North Cumbria University Hospitals NHS Trust

NHS

annual plan | 2011-2012

Caring for North Cumbria
Your hospitals, our priority

North Cumbria University Hospitals NHS
NHS Trust

ANNUAL PLAN 2011/12

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Caring for North Cumbria
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1. Past Year Performance (2010/11)

1.1 Chief Executive's Summary

This section will be completed following the Trust Board review of the draft plan. It will refer to;

- The Trust has continued to provide high quality services under very difficult economic conditions.
- Large CIP however quality and safety were paramount.
- Responded to major incidents and flu surge – keeping acute services open
- Continued to be high performing provider – examples……
- Market changes particularly in relation to TCS, breast screening and GUM
- Turnaround internally focuses on 17 key workstreams based on efficiency and redesigning services. All have clinical leads and detailed plans which continue over next 12 months. In addition we are involved in 4 local health economy workstreams in partnership with NHS Cumbria.
- Continue focus on redevelopment of WCH and ensuring we develop long awaited facility which represents the best of healthcare technology and service provision.
- Commissioning intentions for PCI – exciting development which will benefit patients across Cumbria and successful proposal for Trauma Unit Plus status.
- Development of the Integrated Clinical Strategy based on 'One team – Two hospitals'

Having made the decision re M&A we must focus developing the integrated clinical strategy to next level with our primary care colleagues and securing a partnership with a high quality organisation which is equally committed to providing acute healthcare across north Cumbria. M&A must add value to north Cumbria services – critical period ahead to manage the process and ensure we achieve this.

1.2 Executive Summary

This plan provides an overview of our priorities and corporate objectives for 2011/12. These objectives have been revised to reflect the current financial drivers in the local health economy and the Board decision to seek a partner for merger or acquisition in order to achieve Foundation Trust status by April 2013.

Vision

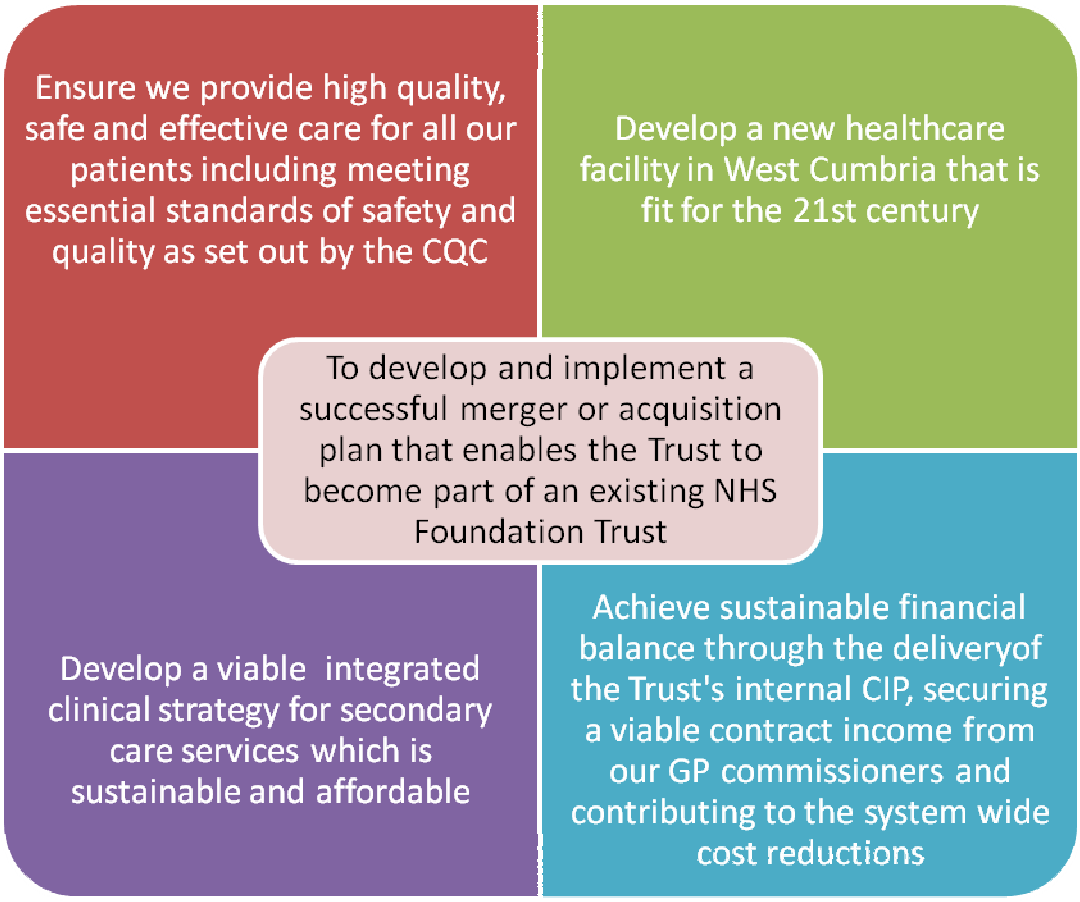
The proposed strategic vision for merger or acquisition is;

'We will deliver clinically sustainable and high quality acute services from two Hospitals in North Cumbria by becoming part of an existing Foundation Trust which delivers high quality safe patient care, and is financially strong.

Together we will develop an organisational approach and critical mass which will enhance access to acute healthcare for all patients across our catchment areas (north Cumbria and other) by combining the synergies of our clinical services and teams, developing high quality innovate service models and new integrated patient pathways.'

Strategic Aims

Our 5 key strategic aims have been revised to reflect the latest changes in policy and local market dynamics. The key challenges over the next 12 months.



Becoming a Foundation Trust Through Merger or Acquisition

In February 2011 the Trust Board concluded that the best way forward for the Trust to achieve Foundation Trust Status within the timescales set out in the White Paper, was to formally seek to merge with or be acquired by an existing NHS Foundation Trust.

This move was necessary in order to achieve the plans set out in the new government's White Paper, which requires all NHS Trusts to become Foundation Trusts by 2013. The decision was based on careful consideration of the following issues;

- Changes to the timeline available for Trusts to achieve Foundation Trust status as outlined in the White Paper: *Liberating the NHS* and the Operating Framework for 2011/12.
- Realigning the clinical strategy in partnership with GP commissioners at the same time as facing a challenging contract position next year.
- The challenge of providing two district general hospitals, based 40 miles apart, necessitating duplication of services within their current configuration, as well as below average activity levels, resulting in a higher cost base than the income the Trust receives.
- PFI scheme at Carlisle.
- National efficiency requirements and the repayment of historic debt further impacting on the overall financial position.

The project management arrangements have now been established and the timeline to complete the transitional arrangements is expected to take 12-18 months. The overall process will be led and managed by the Trust with support and direct input from NHS North West.

Quality Innovation Productivity & Prevention

Quality and patient safety is a key priority for the Trust and is an integral part of delivering our core business. The aim of the Trust is to ensure the Quality Risk Profile (QRP) for our services represents the very best of acute healthcare delivery meeting targets and standards as they are developed through CQUIN and the national outcome framework. The Trust has set specific quality priorities for 2011/12 which are described in this annual plan.

We also need to focus on productivity and efficiency in response the financial challenge facing the NHS. Integrated service delivery and structural change across all sectors of healthcare will be required if the NHS is to provide more care for less cost. Our internal turnaround plan is based on 17 workstreams. Each workstream has a detailed delivery plan led by a management and clinical lead. The workstreams are listed overleaf;

Turnaround Workstreams 2011/12		
• Estates productivity and efficiency • Pharmacy Reconfiguration • Radiology • Midwifery Review • AHP Review • Hospital at Night	• Outpatient Follow-up • Length of Stay • Procurement • Pathology Reconfiguration • Consultant Job Planning, Locums, additional sessions	• Theatre Efficiency • Nursing Reconfiguration • IM&T, Clinical coding and Forward • Financial Controls • Workforce – organisation structure and sickness • SBS – Finance and procurement

Regionally there is an expectation that the Cumbria health economy will return to balance through substantial structural change and delivering service differently. Our cost base therefore needs to be aligned to the local health economy requirements and ensure that achieve higher productivity whilst continuing to drive quality improvements across all aspects of our services. In addition to the internal workstreams there are 4 health economy workstreams which will be delivered jointly with NHS Cumbria. The workstreams cover unplanned care, planned care, diagnostics and repatriation.

Our key Trust-wide developments are:

- Develop and implement key stages of the integrated clinical strategy with GP commissioners
- Deliver the 17 internal turnaround workstreams and work in partnership with NHS Cumbria to deliver 4 health economy wide workstreams
- Deliver the nursing reconfiguration programme and develop the role of nurse leaders at ward level
- Improve Consultant job planning to ensure resources and priorities are aligned to commissioning intentions and the contract for acute services
- Deliver improved value for money for non-pay expenditure through key development in our procurement processes from product standardisation to use of framework contracts
- Redevelop the Hospital at Night service model
- Ensure consistency in the roll out of the Productive Ward programme across all inpatient areas
- Complete the programme for redesigning and rightsizing outpatient services
- Implement key IM&T programmes starting with real time ADT and E-rostering
- Improve value for money from estates and facilities including switchboard, space utilisation and outsourcing

Our key 2011/12 Divisional service developments are:

Division	2010/11 Priorities
Surgery	• Develop the surgical pathway to maximise patient experience and efficiency • Implement the Theatre Efficiency programme • Develop pre-assessment to minimise length of stay and cancellations • Develop the day case model/pathway • Consolidate out of hours surgery • Consultant job planning to reflect clinical priorities • Maximise the opportunity for becoming a Vascular Centre in the Cumbria and Lancashire Vascular service review
Medicine and Cancer Services	• Review stroke pathway and implement telemedicine • Consolidate cardiology and implement PCI • Develop community cardiology service model • Implement integrated Emergency care model • Develop hub and spoke model for specialist services • Implement the Trauma Unit Plus model • Implement Cancer Reform Strategy developments e.g. IMRT
Division	**2010/11 Priorities**
Child and Family	• Reconfigure midwifery services • Redesign gynaecology pathways – implement OP hysteroscopy • Introduce epidural service • Develop and implement paediatric assessment model
Clinical Support	• Implement Pathology and Pharmacy service reconfiguration • Improve radiology capacity through job planning and service redesign • Develop AHP service level agreement for West Cumberland Hospital

Financial Outlook

Our key financial targets for 2011/12 are:

- Meet all of our statutory financial duties, including a £1m surplus
- Deliver cost improvement programme of £15.3m
- Maximise our CQUIN income

- Invest our capital in a comprehensive IM&T programme, CT scanner and medical equipment
- The redevelopment of West Cumberland Hospital
- Continue the implementation and development of NHS Shared Business Services leading to paperless requisitioning in Procurement

2. Background and Context

2.1 Trust Profile

North Cumbria University Hospitals NHS Trust operates from two acute hospital sites providing secondary care to the residents of Carlisle, Eden, Allerdale and Copeland. The Trust was formed in 2001 when the Cumberland Infirmary in Carlisle and West Cumberland Hospital in Whitehaven were merged into one Trust.

