid in full
2	One Financial Criterion at "1"
3	One Financial Criterion at "2"
1	Two Financial Criteria at "1"
2	Two Financial Criteria at "2"

FINANCIAL RISK TRIGGERS 2011/12

The Shrewsbury and Telford Hospital NHS Trust

Insert "Yes" / "No" Assessment for the Month

Criteria	Apr 2011	May 2011	June 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Comments on Performance in Month
1 Unplanned decrease in EBITDA margin in two consecutive quarters	No	No	No	No	No	No	No	No	No	No	No		
2 Quarterly self-certification by trust that the financial risk rating (FRR) may be less than 3 in the next 12 months	No	No	No	No	No	No	No	No	No	No	No		
3 FRR 2 for any one quarter	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		
4 Working capital facility (WCF) agreement includes default clause	No	No	No	No	No	No	No	No	No	No	No		
5 Debtors > 90 days past due account for more than 5% of total debtor balances	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		
6 Creditors > 90 days past due account for more than 5% of total creditor balances	Yes	No	No	No	No	No	No	No	No	No	No		
7 Two or more changes in Finance Director in a twelve month period	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No		
8 Interim Finance Director in place over more than one quarter end	No	No	No	No	No	No	No	No	No	No	No		
9 Quarter end cash balance <10 days of operating expenses	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		
10 Capital expenditure < 75% of plan for the year to date	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		
<b>TOTAL</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>4</b>	<b>4</b>	<b>4</b>	<b>0</b>	

NB Scoring: An answer of "YES" = 1.0

RAG RATING :

**GREEN** = Score between 0 and 1

**AMBER** = Score between 2 and 4

**RED** = Score over 5



**QUALITY**

**The Shrewsbury and Telford Hospital NHS Trust**

**Insert Performance in Month**

Criteria	Unit	Apr 2011	May 2011	June 2011	Jul 2011	Aug 2011	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Comments on Performance in Month
1	SHMI - latest data	Ratio								93.4	89.5	86.7		February number relates to Decemberr performance as this is the most recent data available (ie 2 months in arrears)
2	Venous Thromboembolism (VTE) Screening	%								91.4	91.5	91.58%		February data unvalidated at time of submitting report
3a	Elective MRSA Screening	%								TBC	TBC	TBC		SaTH is currentl unable to provide the Elective MRSA Screening report.
3b	Non Elective MRSA Screening	%								95.85	94.83	95.63		Data taken from the MRSA Screening Compliance report
4	Single Sex Accommodation Breaches	Number								0	0	0		
5	Open Serious Incidents Requiring Investigation (SIRI)	Number								57	70	92		Information provided by the Patient Safety Team Manager - Relates to all SIs, 23 new SIs reported in February, 13 SIs still being investigated or awaiting internal sign off, 56 awaiting closure by the PCT or SHA
6	"Never Events" in month	Number								2	0	2		
7	CQC Conditions or Warning Notices	Number								no	no	No		Confirmed by Chief Compliance Officer
8	Open Central Alert System (CAS) Alerts	Number								12	10	14		14 open CAS issues on the SaTH system, 3 past completion deadline. Number accessed from the CAS report on the
9	RED rated areas on your maternity dashboard?	Number								Yes	Yes	Yes		Based upon the locally agreed maternity dashboard - SHA aware there is currently no regional or national standard report.
10	Falls resulting in severe injury or death	Number								2	11	1		1 RIDDOR reportable falls were logged in February
11	Grade 3 or 4 pressure ulcers	Number								1	4	3		
12	100% compliance with WHO surgical checklist	Y/N								NO	NO	No		Contracts & Performance Team unable to confirm that we are 100% compliant
13	Formal complaints received	Number								40	84	54		
14	Agency and bank spend as a % of turnover	%								5.71%	6.70%	6.70%		
15	Sickness absence rate	%								4.90%	4.50%	4.50%		February number relates to October performance as this is the most recent data available (i.e. 4 months in arrears)

# Board Statements

For each statement, the Board is asked to confirm the following:

For CLINICAL QUALITY, that:		Response
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the SHA's Provider Management Regime (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), its NHS trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	✓

