Appendix A

North Cumbria University Hospitals NHS
NHS Trust

ANNUAL PLAN 2012/13

DOCUMENT CONTROL:

LEAD DIRECTOR	CHIEF EXECUTIVE
VERSION	FINAL DRAFT FOR BOARD APPROVAL

Caring for North Cumbria
Your hospitals, our priority

1. Past Year Performance (2011/12)

1.1 Chief Executive's Summary

I joined the Trust in May 2011 as the interim Chief Executive during a very important but challenging period for the Trust. The Trust was concluding a difficult contract negotiation with its commissioners which represented substantial disinvestment in services and was also required to deliver a substantial £15.2m cost reduction programme whilst maintaining performance. In addition the Trust had embarked on an acquisition process to identify a preferred bidder from the four Foundation Trusts which initially expressed an interest in acquiring the Trust.

This agenda could be considered as very ambitious for any organisation in the rapidly changing economic environment. However over the last 12 months the Trust has not only delivered its contractual requirements it has also achieved a significant cost reduction. Performance and quality of service has continued to be amongst the best in the NHS North West group of acute providers and significant developments have been delivered including the launch of a Telestroke service, the opening of the Heart Centre providing PCI at the Cumberland Infirmary and the development of a transformational clinical strategic programme for improving emergency care, elective care and paediatric services across our two hospitals.

Significant progress has been made this year for the redevelopment of West Cumberland Hospital. The Full Business Case has been approved by the Strategic Health Authority having received full support form NHS Cumbria and the Cumbria Clinical Commissioning Group. Enabling works have also been completed in preparation for work to start on the new section of the development in July 2012.

Finally, we have identified an excellent preferred bidder in Northumbria Healthcare NHS Foundation Trust which brings a wealth of experience in providing high quality acute and integrated services to disperse rural populations. There is tremendous enthusiasm from both parties (our Trust and Northumbria) however the regulatory approval process is both complex and unique to each transaction and as such the timescales for completion of the transaction will be largely outside our control.

The 2012/13 Annual Plan reflects the continuation of the key strategic aims which underpinned the previous plan. In particular the development of the key themes for the clinical strategy have important milestones for implementation this year, the new build aspects of the redevelopment of West Cumberland Hospital will become a reality and the Trust will continue to maintain performance and quality whilst delivering cost improvement across a wide range of efficiency projects. In addition we will support Northumbria in the development of the Transition Plan for the transaction and submission of application for approval to the Cooperation and Competition Panel and Monitor. The expected timescale for completing the acquisition is expected to be in December 2012.

1.2 Executive Summary

This plan provides an overview of our priorities and corporate objectives for 2012/13. These objectives have been revised to reflect the current financial drivers in the local health economy and the requirements for completing the acquisition by Northumbria Healthcare NHS Foundation Trust.

Vision

The strategic vision for the 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 remain unchanged as we progress towards completing the transfer of the Trust and its service to Northumbria.

Becoming a Foundation Trust through Acquisition by Northumbria Healthcare

Following a highly competitive bidding process and submission of proposals for acquiring the Trust the Trust Board selected Northumbria Healthcare NHS Foundation Trust (NCHT) as the preferred bidder in January 2012.

The Trust and NCHT need to work closely together in order to ensure the next stages of the acquisition are completed in line with the milestones the Trust agreed with the SHA in the TFA. The key tasks in the next stage are:

- Finalise the agreement of transitional financial support
- Agree Heads of Agreement for the Transaction
- Complete NHCT due diligence
- Feedback from the NCHT due diligence process and identification of any material issues
- Develop a planning framework and governance arrangements for undertaking the transition, including addressing and due diligence issues as required
- Development of detailed and shared communication strategy
- Recruiting members and establishing the Governors Body
- Submit a proposal for CCP consideration
- Undertake Monitor assessment
- Submit proposal and the Business Case for approval by the Secretary of State

- Recruit North Cumbria membership and elect local governors

The governance and project management arrangements have been agreed and will be established to lead the development of the Transition Plan and regulatory approval process with the aim of completing the transaction by December 2012 (subject to regulatory approval timescales).

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 2012/13 which are described in this annual plan. These priorities reflect the future requirements for self-certification of compliance within the Monitor Compliance Framework once the Trust's services are transferred to NHCT.

We also need to continue 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 facilitated through a central Programme Management Office (PMO) which coordinates the development and delivery of service based projects.

Each project is clinically impact assessed at an Executive level to provide assurance that the project does not compromise quality or safety. The key projects are listed below:

Turnaround Workstreams 2012/13		
• Pharmacy Reconfiguration • Pathology reconfiguration • Radiology reconfiguration	• Estates productivity and efficiency • Consultant Job Planning • Nursing Review • Midwifery Review	• Theatre Efficiency • Procurement • IM&T, Clinical coding and Forward • Administration Review • Reduced Locum staffing

Regionally there is an expectation that the Cumbria health economy will return to balance through substantial structural change and delivering services differently. Our cost base therefore needs to be aligned to the local health economy requirements and ensure that we will achieve higher productivity whilst continuing to drive quality improvements across all aspects of our services.

Our key Trust-wide developments are:

- Develop and implement key stages of the integrated clinical strategy with clinical commissioners for emergency care, elective care and paediatrics
- Deliver the nursing reconfiguration programme and develop the role of nurse leaders at ward level
- Deliver a reconfiguration programme for midwifery services
- Deliver a reconfiguration programme for administration services supported by IM&T technology for dictation
- 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
- Implement key IM&T programmes starting with real time ADT via the ForWard programme.
- Improve value for money from estates and facilities including switchboard, space utilisation and outsourcing

Our key 2012/13 Divisional service developments are:

Division	2012/13 Priorities
Surgery	• Develop the surgical pathway to maximise patient experience and efficiency • Implement the Theatre Efficiency programme • Develop the day case model/pathway • Consolidate out of hours surgery • Introduce epidural anaesthetic service at Cumberland Infirmary • Maximise the opportunity for becoming a Vascular Centre in the Cumbria and Lancashire Vascular service review • Extend treatment modalities in Urology for patients suffering from kidney stones

Medicine and Cancer Services	• Deliver stroke improvement plan • Implement the national dementia strategy • Develop PPCI in the cardiology service • Implement a new model for emergency care across both hospital sites supported by new ambulatory care pathways • Develop hub and spoke model for specialist services • Achieve accreditation for Trauma Unit status • Review capacity and demand for acute rehabilitation • Implement Cancer Reform Strategy developments e.g. IMRT and acute oncology
Child and Family **Clinical Support**	• Develop and implement Paediatric assessment model and new model for supporting locality services • Implement new workforce model for Obstetrics at West Cumberland Hospital • Review midwifery services • Redesign gynaecology pathways – implement OP hysteroscopy • 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 and milestones for 2012/13 are:

- Meet our statutory financial duties, including a £1m surplus
- Deliver a cost improvement programme of £16.9m
- Maximise our CQUIN income which has increased to 2.5%
- Invest our capital in a comprehensive IM&T programme and medical equipment.
- Gain Department of Health and Treasury approval for the redevelopment of West Cumberland Hospital

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.

Our local market is changing rapidly as Cumbria GP's seek accreditation for becoming a first wave Clinical Commissioning Group (CCG) which will involve 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.

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 continue to operationalise the integrated clinical strategy and provide essential clinical input into the development of clinical pathways and commissioning intentions.

2.2 Activity Trends in 2011/12

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

Activity Type	2008/09	2009/10	2010/11	2011/12
A&E Attendances	68,779	72,353	71,414	72,474
Daycases	26,729	28,543	29,385	27,479
Elective Inpatients	8,733	9,121	7,842	7,584
Non-Elective Inpatients	36,858	37,412	36,318	36,585
Outpatient Attendances New	85,670	85,151	71,560	67,010
Outpatient Attendances Follow-up	186,314	185,943	168,510	151,145
Outpatient Procedures	4,847	12,692	43,038	58,151
TOTAL	**417,930**	**431,215**	**428,067**	**420,428**

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

- A&E activity and Non-Elective activity increased in line with the broad trend witnessed throughout the North West.

- Daycase activity reduced as more activity under this category was undertaken as an Outpatient Procedure
- Outpatients in general reduced with the ratio of Follow Up Attendances to New Attendances improving

Whilst the commissioning intentions for 2011/12 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 2011/12

The Trust annual turnover in 2011/12 was £228,312 and 74% of our total income was from our contract with NHS Cumbria. The 2011/12 contract income agreed with NHS Cumbria took into consideration activity reductions which would be delivered through demand management schemes and investment 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 trends above.

