Salisbury Health Care NHS
NHS Trust

Application NHS Foundation Trust Status

Service Development Strategy

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November 2005

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1 Executive Summary

1.1 Introduction

This document sets out the service development strategy for the proposed Salisbury NHS Foundation Trust between 2006/7 and 2010/11. It builds on the information detailed in the preliminary application submitted in November 2004, following which the Secretary of State invited the Trust to submit a preparatory application.

In preparing this strategy the Trust has consulted with local stakeholders including Primary Care Trusts and Local Authorities, clinical directors, service managers and members of staff. A participative approach have been taken to ensure the opinions of a broad range of colleagues and partner organisations has been reflected. An extensive consultation process was carried out which took in the views of local stakeholders, staff, community groups and members of the public. The response was overwhelmingly positive and indeed a request was made to extend the geographical area covered by the proposed Salisbury NHS Foundation Trust resulting in an additional constituency being added and another being extended.

1.2 The Trust

Salisbury Health Care NHS Trust is a 550 bed hospital, which provides general, acute and emergency services to approximately 200,000 people in Wiltshire, Dorset and Hampshire. This involves working with 3 main Primary Care Trusts in 3 Strategic Health Authorities:-

- South Wiltshire PCT in Avon, Gloucestershire and Wiltshire SHA
- North Dorset PCT in Dorset and Somerset SHA
- New Forest PCT in Hampshire and Isle of Wight SHA.

Additionally specialist services such as Burns, Plastic Surgery, Cleft Lip and Palate and Genetics extend to a much wider population of more than 3,000,000 people for the counties of Wiltshire, Dorset and Hampshire and the Isle of Wight. In addition the Spinal Injuries Unit covers a population of 11 million stretching from Cornwall to Sussex.

The Trust employs around 3540 members of staff – this figure includes full and part time staff. The majority of the hospital is located in modern accommodation with a major PFI-funded scheme due to be operational in April 2006.

1.3 Principles for Future Development

The Trust has identified 5 key strategic principles for the future and they are:-

- To be the hospital of choice for local people for acute hospital services
- To be the hospital of choice for a wider population under Choice and PBR
- To deliver high quality tertiary services
- To be an exemplary employer who is known for the development of staff
- To contribute to the growth and development of the local community.

These principles are supported by six strategic objectives which have been used to underpin the Trust's strategic planning and take into consideration the findings outlined in the SWOT analysis.

1.4 Finance

The Trust has an excellent reputation for financial management never having failed to achieve a balanced position or receive an unqualified audit report from the external auditors. This has recently been achieved in a climate which has seen several of the Trust's partners experience financial difficulties and where the Trust has been able to provide tangible support.

Turnover for 2004/5 amounted to some £125,000,000 and the Trust currently has a reference cost index of 90. This means the Trust should positively benefit from the roll out of Payment by Results. The financial plans demonstrate the Trust is able to meet its financial duties over the next 5 years based on the activity plans agreed with our key commissioners. This Service Development Strategy and the activity and finance modelling it contains, is supported by the Trust's local commissioners – see Appendix AR for letters of support.

The new financial freedoms will be used to prudently support the development of services and the infrastructure while the ability to retain surpluses will help the Board make future choices.

1.5 Leadership

The Trust has a strong, capable and stable executive and senior management team. The Chairman is currently the Compliance Director with The Royal Mail and the Chief Executive has a PhD in Corporate Governance in the NHS. This combined level of knowledge within the Board and senior management team will be vital in managing the change and implications of becoming a Foundation Trust, particularly in the areas of finance, governance, risk and performance management. Existing systems and procedures are currently being reviewed against the requirements of being a Foundation Trust.

1.6 Membership and Governor Benefits

The Trust will seek to engage an active membership and council of governors who will help determine the strategic direction of the Trust for the benefit of patients and the local community. The Trust already enjoys strong partnership working with various patient groups and looks forward to developing these links to build a shared vision of hospital services for the future. The need to develop as a public benefit corporation has been central to our thinking and preparations.

1.7 Change of Title

Subject to formal approval of Salisbury Healthcare NHS Trust's application and the granting of a license, the name of the Trust will be changed to Salisbury NHS Foundation Trust. There are no issues with similarity of name with other organisations.

1.8 Conclusion

The Trust considers that this document sets out a clear and exciting way forward for the organisation. Research and patient feedback clearly demonstrates the Trust already enjoys a strong reputation for the quality of its services. Care will be taken to ensure the focus and attention to detail, which has earned the Trust its current ranking, is maintained as the transition to foundation status takes place.

This strategy is supported by the Trust's Human Resources strategy and governance arrangements and, together, these 3 documents present the vision for Salisbury NHS Foundation Trust.

2 Context

This Service Development Strategy (SDS) for Salisbury Health Care NHS Trust has been created against an evolving NHS environment in which there are a number of policy initiatives that are key strategic drivers.

The first is the development of national standards, which are explicit and will form the basis of inspection by the Healthcare Commission. The standards encompass every area of a hospital's activities and set a minimum benchmark to be achieved. At the same time performance against the standards will be published publicly and influence how each healthcare organisation is viewed. The Board has assessed the Trust as being compliant in each of the 24 core standards as at 30 September 2005.

The introduction of Choice at the end of 2005 will bring contestability to the delivery of health services. As such it represents both an opportunity and threat to each NHS provider. A sense of consumer focus and responsiveness will be required of the NHS as never before.

In parallel, to strengthen contestability the Government is committed to plurality of provision of services. The introduction of the first wave of Independent Sector Treatment Centres (ISTCs) will begin to operate in 2005 whilst the procurement of a second wave is now underway. NHS providers will not only have to compete with other NHS organisations but with new entrants to the arena from the independent sector both from within and outside of the UK.

To assist the delivery of choice through a plural system of providers and to prevent a focus on low cost, the introduction of a standard tariff approach under Payment By Results (PBR) will ensure that quality of care and service will be the basis of contestability.

Finally, healthcare organisations have to operate this new system whilst delivering challenging targets, of which the total treatment time of 18 weeks by December 2008 is the key focus.

3 Vision

3.1 Key Principles

The Trust believes that its future development should be based on five key principles:

- To be the hospital of choice for local people for acute hospital services
- To be the hospital of choice for a wider population under Choice and PBR
- To deliver high quality tertiary services
- To be an exemplary employer who is known for the development of staff
- To contribute to the growth and development of the local community.

3.2 Values

Our work will be underpinned by a set of values, which have been developed by staff:

- **Patients**
  We will always put the interests of patients first
- **Integrity**
  We will maintain the highest standards of integrity in all we do
- **Culture**
  We will maintain the welcoming, friendly atmosphere and the sense of community spirit, which we currently enjoy
- **Involvement**
  We will ensure that we listen to patients and staff and that they are fully informed and involved in all decisions affecting them
- **Respect**
  We will show respect for, and treat fairly, our patients, our staff and every organisation with which we work
- **Innovation**
  We will encourage staff to be innovative, and strive to be a dynamic organisation to best respond to the needs of patients
- **Partnership**
  We will work in partnership within the Trust, in the local community and more widely
- **Teamwork**
  We will encourage an environment across the Trust where team-working enable staff to develop their full potential and improve the quality of patient care
- **Stewardship**
  We will use all our resources wisely

- **Celebration**
  We will recognise and celebrate the achievements of individuals, teams, departments and directorates across the Trust.

3.3 Strategic Objectives

This vision will be delivered through a focus on six strategic objectives:

3.3.1 Delivery of Patient Focused Care and Services:

- Services will be responsive to patients and provided at times and places convenient to them
- Care and services will be provided in a clean, safe and modern environment
- Patient information which is relevant and comprehensible will be accessible through a variety of media
- Continued development of patient and public involvement in the planning, monitoring and improvement of services will involve the membership and governors
- Working with partners to deliver new models of care

3.3.2 Improvement of Organisational Effectiveness

- The Trust will benchmark its performance against NHS acute providers and ensure that it is in the top 25% in the country
- Access times will be delivered in accordance with national targets
- The Trust will meet the National Standards for Better Health
- A timely performance management system will allow the organisation to proactively manage the business
- The Trust will play its role in the development of sustainable communities for the area we serve and will seek closer links with local government

3.3.3 Delivery of Effective Risk Management Systems

- The Trust will have systems that clearly identify and reduce risk at all levels in the organisation
- Patient safety will be a particular focus with an emphasis on infection control
- Clinical information will be used regularly by clinical staff in the delivery of care and to assess their own performance

3.3.4 Develop an Excellent Workforce

- The Trust will be seen as a first class employer
- Staff will feel involved in the organisation and committed to its success
- Staff will be appraised and have access to learning and development opportunities which contribute to organisational and personal success supported by the Knowledge & Skills Framework (KSF) process

- Services will be improved through staff innovation
- Effective partnership working will continue with staff organisations
- Staff will work in multidisciplinary teams that are focused on the needs of patients

3.3.5 Generation of New Income Streams

- The organisation will capitalise on the benefits of its leading edge tertiary services
- The hospital will market its services to maximise the opportunity of Choice
- The creation of profitable non-traditional NHS services will be pursued
- New NHS service opportunities will be developed

3.3.6 Development of the Hospital's Infrastructure

- The Trust will continue to develop modern patient facilities to replace outdated estate
- The Trust will use its land to further its strategic objectives
- The implementation of NPfIT systems will take place to support the delivery of services

3.4 Our Unique Selling Points

We believe that we have a strong base from which to take advantage of Foundation Trust status (and which are described in more detail in section 6.5):

- Excellent reputation with patients
- Growing catchment area
- High standards of care
- Strategic geographical position
- High quality tertiary services
- Ability to recruit staff, in particular, doctors
- A track record of delivery.

The following section outlines what Salisbury Health Care Trust believes to be the benefits of Foundation Trust status which will be realised locally.

4 Benefits of Foundation Trust Status

The Trust believes that Foundation Trust status will assist greatly in the delivery of its vision and has identified benefits in four areas:

4.1 Development of a Membership Organisation

Salisbury Health Care Trust has an important role to play in the life of the wider local community. As the largest employer in the area the Trust plays a major part in the economy and society in addition to its primary function in delivering health care. Local people have a significant interest in and affection for Salisbury Hospital. This is reflected in the number of local people who work in the hospital as volunteers and in the generosity shown to recent fundraising campaigns.

The principles of managing a public benefit corporation are fully understood. Achievement of Foundation Trust status allows interested members of the community to become 'shareholders' in their local hospital. This will signify a major change for the Trust as it learns to account to local people for its performance and actions. These shareholders will have a key role in ensuring that the hospital is focused on the delivery of care to patients and aspires to clinical excellence.

The proposed governance structures will allow local autonomy where individuals in our community will elect governors who live and work in the area. At the same time an involved membership will allow the organisation to learn from their experiences and knowledge. The Trust's members will educate the organisation on the effectiveness and appropriateness of its services from the patient's perspective. This will allow the Trust to keep what works well and change/discard what is not working.

4.2 Creation of an Organisation which Involves Staff

The Trust employs a significant number of staff, 3,540, which contains a major pool of knowledge and talent for improving patient care. Through the vehicle of a Foundation Trust the organisation will seek to actively tap this creativity. We will enable staff to create new opportunities which the organisation will seek to implement quickly.

Foundation Trust status will allow the establishment of a more participative workforce which is able to influence change at the planning stage. The organisation has chosen to double the number of Staff Governors from the minimum of three to six. This

positive action has been proposed to ensure that staff members are well represented on the Council of Governors and can exercise influence on the direction of the organisation.

4.3 Establishment of a Local Health Care Organisation

The Trust has a successful track record of patient and public involvement. Membership will further enhance this work, as there will be a significant number of people who will be willing to work with us to improve care and services.

Additionally, the opportunity to create and own a strategy, which serves and develops the hospital, has major attractions. It will allow local management, in collaboration with the membership, to devise a way forward which is influenced by our community and avoids the one size fits all approach often espoused for the NHS but which can miss local needs and aspirations.

As the largest employer in the area the organisation views working with local partners from the public, private and voluntary sectors as essential to our future. Collaborative working can be more easily pursued when the focus is the local community. The Trust has a role to play in issues such as the environment, transport and housing and is keen to make its contribution in these areas.

The journey towards Foundation Trust status involves an organisational development process, which will continue for many years as the Trust learns how to maximise the advantages of becoming a public benefit corporation. This organisational development work will require the Trust to raise its capabilities in terms of patient involvement, risk identification and business management. Embarking on the journey itself is seen by the organisation as a huge benefit.

4.4 Financial Freedoms

As a low cost provider the introduction of a national tariff system will have clear advantages to the Trust and allow investment in identified gaps and weaknesses, as well as the creation of new service opportunities. The ability to retain and use surplus funds for future investment will be of significant value. The revised capital arrangements will mean that the organisation can invest in modernising its infrastructure to meet patient needs and expectations.

In addition, there will be the potential to develop business and commercial opportunities. This ability to support creativity and pursue non-traditional activities for the NHS is viewed as an important building block in the development of a successful Foundation Trust and this organisation has a number of initiatives it will wish to explore.

4.5 Participation of Stakeholders

The Trust's acute, general and emergency services cover three counties and this can cause difficulties in achieving a common approach from different agencies. A Foundation Trust allows some of these agencies to be part of the governance arrangements and thereby influence the direction of the organisation.

The South Wiltshire Strategic Alliance exists to foster joint working where this activity adds value. The Trust actively contributes to this work which will need to grow in stature if sustainable communities are to be developed and economic growth secured. Stakeholders will be able to promote a common agenda on which the new organisation should work. The Alliance has four current priorities; access to services, affordable housing, exemplar employers and crime and disorder.

For commissioners of health care often the service level agreement mechanism used in the NHS is unhelpful, opaque and divisive. It can lead to much wasted effort and large amounts of frustration. A Foundation Trust uses the mechanism of legally binding contracts which ensures transparency for both parties as to what has to be delivered, in terms of both quality and quantity of services. Service improvements will be clearly identified and, as a Foundation Trust, the acute hospital will be able to work flexibly with commissioners and providers of community services to deliver services that truly meet local needs and priorities.

5 The Trust

5.1 Background

Salisbury Health Care NHS Trust was established in 1993 as an integrated whole district Trust. In 2001, Community, Mental Health and Learning Disabilities services moved to other NHS providers, with the result that the Trust became an acute secondary and tertiary care provider. Salisbury Health Care NHS Trust is a 550 bedded district general hospital (DGH) which has a full range of general acute services as well as providing a number of specialist tertiary services. The Trust employs 3,540 staff (2,457 whole time equivalents) and has an annual turnover of £136m with assets valued at £104m.

The hospital is located 2 miles south of the city, which is in the south-east corner of Wiltshire and lies within the Avon, Gloucestershire and Wiltshire (AGW) Strategic Health Authority (SHA). However, only about 60% of patients who attend the hospital come from within this area. To the south-west is the county of Dorset which provides some 20% of the hospital's patients, whilst to the south-east is Hampshire from where 12% of patients come. The result is that the Trust deals with 3 SHAs and 7 Primary Care Trusts (PCTs) for local and tertiary services, and some 20 plus PCTs for spinal injuries.

The Trust provides a full range of DGH services to a population of around 200,000 people. In addition, a number of tertiary services are provided to 3 million people who live in the counties of Wiltshire, Dorset and Hampshire together with the Isle of Wight and the Channel Islands. These cover plastic surgery, burns, cleft lip and palate and, genetics which includes one of two national reference laboratories. Finally, the hospital is the location for one of the eight national spinal injuries units and serves a population of 11 million, which stretches across Southern England from Lands End through into Sussex.

5.2 Trust Performance

Since its inception as a Trust, Salisbury Health Care Trust has proved an extremely successful organisation with a proven record of delivering high quality care, achieving national priorities whilst delivering financial balance. It has a proven record of

performance and is well-regarded by patients, commissioners and local stakeholders. Some of the main achievements over the last 5 years include:

- Achieved all inpatient and outpatient waiting time targets, with a major modernisation programme in A&E delivering significant improvements in performance
- Financial balance achieved in every year
- Three stars achieved for 2003/4 and 2004/5 performance ratings
- Major site improvement programme including major PFI scheme currently on site
- Acknowledgement of successful approach to staff management – South West Employer of the Year (2001), Investor in People, Improving Working Lives.
- Invested in staff facilities – leisure centre, day nursery and staff residences
- Designation as one of two national reference laboratories for Genetics
- Accredited as one of two site centre for Cleft service with the Oxford Radcliffe Hospital
- Achieved Beacon status for breast cancer services
- Maintained low rate of infection – one of top 20 hospitals in country for MRSA rates
- Scored maximum PEAT score for last 3 years
- High daycase rates
- Strong record in patient and public involvement
- Achieved CNST Level 2 (July 2005)
- Excellent results from patient and staff surveys
- Use of artwork to improve the patient experience culminating in the Trust winning the NHS Estates "Outstanding Use of Art in Hospitals" award in November 2004.

5.3 Trust Activity

Salisbury Health Care Trust has undertaken the following levels of activity over the last 3 years:

Table 5-1: Trust Historic Activity

	2002/3	2003/4	2004/5
Non Elective Spells	17,957	19,019	21,208
Daycase Spells	16,884	16,776	17,415
Elective Spells	5,829	7,096	6,183
New Outpatients	46,790	48,488	58,772*
Follow Up Outpatients	98,562	100,557	108.995*
First A&E Attendances	32,256	33,881	35,633

* Increase in outpatient figures reflects project to increase recording of non-consultant activity

Appendix A contains activity for 2004/5 expanded by speciality.

5.4 Clinical Directorate Structure

The Trust has adopted a devolved management approach with an emphasis on the involvement of clinical professionals in the day-to-day running of the organisation. Each Clinical Director works with a Senior Nurse Manager and General Manager. This triumvirate is supported by Finance, Information and HR to manage the six Directorates, which are at the heart of the organisation.

- Surgery
- Critical Care
- Medicine
- Ambulatory Care and Child Health
- Clinical Support
- Cancer

Within each Directorate there are a number of specialities and departments (see Appendix B for a full listing) each of which has a Lead Clinician. The Clinical Directors have been involved in the development of this strategy and organised the participation of large numbers of staff in the reviews of each speciality/department that took place.

5.5 Leadership

The Trust has an experienced and capable Board with an appropriate level of individual ability and experience, and a collective skill mix to manage the hospital as a Foundation Trust.

While the Chairman was only a relatively recent appointment (1 January 2005) he brings substantial experience from a number of NHS organisations as well as significant Board level involvement with large scale companies. Additionally he has served as a national regulator. This combination makes him well equipped both to lead the Board and Chair and develop the Council of Governors.

Following his appointment, and as part of his own evaluation process, the Chairman asked each Non Executive Director to carry out a self-assessment exercise. This showed a good range of key business skills were present but it was also apparent the Trust would benefit from a legally qualified individual and another with Clinical experience on the Board. This gap will be addressed post Foundation Trust status.

A review of the NEDs individual roles/representation on Board sub-committees is undertaken annually. Regular appraisal and the agreement of individual objectives is a feature for all Directors. Four of the five Non-Executive Directors are now into their second term and while this is a current strength the need to prepare for 'new faces' in 2007/08 is fully recognised.

The Chief Executive has worked at this level since 1995 and has been in post since 2001, has a PHD in Corporate Governance and is supported by a strong Executive Team with an excellent track record of 'delivery'. This is evident by three star status in 2003/04 and 2004/05 together with feedback from a variety of external reviews. There are appropriate contingency arrangements in place so that any unforeseen or lengthy absence of an Executive Director can be appropriately covered.

A tailor-made induction programme is drawn up for each new Board Member and a training programme agreed and reviewed as part of the appraisal process. Additionally all Board training is delivered as necessary. Examples range from a 4 day Clinical Governance Programme to a presentation in November from the Healthcare Commission about the Standards for Better Health and the Board's responsibilities. Specific training about the management of Foundation Trusts has been held regularly and this has included presentations from Peter Hunt of Mutuo, David Owens of Bevan Brittan and Giles Newman of Robson Rhodes. Additionally the Chair and Chief Executive have attended Finnamore's learning sets and fed back the key learning points from these sessions.

The Directors understand the importance of performance management and have introduced a new Finance Committee which is meeting monthly to ensure that appropriate attention and understanding is given to the total Financial Management of the Trust including Treasury and cash flow. The Finance Team has been strengthened in this direction and also in contract management. This is illustrative of the forward thinking and pro-active stance adopted by the Board. Development of new business opportunities such as Odstock Medical Ltd is another example alongside the process of redeveloping the site.

The Board agrees annually a business plan for the year which consists of all the key clinical and non-clinical objectives for the Trust. To monitor this plan the Board takes care with the content of its meeting agendas, agreeing at the start of each year a draft

agenda for each Board meeting and using this process to check that the Trust's work programme and plans for the year are being delivered on time. Outcomes are pro-actively related to risk. This leads to a process of 'managed delegation' where Lead Clinicians and staff feel involved and supported at Board level. The feedback from staff surveys supports this statement.

The board recognises the benefits of building strong partnerships, and working with three SHA's and 3 principal PCTs, together with a number of other PCTs is a strong driver. Links are in place with local government and the Board has representatives on a number of other bodies in the community especially Social Services and the Voluntary Sector.

Appendix C provides a brief summary of each of the Board members' experience, skills and qualifications.

5.6 Performance Management

Whilst the Trust's management structure is highly devolved there remains close performance management to ensure delivery of key targets.

5.6.1 Annual Business Plan

Agreed by the Trust Board at the start of each financial year, the Trust Business Plan brings together the relevant elements from the Trust's Strategic Direction, Local Delivery Plans, Standards for Better Health/National Standards and DoH directives. As well as being determined by strategic factors, it incorporates a bottom-up element in the shape of the Directorate's individual business plans.

5.6.2 Six Monthly Reviews

The Trust Board reviews progress against the Business Plan at the mid-point and at the end of the year. In addition the Chief Executive leads his own review of each of the Clinical Directorates and the Facilities Department at the same points in the year.

5.6.3 Monthly Reviews

On a monthly basis the Directors of Operations and Nursing together with the Medical Director meet with each of the Directorate Management Teams to monitor performance against Directorate plans.

5.6.4 Board Reporting

The Trust Board meets formally every two months at which the Director of Finance presents a Performance Report. All Directors also receive this report in the non-Board month, and meet in private session to discuss the current position.

5.6.5 Quarterly Audit Reviews

The Trust's Audit Committee meets on a quarterly basis.

5.6.6 Joint Board of Directors

This monthly forum brings together the executive directors and the key clinical leaders to manage the key developments and operational issues for the Trust.

5.6.7 Individual Appraisal

The Trust believes strongly in individual appraisal and holds Investors In People for the whole organisation. It is expected that every member of staff will have appraisal and objective setting each year supported by the KSF process.

5.7 Quality

The Trust has a reputation both locally and nationally for its high quality care and treatment supported by its Clinical Governance framework. The Health Commission review in 2002 included a number of areas of good such as the comprehensive approach taken for the development of care pathways that involve both primary and secondary care. Staff and services across the Trust have also won national recognition for their innovation for example; national nursing awards have been gained in plastic surgery and spinal injuries.

The Trust has strong and effective strategic leadership in place supported through the Clinical Governance Committee, a sub committee of the Trust Board. The Directorate for Clinical Effectiveness takes the lead for Clinical Governance within the Trust under the direction of the Medical Director. The Directorate ensures that the focus of clinical governance and clinical effectiveness is always on best patient care and positive outcomes.