The population base across the north Cumbria localities is 324,000 and there are also patient flows from Tynedale and nearby communities in south west Scotland. The north Cumbria communities are located in one of the most geographically remote and sparsely populated areas in England. Travel times to specialist tertiary care are amongst the highest in the country with over 2 hours travel by road from Whitehaven to the nearest tertiary centres in Newcastle or Middlesbrough.

We provide an extended range of "District General Hospital+" services such as a full range of cancer services (oncology, chemotherapy, nuclear medicine and radiotherapy), maxillo-facial surgery and rehabilitation medicine. In order to ensure there is local access to key services we provide paediatrics, maternity and A&E services on both hospital sites.

We have a strong reputation for providing high quality training and have well established links with the North East Deanery, Newcastle University, University of Cumbria and Lancashire University. Maintaining this reputation is key to ensuring the future sustainability of our services and our ability to recruit high quality staff.

Our local market is changing rapidly as Cumbria GP's become a pathfinder for developing the new models for involving front line clinicians in setting priorities and driving improvements in commissioning healthcare for their population. Arranged in 6 locality commissioning boards the GPs in Cumbria will work together to manage their local budgets and purchase services for patients. Whilst nationally GP consortia take on statutory responsibilities from April 2013 this is not a new process to Cumbria and the advanced work in localities and the Senate will drive the future market trends for secondary care in Cumbria. This will inevitably lead to some fragmentation as localities and providers balance individual priorities and private sector offerings with the need to ensure this does not destabilise essential services.

GP pathfinders will be supported by the National Clinical Commissioning Network, the National Leadership Council, and by national primary care bodies, such as the Royal College of GP's Centre for Commissioning. The support infrastructure is however at an early stage of development and the overall framework for accountability has yet to be confirmed. In the meantime we must anticipate the uncertainty this will generate in our local market. In response to these changes we have however established West and East Clinical Advisory Groups and a Trust wide Clinical Network which includes primary and secondary care clinicians and managers.

These groups will operationalise the integrated clinical strategy and provide essential clinical input into the development of clinical pathways and commissioning intentions.

2.2 Activity Trends in 2010/11

Activity trends by point of delivery are summarised in the table below.

Activity Type	2008/09	2009/10	2010/11
A&E Total attendances	66,049	71,798	71,416
Daycases	26,552	28,005	29,899
Elective Inpatients	9,370	8,686	7,842
Non-Elective Inpatients	30,728	36,963	36,318
Outpatient Attendances New	69,447	78,333	71,560
Outpatient Attendances Follow-ups	156,359	157,197	168,510
Outpatient procedures			43,038

During the last 12 months the following activity trends have been seen;

- Minor reduction in A&E activity
- Increases in day case activity reflecting changes to minimally invasive procedures
- Reductions in elective inpatient procedures reflecting the changes to day case procedures
- A small reduction in non-elective inpatient admissions
- A reduction in new outpatient attendances some of which is due to the reclassification of outpatient procedures

Whilst the commissioning intentions for 2010/11 anticipated substantial shifts in activity from secondary to community care this was not apparent in the demand trends in particular those driven by new GP referrals.

2.3 Financial Outturn and Performance for 2010/11

The Trust annual turnover in 2010/11 was £222,501k and 85% of our total income is from our contract with NHS Cumbria. The 2010/11 contract income agreed with NHS Cumbria took into consideration activity reductions which would be delivered through Closer to Home investments in community and primary care services. The full impact of these investments on demand for acute hospital services has yet to be realised as shown in the activity trend above.

The contract also included a schedule of Commissioning for Quality and Innovation (CQUIN) requirements which resulted in an income of £2.65m.

Trust's financial outlook for 2011/12 is summarised in section 6 but the table below highlights our retrospective 2010/11 performance against targets.

2010/11 Performance Against Financial Targets		
Duty	**Target**	**M12**
Breakeven Duty	To achieve a breakeven I&E	£1,356k surplus
Capital Absorption Rate	To achieve a rate of 3.5%	3.5%
Better Payment Practice Code	95% of payments within 30 days by volume and value	Red
External Financing Limit (EFL)	To achieve EFL	Green
Capital Resource Limit (CRL)	To remain within the CRL	Green

Income and Expenditure

The year end position for income and expenditure is expected to be in line with the forecast of £1m as shown above.

	Actual 2007/08 £000	Actual 2008/09 £000	Actual 2009/10 £000	Actual 2010/11 £000
Clinical Income	187,755	199,581	202,420	207,617
Other Income	10,069	12,655	13,678	14,921
Total Income	**197,824**	**212,236**	**216,098**	**222,538**
Total costs	(189,858)	(202,133)	(217,490)	(212,741)
EBITDA	**7,966**	**10,103**	**(1,392)**	**9,797**
Depreciation	(5,814)	(6,311)	(6,751)	(6,291)
Other gains & Losses				(212)
Interest	139	(104)	39	27
DC Dividend	(2,240)	(2,695)	(2,026)	(1,757)
Surplus/(Deficit)	**51**	**993**	**(10,130)**	**1,564**
Normalised Earnings				

Underpinning the Trusts overall financial position was the delivery of a significant and challenging Cost Improvement Programme (CIP) of £21m. The delivery of this CIP was £12.1m with a trajectory of £9.3m full year effect. Underachievement of the target was primarily due to the delays in developing and implementing key turnaround plans. However significant progress has been made since September 2010 starting with bed reductions on both hospital sites. Plans have now been developed for key projects which are a blend of schemes to deliver improved efficiency i.e. higher throughput within the same resource base, cost reductions and eliminating waste wherever possible.

Reference Cost Position

All Trusts are required to undertake an annual costing exercise as part of the National Schedule of Reference Costs submission. The output of the nationally collated information is an index which shows the Trust's cost base relative to the national average, where the national average is 100. A Trust reference cost index in excess of 100 indicates a relatively higher than average cost provider with a reference cost index of below 100 indicating a relatively lower than average cost provider.

The National Schedule of Reference Costs Index (NSRCI or RCI for short) has been announced for 2009/10. The Trusts index is 108, an improvement from 2007/08 which was 110. The inherent inefficiency of providing services over two sites, which are 40 miles apart, is a significant contributor to our running costs, which is reflected in the Trust RCI. Further reductions in the RCI are expected as the Trust implements comprehensive productivity programme to improve use of resources. The Trust will also use the indicators and comparison to peers (such as Better Care, Better Value indicators) as a marker for potential areas for cost improvement in future periods.

Capital Programme

The capital programme for 2010/11 is shown in the following table:

Category	Budget (000)	Investment (000)
2009/10 Schemes Carried Forward		
Dermatology	343	254
Laminar Flow	130	(30)
Disinfection	250	
Other Schemes	127	283
Medical Equipment		
CT Scanner (Radiotherapy)	750	451
CCU Monitoring WCH	250	
Patient Self Serve	24	24
Various Other Equipment	1,750	1,169
Major Schemes		
PFI Life Cycle Additions	0	1,375
WCH redevelopment	1,750	2,253
IM&T	1,500	1,182
Other Minor Schemes	450	275

The Trust received had an agreed Capital Resource Limit (CRL) of £11,261k. The Trust planned and underspend of £405k to conserve cash so that capital expenditure did not exceed internally generated resources (depreciation).

The Trust also agreed with the Department of Health that unused funds relating to the WCH redevelopment could be carried forward to 2011/12.

2.4 Trust Performance - Key National Healthcare Targets

We continued to improve on our existing track record for achieving national targets and standards. Whilst the Care Quality Commission (CQC) ratings have not been published this year we continued to make significant improvements as evidenced through our internal compliance system. The Trust has also successfully completed the Care Quality Commission registration requirements.

The following table summarises performance against key national targets:

Target	Outturn 2010/11	Target 2010/11	RAG
ACCESS			
Total Time in A&E 4 hours or less (Type 1 A&E only)	98.0	>=95	G
Median waiting time in A&E (hrs)	1.33	<=2	G
Percentage of admitted patients treated within 18 weeks	90.8	>=90	G
Median of admitted patients (weeks)	8.0	<=11.1	G
95th percentile of admitted patients	26.0	<=27.2	G
Percentage of non-admitted patients treated in 18 weeks	96.8	>=95	G
Median non-admitted patients (weeks)	4.9	<=6.6	G
95th percentile of non-admitted patients	15.0	<=18.3	G
CANCER WAITING TIMES			
14 day Cancer referral target – all cancers	94.5	>=93	G
31 day Cancer treatment target – first treatment – all cancers	98.7	>=96	G
62 day Cancer treatment – all cancers	88.7	>=85	G
31 day Cancer treatment target – subsequent treatment surgery	97.3	>=94	G
31 day Cancer treatment target – subsequent treatment drugs	100.0	>=98	G
31 day Cancer treatment target – subsequent treatment radiotherapy	95.9	>=94	G
31 day Cancer treatment target – subsequent treatment palliative	100.0	>=94	G
62 day Cancer treatment target – urgent screening referrals	95.8	>=90	G

62 day Cancer treatment target – consultant upgrade	100.0	>=85	G
14 day wait for symptomatic breast patients target	85.1	>=93	A
Rapid Access Chest Pain patients seen within 2 weeks	99.9	>=98	G

Target	Outturn 2010/11	Target 2010/11	RAG
EXISTING COMMITMENT INDICATORS			
Thrombolysis 60 mins call to needle	73.4	>=68	G
Delayed Transfers of Care	0.2	<=3.5	G
Cancelled Operations (%)	1.1	<=0.8	A
Cancelled operations - 28 day readmission (%)	2.6	<=5.0	G
Data quality on ethnic groups – completeness of Trust coding	93.3	>=85	G
Access to GUM clinics – 48 hr target (offered appointments)	100	100	G
NATIONAL PRIORITY INDICATORS			
Infant health - smoking during Pregnancy	16.0	<=18.95	G
Infant health – breast feeding initiation	67.0	>=68	A
Maternity HES – data quality indicator	16.3	<=15	G
QUALITY METRICS			
C Diff	57	<=120	G
MRSA	2	<=6	G
Risk adjusted mortality (CHKS data)	89	<100	G
Slips, trips and falls (inpatients)	1026	<1200	G

The Trust continued to perform very well against the new range of Department of Health's targets for access and cancer waiting time targets for referral and treatment. Furthermore performance against previous and new A&E targets was one of the best in the NHS North West region.

