

Northumbria Healthcare NHS Foundation Trust

**Northumbria Healthcare NHS Foundation Trust**

**APR Strategy Document**

### ***Template 1: Vision and key priorities***

Guidance: The Board should be able to describe where it believes the Trust is currently placed in terms of progress towards the delivery of its overall vision and strategy, where in this context it aims to get to over the next three years, and the main priorities which will need to be delivered to secure the required progress.

The Trust's vision should describe at the highest level the strategic objective of the Trust and in particular how it wishes to be viewed by its patients and service users, staff, commissioners and other key stakeholders. In most cases this will reflect but not be the same as the Trust's vision statement. The vision should be shared in particular by the Board of Directors and the Board of Governors. Comment as to the likely timescales for the delivery of the vision may be appropriate particularly if this falls outside the three year period of the annual plan.

The Trust Board should be able to articulate the key changes required in order to evolve and develop the Trust from its present position and the key elements of the organisation that need to be in place to achieve the vision. In all parts of the Trust's plan, including the financial forecasts, there must be a clear link between its overall vision and the strategic objectives, operational plans and key assumptions. These main priorities for the next three years are likely to be high level and may, for instance, represent the „top five' for the Trust. Milestones should similarly be high level but measurable by the Board, to enable an objective assessment as to progress towards their delivery.

## **Our Current Performance is:**

### **Introduction**

Northumbria Healthcare NHS Foundation Trust is a successful top performing Trust providing secondary healthcare to over 550,000 people spread over the largest geographical area of any Trust in England, from Tyneside in the South and East, to the Scottish Border in the North, and to Hexham and Haltwhistle in the West of the County. We became an NHS Foundation Trust on 1st August 2006

We are in the Top 25% of Hospital Trusts as defined by CHKS a leading company that benchmarks hospitals performance. Our performance is recognised regionally and nationally as having very strong clinical services in a range of specialties, excellent clinical leadership, a track record of delivery with limited resources, innovative approach to service delivery and excellent relationships with primary care. We also have a first class reputation for teaching, being a key unit of Newcastle Medical School and partnerships with Northumbria and Sunderland Universities for nurses and other professionals. Mr. Lester Sher, Orthopaedic Surgeon, is Head of the Northern Academy of Surgery and Professor Roger Barton is Chair of the Board at Newcastle Medical School and Dr Richard Thomson is Sub-Dean – Northumbria for Newcastle University Medical School.

### **Strategic Corporate Objectives**

We have listened to our key stakeholders, that is, patients, staff, General Practitioners, Governors and members and this has influenced our priorities for the next three years and more importantly for 2010/11. These priorities build on our success in the last year when we concentrated on our key strategic objectives which were:

#### **i. High Quality Care**

2009/10 has been an exceptional year for Northumbria Healthcare. We have continued to enhance the quality of care delivered by our caring and dedicated staff. For example:

- a) Recognised as one of the top 40 Hospitals in the country for our low risk adjusted mortality rate and complication rate.
- b) Board of Directors were the national winners of the board leadership in patient safety award.
- c) Fully met the Care Quality Commission Core Safety Standards and registered, the 26 Essential Safety and Quality Outcomes, without conditions.
- d) Reduced our standardised hospital mortality ratio from the top 25% to the top 15%.
- e) Participated in the Patient Safety First, leadership in patient safety programme and won the award for most improved trust. Using this programme we adopted the Institute of Healthcare Improvement reduce harm methodology known as the global trigger tool which provided us with a better understanding of our harm rate. As a result the board of directors agreed that the challenge was to reduce our harm rate, by half, by June 2011, that is, a harm rate of 45 per 1000 patient events. By the end of March 2010, we have achieved this target and will be setting a new target to reduce our harm rate by half again, hence our target by June 2011 is 22 per 1000 patient events.

- f) Significantly reduced our hospital acquired infection rates. We reduced our MRSA cases from 14 to 9 and reduced our clostridium difficile cases from 190 to 129. We also had a local target to reduce our surgical site infections and they reduced from 56 to 51 cases. We achieved this by an outstanding performance of over 97% compliance with our infection control practice. These achievements were recognised by the North East SHA, awarding the trust the winner of the Safer Care North East award in September 2009.
- i) Our aim is that over 90% of patients experience an excellent/very good service. We have specifically targeted trust wide improvements and these are, to reduce the number of patients experiencing same sex showers and toilet accommodation, to enhance our communication standards to meet more of our patients' needs, and to reduce the out-patient waiting experience to be within 15 minutes of the booked appointment.

### **Modern and Effective Healthcare**

Our success in the future will be defined by our staff continuing to provide modern and effective healthcare. We have great strides in the most significant priorities:

#### **a) Specialist Emergency Service**

The North of Tyne Commissioners led one of the most ambitious and engaging public consultations in England during 2009 on the clinical case for a new specialist emergency care centre. The outcome of the public consultation was agreement by the North of Tyne Commissioners and Monitor to the outline business case. During 2010/11, the emphasis will change to the design, costing and planning permission. The strategic improvement is critical to the delivery of specialist emergency care because we intend to achieve:

- Best possible outcome for patients
- International best practice
- Access to specialists as soon as possible
- Reducing reliance on junior doctors
- Sustainable high quality service for Northumberland and North Tyneside

- b) Existing General Hospitals will continue to provide ongoing inpatient care, Outpatients, diagnostics, the majority of elective surgery and walk-in services with opportunities for development, eg community services and pharmacy etc. They will have a better environment, space created will allow us to increase the number of single rooms and move from 6-bedded bays to 4-bedded bays.
- c) Existing Community Hospitals will focus on their core business that is rehabilitation for older people, outpatients, diagnostics and some surgery. The Board of Directors has continued its commitment to the long-term success of local community hospitals. The community hospitals have detailed plans to have a better environment with the redevelopment of Haltwhistle Memorial Hospital planned to be ready by 2011 subject to a public consultation process, Morpeth services in the town centre by 2012, this followed a very successful public consultation in 2007 and land to be purchased in 2010 for the re-development of Berwick Infirmary. The date for the re-development is indicative within our 10 year plan however the earliest date would be 2014/15.

## **Contributing Our Personal Best**

The Trust has worked hard over the last 12 months to ensure that staff have access to appraisal, personal development plans and essential training. We want every member of staff to feel that they are valued and that requires commitment and investment from the organisation as well as the individual. We will continue to improve performance appraisal and training attendance, and sickness absence rates. Regular attendance improves morale and allows more time and money for training and development to take place.

We will develop a code of behaviour this year to support and demonstrate the type of work relationships to create a climate in which we can all give our personal best.

## **From Good to Excellent**

### **a) Care Quality Commission**

The Healthcare Commission published the Annual Performance Ratings of Trusts for 08/09, in October 2009, and rated the trust as a double excellent, that is, Excellent for Quality of Services and Excellent for Use of Resources.

### **b) Monitor**

Monitor rates the Trust at the beginning of the year based on the Board of Directors risk assessment. In August 2009, Monitor confirmed the Board of Director's assessment which was Green (recognised as excellent) for governance and a financial risk rating of 4 (recognised as excellent) for financial management. During 09/10, the trust delivered a standard of excellent during each of the four quarters.

### **c) Engagement of Governors and Members**

Governors were actively involved in the refreshing our strategic plan 2010-2015, and very actively involved in the planning and delivery of the public consultation on our specialist emergency care centre.

We set ourselves an ambitious aim of recruiting 100,000 members and we have recruited 78,117.

Members have been invited to attend the quarterly Governors Body General meetings, Annual General Meeting and local constituency meetings. Communicating with members and member engagement is a challenge and a range of initiatives have been introduced that is, involvement of members to review patient information literature, participation in speciality specific groups e.g. arthritis, breast care and the development of the healing arts programme and Introduction of a members' newsletter.

## **Summary of Financial Performance**

### **a) Income and Expenditure (Revenue)**

The Trust reported a surplus (before exceptional items) of £ 3.4m. This was below the original plan of £4.5m but in line with in-year forecasts.

This improved performance was the consequence of higher than anticipated activity levels across both elective and non-elective services.

This will be an excellent result given the challenges the Trust had to respond to such as:

- significant increase in elective activity to meet the maximum wait of 18 weeks for elective treatment
- a substantial cost reduction programme of £ 7m
- More Patients treated.

The position is subject to external audit. It is important to highlight there were exceptional costs or “one-off” costs of £ 12.9m incurred within the year these costs were due to revaluations of assets. The Trust will therefore report a deficit of £ 9.5m after taking into account exceptional items. Monitor explicitly excludes exceptional items when determining performance.

<b>Patient Activity by PbR only</b>	<b>Plan 2009-10</b>	<b>Outturn 2009-10</b>
Non-elective inpatient spells	59,098	59,187
Elective inpatient and day case spells	46,407	49,068
Outpatient New	99,894	102,693
Outpatient Follow-up	239,004	246,106
Diagnostic tests (direct access only)	1,507,373	1,666,548
A&E attendances	148,977	161,889

**b) Working Capital and Liquidity**

The Trust had a cash balance of £ 24.6m at year-end.

## The Trust's vision over the next three years is to:

The main business of Northumbria Healthcare NHS Foundation Trust is to help improve the health and quality of life of people by providing world class healthcare services from accident and emergency care to long term conditions. To do this we need to be excellent at three things. The first is to deliver world class quality emergency care and other healthcare services, secondly to provide excellent patient centred customer services and thirdly to deliver the safest care and excellent regulatory standards.

The board of directors has identified a number of core competencies to achieve these strategic goals. We will continue with our strong track record to develop, improve and innovate what we deliver and how we deliver it and we will build on this by the use of world class improvement methodologies. We will continue to work in close partnership with primary, tertiary and social care providers to provide seamless pathways of care and deliver this care in the best place for patients. We have a wide range of key stakeholders and we intend to continue our active engagement and acting on their views. This proactive approach with our partners and stakeholders will provide us with better business intelligence to make better decisions about continually improving care and our priorities. We will continue to market our services to our customers and aim to build a stronger brand with a reputation for excellence.

