

# Annual Plan

**FOR PUBLICATION**

**May 2009**

**Bruce Laurie**  
**Chairman**

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**Chief Executive**

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# 1 Past Year Performance

## 1.1 Chief Executive's Summary of the Past Year

The Swindon and Marlborough NHS Trust became the Great Western Hospitals NHS Foundation Trust on the 1<sup>st</sup> December 2008. Although a Foundation Trust for 4 months of 2008/09, this summary covers the whole year.

2008/09 was an exceptionally strong year for our Trust, we improved safety, quality and patient satisfaction and delivered on all the key performance targets, despite the operational pressures caused by the severe weather, increased demand for our services above that planned and whilst undergoing the rigorous FT authorisation assessment. Post authorisation this strong performance has continued.

### Quality & Safety

Our top priority for the year was to reduce the rates of hospital acquired infections (HCAs). We have excellent hospital estate (we moved into the Great Western Hospital in December 2002) and over 30% of our patients are accommodated in single rooms with en suite facilities. With this infrastructure and through further investment in Infection, Prevention and Control nurses working with the Ward teams, unrelenting attention on hand hygiene and cleanliness and strict control of antibiotic prescribing, we have reduced hospital acquired infection rates:

	<b>2007/08</b>	<b>2008/09</b>	<b>2008/09</b>
	Actual Number	Target	Actual Number
MRSA hospital acquired	12	10	6
Clostridium Difficile	221	220	75

The national comparators for Clostridium Difficile and MRSA for 2008/09 will be published by the Health Protection Agency in June 2009. When last published we had significantly improved our national ranking for both and we expect to see further improvements. As a result of our efforts in this area in March 2009 we received a Regional Award.

To support our endeavours to improve safety, quality and patient satisfaction, we joined the Patient Safety First campaign. The National Patient Safety Agency publish data which shows that we are a high reporter of near misses and incidents, and this reflects the Trust's robust reporting culture. We have implemented a system of electronic incident reporting which has made reporting easier for staff, saving their time and ensuring incidents are reported quickly so that we can take speedy action where we need to. We are proud of this reporting culture. Assurance about our approach to safety is important and in November 2008 we were one of the first Trusts to pilot and achieve the new NHSLA Level 3 standards for Maternity services.

We have strengthened our system for investigating Serious Untoward Incidents and conduct post incident reviews for every RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences), this helps us to identify problems and learn lessons across the Trust. Our health and safety culture and management of risk continues to improve and we have made progress during the year on staff sickness, particularly around stress. These improvements were achieved with support from our Occupational Health & Safety Team whose efforts were praised by the Health & Safety Executive who visited at the year end. Our staff sickness for the year was 4.18% compared to the previous year's 4.67%. Although we have made progress we are not complacent and are determined to improve patient and staff health and safety further.

We improved our Hospital Standard Mortality rate (HSMRs) to 94.9 (April 08 to February 09). This improvement has been achieved through our work on HCAs and the pre optimisation of patients before their surgery.

### **Patient & Staff Satisfaction**

Patient and staff satisfaction surveys conducted in 2008 have both shown improvements on the 2007 results. The patient survey showed we were significantly better on 32 of the questions, worse on none and no different on 48 questions. Patients have told us that we can do more by asking them for their views on the quality of care, improve discharge information to their GP and family and explain any delays.

Our staff survey results also show improvement although we know that staff feel under work pressure and would like to do more for their patients. In response to the patient and staff surveys results we are investing a further £0.7m in ward nursing staff in 2009 and have made further investment in junior doctors who have told us that the intensity of their work has increased, particularly as we have moved them to different shift patterns to meet the European Working Time Directive.

In response to feedback from the public we made changes to our car parking fees and arrangements by reducing the upper charges for long stay patients and visitors. As part of the planning condition of the hospital we were required to reduce journeys to hospital by single car users (termed as the modal shift) we have increased people coming to hospital in a private car with other users from 27% to 54% in a survey conducted in March 2009. Whilst our car parking and access is generally better than other hospitals in the area we know this is a subject of concern to our Governors, members and patients.

### **Governors & Members**

Whilst mentioning Governors and members it is pleasing to see our membership growing. At the end of March 2009 we had 8531 members, represented by an active group of Governors, who bring a wealth of experience and have influenced our future strategy. The Governors have been very active and have set up a number of groups focusing on important areas such as patient satisfaction. Other activities have included a number of constituency meetings that Governors have held in various locations.

## **Patients Treated and Finance**

Primary Care Trusts, who plan and commission health services for their local population, told us they expected to reduce demand on hospital services. This mirrors national policy to see and treat more patients in the community and avoid patients attending hospital. The Trust therefore planned its services accordingly. However, the planned reductions did not happen and the Trust saw an increase of 17% in GP out patient referrals and 7.5% growth in emergency admissions.

In response to this and to ensure delivery of our targets, we flexed up services and staffing. We received additional income for this unplanned activity and used this to open additional beds, using our existing staff and employing Agency nurses. This meant that we spent more on agency nursing staff than we had planned to and using staff through an agency was more costly than using directly employed staff. Despite these additional costs we had sufficient additional income to invest creatively and we invited staff to come forward with ideas that would improve patient satisfaction, quality or efficiency – we called this initiative “Dragons Den” and were able to invest in ideas that would not normally have been funded. At the end of the year we achieved our financial plan and had a surplus of £1.9m.

## **Targets & Efficiency**

In 2008/09, in conjunction with our Commissioners, we had set ourselves challenging targets to reduce waiting in a number of areas. We were determined to reduce the time patients had to wait for their first appointment, diagnostic tests and the length of time they had to wait for treatment. Our aim was to be better than the national target (which was 18 weeks from referral to treatment at the end of December). With the support and funding from our Commissioners we agreed a local target of 13 weeks by the end of December and to achieve this in each specialty. I am delighted to report we did achieve this at the end of December and despite the adverse weather and increased operational pressures during January and February we sustained this position at the end of March 2009. In the last year we also significantly reduced waiting times for hearing aids to 3 weeks and reduced our waiting times for all diagnostics tests; our waiting times in Radiology are some of the best in the South West Region. Audiology and Radiology have reduced waiting times by providing appointments outside routine working hours and our patients have told us they appreciate the flexibility these evening and weekend services offer them. These waiting time reductions would not have been achieved without reviewing how we do things - we have reduced repetitive processes which do not add value to the patient experience and at the same time improved patient satisfaction and our efficiency.

Alongside this we achieved the Accident & Emergency 4 hour target; the hospital saw 98.26% of its patients within 4 hours and the whole health community achieved 99.1%.

In summary, whilst we have had a very demanding and busy year, we have achieved a great deal and significantly improved the services we offer to patients. With input from our Governors we have a clear view of our priorities for further improvement and have excellent foundations on which we can move from being good to consistently excellent. This will enable us to deliver on part of our promise which is to “delight our patients and

commissioners". These remarkable achievements have been delivered because of the willingness of our staff to do things differently, to challenge and change clinical practice, and through their hard work and dedication.

Mrs. Lyn Hill-Tout  
Chief Executive  
May 2009

## 1.2 Summary of Financial Performance

### Income and Expenditure 2008/09

The Trust achieved an actual surplus of £1.939m of income over expenditure against a plan of £1.912m giving a year-end variance of £27k.

	Plan £'m	Actual* £'m	Variance £'m
<b>Income</b>			
NHS Clinical income	167.8	170.7	2.9
Private patient income	2.4	2.3	(0.1)
Other income	16.0	17.1	1.1
<b>Total income</b>	<b>186.2</b>	<b>190.1</b>	<b>3.9</b>
<b>Expenses</b>			
Pay Costs	(103.8)	(107.6)	(3.8)
Drug costs	(11.6)	(11.0)	0.7
Other Costs	(63.9)	(64.6)	(0.7)
<b>Total costs</b>	<b>(179.4)</b>	<b>(183.2)</b>	<b>(3.8)</b>
<b>EBITDA</b>	<b>6.8</b>	<b>6.9</b>	<b>0.1</b>
Depreciation	(3.4)	(3.3)	0.2
Net Interest	0.8	0.6	(0.2)
PDC dividend	(2.2)	(2.2)	(0.0)
	<b>1.9</b>	<b>1.9</b>	<b>0.0</b>
Exceptional items	0.0	0.0	0.0
<b>Net surplus / (deficit)</b>	<b>1.9</b>	<b>1.9</b>	<b>0.0</b>
EBITDA % income	3.7%	3.6%	0.0%

\* Un-audited results for the year ended 31<sup>st</sup> March 2009 based on UKGAAP

Within the results the main variances relate to additional activity, this includes emergency over-performance (activity carried out beyond that planned) and elective activity to deliver and sustain 13 weeks referral to treatment, linked to GP referral growth.

The over-performance has been included within the initial activity assumptions for 2009/10 capacity plan with PCTs. The Trust has agreed further productivities with NHS Wiltshire and Swindon PCT to reduce activity over-performance.

## Cash Flow

The closing cash balance as at 31<sup>st</sup> March 2009 was £20.4m compared to a £14.1m planned.

	Plan	Actual	Variance
	£'m	£'m	£'m
<b>EBITDA</b>	<b>6.8</b>	<b>6.9</b>	<b>0.1</b>
Debtors	(1.3)	(0.8)	0.5
Creditors	3.6	5.0	1.4
Other change in WC	7.7	11.4	3.7
Non cash I&E items	(0.2)	(0.2)	0.0
<b>CF from operations</b>	<b>16.5</b>	<b>22.3</b>	<b>5.8</b>
Capital Expenditure	(3.8)	(2.6)	1.3
Net Interest	0.8	0.8	(0.0)
Dividends paid	(1.3)	(2.2)	(0.9)
Other	(0.1)	0.0	0.1
<b>Net cash inflow/outflow</b>	<b>12.1</b>	<b>18.3</b>	<b>6.3</b>
Opening Cash balance	2.1	2.1	0.0
<b>Closing Cash Balance</b>	<b>14.1</b>	<b>20.4</b>	<b>6.3</b>

The variance is due to £1.8m of deferred income relating to services and ring fenced schemes where the expenditure is yet to occur, e.g. Cardiac Network, £2.2m relating to accruals for the additional costs of activity completed March and £1.6m of outstanding invoices for capital enabling works.

