East Lancashire Hospitals NHS
NHS Trust

EAST LANCASHIRE HOSPITALS NHS TRUST ANNUAL BUSINESS PLAN 2011/12

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EAST LANCASHIRE HOSPITALS NHS TRUST
ANNUAL PLAN 2011/12

1. INTRODUCTION

Trust Profile

1.1. East Lancashire Hospitals NHS Trust (ELHT) was formed on the 1st April 2003, following the merger of Blackburn, Hyndburn and Ribble Valley Health Care NHS Trust and Burnley Health Care NHS Trust.

1.2. East Lancashire Hospitals NHS Trust is a major acute Trust serving a population base of 521,400 people (Source: ONS 2008-based Subnational Population Projections by sex and quinary age), consisting of approximately 140,000 people in Blackburn with Darwen and 381,400 people in East Lancashire.

1.3. The Trust provides a full range of acute hospital services predominantly from its two main hospital sites: Burnley General Hospital and the Royal Blackburn Hospital (located approximately 14 miles apart). It is a specialist centre for Hepatobiliary, Head and Neck and Urological Cancer services, in addition to being a growing centre for Cardiology services and a network provider of Level III Neonatal Intensive Care.

1.4. The Trust has an annual turnover of circa £377m and employs 6279 whole time equivalent staff.

1.5. The Trust currently has a total of 971 beds, comprised of 632 beds at the Royal Blackburn Hospital site, 291 beds at the Burnley General Hospital and Pendle Community Hospital sites, 30 community inpatient beds at Clitheroe Community Hospital and 18 community inpatient beds at Accrington Victoria Hospital.

1.6. The Trust has two private finance initiative (PFI) schemes at the Royal Blackburn Hospital and Burnley General Hospital sites, valued at over £70m and £20m respectively. In addition to this the Trust has continued to make major investments in its healthcare facilities, predominantly focusing on its commitment to the Burnley General Hospital site, with the £32m development of a new Lancashire Women and Newborn Centre which is a fundamental part of the final phase of the Meeting Patient's Needs (MPN) clinical reconfiguration process (2007 – 2011).

1.7. In April 2011, adult community services transferred to the Trust from NHS East Lancashire with a value of c£42 million and 998 whole time equivalents (WTEs) which will help transform the Trust into a fully integrated healthcare provider.

Vision and Values

1.8. As a result of comprehensive consultations with staff in 2010/11, the following vision and values were identified for the organisation which aim to improve patient experience by putting quality at the centre of everything we do.

Vision: East Lancashire Hospitals NHS Trust's vision is to 'be a great Trust providing the best possible healthcare to the people of East Lancashire'

Values:

- Respecting the individual
- Putting patients and customers first
- Promoting positive change
- Acting with integrity
- Serving the community

1.9. Underpinning the Trust's vision and values are the following key operating principles that influence the way in which the Trust does business:

- Understand the world we live in and deal with it
- We are clinically led and management supported
- Support departments support the front line
- Everything is delivered by and through Divisions
- Compliance with standards and targets are a given. They are the things we do to help secure our independence and influence
- Quality is our organising principle - driving quality up and cost down is not mutually exclusive
- We deliver what we say we need to

Key Achievements 2010/11

1.10. The Care Quality Commission has registered and therefore licensed East Lancashire Hospitals NHS Trust to provide services without conditions.

1.11. We have significantly improved our performance against key access, quality and performance indicators which include:

- year on year reductions in the number of hospital acquired (post 48 hours) MRSA cases
- year on year reductions in the number of C Difficile cases
- a reduction in our hospital standardised mortality rate.
- full achievement of the 18 week referral to treatment median waiting times
- full achievement of all cancer waiting time targets
- full achievement of the accident and emergency target requiring 98%+ of patients to spend a total time of 4 hours or less in the Accident and Emergency service

1.12. Relationships with the public, commissioners and local General Practitioners have been enhanced which has contributed to ELHT maintaining its market share.

1.13. We have implemented sophisticated demand management and lean initiatives including implementation of the productive theatre, productive ward and productive community services programmes in consultation with the NHS Institute for Innovation and Improvement.

1.14. Clinical engagement and leadership has been strengthened across the health economy by the establishment of a Clinical Transformation Board, consisting of senior clinicians and managers from across the health economy, who now meet regularly to discuss and plan all aspects of service transformation/ integration.

1.15. A renewed focus on patient safety and quality has been driven through the following key initiatives:

- We have maintained visible leadership – Board and Clinical leaders have participated in Board to Ward patient safety walk rounds and reviews of services.
- We have continued participation in the Advancing Quality Initiative: we have used PROMS (Patient Reported Outcome Measures) PEMS (Patient Experience Measures) and have undertaken initiatives as part of the Quality, Innovation, Productivity and Prevention initiative (QIPP).
- We have participated in the Northwest Mortality Reduction collaborative. The Trust participated in the National Patient Safety First Initiative, and is now participating in the National Safety Express programme as a host organisation and that this feedback informs our improvement work.
- The Trust has participated in the Safety Net visit programme, ensuring our commissioner and lay personnel have access to Trust Service.

- We have introduced Clinical Safety Bundles to key clinical pathways across the organisation.
- Visible Nursing leadership has been maintained with our Matrons and identified Leaders monitoring our standards and nurse sensitive indicators.
- We have the use of the Patient Experience Tracker system across the Trust and we have reporting for real time patient feedback submitted for the past year.
- We have strengthened the Complaints/PALS triaging process to ensure more effective management of concerns raised and we have ensured an increase in face to face complaints handling to resolve concerns directly and in a timely fashion.
- The Ward Quality Framework has continued and the Patient Safety Thermometer has been implemented and monitored.
- Internal Governance Review and practice reviews have been systematically implemented and we are monitoring areas of concern aligned to Practice. This has led to the development of Directorate Quality and Risk Profiles across the Trust mirroring those used by the Care Quality Commission
- A review of our appraisal and development processes and a strengthening of the Human Resources and Organisational Development functions in the organisation have supported our quality initiatives.
- Our Improving patient experience work plan and monitoring arrangement with a specific focus on privacy and dignity and nutrition and hydration has enabled us to respond to patient feedback and concerns whilst improving the quality of care we deliver.

1.16. The Trust has successfully retained NHSLA Level 2 accreditation for Maternity and Neonatal services in February 2011, scoring 49 points out of a possible 50 against standards covering governance procedures, the competence and capability of its workforce, the quality of its clinical care, and the ways in which it has learned from experience. This is in addition to the Trust maintaining the standards required to achieve NHSLA (National Health Service Litigation Risk Management) Level 3 status in our Trust Wide Acute Services in November 2009 with an exceptionally high level of compliance. Placing the Trust in the top 10% of Trusts nationally for patient safety.

1.17. We have enhanced our engagement and collaborative working with patient groups, local involvement networks, local authorities and social care and third sector providers to enhance strategic planning across the health economy, to improve public health and reduce health inequalities. Trust representatives participate in local strategic partnership planning events and regularly attend local Overview and Scrutiny Committee meetings to respond as requested to healthcare related issues.

1.18. The division of Family Care have also consulted extensively with the public and local patient and birthing groups as part of the design and opening of the new Lancashire Women and Newborn Centre at Burnley General Hospital. The new Lancashire Women and Newborn Centre opened in November 2010 at a cost of £32 million and brings world-class facilities for obstetric, gynaecology and neonatal care to families in East Lancashire and beyond. This new, state-of-the-art, purpose-built facility provides services for all types of gynaecological care, and its purpose-built maternity and obstetrics unit and level 3 Neonatal Intensive Care Unit offers high levels of consultant care for women and their babies in the best possible environment, supported by expert teams of doctors, midwives, neonatal nurses, health care assistants and support workers all in one specialist location.

1.19. We have delivered consecutive financial surpluses for the years 2007/8 to 2010/11 whilst experiencing activity growth, increases in complex case mix and general cost pressures throughout the aforementioned period; and

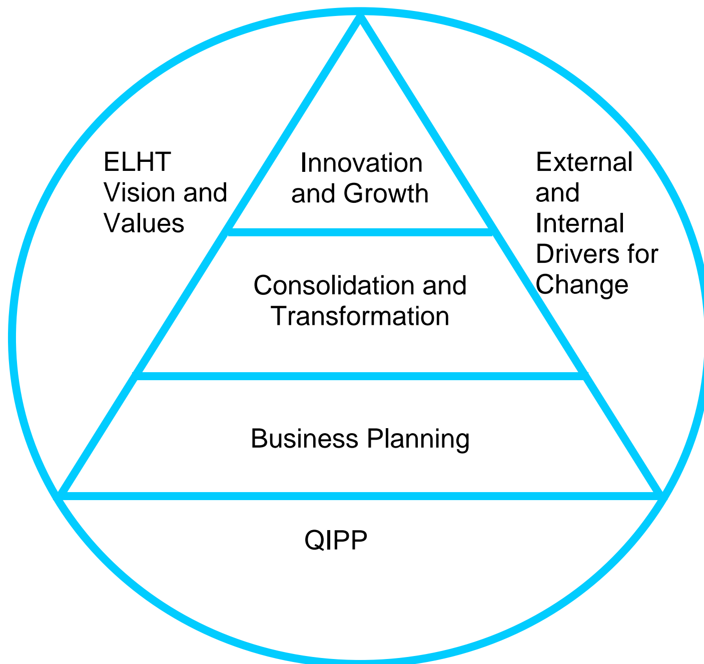
1.20. We have achieved an in year surplus of £723,000 in 2010/11 and cost improvement savings of £18.3m.

2. STRATEGY

2.1 The strategic planning framework within the Trust aims to build upon our core competencies and deliver our vision and values. The strategic planning framework is the mechanism by which the Trust identifies its Corporate Strategic Goals and Objectives and consists of the following key elements.

The Trust's Business Strategy

2.2 Our long term business strategy aims to deliver year on year service improvements by embedding the Trust's business planning processes and thereby consolidate and transform services in a structured way, resulting in clinically led innovation and growth.



2.3 This is achieved by identifying and building upon the unique selling points of our core/non-core services, taking advantage of market opportunities and potential local, health economy and regional productivity and efficiency gains, and through the implementation of robust five year clinical strategies in consultation with key internal and external stakeholders.

2.4 The Trust's business strategy is implemented through the annual business planning cycle, the outputs from which inform the budget setting and contracting processes, and directly contribute towards the Trust agreeing its corporate strategic goals and objectives.

2.5 Divisional, directorate and team objectives are mapped to the above with progress monitored throughout the year by virtue of our integrated performance reports, monthly divisional performance meetings and personal development review processes.

Corporate Strategic Objectives 2011/12

2.6 Based upon the Trust's key internal and external drivers for change and the intelligence gathered through the annual business planning cycle, the following corporate strategic objectives have been identified for the organisation in 2011/12.

Objective 1	To further develop clinical services with key internal and external stakeholders to reduce health inequalities, improve public health and reduce cost across the health economy
Objective 2	To maintain and improve patient experience and outcomes through the achievement of the key indicators/ objectives outlined in the Trust's quality account
Objective 3	To invest in and develop our workforce, and improve staff engagement and satisfaction levels
Objective 4	To maintain all regulatory requirements with the CQC and therefore be licensed to provide services without conditions
Objective 5	To improve the Trust's liquidity position and deliver a cost improvement programme of 5%
Objective 6	To develop services of the highest quality through innovation, pathway reform and the implementation of best practice
Objective 7	To continually promote equality and diversity at every level within the organisation

Divisional Strategic Objectives 2011/12

2.7 Divisional strategic objectives in 2011/12 have been mapped to and directly contribute to the Trust's strategic objectives as outlined in the table below.

2011/12 Divisional Strategic Objectives		Mapped back to Corporate Strategic Objectives						
		Objective 1	Objective 2	Objective 3	Objective 4	Objective 5	Objective 6	Objective 7
Medicine								
1	To develop services in partnership with TCS							
2	To review Consultant Job Planning							
3	To review nurse staffing levels and skill mix							
4	To move towards best possible performance against all targets and indicators and deliver high quality services with the patients at the centre							
5	To under spend against budget and deliver a minimum 5% recurrent CIP							
6	To deliver against all agreed workforce plans							
Surgery								
1	To achieve contracted activity targets							
2	To achieve all national and local performance targets and deliver high quality services with the patients at the centre							
3	To redesign the patient administrative function to support the patient pathway							
4	To continue to roll out enhanced recovery pathways							
5	To continue to develop laparoscopic surgery							
6	To increase day case rates in laparoscopic procedures							
7	To reduce length of stay in # neck of femur							
8	To under spend against budget and deliver a minimum 5% recurrent CIP							
9	To deliver against all agreed workforce plans							
Family Care								
1	To complete comprehensive productivity review, capacity/workforce/facilities vs demand							
2	To strengthen business critical systems, processes and controls to deliver improved strategic planning and performance management, to deliver high quality services with the patients at the centre							
3	To review and transform the way we do things, specifically Paediatric and Obstetric service redesign and to move to a two Directorate Divisional structure							
4	To under spend against budget and deliver a minimum 5% recurrent CIP							
5	To deliver against all agreed workforce plans							
Diagnostic & Treatment Services								
2	To manage demand down by 5% against 10/11							
3	To deliver high quality services with the patients at the centre							
4	To review and reduce estates footprint by 5%							
5	To review and reduce management costs							
6	To delivery plan for IM&T and capital developments							
7	To support clinical divisions							
8	To deliver against the divisional OD plan							
9	To continually strive to improve staff engagement							
10	To under spend against budget and deliver a minimum 5% recurrent CIP							
11	To deliver against all agreed workforce plans							
Community Services								
1	To realise the benefits of the TCS Programme via the development of an ICO and deliver high quality services with the patients at the centre							
2	To agree and deliver a prioritised programme of service transformation in line with ELHT strategic direction and commissioning intentions							
3	To meet all required national standards and targets as applicable to the community services division							
4	To ensure that all our patients receive the care that matters to them							
5	To agree and deliver a Workforce Development Plan that equips the division to meet its objectives							
6	To roll out the PCS Programme building on early successes and productivity gains.							
7	To under spend against budget and deliver a minimum 5% recurrent CIP							
8	To deliver against all agreed workforce plans							

Corporate Strategic (Medium to Long Term) Goals 2011/12 – 2017/18

2.8 The Trust's corporate strategic objectives for 2011/12 directly contribute towards the following medium to long term corporate strategic goals for the Trust, which have been mapped to QIPP, and aim to build on the Trust's core competencies and deliver our vision and values.