To achieve these improvements we will develop a patient focused and performance driven culture built on trust and empowerment with greater transparency to help the organisation learn and improve. Everyone will know what we want to achieve and how they contribute to the things that really matter resulting in happier and engaged patients and staff that recommend our services to others. We will recruit, develop, motivate and communicate with our people and support them with the appropriate training and competencies to do the right thing, every time. All parts of Northumbria will work to bring about innovative improvements in service delivery for the benefit of our patients. To do this, we will re-align resources making better use of technology and information to make better decisions, develop and leverage our estate and maximise our long term financial strength. The vision has been created into a visual strategic map which is on the next page. The strategic visual map has been risk assessed to determine the effort and focus of the organisation to deliver the vision. The risk assessment is based on qualitative and quantitative information the board of directors has considered and is defined as follows:

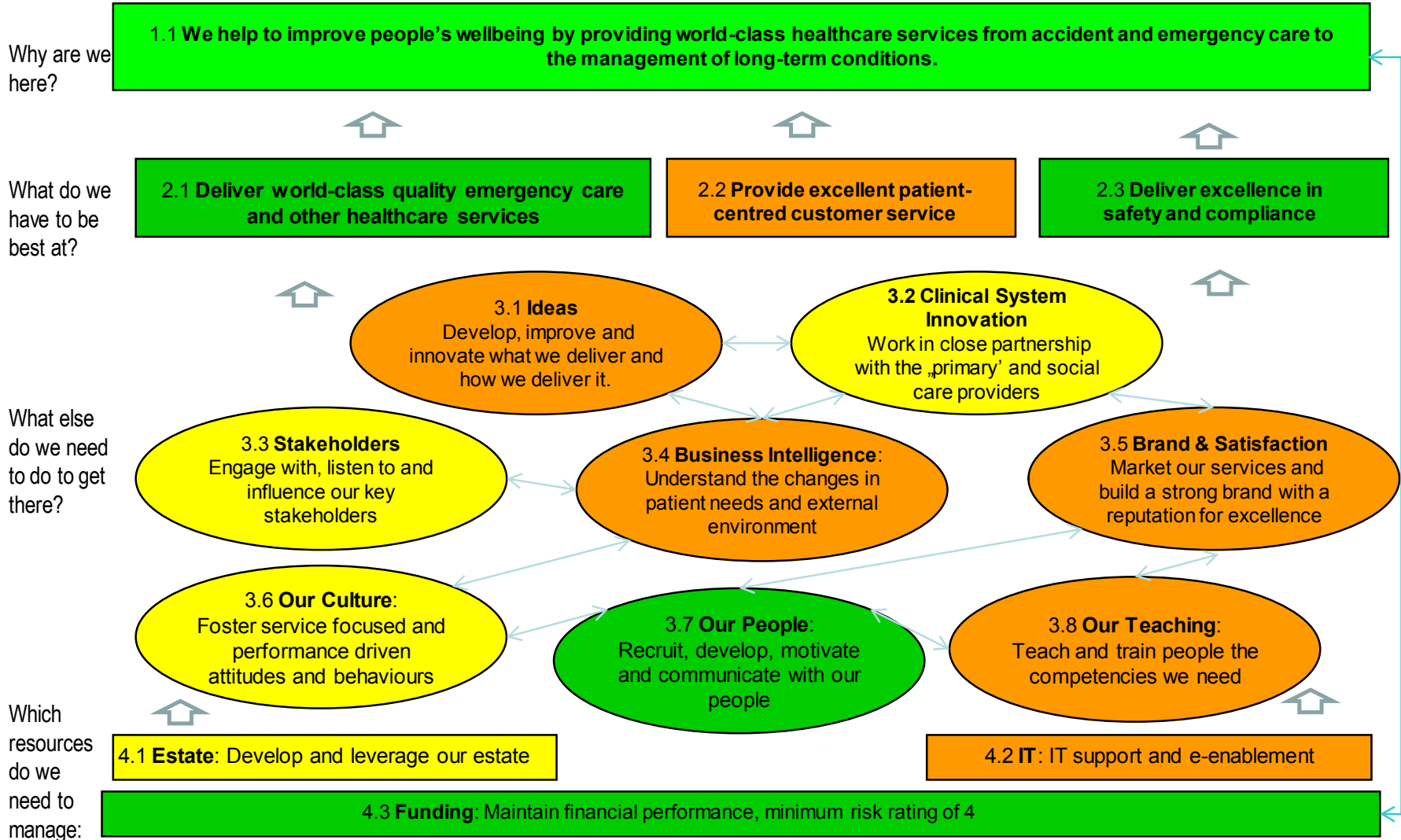
Green - everything good

Yellow - some issues

Orange - bigger issues

Red - not good at it.

# Strategic Plan on a Page



**Key priorities for the Trust which must be achieved in the three years of the annual plan to underpin the delivery of the Trust's**

Key priority (and timescales)	How this priority underpins the strategic vision	Key milestones (2010/11)	Key milestones (2011/12)	Key milestones (2012/13)
<p><b>New specialist emergency care centre, re-develop the district general hospitals and the community hospitals.</b> The next three years provide many challenges in terms of the significant project management tasks. During 2010/11, the emphasis is on the design, costings and planning permission for the specialist emergency care centre, the district general hospitals and the community hospitals.</p> <p>The timescale for 10/11 is informal discussions with local residents from February, commercial negotiations and contract signed by May, formal pre-planning application consultation from June and submission of planning application from October.</p>	<p>Deliver world class quality emergency care and other healthcare services</p>	<p>Design, costing and planning permission stage for the specialist emergency care centre, district general hospitals and the community hospitals.</p> <p>Risk assessment High</p>	<p>Building works commence for the specialist emergency care centre and Haltwhistle Memorial Hospital.</p> <p>Risk assessment High</p>	<p>Commissioning phase of the specialist emergency care centre to support its opening in early 2014.</p> <p>Risk assessment High</p>
<p><b>Board self-assessment of clinical services</b></p> <p>A structured approach is in place over the next three years for each specialty clinical team to produce a self-assessment using the evidence available to define and measure world class care. Furthermore, each specialty team is expected to have</p>	<p>Deliver world class quality emergency care and other healthcare services</p>	<p>Review 33% of services.</p> <p>Risk assessment Moderate</p>	<p>Review 66% of services.</p> <p>Risk assessment Moderate</p>	<p>Review 100% of services.</p> <p>Risk assessment Moderate</p>

<p>engaged with patients and staff to agree specific clinical outcomes measure, the current baseline standard and world class standard. The expectation is continual improvement overtime to achieve the world class standard and the board of directors provided with the necessary assurance.</p> <p>The timescale is to agree the three year plan at the board of directors in April 2010. The first services to be self-assessed will take place by July 2010 and thereafter at regular intervals.</p>				
<p><b>Acquisition of services</b> Our work is dependant on collaboration with our partners in the provision of health and social services. There is a need for better integration of these services. This requires close working relationships so they understand the services we offer and we are able to fine tune or re-define them as necessary.</p> <p>There is now an opportunity using the national policy guidance to respond to an expression of interest to integrate community services provided by the North of Tyne Commissioners. If we are successful, this would present a significant advantage to the outcomes for patients, bring operational gains in terms of productivity and effectiveness</p>	<p>Deliver world class quality emergency care and other healthcare services</p>	<p>Expressions of interest to be responded by end of May 2010.</p> <p>Risk assessment High</p>	<p>Start of new service specification from April 2011.</p> <p>Risk assessment High</p>	<p>Achieved a minimum of good within the regulatory framework, that is, Monitor, Care Quality Commission and the NHS litigation authority.</p> <p>Risk assessment High</p>

<p>and be considered as a new joint venture by Monitor and need to be assessed in line with the compliance framework.</p>				
<p>To be rated as Excellent by our key regulators of quality of care, that is, the Care Quality Commission, Monitor and the NHS Litigation Authority and the local Commissioner.</p> <p>The achieve Excellent by the Care Quality Commission we need to continue to fully met the 26 safety. The most significant challenge is to put in place a robust performance managements system to demonstrate that the appropriate process and outcomes are met.</p> <p>Furthermore, we will ensure we meet the national policy standards regarding reduction in hospital acquired infections, 18 week from referral to treatment, the maximum wait of four hours in accident and emergency and the national cancer targets. The most challenging of these targets is the reduction in hospital acquired infections. This will require excellence in the infection control practice. We achieved this in 09/10 and intend to maintain this standard, however, this target stretches the trust once again because each year the target is smaller and smaller. Our aim is to have less</p>	<p>Deliver excellence in safety, quality and the regulatory system.</p>	<p>Rated excellent by Care Quality Commission, Monitor and the NHS Litigation Authority.</p> <p>Risk assessment High</p>	<p>Rated excellent by Care Quality Commission, Monitor and the NHS Litigation Authority</p> <p>Risk assessment High</p>	<p>Rated excellent by Care Quality Commission, Monitor and the NHS Litigation Authority</p> <p>Risk assessment High</p>

<p>hospital acquired cases than last year (that is less than 6) but we has 2 hospital acquired cases in April so the board of directors decided in April to rate this risk as a very high risk.</p> <p>This year we have a new Monitor target, that is, the new mental health target. We have invested in a new reporting system and this goes live in April 2010. This is a moderate risk.</p> <p>To be recognised by our local Commissioner as having fully met the safety and quality standards in the legally binding contract. The risk rating is high risk given the introduction of the higher financial penalties attached to commissioning for quality and innovation (CQUIN). The trust income for CQUIN is 1.5% that is £3,900,000. A robust performance management system is in place to deliver this strategic objective.</p> <p>Achieve NHS litigation authority rating, level 3 (top rating) for maternity services. This is high risks given the new standards were published in April 2010 and expect a higher standard of care and evidence.</p>				
<p><b>To operate as the safest hospital in the North East of England.</b> We intend to achieve this by reducing our</p>	<p>Deliver excellence in safety, quality and the regulatory system.</p>	<p>SHMR to be in the top 20%. Our harm rate to</p>	<p>SHMR to be in the top 15%. Our harm rate to</p>	<p>SHMR to be in the top 10%. Our strategic harm</p>

<p>standardised hospital mortality ratio so that it operates in the top 10% of England and half our harm rate from 90 per 1000 patient bed days to 45 per 1000 as measured by the Institute of Healthcare Improvement.</p> <p>To do this we have prioritised our primary causes of harm. Our priorities for improvement are to provide safer care and more effective care. To do we will continue to reduce hospital acquired infections, reduce medicinal errors, particularly high risks medicines, 100% of patients on admission will be risk assessed for venous thromboembolism, and introduce a balance scorecard for best nursing practice care.</p> <p>To work towards the strategic aim of our mortality being in the top 10% of hospitals we have started a proactive and systematic review to the causes of our death and compared our excess deaths with our peers.</p>		<p>reduce to 45 events per 1000 bed days.</p> <p>Risk assessment High</p>	<p>reduce to 22 events per 1000 patient bed days.</p> <p>Risk assessment High</p>	<p>rate to reduce to 11 events per 1000 patient bed days.</p> <p>Risk assessment High</p>
<p><b>Excellent long term financial strength.</b> Our funding enables us to do our job. With tightening budgets in the NHS we need to ensure we generate sufficient funding and that we operate in the most efficient way. We need to become more entrepreneurial and provide services to increase our</p>	<p>Maintain financial performance and a minimum risk rating of 4.</p>	<p>Achieve risk rating 4.</p> <p>Risk assessment High</p>	<p>Achieve risk rating 4.</p> <p>Risk assessment High</p>	<p>Achieve risk rating 4.</p> <p>Risk assessment High</p>

