Salford Royal NHS
NHS Foundation Trust

University Teaching Trust

safe • clean • personal

Annual Plan 2012/2013

Contents

Section 1: Summary of Performance in 2011/12

1.1 Chair and Chief Executive's Summary

1.1.1 This report marks the end of another successful year for Salford Royal NHS Foundation Trust, the first year as a integrated provider of both hospital and community services

1.1.2 We are proud of Salford Royal's achievements over this last year. They include:

1.1.3 Having the lowest mortality rate in the North West, according to the national Dr Foster Hospital Guide;

1.1.4 Pioneering the 'harm free care' concept for improving patient safety - with some of the highest patient safety results;

1.1.5 Treating patients in our new, state-of-the-art Hope Building - the major clinical building within our redevelopment programme;

1.1.6 Opening *The Christie at Salford Royal* to provide care closer to home for patients with cancer;

1.1.7 Safely reducing our costs by £18m.

1.1.8 Being rated as the Best Acute Trust nationally in the NHS Staff Survey 2011.

1.1.9 We had one of the highest ratings in the country for staff recommending the Trust as a place to work or receive treatment.

1.1.10 Further details of progress in delivering the Trust's service and financial plans for 2011/12 are contained within section 2 and 6 of this report and detailed in the 2011/12 Annual Report.

Section 2: Strategy & Service Plans

2.1 Vision and Values

2.1.1 The vision and values to which Salford Royal NHS Foundation Trust aspires were set out in the 2009 service development strategy and remain relevant for 2012/13

2.1.2 Values have been further developed as the Organisational Development Strategy has been implemented and have become a fundamental part of the appraisal process and development of staff

2.1.3 The Trust, delivers care for **Patients** by being:

- The safest hospital in the country as measured by mortality and harm rates.
- Viewed as the leading hospital for Quality Improvement and the hospital of choice for patients in the North West.

- Focused on improving the patient experience, requiring respect, compassion and the right attitude to patients as our customers.
- Ensuring the highest standards of environmental cleanliness.

The Trust's approach is captured in the commitment to provide care that is 'safe, clean, personal'.

2.1.4 Supports **Professionals** by being:

- Attractive to staff, ensuring people have pride in working for the Trust, feel their contribution matters and want to deliver to their fullest potential.
- Supportive of clinical staff, enabling them to access appropriate education and training, to give of their best and be accountable for delivering safe and effective care.

2.1.5 Works with **Partners and the Public**:

- Respected by partner organisations – people will want to do business with Salford Royal.
- Promotes and upholds high standards of conduct in line with public service values of accountability, probity and openness.
- Works in partnership with primary care providers to give first class care to the people of Salford, promoting health improvement and integrating services.
- Supported by an active membership, people who are genuinely interested in seeing the Trust succeed and want to be involved in shaping the organisation's future.

2.1.6 An innovative, successful **Organisation** that is:

- Highly productive and understands its cost base in order to improve efficiency and generate surpluses for future stability and investment.
- Entrepreneurial, seeking out new opportunities to deliver excellent care and be successful commercially.
- Able to develop its position as a specialist provider of tertiary services.
- Successful in using information to take better decisions, monitor performance and drive improvement.
- Recognised for its contribution to the education of health care professionals and for innovative Research and Development (R&D).

2.1.7 In 2011/2012 The Trust agreed some core values to support the Trust's Quality Improvement aims and set out expectations as to how staff should behave towards each other and to patients. All members of staff at Salford Royal Foundation Trust are expected to be:

2.1.8 **Patient and customer focussed:**

- Communicates to all relevant parties in an holistic, timely manner
- Anticipates and delivers on patient needs
- Cares for the patient and their families as well as for Salford's reputation

2.1.9 **Supportive of continuous improvement:**

- Responds well to change and embraces initiatives
- Open to new ideas and encourages forward thinking
- Takes ownership for continuous learning and self development

2.1.10 **Respectful:**

- Strong focus and personal accountability on actions and results
- Takes responsibility for own actions
- Accounts for wider pieces of work rather than limited job description duties

2.1.11 **Accountable:**

- Acts as a team player; Recognises and rewards others
- Fosters a participative work environment
- Respects policies & procedures & resources

2.1.12 The strategy highlights the commitment to the development of a safety culture. The main elements of a safety culture being:

- Open and frequent communication
- High functioning multidisciplinary teams
- 'Just' culture (understanding of system vs. individual errors)
- Robust error reporting systems that 'close the loop'
- HR practices that support a culture of safety
- Leadership:
- Focus on never events
- Willingness to address bad behaviours
- Accountability for improvement and safety at all levels
- Measurement for improvement

2.1.13 Using Foundation Trust flexibilities to react quickly to changing challenges and opportunities

2.2 External Environment

2.2.1 The national healthcare environment changed significantly, largely associated with the Coalition government.

2.2.2 The NHS landscape will see significant changes: Greater Manchester has defined Clinical Commissioning Groups (CSG) which have reduced in number as optimal configuration has been agreed. Many have coterminous boundaries with Local Authorities. Many have ambitions to be considered for authorisation

2.2.3 Locality Boards are being replaced by CSG Governance arrangements and support the development of Health and Wellbeing Boards and integrated commissioning between CSG's and local authorities.

2.2.4 The clusters Clinical Commissioning Board is the formal committee of CSG leaders providing a lead on pan Greater Manchester collaborative and strategic commissioning.

2.2.5 The CSG Chairs have led on Pathology reconfiguration, Dementia commissioning, Stroke and cancer strategies as well as procurement of patient transport services. Salford Royal detail local plans in response to these in its plans.

2.2.6 Clinical Networks and the Greater Manchester Clinical Senate will be developed to support delivery of the 'Safe and Sustainable Strategy' and the Trust will be working with partners in response.

2.2.7 There have been a number of national policy changes that impact on the environment within which SRFT operates. These include:-

- A greater focus on competition: both *within the market* (Any Willing Provider) and *for the market* (tenders);
- Increased emphasis on patient choice, largely supported by the extension of the Any Willing Provider policy to a much broader range of clinical areas (e.g. community services, diagnostics, maternity, inpatients);
- An increased focus on outcomes though the national outcomes framework;
- The requirement for all existing Trusts to have secured FT status by April 2013, with take-over or merger required for those that can not pass this threshold.
- Removal of the private patient income cap for FTs;
- Changes to the tariff: short term adjustments, increased use of best practice tariff, potential for competition on price.
- Transfer of community services, primarily to acute and mental health Trusts.

2.2.8 The next few years are likely to see a drive to consolidate acute services, driven by a twin focus on clinical standards and tariff reduction. NHS Trusts that do not gain Foundation Trust status are likely to be franchised or see their services disaggregated.

2.2.9 Salford Royals strategic intent is to consolidate surgical services wherever it can be demonstrated that this will enable costs to be reduced and quality improved. This may be achieved through partnering with other organisations,

2.2.10 SRFT has considered its approach to mergers and acquisitions and agreed Acquisition of new services / organisations needs to bring tangible benefits to SRFT

2.2.11 The key consideration will be service fit, aligned to micro, meso, macro approach The Trust is unlikely to pursue geographically remote acquisitions (e.g. outside of Greater Manchester) nor is it interested in the franchise / turn-around model

2.2.12 In April 2011, the criteria were used to assess the invitation to bid for Trafford Healthcare NHS Trust. As a result of this, the Trust decided not to progress the bid unless an alternative service model was developed by commissioners.

2.2.13 SRFT has a strategic interest in services provided by Pennine Acute due its geographical proximity and natural population flows. If the Pennine Trust were not to secure Foundation Trust, the Trust would want to consider opportunities to acquire services at its North Manchester site. As well as having services that could enhance SRFT's portfolio, this would provide an opportunity to consolidate services thereby reducing cost and increasing service resilience.

2.2.14 The Trust will be undertaking a capacity review to understand the extent to which it could accommodate changes relating to the consolidation of services on the hospital site and to inform priorities for the next phase of the capital programme.

2.2.15 Following the acquisition of Trafford hospital by Central Manchester Foundation Trust, a consultation exercise will commence in Summer 2012. This will consider the

redesign of service provision across sites with some expected consequences in patient flow to SRFT. The Trust will continue to engage to ensure this is understood and planned for.

2.2.16 The Trust Plans reflect the commissioning intentions of National, Specialist and Local commissioners (Hundreds Health – Salford) as outlined in commissioning strategies and within the standard contract.

2.2.17 Further details of the financial implications of external factors are detailed in the Finance section 6 and refer to

- Tariff changes
- Changes in Non patient related NHS Income (Education, R&D, Provider to Provider SLA's etc)
- PFI Income & Costs
- The Unitary Payment (UP)
- Specialist Commissioners
- CNST
- Cost pressures within budget setting

2.3 Service Plans for 2012/13

2.3.1 Plans for 2012/13 aim to progress even further Salford Royal's position as one of the best NHS Trusts in the Country

2.3.2 The Service Plans are presented under the same priority themes identified as 'The Salford Royal way' in the 2010/11 and 2011/12 Plans and consistent with the service development strategy 2009-2014.

2.3.3 The Strategic themes include

- Pursuing Quality Improvement to become the safest organisation in the NHS
- Achieve cost improvements, income & cost targets to improve margins
- Supporting high performance and improvement
- Improving care & services through integration & Collaboration

Underpinned by

- Compliance with Mandatory Standards
- Implementation of Enabling Strategies

These are detailed further in the next section

Strategic Theme	Principal Objective
1. Pursuing Quality Improvement to become the safest organisation in the NHS	1.1 Maintain the relative risk of mortality to be within the top 10% of acute Trusts in the NHS
	1.2 Improve the reliability of care to be the safest organisation in the NHS
	1.3 Improve patient experience to maintain indicators in the top 20% nationally
2. Achieving Cost improvements, income and cost targets to improve margins	2.1 Safely reduce costs by £18m
3. Supporting high performance and improvement	3.1 Improve Staff Contribution to Corporate Objectives & Values
	3.2 Developing a High Performance Culture
	3.3 Implement the Membership Development Strategy
4. Improving care & services through integration & Collaboration	4.1 Deliver the Transformation Programme and develop opportunities for an Integrated Care System
	4.2 Integration & Collaboration within the North West Sector
	4.3 Collaborate within Greater Manchester & beyond
	4.4 Service Developments & Redesign
5. Demonstrate Compliance with Mandatory Standards	5.1 Clinical & Quality Standards
	5.2 Financial Standards
	5.3 IM&T Standards
	5.4 Access Standards
	5.5 Workforce Standards
	5.6 Buildings & Facilities Standards
6. Implement Enabling Strategies	6.1 Research & Development Strategy
	6.2 Under & Post Graduate Education
	6.3 Hospital Redevelopment/Estates Strategy
	6.4 IM&T Strategy
	6.5 Public Health & CSR Strategy

Theme 1: Pursuing Quality Improvement to become the safest organisation in the NHS

2.3.4 2012/13 will be the fifth year of a focus on Quality Improvement, with the 2011-2014 Strategy building on the original 2008-2011 Quality Improvement Strategy. The aim continues to be '*the safest organisation in the NHS*'.

2.3.5 The principal aims of the strategy are to reduce mortality and harmful events and to improve the patient experience

2.3.6 The Trust aims to provide safe, clean and personal care to every patient, every time. To achieve this activity is organised under 4 themes:

- Leadership;
- Measurement;
- Building staff capability; and
- A targeted portfolio of projects

2.3.7 Implementing the Quality Improvement Strategy requires the use of evidence-based methods and a rigorous discipline to the application of both methodology and techniques. We use the Model for Improvement in many of our quality initiatives as a framework to help us make changes. The Model for Improvement helps us to define what the problem is, state how we will measure whether our improvements are having an impact and define areas where we must make changes.

2.3.8 The Trust has also begun to develop the use of an approach called 'Clinical Micro systems'. This was initially tested within the intensive care unit and has now been spread through our harm free care work. Teams use the micro system approach to identify local improvements. Initial work has seen positive outcomes. The Harm Free Care project uses the clinical micro system technique.

Leadership

2.3.9 There are a number of initiatives to embed the core values and behaviours that will support the quality improvement aims.

