Supporting all NHS Trusts to achieve NHS Foundation Trust status by April 2014

Tripartite Formal Agreement between:

- University Hospital North Staffordshire NHS Trust
- NHS West Midlands
- Department of Health

Introduction

This tripartite formal agreement (TFA) confirms the commitments being made by the NHS Trust, their Strategic Health Authority (SHA) and the Department of Health (DH) that will enable achievement of NHS Foundation Trust (FT) status before April 2014.

Specifically the TFA confirms the date (Part 1 of the agreement) when the NHS Trust will submit their "FT ready" application to DH to begin their formal assessment towards achievement of FT status.

The organisations signing up to this agreement are confirming their commitment to the actions required by signing in part 2a. The signatories for each organisation are as follows:

NHS Trust – Julia Bridgewater, Chief Executive Officer
SHA – Ian Cumming, Chief Executive Officer
DH – Ian Dalton, Managing Director of Provider Development

Prior to signing, NHS Trust CEOs should have discussed the proposed application date with their Board to confirm support.

In addition the lead commissioner for the Trust will sign to agree support of the process and timescales set out in the agreement.

The information provided in this agreement does not replace the SHA assurance processes that underpin the development of FT applicants. The agreed actions of all SHAs will be taken over by the National Health Service Trust Development Authority (NTDA)[1] when that takes over the SHA provider development functions.

[1] NTDA previously known as the Provider Development Authority – the name change is proposed to better reflect their role with NHS Trusts only.

The objective of the TFA is to identify the key strategic and operational issues facing each NHS Trust (Part 4) and the actions required at local, regional and national level to address these (Parts 5, 6 and 7).

Part 8 of the agreement covers the key milestones that will need to be achieved to enable the FT application to be submitted to the date set out in part 1 of the agreement.

Standards required to achieve FT status

The establishment of a TFA for each NHS Trust does not change, or reduce in any way, the requirements needed to achieve FT status.

That is, the same exacting standards around quality of services, governance and finance will continue to need to be met, at all stages of the process, to achieve FT status. The purpose of the TFA for each NHS Trust is to provide clarity and focus on the issues to be addressed to meet the standards required to achieve FT status. The TFA should align with the local QIPP agenda.

Alongside development activities being undertaken to take forward each NHS Trust to FT status by April 2014, the quality of services will be further strengthened. Achieving FT status and delivering quality services are mutually supportive. The Department of Health is improving its assessment of quality. Monitor has also been reviewing its measurement of quality in their assessment and governance risk ratings. To remove any focus from quality healthcare provision in this interim period would completely undermine the wider objectives of all NHS Trusts achieving FT status, to establish autonomous and sustainable providers best equipped and enabled to provide the best quality services for patients.

Part 1 - Date when NHS foundation trust application will be submitted to Department of Health

1 January 2014

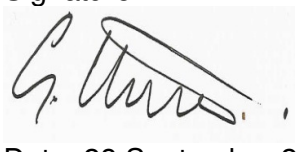
Part 2a - Signatories to agreements
By signing this agreement the following signatories are formally confirming:

- their agreement with the issues identified;
- their agreement with the actions and milestones detailed to support achievement of the date identified in part 1;
- their agreement with the obligations they, and the other signatories, are committing to;

as covered in this agreement.

Julia Bridgewater Chief Executive University Hospitals of North Staffordshire	Signature  Date: 28 September 2011
Ian Cumming OBE Chief Executive NHS West Midland	Signature  Date: 28 September 2011
Ian Dalton	 Signature Date: 30 September 2011

Part 2b – Commissioner agreement
In signing, the lead commissioner for the Trust is agreeing to support the process and timescales set out in the agreement.

Graham Urwin Chief Executive of Staffordshire Cluster	Signature  Date: 28 September 2011

Part 3 – NHS Trust summary

Short summary of services provided, geographical/demographical information, main commissioners and organisation history.

Current CQC registration (and any conditions): The Trust is registered with the Care Quality Commission (without conditions), and has been registered since April 2010.