There is an organisational culture of enquiry, including promotion of research and development activity, of care based on best evidence, of team working and learning, and of continuous improvement linked to the modernisation programme for the benefit of our patients.

The use of Clinical Governance half days when no elective activity takes place, enables multi-professional teams to meet to focus on aspects of clinical governance. Trust core agendas on these days ensure a wider debate on areas of concern, innovation and the sharing of best practice for example the reduction in the use of x-rays postoperatively in orthopaedics.

The Trust has effective processes to identify, manage and monitor all aspects of quality. This is achieved by intelligent links with PALS and PPI, Modernisation, Learning and Development, Risk, Complaints, Information Governance and Clinical Information. There are robust systems for the implementation of NICE guidance and National Service Framework standards and the auditing, through the clinical audit programme, for compliance.

The Clinical Governance report card is a recent innovation that gives a full picture of the performance of each Directorate across all elements of clinical governance.

5.8 Modernisation

The organisation has a strong record on modernising its services having been one of the first cancer beacon sites. Within the SHA the Trust is well known for its high day surgery rates which have been consistent for a number of years. Separately, the 'Action On' principles have been adopted by a range of services, notably General Surgery. Our cancer work has been recognised with Beacon status and a Health and Social Care Award for Breast Cancer. Recent work has involved participation in Patient Accelerated Change and a roll out of Copying Patient Letters across the organisation.

To concentrate much of this work a post of Head of Modernisation was created in 2003 and now has a team of individuals whose focus is modernisation activity. Recently with the demise of the Modernisation Agency (MA) the Trust bid for a member of staff and the organisation now has an experienced resource who led a national programme for the MA and has been recruited to lead on diagnostic redesign.

5.9 Workforce

At 31 March 2005 the Trust employed 3540 staff. Some key workforce statistics are given below.

Table 5-2: Key Workforce Statistics

Staff Group	H/Count	WTE	F/Time %	P/Time %	Female %	Male %	Ave Age	BEM %	Sick %	T/Over %	Stability (1 Year)
Consultants	108	101	78	22	23	77	48	6	1.5	3	91
Doctors in Training	133	131	95	5	44	56	31	30	1.5	N/A	N/A
Other Medical	49	21	27	73	57	43	51	8	1.5	13	96
Nurses inc HCA's	1556	953	39	61	92	8	39	8	5.8	17	86
AHP's/Scientific	533	420	61	39	73	27	40	2	3.2	16	83
Admin/Clerical	624	433	42	58	87	13	44	1	3.7	17	83
Professional/Managerial	117	110	88	12	51	49	46	2	1.2	12	89
Ancillary	392	256	46	54	48	52	42	6	5.2	20	77
Maintenance	28	28	100	0	0	100	45	0	2.2	0	100
	3540	**2453**	**49**	**51**	**77**	**23**	**41**	**6**	**4.3**	**16**	**86**

The table shows that the Trust currently employs 3540 individual staff members. Their combined **contracted hours** equate to 2453 whole time staff (whole time equivalent or WTE). Staff are divided equally between full-time and part-time staff. Three-quarters of staff are female, and the average age of the workforce is 41 years old. Approximately 6% are from black or other ethnic minority groups. The average rate of sickness absence was 4.3% for the year 2004 / 2005. In excess of 80%% of staff have been employed by the Trust for one year or more and the average length of service of staff with the Trust is 8 years.

In general, staff express good levels of satisfaction with the Trust as an employer. This is reflected in the local results from the national NHS staff surveys carried out in 2003 and 2004. Measuring across 28 key areas, the survey placed this Trust in the top 20% of acute hospital Trusts in 15 of the measures, and above average in a further 10.

5.10 Recruitment and Retention

Being located in rural surroundings, the Trust offers a pleasant environment for staff to live and work. South Wiltshire is an ideal location to raise a family, with a range of good quality schools, and many opportunities to pursue a variety of leisure activities. However, there are several constraints that are relevant to the recruitment and retention of staff:

The rate of unemployment, currently 0.7% in the Salisbury travel to work area, is amongst the lowest in southern England. This means that recruitment and retention of staff from the local workforce is challenging, and requires specific initiatives to ensure success. There is no pool of unemployed workers seeking employment. To attract

staff from the local labour market the Trust must appeal as a better alternative than an individual's present employer, or recruit directly on completion of secondary or higher education.

The cost of housing in Salisbury and the surrounding area is well above the national average. For comparison, a terraced house in Salisbury costs an average £188,000, whilst the average in England and Wales for a similar property is £138,000 (Source: Land Registry). The effect is that staff recruited from outside the travel to work area of the Trust often find the cost of accommodation a major factor in their ability to take up employment with the Trust, especially those staff in more junior positions.

Although a very pleasant place to work and live, Salisbury does not have some of the attractions of other towns and cities, in particular those which might prove attractive to a younger workforce. Some nearby towns (e.g. Bournemouth, Southampton) do have these attractions. Whilst this to some extent mitigates the issue, these towns must be considered South Wiltshire's competitors for staff.

5.11 Pay Modernisation

Over the past two years the Trust has implemented both the new Consultants' Contract and Agenda for Change. The organisation is seeing a number of benefits, which include:

- Planning the availability on site of the 'Consultant Physician of the Day' in the evening to provide senior support to the on-call medicine team to bring clinical activities from night-time to early evening.
- Changing the working patterns of Operating Theatre staff so that weekend working for elective surgery becomes the norm and is not paid for at premium rates.
- Using the flexibility of Agenda for Change to create a new role of Maternity Assistant to undertake a range of duties on the Labour Ward and thereby change the skill mix of the workforce.
- Using the band 4 grading, which does not have an equivalent under the Whitley Scheme, to introduce Assistant Practitioners in Radiology and, in the future, deploy Health Care Support Workers with a NVQ at Level 3, within ward teams to deliver much of the hands on, routine care.
- Planning the introduction of the Knowledge and Skills Framework so that those staff, who will potentially go through a gateway in late 2006 and thereby access higher salaries, have clear development plans so that the organisation receives enhanced skills and knowledge for the additional financial outlay.

5.12 Education and Learning

The Trust is recognised for being a supportive employer with regard to education and learning opportunities for staff. The need to ensure that the workforce is fit for purpose with the requisite skills and knowledge will be a major factor in the success of the organisation. The implementation of the Knowledge and Skills Framework (KSF) is seen as pivotal to this goal.

For junior medical staff the implementation of Modernising Medical Careers will significantly change the way individuals progress through their hospital career. Education and learning will be far more focused with a greater input from consultants to guide trainees to meet their training needs.

The changing workforce with creation of new roles and blurring of professional boundaries will require the organisation to develop and/or commission new learning packages. For non-medical staff the KSF can be used as a tool to guide this work. The Trust is an accredited NVQ training centre and will evolve this work to ensure staff have a recognised qualification that adds value to the patient care and the reputation of the hospital.

The South Wiltshire Community has agreed to establish an Academy. It will be a virtual organisation with physical facilities at the hospital and at various community locations. Its aim is to develop education and learning where appropriate, on an inter-professional basis. As part of the project the Academy will have an electronic virtual learning network that will cover the whole AGW area allowing staff access to common learning materials.

The Trust benefits from having the Education Centre on site, an excellent facility at the heart of the main part of the hospital. A first class library is available which in the last round of accreditation achieved the highest rating possible. Practical skills laboratories are available which use modern trainings aids such as simulators to allow clinical staff to practice their skills in a safe environment. In 2004 the Trust established an e-learning centre that allows staff to access a large number of computers through which they can undertake learning activities at convenient times.

5.13 Research and Development

The Trust supports departments to develop research independently, in partnership with academic organisations, and to maintain research programmes of international renown. In a number of areas the Trust plays a leading role in health-related research. This activity is supported by an effective R&D Office, which facilitates management and governance. Staff are encouraged and supported to take an active role in research. The Trust hosts a Research and Development Support Unit (National Coordinating Centre for Research Capacity Development – Infrastructure) to advise on research. This includes education and training for those new to research along with mentorship and partnership on research projects with research leaders. The Unit provides skilled input in research design, statistics, health economics and qualitative research.

The Trust receives NHS Support Funding of £834k (05/06), which supports a diversity of research activity, including two NHS Programmes, both consistently graded strong. The Programmes also attract external funding of:

- Genetics (Molecular and Cyto-genetic Services) £1.6m (03/04);
- Medical Physics (Functional Electrical Stimulation Chronic Neurological Disorders and Stroke) £400k (03/04)

Other non-programme research attracted £78K in 2003/04; total external income was therefore over £2m. The Trust has a strong track record for publication of research findings with the Genetics group publishing 67 papers in 2003.

The Trust is a registered Research Sponsor and has maintained a record for 100% accuracy of submissions to the National Research Register. On average there are around 70 to 80 active projects ongoing within the Trust.

5.14 The Hospital Estate

5.14.1 Buildings

The Salisbury District Hospital covers an area of 21 hectares, and has buildings with a total floor area of 87,623m^2. The hospital can be divided into three categories of building types.

At the northern end of the hospital site is the modern development (Phase 1) totalling approximately 38,000m^2 of floor space. It houses most of the acute inpatient wards,

A&E, main theatres, diagnostic services, the main outpatient departments and an education centre. Extensions for an MRI Scanner and an Endoscopy/Dermatology Unit were made in 1998 and 2004 respectively. A further extension (8,000m^2) is currently under construction as a PFI scheme (Phase 2), together with a modern stand-alone laundry capable of processing 300,000 pieces per week.

The southern end of the site comprises a mixture of 1940s wartime and more recent single storey buildings. These include the regional burns service, a number of care of the elderly wards, plastic outpatients department, maxillo-facial unit and cleft lip and palate service all of which are planned to move into the new purpose built PFI extension (Phase 2) by April 2006. Medical engineering workshops (part of the medical physics department), the Salisbury Hospice, Wessex Rehabilitation Centre and a number of administrative buildings will remain in this area to sit alongside future redevelopments.

The centre of the site comprises predominately 1940s, single storey buildings. Nearly 4,000m^2 of these wartime structures still house clinical services, including short stay surgical and cancer services and women's and children's services. Also in this part of the site are the day surgery unit (DSU), a satellite radiology department and the regional spinal unit. The spinal unit is a modern building opened in the 1980s and the DSU is a modular building built in 1993 that was subsequently extended in 1999 and again in 2003.

5.14.2 Estates Strategy

The Trust's Estate Strategy sets out the way forward for the estate through to 2012. Updated annually, it aims to assist the organisation in strategic decision making in which capital investment plans and business cases can be developed and evaluated.
The key estate outcomes are summarised as:

- Providing high quality environment for patients and staff
- Making best use of existing estate and to maximise development space
- Reducing backlog maintenance
- Providing facilities which are fit for the 21st century and which retain sufficient flexibility to meet future challenges
- Assisting in the attainment of accreditation requirements
- Supporting recruitment policies by improving staff facilities
- Maintaining NHS capacity
- Meeting environmental concerns, for example over transport and waste

5.14.3 Approach to Planning

Both the estates and transport strategies are both embodied within a Development Brief for the Salisbury District Hospital site (currently being consulted on) that will be agreed and approved with the Salisbury District Council during 2005 to assist in determining future planning applications.

The purpose of the Development Brief is to share the vision of future health provision at Salisbury District Hospital with the Local Planning Authority and to enhance everyone's understanding of the site operation. The Brief shows where clinical services will be improved, indicates the standards of estate development required and where enhancement of the hospital environment will meet the planning aspirations of the Salisbury District Council.

5.14.4 Hospital Art

The Trust has a well-established and innovative ArtCare Department constantly making improvements to the patients' environment and experience. This department was the winner of the "Outstanding Use of Art in Hospitals" section in the Building Better Healthcare Awards 2004. It is responsible in partnership with patients and staff for commissioning new arts projects, and selecting the colours and materials used in all refurbishments and new building schemes.

5.14.5 Patient Environment Inspections

The Trust has made significant efforts to ensure that the patient's experience of the physical environment is positive. A green rating has been awarded in three successive Patient Environment Action Team (PEAT) assessments and national patient surveys have identified good levels of patient satisfaction, with a higher than average number of patients reporting that the facilities were clean and provided them with privacy during their consultation. This is an important factor in the good performance of the organisation with regard to infection control. Improvements have been made in the hospital catering service, and further developments are required.

5.15 Information Technology

Historically the Trust has a record of investment on Information Management and Technology (IM&T). Across the AGW SHA area for 2004/05 the Trust spent 2.6% on IM&T which is above the indicative 2% target suggested by Connecting for Health.

In 2002 the Trust made the strategic decision to upgrade to the next version of the iSOFT Patient Administration System (PAS), iPM. With the introduction of Local Service Providers (LSP) under NPfIT, and the successful tendering of Cerner to supply their PAS for the southern LSP the Trust was faced with the likelihood of replacing iPM with Cerner even though 60% of England would be installing iSOFT's product through three other LSPs. This position has changed as from April 2005 when Connecting for Health announced a policy of allowing existing iSOFT providers to continue until at least 2010/2011. At which time if the southern LSP's PAS provider has functionality equal to or better than iSOFT the Trust would be expected to transfer and use its savings from the iSOFT contract to fund the transition costs. An agreement is about to be signed which would see the Trust begin implementation of the latest iSOFT products in 2006.

The organisation has invested in other key systems. In 2003/04 a new A&E system was installed which uses wireless technology giving the Trust valuable experience of a delivery system that will become the norm over time. In the current year a new Radiology Information System (RIS) has just been installed in tandem with Picutre Archiving and Communication System (PACS), which is delivering digital imaging throughout the hospital.

In 2004/05 the Trust invested in a new finance and procurement system, which is constructed on Oracle database technology. The procurement module allows paperless ordering to be undertaken by over 300 staff and has greatly enhanced the efficiency of the procurement process.

Infrastructure investment has been a key priority. A number of years ago the Trust adopted a thin client environment which allows for more efficient upgrading of systems. Firewall protection has been another significant priority to ensure that the organisation is not vulnerable to virus or hackers. In 2005/06 major effort has been devoted to the installation of an additional hospital wide network, which will be used for digital images. This will ensure that the existing network can be used for all other traffic and have no degradation of performance. At the same time an additional computer room is being constructed and planning has commenced to replace the Trust critical storage area network (SAN).

5.16 Information

When CHI reviewed the Trust's clinical governance processes in 2002, the reviewers were rightly critical of the Trust's approach to, and use of, information. A significant effort has been made in the intervening period to improve this situation.

A real focus on data quality has seen the Trust's performance leap in the space of two years to above the national average. The use of information within the organisation has increased significantly. The development of clinical governance report cards provide the Clinical Governance Committee and directorate teams with a summary of clinical performance. Both Trust Board and the Directorates receive routine summary information on the Trust's performance focusing on the key performance indicators.

Systems have been put in place to collect patient level data on the wards and at a departmental level, rather than having paper based systems requiring subsequent data entry. Whilst the information is not yet real time, there have been real benefits in individual members of staff taking responsibility for the data entered on the system. The Trust is putting together a reward system to recognise those ward areas which make a concerted effort to improve the quality of their data.

A dedicated clinical information system (Dendrite) was purchased in 2001 and has been successfully used to implement a number of clinical registries providing clinical staff with a flexible data collection and analysis tool. A Clinical Information Group (CIG), chaired by the Medical Director, has been set up to oversee the way in which the Trust develops its clinical information systems. A data warehouse is in development to ensure that the Trust is able to meet the growing demands for information.

The Trust has a strong track record in relation to the quality of its clinical coding. Successive audits have found that the quality of the coding is of a high standard. Coding completeness continues to increase and the CIG has sponsored pilots to increase joint working between clinicians and coding staff.

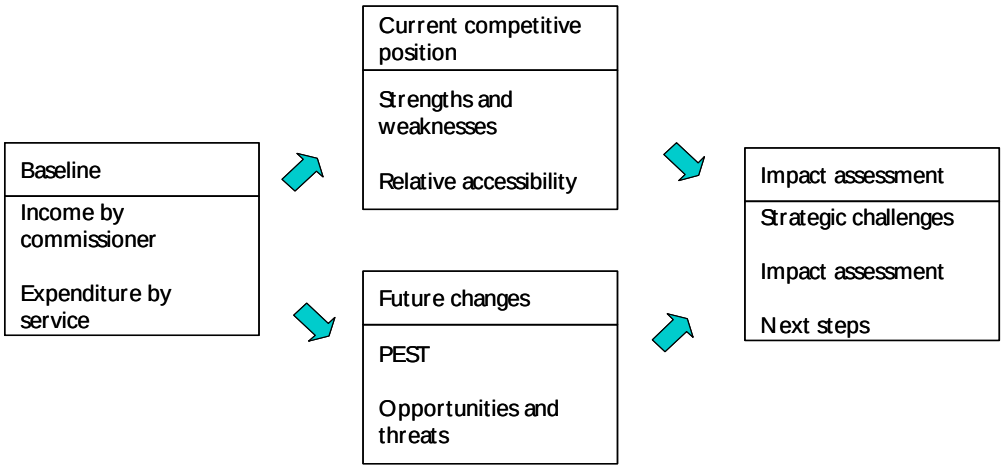
The Trust has purchased the Dr Foster system which enables the Trust to compare its performance on a range of clinical measures such as mortality, readmission and daycase rates and length of stay against a range of variables and in comparison to something like 150 other hospitals. A training programme is well underway.

6 Market Analysis

6.1 Introduction

This analysis is based on desktop research using publicly available data or data available to the Trust, plus interviews with internal and external stakeholders.

Figure 1: Project Scope



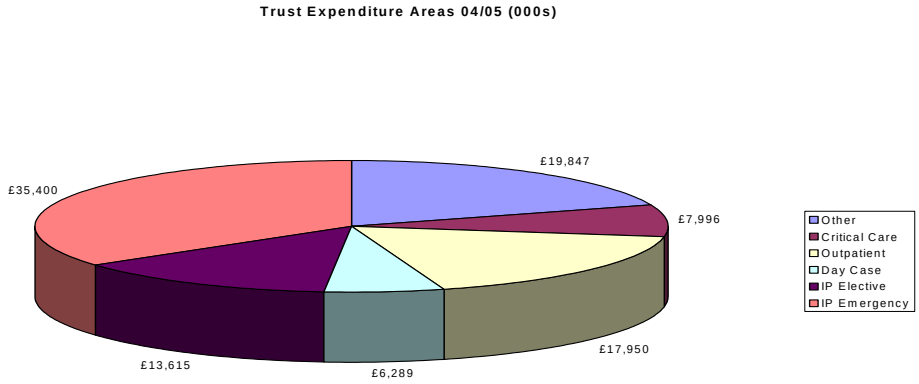
6.2 Activity and Finance 2004/05

The Trust received approximately £101 million of income from Service Level Agreements with PCT Commissioners, providing approximately:

- 21,000 inpatient emergency FFCEs.
- 6,200 inpatient elective FFCEs.
- 17,000 daycase FFCEs.
- 140,000 outpatient attendances.

In addition the Trust received around £25 million of non-PCT income. Expenditure in key service areas is shown in the figure below.

Figure 2: Trust expenditure areas

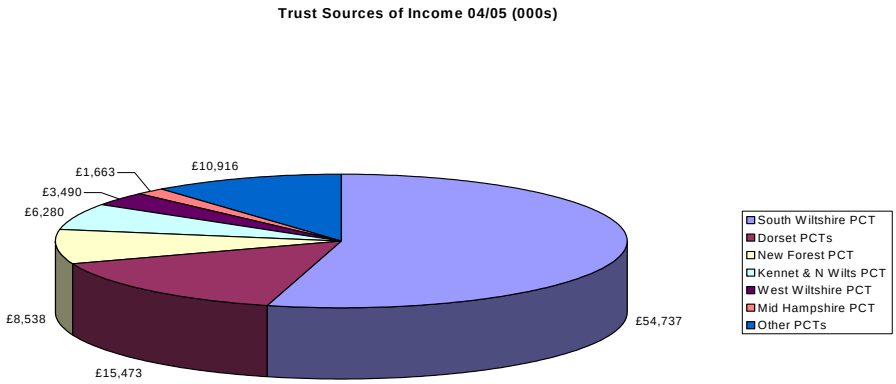


The Trust's income comes from a larger range of commissioners than many District General Hospitals, as a result of its:

- Geographical position at the border of Wiltshire, Dorset and Hampshire.
- Range of specialist services, which are commissioned by PCTs across Southern England, from Land's End to Sussex.

South Wiltshire PCT, the Trust's host PCT, has Service Level Agreements (SLAs) with the Trust totalling approximately £55 million, accounting for around 54% of its income from PCTs. North Dorset PCT has SLAs with the Trust worth approximately £15 million for its own population and other PCTs in Dorset. New Forest PCT is the Trust's third largest commissioner, with SLAs in excess of £8 million.

Figure 3: Trust sources of income



Income from specialist services accounts for approximately 12% of the Trust's total income. Appendix A sets out the total Trust income by specialty. Table 6-1 below shows income by service type and commissioner.

Table 6-1: Trust income by commissioner and service type

Service Type	All commissioners	S Wilts PCT	N Dorset S&E Dorset PCTs	New Forest PCT	Kennet & N Wilts PCT
Inpatient Emergency	35%	22%	5%	3%	2%
Inpatient Elective	13%	6%	2%	1%	1%
Daycase	6%	4%	1%	1%	0%
Outpatient	18%	11%	3%	2%	1%
Critical Care	8%	2%	1%	0%	0%
Other	20%	10%	3%	1%	1%
Total	**100%**	**55%**	**15%**	**8%**	**5%**

6.3 Current competitive position

The Trust's current market position has been assessed in relation to Independent Sector providers and specific NHS providers identified by the Trust. This section looks at the Trust's current market position by considering:

- Current strengths and weaknesses
- Catchment population and the accessibility of alternative providers (ie how captive is the market)
- Waiting times for treatment and other indicators likely to impact upon patient choice

6.4 Strengths and weaknesses

A full SWOT analysis has been prepared with input from internal and external stakeholders and this forms Appendix D. The summary table below highlights the most significant Trust strengths and weaknesses in relation to the marketplace changes expected between 2005 and 2010 and described later in this report.

Table 6-2: Trust strengths and weaknesses

Strengths	Weaknesses
Stable and effective operational and financial management, recognised in Three Star status. Reference costs position – under PbR tariff by around 10%. Management & clinician close working. Established catchment areas. Public involvement and local stakeholder support. Secure specialist services as a result of Specialist Services Reviews, which reinforce the need for comprehensive DGH services onsite.	Host commissioner finances. Fragmented commissioner base and relative importance of Trust to non-host commissioners. Small size of home catchment population. 'Traditional' models of emergency and elective care. Limited intermediate and community care infrastructure. Booking infrastructure and ICT linkages with new Dorset referral system. Cost of living in surrounding areas as a deterrent to staff recruitment.

6.5 Key Strengths

The Trust believes it has a number of unique selling points which make it well placed to flourish in the FT environment:

6.5.1 Local Reputation

The Trust has an extremely good reputation locally and the hospital is viewed as providing a high quality of care and as being well managed. It is well regarded by both patients and GPs and there is a strong sense of loyalty to SDH. This perception has been endorsed by the consultation exercise on Foundation Trust status where the interest has been high and the feedback received about Salisbury hospital has been generally positive. The national patient surveys carried out in the last three years have all painted a picture of a hospital which is valued by its patients, both in terms of the survey response rates and in terms of the feedback given. The Trust will hope to benefit from that reputation by maintaining the quality of its services and its focus on the needs of patients thereby seeking to ensure local patients do not seek alternative providers of secondary care.