		Key deliverable(s)/ Measures of success	(Quality Innovation Productivity Prevention) Alignment	Key Milestones
Strategic Goal 1	The Trust will complete the Transforming Community Services programme and will become a fully Integrated Care Organisation.	Fully Integrated Care Pathways	QIPP	1st April 2011
Strategic Goal 2	The Trust will realise the five year clinical visions and strategies set out in the directorates' business plans.	Necessary changes in levels and types of activity and sub-specialisation in accordance with demand and commissioning priorities	QIPP	Monthly Performance Meetings Annual Business Planning Cycle
Strategic Goal 3	The Trust will continue to invest in and develop its workforce and improve staff engagement and satisfaction levels.	Training budget spend maintained Staff survey results Improved turnover rates	QIP	Monthly budget monitoring Staff survey results
Strategic Goal 4	The Trust will deliver against all essential standards of quality and safety, contractual obligations and quality account priorities.	NHSLA Level 3 and NHSLA Level 2 accreditation for Maternity and Neonatal services Full CQC registration and licence without conditions	QIPP	Acute Trust + Community Contract KPIs CQC Registration and Compliance
Strategic Goal 5	The Trust will continue to develop its strategic planning framework and associated systems and processes to consolidate, transform, innovate and grow its specialty business models to address prevailing healthcare needs and maximise market share, reduce cost and increase the profitability of all core/ non- core services.	Achievement of planned contracted activity by directorates within budgeted resource limits with a minimum 5% CIP requirement	QIPP	Monthly Performance Meetings Acute Trust + Community Contract KPIs Annual Business Planning Cycle
Strategic Goal 6	The Trust will be authorised as a Foundation Trust by March/ April 2013.	Authorisation March/ April 2013	QIP	SHA-led Trust Development Phase: March/ April 2012 Secretary of State Support Phase: 1st October 2012 Monitor Assessment Phase: November/ December 2012
Strategic Goal 7	The Trust will establish and enter into a Healthcare Group model to promote best practice and reduce costs across organisational and regional boundaries.	Improved clinical efficiency through shared best practice and back office function support	QIP	Full business case and implementation plan produced: 2011/12
Strategic Goal 8	To implement an effective marketing and communications strategy	Stable market share across all segments of the market. Comprehensive and timely feedback from key internal and external stakeholders	QIP	Formal review of comms function: 2011/12 Marketing and communication strategy in place: 2011/12

3. EXTERNAL ENVIRONMENT

Summary of National Factors

3.1 This plan and the plans of individual directorates/ divisions are reflective of the following key publications.

NHS Operating Framework

3.2 The Trust acknowledges and has reflected in its planning the challenges set out in the 2011/12 NHS Operating Framework. In particular the need for the NHS to realise £20 billion efficiency savings by 2014-15, to be reinvested into front line services to keep pace with generic pressures within the healthcare system i.e. pay and price inflation, deflations in income, a more complex case mix and rising demand for services from an ageing population.

3.3 Average national growth in recurrent commissioner funding currently stands at 2.2% for 2011/12, and therefore the Trust realises that with tariff deflation at 1.5%, generic pressures at 2.5% and local pressures at 1% of turnover, the Trust will need to achieve minimum 5% of turnover year on year cost improvement savings in order to remain financially viable and achieve a minimum 1% recurrent surplus.

NHS Outcomes Framework and NHS Constitution

3.4 The Trust acknowledges and has taken into account the challenges and operating principles set out in the NHS Constitution and 2011/12 NHS Outcomes Framework and has made reference to these documents in 2011/12 to inform health economy discussions. In particular these documents have been referred to in negotiating capacity for orthopaedic elective work to ensure the 18 week trajectory was achievable whilst providing a range of choices for patients. The NHS outcome framework was key in developing the local CQUIN outcomes, specific examples being end of life care and compliance with same sex accommodation in critical care environments.

Local Health Economy Objectives

3.5 East Lancashire Hospitals NHS Trust will continuously deliver measurable contributions towards the following local health economy objectives identified in the following key documents by 2013:

- *Local Strategic Partnership Local Area Agreement*

(1) less alcohol and drug abuse;
(2) fewer deaths from heart disease and smoking; and
(3) fewer teenage pregnancies

- *NHS East Lancashire Commissioning Strategy*

(1) To significantly increase life expectancy and reduce health inequalities
(2) To improve the quality of life for those people with longer term conditions. (3) To enhance the quality of services and patient experience to improve outcomes, levels of accessibility and safety.

- *NHS BwD Commissioning Strategy*

(1) To have improved lifestyles and wellbeing
(2) To increase life expectancy and reduce health inequalities
(3) Pts to experience safe and integrated healthcare services
(4) Patients to have access to the latest and most effective prevention and healthcare treatments; and
(5) Patients to receive personalised and caring services

Summary of Local Factors

3.6 The Trust aims to demonstrate at all times that it knows its business, and is therefore competitively placed to remain the provider and employer of choice for its locality.

3.7 In order to ensure that we are meeting patient and commissioner expectations the Trust therefore keeps a constant check on the following key pieces of market intelligence, in addition to its PEST, SWOT and Ansoff analysis.

Local Demographics and Epidemiology

3.8 Blackburn and Burnley have areas of significant social deprivation with related problems of poor diet, smoking and excessive alcohol consumption. This is reflected in low life expectancy and a high prevalence of cancer, coronary heart disease and digestive disease in both the male and female populations. Although the population is expected to remain fairly static, the profile is ageing.

3.9 Although significant efforts are being made in both boroughs to reduce health inequalities, it is accepted that prevention initiatives will take time to produce results. During the life of this plan, it is expected that the impact on demand of health improvements will be balanced by the increasing healthcare needs of an ageing and more obese population.

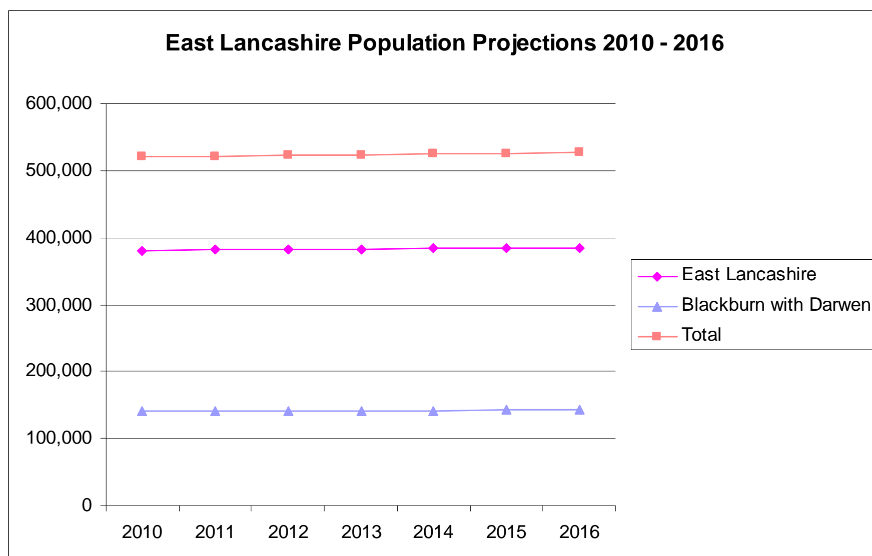
3.10 The Trust has a dominant market position in Burnley which will be maintained through the Trust's business and marketing strategies.

3.11 In the Blackburn area, the market is more competitive and the Trust's marketing and engagement strategy and plan reflects the need for more focused work with patients and referring GPs to maintain market share in this area.

3.12 Whilst demand for services will continue to grow, competition is also likely to increase further as surrounding regional hospitals achieve and develop their status as specialist centres and Foundation Trusts, GP Commissioning Consortia's are developed, and more independent sector providers enter the market through the 'any willing/ qualified provider' commissioning framework.

3.13 NHS reforms will continue to shape the Trust's priorities. Key drivers impacting on the Trust's business strategy will include the need to develop strong relationships with emerging GP Commissioning consortia, to ensure that the Trust's services meet the needs of their patients by delivering care closer to home for patients in the most clinically effective and cost efficient way.

3.14 Population projections for the next five years show a modest increase within the East Lancashire population base.



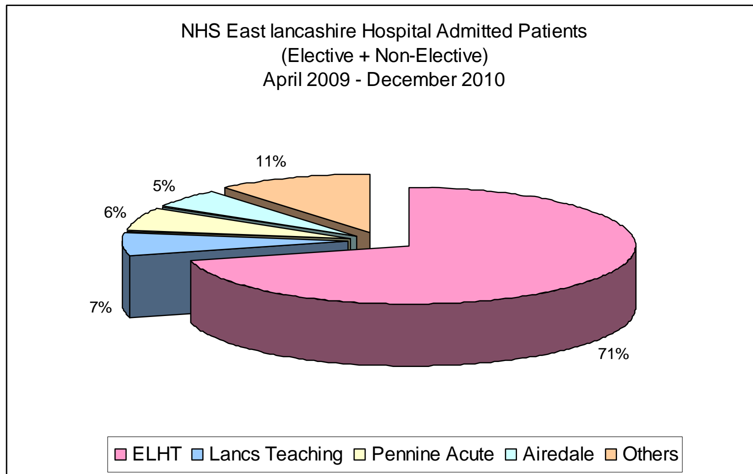
East Lancashire (Inc BwD) Population Projections (000's)											
Age Range	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
0-4	35.0	35.7	36.0	36.2	36.3	36.1	35.8	35.7	35.5	35.4	35.4
5-9	33.0	32.7	32.9	33.4	34.0	34.9	35.6	36.0	36.2	36.3	36.1
10-14	36.2	35.6	35.1	34.2	33.4	32.9	32.7	32.9	33.5	34.1	35.0
15-19	37.9	37.0	36.2	35.4	34.6	33.9	33.4	32.8	31.9	31.2	30.7
20-24	31.7	32.1	32.0	31.7	31.7	31.0	30.5	29.9	29.2	28.5	28.0
25-29	28.8	29.7	30.7	31.7	32.7	33.9	34.3	34.3	34.2	34.2	33.7
30-34	29.2	28.6	28.5	28.7	29.2	29.7	30.6	31.6	32.6	33.6	34.8
35-39	36.8	35.3	33.9	32.2	30.3	29.2	28.6	28.7	28.9	29.5	30.1
40-44	39.2	39.2	38.6	38.3	37.8	36.7	35.1	33.8	32.1	30.3	29.1
45-49	37.3	38.0	38.7	39.0	39.0	38.8	38.6	38.2	37.7	37.3	36.1
50-54	33.4	33.7	34.1	34.7	35.6	36.4	37.2	37.9	38.3	38.2	38.0
55-59	32.1	31.6	31.4	31.7	31.9	32.1	32.3	32.8	33.4	34.2	35.1
60-64	30.9	31.7	32.0	32.0	30.9	30.1	29.5	29.5	29.7	29.9	30.1
65-69	22.6	23.2	23.9	24.8	26.9	28.3	29.1	29.5	29.6	28.4	27.7
70-74	19.3	19.5	19.7	19.7	19.9	20.3	20.8	21.6	22.3	24.3	25.6
75-79	15.4	15.4	15.5	15.6	15.9	16.4	16.8	17.0	17.0	17.3	17.6
80-84	11.4	11.3	11.5	11.5	11.7	11.8	11.9	12.1	12.4	12.7	13.2
85-89	7.3	7.5	7.4	7.2	7.2	7.2	7.3	7.5	7.6	7.9	8.0
90+	3.0	3.1	3.3	3.7	3.9	4.1	4.3	4.4	4.5	4.6	4.7
All ages	520.3	520.8	521.4	521.9	522.7	523.6	524.6	525.7	526.8	528.1	529.2

Source: Office for National Statistics 2008-based Subnational Population Projections by sex and quinary age

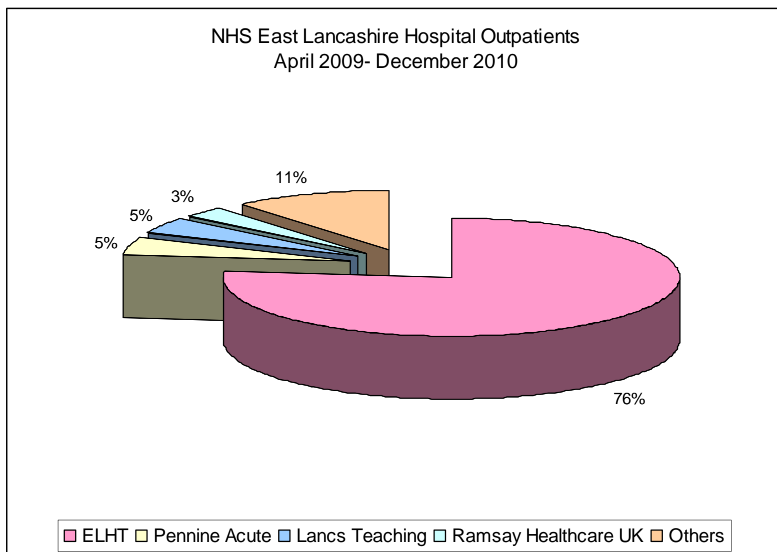
3.15 The most significant population increase in East Lancashire is predicted to occur between the age range of 60 – 90+ in both PCT localities between 2010 and 2016, with a combined 9.3 and 6.3% increase respectively across East Lancashire and Blackburn with Darwen. This suggests that demand for services will be greatest in an age range that will benefit most significantly from the integration of care pathways and the long term benefits that an Integrated Care Organisation will bring.

Market Share and Segmentation

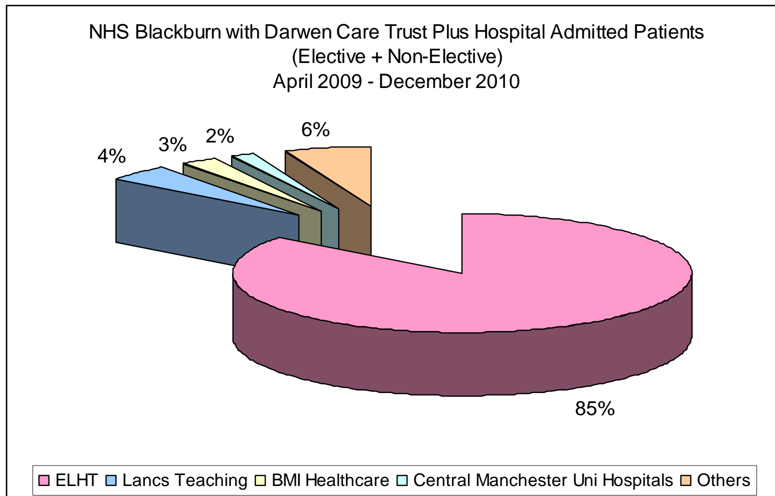
3.16 The analysis of the Trust's market share and segmentation (below) shows that ELHT enjoys the majority of commissioned activity from its two main commissioners across all segments of the market and main points of delivery.



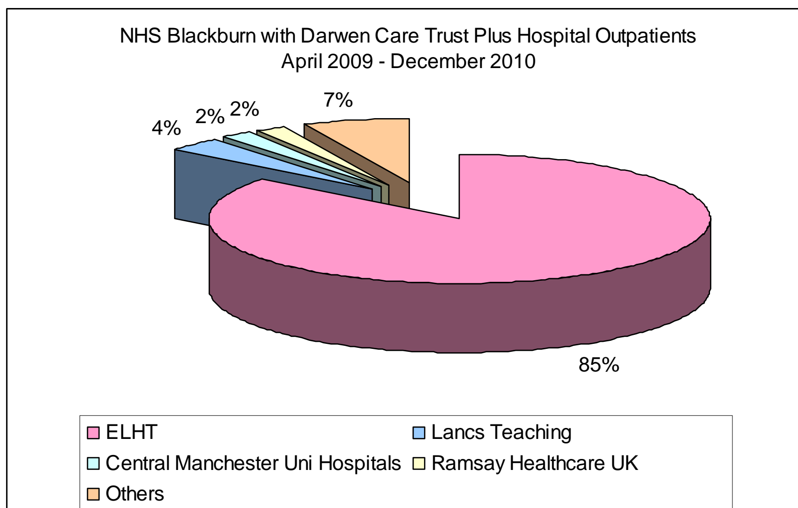
Source Dr Foster - Data set: PCT Registered Hospital Admitted Patients Outcome: Spells - April: 2009 to: December 2010. Sex: All Age band type: Dr Foster (20) Age: All Ethnicity: All Measure of deprivation: Carstairs 2001 Classification: National Quintile Deprivation: All HRGs v.4.