### 1.3 Other Major Issues

During the year 2008/09 the Trust Board has been significantly strengthened with the appointment of three new Non Executive Directors. Roger Hill has a commercial background in IT; Robert Burns is a Chartered Accountant with extensive commercial and financial management experience; Liam Coleman is currently Group Treasurer and part of the senior management team at Nationwide Building Society. Helen Bournier was appointed to the newly created Executive Director post of Director of Business Development and Maria Moore was recruited as the Director of Finance to replace Charlotte Moar. Maria had previously been the Deputy Director of Finance at the Trust.

The Board Committee and governance structures have also been strengthened with the establishment of a Finance Committee and Integrated Governance and Risk Committee in addition to the Audit Committee and Mental Health Act Committee. The work of these committees is co-ordinated by the Board through cross-membership of each committee and by regular reports from the Chairmen of each committee to it.

RSM Bentley Jennison currently provides internal audit, and the Audit Commission provides the external audit support. Both these contracts will be tendered during the

year 2009/10, and the governors will be responsible for awarding the contract for external auditors. Work on this will commence in quarter 2.

## 2 Future Business Plans

### 2.1 Overall Vision

#### 2.1.1 Vision Statement

Great Western Hospitals NHS Foundation Trust developed an Integrated Business Plan (IBP) as part of its application to become a Foundation Trust which outlined its vision and strategy for its future as a Foundation Trust. This document was created with input from the staff in the organisation and was shared widely with stakeholders. It is the Board's belief that the vision remains the right one for the organisation. It is that the Trust should become:

**“The provider of choice by delivering high quality specialist services, within the resources available, which delight our patients and commissioners and to establish sound, viable business partnerships by forming strategic alliances with our primary care trusts and other key partners”.**

This vision is linked to 5 key strategies which are:

1. To provide safe, high quality care which patients are satisfied with and staff are proud to provide and maximise the value of being a Foundation Trust by ensuring our services are embedded in and valued by our communities
2. To continue to be the local healthcare provider of choice for Swindon residents
3. To increase numbers of patients from Wiltshire, Oxfordshire, Berkshire and Gloucestershire
4. To play a key part in the network of care for patients, providing clinically appropriate and safe outreach services in the community which meet commissioners and patients needs
5. To support our commissioners in improving health and reducing health inequalities.

To achieve this vision and ensure delivery of the key strategies, the Trust will focus on four keys themes in 2009/10. These are:

- Quality and Safety
- Service Improvement
- Workforce development
- Performance management

#### 2.1.2 Formation

The Council of Governors was formally established on 1<sup>st</sup> December 2008. They have had a very busy agenda, and assimilated a significant amount of information. The Trust

Board is committed to pursuing the strategic objectives set out in the IBP as the basis for its Annual Plan in 2009/10 and the IBP has been shared with the Council of Governors and is supported by them.

The vision and themes were presented to the governors at a joint Board workshop at the end of January 2009 and were broadly endorsed. The Board received a clear steer from the Governors that they wished to see improvements in patient experience as it is critical to everything that we do and an overarching theme.

At a Joint Council of Governors and Trust Board meeting in May, Governors and Board members had a useful discussion about the challenges faced by the Trust in ensuring that it has a viable business plan that ensures patients in the local area can access the treatment that they need, and that the Trust can be paid for the work it carries out by the local PCTs. The Governors are understandably concerned that patients should receive the care that they need, and not be at risk of any 'rationing' that may be applied to ensure financial balance. The Governors were assured by the Trust Board that this would not happen, and plans were in place between the PCTs and the Trust to manage such eventualities.

The governors have set out the key issues that they wish to see addressed during 2009/10 and these are complementary to both the IBP and the four themes that the Trust is pursuing this year:

- Improve the patient experience
- Effective Communication with our communities, and staff
- "Be a really good district general hospital (DGH)" for the communities we serve
- Establish and ensure good links with other healthcare providers (e.g. GPs, Tertiary centres)

The Governors are supportive of developing strategies for repatriation of limited tertiary services where it is clinically safe, economically feasible and in the interests of patients but wish for us to remain primarily a soundly-based general hospital rooted in its community and with proactive links with the appropriate tertiary networks.

As the work of the Council of Governors matures, the governors will become involved at a much earlier stage in the planning process and this is already reflected in the 2010/11 business planning cycle with the participation of governors and stakeholders at the outset.

### **How are the Trust themes and the Governors' identified priorities being addressed?**

The Trust Board has committed circa £100k expenditure over the three years from 2009/10 for the implementation of an Organisational Development strategy. This work is divided into four sections:

- a) vision and strategy
- b) structural: to drive the upskilling of staff and future talent management

- c) process: to ensure that the organisation is “fleet of foot” and innovative in its approach to doing business
- d) culture: create and drive a responsive attitude among all staff in their dealings with customers – be they internal or external. Among the outputs of this work will be improved services, engaged staff and an organisation that has learning at its very core

The Trust is in the selection process, following OJEU requirements, and will engage a partner in July 2009 to support the Trust achieve its vision.

The Governors’ priority of an improved patient experience will be addressed during 2009/10 through a new focus on securing patient feedback through regular surveys, the results of which will inform the work on the wards and future strategy. The Trust has adopted and is rolling out the NHS Institute for Innovation and Improvement’s “Productive Ward” programme which will release more time for nurses to spend in one-to-one care with patients.

The focus on quality and safety is a major theme for the Trust in 2009/10 and more detail on this is contained in section 2.2.1.

### **How will the organisation be assured of progress in the key priority areas?**

The organisation’s approach to performance management has been reviewed and its newly introduced Corporate Dashboard will reflect the organisation’s progress towards achievement of its key objectives and its vision.

In addition, the Trust-wide risk register and the Board Assurance Framework have been reviewed to ensure that the risks from both are addressed and mitigating actions and controls are in place.

Further, Trust Board meetings will feature an in depth Quarterly Performance Review, in addition to the normal monthly reviews at Board and within Finance Committee.

### **How does the Annual Plan align with local commissioning intentions?**

The Annual Plan aligns with the key intentions of the South West SHA and the two primary care organisations that are the Trust’s main customers, Swindon PCT and NHS Wiltshire. However, in the case of both PCTs, the funding allocated for secondary (acute) care is less than the activity they wish to commission. As a result, the lead commissioner Swindon PCT, and the Trust have developed a detailed programme of work for 2009/10 to ensure that all three organisations work effectively and drive new ways of working that will create the efficiencies to prepare the health economy for the challenges of the future.

This will focus efforts in the following areas:

- Reducing excess bed-days
- Repatriation of tertiary activity
- Management of frequently attending patients

- Community wide review of urgent care
- Demand management of GP referrals

To ensure that the local health community is fit for the future, the two primary care organisations and the Trust have agreed to work towards a comprehensive range of productivities in clinical areas, based on the NHS Institute for Innovation and Improvement clinical benchmarks. This will enable the local health community to prepare for the reductions in funding that the April 2009 budget has set out.

With the opening of the ISTCs in Cirencester and Devizes in November 2009 the PCTs and the Trust are working to ensure that the flow of elective (planned work) is managed effectively. The Trust will use service line data to review each specialty and explore the opportunities to reconfigure services in light of the opening of the ISTCs. It is the intention of the Trust to collaborate as far as possible with UKSH, the ISTC provider.

Swindon PCT has signalled its strong support to work with the Trust to manage the case mix that will be transferred to the ISTC so that none of the services currently provided by the Trust are destabilised by the loss of activity and the continued viability of the Trust is assured.

## **2.2 Strategic Overview**

### **2.2.1 National and Local Challenges**

#### **Economic Climate**

The Trust is very aware of the challenges faced nationally by the current economic climate. The short-term closure of the local Honda manufacturing plant has caused particular concern in Swindon and the surrounding area. As a significant local employer we have sought to support the Honda team and their staff, and have been able to offer temporary contracts to a small number of specialist ergonomics staff and extended volunteering opportunities to others.

The economic downturn has also affected the planned population growth in Swindon and the surrounding area, which the PCTs, in conjunction with the local authorities had originally planned at 1.7% for 2009/10. This has now been revised to 0.5% for the same period.

#### **Commissioning Climate**

The Trust is working to understand the ramifications of the new commissioning climate and has already participated in the NHS Wiltshire/Bath and North East Somerset (B&NES) tender for their regional CAAMHs service. While the Trust has not been successful in moving into the final stage of this process – the competitive dialogue – its involvement in the process has been extremely useful. A project manager has now been employed to manage the Trust's response to tenders and bids, and one of the

Trust's Non Executive Directors with significant commercial experience in this area is supporting this work.

### **Introduction of new tariffs/HRG4 in 2009/10**

2009/10 is the 1<sup>st</sup> year of the new tariff based on HRG4, which includes the introduction of a new 'market forces factor' (MFF). The main issues for the Trust as a result of this introduction are:

- Planned same day (PSD) activity with no tariff - there are approximately 140 episodes where no PSD tariff exists, the Trust has validated the coding and confirmed that the patients were treated as day cases. The Trust has agreed a local tariff for 2009/10 with commissioners based on 80% of the inpatient tariff. This will be reviewed for 2010/11 onwards.
- Out-patients procedures – there are no mandatory tariffs for any of these procedures and PCTs are not prepared to pay for this activity based on the non-mandatory tariffs. The Trust has agreed to a local tariff based on 2008/09 prices inclusive of 15.4447% MFF uplifted for inflation.
- Un-bundled radiology for outpatients – radiology has been removed from the out patient tariff; however PbR guidance does not provide a mandatory tariff for charging for this activity. The PCTs view is that the non-mandatory tariff doesn't reflect the true cost of the service to the Trust and therefore they are not prepared to pay based on this basis. The PCTs have agreed to a block contract value in 2009/10 based on information provided by the Trust, moving to a cost per case tariff from 2010/11 onwards.

### **Increase NHS Litigation Authority (NHSLA) Fees**

The increase in contribution to the NHSLA 2009/10 has increased by £1.349m i.e. 57%. This increase in contribution is net of the discount for achieving level 3 in maternity (30% discount) and level 1 in general acute (10% discount). This increase is a national issue.