<p>income. In doing so, we must ensure we control costs to ensure on-going profitability and re-investment into services.</p> <p>To do this we have produced a 10 year investment strategy approved by the board of directors in September 2009.</p> <p>Implementation is critical so we have approved the first year of the plan and started the key steps in implementation. Reporting to the board of directors will be enhanced by fortnightly reporting to the executive management team.</p> <p>Enhanced productivity is a major part of our financial strategy. The key areas of focus are, better length of stay, better bed occupancy rates, better new to follow-up ratio in our outpatient service, enhanced workforce and back of office productivity. Targets are in place for each of these and they are part of the regular report to the board of directors and executive management team.</p>				
<p><b>Place clinical and business need at the centre of our information and technology service delivery.</b> Elements such as electronic patient record and e-enablement of services will be a key aspect to deliver better and more efficient services by 2015.</p>	<p>Electronic integrated health record.</p>	<p>Electronic single view of existing clinical systems by October 2010.</p> <p>Timeliness of clinical coding</p>	<p>Scoping of work to produce prioritised plan of e-enablement of the remaining case note documentation.</p>	<p>E-enablement of existing documentation in the patient case note.</p> <p>Accuracy and depth of coding to be</p>

<p>Providing greater accuracy, timely, complete and meaningful information will continually improve patient care.</p> <p>To do this we have designed three phases to the implementation of an electronic integrated health record. Phase 1 will result in a single view of existing key clinical electronic systems by October 2010. Phase 2 will result in the e-enablement of the paper records in the existing patient case note by 2012. Phase 3 is the comprehensive integration of all these systems and the use of these systems to a high standard of compliance, every time, for every patient by 2015. The outcome will be the archiving of the patient record.</p>		<p>maintained at 99.5% and improved where possible. Accuracy and depth of coding within 95% of accuracy.</p> <p>Risk assessment High</p>	<p>Timeliness of clinical coding at 100%. Accuracy and depth to be best in class.</p> <p>Risk assessment High</p>	<p>maintained at best in class.</p> <p>Risk assessment High</p>
<p><b>At the same time as delivering the best quality healthcare we strive to provide excellent patient centred services.</b> People rightly expect better standards of service and with the advent of patient choice it is critical that we meet their expectations. We aim to apply consistently excellent customer care across the organisation at all times, wherever patients, their family, carers, or visitors come into contact with the trust, to the same level as you would expect from a world class commercial organisation.</p> <p>We will develop a patient experience</p>	<p>Excellent patient centred services.</p>	<p>More than 85% of patients experience excellent/very good care in our inpatient and outpatient service.</p> <p>The national patient survey results are in the top 20%.</p> <p>Risk assessment</p>	<p>More than 90% of patients experience excellent/very good care in our inpatient and outpatient service.</p> <p>The national patient survey results are in the top 20%.</p> <p>Risk assessment</p>	<p>More than 95% of patients experience excellent/very good care in our inpatient and outpatient service.</p> <p>The national patient survey results are in the top 20%.</p> <p>Risk assessment Moderate</p>

<p>strategy and action plan and implement this across the trust, identify resources and training for staff at ward and front of house levels to improve patient satisfaction, particularly in areas of communication, involving patients in their pathway decisions and ensuring a seamless transition for patients between our own services and those of other providers.</p> <p>Our priorities determined from listening to patients from our local patient survey and the national patient survey is to enhance the communication between staff and the patients to meet more of the patients needs; enhance the outpatient waiting experience for patients so less patients wait more than 15 minutes for their booked appointment and at the point of discharge more patients feel ready for discharge and their medication is fully explained.</p>		Moderate	Moderate	
<p><b>All our achievements are the consequence of the staff we employ.</b> We are a major employer in the region and we need to serve the people who service the people therefore, ensure our people are motivated we want staff to be proud to work here and take pride in their job. Recruit high calibre people and offer a flexible, patient centred and family friendly work environment. Develop our people with good talent management and succession planning</p>	<p>To recruit, develop, motivate and communicate with our people.</p>	<p>Staff survey results are in the top 20% of trusts.</p> <p>Risk assessment moderate</p>	<p>Staff survey results are in the top 20% of trusts.</p> <p>Risk assessment moderate</p>	<p>Staff survey results are in the top 20% of trusts.</p> <p>Risk assessment moderate</p>

<p>and finally, engage and communicate with our staff.</p> <p>To know that we are delivering against this strategy we have decided to measure the following, to what extent do people take pride in their work and their employer? To what extent are we recruiting the best people and developing and managing the lead? To what extent do our people feel that we engage and communicate well? And finally, To what extent do people take ownership of issues and their resolution?</p> <p>Staff wellbeing will be measured by a number of means for example, the national staff survey report, management assessments, exit interviews, staff turnover rates and sickness levels.</p>				
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## Template 2

Guidance: The key external impacts template should reflect the significant external impacts on the Trust's plans, and for each of these, a brief description of the related risks and impact on the delivery of the plan, the actions taken and/or planned to be taken to mitigate the impact and residual risks which may then remain, the expected or planned outcome, measures of progress and the person accountable in each case.

Key external impacts will vary by Trust and also evolve or develop over time, but may include:

- Overall healthcare funding and the wider economic environment (both with regard to the Trust and its commissioners)
- Tariff changes
- Quality incentives/penalties
- Other contractual arrangement and challenges
- Service reconfiguration
- Demand management (e.g. practice based commissioning)
- Innovation and technology
- Pay – national and local negotiations
- Other changes in national or local policy or law
- Competition, co-operation and patient choice
- Demographic changes.

Key external impact	Risk to the plan	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
<p><b>Overall healthcare funding including wider economic environment</b></p> <p>The wider economic environment has strongly influenced the financial downturn planning done by the board of directors and approved by Monitor.</p> <p>It has also strongly influenced the strategic plan by the Commissions and the latest contract agreed with the North of Tyne Commissioners as at 31<sup>st</sup> March 2010.</p>	<p>High risk because the 10 year financial downturn requires a substantial reduction in our costs. In the first five years the reduction is £68m.</p> <p>High risk because of the impact on the non-elective tariff which is described below under tariff changes.</p>	<p>The financial strategy has been developed on prudent assumptions this includes an explicit contingency reserve the purpose of which is to provide financial stability. In addition, the plan includes “discretionary” investment which will only be deployed if assurance is gained regarding the on-going deliver of cost reduction and activity/tariff income.</p>	<p>The Trust has modelled a multiple risk scenario which indicates overall that the Trust would have sufficient “headroom” to deal with the risk outlined.</p>	<p>The Trust has established 10 year strategy and will monitor, review and adjust on an on-going basis the plan to ensure achievement of the key objectives outlined in the strategy. The key target is to maintain a risk rating of 4. The Finance, Investment and Performance Committee will oversee progress against the milestones in the strategy.</p>
<p><b>Tariff changes and demand management</b></p> <p>The significant issue is the tariff change to the non-elective admissions.</p>	<p>Moderate risk as embedded within financial assumptions for 2010/11.</p>	<p>We mitigated this risk by including in the contract agreement that we would work in partnership to secure a joint agreement and revised clinical protocol with the aim to reduce emergency admissions. This agreement is to be reached by end of first quarter and then this would be used to access £2m in the transitional fund held at</p>	<p>The expected outcome is measured by the changes in emergency admissions. This is not possible to quantify at this juncture based on the agreement that needs to be reached by the end of June.</p> <p>It is also measured by the success in accessing the transitional fund as agreed in the contract agreement.</p>	<p>Measures of progress will be a monthly report on the key elements agreed with the commissioner to the Finance, Performance &amp; Investment Committee and the Board of Directors.</p> <p>Accountability is the Executive Director of Finance and the Chief Operating Officer.</p>

<p>Best practice tariff changes are material not significant. Three of the four best practice tariff changes are applicable, that is, stroke care, fracture neck of femur and cholecystectomy.</p>	<p>Moderate risk because we already meet the cholecystectomy best practice standard, the commissioners have agreed to pay the stroke best practice tariff standard given our very high standard of stroke care and our agreed strategic plan and finally, we expect to be close to the fracture neck of femur best practice tariff by the end of quarter 1.</p> <p>Worst financial risk is £200,000 for the fracture neck of femur.</p>	<p>the North East SHA to support the implementation of the plan.</p> <p>Mitigating risk is moderate in the first year. This returns to high risk in the 2<sup>nd</sup> and subsequent years because it is dependent on the national payment by results published in December 2010.</p> <p>Mitigating actions are to continue with our strategic plan to enhance our stroke care. The qualifying threshold is that the 9 quality standards that make up the bundle of care are increased from to 60% by March 2011, 70% by March 2012 and 80% by March 2013.</p> <p>The mitigating actions for fracture neck of femur are to establish a baseline using the national database for fracture neck of femur by the end of quarter 1. The risk assessment is that we are very close to this standard</p>		
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		now.		
<b>Quality incentives and penalties including commissioning for quality and innovation (CQUIN)</b>	<p>There are 12 quality improvements as part of CQUIN in the legally binding contract with the Commissioner.</p> <p>The value of the 12 improvements is £3,900,000 in 10/11. The risk of not earning this incentive is moderate.</p> <p>The highest risk is the patient experience indicator given the increase expected within the time limit of 12 weeks, all other improvements are expected to be achieved over 12 months.</p> <p>The maximum risk is no payment for one of the indicators valued at £400,000, the likely risk is £200,000 given our mitigating actions.</p>	<p>An improvement plan is in place for each of the 12 improvement goals and the contract agreed with the commissioner makes these goals stretching but achievable.</p> <p>The residual risk is moderate based on a financial risk of £200,000.</p>	<p>The expected outcome is the 12 quality improvement indicators are met and the Trust earns £3,900,000 less the likely risk from the patient experience, that is, £200,000.</p>	<p>Each indicator has a monthly milestone, quarterly threshold and is reported to the Executive Team, Finance, Investment &amp; Performance Committee and the Board of Directors.</p> <p>Accountable officer is the Chief Operating Officer.</p>
	<p>There are 39 quality performance standards agreed between the Trust and the Commissioners in the legally binding contract.</p>	<p>During 2009/10 the Trust enhanced the operational processes for each of these standards and intends to continue to reduce the risk.</p>	<p>The expected outcome is a financial loss of £290,000 compared to £390,000 in 09/10. The £100,000 gain will primarily be from a reduction in the number of</p>	<p>Each indicator has a monthly milestone, a quarterly threshold and is reported to the Finance, Performance &amp; Investment Committee and the Board</p>