Source: Dr Foster - Data set: Hospital Outpatients Outcome: Attendances April: 2009 to: December 2010 Sex: All Age band type: Dr Foster (20) Age: All Ethnicity: All Measure of deprivation: Carstairs 2001 Classification: National Quintile Deprivation: All HRGs v.4



Source Dr Foster - Data set: PCT Registered Hospital Admitted Patients (Elective +Non-Elective) Outcome: Spells - April: 2009 to: December 2010
Sex: All Age band type: Dr Foster (20) Age: All Ethnicity: All Measure of deprivation: Carstairs 2001 Classification: National Quintile Deprivation: All HRGs v.4



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Sex: All Age band type: Dr Foster (20) Age: All Ethnicity: All Measure of deprivation: Carstairs 2001 Classification: National Quintile Deprivation: All HRGs v.4

3.17 A more detailed analysis of the Trust's market share at specialty level also shows that opportunities exist across Trauma & Orthopaedics, Urology, ENT and Oral Surgery in both elective and day case activity to increase the Trust's overall market share.

3.18 Key risks to the Trust's current market share and income streams have been identified in our annual PEST and SWOT matrices outlined below, which have informed directorate/ divisional clinical strategies through our annual business planning cycle.

PEST Analysis

3.19 The following key internal and external drivers for change have been identified as part of our annual PEST analysis, which have informed directorate/ divisional clinical strategies.

	Factor	Impact	Actions/ Initiatives/ Risks
POLITICAL	National standards/targets.	National standards/targets continue to drive change, particularly in terms of the amount of time patients wait to access services.	The Trust will continue to achieve the 18 week referral to treatment median waiting times. Key areas of focus in 2011/12 will also include: - Performance against Stroke and TIA targets; - Performance against the new Accident and Emergency indicators; - Continued year on year reductions in healthcare associated infections.
	Reducing health inequality	The East Lancashire population has reduced life expectancy compared with national averages.	ELHT will improve planning and access to services to prevent the need for acute care by virtue of integrated care pathways with community services and collaborative working with the third and social care sector to improve public health and prevent unnecessary admissions.
	Patient choice	Patient Choice continues to have potential to have an impact on patient flows for elective surgery.	The transformation of patient pathways and the reconfiguration of services as part of the integrated care model will be undertaken in consultation with patients, commissioners, local authorities and other key stakeholders to ensure that patient choice is maintained to maximise the benefits to patients whilst reducing costs.
	High Quality Care for All (NHS Next Stage Review)	Focuses on patient experience, accessibility, safety and effectiveness and measurable patient outcomes. Emphasis on public health and prevention/ promotion to reduce the number of patients requiring acute hospital care, with care delivered in a local setting/ closer to home wherever possible.	The integrated care model will allow the necessary changes to take place in accordance with the recommendations of 'High Quality Care for All', in a structured and facilitated way that will not adversely affect the local health economy.
	Increasing range of providers (including NHS funded private sector provision)	Competition, including NHS funded private sector provision) continues to shape the local health economy market place within East Lancashire.	The Trust will work more closely with GPs/ Commissioners (GP Consortia) to ensure fairness, transparency and equality in all procurement processes to ensure that care is delivered in the most appropriate location for patients, to improve clinical outcomes and patient experience whilst reducing cost.
	Increased accountability	As the Trust prepares for Foundation Trust status and we aim to deliver new innovative models of care, national requirements and local expectations must be met.	The Trust will endeavour to deliver all services in accordance with its registration requirements with the Care Quality Commission, NHSLA level three standards, and its future terms of authorisation as a Foundation Trust, in consultation/ agreement with commissioners, patients and the public and local authorities. Revised service models will be based upon clinical evidence and will develop and support patient choice.
	NHS Outcomes Framework (April 2012)	New key performance indicators to be established.	The integrated care model will provide the health economy with an overall health service that is more flexible in terms of its workforce and resources, allowing it to respond quickly to the prevailing health care needs of the local population. This will improve patient experience and clinical outcomes by ensuring patient care is delivered in the most appropriate setting, by the most appropriate professional in accordance with the patient's condition. Funding decisions and/ or pension debaters nationally may have a negative impact however resulting in industrial action.
	NHS Commissioning Board (April 2012)	Possible increase in the number of commissioning representatives and priorities.	The Integrated Care Organisation will be better positioned to respond to the requirements of the NHS Commissioning Board and GP Consortia by providing an integrated approach to treatment and care.

	Factor	Impact	Actions/ Initiatives/ Risks
	Formal Establishment of GP Consortia (2012)	New Relationships to be developed and expectations to be met.	An integrated approach to care in the home, community and hospital settings based upon new clinical pathways agreed between primary and secondary care clinical colleagues, in addition to improved access to acute services, will provide the General Practitioners with a solid foundation upon which to reform and commission local healthcare services. A senior GP representative (non commissioning) will also sit on senior East Lancashire Hospitals NHS Trust Management Board.
	New Local Authority Health & Well Being Board (April 2012)	Has the potential to increase the reporting requirements and accountability of local NHS providers whilst influencing the views and choices of patients.	The organisational transformation and integration of care pathways associated with implementing the ICO model will provide the Trust with a unique opportunity to consult with local patient support groups, Local Involvement Networks and Local Authorities, with regard to planning and developing future services to reduce health inequalities.
	Health Watch Established (April 2012)	Increased scrutiny and accountability.	Reporting requirements will be established and appropriate information provided in accordance with all relevant standards/targets.
	Abolition of SHAs (2012/13)	Shared knowledge and regional joint working maybe compromised.	In addition to the implementation of the integrated care model and the subsequent authorisation of the Trust as a Foundation Trust, in association with key partners ELHT aims to form a federated healthcare group, to share best practice and resources with other high performing Trusts for the benefit of its patients.
	Abolition of PCTs (April 2013)	Existing relationships, joint working processes and agreements with commissioners maybe compromised.	The Trust has successfully agreed the 2011/12 NHS acute and community care contracts and will aim to secure similar agreements for the benefit of patients and the taxpayer when the NHS standard contracts and guidance for Acute Hospital and Community Services are published in January 2011.
	All NHS Trusts become, or are part of, Foundation Trusts (2013/14)	The Trust will have to demonstrate that is it financially viable, legally constituted and well governed in accordance with the new (July 2010) Monitor guide for applicants and (subsequently) the Monitor compliance framework.	The integrated care model will streamline care pathways, standardise work practices and enhance the purchasing power of the Trust as an organisation. This in turn will reduce the Trust's cost base and put the Trust into a sustainable financial position to demonstrate its financial viability as a Foundation Trust.

	Factor	Impact	Actions/ Initiatives/ Risks
ECONOMICAL	National Economic Context	Spending Review completed – NHS to receive 0.1% growth in real terms each year over the next 4 years. Need to deliver £15-20 billion efficiency savings over the next four years by improving quality and productivity so that this can be re-invested back into the service.	Regional, local and internal Quality, Innovation, Productivity and Prevention structures and lean thinking will be at the forefront of any service redesign. Thus ensuring that services are delivered in the most clinically effective, cost efficient way. At a local level health economy QIPP plans contribute towards the Trust's 5 years CIP plans which aim to deliver £63m in cost improvement savings over the next 5 years, £18.9m in 2011/12.
	Transforming Community Services	The health economy must establish clinical service models that are financially viable and clinically effective, in accordance with Payment by Results.	The Trust will ensure that all services are delivered under contract in accordance with the relevant mandatory/ non-mandatory recommended tariffs wherever possible, and will endeavour to achieve all best practice tariffs and CQUIN requirements in accordance with local commissioning intentions.
	Increased competition and the re-introduction of the 'Any Willing/ Qualified Provider' initiative.	The choice of 'any willing provider' may impact negatively upon the Trusts market share, financial viability and reputation.	The ICO model will ensure that the Trust is competitively placed to maintain its market share by delivering quick and efficient care to patients in the most appropriate settings. The integration of the community based services will also provide the Trust with an opportunity to increase its market share in other areas and further refine/ develop its overall business model and core business.

<table>
<tr><td></td><td>Financial position of the local health economy and the need to reduce NHS Management Costs by over 45% (by end of July 2014)</td><td>The local health economy must deliver financial balance and minimum 4% cost improvements each year over the next five years.</td><td>The plateau in central government NHS funding over the next few years means all NHS providers must critically evaluate their income and expenditure streams and ensure that efficiencies are realised and that value for money and return on investment is maintained at all times.</td></tr>
<tr><td></td><td>Payment by results</td><td>For the next two years it has been confirmed that the tariff will be reduced by 2% for each year. In addition to this the Trust will have to meet a series of cost increases, including, pay awards, incremental drift, VAT increases, increases to National Insurance and general inflation. None of this will be funded centrally and resources must be released from existing services in order to meet these financial pressures.</td><td>The Trust will apply lean methodologies and best practice when re-designing services to ensure that services are developed in a way that applies innovation to delivery with improved productivity and quality outcomes.

Examples of this include the development of fully integrated care pathways for specific conditions such as COPD, Urgent Care and MSK in 2011/12, to reduce costs and maximise patient satisfaction and turnover.

These initiatives are supported key clinical developments within the Trust examples of which include the Surgical Triage Unit and the enhanced recovery programme which are both delivering real benefits for patients and the Trust.</td></tr>
<tr><th></th><th>Factor</th><th>Impact</th><th>Actions/ Initiatives/ Risks</th></tr>
<tr><td rowspan="6">SOCIAL</td><td>Health and lifestyle choices of the local population</td><td>These play an important role in driving demand for our services – this is evidenced by comparatively high incidence of conditions relating to smoking and alcohol usage in East Lancashire.</td><td>Necessitates close working with commissioners, local Directors of Public Health and Health watch, Health & Wellbeing Partnership and Public Health England representatives to promote public health and prevention.</td></tr>
<tr><td>Changing demography</td><td>As the population of East Lancashire grows the age structure will change, based on current trends there will be an increase in the 45+ population.</td><td>This will impact upon future demand, but the ICO model will strengthen the resilience of the local health economy by delivering seamless care pathways which address long term conditions and co-ordinate the efforts of primary and secondary care and the third and social care sectors. The ablation of the default retirement age will however make it more difficult to predict future staffing requirements and lead to an aging workforce which future workforce policies must take account of.</td></tr>
<tr><td>Increased influence of the local public in how we deliver health care</td><td>The Trust expects to continue to see an increase in the role individuals play in their own care as well as influencing how services will develop in the future.</td><td>Need for greater openness and transparency – particularly through the relationship with the Trust membership, local patient groups and Health watch and Health & Wellbeing Partnership representatives.</td></tr>
<tr><td>Litigation culture</td><td>Increased levels of litigation.</td><td>Risk in terms of increased costs and clinical time associated with litigation if a clinically driven and evidence based approach is not taken with regard to the dispersal of community services and the restructuring of clinical pathways.</td></tr>
<tr><td>Level of concern about hospital acquired infections</td><td>Increased MRSA and C.Diff rates and other infections are detrimental to patient care and undermine patient/public confidence.</td><td>Requires continued focus and effective leadership through ongoing strengthening of infection control arrangements in order for the Trust to continue to exceed its targets in this area throughout any transitional process.</td></tr>
<tr><td>Changing labour market</td><td>High unemployment within the local economy provides the Trust with a rich labour pool of professional and skilled/ unskilled workers who have a vested interest in their local healthcare services. An increasingly elderly population may however provide challenges for recruitment.</td><td>East Lancashire Hospitals NHS Trust's HR and workforce plans will be developed to address these issues.</td></tr>
</table>

	Factor	Impact	Actions/ Initiatives/ Risks
TECHNOLOGICAL	Concentration of specialised services for improved outcomes	Regional and national reviews all point towards increased concentration of specialised services to support clinical quality	Service plans will reflect both the opportunities and constraints that this provides.
	Developments in new drugs and medical technologies	These provide new ways to develop existing and new services as well as providing new financial pressures and/ or long term efficiencies.	This will be reflected within all service plans and will require tight financial discipline. East Lancashire Hospitals NHS Trust will seek to employ technology in community settings e.g. Telemedicine.
	NICE and Improving Outcomes Guidance	Set out specific requirements for individual services.	Compliance as part of the assurance of service quality.

SWOT Analysis

3.20 Based upon the Trust's PEST analysis and other key internal and external drivers for change identified with key stakeholders, the Trust has determined the following strengths, weaknesses, opportunities and threats in 2011/12. The annual business planning cycle ensures that divisional and corporate plans have a focus on these key issues.

Strengths	Weaknesses
• Strong reputation for clinical quality locally and regionally • Over 70% of East Lancashire elective patients choose ELHT • Strong track record of delivery against key national targets and standards • Skilled, stable and committed workforce • Track record of delivering efficiencies within clinical services through adopting new ways of working. In particular demonstrated by reduced lengths of stay and increased patient flows • High quality estate including new RBH and Phase V facility • Strengthening financial controls resulting in consecutive financial surpluses for the years 2007/8 to 2010/11 • Clinical Education and Training	• Ageing workforce • Duplication of some services across sites • Condition of parts of the hospital estate • Geographic separation of two main sites • Capacity constraints within some areas • Ability to recruit junior medical staff • Viability of some sub-specialties • Local political context
Opportunities	**Threats**
• Development of some tertiary services e.g. cardiology services and HpB surgery • Potential to increase productivity and improve efficiency through ICO model, thereby reducing reference costs • A reduction in the number of acute trust beds and a refocus of services around community provision • Rationalisation of the current acute Trust's estate • Rationalisation of support services/ back office functions • Achievement of best practice tariffs • Partnership working with neighbouring Trusts and local organisations e.g. local authorities • Availability of modern IT and information systems • Further development of local research expertise • Developing further nurse led activities • Developing Lean approach • Commissioner focus on addressing health inequalities • Maintaining and further developing a customer centred approach • Further development of management capability below Board level • Potential to increase in market share through patient choice and integrated care pathways • Clinical and financial benefits from joint working with partner organisations and whole system integrated health and social care pathways • The ability to grow and develop community services • Foundation Trust status	• Competition for elective, outpatient, diagnostic and community work under 'any willing/ qualified provider' approach and the 'right to request/ provide' scheme for staff. • Failure to manage reductions in capacity in response to reduced elective demand • Unplanned growth in urgent care • Unplanned changes in patient flows and demand • Absence of clear commissioning strategies and quantitative supporting data • Competition for workforce – surgery, maternity, neonatology and theatres • Potential negative impact of Modernising Medical Careers (MMC) • Large number of acute Trusts and private providers in close proximity • Demography of local population – aging population, levels of chronic disease etc • Rising drug costs and other financial pressures • Failure to deliver financial efficiencies • Impact of GP Consortia • Impact of PCT Cluster arrangements

Ansoff Matrix – Key Divisional Product/ Service Expansion, Retraction and Diversification Opportunities 2011/12 – 2017/18

3.21 Key areas of focus for our clinical divisions in 2011/12, identified through the Trust's annual business planning cycle, are detailed below. These service areas are coherent with the Trust's long term business strategy and will contribute to its continued clinical and financial viability as an integrated care organisation and future Foundation Trust.