The contract included an income stream for Commissioning for Quality and Innovation (CQUIN) requirements which resulted in income of £2.7m.

The Trust's financial outlook for 2012/13 is summarised in section 6 but the table below highlights our retrospective 2011/12 performance against targets.

2011/12 Performance Against Financial Targets		
Duty	**Target**	**M12**
Breakeven Duty	To achieve a breakeven I&E	✓
Capital Absorption Rate	To achieve a rate of 3.5%	✓
Better Payment Practice Code	95% of payments within 30 days by volume and value	x
External Financing Limit (EFL)	To achieve EFL	✓
Capital Resource Limit (CRL)	To remain within the CRL	✓

The Trust failed to achieve the Better Payment Practice Code target due to the on-going liquidity issues faced throughout the year.

Income and Expenditure

A summary of the Trust's financial performance over the last 5 years is shown below.

	2007/08 £000	2008/09 £000	2009/10 £000	2010/11 £000	2011/12 £000
Clinical Income	187,755	199,581	202,420	207,635	205,047
Other Income	10,069	12,655	13,678	15,136	22,436
Total Income	**197,824**	**212,236**	**216,098**	**222,771**	**227,483**
Total costs	(189,858)	(202,133)	(217,490)	(212,877)	(215,126)
EBITDA	**7,966**	**10,103**	**(1,392)**	**9,894**	**12,357**
Surplus	**51**	**993**	**(10,130)**	**1,661**	**3,476**
Technical Adjustments			10,457	(305)	(2,381)
Adjusted Surplus	**51**	**993**	**327**	**1,356**	**1,095**

Underpinning the Trust's financial position in 2011/12 was the delivery of £7.9m of CIP against the target of £15.2m. Underachievement of the target was primarily due to the delays in developing and implementing key turnaround plans. However, a restructured Project Management Office (PMO) has been in place since October 2011 and good progress has been made embedding new systems and processes to actively engage the whole organisation. 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, staffing reviews and eliminating waste wherever possible. Additional strategic support income was secured from the SHA to cover the shortfall in the delivery of CIP.

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 a Reference Cost Index (RCI) which shows the Trust's cost base relative to the national average, where the national average is 100.

A Trust with a RCI 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 Trust's RCI for 2010/11 is 110; this is an increase in the previous year's RCI which was 108. The inherent inefficiency of providing services over two sites, which are 40 miles apart, combined with the PFI hospital at Carlisle are significant contributors to our high running costs, which is reflected in the Trust's RCI. The Trust expects the RCI to reduce as the organisation implements a 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 Trust spent £7.7m on capital expenditure, against a Capital Resource Limit of £10.5m. £4.2m of this expenditure relates to the redevelopment of the West Cumberland Hospital. Expenditure was less than planned due to the delay in approving the Full Business Case, however it is now expected to go ahead as planned in summer 2012. These investments were successfully managed within the cash and external borrowing limits agreed with the Department of Health, which include the required dividend payment to Government of 3.5%.

The Trust continued to invest in new medical equipment during the year, spending £1.4m. This included;-

- a new laser for the treatment of Urological related conditions
- investment in the new Cardiology PCI service to provide a local service
- a new ENT microscope
- replacement of mattresses throughout the two hospitals
- investment in Radiotherapy facilities

The investment in information technology continued in year, spending £1.2m on clinical systems and the continued development of IT infrastructure.

Schemes over £100,000 are listed below.

	£
WCH Redevelopment	4,249,091
Computer Refresh Programme	240,396
Radiotherapy Extension	195,091
Mattresses	180,216
Urology Laser	168,000
Endoscopy Scopes	130,891
PCI Equipment	129,400
PFI Upgrades & Maintenance	116,296
IT Infrastructure Upgrades	100,812

2.4 Trust Performance - Key National Healthcare Targets

We continued to improve on our existing track record for achieving national targets and standards. The following table summarises performance against key national targets:

Performance Dashboard for Annual Plan: 2011 - 2012

Code	Integrated Performance Measure		Criteria for Traffic Lighting		Final Required Position	Outturn
QUALITY: HEADLINE MEASURES						
HQU01	MRSA Bacteraemia (Attributed to Trust)		<=4	>4	<=4	0
HQU02	Clostridium Difficile Infections (Attributed to Trust)		<=69	>=69	<=69	53
HQU05	Referral to Treatment: Admitted Patient Care 95th Percentile (weeks)		<=23	>23	<=23	45.1
HQU06	Referral to Treatment: Non-Admitted Patient Care 95th Percentile (weeks)		<=18.3	>18.3	<=18.3	15.43
HQU07	Referral to Treatment: Incomplete Pathways 95th Percentile (weeks)		<=28	>28	<=28	22.00
HQU08	Mixed Sex Accommodation Breaches		<=5	>5	<=5	27
HQU09	A&E Clinical Quality Unplanned Re-Attendance Rate		<=5%	>5%	<=5%	5.5%
	Total Time in A&E (% of patients who have waited <= 4 hours)		>=95%	<95%	>=95%	96.6%
HQU10	A&E Clinical Quality: Total Time spent in A&E Dept (hh:mm)- 95th Percentile		<=04:00	>4:00	<=4:00	03:54
HQU11	A&E Clinical Quality: Left Without Being Seen Rate		<=5%	>5%	<=5%	2.2%
HQU12	A&E Clinical Quality: Time to Initial Assessment - Ambulance Only (hh:mm) - 95th Percentile		<=00:15	>00:15	<=00:15	00:31
HQU13	A&E Clinical Quality: Time to Treatment decision - median (hh:mm)		<=01:00	>01:00	<=01:00	00:28
HQU14	Cancer: 2 Week Waits	All Cancers	>=93%	<93%	>=93%	95.1%
		Breast Symptomatic	>=93%	<93%	>=93%	93.0%
HQU15	Cancer: 62 Day Waits	All Cancers: 2 month Urgent Referral to Treatment	>=85%	<85%	>=85%	86.0%
		62 Day Wait For First Treatment - Screening	>=90%	<90%	>=90%	97.1%
		62 Day Wait For First Treatment - Cons Upgrade	>=85%	<85%	>=85%	n/a
HQU16	Emergency Re-admissions (within 30 days)		<=6%	>6%	<=6%	6.0%
QUALITY: SUPPORTING MEASURES						
SQU01	VTE Risk Assessment		>=90%	<90%	>=90%	91.1%
SQU05	Cancer: 31 Day Waits	One month Wait For First Definitive Treatment	>=96%	<96%	>=96%	97.9%
		31 Day Wait for Subsequent Treatment - Surgery	>=94%	<94%	>=94%	98.6%
		31 Day Wait for Subsequent Treatment - Drugs	>=98%	<98%	>=98%	98.4%
		31 Day Wait for Subsequent Treatment - Palliative	>=94%	<94%	>=94%	100.0%
		31 Day Wait for Subsequent Treatment - R'therapy	>=94%	<94%	>=94%	94.9%
SQU06	Strokes: Patients with 80% of their admission on a Stroke Ward		>=80%	<80%	>=80%	74.4%
	Strokes: TIA Referrals Assessed & treated within 24 Hours		>=90%	<90%	>=90%	56.1%
SQU24	Referral to Treatment: Admitted Patients Median Wait (weeks)		<=11.1	>11.1	<=11.1	8.6
SQU25	Referral to Treatment: Non-Admitted Patients Median Wait (weeks)		<=6.6	>6.6	<=6.6	4.0
SQU26	Referral to Treatment: Incomplete Pathway Median Wait (weeks)		<=7.2	>7.2	<=7.2	5.3
RESOURCES: SUPPORTING MEASURES						
SRS06	Length of Stay for Acute G&A Spells (days)		<=4.8	>4.8	<=4.8	4.7
SRS09	Daycase Rate (G&A)		>=80%	<80%	>=80%	80.1%
SRS10	Delayed Transfers of Care		<=3.5%	>3.5%	<=3.5%	5.8%
SRS19	Staff Absences (Sickness absence rate)		<=3.5%	>3.5%	<=3.5%	4.5%
SRS20	Temporary Staffing Costs (Including agency costs)		<=2%	>2%	<=2%	4.3%

LOCAL PRODUCTIVITY METRICS					
	Reduce inpatient length of stay (elective)	<=3.1	>3.1	<=3.1	2.8
	Reduce inpatient length of stay (non-elective)	<=4.2	>4.2	<=4.2	4.7
	Day Case rate for Basket of 25 procedures	>=80%	<80%	>=80%	77.9%
	Pre-operative bed days (elective)	<=6%	>6%	<=6%	8.5%
	Outpatient Follow-up to New (FU:N) Ratio	<=2	>2	<=2	2.1
	Outpatient Did Not Attend (DNA) rate	<=7%	>7%	<=7%	6.2%
LOCAL WORKFORCE METRICS					
	Sickness \ Absence Cost (£000)	n/a	n/a	n/a	£4,768.4
	Turnover Rate (%)	<=1%	>1%	<=1%	0.84%
	KSF Development Reviews (Rolling Total)	>=80%	<80%	>=80%	58.7%
LOCAL QUALITY METRICS					
	Risk Adjusted Mortality (CHKS data - Rolling Year)	<=100	>100	<=100	95
	Slips, Trips & Falls (inpatients)	<1200	>1200	<1200	982
	MSSA (Attributed to Trust)	<=11	>11	<=11	13

The Trust embarked on a programme to improve access and address the overall waiting time for the elective pathway. This improvement plan is set to achieve the target by July 2012. In the meantime the programme has had an impact on the 2011/12 performance distorting the overall waiting times.