The required target level for thrombolysis is 68% and the Trust has made significant progress this year in exceeding this target for 5 months. The greatest issue in relation to this target is the rurality of our catchment area we will continue to work on action plans in conjunction with North West Ambulance Service (NWAS) in order to consolidate this performance.

The Trust continues to perform very well against the Department of Health's targets for reducing the incidence of MRSA bacteraemia; the trajectory for 2010/11 is 2 cases against a challenging target of 6. The Trust also achieved the performance target for C difficile with only 57 cases reported during the year.

2.5 Achievement of 2010/11 Business Objectives

In 2010/11 we continued our plans to deliver five strategic aims. The key priorities during the year reflected the continuous development of the organisation and a series of corporate initiatives relating to these aims were identified and agreed in the 2010/11 Annual Plan objectives.

A lead Director and responsible manager developed implementation plans for each initiative and have reported progress to the Trust Board on a regular basis. The year end position is currently under review and estimated position for Q4 is shown below:

Strategic Aim	2010/11 Corporate Initiatives	Outcome
Ensure we provide high quality, safe and effective services for all our patients	• Implement a comprehensive quality and safety improvement plan • Develop an integrated framework for quality governance and risk in line with external risk profiling (assurance, compliance and CQC registration) • Implement the Workforce Strategy to enable staff to fully contribute to the future development of our organisation and services • Ensure the Trust's systems and processes support the delivery of safe, high quality care • Implement effective workforce education and training programmes to support the delivery of high quality care • Ensure our hospital environment supports the delivery of safe care, including our responsibilities under energy and sustainability	All objectives are on track for delivery by year end with the following exceptions; AQ pathways Patient and public engagement toolkit Appraisals and mandatory training programmes Development of cadet and apprentice roles NHSLA level 2
Achieve sustainable Financial balance through comprehensive and challenging financial recovery programme	• Develop and implement a long term financial strategy • Develop a sustainable contract with our commissioners • Improve financial management and value for money • Develop and implement a commercial market strategy to support business objectives and DGH+ service model • Implement and deliver a robust CIP programme for 2010/11	All objectives are on track for delivery by year end with the following exceptions; ALE level 3 Service Line Reporting Minimum financial risk rating of 3 Market strategy for Choice

Strategic Aim	2010/11 Corporate Initiatives	Outcome
Develop and implement system change through comprehensive service reconfiguration	• Develop and implement a programme for increasing productivity, efficiency and maintaining performance • Develop sustainable and affordable service strategy	All objectives are on track for delivery by year end with the following exceptions; 90th centile performance for Daycase, pre-op bed days, length of stay, DNA rates and FUNs Developing anaesthetic service to increase theatre efficiency and provide epidural service at CIC
Develop a new healthcare facility in West Cumberland which is fit for the 21st Century	• Develop the OBC and FBC for SHA, DH and Treasury approval • Enabling works and delivery of the West Cumberland redevelopment project	All objectives are on track for delivery by year end
Develop our Trust to become a FT	• Well governed • Business Strategy • Financially viable • Legally constituted	The Trust continued progress in relation to key aspects of governance and the business strategy however the LTFM failed to achieve the required risk rating

All outstanding objectives and in particular those relating to productivity, cost improvement and the service strategy will be carried forward in terms of the 2011/12 objectives and outcome measures.

2.6 Other Major Issues

20010/11 Contract Arbitration

It is disappointing the Trust and its commissioner NHS Cumbria failed to reach agreement on the 2010/11 contract value and therefore went through the SHA managed arbitration process. The Trust maintained that it required a contract value of c £182m whilst NHS Cumbria contended that a contract value of £162m should be paid.

The outcome of arbitration settled on a contract value of c £172m. Within the arbitration context there were elements upon which the SHA supported the Trust and elements upon which the SHA supported the PCT.

The narrative supporting each element of the SHA outcome process is reflected within the table below.

Dispute Area	SHA Arbitration Decision
Line by Line Review – the Block contract has been set at the 9/10 outturn value of £42.499m.	SHA supported **PCT** position
Planned procedures not carried out for clinical reasons will be reimbursed at £250 per procedure.	SHA supported **PCT** position. Valued at c£600k
Best practice tariffs, the PCT should plan to pay best practice tariffs and reflect this within their financial plan.	SHA supported **Trust** position. Valued £307k
Premium for two site working and PFI.	The SHA supported the **Trusts** contention that there were additional costs in providing the commissioned service across two sites. Valued at £2.7m
New to follow-up out-patients (C2H) valued at £3m.	SHA supported **Trust** position
Unbundled tariffs (C2H).	SHA finds in favour of the **Trust** in that where the Trust provides some or all rehab the PCT will pay the full tariff. Value £260k
Zero length of stay for emergency admissions (C2H).	SHA supported the **PCT** in setting an upper limit at 9/10 outturn. Valued at £2.3m, however the SHA recognises that costs may not be quickly removed.
Transfers with a zero length of stay (C2H).	SHA finds in favour of **PCT**, valued at £21k.
Readmissions within 14 days (C2H).	SHA finds in favour of **PCT** to set upper limit at 9/10 outturn. Valued at £570k
Impact of 9/10 allocation adjustment.	SHA find in favour of the **Trust**, valued at £2.5m.
Non recurrent support following arbitration,	SHA find in favour of **PCT**, valued at £4m.
Impact of IFRS £1.2m	Trust to repay

Closer to Home and Demand Management

One of the key outcomes of the SHA facilitated arbitration process for the 2010/11 contract was that both organisations were asked to develop a clinical strategy and plan which incorporated key capital developments including West Cumberland Hospital, Cockermouth Community Hospital and a community facility in Cleator Moor. In addition the key findings of an NCAT review of the Closer to Home strategy identified a number of issues which needed to be addressed through a jointly developed clinical strategy which fully integrates services in an affordable and sustainable model.

In addition it was noted that the clinical strategy should interface coherently with the current turnaround plans for the Cumbrian health economy, that it should inform the Long Term Financial Model (LTFM) for the Trust and that it should also take account of the development of Transforming Community Services (TCS) in Cumbria. The key output being a clinically and financially sustainable model of future care within North Cumbria.

Two clinical engagement events were subsequently held involving the executive management teams and senior clinical leaders from NHS Cumbria, NCUHT and the GP locality areas. The two planning days were informed by the excellent work that had already been undertaken in West Cumbria where senior clinical leaders and GPs were already meeting to develop integrated service models linked to the redevelopment of the West Cumberland Hospital and the developments in Cockermouth and Cleator Moor. A number of work streams had already been established to support the Closer to Home strategy with the emphasis on building a health economy wide approach to ensuring health resources would be used to maximum effect and maximum levels of efficiency are achieved.

The two clinical engagement workshops held were held in January 2010. They focussed on how acute services in particular, could be effectively provided from the Trust's two hospital sites (the Cumberland Infirmary and the West Cumberland Hospital) making sure that the overall clinical strategy that emerged provided a framework for clinically safe and sustainable services for the population of North Cumbria.

All participants recognised and acknowledged that the workshops had been extremely productive in terms of identifying a sustainable framework for the clinical strategy. It was strongly felt that the outputs of this work should satisfy the NCAT requirement for demonstrating a whole systems approach to the future sustainability and viability of services within North Cumbria.

Developing The Integrated Clinical Strategy for North Cumbria

The background to the development of the clinical strategy is outlined above. The development of the clinical strategy reflects work that initially started in September 2010 with senior clinical engagement sessions being instigated in order to help develop integrated service models to underpin capital developments for healthcare facilities in West Cumbria, including the redevelopment of West Cumberland Hospital. This work was extended to include the wider North Cumbria footprint with the aim of developing a whole system strategy for a clinically and financially sustainable model of future care. The commissioning drivers for developing the strategy with the Trust are;

- To move beyond Closer to Home and develop a strategy which is clinically led, affordable and sustainable
- Distribute resources fairly across the county and invest in services in Barrow-in-Furness
- Reduce the cost of overall care in Cumbria through greater integration and highly efficient service models
- Building capacity based on the principles of 'right care, right place, right person' and ensuring the resources available are used to the maximum effect

In addition to the acute hospital strategy the strategy covers a wide range of primary and community healthcare services. The strategic plans and associated investment in these services are expected to reduce the demand on hospital based services and therefore have a direct impact on the clinical model for acute secondary care. The service models developed in the workshops are being fully costed to ensure there is a clear link with affordability and commissioning intentions. This work is also needed to underpin and support the following processes;

- The Trust and PCT turnaround plans
- The contract negotiations with NHS Cumbria for the 2011/2012 contracting round
- The Full Business Case for the new West Cumberland Hospital
- The due diligence process for merger or acquisition

3. Future Business Plans for 2011/12

3.1 Strategic Context

The new coalition government published the health white paper 'Equity and excellence – Liberating the NHS' in July 2010. This document set out the plan for a new direction and system which is the most radical change to the NHS since its creation. The Operating Framework for 2011/12 was subsequently published in December 2010.

The white paper aims to make the NHS more accountable to patients and free staff from excessive bureaucracy and top-down control. Patients will be at the heart of the NHS and will have more choice and control; supported by easy access to the information they need about the best GPs and hospitals. The Framework sets out the transition arrangements for national and local systems covering the NHS Commissioning Board, the economic regulator, GP Commissioning Consortia and the development of the Foundation Trust pipeline for providers. The four year transition period will enable the new arrangements to be tested and refined using models for 'early adopters' such as GP Consortia Pathfinders including the locality commissioning groups in Cumbria.