Financial data (figures for 2011/12 based on latest forecast)

	2009/10 - £m	2010/11 - £m	2011/12 £m
Total income	408.9	418.1	415..0
EBITDA	29.1	21.0	21.3
Operating surplus\deficit	-62.5	2.1	-97.0
Operating surplus\deficit - Before Impairments & IFRS adjustments	5.6	4.1	1.6
CIP target	18.5	22.0	24.0
CIP achieved recurrent	16.7	19.7	17.6
CIP achieved non-recurrent	0	0	9.0*

The Trust has identified 117.2 % of the £24m CIP target recurrently as at August 2011. £17.6m of this will be achieved in the current financial year. This therefore leaves a gap on CIP to identify of £6.4m*. In addition changes to the contract has added a further £2.6m* to the non-recurrent target to achieve this year. Plans are being reviewed and additional plans developed to ensure that the Trust meets the financial target.

In 2010/11 the Trust identified 90% of the £22m CIP target recurrently. The balance (£2.3m) to the full target was made non- recurrently. In line with the Trust policy only recurrent savings are recognised and reported internally. However in achieving the control total non-recurrent savings were delivered.

In 2009/2010 there is a very large difference between the retained deficit for the year under IFRS of £62.5m and the Trust's performance against the statutory break even duty (a surplus of £5.6m) because:

- The value of the Trust's land and buildings has been reduced significantly as the result of a professional valuation. This reduction is attributable to a general fall in land and building values and the Trust's plans to move out of its old buildings into the maternity and cancer building and other new buildings currently being built as part of the PFI scheme.
- The treatment of the PFI scheme in the accounts under IFRS is very different from the treatment in previous years.

The NHS Trust's main commissioners The Trust's main Commissioners are NHS Stoke on Trent and NHS North Staffordshire for secondary acute care and West Midlands Specialised Services Commissioners for tertiary acute care.

Summary of PFI schemes (if material) The Trust is currently taking forward a capital development programme that will redevelop the City General site to co-locate all acute services. The plans have been developed as part of a whole health economy reconfiguration of acute and community services. The scheme consists of a new building to accommodate maternity and oncology services, which was completed in 2009, and a new hospital and refurbishment of some retained buildings will take place as part of a Private Finance Initiative (PFI) (scheme capital cost £274m). Overall this will provide new emergency services, an outpatient centre, theatres, critical care and inpatient services. The new hospital will operate with 1,018 beds (with the potential to grow by 16 subject to commissioned business cases). As a result of the reconfiguration of the PFI scheme the Trust needs to fund an additional £40m of capital expenditure to ensure that the hospital can operate as an integrated unit. The PFI also included a £30m development of a community hospital in North Stoke which is managed currently by NHS Stoke on Trent.

Further information
The University Hospital of North Staffordshire (UHNS) is located on the border of Stoke-on-Trent and Newcastle-under-Lyme. It is one of the largest acute, general hospitals in the West Midlands and currently operates over 3 sites, the Royal Infirmary, Central Outpatients and the City General site.

UHNS became a NHS Trust in 1993 and was awarded teaching status in 2003. As a small but growing

Teaching Hospital the Trust is continuing to develop a portfolio of research, development and innovation to improve services. The Trust has strong links with Keele University including the Medical School.

UHNS is the main provider of acute, general hospital services to a population of approximately half a million people living in and around North Staffordshire. The Trust is one of four major tertiary centres in the West Midlands providing a range of specialist services to a wider population of around three million. The Trust has a turnover in excess of £418m per year a workforce of 6,763 whole time equivalents (as per Annual Accounts 2010/11).

The Trust provides a full range of general acute services, as well as the following specialist or tertiary services: cancer diagnosis and treatment, bone marrow transplants, cardiothoracic surgery, neurology and neurosurgery, complex orthopaedic procedures (including spinal surgery), renal and dialysis services, neonatal intensive care and paediatric intensive care. The Hospital is recognised for its particular expertise in respiratory conditions, spinal surgery, upper gastro-intestinal surgery, laparoscopic surgery and management of liver conditions.

The Trust operates the busiest Accident and Emergency Department in the region and in 2010/2011 over 100,000 people attended this department. Emergency care accounts for just under half of inpatient activity provided by the Hospital. As well as local emergency patients, trauma cases from outside the local area are brought by land and Air Ambulance from traffic accidents and other incidents.