6.5.2 Growing Catchment Area

The Trust is seeing increasing signs of its established catchment area expanding at the margins. In particular for the areas towards Devizes and Westbury to the northwest, increasingly referrals for both elective and emergency care are coming to Salisbury rather than to RUH Bath and, to a lesser extent, Swindon. The Trust's services are included within the Directory of Services as a provider of choice for in excess of 20 PCT's.

6.5.3 Clinical Quality

The Trust provides a high standard of care. Infection rates are one of the lowest in the country with the Trust in the top twenty performing hospitals in England. The Trust has a robust approach to clinical governance issues and has confirmed compliance with all the 24 core Standards for Better Health. In all the key clinical indicators the Trust performs well and the Dr Foster clinical benchmarking system is now being used to monitor clinical quality. Again maintaining the focus on clinical quality will be essential to the new Foundation Trust in providing the highest standards of care to patients to ensure the Trust's reputation for clinical quality is maintained and enhanced.

6.5.4 Patient Accommodation

By April 2006 the majority of the Trust's services will be provided from accommodation which will be at most 12 years old. Those services in older buildings within SDH Central, with the exception of child health services, have received significant recent investment with a £1m upgrade for the maternity department and a £600k investment in cancer services. Consequently the Trust will be able to market to patients and GPs the advantages of a secondary health care service provided in new, purpose built facilities to modern standards.

6.5.5 Specialist Services

Tertiary services account for around £13 million, approximately 12% of total Trust SLA income. The Trust is confident that its position in this market area is strong. The future provision of specialist services at Salisbury has been reaffirmed recently, with continuing support from tertiary services commissioners. The national review of Burns has recommended that Salisbury should have burns unit status for adult patients whilst for cleft lip and palate the Spires Centre has been implemented in partnership with the Oxford Radcliffe. The Government's policy on expansion of Genetics has seen the establishment at Salisbury of one of two national reference laboratories which puts the service at the forefront of activity in this field.

6.5.6 Financial Position & Track Record

As is outlined elsewhere the Trust is in a strong financial position due to a number of years of sound financial management. The Trust's reference cost position places it at an advantageous position regarding its local competitors and will enable it to benefit from the introduction of Payment by Results. Again, the Trust will be looking to maintain that position by placing emphasis on close cost control and robust income collection.

6.6 Competitors

The Trust has a number of external challenges to face from increased competition as a result of the Government's policies of:

- Provider Plurality, where the Independent Sector is being encouraged to treat NHS patients
- Payment by Results, where providers are paid a standard tariff for the patients they treat

Competitor provider hospitals include the following NHS and Independent Sector providers:

- Winchester & Eastleigh Healthcare NHS Trust.
- Southampton University Hospitals NHS Trust.
- Royal Bournemouth and Christchurch Hospitals NHS Trust.
- Poole Hospital NHS Trust.
- Shepton Mallet Independent Sector Treatment Centre.
- New Hall Hospital, Salisbury (a private hospital)
- Swindon & Marlborough NHS Trust.

Since July 2005, New York Presbyterian Healthcare System's Independent Sector Treatment Centre (ISTC) at Shepton Mallet has been competing for elective surgical patients. This ISTC has introduced capacity for a further 13,000 General Surgery, Orthopaedic and Ophthalmic procedures per annum. New Hall Hospital (Capio) is undertaking a number of orthopaedic procedures each year for the NHS in Hampshire and Dorset.

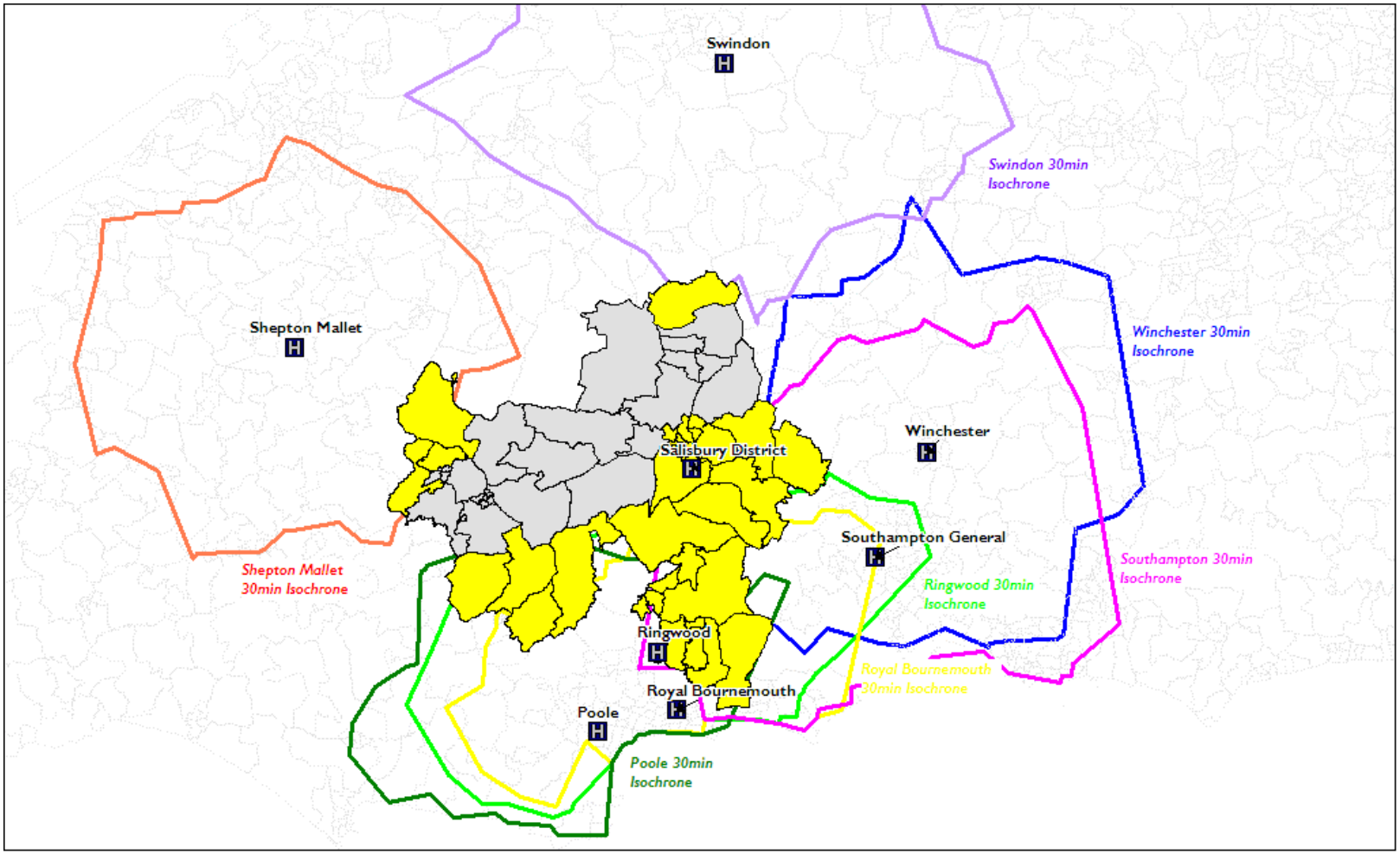
6.6.1 Competitive position

Improved access to NHS provision is an important goal of Government policy and access to services is a key determinant for Patient Choice. The Trust's competitive position in terms of access has been analysed from two perspectives.

Firstly, in relation to geographical travel time between providers. Thirty minute travel time isochromes have been constructed for the above competitors and the overlap between competitors '30 minute catchment' and the Trust's 'home catchment' has been mapped. This isochrome analysis is shown on the following page together with information showing the size of the overlap with the Trust's 'home catchment'. Secondly, the Trust's competitive position has been analysed in relation to the issues which are likely to influence the patients' choice of Salisbury or competing providers, waiting times for access, star ratings, infection rates.

The following analyses ignore the New Hall Hospital, as it is so close to Salisbury that it could compete for work from nearly all of the local catchment population.

Figure 4: Travel time for Salisbury District Hospital's home catchment



Grey shading = 'Home' catchment outside competitor 30 min radius	Yellow shading = Competitor 'overlap'areas

The 'home' catchment population of 218,000 is based on part-postcode information provided and this appears to exaggerate the Trust's 'home' catchment by almost 10%. It should be noted that the more significant variable is the 30 minute travel time assumption as the scale of competition reported would vary significantly if twenty or forty minute travel times were plotted.

Table 6-3 identifies the proportion of the Trust's 'home' catchment that is at risk from competitors. At risk is defined as being within 30 minutes travel time of a competitor hospital. Ignoring New Hall hospital on the outskirts of Salisbury, 57% of Salisbury's 'home' catchment are within 30 minutes travel time of at least one other hospital.

MORI's 2003 market research contribution to the national consultation on "Choice, Responsiveness & Equity" found that 89% of the public would accept an earlier date for treatment from an alternative hospital. Experience to date in Dorset & Somerset Strategic Health Authority supports this view of patient willingness to travel for speedier treatment. Between 57% and 90% of patients, to whom choice was made available have taken up the option in Dorset & Somerset. Based on this level of patient interest in speedier treatment, a 30 minutes travel time is assumed to be a reasonable scenario to model.

Table 6-3: Competitor catchment population overlap (excluding New Hall)

	Population overlapping with a competitor (excluding New Hall)	
Provider	**Home catchment overlap**	**%**
Winchester & Eastleigh	51,000	23%
Southampton	103,000	47%
Royal Bournemouth and Christchurch	90,000	41%
Poole	63,000	29%
Shepton Mallet	17,000	8%
Swindon & Marlborough	2,000	1%
Any of the above competitors	124,000	57%
Total	**218,000**	**100%**

6.6.2 Comparative Performance

The Trust's relative performance against key access targets is summarised below alongside the 2005 star rating from the NHS Performance Ratings. Using this data,

the Trust is ranked third on access to inpatient services behind the two Trusts in Dorset, although the differences are small. The Trust scores the highest on issues relating to hospital cleanliness and infection rates. Salisbury's performance in relation to cancelled operations appears broadly comparable with other trusts.

Table 6-4: Performance against key access targets 2004/05

Provider	Performance Assessment Framework rating	Inpatient waits > 6 months	Outpatient waits > 13 weeks	Hospital Cleanliness	MRSA Rates per 1,000 bed days	Cancelled ops as % of elective admissions
Salisbury Health Care	***	98%	88%	5.0	0.06	1.4%
Winchester & Eastleigh	**	91%	79%	4.0	0.09	3.3%
Southampton	*	85%	78%	3.2	0.19	1.5%
Royal Bournemouth & Christchurch	***	100%	89%	4.2	0.06	0.5%
Poole	**	100%	93%	4.0	0.13	1.1%
Swindon & Marlborough	**	94%	85%	5.0	0.14	0.5%

Source: Department of Health

6.7 The strategic challenges facing the Trust and their potential impact

The analysis above suggests that there are a number of key strategic challenges in marketing terms which the Trust needs to address. These have been derived by applying the PEST, SWOT and Competitor analyses to specific areas of the Trust's business. The nature of the challenges is as follows:

6.7.1 Plurality of Secondary Care Provision

Increases in capacity for elective surgery threaten historical flows of elective patients to the Trust. Commissioners are committed to funding a number of procedures with New Hall and 13,000 procedures with the New York Presbyterian Healthcare System at Shepton Mallet.

6.7.2 Patient Choice

Over 50% of the Trust's 'home' catchment is within 30 minutes travel of a large competitor and the 30-bed New Hall hospital is in the centre of the catchment area. The Trust's maximum waiting times are greater than competitors to the south and

efforts to secure funding from North Dorset PCT to reduce waiting times to the level of Dorset & Somerset providers have been unsuccessful to date, despite good working relationships with this commissioner and with its SHA. However both the local hospitals, and especially New Hall, do not have the potential to increase their capacity significantly.

Patient choice is likely to be influenced by access to services and by the quality of the physical environment. On this basis, the Trust feels it will be extremely competitive (and this is borne out by referrals continuing to increase in 2005/6) however it does need to consider further how it could respond to net loss of elective patients as a result of Patient Choice.

6.7.3 Local Health Economy Financial Balance and Reconfiguring Care Pathways

South Wiltshire PCT has a recurring financial imbalance of around £4 million. They are expected to address this through:

- Practice-based commissioning as a tool to manage demand and reduce referrals to secondary care.
- Care pathway redesign to find community-based alternatives to hospital, for both elective and emergency patients.

South Wiltshire PCT and Avon, Gloucestershire & Wiltshire SHA foresee a change in the threshold at which patients require hospital services for chronic and acute conditions. Investments in community-based facilities and services need to be twinned with service redesign. Along with other strategic drivers, this will redefine the role of the Trust. Clearly there is a long-term threat to the Trust's income from these changes.

6.7.4 Community-Based Diagnostics & Testing

Community based diagnostics will need to be expanded in this period to provide the capacity to meet the 18 week target. The future development of ISTC's may well focus on diagnostics given the level of capacity for surgery. The South Wiltshire LIFT scheme will incorporate some community diagnostics, mainly x-ray and ultrasound.

It is important to ensure that the Trust plays a major part in expanding community based diagnostics and testing, if it does not want to lose market share in this area. From discussions with commissioners it is clear that there is a market for direct access MRI which the Trust will be pursuing once waiting times have been normalised. In addition the Trust will work with GP's to ensure that the hospital's

diagnostic services are meeting the timeliness and quality of reporting standards which GPs are looking for from the service.

6.8 The impact of the challenges

The table below maps the Trust's current areas of business to the strategic challenges described above. Since elective services are affected by each strategic challenge a summary expenditure line has been added for Elective Surgery services. Of all elective activity, surgery is most affected. The current income derived from elective surgical services has been estimated by adding outpatient, daycase and inpatient elective income for: General Surgery, Urology, Orthopaedics, ENT, Ophthalmology, Oral Surgery, Plastic Surgery and Gynaecology. It should be noted that the £26.9 million attributed to elective surgery includes all outpatient income for the above specialties.

Table 6-5: Areas of Trust spend affected by strategic challenges

	Strategic Challenges				
	Plurality	Choice	Local financial balance	New care pathways & care models	Community-based diagnostics
Inpatient emergency, £35.4m			Y	Y	Y
Inpatient elective, £13.6m	Y	Y	Y	Y	Y
Daycase, £6.3m	Y	Y	Y	Y	Y
Outpatient, £18.0m	Y	Y	Y	Y	Y
Critical Care, £8.0m	Y		Y	Y	Y
Other, £19.8			Y	Y	
NB Services linked to elective surgery, £26.9m	Y	Y	Y	Y	Y

The likelihood of threat from each challenge and the potential impact has been estimated, using a scale of High, Medium and Low. This has been done by commissioner.

Table 6-6: Areas of Trust spend affected by strategic challenges

	Strategic Challenges									
	Plurality		Choice		Local financial balance		New care pathways & care models		Community-based diagnostics	
Commissioner	Likelihood	Impact	Likelihood	Impact	Likelihood	Impact	Likelihood	Impact	Likelihood	Impact
S Wilts PCT	H	H	M	L / M	M	M	M / H	L / M	H	L / M
N Dorset & S&E Dorset PCTs	H	L/M	M	M / H	n/a	n/a	M / H	L / M	H	L
Spec. Services commissioners	L	L/M	L	L	n/a	n/a	L / M	L / M	L	L

An initial estimate has been made of the potential income risk from each area. Clearly it is very unlikely that anywhere approaching the full risk would materialise in any particular area. However, it is shown as a tool for the prioritisation of action to address the risk.

Table 6-7: Assessment of impact of identified strategic challenges on areas of current income:

Risk	Services	Commissioner	Total value at risk £ million
Medium	Inpatient Elective, Daycase, Outpatients	S Wilts PCT	20.9
Medium	Emergency, Critical Care, Other	S Wilts PCT	33.8
Medium	Inpatient Elective, Daycase, Outpatients	Dorset, New Forest, Kennet & N Wilts PCTs	12.4
Low	Emergency, Critical Care, Other	Dorset, New Forest, Kennet & N Wilts PCTs	18.4

Clearly the area of greatest concern is the potential for the Trust to lose elective activity, regardless of commissioner, as a result of Patient Choice. Consequently section 6.9 majors on how the Trust will look to manage the risk in terms of reduction in elective surgery. This is also reflected in the low scenario in the activity modelling where the planning assumption is made that elective cases reduce by 5% per year.

6.9 Managing the Risk

Section 6.8 sets out a number of core risks which the Trust will have to manage and it is essential the Trust is not complacent regarding the potential for radical change in the NHS environment. The proposed Foundation Trust must look to manage the risks ensuring that these strategic changes do not materially impact upon the financial stability of the Trust and that the Trust seeks to benefit from the changes where it can.

The Trust has stressed in section 6.5 its strong belief that it has a number of key qualities which will enable it to continue to prosper. These traits will go a long way to allowing the Trust to meet successfully the challenges set out in sections 6.6 to 6.8. The Trust will need to ensure that those traits which have seen it prosper are built upon and the Trust continues to develop its services in a fashion that is attractive to patients.

A key test of that will be the Trust's success under Patient Choice. The Trust believes it is making progress to ensure that it remains successful under the new regime where patients choose from which hospital they will receive treatment. The Trust is working hard to contribute to the Directory of Services and preparing the

ground for electronic booking – this project has been carried out collaboratively with primary care. It is proposed that the fully integrated Choose & Book system allowing GPs to directly book outpatient appointments will be operational by the summer of 2006, ahead of the national programme. The Trust is continuing to ensure that relations with primary care are strong and are looking to improve the service provided to GPs, for example by improving on the quality and timeliness of discharge summaries. The qualities the Trust has highlighted particularly in relation to the standard of its accommodation and its clinical quality will be a strong driver in attracting patients to the hospital for planned treatment.

The risk of losing activity, especially elective surgery, to other hospitals is double-edged. Given the overlapping catchment populations with other hospitals, there is an opportunity for the Trust to market its services forcefully and look to expand its catchment population still further. Whilst the Trust has made no bold assumptions within its activity planning (see below) on this, it is clear to the Trust that now is the time to take advantage of its Foundation Trust status in advance of other surrounding Trusts and will develop a marketing strategy in the early part of 2006 to promote this aim.

Just as with Patient Choice the Trust will need to meet the challenge posed by ISTC's head on. The Trust feels increasingly well placed to compete with the private sector on the quality of the service it provides with the improved accommodation, the quality of care and reputation it can build on. The ISTCs commissioned to date have had minimal impact on the Trust's elective workload and the geographical locations of existing and proposed ISTC's are such that the Trust does not believe it will lose significant volumes of elective work. This is borne out by referral rates which are increasing for Dorset PCTs and also the Trust has been asked by Mendip PCT (the host commissioner for Shepton Mallet) to undertake additional orthopaedic cases which Shepton Mallet are not able to perform. Where the impact of the ISTC's may be felt is on a reduction in the growth of the catchment populations highlighted in section 6.5.2.

The Trust's specialist services offer the organisation an excellent opportunity to develop services which have only limited local competition. The nearest Spinal unit is Stanmore in Middlesex, the nearest burns and plastic services are in Bristol and East Grinstead in Sussex and the Genetics service already has a supra-regional

status. The Trust must take full advantage of these services to provide a counter to any reductions in elective activity which might occur.

Whilst it is clear that commissioners wish to reduce the number of secondary care emergency medical bed days this is in the context of steadily increasing admission rates. The Trust has always supported initiatives to ensure patients are managed in the care environment most suited to their needs. For example the Trust has supported the HAT (Hospital Alternatives Team) team and is working with primary care on the more appropriate management of patients with diabetes. In this context the Trust would actually view a plateauing of medical admissions, if accompanied with a fall in delayed transfers of care, as a positive measure and will work with commissioners to achieve these outcomes.

The Trust is collaborating with South Wiltshire PCT over the financial issues which are faced by that organisation. The Trust has made prudent assumptions in its planning for future years to ensure that changes in PCT commissioning intentions do not destabilise the Trust's finances. The Trust has planned within its financial projections for the PCT to remove additional funding, although it remains unclear as yet at to what form this will take. Notwithstanding this the certainty which legally binding contracts will give both parties will be extremely important in managing the risk to the Trust of changing commissioning intentions.

The Trust is working with South Wiltshire PCT to understand what is proposed in relation to the community diagnostics element of the proposed LIFT scheme at Fountain Way in Salisbury. The Trust will be robust in ensuring that what is proposed fits a rational service model and genuinely improves access for local services. At the same time the Trust will be looking to work with GP's to see how the direct access radiology service can be improved to meet the needs of primary care.

See section 10 and Appendix AP for further information on how the Trust proposes to manage the risks suggested by this analysis.

7 Developing Services

7.1 Introduction

A service plan for the Trust over the five year period has been produced to determine clear objectives based on the outline strategic direction for the emergent Foundation Trust. Each specialty has undergone a service review to determine what the future plans should be over the five year period. The sessions, which were led by the Chief Executive, were structured around the Trust's six strategic objectives set out in chapter 2. The following sections summarise the key objectives highlighted. Appendix E sets out the plans in more detail by clinical directorate and links each objective back to the Trust SWOT analysis. It also highlights where there are proposed implementation dates or where schemes are aspirational requiring further analysis and the development of detailed business cases.

7.2 Delivery of Patient Focused Care and Services

It is essential for the development of the business that the Trust is able to demonstrate a clear willingness to develop services which meet the needs of its patients and their carers. In order to encourage patients to choose to receive their treatment at SDH the Trust needs to be attentive to what its patients want from its services and look to adapt accordingly. Some areas where the Trust is aware there is a requirement for change to fit in with patient expectations include the following:

- Offer patients booked appointments for all surgery, new outpatients appointments and ultimately for follow up attendances to give patients the maximum choice.
- Increase the proportion of elective theatre sessions and outpatient clinics that take place in the evenings and at weekends again to increase patient choice and particularly the opportunity to choose appointments most convenient to their lifestyles.
- Develop a one stop haematuria service to include outpatient appointment, ultrasound and flexible cystoscopy at the same attendance, reducing patient visits and providing quicker results.
- Develop shared care arrangements for patients with glaucoma between consultant ophthalmologists and optometrists. Arrange for follow-up attendances following cataract surgery to be undertaken by optometrists saving patients a journey to hospital.
- Develop an integrated lower back pain service comprising the Wessex Rehabilitation Service, community services, and anaesthetics. One stop service receiving triaged referrals from spinal consultants, physiotherapy, GPs.

- Extend the range of cardiological interventions carried out – increased number of angiographies, develop PCI (percutaneous cardiological intervention) service providing a more local service for patients who currently go Bournemouth or Southampton.
- Work with primary care to improve chronic disease management providing outreach services to help patients stabilise their condition.
- Establish a satellite renal dialysis unit on the SDH site to improve access for local people. Patients currently have to travel either to Totton (15 miles away and with limited capacity) or to Portsmouth (30 miles from Salisbury) for their treatment which is required three times a week.
- Carry on progress from the Improvement Partnerships for Hospitals review of radiology. To include extended working day, review of out of hours staffing, exploiting the benefits of PACS.