### **Non payment for over performance of activity plans**

NHS Wiltshire and Swindon PCT have both expressed concerns about the affordability of continued over-performance and the level of growth in GP referrals experienced in 2008/09. As part of the contract negotiations the Trust has agreed to work in partnership with the PCTs to implement productivities to minimise the risk of over-performance, this includes PCT demand management plans to reduce GP referrals. Both PCTs have agreed that activity will be paid for in line with PbR guidance, however there is risk that over-performance activity is not payable within the parameters within the contract, therefore the Trust has agreed to work with the PCT to develop a risk framework for over-performance for inclusion in the contract.

### **Lower funding growth**

Due to the economic climate, funding growth will be significantly lower (potentially zero) in the future, health communities will be expected to deliver productivities in order to implement service change to meet the national NHS reform.

The Trust is working closely with the PCTs to develop plans across the health community.

### **Operating without Contracts**

The Trust is close to agreement on the contract for 2009/10 and has agreed in principle with NHS Wiltshire. Both PCTs have agreed, in the interim, to pay the Trust for activity that it carries out.

### **Care Quality Commission Registration**

The Trust was delighted to have its application for registration under the new Care Quality Commission approved without conditions.

### **Performance-related payments Linked to Quality Outcomes**

The Trust welcomes the 2009/10 lower trajectory for MRSA and clostridium difficile performance and is confident of delivery and thus will not incur any penalties under the national penalty clause in the contract. Trust staff, patients and visitors have responded very positively to the 'HIT' (Hit Infection Together) campaign which has focussed efforts to bring down infection rates in the last 12 months.

### **The Impact of European Working Time Directive**

From 1<sup>st</sup> August 2009, the European Working Time Directive (EWTD) comes into force and when combined with the existing New Deal regulation will lead to a reduction in junior doctors actual working hours from current 52 hours per week to 48 hours per week. This will have a significant impact on the availability of junior doctor workforce cover and will also have an impact on their training opportunities. The Trust has prepared for this challenge by reviewing rotas and implementing solutions around redesigning services, introducing new ways of working and is also currently working on designing and implementing a long-day model. The Trust has invested £210k in 2008/09 and a further £700k for additional Medical workforce staff to achieve and sustain EWTD compliance whilst maintaining quality and safety in all aspects of patient care. We have adopted a more innovative approach to recruiting medical staff, and are currently recruiting in India using established agencies. The Trust is also taking part in an SHA and Deanery initiative to recruit internationally.

## **Social Impacts on Healthcare Provision of Higher Levels of Unemployment**

Evaluated on an epidemiologic basis, evidence suggests a strong, positive association between unemployment and many adverse health outcomes including cardiovascular diseases. In the Swindon area, there has been the short term closure of Honda which employs circa 4,000 staff and the closure of Woolworth's warehouse. For Trust staff who may have partners out of work or on reduced hours, we are directing them to financial support and advice and offering staff support services for general advice and guidance. We are working with our trade union colleagues to obtain further literature and advice. Also for our staff we have an excellent Health and Wellbeing Service and through our 'Waist Away Campaign', cycling/walking and other initiatives, we are supporting our staff to keep well. For our local community, we are working with JobCentrePlus to ensure that jobs available in the hospital are available across the community and we are also holding recruitment fairs which have a strong career advice component. We continue to recruit volunteers as evidence suggests that local people out of work are keen to stay in a work routine.

We have noticed a significant increase in the number of applicants for all advertised vacancies, often with greater levels of skills which is enabling us to fill posts with very strong candidates.

For our patients, we are working closely with our commissioners to make sure that the healthcare we provide meets local needs and we are implementing a cardiology strategy which includes enhancing services to meet increased demand.

## **Quality Account Reporting**

The Trust has adopted the Monitor Quality Account framework, and will report monthly to the Integrated Governance Committee on the following nine Quality Accounts:

1. To reduce our number of MRSA bacteraemias
2. To reduce our number of *clostridium difficile* infections
3. To reduce our number of reported medication errors
4. To reduce our number of Grade 4 Pressure Ulcers
5. To reduce our number of Grade 3 Pressure Ulcers
6. To reduce the number of our patients who fall in hospital
7. To reduce the number of our patients who acquire a fracture associated with a fall in hospital
8. To transfuse our patients with the correct blood transfusion products
9. To perform the correct site surgery on our patients

A clinical lead has been identified for each and a performance target set for the year with interim milestones to be achieved.

## **Implications of competition and competition regulation**

We have contributed to the consultation on employment of consultants in ISTCs and while not opposed to this, we nevertheless feel that ISTCs need to contribute to the overall training and governance requirements of consultants, perhaps via a training levy.

### **2.2.2 Quality**

Over the past 12 months, the Trust has made enormous progress and achieved significant improvements in key quality measures in line with the organisational business objectives.

Specifically, we have reduced our hospital acquired MRSA bacteraemia and clostridium difficile infections and the numbers reported are under the trajectories required by the Department of Health. We have also reduced our numbers of hospital acquired grade 3 and 4 pressure ulcers and reduced the number of patients who fall in hospital. We have reduced our hospital mortality rate and the number of drug errors and improved the overall patient experience in relation to the promotion of privacy and dignity and providing information on treatment and conditions. More patients rated their care as excellent or good and more patients would recommend the Great Western Hospital to family and friends.

The Quality Improvement Plan 2009/10 has been developed utilising the quality accounts framework described by Monitor. The plan builds on the quality improvement initiatives delivered over the last 12 months and provides the rationale for the prioritisation in 2009/10 for clear quality improvement measures and the activities that will be implemented (or progressed) to deliver. The overall quality account comprises 25 indicators based on the three elements of quality described in the report High Quality Care for All: safety, effectiveness and experience (*and also provides 6 regulatory quality indicators*).

A summary of the Trust's Quality Improvement Plan 2009/10 is as follows:

#### **Safety**

- To continue to reduce hospital acquired infections
- To continue to reduce preventable hospital mortalities
- To reduce medication errors
- To reduce patient falls in hospital
- To provide the correct site surgery and procedures on our patients
- To transfuse the correct blood products to our patients

## **Effectiveness**

- To reduce hospital acquired pressure ulcers
- To reduce emergency re admission rates
- To fully implement a trust-wide venous thrombo-embolism (VTE) policy and determine the current numbers of hospital acquired VTES
- To increase the percentage of patients with a fractured neck of femur who wait for 24 hours or less for surgery
- To increase the number of women who experience an unassisted delivery
- To implement a system for monitoring patient reported outcome measures as advised by the Department of Health

## **Patient experience**

- To sustain the percentage of patients who would recommend the hospital to a friend or relative
- To sustain the percentage of patients who stated they were treated with dignity and respect
- To increase the percentage of complaints that are responded to within 25 days
- To increase the percentage of patients whose call bells are responded to within 5 minutes
- To review the local methodology for asking patients about their hospital experience with a view to increasing the number of patient responses

## **Regulation**

- Sustain full compliance with the hygiene code
- Sustain full compliance with the Care Quality Commission's Standards for Better Health
- Attain NHSLA Acute Standards at Level 2
- Sustain NHSLA Maternity Standards at Level 3
- To comply with NICE guidance with no significant lapses
- To comply with central alert bulletins with no significant lapses

### **2.2.3 Key Actions**

#### **Utilisation of NHS Foundation Trust Freedoms**

The Trust has developed a "Dragons Den" initiative to encourage new ideas for service

developments and improvements, funded from the Trust's surplus. This has been very well received by staff, and a Governor has been invited to join the Chief Executive, Medical Director and one of the Non Executive Directors on the panel of "dragons". It is anticipated that this will be run again during 2009/10.

During 2008/9, 50 projects were approved, with a total value of circa £400K.

### **Innovation and Development of Commercial Opportunities**

As a recently authorised foundation trust, the Trust Board is both aware of and keen to develop a commercial focus. With this in mind a forum involving a number of Executive and Non Executive Directors has been established as a Business Development and Advisory Group to review internally generated business ideas and to respond to external factors that will affect the Trust's operation.

The Trust Board considered submitting a bid to merge with the Royal National Hospital for Rheumatic Diseases Foundation Trust in Bath when the opportunity arose in March 2009, but considered that as a recently authorised Foundation Trust it would be more prudent to focus on operating effectively as a foundation trust before seeking new challenges.

From this work, the Trust has developed assessment criteria to use when considering future business opportunities to ensure fit with and contribution to the Trust's strategic direction.

The recent work undertaken to bid for Wiltshire and B&NES CAAMHs services has been extremely useful and the Trust will build on this experience by creating the capacity to deal with tenders and bids in the future, recognising that as local PCTs develop their market assessments, more services will be put out to tender and being 'fleet of foot' and commercially skilled in dealing with tenders will be critical for the Trust's future success.

Following on from recent successes in nursing and non medical research, the Academy will continue to work to build non-medical research through its Nursing and Health Professional Research Centre.

The aim is to develop the skills and confidence of nurses and allied healthcare professionals to undertake high quality original research, and to improve the ability of senior staff to appraise, analyse and apply research findings, to further develop the quality of care and patient experience within the organisation. It is envisaged that there may over time be some interest in this work from other healthcare organisations.

### **Compliance with the Private Patient Cap**

The Trust has underperformed against the private patient income in 2008/09 as a result of a number of contributory factors, including the reduction in waiting times to 13 weeks, the increase in day cases reducing the number of patients requiring an overnight stay and the economic impact leading to a reduction in self-payers. As a result the private patient unit finished the year behind plan and with no risk of breaching the private patient cap. In 2009/10 the Trust will review its operation of the private patient unit and the options available to ensure its longer term success either through in-house or alternative management structures. It will not breach the private patient cap in 2009/10.

## **Research and Development Proposals**

The Trust has secured an additional £166k funding for the year 2009/10 which will support a further six additional part time positions in the Research and Development team. This expansion will enable the organisation to increase its total of NHS portfolio studies and further expand its commercial work.

## **Investments**

Investment is available in the plan from three sources:

- Funding relating to activity increases (population growth) net of any lost activity/demand management
- Funding relating to additional savings above tariff requirements for surplus
- Capital investment is funded from internally generated cash from depreciation, the annual capital plan is £3.9m

Investment in both capital and revenue is prioritised and approved as part of the annual business planning process and priorities against the following criteria:-

- delivery key targets including activity and quality
- delivery of statutory or legal obligations
- Investment to save schemes that improve efficiencies and quality
- Investment in service developments that delivers a positive contribution to the Trust surplus, which can be reinvested in other services/priorities

## **Divestments**

The Trust will not provide CAAHMs services from 31 March 2010 as a result of NHS Wiltshire, Swindon PCT and NHS Gloucestershire giving notice on the contract. NHS Wiltshire partnered with B&NES PCT (Bath and North East Somerset) in putting their services out to tender through a competitive dialogue process; the Trust bid, but was not selected to proceed to preferred bidder status. As a result of this, and having reviewed the contribution levels, the Trust decided not to participate in the bid for the Swindon CAAHMs service.