Part 4 – Key issues to be addressed by NHS trust

Key issues affecting NHS Trust achieving FT	
Strategic and local health economy issues	
Service reconfigurations	☒
Site reconfigurations and closures	☒
Integration of community services	☐
Not clinically or financially viable in current form	☐
Local health economy sustainability issues	☐
Contracting arrangements	☐
Financial	
Current financial Position	☒
Level of efficiencies	☒
PFI plans and affordability	☒
Other Capital Plans and Estate issues	☒
Loan Debt	☒
Working Capital and Liquidity	☒
Quality and Performance	
QIPP	☒
Quality and clinical governance issues	☐
Service performance issues	☒
Governance and Leadership	
Board capacity and capability, and non-executive support	☒

Please provide any further relevant local information in relation to the key issues to be addressed by the NHS Trust:

Strategy and Local Health Economy

The Fit for the Future (FFtF) programme aims to reshape the way in which healthcare is provided through moving care closer to home and providing acute hospital services from a single site in Stoke. The programme was reviewed in 2010 to ensure that the efficiencies required within the acute services and the reduction in the demands on acute services were secured. As a result a new programme structure and leadership were put in place. Whilst risks remain, the changes have resulted in stronger clinical leadership and a greater focus across the health community. The Trust Board has allocated significant resources to ensure delivery of the programme over the next 12 months.

The Trust has been reviewing its Strategic Direction with the full engagement of primary and secondary care clinicians and key stakeholders including social care, GP Commissioning leads, local authorities,

PCTs, the universities, patients and the public. This has resulted in the approval by the Board and publication of the Trust's Strategic Framework for 2011-15. The strategy will be translated into the Trust's five year Integrated Business Plan (IBP).

The Trust provides a number of tertiary services and is currently engaged in the review of trauma centres across the West Midlands. Securing the designation of UHNS as a Trauma Centre is critical in UHNS continuing to be a tertiary centre providing a range of specialist services including neurosciences and cardiac surgery. It is also important in UHNS's development as a teaching and research centre.

As a tertiary centre and the largest acute hospital in the area, The Trust continues to work closely with a number of other acute trusts. This includes supporting Mid Staffordshire NHS Foundation Trust , for instance, the provision of surgical and pathology services The Trust is also taking a key role in the formation of a Pathology network spanning several Trusts.

The Trust has an important role in providing leadership within the health and social care community. In addition, as one of the largest employers within North Staffordshire, the Trust plays a key role in the local economy. The Chair and CEO are currently undertaking a series of meetings with all key stakeholders to discuss how best to work together in the future.

Finance

The most significant financial challenge facing the Trust is that it needs to achieve very significant reductions to its existing cost base as:

1. Income is expected to fall as a result of Fit for the Future and changes to tariff
2. There is a significant increase in the PFI unitary payment over the next two years.

Short Term Financial Position

The Trust has a recurrent CIP target of £24m. £28.2m of recurring schemes have been identified so far (at Aug 2011), £17.6m of which will be achieved in the current financial year. This, therefore, leaves £6.4m to be identified. Changes to the contract have added a further £2.6m to the non-recurrent target to achieve this year. Plans are being reviewed and additional plans developed to ensure that the Trust meets the financial target.

The Trust achieved the £4.1m control total in 2010/11 and therefore cleared the historic deficit from 2005/06.

Negotiations for the 2011/12 SLA are complete but currently the position for the financial year 2011/12 is:

1. The CIP will be £24m - £28.2m of schemes have been identified so far (£17.6m part year effect). It is acknowledged that UHNS has both the opportunity and requirement to increase its internal efficiency with particular regard to acute length of stay. The recent McKinsey benchmark review identified some opportunities but not significant areas to exploit efficiencies.
2. The PCTs have assumed in their plans their QIPP Schemes will take out £20m or approximately 7.8% of activity in year one. Whilst this is consistent with the FftF plan it represents a rollup of previous year's non delivery into the final year.

2011/12 sees the ramp up of the major retained estate capital programme and occupation of many of the new PFI buildings on the City General site and progression of plans to vacate the North Staffordshire Royal Infirmary site. This will require savings targets to be achieved, a capital loan and the ability to retain all land sale proceeds.

Longer Term Financial Position (2012/13 to 2015/16)

The longer term financial view predicts a further year (2012/13) of significant cost improvements to be delivered due to the impact of the changes resulting from implementing Fit for the Future and the ramp up of the unitary charge. The financial horizon improves as the local health economy reaches a steady state from 2013/14.