	<p>The most significant risks are no payment for treatments if not coded before 20 days of the end of the month (£150,000), cancellation of elective procedures (£200,000) and enhanced choose and book standard (£40,000), thus a total of £390,000 during 10/11.</p> <p>The risk is moderate.</p>	<p>The worst case will therefore be a maximum loss of £390,000 but we intend to reduce this risk by another £100,000 by March 2011 by continuing to enhance our data quality, ensure executive director approval for any cancellation of patient treatment and put in place the right capacity to meet our choose and book standards.</p> <p>The residual risk is moderate.</p>	<p>elective patients cancelled prior to treatment.</p> <p>.</p>	<p>of Directors.</p> <p>The accountable officer is the Chief Operating Officer.</p>
<b>Demographic changes</b>	<p>The demographics predictions present significant changes in the Northumbria region. We can expect improved life expectancy and as a consequence an increase over 65 years, particularly over 80 years. This is a high risk for the trust.</p>	<p>The mitigating actions are as explained in template 2, the “overall health funding and the wider economic environment”.</p>	<p>The expected outcome is explained in template 2, “overall health funding and the wider economic environment”.</p>	<p>As explained in template 2, “overall health funding and the wider economic environment”.</p>
<p><b>Competition, co-operation and patient choice</b></p> <p>National policy drive to commission integrated care</p>	<p>The trust strategic direction has been to maximise the patient experience by the delivery of integrated care. National policy is providing an opportunity</p>	<p>Explained in template 4.</p>	<p>Explained in template 4.</p>	<p>Explained in template 4</p>

	for this direction to be realised. This is explained in section 2 of our vision.			
<b>Pay: national and local negotiations</b>	We are currently participating in the research for the national review of on call payments	No material risks at this stage.	No material risks at this stage.	Not applicable.
<b>Other contractual agreements</b>	There are no material changes planned by the trust.	Not applicable	Not applicable	Not applicable

### **Template 3: Clinical quality**

Guidance: A key strategic focus of the Trust's plan is to describe its main clinical quality priorities for the three years of the plan, key actions required to deliver these, the risk of delivery and how the Board will measure progress for each and gain appropriate assurance in a reliable and consistent manner.

These clinical quality priorities should be consistent with those disclosed in the quality accounts within the Trust's published report and accounts. It is important that the key clinical quality objectives reflect not only the Trust's own strategic focus but also those of its commissioners, patients and service users.

Clinical quality priorities	Contribution to the overall vision	Key actions and delivery risk	Performance in 2009/10	3 year targets/measures 2010/11 2011/12 2012/13
<b>Safer Care</b>				
<p>Zero tolerance for hospital acquired infections that is MRSA, Clostridium difficile and surgical site infections.</p> <p>The target agreed with the Commissioner is 7 hospital acquired MRSA cases, 124 hospital acquired clostridium difficile cases, (the target includes the use of the 1 std.dev. per quarter) and a further reduction of our surgical site infections to 1.5% at each of our hospital sites.</p> <p>The risk assessment is very high.</p>	<p>Deliver excellence in safety, quality and the regulatory system.</p>	<p>We have defined and implemented enhanced infection control standards.</p> <p>Our infection control standards are operating at greater than &gt;95% compliance and this performance is delivered consistently throughout the year.</p> <p>The risk rating is very high due because the trajectory is two MRSA cases for quarter 1 and we have two MRSA cases by the end of April 2010.</p>	<p>Hospital acquired MRSA reduced to 6. Our target was a maximum of 19.</p> <p>Hospital acquired clostridium difficile reduced to 131. Our target was a maximum of 221.</p> <p>Hospital acquired surgical site infections reduced from to the England national average of 1.5%.</p>	<p><b>2010/11.</b> A maximum of 7 hospital acquired MRSA.</p> <p>A maximum of 131 hospital acquired clostridium difficile. A local agreement is in place with our commissioner.</p> <p>A maximum of 1.5% of surgical site infections.</p> <p><b>2011/12.</b> The targets for 2011/12 are not set by the Operating Framework these will be negotiated at the appropriate time. We are aware of the ambitious target for clostridium difficile and we are working to assess this number and who is achieving “best practice” now and learn from them in time for delivering this target.</p> <p><b>2012/12.</b> The targets for 2012/13 will be set by the Operating Framework and these will be negotiated at the appropriate</p>

				time.
Improved safety of high risk medicines.	Deliver excellence in safety, quality and the regulatory system.	In April last year, the Trust adopted a „zero tolerance’ approach to the top four priority areas that would result in a reduction in medicinal errors.	Our performance in 09/10 was to achieve over 90% compliance in the enhanced standards to reduce medicinal errors, that was, drug charts with the correct patient details, drug charts with the complete allergy status, charts compliant with prescribing policy and charts with no unaccounted for missed doses.	<p><b>2010/11</b> Our target for the future years is focus is better compliance with high risk medicinal errors, e.g., anti-coagulant medicines and other high risk medicines.</p> <p><b>2011/12</b> Continue to improve compliance.</p> <p>Develop and consider a business case for e-prescribing.</p> <p><b>2012/13</b> Continue to improve compliance.</p>
Best practice in nursing care	Deliver excellence in safety, quality and regulatory system.	To introduce a balanced scorecard for the best practice nursing standards at clinical team level.	<p>Our performance in 09/10 was to agree at the board of directors on this strategic approach and the content of the balance scorecard the timetable for implementation over the next three years.</p> <p>We introduced the infection control bundle of care during 2007/8.</p> <p>During 08/09, we</p>	<p><b>2010/11</b> Our focus will be on a consolidated report that is open and transparent to the clinical team. Further additions to the report will include falls, nutritional assessment, VTE risk assessment, pressure ulcers, patient experience, actual mortality and discharge communication.</p> <p><b>2011/12</b></p>

			introduced the bundle of care for the early warning system, and during 09/10 we introduce the medicinal errors.	Further additions will be right number and the right skill of nursing staff, harm rate and pain management.  <b>2012/13</b> This would be reviewed in light of best practice at the time.
Risk assessment of venous thromboembolism (VTE)	Deliver excellence in safety, quality and the regulatory system	To introduce the national standard to record a risk assessment on admission and review 24 hours after admission and deliver 90% compliance by quarter 4.  To undertake a clinical audit of compliance with the NICE guidance during quarter 4 and deliver 100% compliance.	The trust has undertaken risk assessment of VTE for many years. The NICE guidance requires the trust to report our performance.	<b>2010/11</b> Establish a system to use the national system to record and report to the Department of Health from June 2010 and achieve at least 90% compliance by November 2010.  Achieve 100% compliance in our clinical audit standard.  <b>2011/12 &amp; 2012/13</b> Maintain this system and outcomes. Monitor clinical events and learn how we can use this information to continually improve our outcomes of care.
<b>Effective Care</b>				
Save more lives and	Deliver excellence in safety, quality and the	Our strategic aim is to operate in the top decile of	The standardised hospital mortality rate methodology	<b>2010/11</b> We aim to enhance our

reduce harm	regulatory system.	<p>the standard hospital mortality rate and our half our harm rate by 2011.</p> <p>We already provide excellent health care and we aim to provide world class healthcare. To do this we will continue to use international best practice to review the primary causes of our mortality and harm and put in place appropriate continuous improvements to provide better care to our patients.</p>	<p>has changed and so a like for like comparison with the beginning and end of year is not possible however progress has been made during the year.</p> <p>In the first three quarters of the year, our SHMR improved from the top 25% to the top 15% hospitals in England. The change in the methodology moved us back into the top 25% of hospitals.</p> <p>In June 2009, we determined our harm rate as 90 events per 1000 bed days and committed to a reduction of 50% by June 2011. By the end of March 2010 we had already achieved this reduction.</p>	<p>SHMR and operate in the top 20% and half our harm rate from 45 events per 1000 patient days to 22 events per 1000 patient days.</p> <p><b>2011/12</b> We aim to enhance our SHMR and operate in the top 15% and halve our harm rate to 10 events per 1000 patient days.</p> <p><b>2012/13</b> We aim to enhance our SHMR and operate in the top 10% and halve our harm rate to 5 events per 1000 patient days.</p>
Better productivity by reduced length of stay and re-admission rate	Deliver excellence in safety, quality and the regulatory system	Our strategic aim is to enhance our productivity rate by reducing waste and operating more added value processes. Our average length of stay provides opportunities, for example, we could trim 0.5 days from our medical and surgical specialties.	During 09/10 we focused our improvement on our surgical specialties by implementing innovative practices in our orthopaedic services. This was known as the "fast track orthopaedic service". The average length of stay reduced from five days to	<p><b>2010/11</b> Put in place arrangements to reduce the average length of stay.</p> <p><b>2011/12</b> Improve productivity by reducing the average length of stay elective care by 0.5 day that is, from</p>

		<p>There is an opportunity to reduce our re-admission rate by 2% bringing us closer to the England average.</p>	<p>four days.</p> <p>Across all elective care, the average length of stay has reduced from 4.0 to 3.9 days this compares favourably with the England average.</p> <p>The average length of stay for non-elective care has reduced from 5.5 to 5.3 days.</p>	<p>four to 3.5 days matching the best standard. Furthermore, reduce the average length of stay for non-elective care from 5.3 days to 5.0 days which would provide a consistent standard of care across our general hospitals.</p> <p><b>2012/13</b> Review and consider the next stage to reduce the ALOS further.</p>
<p><b>Deliver the highest quality of stroke care</b></p> <p>We are already one of the top 10 providers of stroke care and we aim to maintain this high standard of service.</p>	<p>Deliver excellence in safety, quality and the regulatory system</p>	<p>The England average for the nine indicators of care was 17% and our performance was 37% this is a strong outcome but we need to do more. We already have a service improvement plan in place to achieve 80% by 2013.</p>	<p>By March 2010 we increased the performance of the nine quality standards that make up the bundle of care from 37% to 55%.</p>	<p><b>2010/11</b> Achieve 65% for the 9 quality standards that make up the bundle of care.</p> <p><b>2011/12</b> Achieve 70% for the nine quality standards that make up the bundle of care.</p> <p><b>2012/13</b> Achieve 80% for the nine quality standards that make up the bundle of care.</p>