7.3 Improvement of Organisational Effectiveness

The new Foundation Trust will need to review the effectiveness of its services ceaselessly if it is to maintain its beneficial reference cost provision and to offer commissioners a cost effective and efficient provider of secondary care. The Trust's modelling (see section 8) requires that it reduces length of stay, improve day case rates and outpatient efficiency. This will require intense effort across the whole organisation. In order to achieve its aim of being in the top 25% performing Trusts, Salisbury Health Care Trust will:

- Take all opportunities to review, benchmark and improve upon the Trust's length of stay.
- Improve discharge planning so that no patient stays in hospital beyond the time he or she is medically fit for discharge.
- Replace all the Trust's main radiological equipment, including the MRI and CT scanners (see section 7.8.3 for the efficiency benefits this will bring)
- Develop fast track recovery service in order to reduce post-operative stays for major colo-rectal surgery from 11 days to 4 days.
- Promote the concept of 23 hour surgery service to increase the range of procedures carried out on a day case basis.
- Start to work with GP's with specialist interests (GPSI's) to manage a proportion of ENT and dermatology referrals in primary care.
- Develop a nurse/physio led step down unit for orthopaedic patients to promote rehabilitation prior to discharge.
- Develop minimally invasive approach to hip and knee replacements, reducing length of stay by 50%.
- Improved joint working between the Emergency Department and primary care out of hours services to include common triage of patients and co-location of services.

- Expand the range of robotic equipment within laboratory medicine to increase automation.
- Harness the benefits of the new diagnostic opportunities arising from mapping of human genome.
- Using technology to improve organisational efficiency. A project group has been set up to review how the benefits of technology, particularly IT, can be harnessed to increase the overall efficiency of the organisation.

7.4 Delivery of Effective Risk Management Systems

The most patient-friendly arrangements and cost effective hospital will not attract patients if there are concerns regarding the quality of care and that measures are not in place to ensure that standards are maintained. The Foundation Trust will need to develop its existing risk management systems. In order to protect our patients and staff, we will introduce the following measures:

- Develop high dependency area within theatres to reduce cancellations due to lack of HDU beds.
- Develop rolling replacement programme for medical equipment.
- Improve information provided to patients about their drugs to reduce medication errors and readmissions
- Recruit blood transfusion specialist nurse to promote and enhance training for staff handing blood products.
- Increase the proportion of patients whose breast reconstructions are carried out using the TRAM method which reduces the requirement for subsequent revision surgery.
- Invest in robotic system for the pharmacy department for automatic preparation of prescriptions to reduce dispensing errors.
- Move to consultant led service delivery, particularly in relation to the delivery of emergency surgery.

7.5 Developing an Excellent Workforce

The patient's experience is shaped by the care they receive, the interaction they have with staff at all times and the quality of their surroundings in which the care is delivered. The Foundation Trust's ability to implement this Service Development Strategy requires a workforce of the highest order – highly skilled, appropriately trained and with a clear customer care ethic. In order to recruit and retain a first class workforce, we will:

- Invest in additional nursing and consultant staff to deliver high-quality services within the context of the changes in junior doctors' hours and the European Working Time Directive.

- Train staff to undertake radiological procedures (eg ultrasound in A&E, prostate biopsies, kidney ultrasounds) offering staff development as well as reducing the Trust's reliance on a constrained number of radiographers.
- Develop extended roles for specialist nurses to include initial assessment, pre-operative assessment and follow ups. Also additional nurse endoscopists, nurse led clinics in plastic surgery, nurses performing biopsies of the skin, etc. These developments relate to extending the skills of existing staff, rather than new posts.
- Review skill mix within theatres – develop anaesthetic nursing roles, advance healthcare workers role.
- Extend range of nurse and pharmacist led prescribing.

7.6 Generation of New Income Streams

As a business the Trust will seek to exploit all the opportunities at its disposal to maximise its income. At its most prosaic, this will involve ensuring that all data is accurately captured and that all patient activity is invoiced. However the Trust has numerous opportunities to secure additional income building on the skilled members of staff it employs. As clinical practice develops the Trust is well placed, for example with its specialist services, to secure additional income which will enable the Trust to re-invest in patient services. Some examples are:

- Seek to generate additional income from the Patient Choice initiative by offering high quality, patient focused services.
- Employ the additional capacity offered by the new laser treatment centre to increase the volume and range of treatments offered.
- Increase the volume and range of assisted conception services provided in accordance with NICE guidance.
- Develop new lower arm service in collaboration with the plastic surgery service. Build up ankle surgery sub-specialty to include lower limb reconstruction service, again in conjunction with the regional plastic surgery service.
- Subject to NICE guidance, advance the cartilage replacement surgical technique. One of the Trust's orthopaedic consultants is already trained in the procedure having been involved in the original research.
- Promote the community palliative care service to an extended geographical area.
- Promote the spin out company set up for the marketing of the Odstock Drop Foot Service. Trust has a world wide UK, US and Canada (pending) patents for this technology which gives patients with neurological conditions (MS, stroke) additional movement.
- Build on the success of the National Reference Laboratory for the genetics service to develop additional income streams.

7.7 Develop the Hospital's Infrastructure

It will be essential for the Trust to be able to compete for patients that it offers a high standard of accommodation, both in terms of the infrastructure itself and in terms of the maintenance and cleanliness of the hospital. Increasingly the Trust will have to compete with ISTC's delivered from purpose-built accommodation requiring the Trust to provide as much of its planned surgery from new facilities as possible. Further investment in infrastructure will be required to deliver a number of the service improvement proposals outlined above. Therefore, and building on recent achievements in improving the hospital's infrastructure, the Trust will:

- Use the land to be freed up on SDH South to secure additional income and develop Trust services, eg the potential development of nursing home facilities on the site.
- Develop a Surgical Admissions Lounge so that patients requiring elective surgery are admitted to a calm and reassuring environment improving the overall patient experience.
- Bring forward plans for the Phase 3 redevelopment of the SDH site, ie the reprovision of women's and children's services.
- Redesign the A&E department to offer: improved waiting area, better management of the different patients and improved observation. To include a minor injuries service linked to a primary care out of hour service.
- Build new cardiac investigation suite, with two intervention rooms (50% increase in capacity).
- Improve IT systems within the context of NPFIT.

7.8 Capital Programme

7.8.1 Objectives

One of the advantages of Foundation Trust status is the ability of the Trust to use cash flow funding and, if necessary, to borrow up to agreed limits to support capital expenditure. The Trust has developed the following priority areas for its future capital programme.

A. Development of modern fit-for-purpose clinical facilities
B. Development of new facilities to address new or expanding clinical practice
C. Changes to facilities to meet patient and public expectations
D. Upgrading of medical equipment to gain patient benefits from newer technologies and staff effectiveness
E. Maintenance of the estate in particular a reduction of backlog maintenance
F. Risk reduction for patients, public and staff
G. Compliance with statutory requirements

H. Meeting environmental concerns, for example in relation to transport and waste
I. Development of unregulated services
J. Implementation of NPfIT

7.8.2 Priorities

From these key areas the Trust has proposed an expenditure plan which takes forward these objectives. Examples of individual schemes, with the objectives they promote, include the following:

- Redevelopment of the A&E Department to be fit-for-purpose in the 21st Century (A C F)
- Development of a two procedure room Cardiac Catheter Laboratory to allow to expand the diagnostic and therapeutic procedures locally (B)
- Installation of a pharmacy robot system to assist in the reduction of patient waiting times from the dispensary (B C D)
- Replacement of all radiology equipment over the 5 years of this Strategy to benefit from the implementation of PACS and new working practices (A D E)
- Replacement of the hospital's main boilers improving the Trust's performance in relation to energy efficiency targets (E F)
- Ongoing replacement of hospital beds to electric versions to reduce the possibility of back injuries to staff (C F G)
- Development of an expanded Medical Physics Department which will include space for the base of a spin-out company (A B C E F I)
- Installation of enhanced Patient Administration and Pathology Computer systems (J)

7.8.3 Efficiency Gains

From the priorities outlined in the section above, the following specific productivity gains will be made:

- The installation of the pharmacy robot will deliver £50,000 savings in core workforce costs and eliminate £11,000 of overtime payments.
- The replacement of the suite of radiological equipment produces varying gains in patient throughput: general rooms (25%), mammography (50%), MRI (40%), and CT (improved quality of image).
- The replacement of the hospital boilers will see an efficiency gain of 7% which at November 2005 usage and prices equates to a saving of £10,000 per annum.

7.8.4 Five Year Capital Programme

The proposed Programme is at Appendix F. The Trust wishes to see early gains from Foundation Trust status so the first three years of the programme would be well committed. However, in years 4 and 5 there are significant sums unallocated so as

to allow the organisation to respond to new opportunities or threats as they arise. In addition the Trust is keen to see the Phase 3 development of the hospital take place but which at the present time requires more detailed work and includes funding options. It is possible that the organisation would bring forward a proposal, which uses a mix of local resources and a loan to fund such a scheme and thereby avoid a PFI solution. At this time the Trust is not proposing to use capital borrowing as it believes that it does not need to do so to achieve its objectives in the early years of the SDS.

8 Financial Analysis

8.1 Content

In consideration of Foundation Trust status the following areas are detailed below:

- Historic Financial Performance
- Current Base Case Financial Assessment – Continuing as an NHS Trust
- Financial Freedoms of Foundation Trust Status
- Foundation Trust Financial Assessment

8.2 Historic Financial Performance

The Trust has a strong track record of financial management such that during its existence it has never failed to meet its statutory financial objectives.

The Trust has achieved financial balance for the past three years as shown in Table 8-1 below, as it has in each year since becoming a Trust. A full set of accounts for the past three years is shown in Appendix G.

Table 8-1: Analysis of the historic income & expenditure account for the three years ended 31 March 2005

Income & Expenditure	**2002/03 £000**	**2003/04 £000**	**2004/05 £000**
Total Income	106,695	117,505	126,801
Total Expenditure	101,717	114,317	123,586
Operating surplus	**4,978**	**3,188**	**3,215**
Net Interest	115	100	220
PDC Dividends	5,093	3,288	3,435
Retained Surplus	**0**	**0**	**0**

The underlying position in this three year period was to receive excess income over budgeted levels to meet expenditure in respect of overperformance of patient activity. In 2004/05 this amounted to over £2M using a 50% marginal cost charging basis. If full cost tariff or local prices had been applied the Trust would have made a substantial surplus.

The Trust received £5m of non-recurring income in 2004/05, of which it is anticipated that £2m will recur again in 2005/06, as shown in Appendix H. This income is from a number of sources including the National Reference Library for Genetics Research, patients receiving Functional Electrical Stimulation (FES)

treatment, and courses for educational support. In addition, PCT's have agreed to consolidate non-recurring NICE funding into recurrent contract baselines. At month seven in 2005/6 the Trust is currently projecting non-recurring income to be in the region of £6.7M, again shown in Appendix H. The Trust received £5.5m unregulated income in 2004/05, this included private patient income, income from catering services, accommodation, training and development and services to other Trusts. A breakdown is shown in Appendix I.

Key financial duties have been met in each of the three financial years, shown in Table 8-2 below, and includes our excellent achievement of cost improvement targets, which has an achievement rate of at least 92% each year. Detailed analysis of the Cost Improvement Targets are shown in Appendix J.

Table 8-2: Financial Targets

Summary Financial Target Information	**2002/03**		**2003/04**		**2004/05**	
	Financial Target £000	Actual £000	Financial Target £000	Actual £000	Financial Target £000	Actual £000
Breakeven	0	0	0	0	0	0
External financing limit	-945	-945	-859	-859	953	953
Capital resource limit	4,025	4,025	4,988	4,988	6,866	6,866
Capital cost absorption rate	6.5%	6.5%	3.7%	3.7%	3.4%	3.4%
Cost improvement target	4,174	3,849	3,155	2,905	4,436	4,383
Achievement of CIP		92.21%		92.08%		98.80 %
Public sector payment policy						
- Volume	100%	95.02%	100%	94.69%	100%	87.00 %
- Value	100%	95.68%	100%	95.54%	100%	88.00 %
Reference Cost Index		90		88		90

The reduction in performance in achieving the public sector payment policy compared with the previous year was caused by the introduction of a new integrated Finance and Procurement system in December 2004, which resulted in a change of procedures and the need for staff to adapt to the new system. The Trust expects to improve the results during the coming year.

A summary of the Trust's balance sheets is shown in Table 8-3 below.

Table 8-3: Summary of historic balance sheets

Summary balance sheet information	2002/03 £000	2003/04 £000	2004/05 £000
Fixed Assets	93,171	100,332	103,041
Net current assets	-1,899	-1,901	-1,444
Creditors > 1 year & provisions	-486	-831	-1465
Total Assets Employed	**90,786**	**97,600**	**100,132**
PDC	51,855	51,016	51,969
Revaluation Reserve	33,875	41,555	43,019
Donations Reserve	1,155	1,022	1,137
I & E reserve	3,901	4,007	4,007
Total Taxpayers Equity	**90,786**	**97,600**	**100,132**

8.2.1 Income and Expenditure Account

The balance on the Income and Expenditure (I & E) Account of £4.007m has arisen due to the following reasons:

- A sum of £1.893m arose during the period from 1 April 2000 to date. It results from the transfer of realised profits to the I & E Account from the Revaluation Reserve on assets disposed of by the Trust. The NHS is required to maintain assets at their current cost value and applies indices to the assets each year to enhance their value, without having to undertake a frequent revaluation. The credit is posted to the Revaluation Reserve. A similar exercise occurs when all land and buildings are formally revalued every 5 years. When an asset is disposed of, the balance on the Revaluation Reserve in respect of that asset is transferred to the I & E account, as any unrealised profit becomes realised.
- In the year ended 31 March 2002 there was a charge of £310k against the I & E Reserve resulting from a prior year adjustment following a change in accounting policy. It related to the provision for early retirement costs in respect of employees retiring before 6 March 1995. The costs had previously been charged to the I & E account each year.
- In the period from establishment of the Trust to 31 March 1998, a balance of £2.424m arose as a result of annual surpluses the Trust was required to make to achieve the targets set by the Health Authority.

Unqualified audit reports have been issued by the Audit Commission for 2004/05 and each of the preceding three financial years. The external auditor (The Audit Commission) has not brought any concerns to the attention of the Trust during, 2002/03, 2003/04 or 2004/05 in relation to the arrangements in place to maintain proper standards of financial conduct and to prevent and detect fraud and corruption.

Disclosures made in the statement of internal control were confirmed by the external auditors in their 2004/05 annual letter to support the work performed by internal audit and their opinion. The external auditors have concluded that the internal audit service provided by South & West Audit was satisfactory in 2002/03, 2003/04 and 2004/05.

The Finance Department has a strong stable staff base, with a large number of qualified accountants, in additional it is committed to training and personnel development, supporting a number of staff to gain AAT and then further progress to become qualified accountants. Over the last 20 years the department has received a continuous stream of Region/National trainees and is recognised as providing a good grounding for the development of future senior finance staff in the NHS.

The Trust has recently employed RSM Robson Rhodes to complete a review of the Finance Department, assessing current management, processes and workload capacity. See section 9.3 for further details.

8.2.2 Reference Costs

The Reference Costs/Reference Costs Index publication is the richest source of financial data on the NHS ever produced. As in previous years, its main purpose is to provide a basis for comparison within (and outside) the NHS between organisations, and down to the level of individual treatments. It is the responsibility of the Boards of Trusts and PCTs to take careful note of significant variances affecting their organisations and to take appropriate action.

The National reference cost index for Salisbury Health Care NHS Trust for the year ended 31 March 2005 was **90**, compared with the national average of 100. This index is after adjusting for the market forces factor (MFF). The MFF is designed to remove any location-specific cost differences.

Overall, SHCT costs are some 7% lower than the average costs of neighbouring Trusts as summarised in Appendix K

The use of reference costs, combined with the October 2005 PbR exercise has enabled the Trust to benchmark procedures against national reference costs and

the 'Transitional tariff'. Analysis of the top twenty procedures in value for each patient care category is shown in Appendix L. This identifies some instances where Trust costs are above average reference cost and tariff which will be investigated.

Detailed benchmarking of Trust Costs have been specifically undertaken with a local Trust and also further benchmarking with other surrounding Trusts. The report is included in Appendix M and confirms the Trust's reference cost position. Areas that have been identified for further investigation by the Trust are catering income, provisions, energy and utilities costs and intensive care direct costs.

8.3 Current Base Case Financial Assessment – Continuing as an NHS Trust

The base line financial position currently reflects activity assumptions which have been discussed and agreed with PCT commissioners. The transfer of Hillcote services back to South Wiltshire PCT has been included, however, no significant service development changes have been included.

8.3.1 Activity and Baseline Position

The base case financial position currently reflects activity assumptions which have been discussed with PCT commissioners.

The financial modelling and analysis included assumes reductions (as shown in Table 8-4 below).

Table 8-4: Indicative Growth Rates in Base Case Model

Activity Type	2006/07	2007/08	2008/09	2009/10	2010/11
Elective	-3.20%	-0.68%	-0.60%	-0.73%	-0.70%
Non elective	-0.91%	1.05%	-0.75%	-0.13%	0.03%
Outpatients -total	-1.36%	-0.65%	-1.24%	-0.62%	-0.66%
Outpatients - new	-0.41%	0.24%	-0.38%	0.12%	0.11%
Outpatients – follow up	-1.88%	-1.14%	-1.72%	-1.04%	-1.10%
A&E	0.2%	0.8%	0.9%	0.8%	0.7%

The baseline activity workload, on which growth is compounded, and expenditure projections are based on 2005/06 budgeted levels of activity (Appendix N). The budget position has incorporated the need to be in recurrent balance.

The Trust has prepared its budgets for 2005/06 with regard to the LDP negotiations and the business planning process within the Trust.

Service level agreements (SLA's) have been finalised for 2005/06. Estimated sources of income for 2005/06 are identified in Appendix M and amount to £131M recurring, these form the basis for future projections. The Trust also anticipates £7M of non-recurring income in 2005/06, which has been included in the financial projections, as shown in Appendix H. Income has been adjusted year on year, as detailed below.

8.3.2 Income

The Trust's current income baseline for 2005/06 is shown in Table 8-5 below.

Table 8-5: 2005/06 Income Analysed by Activity Type

Activity Type	£M	%
PbR Elective	23	17
PbR Transition Path	-2	-2
Deferred PbR		
Non-Electives	39	28
Outpatients	18	14
A&E	5	4
Non PbR	34	24
SLA Income	**117**	**85**
Non-SLA Income	8	6
Total Regulated Income	**125**	**91**
Unregulated Income	6	4
Total Recurring Income	**131**	**95**
Non-Recurring Income	**7**	**5**
Total Income	**138**	**100**

The introduction of 'Payments by Results' will require significant changes in the way that Trusts generate their income

Establishing 'Payment by Results' in the NHS, underpinned by a national tariff, will help the NHS use its resources more efficiently and effectively. Once in place Payment by Results will

- Support patient choice;
- Encourage plurality of provision;
- Reward efficiency;

- Contribute to sustainable reductions in waiting times, and
- Ensure a fair and consistent basis for funding NHS services.

Its operation depends in part on the availability of accurate and timely data on costs, which in turn are translated into the tariff.

From 2006/07, the majority of elective, daycase and inpatient services will be covered by a national tariff, directly linking payment for services to the volume and casemix of activity actually performed.

For those services assumed to be within tariff, income projections have been modelled on a bottom-up basis, multiplying projected activity by the national tariff for each year in the five-year projection. It is assumed that there will be no provision for cost and volume tolerances or marginal cost adjustments in respect of activity variations. Therefore, any variation from the 2005/06 baseline is assumed to attract the full tariff, up or down.

The Department of Health has published the final tariff uplift for 2005/06 of 7.0%, of which 1.7% is the achievement of the Trust CIP. However, for the succeeding years, it has been necessary to make some assumptions about uplifts in the national tariff to reflect generic cost pressures, drugs & technology and efficiency savings. The Trust's working assumption is that the national tariff will increase by a base of a net 4.3% (after deducting 1.7% CIP) per annum for the period 2006/07 to 2008/09 and will then reduce to 3% (after deducting 1.7% CIP) per annum for the period 2009/10 to 2010/11.

As a consequence of the introduction of Payments by Results, the Trust expects its present income baseline, which is based upon current Service Level Agreements, to be uplifted in real terms by repricing existing activity at the national tariff. This reflects a number of factors including a below average National Reference Cost position, relative activity changes and the transition path for migrating reference costs to the national tariff. The Department of Health has increased the allocations to the Trust's commissioners to preserve their purchasing parity as a result of the repricing effects caused by the adoption of the national tariff. Similarly, the repricing gain received by the Trust would be the subject of a three-year transitional process to smooth the introduction of Payments By Results. The transition has been based upon retaining 25%, 50%

and 75% of any gain for 2005/06, 2006/07, 2007/08 respectively. However, the percentage cap on PbR gains also applies to the Trust and has been included in the income projections. The transition ends in 2008/09 when the Trust retains all gains from the tariff.

Although there is a clear expectation that all the other services provided by the Trust will eventually be incorporated into Payments By Results, there is no definite indication as to the nature and timing of this decision. As such, the Trust has built up income budgets for these services by assuming that deferred PbR activities in 2005/06 (e.g. non-electives, outpatients and A&E etc) become live in 2006/07. For all other non-PbR services the Trust has built up income budgets based upon marginal changes to existing baselines to reflect service changes, inflation and activity changes.

The Trust has completed its calculations of future income under PbR as part of the national data collection exercise in 2004/05. This demonstrated that once the national tariff was adjusted for the new Market Forces Factor (MFF), in respect of elective patient care only, the Trust would receive a net gain from the new funding system, totalling £2.6M (at 2005/06 prices, before transitional arrangements). PbR activities deferred in 2005/06 are expected to be included within the scheme from 2006/07 onwards. The Trust has taken a prudent view with these activities and a nil financial impact in transitional arrangements (i.e. no gain or loss) has been included in the financial projections.

The Trust is subject to the current cap of 2% of income in 2005/06 and this means that the Trust will gain by £415,000. The total gain has been phased in over the transition period from 2005/06 to 2008/09.

The amount by which the Trust will gain in the medium to long term will depend on the outcome of the October 2005 exercise, and any changes to the national tariff or MFF funding formula. The October 2005 Payment By Results exercise is to inform the Department of Health in determining the tariff for 2006/07 and transitional funding arrangements for Trusts that may gain or lose from the implementation of the national tariff. The Trust submission is currently being validated by PCTs and the Strategic Health Authority. The information calculated to date identifies a potential gain to the Trust of £9M at the end of the phased transition period. At this stage it should not be assumed that this sum will be

available to the Trust, as the Department of Health must now review the national exercise to ensure that the PBR system is contained within the national financial envelope. The expectation should be that the Trust should gain but the resulting position will be scaled downwards. The full results are expected in the New Year, and will be reflected in modelling at that time.

The output of the October 2005 exercise is summarised by each PCT in Appendix P. The results have been compared to the original exercise and are shown in Appendix Q.

The Trust has taken a very prudent view of potential PbR benefits and has used the results of the 2004/05 original exercise within all of its financial models.

For such services not covered by the national tariff, the Trust has assumed that this level of income will also be uplifted by the same proportion as for the national tariff (ie. a base 4.3% per annum). In the event that these services are eventually included within the scope of the national tariff, the Trust would not anticipate a material change in these assumptions. In addition to this general uplift, the Trust has made assumptions, where appropriate, regarding specific uplifts for significant steps in activity and full year effects of agreed developments.