- Executive Quality and Safety WalkRounds
- Integration into operational management within Divisions
- Staff training

Measurement

2.3.10 Dashboards have been created to measure improvements and these are monitored by the Board of Directors. These will evolve during 2012/13 to include additional measures

Workforce capability

2.3.11 The quality improvement and learning and development teams are working together to develop a competency framework for SRFT staff around quality and safety.

2.3.12 A comprehensive QI and Patient Safety programme has been established for middle managers and a first session has taken place.

2.3.13 A series of 90 minute modules on key quality and safety topics launched in March 2012. These modules will be offered to all groups but will be the next stage in the middle manager programme.

2.3.14 Quality improvement content is also being inserted into several existing training offerings, including: the clinical leadership programme and the band 6 & 7 development programmes

Clinical Quality Academy

2.3.15 The third CQA programme commenced in January 2012 and will involve 12 teams from a host of clinical areas. The programme will run up to a summit in November 2012 and details of what each team is working on can be seen below:

Project Title	**Project Aim**
Pain Team - Improving analgesia in the Elderly Hip Fracture population	Improving analgesia in the Elderly Hip Fracture population
ICU Delirium Team	To reduce accidental device removal on the ICU by 50% by August 2012
Palliative Care Team - Improving Care in the last year of life	1) Increase the percentage of people dying in their place of choice; 2) Decrease time spent in hospital by people in the last year of life; 3) Increase the use of LCP for expected hospital deaths 4) cost saving
Spinal Team -Direct Access Service, One Stop Injection Service	Set up One Stop Injection Service
Theatres Team - Flow of patients through Emergency Theatre	To decrease the number of emergency theatre patients not operated on within local NCEPOD guidelines by 50% by June 2012, then ultimately by 90% by 2014
Stroke Team	Study of factors influencing length of stay on the Stroke Rehabilitation Unit (SRU).
Renal Team - Steps to Success – Quality Improvement in Dialysis Nurse Education	50% of Band 5 & 6 dialysis nurses to reach "level 3 competent " by August 2012 (competency scale 1-5)
ICU (Nutrition Team)	To increase the number of enterally fed patients meeting their nutritional requirements to 90% by August 2012
EAU team - Patient Experience	Improve Patient experience in AAA
Radiology team - 1 stop clinic	Set up One Stop Service for head and neck specialty for thyroid lump patients
EAU team - Patient flow	Improve Patient flow
Theatres Team - Use of instrumentation and checklists	This group came to the CQA programme after the initial launch and are currently devising an aim

Details of projects being pursued in 2012/2013 are detailed under other headings

Maintain the relative risk of mortality to be within the top 10% of acute Trusts in the NHS

2.3.16 Reliable care is at the centre of the quality strategy, delivered to all patients, every time. The 'Salford Standard' developed in 2011/2012 will be further embedded within the organisation to ensure that there is consistency in care delivery across the working week.

Themes to be pursued will include a focus on compliance with the sepsis six and timely commencement of end of life care pathways.

2.3.17 Mortality will be measured by both HSMR (Hospital Standardised Mortality Rate) and SHIMI (Standardised Hospital Level Mortality Indicator) in 2012/13. SHIMI will add a focus on deaths within 30 days of leaving the hospital

2.3.18 The mortality review process put in place in 2011/2012 will continue to report themes and learning within Divisional Governance reporting mechanisms and between Divisions (i.e. Critical Care) where appropriate).

2.3.19 The Division of Neurosciences and Renal Medicine will pilot an electronic tool to support mortality reviews.

Improve the reliability of care to be the safest organisation in the NHS

Reducing Avoidable Harm

2.3.20 In 2012/13 there will be ongoing measurement of harms as commenced in earlier years these include

- Hospital acquired infections
- Cardiac arrests
- Safety Thermometer measures
  Pressure Ulcers, Falls, CAUTI &
  Venous Thromboembolism
- Intentional Rounding
- Medication errors
- Surgical Site Infections
- Sepsis

Other Quality workstreams include;

- Supporting Implementation of the Dementia Strategy
- Global Trigger Tool
- Advancing Quality Standards
  Acute myocardial infarction
  Heart Failure
  Community acquired Pneumonia
  Patient Experience Measures

2.3.21 Further embed the Salford Standard will be seven day working of acute physicians, development of standardized documentation and electronic records and evening reviews in Urology and General Surgery.

Reducing Length of Stay and Readmission

2.3.22 Length of stay will be measured to ensure patients do not stay in hospital any longer than they need.

2.3.23 Work commenced in 2011 to look at the impact of unnecessary admissions In 2012/13 there will be further work to reduce the readmission rate. Key projects include

- Alcohol assertive outreach
- Discharge planning
- Frail elderly
- Community Nursing

Pressure Ulcers

2.3.24 The Trust aims to

- completely eliminate all grade 3 and 4 pressure ulcers
- improve data collection in community services so improvements can be measured

- Focus on pressure ulcers related to devices

Falls

2.3.25 The falls steering group will review

- the policy and falls risk assessment process
- equipment
- the Falls Bundle

CAUTI (Catheter Associated Urinary Tract Infection)

2.3.26 The focus will be to reduce the number of days patients have a catheter fitted and the number of associated infections.

Intentional Rounding

2.3.27 The impact of intentional rounding will be monitored and all teams will be working to ensure intentional rounding is undertake reliably

Medication Safety

2.3.28 Measurement of drug administration errors will be developed and storage reviewed. The safer clinical systems initiative will also be progressed as part of a Health Foundation project.

Surgical Site Infections

2.3.29 The aim to achieve 95% compliance with surgical site care bundles will continue in 2012-2013. Further improvement work will focus developing best practice with standardisation of skin preparation, engagement with Community teams in respect of 30 day period post-op care, wound care, guidelines for dressing selection and use and practice in outpatient clinics and minor follow up procedures on surgical wards.

Sepsis

2.3.30 The sepsis project will be re-launched across Emergency and Inpatient areas

Dementia Strategy

2.3.31 The national dementia strategy has resulted in some targeted work within the QI Strategy and some Commissioner defined CQUIN's

The focus for 2012/13 will be to

- develop care pathways for patients with dementia
- develop training and awareness
- reduce the number of adverse incidents such as urinary tract infections and falls
- reduce the inappropriate use of anti-psychotic drugs
- Identify a named person to take responsibility for discharge co-ordination for people with dementia

Global Trigger Tool

2.3.32 The Tool will continue to be used to review records and measure a rate of harm.

QIDIS (Quality Improvement, Development and Initiative Scheme in Intestinal Failure

2.3.33 Priorities for the QIDIS project in 2012/13 will be to reduce waiting times for Radiology, review training and home care support for patients on home parental nutrition, improving outpatient flow, patient experience, referral processes and discharge planning

Improve patient experience to maintain indicators in the top 20% nationally

2.3.34 The experience of patients continues to be of utmost importance and it is the Trust's ambition that we make that experience the best that it can possibly be. The priorities are to

- Respect patients' values, preferences and expressed needs
- Coordinate and integrate care across boundaries of the system
- Provide the information, communication, and education that people need and want
- Guarantee physical comfort, emotional support, and the involvement of family and friends

Theme 2: Achieving cost improvements, income & cost targets to improve margins

2.3.35 Cost Improvement programmes have been agreed with all clinical divisions and corporate departments supported by a focus on improving profitability and margins.

2.3.36 A quality and safety assessment has been added to the governance arrangements of the safety reducing costs programme. The assessment is undertaken by the clinical divisions to ensure there is cross referencing across divisions and the impact plans have been thoroughly assessed for impact on service.

2.3.37 Details of the financial plans for 2012/13 are provided in section 5

Theme 3: Supporting high performance and improvement

Improve Staff Contribution to Corporate Objectives & Values

2.3.38 The core values agreed in 2011/2012 will support the Trust's Quality Improvement aims and set out expectations as to how staff should behave towards each other and to patients. These are set out in section 2 of this plan

Develop a High Performance Culture

2.3.39 The focus for 2012/2013 will be to deliver the Executive Development and Divisional & Directorate team performance & talent management programmes, a framework for earned autonomy and further development of clinical leaders

2.3.40 The approach will include

- Shared understanding & consistency across Divisions, defining autonomy and creating a compact between Divisions and the 'corporate entityDevelopment of a coaching approach and embedding a Divisional team coaching style
- Developing earned autonomy
- Developing a common purpose
- Mentoring and coaching to the second cohort of clinical leaders
- Undertaking performance assessments of clinical leaders using the new framework

Implement the Membership Development Strategy

2.3.41 In 2012/13 the Trust will further develop and implement the Trust's Membership Development Strategy. Key priorities will be

- to ensure the Trust's membership is representative of the population served during 2012/13 with focussed membership recruitment activity
- implement an effective Governor-led engagement programme that results in meaningful feedback to the Council of Governors and Board of Directors.
- Trust wide engagement activities focused on seeking views/feedback about key Trust services from staff, patients and public and using this information to make improvements and develop services

Theme 4: Improving care & services through integration & Collaboration

Deliver the Transformation Programme and develop opportunities for an Integrated Care System

2.3.42 Following the integration of Community services in April 2011, a transformation programme has commenced to ensure benefits are realised and pathways improved for patients. The projects include

- Adult Community Nursing
- Integrated Audiology & ENT Care Pathways
- Children's Scheduled Care
- Children's Unscheduled Care
- Emergency Assessment Unit
- Dermatology Services
- Discharge Planning
- Frail Elderly and Complex Care
- Frequent Fliers
- Long Term Conditions
- MSK Services
- Neurology Pathways
- Neuro Rehabilitation
- Sexual Health
- Urgent Care
- Anticoagulation

Work with partners to implement an integrated care programme

2.3.43 The Trust will redesign services for the frail elderly population and pilot the approach. Interventions in 2012/13 will be targeted in a locality within Salford to reduce hospitalisation and promote a commensurate increase in independence

Integration & Collaboration within the North West Sector

Pathology

2.3.44 The Pathology at Wigan and Salford (PAWS) formed in February 2012 will see changes to the service model operationalised in a phased approach during 2012/13. The service will deliver 20% costs savings and an increase in service quality as required by commissioners in 2012/13.

2.3.45 Discussions with pathology services in the South sector of Manchester hospitals will explore further opportunities for collaborative working

Radiology

2.3.46 Opportunities to work collaboratively to cover out of hours reporting and on call arrangements will be pursued in 2012/13.

Facilities

2.3.47 The Facilities team will explore opportunities to introduce Measured Term Contracts from small works, a single contractor for Theatre Validation and air handling maintenance and a joint review of Estates Staffing.

Occupational Health

2.3.48 The Occupational Health team is engaging with teams from Wigan and Bolton to develop collaborative working to reduce costs in some administrative areas such as training and policy provision whilst also collectively bidding for further external business to reduce the cost per head of the service.

Cardiology

2.3.49 There is agreement within the sector to develop services which complement each other, providing a full range of diagnostic services within the sector. The provision of cardiac imaging services at Salford Royal will be pursued in 2012/13.

Collaborate within Greater Manchester & beyond/Service Developments

2.3.50 In 2011/12 The 'Safe and Sustainable Strategy for Greater Manchester' set out commissioner plans for the future of secondary and tertiary services in Greater Manchester. The strategy focuses on improving clinical outcomes with Trusts working collaboratively to reduce the number of sites providing specialist services.

2.3.51 The Trust will continue to develop its position and pursue its ambition as a centre for complex cancer surgery.

Developing Cancer Services with the Christie Trust

2.3.52 A joint Management Board has been established with the Christie Trust to oversee ongoing collaboration between the Trusts. The Board will review operational issues including activity, patient experience, clinical outcomes and risks and strategic plans for proposed service developments and commissioning plans. Development of private patient services will also be reviewed by this board.

Existing and planned service collaborations include

Stereotactic Radio Surgery (SRS)

2.3.53 A joint operational policy has been developed to support this service and it will be expanded in 2012/13. Salford Royal will work with the Christie to agree how this service is developed to treat a wider range of cancers.