Markets: New (top) – Existing (bottom)

Market Development

Medicine

ICD
Elective PCI

Surgery

T+O one stop shop service for West of Blackburn
Gen Surg Private Work
Gen Surg Breast Reconstruction
Gen Surg Laparoscopic work
Ophthalmology – AMD+ DRSP
Become the centre for Lancashire H&N cancers

Family Care

Core Obstetrics & Gynaecology
Termination of Pregnancy (TOP) service
Fertility Services
Uro-gynaecology
Private Cosmetic Gynaecology
Private Obstetrics and Free Choice Network
GUM Levels 1,2,3
Core Paediatric services
Home Ventilation Nursing service
Sub-specialty paediatrics
Renal – Lancashire wide shared care
Looked After Children service
Self Harm Assessment & Treatment
Post Abuse (Trauma) CAMHS
16+ ADHD

Diagnostic + Treatments Services

MRSA
Renal – RFA (EL Health Economy and the wider L&C Network)
Physiotherapy to the independent sector
Dietetics to the independent sector

Diversification

Medicine

Dementia
Intermediate Care
Virtual ward
MAU Clinics (Blackburn)
Cystic Fibrosis
Sleep apnoea
CT Angiography
Soft Tissue Injury Clinic
Nurse-led Dermatology

Surgery

Gen Surg Bariatric Surgery
Gen Surg 23 hour Mastectomy
Secure tender for tier 2 dental service
Develop nurse led clinics in Lift centres for basic oral and ENT care

Family Care

Office Gynaecology
Sacral Neuro Modulation (SNM)
Perinial Tibial Nerve Stimulation (PTNS)
PP Cosmetic Gynaecology
Autism Assessment d/c package (and others)

Diagnostic + Treatments Services

Phlebotomy Training
Private Sector Clinics
GP Phlebotomy Service (eg 5pm to 8pm)
Specialist Network MDT
Cardiac CT/MRI (EL Health Economy and the wider L&C Network)
Physiotherapy to occupational health (independent sector)
Therapies 'lifestyle advice' to the independent sector

Market Penetration

Medicine

Stroke and TIA
Orthogeriatrics
Neuro-rehab
OP cellulitis Abx
PE
Integrated COPD
NIV
Hep B+C
Nutritional
OOH GI Bleed
Fast flow wards
Zero stay chest pain
Diabetes

Surgery

Increase T+O Elective activity
Repatriation of ALL T+O EO5 activity
Regional Review - Potential to become regional centre for Gen Surg
Gen Surg Laparoscopic work
ENT/ OFMS - Supplying of tier 2 services in community under tender agreement
ENT/ OFMS - Aural care clinics in community

Family Care

Core Obstetrics & Gynaecology
Termination of Pregnancy service
Fertility Services
Urogynaecology
GUM Levels 1,2,3
Gynaecological Cancer
Core Paediatrics services
Paediatric assisted ventilation service
NICU
NICU Community outreach
Substance Misuse service
Looked After Children service
Post Abuse (Trauma) CAMHS
16+ ADHD

Diagnostic + Treatments Services

RBH OPD
BGH OPD (Consolidation)
AVH OPD
Pendle Hospital OPD
Rossendale OPD
Direct Access Pathology
Microbiology
Blood Sciences
Clinical Haematology
Infection Control
Cellular Pathology
CT, MRI, Nuc Med, Fluor, Angio, US (obstetric and non obstetric), Breast (PE)
Non Vascular Intervention
HpB Intervention
Increased MSK Physiotherapy activity
Increased outpatient OT activity
Increased outpatient dietetics activity
Increased orthotics activity

Product Development

Medicine

Falls
Fast Flow Pharmacy
Frequent flyers
Pleural thoracoscopy
EBUS
CT Angiography
Alcohol liaison service
Ablation
Soft tissue injury clinic
Nurse-led Dermatology

Surgery

New tariff structures for new T+O community outpatient services
Gen Surg Laparoscopic work
ENT/ OFMS - Supplying of tier 2 services in community under tender agreement
Skin cancer work
Development of complex H&N cancers
MSK

Family Care

4D Scanning
New model for Colposcopy
Office Gynaecology
SNM
PTNS
Nurse-led Sonography
Diabetes transitional care
Cystic Fibrosis – higher level spec. of care
Pathway based integrated children's services
Neonatal Triage
Autism Assessment d/c package (and others)
Youth Justice service
Substance Misuse service

Diagnostic + Treatments Services

Primary Care Clinics
Community Hospitals (eg Clitheroe)
POCT
Molecular Diagnostics
Breast MRI
Daycase Angiography
Daycase Intervention ie lung/liver biopsies
Regional Hepatobiliary intervention
Physiotherapy to occupational health (NHS)
MSK

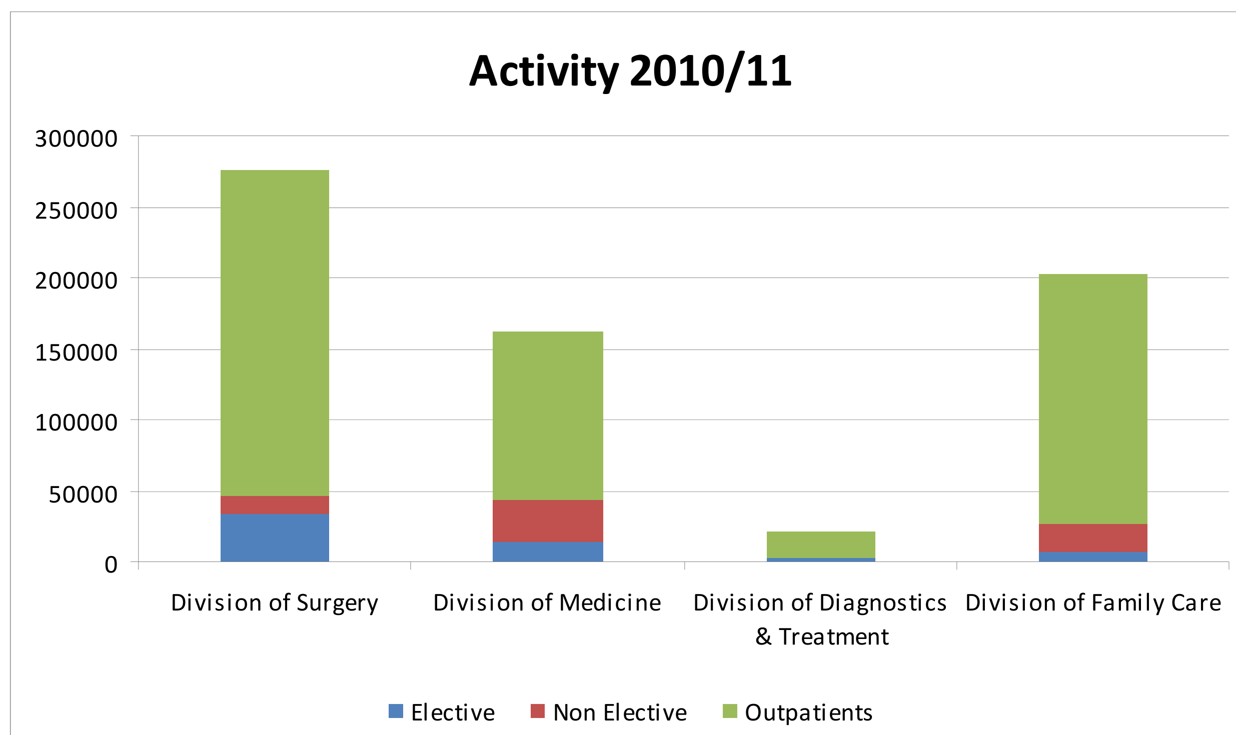
Products/ Services: Existing (left) – New (right)

Markets	Existing Products/ Services	New Products/ Services
New	**Market Development** **Community Services** Increase contract for supply of equipment to neighbouring localities Refocus rehabilitation services to outreach re-enablement MD teams. Minor op's/day case suitable for delivery from OPD/rehab day unit/wards e.g. day case infusions – anti TNFs – injections, other. Flu vacs for housebound patients and those in care homes on behalf of GP practices with recharge arrangements. Use if technology such as Lymph-assists as an adjunctive therapy for manual lymphatic drainage to direct resources on other activities Fast track access for assessment and treatment for ELHT staff Injection clinic via direct booking. Work assessment for Department of work and pensions.	**Diversification** **Community Services** Develop sports injuries service alongside MSK Training and development to nursing homes – prevention e.g. continence/pressure ulcers/medicines management/sub acute care. A private patient's "wing" for rehabilitation/private respite care in community hospital. Expansion of OPD services to independent practitioners in health associated specialties e.g. Neuro-linguistic Programming, Counselling, lifestyle counselling. Delivery of urology services within the community for trials without catheter – potential cost saving between home care vs day case/outpatient care tariffs. Delivery of vaginal pessary changes within the community – potential cost saving between community/home care vs outpatient care tariffs. Develop Drop in service for falls prevention advice based on leg café model. Hospice @ Home service (H@H). Development of a community based Hospice at Home service for rapid crisis response as an invest to save project for those at the end of life to prevent hospital/hospice admissions. Secure contract to manage non-cancer related Lymphoedema referrals. Sports and Exercise Clinic to run alongside the MSK service Training and development packages to GPs and Northwest Deanery and other health care professionals Development of integrated Occupational Health Services alongside Fast Physio, Podiatry, Occupational Health etc Provision of medico-legal service to solicitors Provision of work place assessments Fast track for staff from private companies i.e. M&S Work place/ ergonomic assessments/work rehabilitation for Occupational health or private industry. Development of a Podiatric Surgery service alongside Orthopaedic Service. Development of a dedicated Nail Surgery unit and establish Podiatry Services as preferred provider.
Existing	**Market Penetration** **Community Services** Secure contract to provide community services into BwD localities. Capitalise on Health care group initiative with a range of services delivered to neighbouring areas e.g. virtual ward. Nurse-led osteoporosis clinics. Dementia screening and early assessment – signposting and flagging to other agencies/services. Secure funding for existing tier 2 work within weekly bladder assessment clinic at BGH.	**Product Development** **Community Services** Develop community re-enablement MD teams. Secure contract for delivery of primary care services and integrate into virtual ward. Disinvest in local GP medical cover to CCH and develop more appropriate contract. Develop Elderly care in the community linked into medical division but delivered in community settings. Develop service for patients to receive treatments such as intravenous diuretics as a day case utilising community hospitals. Therapy –led review clinics (ENT) with nas-endoscopy (QIPP model). Develop community burn care management in partnership with regional burns unit.

4. TRUST PLANS

Activity 2010/11 and 2011/12

4.1 As shown in the charts below, in 2010/11 the Trust consistently performed well against its totals of planned activity, delivering a total of 58,194 elective spells, 60,529 non-elective spells, 152,892 first appointments and 390,487 review appointments.



4.2 In addition to those areas that have over/ under performed in 2010/11 key areas of focus in 2011/12 will be:

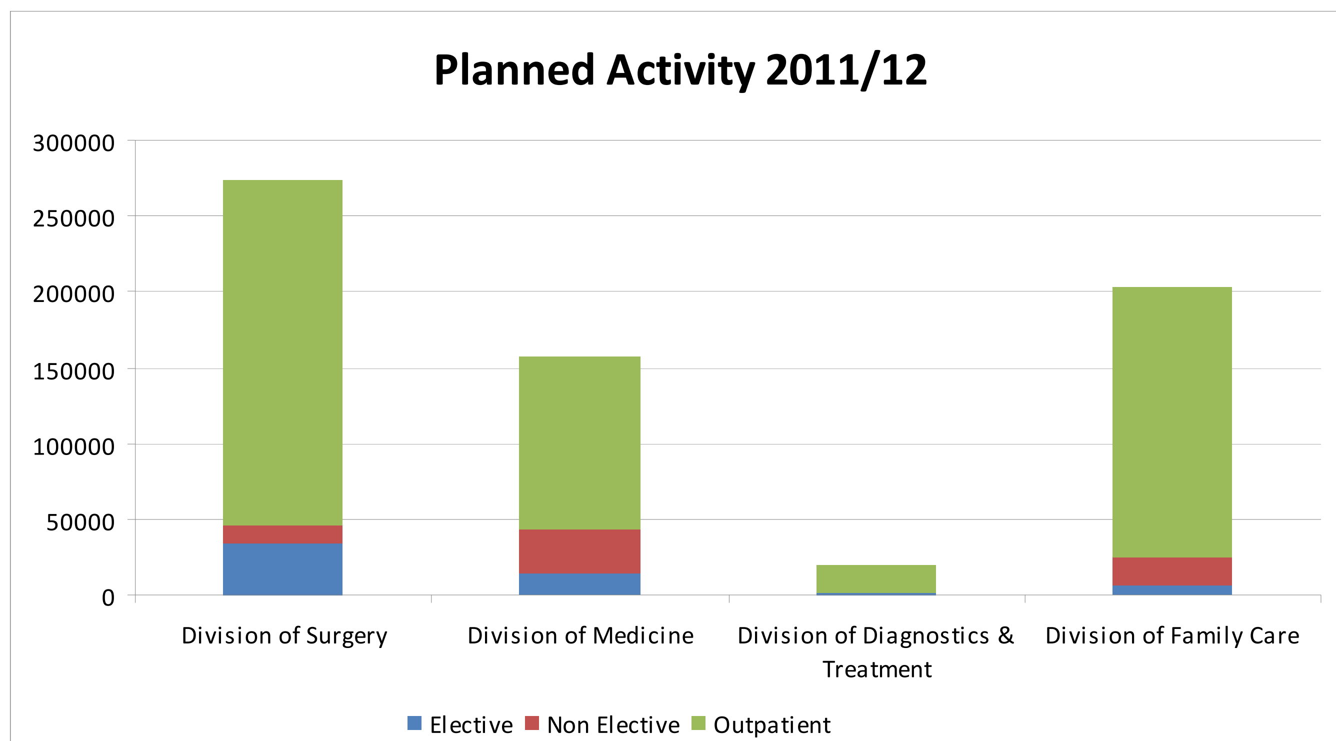
- Reductions in avoidable emergency admissions
- Reductions in unnecessary outpatient appointments, follow ups and DNAs
- Reductions in unnecessary procedures
- Improvements in day case performance
- Reductions in wasted bed days
- Improvements to the accuracy of clinical coding
- Reductions in the variations in length of stay
- Improvements in staff productivity
- Improvements in sickness/ absence rates
- Continued measurable improvements in patient experience and outcomes
- Managed reduction in workforce

4.3 Commissioning intentions that will impact upon contracted activity in 2011-12 include:

- The requirement to reduce readmissions within 30 days of discharge following an elective admission to support funding for reablement and post discharge support.
- The need to maintain referral to treatment waits at 95th percentile performance.
- The impact of the new A&E Quality Indicators (5 measures) upon commissioning plans.
- The need to continue to achieve all cancer waiting time targets.
- The implementation of further new to review ratios during 2011-12 as per agreed ratios and timescales for implementation.
- The desire of PCTs to only commission agreed services (incorporating the PCTs Low Priority Procedures Policy).
- The review of the provision of rehabilitation beds with the potential to revise the current service model.

- The network review of the provision of level 3 Neonatal Intensive Care across the health economy in 2011/12.

4.4 With this in mind the Trust has agreed the following activity plans with its commissioners for 2011/12.



4.5 Over the next five to ten years the Trust is expecting continued linear growth across all of its main points of delivery for elective, non-elective and outpatient activity based upon previously commissioned activity and Office for National Statistics population projections. Activity growth will be experienced at different rates from each of the two main commissioners, with similar levels of growth in demand expected from both sets of commissioners in terms of outpatient activity, but a greater degree of growth in demand for elective and non-elective services anticipated from East Lancashire commissioners.

Finance 2010/11 and 2011/12

Introduction

4.6 The Trust's financial plan for 2011-12 was approved by the Trust Board in March 2011. The plan also provides the detailed framework for the establishment of budgets for 2011-12. This plan will be revised during the year for any appropriate changes. A key requirement to enable the achievement of financial targets will be the need to deliver efficiency savings of £18.9 million (5%).

4.7 In the medium term the NHS will not see a return to financial growth due to the impact of the current economic climate and it is anticipated that there will be further changes to implied efficiency improvements, particularly for acute secondary care.

2010-11 Financial Outturn and the 2011-12 Financial Plan

4.8 The Trust delivered all of its financial duties for 2010-11 despite a demanding efficiency target of £18.3 million and a wider set of challenging economic conditions. Key achievements in 2010-11 included delivering a revenue under spend (£723,000 under spent in year), living within the Capital Resource Limit and External Financing Limits and providing an agreed rate of return on its assets of 3.5%.