The South Wiltshire PCT is in the process of formulating plans to achieve financial balance. The Trust is aware of the targets that the PCT is setting for their providers, but firm detail on activity reductions are required .Within the financial model an allowance of reduced income of £2M has been made between 2006/07 and 2007/08. The Trust has assumed that operating expenditure will fall due to reduced capacity requirements of £1M in the period. In addition a provision of £400,000 has been made for accelerated depreciation in 2006/07 as wards could become surplus to requirements.

Table 8-6 below shows the full tariff income at 2005/06 prices and reflects the downturn in activity as discussed with PCT commissioners.

Table 8-6: Full tariff income

	2005/06 £000	2006/07 £000	2007/08 £000	2008/09 £000	2009/10 £000	2010/11 £000
PbR SLA Income (Inc MFF)	83,386	84,751	83,882	82.923	82,513	82,215

For non-SLA healthcare and unregulated income, the Trust has assumed an uplift of 2% per annum for inflation. The lower annual increase reflects the fact that this source of income mainly covers pay expenditure, and therefore the uplift bears a closer relationship to projected pay awards.

In addition, it is anticipated that the transfer of Hillcote services to South Wiltshire PCT will generate the Trust £180,000 per year from 2006/07, as the Trust will continue to provide a number of non-healthcare services.

The unregulated income reflects the growth in laundry income expected by the Trust. The new laundry (built alongside the Trusts Phase 2 PFI development) has four times the current laundry capacity and the Trust has plans to develop this business area, gaining laundry service contracts with other surrounding Trusts and expanding on the current private company work.

In addition, unregulated income also includes expected recurring income of £100,000 in 2008/09 from the company formed by the Trust, Odstock Medical Ltd, for the application of Functional Electrical Stimulation (FES).

Income has been included, on a tapered basis, from the NHS Bank in respect of support for the PFI scheme in accordance with advice received from the Bank. The amounts received are show below in Table 8-7.

Table 8-7: Level of Bank Support received for PFI Scheme

	2005/06 £000	2006/07 £000	2007/08 £000	2008/09 £000	2009/10 £000
Bank Support	569	711	426	284	142

In 2004/05 non-recurring income totalled £5m. The system of budgeting within the Trust identifies separate non-recurring income and expenditure budgets, so that the non-recurrent income cannot subsidise recurrent expenditure. Non-recurrent income has been running at this level consistently for a number of

years. A breakdown of this is shown in Appendix H, the Trust has taken a prudent view regarding whether this income will be recurrent and has anticipated that £2.5M will recur and this has been included in the financial projections.

Combining each of these assumptions (volume changes, inflation, movement to tariff and locally agreed variations), the Trust has estimated annual uplifts in income as summarised in Table 8-8 below.

Table 8-8: Income Uplift Assumptions (After 1.7% CIP)

Income	2005/06 £000	2006/07 £000	2007/08 £000	2008/09 £000	2009/10 £000	2010/11 £000
SLA Income	118,475	124,745	129,164	131,964	135,450	139,159
PbR Transitional Relief/(Gain)	(2,182)	(1,843)	(1,471)	0	0	0
Non-SLA Income	7,710	10,393	9,581	9,773	9,968	10,167
Total Regulated Income	**124,003**	**133,295**	**137,274**	**141,737**	**145,418**	**149,326**
Unregulated Income	5,402	6,509	7,772	8,614	8,730	8,748
Non-Recurring Income	6,660					
Transfers from Donated Asset Reserve	**160**	**157**	**135**	**120**	**86**	**88**
Total Income	136,225	139,961	145,181	150,471	154,234	158,162

NB. The increase in 2005/06 unregulated income includes the initial development in laundry activity.

8.3.3 Baseline Expenditure

The Trust's current expenditure baseline for 2005/06 is shown in Table 8-9 below.

Table 8-9:2005/06 Expenditure Subjective Analysis

	£000	%
Operating Costs	125,089	92.0
Depreciation	7,490	5.5
Dividends	3,372	2.5
Total Expenditure	**135,951**	**100**

A summary of the application of funds in 2005/06, taking into account all the factors above is detailed in Appendix R, and forms the basis of our further financial projections.

In rolling forward the 2005/06 cost base, the Trust has made some assumptions regarding future inflation uplifts for factors such as pay awards, capital charges indexation and the cost of implementing NICE guidance. These assumptions are distinct from the Trust's assumption regarding the extent that income will be uplifted for these same factors. For a number of items, there is an expectation that the additional income that the Trust will receive will not necessarily cover the additional costs.

The reduction in activity, as discussed with PCT commissioners, has resulted in a reduction in the pay and non-pay expenditure based on manpower and capacity projections.

The Trust has assumed that tariff inflation and other Department of Health initiatives for the next three years will amount to 6% on the overall cost base, it is anticipated that this will reduce to 4.7% for the remaining years, this is made up as follows:

- Pay inflation (3.225%)
- General non-pay inflation (2.00%)
- Other Department of Health initiatives (3.00%) (to be specified)

Within the financial projections base case, the Trust has separately estimated the impact of nationally generated agreements and guidance for specific cost items. The Trust has made a number of assumptions in respect of other costs above inflation, these have been included in our financial projections. These assumptions have been summarised in Appendix S.

8.3.4 Pay Costs

Cost pressures relating to pay are considered as set out below;

- **Agenda for Change**: increased costs of £1.75M have been included on a recurrent basis in 2005/06 in respect of the full year effect of the initiative being implemented, starting in October 2004. In subsequent years additional costs of £300,000 have been included each year in respect of progression of staff through the pay bands. In addition, costs for training and the development of staff to progress through the KSF programmes have also been included.

- **Consultants Contract**: anticipated costs of £290,000 have been included in 2005/06 in respect of those consultants still to accept and transfer onto the new contracts. This includes consultants from the Trust and those contracted-in from other organisations. The sum also includes costs for other non-consultant lead initiatives to achieve acceptable work plans.
- **EU Working Time**: increased costs of £220,000 have been included in 2005/06 to achieve acceptable Junior Doctor working hours.
- **Incremental Drift**: costs of £90,000 have been included in 2005/06, recognising the specialist registrars entry salary scale point with the Trust.
- **Manpower**: activity and efficiency changes in inpatient and outpatient activity has resulted in the reduced need for bed and clinic capacity. The manpower and financial consequences are shown in Appendix T.
- **On-Site Primary Care Services:** the Trust invested £160,000 in A&E in 2005/06 recurrently in order to meet demand and national waiting time targets. However, South Wiltshire PCT has plans to develop an on-site primary care service adjacent to A&E. With this service development it is anticipated that the Trust will make cost savings and the additional investment made in 2005/06 will then be withdrawn from 2006/07 onwards.
- **Health economy brokerage**: the Trust has agreed with the local Strategic Health Authority to pass £1M of income, to the SHA so as to help with the SHA financial balance. The SHA will return the £1M to the Trust in 2006/07.

8.3.5 Non pay costs

Cost pressures relating to non-pay above tariff inflation rates are considered as set out below;

- **Drugs**: the financial model assumes that drug costs will increase by approximately £250,000 per annum, above inflation. This represents the increase in drugs budgets due to the implementation of NICE guidance, and the introduction of new technologies.
- **PACS**: the Trust is also investing in PACS technology, and the additional recurrent and non-recurrent costs of this, net of benefits, have been built into the model from 2005/06 onwards. It has been expected within the business case that a tariff uplift of 0.2% in respect of the revenue consequences of capital expenditure would cover this cost. However, in order to minimise risk the Trust has been prudent in identifying the cost and has included these as additional costs above tariff uplift.
- **NPFIT**: The model anticipates additional expenditure for the implementation of NPFIT initiatives, using the national implementation costing model (published in 2003) staff costs of £300,000 have been included for 2006/07, these include costs for the systems implementation, training provided and support, reducing to £100,000 recurring from 2007/08 for support. No costs have been included for the backfill of staff

during training, as the Trust anticipates that as in previous circumstances backfill will be managed operationally within the departments. In addition, with the planned changes of NPfIT the Trust has anticipated a saving of £250,000 per year from 2008/09 with the cancellation of the current contact.

- **PFI**: the model anticipates recurrent and non-recurrent revenue expenditure in these areas in the years 2005/06 to 2010/11. The PFI unitary payment is £2.5M and is currently funded within local prices, revenue savings from closures of the south site and income generation from the laundry. The variable and semi-fixed costs of additional laundry activity have also been included, these are detailed in Appendix U.
- **Energy**: due to current evidence expectations are that energy prices are likely to increase above tariff and an estimate of extra costs has been included in the financial projections.
- **Decontamination**: costs of £200,000 per annum have been anticipated to meet decontamination and MRSA requirement standards in the future;
- **Modernisation**: the Trust anticipates that additional costs will be incurred for IT service developments, information services and medical records and other modernisation initiatives.
- **Changing Clinical Practice**: additional costs for medical consumables and developments in clinical practice are anticipated from 2005/06 onwards.
- **Contingencies**: the Trust has followed current national guidance in calculating its gain under PbR at plan levels of activity, not outturn levels of activity. The gain in the financial model is modest. However, due to the potential risk of price deflation the Trust has included a contingency within the expenditure projections. In addition, the Trust has recognised the potential loss of contribution to overheads from the reduction of facilities services provided to other NHS bodies.
- **Foundation Trust Costs**: a recurring budget of £100,000 from 2005/06 has been included to cover the additional staff and office expenses in preparation for a successful Foundation Trust application.
- **Cardiology**: the Trust has agreed plans to grow the level of activity within Cardiology, in order to complete this higher level of activity addition staff and non-staff costs will be incurred, these have been estimated at £70,000 per year and included in the finance projection from 2006/07.
- **Pathology**: the development of the new Pathology System within the Trust is estimated to cost the Trust an additional £135,000 per year for the maintenance and management of the system.

8.3.6 Expenditure Model

The Trust has modelled the projected non-staff expenditure by using activity and expenditure as at the end of 2004/05 to base future costs. The Trust has identified the fixed and non-fixed costs associated and the activity drivers

attached to these non-fixed costs. Where activity has increased the expenditure is then increased in proportion.

For example, when surgical elective activity increases or decreases, the relating expenditure in this area is increased or decreased in proportion. The Trust has been able to recognise that 50% of the current costs would be fixed costs and would not change, though the other 50% would increase or decrease in proportion to the activity associated.

8.3.7 Capital investment

The Trust has previously spent capital in line with its strategic capital allocation. The 2005/06 capital programme is shown in Appendix V.

The financial projections assume that the level of investment for future years in capital is in line with the level of depreciation incurred by the Trust. This is in line with the update issued from the Strategic Health Authority, which states that 'Trusts will in future retain "Trust Depreciation" in lieu of "Operational Capital" and will access additional capital borrowing under the FT style prudential borrowing limits, based on ability to service and repay funding borrowed. The capital expenditure included is detailed below.

Table 8-10: Basecase Capital Programme

	2006/07 £000	2007/08 £000	2008/09 £000	2009/10 £000	2010/11 £000
Depreciation	5,854	5,755	6,054	6,244	6,826
Capital Sales	1,000				
Total Available Spend	6,854	5,755	6,054	6,244	6,826
PFI Deferred Asset	(64)	(68)	(72)	(77)	(82)
Brokerage	(1,700)		(275)	(275)	
Capital Programme	(5,090)	(5,687)	(5,707)	(5,892)	(6,744)
Total	(6,854)	(5,755)	(6,054)	(6,244)	(6,826)

8.3.8 Assets

The financial projections have included indexation at 5% per annum for land and 2% per annum for buildings and equipment per annum.

8.3.9 Cash

The Trust's future cash flows have been calculated by the model in line with the code of practice set out by Monitor.

- This means that although the Trust does not have to operate under that regime yet, its cash flows and liquidity in its base case are more than sufficient for its day to day operations, and would meet Monitor's Prudential Borrowing Limits.
- The model does not show significant cash surpluses, as it has been assumed that 'excess' cash balances would be paid back to the Department of Health through the External Financing Limit, as is current practice for NHS Trusts.

8.3.10 Cost Improvement Programme

The CIP for 2005/06 is identified in Appendix W and amounts to £7.96M. Detailed directorate plans of £3.38M are in the process of being implemented and targets have been achieved during the first seven months of 2005/06. The remaining £4.58M has been realised through a number of tariff income expectations, NHS Bank, PACS support, and savings from the impact of the PFI. The current achievement rate of the 2005/6 cost improvement programme is 88%. The Trust targets for future years range from 2% in 2006/07 to 2.7% in 2010/11. Detailed cost improvement plans for 2006/07 to 2010/11 are detailed in Appendix X and shown in the table below:

Table 8-11: Cost Improvement Plan Achievements to date

Cost Improvement programme	2002/03 £000	2003/04 £000	2004/05 £000	2005/06 £000
Recurrent CIP Target (+)	4,174	3,155	4,436	7,961
Recurrent CIP achieved	1,500	1,630	1,632	5,942
Non recurrent CIP achieved	2,349	1,275	2,751	2,019
Achievement vs. target %	92.21%	92.08%	98.81%	
Cumulative impact on I&E position, £m				7,961
% cost base	1.7	1.7	1.7	1.7

Table 8-12: Cost Improvement Future Plans

Cost Improvement programme	2006/07 £000	2007/08 £000	2008/09 £000	2009/10 £000	2010/11 £000
Recurrent CIP Target (+)	3,223	2,757	3,525	4,040	4,141
Recurrent CIP achieved	3,223	2,757	3,525	4,040	4,141
Non recurrent CIP achieved					
Achievement vs. target %					
Cumulative impact on I&E position, £m	11,184	13,941	17,466	21,506	25,647
% cost base	2	2	2.5	2.7	2.7

8.3.11 Financial Modelling – Base Case Outputs

The following tables summarise the Trust's financial projections for the next five years as an NHS trust and are analysed by year in Appendix Y:

The income & expenditure account as shown in Table 8-13, shows a breakeven / small surplus over the period 2005/06 to 2010/11.

Table 8-13: Summary of base case financial projections – Income & Expenditure

Summary income & expenditure forecasts – base case	**2005/06 £000**	**2006/07 £000**	**2007/08 £000**	**2008/09 £000**	**2009/10 £000**	**2010/11 £000**
Total Income	136,225	139,961	145,181	150,471	154,234	158,162
Total Expenditure	(125,089)	(129,710)	(135,737)	(140,430)	(144,026)	(147,471)
Earnings Before Interest & Depreciation	**11,136**	**10,251**	**9,444**	**10,041**	**10,208**	**10,690**
Depreciation	(7,490)	(5,854)	(5,755)	(6,054)	(6,244)	(6,826)
Net Interest	64	117	153	164	168	161
PDC Dividends	(3,372)	(3,558)	(3,578)	(3,648)	(3,708)	(3,768)
Retained Surplus	**338**	**956**	**263**	**504**	**425**	**258**

Table 8-14: Summary of base case financial projections – Balance Sheets

Summary balance sheet forecasts – base case	**2005/06 £000**	**2006/07 £000**	**2007/08 £000**	**2008/09 £000**	**2009/10 £000**	**2010/11 £000**
Fixed Assets	104,357	104,945	107,399	109,756	112,305	115,401
Net Current Assets	(2,515)	(1,744)	(1,819)	(1,759)	(1,881)	(2,384)
Creditors >1 year and provisions	**(216)**	**(216)**	**(216)**	**(216)**	**(216)**	**(216)**
Total Net Assets	**101,626**	**102,985**	**105,364**	**107,781**	**110,209**	**112,802**
PDC	51,969	50,269	50,269	49,995	49,720	49,719
Revaluation Reserve	44,058	46,293	48,521	50,808	53,154	55,560
Donations Reserve	1,254	1,122	1,010	910	842	772
Retained Surplus	4,345	5,301	5,564	6,068	6,493	6,751
Total Taxpayers Equity	**101,626**	**102,985**	**105,364**	**107,781**	**110,209**	**112,802**

Table 8-15: Summary of base case cash flow projections

Summary cash flow forecasts – base case	2005/06 £000	2006/07 £000	2007/08 £000	2008/09 £000	2009/10 £000	2010/11 £000
Cash from operations	**10,817**	**10,966**	**9,582**	**9,999**	**10,137**	**10,612**
Capital Expenditure	(7,490)	(4,181)	(5,958)	(6,103)	(6,429)	(7,498)
Cash Brokerage	0	(1,700)	0	(275)	(275)	0
Cash flow before finance	**3,327**	**5,085**	**3,624**	**3,622**	**3,433**	**3,113**
Cash flow to Taxpayers' Equity	**3,327**	**5,085**	**3,624**	**3,622**	**3,433**	**3,113**
PDC Dividends paid	(3,372)	(3,558)	(3,578)	(3,648)	(3,708)	(3,768)
Interest received	64	117	153	164	168	161
Change in cash	**(19)**	**(1,644)**	**(199)**	**(139)**	**106**	**494**
Opening cash balance	**339**	**358**	**2,002**	**2,200**	**2,339**	**2,233**
Closing cash balance	**358**	**2,002**	**2,200**	**2,339**	**2,233**	**1,740**

8.4 Financial Freedoms of Foundation Trust Status

Reforms to payment mechanisms and activity currencies across the NHS will have a significant effect on the flow of money between the providers and commissioners of NHS services. The policy of Payment by Results and the introduction of a national tariff will provide a financial infrastructure that can support the introduction of wider choice for patients in their choice of treatment location

Salisbury Health Care NHS Trust is established as an efficient provider of high-quality services and has consistently achieved a good reference cost index. The Trust RCI for 2004/05 was 90, which indicates case mix unit costs of 10% below the national average cost. On this basis the Trust expects to gain substantially from the introduction of Payment by Results. However, within the financial model a prudent view has been taken for a number of reasons. Firstly, capital revaluation will increase costs by £2.7M, which will impact on future reference costs. Secondly, the RCI is based on FCE's (Finished Consultant Episode) and the Payments by Results tariff is based on spells.

Some of the PbR gain would be expected from the Trusts specialist burns and spinal services, but as this is not yet in tariff. We have not included this in our income forecasts but have included 50% of the likely gain within the Cost Improvement Programme from 2007/08.

The Trust has a slightly high FCE to spell ratio that would suggest that a PBR gain based purely on RCI would be overoptimistic. Lastly, a downward revision to the Market Forces Factor, has also had an effect on potential Payment by Results gains.

As the main provider of services to the population of Salisbury and surrounding areas, we aim to become a hospital of choice for these populations. Increased, flexible capacity is required to provide responsive services within agreed timescales. The financial freedoms associated with NHS Foundation Trust status will also give us access to capital funds to better respond to those needs without recourse to lengthy NHS approvals processes or the Private Finance Initiative.

As a Foundation Trust, capital expenditure is funded by the Trusts depreciation, for which the Trust has established a capital expenditure plan, as shown in Appendix F. In addition, with agreement from Monitor, the Trust will be able to borrow cash up to a set limit. This is referred to as the Prudential Borrowing Limit. There are currently no plans to borrow cash to support the achievement of the capital expenditure plan.

The recent update received from the Strategic Health Authority detailing changes to capital expenditure for NHS Trusts may result in all Trusts operating under the same financial regime. However, the level of borrowing may be different as a Foundation Trust, this is to be confirmed.

However, if required, responsible borrowing against a robust financial plan will provide the additional flexibility needed to ensure clinical equipment is replaced, additional capacity can be flexed to meet demand, and the physical environment for staff and patients can be maintained and improved.

8.4.1 Indexation and Revaluation Changes

Under the Foundation Trust regime the Trust is not required to index assets on an annual basis, though assets will be revalued every three years and in line with

current district valuer assessments (every five years). The financial projections therefore do not include indexation on assets, but do account for a level of revaluation in year three and five, which has been estimated by the levels of indexation that would have been applicable.

8.4.2 Service Level Agreements and Income

The Trust has a history of effective negotiation in the context of agreeing SLAs with commissioners. In particular a robust stance has always been taken with regard to ensuring that agreements reflect the need for any activity to be paid for, and stipulating the rates payable for over/under performance. Under the former internal market the Trust was very successful in selling its services to GP Fundholders and obtaining payment.

In moving towards Foundation Trust status the Trust welcomes the added security inherent in legally binding contracts and is taking steps to ensure that the issues involved are understood:

- The Foundation Trust model contract is being used as the basis for planning for agreements in 2006/07.
- Training has been undertaken by key staff (NHSFT Contracts and Partnership Event October 2005) and further training is being considered for areas such as negotiating skills.
- Discussions have taken place with local PCTs regarding how contracts should be structured, timescales, and who should produce the documentation.
- There has been regular exchanges of information with PCTs regarding the forecasts of activity for 2006/07 and future years so that the schedules to the contracts should not create any surprises.
- The Trust has been reviewed by Dickinson Dees, solicitors, on behalf of the Department of Health and the outcome is awaited. However it is not expected that the Trust will be perceived as a high risk.
- The staffing of the Contracts and Income Section is being strengthened through an additional accountant post.
- Consideration is being given to the level of legal support that the Trust may need to commission.
- Substantial amounts of work are being undertaken to ensure that all activity is counted and coded effectively and efficiently. A working group has the objective of achieving 100% coding within 3 weeks and 90% within 1 week of discharge.

- The intention will be to use best practice from other Foundation Trusts rather than reinvent new clauses for the contracts (e.g. Demand Management Clause)
- Consideration is being given to the internal approval process for the signing of contracts which may be for many millions of pounds.
- The performance against contracts will be monitored very closely and on a timely basis. Consideration will be given to how this can be linked into an Executive Information System.

8.5 Unregulated Services

The Trust's unregulated income amounts to £6M and is a significant proportion of the total income base of the Trust, as shown in Appendix I. The Trust at present provides its own trading services to the public and other organisations.

The Trust as part of its current PFI scheme has included a replacement laundry, and with much greater capacity the Trust expects to generate additional income, as shown in Appendix U.

The Trust has received approval from the Department of Health for a spin-out company, Odstock Medical Ltd, which will market the 'Functional Electrical Stimulation' (FES) devices developed by the Trust. The company is projected to generate profits of £100,000 per year from 2008/09 and this income has been included in the financial projections for the Trust. Total income and expenditure has not been consolidated into the projections as final guidance is still awaited from the Department of Health.

In addition, the Trust is exploring the development of a range of research projects to be undertaken with private sector partners, including research into the rapid diagnosis of MRSA.

In addition, private patient treatment currently accounts for less than 1% of the hospital's patient care income. This activity will only grow in proportion to the growth of the rest of the hospital. A constraint of applying for NHS Foundation Trust status is the cap on the private patient income. The private patient income received in 2002/03 amounted to 0.55% of Trust income. However, in the following years the private patient income has increased considerably as part of the income generating activities of the Trust. In order to comply with the Foundation Trust licence the Trust will have to manage a reduction in private

patient income by £600,000 in future years. This will be done by raising awareness throughout the Trust and implementing controls to ensure that the cap is not breached.

8.6 Foundation Trust's Financial Assessment

In order to support the development of the Trust's financial strategy for the medium term, the Trust has produced a detailed financial model, which covers the five year period from April 2005 through to March 2011.

The financial model is based upon rolling forward the Trusts existing financial position to reflect the financial consequences of separate activity and capacity projections, together with investments in infrastructure, that the Trust would like to make in the event that its application is successful.