The Trust is currently reviewing the performance against the 'mixed sex accommodation' target as the majority of patients recorded as breaches were cared for in an intensive care bed. The review will look at consistency in how the Trust records breaches compared to other Trusts as well as the discharge arrangements for ITU.

As greater emphasis is placed on the efficient use of capacity the current level of delayed discharges must be addressed. The Trust is currently working with primary and community service providers to improve patient flows and access to services provided in the local community. This is a key quality and performance priority for our patients for 2012/13.

The Trust has enhanced monitoring systems for the delivery of Stroke services and has developed an improvement plan to meet the national targets for TIA referrals and spending over 90% of the admission in a dedicated stroke bed.

2.5 Achievement of 2011/12 Business Objectives

In 2011/12 we continued our plans to deliver five strategic aims. A lead Director and responsible manager developed implementation plans for each initiative and progress has been reported to the Senior Management Team, clinical leaders and Trust Board on a regular basis.

The year-end position is currently under review and estimated position for Q4 is shown below:

Strategic Aim	2011/12 Corporate Initiatives	Achievement
Ensure we provide high quality, safe and effective services for all our patients	• Fully implement the quality account priorities • Implement the Governance Improvement plan • Implement the HR strategy to enable staff to contribute to the future development of the organisation and its services • Ensure systems and processes support the delivery of safe high quality care including CQC registration and other regulatory requirements • Implement effective workforce education and training programme to supports delivery of safe care • Ensure the hospital environment supports delivery of safe care	Governance restructure implemented Improvement plan implemented QRP has two regulations which are amber status Positive PEAT assessments Additional e-learning modules introduced and improved monitoring of mandatory training implemented Improved monitoring and reporting to Board for complaints, SUI's, Claims and Inquests
Achieve sustainable Financial balance through comprehensive and challenging financial recovery programme	• Develop a robust financial plan in line with the acquisition process • Develop robust systems to respond to the commissioning and contracting position of Cumbria PCT • Implement and deliver a £15m cost improvement programme	Financial plan with external SHA support has met objective. Year end contractual position agreement with in year amendments reflected demand and key service changes. New PMO arrangements in place from October 2011 delivering CIP of £7.9m.

Develop and implement system change through comprehensive service reconfiguration	• Develop a costed clinical strategy that is fully supported by clinical commissioners • Develop an implementation plan to deliver the clinical strategy	Work is still in progress to cost the individual clinical models. This is due to the need to develop granular plans for elective care, emergency care and paediatrics. Additional financial support agreed by clinical commissioners for obstetric services and 'block' contract for paediatrics to support implementation of the new model. Models have been developed and agreed with clinical commissioners and key milestones identified in detailed implementation plans.
Develop a new healthcare facility in West Cumberland which is fit for the 21st Century	• Develop the FBC for SHA, DH and Treasury approval • Provide NCAT response and assurance re the proposed clinical models • Enabling works and delivery of the West Cumberland redevelopment project	Addendum to the FBC developed in January 2012 to support SHA and NCAT review/approval of the FBC. All objectives are on track for delivery.
Develop our Trust to become a FT through an acquisition process	• Undertake market soundings re acquisition • Develop a competitive process to identify the bidder best placed to achieve the objective • Ensure the process has External Stakeholder involvement • Select preferred bidder by November	Objective achieved. Supplementary process initiated in November to ensure value for money and competition amongst bidders. Preferred bidder identified January 2012 with stakeholder support.

2.6 Other Major Issues

2011/12 Contracting Process

The Trust agreed its main commissioner contract with NHS Cumbria without going into mediation or arbitration. The contract value was however less than the Trust had planned for, and therefore strategic support income was secured from the SHA to help bridge this gap.

SHA Financial Support

In order to achieve a balanced financial position the Trust has been supported with £28m non-recurrent, non-repayable resource from the North of England Strategic Health Authority. This resource has bridged the gap between the on-going imbalance of expenditure in excess of income which must be addressed through the turnaround process.

Closer to Home (C2H) and Demand Management

The Trust undertook an internal review of Closer to Home assumptions in October 2011 looking at the latest demand trends for acute secondary care services. This review concluded that:

- The strategic intent for C2H was sound, particularly in relation to changing pathways and best practice models applied to the local health system, although the assumptions were not fully developed in terms of understanding health need and priorities for reducing mortality rates in Cumbria.
- Activity has not been reduced across the specialties or HRG groups as forecast with the exception of musculoskeletal disorders and casemix changes in non-elective care (not included in the original model) that have resulted in increased demand on secondary care and an increased cost base.
- Delayed benefit realisation as reviewed by the PCT and localities has resulted in greater secondary care expenditure than forecast in the model. The PCT identified additional income reductions associated with further best practice and reduced demand over and above the original objective which have not delivered reductions and initiatives to reduce paediatric admissions.
- Despite previous downward trends in activity the more recent trend from early 2010/11 to date is upward, which is consistent with the original NHS Cumbria C2H plan. However, this is contrary to the latest proposed reductions which indicate that a further absolute 14% reduction in non-elective activity will be achieved from 2010/11 to 2012/13.
- C2H targets have not been updated to take account of health priorities, achievement in activity reductions to-date or the latest activity trends.

The review recommended the following actions;

- Complete a C2H stock take and agree to rebase C2H assumptions to develop the forward model for service planning and commissioning.
- Ensure that the revised C2H strategy is owned and led by primary and secondary care clinical leaders to help ensure the model has appropriate triangulation with demand drivers for the local health system.
- Develop clear implementation plans, integrated and coordinated across sectors, with equally clear programme management arrangements.
- Develop a revised, sustainable financial strategy, which is owned by health system leaders, linked to clinical commissioning groups and consistent with locality based commissioning plans.

- As part of the above, negotiate a new financial agreement with commissioners on the basis that currently agreed clinical strategic changes are unlikely to achieve a material reduction to the Trust's cost base.
- Ensure that locality based commissioning plans are based on the most up-to-date information and data rather than historical positions which may have lost some validity due to the passage of time.
- Ensure that planning not only reflects increasing activity but is also based on the implementation of previously agreed clinical strategic changes, specifically the modelling of their impact, for example emergency flow/floor, new paediatric model, revised elective care pathways, etc.
- Ensure that health system wide changes to pathways and development of integrated change plans are developed with implementation spanning primary, community and secondary care.
- Consolidate clinical practices and teams where appropriate across the two sites of the Trust to ensure that all patients are able to access the same level of services at the appropriate time, recognising that access to service may require movement between sites.
- Agree metrics for measuring and monitoring C2H benefits and develop a common performance framework owned by health system leaders, which reflects the needs of commissioners, the Trust and other relevant partners, for example Cumbria Partnership FT and social care. This should include value for money and quality and patient experience assessments with clear accountability for delivery.

These recommendations have been incorporated in the current Cumbria System Board priorities and individual workstreams for clinical transformation and integrated pathways.

Developing the Integrated Clinical Strategy for North Cumbria

Following the 2010/11 contract arbitration facilitated by NHS North West, 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.

The clinical strategy was required to interface coherently with the current turnaround plans for the Cumbrian health economy in that it should inform the Long Term Financial Model (LTFM) for the Trust (as a fully costed strategy) 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.