<b>Patient Experience</b>				
<b>&gt;90% of outpatients to experience a reduced waiting time prior to their appointment</b>	Deliver excellence in safety, quality and the regulatory system	<p>We started to performance manage the patient waiting time against the time of the booked appointment and 15 minutes after the booked appointment. The performance management is at consultant level and published on our intranet and is part of the monthly performance management.</p> <p>Four specialties need to transform their services and the clinical leads have worked on the smarter improvements required, the demand and capacity issues and balanced this with the views of their patients. The clinical leads will be presenting their ideas at the clinical policy group during Spring 2010.</p>	We increased the number of out patients experiencing a maximum wait of 15 minutes for an outpatient appointment from 84% to 86.2%	<p><b>2010/11</b> A further 1% of outpatients experience a 15 minute wait only, that is, 87.2%</p> <p><b>2011/12</b> A further 1% of outpatients experience a 15 minute wait only, that is, 88.2%.</p> <p><b>2012/13</b> A further 1% of outpatients experience a 15 minute wait only, that is, 89.2%.</p>
<b>Continue to improve meeting patients' communication needs</b>	Excellent patient centred care.	We have used the local, ward based and real-time patient survey information, national patient survey and complaints to determine our most important areas to continue to improve.	Our priorities are now confirmed following discussions with governors and staff and these are to give even more attention to easing patients' worries and fears and ensuring that on discharge they fully understand the	<p><b>2010/11</b> To operate in the top 20% of trusts.</p> <p><b>2011/12</b> Operate in the top 20% of trusts in the national patient survey.</p>

			medications and their side effects.	<p><b>2012/13</b> Operate in the top 20% of trusts in the national patient survey.</p>
<p><b>Enhance our safety culture and capacity</b></p>	<p>Deliver excellence in safety, quality and the regulatory system</p>	<p>Our focus is to enhance our communication and teamwork standards by using a standardised methodology for the handover of patients. To continue to embed human factors training for clinical teams, this concentrates on communication and team working skills. Finally, to put in place safety walk-rounds for our safety and quality priorities.</p>	<p>During 09/10, we won the leadership in patient safety award the user of the global trigger tool and the early adoption of the use of a standard methodology for communication. This was piloted in two wards and is now being rolled out across the trust.</p> <p>We were success in being awarded funds for one year to introduce human factors training. We will now bid for a second year of funds. We aim for clinical teams to be aware of human factors training over the next three years.</p> <p>Demonstrating leadership in the implementation of safety and quality priorities is an important element of leadership. These started for our standard methodology for communication.</p>	<p><b>2010/11</b> 20/68 (30%) clinical teams to use the standard methodology for communication and learn from human factor skills.</p> <p>Safety walks rounds in place for 100% of safety and quality priorities.</p> <p><b>2011/12</b> 40/68 (60%) of clinical teams to use the standard methodology for communication and learn from human factor skills.</p> <p>Safety walks rounds in place for 100% of safety and quality priorities.</p> <p><b>2012/13</b> 68/68 (100%) of clinical teams to use the standard methodology for communication and learn from human factor skills.</p>

				Safety walk rounds in place for 100% of safety and quality priorities
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## Template 4

Guidance: the main service development priorities in the plan should be described in enough detail so as to provide evidence as to the contribution they are expected to make to the plan, the actions necessary to implement them, key risks, resourcing requirements (financial and human capital), and measures by which the delivery of the service development will be tracked and assessed.

Each of these priorities should be categorised under one of three headings: (1) organic or innovation (i.e. delivered internally by the Trust or through co-operation); (2) acquisition, merger, investment, tender etc (i.e. through some form of corporate action or activity external to the Trust); or (3) by transferring out/discontinuing an activity (in agreement with commissioners).

Where relevant details are included within the input sheets from which the financial forecasts are derived, then reference to those service development plans should be made in the template above.

<b>Service development priorities</b>	<b>Contribution to the overall vision</b>	<b>Key actions and delivery risk</b>	<b>Key resource requirements</b>	<b>Measures of progress 2010/11 2011/12 2012/13</b>
<b>Organic/innovation</b>				
Specialist emergency care centre, re-design of the district general hospitals and the re-development of the community hospitals	Deliver world class quality emergency care and other healthcare services	As explained in template 2.	A £200m capital investment plan approved by Monitor in October 2009.	<b>2010/11 and future years.</b> As explained in template 2.
Explore the development of the concept of a Community Interest Company in partnerships with General Practices.	Deliver world class quality emergency care and other healthcare services	GPs in north Tyneside are exploring the development of a Community Interest Company involving the GP practices. We will continue to develop plans with them for elective care pathways, older people services, emergency care and other services as appropriate.	As appropriate, no material resources required.	<b>2010/11</b> Develop joint priorities for service development and service change.  <b>2011/12 &amp; 2012/13</b> Improving these measures and share the learning to other pathways and other areas of partnership.
Explore the development of the concept of a Community Interest Company in partnerships with General Practices	Deliver world class quality emergency care and other healthcare services	A new organisation has been created called Northumberland Primary Care Community Interest Company of which there are four members: northern Doctors Urgent Care, Brockwell Medical	This company will tender for the new GP-led health centre at Cramlington. The outcome of the process will be confirmed during 10/11. The services the trust would provide via this company	<b>10/11</b> Confirmation of success of tender and start the service during 10/11/  11/12 First full year of delivery of the service.

		group, Forum Family Practice and Northumbria. This organisation is a not-for-profit and a community interest company. There are two directors from Northumbria board of directors that are on the board of the new organisation.	would be diagnostic services, specifically x-ray and ultrasound. These resources would be funded via the commissioner.	
Explore the development of the concept of a Community Interest Company in partnerships with General Practices	Deliver world class quality emergency care and other healthcare services	GPs in Northumberland are planning to work together and considering similar joint ventures and we will continue to work with them in developing their plans.	As appropriate, no material resources required.	<p><b>10/11</b> Agree which community interest companies are established.</p> <p><b>11/12</b> Establish community interest companies.</p>
Electronic summary clinical record by 2012.	E-integrated patient health record.	<p>Single view of existing clinical systems by October 2010.</p> <p>Patient administration system replaced by 2012.</p> <p>Electronic and integrated discharge communication within 24 hours by March 2012.</p> <p>Risk assessment is high.</p>	<p>Single view system valued at £850K and included in the capital investment plan</p> <p>Estimates to be finalised based on procurement process but present no material risk.</p> <p>Initial cost of this system is £150K and included in the capital investment plan.</p>	<p><b>2010/11</b> Data quality standards improved.</p> <p>Reduce in duplicate requests for pathology and radiology.</p> <p>Reduction in costs due to a reduction in paper.</p> <p>Increase in outpatient capacity.</p> <p>Increase in patient experience.</p>

				<p><b>2011/12</b> 50% of consultants deliver discharge communication to general patients and patients within 24 hours.</p> <p><b>2012/13</b> 100% of consultants deliver discharge communication within 24 hours.</p>
<b>Acquisition &amp; mergers</b>				
To produce a strategic outline case for the acquisition of integrated community services.	Deliver world class quality emergency care and other healthcare services.	<p>The Commissioners issued a timetable to identify a management partner to transform community services. The process is in five stages.</p> <p>We have established a strategic project team to respond to this challenge.</p> <p>Phase 1: commissioners to review provision of services.</p> <p>Phase 2: commissioners to produce a provider information portfolio and identify potential Foundation Trust partners.</p> <p>Phase 3: Invitations to partners to produce a</p>	No material resource requirements.	<p><b>2010/11</b> Approved provider of the community services by the North of Tyne Commissioners and Monitor.</p> <p><b>2011/12</b> Provider of the services from 1<sup>st</sup> April and financial risk rating is secured at a level 4 and governance rating is secure at Green.</p> <p><b>2012/13</b> Financial risk rating is operates at level 4 and governance rating is operates at Green</p>

		<p>Strategic outline case will be issued.</p> <p>Phase 4: Commissioners will review the strategic outline case with the Foundation Trust partners.</p> <p>Phase 5: Commissioners will review and the SHA North East will assess the PCT review.</p> <p>Our key action is to secure this acquisition.</p> <p>Risk assessment is high given the culture and capacity issues of this major acquisition.</p>		
<b>Transferred/discontinued activity</b>				
Urology emergency care service to be transferred to the hub and spoke centre.	Excellence in safety and quality and compliance.	<p>Assessment completed and approved in principle by the Commissioner.</p> <p>Hub and spoke centre to agree to the transfer.</p> <p>Risk assessment is moderate.</p>	This is not a material risk to the Trust.	<p><b>2010/11</b> Contract variation agreed with the commissioner.</p> <p><b>2011/12 and 2012/13</b> No change to the urology outpatient and day case contract.</p>

## Template 5: Workforce strategy

Guidance: the main workforce focused priorities envisaged in the plan should be described, the actions necessary to implement them, key risks to implementation, resourcing requirements (financial and human capital), and measures by which the delivery of the planned changes in workforce size, mix or configuration will be tracked.

When considering the main workforce priorities, the following may be included:

Changes in headcount (including benchmark evidence), mix or flexibility (i.e. mix of agency, bank, and permanent)

Key recruitment, training, retention and development initiatives

Redundancy and natural wastage programmes

Pay, rewards and other key remuneration initiatives or work streams

Other workforce issues which may impact the plan.

We will publish plans in full except where the Trust indicates that it wishes to exclude specific limited information for publication purposes. For instance, where there are workforce related activities which include commercial or confidential matters which the Trust may not at this stage wish to be published in full, the Trust should indicate this clearly on its plan submission.

Where proposed workforce changes may risk impacting service provision or clinical quality, this potential risk should be recognised explicitly in the plan.

Key workforce priorities	Contribution to the plan	Key actions and delivery risk	Key resource requirements	Measures of progress 2010/11 2011/12 2012/13
Workforce planning and execution of the plan to meet the requirements of the new emergency care centre	Development of a workforce plan that recognises the service need to develop a new emergency care centre and leave effective well equipped teams at each of the base sites	Plan, train, recruit, consult, change current ways of working, alter skill mix  Risk assessment is high risk.	Project team Resource for training and additional consultant recruitment	<p><b>10/11</b> Effective plan, and commence lead in training and recruitment</p> <p><b>11/12</b> Consult on workforce e changes continue training and recruitment for some consultant posts</p> <p><b>12/13</b> Effectively open the new unit with skilled, effective teams at each site</p>
Implementation of the Boorman Review on achieving a healthy workforce	<p>Improve staff engagement and motivation and therefore contribute to improved patient care.</p> <p>Reduce sickness absence.</p>	<p>Reduce incidence of stress obesity back pain and smoking in the workforce.</p> <p>Recognise the organisational contribution to health and take steps to improve in some areas</p> <p>Improved management controls and impact of the above</p> <p>Risk assessment is moderate.</p>	No additional resources required Some training and education of staff and managers	<p><b>10/11</b> Reduction in sickness absence to 4.5%</p> <p><b>11/12</b> Reduction in sickness absence to 4.% thereafter</p>

Improving productivity	Various productivity initiatives at business unit level. Improve connectivity between patient activity and staffing levels by the development and tracking of key metrics Introduction of e rostering system and harmonisation of some flexible working arrangements across the Trust	Tracking of workforce productivity key performance indicators. Development of new metrics  Reduction in use of bank and agency staff.  Risk assessment is low risk	Training coaching and education	Metrics currently still being determined
Meeting the requirements of the financial downturn plan	Supporting the major changes programmes, and stimulating labour turnover in specific areas by the use of targeted voluntary severance	Redeployment of staff affected by major change initiatives.  Management of a voluntary severance programme.  Effective partnership working with staff side unions.  Risk assessment is high.	Treasury and Monitor approval of voluntary severance terms	Improved productivity and organisational performance over the 3 years
Integration of community services	Planning and consultation for the integration of community services into the Trust	Successful agreement of transfer. Consultation in accordance with TUPE Effective assimilation into the workforce Completing service reviews as required to ensure effective patient	Project team	<b>10/11</b> Planning and consultation.  <b>11/12</b> Integration to be completed from April 2011.  <b>12/13</b>