If the Trust Board is unable to make the above statement, the Board must:

2	Be satisfied that, to the best of its knowledge and using its own processes (supported by CQC information and including any further metrics it chooses to adopt), its Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	✓
---	---	---

3	Be satisfied that, to the best of its knowledge and using its own processes, plans in place are sufficient to ensure ongoing compliance with the CQC's registration requirements	✓
---	--	---

4	Certify it is satisfied that processes and procedures are in place to ensure that all medical practitioners providing care on behalf of the NHS foundation trust have met the relevant registration and revalidation requirements.	✓
---	--	---

5	Be satisfied that the Trust is embedding patient experience into the service design, improvement and delivery cycle.	✓
---	--	---

For SERVICE PERFORMANCE, that:		Response
6	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds), and compliance with all targets due to come into effect during 2011/12.	✓

For RISK MANAGEMENT PROCESSES, that:		Response
7	Issues and concerns raised by external audit and external assessment groups (including reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner	✓

8	All recommendations to the board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned	✓
---	---	---

9	The necessary planning, performance management and risk management processes are in place to deliver the annual plan	✓
---	--	---

10	A Statement of Internal Control ("SIC") is in place, and the trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to the most up to date guidance from HM Treasury (see <a href="http://www.hm-treasury.gov.uk">http://www.hm-treasury.gov.uk</a> )	✓
----	---	---

11	The trust has achieved a minimum of Level 2 performance against the key requirements of the Department of Health's Information Governance Toolkit	✓
----	---	---

For COMPLIANCE WITH THE NHS CONSTITUTION, that:		Response
12	The Board is assured that the trust will, at all times, have regard to the NHS constitution	✓

For BOARD, ROLES, STRUCTURES AND CAPACITY, that:		Response
13	The Board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the Board	✓

14	The Board is satisfied that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability	✓
----	--	---

15	The selection process and training programmes in place ensure that the non-executive directors have appropriate experience and skills	✓
----	---	---

16	The management team have the capability and experience necessary to deliver the annual plan	✓
----	---	---

17	The management structure in place is adequate to deliver the annual plan objectives for the next three years.	✓
----	---	---

	Signed on behalf of the Trust:	Print name	Date
CEO			
Chair			

Appendix C  
Annual Plan – Section 13 Declarations

13.1 – Draft Consultation Board Statements for Monitor Compliance Framework  
2012/13

	New Statement
1	Board confirmation of compliance with targets.
2	Trust achievement of minimum level 2 performance against the Information Governance Statement of Compliance requirements.
3	Board fulfilment of criteria relating to major Joint Ventures or Academic Health Science Centres, where relevant.
4	The board is satisfied that, having used its own processes and having assessed against Monitor's <i>Quality Governance Framework</i> (supported by relevant information from the trust and third parties such as the Care Quality Commission), it has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.
5	The board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.
6	The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.
7	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.
8	The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.
9	An Annual Governance Statement is in place pursuant to the requirements of the NHS Foundation Trust Annual Reporting Manual, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury ( <a href="http://www.hm-treasury.gov.uk">www.hm-treasury.gov.uk</a> ).
10	The board will ensure that the trust remains at all times compliant with its terms of authorisation and has regard to the NHS Constitution.
11	All current key risks to compliance with the trust's Authorisation have been identified (raised either internally or by external audit and assessment bodies) and addressed in a timely manner.
12	The board has considered all likely future risks to compliance with its Authorisation and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.
13	The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability.
14	The board is satisfied that the management team has the capability and experience necessary to deliver the annual plan; and the management structure in place is adequate to deliver the annual plan.
15	The necessary planning, performance management and corporate and <i>clinical risk</i> management processes and mitigation plans are in place to deliver the annual plan, including that all audit committee recommendations are implemented satisfactorily to the board.
16	The board will ensure that <i>the trust will at all times operate effectively within its constitution</i> . This includes: maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; that <i>all board positions are filled, with plans in place to fill any vacancies</i> ; and that all elections to the board of governors are held in accordance with the election rules.