Solid Tumour Chemotherapy

2.3.54 Following the successful launch of The Christie at Salford radiotherapy centre, The Christie will be providing solid tumour chemotherapy in Salford's Haematology Unit in 2012 for common cancer types starting with breast. The service will be part of delivering cancer treatments closer to patient's homes

Acute Oncology

2.3.55 During 2012/2013 an Acute Oncology service (in partnership with The Christie) will be developed at Salford Royal which will improve access to oncology opinion, and allow for decisions to be made in coordinated and timely manner, reducing LOS and number of diagnostic tests.

Improved access to Neurology Services

2.3.56 Following implementation of the collaborative outpatient model the team will set up a system to accommodate emergency out patient access from emergency departments across Greater Manchester

Collaborative Commissioning for Neurosurgery

2.3.57 Following the successful implementation of collaborative commissioning arrangements in Neurology in 2011/12 the model will be replicated in Neurosurgery. A phased plan has been agreed with other Trusts in Greater Manchester.

Stroke Services

2.3.58 The Trust will also respond to the Greater Manchester review of Stroke services including re-evaluation of the Comprehensive Stroke model The service will also respond to commissioner requirements in respect to review of Stroke Units

Specialist Neurosciences

2.3.59 The teams will develop relationships with other specialist centres (The Walton Centre/Preston and Paediatric centres) to review the provision of specialist sub specialties, share good practice and learning

The Greater Manchester Renal Strategy

2.3.60 The Trust is working with Commissioners and partner Trusts to re-provide the Rochdale dialysis capacity and support the opening of capacity in Oldham. Capacity for dialysis across the sector will also be kept under review.

2.3.61 Models of care for satellite clinics and patients with Kidney injury will also be reviewed.

2.3.62 Arrangements to improve vascular access will continue to be pursued.

Neonatal and Children's Services

2.3.63 New relationships, reporting arrangements and Partnership Working following the 'Making it Better' reorganisation have been put in place and will evolve.

2.3.64 Liaison will continue with other organisations' specialist paediatric services in respect of transfer of patients required to stay longer than 24 hours in hospital.

Service Developments & Redesign

Trauma Centre

2.3.65 From April 2012 the Trust is identified as part of the Greater Manchester Trauma collaborative as a Major Trauma centre. This development will involve close working with Central and South Manchester Trusts as partner Trauma centres, designated Trauma units as well as all Greater Manchester Trusts, NWAS and specialist centres.

2.3.66 The Trauma model is based on agreed patient pathways and repatriation criteria. The Trust has demonstrated compliance against the key standards in a peer review in March and will keep these under review as the key milestones in implementation are met. There is a phased approach to opening up capacity and implemented pathways across the day and week

2.3.67 The Trust will open a polytrauma ward and increase Neuro-rehabilitation capacity to meet the demands of the new model.

Dermatology Strategy

2.3.68 In developing the Dermatology Strategy in 2011/12 some general principles were agreed as outlined in the Directors report. In 2012/13 the Strategy will be further developed and implemented including

- Defining catchment and service models
- Implementing Outpatient improvement
- Align service with Research & Development activity
- Responding to tenders as they arise
- Pursue the opportunities of partnership working with the private sector /charities
- Identifying the dermatology private provider market within Greater Manchester and potential opportunities
- Develop a private patient service delivery model
- Developing the MOH's service
- Piloting of telemedicine

Outpatient Improvement Plan

2.3.69 The Trust is developing a 10 year strategy for improvement in outpatients to develop new service models and improve patient experience. The review commenced in 2011/12 and is being rolled out across specialties in 2012/13. The project encompasses review of

- Department Structure
- Communication
- Appointment & Way finding
- Information during clinic /Consultation
- Complaints
- Waiting times
- Reducing unnecessary attendances
- Reducing DNA's
- Reducing Follow ups
- Use of technology
- Facilities/location

2.3.70 The review will consider service models which differ from those traditionally provided including use of telemedicine.

Theme 5: Demonstrate compliance with Mandatory Standards

2.3.71 There are an increasing number of mandatory standards under the following headings

- Monitor Standards
- Care Quality Commission Standards
- National, Specialist Commissioner and Local Commissioner CQUIN standards

2.3.72 These are assigned within the organisation in line with the assurance framework to be managed by service lines, directorates and divisions.

2.3.73 Assurance on compliance will be received through the divisional and corporate assurance committees

Theme 6: Implement Enabling Strategies

2.3.74 The enabling strategies in this section are reviewed and updated as part of the annual planning process and where necessary to reflect longer term strategic intentions

Deliver the Research & Development Strategy

2.3.75 In 2012/2013 the Research and Development Strategy will be refreshed to realise Salford's potential

as a Centre for Population Health Improvement this will be underpinned financial plan for growth and investment. The strategy will enhance the Trust's ability and awareness of innovation and to maximise success in achieving external funding. Public engagement will continue to be developed in clinical research through the citizen scientist project

2.3.76 The development of the Strategy will include a review of Commissioning changes and engagement with the emergent structures in primary care and the wider health economy. Working arrangements with all partner organisations engaged in research activity and standardisation of sharing arrangements within MAHSC will be agreed. The contribution of MIMIT, Trustech and other organisations that support innovation within the Trust will be reviewed

2.3.77 Within the Trust there will be better links made with both service and quality improvement teams to enable translation of research into clinical service and health improvement, identification of clinical leads within Divisions will be key to realising these changes. Infrastructure to create a Clinical Research Facility to underpin research delivery will be reviewed

2.3.78 A research training academy will be developed with the appointment of a Professional lead and sign up from the research establishment (research nurses, associates and AHPs).

2.3.79 Key performance indicators will be confirmed after consideration of those to be developed nationally, within MAHSC, those required for Quality Accounts and for NIHR. These will include KPIS in the areas of Research Governance, delivery, capacity and outputs

2.3.80 The team will undertake a review of MHRA inspection readiness & implement measures to ensure compliance with regulatory and other standards

Deliver Under & Post Graduate Teaching

2.3.81 Standards for Undergraduate Medical Education are set by the University and sector and monitored under a series of domains to ensure Patient Safety, Quality Assurance, delivery of the curriculum, appropriate educational resources & capacity, Equality Diversity & Opportunity, Staff recruitment & selection and support & development of student, tutors & local faculty.

2.3.82 Post Graduate Medical Education will be provided in accordance with PMETB Standards.In order to achieve this consultant job plans have been reviewed to ensure the scheduled teaching sessions are delivered as planned and teaching takes place as part of the normal consultant work programme. Outcomes are measured by exam results and student feedback.

2.3.83 Review of Educational SPA’s, supervisors and tutors has been encompassed within the appraisal system and service level agreements are being developed between Education and service to ensure standards and met and maintained.

2.3.84 Training for Nurses and Allied Health Professionals will be delivered with placements in hospital and community services. Outcomes will be monitored by results and feedback from students

2.3.85 Work will continue to ensure there is increased transparency of funding streams into clinical divisions so that this can be demonstrated to the University and sector in the renegotiation of educational funding.

Deliver the Hospital Redevelopment Strategy

2.3.86 2012/2013 will see the final stages of the PFI redevelopment and new plans for reconfiguration and development of the estate. Projects include

- The final phase of the PFI redevelopment in June 2012. This will see the completion of the patient and visitor car parks, landscaping, a new Main Entrance and supporting accommodation on the ground floor of Hope Building.
- Opening of a Polytrauma ward (B3/4)
- Reconfiguration of the old A&E area to adapt the space to create an inpatient discharge lounge; PANDA waiting area and office accommodation; mental health accommodation
- The reconfiguration of the Main Outpatient reception including self check in
- Repatriation of GI Physiology from the University Teaching Building to Endoscopy. Second phase of adaptation of Level 1 for Day surgery.
- The introduction of a new site wayfinding strategy
- Adaptation of Pathology to Redesign the space to take account of Wigan work
- Relocation of the Spinal Ward
- Increased theatre capacity including the upgrade of the maternity theatre for spinal procedures and creation of an injection room to free up capacity in theatre 9
- Turnberg Level 3 including interventional radiology- Replacement and additional angiography room. An additional fluoroscopy room and 2 new theatres
- Conversion of Level 0 for Receipt & Distribution. Realignment of external road layouts
- Ward refurbishments and upgrade of sanitary accommodation
- Development of a strategy for office accommodation on site and in the wider estate
- A Second VIE Plant
- A Second server room
- Development of a strategy to decant and demolish the clinical sciences building (CSB)
- Develop plans and costs to build on the CSB site

Deliver the IM&T Strategy

2.3.87 The priorities for 2012/13 include;

- Procurement of a new EPR system to replace and extend the scope of the existing electronic record and future proof with additional functionality.
- Improving GP communication and development of GP requesting
- Improved support to clinical pathways within the Trust including electronic requesting of pathology and radiology, electronic requesting of investigations and referrals, elective surgical pathways
- Supporting the Outpatient Improvement plan, including the introduction of an outpatient appointment text reminder service and self check in system.
- Providing integrated records within Salford and developing links with partner organisations including;

the transfer of former Salford Community Health records onto the Patient administration system, development of NWeH to support the Salford Lung Study,

clinical access of data from the Christie and South Manchester Foundation Trusts

integration of Pathology services

- The team will also pursue the further roll of EDMS scanning, patient centre and SMART workforce management system
- New technologies will be reviewed including enabling the piloting of Telemedicine.

2.3.88 In year there will also be a review of the IM&T infrastructure including development of a second data centre.

Deliver the Corporate & Social Responsibility & Public Health Strategy

2.3.89 The Trust continues to implement the strategy agreed in 2011/12 with the following priority themes

2.3.90 The Patient & Staff Health & Well Being objectives include

- Alcohol screening & referral in pre-operative assessment
- Brief intervention & referral to smoking cessation services
- Reduced Accidental injuries in children
- Supporting Infection Control measures in hospital and community

2.3.91 The social responsibility element of the strategy includes

- Further Implementation of the Volunteering strategy
- Increased community engagement
- Work placements and career opportunities
- Engagement with the membership in respect of service developments and redesign

2.3.92 The sustainability and environmental impact part of the strategy builds on the work done so far and has set further targets to

- Reduce and recycle waste
- Reduce energy use
- Reduce carbon emissions
- Implement the Green travel plan
- Increase the use of local and fair-trade goods

2.4 Leadership & Governance

2.4.1 In order to effectively implement the Trust's objectives, each clinical and non clinical team have interpreted the objectives of the organisation and agreed Divisional and departmental objectives.

2.4.2 In turn, these are being translated into team and personal objectives.

2.4.3 The Corporate and Divisional Assurance Frameworks, Service Review and Appraisal Processes will provide the framework to monitor progress against objectives.

2.5 Risk Analysis

2.5.1 The Trust reviewed its Assurance framework for 2012/13 to ensure that all elements of the organisational objectives and risks are managed by Assurance Committees on behalf of the Board of Directors.

2.5.2 The sub-committees of the Board are:

- Executive Risk & Assurance Committee

Executive Governance Committees include:

- Quality & Safety Committee
- Patient & Staff Experience Committee
- Finance & Information Committee
- Clinical Effectiveness Committee

The Trust also has a:

- Strategy Advisory Group
- Hospital Redevelopment Group

2.5.3 From 1st April 2011 the four clinical Divisions have developed Divisional assurance systems replicating the functions of the Executive Governance Committees for their Divisions. These will continue to mature in 2012/13.

2.5.4 The Trust has established systems and has processes in place to manage and mitigate significant risks:

- Trust Board review of Board Assurance Framework, risk register and action plans.
- Audit committee scrutiny of controls in place.
- Review of serious incidents and learning by the standing committees.
- Review of progress in meeting Care Quality Commission Standards through service reviews and the board's assurance committees.
- Internal Audits of effectiveness of systems of internal control.

2.5.5 In setting its development plans for 2012/13, the Trust has reviewed residual risks from the 2011/12 Assurance Framework to ensure these are addressed within its objectives.

2.5.6 The issues below identify the risks that the Board of Directors considers to be of particular significance. There maybe other risks or uncertainties not yet identified by the Trust that could impact on future performance.

The Trust continues to face risks to achieving its strategic developments. A robust Assurance Framework is maintained which enables the identification, analysis and management of risk. The issues below describe the risks that the Board of

Directors considers to be of particular significance. There maybe other risks or uncertainties not yet identified by the Trust that could impact on future performance.