Key priorities in the Operating Framework for 2011/12 include;

- Continuing to reduce healthcare associated infections
- Reducing the emergency admission rate
- Eliminating mixed-sex accommodation
- Ensuring good and timely cancer screening services
- Being prepared to respond in a state of emergency such as pandemic flu outbreak
- Delivering good respiratory disease services
- Improving stroke outcomes

A brief summary the key changes which will impact on local systems are shown below;

	Commissioners	Providers	NHS Finance
Key Developments 2011/12	• GP consortia pathfinders to be extended with delegated responsibilities • Consortia will not be responsible for PCT debt • Commissioning support units to be developed including SEs and JVs • £2 per head of population allocation for commissioning consortia • AWP introduced for community providers • Clearer separation of providers and commissioners • Revised standard contracts to support AWP • Contract to include FUNs and sanctions applied to data quality and completeness	• Marginal rate for emergency admissions retained (30%) • National efficiency requirement of 4% • Best practice tariffs extended and new tariffs introduced • National priority is VTE • Quality framework with 31 new standards from NICE • Baselines for Outcomes Framework established • Choose and Book revised to reflect contract requirements • SHAs continue to support FT pipeline until 2012/13 • Guidance on application of Right to Provide to NHS • Reporting MSA breaches from April 2011 • No reimbursement for readmissions within 30 days	• Aggregate surpluses carried over for 2011/12 excl. capital • Average growth in PCT allocations is 2.2% • PCTs to secure post discharge support using £150m re-ablement investment • £648m separate allocation to support health and social care integration • 2% PCT budgets allocated for non-recurrent investments and risk • Two year pay freeze for staff earning above £21k • Potential freeze for pay increments • Tariff changes for Designated Major Trauma Centres from April 2011 • 2% efficiency requirement embedded in tariff, HRG4 for A&E, new trim point and local reduced tariffs

Other System Developments	• PCTs remain statutorily responsible until April 2013 forming clusters by June 2011 to consolidate capacity (managed consolidation) and reduce running costs during this period • SHAs remain accountable for leading transition and operational delivery during 2011/12 • The NHS Commissioning Board (NHSCB) will be established in shadow form during 2011/12 • The model for Health and Wellbeing Boards will be developed based on pathfinders with the aim having shadow arrangements in place nationally by the end of 2011/12 • All PCTs to divest community services by April 2011 • Running costs of the NHS will be reduced from £5.1bn to £3.7bn (45%) during the period of the spending review – including anticipated savings on functions transferred to the NHSCB • Gradual removal of controls on existing FTs with the staged introduction of the new regulatory regime • Relationship between NHS Commissioning Board, Monitor and CQC will be set out in greater detail with CQC key role in maintaining quality and safety during the transition period • MARS will be extended and include pre-authorised MARS to ensure capacity during the transition period

The quality and performance priorities will be underpinned by the NHS Outcomes Framework which will include key and new quality standards (est. 31 in total) will be published by the National Quality Board. Both developments will form the basis of the first mandate for the national NHS Commissioning Board.
Delivering change while maintaining performance against the QIPP challenge will be dependent on the flexibility of local systems and their ability to work across boundaries. This will be essential if local changes are to achieve the low running costs in the new system expected at the start and ensure they remain low in line with national projections.

During this period of substantial change all NHS organisations are expected to ensure there are rigorous processes in place to maintain quality and safety and thoroughly assess the quality impact of planned changes. In addition local systems are expected to maintain the improvements made to date such as waiting times, reductions in HAIs and QIPP targets all of which will continue to be monitored centrally. Any under-performance will trigger proportional action which could include intervention from the centre.

There is an expectation that plans are integrated at a local level (reflecting QIPP requirements) and are geographically based rather than functionally based. Each locality is therefore expected to have a clear strategic vision for improvements in quality and productivity and plans to ensure they support the transition to the new system and delivery of the NHS Operating Framework.

3.2 Strategic Commissioning for Cumbria

It is anticipated that the core basis of locality commissioning plans will largely reflect the NHS Cumbria plan which was published in March 2010. This plan set out how the PCT intends to integrate services in the future and release resources by building community capacity. It applies to all localities in Cumbria with a particular focus on Furness as a high priority for reducing health inequalities.

The base case scenario (incorporating QIPP plans) identifies almost £100m disinvestment across providers over 4 years, £47m of which is expected to come from this Trust. This level of disinvestment and efficiency is required to generate future surpluses which will fund a range of strategic investments including 'Closer to Home', mental health services and acute services for cancer and CHD.

In terms of delivering the next stage of 'Closer to Home' the development of the integrated clinical strategy has been described in previous sections in this plan. In addition to the acute hospital strategy the strategy covers a wide range of primary and community healthcare services. The strategic plans and associated investment in these services are expected to reduce the demand on hospital based services and therefore have a direct impact on the clinical model for acute secondary care.

Primary Care Developments

- Primary care recruitment and redeployment where GP to patient ratios are below the optimum (investment in Copeland, Furness and parts of Carlisle)
- Support practices with managing resources (medicines management and clinical interface teams)
- Integrate primary and community services to support the management of long term conditions (such as the service model for diabetes)
- Develop primary care 'federations' which support extended and enhanced out of hospital care (such as GPwSI services and minor surgery)

Community Hospital Developments

- Greater integration of GP practices with community hospital services (such as Cockermouth and Millom)
- Minor injuries units operating within a single governance framework with emergency floors on the hospital sites
- Integrated care teams, particularly for joint health and social care services
- Provision of a wide range of community services (ambulatory care) closer to home (diagnostic and therapy services, outpatient clinics, minor injuries and minor surgery, consultants outside hospital and respite care)
- Community hospital staff working within the bed complement and then out in to communities in 'virtual wards'; as well as linking-up with hospital settings to support more effective discharge
- Integration with the 3rd sector providing facilities in community hospitals

Community Services Developments

- Building GP led planning and delivery teams in each locality (transition arrangements)
- Fair shares reallocations in community based services
- Development of new service pathways for long term conditions and paediatric services
- Effective management of unscheduled admissions to hospital involving the co-location of A&E, PCAS and CHOC services

- More effective controls for referrals which have limited clinical value to the patient
- Providing alternative bed and service options for patients requiring post acute rehabilitation services

In addition localities are developing new integrated pathways for the following services:

- Musculoskeletal disorders
- Children's services
- Chronic Obstructive Pulmonary Disease (COPD)
- Asthma
- Heart Failure
- Acute coronary care
- Stroke
- Urinary tract infections (UTIs)

Responsibility for the delivery of community provider services transferred to the Cumbria Partnership NHS Foundation Trust on 1 April 2011. GP commissioners are therefore developing a full specification for service delivery funding which has been identified in the NHS Cumbria Financial Plan to allow for service developments.

The primary care and community service developments outlined above are reflected in the initial NHS Cumbria commissioning plans. These plans indicate a significant impact on assumptions for both non-elective and elective demand as follows:

Summary Impact of Commissioning Plan – patient activity

	2010/11 No.	Change No.	Planned 2012/13 No.	Repatriated No.	Total 2012/13 No.
Elective	34,800	-1,870	32,930	+3440	36,370
Unplanned	30,190	-4,470	25,720		25,720
Early supported discharge					
Excess beddays	13,760	-2,560	11,200		11,200
Outpatients - new	59,000	-3,470	55,530		55,530
Outpatients – follow up	142,620	-41,900	100,720		100,720
Outpatients - procedures	40,160		40,160		40,160
A&E attendances	69,000	-270	68,730		68,730

Summary Impact of Commissioning Plan – resources*

	2010/11 £'000	Change £'000	Planned 2012/13 £'000	Repatriated £'000	Total 2012/13 £'000
Elective	36,010	-3,800	32,210	+4,180	36,390
Unplanned	51,710	-14,200	37,510		37,510
Early supported discharge		-1,150	-1,150		-1,150
Excess beddays	2,900	-610	2,290		2,290
Outpatients - new	9,960	-820	9,140		9,140
Outpatients – follow up	12,800	-4,190	8,610		8,610
Outpatients - procedures	5,820	-140	5,680		5,680
A&E attendances	5,980	-200	5,780		5,780
PbR total	125,180	-25,110	100,070	+4,180	104,250
Non PbR	41,950	-6,590	35,360		35,360
CQUIN	2,540	-430	2,110	+60	2,170
TOTAL	**169,670**	**-32,130**	**137,540**	**4,240**	**141,780**

* This table includes the impact of the tariff deflator across 2011/12 and 2012/13, which is estimated at £4.4m in total across the two years.

Whilst the summary above highlights the planned levels of disinvestment there are repatriation opportunities. The value of the opportunities available to NCUHT to secure the repatriation of activity currently delivered by providers outside of Cumbria is estimated as £850k for 2011/12 increasing to just over £3m by 2013. This estimate is based on 2008/09 activity data which showed that approximately 3,400 non specialist elective episodes were undertaken out of county for the residents of the four north Cumbria localities (where NCUHT was already undertaking more than 10 episodes in that HRG in 2007/08).

The Trust and NHS Cumbria also has well advanced plans for the development of elective and primary PCI. There is an expected start date of September 2011 with the number of PCIs performed at Carlisle rising to 660 over a two year period.

In summary the key market opportunities for our Trust are:

- Investment in cancer screening and services in line with the national Cancer Reform Strategy
- Development of local cardiology and stroke services in the community and specialist services including PCI and stroke telemedicine

Whilst the PCT has confirmed its commitment to repatriating patients currently receiving care from out of area providers (including the development of PCI in cardiology) we will see further disinvestment in a wider range of our services through the development of Transforming Community Services by Cumbria Partnership Foundation Trust and this will represent a significant shift in our core services over the next 4 years.

The potential commercial risks to our business include;

- Development of integrated community services by Cumbria Partnership Trust e.g. appointed as lead provider for neurosciences
- Redesign of the COPD pathway and disinvestment in acute services
- Development of radiotherapy service at Kendal
- Capital developments in community hospitals using express LIFT
- Commissioning intentions out of line with contract and financial envelope

The PCT has now fully implemented commissioning at locality level, devolving planning and decision making to autonomous management teams operating Locality Boards. The model is developing at different rates in each locality and this represents some risk in terms of consistency and timing.