This will result in a change to the Schedule of Mandatory services for the year starting 2010/11.

## **Contracting and Influencing Strategies**

The Trust's strategy in relation to business opportunities is "to collaborate where appropriate, compete where necessary".

The Trust is using this approach to the arrival of the ISTCs in Cirencester and Devizes, where discussions are ongoing in relation to the setting up of SLAs for a number of

services such as chaplaincy and some pathology services.

### **Patient Safety and Service Delivery**

The Trust has signed up to the national Patient Safety First campaign as part of its major focus on quality and safety in 2009 and information about this and the drive to improve quality is contained in section 2.2.2.

A major focus for the Trust in 2009 will be improving service delivery by capturing patient experience and feedback more effectively and ensuring that this is used to feedback to front-line teams to inform improvements and changes.

The Trust is currently exploring a better way to gather feedback from patients, and is considering electronic patient questionnaire services so that those patients who wish to can provide their feedback electronically either at bedside, at a kiosk in the hospital, via a handheld device or tablet or via the internet once they have returned home. For patients who prefer, the same questionnaire will be provided in paper form so that it can be completed by hand.

Part of the Trust's marketing strategy is the redesign of the website to make it more user-friendly and informative and 'interactive'. Linked to this will be work to develop a wider web presence through an e-marketing campaign, ensuring that where appropriate, the Trust makes the most of the proliferation of health websites and patient web forums. The more we can interact with as wide as possible groups of patients, the better information can be fed back into service redesign and improvement work.

### **Commissioning intentions**

The commissioning intentions of Swindon PCT and NHS Wiltshire are compatible with the World Class Commissioning agenda – to ensure that their communities have access to safe high quality services with positive outcomes, delivered as close to home as is feasible. The Trust believes that these intentions align well with its key strategies; to provide safe, high quality care, to be the local healthcare provider of choice; to increase the number of patients from the wider catchment area; to play a key role in the network of care; and to support our commissioners in improving health and reducing health inequalities.

### **The Competitive Situation within the Local Health Environment**

The Great Western Hospital is well-located for patients from a very wide geographic area, with junction 15 of the M4 being half a mile from the hospital. As a new hospital it has a good reputation for its design, environment and parking, so continues to attract patients away from the city centre locations occupied by a number of neighbouring acute trusts. The Trust's success in meeting the very challenging 13 week referral to treatment (RTT) target at the end of March 2009 has made it very popular with patients from a wider catchment area.

Of its nearest competitor acute trusts, 5 out of 7 are Foundation Trusts and have been so

for longer than Great Western Hospitals NHS Foundation Trust. Their marketing plans, branding and work with GPs are all further advanced. This means that we need to work much harder at ensuring that the services patients experience are well run and professional and provide the patient with no option to consider using another local trust.

While for some services local trusts will be competitors, they are also partners. For example tertiary work in a number of specialties goes to Oxford and Bristol. A number of the Trust's consultants work in other acute settings, so the use of the term 'competitor' must be used with care.

In terms of competition, the Trust faces a significant challenge in November 2009 with the opening of the three Independent Sector Treatment Centres (ISTCs) run by UK Specialist Hospitals (UKSH) at Emersons Green Bristol, Cirencester and Devizes.

Private sector competitors will also prove a threat to the Trust, especially as more services can be provided through mobile resources. Although the location of the Great Western Hospital is considered a key asset, alternative providers that can arrive at a GP surgery with services such as ultrasound or other diagnostic facilities in the back of a vehicle will prove very attractive to GPs and their patients.

## **Marketing Proposals**

The Trust is committed to developing strong relationships with its GPs across the catchment area.

## **Relationships with Healthcare Stakeholders (e.g. PCTs, SHA)**

The Trust has enjoyed a positive relationship with its lead commissioner Swindon PCT and is keen to develop this further to ensure that the Trust continues to deliver the aspirations and commissioning intentions of the PCT. Swindon PCT is currently developing its PBC groups, whilst NHS Wiltshire is further ahead with this. The Trust is pursuing relationships successfully with the PBC clusters in east, north and south Wiltshire.

The Trust has initiated discussions with PCT provider services to explore how we can improve the patient experience as patients move through primary into secondary care and back again, looking at areas where we can jointly improve the care that we offer.

The Trust is keen to maintain a positive and strong relationship with the South West SHA consistent with our independence as an FT, and directors, clinicians and managers attend a number of regular forums relevant to their interests and specialties.

In moving away from balancing the books across the health economy to legally binding contracts, there are understandable tensions with the PCTs, but all parties are confronting them in a principled and constructive manner.

## **Board Development**

As a new Foundation Trust, the Trust recognises the need for continuing development for the Board and further Away Days are planned. The Trust is embarking on a 3-year Organisational Development programme which will have Board Development as one of its key objectives.

## **Engagement with Governors, Members and Delivery of Local Accountability**

The Board of Directors, led by the Chair, respects and values the Council of Governors. Non Executive and Executive Directors attend the meetings of the Council of Governors and its four working groups. The Chair presents a formal monthly letter of the work of the Board to the Council of Governors and the Chair presents the work of the Council of Governors to the Board. The Board and Council of Governors also have several joint sessions during the year.

The Chair meets members of the Council of Governors regularly and staff and directors are engaged with the process of engaging the governors in the areas of interest to them.

Members receive regular newsletters from the Trust and are informed of meetings in their constituencies. As described in section 5 below, the Trust is developing ways to engage effectively with members assisted by the membership working group of the Council of Governors.

The Trust aims to deliver accountability to its catchment area by the democratic process of members electing the governors who in turn may influence the strategy of the organisation through the work of the Council of Governors. The Trust therefore continues to increase its membership, to review the demographic composition of its membership and work with the Council of Governors to engage with the membership in order to deliver accountability.

The combination of a manageable number of governors (19), the high quality of the governors both elected and nominated and the roles played by the Lead and Deputy Lead Governors have ensured that in the relatively short time since Authorisation, the governors are already providing constructive challenge to the Board. There has been a tradition of volunteers in the hospital and the governors both represent and champion this role. There has been less of a tradition of patient involvement in clinical service design and the members are beginning to be engaged in this, for instance, in the design of a birthing centre as described below.

### **2.2.4 Service Development Plans**

Service improvement / development is one of the four key themes for the Trust for 2009/10 and this will be delivered by expanding a number of services, and where appropriate reviewing and benchmarking our services. Our ophthalmology service took part in the Foundation Trust Network benchmarking round earlier in 2009, and we will apply for other opportunities as they arise.

Whilst the Trust faces competition from the ISTCs, the Trust's short waiting times will give us an opportunity to market our services to trusts that are struggling to meet their 18 week referral to treatment targets and other commissioners may wish to buy shorter referral to treatment pathways.

### **Capabilities to Deliver Volume Growth**

As part of the clinical directorates' business plans, the additional resources required to deliver these services has been reviewed and identified, and where appropriate, business cases are in train at the Trust.

It is the Trust's view that development of a number of key services will not increase the Trust's exposure to Risk.

### **How these changes will be delivered in the context of the wider health economy.**

The initiatives have the support of the Trust's two major PCTs, and are seen as key to ensuring quality service within the local area for patients. In the case of stroke, the Trust's performance in the national Sentinel audit had been disappointing, and this work is making dramatic improvements to the service and speed of response for patients. The Trust is aware that the ISTCs are in the process of applying for JAG accreditation which will increase the choice for patients who require screening and there are ongoing discussions to ensure the viability of the service at Swindon.

### **Movements on Schedule 2 – mandatory services**

- Chemo & Radiotherapy increased by 2146, previous excluded as it was a block contract
- Un-unbundled Radiology 3672, new category previously included as part of the spell
- Out-patients movement includes:-
  - 7,736 midwifery episodes, these were previously excluded as the activity was paid as block
  - 16,199 inclusion of out-patient procedures
  - 43,418 inclusion of pre-assessment activity

### **Compliance with schedule 4 – the cap in private patient income (PPI)**

The income planned from private patients is £2.75m, this is within the PPI cap of 1.6% of total clinical activity.

## 2.2.5 Summary of Key Service Developments

## 2.3 Summary of Financial Forecasts

### 2.3.1 How the Plan was built

The Annual Plan 2009/10 has been based on the Integrated Business Plan (IBP) that was prepared for the Trust's authorisation as a Foundation Trust and supplemented by the detailed business planning work that has been undertaken by the directorates as they have prepared their plans for activity and delivery of their objectives for 2009/10 and onwards.

*NB. Please note that the finance data within the tables in this Annual Plan have been formatted to one decimal place not rounded to one decimal place. This has in some cases led to minor rounding differences, however this does not affect the overall totals.*

### 2.3.2 The Impact of IFRS (International Financial Reporting Standards)

The key impact of the IFRS implementation will be to bring the PFI hospital onto the balance sheet. The Trust has already produced restatement of the March 2007 balance sheet, the restatement of the 2008/09 accounts will be completed by 30<sup>th</sup> August for submission to Monitor and the auditors. The audited accounts are due for completion by 30<sup>th</sup> October 2009. The key variables determining the financial impact are the value of the hospital asset when it is entered onto the balance sheet and the treatment of the lifecycle maintenance.

The Financial Risk Rating (FRR) will improve from 3 to 4.