		<p>pathways</p> <p>Risk assessment is high risk.</p>		Second year of integration.
Meeting the requirements for regarding validation and re-certification of medical staff	Completion of action plans associated with the development of medical appraisal suitable for revalidation and recertification	<p>Agreement of the common data set and ensuring this information can be generated.</p> <p>Appointment and training of appraisers.</p> <p>Appointment of the responsible officer</p> <p>Risk assessment is low risk.</p>	<p>Further guidance from the GMC/DOH</p> <p>National system for the collection of appraisal information would be useful</p>	<p><b>10/11</b> Preparation and awaiting further guidance</p> <p><b>11/12</b> Identification and appointment of responsible officers and appraisers. Training of the above to fulfil their roles</p>
Organisational development plan to support all the above	Organisational development plan to cover improving organisational understanding of productivity, also interventions associated with effective integration and supporting new ways of working. Effective leadership.	Risk assessment is low risk.	Organisational development budget level to be maintained.	Detailed plan tied to achievements required in each year

## Template 6: Capital programmes (including estates strategy)

Guidance: The main capital expenditure priorities in the plan should be documented, together with amounts, timing and linkages to the delivery of the plan. In addition, key actions and delivery risk underpinning each should be identified. Each of the capital expenditure priorities should be shown under the following main headings:

- Development – this includes building of new capacity (through whatever funding source) or significant reconfiguration or upgrade of existing facilities
- Maintenance or replacement capex – this includes planned or urgent maintenance capital expenditure or expenditure to replace existing facilities.
- Other capital expenditure – this includes purchases of equipment, technology, intellectual property and significant IT expenditure etc
- Other estates strategy – this includes net proceeds or expenditure on estates reorganisation or other estates strategy to either use the existing estate more efficiently or to release proceeds from surplus or unused assets.

Where delays either in proposed capital investment programmes (including maintenance, equipment, refurbishment or new builds) or in the delivery of an estates strategy may risk impacting service provision or clinical quality, this potential risk should be recognised explicitly in the plan. Where relevant details are included within the input sheets from which the financial forecasts are derived, then reference to that capital expenditure

Key capital expenditure priorities	Amounts and timing	Contribution to the plan (including service delivery)	Key actions and delivery risk
<b>Development</b>			
<b>Emergency Care Centre</b>	2010-11 £ 8.2m 2011-12 £ 17.9m 2012-13 £ 32.9m  (inclusive of amortised interest = £5m)  <b>2010-11</b> Design and Planning  <b>2011-12</b> Commence construction  <b>2012-13</b> Construction  <b>2013-14</b> Commissioning and operational go live in early 2014	Enables delivery of Emergency Care Strategy	<p><b>Key Actions/Risks</b>            The scheme is currently in the detailed design stage in lead up to going through the planning process. The scheme gained string public and Commissioner support. Land has been secured under an option.</p> <p>The Project is managed via a Project Board and the Trust is supported by external cost advisors.</p> <p>The risk related to the scheme is one of capital exposure and within the approval process this was identified as being approximately 10%.</p> <p><b>Mitigation</b>            Within the Monitor approval process the modelled sensitivities around the scheme related to capital exposure these have been re-worked and the trust can demonstrate the risk is manageable.</p> <p>The external cost advisors (based upon their extensive knowledge of market conditions) have supported the current assessment contained within the plan.</p>
<b>Information Technology/Single View</b>	2010-11 £1.1m 2011-12 £0.2m 2012-13 £0.2m	Improved clinical and data quality	<p><b>Key Actions/Risks</b>            The major element of the current programme (Single View) is scheduled to go live in October 2010. The risk is one of timing.</p>

	<b>2010-11 (October)</b> Go live with single View		Mitigation The project is lead by a project Board which meets regularly and has both Clinical and Technical involvement in order to ensure the project is delivered on both time and in line with the key benefit objectives.
<b>Haltwhistle War Memorial</b>	2010-11 £0.0m 2011-12 £1.5m 2012-13 £0.0m  <b>2010-11</b> Design and Planning  <b>2011-12</b> Construction and Redevelopment  <b>2012-13</b> Commissioning and operational go-live	Replaces Current Facilities	Key Actions/Risks Re-development of the existing Haltwhistle site. Potential Risk is one of cost over-run.  Mitigation Project Boards are tasked with bringing each scheme in line with budget and this is their prime responsibility. The capital programme is staggered in such a way that no one project can have a material impact on the overall programme or the Trust financial position as a whole.
<b>Maintenance and other capital expenditure</b>			
<b>Mortuary</b>	2010-11 £ 1.9m 2011-12 £ 1.3m 2012-13 £ 0.0m  2009-10 Design 2010-11 Construction Commences (NTGH) 2011-12 Construction Commences (WGH) 2011-12 Schemes	Maintenance/ improvements to Environment	Key Actions/Risks The scheme has been subject to various design and cost reviews. The inherent risk in this scheme is one of cost over-run.  No material quality issues  Mitigation Project Boards are tasked with bringing each scheme in line with budget and this is their

	Completed		prime responsibility. The capital programme is staggered in such a way that no one project can have a material impact on the overall programme or the Trust financial position as a whole.
<b>Endoscopy</b>	<p>2010-11 £1.8m 2011-12 £0.0m 2012-13 £0.0m</p> <p>2010-11 Design 2010-11 Construction Commences (NTGH) 2011-12 Construction Commences (WGH) 2011-12 Schemes Completed</p>	Maintenance/ improvements to Environment	<p>Key Actions/Risks The scheme has been subject to various design and cost reviews. The inherent risk in this scheme is one of cost over-run.</p> <p>No material quality issues as service relocating within existing site</p> <p>Mitigation Project Boards are tasked with bringing each scheme in line with budget and this is their prime responsibility. The capital programme is staggered in such a way that no one project can have a material impact on the overall programme or the Trust financial position as a whole.</p>
<b>Electrical Infrastructure</b>	<p>2010-11 £1.9m 2011-12 £0.0m 2012-13 £0.0m</p> <p>2009-10 Design 2010-11 Project commencement and completion</p>	Maintenance/ improvements to Environment	<p>Key Actions/Risks The scheme has been developed in line with external technical advisors in line with an overall scheme to replace the electrical infrastructure on the North Tyneside site.</p> <p>Mitigation Project Boards are tasked with bringing each scheme in line with budget and this is their prime responsibility. The capital programme is staggered in such a way that no one</p>

			project can have a material impact on the overall programme or the Trust financial position as a whole.
<b>Pharmacy Suite</b>	2010-11 £0.9m 2011-12 £0.0m 2012-13 £0.0m  2009-10 Design 2009-10 Construction Commences 2009-10 Construction Completion	Maintenance/ improvements to Environment	<b>Key Actions/Risks</b> The scheme has been subject to various design and cost reviews. The inherent risk in this scheme is one of cost over-run. No material quality issues as contingency plans in place <b>Mitigation</b> Project Boards are tasked with bringing each scheme in line with budget and this is their prime responsibility. The capital programme is staggered in such a way that no one project can have a material impact on the overall programme or the Trust financial position as a whole.
Other	2010-11 £6.5m 2011-12 £2.8m 2012-13 £4.8m	Maintenance/ improvements to Environment	<b>Key Actions/Risks</b> Various small schemes including fixed life cycle costs for PFI schemes  <b>Mitigation</b> Project Boards are tasked with bringing each scheme in line with budget and this is their prime responsibility. The capital programme is staggered in such a way that no one project can have a material impact on the overall programme or the Trust financial position as a whole.

## **Template 7: Operational/financial effectiveness**

Guidance: any other significant productivity/efficiency priorities in the plan should be set out, together with amounts, timing and linkages to the delivery of the plan. In addition, the key actions and potential delivery risks, any resource requirements (capital and human) and key milestones underpinning these should be identified. Clearly, in some instances there will be overlap with other priorities included in other templates (e.g. workforce strategy, capital expenditure and service development strategy) and where this is the case these should be referenced in the template. The key focus of this template will be to bring together any other operational efficiency priorities not already identified elsewhere (e.g. procurement, other non-front line services, development and realisation of specific commercial opportunities, improvements in financing or other costs etc.

Where relevant details related to CIPs are included within the input sheets from which the financial forecasts are derived, then reference to those CIPs should be made in the template above.

Key operating efficiency programmes	Amounts and timing		Contribution to the plan	Key actions and delivery risk	Resource requirements	Milestones	
	2010/11	2011/12				2010/11	2011/12
Business Unit Plans	2010-11	£4.8m	Achieve risk rating of 4	<u>Key Actions</u> Reconfiguring capacity to match actual demand.  Reducing Length of Stay (LOS).  Reduction in DNAs and Cancellations.	None.	2010-11	£4.8m
	2011-12	£4.0m		<u>Delivery Risks</u> <b>Year 1</b> Traffic light assessed with "red " light assessment of £0.8m relating to potential closure of a surgical ward.		2011-12	£4.0m
	2012-13	£4.5m		Three ward amalgamations (or closures) have now been undertaken therefore a major element of the programme has been achieved the pace of the delivery regarding savings is however determined by turnover given		2012-13	£4.5m

			<p>location of wards.</p> <p><b>Year 2 - 3</b></p> <p>Dependent upon further ward closures and therefore continued reduction in LOS plus active demand management in primary care to manage demographic growth.</p> <p><u>Mitigation</u></p> <p><b>Year 1</b></p> <p>The majority of material schemes have now been implemented. The major issue relates to the level of turnover in particular locations and this is being addressed through the voluntary severance scheme.</p> <p>The potential closure of the surgical ward at North Tyneside represents the major risk and this proposal is being finalised should this not be</p>		
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			<p>delivered in full the Business Unit concerned will be required to implement a contingency list of reserve schemes which it has developed.</p> <p><b>Year 2 - 3</b></p> <p>The actions from Year 1 deliver £1.2m of the year 2 programme. The LOS issue is one which the Trust can control to a large extent and the Medicine and Emergency Care BU has identified new ways of working to deliver the change required.</p> <p>Should active demand management not take place then there will be additional income over and above that assumed in the plan.</p> <p>In agreeing the 2010-11 contractual position the Trust has agreed with</p>		
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			<p>Commissioners the ability to access a £2m transitional fund. This could be utilised to mitigate any short-fall planned cost reduction targets.</p> <p>Should there be any short-fall the first mitigation will be the requirement of Business Units to implement any reserve schemes before any internal contingency funds are accessed.</p>		
<b>Corporate Services (“Back Office”)</b>	2010-11 £ 0.7m 2011-12 £ 0.7m 2012-13 £ 0.7m	Achieve risk rating of 4	<u>Key Actions</u> Specific annual reduction in the cost of administration  Establishment of SLAs and new working practices to remove duplication and activities that add no value  <u>Delivery Risks</u> <b>Year 1 – 2</b>  Clear plans established for year 1	None	2010-11 £ 0.7m 2011-12 £ 0.7m 2012-13 £ 0.7m