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 were:

- 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
- Build capacity based on the principles of 'right care, right place, right person' and ensure the resources available are used to the maximum effect

The continued development of the integrated strategy is reflected in the Trusts internal clinical transformation plans for:

- Emergency care
- Elective care
- Paediatrics

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.

This work was needed to underpin and support the following processes:

- The Trust and PCT turnaround plans
- The contract negotiations with NHS Cumbria for the 2011/12 contracting round
- The Full Business Case for the new West Cumberland Hospital
- The due diligence process for acquisition

3. Future Business Plans for 2012/13

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 white paper became legislation in March 2012.

The bill 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 Operating Framework for 2012/13 sets out the transition arrangements for national and local systems covering the NHS Commissioning Board, the economic regulator, Clinical Commissioning Groups and the development of the Foundation Trust pipeline for providers.

Key priorities in the Operating Framework for 2012/13 include:

- **Commissioning Reforms**, phasing out of SHAs and PCTs by 2012 to be replaced by the NHS Commissioning Board and Clinical Commissioning Groups (CCG's). Essentially, commissioning will transfer to GP's. PCT's will be required to support the evolution of CCG's, including any staff transfers and adequate funding including clearance of any legacy debts. No SHA or PCT should plan for a deficit in 2012/13.
- **Reforms for Patients,** In parallel with the above, the aim is to ensure that patients are aware of the levels of care that they should be expecting and also that this can be delivered in ways that better suit them. Essentially, this puts patients at the centre of decision meeting about their care 'no decision about me without me'.
- **Quality and patient care** issues are fundamental to the Operating Framework, which includes requirements on clinical audit in key areas of basic care, on-going inspections by the Care Quality Commission and a renewed push on implementation of the national dementia strategy as well as increased support for carers. Meeting the minimum standards is not good enough and the Outcomes Framework is intended to determine appropriate measure for monitoring performance with an emphasis on outcomes of the system rather than the inputs. Furthermore providers will be expected to be compliant with relevant NICE quality standards and ensure sufficient information is published in providers' quality accounts. Commissioners need to ensure that providers are
- **Dementia and Care of the Elderly**, including the application of standards in an outcomes-based system, improved diagnosis, greater emphasis on dignity issues and inappropriate re-admissions. PCT's are already compelled to actively support the National Dementia Strategy and this will be expanded in 2012/13 to embrace local and national CQUIN goals.
- **The Outcomes Framework** is centred on 5 domains - each supported by NICE quality standards which define high-quality care for each care pathway.
    a) Preventing people from dying prematurely, including mortality monitoring and use of the Summary Hospital Mortality Indicator (SHMI to identify outliers)
    b) Enhancing the quality of life for people with long term conditions, including the use of Telehealth and monitoring unplanned hospitalisation of patients with long term conditions.
    c) Helping people to recover from episodes of ill health or injury, including monitoring emergency admissions and re-admissions.
    d) Ensuring that people have a positive experience of care, including listening to patients' experiences, the response to complaints, access to services, improved front-line care (A&E) and the elimination of mixed sex accommodation.
    e) Treating and caring for people in a safe environment and protecting them from avoidable harm, including the control of exposure to infectious diseases, emergency preparedness and achievement of QIPP.

- **Other Non-Financial Items** include ensuring that the NHS Constitution right to treatment within 18 weeks is met, continued progress towards Foundation Trust status, development of "Any Qualified Provider (AQP)", and personal health budgets 2013/14.
- **Delivering £20bn efficiency savings,** by focussing on service delivery and strong financial management. Key changes are; expansion of the tariff system to cover more areas (e.g. mental health, chemotherapy delivery, ambulances etc.); a net tariff reduction of at least 1.5% for 2012/13 (to include non-tariff NHS services); efficiency savings of at least 4.0% to fund mandatory/uncontrollable cost pressures (e.g. assuming 2.5% inflation).
- **Rewarding Best Practice** for the following services:

  1 Adult renal dialysis

  2 Cataracts

  3 Day cases

  4 Fragility hip fracture

  5 Interventional radiology

  6 Major trauma

  7 Outpatient procedures

  8 Paediatric diabetes

  9 Primary total hip and knee replacements

  10 Same day emergency care

  11 Stroke care

  12 Transient ischaemic attack
- **Funding for Emergency Admissions,** will include the 30% marginal rate for activity above the threshold and the policy of non-payment for certain re-admissions will also be retained.
- **Non-recurrent CQUIN** funding will again be available in 2011/12, with plans to increase this from 1.5% of standard contract value to 2.5% with about 1/5 of this being measured against national targets.
- **Planned pay freeze** for all staff earning salaries greater than £21,000 per annum, in line with the agreed 2-year pay deal. Also, the aim is to reduce staff sickness towards 3%, with this and other workforce improvements having a significant impact on QIPP.
- **PCT Allocations** for 2012/13 will grow by at least 3.0% including reablement funding for transitional service developments which equated to £24.7m for NHS Cumbria. PCTs are expected to hold back 2% of their recurrent funding to support non-recurrent organisational costs of transformation.

As described above 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) published by the National Quality Board. Both developments will form the basis of the first mandate for the national NHS Commissioning Board.

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 and escalation in line with the system for monitoring and RAG rating the FT Pipeline.

3.2 Strategic Commissioning Priorities and Strategy for Cumbria

The Trust received information on the Interim Clinical Commissioning Group contracting strategy and commissioning intentions for secondary care in November 2011. For North Cumbria many of the issues outline in the strategy linked directly to the work already embedded within the integrated clinical strategy workstreams approved by the Systems Board.

The key priorities for the clinical commissioners described in the strategy are:

- Improving elective care
- Transforming the unscheduled care system through integrated pathways of care
- Improving children's services, especially paediatric assessment arrangements and pathways such as for the acutely ill child
- Better management of long term conditions through the year of care model
- Improving mental health services especially community health
- Developing a care pathway for frail older people
- Continuing to transform primary care

The strategy recognises the QIPP gap for the clinical commissioner which largely stems for increasing demand and changing demographics. Financial stability therefore is dependent on developing a collaborative approach with providers to manage demand across health and social care. The commissioners identify seven strategic themes which will be the key focus over the next three years:

- Long term condition management for diabetes and respiratory conditions which include more effective patient engagement and care planning together with enhanced community services
- Developing community cardiology services
- Developing new pathways for paediatric medicine for constipation, asthma and the acutely ill child delivered through a new model for paediatric assessment
- Developing a pathway for frail older people including dementia and end of life care
- Better care and early intervention for patients with alcohol and drug problems

- Improving primary care access and better integration of out of hours services
- Enhancing the infrastructure and fully implementing the new models for emergency floor, single point of access and discharge liaison

Delivering these themes is expected to lead to better patient outcomes and a £9m cost improvement plan. Whilst this target is seen as tough it is thought to be an achievable reduction in secondary costs in the following areas:

- Developing arrangements to manage procedures of limited clinical benefit across 10 procedures (such as carpal tunnel surgery, grommets, tonsillectomies and varicose veins)
- Reducing follow up appointments using a 'needs based' approach for patients to opt in to follow care via an 'SOS' style help line
- Reducing the volume of patients 'lodged' in the Accident and Emergency department
- Improving care models to reduce the level of readmissions
- Reducing the number of zero length of stay admission by 'assess to admit not admitting to assess'
- Improving discharge arrangements to reduce unnecessary excess bed days
- Introducing penalties for planned procedures which are not carried out for no legitimate clinical reason
- Introducing pathway changes for dermatology, ophthalmology, stroke, musculoskeletal, minor ops and direct access diagnostic services

Whilst the areas highlighted above will drive better use of the overall resources available there is a commitment from clinical commissioners to support local services through the repatriation of patient activity from out of area providers. We will however continue to see further disinvestment in a wider range of our services through the development of Transforming Community Services by Cumbria Partnership NHS Foundation Trust and this may 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
- Redesign of chronic disease pathways and associated disinvestment in acute services
- Development of radiotherapy service at Kendal
- Implementation of commissioning plans for any qualified provider (AQP) for diagnostics
- Service models required to underpin capital developments in community hospitals

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 2012/13 Contract and Financial Outlook

Contract 2012/13

The Trust agreed its contract with Cumbria CCG/PCT by the required deadline in March 2012, this is the first time this has been achieved within the national deadline for a number of years. The agreed contract value is £169.4m, an increase of £4.8m compared to the previous year.