4.9 For 2011-12 we plan to achieve a surplus of £1.9 million. As in 2010-11 the Trust's business model continues to be based on releasing efficiency from its expenditure budgets. A limited amount of additional income may be gained as a result of demographic changes together with specific initiatives being established to gain market share in some areas, including Dermatology, Obstetrics, Orthopaedics and General Surgery. Clearly a key factor in stabilising our financial performance has been ensuring that the Trust is paid for the work we do and stabilising our income streams with PCTs.

4.10 Planning assumptions for the NHS however continue to show significant reductions in the level of growth in PCT allocations, and suggest that annual efficiency gain requirements will rise above 5.0%. In this environment the Trust's business model will need to be reviewed and will rely on higher levels of expenditure savings which is why the development of the approach to the medium term financial plan will be crucial to our future success.

Overall Income and Expenditure Account

4.11 As is highlighted above, the Trust successfully transferred adult community services from NHS East Lancashire on 1st April. The value of transferring budgets was £42 million. In 2011-12 we expect to achieve a surplus of £1.9m (before technical items) which equates to 0.5% of turnover. The financial position is summarised below. In overall terms, it highlights total income streams of £377.7 million which will be allocated to baseline budgets.

Income and expenditure position (Statement of Comprehensive Income)

	2010-11 Outturn £m	2011-12 Plan £m
Income		
Income from activities	321.9	348.4
Other operating income	20.1	29.3
Total Income	**342.0**	**377.7**
Expenditure		
Pay	(229.3)	(261.6)
Non Pay	(87.0)	(87.9)
Total Expenditure	**(316.3)**	**(349.5)**
EBITDA	**25.7**	**28.2**
Non operating costs	(22.3)	(22.4)
Impairments	(12.8)	(0.5)
Net surplus/(deficit)	**(9.4)**	**5.3**
Add back technical adjustments	10.1	(3.4)
Underlying position	**0.7**	**1.9**

4.12 Funding to meet the costs of the following pressures and developments have been provided in the overall plan to derive the total efficiency requirement of £18.9 million as reflected in the table below.

Pressures, developments and efficiency

	£m	£m
Generic pressures		
Pay awards and cost of increments	4.1	
Inflation	2.0	
VAT increase	1.2	
CNST increase	0.6	
Total generic pressures		**7.9**
Other pressures and developments		5.9
Income pressures		3.2
Planned surplus		1.9
Efficiency requirement		**18.9**

4.13 To create the above budget structure and ensure its overall affordability whilst also planning to deliver an in year surplus, the Trust will need to achieve savings of 5%. This reflects the overall tariff and operating framework requirement to deliver 4% for 2011-12, together with a further 1% saving to support additional localised pressures.

4.14 The efficiency savings programme required by each division is summarised the table below, and the Trust plans to achieve the savings from a combination of measures as developed by the QIPP work streams.

Efficiency Savings targets by division

	£m
Community division	2.1
Diagnostics and therapeutics division	5.5
Family care division	2.7
Medical division	3.1
Surgical division	2.5
Other (corporate)	3.1
Total	**18.9**

4.15 The Board has recognised that the achievement of a 5% savings in 2011-12 on top of the level of savings achieved in previous years will be challenging. At this stage therefore the financial plan reaffirms the requirement to deliver this level of saving. The delivery of the 2011-12 efficiency programme is essential to the successful achievement of the Trust's financial plans and its desire to be authorised as a foundation trust. Enhanced performance monitoring, review and management arrangements have been established to support the delivery of this key element of the plan.

Capital Investment

4.16 The Trust agreed its capital plan for 2011-12 at its Board meeting in March 2011. Having completed the showcase £32 million Women and Newborn unit on the Burnley General Hospital site the main focus for the capital investment in 2011-12 will be to extend and enhance the current Emergency Department on the Royal Blackburn site. This will allow for the relocation of the Urgent Care Centre which is currently provided in temporary accommodation. Whilst

4.17 The Capital Cash Management Plan is summarised in the table below.

Capital Cash Management Plan 2011-12 and 2012-13

Capital programme	**2011-12 £m**	**2012-13 £m**
Buildings and compliance	3.5	3.1
IM&T	0.5	0.5
Equipment	1.5	1.3
Contingency	0.3	0.3
Lifecycle	1.4	3.1
Prior year schemes carried forward	1.1	0.0
Total programme	**8.3**	**8.3**
Funding summary		
Programme	8.3	8.3
Less lifecycle	(1.4)	(3.1)
Net capital spend (cash)	**6.9**	**5.2**
Funded by:		
Depreciation	11.7	11.6
10-11 capital cash b/f	0.6	0.0
Less PFI depreciation	(3.0)	(3.1)
Less capital loan repayments	(1.3)	(1.3)
Less movement in capital creditors	(1.1)	0.0
Less capital cash carried forward	0.0	(2.0)
Capital (cash) funds	**6.9**	**5.2**

Cash Management

4.18 The Trust's cash position has continued to improve however the underlying liquidity position remains weak. The improved cash position has however enabled the Trust to improve its performance against the Better Payment Practice Policy. Further work is ongoing to further improve the Trust's cash management and working capital. To improve its liquidity, cash flow and to plan more effectively for its capital replacement the Trust is required to generate a meaningful revenue surplus and to build a capital asset replacement fund.

Risk Identification and Analysis

4.19 A risk assessment of the 2011-12 financial plan has been undertaken, and the key financial risks have been identified as:

- Workforce in place to deliver service growth
- Delivery and in year management of contracts with Commissioning PCTs
- Achievement of efficiency savings programme
- Changing capacity in line with demand

4.20 These risks have been incorporated into the Trust's overall risk register, and progress on managing and eliminating those risks will be reported to the Board on a monthly basis as part of the overall Corporate Performance report to the Trust.

Estates Strategy 2011-16

4.21 The Trust has recently completed the annual series of strategic planning meetings to develop the clinical strategy. There are a series of proposals from the clinical strategy which will have a bearing on the Estate Strategy. These include:

- Development of Paediatric area within the Emergency Department at RBH
- Incorporation of Urgent Care Centre into the Emergency Department at RBH
- Improvements to surgical capacity
- Increased laparoscopic surgery
- Reduction of in-patient beds

4.22 Development Control Plans produced for the 2008 Estate Strategy have been reviewed in the light of significant changes in the assumptions made at the time. The general downturn in the economy and the uncertainty over the future provision of mental health facilities across East Lancashire have had an effect on the strategy as have the Division's responses to the challenges presented by the Health and Social Care Bill 2011 and the need to make significant savings.

4.23 It is important to note that the principles of the previous Development Control Plans are still valid but that some of the detail has changed.

General Principles:

To aim to reduce the Estate footprint by 20% over 5 years through:

- Rationalisation of the estate
- Improved utilisation of protected assets (e.g. PFI buildings and Lancashire Women and Newborn Centre)
- Disposal of unwanted assets
- Working towards a more flexible Estate better able to respond to changes in healthcare provision

Royal Blackburn Hospital

- Continue to improve the utilisation of the clinical part of the estate
- Allocation of vacated space formerly occupied by the Family Care division to the correct services (controlled through Site Utilisation Group)
- Challenge utilisation and roll out estates occupancy costs through service line reporting
- Liaise with Lancashire Care Foundation Trust (LCFT) regarding their plans for development of the Mental Health Zone
- Explore all options to re-provide office accommodation
- Explore re-provision of on-site residential accommodation with Registered Social Landlord

Burnley General Hospital

- Continue to improve the utilisation of the estate
- Continue to clear area for disposal
- Continue to convert Edith Watson building to non-clinical accommodation
- Continue to clear site of Pennine House for future development
- Explore re-provision of on-site residential accommodation with Registered Social Landlord
- Maintain principle of clinical quarters remote from non-clinical quarter
- Maintain principle of central spine with blocks to either side
- Consolidate laminar flow theatres within Wilson Hey block

Capital Plan 201/12

4.24 In line with the principles of the Estate Strategy, the Capital Plan for 2011/12 will invest £3.5million in the Estates buildings, infrastructure and engineering services on the following schemes:

Royal Blackburn Hospital

- New UCC Area within ED RBH
- New Paediatric Area within ED RBH
- Develop Chemotherapy Preparation Unit
- Demolition of Day Nursery & Staff House
- Catering Heating - RBH
- Energy Saving Schemes
- Blueline / redline works
- Statutory compliance
- Alterations to Tower View and external corridor to accommodate Community Paediatrics

Burnley General Hospital

- Relocation of the CAMHS service
- Lancashire Women and Newborn combined heat and power (CHP)
- Procurement and installation of additional clean-air Canopy to Theatre 5
- Refurbishment of Edith Watson for Pennine & Estates Offices
- Adaptations to Ward 21 BGH to accommodate Clinical Psychology
- BGH Kitchens
- Relocate Medical Records from Block 5 and prepare for Vita and Workshops
- Demolition of Centre Block (commenced March 2011)
- Transfer of Clinical Psychology to Ward 21
- Energy Saving Schemes
- BGH roof repair and replacement
- Culpan House boilers
- BGH UCC car park structural repairs
- Statutory compliance

Pendle Community Hospital

- Statutory compliance
- Energy saving schemes

Rossendale General Hospital

- Site closed no capital investment
- Sale pending

Workforce 2010/11 and 2011/12

4.25 The financial constraints faced by the organisation mean that there has to be significant service re-design leading to reductions in the number of staff we employ from 2011/12. Individual divisions are still working up detailed workforce plans but some high level projections have been made.

4.26 The forecast below reflects the fact that 998 whole time equivalents transferred to the Trust from NHS East Lancashire Primary Care Trust in April 2011 as part of the Transforming Community Services programme.

STAFF IN POST - contracted FTE (excluding bank staff)	Baseline April 2011	Forecast staff in post Oct 2011	Forecast staff in post April 2012	Forecast staff in post Oct 2012	Forecast staff in post April 2013	Forecast staff in post April 2014	Change
Medical and dental	454.7	464.5	465.5	465.4	463.1	460.8	-6.07
All qualified nursing, midwifery and health visiting staff	2,125.20	2,113.50	2,058.90	2,055.70	2,034.10	1,976.00	149.23
All qualified scientific, therapeutic and technical staff	692.5	698.2	686.2	678.3	661.4	646.1	46.42
Healthcare assistance and other clinical support staff	1,064.10	1,049.80	1,017.20	1,013.20	1,007.00	982.1	82
Managers and senior managers	96.2	90.1	86.3	82.3	82.3	81.3	14.94
Administration and estates	1,696.20	1,679.10	1,616.30	1,596.20	1,566.20	1,536.70	159.47
Any staff not covered above	5	5	5	5	5	5	0
All staff	**6133.99**	**6100.32**	**5935.34**	**5896.03**	**5818.97**	**5688**	**445.99**

Breakdown of Workforce Reduction April 2011 - April 2014	Forecast staff in post Oct 2011	Forecast staff in post April 2012	Forecast staff in post Oct 2012	Forecast staff in post April 2013	Forecast staff in post April 2014	
Medical and dental	9.8	0.9	0	-2.4	-2.3	6.07
All qualified nursing, midwifery and health visiting staff	-11.7	-54.6	-3.3	-21.6	-58.1	-149.23
All qualified scientific, therapeutic and technical staff	5.7	-12	-7.9	-16.9	-15.3	-46.42
Healthcare assistance and other clinical support staff	-14.3	-32.7	-4	-6.2	-24.9	-82
Managers and senior managers	-6.1	-3.8	-4	0	-1	-14.94
Administration and estates	-17.1	-62.8	-20.1	-30	-29.5	-159.47
Any staff not covered above	0	0	0	0	0	0
All staff	**-33.67**	**-164.98**	**-39.31**	**-77.06**	**-130.97**	**-445.99**

4.27 A key performance indicator for the HR Department is the length of time it takes to resolve employee relations issues. In 2010/11 there was significant improvement in this area. KPIs were established in line with HR policies and monitoring processes were developed. Significant improvements have been achieved in investigation times although they are still longer than they should be in some cases. The Employee Relations Team will work to achieving the following performance targets:-

Policy	Target 2011/12	Performance 2010/11
Grievance	10 working days	36 days
Completion of disciplinary investigation	20 working days	21 days
Bullying & Harassment	Tbc (policy under review)	10 weeks

4.28 Significant work was undertaken in 2010/11 to improve recruitment processes in both general recruitment and medical staffing. However the time to hire remains longer than desired. The following targets have been set for 2011/12.

Area	Target 2011/12 (from vacancy approval to unconditional offer)	Performance 2010/11
General Recruitment	10 weeks	14 weeks
Medical Staffing	16 weeks	26 weeks

4.29 In 2010/11 the Medical Staffing Team assumed responsibility for the administration and monitoring of Job Planning and Appraisal. Appraisal completion rates currently stand at 84% and job plans signed off and submitted at 38%. Further work is required in 2011/12 to improve administration systems to support ongoing improvement.

Area	Target 2011/12	Performance 2010/11
Appraisal	95%	84%
Job Planning	100%	38%

4.30 The Trust performed well in the first half of 2010/11 with regard to its staff turnover rate, however this subsequently reduced from October 2010 onwards and the numbers of FTE in post remained above targeted levels.

2010/11	April	May	June	July	August	September	October	November	December	January	February	March
FTE in Post - Target	5345	5329	5313	5297	5281	5265	5249	5233	5217	5201	5185	5149
FTE in Post - Actual	5334	5309	5301	5289	5252	5241	5253	5246	5248	5238	5272	5274
Variance	11	20	12	8	29	24	-4	-13	-31	-37	-87	-125

2010/11	April	May	June	July	August	September	October	November	December	January	February
Turnover rate	9.75	9.41	9.84	9.75	10.09	9.83	9.81	9.83	9.64	9.54	9.34

4.31 The Trust continues to deliver year on year reductions in the levels of employee sickness and absence, and has introduced a range of measures, including a fast track physio system for staff which have delivered notable improvements in its sickness/ absence levels.

Sickness/ Absence	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
2009/10	4.68	4.89	5.13	5.4	4.44	4.59	5	5.29	5.17	5.48	5.02	4.21
2010/11	4.49	4.2	4.16	4.22	4.05	3.91	4.36	4.4	5.15	5.23	4.45	4.18
Change	0.19	0.69	0.97	1.18	0.39	0.68	0.64	0.89	0.02	0.25	0.57	0.03
	4.06%	14.11%	18.91%	21.85%	8.78%	14.81%	12.80%	16.82%	0.39%	4.56%	11.35%	0.71%

4.32 The Full year expenditure on temporary and agency staff remained high in 2009/10 at £12.2m. The Trust has made significant progress in this area in 2010/11, resulting in a full year decrease in expenditure on temporary and agency staff in 2010/11 of £1.175m to £11.063m. From April 2011, the Trust has established its own staff bank, which it is hoped will contribute towards further reductions.