3.3 2011/12 Contract and Financial Outlook

Contract 2011/12

The key income reduction is £16.7 m by NHS Cumbria; this represents a 9.7% reduction against the 10/11 contract.

The PCT contractual reduction is a blend of volume and price proposals;

- Volume reductions are associated with reducing activities due to Closer to Home on a pure PbR basis
- Price adjustments are negotiable as per the operating framework

All other contractual income will remain relatively stable. The Trust will operate on a pure PbR basis with the exception of those items which remain within the block contract. The Trust will work through Deloittes to secure an improved contractual settlement.

2011/12 Financial Outlook

The Trust is planning for a surplus of £1m in 2011/12 based on a 'likely' set of assumptions, which includes NHS Cumbria's latest contract offer; the overall Trust income will be £208.8m, leading to a financial Cost Improvement target of £15.2m. £7.2m of the total CIP has been allocated to divisions in the base budget, leaving a balance of £8.0m still to be allocated. The Trust will need to secure £27.3 m of strategic support. The surplus is after making adjustments for dual accounting with the PFI being on the balance sheet under IFRS.

	2010/11	2011/12		
	Forecast £000	Likely £000	Best £000	Worst £000
Income	220,168	208,792	209,325	208,122
Expenditure				
Pay	(139,478)	(129,307)	(126,721)	(129,255)
Non Pay	(66,515)	(62,234)	(62,234)	(62,234)
Reserves		(7,002)	(7,002)	(7,002)
Cost Improvement Balance	3,951	8,068	4,948	8,686
Subtotal Expenditure	**(202,042)**	**(190,476)**	**(191,010)**	**(189,806)**
EBITDA	18,126	18,316	18,316	18,316
Interest, depreciation & amortisation	(14,713)	(15,316)	(15,316)	(15,316)
Surplus/(deficit)	3,413	3,000	3,000	3,000
Adjustment for Dual Accounting/IFRIC 12	**(1,932)**	**(2,000)**	**(2,000)**	**(2,000)**
Surplus/(deficit) – Breakeven Duty	**1,481**	**1,000**	**1,000**	**1,000**

The plans for the 2011/12 tariff were initially published in September 2010 and are an attempt to put into action the proposals set out in the revised 2010/11 Operating Framework and the Liberating the NHS white paper.

The changes to the tariff seek to deliver three priorities:-

- Incentivise quality and better patient outcomes (e.g. by expanding the coverage of the Best Practice Tariffs)
- Embed efficiency within the tariff (e.g. by setting prices for a number of high volume procedures at a level below their average cost)
- Expand the scope of the tariff (e.g. by introducing mandatory tariffs for renal dialysis and introducing new currencies in preparation for further expansion of the tariff in future)

The Operating Framework for 2011/12 begins the transition to the system outlined in the NHS White Paper, 'Equity and Excellence - Liberating the NHS'. This follows the largest economic downturn for many years. The consequences of the downturn are seen in record levels of public debt and the announcement that public sector expenditure will reduce over the coming years.

The funding for the NHS remains broadly flat over the coming years but we will be expected to treat more patients and use increasingly expensive drugs to manage an overall ageing population. The NHS has been asked to prepare for a freeze on funding of frontline services and asked to prepare for reductions in the health budget from 2011/12. The first signs of this impact are the reduction in the National Payment by Results Tariff and a pay freeze for all staff with the exception of the lower graded employees.

While the economic outlook and operating environment is challenging for all working in the NHS there are additional risks and opportunities for the local health economy. The Trust is in formal Turnaround and is jointly working with NHS Cumbria to formulate a strategy for the health economy which covers the next stage in the development of the NHS in Cumbria.

The key components of this strategy are to;

- Ensure the health economy gets back into financial balance and becomes sustainable for the future
- Develop a clinical strategy which delivers high quality care within the funding available
- Give an independent view of the cost of providing services across the Trust
- Quantifies the financial benefits of the Closer to Home strategy
- Supports the Trust in identifying a Foundation Trust merger partner

3.4 Trust Vision and Values

To ensure that the Trust is fit for the future and for the challenges ahead, our overriding aim is to provide the best possible clinical and personal care for our patients and local communities by getting best value out of every pound spent. Our vision reflects the significant national and local changes to the NHS environment and our market. In order to continue to deliver our aim the Trust will seek an alternative organisational form and our vision for this is described as follows;

'We will deliver clinically sustainable and high quality acute services from two Hospitals in North Cumbria by becoming part of an existing Foundation Trust which delivers high quality safe patient care, and is financially strong.

Together we will develop an organisational approach and critical mass which will enhance access to acute healthcare for all patients across our catchment areas (north Cumbria and other) by combining the synergies of our clinical services and teams, developing high quality innovate service models and new integrated patient pathways.'

Our values remain consistent with the NHS Values as set out in the NHS Constitution 2009.

Embed quality and safety at the heart of everything we do *To achieve this we will:*

- Treat our patients the public and each other with honesty and openness
- Promote and protect each individual's right to be treated with dignity and respect
- Measure and continuously improve the standards of safety and quality delivered to our patients
- Provide a safe and clean environment that promotes patients' comfort and well-being
- Support and develop our staff to deliver and achieve the best possible standards of care

- Measure and improve the experience of our patients and our staff
- Be polite, courteous and non-judgemental in our communication and engagement with each other
- Be caring, compassionate and kind to others

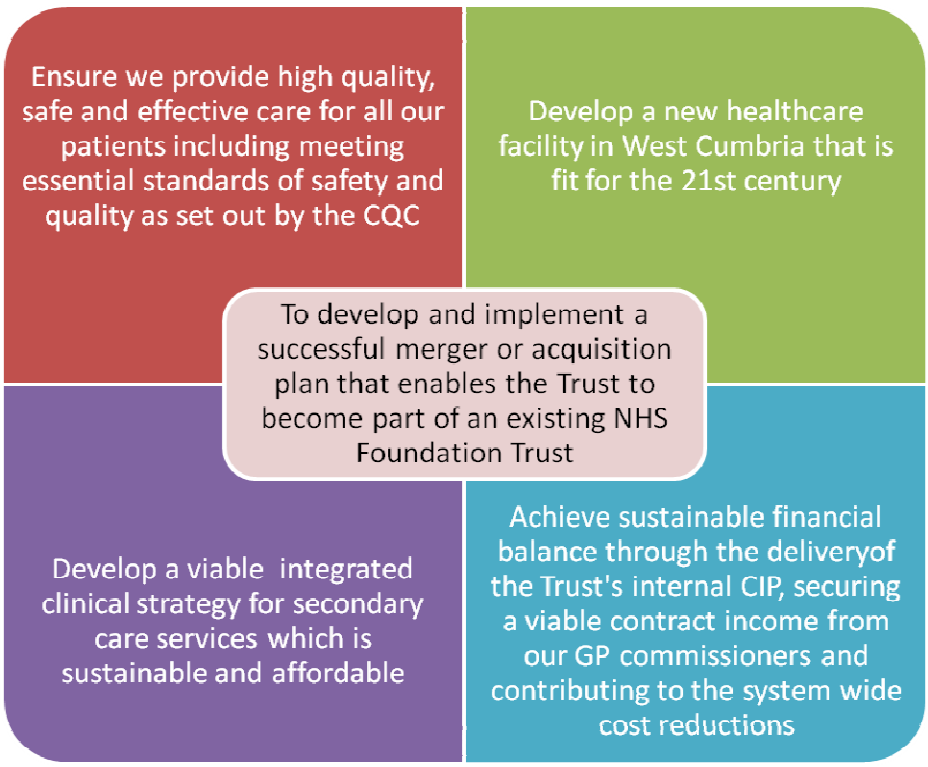
Deliver excellence at every turn *To achieve this we will:*

- Ensure we use our resources in the most efficient way
- Strive to get the basics right, first time, every time
- Practice efficient and effective team working by committing to achieving common goals in every team and department
- Encourage involvement and ownership
- Use evidence, best practice and innovation to develop our services for the future
- Learn from our mistakes
- Celebrate and encourage excellence across our organisation and build pride in our reputation
- Be responsible and accountable for our own and collective actions

3.5 Trust Strategic Aims

Our 5 key strategic aims are still highly relevant in this context however they need to reflect the timeline for reaching Foundation Trust status and the reality of the significant market changes in Cumbria.

The Trust's Strategic Aims have therefore been revised to as follows;



We also recognise that over the next year there will extremely challenging year on year efficiencies required in line with the national Public Sector Agreements, Comprehensive Spending Reviews and Operating Framework requirements for 2011/12. These can only be achieved through the following;

- Delivery of the Trust internal turnaround plan
- Development of a clinically sustainable and affordable integrated clinical strategy
- Delivery of the health economy turnaround plan involving the Trust and NHS Cumbria
- Development of a wider clinical network which will build on innovative service models and economies of scale
- Rightsizing our services and workforce in line with GP led commissioning intentions

In line with national and local strategy we have identified the following critical success factors in taking these aims forward;

- Having a coordinated approach to costing and operationalising the integrated clinical strategy – ensuring services are appropriately funded
- Implementing our HR strategy and policies which enable staff to fully contribute to the future development of our organisation and services whilst enabling the trust to reconfigure key services
- Ensuring we achieve quality and safety standards in line with 80th percentile performance through a comprehensive quality and safety programme
- Improving our operational efficiency to 90th percentile performance for key productivity measures
- Achieving all required CQC standards and KPI targets
- Developing and implementing a “Hospital at Night” model which will be clinically and financially sustainable
- Delivering the 17 internal turnaround workstreams and work in partnership with NHS Cumbria to deliver 4 health economy wide workstreams
- Maximising the use of our capacity across both hospital sites
- Developing and strengthening external relationships with our key stakeholders and locality management teams
- Fully engaging with PCT led service reviews and service specifications
- Improving the overall medium and longer term financial stability in line with a minimum Financial Risk Rating (FRR) of 3 as per Monitor criteria

Our Strategic Aims for 2011/12 have been set in the context of the acute service element of the newly developed Integrated Clinical Strategy. In parallel with the changes to community services outlined above the clinically led development of the acute hospital service element of the clinical strategy proposes:

- Revised service portfolios for the two hospitals as a result of reconfiguration work and the ethos of one service provided across two sites
- A single point of access through an integrated Emergency Floor which directs patients to the most appropriate service and reduces unnecessary admissions
- Improved clinical efficiency leading to further significant changes in workforce and bed capacity
- Integrated service delivery with primary and community services delivered through new ways of working such as consultants working in community and in-reaching to acute care
- Seamless transfer of patients across secondary (hospital based) services and community care
- Implementation of best practice approaches to follow-up outpatient activity, readmissions within 30 days and zero day length of stays etc
- Changes to referrals based on clinical priority and reducing activity with limited clinical benefit
- Use of secondary care capacity and the development of specific services such as PCI to repatriate out of county care

For West Cumberland Hospital the model means:

The new development will be a key facility designed to support the future models of care. Services will be sustainable reflecting strong integration with primary care. The aim will be to attract patients to WCH for designated elective care procedures beyond the existing catchment areas based on developing a reputation as the best service and facilities locally.