Medical Education
Risk:
If consultant educators are unable to provide adequate training opportunities for junior medical staff, then placement of future medical staff may be at risk.

Management Control:
Clinical Divisions and Hospital Dean for post-Graduate Education to ensure understanding, agreement and effective implementation of adequate protected educational time in consultant educator job plans.

Cancer Surgical Services
Risk:
There is a risk that the commissioner framework for developing cancer surgical services across Greater Manchester may not be consistent with Salford Royal NHS Foundation Trust's business plan.

Management: Control
Preparations underway to promote SRFT's preferred configuration.

Management of Intermediate Rehabilitation Units
Risk:
If intermediate rehabilitation across Greater Manchester is not managed effectively, then patient flow and quality of care will be adversely affected.

Management Control:
SRFT actively pursuing solution with commissioners, network boards and neighbouring FTs.

Trauma Centre
Risk:
If the Trust fails to deliver the required standards as a Greater Manchester Trauma Centre, then the intended improvements in patient outcomes will not be realised.

Management Control:
Comprehensive Divisional objectives and action plans in place, which are being overseen to completion by a designated project manager. Collaborative working across the Greater Manchester health economy.

Risk:
If the assumed activity for the Trauma Centre is not realised then income and sustainability of the service will be at risk.

Management Control:
Pathfinder protocol agreed with the NW Ambulance Service to ensure trauma patients are correctly identified. Robust monitoring arrangements and performance dashboard.

Healthcare acquired infections
Risk:
If the Trust fails to have effective measures in place for the prevention of Clostridium difficile infections then patients may be adversely affected and financial penalties will be applied

Management Control:
Effective and proven-effective infection control programme in place. Work underway with primary care colleagues to ensure appropriate antibiotic prescribing.

Theatre accommodation
Risk:
If the Trust is unable to obtain alternative off-site theatre accommodation then essential theatre maintenance and

upgrade will not be possible impacting on patient care and achievement of business objectives.

Management Control:
Plan underway to secure theatre space at neighbouring hospital.

Section 3: Declarations and Self Certification

Self Certification

3.1 Separate templates are included with the Annual Plan submission, as required but are also set out below including the signatures of the Accounting Officer and the Chairman.

Board Statements

Quality

3.1.1 The board is satisfied that, to the best of its knowledge and using its own processes and having assessed against Monitors Quality Governance Framework (supported by Care Quality Commission information, its own information on serious incidents , patterns of complaints, including further metrics it chooses to adopt), its 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.

3.1.2 The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements

3.1.3 The board 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

Finance

3.1.4 The board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months

3.1.5 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.

3.1.6 The board will ensure that the trust remains at all times compliant with its Authorisation and has regard to the NHS constitution;

Governance

3.1.7 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 - or there are appropriate actions in place to addre ss the issues - in a timely manner.

3.1.8 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

3.1.9 The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily

3.1.10 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

3.1.11 The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix B of the Compliance Framework; and a commitment to comply with all known targets going forwards.

3.1.12 The trust has achieved a minimum of Level 2 performance against the key requirements of the Information Governance Toolkit.

3.1.13 The board will ensure that the trust will at all times operate effectively within its constitution. This includes: maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; that all board positions are filled, or plans are in place to fill any vacancies; and that all elections to the board of governors are held in accordance with the election rules.

3.1.14 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 risks and ensuring management capacity and capability

3.1.15 The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual plan; and the management structure in place is adequate to deliver the annual plan

3.1.16 For an NHS foundation trust engaging in a major joint venture, or any Academic Health Science Centre, the board is satisfied that the NHS foundation trust has fulfilled, or continues to fulfil, the criteria set out in Appendix C of the Compliance Framework

Signed on behalf of the board of directors, and having regard to the views of the governors

David N. Dalton
In capacity as Chief Executive and Accounting Officer

James J. Potter
In capacity as Chairman

Signed on behalf of the Board of Directors, and having regards to the views of the governors.

Section 4: Foundation Trust Membership

4.1.1 Within the Trust's 2011/2012 Annual Plan, a principal objective was the implementation of the Membership Development Strategy. The objective was to increase a representative membership and ensure engagement in service development and redesign. We believe that involving members, public and patients in decisions leads to increased patient satisfaction, more positive outcomes and improved relationships with patients. Our members provide a means by which the Trust can engage with the communities it serves with regard to their views of its services and their needs and wishes in respect of future development.

4.1.2 The objective remains in 2012/2013 with further development of the Membership Engagement Plan

Membership Eligibility Requirements

4.1.3 Salford Royal NHS Foundation Trust membership community includes two classes of members – Public and Staff.

Public Members:

4.1.4 There are nine public constituencies – eight of these coterminous with clusters of Salford City Council wards, the ninth is for people who live in any areas served by the Trust but outside of Salford. All members of the public who are over 16 years of age, living in one of the following constituencies can become a member:

Claremont, Weaste and Seedley
East Salford
Eccles
Irlam and Cadishead
Little Hulton and Walkden
Ordsall and Langworthy
Swinton
Worsley and Boothstown
Outside of Salford

Staff Members:

4.1.5 Staff who are permanently employed by the Foundation Trust or hold a fixed term contract of at least 12 months, or who have been continuously employed by the Foundation Trust for at least 12 months are automatically registered as members unless they choose to opt out.

Membership Overview

4.1.6 Following implementation of planned recruitment initiatives throughout 2011/2012 the Trust has exceeded all public membership targets. Targeted recruitment initiatives will be planned for 2012/2013 to ensure the Trust is on course to achieve its 5 year membership target and is truly representative of the community it serves. However, the main focus for 2012/2013 will be further recruitment to ensure membership is representative of the population served and aligning member, patient and public engagement as set out in the Membership Development Strategy.

4.1.7 The following tables analyse the current and estimated membership figures for a number of indicators to highlight areas of representation.

Public constituency	**2011/12**	**2012/2013 (Estimated)**
At year start (April 1st)	13,491	14,216
New Members	1,781	484
Members leaving	1,056	400
At year end (March 31st)	14,216	14,300
Staff constituency	**2011/12**	**2012/2013 (Estimated)**
At year start (April 1st)	4,844	5503
New Members	1,278	200
Members Leaving	619	103
At year end (March 31st)	5503	5600

Membership Information

4.1.8 The Trust set out its objectives to increase a representative membership and ensure engagement in service development and redesign within the Membership Development Strategy. The Communications and Marketing Sub-group of the Council of Governors worked in partnership with the Trust's Membership Engagement Manager and supporting members of the Board of Directors to develop a Membership Engagement Plan (MEP) to support this Strategy. The MEP 2011-2012 included planned initiatives for recruitment and engagement with members, patients and other key stakeholders. Within the Strategy the Trust committed; and will continue to commit in 2012/2013, efforts to engaging people who are easy to overlook within our membership constituencies.

4.1.9 The Quality Subgroup of the Council of Governors receives assurance from the Trust on the progress of the Quality Improvement Strategy and quality of patient care via a robust reporting schedule. In addition, the Quality Subgroup have worked in partnership with the Membership Engagement Manager and supporting members of the Board of Directors to engage with members regarding 'Quality' related matters. In response to the National Patient Survey results the Trust developed an action plan, from which the Quality Subgroup identified areas for direct membership engagement; ensuring members are involved in the improvement of services. One area selected was improving the patient experience. Governors led Patient Information Workshop which considered and discussed different sets of patient information. Feedback from the event is being used to establish key guiding principles for the production of written Trust documentation and a checklist of key considerations to form part of the final sign off process in order to publish documentation.

4.1.10 The Strategic Direction Subgroup of the Council of Governors has supported the Trust in the production and review cycle of the Service Development Strategy and Annual Plan. The Strategic Direction Subgroup had a key role in the identification of relevant stakeholders and groups within the community with whom the Trust must engage to inform the future plans of the Trust. In 2011/2012 the Trust continued to develop its engagement with Community Committees, Patient Interest Groups and Salford LINk, in addition to the wider Foundation Trust membership. Over 1000 Level 2 and 3 members contributed to the formulation of the Trusts Annual Plan 2011/2012 via an annual membership survey. In addition a wide range of community and voluntary groups were consulted regarding priorities for the forthcoming year. This process was repeated during 2011 in order to inform the Annual Plan 2012/13, with over 1200, 36% of Level 2 and 3 members completing the annual membership survey. Again, a number of key stakeholders and community and voluntary groups were

consulted including Greater Manchester Neurological Alliance, Community Committees, Salford Disability Forum, Salford LINk and Salford Carers Partnership Board.

4.1.11 To ensure regular communication with members the Trust implements a number of feedback mechanisms these include; quarterly membership newsletter including engagement updates and information on how members can get involved, membership events and the Trust's Annual Open Day.

Section 5: Financial Plans

5.1 Introduction

The financials contained within that Annual Plan cover the three years 2012/13 to 2014/15, with the 2012/13 being the budgets approved by the Board in March 2012, as adjusted for any known changes, along with 2013/14 and 2014/15 assumptions being approved by the Board of Directors at its May 2012 meeting.

5.2 Contractual Position with Commissioners

5.2.1 Activity

The following table sets out the summary position of the activity plans agreed with Commissioners as part of the process of signing contracts for 2012/13.

Heading	Plan 2011/12	Forecast Out turn 2011/12	Proposed Plan 2012/13
In-patients			
Day Case	29,351	29,659	30,059
Electives	11,531	11,428	11,170
Non Elective	39,321	37,893	32,196
Out-patients			
New	91,043	86,111	84,594
Follow Up	233,293	228,008	222,551
CATS Activity	34,899	21,500	24,486
Other	4,181	3,975	3,948
Community Contacts etc.	592,831	576,910	588,709

5.2.2 Movements from Forecast Out-turn to 2012/13 Plan

The major movements in both in-patients and out-patients relates to the removal balance to full year of the Maternity and Neonates changes, with 8,800 Non Elective spells and 6,400 Out-patient attendances coming out of the contractual activity.

5.2.3 Process for agreeing contracts 2012/13

Contracts with the majority of main Commissioners were signed in line with the Department of Health guidance by the 15th March 2012.

The process by which activity plans have been agreed with Commissioners is as follows.

- The month 7 (October 2011) cumulative actual activity is the starting point this position is then projected forward on a straight line basis to give a 12 months forecast position.
- A number of known changes are then made to this forecast position which include technical changes, service developments and any service design and / or capacity changes. These are then mutually agreed with the Commissioners and are reflected in the activity plans that are used as the baseline for 2012/13
- This activity is then valued at the appropriate prices either national or local tariff.

5.3 New Contract Structures, Quality and Obligations

5.3.1 Overview of the contract

On 15th March 2012, the Trust signed a new legally binding contract with commissioners for 2012/13. The new contract is similar to previous contracts in terms of content, but there are significant differences in terms of

the structure of the contract (with more focus on services rather than core legal requirements) and the contract covers both acute and community services and incorporates the policy requirements from the Operating Framework. With the exception of the NCG Contract (see section 2.5) all material contracts have been signed with commissioners.

The key elements of the contract are described below.

5.3.2 Quality

Quality indicators (KPI's and CQUIN's) lie at the heart of the contract reflecting the message from the 2012/13 Operating Framework that "*The NHS is moving to a system where quality and outcomes drive everything we do".* For 2012/13, the Trust has agreed:-

- 6 national CQUIN indicators (covering the 4 national goals of VTE risk assessment, patient survey, dementia and NHS safety thermometer)
- 23 Greater Manchester Cluster CQUINs (harm free care and public health indicators)
- 6 Regional (AQ) CQUIN goals
- 16 local CQUIN goals
- 85 Key performance indicators
- 25 "never events"

These CQUIN's and KPIs have been negotiated by the contracting team in conjunction with Divisional Managing Directors, senior managers, Divisional Directors of Nursing and service leads. For 2012/13 the value of the core contract CQUIN's equates to 2.5% of the overall outturn value of the contract (approximately £5.1m for core services)

5.3.3 Contractual Obligations

The contract describes the responsibilities of both the Commissioner and the Trust in the commissioning and delivery of services for 2012/13. The content includes:-

- Agreed protocols (including the outpatient follow-up and consultant to consultant protocols, prior approval protocol, cancer breach sharing policy and protocol for the performance management of the contract) and service specifications (including those which are included within the contract but require further review as part of the service development and improvement plan)
- Finance and activity plan
- Eliminating Mixed Sex Accommodation (EMSA) plan
- Equality and diversity plan
- Information requirements and monitoring
- Safeguarding and SUI policies
- Core legal clauses (see below)

5.3.4 Core legal clauses

There are a number of core legal clauses which need to be brought to the attention of the Committee. Most of these clauses are not new but it is worth reviewing specific elements as we embark on a new contracting year.