If the Trust achieves its savings targets it should not require a working capital facility over the next 12 months.

Extract from LTFM

	2011/12	2012/13	2013/14	2014/15	2015/16
Income	415.1	400.0	388.0	390.3	389.2
Expenditure	510.3	417.7	376.8	375.9	374.7

Surplus / (Deficit)	-95.2		-17.7		11.2		14.4		14.5
Adjustment for Impairment	98.5		25.3		0.0		0.0		0.0
Other Adjustments	-1.7		-5.1		-6.2		-6.4		-6.5
Adjusted Surplus / (Deficit)	1.6		2.5		5.0		8.0		8.0
CIP Assumed in Expenditure	24.0		47.0		15.3		15.7		15.7
CIP as % of Income	5.8%		11.7%		3.9%		4.0%		4.0%

Income Per LTSM Summary 18th March 2011, plus £3m non-recurring SCR 12/13and reflecting the £10m of saving identified as already assumed in the cost base.

In order to mitigate the CIP risks for 2011/12 and 2012/13 the Trust has engaged Deloittes/Finnamores management consultancy as external advisers to provide assurance and drive productivity/cost reductions. The team started in April 2011 and have worked with the Trust to develop additional productivity and cost reduction plans. The level of CIP in 2012/13 at 11.7% is significant and will present a challenge to deliver. Key to delivery will be the health economy wide QiPP programme to reduce demand for hospital based acute services enabling the Trust to reduce capacity and therefore costs. The cost base for 2012/13 has already been reduced by £10m to take account of changes related principally to FftF/PFI issues. Considerable work has been undertaken to test the validity of the 2012/13 position. There are three drivers to this level of cost improvement:

PFI Ramp up of UP	£18m
Loss of Income	£15m
Tariff Changes and Cost pressures	£14m
Total	£47m

The LTSM/LTFM already includes £12m of transitional Strategic Change support. The McKinsey benchmarking element of the recent review identified some but not significant opportunities for improvement in efficiencies. Especially as this was based on 2009/10 data and the Trust has since that time identified £48m of recurrent savings. It is clear that if the level of income projected is maintained, on its own the transitional support will not be sufficient to deliver the financial performance required. The Cluster is leading a process to determine the level of Strategic Change Reserve required to smooth the level of CIP in 2012/13 and beyond. The process is system wide and is providing a balanced focus not only on the acute Trust but also the Partnership Trust and social care.

PFI

A national financial review of Trusts with a PFI hospital has been commissioned to gain a common understanding of any issues that might be an obstacle to passing the financial elements of the FT assessment process. The Trust is still awaiting the outcome of the McKinsey Review. Our own analysis of our estate costs, largely driven by the unitary payment, is indicating that our costs are considerably higher than comparable Trusts. Once the outcome of the McKinsey Review is known we will incorporate this into our work as we seek to identify solutions to the exceptional financial challenges facing the Trust.

Financial Risk Ratings (FRR)

Resolution of the capital loan and capital receipt issue will support the Trust in achieving a liquidity ratio of 3. However resolving these issues on their own will not secure the Trust FRR. There is a requirement to deliver £47m CIP in 2012/13 which at 11.7% of projected turnover is not deliverable and therefore requires the Cluster led piece of work to resolve.

Capital

The Trust has a significant development of retained estate c£40m over the next 2 years. If the Trust achieves its savings target, it will still require a capital investment loan for 4 years from 2012/13. Key to this programme is the Renal Scheme which enables the Trust to vacate the Royal Infirmary earlier than originally planned thus releasing savings in advance. As we are unable to apply for the loan until the year it is required, and we do not need the loan until 2012/13, and the schemes needed to start in 2011/12 the Trust Board has approved the contracts to be let on these schemes. At stake for the Trust, apart from the clear benefit to patients, is the opportunity to bring saving forward by 2 years amounting to £3m pa.

Support Required

Support is requested in four specific areas:

1. That the contractual arrangements across the local health economy support the changes in the way that healthcare is delivered and that the risks in making these changes are appropriately managed and that depending on the outcome of 2012/13 SLA agreement that additional non

recurrent support will be required.