Temp Staff Exp (£)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Total(s)
2009/10	1,023,551	1,081,643	1,337,432	1,248,283	808,236	792,922	1,015,153	985,066	887,973	965,988	974,293	1,118,413	12,238,953
2010/11	942,768	943,533	1,104,659	1,039,258	1,326,420	1,143,966	1,016,512	841,551	776,601	677,625	602,597	647,806	11,063,296
Change	80,783	138,110	232,773	209,025	-518,184	-351,044	-1,359	143,515	111,372	288,363	371,696	470,607	1,175,657
	7.89%	12.77%	17.40%	16.75%	-64.11%	-44.27%	-13.00%	14.57%	12.54%	29.85%	38.15%	42.08%	9.61%

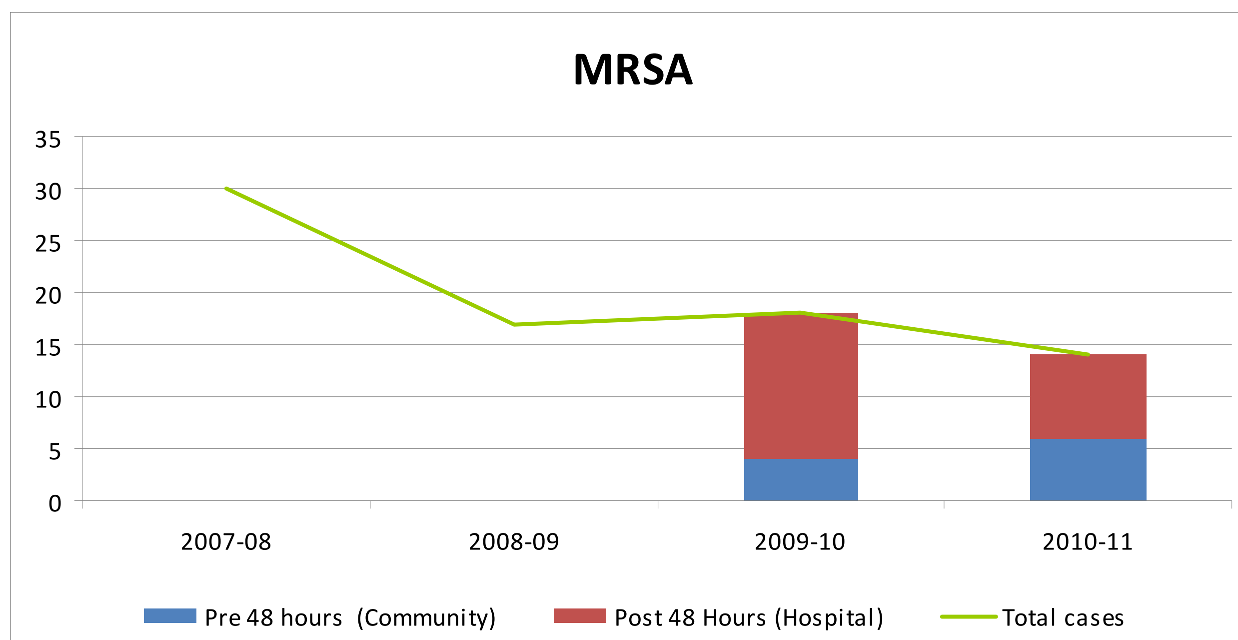
Quality 2010/11 and 2011/12

4.33 All divisional clinical strategies and business plans contribute to the achievement of the following key quality and performance indicators over the next five years:

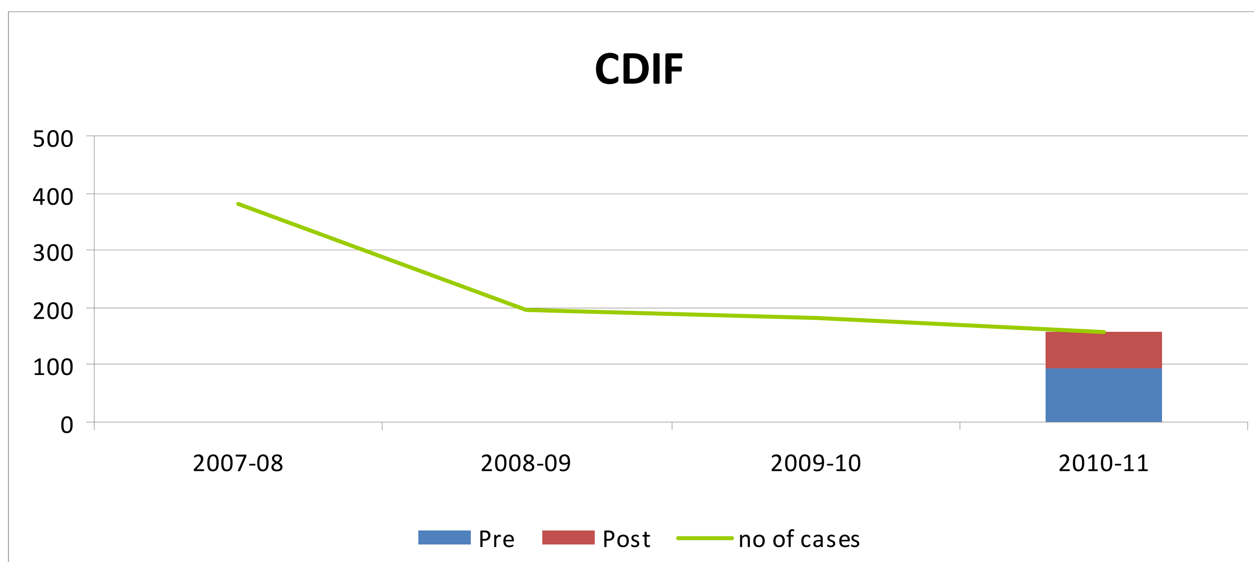
- To maintain and improve patient experience through achievement of the patient experience indicators as outlined in the Trust's quality account.
- To reduce avoidable harm to patients against an annual trajectory as outlined in the Trust's quality account.
- To deliver in full the quality schedule of the acute trust contract, ensuring achievement of CQUIN objectives.
- To reduce mortality across the organisation in line with annual trajectory set in the quality account.
- To deliver the clinical effectiveness objectives as set out in the quality account.
- To maintain all regulatory requirements of the CQC.
- To maintain compliance with NHSLA standards at future assessments in 2012.

4.34 As a result of the above and the 3 dimensions of quality outlined in the Trust quality account, the Trust has significantly improved its performance against key access, quality and performance indicators which include:

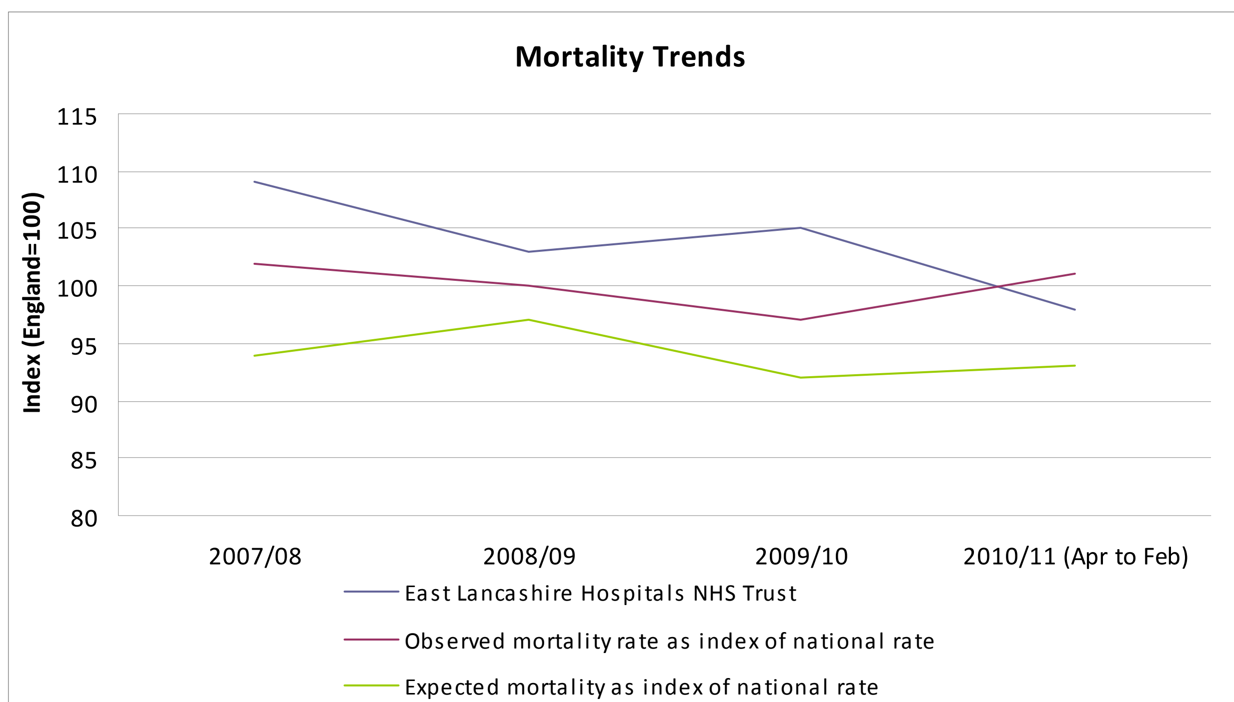
Year on year reductions in the number of hospital acquired (post 48 hours) MRSA cases



Year on year reductions in the number of C Difficile cases



A reduction in our hospital standardised mortality rate



Full achievement of the 18 week referral to treatment median waiting times

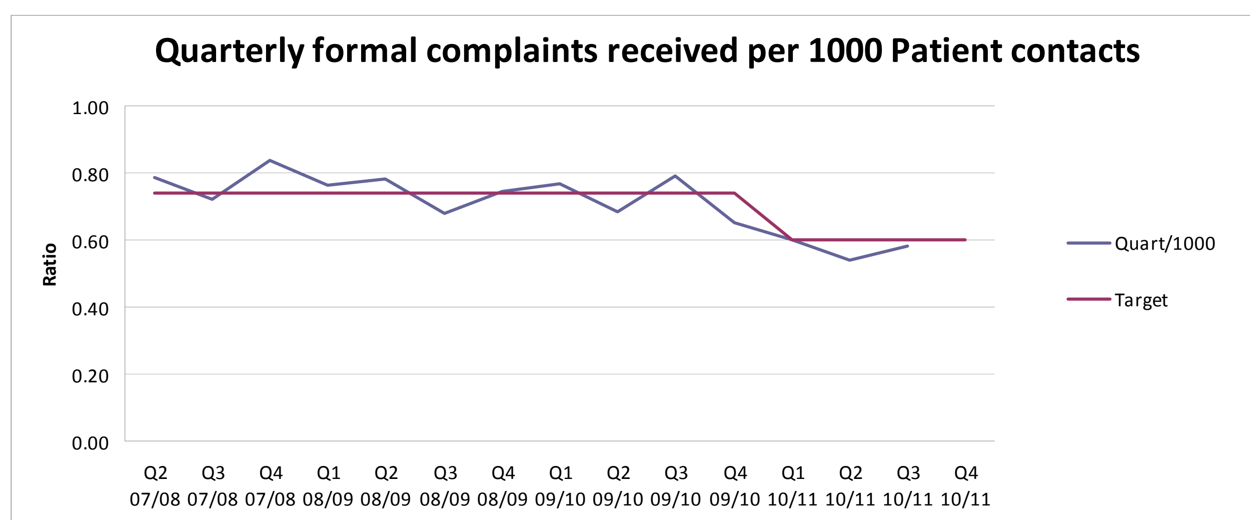
Full achievement of all cancer waiting time targets

Full achievement of the accident and emergency target requiring 98%+ of patients to spend a total time of 4 hours or less in the Accident and Emergency service

Clinical Effectiveness, Quality and Performance indicators	Reported position	Achieved required standard
18 WEEKS REFERRAL TO TREATMENT/MEDIAN WAITS		✓
CANCER WAIT TIMES		
Percentage of patients with a waiting time of 14 days or less from a GP Urgent Cancer Referral to first Outpatient appointment	96.17%	✓

Percentage of patients with a waiting time of 31 days or less for a diagnosis of Cancer treatment from date of decision to treat.	99.05%	✓
Percentage of patients with a waiting time of 31 days or less to receive Subsequent Treatment (Surgery) from date of decision to treat	98.47%	✓
Percentage of patients with a waiting time of 31 days or less to receive Subsequent Treatment with Anti-Cancer Drugs from date of decision to treat	100.00%	✓
Percentage of patients with a waiting time of 62 days or less for cancer treatment from the date of referral form GP	90.02%	✓
Percentage of patients with a waiting time of 62 days or less for cancer treatment from the date of referral from a screening programme	99.53%	✓
Percentage of patients with a waiting time of 62 days or less for cancer treatment from the date of referral from hospital specialist	98.34%	✓
Percentage of patients with a waiting time of 14 days or less for Breast Symptomatic patients.	96.71%	✓
Percentage of patients who spend a Total Time of 4 hours or less in the Accident and Emergency service	97.40% /98.01%	✓

A reduction in the number of complaints (per 1000 contacts) to below 0.6 per 1000 patient contacts



4.35 Reference should be made to the Trust's published 2010/11 Quality Account for a complete summary of performance against all Clinical Effectiveness, Quality and Performance indicators.

4.36 In 2011/12 we will:

- Further reduce our infection rates and we will achieve or perform better than if not exceed expected target levels of infection rates
- Improve our Patient Experience of Care and the perception of the quality of care received. (This will be measured using the National Patient Survey, regional and local experience measures)
- Achieve the Emergency Care indicators as outlined in the NHS operating framework.
- Stroke Care – We will implement our action plan to improve against the findings of the 2010 Sentinel Stroke Audit and ensure that Stroke indicators are met.
- We will continue to work with the Northwest Mortality Collaborative and aim to continue to reduce our adjusted mortality rate.
- We will participate in the Safety Express initiative. We will measure and demonstrate a reduction in harm resulting from :-

(a) Venous Thrombo Embolism (VTE)
(b) Falls
(c) Pressure Ulcers

(d) Catheter associated Urinary Tract infections

- We will achieve a risk assessment rate of at least 90% in eligible patients for Venous Thrombo Embolism
- Continue to implement the Advancing Quality objectives for Acute Myocardial Infarction, Heart Failure, Hip and Knee replacement, Community Acquired Pneumonia and Stroke care with the aim of being in the top 50% of performing Trusts for all 5 indicators.
- We will improve our Patient Reported Outcome Measures against Hip, Hernia, Knee, and Varicose Vein indicators when compared against our 2010/11 position.
- We will implement our Dementia Care Action plan and ensure the milestones associated with the plan are delivered and achieved

4.37 Key areas of focus in 2011/12 include:

- Transient Ischaemic Attack (TIA) cases (mini strokes) with a higher risk of stroke who are treated within 24 hours. In 2011/12 60% of high risk patients with symptoms of TIA must be seen and assessed in a specialist clinic and receive carotid dopplar within 24 hours of presentation to GP.
- New Accident and Emergency indicators. The Trust has scoped the new indicators, which did highlight some data quality issues which have now been rectified. New pathways have been put in place to ensure that the new indicators will be met. However, this remains challenging.
- The continued challenge of Healthcare Associated Infection trajectories. Due to the year on year reducing numbers of the trajectory. The Trust continues with its infection prevention actions in order to mitigate the risk of not achieving the trajectories.

QIPP 2010/11 and 2011/12

4.38 Given the national challenge in improving quality of services whilst reducing cost that will face all organisations over the next four years, and recognising the need for transformational change, a clinical and managerial director led QIPP steering group is in place that provides co-ordinated support to clinical divisions and corporate teams in delivering the Trusts annual plan.

4.39 Whilst the performance management of cost reduction and quality improvement plans will remain through the divisions, the QIPP Steering Group will ensure that there is appropriate linkage with system based working both across the Trust and the wider health economy.