			<p>(+ year 2), there remains a risk regarding turnover within functions</p> <p><b>Year 3</b></p> <p>Staff turnover remains a risk plus the ability to sustain on-going reduction</p> <p><u>Mitigation</u> <b>Year 1 to 3</b></p> <p>The Trust has agreed a Voluntary Severance Scheme which will stimulate turnover, in addition external recruitment for A&amp;C staff will no longer be undertaken.</p> <p>The growing level of external commercial income generated by the Trust also offers the opportunity to provide alternative opportunities to staff to further aid turnover and also absorb overheads previously charged against core NHS funding.</p>		
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<b>Travel/Car Parking</b>	2010-11 £ 0.8m 2011-12 £ 0.1m 2012-13 £ 0.1m	Achieve risk rating of 4	<p><u>Key Actions</u>  Increased tariff for car parking and revised travel reimbursement regime</p> <p><u>Delivery Risks</u>  <b>Year 1 to 3</b></p> <p>Car Parking - minimal staff side have agreed new charges and agreement in place for three years.</p> <p>Travel – part of national (A4C) agreement to be brought into effect by Trust on 1<sup>st</sup> June 2010. This will at least halve travel costs but will also stimulate commercial income from lease cars.</p> <p><u>Mitigation</u>  Given minimal risk no mitigation strategy required indeed the trust has been able to further stimulate market penetration in the lease car market by offering to support</p>	None	2010-11 £ 0.8m 2011-12 £ 0.1m 2012-13 £ 0.1m
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			other Trusts in implementing similar schemes as our business proposal represents a “cost reduction” opportunity for client organisations.		
<b>Paybill</b>	2010-11 £ 2.7m 2011-12 £ 3.3m 2012-13 £ 2.4m	Achieve risk rating of 4	<p><u>Key Actions</u> Various actions highlighted in the table above including grade control, reducing overtime etc.</p> <p><u>Delivery Risks</u> <b>Year 1 – 3</b></p> <p>There are three risks :</p> <ul style="list-style-type: none"> <li>- Staff turnover</li> <li>- the ability to reduce overtime etc. when set against target delivery (eg 18 weeks)</li> </ul> <p>the ability to realise savings from reduced sickness</p> <p><u>Mitigation</u> Where savings are dependent upon turnover mitigation strategy will be</p>	None	2010-11 £ 2.7m 2011-12 £ 3.3m 2012-13 £ 2.4m

			employed :  the targeted re-organisations or restructuring of services and departments  external vacancy freezes the voluntary severance scheme		
<b>Catering</b>	2010-11 £ 0.1m 2011-12 £ 0.3m 2012-13 £ 0.0m	Achieve risk rating of 4	<u>Key Actions</u> Reduce current subsidy of staff catering  <u>Delivery Risks</u> A combination of factors being developed changed opening hours, revised staffing and increased charges. Risk is one of reduced takings.  <u>Mitigation</u> Not seen as material risk in overall programme	None	2010-11 £ 0.1m 2011-12 £ 0.3m 2012-13 £ 0.0m
<b>Premises and Energy</b>	2010-11 £ 0.8m 2011-12 £ 1.1m 2012-13 £ 1.5m	Achieve risk rating of 4	<u>Key Actions</u> This theme is based upon improved utilisation of the estate.	Minimal Investment included in Capital Programme equivalent to £ 0.1m per annum	2010-11 £ 0.8m 2011-12 £ 1.1m 2012-13 £ 1.5m

			<p>A series of schemes funded via Saalex funding and we have also made recurring provision in our capital programme</p> <p>In addition we are looking to bring in a new charging regime for tenants of our premises.</p> <p><u>Delivery Risks</u> <b>Year 1</b></p> <p>Scheme largely delivered in 2010-11 as a consequence of reduced TDR and agreed schemes to reduce energy usage. There remains a risk of £ 0.1m (timing) of new tenants taking up occupation of our facilities.</p> <p><b>Year 2-3</b></p> <p>Business units have agreed a site utilisation strategy and are in the process of enacting the</p>		
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			<p>strategy to release premises for alternative use, sale or “mothballing”. The main risk is one of timing to realise savings.</p> <p><u>Mitigation</u> <b>Year 1</b></p> <p>Limited risk relating to timing of occupation</p> <p><b>Year 2</b></p> <p>The significant risk is one of timing, the cost reduction programme assumes a contingency of £ 1.2m + £ 0.6m which could be set aside this timing risk in the short-term (note combined with North Tyneside Ward)</p>		
<b>Commercial</b>	<p>2010-11 £1.0m</p> <p>2011-12 £1.0m</p> <p>2012-13 £1.0m</p>	Achieve risk rating of 4	<p><u>Key Actions</u></p> <p>Increasing income from external clients in particular the growth of our lease car service.</p> <p><u>Delivery Risks</u> <b>Year 1 to 3</b></p>	None	<p>2010-11 £1.0m</p> <p>2011-12 £1.0m</p> <p>2012-13 £1.0m</p>

			<p>The Trust could face competition from the private sector however the NHS VAT rules plus the benefit the Trust derives from being part of the NHS provide provides the Trust with a strong competitive edge.</p> <p>The trend in growth might not be maintained although our forward plan indicates that over the three year medium term planning horizon indicates this is not a significant risk.</p> <p><u>Mitigation</u> <b>Year 1 to 3</b></p> <p>There are considerable barriers to entry and the service on offer has been specifically tailored to meet the requirements of the economic downturn. The added experience the Trust</p>		
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			<p>has gained by implementing a new travel reimbursement scheme should further enhance our unique selling point and stimulate further growth.</p> <p>There is a clear Business Plan in place with targets for recruitment of clients etc. which monitored very closely as well as actual sales on a daily, weekly and monthly basis.</p> <p>Once signed up a client is tied in for at least three years.</p>		
<b>Rothbury</b>	2010-11 £ 0.0m 2011-12 £ 0.3m 2012-13 £ 0.0m	Achieve risk rating of 4	<p><u>Key Actions</u> Partial closure of facility</p> <p><u>Delivery Risks</u> That the partial closure may not be agreed</p> <p><u>Mitigation</u> The Trust will seek alternative funding through the potential relocation of a GP</p>	None	2010-11 £ 0.0m 2011-12 £ 0.3m 2012-13 £ 0.0m

			Practice in the facility. Discussions with the Practice are currently underway.		
<b>Medical Secretaries and Other Headcount Reduction</b>	2010-11 £ 0.5m 2011-12 £ 1.0m 2012-13 £ 0.0m	Achieve risk rating of 4	<p><u>Key Actions</u> General reduction in management posts plus reconfigured medical secretary provision</p> <p><u>Delivery Risks</u> The risk with the scheme relates to the level of staff turnover</p> <p><u>Mitigation</u> Where savings are dependent upon turnover mitigation strategy will be employed :</p> <p>the targeted re-organisations or restructuring of services and departments</p> <p>external vacancy freezes the voluntary severance scheme</p>	None	2010-11 £ 0.5m 2011-12 £ 1.0m 2012-13 £ 0.0m
<b>Berwick Maternity</b>	2010-11 £ 0.5m	Achieve risk rating of	<u>Key Actions</u>	None	2010-11 £ 0.5m

	2011-12 £ 1.0m 2012-13 £ 0.0m	4	<p>Closure of service</p> <p><u>Delivery Risks</u> The Trust has agreed with Commissioners that there should be a public consultation exercise regarding the provision of maternity services. The Trust has taken a prudent view that this could lead of the Berwick service (although this could impact on other services).</p> <p>The risk is that this closure is not upheld through public consultation</p> <p><u>Mitigation</u> The Trust currently incurs a considerable loss across a number of small volume maternity units.</p> <p>Should the public consultation not lead to closure then the Trust will seek to funded on a recurring basis of the flexibilities outlined in</p>		2011-12 £ 1.0m 2012-13 £ 0.0m
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				the PbR guidance.		
<b>North Tyneside Ward</b>	2010-11 £ 1.0m 2011-12 £ 1.0m 2012-13 £ 0.0m	Achieve risk rating of 4		<u>Key Actions</u> Closure of Ward  <u>Delivery Risks</u> The risk is one of timing the plan is in the process of being signed off.  <u>Mitigation</u> The significant risk is one of timing, the cost reduction programme assumes a contingency of £ 1.2m + £ 0.6m which could be set aside this timing risk in the short-term (note combined with Premises).	None	2010-11 £ 1.0m 2011-12 £ 1.0m 2012-13 £ 0.0m
<b>Procurement</b>	2010-11 £1.8m 2011-12 £1.8m 2012-13 £1.8m	Achieve risk rating of 4		<u>Key Actions</u> Delivering better value with our supplies. Product standardisation and rationalisation.  <u>Delivery Risks</u> There are 60+ work-streams in place with a strategic workgroup established to oversee progress. The programme pulls	None	2010-11 £1.8m 2011-12 £1.8m 2012-13 £1.8m

			<p>together national, regional and Trust activities. In the context of overall spend the Trust has a prudent target.</p> <p>Whilst the quantum is prudent the delivery in terms of timing may be the risk with this theme.</p> <p><u>Mitigation</u> The strategic workgroup are required to deliver the overall quantum in line with the timescales identified. They will manage, monitor and amend the components of the programme in order to ensure the timing of delivery does not arise as a material risk.</p>		
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## Template 8: Leadership and governance

Guidance: the leadership skills, and supporting governance processes and procedures, necessary to deliver the plan are a key focus and will develop and may fundamentally change as:

Current contracts expire or key personnel leave

Current gaps are filled

Service development initiatives (either organic or external) are implemented

Workforce, efficiency or estates programmes are rolled out

Acquisitions, investments or mergers are considered and progressed

Specific and material financial or operational challenges grow or decline

External impacts change.

Planning leadership change, succession and development is core to ensuring that skills are in place to design and then deliver plans to mitigate risk and deliver the overall vision and strategy for the Trust. These should be supported by effective and functioning governance and assurance processes and procedures. Where there are shortfalls, gaps or specific risks then plans need to be in place and described to rectify them. Clear evaluation of current or future skills gaps and requirements going forward, leadership change and governance changes is important.

In the context of the current state of Board leadership and effectiveness, and the needs in the future to deliver the three year vision, the Trust Board should set out its priorities for leadership and governance development and evolution consistent with the plan. This may in many cases entail external advice and periodic re-assessment to assist the Board to agree and then build its own effectiveness.