2. Approval of a capital investment loan from 2012/13 to enable the release of the Renal Scheme to facilitate the Trust to vacate the NSRI site early.
3. Flexibility in allowing the Trust to retain the land sales proceeds for the NSRI in line with the original FBC.
4. That once the review by McKinsey is received and the PFI categorisation known that the Trust work with the LHE and the SHA to identify solutions

Governance and Leadership

An interim Chair was appointed for 12 months from 14 November 2010 and was made substantive in August 2011. The Trust has appointed an interim Director of Finance commencing in October 2011 whilst going out to re-advert for a substantive appointment.

The Board completed a capacity and capability review in January 2011. As a result, the structure and reporting mechanisms of the Board and its Sub Committees have been revised to emulate that of a Foundation Trust. The revised arrangements were operational from 1 April 2011. There is clear Executive and Non-Executive Director leadership for the Trust's governance framework along with robust reporting and assurance frameworks. These frameworks are now further enhanced following the capacity and capability review and the associated Board and Sub Committee restructure.

The Board will continue to develop clinical leadership capability and capacity within the Trust. It will achieve this by building on the existing Service Line Management Programme and Clinical Leadership OD Programme. This will include aligning the objectives and job plans of the Trust's clinical leaders with both the organisation's and wider health economy strategies.

The Board are making good progress with Membership and have an established Health Panel of members of the public and very active public engagement. The plan is to work to develop a shadow governor group during 2012.

The Trust is implementing a Quality Assurance Framework linked to the revised Strategy. This will bring together all the aspects of patient safety and quality improvement and allow the Trust to meet the Quality Governance criteria demonstrating that quality drives the Trust strategy.

Part 5 – NHS Trust actions required

Key actions to be taken by NHS Trust to support delivery of date in part 1 of agreement	
Strategic and local health economy issues Integration of community services	☐
Financial Current financial position	☒ **Plan to deliver 2011/12 plan agreed.**
CIPs	☒ **External support to deliver CIP in 2011/12 actioned. Significant progress for 2012/13 (circa £18m) but not the £47m required.**
Other capital and estate Plans	☒**Loan requested, cash forecast maintained to identify internally generate cash of £20m. Renal scheme just received SHA approval.**
Quality and Performance Local / regional QIPP	☒
Service Performance	☒
Quality and clinical governance	☐
Governance and Leadership Board Development	☒
Other key actions to be taken (please provide detail below)	☒

Describe what actions the Board is taking to assure themselves that they are maintaining and improving quality of care for patients.

Quality and Performance

The Board is satisfied that by using its well established internal governance processes (supported by the Care Quality Commission information and a comprehensive range of external reports and assessments, including public comments), the Trust has, and will continue to have effective leadership arrangements for the purpose of monitoring and continually improving the quality, safety and patient experience provided to its patients. Quality and safety are key drivers within the Trust and is committed to ensure the highest quality in all aspects of service provision. Within our quality strategy, the Trust has identified three key dimensions of quality to continually improve the services we provide. These are patient safety, patient experience and clinical effectiveness. Our priorities for improvement are outlined in our Quality Account for 2010/11 and are aligned to these key dimensions. These include:

- Leading Improvements in Patient Safety (LIPS)
- Safety Express – we are a pilot site for the Department of Health during 2011/12
- CQUINs
- Quality impact assessment on cost improvement schemes

The Trust is due to begin the phased move into the new hospital buildings from November 2011 through to September 2012. The Trust has a large Transformation Programme in place and is committing significant management resource to achieve this move as smoothly as possible and mitigate / manage any risks to the quality of service provided.

The Trust has plans to ensure service delivery is improved in respect of all service performance, but with a particular focus on infection control; access to services (18 weeks; A&E and 62 day cancer waits), delayed transfers of care. In relation to 18 week delivery, the Trust is taking part in the national spinal review as this remains the greatest risk to 18 weeks.

Please provide any further relevant local information in relation to the key actions to be taken by the NHS Trust with an identified lead and delivery dates:

(Leads identified in Part 9.)

Part 6 – SHA actions required

Key actions to be taken by SHA to support delivery of date in part 1 of agreement	
Strategic and local health economy issues Local health economy sustainability issues (including reconfigurations)	☐
Contracting arrangements	☐
Transforming Community Services	☐
Financial CIPs\efficiency	**X** ☐
Quality and Performance Regional and local QIPP	☐
Quality and clinical governance	☐
Service Performance	☐
Governance and Leadership Board development activities	☐
Other key actions to be taken (please provide detail below)	☐

Please provide any further relevant local information in relation to the key actions to be taken by the SHA with an identified lead and delivery dates.