4.40 We are clear that in improving the services for our patients we need to review quality and productivity and efficiency together and the focus over the next twelve months will be on improving the processes that deliver clinical outcomes and experience whilst embedding the principles of QIPP into everything that we do. This will be taken forward through eight overarching core programme work streams:

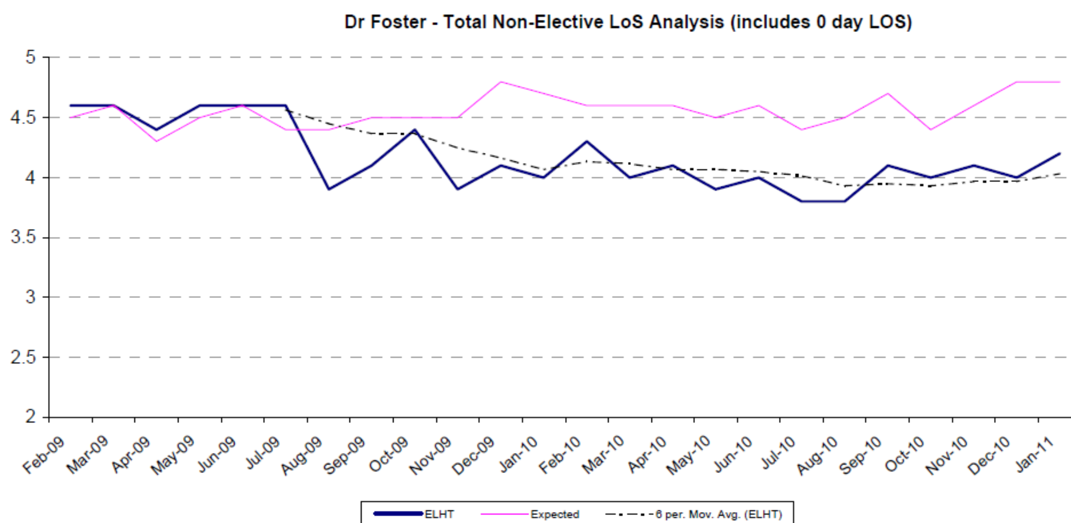
- Productive clinical services: making our clinical teams as efficient and productive as they can be, with a focus on reducing length of stay, cutting out unnecessary steps on the patient pathway and improving the efficiency within outpatient clinics
- Estate utilisation: getting the best use out of the buildings that we own and lease, including estate rationalisation
- Patient administration and booking: making our trust processes more efficient including the use of document management systems and information technology solutions
- Strategic Advantage Programme: getting the best value for money out of the contracts we have with all our suppliers, and ensuring that we purchase at optimum value-for-money levels
- Medicines management: optimise medicines management at all steps in the medicines management pathway through integration with national, regional and local work programmes
- Pathology: consolidation of pathology services and streamlining the way in which services are delivered
- Workforce: minimising absence from work and the use of agency staff, and effective workforce planning, utilisation and transformation

- Clinical pathways: review and develop integrated care pathways for specific conditions such as COPD, Urgent Care and MSK.

Productivity and Efficiency 2010/11 and 2011/12

4.41 The Trust regularly reviews at Board level its performance against the following key performance indicators, with the aim of reducing our lengths of stay and bed base and thereby move towards a more community based model of care, closer to the patient's home, with the emphasis on promoting public health.

Length of Stay



- Expected adjusted to reflect case mix and based on national average.
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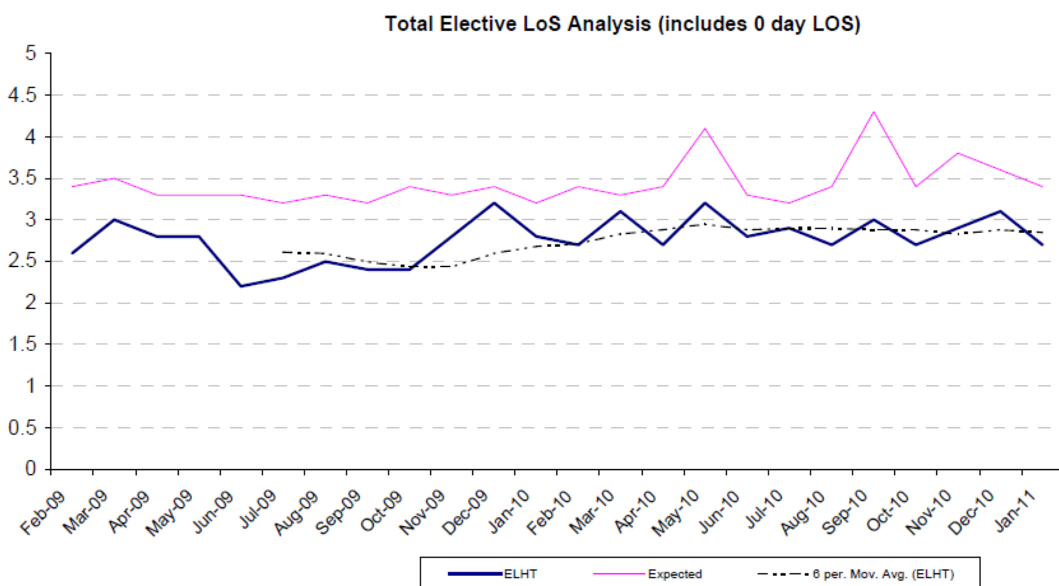
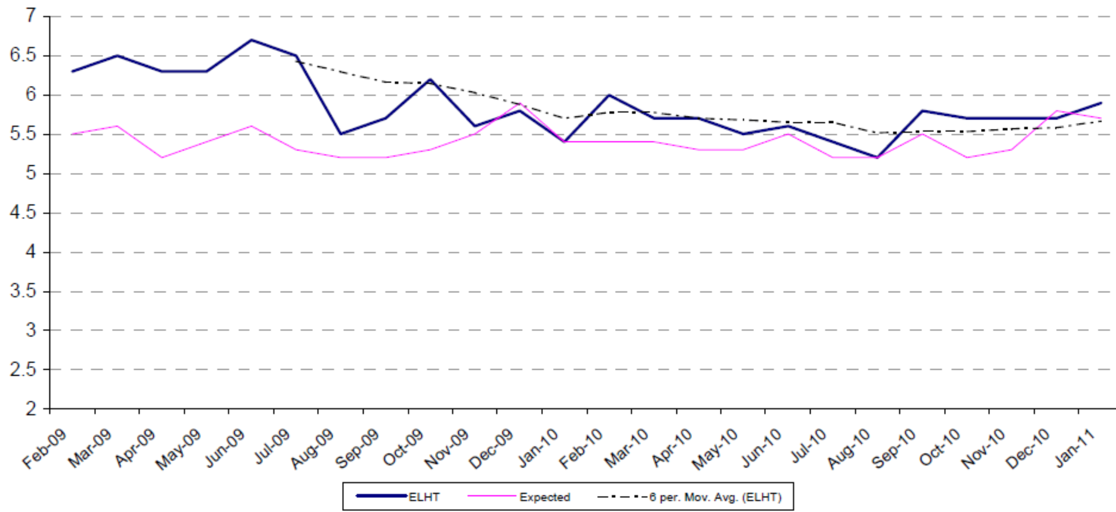
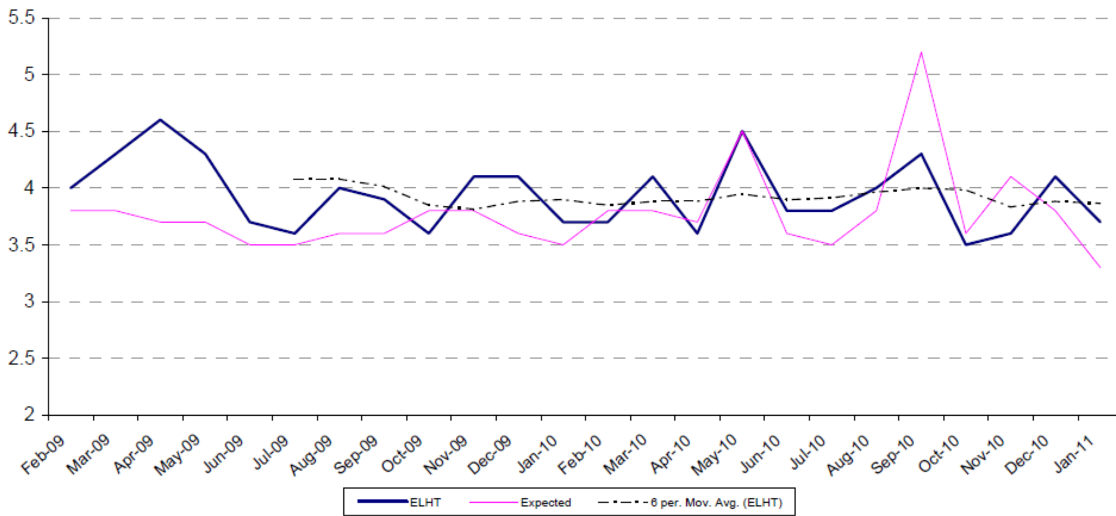
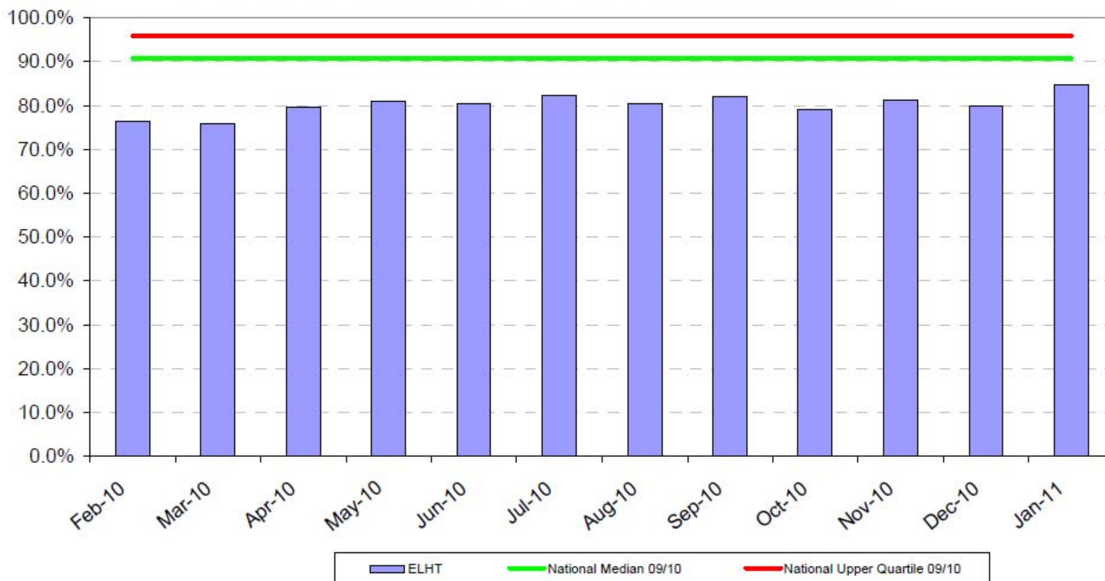


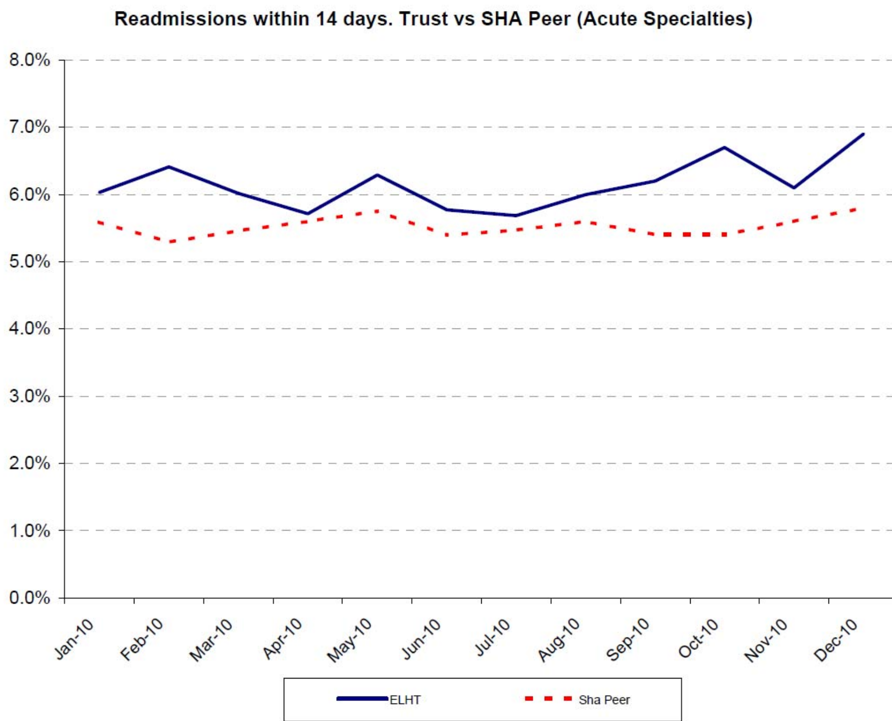




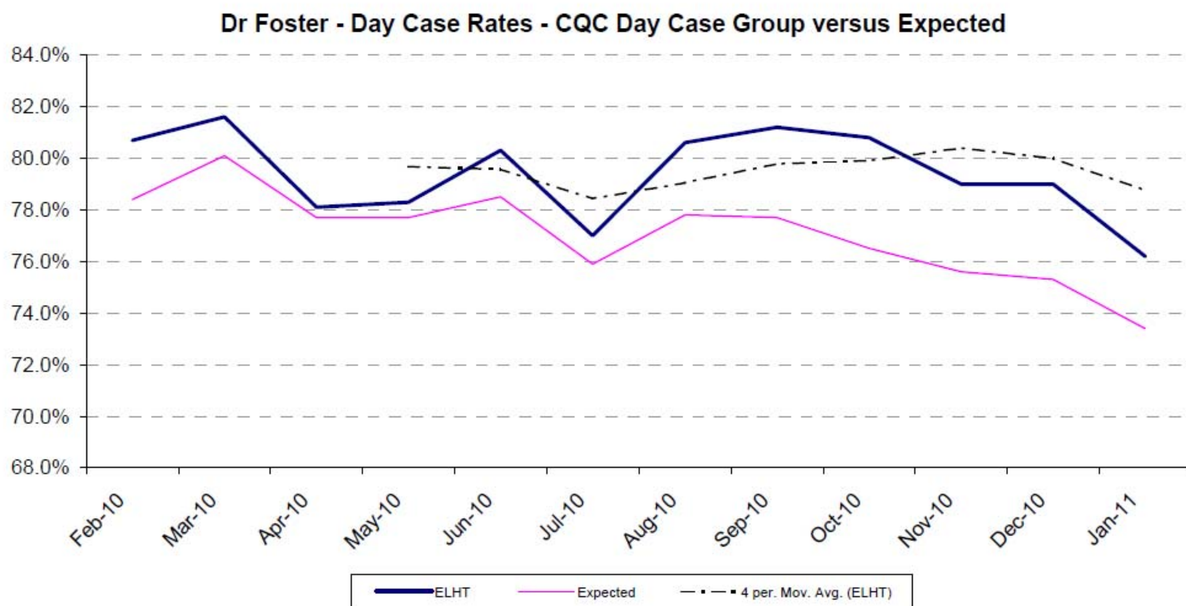
Admission on Day of Surgery



Readmissions



Day Case Rates



4.42 The Trust's 18 week referral to treatment aggregate position remains well within the Department of Health's stated tolerance for each measure. At specialty level work continues in Orthopaedics and General Surgery to improve the position against the admitted 95th centile threshold of 23 weeks which stands at 23.5 weeks for both specialties. The 18 week backlog position has improved considerably in Orthopaedics reducing to 190 from 263 reflecting ongoing actions to manage the situation.

4.43 With regard to Transient Ischaemic Attack (TIA) cases (mini strokes), the Trust's performance continues to under perform against the 60% threshold as confirmed in the Operating Framework indicators for 2011/12. TIA clinics were extended to a 6 day service from the beginning of February which should result in an improvement towards the target from March onwards and a Task and Finish Group is being convened to explore more radical approaches to delivery against

4.44 Monitor have now released their finalised Compliance Framework for 2011/12 and scoring mechanism. As regards the new A&E indicators, during Quarter 1 only the total time in A&E will be monitored with the remaining indicators coming on line for monitoring during Quarter 2.

4.45 The post 48 hour trajectory for MRSA was achieved for the year. Going forwards into 2011/12 the trajectory of 6 for the year will pose a challenge.