The financial model provides full statutory income & expenditure and balance sheet projections, however its main function is to determine the extent to which the Trust can finance its borrowings from operating cash flow whilst achieving its target liquidity ratios. The broad assumptions on activity growth and inflation are consistent with the base case model, as described above.

The changes in the Foundation Trust financial projections include the removal of annual indexation on assets and the inclusion of a revised capital expenditure programme, which is based on achieving Foundation Trust Status. The revaluation process of assets every three years has been included, this has been based on the cumulative indexation figures in 2008/09 and 2010/11.

The protected services of the Trust are defined as those for which it has a contract with a PCT or other service commissioner. These services are subject to regulation by the Monitor. A list of services covered by legally binding contracts with commissioners requires further development.

Assets relating to the delivery of clinical services are located on the Salisbury District Hospital site. Assets relating to the provision of NHS services outlined have been classified as protected. Those assets that are used for other purposes have been classified as unprotected. A breakdown of those assets protected and unprotected is shown in Appendix Z and Appendix AA.

8.7 Working Capital & Financing

In terms of working capital, the Trust has assumed that existing current asset and liquidity ratios will be improved, particularly in respect of debtors and creditors, by the current number of days by which income is received and payments are made. The Trust will seek to concentrate resources to ensure that debts are collected as soon as possible

The Trust recognises that debt collection can continue to be improved. There have been invoice disputes with the main commissioner, South Wiltshire PCT, that have taken a considerable time to resolve. As a result, the Trust is working closely with the PCT to improve the position now and in the future.

The Trust will also review its procedure for the payment of invoices to suppliers, to ensure that the maximum credit terms are taken and cash is retained within the Trust for the longest possible length of time.

The appointment of a Treasury Manager will further strengthen the Trust resources focusing on working capital, with the aim of maximising cash available to the Trust and the investment returns from this.

It has been assumed that the relative proportion of stock will remain constant. The Trust has recently introduced a fully electronic finance and procurement system, which enables goods and services to be requisitioned directly from the desktop and orders sent electronically to the supplier without any manual intervention or delay. This ensures the time from raising the requisition to the goods arriving on site is kept to a minimum and this is reflected in maintaining minimal stock levels. The Trust is constantly reviewing how goods are procured and is extending the use of materials management across the Trust to further improve the efficiency of stockholding.

The current financial regime for the Trust requires the cash balance at the 31 March 2006 to be £339,000. The income and expenditure and capital expenditure forecasts for the five years ending 2010/11 indicate that this will be the minimal cash level held by the Trust at the end of each year.

In order to comply with Foundation Trust regime requirements the Trust will establish a working capital facility of approximately £11M to ensure that has it has sufficient funds to cover potential shortfalls during this periods.

8.8 The Prudential Borrowing Limit

The Prudential Borrowing Limit is to be agreed between the Trust and Monitor. It places a control on the level of additional external financing that the Trust is able to raise in any particular period by requiring the Trust to generate sufficient resources to meet in-year debt service commitments. In this manner, additional financing may only be raised if the Trust is in good financial health. It is based on a formulaic approach using a combination of five financial ratios. The Trust is required to demonstrate that it meets all five in combination:

- **Dividend Cover Ratio (DCR)**
  Earnings Before Interest Tax Depreciation and Amortisation (EBITDA) less all interest payable on long term borrowings divided by annual interest payable on PDC in year. This must produce a DCR of at least 1 times
- **Interest Cover Ratio (ICR)**
  Earnings Before Interest Tax Depreciation and Amortisation (EBITDA) divided by all interest payable on long term borrowing. This must produce an ICR of at least 3 times.
- **Debt Service Ratio (DSCR)**
  Earnings Before Interest Tax Depreciation and Amortisation (EBITDA) divided by all interest and principle payable on long term borrowing. This must produce a DSCR of at least 2 times
- **Debt Capital Ratio (DCR)**
  All borrowings from the Foundation Trust financing facility, including all group borrowings, finance leases and similar items, on-balance sheet PFI's and any accumulated dividend divided by all assets of the NHSFT. This must produce a DCR of less that 10%.
- **Debt Service to Revenue (DSR)**
  All interest and principal payable on longer term borrowing divided by income from activities and other operating income over the financial year. This must produce a DSNR of less than 3%.

8.9 Activity Modelling

8.9.1 Activity Model

Salisbury Health Care Trust commissioned Tribal SECTA to undertake activity modelling for projecting the activity implications of the period of the service development strategy. The model comprises three elements:

- Inpatient activity (currency = spells)
- Outpatient activity (currency = attendances)
- A&E activity (currency = attendances)

The approach that has been adopted in projecting future admitted patient activity and capacity requirements at the Trust is as follows:

- Start with baseline activity according to 2004/05 outturn; that being the most recent complete financial year;
- Apply growth to the baseline activity;
- Apply performance improvement assumptions to the grown activity to give projected activity in future years;
- Apply throughput, availability and utilisation assumptions to the projected activity in order to derive future capacity requirements.

Each model uses a base year of 2004/5 financial year to project forward future activity assuming certain planning assumptions (see below). The model predicts activity for each year up to 2020 and summarises the outputs by the following factors:

- Healthcare resource group (HRG)
- Primary care trust (PCT)
- Method of admission
- Specialty

In addition to activity analyses by the above criteria, the model also contains tariff information allowing the Trust to predict future patient activity income streams. This includes information on excess bed days, mandatory and non-mandatory tariffs. Further, the inpatient model includes a capacity modelling function allowing the Trust to predict the number of beds (acute, ICU and HDU) and the number of theatres (day surgery, mains and endoscopy) required.

The following planning assumptions have been used to adjust the baseline data over the period across all three settings:

- An allowance has been made for population changes using ONS data to allow for changes in population by PCT, age and sex.
- A waiting list model has been used which profiles the elective workload required to achieve the 18-week wait from referral to surgery by December 2008. This assumes that the 18 weeks comprise 8 weeks for the outpatient/diagnostic element and 10 weeks from addition to waiting list and surgery. Activity levels beyond this period are profiled to ensure that the target waiting times are maintained.
- The Trust has projected that it will achieve the top twenty fifth percentile performance for length of stay by HRG over a five year period for both electives and non-electives. For those HRG's where Trust is already achieving the target length of stay, no change is made. Where the Trust has a higher length of stay than the target a reduction in length of stay is forecast over a five year period.
- Increased daycase rates have been modelled for the basket and trolley of procedures appropriate for day surgery. Ultimately all admissions for the basket and trolley procedures where there is currently a length of stay of 3 days or less it is planned will be treated on a daycase basis.
- Bed occupancy rates have been set at 87% for medicine and 88% for surgery.
- Capacity assumptions for theatre times, utilisation times and availability of theatres (including endoscopy rooms) have been used to determine theatre requirements.
- Where emergency hospitalisation rates differ significantly for the Salisbury Health Care Trust catchment population, these have been adjusted. The impact of this is extremely slight.
- Activity figures received from North Dorset PCT have enabled the Trust to model the impact of the Shepton Mallet ISTC which opened in July 2005.
- A model has been developed assessing the impact of the introduction of colo-rectal screening and the implication for additional colonoscopy activity. These figures have been included across all scenarios.
- Achieving benchmarked performance for outpatients: first and follow up DNA rates and new to follow up ratios will be in the top twenty fifth percentile by 2011.

8.9.2 Consultation with PCTs on Activity Projections

The Trust met with each of its major PCTs to discuss the results of the activity modelling as they applied to them. A number of PCTs required the Trust to use their planned levels of activity, rather than outturn, as the basis of the modelling. Where firm activity levels were available, PCT plans for changes in

commissioned activity due to practice based commissioning, changing commissioning intentions or increased usage of ISTC were all incorporated.

It should be noted that the use of planned levels of activity create an immediate discrepancy against outturn figures as PCTs have largely not commissioned at outturn levels. Consequently PCTs will need to work with the Trust to implement demand management initiatives to ensure that the planned levels are deliverable.

8.10 Scenario Modelling

Three scenarios have been modelled, these represent high, medium and low forecasts of activity. Each scenario is modelled from the base case as a starting point with relevant changes to the capital expenditure programme, revenue income and expenditure, including inflation factors. A detailed breakdown of inflation assumptions used in all three scenarios is contained in Appendix AB.

8.11 Medium Scenario

8.11.1 Activity Modelling

The medium scenario took 2004/5 activity levels or 2005/6 planned levels in the case of South Wiltshire and North Dorset PCT and applied the performance assumptions set out in section 8.9.1. A further reduction was made for New Forest PCT who intend to reduce the value of their SLA with the Trust by £900k in 2006/7. For A&E it is modelled that minor A&E attendances will reduce by 1% per annum from the predicted 2005/6 outturn figure. Full details are shown in Appendix AC.

The results of the activity modelling for the Medium scenario are contained in the following tables:

Table 8-16: Medium Scenario Inpatient Activity, to 2010/11

Year	Non Elective	Daycase	Elective	Total	Percent Change
2005/6	21,451	17,228	6,411	45,089	
2006/7	20,764	18,180	6,242	45,185	1.50%
2007/8	20,622	18,597	6,376	45,595	0.91%
2008/9	20,499	18,545	6,274	45,317	-0.61%
2009/10	20,348	18,613	6,286	45,246	-0.16%
2010/11	20,205	18,717	6,315	45,237	-0.02%

Table 8-17: Medium Scenario Outpatient Activity, to 2010/11

	First	Follow Up	Total	Percent Change
2005/6	58,744	107,403	166,147	
2006/7	58,501	105,387	163,888	-1.36%
2007/8	58,640	104,182	162,822	-0.65%
2008/9	58,415	102,395	160,810	-1.24%
2009/10	58,488	101,330	159,817	-0.62%
2010/11	58,555	100,211	158,766	-0.66%

Table 8-18: Medium Scenario A&E Attendances, to 2010/11

	Attendances	Change
2005/6	36,091	
2006/7	36,163	0.2%
2007/8	36,438	0.8%
2008/9	36,753	0.9%
2009/10	37,035	0.8%
2010/11	37,297	0.7%

8.11.2 Capacity Planning – Medium Scenario

The modelling for the medium scenario predicts the following requirements for beds and theatres:

Table 8-19: Medium Scenario Bed Requirements, to 2010/11

	Critical Care	Day case	Inpatients	Total
2005/6	7	44	554	604
2006/7	7	46	529	582
2007/8	7	47	515	568
2008/9	7	47	499	552
2009/10	7	47	486	540
2010/11	7	47	475	529

Table 8-20: Medium Scenario Theatre Requirements, to 2010/11

	Elective	Non Elective	Daycase
2005/6	7.2	0.7	4.1
2006/7	6.6	0.7	5
2007/8	6.8	0.7	5.1
2008/9	6.6	0.7	5
2009/10	6.6	0.7	4.9
2010/11	6.6	0.7	5

The reduction in bed numbers is driven by the Trust's expectations of improvements in relation to length of stay and by PCT's commissioning intentions including the impact of ISTC's. Each of the two comprise approximately 50% of the impact on bed numbers. The Trust has assumed that costs are released by closing beds, although if the actual activity does not reduce in line with expectations then the Trust has the physical capacity to meet the higher activity requirements.

8.11.3 Financial Modelling – Medium Scenario

The medium scenario is modelled on the base case assumptions, as already detailed above, with the following differences, which are detailed in Appendix AD.

- PPI: the level of PPI income is reduced by £600,000 from 2006/07 onwards in order to comply with the FT licence. The reduction of costs from not undertaking the existing level of private patient treatment is estimated at £300,000 and included in the CIP programme.
- Medical Physics: additional income of £100,000 is expected from the new company planned to market the 'Functional Electrical Stimulation' (FES) devices developed by the Trust. This is expected to be operational from 2008/09
- Working Capital Facility: costs of £100,000 have been included from 2006/07 for cash-flow management purposes.
- Expenditure reductions in Clinical and IT developments: due to the loss of private patient income.

Having applied the assumptions set out above, Table 8-21 below provides a summary of the Trust's overall financial position for the next five years in the medium scenario. This information is set out in full in Appendix AE.

Table 8-21: Summary Income & Expenditure Medium Scenario 2005/06 to 2010/11

Summary income & expenditure forecasts – FT case	2005/06 £000	2006/07 £000	2007/08 £000	2008/09 £000	2009/10 £000	2010/11 £000
Regulated Income (Net of PbR transition contribution)	132,380	134,526	138,121	141,100	144,768	148,664
Unregulated Income	5,867	6,509	7,772	8,614	8,730	8,748
PBR Transitional Relief	(2,182)	(1,843)	(1,471)	0	0	0
Transfer from Donations Reserve	157	151	127	112	78	78
Total Income	**136,222**	**139,343**	**144,549**	**149,825**	**153,576**	**157,490**
Expenditure	(125,089)	(129,201)	(135,219)	(139,691)	(143,273)	(146,705)
Earnings Before Interest & Depreciation	11,133	10,141	9,329	10,135	10,303	10,784
Depreciation	(7,366)	(5,623)	(5,492)	(5,919)	(5,827)	(6,396)
Net Interest	87	170	196	204	210	215
Surplus After Interest	3,854	4,688	4,033	4,420	4,686	4,603
PDC Dividends	(3,372)	(3,483)	(3,431)	(3,592)	(3,606)	(3,706)
Retained Surplus	**482**	**1,205**	**602**	**827**	**1,080**	**897**

This indicates that the overall cumulative surplus projected over the five-year period is £5.1M. This accumulates in a relatively even profile.

Table 8-22: Summary Balance Sheet Medium Scenario 2005/06 to 2010/11

Summary balance sheet forecasts – FT case	2005/06 £000	2006/07 £000	2007/08 £000	2008/09 £000	2009/10 £000	2010/11 £000
Fixed Assets (Protected)	87,706	87,264	88,843	94,505	95,692	100,125
Fixed Assets (Unprotected)	15,068	14,612	14,212	14,777	14,385	14,600
Donated Assets	1,268	1,117	990	921	843	795
Net Current Assets	(2,368)	(1,965)	(2,543)	(2,667)	(2,658)	(2,400)
Long-term Liabilities	(216)	(216)	(216)	(216)	(216)	(216)
Total Net Assets	**101,457**	**100,811**	**101,286**	**107,320**	**108,047**	**112,904**
PDC	51,654	49,954	49,954	49,679	49,404	49,404
Revaluation Reserve	44,058	44,058	44,058	49,607	49,607	53,615
Donations Reserve	1,258	1,107	980	911	833	785
I & E Reserve	4,489	5,694	6,296	7,123	8,203	9,100
Total Taxpayers Equity	**101,457**	**100,811**	**101,286**	**107,320**	**108,047**	**112,904**

Table 8-23: Summary of Foundation Trust Cash Flow Projections Medium Scenario 2005/06 to 2010/11

Summary cash flow forecasts – FT case	**2005/06 £000**	**2006/07 £000**	**2007/08 £000**	**2008/09 £000**	**2009/10 £000**	**2010/11 £000**
Income received	138,999	140,868	145,429	149,501	153,332	157,261
PbR transition	(2,182)	(1,843)	(1,471)	0	0	0
Operating Costs	(124,635)	(128,078)	(134,175)	(139,139)	(143,066)	(146,546)
Cash from operations	**12,182**	**10,947**	**9,784**	**10,362**	**10,266**	**10,716**
Capital Expenditure	(7,051)	(4,574)	(6,545)	(6,484)	(6,545)	(6,957)
Cash Brokerage	(315)	(1,700)	0	(275)	(275)	0
Cash flow before Finance	**4,815**	**4,673**	**3,239**	**3,603**	**3,446**	**3,759**
Cash flow to Taxpayers' Equity	**4,815**	**4,673**	**3,239**	**3,603**	**3,446**	**3,759**
PDC Dividends paid	(3,372)	(3,483)	(3,431)	(3,592)	(3,606)	(3,706)
Interest received	87	170	196	204	210	215
Change in cash	**(1,531)**	**(1,360)**	**(4)**	**(215)**	**(50)**	**(267)**
Opening cash balance	**339**	**1,870**	**3,230**	**3,234**	**3,449**	**3,499**
Closing cash balance	**1,870**	**3,230**	**3,234**	**3,449**	**3,499**	**3,767**

Table 8-24 Cash Flow and Liquidity Ratios Medium Scenario 2005/06 to 2010/11

Ratio	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**2010/11**
EBITDA/Total Debt (Excludes PDC)	5154.0%	4695.1%	4319.1%	4691.9%	4769.7%	4992.8%
EBITDA/Total Debt (Includes PDC)	25.1%	20.2%	18.6%	20.3%	20.8%	21.7%
Total Debt/Income (Excludes PDC)	0.2%	0.2%	0.1%	0.1%	0.1%	0.1%
Total Debt/Income (Includes PDC)	31.9%	35.6%	34.5%	33.4%	32.4%	31.6%
Income/Debt (Excludes PDC)	64351.3%	65216.6%	67328.4%	69213.5%	70987.2%	72806.1%
Income/Debt (Includes PDC)	1159.1%	1250.8%	1190.2%	1301.3%	1211.3%	1301.6%
Acid Test	0.16	0.25	0.24	0.24	0.24	0.25
Current Ratio	0.79	0.84	0.82	0.81	0.82	0.84

Table 8-25: Prudential Borrowing Code Ratios Medium Scenario 2005/06 to 2010/11

Ratio	Target	2005/06 Plan	2006/07 Plan	2007/08 Plan	2008/09 Plan	2009/10 Plan	2010/11 Plan
Dividend Cover Ratio	>1x	3.35	3.01	2.83	2.93	2.97	3.03
Interest Cover Ratio	>3x	N/A	N/A	N/A	N/A	N/A	N/A
Debt Service Ratio	>2x	N/A	N/A	N/A	N/A	N/A	N/A
Debt Capital Ratio	<10%	0	0	0	0	0	0
Debt Service to Revenue	<3%	0	0	0	0	0	0
PBL Ratios Achieved	√	√	√	√	√	√	√

The debt capital ratio represents the level of borrowing required of approximately £11M within the working capital facility.

8.12 Low Scenario

8.12.1 Activity Modelling

The Low scenario is based on the Medium scenario with a reduction of 5% for elective activity (both inpatient and daycases). Non-elective activity is modelled to mirror the Medium scenario. First outpatient attendances are also reduced by 5%. A&E attendances are predicated to reduce by 1% per year for higher cost attendances and by 2% per year for the minor cases to reflect improved out of hours provision. Full details are shown in Appendix AF.

The results of the activity modelling for the Low scenario are contained in the following tables:

Table 8-26: Low Scenario Inpatient Activity, to 2010/11

Year	Non Elective	Daycase	Elective	Total	Percent Change
2005/6	21,451	17,228	6,411	45,089	
2006/7	20,764	17,669	5,930	44,362	-11.34%
2007/8	20,622	18,071	6,057	44,750	0.87%
2008/9	20,499	18,027	5,960	44,486	-0.59%
2009/10	20,348	18,099	5,971	44,418	-0.15%
2010/11	20,205	18,205	5,999	44,409	-0.02%

Table 8-27: Low Scenario Outpatient Activity, to 2010/11

	First	Follow Up	Total	Percent Change
2005/6	58,744	107,403	166,147	
2006/7	56,338	105,387	161,725	-2.66%
2007/8	56,473	104,182	160,654	-0.66%
2008/9	56,256	102,395	158,651	-1.25%
2009/10	56,325	101,330	157,655	-0.63%
2010/11	56,390	100,211	156,602	-0.67%

Table 8-28: Low Scenario A&E Attendances, to 2010/11

	Attendances	Change
2005/6	36,091	
2006/7	35,498	-1.6%
2007/8	34,915	-1.6%
2008/9	34,342	-1.6%
2009/10	33,780	-1.6%
2010/11	33,227	-1.6%

8.12.2 Capacity Planning – Low Scenario

The modelling for the Low scenario predicts the following requirements for beds and theatres:

Table 8-29: Low Scenario Bed Requirements, to 2010/11

	Critical Care	Day case	Inpatients	Total
2005/6	7	44	554	604
2006/7	7	43	523	573
2007/8	7	44	509	560
2008/9	7	44	493	544
2009/10	7	44	481	531
2010/11	7	45	469	520

Table 8-30: Low Scenario Theatre Requirements, to 2010/11

	Elective	Non Elective	Daycase
2005/6	7.2	0.7	4.1
2006/7	6.27	0.7	4.8
2007/8	6.46	0.7	4.8
2008/9	6.27	0.7	4.8
2009/10	6.27	0.7	4.7
2010/11	6.27	0.7	4.8

The reduction in bed numbers is driven by the Trust's expectations of improvements in relation to length of stay and by PCT's commissioning intentions including the impact of ISTC's. Each of the two comprise approximately 50% of the impact on bed numbers. The Trust has assumed that costs are released by closing beds, although if the actual activity does not reduce in line with expectations then the Trust has the physical capacity to meet the higher activity requirements.

8.12.3 Financial Modelling – Low Scenario

The Low scenario is modelled on the base case assumptions, as already detailed above, with the following differences, which are detailed in Appendix AG.

- Activity: the number of electives and outpatient attendances have been reduced by 5%, this leads to a reduced level of income and relating expenditure.
- PPI: the level of PPI income is reduced by £600,000 from 2006/07 onwards in order to comply with the FT licence. The reduction of costs from not undertaking the existing level of private patient treatment is estimated at £300,000 and included in the CIP programme.
- Medical Physics: additional income of £100,000 is expected from the new company planned to market the 'Functional Electrical Stimulation' (FES) devices developed by the Trust. This is expected to be operational from 2008/09
- Working Capital Facility: costs of £100,000 have been included from 2006/07 for cash-flow management purposes.
- Expenditure reductions in IT service developments, training, Information services and medical records, modernisation and clinical practice: due to the loss of income from electives and private patient income.
- Contingency: due to the reduction in income from electives the contingency included in expenditure for a potential risk of price deflation has been removed. This places the Trust at risk, should the price deflate.
- Manpower: an additional saving of £200,000 has been included from 2006/07 in the financial projections, in total reducing the nursing staff by 78 WTE or 7.96% of the nursing workforce over the next five years to 2010/11. There would be no changes of any significance in any other staff groups. This reduction could be achieved through natural wastage, (staff turnover) and freezing vacancies. No costs have been factored in for redundancy costs as the Trust and local health economy have absorbed considerable changes in the past without resorting to redundancies as shown in Appendix AH.

Having applied the assumptions set out above, Table 8-31 below provides a summary of the Trust's overall financial position for the next five years in the low scenario. This information is set out in full in Appendix AI.

Table 8-31: Summary Income & Expenditure Low Scenario 2005/06 to 2010/11

Summary income & expenditure forecasts – FT case	**2005/06 £000**	**2006/07 £000**	**2007/08 £000**	**2008/09 £000**	**2009/10 £000**	**2010/11 £000**
Regulated Income (Net of PbR transition contribution)	132,380	132,847	136,359	139,311	142,925	146,758
Unregulated Income	5,867	6,509	7,772	8,614	8,730	8,748
PBR Transitional Relief	(2,182)	(1,843)	(1,471)	0	0	0
Transfer from Donations Reserve	157	151	127	112	78	78
Total Income	**136,222**	**137,663**	**142,787**	**148,037**	**151,733**	**155,584**
Expenditure	(125,089)	(127,934)	(133,857)	(138,243)	(141,745)	(145,069)
Earnings Before Interest & Depreciation	11,133	9,729	8,930	9,794	9,988	10,516
Depreciation	(7,366)	(5,623)	(5,492)	(5,919)	(5,827)	(6,396)
Net Interest	87	160	165	158	151	143
Surplus After Interest	3,854	4,266	3,604	4,033	4,312	4,263
PDC Dividends	(3,372)	(3,483)	(3,431)	(3,592)	(3,606)	(3,706)
Retained Surplus	**482**	**784**	**173**	**441**	**706**	**557**

This indicates that the overall cumulative surplus projected over the five-year period is £2.6M. This accumulates in a relatively even profile.