- Care planning
- Tertiary referrals
- VTE
- Coding
- Information requirements
- Cancellation of operations
- Prior approval scheme
- Financial adjustments

- Sub-contracting
- Variations

5.3.5 PbR rules

The contract reflects PbR guidance for 2012/13. The main changes from 2011/12 PbR rules are:-

- **Best Practice Tariffs** – an increase in the number of best practice tariffs e.g. for paediatric diabetes as well as extensions to existing BPTs e.g. for procedures undertaken in a day case setting
- **Introduction of Post Discharge Tariffs** – for cardiac rehabilitation, and rehabilitation following hip and knee replacements
- **Emergency readmissions** – from 1st April 2012 the readmissions policy will be based on a clinical review of readmissions. Trusts will not be reimbursed for any proportion of readmissions judged to have been avoidable *by any agency* following a review by a panel led by a GP or public health physician but including relevant clinical staff from the Trust. NHS Salford has already stated that they intend to build on the work undertaken by the clinical divisions within SRFT during 2011/12. It is anticipated that the impact of this initiative will be considerably less than the 2011/12 impact of circa £1.5 million. Whilst work has yet to commence on this it is anticipated that this will be managed within the committed reserves set aside.
- **New mandatory tariffs** – for direct access diagnostic imaging
- **Chemotherapy** – introduction of mandatory currencies
- **Tariff** National adjustment of -1.8%, it is estimated that the value of tariff deflation and the impact of PBR changes in 2012/13 is a reduction in income of circa £3.3 million pounds and this is built into these contracts and financial plans.

5.3.6 Specialist Commissioning

For 2012/13 we have agreed a separate contract for specialist commissioned activity. For SRFT this covers renal, neurosurgical and spinal activity plus (as part of the "minimum take") major trauma and bi-ventricular pacing. The specialist contract mirrors the contract agreed with NHS Salford to a large extent but there are a number of sections which are specific to the specialist contract such as the service specifications, activity and finance plans, CQUIN goals (described below) and information requirements.

The specialist commissioned contract has its own CQUIN goals which reflect the national CQUIN goals plus the development of clinical dashboards for renal services and major trauma and three renal specific CQUIN goals. The specialist CQUIN goals equate to £1.5m.

In addition the opportunity has been taken to re-balance a number of local tariffs that have, over time, got out of synch with the costs of those services. Effectively a circular flow of monies has been actioned that re-balances a number of tariffs that yielded significant profits (e.g. Neurosciences Out-patient tariffs) with the offset being increases that are equal and opposite in value (e.g. Spinal HRG's)

5.4 Summary Income and Expenditure Position – 2012/13 to 2014/15

The following table sets out the summary Income and Expenditure Position for the 3 years covered by the Annual Plan, with the 2012/13 numbers being based upon the March 2012 Budget approved by the Board of Directors, with the assumptions under pinning the 2013/14 and 2014/15 numbers are as set out below. Further details of the Income and Expenditure for the

three years of the Financial Plans can be found in Appendix 1(i) for 2012/13, Appendix 1(ii) for 2013/14 and Appendix 1(iii) for 2014/15. The full exposition of the financial plans can also be found with the Monitor Templates that accompany the Annual Plan submission.

	2012 / 2013 £000's		2013 / 2014 £000's		2014 / 2015 £000's	
Income	**400,215**		**395,597**		**388,577**	
Operating Expenditure	**377,145**		**370,327**		**361,100**	
EBITDA		**23,070**		**25,270**		**27,477**
Interest Receivable		**(85)**		**(85)**		**(85)**
Depreciation		**8,704**		**9,027**		**9,774**
PFI Depreciation		**2,278**		**2,331**		**2,793**
PFI Interest Payable		**4,354**		**6,007**		**6,422**
Contingent Rent		**1,199**		**1,253**		**1,309**
Unwinding of Discount		**60**		**60**		**60**
PDC Dividends		**3,683**		**3,830**		**4,372**
Surplus / (Deficit)		**2,878**		**2,847**		**2,832**
Normalising Adjustments:						
Impairment Reversals		**0**		**4,621**		**4,735**
Surplus / (Deficit)		**2,878**		**7,468**		**7,567**

5.5 Factors Affecting Income

Within the Budget Setting Paper to the March 2012 Board of Directors Meeting the 2012/13 budgeted income is largely based upon the forecast out turn of 2011/12 adjusted for any known changes in activity levels. This was then priced at the agreed PBR and Non PBR tariffs, opportunity has been taken to rebalance a number of local Tariffs to ensure that costs equals price, this has been done with the agreement of commissioners.

5.5.1 Tariff Deflation

Given that the overall impact of tariffs on SRFT in 2012/13 was a reduction in overall income of circa 1.5%, it is likely that the Department of Health will wish to reduce the tariffs in future years essentially reflecting the need for the Acute Sector to deliver efficiency at a level broadly similar to that seen in the last few years (circa 4% to 5%). The overall level of tariff income has been reduced by a further 1.5% in 2013/14 (£5.1 million) and a further 1% in 2014/15 (£3.4 million) to reflect this continued trend, but with a downsizing of the reduction in income to reflect the increase in costs that are likely to be at play during 2014/15 that are usually factored into the DH tariff deflator (see expenditure section for details).

5.5.2 Tariff Pricing

No further changes to tariff pricing constructs have been forecast within 2013/14 and 2014/15.

5.5.3 Non PBR Tariffs

A reduction of 1.5% has been included with 2013/14 and a reduction of 1% in 2014/15 the values are included within the financial plans.

5.6 Other Changes to Income

5.6.1 MIB Transition

The budgets presented with this paper are net of the full consequences of the Making It Better arrangements. The un-releasable costs of £2.5 million will be dealt with via the overall Safely Reducing Cost (SRC) Programme, as £1.4 million of the transitional relief is included within the

income steams for 2012/13, effectively meaning that £1.1 million is part of the SRC requirement in 2012/13. The remaining £1.1 million will be dealt with in 2013/14, with £0.8 million of transitional funding being paid to the Trust.

5.6.2 Changes to Education Tariffs

There have been a good number of attempts to make changes to the method of funding Education. The changes will start to be implemented with effect from 1st October 2012. The exact values that will impact on the Trust have yet to be finalised. However, given likely size of the changes the Department of Health have indicated that no more than 0.25% of Trust turnover should be taken from any trust through the transition in any one year. Given that 0.25% of Trust turnover is estimated to be £800K and the start date is the 1st October 2012, it is anticipated that the 2012/13 impact is £400K, and a Reserve has been set aside accordingly, with the full £800K being lost in each of the subsequent two years (2013/14 and 2014/15).

5.6.3 NHS Bank Funding

Board members will recall that the Trust had received £14.7 million of "NHS Bank" Funding via the SHA and the full value of that funding (cash backed) was sitting within the deferred income on the Trust's statement of financial position. However, given the Department of Health policy on the ability of Commissioners to provide funding in advance of need, the SHA has withdrawn £7.5 million of this funding from SRFT as at 31st March 2012. In addition the Trust has utilized £2.0 million of the NHS Bank funding within the 2011/12 overall financial position, and this is contained within the overall underlying trading surplus of £8.3 million as recorded in the Annual Report and Accounts for 2011/12.

This leaves a balance of deferred income as at 31st March 2012, which effectively was the balance as at 31st March 2011 and was paid to the Trust during 2010/11.

The PFI plans have always included utilizing NHS Bank Funding in 2012/13 at a value of £3.6 Million, and the financial plans include this sum within the overall income (released from deferred income).

The Trust is now working with the SHA to ensure that the Trust's requirement for this approved funding is provided in such a way as to avoid any of the "Whole of Government Accounts" issues which is likely to mean that only the resources required within the Annual Plan Years being drawn down.

The following table sets out the requirement for the NHS Bank Funding across the 3 years of the Annual Plan.

Year	£000's
2012/13	3,690
2013/14	3,690
2014/15	1,580

5.6.4 Unscheduled Care

The 2012/13 year is the second year of changes around the Unscheduled Care Services, which ultimately will result in a saving of £4.3 million from a combination of ward closures and reductions in costs within the Emergency Village. The full value of the £4.3 million savings has been taken out of the Trust's contract with NHS Salford and non recurrent support is provided until savings are realised. For 2012/13 the Trust will receive

non recurrent support of £1.7 million with savings of £1.8 million being required to be delivered by SRFT during 2012/13, this is the plan agreed with Commissioners and the Trust during 2010/11.
The plans also require that a further £1.7 million of cost savings are made by the end of 2013/14, which in aggregate across the 3 years has total savings of £4.3 million. There is no non recurrent support planned for 2013/14.

5.6.5 NCG - IFU

As highlighted in the March 2012 Budget Setting Paper the National Commissioning Group have indicated that they wish to undertake a review of the funding of the IF Service provided by both SRFT and St Marks Hospital. The first phase of this work is to carry out a benchmarking exercise between St Marks and SRFT to understand the services that are provided by both Trusts to ensure that a valid comparison is being undertaken. This work has commenced and a joint benchmarking template has been agreed and the data capture phase of this work is now in progress.

Whilst the financial plans include a reduction in income of circa £2.0 million, the Trust and NCG have agreed that a Joint piece of work will be undertaken to ensure that the "Hinterland" patients who come to the IF centres for treatment post IF treatment should be paid for (in full) by the appropriate commissioners.

5.6.6 Service Developments – Included within Financial Plans

Major Trauma

The Trust has been designated as a Major Trauma Centre within the Greater Manchester Trauma Collaborative which also includes Central Manchester FT and University Hospitals of South Manchester FT. A clinical model of deployment has been agreed across Greater Manchester with SRFT being main the recipient of Head Trauma. Whilst the service commenced on the 16th April 2012 there is a period of ramp up of the services culminating in full service provision by September 2012. The plans that have been agreed with commissioners are built upon the activity assumptions derived from the TARN (Trauma Audit & Research Network) data base using the Injury Severity Scoring (ISS) methodology. PBR guidance for 2012/13 includes best practise tariffs for ISS of 8 and above.

The Trust has made significant investment in infrastructure to enable it to deliver the required Trauma standards as well as receiving additional activity previously seen within District General Hospitals around Greater Manchester. The following table sets out the anticipated increase in levels of activity for the Trauma Centre at SRFT.

A&E additional Attendances	2,500
Observation – Spells	2,000
Vented patients - ICU	80
Vented patients – NHDU	80
Admitted – HRG – Spells	520

The activity above will generate circa £5.5 million of additional Income for the Trust.

The estimated increase in the Trust's cost base to enable the delivery of the new Trauma standards and the additional activity has been estimated at £7.3 million. This leaves a shortfall of £1.8 million of costs over and

above the income through the normal PBR routes. Agreement has been reached with Greater Manchester Commissioners that the shortfall in costs above the income from PBR will be funded on a non recurrent basis, until such time as the Trauma Collaborative has bedded down and the activity flows have been established.

The Trusts Financial Plans include income and expenditure of £7.3 million.

5.6.7 Stroke Expansion beyond the Existing Service

The Trust is the Comprehensive Stroke Centre (CSC) for Greater Manchester and has been operating this service very successfully for around 3 years. The Greater Manchester Commissioners have indicated that they wish the Trust to extend the Stroke Service provided by CSC at SRFT, from the current 4 hour window up to a 72 hour window of onset of Stroke. Whilst this is in the early planning stages the financial impact of this change is not known and has yet to be worked through with Commissioners. On that basis the financial plans submitted with this do not include the consequences of this expansion. The financial plans for both 2013/14 and 2014/15 include income of £6.4 million, with expenditure of £6.08 million giving an EBITDA contribution of £0.3 million.