Reconciliation of expected movement from UK GAAP to IFRS for 2008/09

<b>Income &amp; Expenditure</b>	<b>UK GAAP</b>	<b>Adjustment</b>	<b>IFRS</b>
	<b>£'m</b>	<b>£'m</b>	<b>£'m</b>
EBITDA	6.9	16.3	23.2
Surplus	1.9	(0.8)	1.1

	UK GAAP £'m	Adjustment £'m	IFRS £'m
Assets	99.0	147.4	246.4
Liabilities	(29.7)	(139.6)	(169.3)
<b>Net Assets</b>	<b>69.3</b>	<b>7.8</b>	<b>77.1</b>
<b>Reserves</b>			
Public dividend capital	27.1		27.1
Revaluation	28.2	9.8	38.0
Other	1.1	0.3	1.4
Income & Expenditure	12.9	(2.3)	10.6
<b>Total Reserves</b>	<b>69.3</b>	<b>7.8</b>	<b>77.1</b>

### 2.3.3 Key Financial Assumptions

- The start point for the activity plans have been agreed with the commissioners, this is based on 2008/09 out-turn adjusted for growth, loss of activity to the independent sector, demand management and productivities.
- Tariff uplift is 1.7% in 2009/10, 1.2% in 2010/11 and 0.5% in 2011/12
- General activity growth is assumed to be 1% across each year
- Loss of activity to the independent sector has increased to £4.7m. This is £2.4m for Swindon PCT and £2.3m for Wiltshire PCT. The PCTs have assumed that £1.954m will transfer in 2009/10 with the balance transferring in 2010/11. The Trust has assumed that only 80% of this activity will transfer i.e. £1.57m. The Trust has agreed to review the case mix and identify activity that we would prefer transfers to the ISTC. The Trust has not agreed to transfer patients off the waiting list to the ISTC
- In 2009/10 £2.7m demand management and productivities (£1.7m. for Swindon PCT and £1m for NHS Wiltshire) have been included within the activity and income assumptions for PCT contracts. These include:
  - 5 surgical interventions
  - Emergency demand management including, reductions due to frequent fliers and falls
  - Elective demand management
  - Excess bed days
- Demand management/ transfer to primary care 2010/11 onwards has been assumed at 0.5% for emergency activity and 0.25% for elective.
- £1.276m caps/thresholds these include:

- N12 capped at 2007/08 % of live births
- S22 capped at 2007/08 levels
- Emergency department conversion rates capped at 2008/09 levels
- 0-4 hr length of stay capped at 2007/08 levels

These are consistent with 2008/09 thresholds.

- £1m additional income relating to service developments and marketing. With an additional £3.2m in 2010/11 and £4m in 2012/13.
- Non-recurring income and expenditure for movement to 13 weeks referral to treatment, has been removed from the plan. The Trust has not assumed moving to 8 weeks within the plan, as the PCTs do not have the funding to commission this RTT.

### 2.3.4 Phasing

The income and expenditure has been profiled to take into account the loss of activity to the ISTCs from November 2009, effective dates of the productivity measures and the cost improvement plans. As a result income in Q1 is expected to be £3m higher than Q4.

	Quarterly Plan			
	Q1 £'m	Q2 £'m	Q3 £'m	Q4 £'m
<b>Income</b>				
NHS Other	44.8	44.6	43.2	41.7
Private patient	0.7	0.7	0.7	0.7
Other	3.8	3.8	3.8	3.8
<b>Total income</b>	<b>49.3</b>	<b>49.1</b>	<b>47.7</b>	<b>46.2</b>
<b>Expenses</b>				
Pay	(27.6)	(27.4)	(27.3)	(26.6)
Drug	(3.2)	(3.2)	(2.9)	(2.7)
Supplies (clinical & non-clinical)	(5.0)	(5.0)	(4.5)	(4.2)
PFI	(2.6)	(2.6)	(2.6)	(2.6)
Other	(4.9)	(5.0)	(4.5)	(4.3)
<b>Total costs</b>	<b>(43.4)</b>	<b>(43.2)</b>	<b>(41.9)</b>	<b>(40.4)</b>
<b>EBITDA</b>	<b>5.9</b>	<b>5.9</b>	<b>5.8</b>	<b>5.8</b>
Depreciation	(1.8)	(1.8)	(1.9)	(2.1)
Net Interest	(3.0)	(3.0)	(3.0)	(3.0)
PDC dividend	(0.5)	(0.5)	(0.5)	(0.5)
	<b>0.6</b>	<b>0.6</b>	<b>0.5</b>	<b>0.3</b>
Exceptional items	0.0	0.0	0.0	0.0
<b>Net surplus / (deficit)</b>	<b>0.6</b>	<b>0.6</b>	<b>0.5</b>	<b>0.3</b>
EBITDA % income	11.9%	12.0%	12.2%	12.6%

### 2.3.5 Investment and Disposal Plans

The Trust has approved the capital budget for the next three years; this allows for equipment replacement and schemes to support the delivery of activity, efficiencies and quality.

<b>Project</b>	<b>2009/10 spend £'m</b>	<b>2010/11 spend £'m</b>	<b>2011/12 spend £'m</b>	<b>Details</b>
Equipment replacement	1.2	1.2	1.2	Rolling replacement schedule for all Trust capital equipment
Digital Breast Screening	0.2	0.8	0.5	Conversion of analogue to digital equipment to meet national requirement
2nd MRI scanner	0.0	0.4	0.8	Additional MRI scanner to cope with reduced targets for diagnosis and treatment
IT replacement programme	0.3	0.3	0.3	Rolling replacement schedule for replacement and upgrade of Trust IT equipment
Electronic Document Management System	0.1	0.3	0.1	Project to bring online all documents within the Trust onto one database
Other minor projects	2.1	1.0	1.0	Projects including robot for pharmacy, birthing centre, data warehouse and cardiac ultrasound
<b>Total</b>	<b>3.9</b>	<b>3.9</b>	<b>3.9</b>	

There no planned disposals during 2009/10.

### 2.3.6 Loans and Working Capital

Upon authorisation as a Foundation Trust, the Trust negotiated a working capital facility with Barclays Bank to ensure that it has sufficient funds to cover any cash shortfalls, the initial agreement with Barclays Bank is for £14m for a period of 2 years.

### 2.3.7 Cost Improvement Plans (CIPs)

The Trust set a five year savings plan covering the 2009/10 to 2013/14, as part of its application for Foundation Trust. These plans aimed to generate 1% surplus and funding for investment in services and equated to approximately 3% per annum.

	Plan 2008/09	Actual 2008/09	Plan 2009/10	Plan 2010/11	Plan 2011/12
<b>CIP amount (£'m</b>	5.3	5.3	6.2	5.4	5.4
<b>CIP as % of operating costs</b>	3%	3%	4%	3%	3%

The plan for 2010/11 onwards needs to increase to take account of:

- Additional efficiencies included within tariff, 0.5% in 2010/11 and 1% in 2011/12
- Increase loss to the ISTC, this has increased from £2.4m to £4.7m (full year effect)
- Lower/ zero funding growth

The Trust commissioned an independent partner to review existing plans and to work in partnership with the Trust to identify additional productivity opportunities, with a specific focus on the period 2011/2014.

It is the view of the independent partner that the Trust is pro-active in its planning for the financial challenges facing the NHS in light of the anticipated reductions in public spending from 2011 onwards. The Trust's target CIP savings is £5.5m in 2012/13 and £5.5m in 2013/14 and the Trust realises that it will need to identify opportunities over and above these targets as a contingency for factors including demand management from PCTs and the expected reduction in NHS funding.

A key element of the work that the independent partner carried out in the Trust was a number of facilitated workshops with directorates and corporate functions to identify further savings schemes for the years 2011/12 and onwards. These were well attended by clinicians, managers and directors.

A number of schemes have been identified for the years 2011/12 and onwards, some of which are rolling year on year savings (eg drug savings) which whilst they represent very achievable targets are at an early stage of development. The independent partner was not unduly concerned about this, given the timeframe, and the Trust recognises the need to develop robust delivery plans.

These additional CIPs currently range from £5m to £15m per annum and have been rated by the Trust teams in terms of challenge versus delivery. Many of the schemes involve productivity and performance improvements, and fit with the Trust's ambition to move its performance to best in peer in national benchmarking schemes such as those run by the National Institute for Innovation and Improvement.

## 3 Risk Analysis

### 3.1 Governance Risk

#### 3.1.1 Governance Commentary

No significant risks to the governance stability of the Trust have been identified. The Trust's predicted 2009/10 performance in the seven governance elements, defined in the *Compliance Framework 2009/10 published in March 2009*, is as follows:

1. **Legality of Constitution.** The Trust's constitution is legally compliant and the current version has been approved by Monitor.
2. **Growing a Representative Membership.** The Trust's membership is representative and growing – as detailed in section 5.1 below.
3. **Appropriate Board Roles and Structures with a Collaborative Relationship between the Council of Governors and the Board** The Trust's board roles and committee structures have been kept under review. The committee structure has been allowed to embed following restructuring in July 2008. The Trust maintains its register of interests and can confirm there are no material conflicts of interest at the Board.

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.

The Board is satisfied that the Executive Team has the capability and experience necessary to deliver the Annual Plan and to deliver the Trust's objectives for the next three years.

The Governors have assumed their responsibilities following authorisation on 1<sup>st</sup> December 2008. The Council of Governors has set up working groups of governors to engage with membership, finance, nominations and the patient experience. The governors have a schedule of meetings with their constituents.

There is a collaborative relationship with the Board of Directors and joint meetings of the Board and Council have taken place. The Council will contribute to this Annual Plan. The Governors are invited to contribute to initiatives within the Trust (such as the Quality Accounts) and will continue to do so through the structural relationship between the Council and the Board.

4. **Service Performance - ongoing compliance with existing targets and national core standards and prospective compliance with known targets due to come into force.** The Trust is satisfied that sufficient controls are in place to ensure ongoing compliance with all existing national core standards and targets and is committed to complying with all known targets due to come into force in the next 12 months. The Trust will declare full compliance with all core standards to the Care Quality Commission for 2008/09 and expects to declare full compliance with 2009/10.

The Trust has historically demonstrated compliance with waiting time reductions set

by the Department of Health and the requirements of the South West SHA to 18 weeks referral to treatment (March 2008) and 13 weeks referral to treatment targets (March 2009) respectively.

5. **Clinical Quality - effective arrangements are in place to monitor and continually improve the Quality of Healthcare (including Patient Safety) provided to the Trust's patients.** The Trust has and will keep in place effective arrangements to monitor and continually improve the Quality of Healthcare (including patient safety) provided to the Trust's patients. The introduction of Quality Accounts in 2009/10 continues to strengthen these arrangements.
6. **Effective risk and performance management to identify and address risks to ensure continued compliance with the Trust's authorisation.** The necessary planning, performance and risk management processes are in place to deliver the annual plan.

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. Any key risks to compliance with the authorisation have been identified and addressed. Any Issues or concerns raised by internal or external audit are addressed and reviewed by the Audit Committee until they are satisfactorily resolved.