Table 8-32: Summary Balance Sheet Low Scenario 2005/06 to 2010/11

Summary balance sheet forecasts – FT case	**2005/06 £000**	**2006/07 £000**	**2007/08 £000**	**2008/09 £000**	**2009/10 £000**	**2010/11 £000**
Fixed Assets (Protected)	87,706	87,264	88,843	94,505	95,692	100,125
Fixed Assets (Unprotected)	15,068	14,612	14,212	14,777	14,385	14,600
Donated Assets	1,268	1,117	990	921	843	795
Net Current Assets	(2,368)	(2,386)	(3,393)	(3,904)	(4,269)	(4,351)
Long-term Liabilities	(216)	(216)	(216)	(216)	(216)	(216)
Total Net Assets	**101,457**	**100,390**	**100,436**	**106,083**	**106,436**	**110,953**
PDC	51,654	49,954	49,954	49,679	49,404	49,404
Revaluation Reserve	44,058	44,058	44,058	49,607	49,607	53,615
Donations Reserve	1,258	1,107	980	911	833	785
I & E Reserve	4,489	5,272	5,445	5,886	6,592	7,149
Total Taxpayers Equity	**101,457**	**100,390**	**100,436**	**106,083**	**106,436**	**110,953**

Table 8-33: Summary of Foundation Trust Cash Flow Projections Low Scenario 2005/06 to 2010/11

Summary cash flow forecasts – FT case	2005/06 £000	2006/07 £000	2007/08 £000	2008/09 £000	2009/10 £000	2010/11 £000
Income received	138,999	139,251	143,671	147,714	151,491	155,358
PbR transition	(2,182)	(1,843)	(1,471)	0	0	0
Operating Costs	(124,635)	(127,120)	(132,822)	(137,701)	(141,514)	(144,853)
Cash from operations	**12,182**	**10,289**	**9,378**	**10,013**	**9,977**	**10,505**
Capital Expenditure	(7,051)	(4,574)	(6,545)	(6,484)	(6,545)	(6,957)
Cash Brokerage	(315)	(1,700)	0	(275)	(275)	0
Cash flow before Finance	**4,815**	**4,015**	**2,833**	**3,254**	**3,157**	**3,548**
Cash flow to Taxpayers' Equity	**4,815**	**4,015**	**2,833**	**3,254**	**3,157**	**3,548**
PDC Dividends paid	(3,372)	(3,483)	(3,431)	(3,592)	(3,606)	(3,706)
Interest received	87	160	165	158	151	143
Change in cash	**(1,531)**	**(692)**	**433**	**180**	**298**	**15**
Opening cash balance	**339**	**1,870**	**2,562**	**2,129**	**1,949**	**1,651**
Closing cash balance	**1,870**	**2,562**	**2,129**	**1,949**	**1,651**	**1,636**

Table 8-34: Cash Flow and Liquidity Ratios Low Scenario 2005/06 to 2010/11

Ratio	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
EBITDA/Total Debt (Excludes PDC)	5154.0%	4504.3%	4134.5%	4534.4%	4624.1%	4868.4%
EBITDA/Total Debt (Includes PDC)	25.1%	19.4%	17.8%	19.6%	20.1%	21.2%
Total Debt/Income (Excludes PDC)	0.2%	0.2%	0.2%	0.1%	0.1%	0.1%
Total Debt/Income (Includes PDC)	31.9%	36.0%	34.9%	33.8%	32.8%	31.9%
Income/Debt (Excludes PDC)	64351.3%	64468.1%	66514.2%	68386.0%	70134.8%	71925.1%
Income/Debt (Includes PDC)	1159.1%	1236.4%	1175.8%	1285.7%	1204.1%	1302.5%
Acid Test	0.16	0.21	0.16	0.14	0.12	0.11
Current Ratio	0.79	0.81	0.75	0.72	0.70	0.70

Table 8-35: Prudential Borrowing Code Ratios Low Scenario 2005/06 to 2010/11

Ratio	Target	2005/06 Plan	2006/07 Plan	2007/08 Plan	2008/09 Plan	2009/10 Plan	2010/11 Plan
Dividend Cover Ratio	>1x	3.35	2.88	2.70	2.81	2.85	2.91
Interest Cover Ratio	>3x	N/A	N/A	N/A	N/A	N/A	N/A
Debt Service Ratio	>2x	N/A	N/A	N/A	N/A	N/A	N/A
Debt Capital Ratio	<10%	0	0	0	0	0	0
Debt Service to Revenue	<3%	0	0	0	0	0	0
PBL Ratios Achieved	√	√	√	√	√	√	√

8.13 High Scenario

8.13.1 Activity Modelling

The High scenario is based on the outputs of the model using 2004/5 outturn, rather than plan. A number of areas have been increased in line with predictions made by clinical teams during the service planning discussions which have then been validated with available data. These include:

- An increase in the number of angiographies performed (5% increase per year)
- Increases in the incidence of skin cancer (6% a year)
- Additional hand trauma and microsurgery
- Increase in referrals the Warminster area for ophthalmology and maternity (50 deliveries per year)
- Increases in activity for laser clinic service (5% per year)

Under the High scenario, A&E attendances are predicated to increase by 5% per year for higher cost attendances and by 1% per year for the minor cases.

The results of the activity modelling for the High scenario are contained in the following tables:

Table 8-36: High Scenario Inpatient Activity, to 2010/11

Year	Non Elective	Daycase	Elective	Total	Percent Change
2005/6	22,229	17,325	7,218	46,772	
2006/7	22,401	19,380	6,340	48,121	2.88%
2007/8	22,559	19,903	6,503	48,964	1.75%
2008/9	22,783	19,965	6,480	49,228	0.54%
2009/10	22,993	20,172	6,514	49,679	0.92%
2010/11	23,218	20,482	6,592	50,292	1.23%

Table 8-37: High Scenario Outpatient Activity, to 2010/11

	First	Follow Up	Total	Percent Change
2005/6	58,986	106,051	165,037	
2006/7	59,424	104,043	163,467	-0.95%
2007/8	59,824	102,084	161,908	-0.95%
2008/9	60,373	100,561	160,934	-0.60%
2009/10	60,927	99,393	160,321	-0.38%
2010/11	61,502	98,138	159,641	-0.42%

Table 8-38: High Scenario A&E Attendances, to 2010/11

	Attendances	Change
2005/6	36,335	
2006/7	37,226	2.5%
2007/8	38,153	2.5%
2008/9	39,116	2.5%
2009/10	40,119	2.6%
2010/11	41,162	2.6%

8.13.2 Capacity Planning – High Scenario

The modelling for the High scenario predicts the following requirements for beds and theatres:

Table 8-39: High Scenario Bed Requirements, to 2010/11

	Critical Care	Day case	Inpatients	Total
2005/6	7	44	593	644
2006/7	7	49	579	635
2007/8	7	50	573	630
2008/9	7	50	565	622
2009/10	7	51	560	618
2010/11	7	51	556	614

Table 8-40: High Scenario Theatre Requirements, to 2010/11

	Elective	Non Elective	Daycase
2005/6	7.3	0.7	4.1
2006/7	6.8	0.8	5.1
2007/8	6.9	0.8	5.3
2008/9	6.9	0.8	5.2
2009/10	7	0.8	5.3
2010/11	7.1	0.8	5.3

The reduction in bed numbers under the High scenario is largely driven by the Trust's expectations of improvements in relation to length of stay with some impact from the loss of activity to ISTC's. The Trust has assumed that costs are released by closing beds, although if the actual activity is higher than modelled, the Trust will still retain the physical capacity to meet the higher activity requirements. Full details are shown in Appendix AJ.

8.13.3 Financial Modelling – High Scenario

The High scenario is modelled on the base case assumptions, as already detailed above, with the following differences, which are detailed in Appendix AK.

- Increase activity, income and expenditure: an increase in potential activity, income and relating expenditure has been included.
- PPI: the level of PPI income is reduced by £600,000 from 2006/07 onwards in order to comply with the FT licence. The reduction of costs from not undertaking the existing level of private patient treatment is estimated at £300,000 and included in the CIP programme.
- Medical Physics: additional income of £100,000 is expected from the new company planned to market the 'Functional Electrical Stimulation' (FES) devices developed by the Trust. This is expected to be operational from 2008/09
- Working Capital Facility: costs of £100,000 have been included from 2006/07 for cash-flow management purposes.
- Expenditure reductions in IT service developments and clinical practice: due to the loss of income from electives and private patient income.
- Contingency: an allowance has been built into this high scenario to reflect purchaser affordability and to reflect a step in increase costs for additional activity.
- Manpower: costs of £1.2M have been included for an increase in nursing staff of 34 WTE or 3.07%. In 2006/07, these costs have then been decreased over the following years for a decrease of 13 WTE as shown in Appendix AL.

Having applied the assumptions set out above,

Table 8-41 below provides a summary of the Trust's overall financial position for the next five years in the High scenario. This information is set out in full in Appendix AM.

Table 8-41: Summary Income & Expenditure High Scenario 2005/06 to 2010/11

Summary income & expenditure forecasts – FT case	2005/06 £000	2006/07 £000	2007/08 £000	2008/09 £000	2009/10 £000	2010/11 £000
Regulated Income (Net of PbR transition contribution)	132,380	139,416	144,235	148,691	153,778	159,284
Unregulated Income	5,867	6,509	7,772	8,614	8,730	8,748
PBR Transitional Relief	(2,182)	(1,843)	(1,471)	0	0	0
Transfer from Donations Reserve	157	151	127	112	78	78
Total Income	**136,222**	**144,232**	**150,663**	**157,417**	**162,586**	**168,110**
Expenditure	(125,089)	(132,646)	(139,845)	(145,814)	(150,706)	(155,716)
Earnings Before Interest & Depreciation	11,133	11,587	10,818	11,603	11,880	12,394
Depreciation	(7,366)	(5,623)	(5,492)	(5,919)	(5,827)	(6,396)
Net Interest	87	193	281	356	432	513
Surplus After Interest	3,854	6,156	5,607	6,039	6,486	6,511
PDC Dividends	(3,372)	(3,483)	(3,431)	(3,592)	(3,606)	(3,706)
Retained Surplus	**482**	**2,673**	**2,177**	**2,447**	**2,880**	**2,805**

This indicates that the overall cumulative surplus projected over the five-year period is £13M. This accumulates in a relatively even profile.

Table 8-42: Summary Balance Sheet High Scenario 2005/06 to 2010/11

Summary balance sheet forecasts – FT case	2005/06 £000	2006/07 £000	2007/08 £000	2008/09 £000	2009/10 £000	2010/11 £000
Fixed Assets (Protected)	87,706	87,264	88,843	94,505	95,692	100,125
Fixed Assets (Unprotected)	15,068	14,612	14,212	14,777	14,385	14,600
Donated Assets	1,268	1,117	990	921	843	795
Net Current Assets	(2,368)	(497)	500	1,995	3,804	5,969
Long-term Liabilities	(216)	(216)	(216)	(216)	(216)	(216)
Total Net Assets	**101,457**	**102,279**	**104,329**	**111,982**	**114,508**	**121,273**
PDC	51,654	49,954	49,954	49,679	49,404	49,404

Revaluation Reserve	44,058	44,058	44,058	49,607	49,607	53,615
Donations Reserve	1,258	1,107	980	911	833	785
I & E Reserve	4,489	7,162	9,338	11,785	14,665	17,470
Total Taxpayers Equity	**101,457**	**102,279**	**104,329**	**111,982**	**114,508**	**121,273**

Table 8-43: Summary of Foundation Trust Cash Flow Projections High Scenario 2005/06 to 2010/11

Summary cash flow forecasts – FT case	**2005/06 £000**	**2006/07 £000**	**2007/08 £000**	**2008/09 £000**	**2009/10 £000**	**2010/11 £000**
Income received	138,999	145,575	151,498	157,038	162,289	167,821
PbR transition	(2,182)	(1,843)	(1,471)	0	0	0
Operating Costs	(124,635)	(131,132)	(138,563)	(144,974)	(150,210)	(155,257)
Cash from operations	**12,182**	**12,600**	**11,464**	**12,064**	**12,079**	**12,564**
Capital Expenditure	(7,051)	(4,574)	(6,545)	(6,484)	(6,545)	(6,957)
Cash Brokerage	(315)	(1,700)	0	(275)	(275)	0
Cash flow before Finance	**4,815**	**6,326**	**4,919**	**5,305**	**5,259**	**5,607**
Cash flow to Taxpayers' Equity	**4,815**	**6,326**	**4,919**	**5,305**	**5,259**	**5,607**
PDC Dividends paid	(3,372)	(3,483)	(3,431)	(3,592)	(3,606)	(3,706)
Interest received	87	193	281	356	432	513
Change in cash	**(1,531)**	**(3,036)**	**(1,770)**	**(2,068)**	**(2,085)**	**(2,414)**
Opening cash balance	**339**	**1,870**	**4,906**	**6,676**	**8,744**	**10,829**
Closing cash balance	**1,870**	**4,906**	**6,676**	**8,744**	**10,829**	**13,243**

Table 8-44: Cash Flow and Liquidity Ratios High Scenario 2005/06 to 2010/11

Ratio	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**2010/11**
EBITDA/Total Debt (Excludes PDC)	5154.0%	5364.1%	5008.3%	5371.6%	5500.0%	5738.0%
EBITDA/Total Debt (Includes PDC)	25.1%	23.1%	21.6%	23.3%	23.9%	25.0%
Total Debt/Income (Excludes PDC)	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%
Total Debt/Income (Includes PDC)	31.9%	34.5%	33.1%	31.8%	30.6%	29.6%
Income/Debt (Excludes PDC)	64351.3%	67395.7%	70137.9%	72702.6%	75133.8%	77695.0%
Income/Debt (Includes PDC)	1159.1%	1292.6%	1239.9%	1366.9%	1272.3%	1366.9%
Acid Test	0.16	0.38	0.46	0.57	0.69	0.81
Current Ratio	0.79	0.96	1.03	1.13	1.24	1.37

Table 8-45: Prudential Borrowing Code Ratios High Scenario 2005/06 to 2010/11

Ratio	Target	2005/06 Plan	2006/07 Plan	2007/08 Plan	2008/09 Plan	2009/10 Plan	2010/11 Plan
Dividend Cover Ratio	>1x	3.35	3.44	3.32	3.43	3.53	3.62
Interest Cover Ratio	>3x	N/A	N/A	N/A	N/A	N/A	N/A
Debt Service Ratio	>2x	N/A	N/A	N/A	N/A	N/A	N/A
Debt Capital Ratio	<10%	0	0	0	0	0	0
Debt Service to Revenue	<3%	0	0	0	0	0	0
PBL Ratios	√	√	√	√	√	√	√

8.14 Planned Capital Developments

The following capital programme has been included in all three Foundation Trust scenarios. The detail of the investment in buildings, equipment and other fixed assets is set out in section 7.8. This programme is summarised at future prices in Table 8-46 below and detailed in Appendix F.

This represents an increased pace of capital investment over that available as an NHS Trust, illustrating a significant benefits to the Trust and its patients of foundation status.

Table 8-46: Summary Capital programme 2005/06 to 2010/11

Capital Category	2006/07 £000	2007/08 £000	2008/09 £000	2009/10 £000	2010/11 £000
2004/05 B/fwd					
Delivery of Patient Focused Care and Services	400	1,100	2,300	1,000	0
Improvement of Organisational Effectiveness	2,334	2,508	1,648	1,520	810
Delivery of Effective Risk Management Systems	200	650	60	90	70
Develop an Excellent Workforce	0	0	0	0	0
Generate New Income Streams	650	100	150	200	200
Develop the Hospital's	1,900	1,950	1,550	1,500	1,800

Infrastructure					
Other	26	169	490	1,883	3,583
Capital Expenditure Programme	**5,510**	**6,477**	**6,198**	**6,193**	**6,463**
PFI Deferred Asset	64	68	72	77	82
Brokerage	1700	0	275	275	0
Sales	-1000	0	0	0	0
Total	**6,274**	**6,545**	**6,545**	**6,545**	**6,545**

If the Trust were to become a Foundation Trust, it is understood that it would no longer be subject to a Capital Resource Limit (CRL) and would be largely dependent upon internally generated resources. If the capital expenditure future requirements were to exceed the level of internally generated resources then it would be necessary to borrow. If necessary the Trust's borrowing capacity will be dependent upon the overall level of cashflow generated by operations, subject to the achievement of target liquidity ratios set by the Monitor.

Currently the Trust will not need to make arrangements to drawdown loan financing to support the capital programme.

The level of donated assets is unlikely to be nil in practice, however, all of the items included within the Trust's capital programme relate to items which will need to be funded by internally generated funds.

8.15 Normalised Earnings

The Trust has examined the five year financial projections and identified the non-recurring income and expenditure, along with any exceptional items. This review then details the normalised earnings of the Trust. The results are detailed in Appendix AN which show that the Trust will continue to generate acceptable levels of surplus year on year.

8.16 Sensitivity Analysis

The Trust has undertaken some sensitivity analysis in order to ascertain the robustness of the financial projections. The Trusts financial projections have erred on the side of caution. The analysis allows the Trust to test 'what if' in the event of the worst case. The Trust has anticipated one variable as a change in PbR tariff of 2%, both upwards and downwards on all SLA activity related patient income. The 2% change in income has the same impact as a 1.75% change in total costs. Table 8-47 below shows the impact that these changes would have.

The medium scenario would result in an £8M cumulative deficit in the five year period to the end of 2010/11, should PbR tariff income be reduced by 2%.

Table 8-47: Effect of variations in tariff price on surplus (deficit)

Scenario	Variation	2006/7	2007/8	2008/9	2009/10	2010/11
Medium	-2%	(1240)	(1915)	(1729)	(1536)	(1767)
	Now	1205	602	827	1080	897
	+2%	3650	3119	3383	3969	356
High	-2%	132	(460)	(258)	87	(68)
	Now	2673	2177	2447	2880	2805
	+2%	5214	4814	5152	5673	5678
Low	-2%	(1631)	(2312)	(2083)	(1876)	(2072)
	Now	781	170	438	704	555
	+2%	3193	2652	2959	3284	318

In addition, should the Trust total expenditure increase by 1.75% the results would be the same, the Trust would be an £8M cumulative deficit by the end of 2010/11.

At present the Trusts cumulative retained surplus would increase from a current surplus of £4M, increasing to £9M by 2010/11. However, should the decrease in income occur the Trust would reduce the retained surplus to £1M by 2010/11.

As shown in Table 8-48 below. the Trust has already included a financial contingency for the reduction in the PbR tariff of £600,000 in 2006/07 and has increased this to £800,000 in 2007/08. In addition the Trust would envisage a managed reduction in expenditure on Trust clinical developments and a recurring increase in the Cost Improvement Plan (CIP).

Table 8-48: Financial recovery plan for 2% reduction in income

Medium reduction income 2%	2006/07 £000	2007/08 £000	2008/09 £000	2009/10 £000	2010/11 £000
Potential Loss	(1,240)	(1,915)	(1,729)	(1,536)	(1,767)
PbR Contingency	600	800	800	800	800
Reduction in developments	200	200	200	200	200
Increase in CIP pa	440	915	729	536	767
Total	1,240	1,915	1729	1536	1767

Balance	0	0	0	0	0

Recurring savings on the CIP can only be achieved on a substantive scale by staff reductions. These reductions would be targeted in areas where there would be minimal impact, so as not to affect the achievement of activity volumes. This equates to a reduction of 15 WTE in 2006/07 for £440,000 and increased savings would continue to be managed through staff reductions. A reduction of 30 staff equates to only 1% of the total Trust WTE. It is thought that such a reduction in staff could be achieved through natural wastage (staff turnover) and freezing vacancies.

The Trust has regular monthly financial monitoring, in year variations in income and expenditure have been managed to ensure that the Trust remains in financial balance.

8.16.1 Financial Risk Scoring

The Trust has taken the opportunity to assess the financial risk of 2006/07 financial plan contained within the medium scenario using the compliance framework issued by Monitor in March 2005. The results are shown in Table 8-49 below and indicate that the Trust has a reasonable risk rating.

Table 8-49: Indicators used to derive financial risk rating 2005/6.

Financial criteria	Weight (%)	Metric to be scored	**Score**	**Rating**	**Weighted score**
Achievement of plan	25%	EBITDA achieved (% of plan)	n/a	*4*	*4*
Underlying performance	25%	EBITDA margin (%)	9.3%	4	4
Financial efficiency	12.5%	Return on assets excl. dividend (%)	3.5%	3	1.5
	12.5%	I&E surplus margin net of dividend (%)	0.1%	3	1.5
Liquidity	25%	Liquidity ratios (days)	23	3	3
		Weighted average =			**3.5**

8.17 Conclusion

The scenario modelling as outlined above shows that the Trust is able to remain as a financially viable organisation as shown in Table 8-50 below. The Trust's view is that the medium scenario is most likely to occur, the financial modelling has included contingency reserves to offset potential risks and sensitivity tests. The low scenario details the viability of the Trust should a reduction in elective

patients and income occur, the Trust recognises that relating costs would have to be cut and this has been included in the model. The high scenario details potential increases in income should activity increase and income is received from all PCT commissioners, but allowances have been made to reflect purchaser affordability.

Table 8-50: Income and Expenditure Movements – 3 scenarios

Scenario	2005/06 £000	2006/07 £000	2007/08 £000	2008/09 £000	2009/10 £000	2010/11 £000
Medium	482	1205	602	827	1080	897
High	482	2673	2177	2447	2880	2805
Low	482	781	170	438	704	555

9 Supporting Delivery of the Service Development Strategy

9.1 Performance Management Arrangements

Whilst the Trust's existing approach to performance management has served it well, the Trust needs to raise its game in advance of Foundation status to ensure that it is fully prepared for the more commercial demands of the Foundation Trust and will accordingly be looking to make a number of improvements.

9.1.1 Integration of Risk into Business Planning

Risk management is now key to the success of the organisation. Identification of risk with clarity of avoidance, elimination or reduction will be essential. The annual business planning process has pointed to some risks but not in sufficient depth or breadth.

The Trust will introduce a revised process which integrates the risks identified from the organisation's own risk management systems with the requirement of the Standards for Better Health. At the same time we will develop a capacity planning model which will underpin the development of both directorate and organisational business plans.

To aid the delivery of the Trust's Business Plan greater clarity is required between the organisation and each Clinical Directorate. It is proposed to develop a formal service level agreement, which can be the basis of the monthly performance review meetings.

9.1.2 Benchmarking

The Trust has used benchmarking data, eg the Audit Commission's Acute Trust Portfolio, however, there is no ongoing review of its main services to identify the opportunities for performance improvement. An ongoing benchmarking system, which is easily accessible via IT, will be introduced to allow individual clinicians, specialities and the organisation to review performance against other NHS acute providers. The Dr Foster system has recently been purchased and a training programme is underway to ensure directors, clinicians and directorate management teams are trained in the use of the system.