5.6.8 Oldham Renal Expansion

The Board of Directors agreed the business case for the expansion of the Renal Service with the development of the Oldham Satellite Unit. The 2013/14 financial plans include income of £1.3 million with expenditure of £1.2 million giving an EBITDA contribution of £0.1 million.

5.6.9 Service Developments – Not Included within Financial Plans

Intermediate Rehabilitation Unit Development (IRU's) – inc. Taylor Unit

The Trust continues to be under pressure from the consequences of problems with repatriation of Neuro-rehabilitation patients from the Trust to the IRU's across Greater Manchester. Discussions are continuing with the both Commissioners and providers to help alleviate these problems. Negotiations are at an early stage around the transfer of the Taylor Unit, currently under the management of Wrightington, Wigan and Leigh FT, over to the management of SRFT. Given that the negotiations are still in the early stages, the financial plans do not include any income or expenditure relating to this transfer.

5.7 Factors Affecting Expenditure 2013/14 and 2014/15

5.7.1 Incremental Drift

As in previous years the Trust has made an assessment of the likely costs of the impact of the staff moving through the incremental points on the Agenda for Change pay scales. For 2012/13 budgets have been uplifted to reflect an increase in costs of £3.3 million. It is anticipated that for 2013/14 and 2014/15 that the Trusts pay bill will rise by circa £3.3 million per annum in each of those two years as a result of incremental drift.

5.7.2 Pay Awards

At this stage it is unclear the extent to which the level of pay awards will get back to the levels seen prior to the downturn in the economy. As part of the budget announced by the Chancellor of the Exchequer public

sector pay awards are not to exceed an overall increase of 1% per annum. Whilst there is no specific details around this announcement the pay budget have been increased by circa 1.0% which will require approximately £2.3 million to be added to budgets in both 2013/14 and 2014/15.

As set out in the Budget approved at the March 2012 meeting the budget for the year 2012/13 include an estimate of £0.9 million for pay awards as this is the last year of the pay deal negotiated with staff representatives nationally by NHS Employers where the majority of staff have a pay freeze with the exception of staff earning less than £21K, who receive an additional £250.

Other Cost Changes

5.7.3 Consultants Training

The Trust has agreed to provide each of its Consultants (via the Divisional Chairs) with a budget for CPD and other training requirements, a Reserve of £250K has been set aside for this. Given that this is a recurrent Reserve and that this will fully fund the agreed Consultant Training requirements for the numbers of Consultants currently within the Trust it is not anticipated that this level of funding will required to be provided over and above the 2012/13 level.

5.7.4 CQUIN

The development of CQUIN is continuing at pace with the increase in CQUIN funding to 2.5% of contract value. To date no additional expenditure has been required for the delivery of CQUIN however, as a contingency against the need a Reserve of £470K has been set aside within the 2012/13 budgets, with a further £500K in each of the subsequent years of the plan.

5.7.5 Distinction Awards / CEA's

Each year the Trust is required to agree a number of local Distinction Awards and Clinical Excellence Awards, for 2012/13 a Reserve of £350K has been set aside. Given that it is likely that this cost pressure will continue into futures years the same value has been included within both 2013/14 and 2014/15.

5.7.6 Drugs

Drugs costs continue to rise and it is anticipated that this will continue on into the second and third years of this annual plan submission. At this stage it is difficult to accurately predict the actual drugs that will be the driver of the increase in costs and this will be a part of the Director of Pharmacy's annual horizon scan each year. However, as a prudent measure the second and third year of the annual financial plan include an estimate of £1.0 million increase in Drugs costs. This is in addition to the £1.5 million included within the budget for 2012/13 as set out in the March budget.

5.7.7 Given that the PBR Guidance year on year makes changes to drugs that are excluded from tariff these will be negotiated each year with commissioners but have not been included within the 2013/14 and 2014/15 financials as these are difficult to predict what the DH will treat as exclusions up until they publish the guidance each year.

IM&T Investments

5.7.8 In line with the Boards decision to enter negotiations with preferred bidder to look to secure an EPR, it is estimated that £1 million of revenue costs will be required during 2012/13 and a Reserve has been set aside for this value. In addition the consequences of EDMS roll out continue with an estimated cost of circa £0.7m being set aside in 2012/13.

5.7.9 In line with previous years a budget has been set for the further development of IM&T Infrastructure and in line with previous years a budget of £250K has been included within the budgets for 2012/13, along with an investment requirement of £250K for both 2013/14 and 2014/15.

Non Pay Inflation

5.7.10 For 2012/13 a general non pay inflation reserve has been set aside totalling £800K, this is in line with previous years and is felt to be sufficient to be able to meet the inflationary costs not included elsewhere. The plans for 2013/14 and 2014/15 also include an estimate of General Non pay Inflation of circa. £1 million, whilst there is no specific costs identified at this stage non pay inflation is a feature each year and as such a prudent approach has been taken with the inclusion of these values within the plans.

CNST Contributions

5.7.11 In line with previous years the value of the Trusts CNST contribution has risen, after allowing for the reduction in premium associated with the transfer of Maternity and Neonates, the increase in premium for 2012/13 will be £540K. Given that the NHSLA do not announce premiums for anything other than the year ahead, the Trust has estimated that the premiums are likely to rise by similar values to 21011/12 in both 2013/14 and 2014/15. Therefore, £600K additional costs have been assumed in each of these years.

Rates and Energy Costs

5.7.12 As a result of the commissioning of the Hope Building and general improvements made to the site through capital investments the Rateable Value of the site has increased. This means that the overall value of Rates that are payable by the Trust will rise in 2012/13. This is estimated to be circa £951K. Work is on-going with advisors to ensure that the Trust minimises its Rates bill with the City Council with any reduction being a benefit to the Trust in future. At this stage it is not anticipated that costs will rise beyond the level payable in 2012/13, therefore no further cost increases have been built into the forward plans.

5.7.13 Costs of utilities continue to rise and whilst the Trust takes an active role in ensuring optimum prices are obtained for Utilities there will be an increase in costs in 2011/12 resulting in a cost pressure for 2012/13 of £415K.

Medical Equipment Maintenance

5.7.14 The Trust continues to invest in new and replacement medical equipment and this new and replacement kits needs to be maintained to ensure the safe utilisation by staff. The 2013/14 and 2014/15 plans include an additional £250 per annum for equipment maintenance.

Microsoft Licences

5.7.15 The Enterprise licence in place with the NHS has effectively expired. Whilst it is uncertain at this time what impact this will have a budget has been set aside of £500K to cover any potential costs in 2013/14, should this prove not to be required this will be held in Trust Reserves.

5.7.16 The following table provides a summary of the additional costs included within the budgets and plans for 2012/13 to 2014/15

Summary	2012/13 £000's	2013/14 £000's	2014/15 £000's
Consultants Training	250	0	0
CQUIN	470	500	500
CEA's	350	350	350
Drugs	500	1,000	1,000
EPR	1,000	395	593
EDMS	751	0	0
Other IT Projects (Rostering, Ward ordering, Patient centre)	596	0	0
IT Infrastructure	250	250	250
Non Pay inflation	800	1,000	1,000
CNST	540	600	600
Rates	951	0	0
Energy	415	0	0
Medical Equipment Maintenance	Within budget	250	250
Microsoft Licences	0	500	0
Total	**7,273**	**4,745**	**4,543**

5.8 PFI Costs

Unitary Payment (excludes The Maples)

5.8.1 Given that the Hope Building became fully operational in September 2011, this has a consequential increase in the Unitary Payment that is paid to Consort. The following table sets out the basic increase in the Unitary Payment as well as the impact that this has on the Financial Statements of the Trust. In addition the table sets out the accounting treatment that International Financial Reporting Standards requires of the Trust relating to the Unitary Payment and associated transactions.

Heading	**2012/13 Requirement**	**2013/14 Requirement**	**2014/15 Requirement**
	£000's	**(estimated) £000's**	**(estimated) £000's**
Real Change in Costs	13,742	15,198	16,150
Unitary Payment			
Cost Changes as a consequence of IFRS			
Service Payment	4,603	4,563	4,886
Interest Payable	5,553	7,260	7,731
Repayment of principal	3,469	3,026	3,039
Lifecycle costs	117	349	494
Total	**13,742**	**15,198**	**16,150**
Charged to SOFP			
Repayment of Principal	(3,469)	(3,026)	(3,039)
Depreciation on PFI Assets	2,236	2,500	2,500
Impact on SOCI (I&E)	**12,509**	**14,672**	**15, 611**

The Trust's Retained Surplus has been increased above the minimum requirement previously agreed at 0.5% (circa £1.9 million) up to £2.9 million to take account of the requirements to generate surplus to ensure that cash is available to pay the full cash value of the Unitary Payment where elements of the Unitary Payment are charged to the Trusts Statement of Position rather than the Statement of Comprehensive Income.

The values included within the above table include an estimated increase in the RPI that the Trust is contractually bound to pay of 5% for 2012/13, 2013/14 and 2014/15.

5.9 Transforming Community Services

The Board will recall that the Salford Health Care Services where integrated into the Trust on 1st April 2011, and full details of the transfer where included within the Annual Plan for 2011. The transferred services are now fully integrated into the SRFT structures and the costs of these services are within the agreed baseline budgets for 12/13 on a recurrent basis.

5.10 Safely Reducing Costs (SRC)

The Salford Way

5.10.1 Salford Royal is committed to the delivery of high quality services to its patients and Safety and Quality are of paramount importance in all that the Trust does. This applies equally to the delivery of financial plans and very specifically to the Safely Reducing Costs programme that is deployed each year to deliver the financial plans of the Trust. The Trust has an excellent record of achieving the SRC target cost reductions in a safe and sustainable manner.

5.10.2 The Trusts manages its SRC programme through its Finance and Activity Executive Governance Committee. The Trust has a well established programme management approach to the SRC, with three Boards focusing in on Safely Reducing Costs these are Workforce Board, Waste Board and Corporate Board.

5.10.3 The Workforce Board concentrates primarily on the workforce issues faced by the Trust, this can include the various terms and conditions of staff groups, as well as the alternative ways of deploying staffing. This Board is Chaired by the Director of OD and Corporate Affairs.

5.10.4 The Waste Board is focused on the eradication of Waste within the clinical processes that are deployed across the Trust, this looks at flow of patients around the various departments and services of the Trust along with how the various clinical departments interact together to deliver the optimal service to patients. This Board is chaired by the Medical Director of the Trust.

5.10.5 The Corporate Board focuses on the optimum delivery of Corporate Services, which includes Finance, IM&T, Estates as well as the other Corporate functions. The focus of this Board is to ensure that the Corporate Services reduce costs in line with Board requirements but are managed in such as way as to not affect the level of service delivered to front line services such as deployment of technology or contracting out of services.

5.10.6 In order to deliver the Income and Expenditure plans set out in this plan the Trust will be required to deliver cost reduction plans at the following level.

	£000's	% age of Turnover
2012/13	17,600	4.4
2013/14	19,800	4.9
2014/15	19,900	4.9

These savings will continue to be managed through the Divisional Structures with the Managing Director and Chair of Division working with their teams to identify the required savings, whilst ensuring that services continued to be delivered in a safe and sustainable manner.

5.11 The 2012/13 Safely Reducing Costs Programme

The following table sets out the 2012/13 position in summary form showing the latest position with regards

to the identification of the target levels of savings by each of the Divisions. The full value of the £17.6 million of target savings requirements has been removed from the front line budgets and the values included within the financial templates.

	Target	Identified	Difference
	£	£	£
SHC	2,719,685	2,719,218	- 467
CSS & TM	3,899,863	3,901,714	1,851
Surgery	3,078,574	3,100,422	21,848
N&R	2,712,782	2,713,031	249
WS			
Facilities	1,097,464	1,098,980	1,516
R&D	77,120	110,253	33,133
Finance	287,658	303,213	15,554
IM&T	404,163	404,163	0
HR	166,117	181,235	15,118
L&D	82,680	82,680	0
Education	121,442	121,443	0
Nurse	263,988	333,537	69,549
OP	-	-	-
S&D	57,472	57,472	0
Exec	132,212	200,616	68,404
SCH Corporate	200,265	200,265	-
Trustwide	2,309,284	1,682,405	- 626,879
Grand Total	**17,610,771**	17,210,647	- 400,123

The shortfall is subject to a number of work streams and the progress in reducing the shortfall will be reported to the Board of Directors on a monthly basis as well as being proactively managed through the Trusts Finance and Information Executive Governance Committee.