Clinical services will be provided by secondary care specialists based in the hospital but who also work into the community services. North Cumbria specialist teams such as Cardiology, ENT and Respiratory services will work across both hospital sites from a designated base. Senior clinical assessment will be provided through an integrated emergency floor staffed by a range of clinical professionals (from secondary and primary care) to ensure rapid assessment and care planning for patients. This could range from return to home with appropriate on going support, hospital care at West Cumberland or Carlisle, or out of county tertiary service provision.

For the Cumberland Infirmary this means:

The new models of clinical care will make the Cumberland Infirmary the main hospital site for complex and emergency care and more specialised procedures such as PCI services and it will be the hospital site that undertakes the majority of unscheduled emergency surgery in north Cumbria. Patients who currently travel out of the county for their care will be repatriated back to north Cumbria through better access and use of the overall capacity.

As with West Cumberland Hospital clinical services will be provided by secondary care specialists based in the hospital but who also work into community services along with integrated teams of primary care and secondary clinicians working together in the hospital. The north Cumbria specialist teams such as Cardiology and Respiratory medicine etc. will again work across both hospital sites. The clinical assessment and emergency floor will be consistent with West Cumberland and will be provided by a range of clinical professionals.

4. Strategic Objectives 2010/11

The strategic objectives for 2011/12 are summarised in the following sections:

4.1 Ensure we provide high quality, safe and effective care for all our patients including meeting essential standard as set out by CQC

During 2010/11 the Trust reviewed its key strategies for Governance, Quality and Risk Management and a new strategy was subsequently approved and implemented across the organisation. The new strategy is built on six core pillars of governance which continue to be integrated into the day to day delivery of care to patients:

In addition to the new strategy the Trust also embarked upon a review of clinical governance in 2010/11, which set out the following objectives to be achieved;

- To examine compliance and evidence of meeting CQC Essential Standards of Safety and Quality and how this information is shared with stakeholders.
- Independent assessment of the robustness of the Trust's Clinical Audit function.
- Independent assessment of the provision and monitoring of mandatory training across nursing, medical and non clinical staff.
- Independent assessment of the robustness of the Trust's system for the recording and monitoring of appraisals for all staff.
- Independent assessment of the robustness of the Trust's system for recording and monitoring compliance with NICE clinical guidance, including the reviewing of clinical guidelines based on best practice.
- To determine whether the Trust's strategy for Governance, Risk and Quality is fully embedded across all wards and departments in the Trust.
- To determine whether the current governance support structure is fit for purpose to support the implementation and development of effective clinical governance across the Trust.
- To determine whether all specialties have in place robust clinical audit and review systems, including external peer review and benchmarking to ensure effective clinical governance arrangements are in place for all clinical specialties.

The above objectives are scheduled to be completed in June 2011, which may result in potential areas for improvements to be made to further strengthen the Trust's

Governance arrangements. Any recommendations or priorities will form part of the Trusts key governance objectives for the year.

Focussing on quality

The Trust's first strategic aim states that we will ensure we provide high quality, safe and effective care for all our patients, including meeting the essential standards of safety and quality as set out by the Care Quality Commission.

The national focus on the quality agenda continues to grow and be fundamentally linked to the productivity and efficiency drivers that face all NHS organisations. In 2010 all NHS Trusts were required to produce a Quality Account, which outlined the quality of care that had been delivered to patients during that year but also set out specific quality priorities that would be achieved in the forthcoming year.
The Trust has set out the following quality priorities which will be delivered during 2011/12:

SAFETY

- All wards to implement the productive ward
- Reduce infections to agreed targets
- Improve our practice in relation to medicines management
- Reduce incidences of slips, trip and falls by the agreed CQUIN target %
- Reduce the incidence of # neck of femur following a slip, trip or fall
- Implement a robust process for patient safety walkabouts
- Reduce the incidence of hospital acquired VTE by 50%
- Reduce the incidence of hospital acquired Grade 3 & 4 pressure

EFFECTIVENESS

- All wards to implement the productive ward
- Review and implement the ward clinical indicators within 'AuditR'
- Implement the use and monitoring of the CHKS tool in all specialities
- Develop and implement the Trusts's performance and outcomes from national and local clinical audits
- Ensure all areas have consistent and robust review systems in place for mortality and morbidity

EXPERIENCE

- All wards to implement the productive ward
- Implement the patient and public involvement toolkit
- Increase our team of hospital volunteers
- Maintain single-sex accommodation
- Revised the complaints policy in order to ensuring the investigation outcomes result in lessons learnt.

In addition to the quality account priorities it is also important to outline the additional quality measures that will form part of the Trust's priorities during the year. These include:

- Ensuring full compliance with the CQC essential standards of safety and quality
- Achievement of NHSLA and CNST Level 2
- CQUIN Targets
- Advancing Quality Measures

4.2 Develop a viable integrated clinical strategy for secondary care services which is sustainable and affordable

Clinical models for the delivery of the Integrated Clinical Strategy are being developed in greater detail together with and independently costed final model. The key developments represented in the 2011/12 objectives are summarised below;

Future Clinical Models	
The Emergency Floor	There will be an Emergency Floor and integrated assessment service on both hospital sites which has three key components: • Single call handling and triage • Integrated assessment and treatment services • Community based urgent care service The Emergency Floor will integrate all the services currently delivered by CHOC, PCAS, A&E Departments and Nurse Practitioners. Community Hospital based minor injury services will be integrated with Community Teams however the new service operate under a single governance framework. The Emergency Floor will be staffed to provide senior assessment. The team will include A&E consultants, acute physicians, surgeons, GPs and nurse practitioners working shifts and sharing skills.. Rapid access to diagnostics and specialist support will include telephone and telemedicine.
Acute Medicine	Both sites will have a team of consultants operating as Acute Physicians working in the A&E and the assessment areas as part of the Emergency Floor. It is expected that all admitted patients will be reviewed the following morning by a senior physician (consultant or middle-grade) from the team for that ward to confirm the ongoing care pathway and to ensure a predicted length of stay is established prompt intervention or discharge.
Non Elective Care	There will be a range of skills and facilities available 24/7 to provide stabilisation, initial treatment and ongoing care in the place most appropriate to the clinical needs of the patient. This will involve transferring patients from West Cumberland Hospital to the Cumberland Infirmary and from both hospitals to other specialist units when and if required due to the severity and complexity of their problems.
Hospital at Night	A Hospital at Night system will be implemented on both hospital sites. The evidence is that it is efficient and can improve outcomes. A team led by Nurse Practitioners with senior medical support which could include primary care doctors who are working on-site at night in the Emergency Floor.

Elderly Care	The model of integrated working is expected to include a rapid assessment service, led by Elderly Care Physicians as part of the development of the Emergency floor. Elderly Care Physicians will also support primary care teams in General Practice, Community Hospitals and other community services.
Trauma & Orthopaedics	Standard orthopaedic trauma will be operated on in-hours on both sites particularly for elderly patients with a fractured neck of femur. As elective surgery is carried out on-site these patients will be scheduled onto theatre lists according to anticipated numbers. Patients should be discharged for rehabilitation in the community setting within 2-5 days but this will require unbundling of PbR tariffs to make this a cost effective proposition across network providers.
Acute Specialist Medicine	The full range of Acute General Medical Services will be available 24/7 and will be delivered in the most cost effective and clinically appropriate setting. Specialist rotas, for cardiology, gastroenterology, respiratory medicine, GI bleeding and stroke will be established on a single north Cumbria basis but serving both hospital sites. The model for cardiology will concentrate expertise on the Cumberland Infirmary site in order to facilitate the development and delivery of PCI and other interventions. In relation to stroke services the Telestroke initiative will provide local scanning, remote reading and assessment followed by thrombolysis as appropriate. Acute stroke services will be provided on both sites. In relation to GI bleeding a scoring system is used to identify patients at risk and those which will benefit from early endoscopy with possible injection therapy. This service will be at CIC. The majority of endoscopic intervention can be done within hours. Access to night-time advice is however needed and the ability to scope at the weekend will be required. Trust-wide rotas of all skilled staff, including surgeons will therefore be required taking into consideration as the GI physicians will be required to support acute medicine.
Maternity	There should be one consultant-led service delivered across two sites with a dedicated anaesthetist in support such to ensure emergencies can be responded to within 30 minutes. The implementation of cross-site rotas, particularly to cover the smaller number of deliveries at WCH, will be required. SCBU services will be at both sites, with increased use of nurse practitioners particularly at WCH. Anaesthetic cover at WCH should also be utilised to support other on site anaesthetic needs, prioritising obstetric care but not constrained only to obstetric care given the low levels of anaesthetic obstetric activity.

Children	The hospital element of an integrated local service will be provided at both hospital sites. It will include robust assessment, rapid response and hospital at home services supported by the paediatricians working in the community, in-reaching into the hospital assessment services and working as part of the Emergency Floor. Senior A&E practitioners will have advanced paediatric life support skills. The Cumberland Infirmary will provide a full range of inpatient, outpatient and paediatric assessment and treatment services. Further modelling of paediatric inpatient beds needs to be undertaken. At West Cumberland Hospital there will be a senior paediatrician presence as part of the Emergency floor team at peak times to reduce the need for hospital admissions. There will be a paediatric assessment and treatment service (PATS) acting as the front end of the hospital, supported by a paediatric short stay assessment unit of 5-8 beds.