The SHA will continue to work closely with the Trust to ensure it achieves its key milestones including appointment of a substantive Finance Director, a robust long term financial strategy and delivery of underlying financial balance.

To work with the Trust and the DH to secure approval of a capital investment loan from 2012/13 to enable the release of the Renal Scheme to facilitate the Trust vacating the NSRI site early. The Trust will be seeking approval to retain the land sales proceeds for the NSRI in line with the original FBC.

he SHA is contributing to the national work on PFI and will work with the Trust in resolving the outstanding PFI issues as a result of the national financial review.

Part 7 – Supporting activities led by DH

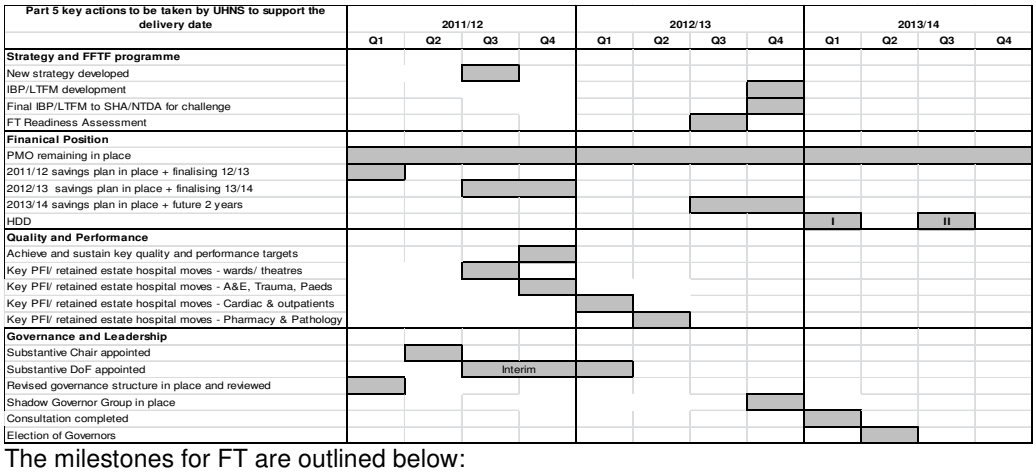
Actions led by DH to support delivery of date in part 1 of agreement	
Strategic and local health economy issues Alternative organisational form options	☐
Financial NHS Trusts with debt	☐
Short/medium term liquidity issues	☐
Current/future PFI schemes	**X**☐
National QIPP work streams	☐
Governance and Leadership Board development activities	☐
Other key actions to be taken (please provide detail below	☐

Please provide any further relevant local information in relation to the key actions to be taken by DH with an identified lead and delivery dates:

A national financial review of Trusts with a PFI hospital is taking place to gain a common understanding of any issues that might be an obstacle to passing the financial elements of the FT assessment process. Some elements contained within the TFA will be subject to the outcome of this review in enabling any issues outlined in this agreement to be resolved. This will be confirmed on a case by case as the PFI work is completed and communicated.

Part 8 – Key milestones to achieve actions identified in parts 5 and 6 to achieve date agreed in part 1

The key milestones to deliver the actions outlined in parts 5 & 6 is outlined in the table below:



The milestones for FT are outlined below:

Date	Milestone
Jan-March 2013	Draft IBP/LTFM
Jan-March 2013	Assess and Challenge IBP/LTFM (one month)
March 2013	SHA Consultation Sign Off
May 2013	HDD Stage I starts
April 2013	Consultation starts
August 2013	Finalise IBP/LTFM
August 2013	SHA Approval Review
September 2013	FT Quality and Safety Assessment
October 2013	HDD Stage 2 starts
December 2013	SHA Recommend to Executive Board – 2nd B2B
January 2014	Submission of papers to DH

The SHA will follows its normal escalation process in the event of a key milestone being missed and no improvement achieved.