5.12 Themes for SRC for 2013/14 and 2014/15

The following are the broad themes that the Trust is developing for utilisation within the 2013/14 and 2014/15 SRC programmes.

5.12.1 Further Bed Reconfiguration and Patient Flow

The Trust following Integration of the provider arm from NHS Salford have developed 16 individual projects, which are designed to optimise the patient pathway across both hospital and community settings. This will enable the most efficient patient pathway to be developed releasing costs across the patient pathways.

5.12.2 Further focus will be given to improved discharge planning to reduce LOS, including working collaboratively with Social Care. Reduction in admissions & readmissions, with the development of a Community Elderly care service in reaching into residential and nursing homes to reduce inappropriate admissions. To retain elderly patients in their own home with care from the hospital in reaching and linking to SRFT primary care services.

5.12.3 To work with external stakeholders (such as Age Concern) in the treatment of Dementia patients to explore the provision a virtual ward facility to support patients and carers, with the ultimate aim of reducing admissions to the Trust. Further develop plans to improve the discharge planning process working collaboratively with residential and nursing homes for improved repatriation of patients

Capacity planning

5.12.4 The Trust is active in demand and capacity planning across surgical specialities to improve patient flow and

facilitate further change in bed configuration across specialities.

Rapid improvement techniques are being deployed across a range of services within the Trust particularly emphasis will be given to Theatres, to drive through theatre efficiency, reduced cancellations and optimise the use of the Theatre capacity of the Trust.

The reliability of care is of vital importance to the Trust and development of services on a 7 day week basis will be explored, thereby improving quality, reliability and reducing costs of the care provided by the Trust. This will also extend across a range of supporting and diagnostic services within the Trust.

Clinical Staffing productivity

5.12.5 To continue with robust job planning and consideration for medical rostering to drive through efficiencies without any impact on quality and clinical care.

Pathway redesign

5.12.6 As part of transformation following integration of community with acute services efficiencies across pathways will be investigated with reduction in on added steps e.g. Audiology, MSK/Orthopaedics'.

Rationalisation of Clinical services

5.12.7 As part of the integration and joint venture between Wigan FT and SRFT to have a joint pathology services resulting in improved efficiencies with pathology requesting and benefits realisation in pay and non-pay.

5.12.8 Pharmacy to drive through efficiencies and deliver cost reductions with new outpatients pharmacy provision, , reduced prescribing across the trust and reduction in waste due to enhanced education with patients, local prescribing on the wards and in the community.

New outpatient strategy

5.12.9 The Trust is developing a strategy for the best management of out-patients, this includes the use of new technologies to reduce DNA's and reliability of attendance at the various clinics. In addition the Trust is to start to review the most appropriate location for out-patient services to be delivered, both on and off the hospital site, with a view to moving a significant proportion of attendances off site. This will be done in conjunction with a review of the utilisation of community clinic capacity to ensure optimum utilisation of clinic capacity offsite at a reduced cost.

Innovation

5.12.10 The Trust is an innovator in its use of technology to support the clinical process, and have been utilising an Electronic Patient Record for a number of years. The Trust is procuring a state of the art replacement for its existing EPR which will enable a range of improvements to clinical processes whilst allowing better efficient deployment of staff and other resources. The implementation of the new EPR is a major undertaking but will facilitate savings over a number years into the future. There are a range of other projects that support the clinical process that are designed to make them more efficient and paper light, such as digital dictation and document management systems.

Corporate Services Projects

5.13 The Trust will continue to explore opportunities across the whole of the range of Corporate Functions including the development of technology to improve the administrative processes, such as eProcuerment, and the exploitation of financial systems. Further work will be done to minimise the Trusts exposure to rising costs of energy with a range of measures designed reduce demand whilst working with other Trusts to ensure best price for the utilities purchased.

Improvements will be made in the management of clinical supplies covering whole range of products and commodities used by the Trust, including optimal stock management systems and best value pricing deals through collaboration with other Trusts through the Greater Manchester QIPP Strategic Advantage Programme.

5.14 Capital Expenditure

The financial plans for 2012/13 to 2014/15 include the capital expenditure approved by the Board of Directors at its April 2012 meeting. A summary of the position excluding capitalised PFI lifecycle costs is set out in the table below.

Year	£000's
2012/13	16,864
2013/14	12,963
2014/15	12,924
Total	**42,751**

The Financial Templates include a breakdown of the capital expenditure into the various headings required within the Monitor Submission.

5.15 Risk Rating

Based upon the assumptions built into the financial plans set out in this paper the Risk Rating for the Trust for the three years covered by the plan is set out in the table below.

	2012 / 2013		2013 / 2014		2014 / 2015	
	Value	Score	Value	Score	Value	Score
EBITDA	5.8%	3	6.4%	3	7.1%	3
EBITDA Achievement	111%	5	111%	5	111%	5
Rate of Return	1.3%	3	1.2%	3	1.1%	3
Surplus Margin	0.7%	2	0.7%	2	0.7%	2
Liquidity(days)	29.1	4	24.0	3	22.2	3
Weighted Average Rating		3.25		3.00		3.00
Rounded		**3**		**3**		**3**

As can be seen from the above table the Trust is forecasting a Risk rating of 3 for the three years of this Annual Plan submission. Full Details of the breakdown of the rating can be found in the Monitor Template Spreadsheet that accompanies this paper.

5.16 Reversals of Impairments

For a number of years the value of the Trust's assets has been subject to revaluation by the District Valuer (DV), this is good practise during periods of major change to the asset base (for example during the hospital redevelopment programme) but also during periods where asset values are changing. The financial plans assume that the values of the Trust's assets will start to rise (as opposed to reducing that has been the case over recent years). This means that a technical surplus will be

generated as the values of the assets increase and these benefits are taken through the Trusts Income and Expenditure Plans (Statement of Comprehensive Income SOCI).

For both 2013/14 and 2014/15 the value of the Trust asset base has been assumed to rise by 5% in each of the two years. This gives rise to the technical surpluses of £4.6m in 2013/14 and £4.7m in 2014/15.

Appendix 1(i)
Summary Income and Expenditure – 2012 / 2013

Salford Royal NHS FT

Income		Total £'000
Patient Income	Daycase	19,485.0
	Elective	34,808.6
	Non elective	59,212.2
	OP	50,203.0
	A&E	9,839.2
	Non FCE	123,057.8
	Community	42,219.7
	NHS Bank (Nrec)	3,690.0
	MiB Transitional (Nrec)	1,350.0
	NWSC (Nrec)	4,000.0
	Unscheduled Care (Nrec)	1,649.0
		-
		349,514.5
Other Patient Related	PP	938.2
	OSV Non Recip	-
	RTA	1,129.3
	Other	129.0
		2,196.4
Education	SIFT	11,044.7
	MADEL	8,765.9
	PGME	435.4
	NMET	1,351.3
		21,597.3
R&D		7,540.2
Non Patient Related	Carparking	1,315.6
	Catering	1,220.8
	CEA's	1,870.9
	NHS Recharges	4,734.6
	AQuA/QIPP/QUEST	6,300.0
	Other	3,925.3
		19,367.1
Total Income		**400,215.6**

Appendix 1(i)

Expenditure		£'000
Pay	Execs/Non Execs	1,234.3
	Medical	63,120.1
	Nursing	71,380.2
	S&T	31,862.3
	Support/HCA's	23,471.2
	Admin	33,754.2
	Other	1,794.2
	IM&T Projects (Nrec)	2,097.7
	Non contract	538.4
		229,252.6
Non Pay	Drugs - Tariff	9,785.7
	Drugs - Exclusion	47,004.1
	M&S	29,417.1
	Non clinical	14,295.2
	CNST	3,927.6
	Purch Of Healthcare Non NHS	1,657.5
	Consultancy Services	3,214.0
	PFI UP	4,720.3
	R&D	3,656.1
	Utilities	3,811.3
	Rates	2,522.1
	IM&T (Nrec)	250.0
	CIP	
	Other	23,631.7
		147,892.4
Total Operating Expenditure		**377,145.1**
EBITDA		**23,070.5**
Donated Asset Income		
Interest Rec'd		- 85.0
Depreciation		8,703.5
PFI Depreciation		2,278.0
Interest Payable - PFI		4,353.8
Contingent Rent		1,199.1
Unwinding Discount		60.0
Dividends		3,683.0
		20,192.4
Surplus before exceptional items		**2,878.1**
Depreciation - Accelerated		
Surplus after exceptional items		**2,878.1**

Appendix 1(ii)
Summary Income and Expenditure – 2013 / 2014
Salford Royal NHS FT

Income		Opening 13/14
Patient Income	Daycase	19,192.8
	Elective	34,286.5
	Non elective	64,724.0
	OP	49,450.0
	A&E	9,691.6
	Non FCE	122,446.0
	Community	41,586.4
	NHS Bank (Nrec)	3,690.0
	MiB Transitional (Nrec)	700.0
	NWSC (Nrec)	-
	Unscheduled Care (Nrec)	-
		-
		345,767.2
Other Patient Related	PP	938.2
	OSV Non Recip	-
	RTA	1,129.3
	Other	129.0
		2,196.4
Education	SIFT	10,244.7
	MADEL	8,765.9
	PGME	435.4
	NMET	1,351.3
		20,797.3
R&D		7,540.2
Non Patient Related	Carparking	1,315.6
	Catering	1,220.8
	CEA's	1,870.9
	NHS Recharges	4,663.6
	AQuA/QIPP/QUEST	6,300.0
	Other	3,925.3
		19,296.1
Total Income		**395,597.2**

Appendix 1(ii)

Expenditure		£'000
Pay	Execs/Non Execs	1,246.7
	Medical	64,901.3
	Nursing	77,394.0
	S&T	32,180.9
	Support/HCA's	24,705.9
	Admin	34,091.7
	Other	1,812.2
	IM&T Projects (Nrec)	1,683.6
	Non contract	543.8
		238,560.0
Non Pay	Drugs - Tariff	11,274.9
	Drugs - Exclusion	47,004.1
	M&S	32,023.4
	Non clinical	15,251.1
	CNST	4,320.3
	Purch Of Healthcare Non NHS	1,632.6
	Consultancy Services	3,214.0
	PFI UP	4,912.0
	R&D	3,656.1
	Utilities	4,040.0
	Rates	2,672.1
	IM&T (Nrec)	348.8
	CIP	- 19,800.0
	Other	21,218.3
		131,767.7
Total Operating Expenditure		**370,327.7**
EBITDA		**25,269.5**
Donated Asset Income		-
Interest Rec'd		- 85.0
Depreciation		9,027.0
PFI Depreciation		2,331.0
Interest Payable - PFI		6,006.9
Contingent Rent		1,253.1
Unwinding Discount		60.0
Dividends		3,830.0
		22,423.0
Surplus before exceptional items		**2,846.5**
Depreciation - Accelerated		- 4,621.0
Surplus after exceptional items		**7,467.5**

Appendix 1(iii)
Summary Income and Expenditure – 2014 / 2015
Salford Royal NHS FT

Income		Opening 14/15
Patient Income	Daycase	19,000.8
	Elective	33,943.6
	Non elective	64,076.8
	OP	48,955.5
	A&E	9,594.7
	Non FCE	121,221.5
	Community	41,170.5
	NHS Bank (Nrec)	1,580.0
	MiB Transitional (Nrec)	250.0
	NWSC (Nrec)	-
	Unscheduled Care (Nrec)	-
		-
		339,793.4
Other Patient Related	PP	938.2
	OSV Non Recip	-
	RTA	1,129.3
	Other	129.0
		2,196.4
Education	SIFT	9,244.7
	MADEL	8,765.9
	PGME	435.4
	NMET	1,351.3
		19,797.3
R&D		7,540.2
Non Patient Related	Carparking	1,315.6
	Catering	1,220.8
	CEA's	1,870.9
	NHS Recharges	4,617.0
	AQuA/QIPP/QUEST	6,300.0
	Other	3,925.3
		19,249.5
Total Income		**388,576.8**