Achieve sustainable financial balance through the delivery of the Trust's internal CIP, securing a viable contract income from our GP commissioners and contributing to the system wide cost reductions

The Trust has a comprehensive internal turnaround programme which consists of 17 workstreams. The combined cost improvement of this programme is in the region of £7-8m. Additional schemes will be developed with the aim of identifying an additional £8m cost reductions. The turnaround programme worksreams are listed below;

Turnaround Workstreams 2011/12		
• Estates productivity and efficiency • Pharmacy Reconfiguration • Radiology • Midwifery Review • AHP Review • Hospital at Night	• Outpatient Follow-up • Length of Stay • Procurement • Pathology Reconfiguration • Consultant Job Planning, Locums, additional sessions	• Theatre Efficiency • Nursing Reconfiguration • IM&T, Clinical coding and Forward • Financial Controls • Workforce – organisation structure and sickness • SBS – Finance and procurement

In addition to these workstreams expenditure controls will need to be in place to ensure all budget holders adhere to pay and non-pay budgets. Particular emphasis will be required on the following aspects of the programme;

- Delivering improved value for money for non-pay expenditure through key development in our procurement processes from product standardisation to use of framework contracts
- Improved data capture and coding to accurately reflect the services delivered
- Reducing expenditure on high cost locum staff to within Directorate budgets
- Delivering the nursing reconfiguration plan and developing the role of nurse leaders at ward level

- Improving Consultant job planning to ensure resources and priorities are aligned to commissioning intentions and the contract for acute services
- Redeveloping the Hospital at Night service model
- Improving the value for money from back office functions and estates and facilities services including managed service options

In addition to the internal turnaround programme the Trust will fully participate in the health economy turnaround plans for;

- Planned care
- Unplanned care
- Diagnostics
- Repatriation

The Trust will work with the PCT and external advisors to ensure that the new clinical models are appropriately costed. In addition the Trust will pursue all income associated with contracted activity and 3rd party services provider to provider services at market and PbR rates.

4.3 Develop a new healthcare facility in West Cumbria that is fit for the 21st Century

This major scheme continues to be a key strategic aim for the Trust. Over the last 12 months the Trust developed the Full Business Case for the redevelopment and obtained planning permission. However during the year the changes to Development Agencies post election led to a reduction of £10m funding for the scheme.

During the last 12 months the Trust has worked with key stakeholders including mental health services to ensure the scheme reflects the capital envelope and provides best value for money. This included reviewing the overall design, reprovision and reduction of overall floor space. This has also been undertaken in conjunction with clinical commissioners to ensure the underpinning clinical models are high quality, safe, sustainable and financially viable.

The draft clinical strategy is now published and an external review of affordability is being undertaken as described in other sections of this plan. The key milestones for 2011/12 predominately relate to the next stages of approval for the Full Business case for this project and enabling works as follows;

- Approval of the Full Business Case by the Trust Board in May 2011
- Commencement of J Block works in May 2011
- Submission of the Full Business Case to the PCT Board in June for letter of support
- SHA approval of the Full Business Case in July 2011
- DH/HMT approval of the Full Business Case in September 2011
- Start new build on site October 2011
- Completion of J Block works and decanting of Yewdale Ward in February 2012

Completion of the new build aspects of the scheme are expected to be completed by June 2015 with final demolition following by March 2015. Sitting alongside the approval process and enabling works key negotiations on the guaranteed maximum price will be completed in Q1 2011/12 and the approval of the procurement strategy will be secured before the DH review of the Full Business Case in September 2011.

4.4 To develop and implement a successful merger of acquisition plan that enables the Trust to become part of an existing FT

There are a number of routes which the Trust could take in managing the merger and acquisition process based on similar initiatives such as Trafford, Barts,The London and Whipps Cross, Ealing and North West London. SHA support for the preferred approach is also key to ensuring the timescales set out in the Tripartite Formal Agreement are achieved.

To date the Trust has identified a number of neighbouring Foundation Trusts which may respond positively to an invitation to partner with our Trust. We have reviewed the management arrangements in other merger and acquisition projects and have sought extensive external advice on the options available. In line with the Trust's preference to identify a suitable partner at the earliest opportunity we have agreed an accelerated option appraisal process with the SHA which engages, assesses and selects a preferred partner in a fully transparent and inclusive way involving key stakeholders and our commissioner NHS Cumbria.

The process must be sufficiently robust and able to sustain external scrutiny by ensuring any risks associated with external challenges either by potential partners or stakeholders are effectively managed throughout the process. The key requirements for a robust process are;

- An approach based on local needs and the lessons learned nationally from projects at a more advanced stage
- Clear project governance which includes external assurance
- Inclusive approach to all interested parties
- Robust criteria which reflect 'must do' requirements for the future delivery of acute healthcare in north Cumbria e.g. financial viability, patient safety and quality of service, pathway development, clinical synergies and ability to achieve economies of scale and maximise the use of current estate
- Regular briefings on process for relevant MPs
- Stakeholder engagement at an early stage in process – internal and external
- Management of key external relationships through a 'neutral' third party

The Trust Board has a key role in confirming the strategic objective for the merger or acquisition and in developing a robust set of criteria which will be critical to ensuring the future organisational form provides high quality acute care for the people of north Cumbria.

The proposed timeline for the overall process;

	Start Date	End Date
Key milestones - phase 1		
Establishment of Project	March 2011	May 2011
Determining entity for acquisition	April 2011	May 2011
Board agreement on criteria for partner selection	May 2011	May 2011
Information process and development	May 2011	September 2011
Partner selection move to phase 2	September 2011	October 2011

Key milestones - phase 2	
	End Date
Confirm Board decision to move to phase 2	1st November 2011
Confirm and gain agreement to and approvals for transaction type *(formal acquisition by contract or franchise)*	January 2012
Develop and agree revised project plan to deliver phase 2	January 2012
Agree process for phase 2	January 2012
Commence process	February 2012
Commence transaction development and approvals period	May 2012
Approvals achieved – Monitor, CCP, DoH Contract exchange	September 2012
Dissolution of North Cumbria University Hospitals NHS Trust Contract Completion Transfer of all assets and liabilities	31st October 2012

As stated above the development of the evaluation criteria used in the assessment and selection of a preferred partner is a critical success factor and must therefore be developed in a robust way involving key internal stakeholder groups. This is one aspect of the process which will be subject to a great deal of scrutiny in terms of whether the criteria are evidence based and how the Trust has applied the criteria in selecting a preferred partner. The process needs to be transparent and able to respond confidently to any challenge from a potential partner which has been unsuccessful.

There are a number of lessons learned from other similar projects engaged in this process and the development of the assessment criteria will utilise external support from specialist advisors. Whilst we are cognisant of the need to consider essential economic criteria (and that these will play a key part of the evaluation) however we intend to extend the criteria to include other key factors such as;

- Quality of service currently provided and patient safety including clinical outcomes and patient satisfaction
- Pathway requirements including cancer pathways
- Accessibility of future services for the population in north Cumbria
- Providing high quality services - outcomes, patient satisfaction etc.
- Potential for redesigning and modernising services through larger multidisciplinary clinical teams

- Potential for workforce development including new roles and ways of working
- Understanding and experience of rural population health needs and culture
- Proposal for delivering the WCH redevelopment
- Potential for efficiency, productivity and asset utilisation including high cost capital equipment
- Training and education strengths and ability to sustain training programmes
- Success in commissioning and contracting
- Organisational capacity and impact on exiting services

4.5 Divisional Priorities

Our key 2011/12 Divisional service developments are:

Division	2010/11 Priorities
Surgery	• Develop the surgical pathway to maximise patient experience and efficiency • Implement the Theatre Efficiency programme • Develop pre-assessment to minimise length of stay and cancellations • Develop the day case model/pathway • Consultant job planning to reflect clinical priorities • Vascular service review – future status of service
Medicine and Cancer	• Review stroke pathway and implement telemedicine • Consolidate cardiology and implement PCI • Develop community cardiology service model • Implement integrated Emergency care model • Implement Cancer Reform Strategy developments e.g. IMRT • Develop hub and spoke model for specialist services • Implement the Trauma Unit Plus model
Child and Family	• Reconfigure midwifery services • Redesign gynaecology pathways – implement OP hysteroscopy • Introduce epidural service • Develop and implement paediatric assessment model

Clinical Support	• Pathology and pharmacy reconfiguration • Improve radiology capacity through job planning and service redesign • AHP service level agreement for West Cumberland Hospital

4.6 Corporate Service Development Plans

Streamlined Pathways

Given the national strategic agenda the Trust will focus on pathways developments across all services maximising any opportunities for simplifying and shortening the patient journey. Increasingly pathways will be integrated across all aspects of health and social care minimising unnecessary duplication and delays.

Comprehensive IM&T Programme

The 2011/12 capital programme includes a major commitment to delivering a comprehensive programme of IM&T projects designed to support quality and efficiency. The focus of the programme is improving access to clinical information via a clinical portal and more effective use of clinical resources through Admission Discharge and Transfer systems, voice recognition and automation.

5. Workforce, Training and Education

In 2011/12 we will need to make further progress in aligning our workforce profile to activity and income. This year workforce planning has been introduced as a core aspect of the annual planning process ensuring we are working across divisions to implement realistic workforce changes. The key aspects of the supporting workforce plan are;

- Identify roles suitable for role-redesign and skill mix focusing on band 4 with reductions at higher bands
- Develop a more comprehensive selection of HR performance metrics to identify opportunities for improvement and areas of good practice
- Reduce sickness absence from 5% to the national average of 4.2%.
- Increase the uptake of appraisals to 90% encompassing the concepts of competencies and continuous professional development.
- Implement a comprehensive programme to improve staff satisfaction
- Continued workforce controls
- Introduction of a voluntary severance scheme to support reduction in capacity and service reconfigurations?

We also need to continue to decrease flexible workforce costs particularly in relation to locum medical staff.

Equality and Diversity will need to be taken into account when updating and introducing new policies. The Trust needs to ensure progress on the action plan for all the equality and diversity work streams.

We recognise that we need effective staff engagement and communication if we are to deliver our strategic aims and objectives. In 2009/10 the Trust Board approved a comprehensive Organisation Development Strategy which was designed to support the organisation and our staff in delivering major service changes over the next 10 years. This strategy will be developed further in conjunction with the merger and acquisition process.