A summary of the key contract points is described below:

- CQUIN for 2012/13 has been increased to 2.5%, an increase of 1% compared to last year (1.5% in 2011/12), with a value of £4.1m
- The national tariff has reduced by on average 1.5%
- The contract is based on a forecast outturn at month 8 in 2011/12, with £1.6m being added for demographic change and £1.9m being deducted for demand management schemes (this includes a reduction of £654k for evidenced based referrals)
- The contract includes a provisional amount for PCI activity of £1.2m, although it is recognised that the final activity volume and values may be closer to £3m.
- Investment of £0.6m in high cost drugs, recognising that further investment may be required
- Investment in bowel screening, Sleep Apnoea and best practice tariffs (BPTs)
- A reduction in the contract of £1.6m for readmissions within 28 days, subject to an audit being completed by the end of June 2012 in line with the national PbR guidance
- The contract is on a Payment by Results and cost and volume basis, with the exception of Paediatrics which are paid for as a block as we reconfigure the service during the year
- The contract has no floors, ceilings, collars or caps – commissioners will pay for the activity we undertake with no risk share arrangements
- The Quality schedule has been enhanced and does create some financial risks, most notable the requirement for the Trust to implement electronic discharge summaries.

2012/13 Financial Outlook

The Trust is again planning to achieve a surplus of £1m in 2012/13 as the organisation needs to generate sufficient cash to enable it to meet its liabilities. Implicit within the national payment tariff is the requirement for the Trust to achieve a 4% efficiency target, this equates to £8.7m for the Trust. Due to the Trust's past levels of expenditure and non-achievement of cost improvement programmes the in year savings target will also need to address historic issues valued at £8.2m. Combining these requirements gives the need to achieve a £16.9m cost improvement programme to deliver a planned surplus of £1m.

Whilst the main income SLAs has been agreed the Trust is yet to formally agree the strategic support income with the SHA. The 'likely' base budget requires the Trust to secure £19m of strategic support in order to deliver the planned financial surplus.

The surplus of £1m is after making technical adjustments for dual accounting with the PFI being on the balance sheet under IFRS.

	2012/13		
	Likely £000	Best £000	Worst £000
Income	217,209	218,464	216,029
Expenditure			
Pay	(137,906)	(137,906)	(137,906)
Non Pay	(72,290)	(72,290)	(72,290)
Reserves	(7,094)	(7,094)	(7,094)
CIP	16,930	15,675	18,110
Subtotal Expenditure	**(200,359)**	**(201,614)**	**(199,179)**
EBITDA	16,850	16,850	16,850
Finance Charges	(15,507)	(15,507)	(15,507)
Surplus / (Deficit)	**1,343**	**1,343**	**1,343**
Adjustment for Dual Accounting / IFRIC 12	(343)	(343)	(343)
Surplus / (Deficit) - Breakeven Duty	**1,000**	**1,000**	**1,000**

The Department of Health have recently announced that the Trust will receive financial support from 2012/13 onwards in recognition of the financial pressures imposed by the Cumberland Infirmary PFI scheme. The indications are that this will be in the region of £6m. It is the Trust's expectation that any Strategic Support agreed with the SHA would be reduced by the level of PFI support secured.

The Operating Framework for 2012/13, published in December 2012, focusses on getting the basics right every time, maintaining high performance against quality and access targets and meeting the delivery of the financial and efficiency agenda. 2012/13 will also be the critical year in building the new system envisaged in the health service White Paper; Liberating the NHS. The Operating Framework sets out clear expectations for delivering the changes. In managing these changes it is essential that the Trust maintains a focus on its core purpose, particularly as it moves through the acquisition process and modernises service delivery. Clinical Commissioning Groups with a clear focus on improving long term conditions care, building on the role of GPs as navigators of the wider health system will come to the forefront of commissioning in 2012/13 as they take over the commissioning role from Primary Care Trusts.

The economic outlook and operating environment remains challenging for the NHS with additional risks and opportunities for the local health economy. The Trust continues to be 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 NHS has been told to plan for a freeze on funding of frontline services and to prepare for reductions in the health budget from 2011/12.

The National Payment by Results Tariff has been reduced by 1.5% for 2012/13 and a pay freeze remains in place for all staff with the exception of the lowest paid workers.

Cost Improvement Plan

2012/13 will be a challenging year for the organisation as like for like payments through the national tariff system reduce. This means that the Trust will have to deliver a high level of cost and efficiency savings in order to achieve the statutory financial duties. This must be balanced with continuing to deliver high quality services and maintaining or improving access targets.

The efficiency target of £16.9m for 2012/13 represents 7.8% 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. Inevitably such significant cost reductions will impact upon the number of staff the Trust employs and the roles and responsibilities of each and every employee.

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.

The delivery of CIP will continue to be managed through the Project Management Office (PMO) which is now well embedded in the organisation. The size of the CIP target represents a significant risk. Our main risks and mitigations are as follows:

- **Risk** - Additional schemes are not fully identified in Quarter 1.

  Mitigation - The PMO is working in close collaboration with the divisions to identify and implement new schemes as soon as possible.

- **Risk** - Management Capacity

  Mitigation - additional resource is in place via the PMO to support the delivery of all CIP schemes.

- **Risk** - staff engagement cannot be maintained.

  Mitigation - Additional communication through post masters and further clinical engagement programmes have established to support maintaining organisational engagement.

Capital Programme

The capital programme for 2012/13 – 2016/17 is shown below. The Trust's capital programme for 2012/13 is £38.0m which includes £33.1m for the West Cumberland Hospital redevelopment, subject to final approval by the Department of Health. A similar level of investment will be required the following year to support the redevelopment. Lower amounts of £8.7m and £3.4m will be required in 2014/15 and 2015/16 respectively, with the project due to conclude in summer 2015/16.

Other capital expenditure will be funded through internally generated depreciation with continued investment of £1m in information technology each year to help improve real time data for clinicians and improve governance and quality systems.

The Trust will continue to invest in medical equipment when it needs replacing and essential environmental and health & safety work will also be undertaken as required throughout the year.

A summary of the capital programme is shown below:

	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	TOTAL £000
Minor Medical Equipment	690	650	650	1,650	1,050	**4,690**
Major Medical Equipment	1,135	0	0	0	0	**1,135**
IM&T	1,000	1,000	1,000	1,000	1,500	**5,500**
Minor Works	250	250	250	250	500	**1,500**
PFI Lifecycle Additions	1,754	2,559	4,607	4,376	3,067	**16,363**
WCH Redevelopment (NCUHT)	1,900	2,900	2,150	1,150	0	**8,100**
Unallocated	25	0	150	150	1,650	**1,975**
Subtotal Trust Allocation	**6,754**	**7,359**	**8,807**	**8,576**	**7,767**	**39,263**
WCH Redevelopment (PDC)	31,216	29,011	6,568	2,205	0	**69,000**
CRL	**37,970**	**36,370**	**15,375**	**10,781**	**7,767**	**108,263**

3.4 Trust Vision and Values

To ensure that the Trust is fit for the future and the forthcoming acquisition, 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 as well as the need to make as much progress as possible in terms of improving quality and our financial position in preparation for completing the transfer of Trust services and assets to Northumbria Healthcare in December 2012.

Our vision for this transaction is described below:

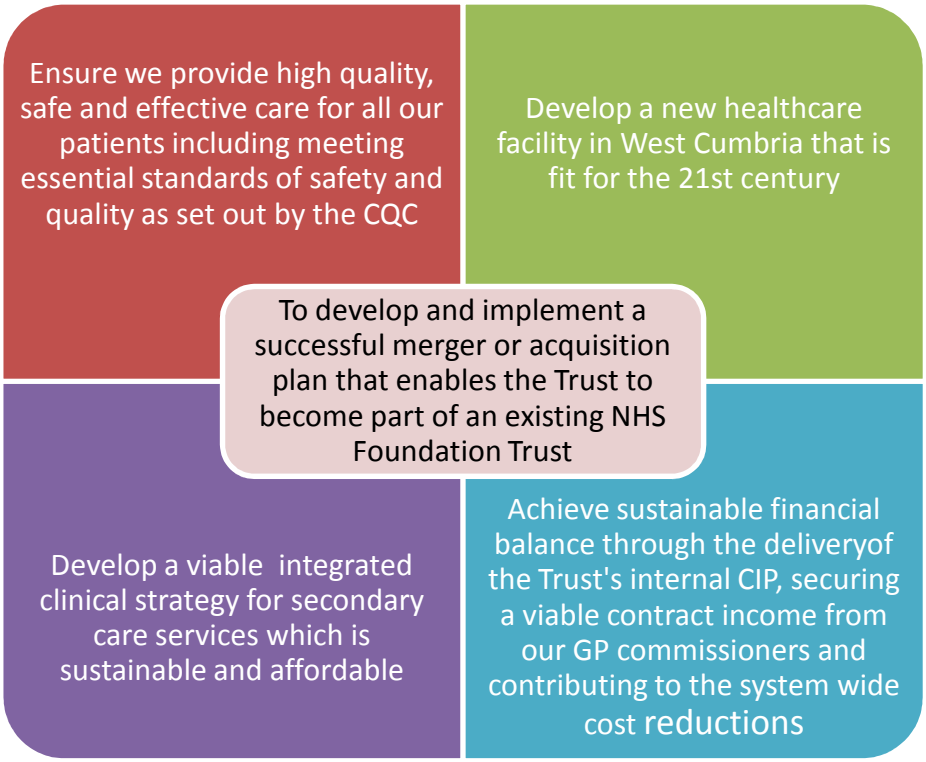
'We will deliver clinically sustainable and high quality acute services from two Hospitals in North Cumbria by becoming part of an existing Foundation Trust which delivers high quality safe patient care, and is financially strong.