9.1.3 Quality

In order to maintain and build upon the achievements made to date in the assessment of the Trust's clinical quality, the following will be undertaken:

- Integration of the 'Standards for Better Health' into our existing governance systems ensuring links to the developing Knowledge Skills Framework (KSF) and Modernising Medical Careers (MMC) work streams
- Strengthen the 'introduction of new procedures' policy with the service planning cycle
- Continue the work on the collection and use of 'intelligent information' through the Clinical Governance Report Card, ensuring links are formed with the Dr Foster benchmarking information
- Strengthen performance management targets around the patient experience themes arising from PALS, clinical audit, complaints and patient surveys.

9.1.4 New Financial Regime

The introduction of Payment By Results and its associated tariff system mean that the financial regime for an acute provider will be significantly more volatile than that of block contracts. Whilst in 2005/06 only some 30% of Trust income will be secured under the new system a revised system needs to be put in place to ensure the Trust understands the variability to its potential income and can plan accordingly.

The Trust will implement a revised monitoring system, which will allow the organisation to know in great detail what is happening to its actual income and therefore identify well in advance any potential difficulties.

9.1.5 Financial Monitoring

A formal Board meeting every two months is insufficient to ensure adequate Board control of the finances of the business under the new regime. A new sub-committee of the Board, the Finance Committee, was introduced in September to allow more detailed scrutiny of the financial performance of the organisation on a monthly basis. It will form part of the Assurance Framework of the organisation. Terms of reference are at Appendix AO to this chapter.

9.1.6 Content of Board Reports

The financial environment and reporting arrangements for a Foundation Trust are substantially different from a NHS Trust. For example, cash flow management and the monitoring of key ratios becomes considerably more important in the

new world. A revised Board performance report will be introduced which is applicable for an aspiring Foundation Trust.

9.1.7 Improving the Quality of Appraisal

The Trust has worked hard to ensure appraisal takes place. The focus must now move to the quality of the process so that both individual and organisation are clear what is expected from each party.

The introduction of both the new Consultant Contract and Agenda for Change (A4C) offer significant opportunities to improve this process and ensure that the Trust receives a greater return for its investment. Consultants will not move up their pay scale unless objectives have been achieved. Similarly, staff under A4C can be denied salary progress unless competencies are achieved.

9.2 Management Development

The Trust is clear about the need to develop the skills of its existing managers, and to plan for future needs.

The Board recognises that it has a number of development needs which will be addressed in the run up to the application submission and, if successful, in the early years of operation as a Foundation Trust. Individually all Board Directors have a personal development plan, which will address their specific needs.

It is a fact that the Trust, in common with the NHS in general, has many managers who have moved into management roles through clinical career pathways. Many continue to combine clinical roles with management responsibilities. The Trust recognises the need to develop management skills in this group, and has undertaken a considerable amount of work in this area, examples of which are described below. At the same time the Trust recognises the need to prepare the next generation of managers to provide replacements for current postholders as they move on or retire.

In 2006 a number of Clinical Directors will come to the end of their term in office. Succession planning is in hand with a number of Consultants undertaking appropriate training to take on the role of Clinical Director. At Lead Clinician level the Medical Director has put together an in-house development programme to support these individuals and seek to engender a common approach to the role.

The Trust has an excellent record in identifying individuals who can be developed to take up more senior posts and many of those who currently hold management posts within the trust are examples of past success. The Trust will continue to be pro-active in this area, both to secure an appropriate amount of management succession via internal development, and also to provide cover in the short term for illness or secondments/ maternity leave/ career breaks etc.

A key group of senior managers have recently undertaken a programme run by an external company with the theme of personal accountability, which the Trust sees as one of the key contributions to the success of a Foundation Trust. For Ward Leaders the Director of Nursing ran an in-house programme in 2004/05 to give these pivotal staff the tools and confidence to be effective in their role. In 2005/06 the programme is to be repeated for departmental nurse leaders.

As far as Executive Directors are concerned, each post has a recognised deputy whose development is planned so as to ensure cover for their director in the short term. This is frequently replicated at more junior levels throughout the management structure. The environment within which Foundation Trusts operate will require changes to the portfolio of knowledge and skills currently identified as required by Trust managers. For instance, there will be a requirement for managers to adjust the way they work to suit the Trusts' new identity as a mutual organisation, a social enterprise, operating in a more commercial environment where developing entrepreneurial skills is important than at present.

In the autumn of 2005 developmental work will be undertaken with senior managers to ensure that they are prepared to operate in a Foundation Trust environment. Trust management development initiatives will change their emphasis in order to ensure they continue to reflect the requirements of the organisation, whether these are a result of Foundation Status or because of changes in the NHS environment in general.

9.3 The Finance Function

The Trust commissioned Robson Rhodes to undertake a review of the finance function in order to ensure that arrangements will meet the requirements of being a Foundation Trust. In general the review was very positive and concluded

"…that the existing Finance infrastructure provides a sound base on which to build up the capacity and capability that will be required to ensure sustained performance as an NHSFT".

The key recommendations from the review, with proposed action points, are as follows:

- **Additional commercial senior resource**. Action: a senior level post has been created seeking someone with a commercial background to address treasury management and management of the capital programme. Two existing accountants also have a commercial background.
- **Management arrangements with commissioners need to be reviewed**. Action: an additional accountant post is being created within the Contracts and Income Section which will be responsible for contracts with commissioners.
- **An internal SLA is developed between the Finance and Information Systems Departments**. Action: there is already a close working relationship but we will review as to whether this can be improved through a more formal arrangement.
- **The Trust reviews the work of the finance projects team**. Action: Some of the other changes in the Finance Department will enable the support to projects be more focussed.
- **The Trust installs a dedicated systems administrator for the Oracle system**. Action: a new post of Systems Administrator is being created.
- **Operational managers and budget managers are trained in budget management**. Action: training has routinely been provided but more formal training is being implemented particularly to do with Foundation Trust status and Payment By Results.
- **The Financial Accounting Team is reinforced with new skills, either through additional resource or training**. Action: the intention is that the new Treasury Management and Capital post will bring more commercial skills to the Department and will have an in-house training role. In addition a budget of up to £10,000 is to be set aside in order to bring in external experts to train staff particularly with regard to the latest commercial thinking.

9.4 Recruitment and Retention

The Trust aims to be a model employer, to become an employer of choice for staff, both existing and potential. This will be vital if we are to attract and retain staff in a difficult and competitive labour market. To do so the Trust must continue to be viewed as an attractive employment proposition by staff. As mentioned above, the local area is an attractive place for young families to live. We must pay particular attention to our 'family friendliness' and offer work

opportunities that those with family commitments can take up if we are to fully tap the potential labour market locally.

The Trust will continue to refine and further develop its recruitment processes and systems to enable it to successfully attract the staff it requires to make an application to the Trust, and to then facilitate new staff to take up a post. Initiatives will include:

- Further development and use of e-recruitment (in particular 'NHS Jobs)
- Improved job packs and information about the Trust as an employer
- Development of initiatives to enable new staff to more easily take up their post (especially the temporary provision of accommodation)
- Improved induction processes to enable new staff to quickly fit in and equip them with the skills necessary to perform well in their posts.

The Trust, in partnership with South Wiltshire Primary Care Trust, has developed a Recruitment and Retention Strategy which addresses the above issues, and which has an associated workplan for 2005 / 2006. Monitoring the delivery of the Recruitment and Retention Strategy is the responsibility of the South Wiltshire Local Workforce Development Group (LWDG) chaired by the Trust's Chief Executive. The Trust is the major player within the LWDG, as the largest local employer and provider of health services. Individual initiatives are described in more detail in the Trust's Human Resources Strategy.

For the Trust to remain an attractive proposition for staff, they must be able to see their employment as supporting a career pathway, and be confident that the Trust will provide them with the development and employment opportunities to enable them to progress along their pathway. To a large extent such aspirations will often coincide with the Trust's desire to improve the skills and competence of its workforce and develop new roles and ways of working.

To assist with the difficulties in finding affordable housing, the Trust currently has 339 single units of staff accommodation on site, and 13 family flats and houses. The Trust has a further 21 single and double units of accommodation and 6 family houses available off site (NB includes Charitable Fund properties). The Trust recently opened a further 5 houses on the site to accommodate up to 20 members of staff. At the present time the Trust is working with its local public sector partners through the Wiltshire Strategic Alliance to identify and plan the

provision of key worker and affordable housing in order to meet present and future needs.

A housing needs assessment has been carried out. It has concluded that the Trust needs to review both the quantity of the staff accommodation and the standard that is offered. In addition the Trust needs to continue its partnership work with other organisations to help make available low cost housing to enable key workers to purchase their own homes.

9.5 Information Development

The development of information systems which meet the operational and business needs of the organisation will be fundamental to the success of the prospective Foundation Trust. Some of the priorities identified over the five year period of this strategy are to:

- Implement the Integrated Care Record System (ICRS) in accordance with the agreed programme
- Expand the computer network infrastructure to ensure timely speed of response as network usage grows
- Introduce an electronic document management system to ensure compliance with Freedom of Information legislation
- Introduce the Electronic Staff Record (ESR)
- Commission systems to provide real time information for the operational management of the Trust
- Implement clinical information systems which support care pathway working incorporating the requirements of the National Services Frameworks
- Increase capture of clinical outcome data and ensure data is collected to support (re)validation
- Collect and publish data which will enable patients to make informed choice on whether to be treated at SDH
- Achieve 100% clinical coding capture and increase role of clinicians in the coding of clinical activity. Additional clinical coders are being recruited now to achieve this aim.
- Ensure data quality remains at or above national standards. A data quality strategy and group dedicated to improving data quality are both well established.
- Increase data capture, eg ward attenders, outpatient consultations on wards
- Increase use of benchmarking data and improve data sharing with other organisations to improve shared care arrangements

9.6 Modernisation Programme

Last year the Trust began the Improving Partnership for Hospital Programme which is continuing to a conclusion in 2005/06. Three areas of activity were agreed; diagnostic redesign, discharge planning and capacity planning. Key targets include:

9.6.1 Radiology

- Reduction in MRI and CT waiting times by 66%
- Develop local 3 year waiting time targets for all modalities
- Reduce variation in reporting times to less than 10%
- Establish extended hours service for MRI
- Improve staff and patient satisfaction scores

9.6.2 Improving Discharge

- Reduce average Trust length of stay by 10% (measured against 2003 /04 figure)
- Improve median time of discharge to 2pm (from 7pm)
- Increase weekend discharges by 15% (measured against 2003/04 figure)
- Reduce the variation rate to 10% when measured by ward/consultant/HRG/day of the week.
- Deliver 90% compliance with Nurse Led Discharge Policy (measured through audit)

9.6.3 Capacity and Demand

- Ensure that the Trust is in the upper quartile for day surgery when measured against all 25 day case procedures
- Develop specialty based action plans to improve outlying new to follow up outpatient ratios (gynaecology, general medicine, ENT)

9.6.4 Other Projects

Separately there are a number of projects in hand or planned:

- Introduction of Choose and Book
- Computerisation of non-consultant clinics to ensure the activity is captured and income achieved
- Introduction of an Admissions Lounge with integral pre-operative assessment will allow increased day of admission, risk reduction for consent, and greater efficiencies on Surgical Wards who can focus on discharge arrangements
- Further development of our Hospital At Night Team to provide clinical expertise out of hours following the introduction of the European Working Time Directive

- The development of a fast throughput Genetics Laboratory facility which includes robotics and will speed up significantly the screening of samples for diseases such as breast cancer
- Participate in the Hospitals Medicine Management Collaboration to improve efficiency and risk reduction

9.7 Estate Development

9.7.1 Future Estate Plans

The Trust's Estate Strategy sets out the way forward for the estate through to 2012. Phase 2 is due for occupation by April 2006 and Phase 3 was granted outline planning permission at the beginning of this year and will be worked up into an outline business case during 2006. At that time the Trust will determine what is the most appropriate source of funding for the scheme, with FT status offering the Trust a potential alternative to PFI funding.

Medium and long-term site development plans will be accelerated as a result of the capital freedoms NHS Foundation Trust status may provide. Any acceleration would be dependant on robust financial modelling of the cost implications of developments proposed. The longer term plans developed will be consistent with the Trust's Estates Strategy, the Development Brief and this Service Development Strategy.

10 Risk Management

The Trust has a comprehensive risk management strategy, which provides a framework for managing risk and sets out clear expectations about the roles, responsibilities and requirements of all staff. The risk management strategy is designed to:

- Identify and prioritise the risks to the achievement of the organisations polices, aims and objectives.
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.
- Identify all financial risks to ensure immediate intervention is taken and progress/remedial action proactively managed.

The Trust Board monitors the implementation and effectiveness of the strategy. The Assurance Framework is the key tool used to inform the Board of those principal risks, which may, if not managed effectively, pose the greatest threat to the Trust in the delivery of the corporate objectives. This allows the Board to reinforce expand or develop controls and assurances in ensuring objectives are ultimately delivered.

The Assurance Framework is agreed annually by the Trust Board. The framework identifies the principal risks by risk assessing the delivery of the objectives outlined in the Service Plan, this includes achievement of the Standards for Better Health, meeting national targets, and also by analysing the Trust Risk Register. Once the principal risks are identified, an executive lead is designated to manage each of the risks. An Assurance Committee is also identified to assure the Board that each principal risk is being independently scrutinised to ensure key controls are in place, that assurances on controls are evident, gaps in controls have been identified, that positive assurances are effective, and gaps in assurances known.

The Assurance Committees meet quarterly to review progress against the Assurance Framework, and to identify any new principal risks, which may have arisen through the Trust Risk Register. The Risk Register clearly identifies the likelihood and impact of the risks to the organisation. The Committees report their assessments and action plans to the Board. Currently there are three Assurance Committees, which monitor different categories of risk. The Clinical Governance

Committee monitors all clinical principal risks, the Joint Board of Directors monitors operational and health and safety principal risks, and the Finance Committee monitors all the financial principal risks. The finance risks include any risk which threatens cash flow, activity, income or expenditure. The Audit Committee monitors the effectiveness of the Assurance Framework on behalf of the Trust Board

Clearly the Trust has in place longstanding and effective systems to manage clinical risk. The Trust has been refining its approach to business and financial risk since the introduction of the Assurance Framework and the Financial Governance Committee was established in September 2005. The need to develop Management Information systems to provide accurate and timely information is fully recognised and the Draft Terms of Reference refer.

10.1 Risk Management Analysis

The Trust Board have considered the risks involved in delivering the Service Development Strategy, and have assessed how best to manage each of these risks. (Appendix AP).

The risk assessment process involved firstly an analysis of each risk. This analysis sought to identify what may happen if the risk is realised in terms of productivity, finance, capacity, reputation and patient flows. The outcome of the analysis was then evaluated to identify current control measures and the effectiveness and adequacy of these controls. The information gained from the risk analysis and evaluation was used to apply a risk score to each of the identified risks. The risk score was made up of Consequence x Likelihood giving an overall risk descriptor, which was then applied to the risk assessment matrix (Appendix AQ).

The second part of the assessment involved the development of a risk management plan to ensure each risk would be monitored, evaluated and managed effectively.

11 Seizing the Future

11.1 Transition

Salisbury Health Care has been a successful NHS Trust and now has the significant opportunity to evolve and become a public benefit organisation. We believe that as a NHS Trust we would:

- Maintain its gains in performance
- Make progress to fully meet the core NHS standards
- Continue to balance the books
- Take forward its approach to patient and public involvement at a steady pace
- Not realise the full benefit of our relative efficiency under PBR
- Continue to struggle with fragmented ad hoc stakeholder involvement
- Take forward our plans for updating the estate and equipment at a pace dictated by our limited capital resource
- Continue to have difficulties with Commissioners in three Strategic Health Authority areas because of a lack of transparency in service level agreements
- Implement the Phase 2 development of the hospital

However as an aspiring Foundation Trust our view is that this position can be improved significantly. We will:

- Enhance our reputation as a high performing organisation
- Meet the core NHS standards and make progress on the developmental standards
- Begin to create a surplus through PBR and other new income streams
- Realise the full potential of a well developed membership/governor influence
- Begin to upgrade major equipment, in particular radiology
- Implement a Board development programme with a particular focus on risk management
- Introduce an enhanced performance management system to underpin control of the organisation
- Develop business cases to explore the opportunities offered by Foundation Trust status
- Achieve transparency of commissioning requirements through contracting arrangements

As the organisation gains experience as a Foundation Trust we will see:

- Performance consistently in the top quartile of NHS organisations
- Recognition by Monitor that we are a high performer under their compliance regime
- The NHS standards, both core and developmental were being met
- The full benefits of our PBR position in the organisation's finances
- Membership has grown and members involvement and influence in the organisation is routine and productive
- Equipment modernisation has happened
- All in-patient areas in modern facilities
- New facilities eg cardiac catheter laboratory, developed
- Appropriate existing services expanded and new services introduced
- Benefits being accrued from the introduction of NPfIT programme

11.2 Unregulated Services

If established the Foundation Trust would exist to provide health care to local people, and wider populations for tertiary and supra-regional services. In addition the organisation believes that there are a number of non-traditional opportunities which exist.

11.2.1 Spin Out Company

Salisbury Health Care NHS Trust formed Odstock Medical Ltd in 2005 following approval by the Department of Health. The Company will initially exploit the Trust's patented intellectual property in respect of the application of Functional Electrical Stimulation to assist walking following stroke and other medical conditions. The Trust is a world leader in the application of this technology and has recently received FDA approval to enable marketing in the USA. A partner has already been appointed to do this.

Partnerships are being developed under licence in other parts of the world. The Trust has not been able to adequately address demand and the formation of a Company under a focussed Chief Executive will facilitate a significant increase in sales. The business plan forecasts sales of £500,000 in the first year of operation rising to £1,225,000 after five years. Income in 2004/05 was £394,000 and the forecast growth is considered very prudent. Indeed it is expected that the Company will be the vehicle to exploit other technologies in due course.

Ownership of the Company is as follows: Salisbury Health Care NHS Trust 68%, Salisbury Health Care Charitable Trustees 18%, Bournemouth University 2%, and the inventors 12%.

11.2.2 Nursing/Residential Home

In early 2006 much of the southern part of the hospital site will be vacated when a number of clinical services transfer to the newly commissioned facilities in Phase 2. This vacated land presents a development opportunity but is limited by planning constraints of green belt. The land can only be used for health related activities and, therefore, the organisation will explore in the first year of operation the development of a nursing/residential home. In the local community there is a shortage of these facilities and informal discussions with private sector partners have indicated that such a location would be attractive.

11.2.3 Genetics Laboratory

The Trust houses one of the two national Reference Laboratories for Genetics. In mid 2005 a fast throughput facility was opened using the latest robotic technology. The Laboratory is at the forefront in the development of new techniques, which present opportunities for commercial exploitation.

11.3 External Partnerships

11.3.1 Approach

The Trust has welcomed the opportunity to involve our partners in the development of the application. A Project Board involved a number of them and their contribution and insight has been important. Specific consultation meetings and workshops have been held to gain detailed agreement to our plans. The proposed governance arrangements give a voice to many of our local partners whilst the public consultation process has allowed us to engage actively with many bodies in their own settings.

11.3.2 Key Relationships

(a) Patients and the Public

This significant group will be at the heart of the Foundation Trust and will be actively involved in the work of the organisation. The proposed constitution has been designed to ensure good representation from the three counties from which patients are referred. The Membership Strategy will see growth in numbers over time as the development of a membership which is representative of the local community.

(b) Patients' Forum

The Trust has an excellent relationship with the current Patient Forum for Salisbury Health Care. The Chair of the Patient's Forum was a member of the Project Board for the FT application. The organisation welcomes the involvement of the Forum in our work.

(c) Primary Care Trusts

This relationship will develop as changes to PCTs role and structure take place. The Trust will work closely with these organisations to ensure that information flows are timely and accurate to support business discussions. At the same time the organisation will support the demand management agenda which PCTs wish to undertake.

Within South Wiltshire an option appraisal is underway to decide the optional organisational configuration. One of the options, which has strong support within the local PCT, is for the Trust to take over the management of the provider arm of the PCT with commissioning moving to a bigger Wiltshire organisation. This option is the preferred direction of travel for community services in South Wiltshire. Work is underway to confirm the decision and to quantify the range of services, finances and manpower which would transfer to the Trust.

(d) Neighbouring NHS Providers

Strong links exist between the Trust and Southampton University Teaching Hospital as we provide tertiary services to each other. Together with Winchester the three hospitals collaborate in an ENT network which works to everyone's mutual benefit. At Bournemouth the Trust has a number of clinical links, for example Upper Gastro-intestinal cancer, and cardiac interventions.

Clinical networks are now a key component of NHS working. The Trust participates in cancer, critical care, neonatal care and coronary heart disease networks which are mainly Hampshire based and orientated. In addition there is a genetics network across the southern part of England as well as the cleft lip network with Oxford which covers nine counties of southern England.

(e) Strategic Health Authorities

The Trust relates to three SHAs and will maintain a good dialogue with their successor bodies to ensure that the Foundation Trust plays its part in the delivery of a Patient Led NHS and participates in collaborative working.

(f) Local Authorities

There are two major partnerships. Firstly, with Wiltshire County Council where our links for Social Services and Children Services are key for moving forward both the Older People and Children's NSFs. Secondly, with Salisbury District Council where our status as the largest employer in the area means that we have a role to play in the development of a sustainable community. Increasingly, this work is being undertaken via the South Wiltshire Strategic Alliance through its four priorities.

(f) Voluntary Sector

The Trust enjoys a very positive relationship with many voluntary bodies and wishes to enhance this work in the future. To reinforce this aim the local umbrella organization for the voluntary sector, the Salisbury Council for Voluntary Services, has been given a seat on the proposed Council of Governors.

(g) Academic Partnerships

The Trust has a mix of relationships depending on the professional group. Medical students are placed at the hospital from medical schools at Southampton, Bristol, and Kings, Guys and Thomas' in London. Nursing and Midwifery is based at Bournemouth which has a presence on site at the hospital to support students in practice. Physiotherapy and Occupational Therapy are at Southampton whilst Pharmacy is located in Portsmouth. The Trust values those relationships and the placement of students who are a good source for recruitment at the end of training.

The Trust aims to build closer links with its academic partners and encourage more departments to become research active, hosting and developing high-quality research projects. Improving access to research education and training will be fostered through the RDSU and academic routes to ensure Trust staff have the skills to interpret, take part in and lead research.

(h) Salisbury College and Local Schools

The organisation works with local education providers presently but will wish to enhance this relationship to ensure young people are made fully aware of the wide range of careers available in the NHS.

12 The Way Forward

Salisbury Healthcare Trust believes it has a strong case for becoming a Foundation Trust. The recently completed consultation exercise has shown a clear support for the Trust's application and has reinforced just how positively the hospital is viewed by its local population. This Service Development Strategy, together with the Governance arrangements and the Human Resources Strategy, provides a cogent analysis of how the Trust would seek to use the freedoms offered by foundation status to improve services for patients. The three documents show an organisation which is underpinned by a sound financial position and has a management culture which will ensure that this position is maintained and used to its maximum advantage.

The proposed Salisbury NHS Foundation Trust believes that it is prepared for the challenges of Foundation Trust status and will continue to approach the application process in a manner befitting a prospective Foundation Trust.