Appendix 1(iii)

Expenditure		£'000
Pay	Execs/Non Execs	1,259.1
	Medical	65,900.3
	Nursing	80,968.0
	S&T	32,502.7
	Support/HCA's	24,953.0
	Admin	34,432.6
	Other	1,830.3
	IM&T Projects (Nrec)	2,125.2
	Non contract	549.2
		244,520.4
Non Pay	Drugs - Tariff	12,338.7
	Drugs - Exclusion	47,004.1
	M&S	32,913.9
	Non clinical	15,556.1
	CNST	4,752.4
	Purch Of Healthcare Non NHS	1,616.3
	Consultancy Services	3,214.0
	PFI UP	5,380.0
	R&D	3,656.1
	Utilities	4,282.4
	Rates	2,672.1
	IM&T (Nrec)	497.0
	CIP	- 39,696.0
	Other	22,392.7
		116,579.6
Total Operating Expenditure		**361,100.0**
EBITDA		**27,476.8**
Donated Asset Income		-
Interest Rec'd		- 85.0
Depreciation		9,774.0
PFI Depreciation		2,793.0
Interest Payable - PFI		6,421.6
Contingent Rent		1,309.4
Unwinding Discount		60.0
Dividends		4,372.0
		24,645.0
Surplus before exceptional items		**2,831.8**
Depreciation - Accelerated		- 4,735.0
Surplus after exceptional items		**7,566.8**

Appendix 2
Detailed Analysis of the Financial Risk Rating – 2012/13 to 2014/15

Underlying performance	2012/13	2013/14	2014/15
EBITDA	23.070	25.270	27.476
Operating Income	400.215	395.597	388.576
EBITDA Margin metric	5.8%	6.4%	7.1%
EBITDA Margin rating	**3**	**3**	**3**
Achievement of plan			
Actual EBITDA 2011-12 from SoCI			
Planned EBITDA 2011-12 (original plan or assessment figure)			
EBITDA % of plan achived metric	110.9%	110.9%	110.9%
EBITDA % of plan achived rating	**5**	**5**	**5**
Financial Efficiency			
Net return after financing costs	2.879	2.847	2.832
Opening Financing	220.984	234.719	244.626
Closing Financing	234.719	244.626	254.868
Net return after Financing metric	1.3%	1.2%	1.1%
Net return after financing rating	3	3	3
Surplus YTD	2.879	7.468	7.567
Profit (loss) on asset disposals	-	-	-
I & R (Impairments & restructuring) expenses	-	4.621	4.735
Operating Income YTD from IS	400.215	395.597	388.576
IS Surplus margin metric	0.7%	0.7%	0.7%
IS Surplus margin rating	2	2	2
Financial Efficiency rating	**3**	**3**	**3**
Liquidity			
Cash for liquidity purposes	30.541	24.785	22.403
Operating expenditure YTD	377.145	370.327	361.100
WCF in terms of Operating Expenditure YTD	27.7	28.2	28.9
Liquidity days metric (WCF limited to 30 days)	29.2	24.1	22.3
Liquidity rating	**4**	**3**	**3**
Weighted Average Rating	**3.25**	**3.00**	**3.00**
Financial Risk Rating	**3**	**3**	**3**

Appendix 3

Salford Royal NHS
NHS Foundation Trust

University Teaching Trust

safe • clean • personal

Annual Plan 2012/2013

Principal Objectives and KPI's

Strategic Theme	Principal Objectives	Executive Lead	Objective	KPI's	Timescale
1. Pursuing Quality Improvement to become the safest organisation in the NHS	1.1 Reduce the risk adjusted mortality	Elaine Burke	Maintain the relative risk of mortality to be within the top 10% of acute Trusts in the NHS	• HSMR Relative risk • SHMI	By 31st March 2013
	1.2 Improve the reliability of care to be the safest organisation in the NHS	Elaine Burke	Deliver the Quality Improvement Strategy : Safe & Clean	**Safe** • 95% of patients receive harm free care • 95% reliability in the agreed care bundles • Global trigger tool • Reduce medication errors • Improve reliability of care across 7 days • Demonstrate compliance with the Salford Standard • Demonstrate rigorous Governance systems supporting safety for patients and staff • Readmissions **Clean** • Reduce hospital acquired infections	By 31st March 2013
	1.3 Improve patient experience to maintain indicators in the top 20% nationally	Elaine Burke	Deliver the Quality Improvement Strategy : Personal	**Personal** Maintain patient experience indicators in top 20% nationally • Patient Surveys (Picker/Hospedia) • Patient Experience trackers • Patient Reported Experience Measures (PREM's) • Nursing Accreditation and Assessment System (NAAS) • PALs feedback • Implement the HELP system to inpatients	From 1st April 2012
2. Achieving Cost Improvements, income and cost targets to improve margins	2.1 Achieve cost improvements, income & cost targets to improve margins	Tony Whitfield	Reduce costs by £18m/5%	Deliver the Cost improvement plan without impact on margins • Improve Productivity • Reduce Corporate costs • Reduce Waste • Reduce Workforce costs	From 1st April 2012
3. Supporting high performance and improvement	3.1 Improve Staff Contribution to Corporate Objectives and Values	David Wood	Deliver the Organisational Development Strategy	• Implement Workforce Plans • Roll out Performance Framework • Staff Engagement & Communication • Implement Communications Strategy • Implement the Volunteer Strategy • Develop a Reward strategy	From April 2012

Strategic Theme	Principal Objectives	Executive Lead	Objective	KPI's	Timescale
	3.2 Develop a High Performance Culture	David Wood	Development of a Coaching Style within the environment of earned autonomy	• Deliver the Executive Development Programme (performance & talent management) • Develop Divisional & Directorate teams (performance & talent management) • Develop a framework for earned autonomy • Develop Clinical Leaders	From 1st April 2012
	3.3 Implement the Membership Development Strategy	David Wood	Implement the Membership Development Strategy (Inclusive of Patient & Public Engagement)	• Representative Membership • Membership numbers • Engagement plan	From 1st April 2012
4. Improving Care and services through integration and collaboration	4.1 Deliver the Transformation Programme and develop opportunities for an Integrated Care System	Simon Neville	Deliver the transformation programmes & work with partners to implement an integrated care programme	• Deliver the transformation programme • Pilot approach for the frail elderly population. Interventions in 2012/13 targeted within two localities within Salford	From 1st April 2012
	4.2 Integration & Collaboration within the NW Sector	Simon Neville	Work with Partners to identify areas for collaboration and implement agreed plans	• Pathology • Radiology • Sterile Services • Finance • Facilities • Cardiology • Urology • Orthopaedics	From 1st April 2012
	4.3 Integration & Collaboration within Greater Manchester & beyond	Simon Neville	Work in partnership with organisations in Greater Manchester and beyond to improve clinical outcomes and improve efficiencies	• Christies • South Manchester • Central Manchester • Pennine	From 1st April 2012
	4.4 Service Developments/redesign	Simon Neville	Develop services/respond to tenders as opportunities arise and where agreed criteria are met	Service Developments/Redesign • Trauma Centre • Develop the Dermatology Strategy • Implement the Outpatient Improvement Plan Consider Acquisitions & tenders Consider opportunities to develop • Private Patient services • Adolescent Spinal Surgery • Pathology • Radiology	From 1st April 2012

Strategic Theme	Principal Objectives	Executive Lead	Objective	KPI's	Timescale
5. Demonstrating Compliance with Mandatory Standards	5.1 Achieve Clinical & Quality Standards	Chris Brookes	Demonstrate compliance with the Clinical & Quality Standards	• NHSLA Standards • Monitor Infection Control Quality Targets • CQC Outcomes 1-21 • National CQUIN Standards • Greater Manchester CQUIN Standards • Regional AQ CQUIN Standards • Local CQUIN Standards	From 1st April 2012
	5.2 Financial Standards	Tony Whitfield	Achieve Monitor Finance Standards	• Monitor Financial rating • I&E • Surplus • EBITDA • Capital • CIP	From 1st April 2012
	5.3 IM&T Standards	Tony Whitfield	Demonstrate compliance IM&T Returns, standards & CQUIN's	• Mandatory returns • Information • IM&T CQUIN	From 1st April 2012
	5.4 Access Standards	Simon Neville	Achieve Monitor, Contractual and Trust Stretch Access Targets	Monitor Access Targets • 18 weeks • 6 week diagnostic wait • Cancer 14, 31 & 62 days • A&E/Ambulance Transfer Local Access Standards • Cancelled Operations • Choose & Book Slots/Named Consultant • Delayed transfer of care • Emergency readmissions	From 1st April 2012
	5.5 Workforce Standards	David Wood	Demonstrate Compliance with workforce standards	Achieve above average results in the NHS Staff survey • 80% of key scores above average or 'best 20%' • Selected questions from the NHS Staff Survey will be used to calculate a job satisfaction key score, which will be used to score this indicator overall • Sickness absence levels • Appraisal standards • Mandatory Training compliance • Fit and Healthy Workforce • Achieve CQUIN Workforce Standards	From 1st April 2012

Strategic Theme	Principal Objectives	Executive Lead	Objective	KPI's	Timescale
	5.6 Building and Facilities Standards	Simon Neville	Demonstrate compliance with Building & Facilities Standards	• Health & Safety Standards • PEAT assessments • CQUIN Standards	From 1st April 2012
6. Implement Enabling Strategies	6.1 Deliver the Research & Development Strategy	David Wood	Develop a 5 year plan for the delivery and implementation of the R&D strategy which will realise Salford's potential as a/the Centre for Population Health Improvement.	Completion of 3-5 year plan for growth and investment within 6 months	From 1st April 2012
	6.2 Under & Post Graduate Teaching	David Wood	Deliver Under & Post Graduate Education	• Deliver Undergraduate Medical Education • Deliver Post Graduate Medical Education • Deliver Student Nursing/clinical placements • Demonstrate compliance with Deanery Standards • Fulfil the SHA Learning Contract • Demonstrate transparency of funding streams into Divisional budgets	From 1st April 2012
	6.3 Deliver the Hospital Redevelopment/Estates Strategy	Simon Neville	Deliver the Capital Programme	• B4 (polytrauma ward) • Trauma theatre • Turnberg Level 0 (R&D & FM) • Day Surgery; Endoscopy • Pre-Op clinic & Main OPD Reception • Clinical Sciences Building • CSB replacement building • Site consolidation post PFI • Ward Refurbishments/Sanitary Upgrades • Old A&E Reconfiguration • Pathology Reconfiguration • 2nd VIE Plant • Offices • 2nd Server Room • Turnberg Level 3 including interventional radiology • Outpatient Self Check In	By 31st march 2013

Strategic Theme	Principal Objectives	Executive Lead	Objective	KPI's	Timescale
	6.4 Deliver the IM&T Strategy	Tony Whitfield	Deliver the key projects in the IM&T Strategy	• EPR replacement • GP Communication • GP Requesting • EDMS scanning • Outpatient appointment text reminder service • Outpatient Self check in • Transfer former SCH services to SRFT PAS • Clinical access of data from the Christie & UHSM • Electronic requesting, investigations & referrals • Elective surgical pathway • Electronic requesting pathology & radiology • Patient centre roll out • SMART workforce management system • Integrated Pathology services • NMeH Salford Lung Study • IM&T Infrastructure review • Second data centre • Enable Telemedicine pilots	By 31st March 2013
	6.5 Deliver the Corporate & Social Responsibility & Public Health Strategy	Simon Neville	Deliver the Corporate & Social Responsibility & Public Health Strategy	**Patient & Staff Health & Well Being** **Social Responsibility** • Volunteering • Community engagement • Work Placements & Career opportunities • Membership • Well Being strategy **Sustainability & Environmental Impact** • Waste • Energy Use • Carbon emissions • CO2 emissions tonnes • CO2 emissions kg/m2 • Green travel plan • Procurement – local goods/fair trade	From 1st April 2012