<b>Key leadership and governance priorities</b>	<b>Key risks (and gaps)</b>	<b>Actions to rectify/mitigate</b>	<b>Milestones</b> <b>2010/11</b> <b>2011/12</b> <b>2012/13</b>
Current contract expire or key personnel leave	Two non-executive directors contract are due for renewal during each of the three consecutive years. We do not anticipate any material gaps in our non-executive appointments.  Risk assessment is moderate.	We have a robust process in place for the consideration of out board skills and competencies and the appointment of our board members.	<b>2010/11</b> Two non-executive directors' contracts to be reviewed.  <b>2011/12</b> Two non-executive directors' contracts to be reviewed.  <b>2012/13</b> Two non-executive directors' contracts to be reviewed.
Current gaps filled	Executive and non-executive board appointments are filled. We do not anticipate any material gaps in our board appointments.  Our senior management capacity is at the right number and skill level.  Risk assessment is moderate.	We have a robust process in place for the consideration of out board skills and competencies and our senior management capacity and competencies.	<b>2010/11</b> No material milestones  <b>2011/12</b> No material milestones  <b>2012/13</b> No material milestones
Service development initiatives	Leadership and project management are in place to deliver the strategic developments and approved by the board of directors.  Risk assessment is high.	This is will remain under review by the board of directors given its strategic significance.	<b>2010/11</b> No material milestones  <b>2011/12</b> No material milestones  <b>2012/13</b>

			No material milestones
Acquisitions, investments or mergers	<p>Leadership and project management arrangements are in place to deliver this strategic change because it has been a significant part of our strategic direction for some years.</p> <p>Risk assessment is high.</p>	This will be a significant strategic business matter for the board for this year and future years.	<p><b>2010/11</b> Decide on the board of directors governance arrangements.</p> <p><b>2011/12</b> Implement the board of director's governance arrangements.</p> <p><b>2012/13</b> No material milestones</p>
Specific and material financial or operational challenge grow or decline	Leadership and execution has been a dominant feature of the business of the board members and senior management in the lasts six months since we published our 10 year financial plan and will continue to be so.	This is a major item of business for the board of directors, finance, performance and investment committee and the business unit boards.	<p><b>2010/11</b></p> <p><b>2011/12</b></p> <p><b>2012/13</b></p>
External impact changes	No material changes other than those explained above.	No material changes other than those explained above.	Not applicable.
Governance and assurance risk assessment	<p>The board of director's governance arrangements are subject to review by the board members and internal audit.</p> <p>Risk assessment is moderate.</p>	<p>Building on our strong performing business unit boards we intend to further empowered the business unit boards by introducing self-declaration at quarterly intervals in addition to the trust self-declaration assessment. This started in March 2010 for one of the four business units and by the end of the year all business units will operate to this higher standard.</p> <p>Internal audit undertake review of our governance arrangements</p>	<p><b>2010/11</b> Pilot and roll-out across business units and corporate teams.</p> <p><b>2011/12</b></p> <p><b>2012/13</b></p>

		every two years and have awarded significant assurance. Furthermore, internal audit review the quarterly declaration prior to approval by the board of directors.	
Strategic leadership assessment	<p>To ensure the strategic direction approved by Monitor in 2006 is still the right direction.</p> <p>Risk assessment is moderate.</p>	The board of directors has refreshed its strategic direction and board effectiveness. This will be part of a stakeholder consultation and finalised by July 2010.	<p><b>2010/11</b> Assessment completed and a new board development plan in place.</p> <p><b>2011/12</b> Subject to annual review.</p> <p><b>2012/13</b> Subject to annual review.</p>

## Template 9: Regulatory

Guidance: the plan should identify current and future regulatory risks, including registration (CQC) and risks to the Authorisation. The plan should also identify key actions to mitigate any material risk and measurement of progress towards rectification. This includes, but is not limited to:

- Service performance
- Clinical quality and governance
- Governance processes and procedures
- Financial stability, profitability and liquidity
- Risk to the provision of mandatory services
- Private patient income cap
- Co-operation or completion rules
- NHS constitution
- Ongoing registration with CQC and any conditions.

Ensuring ongoing regulatory compliance, with the processes, procedures, assurance and oversight in place to first predict potential breaches with confidence and then take action where necessary, is central to the design and delivery of a high quality plan, and then its implementation. Clearer and realistic evaluation of current or future regulatory risks and accountabilities over the three years of the plan is a key requirement.

<b>Key regulatory risks</b>	<b>Nature of risk</b>	<b>Actions to rectify and or mitigate and responsibilities</b>	<b>Measures 2010/11 2011/12 2012/13</b>
<b>Care Quality Commission, ongoing registration.</b>	<p>There is no material risk forecast with the registration requirements of the essential safety and quality outcomes</p> <p>Risk assessment is moderate.</p>	Not applicable.	<p><b>2010/11</b> No material milestones</p> <p><b>2011/12</b> No material milestones</p> <p><b>2012/13</b> No material milestones</p>
<b>Service performance</b>	<p>The material risk is the national policy to extend the significance of the quality standards in the legally binding contract. The material risks are with the commissioning for quality and innovation. The risks are delivering the higher service performance standard, greater financial penalties amounting to 1.5% of our income (£3,900,000) and risk to our reputation.</p> <p>Risk assessment is high.</p>	<p>We have a strong track record of delivering our service performance. We have applied the principles to the commissioning for quality and innovation. We aim to be operating at a moderate risk by the end of quarter 2 to secure our position.</p> <p>Accountability: Chief Operating Officer.</p>	<p><b>2010/11</b> This year, the risk amounts to 1.5% of our income, that is, £3,900,000</p> <p><b>2011/12</b> This year, the risk may amount to 5% of our contract income, that is, approximately £10,000,000.</p> <p><b>2012/13</b> This year the risk may amount to 10% of our contract income, the maximum amount, that is, £28,000,000.</p>
<b>Clinical quality and governance</b>	<p>The material risk is the national policy to match the best performers in the number of hospital acquired infections.</p> <p>Risk assessment is very high risk.</p>	We are delivering in the top quartile for hospital acquired MRSA cases and around the England average for hospital acquired clostridium difficile cases. We need to maintain this	<b>2010/11</b> Review our prescribing polices to support the delivery of a reduced number of clostridium difficile cases and learn from the best.

		<p>very high standard and go further. We will continue to learn from the best and put in place higher standards.</p> <p>Accountability: Chief Operating Officer</p>	<p>Undertake faster root cause analysis of the MRSA cases and learn from the event.</p> <p><b>2011/12</b> To learn from the best in England now and adopt the lessons learnt in 10/11 so we can operate to the higher target effective from April 2011.</p> <p><b>2012/13</b> As 2011/12.</p>
<b>Financial stability, profitability and liquidity</b>	<p>The impact of the economic downturn on the trust.</p> <p>Risk assessment is high risk.</p>	<p>The board of directors has a 10 year financial plan approved by Monitor. This plan addresses how the board of directors intend to deliver the reductions and a financial risk rating of 4.</p> <p>Accountability: Executive Director of Finance.</p>	<p><b>2010/11</b> <b>Risk rating of 4</b></p> <p><b>2011/12</b> <b>Risk rating of 4</b></p> <p><b>2012/13</b> <b>Risk rating of 4</b></p>
<b>Risk to the provision of mandatory services</b>	<p>There is no risk to the provision of mandatory services.</p>	<p>Not applicable.</p>	<p><b>2010/11</b> No applicable</p> <p><b>2011/12</b> Not applicable</p> <p><b>2012/13</b> Not applicable</p>
<b>Private patient cap</b>	<p>Low risk due to historic and projected low level of private patient income.</p>	<p>Not applicable</p>	<p><b>2010/11</b> Income within private patient cap</p> <p><b>2011/12</b> Income within private patient cap</p>

			<b>2012/13</b> Income within private patient cap
<b>Co-operation or competition rules</b>	There are no ventures planned by the board of directors that would contravene the co-operation or competition rules.	Not applicable	<b>2010/11</b> Not applicable  <b>2011/12</b> Not applicable  <b>2012/13</b> Not applicable
<b>Acquisition of services</b>	The material risk is the trust aiming to transform community services in line with the national policy. This will be a significant business item at the board and has the potential to impact on service performance. The venture is a high risk given the strategic aim to operate at a financial risk rating of 4 and a top score on governance for each successive year. However, it is also a high risk should the trust not acquire the community services given its strategic aim.  Risk assessment is high.	Amend the registration of our services with the Care Quality Commission and the NHS litigation authority.  Accountability: Chief Operating Officer	<b>2010/11</b> Agree the transfer of the registration of the community services should we be successful in our acquisition.  <b>2011/12</b> Aim to put in place the NHS litigation authority standard, level 3 by December 2012.  <b>2012/13</b> Prepare for the assessment by the NHS Litigation Authority, December 2012.



## Financial Summary

£m		<b>2009-10</b>	<b>2010-11</b>	<b>2011-12</b>	<b>2012-13</b>
		<b>Actuals</b>	<b>Plan</b>	<b>Plan</b>	<b>Plan</b>
<b>Revenue (Total)</b>		311.2	318.7	312.9	314.9
Employee Expenses		(200.1)	(198.9)	(191.5)	(186.6)
Drugs		(11.3)	(11.3)	(11.8)	(12.4)
PFI operating expenses		(1.3)	(1.3)	(1.4)	(1.5)
Other costs		(74.6)	(83.1)	(82.7)	(88.2)
<b>EBITDA</b>		<b>24.0</b>	<b>24.1</b>	<b>25.5</b>	<b>26.2</b>
Depreciation and amortisation		(8.4)	(8.3)	(7.7)	(7.3)
Net interest		(8.7)	(8.3)	(8.1)	(8.1)
Other		(16.4)	(2.2)	(3.0)	(2.8)
<b>Net Surplus / (Deficit)</b>		<b>(9.5)</b>	<b>5.3</b>	<b>6.7</b>	<b>8.0</b>
<i>EBITDA % Income</i>	%	7.7%	7.6%	8.2%	8.3%
<i>CIP % of costs</i>	%		4.0%	4.3%	3.4%
<b>Net Surplus / (Deficit)</b>		(9.5)	5.3	6.7	8.0
Change in working capital		(0.3)	3.0	(0.0)	(0.2)
Non cash I&E items		33.1	18.7	18.7	18.1
<b>Cashflow from operations</b>		<b>23.3</b>	<b>27.0</b>	<b>25.4</b>	<b>25.9</b>
Cashflow from investing activities		(10.1)	(21.6)	(21.9)	(30.6)
<b>Cashflow before financing</b>		<b>13.2</b>	<b>5.4</b>	<b>3.4</b>	<b>(4.7)</b>
Cashflow from financing activities		5.7	9.4	(3.5)	(14.0)
<b>Net increase/(decrease) in cash</b>		<b>18.9</b>	<b>14.8</b>	<b>(0.1)</b>	<b>(18.7)</b>
<b>Cash at period end</b>		<b>24.6</b>	<b>39.4</b>	<b>39.3</b>	<b>20.6</b>
<b>Cash and Cash equivalents at PE</b>		<b>24.6</b>	<b>39.4</b>	<b>39.3</b>	<b>20.6</b>