A three to five year Education and Training Strategy has been recently developed. In 2010/11 we need to ensure that the Education and Training strategy becomes a reality and that we have a robust plan for implementing the strategy. The strategy sets out key priorities for the following;

- Transforming our organisation into a learning organisation
- Developing a culture that Training and Education is everyone's responsibility and should be central to all activities in our day to day working
- Promoting enhanced leadership and a formalised framework for delivering and evaluating for education and training
- Ensuring a more embedded MDT approach to education and training across the whole organisation.

The Training and Education function has been developing over recent years with employees having undertaken various qualifications in clinical education through the University of Newcastle. The next step to embed this investment is to clarify funding, ensure appropriate job plans and gain clarity around capacity for formal education roles and informal teaching roles. This will include the formalisation of some existing roles. The strategy will be delivered through a formalised education and training structure which incorporates both medical and non-medical education.

The strategy recognises the following key issues and challenges;

- The plans for the WCH development are outlined in the clinical strategy however until final clinical models are developed the future sustainability of formal medical training programmes dependent on activity and staffing levels has yet to be established.
- There needs to be tighter procedures for the policy for study leave and payment to ensure the Trust receives value for the investment.
- There is a lack of consultants wanting to get involved in recruitment of junior doctors. It is hoped that interest will improve if the profile of education and training is raised within the Trust. We must support clinicians through the job planning process to ensure they are comfortable with their educational commitments.
- Increased uptake of mandatory training and educational appraisal is requires and streamlining the current systems will make them more user friendly. More team learning would be possible with access to IT training facilities so that completion of mandatory modules becomes easier
- Documentation and process around re-validation is high priority and will need capacity.

This year the Training and Education department is organising an annual planning day involving key stakeholders which will centre around business and succession planning and formalised CPD.

6. Financial Plan

6.1 Cost Improvement Plan

The Department of Health has confirmed that the efficiency target for 2011/12 will be 4%, and has indicated that this will be broadly consistent in future years as the health service attempts to save £15 – 20bn over the next 4 years due to the rate of funding available to cover the cost of inflation reducing.

To deliver these levels of cost reduction the Trust will be required to review all of its services, with a view to improving the quality and reducing the cost. Increased use of information technology will contribute to the savings with new systems being implemented which will release time for clinicians and improve governance arrangements.

2011/12 is likely to be a difficult year across all public sector services and the Trust is no exception to this. Specifically the organisation must balance the financial impacts of reduced levels of income, a high level of cost and efficiency savings whilst maintaining the highest standards of care provision. The Trust's income is forecast to fall in 2011/12 by £14.7m to £208.8m in 2010/11. Cost pressures for the forthcoming year include price inflation as a result of VAT increasing in January 2011 and the overall rise in inflation.

The efficiency target of £15.2m for 2011/12 represents 7.3% of the Trust's turnover. Achievement will be through a combination of productivity improvements, cost reductions and the delivery of more hospital services to local patients who currently travel outside of the health economy to receive their care.

Achievement of the target will address the historic underlying issues but will not address historic debt nor income shortfalls.

The national payment system to the Trust, Payment by Results (PbR), has not had any significant changes this year, however there has been an expansion of categories for patients who attend A&E departments. Overall the national tariff has reduced by 1.5% for 2011/12.

Outline of CIP	
	£000
4% National Efficiency	7,702
Shortfall of recurrent 2010/11 CIP	7,415
Other	115
Total CIP	**15,232**

With any cost improvement programmes of this size they are not without their risks. Our main risks and mitigations are as follows:

- Risk - Additional schemes are not fully identified in Quarter 1.
  Mitigation - The Trust is working with the support of Deloitte and the economy wide turnaround process to identify further opportunities to supplement existing schemes.

- Risk - Management Capacity

Mitigation - additional resource has been secured specifically to support the pivotal CIP programmes within Theatres and across the organisation on procurement.

- Risk - staff engagement cannot be maintained.
  Mitigation - Additional communication through post masters and further clinical engagement programmes have established to support maintaining organisational engagement.

6.2 Capital Programme

The Trust's capital programme for 2010/11 is £5.1m in addition to any funding agreed for the West Cumberland Hospital redevelopment by NHS North West and the Department of Health.

This level of investment will remain reasonably static over the next 4 years as all capital expenditure will be funded through internally generated depreciation. £5.1m includes further investment of £1.0m in information technology, in particular in relation to clinical systems to improve governance and efficiency, and over £2.2m in new medical equipment, including a new CT scanner in Radiology and an upgrade of the Trust's sterile services equipment.

Environmental and health and safety work will also be undertaken as we progress through the year. We will also continue to work with NHS North West and the Department of Health to get final approval of the Full Business Case for the West Cumberland Hospital redevelopment.

	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	Total £000
Minor Works	250	250	250	250	250	**1,500**
Minor Medical Equipment	1,1150	650	650	500	1,050	**4,000**
Major Medical Equipment	1,100	1,500	240	-	1,300	**4,140**
IM&T	1,000	1,000	1,000	1,000	1,500	**5,500**
WCH Redevelopment	1,500	1,750	2,750	2,500	-	**8,500**
Unallocated	70	20	35	35	235	**395**
CRL	**5,070**	**5,170**	**4,925**	**4,285**	**4,585**	**24,035**

7. Risk Analysis

During the next stage of the annual planning process the Executive Team will identify the principal risks associated with each of our Strategic Aims. These risks will be incorporated in the Assurance Framework at the beginning of the financial year.

The Board reviews the management of the Trust's Assurance Framework on a quarterly cycle and the Audit Committee undertakes a detailed review twice a year with the principal aim of:

- Scrutinising the systems for the effective management of risk
- Ensuring the organisation has in place an effective Assurance Framework

- Supporting the development of the organisations statement on internal control
- Assisting with determining the internal audit priorities and annual plan

All risks have an indentified Director and Lead manager responsible for monitoring and delivering mitigation plans. Key controls for each risk are identified together with assurance on these controls and any gaps in control.

The assessment of key risks for 2011/12 Framework will be undertaken later this month and will include a short list taken from the following table:

Strategic Aim	Potential Risk
Ensure we provide high quality, safe and effective care for all our patients including meeting essential standard as set out by CQC	• Impact of Merger and Acquisition process • Impact of turnaround workstreams • Non delivery of national targets • Non compliance with CQC core standards • Non delivery of CQUIN • Not embedding Governance Strategy at Divisional level • Failure to learn from complaints and SUIs • Inadequate obstetric anaesthesia • Non achievement of NHSLA and CNST level 2 • Failure to deliver IG standards • Failure to meet HCAI targets • Non compliance with Health and Safety legislation • Failure to ensure business continuity in the event of a major incident or Pandemic Flu outbreaks
Achieve sustainable financial balance through the delivery of the Trust's internal CIP, securing a viable contract income from our GP commissioners and contributing to the system wide cost reductions	• Failure to deliver turnaround workstreams • Failure to agree financial model for the Integrated Clinical Strategy with commissioners (affordability test) • Non-pay expenditure and Locum expenditure continues to exceed budget • Lack of completeness, timeliness and accuracy of coding affecting income • Inability to secure tariff plus premium • Insufficient capital resources • Potential fragmentation in commissioning process/intentions across localities • 'Cherry picking' by alternative providers in primary and community care • Local health economy financial viability and lack of delivery of joint turnaround workstreams • Contribution to shared service costs and support services from community and mental health provider
Develop a viable integrated clinical strategy for secondary care services which is sustainable and affordable	• Failure to deliver acute sector elements of Integrated Clinical Strategy • Failure of commissioners to deliver primary and community service elements of the Integrated Clinical Strategy • Failure to deliver 'one team – two hospitals' model in key specialist services • Failure to implement Hospital at Night and EWTD model • Non delivery of service improvement in elective care, outpatients, theatres and critical care • Inability to deliver schemes to 'right size' the workforce • Unplanned service developments • Lack of stakeholder support for service changes

Develop a new healthcare facility in west Cumbria which is fit for the 21st Century	• Failure to maintain existing estate • Failure to get stakeholder support and approval for FBC • Failure to develop FBC based on sustainable and affordable service models • Procurement risk • Risk re affordability and SSDP

Strategic Aim	Potential Risk
To develop and implement a successful merger of acquisition plan that enables the Trust to become part of an existing FT	• DH approval of the TFA • Failure to attract a high quality partner with appropriate cultural fit • Ability to maintain objectivity and local control of process • Failure to realise added value and 'protect' key assets through a partnership • Failure to secure local access and delivery of key services • Lack of staff support for the process and preferred option • Stakeholder management and support for preferred option • National and/or local inquiries which result in a negative impact on reputation

8. Governance

During 2010/11 the Board received updates on progress / status of the delivery of key corporate objectives, which have been 'traffic' light rated. It is recognised that a key area of development for the organisation and Board is developing the assurance and risk management process. Accordingly, in addition the strategic objectives set out in the plan for 2011/12 specific objectives to strengthen the Trust's governance arrangements have also been defined.

8.1 Risk Register Reporting and Assurance Framework

The principal document for the Board to monitor the key risks associated with the delivery of it's objectives is the assurance framework. The Assurance Framework was redesigned in 2010/11 to allow the Board to monitor the delivery of it's objectives as well as the management of strategic risks. The Assurance Framework will therefore be reported to the Board on a quarterly basis throughout the year;

Q1	Q2	Q3	Q4
July 2010	October 2010	January 2010	April 2011

The Audit Committee will continue to scrutinise the effectiveness of the assurance framework during the year to help inform internal audit priorities.

In addition to this the organisations risk management process are also a key area for further development during 2011/12.

8.2 Supporting Committees

It is recognised as good practice for the Board to review its key committees and supporting groups on an annual basis. It is important to highlight this as a key development area as part of the annual plan and objectives for 2011/12 to allow the correct focus of safety, quality is built into the organisations committees and groups to ensure value for money and streamlined ways of working.

8.3 Use of information

The final area of the governance priorities for 2011/12 is the development of information and reporting to allow greater understanding at 'service line' level on the key governance activities of the clinical divisions and corporate departments. The development of the Divisional Governance Reviews and the development of the Divisional reporting to the Governance Committee will provide the basis for reviewing with the Divisional staff the best way to report and review the quality and standards of care delivered across the organisation.

The Gap analysis and review of the Mid Staffordshire Inquiry report will also provide a core building block for the Trust's governance and general organisation development priorities which will support the delivery of the annual plan for 2011/12.