Key Milestones will be reviewed every quarter, so ideally milestones may be timed to quarter ends, but not if that is going to cause new problems. The milestones agreed in the above table will be monitored by senior DH and SHA leaders until the NTDA takes over formal responsibility for this delivery. Progress against the milestones agreed will be monitored and managed at least quarterly, and more frequent where necessary as determined by the SHA (or NTDA subsequently). Where milestones are not achieved, the existing SHA escalation processes will be used to performance manage the agreement. (This responsibility will transfer to the NTDA once it is formally has the authority)

Part 9 – Key risks to delivery

Risk	Mitigation including named lead
Strategy and financial viability risk The Trust faces a challenging CIP target this will be difficult to deliver.	**Lead: Director of Finance** To mitigate this risk the Trust has: • Held two events with teams in the Trust to identify schemes to reduce costs. The process had identified £18.8m, A further team event was held on 25 March 2011 to identify additional savings and was used to confirm and challenge the plans developed to date. • Secured external support to work with services to identify further cost improvements. This will include identification of any shortfall in the 2011/12 plan and the creation of savings plans for 2012/13. • As a result of these actions savings identified have increased to £28.2m (FYE £17.6 (PYE). • 2012/13 current planned CIP at £47m is not considered to be achievable without financial support • PFI costs, subject to the Trust continuing internal review and the outcome of the McKinsey work may prove to unsustainable. • If loan request in 2012/13 not approved Trust will run out of cash as a result of the capital programme.
Risk if Trauma Centre status not achieved.	**Lead: Chief Operating Officer** • Designated clinical and managerial leads to work with Specialised Commissioner and planning group on trauma centre status to understand level of risk and the implications of non-achievement • Developed partnership working with neighbouring providers in Wales and North West to ensure networking and understanding of future demand on UHNS. • Developing the Trust Strategic Direction and underpinning clinical strategies during 2011. This will include option appraisal and identification of risks.
Supporting Mid Staffordshire FT with clinical rotas increasing clinical and reputational risk.	**Lead: Director of Finance** • Clear structure of work through Surgical Strategic Alliance Programme. • Full time Project Manager in post linking with McKinsey Clinical Review. • Final decision on reconfiguration of services subject to Board approval at both UHNS and Mid Staffordshire FT.
Service delivery risks Bed reductions in acute care not achieved	**Lead: Chief Operating Officer** • Agreed overall bed reduction plan within UHNS and SLA agreed and led by Director of Operations, reporting to the Chief Operating Officer • Established performance management of bed reductions by the Health Economy Fit for the Future Steering Group. • Ensured all health economy Boards receive regular reports on bed reductions against planned reductions.
Key performance Indicators not achieved	**Lead: Chief Operating Officer** Strong performance management framework including: • Established A&E Action Group to manage patient flow and achievement of revised performance standards for A&E. • Established 18 week Economy Group continuing to focus on sustaining delivery. Part of the national review of spinal services. • Established Cancer Services Team and Operational Teams to ensure sustained delivery. • Sustained reductions in delayed transfers of care
Key quality targets not achieved / impact on quality of cost improvement requirements	**Lead Chief Nurse and Medical Director** • Formulated the MRSA improvement plan which is now in place to be supported by a new Lead Nurse appointment in April 2011. The Chief Nurse regularly reports on performance to the CEO. • CEO chairing Strategic Infection Control Group with local health economy and SHA representation to embed process and governance issues. This remains a key focus for the Trust Board. • Quality impact assessment carried out on 2011/12 CIP schemes and reported to SHA
Quality Governance risks Failure to implement the new Board and subcommittee structures will adversely affect the Trust's ability to provide an effective and robust	**Lead: Chief Executive** • Scheduled a Board Review of the new committee structure in Autumn 2011. • Tasked the Audit Committee to conduct an audit of the Assurance Framework in 2011/2012.

governance and assurance framework. Non-compliance with Monitor's Quality Governance Criteria.	**Lead:, Chief Executive** • Self-assessment and Internal audit assessment against standards used to develop the action plan for ensuring compliance with the new standards. • Readiness assessment to be commissioned.
Board capability risks Failure to recruit a substantive Chairman Failure to recruit a Director of Finance	**Lead: Strategic Health Authority/Appointments Commission** • Sought SHA help to mitigate risk and Chairman appointed in August 2011 **Lead: Chief Executive** • Recruitment was completed and post holder due to commence in September 2011. Postholder withdraw in July 2011 and interim Director of Finance appointed from October – March 2012. This will enable time to go through the recruitment / headhunting process once again (interviews October 2011).