7. **Duty to Cooperate with NHS Bodies and Local Authorities.** The Trust co-operates effectively with other NHS Bodies, with our local authorities and other partner organisations including those regulatory bodies that are co-signators of the concordat.

### 3.1.2 Significant Risks

The Trust has considered the risks it faces in delivering this plan, and has identified a number of risks to its governance arrangements and these are detailed in the table at section 3.5.

### 3.1.3 HCAI Targets

The Trust's 'target' for clostridium difficile and MRSA infections is detailed in the table below.

Target		Q1	Q2	Q3	Q4
MRSA	2008/09 target	2.5	2.5	2.5	2.5
	2008/09 actual	2	0	1	3
	2009/10 target	1.5	1.5	1.5	1.5
C. difficile	2008/09 target	55	55	55	55
	2008/09 actual	32	20	14	9
	2009/10 target	17.25	17.25	17.25	17.25

## 3.2 Mandatory Services Risk

### 3.2.1 Mandatory Services

The Trust will cease providing CAAMH services from April 1<sup>st</sup> 2010 in line with the contract notice received by NHS Wiltshire, Swindon PCT and NHS Gloucestershire.

### 3.2.2 Significant Risks

The Trust has considered the risks it faces in delivering this plan, and does not believe that other than the loss of the CAAMH service that there are any other significant risks to its mandatory services. It is developing a transition plan, in conjunction with commissioners, to ensure that there is a seamless handover of CAAMH services to the new bidders when identified, and staff and users are at all times kept informed.

## 3.3 Financial Risk

The Trust has considered the risks it faces in delivering this plan, and believes that there are a number of financial risks and these are detailed in the table at section 3.5

### 3.3.1 Commentary on Financial Risk Rating

The overall metric and risk rating for 2009/10 to 2011/12 is shown in the table below:

	2009-10	2010-11	2011-12
EBITDA margin	5	5	5
EBITDA %	5	5	5
ROA	4	4	4
I and E surplus	3	3	3
Liquidity days	4	4	4
Overall risk rating if plan achieved	4	4	4

### 3.3.2 Significant Risks

There are a number of significant risks that have been identified that could impact on the business in 2009/10. These are listed below, and provided in tabular format (section 3.5) with detail of the mitigating actions.

- Commissioners' financial position
- Delivery of productivities linked to contract.

- Delivery of efficiencies and service changes contained in CIPs
- Maintaining and delivering CAAHMs in 2009/10 after losing in Wiltshire bid and withdrawal from Swindon bid
- Major Incident (MAJAX), or catastrophe (which may or may not be H1N1 flu outbreak)
- Staff Recruitment and retention
- Outstanding case (MC) and potential for criminal investigation
- Reputation management.
- Delivery of savings in Year 3 onwards if NHS funding allocation to PCTs falls as part of reduced funding post 2010/11

### **3.3.3 Service–line Reporting**

The FRR is above 3 and analysis of SLR is not required

### **3.3.4 Investment Adjustments**

The Trust does require Monitor to make a discretionary investment adjustment when calculating the Trust's FRR

### **3.4 Risk of any other Non-Compliance with the Terms of Authorisation**

Issues that the Trust considers to be a risk to its successful business operation, or to its terms of authorisation are set out in the table at section 3.5 in this document.

### 3.5 Presentation of Risk

Risk	Potential Impact	Likelihood	Mitigating Action	Residual Risk
<b>Financial</b>				
Commissioners' financial position	PCTs' financial situation means that payment for over performance is not available, and neither Swindon PCT nor NHS Wiltshire have a track record of effective demand management, so current high levels of referrals from GPs is a key risk for 2009/10.	High	<ul style="list-style-type: none"> <li>○ Two senior clinicians from GWH will be working with the Locality /PBC leads at PCT to encourage engagement and adherence to agreed principles.</li> <li>○ Project Group (re productivities) with regular review.</li> <li>○ Regular 1:1s and updates between key personnel within all organisations.</li> <li>○ 'Flag' system to alert GWH to higher than planned activity levels versus profiling</li> </ul>	Medium
Delivery of productivities linked to contract.	Delivery of productivities requires partnership working with PCTs and some elements will not be deliverable without their active participation.	High	<ul style="list-style-type: none"> <li>○ Project Group established between PCTs and GWH to ensure updates and regular reporting.</li> <li>○ Revised performance management arrangements between PCTs and GWH for</li> </ul>	Medium

Risk	Potential Impact	Likelihood	Mitigating Action	Residual Risk
			<p>the year will ensure focus on productivity.</p> <ul style="list-style-type: none"> <li>○ Regular communication at management level at GWH to ensure focus is maintained.</li> <li>○ Monthly update for management committee demonstrating progress.</li> <li>○ Quarterly report to Board.</li> </ul>	
<p>Delivery of efficiencies and service changes contained in CIPs.</p>	<p>Significant CIPs programme agreed for 2009/10; failure to deliver in full will have negative impact on overall Trust performance and year end profitability.</p>	<p>Medium</p>	<ul style="list-style-type: none"> <li>○ Trust has invested in establishing a programme office to oversee reporting of efficiencies so focus is maintained.</li> <li>○ Thorough review of efficiency opportunities has been carried out (KPMG) so in the event of agreed work becoming undeliverable, an alternative scheme can be adopted.</li> </ul>	<p>Low</p>
<p>Delivery of savings in Year 3 onwards if NHS funding allocation to PCTs reduces as part of restricted funding post 2010/11.</p>	<p>Further reductions in funding will result in less activity being commissioned and less opportunity for GWH to find and deliver</p>	<p>High</p>	<ul style="list-style-type: none"> <li>○ Introduction of SLM during 2009/10 will drive improved efficiencies through greater transparency of profitability</li> <li>○ Business Development</li> </ul>	<p>Medium</p>

Risk	Potential Impact	Likelihood	Mitigating Action	Residual Risk
	savings/efficiencies.		function will support more proactive commercial response to trading opportunities; and increase income	
<b>Governance</b>				
Commissioner relationships.	Risk that relationship could shift to a transactional level if GWH and PCTs cannot work better together	Medium	<ul style="list-style-type: none"> <li>○ Revised performance meeting structure to facilitate review and dialogue between PCTs and GWH</li> </ul>	Low
Major Incident (MAJAX), or catastrophe (which may or may not be H1N1 flu outbreak)	Major incident or catastrophe may create staff shortages through sick leave and carers leave, and requirement for increased number of emergency beds will risk delivery of elective activity. Such an incident may have a major impact on infrastructure outwith our control	High	<ul style="list-style-type: none"> <li>○ New Business Continuity Lead in place (Director of EFM) and actively reviewing processes</li> <li>○ Pandemic flu plan in place which contains operational contingency arrangements for predicted events.</li> <li>○ The plan has been assessed as fit for purpose by the Local Resilience forum and SHA.</li> <li>○ Phased reductions in elective activity are incorporated within the plan.</li> </ul>	Medium
Staff Recruitment and	Inability to deliver services.	Medium	<ul style="list-style-type: none"> <li>○ Proactive vacancy</li> </ul>	Low

Risk	Potential Impact	Likelihood	Mitigating Action	Residual Risk
retention.	High usage of agency staffing.		management. <ul style="list-style-type: none"> <li>○ International recruitment for difficult to recruit medical posts.</li> <li>○ Process overseen by the medical staffing group.</li> </ul>	
Outstanding decision on prosecution by HSE	Reputation risk to the Trust regarding media coverage of a prosecution.  Financial risk if sum of potential fine exceeds that estimated by Trust solicitors.	Medium	<ul style="list-style-type: none"> <li>○ The Trust solicitors have advised the Trust that an HSE prosecution has the potential to result in a fine to the estimated maximum sum of £200k.</li> <li>○ Positive recommendation by CMO representative (Prof Jim Reason) that Trust has learnt from this incident and has changed procedure and processes</li> <li>○ Lessons from case shared nationally through NPSA</li> </ul>	Low
Reputation management.	Patients exercising 'choice' to choose another acute provider in the locality due to adverse media coverage of clinical or other general issues.	Medium	<ul style="list-style-type: none"> <li>○ Positive relations with media &amp; joint working on key stories.</li> <li>○ New GP working arrangements continue to strengthen relations with GPs</li> </ul>	Low

Risk	Potential Impact	Likelihood	Mitigating Action	Residual Risk
			<p>across the catchment area.</p> <ul style="list-style-type: none"> <li>○ Strong culture of reporting of IR1s and rigorous approach to SUIs, and learning from same shared across organisation.</li> <li>○ Improved focus on complaint handling</li> <li>○ OD strategy in 2009/10 will have a focus on staff feeling valued.</li> </ul>	
<b>Mandatory Services</b>				
<p>Maintaining and delivering CAAMHs in 2009/10 after losing in Wiltshire bid and withdrawal from Swindon bid.</p>	<p>Trust is contracted to deliver CAAMHs to Wiltshire and Swindon until March 31<sup>st</sup> 2010; keeping and motivating staff during this period of uncertainty will be challenging.</p>	<p>Medium</p>	<ul style="list-style-type: none"> <li>○ Regular and informed HR support for staff and managers.</li> <li>○ Regular briefing for staff</li> <li>○ Close working with both PCTs and their bidders to ensure a smooth handover of services and TUPE transfer.</li> </ul>	<p>Low</p>

## 4 Declarations and Self-Certification

### 4.1 Self-Certification

### 4.2 Board Statements

#### For Clinical Quality, that:

The Board Of Directors is satisfied that, to the best of its knowledge and using its own processes (supported by any relevant Care Quality Commission metrics and including any further metrics it chooses to adopt), that Great Western Hospitals NHS Foundation 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.	✓
The Board of Directors can confirm that Great Western Hospitals NHS Foundation Trust has met and will continue to meet the requirements for registration with the Care Quality Commission in accordance with The Health and Social Care Act 2008.	✓

#### For Service Performance, that:

The Board of Directors is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) and National Core Standards and with all known targets going forwards	✓
The Board of Directors is satisfied that plans in place are sufficient to ensure ongoing compliance with The Health Act 2006: Code of Practice for the Prevention and Control of Healthcare Associated Infections (The Hygiene Code).	✓