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.'

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 through the acquisition as well as the reality of the significant market changes in Cumbria.

The Trust's Strategic Aims therefore remain unchanged 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 2012/13. These can only be achieved through the following:

- Delivery of the Trust internal turnaround plan
- Implementing a clinically sustainable and affordable integrated clinical strategy within challenging milestones
- Delivery of the at risk elements of the 2012/13 contract with the Cumbria Clinical Commissioning Group

In preparation for the acquisition we have identified the following critical success factors in taking these aims forward:

- Implementing our HR strategy and policies together with an Organisational Development Programme which will enable staff to fully contribute to the future development of the new organisation post transaction
- 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
- 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 2012/13 have been set in the context of the acute service element of the Integrated Clinical Strategy and the acquisition requirements. 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:

- A revised model for integrated Emergency Care Floor which directs patients to the most appropriate service and reduces unnecessary admissions
- Improved clinical efficiency for elective care leading to further significant changes in workforce and bed capacity
- A new model for paediatric assessment which reduces admissions and reliance on inpatient services
- Greater integration of clinical services across West Cumberland Hospital and the Cumberland Infirmary to improve quality and patient experience
- Development of specific services such as PPCI to repatriate out of county care

4. Strategic Objectives 2012/13

The strategic objectives for 2012/13 are summarised below:

Strategic Aim	2012/13 OBJECTIVES
1	We will maintain CQC compliance and build on our governance systems to implement quality improvements for both patient experience and clinical outcomes. We will develop a service level approach to delivering the quality, service development and service improvement aspects of our contract.
2	We will gain DH approval for the Full Business Case for the redevelopment of West Cumberland Hospital and conclude the commercial contractual requirements. We will start enabling works on site in Q2 and continue the development of integrated clinical models for emergency, elective and paediatric services.
3	Working with our commissioners we will deliver the key milestones for the core programmes of work for elective flow, emergency flow and paediatric services across both hospital sites. New models of care and integrated pathways will be implemented to improve patient experience ensuring care is provided at the right time in the right place.

4.	We will work with our clinical commissioners to deliver all aspects of our contract coving patient activity, quality, performance and service improvements. We will work collaboratively with our commissioners to redesign pathways and contribute to the system wide QIPP agenda. We will develop new services to improve local access such as 24/7 PPCI. The Trust PMO will continue to coordinate a comprehensive programme of internal projects to deliver cost improvements of £16.9m.
5.	We will work with Northumbria Healthcare Foundation Trust to develop a comprehensive transition plan for completing the acquisition and the post transaction integration plan for the new organisation. This will include workstreams for clinical and operations, communications and engagement, estates and facilities, finance and contract negotiations, governance and legal, human resources, information governance and IT. We will agree Heads of Agreement and proceed with regulatory and Department of Health Approval for the transaction with the aim of completing the acquisition by December 2012.

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

The safety and quality priorities for 2012/13 have been set following the review of clinical governance priorities by the Governance Committee. Here is a summary of the key priorities for 2012/13 to ensure the improvements made are sustained and develop further.

Objective	Key Actions	Priorities for 2012/12
To examine compliance and evidence of meeting CQC essential standards of safety and quality and how this information is shared with stakeholders	• Greater focus has been placed on the outcomes from the Quality Risk Profile (QRP) and the position of the Trust in relation to the Provider Compliance Assessments (PCAs) • Communication materials have been prominently displayed to promote the essential standards of care and empower patients and relatives to challenge or raise concerns if they feel the standards are not being met	• Monitoring of compliance to be extended into the three clinical divisions • Trust reporting and monitoring framework to be developed in accordance with the Monitor Compliance Framework

Independent assessment of the robustness of the Trust's clinical audit function	• A new Clinical Audit Strategy and clinical audit policy have been established • Specific information on clinical audit is now included in the quarterly governance reports	• Development of the clinical audit plan for 2012/13 with identified clinical leads • Produce a status report on the position of improvement plans arising from clinical audits • Performance manage clinical divisions on the delivery of their audit plans • Establish and monitor the clinical directorates on how the outputs from clinical audit are reviewed and reported
Independent assessment of the provision and monitoring of mandatory training across nursing, medical and non-clinical staff	• Work has been undertaken to develop and engage staff with the use of the interactive Training Needs Analysis • The Mandatory Training policy has been updated • Improvements have been made on the reporting of mandatory training to both Trust Board and Divisions	• Performance management of Divisions in the training levels for all staff groups against the specific training priorities set for the Trust • A specific report on mandatory training to be introduced for medical staff to ensure SPA time is being used for mandatory training
Independent assessment of the robustness of the Trust's system for the recording and monitoring of appraisals for all staff	• The Trust system for recording staff appraisal rates is not linked to the main ESR system. Improved reporting on appraisal figures to the divisions has been introduced and are reviewed at the monthly divisional reviews • Recording and monitoring of medical staff appraisals has improved. A new medical staff appraisal policy has been drafted and under consultation. • The Trust policy for appraisals has been updated	• All clinical departments and Directorates with appraisal rates below 50% to produce detailed improvement plan for quarter 1 and 2 of 2012/13 • New medical staff appraisal policy to be implemented in preparation for medical revalidation

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	• A new policy outlines a clear process for the management of NICE guidance across the Trust • The Trust's NICE register has undergone a significant review and has been revised • The governance team are now fully interlinking incidents and complaints against NICE guidance to ensure issues are checked against the guidance	• Position on NICE compliance will be formally reported to the Trust Board as a key quality performance measure during 2012/13 • The updated register will be reviewed by the Governance and Quality Committee in quarter 1 of 2012/13 as part of the Divisional quarterly reports • The outcomes from clinical audit which link to the compliance with NICE guidelines will be specifically reported on at the Clinical Standards Sub Group
to determine whether the Trust's strategy for governance, risk and quality is fully embedded across all wards and departments in the Trust	• Information on the Trust's core pillars of governance has been introduced to the staff induction • The governance reports across the Trust have been tailored to reflect the core pillars • Specific road shows against the core pillars have been carried out in key areas and will continue	• Continuing with the staff road shows for the core pillars of governance during July 2012 • Conduct a 'staff feedback' survey during quarter 2 on the general knowledge of the Trust's governance framework
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	• Additional roles introduced to Medical Director's office • Complaints department centralised on one site • Clinical Audit Facilitators now aligned to an individual clinical division • Head of Patient Safety and Clinical Governance role redefined • Compliance Manager role redefined	• Alignment of the Medical Director and Director of Nursing for the responsibility of clinical governance • Dedicated Director lead to co-ordinate governance across the Trust • Dedicated litigation lead
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	• Investment and improvement in the Medical Director's office has been introduced as part of the review to improve the focus on clinical standards and effectiveness as outlined in earlier sections of the report	• Clinical divisions should undertake a review of how the core pillars of governance are discussed and reviewed within their clinical directorates

A key focus will also be to ensure the CQUIN and Quality account incorporate all nation and local requirements for safety, quality, patient experience and outcomes as shown below.