Key Enablers 2011/12

4.46 In 2011/12 the following arrangements will be put in place by the corporate functions to ensure that the best possible support continues to be available to the clinical divisions.

Clinical Care and Governance

- Senior Management Level Advice and support in relation to the range of complex professional, risk management, regulatory and assurance issues
- Provision and maintenance of statutory, regulatory and core services provided by the directorate including the infrastructure for Divisions to achieve key requirements
- Provision of high quality, validated information to Divisions and Directorates to inform their professional, quality, safety and governance obligations
- Contemporaneous Quality and Risk profiles for each Directorate
- Leadership and coordination of the regulatory compliance assessment requirements

Estates and Facilities

- Continuity of approach
- Structured engagement with divisions
- Membership of delivery boards
- Early consultation

Finance

- Management Accounts
  - Each Division has Divisional Accountant and Support Team
  - Divisions to be further supported by Senior Management Accountant Support in 2011-12
  - CIP costings, CIP idea formulation, Accurate CIP reporting/monitoring
  - CIP facilitated sessions now available through OD/Finance
  - Budget Holder training sessions to continue
  - Work with other Corporate Teams to improve systems and reduce errors/ waste

- Contracting Team
  - Formal Communication with Divisions through the Income & Data Quality Steering Group
  - Regular contact with Divisions to support the improvement of reference costs and SLM (data quality)
  - SLM/ Reference Cost training/ information events
  - Liaison through Service Development Group and Performance meetings to understand key developments that may affect contracting – two–way communication will continue to be key

- Capital & Treasury Team
  - VAT Helpdesk up and running
  - VAT Training in the budget holder training sessions and ad-hoc can be arranged
  - Cash & Debtor Management
    - Allowing for further discounts on items
    - Working with Divisions to free up bad debt

- Lead on Medical Equipment Sub-group to prioritise Medical Equipment purchases/ replacement
- Regular monitoring and reporting of capital plans
- Charitable Funds training/ guidance available from team
- Regular monitoring and reporting of Charitable Funds movements and balances to the divisions

Human Resources and Organisational Development

- HR Consultant now in each clinical division
- Divisions will always have a say in the level and type of HR support provided
- HR Consultants will actively seek the views of the divisions

Information Management and Technology

- IM+T will support the divisions to improve the Trust's Infrastructure to improve productivity and quality
- IM+T will play an active part in developing new integrated care pathways by ensuring that the appropriate supporting infrastructure is in place
- IM+T will work across divisional and organisational boundaries through QIPP & Future CIP challenges to deliver efficiencies at a local level

Procurement

- CIP delivery work plan/ RAG system in place
- Procurement performance management group established
- Cross Divisional Standardisation Group established
- E-enablement in place
- Divisional board attendance/ monthly progress reports to divisions
- Active participation in the implementation of the productive ward, theatre and community services programmes
- Development and implementation of support tools to assist the divisions
- Evidence based procurement systems in place
- Divisional training programmes available for all staff

Key Risks and Mitigations 2011/12

4.47 The Trust has identified, assessed and developed mitigation strategies in relation to all risk areas associated with this plan. All risks are mapped to the Trust's Assurance Framework and Corporate Risk Register. The Trust's SWOT analysis has also been carefully considered and mapped to the Trust's Assurance Framework, to ensure mitigation strategies are in place.

4.48 Principle risks to strategic objectives are regularly reviewed by the Board, via the Trust's Assurance Framework and integrated performance report, to ensure that as far as possible risks have been identified and are fully mitigated against. The Trust's Assurance Framework is compliant with the model set out in the Department of Health Governance guidance, and has been given a status of 'Full Assurance' by the Trust's Internal Auditors.

4.49 All risks have been assessed for likelihood and consequence and in relation to our key financial risks, a full sensitivity analysis has been undertaken.

4.50 The risk profile of the Trust includes financial, clinical, workforce and infrastructure risks.

4.51 Key risks to the organisation can be summarised as follows:

Risk Category	Initial Risk rating	Key Controls (Actions)	Residual Risk rating	Assurances on controls (Evidence)	Tactical Lead (TL) Director Lead (DL)
Failure to realise the benefits of the Transforming Community Services transaction - Failure to maintain and develop further relationship with partner organisations/referrers. Systems processes and working practices may be inconsistent with organisational direction and alignment of the Community Division within the Divisional structure of the organisation.	15	Strategic and operational infrastructure is in place,	15	As above	DL : Chief Executive TL Dir of Service Development
Capacity in partner organisations to develop effective systems to accommodate Trust's activity and impact of this on patient experience e.g. prevention of admission , accommodate effective discharge to reduce length of stay and numbers of delayed transfers of care	20	As above	15	As above	DL : Chief Executive TL : Dir Of Operations
Failure to maintain the requirements of NHSLA Acute Standards Level 3	15	Quality & Safety Board QSB has ensured all 50 criterion from the 5 standards s are in the Trust risk management plan	15	Reports to Governance committee systematic reports from constituent work streams to Quality & Safety Board QSB and sub committees	DL - Director of Clinical Care & Governance & Medical Director Education and Governance
Stroke Indicator	15	Established reporting arrangements providing reports for constituent targets key deliverables - Performance monitoring through to Board reporting,	15	Identified in Performance dashboard and report	DL ; Director of Operations
Failure to reduce the level of staff sickness absence	16	New sickness absence policy introduced. EAP introduced. Establishment of Health and well-being working party. Monitoring and reporting to Divisional Boards and Exec Board.	16	Monthly monitoring at all DMBs and through to Board through delegated performance monitoring structures	DL : Director of Human Resources and OD
Failure to ensure that the Trust meets mandatory financial targets and delivers value for money services	25	Trust Board , Audit Committees, Executive Management Board	25	Audit & Governance Committees Minutes, Executive Management Board Minutes, Reports to Trust Board, Internal Audit Reports, External Audit reports , SHA & Commissioner Performance Management Reports.	DL : Director of Finance, Planning ...
Failure to deliver agreed activity plan	15	Trust Board , Audit and Governance Committees, Executive Management Board, EMB,	15	Reports to performance meeting , Divisional Boards EMB and TB	DL : Director of Operations
Failure to meet CIP thus affecting Trust performance - Failure to ensure CIPS projects are managed within project plans and timescales agreed and failure to monitor variance from CIPS with timely remedial action-Failure to have mitigations in place for non delivery or slippage in CIPs	25	As above - CIP monitoring processes in place - each CIP has project charter and monitoring in place	20	Budget sign off and monthly budget reporting incorporating agreement to CIP targets can be evidenced	DL : Director of Finance, Planning ...

Foundation Trust Trajectory 2011 – 2013

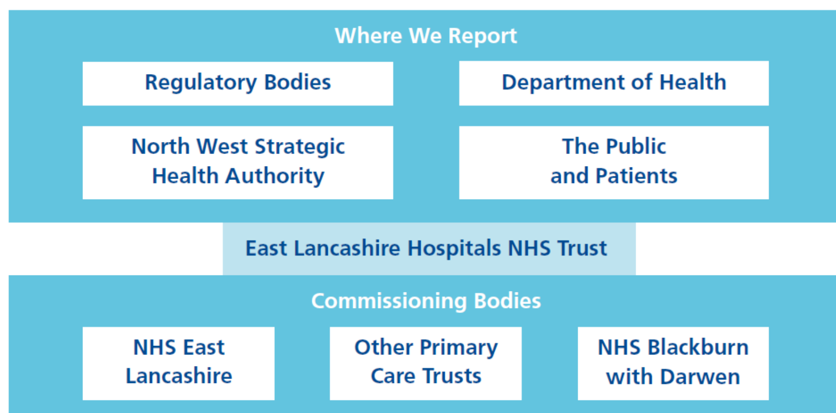
4.52 We have provisionally agreed the following key milestones with NHSNW and the Department of Health with regard to our Foundation Trust trajectory for authorisation, and the Trust is currently on track for authorisation in March/ April 2013.

- Trust formally enters SHA-led Trust Development Phase: March/ April 2012
- Public Consultation May – August 2012
- Trust formally enters Secretary of State Support Phase: 1st October 2012
- Trust formally enters Monitor Assessment Phase: November/ December 2012
- Election of Governors: December 2012 – February 2013
- Authorisation: March/ April 2013

5. LEADERSHIP & GOVERNANCE

5.1 The Trust Board sets the strategic direction of the organisation and oversees the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary. Its role is also to ensure effective financial stewardship, ensure that high standards of corporate governance and personal behaviour are maintained and ensure that there is effective dialogue between the organisation and the local community.

5.2 Our key external stakeholders are summarised in the diagram below.



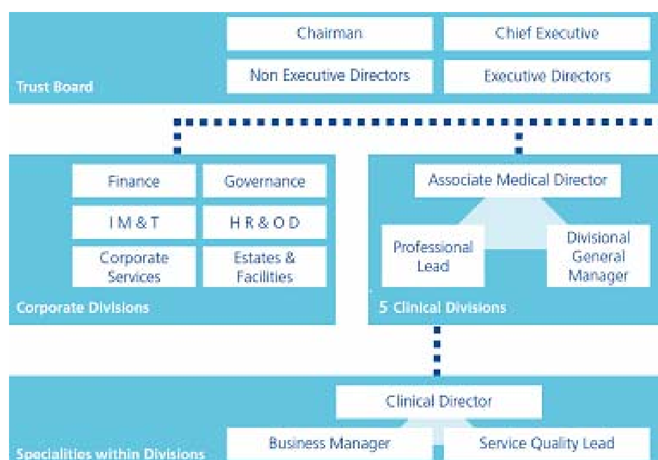
5.3 The Trust Board is led by the Chairman of the Trust, and comprises Executive and Non-Executive Directors. As a 'unitary Board', Executive and Non-Executive Directors share equal responsibility for the Board's decisions, and both share responsibility for the direction and control of the organisation.

5.4 The Board consists of Executive and Non Executive Directors. The Executive Directors lead the operation of the Trust on a daily basis and each have portfolios reflecting their specialist areas of responsibility and expertise. The Non Executive Directors are led by the Chairman and are appointed by the Secretary of State for Health as representatives of the local community.

5.5 The responsibilities of the key roles at Trust Board level can be summarised as follows:

- Chairman – leadership of the Board – its capability, processes and interactions.
- Chief Executive – accountable to the Board for the Trust's performance as Accounting Officer of the Trust.
- Executive Directors – reporting on their accountabilities, acting as NEDs in other areas.
- Non-Executive Directors – monitoring executive activity in executing and building capability and contributing to the development of strategy and stakeholder engagement.

5.6 The relationship between the Executive and Non-Executive Directors and the clinical and corporate divisions is shown in the organisational chart below.



5.7 It is essential that the organisation has a highly effective and efficient Board that has the skill and competence to drive and lead the organisation's strategic agenda.

5.8 It is widely acknowledged that effective boards that have the ability to do this are the product of four factors:

1. Getting the balance right between trust and challenge in the boardroom
2. A healthy relationship between chair and CEO
3. Capable board members
4. Clarity of roles, both at the individual level and the board as whole.

5.9 In order to contribute to these four factors, board members should have the following underpinning capabilities:

- insight into the organisation
- awareness of the organisations environment
- clarity of role
- personal values and motivation
- personal style
- personal development and learning

5.10 ELHT has specific skill set requirements for its board members in addition to the broader capabilities that define functional Boards. These have been developed by the Company Secretary based upon research and best practice.

5.11 They are the skills that should be demonstrated by the whole board and are identified in the table below:

Strategic vision	Clinical Expertise
Commercial awareness	Political awareness/ astuteness
Performance management	Ability to engage with stakeholders
Financial management	IT and HR awareness
Understanding of regulatory framework	Change transition awareness

5.12 Previous board reviews from 2008 undertaken by the Institute of Directors, the Audit Commission and Chantrey Vallacott DFK involved one to one structured interviews, desktop reviews, board challenge and observations.

5.13 These reviews found that the Executive Directors have strong commercial awareness and excellent knowledge of the Trust's business and the key strategic issues which may influence it.

5.14 To strengthen the Trust's leadership further in 2011/12, a comprehensive development programme has been devised for the Board which incorporates a variety of tools including:

- The NW Leadership Academy Aspiring and Existing Foundation Trust Non-Executive Director Development Programme 2011
- The NW Leadership Academy Board Development Guide
- The NHS Institute for Innovation and Improvement Board Development Tool (BDT)
- Leadership Qualities Framework 360° profile (LQF)
- Occupational Personality Questionnaire (OPQ)
- Myers Briggs Type Indicator (MBTI)
- The Aston University ATPI tool

5.15 In addition to the above, the Board continues to receive regular performance reports which directly provide assurance on quality of care; this includes infection prevention, mortality, length of stay, complaints and incidents. The Board also receives information about patient experience from benchmarked national surveys and regular local surveys. External validations of patient safety, risk and quality are also received from the Care Quality Commission and NHSLA. Board members also actively engage in patient safety walk rounds on wards and departments giving

them the opportunity to obtain assurance from frontline staff, and discuss care face to face with patients, relatives and carers. Nurse sensitive indicators and other quality reports are considered by sub-committees of the Board chaired by Non-Executive Directors.

5.16 The Board manages risk via the Trust's Assurance Framework which highlights any potential operational risks to quality and performance, ensuring that the Board have the information necessary to make sure that adequate risk control measures and mitigation plans are in place.

5.17 The Board also reviews the Trust's five year cost improvement plans on a regular basis which includes quality impact assessments for schemes. The Quality and Governance Board Memorandum is nearing completion and will be considered by the Board shortly, and the Trust has received full assurance from internal audit on its Assurance Framework and systems of internal control.

5.18 Feedback on patient experience is also gathered through real time monitoring and by 'enter and view' visits from the local LINk which report back to the Board via the governance structure. The Board also receives assurance on CQUIN indicators and progress against quality initiatives in which ELHT has an involvement, for example, the North West Mortality Collaborative, Advancing Quality and Safety Express initiatives.

5.19 Over the life of this plan the key objectives of the ELHT Board are to ensure that:

- Board development continues and rigorous governance processes continue to be embedded;
- Key skills are developed throughout the organisation e.g. team development, resilience and change management etc; and
- The Board and the organisation's management skills are developed to strengthen leadership, increase commercial awareness and promote shared learning between key internal and external stakeholders.

5.20 The ELHT Board aim to maintain an organisation where

Patients will:

- Experience their care as designed around their needs and preferences.
- Be cared for within clear care pathways based upon the best clinical evidence.

The Trust will be:

- Commercially responsive to market opportunities and to public expectations.
- Business and profit oriented but in a way that enables the Trust to provide better services for patients.
- Focused on relevant research and teaching as well as service delivery.
- 'A brand' that the public, patients, staff and potential recruits recognise and respect.
- Demanding high performance and a disciplined approach from all parts of the organisation.

Clinicians will be:

- More closely involved in planning for the future.
- Given more control over the future development of their services under a system of 'earned autonomy'.
- More productive and less accepting of clinical inefficiency, more willing to challenge each other.
- Feeling they have the power and influence to change those aspects of the Trust's environment that are not conducive to them working efficiently and effectively.

Managers will be:

- Working under the direction of senior clinicians.
- Working with much greater responsibility and accountability for delivery.

- Taking more risks but from a basis of better evidence about the consequences of alternative courses of action.
- Feeling that they have the time and space to realise new opportunities.
- Taking more accountability for team and individual aspects of their roles as well as the task delivery aspects.
- Developing and delivering high performance.

Support staff will be:

- Proud to work in the Trust.
- Working with a greater depth of understanding of what is expected of them and why and how the part that they play contributes to the overall plans for development of the Trust and its services.

Hazel Harding
Chair

Mark Brearley
Chief Executive

Approved on behalf of the Board of Directors by:

Name	Hazel Harding Chair East Lancashire hospitals NHS Trust

Signature Hazel Harding

Date 8th June 2011