#### For other risk management processes, that:

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 of Directors is confident that there are appropriate action plans in place to address the issues in a timely manner	✓
All recommendations to the Board of Directors from the Audit Committee are implemented in a timely and robust manner and to the satisfaction of the body concerned	✓
The necessary planning, performance management and risk management processes are in place to deliver the annual plan	✓
A statement of internal control ("SIC") is in place, and the Great Western Hospitals NHS Foundation 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)	✓


All key risks to compliance with its authorisation have been identified and addressed.	✓
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**For compliance with its authorisation, that:**

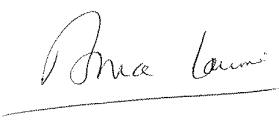
The Board of Directors will ensure that the Great Western Hospitals NHS Foundation Trust remains compliant with its authorisation and relevant legislation at all times	✓
The Board of Directors has considered all likely future risks to compliance with its authorisation, the level of severity and likelihood of a breach occurring and the plans for mitigation of these risks	✓
The Board of Directors has considered appropriate evidence to review these risks and has put in place action plans to address them where required to ensure continued compliance with its authorisation.	✓

**For Board Roles, Structures and Capacity, that:**

The Board of Directors maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the Board of Directors	✓
The Board of Directors 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	✓
The selection process and training programmes in place ensure that the Non-Executive directors have appropriate experience and skills	✓
The Management Team has the capability and experience necessary to deliver the annual plan	✓
The Management Structure in place is adequate to deliver the annual plan objectives for the next three years	✓



**Lyn Hill-Tout**  
Chief Executive Officer



**Bruce Laurie**  
Chair

## 5 Membership

### 5.1 Membership Report

#### *Membership size and movements*

<b>Public constituency</b>	<b>Last year</b>	<b>Next year (estimated)</b>
At year start (1 April or Authorisation)	1871	4151
New members	2438	2441
Members leaving	158	166
At year end (31 March)	4151	6426

<b>Staff constituency</b>	<b>Last year</b>	<b>Next year (estimated)</b>
At year start (1 April or Authorisation)	0	4232
New members	4246	400
Members leaving	14	400
At year end (31 March)	4232	4232

<b>Patient constituency</b>	<b>Last year</b>	<b>Next year (estimated)</b>
At year start (1 April or Authorisation)	N/A	N/A
New members	N/A	N/A
Members leaving	N/A	N/A
At year end (31 March)	N/A	N/A

<b>Public constituency</b>	<b>Number of Members</b>	<b>Eligible Membership</b>
0-16 ( age 12-16 years)	84	73,939
17-21	102	17,637
22+	3915	247,593
<b>Ethnicity</b>		
White	3519	331,368
Mixed	20	2578
Asian or Asian British	115	2272
Black or Black British	36	1153
Other	21	1798
<b>Socio-economic groupings</b>		
ABC1	3224	267,944
C2	465	29,847
D	285	27,812
E	160	13,566

<b>Gender</b>		
Male	1796	167,550
Female	2283	171,619

<b>Patient constituency</b>	<b>Number of members</b>	<b>Eligible Membership</b>
Age:		
0-16	N/A	N/A

17-21	N/A	N/A
22+	N/A	N/A

### Analysis of Election Turnout

Date of election	Constituencies involved	Number of members in Constituency	Number of seats contested	Number of contestants	Election turnout %
21/07/08	Swindon	1520	5	20	54%
21/07/08	Wiltshire	831	3	14	58%
N/A	West Berks / Oxon / Glos	N/A	2	2	N/A
N/A	Staff	N/A	3	3	N/A

## 5.2 Membership Commentary

### Constituencies

Great Western Hospitals NHS Foundation Trust has two constituencies; the Staff Constituency and the Public Constituency.

The Staff Constituency comprises of staff employed by the Trust, staff employed by our designated subcontractor Carillion and members of our volunteer workforce. The Staff Constituency is based upon an opt-out scheme. There are currently 4232 staff constituency members.

The Public Constituency is subdivided into a further three constituencies which are:

- Swindon (all Electoral Wards within the area covered by Swindon Borough Council);
- Wiltshire (all Electoral Wards within the area covered by Wiltshire County Council Area); and
- Gloucestershire, Oxfordshire and West Berkshire (all Electoral Wards Covered by Gloucester County Council, West Berkshire Unitary Authority and Oxfordshire County Council).

Any person who is aged 12 or over and who lives in one of the three constituencies outlined above may become a member. In 2008/2009 we recruited 2438 new members and had 3.67% of the total membership leave.

### Membership Targets

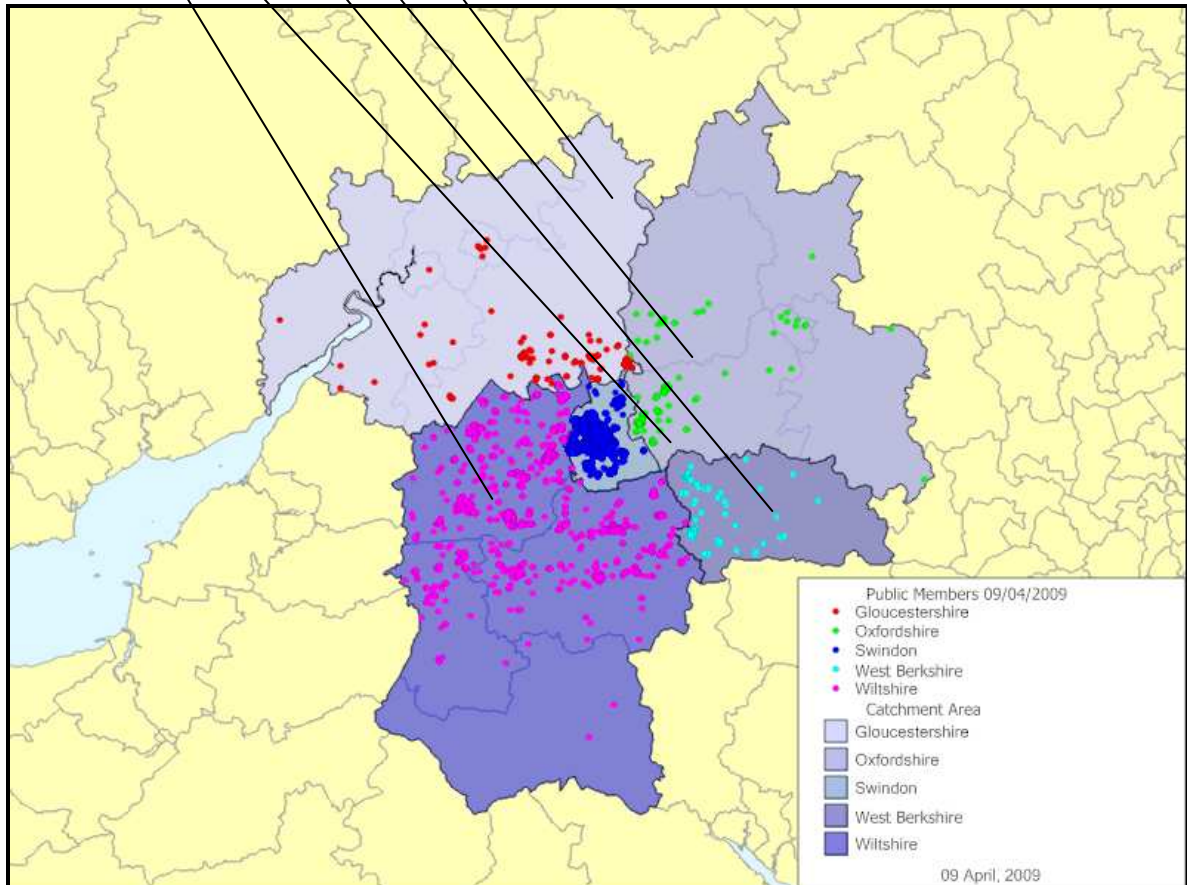
The Governors Membership Working Group have identified the 12-16 and 17-21 age groups as a target area and are looking at ways to engage with them. (The Trust's entry age for membership is 12 years)

We aim to increase representation in our Gloucestershire, Oxfordshire and West Berkshire constituency. This will be done via targeted mailings to service users and their families from those catchment areas. Work will also be undertaken with the

governors representing that constituency to use their local knowledge to build membership numbers.

The following diagram shows the public membership by constituency as at the start of 2009:

Gloucestershire  
Oxfordshire  
West Berkshire  
Swindon  
Wiltshire



## **Board Review of Membership Plans**

The Board of Directors and Council of Governors have formal meetings as well as workshops to review plans for membership development. The Board is kept abreast of membership movements and developments. Board Members also attend Governor Working Groups, enabling them to gain an understanding of consensus of opinion from Governors and members. They will also attend and present updates at constituency meetings. The Board can confirm that all elections to the Council of Governors are held in accordance with the election rules, as stated in the Constitution.

## **Present and Future Membership Plans**

The demographic indicators of our core catchment area have been used to describe our constituency and to target our membership plans.

Our service users represent the community we serve and therefore we would like as many of them to become members as possible. Mailings are also done to previous service users on a quarterly basis. Our quarterly newsletter GW Pulse also encourages membership by asking our current members to pass forms to any family or friends whom they think may be interested. The Trust is represented at external events to engage with the wider public.

The Trust will continue to use these strategies to increase its membership. We plan to target our previous service user mailings to groups in which we are underrepresented to ensure local accountability. We would also like to place particular emphasis on recruiting members who wish to engage and become more actively involved.

## **Engagement with Members**

We are now implementing our membership strategy. Members are being encouraged to attend Council of Governors meetings and the annual meeting for members will also be publicised for members to attend.

A Governor Working Group for Membership has been formed. The Group is designed to engage with members and build upon ideas which can then be fed back to the Council of Governors. The group is actively involved with new member recruitment projects. The Membership Working Group has plans to hold a members social event.

Each constituency has a meeting at which members can ask their questions and comments to the governors who represent them. They are held at a venue within the constituency to encourage members to attend.

A dedicated e-mail address has been set up for members to contact their governors. This e-mail address is publicised in our newsletter, which is distributed to members. This will also be where meeting dates for the forthcoming year will be published.

Focus groups dealing with specific service issues will be held throughout the year for members to attend. There will be specialist staff speaking, enabling members to ask questions and offer opinions. We are also hoping to canvas the opinions of our members on service topics electronically.

There will be an election this year. In our 2008 contested elections there was an average 56% turnout. This is a standard which the Trust would like to maintain and build upon.