Following consultation with our staff and stakeholders the table below illustrates our identified priorities for 2012/13. We will combine these priorities for improvement with the local/regional and national priorities within our Commissioning for Quality and Innovation Payment Framework (CQUIN) together with the Department of Health's 5 domains for improvement which are:

Domain 1: Preventing people from dying prematurely

Domain 2: Enhancing quality of life for people with long-term conditions

Domain 3: Helping people to recover from episodes of ill-health or following injury

Domain 4: Ensuring that people have a positive experience of care

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

2012/13 Priorities			
Domain	**Target**	**Rationale**	**Measure**
Safety	We will review the management and escalation of acutely-ill patients	To ensure patients who are acutely-ill get the right care, in the right place at the right time and in accordance with best practice	We will undertake a base-line assessment of patient observations taken at bedsides with the Modified Early Warning Score Charts (MEWS) to ensure timeliness, completeness and escalation is appropriate to patient needs
Effectiveness	All our wards will continue the implementation of the Productive Ward series	To continue to ensure all our wards are well organised and staff have more time at patient bedsides	All wards will have achieved the 3 core modules and will have identified their priority modules
Experience	We will improve the information given to patients when they are discharged from our care	Feedback from patients (NHS Patient Surveys) has highlighted this is an areas for improvement	Base-line assessment of current information; patient focus group review and in Quarter 4, a survey of patients to test improvement

CQUIN Priorities 2012/13

A number of further targets have been set for next year under the CQUIN programme which has been developed in partnership with our clinical commissioners and GPs. The Trust will prioritising action plans for these locally set priorities of safety, effectiveness and experience. The goal to be achieved is listed in the table below together with a description of the necessary requirements that need to be put in place which also includes a general aim to reduce the number of emergency readmissions to the hospitals.

No	Goal	Goal description	
National/Regional/Local CQUIN			**Value £**
1	VTE Prevention	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	206,554
2	Patient Experience	Improve responsiveness to the personal needs of patients	206,554
3	Dementia	Improve awareness and diagnosis of dementia, using; • Screening • Risk assessment • Referral for specialist diagnosis	206,554
4	NHS Safety Thermometer	Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter and VTE	206,554
5	Advancing Quality	Regionally led quality incentive scheme for pneumonia, hip &knew replacement, acute myocardial infarction, heart failure and stroke	
		AMI	16,524
		Heart Failure	16, 524
		Hips	16,524
		Knees	16,524
		Pneumonia	16,524
		Stroke	16,524
		Patient Experience	16,524
6	Emergency Floor	Implementation of emergency floor model and improved management of ambulatory conditions	826,215
7	Children: Integrated care	Children and young people are helped to recover effectively from illness or injury	826,215
8	Make Every Second Count	Improving recording of: smoking statistics, potential alcohol misuse and nutritional status of patients	206,554
9	Evidence Based Referrals	Implementation of current process and clinical commissioning requirements for procedures of limited clinical value and extension of schedules of procedures	107,408
10	Service Reviews	Two major service reviews to be carried out – dementia and Hospital Mortality Data (SHMI) and end of life.	1,032,768
11	National Survey	Patient Experience Surveys	206,554

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

We have completed developed of the clinical models for the delivery of the Integrated Clinical Strategy and 2012/13 is about ensuring the implementation plan is successful. The key 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 underpinned by new pathways for ambulatory care/emergency care. 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 on-going care pathway and to ensure a predicted length of stay is established prompt intervention or discharge.
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.

4.3 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 coordinated through the PMO. The combined cost improvement of this programme is in the region of £16.9m.

The key turnaround programme workstreams are listed below:

Turnaround Workstreams 2012/13		
• Pharmacy Reconfiguration • Pathology reconfiguration • Radiology	• Estates productivity and efficiency • Consultant Job Planning • Nursing Review • Midwifery Review	• Theatre Efficiency • Procurement • IM&T, Clinical coding and Forward • Administration Review • Reduced Locum staffing

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
- Improving the value for money from back office functions and estates and facilities services including managed service options

4.4 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. Having achieved SHA approval for the FBC the scheme is now entering the final stage of the approval process with the Department of Health and Treasury.

Completion of the new build aspects of the scheme are expected to be completed by June 2016 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 and the approval of the procurement strategy will be secured with the DH in preparation for the start of works on site in July 2012.

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

The Trust has completed a key stage in the acquisition process to identify a preferred bidder by January 2012. The selection of Northumbria as the preferred bidder was supported by our Stakeholders because it identified more opportunities for service development and integrated services.

The overall level of transitional financial support for the acquisition has been agreed between Northumbria, NHS North and the local commissioners. The acquisition will move forward with the signing of a Heads of Agreement setting out how Northumbria and the North Cumbria Trusts will work together over the next few months to conclude the transaction. A Transaction Board and workstreams will be established to deliver and integrated plan for the new organisation.

Key steps in taking forward the acquisition to completion are outlined below:

Key Milestones	Timeline	Lead
Establish Transition Board-Workstreams	May	All
Agreement of Head of Terms	June	All
Completion of Due Diligence	June	Northumbria
Submission of CCP application	June/July	Trusts
Monitor assessment	August	Northumbria
TUPE consultation to commence	September	Northumbria
Recruit North Cumbria members and elect Governors	September	Northumbria
Submit the Business Case for DH and Secretary of State approval	July-September July & October	SHA
Completion of the Business Transfer Agreement	November	All
Anticipated completion of the transaction	December	All

The Trusts are working together to achieve a deadline of 1 December 2012 however, the timescales for some of the external processes cannot be confirmed as they are largely influenced by external regulators.

In addition to the key tasks outlined above there is a complex and detailed programme of work to integrate the systems, processes and clinical models across corporate and operational functions.

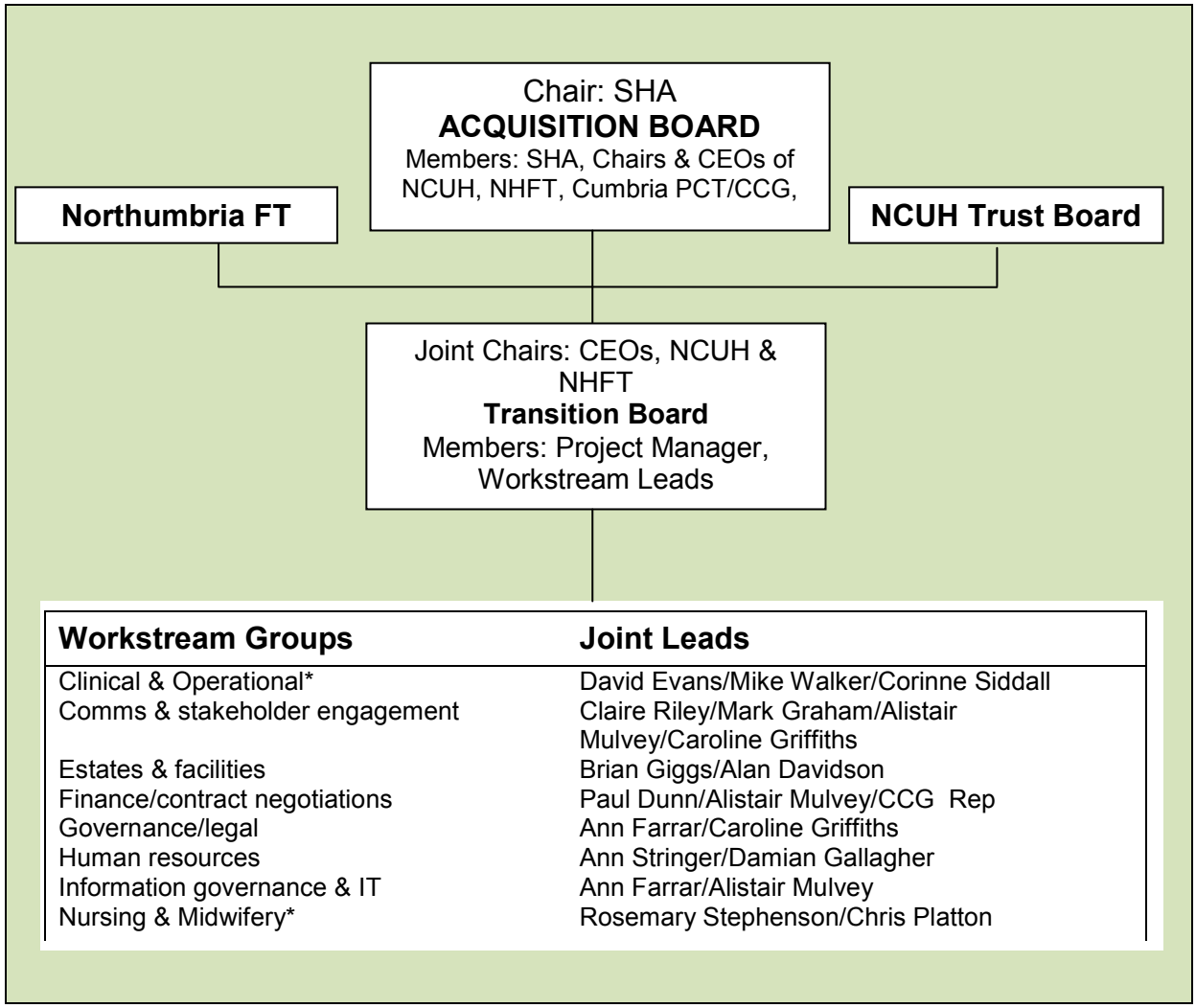
The two organisations therefore need to develop a governance framework together which is capable of delivering the mandatory and regulatory requirements as well as a robust transition plan.

The overall architecture for taking the acquisition forward is designed to fulfil external governance requirements as well as those for each Board of the organisations involved in the transaction. It requires the establishment of the following:

- A small, high level Acquisition Board accountable for completion of the transaction in line with the TFA.
- A Transition Board which is responsible for ensuring there is a robust work programme for the transition which is delivered pre and post transaction.

- Workstream Groups responsible for developing and delivering individual plans which include all tasks required to achieve integration pre- and post-transaction

The overall governance framework for the transaction and transition planning process is shown below:



Workstream Groups	Joint Leads
Clinical & Operational*	David Evans/Mike Walker/Corinne Siddall
Comms & stakeholder engagement	Claire Riley/Mark Graham/Alistair Mulvey/Caroline Griffiths
Estates & facilities	Brian Giggs/Alan Davidson
Finance/contract negotiations	Paul Dunn/Alistair Mulvey/CCG Rep
Governance/legal	Ann Farrar/Caroline Griffiths
Human resources	Ann Stringer/Damian Gallagher
Information governance & IT	Ann Farrar/Alistair Mulvey
Nursing & Midwifery*	Rosemary Stephenson/Chris Platton

* indicates critical interdependency of these workstreams

The purpose of the Transition Board is to ensure there is a robust work programme for the Transition Plan which will be delivered pre and post transaction. It will be responsible for the oversight, clarity, delivery and performance management of the Transition Plan to ensure there is an effective and timely transition of services.

The workstream Groups are responsible for developing and delivering individual plans which include all tasks required to achieve integration pre and post transaction. The Workstreams will be jointly led by a Director from each organisation.

Workstream plans will be structured across 3 distinct phases:

Phase	Focus
Phase 1 Pre- acquisition	Delivery of all pre-acquisition transaction requirements Delivery of safe day 1 requirements.
Phase 2 Safe 100 days	System development, merging both organisations into one legal entity
Phase 3 Transformation	Service modernisation

Phase 1 will be completed at the point of acquisition.
Phase 2 will be completed within 100 days from the date of acquisition
Phase 3 will be delivered within 12 – 36 months

The Trust Board will continue to receive monthly reports on the process and the monthly performance report provided to the SHA in line with the TFA requirements. The aim will be to maintain the status of the FT milestone at amber/green as a minimum.

4.6 Divisional Priorities

Our key 2011/12 Divisional service developments are:

Division	2012/13 Priorities
Surgery	• Develop the surgical pathway to maximise patient experience and efficiency • Implement the Theatre Efficiency programme • Develop the day case model/pathway • Consolidate out of hours surgery • Introduce epidural anaesthetic service at Cumberland Infirmary • Maximise the opportunity for becoming a Vascular Centre in the Cumbria and Lancashire Vascular service review • Extend treatment modalities in Urology for patients suffering from kidney stones

Medicine and Cancer Services	• Deliver stroke improvement plan • Implement the national dementia care strategy • Develop PPCI in the cardiology service • Implement a new model for Emergency care across both hospital sites supported by new patheays for ambulatory and emergency care • Review pathways for chest pain, abdominal pain, stroke, end of life care, COPD, Asthma, Cellulitis, UTI, Syncope, head injury and dementia • Develop hub and spoke model for specialist services • Achieve accreditation for Trauma Unit status • Review capacity and demand for Acute Rehabilitation • Implement Cancer Reform Strategy developments e.g. IMRT and acute oncology
Child and Family **Clinical Support**	• Develop and implement Paediatric assessment model and new model for supporting locality services • Implement new workforce model for Obstetric at West Cumberland Hospital • Review midwifery services • Redesign gynaecology pathways – implement OP hysteroscopy • Implement Pathology and Pharmacy service reconfiguration • Improve radiology capacity through job planning and service redesign • Develop AHP service level agreement for West Cumberland Hospital

4.7 Corporate Service Development Plans

Comprehensive IM&T Programme

The 2012/13 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 and as such projects which are already approved and in the various stages of implementation, including;

- The roll-out of Real-time as part of the ForWard programme
- Electronic ordering at ward level - also part of ForWard
- The integrated discharge summary
- Systemic Anti Cancer Therapy data set - Infoflex
- Digital Dictation (linked to the Admin Review)
- Data warehouse –Pathology and clinical access

- Replacement of Endoscribe
- Electronic Staff Record Self Service
- Preparatory work for new PACS/RIS contract – local image storage

In addition various Cumbria wide infrastructure projects including Multi-Function Devices (printing) will be implemented. There will also be a further work stream, related to Acquisition outcome but yet to be quantified.

Any further new developments and significant feasibility work will require the prior approval of a mandate by the Informatics Steering Board which meets on alternate months with Executive, Divisional and Clinical membership. The Board will be keen to ensure that any such projects are supported by a business case which identifies how benefits will be delivered and that all the required implementation resources are available.

Service Line Reporting

The development of Service Line Reporting has progressed well during the year with a fresh approach being undertaken driven by Patient Level Costing and Information Systems (PLICS). The revised approach calculates a price for each patient treated based on the total resources they have consumed whilst in hospital. The cost of care generated under PLICS takes into account a wide variety of factors such as the length of time spent in theatres, the patient's length of stay in hospital, drugs consumed, cost of diagnostic tests such as radiology and pathology tests etc. This is helping to have a better understanding of the Trust's cost base and is a key enabler to support strategic decision making as resources become increasingly scarce and to fulfil the requirement to deliver further efficiency savings. Additionally the cost of care for each patient can also be compared to the level of income secured for that patient's spell of care allowing the Trust to identify where it provides services which are below or above the national tariff and therefore contributing to a surplus or a deficit position.

5. Workforce, Training and Education

In 2012/13 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:

- Develop a more comprehensive selection of HR performance metrics to identify opportunities for improvement and areas of good practice
- Reduce sickness absence from 3.5%.
- Increase the uptake of appraisals to 80% encompassing the concepts of competencies and continuous professional development.
- Increase uptake of mandatory training
- Implement a comprehensive programme to improve staff satisfaction
- Continue workforce controls

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.

The Education and Training Strategy developed In 2010/11 will continue to be implemented as follows:

- 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.
- Formalisation of roles through the education and training structure which incorporates both medical and non-medical education.

The strategy recognises the following key issues and challenges:

- Increased uptake of mandatory training and educational appraisal is required 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
- There needs to be tighter procedures for the policy for study leave and payment to ensure the Trust receives value for the investment.
- Documentation and process around re-validation is high priority and will need capacity.

6. 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 2012/13 Framework will be undertaken later this month.

7. Governance

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 2012/13 specific objectives to strengthen the Trust's governance arrangements have also been defined. This recognises the need to converge governance and performance systems with the Monitor Compliance Framework in preparation for the acquisition.

7.1 Risk Register Reporting and Assurance Framework

The principal document for the Board to monitor the key risks associated with the delivery of its objectives is the assurance framework. The assurance framework will therefore be reported to the Board on a quarterly basis in preparation for the transaction scheduled for December 2012.

Q1	Q2
July 2012	October 2012

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

7.2 Integrated Governance and Performance Reporting

An internal review of performance and governance reporting has been undertaken comparing NCUH systems with Northumbria.

The NCUH systems require further development to reflect the implementation of the clinical transformation plans, greater emphasis on quality and safety in the 2012/13 contract and the future requirements for self certification once the Trust's services are transferred to Northumbria and are delivered within the Monitor Compliance Framework. The Trust is aiming to converge reporting systems therefore by December 2012.