## 6 Financial Projections

**Table 1 – Income and Expenditure Plan**

	<b>Plan</b>	<b>Actual</b>	<b>Current Plan</b>		
	<b>2008/09</b>	<b>2008/09</b>	<b>2009/10</b>	<b>2010/11</b>	<b>2011/12</b>
	<b>£'m</b>	<b>£'m</b>	<b>£'m</b>	<b>£'m</b>	<b>£'m</b>
<b>Income</b>					
NHS Elective	39.0	41.1	37.3	35.8	36.6
NHS Non-Elective	62.0	62.2	63.5	65.6	67.0
NHS Outpatient	31.8	33.4	36.1	36.4	37.2
NHS A&E	5.6	5.6	5.9	6.1	6.1
NHS Other	29.4	28.4	31.5	27.7	27.9
Private patient	2.4	2.3	2.7	2.8	2.8
Other	16.0	17.1	15.1	15.4	15.4
<b>Total income</b>	<b>186.2</b>	<b>190.1</b>	<b>192.3</b>	<b>189.8</b>	<b>193.1</b>
<b>Expenses</b>					
Pay	(103.8)	(107.6)	(108.9)	(107.8)	(111.3)
Drug	(11.6)	(11.0)	(12.0)	(12.0)	(12.4)
Supplies (clinical & non-clinical)	(15.8)	(17.4)	(18.7)	(18.5)	(18.1)
PFI	(26.3)	(26.1)	(10.6)	(10.8)	(11.4)
Other	(21.8)	(21.0)	(18.7)	(17.0)	(16.7)
<b>Total costs</b>	<b>(179.4)</b>	<b>(183.2)</b>	<b>(168.9)</b>	<b>(166.2)</b>	<b>(170.0)</b>
<b>EBITDA</b>	<b>6.8</b>	<b>6.9</b>	<b>23.4</b>	<b>23.5</b>	<b>23.1</b>
Depreciation	(3.4)	(3.3)	(7.6)	(7.7)	(7.6)
Net Interest	0.8	0.6	(11.9)	(11.8)	(11.3)
PDC dividend	(2.2)	(2.2)	(1.9)	(2.1)	(2.2)
	<b>1.9</b>	<b>1.9</b>	<b>1.9</b>	<b>1.9</b>	<b>2.0</b>
Exceptional items	0.0	0.0	0.0	0.0	0.0
<b>Net surplus / (deficit)</b>	<b>1.9</b>	<b>1.9</b>	<b>1.9</b>	<b>1.9</b>	<b>2.0</b>
EBITDA % income	3.7%	3.6%	12.2%	12.4%	12.0%

**Table 2 – Activity Plans**

	<b>Plan</b>	<b>Actual</b>	<b>Current Plan</b>		
	<b>2008/09</b>	<b>2008/09</b>	<b>2009/10</b>	<b>2010/11</b>	<b>2011/12</b>
Elective spells	32,311	35,828	31,327	30,456	30,795
Non-Elective spells	34,295	36,601	34,079	34,674	35,104
Outpatient FA & FU	245,664	316,907	307,573	313,263	320,147
A&E attendances	60,289	61,618	62,341	62,785	63,233

Elective activity for 2008/9 was higher than contracted levels due to delivery and sustaining of 13 weeks which wasn't included in the PCT activity quantum. The reduction in 2009/10 for elective, non-elective and out-patients relates to the transfer of work to the ISTC and the impact of the productivities.

**Table 3 – Cash Flow and Headroom**

	<b>Plan 2008/09 £'m</b>	<b>Actual 2008/09 £'m</b>	<b>2009/10 £'m</b>	<b>Plan 2010/11 £'m</b>	<b>2011/12 £'m</b>
<b>EBITDA</b>	<b>6.8</b>	<b>6.9</b>	<b>23.4</b>	<b>23.5</b>	<b>23.1</b>
Debtors	(1.3)	(0.8)	(0.1)	(0.3)	(0.3)
Creditors	3.6	5.0	2.2	0.4	1.3
Other change in WC	7.7	11.4	4.9	1.1	(0.8)
Non cash I&E items	(0.2)	(0.2)	(17.5)	(6.4)	(5.4)
<b>CF from operations</b>	<b>16.5</b>	<b>22.3</b>	<b>12.9</b>	<b>18.4</b>	<b>17.9</b>
Capital Expenditure	(3.8)	(2.6)	(3.9)	(3.9)	(3.9)
Net Interest	0.8	0.8	(9.8)	(9.5)	(9.3)
Dividends paid	(1.3)	(2.2)	(1.9)	(2.1)	(2.2)
Other	(0.1)	0.0	5.0	(0.8)	(0.6)
<b>Net cash inflow/outflow</b>	<b>12.1</b>	<b>18.3</b>	<b>2.3</b>	<b>2.1</b>	<b>2.0</b>
Opening Cash balance	2.1	2.1	20.4	22.7	24.8
<b>Closing Cash Balance</b>	<b>14.1</b>	<b>20.4</b>	<b>22.7</b>	<b>24.8</b>	<b>26.8</b>
Working capital facility			14.0	14.0	14.0
<b>Cash headroom</b>			<b>36.7</b>	<b>38.8</b>	<b>40.8</b>

**Table 4 – Balance Sheet**

	<b>Actual</b>		<b>Plan</b>	
	<b>2008-9</b>	<b>2009-10</b>	<b>2010-11</b>	<b>2011-12</b>
	<b>£m</b>	<b>£m</b>	<b>£m</b>	<b>£m</b>
<b>Fixed Assets</b>	<b>61.4</b>	<b>211.9</b>	<b>211.6</b>	<b>211.3</b>
Current Assets				
Cash	20.4	22.7	24.7	26.8
Other	9.6	8.8	9.0	9.2
<b>Total Current Assets</b>	<b>30.0</b>	<b>31.5</b>	<b>33.7</b>	<b>35.9</b>
Current Liabilities (Amounts Due In Less Than One Year)	(22.9)	(28.1)	(29.4)	(31.4)
<b>Net Current Assets (Liabilities)</b>	<b>7.1</b>	<b>3.5</b>	<b>4.3</b>	<b>4.6</b>
Long Term Debtors	7.6	2.0	2.4	2.7
Long Term Creditors	(0.6)	(0.3)	0.0	0.0
Finance Lease	0.0	(132.9)	(128.7)	(126.5)
Provisions	(6.2)	(5.6)	(5.3)	(2.4)
<b>Total Assets Employed</b>	<b>69.3</b>	<b>78.7</b>	<b>84.2</b>	<b>89.7</b>
Public dividend capital	27.1	27.1	27.1	27.1
Revaluation	28.2	38.3	41.5	44.8
Other	1.1	1.2	1.1	1.1
Income & Expenditure	12.9	12.1	14.4	16.7
<b>Total Funds Employed</b>	<b>69.3</b>	<b>78.7</b>	<b>84.2</b>	<b>89.7</b>

*Balance sheet for the year ended 31<sup>st</sup> March 2009 based on UKGAAP, plan is based on IFRS*

## Table 5 – Inflation assumptions

The assumptions used for in the plan for inflation are set out below. National tariff income uplifts are based on the PbR guidance, which includes 3%, 3.5% and 4% efficiencies in 2009/10, 2010/11 and 2012/13.

Cost inflation is based on the 3 year pay deal for staff on agenda for change pay scales, movements on healthcare price retail index and agreed uplifts within contracts.

<b>Inflation</b>	<b>2009-10</b>	<b>2010-11</b>	<b>2011-12</b>
	<b>%</b>	<b>%</b>	<b>%</b>
<b>Tariff Uplift</b>	<b>1.7</b>	<b>1.2</b>	<b>0.5</b>
<b>Cost Inflation:</b>			
Pay	2.3	1.8	1.8
Clinical Supplies	3.1	1.5	1.5
Drugs incl NICE	3.5	2.5	1.5
PFI charges	1.0	0.6	0.6
Other non-pay	3.6	1.5	1.5

## 7 Glossary of Terms

AAU	Acute Assessment Unit
A&E	Accident & Emergency Unit (now known as ED – Emergency Department)
CaAMHs/ CAAMHs	Child and Adolescent Mental Health Services
CDiff	Clostridium Difficile
CF	Carried Forward
CIPs	Cost Improvement Programmes
CMO	Chief Medical Officer
DGH	District General Hospital
EBITDA	Earnings before interest, taxes, depreciation and amortisation
ED	Emergency Department
EFM	Estates & Facilities Management
EWTD	European Working Time Directive
FM	Facilities Management
FRR	Financial Risk Rating
FA	First appointment
FT	Foundation Trust
FU	Follow up appointment
HCAI	Health Care Associated Infections
HIT	Hit Infection Together
HRG	Healthcare Resource Group
HSE	Health & Safety Executive
HSMR	Hospital Standard Mortality Rate
IBP	Integrated Business Plan
I&E	Income & Expenditure
IFRS	International Finance Reporting Standards
IP	Inpatient
IR1	Incident Reference Form 1
ISTC	Independent Sector Treatment Centres
JAG	Joint Accreditation Group
KPMG	Project Company employed by the Trust to support delivery of CIPs
MAJAX	Major Incident
MFF	Market Forces Factor
MRSA	Methicillin Resistant Staphylococcus Aureus
N12	Financial code for births
NHSLA	NHS Litigation Authority
NICE	National Institute of Clinical Excellence
OD strategy	Organisational Development
OJEU	Official Journal of the European Union
OP	Outpatient
Over Performance	Achievement of activity above budgeted level
PBC	Practice Based Commissioning
PbR	Payment by Results
PCT	Primary Care Trust
PDC	Public Dividend Capital
PFI	Private Finance Initiative
PPI	Private Patients Income
PSD	Planned Same Day (treatment)
Q (1, 2, 3 or 4)	Quarters of the financial year

RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
ROA	Return on Assets
RTT	Referral to Treatment Time
S22	Financial Code for a planned procedure not carried out
SLM	Service Line Management
SHA	Strategic Health Authority
SIC	Statement of Internal Control
SLAs	Service Level Agreements
SUI	Serious Untoward Incident
TIA	Transient Ischaemic Attack
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 2006
UK GAAP	UK General Accepted Accounting Principles
UKSH	UK Specialist Hospitals
VTE	Venous thrombo-embolism
WC	Working Capital